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Serious mental illness often brings rapid weight gain – but support is missing

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Being diagnosed with a serious mental illness like schizophrenia or bipolar disorder often brings an overlooked challenge: rapid and sustained weight gain. This side-effect can raise the risk of diabetes, heart disease and early death – widening an already stark life expectancy gap.

A new study my colleagues and I conducted, published in [The Lancet Psychiatry](#), is the largest and longest to track these changes in real-world settings. Analysing GP health records of over 113,000 adults in the UK between 1998 and 2020, we found that weight gain is not only common but predictable.

A 39-year-old newly diagnosed with schizophrenia or bipolar disorder can expect to gain 2kg in the first year and roughly 5kg within five years. Fifteen years on, the average increase is about 5.5kg. In comparison, people of the same age and gender without serious mental illness gained barely 1.5kg over the same period, on average.

Initially, we wondered if some early weight gain might reflect recovery – a bounce-back effect. People typically regain their appetite after a period of acute illness once they begin treatment. But in our study, most people were already overweight at diagnosis, and then gained enough weight to become obese over time. That shows the rise is a sustained, long-term increase, not a rebound related to recovery.

These patterns are not just statistical quirks; they reflect well-known physiological and social factors. Antipsychotics can trigger metabolic and appetite changes, and most people with a serious mental illness take these medications. In our study, people taking antipsychotics showed the greatest weight gain, an average of 5.9kg over 15 years.



People on antipsychotic medication gained the most weight. Gerdesk89/Shutterstock.com

But people who had never been prescribed them still gained substantial weight, averaging 2.5kg over the same period. Other factors also play a role, from social isolation and poverty to poor access to healthy food, exercise and regular routines – but our study could not monitor them because this data is not held in GP records.

We also examined whether people were getting help to lose weight. People with schizophrenia or bipolar disorder who were overweight or obese were around 10% more likely than the average overweight or obese person to be told to lose weight. Yet, despite their much higher risk of diabetes and heart disease, they were no more likely to be offered a place on a weight-loss programme. Only 4.5% had any record of a referral, compared with about 3% of people without mental illness.

The people most at risk of chronic conditions like diabetes and heart disease are being warned to lose weight, but not given help to do so. Community weight-loss groups can be effective – but without a referral, many people don't know they exist or can't get to them.

Mental health staff often have to focus on immediate psychiatric care: managing crises, stabilising symptoms, and keeping people safe. That leaves little scope for preventive physical healthcare. Meanwhile, in GP practices, staff may feel unsure how to approach weight loss with people who have complex mental health needs.

The result is a gap between policy and practice. National plans like the government's recently launched 10-Year Health Plan for England emphasise cardiovascular prevention for people with serious mental illness, but in everyday care many still slip through the cracks. This is not a uniquely British problem; health systems worldwide are struggling to deliver integrated physical and mental healthcare.

What needs to change

This pattern is not inevitable. Weight gain after a diagnosis of serious mental illness is predictable, measurable and, with the right action, preventable.

Our findings show that the years immediately after diagnosis are a critical window to act. Intervening within the first five years could reduce the risk of long-term obesity, diabetes and heart disease, improve quality of life, and narrow the life expectancy gap. It could also ease the strain on health systems already crumbling under rising rates of chronic disease.

Despite this potential, the common belief that people with schizophrenia or bipolar disorder cannot lose weight persists, and it is wrong. Effective support means intervening early with evidence-based care and regular follow-ups. Community weight-loss groups should fit the person, adapting to their changing mental health, medication side-effects, and everyday difficulties like getting to appointments.

People with mental illnesses deserve the same chance of good physical health as everyone else. If potential benefits are to be realised, primary care and mental health services must check weight at diagnosis, and refer patients with schizophrenia or bipolar disorder to tailored weight-loss programmes before rapid gains set in. This is essential to delivering on the ambitions of national plans for cardiovascular prevention in our most underserved communities.