

CLINICAL GUIDELINE

Managing Weight Gain Associated with Antipsychotic Medication in Adults

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Version History

Version	Date Issued	Reason for Change
V1	19/07/2024	New Guidance produced including changes following consultation through clinical policy group.
V1.1	21/11/2025	Additional information on measuring waist to height ratio added. Additional comment on accessing dietetics support for inpatient units added. Revisions following updates to NICE Guidance NG246 – overweight and obesity management.

SUMMARY

Patients of any age who are prescribed antipsychotic medication are at increased risk of obesity, hypertension, and type 2 diabetes mellitus; and psychotic illnesses are associated with a 10 year reduction in life expectancy. The purpose of this document is to describe the different treatment options for patients who are prescribed antipsychotics who gain weight. Not all patients who are prescribed antipsychotic medication will have a psychotic illness.

Ideally, when starting or changing an antipsychotic, BMI should be monitored weekly for the first six weeks, fortnightly to monthly for the subsequent six weeks, and six monthly thereafter.

Waist-to-height ratio should be measured in patients with a BMI below 35. Clinicians should be aware that there are lower thresholds for obesity for patients with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean heritage, as they are prone to central adiposity and their cardiometabolic risks occurs at lower BMI.

Ideally, when starting or changing an antipsychotic, glucose control should be monitored at 12 weeks, six months, then annually.

Offer lifestyle interventions in the first instance. For Wotton Lawn both Physiotherapists and Health and Exercise Practitioners can be consulted. For the GRIP team, discuss with Health and Exercise Practitioners. Physiotherapy may be able to advise on more complex cases. For other teams, details for referrals for lifestyle interventions can be found on G-Care. Consider “booster interventions” if weight loss plateaus or reverses. Do not discontinue lifestyle interventions even if additional interventions become necessary.

If lifestyle interventions are unsuccessful, consider switching to an alternative antipsychotic.

For patients prescribed clozapine or olanzapine; consider adding adjunctive aripiprazole 5mg OD.

Consider adjunctive metformin if lifestyle interventions and a change in antipsychotic are unsuccessful.

Consider orlistat for patients with a BMI above 28 kg/m² with risk factors for health comorbidities: or 30 kg/m² without comorbidities.

For patients with a BMI above 40 kg/m², consider asking their GP to make a referral to the specialist weight management service: but be mindful of their referral criteria.

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ABBREVIATIONS

Abbreviation	Full Description
BMI	Body Mass Index
GHC	Gloucestershire Health and Care NHS Foundation Trust
GRIP	Gloucestershire Recovery in Psychosis
RCTs	Randomized Controlled Trial

1. INTRODUCTION

This guidance is based on guidelines produced by the British Association for Psychopharmacology¹ (BAP) and NICE guidelines: “*Obesity: identification, assessment and management*”²; and “*Type 2 diabetes: prevention in people at high risk*”³. This guidance is adapted from Central and Northwest London NHS Foundation Trust’s “*Guidelines for the management of weight gain associated with antipsychotic treatment*”⁴, with the kind permission of the author.

Excess deaths from cardiovascular disease are a major contributor to the significant reduction in life expectancy experienced by people with psychotic illnesses such as schizophrenia, bipolar disorder, and persistent delusional disorder. Important risk factors in this are smoking, alcohol

misuse, excessive weight gain and type 2 diabetes.

Weight gain can have a negative effect on service users' views of themselves and is a factor in poor adherence with treatment. Being overweight and obese, partly driven by antipsychotic treatment, are important factors contributing to the development of diabetes and cardiovascular disease in people with psychotic illnesses. Antipsychotic medications are prescribed in non-psychotic illnesses; and can contribute to weight gain even in patients without a psychotic illness.

There have been clinical trials of many interventions for people experiencing weight gain when taking antipsychotics. The BAP guidelines¹ reviewed these trials and made consensus recommendations regarding appropriate interventions.

2. PURPOSE

This document is intended to provide guidance for the management of weight gain associated with antipsychotic treatment in patients over 18 years of age. This includes older adults (>65).

3. SCOPE

This guidance applies to all clinical staff working with patients aged 18 and over prescribed antipsychotic treatment. It is of particular relevance to prescribers.

4. DUTIES

General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aim to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to current, evidence-based policy documents.
- Appropriate training and updates are provided to support staff in their roles.
- Staff have access to equipment that meets safety standards and maintenance requirements.

Managers and Heads of Service will ensure that:

- All staff are aware of and have access to relevant policy documents.
- All staff are supported to access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency, and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Familiarise themselves with and adhere to relevant GHC policies and procedures.
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on [MCA Compliance below](#).

5. MENTAL CAPACITY ACT COMPLIANCE

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person is able to consent to the care, treatment or accommodation that is proposed. (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) [Mental Capacity Act 2005 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2005/9).
- Where there are concerns that the person may not have mental capacity to make the specific decision, complete and record a formal mental capacity assessment on the GHC Trust approved MCA forms. These are available as templates on clinical record systems and on the GHC intranet.
- Where it has been evidenced that a person lacks the mental capacity to make the specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 [Mental Capacity Act 2005 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2005/9). Evidence of Best Interests decision making must be provided on the GHC Trust approved forms. These are available as templates on clinical record systems and on the GHC intranet.
- Where a person is admitted to hospital for the treatment of a physical health condition and is assessed as being unable to consent to admission, care or treatment, an application for an Urgent DOLS Authorisation must be submitted to the Local Authority. This applies in all cases where the person lacks capacity, regardless of their compliance with or objection to their admission. Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) [Office of the Public Guardian - GOV.UK \(www.gov.uk\)](https://www.gov.uk).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the person's best interests by other people. To be legally binding the person must have been over 18 when the Advance Decision was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.

6. GUIDELINE DETAIL

6.1 Monitoring Physical Parameters before and during Antipsychotic Treatment

Body mass index (BMI) should be used to monitor whether an individual is becoming overweight or obese. This requires frequent measurement of weight prior to treatment and during the early stages of antipsychotic treatment. Where patients are compliant, this should be weekly for the first 4–6 weeks and then every 2–4 weeks up to 12 weeks; but, as a minimum, once every 4 weeks for the first 12 weeks of treatment. Weight (and BMI) should then be assessed at 6 months and at least annually thereafter unless the clinical situation demands more frequent assessment. This may not always be possible, particularly if patients are not compliant with monitoring. If the situation changes, then it is important to reconsider offering weight monitoring. For most patients in community settings, we would rely on patients to monitor their own weight, with prompting or advice from services. For inpatients, or outpatients attending clozapine or depot antipsychotic clinics, clinicians may be able to monitor weight changes directly.

In the long-term, blood glucose control should be monitored using glycated haemoglobin (HbA1c). However, as HbA1c provides a measure of longer-term control, in the early weeks of treatment, fasting or random plasma glucose may provide a more appropriate measure of glucose control. Glucose control should be further assessed at 12 weeks, 6 months and then annually. This may not always be possible, particularly if patients are not compliant with monitoring. If the situation changes, then it is important to reconsider offering glucose monitoring.

- If there is a change in antipsychotic, then re-visit the steps above.
- A number of simple leaflets are available for patients on these topics on the intranet:
 - Antipsychotics and weight gain: handyfactsheetweightgainantipsychoticsuk.pdf (choiceandmedication.org).
 - Keeping a healthy weight: handyfactsheetweightuk.pdf (choiceandmedication.org)
 - Metabolic Syndrome and the risks: handyfactsheetmetabolicsyndromeuk.pdf (choiceandmedication.org).

See also [Appendix 1: Managing weight in the context of severe mental illness](#): advice from the Specialist Weight Management Service at Gloucester Hospitals.

6.2 Lifestyle Interventions

The NICE clinical guideline on Obesity: identification, assessment, and management 2014, CG189, highlights that individuals with severe mental illness are at greater risk, and provides recommendations for practical interventions.²

Making Every Contact Count (MECC), Public Health England's recommended approach for lifestyle interventions, lists a set of five priority areas for behavioural intervention - all of which can assist in weight loss, either directly or indirectly. These are: healthy eating, physical activity, smoking cessation, reducing alcohol intake and mental well-being.⁵

The MECC approach entails multi-disciplinary involvement to support the patient effectively as well as signposting to support services and relevant activities in the patient's community. Public Health England has also reviewed the evidence and recommendations concerning obesity in adult mental secure units.⁶

Individuals with severe mental illnesses are at greater risk of developing obesity. The following have been synthesised from NICE and Public Health England guidance.

- Lifestyle interventions are recommended as first-line treatment, and “booster interventions” may be needed to maintain effect. These should usually be continued alongside additional interventions.
- Lifestyle interventions (mostly of the “behavioural lifestyle intervention” type) have a positive effect in the majority of RCTs. In most circumstances they should be continued in addition to any additional intervention.
- On average, these interventions reduce existing weight by approximately 3kg and BMI by approximately 1kg/m² versus control treatments.
- Lifestyle interventions attenuate weight gain in first-episode initiations of antipsychotics.
- There is no clear evidence regarding the optimal duration of engagement with such

interventions. The evidence regarding maintenance of effects is limited in both those with long-standing and first episodes of illness. “Booster sessions” may be required to maintain effects.

- A limited amount of evidence suggests that programmes work best if designed specifically for those with psychosis and if they combine elements of group and individual patient approaches.
- Physiotherapy can offer advice to complex cases under the care of community teams, at Charlton Lane, Berkeley House, Laurel House or Honeybourne. They are not currently commissioned to deliver lifestyle interventions.
- For patients admitted to Wotton Lawn, both the Physiotherapists and Health and Exercise Practitioners can offer advice.
- Inpatient services can access GHC dietetic input for advice.
- For patients under the care of the GRIP team, care coordinators can offer lifestyle advice and refer to health and exercise practitioners if further input is required.
- For other teams; information about referral to lifestyle interventions (Tier 2 weight management) can be found on G-Care.

6.3 Switching Antipsychotics

- If lifestyle interventions alone are not successful; consider switching to an antipsychotic with a lower association with weight gain.
- Data suggest that some antipsychotics are associated with a greater risk of weight gain than others:

Risk of Weight Gain	First Generation Antipsychotics	Second Generation Antipsychotics
Low	Fluphenazine, haloperidol, sulpiride, trifluoperazine.	Aripiprazole, amisulpride, lurasidone
Medium	Chlorpromazine hydrochloride, flupentixol, zuclopenthixol	Quetiapine, risperidone, paliperidone
High	-	Clozapine, olanzapine

- Clinicians must balance the possible benefit on weight of switching antipsychotic medication against the risks of relapse or deterioration of mental illness.

6.4 Adjunctive Aripiprazole

- For weight gain associated specifically with clozapine and olanzapine: adjunctive aripiprazole is recommended as a potential intervention (5mg daily). Do not use higher doses, these are not required to address weight gain, and as a partial agonist, higher doses will actively undermine the efficacy of the primary antipsychotic.
- Three RCTs of the effect of adding aripiprazole to clozapine or olanzapine found a mean difference in weight loss for aripiprazole of just over 2kg vs placebo. Only one study was of significant size.
- Do not use doses above 5mg to manage weight gain. Higher doses are not shown to have an effect on weight and may reduce the efficacy of clozapine or olanzapine (partial dopamine agonist effect).

6.5 Adjunctive Metformin

- NICE PH38 recommends that metformin can be offered to support lifestyle interventions to groups at high risk of diabetes.³ This should be considered in patients whose HbA1c or fasting plasma glucose blood test results have deteriorated in spite of switching to an alternate antipsychotic, and adjunctive aripiprazole (if appropriate), particularly if they have a BMI greater than 35.
- It should be explained to the patient that the use of metformin for this indication is off-label use and that this is specific to their need and not a medication for use in people who just want to lose weight. Informed consent should be documented.
- It can be initiated by GHC psychiatrists for inpatients. For patients in the community, the patient's GP should be asked if they would be willing to initiate and monitor its use.
- For patients in the community: confirm to the GP that the patient is aware that is an unlicensed indication and informed consent has been obtained and recorded. Provide the GP with details of the patient's latest weight and, where available, their weight prior to starting antipsychotics. The patient's GP should be asked if they would be willing to prescribe and monitor metformin use. An information sheet for GPs is available ([Appendix 2](#)).
- Start with a low dose (for example, 500 mg once daily) and then increase gradually as tolerated, to 1.5g-2g daily. If the person is intolerant of standard metformin, consider using modified-release metformin. Modified release metformin is significantly more expensive than immediate release formulations and should not be used in the first instance.
- Prescribe metformin for 6–12 months initially. Monitor the person's fasting plasma glucose or HbA1c levels at 3-month intervals and stop the drug if no effect is seen.
- Metformin prescriptions should only continue if weight loss of at least 3kg has been achieved or other significant clinical benefits have been seen after approximately 12 weeks, e.g. if previously gaining weight rapidly, this rapid weight gain has stopped. This should be explained to the patient before the treatment course is started.
- Explain to the patient that the need for continuing metformin treatment will be reviewed if the current antipsychotic is stopped, or the weight is regained. Metformin prescribing should be reviewed at least annually.
- Metformin has been compared to lifestyle intervention for weight reduction in a large 3-year RCT of people at high risk of diabetes in the general population.
- Metformin leads to a modest reduction in weight (approximately 2kg) over the short and long term but is less effective than intensive lifestyle intervention.
- In people taking antipsychotic medications, short-term trials have shown that metformin reduces weight, compared to placebo, by approximately 3kg.
- Metformin attenuates weight gain in first-episode initiations of antipsychotic medication by approximately 5kg, compared to placebo.

risk acknowledgement statement.

6.9 Referral to Specialist Weight Management Services

- Tier 2 Weight Management interventions (Lifestyle interventions) are first line interventions for all patients. Details can be found on G-Care: [Homepage | G-care \(glos.nhs.uk\)](https://www.glos.nhs.uk/g-care)
- Gloucester Hospitals Trust (GHT) operate a Tier 3 weight management service for patients with a BMI over 40. The service accepts referrals from GPs only.
- Patients accessing the weight management service need to be motivated and able to independently follow a weight management programme; and most patients with active symptoms of a psychotic illness would not be able to participate.
- The Weight Management Service have produced a “traffic light system” for potential referrals, as well as guidance for managing weight in severe mental illness. Please see the referral guidance documents in [appendix 4](#).

7. DEFINITIONS

BAP: British Association for Psychopharmacology

BMI: Body Mass Index

NICE: National Institute for Clinical Excellence

HbA1c: Glycated Haemoglobin

MECC: Making Every Contact Count

RCT: Randomised Control Trial

GHC: Gloucester Health and Care [NHS Foundation Trust]

GHT: Gloucester Hospitals NHS Foundation Trust

SPC: Summary of Product Characteristics

GLP-1 Agonists: Glucagon-Like Peptide-1 receptor Agonists

8. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	NO
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9. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

To support monitoring and learning from harm, staff should utilise the Trust’s Incident Reporting System, DATIX. For further guidance, staff and managers should reference the [Incident Reporting Policy](#). For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the [Duty of Candour Policy](#) and Intranet resources. Professional Duty of Candour and the overarching principle of ‘being open’ should apply to all incidents.

10. TRAINING

No additional training needs are anticipated.

11. REFERENCES

1. Cooper SJ, Reynolds GP, Barnes TR, England E, Haddad PM, Heald A, et al. BAP

- guidelines on the management of weight gain, metabolic disturbances and cardiovascular risk associated with psychosis and antipsychotic drug treatment. J. Psychopharmacol. 2016. 1-32. Available from: [BAP Guidelines-Metabolic.pdf](#)*
2. *NICE (2014) Clinical Guideline: Obesity: identification, assessment, and management. NICE CG189. London: National Institute for Health and Care Excellence: [Overview | Obesity: identification, assessment and management | Guidance | NICE](#)*
 3. *NICE (2012) Public Health Guideline: Type 2 diabetes: prevention in people at high risk. NICE PH38. London: National Institute for Health and Care Excellence: [Overview | Type 2 diabetes: prevention in people at high risk | Guidance | NICE](#)*
 4. *Central and North West London NHS Foundation Trust: 2019. Guidelines for the management of weight gain associated with antipsychotic treatment. 16 p.*
 5. *Public Health England. Making every contact count (MECC): implementation guide. London: Public Health England; 2018. 17p. Available from: [Making Every Contact Count \(MECC\): practical resources - GOV.UK \(www.gov.uk\)](#)*
 6. *Public Health England. Working together to address obesity in adult mental health secure units. A systematic review of the evidence and a summary of the implication for practice. London: Public Health England; 2017. 70 p. Available from: [obesity in mental health secure units.pdf \(publishing.service.gov.uk\)](#)*

Appendix 1 - Managing Weight in the Context of Severe Mental Illness – Information from the Specialist Weight Management Service

Managing weight in the context of Severe Mental Illness Helping your patient have the best chance of managing their weight:

Raising the subject:

- 1. Weight is a sensitive issue and the language used can impact upon the outcome –** approach the topic as sensitively as you can
- 2. Taking opportunities to promote a de-shaming, de-stigmatising understanding of weight can also have positive benefits,** particularly, on psychological health for people exposed to both the stigma of weight gain and mental health. For example, where someone may have had previous weight loss but been unable to maintain it: helping them to understand that weight regain is a normal response to weight loss, and which happens for the majority of people, can help to reduce feelings of personal failure.
- 3. Challenge misconceptions that weight “should” be controllable** - often, when faced with uncontrollable and traumatic life events, current stressors and multiple health and social issues, people wrongly believe that weight should be the one thing that they can control. Struggling to achieve weight loss, consistently focus on eating behaviours or repeatedly being pulled to what they recognise are not weight-friendly choices can then be internalised as a lack of will power or self-discipline, fuelling feelings of shame. These can then worsen symptoms of depression, cause binge eating or deliberate self-harm.

Taking a whole person approach:

- 4. Do they have weight related co-morbidities and, if so, are they as well managed as possible? How are they coping with their physical health conditions?** Consider conditions such as diabetes or sleep apnoea, is the person adhering to treatment? Are they feeling overwhelmed or depleted by the presence of both physical and mental health concerns, do they need more support to manage their physical health?
- 5. Are there other medications also contributing to weight gain?** Anti-depressants or pain relief for example? Is it possible to work in a joined-up way with other healthcare providers to help reduce or limit further weight gain?
- 6. Poor sleep increases weight – how is their sleep routine? Are they eating during the night?** Can sleep hygiene be improved? Help your patient to understand the link between poor sleep and increased weight can increase motivation to change habits.
- 7. Is there a possible eating disorder?** Where someone has an undiagnosed eating disorder, it is much harder to lose weight. Getting assessed and diagnosed can be

helpful in reducing the shame and stigma of repeated unsuccessful attempts at weight loss. Consider screening for Binge Eating Disorder or Bulimia to see if referral to the Eating Disorders Service is indicated.

8. Could weight be linked to trauma? If a background of trauma or abuse is known or strongly suspected, it may be that eating is a way to block or avoid difficult thoughts, feelings, or sensations and/or that higher body weight feels safer or protective. Where this is the case, attempting to work on weight can disrupt defences, exacerbating trauma symptoms. If advising lifestyle change, considering checking for binge eating, dissociated eating or increase in anxiety associated with weight loss (often with self-sabotage of weight loss and rapid weight regain).

9. Are weight behaviours part of a wider pattern of difficulties with self-regulation, personality disorder or impulse control? If so, it can be very difficult to engage in any lifestyle change. Helping someone to see the connections here can also help to de-shame or de-stigmatise the struggle they are having managing appetite, cravings or weight. Food may also be used to self-soothe/self-sedate – for example to become sleepy/get to sleep, so consideration may need to be given to how sleep can be achieved if this behaviour is disrupted.

10. Are eating episodes link to a wider pattern of self-harming behaviours? Episodes of uncontrolled or binge eating can be driven by urges to punish or hurt (e.g., eating until uncomfortably full or in pain) or destructive eating can feel the 'safest' form of self-harm. Consider assessing this, particularly, if the person is known to self-harm in other ways. Where this is present, support is needed to look at alternative coping mechanisms before food/weight should be addressed.

11. Is there any substance use/misuse adding to their difficulties – e.g., increased alcohol or cannabis?

Alcohol not only increases calories and weight but also reduces the ability to focus consistently on changing behaviours. Support to work on the relationship with alcohol would be important before recommending weight loss or lifestyle interventions. Similarly, where someone is heavily medicated, over-using prescription medications or taking other substances, this impairs ability to engage in treatment, develop insight and implement treatment goals.

12. Do what you can to limit hopelessness and foster a sense of agency or control- where patients are distressed by weight, but indications are that weight mgmt. treatment may not be helpful (due to the reasons listed above) helping the person take a holistic view of their weight can be helpful. Considering opportunities for the person to work on weight indirectly, through more manageable lifestyle changes like getting more sleep, can reduce feelings of hopelessness and contribute to wider wellbeing.

How to access lifestyle interventions in Mental Health Services?

Physiotherapists and Health and Exercise Practitioners support Wotton Lawn Hospital (adults

aged 18-65). The Gloucestershire Recovery in Psychosis community team (GRIP team) can also access Health and Exercise Practitioner support.

When should I refer to a specialist? Considering Weight Management Treatment or Bariatric Surgery

The relationship between weight and mental health is bi-directional. For many people living with both weight and complex mental health conditions, the severity of their symptoms stops them being able to engage in weight management treatment or get the best outcomes with their weight. Not being able to start treatment or struggling to achieve the desired outcomes can add to distress, worsen symptoms and result in further weight gain.

Misconceptions can also exist about the potential of interventions such as bariatric surgery and again, if this does not prove safe or suitable to consider, this can cause distress or fuel hopelessness, which can cause weight gain.

If referral to any weight management services is being considered, in order to get the best for your patient, please bear the following in mind:

- Engaging in a self-management offer such as Slimming World, Healthy Lifestyles Service or Specialist Weight Management Service requires that people are functioning well enough in their day-to-day life to be able to focus on their diet and exercise behaviours. If people are struggling to manage their activities of daily living because of the complexity of their mental health, it is unlikely that a self-management offer will be effective or helpful.
- Patients with strong cravings for carbohydrates and sugary foods can also struggle to self-manage, especially, where this is worsened by psychotropic medications. Please follow the prescribing guidance before considering referral to specialist services, where there will be a high demand for appointments.
- Patients who are struggling with emotional regulation, severe symptoms of low mood, deliberate self-harm or active symptoms of PTSD are also unlikely to be able to get much benefit from treatment.
- Where an eating disorder is suspected, a referral should be made to the Eating Disorders Service to have this assessed, diagnosed, and treated before referring for weight management.

Specialist Weight Management Service

Please ensure that mental health is as stable and well managed as possible prior to referring/requesting GP referral and that psychotropic medications with the least impact on weight are in place and well tolerated. Your patient also needs to be motivated to engage in treatment, capable of working with the team in sessions and carrying out homework tasks in-between sessions.

Unless there is urgent medical need to lose weight, patients with active symptoms of self-harm or suicidal ideation, untreated trauma (with active symptoms) or unstable mental health will most likely be deferred for further mental health support before assessment or treatment can be considered.

Referrals can be made by GPs via G-Care: <https://g-care.glos.nhs.uk/>.

Bariatric Surgery

Bariatric surgery can offer the best outcomes with regards to weight loss. However, careful management of nutrition and adherence to dietary guidance is essential for managing health and reducing risks post-operatively. Where patients may be unable to adhere to guidance the procedures are unlikely to be considered safe or suitable. Whilst severe and enduring mental health conditions per se should not be an exclusion-criteria for bariatric surgery, decisions regarding safety and suitability can only be made on a case-by-case basis.

There is evidence that, after bariatric surgery, people with complex mental health conditions may be more at risk of:

- Post-operative complications, including hospital admissions and emergency department visits
- Increased alcohol consumption
- Reduced absorption of essential psychotropic medications, causing relapses or increase in severity of symptoms and taking time to stabilise.

Psychotropic medications can also result in metabolic changes post-operatively, impacting upon outcomes.

Furthermore, whilst bariatric surgery can be hugely helpful in reducing weight, improving health and quality of life, weight loss can also impact upon relationships, changing the dynamics and resulting in strain or sabotage of weight loss. Changing relationships with food can have a knock-on effect to other habits (for example, some people find that they start shopping more when they eat less). Considering resilience to cope with changes is important when living with severe and enduring mental health conditions. Also, ensuring that people close to the patient are well informed and supportive.

If you are considering referring to the surgeons, helping your patient have a realistic view that surgery may not be a safe or suitable for everyone is helpful, to manage expectations before they have had a specialist assessment by the Bariatric Surgery Team.

Referrals can be made via G-Care: <https://g-care.glos.nhs.uk/>.

Appendix 2 - Prescribing Metformin for Patients on an Antipsychotic who have Gained Weight and have not responded to other Interventions: Information for GPs

Before considering metformin:

- There must be confirmation from the psychiatrist that:
 - Lifestyle behavioural changes have been tried.
 - If clinically appropriate, a switch to another antipsychotic with less potential to produce weight gain has been tried.
 - If clinically appropriate, adjunctive aripiprazole has been tried.
 - The patient has gained a minimum of 5kg since starting the antipsychotic treatment.
 - That the patient is aware that prescribing metformin solely to reduce weight or stop rapid weight gain is unlicensed. Verbal consent to metformin treatment should be recorded.
- Remind the patient that the continued prescribing of metformin will only occur if weight loss of at least 3kg has been achieved or other significant clinical benefits have been seen after approximately 12 weeks, e.g. if previously gaining weight rapidly, this rapid weight gain has stopped.
- Remind the patient that the need for metformin treatment will be reviewed by the prescriber if their antipsychotic is stopped or changed; or the weight is regained. There is a possibility that the metformin will be stopped at these reviews. Metformin will be reviewed at least annually.

There is a leaflet on the Choice and Medication website specifically written for patients on antipsychotics who need metformin to supplement diet and exercise as an approach to lose weight: [» Printable leaflets \(choiceandmedication.org\)](https://www.choiceandmedication.org/printable-leaflets)

A number of other leaflets are also available for patients on these topics on the Choice and Medication website:

- Antipsychotics and weight gain: [handyfactsheetweightgainantipsychoticsuk.pdf \(choiceandmedication.org\)](https://www.choiceandmedication.org/handyfactsheetweightgainantipsychoticsuk.pdf)
- Keeping a healthy weight: [handyfactsheetweightuk.pdf \(choiceandmedication.org\)](https://www.choiceandmedication.org/handyfactsheetweightuk.pdf)
- Metabolic Syndrome and the risks: [handyfactsheetmetabolicsyndromeuk.pdf \(choiceandmedication.org\)](https://www.choiceandmedication.org/handyfactsheetmetabolicsyndromeuk.pdf).

Prescribing should be in line with NICE diabetes guideline (CG87) and the British National Formulary. The key information is:

- The starting dose of metformin should be 500mg once daily, slowly increasing by intervals of at least 1 week (preferably longer, over two to three weeks) to a usual maximum of 2g/daily, based on tolerability (The licensed maximum dose is 3g/daily, but doses above 2g/daily may not be tolerated) in divided doses.
- Metformin requires periodic monitoring of renal function: at baseline and then at least annually. Those at high risk of renal impairment, or if deterioration of renal function is suspected, should be monitored at least 6-monthly. This is required due to an increased risk of lactic acidosis when renal function drops below a Glomerular Filtration Rate (eGFR) of 45ml/min/1.73m². Metformin should be avoided if eGFR drops below 30ml/min/1.73m².
- Advise patients to take metformin with or after food to minimise gastric side effects.
- Every face-to-face review of continuing metformin prescribing should be accompanied by reinforcing advice on healthy eating and physical activity to maximise the effect of the

intervention.

- Advise patients to avoid alcohol with metformin due to the rare risk of lactic acidosis.
- The summary of product characteristics for metformin recommends withdrawing or interrupting treatment in patients at risk of tissue hypoxia or deterioration of renal function, such as those with dehydration, severe infection, shock, sepsis, acute heart failure, respiratory failure, or hepatic impairment, or those who have recently had a myocardial infarction.

Basis for this advice

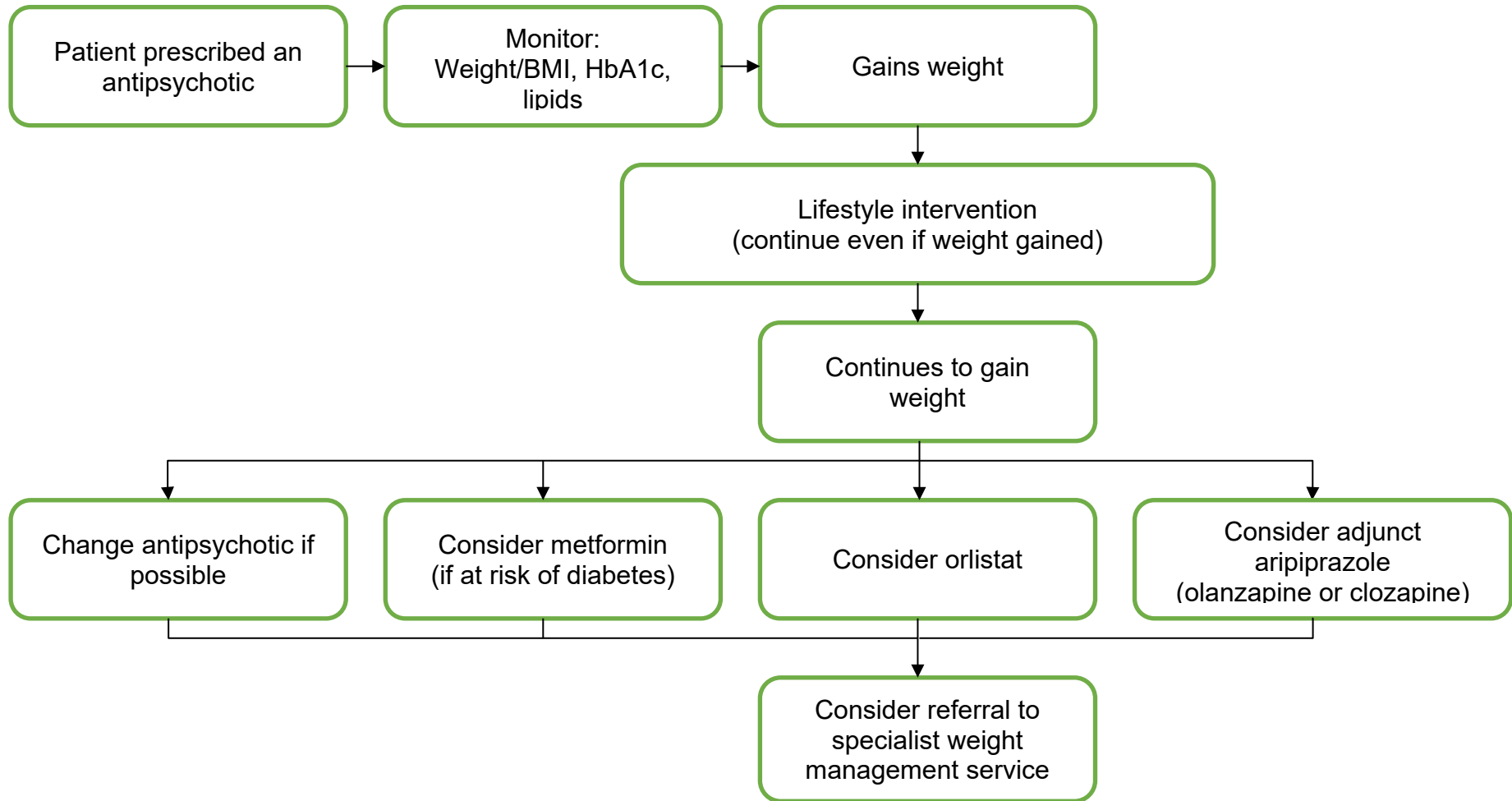
The British Association for Psychopharmacology (BAP) published guidance for managing weight gain for those taking antipsychotics. The main points of the guidance are:

1. Lifestyle interventions are recommended first-line and “booster interventions” may be needed to maintain their effect. These should usually be continued alongside other interventions.
2. If lifestyle interventions alone are not successful, consider switching to another antipsychotic with a lower propensity to cause weight gain.
3. Adjunctive aripiprazole is recommended as a possible intervention for weight gain associated with clozapine or olanzapine.
4. Metformin can be an option if lifestyle interventions, switching antipsychotics and adjunctive aripiprazole (if appropriate) have failed, and the patient is willing to take it outside of its licensed indication.

References:

1. Cooper SJ, Reynolds GP, et al (2016) BAP guidelines on the management of weight gain, metabolic disturbances and cardiovascular risk associated with psychosis and antipsychotic drug treatment. J Psychopharmacol 30:717-48.
https://www.bap.org.uk/pdfs/BAP_Guidelines-Metabolic.pdf
2. NICE (2012) Public Health Guideline: Type 2 diabetes: prevention in people at high risk. NICE PH38. London: National Institute for Health and Care Excellence.
<https://www.nice.org.uk/guidance/ph38>
3. NICE (2014) Clinical Guideline: Obesity: identification, assessment and management. NICE CG189. London: National Institute for Health and Care Excellence.
<https://www.nice.org.uk/guidance/cg189>

Appendix 3: Flowchart



Appendix 4: Traffic Light Guide for Referrals to the Specialist Weight Management Service

Referral Guidance for Tier 3 Weight Self-Management
More likely to benefit from the service and see clinical improvements in health
<ul style="list-style-type: none"> • Mild to moderate co-morbidity – as well managed as possible, with all appropriate treatment avenues explored and treatments optimised • Patient highly motivated and engaging well in Tier 2, but BMI over 40, so needs longer term support/more specialist care to sustain weight loss • Patient fully adherent with medical treatment for co-morbidities impacting upon weight • Patients who have had multiple previous attempts at commercial/dieting models and who are open to a self-management approach
Treatment outcomes likely to be adversely affected; limited intervention may be offered, with recommendations for further management.
<ul style="list-style-type: none"> • Any co-morbidities impacting on weight that are sub-optimally managed or have treatment outstanding • Suspected Binge Eating Disorder • Suspected lymphoedema or lipoedema • Evidence of poor adherence to medical regimen for conditions impacting upon weight • Difficulties engaging with services (e.g. recent multiple DNAs across a range of services) • Patients on any medication known to cause significant weight gain/increased appetite • Current difficult life circumstances (divorce, bereavement, redundancy, etc.) • Patients with multiple co-morbidities (often with limited mobility)
Unlikely to significantly benefit from treatment; potential for adverse effect or harm to some.
<ul style="list-style-type: none"> • End stage comorbidities that cannot be improved through treatment • Recent or active substance misuse (including over-use of prescription medication) • Moderate to severe difficulties with impulse control or emotional regulation as part of wider mental health or neurological difficulties • Acquired brain injury or intellectual disability limiting or preventing engagement with the team or model • Any highly symptomatic, untreated, or sub-optimally managed mental health conditions which impact upon ability to engage in treatment, patient or staff safety • Active symptoms of complex trauma and which may link to food behaviours/weight • Active symptoms of an Eating Disorder • High risk behaviours – e.g. dangerously non-adherent to treatment or medical advice