

Healthcare professional perspectives on antipsychotic-induced weight gain: realist evaluation from the RESOLVE study

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Background

Weight gain is a common, distressing side-effect of antipsychotic medication prescribed for people with severe mental illness. National guidance for antipsychotic-induced weight gain (AIWG) encourages early intervention and physical health monitoring; healthcare professionals (HCPs) often struggle to implement these recommendations in routine care.

Aims

To explore how HCPs understand and respond to AIWG for patients.

Method

This realist evaluation, part of the RESOLVE project, builds on a realist synthesis. Thirty HCPs participated in realist interviews. A programme theory with nine context–mechanism–outcome configurations (CMOCs) was generated, explaining how HCPs perceive non-pharmacological care provision for patients with AIWG. Clinical and lived experience stakeholders reviewed and refined the theory and CMOCs.

Results

The nine CMOCs spanned three areas: (a) systemic and professional challenges; (b) strategies to enhance individualised and meaningful support; and (c) the role and limitations of non-professional support. HCPs described how lack of training, siloed services and system-level constraints limited their ability to offer

integrated care. They highlighted the importance of relational continuity, early and tailored conversations, and alignment with patients' values and motivations. Peer and family support were valued, but structural barriers undermined their consistent implementation.

Conclusions

AIWG was experienced as compromising professional values for HCPs working in mental health settings. Person-centred care was often undermined by fragmented systems, role ambiguity and insufficient training. These issues require investment in professional development, structural integration, and relationship-based approaches that support timely, collaborative action.

Keywords

Antipsychotics; comorbidity; qualitative research; quality of life; psychosocial interventions.

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People living with severe mental illness (SMI) face a 13- to 15-year reduction in life expectancy, largely owing to modifiable physical health conditions.^{1,2} Antipsychotic medications, a cornerstone of treatment, are strongly associated with rapid weight gain and long-term metabolic changes.³ Despite growing awareness of these inequalities, evidence remains limited on how best to support people with SMI in managing antipsychotic-induced weight gain (AIWG).

Management of AIWG

Pharmacological treatments such as GLP-1 receptor agonists and metformin are increasingly considered for AIWG.^{4,5} However, there is limited research on GLP-1 agonists, particularly with respect to long-term data and non-pharmacological approaches in tandem with medication, including how to manage withdrawal of medication.^{4,5} There is most evidence for metformin to manage cardiometabolic outcomes in SMI, including prevention of AIWG. However, again there is a need for further research.^{4,5}

This study focused specifically on non-pharmacological approaches, including lifestyle, psychological, relational and service-level strategies. In this work, which forms part of the wider National Institute for Health and Care Research (NIHR)-funded RESOLVE programme, we aimed to understand how to improve support for people experiencing AIWG. A realist synthesis was

performed to examine international evidence on non-pharmacological interventions.⁶ This paper focuses on the perspectives of healthcare professionals (HCPs).

AIWG is common across individuals treated with various antipsychotics, including clozapine, olanzapine and quetiapine.^{7,8} Although HCPs are expected to manage AIWG through prescribing decisions and lifestyle interventions, prevention and management remain challenging in routine care.¹ Antipsychotic medications disrupt appetite regulation, trigger cravings for carbohydrate- and sugar-rich foods, impair satiety, and alter metabolic processes including insulin sensitivity and lipid metabolism.³ These effects lead to rapid weight gain even without major dietary change,⁹ creating difficulties for patients and for HCPs attempting to intervene in busy and often under-resourced clinical environments.

Policy guidance

Policy guidance increasingly emphasises addressing physical health in mental health services, yet responsibility for managing the physical health of people with SMI remains inconsistently interpreted.¹ Recent policies call for early intervention, multidisciplinary collaboration and prevention at treatment initiation.^{10–12} In England, National Health Service (NHS) guidance mandates annual physical health checks for people with SMI and requires integrated care systems to define roles across primary and

secondary care and provide co-produced outreach and staff training.¹³ Guidance from Wales similarly outlines expectations for medication reviews and multidisciplinary working.¹¹ Internationally, the World Health Organization Mental Health Gap Action Programme guideline frames metabolic monitoring of antipsychotic side-effects as standard psychiatric practice.¹⁴ Other guidelines highlight the need for timely identification of metabolic changes.^{3,12,15}

Implementation

Despite broad consensus, implementation remains inconsistent.^{1,7} Physical health is frequently deprioritised in mental health settings, and primary care support can be hindered by time pressures, diagnostic overshadowing or limited awareness of antipsychotic side-effects.¹⁶ Findings from our realist synthesis show that patients often feel unprepared and unsupported when raising weight-related concerns, reinforcing the need for earlier intervention, proactive monitoring and psychologically safe care.⁶ In principle, AIWG should be managed through shared-care agreements between primary and secondary care services.^{1,3,10,15,17} National Institute for Health and Care Excellence guideline CG 178 specifies that general practitioners (GPs) are responsible for annual physical health checks once patients transition to primary care, whereas specialist secondary care services should initiate monitoring at treatment onset.¹⁷ Combined healthy eating and physical activity programmes are also recommended.¹⁷ However, evidence indicates wide variation in implementation,⁷ and HCPs in mental health services report increasing expectations with respect to physical healthcare, despite limited training, time or system-level support.^{1,7}

AIWG offers a useful lens for examination of wider implementation challenges for HCPs working with individuals with SMI. Management raises questions about role delineation, therapeutic priorities and system readiness, particularly where effective support requires early action, shared responsibility and meaningful engagement. Although biological mechanisms of AIWG are increasingly understood, less is known about how HCPs make decisions about whether, when and how to intervene, or how the wider service context influences their reasoning. In this study, we adopted a realist approach to explore how context shapes professional decision-making in relation to AIWG for community-dwelling patients, with the aim of generating transferable learning to inform policy implementation, service design and workforce development. To our knowledge, this is among the first applications of realist evaluation to AIWG.

Method

This realist evaluation formed phase 2 of the RESOLVE research project, which has explored non-pharmacological approaches.¹⁸ This study builds on phase 1, a realist synthesis,⁶ by examining HCP perspectives.

Rationale for using realist evaluation

Realist evaluation¹⁹ seeks to understand how and why outcomes occur by examining the interactions between context and mechanism. Realist research is increasingly used in health services research to understand the reason or reasons underlying why interventions work or fail to work. This approach is well suited to AIWG, as experiences vary across services, disciplines and organisational conditions^{1,20,21} and understanding of causal processes is essential to inform policy and practice.²² Through iterative data collection and theory refinement, we aimed to develop programme theories explaining how HCPs reason about AIWG and

how service contexts shape their actions. This study follows RAMESES II reporting standards.²² For readers less familiar with realist methodology, accessible introductions have been published elsewhere.^{23–25}

Participant recruitment and sampling strategy

HCPs were recruited from five NHS trusts in England and via Aston University. Initially, trusts acted as participant identification centres, but an amendment permitted them to become research sites to support recruitment. Participants identified via participant identification centres were referred by NHS trust research staff, who shared contact information with the lead researcher (J.H.). At research sites, staff approached participants directly, provided study information and obtained informed consent before introducing the participants to J.H. Participants recruited via Aston University responded to social media or professional network invitations and contacted the team directly. Written informed consent was obtained from all participants.

In line with realist methodology, sampling was purposive. NHS trusts identified staff with differing demographics including ethnicity, gender, discipline and setting, ensuring a broad representation of perspectives.

Programme theories

Initial programme theories (IPTs)

IPTs were intended to be drawn directly from the realist synthesis; delays meant the synthesis and evaluation proceeded concurrently. Emerging findings from the synthesis informed evolving programme theories and the development of interview questions.

Stakeholders

Two stakeholder groups were established: a practitioner group and a lived experience group. Members of both groups were offered reimbursement for their time in line with NIHR guidance. Please see Supplementary File 1 available at <https://doi.org/10.1192/bjo.2026.12097> for a description and overview of practitioner group activities.

Testing and refining programme theories

M.M. and J.H. met regularly to discuss overlapping themes and theory development. For the HCP data-set, tentative context–mechanism–outcome configurations (CMOCs) were constructed and iteratively refined. Draft CMOCs were shared with the wider RESOLVE team, including McPin Foundation staff, and the stakeholder groups for further refinement.

Data collection

Realist interviews

Interviews lasting up to 60 min were conducted with participants between November 2022 and December 2023 via MS Teams and audio recorded with a device. Realist interviews use a teacher–learner approach, enabling participants to comment on and refine emerging theories.^{19,26} Originally, interviews were intended to examine HCPs experiences of AIWG interventions; however, HCPs reported limited existing interventions. Interview questions therefore evolved to explore decision-making, gaps in provision and contextual influences on practice, progressing through theory gleaning, refinement and consolidation.^{21,26}

Data coding and analysis

Interview recordings were transcribed verbatim and anonymised before analysis. Analysis combined deductive, inductive and retroductive approaches. Deductive coding was informed by the IPTs

developed from the realist synthesis, whereas inductive coding allowed concepts not anticipated within the IPTs to be identified from participants' accounts. Retroductive reasoning was used throughout the analysis to interpret how and why observed patterns occurred and to refine emerging CMOCs. A coding framework was developed by M.M., informed by the realist synthesis and stakeholder input. NVivo version 12 (Lumivero, Denver, Colorado, USA; <https://lumivero.com/products/nvivo/>) was used to support coding and organisation of data. Coded data were exported into CMOc tables, and iterative refinement was performed by M.M. and J.H., with involvement of wider team members I.M. and G.W. at appropriate points. These CMOCs and quotes were then shared with the project team, which included members of the McPin Foundation for further discussion and refinement.

Ethics statement

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013. All procedures involving human participants and/or patients were approved by the Health Research Authority (reference: 22/WM/0137).

Reflexivity section

Analysis was led by J.H. and M.M., both of whom are experienced realist researchers who had previously undertaken the realist synthesis informing the IPTs for the evaluation. Although this provided familiarity with the developing programme theory, both remained reflexive to alternative explanations and refinement of the IPTs throughout analysis. J.H. conducted all interviews and, as a realist methodologist without a professional background in mental healthcare delivery, often encouraged participants to make implicit aspects of practice explicit. M.M. brought complementary nursing and organisational perspectives. Emerging CMOCs were further refined through discussions with I.D.M., whose expertise as a mental health pharmacist informed medication-related interpretations, and G.W., who acted as a critical friend to challenge emerging programme theory.

Results

A total of 49 HCPs were recruited to the RESOLVE study, of whom 30 took part in an interview with J.H. Reasons for non-participation included withdrawal ($n = 4$), repeated cancellations ($n = 6$), no response to contact ($n = 3$) and over-recruitment; six individuals were instead offered the option of joining the practitioner group (two accepted). All non-participating HCPs were contacted multiple times and offered flexible scheduling options, including evenings and weekends.

Among the 30 participating HCPs, professional roles included nurses ($n = 10$), pharmacists ($n = 5$), dietitians ($n = 3$), physical activity coordinators or managers ($n = 2$), psychiatrists ($n = 2$), occupational therapists ($n = 2$), psychologists (including assistants; $n = 2$), GPs ($n = 2$), support workers ($n = 1$) and physiotherapists ($n = 1$). Ten participants identified as male and 20 as female. Twenty-four identified as White British, and six identified as Black British, Asian, South Asian, Indian, Black African, or dual-heritage Black African and Black British ($n = 1$ in each category). Length of experience ranged from 3 years to more than 30 years. Participants were drawn from diverse settings, including in-patient services, early intervention in psychosis, community mental health teams, forensic units and primary care. Many of the more experienced

HCPs had worked across several settings and reflected on transitions and variation in service delivery.

The realist analysis generated nine CMOCs relating to HCPs' experiences of supporting people living with SMI and AIWG. These were grouped into three overarching areas:

- systemic and professional challenges (CMOCs 1–3), comprising organisational, training and system-level barriers to integrated physical and mental healthcare;
- strategies to enhance individualised and meaningful support (CMOCs 4–6), including timing, personalisation and motivational support;
- the roles and limitations of non-professional support (CMOCs 7–9), relating to involvement of families and peers in practice.

The refined programme theory and CMOCs are presented in Table 1. Each CMOc is explained below with illustrative quotations. Additional quotations are available in Supplementary File 2.

Systemic and professional challenges

CMOCs 1–3 described systemic barriers that limited HCPs' ability to provide holistic, individualised care for people living with SMI and AIWG. In CMOc1, HCPs reported limited knowledge and confidence with respect to supporting the physical health needs of people with SMI, particularly in relation to medication-induced weight gain.

'We've got physical barriers generally . . . way we separate mind and bodies . . . general health services are there and . . . psychiatric services are there and it contributes to stigma because it's "oh it's them over there, oh the psychiatrist's separate" . . . our patients don't get adequate statins, they don't get adequate bypass, they don't get adequate renal care and when they do attend services, so we've now thrown an additional barrier on top of all the stigma that they've got.' (HCP 5)

'I think the more challenging conditions, where quite a lot of us . . . myself, you feel a little bit more out of your scope of competency with those with more SMI . . . ' (HCP 50)

In CMOc2, participants described how siloed systems, limited integration between physical and mental healthcare, and weak connections to community services restricted opportunities for joined-up care. This often led HCPs to rely solely on their own professional remit.

'Sometimes the priority becomes the mental illness and people forget about physical health . . . lots of services out there that we don't always engage with . . . sometimes we work in silos, forgetting that other people (HCPs) exist unless they show themselves.' (HCP 8)

CMOC3 highlighted how system pressures could erode professional values and leave HCPs feeling demoralised or resigned when unable to deliver the care they believed was needed. High caseloads, under-resourcing and structural inefficiencies contributed to emotional withdrawal.

'[W]e know they're dying fifteen, twenty years too young, but the chances are, for the last few years of their life . . . they're not going to be in good health . . . they're not going to be out and about . . . not going to be making friends . . . it's really sad and it

Table 1 Refined programme theory and CMOCs for HCPs
Programme theory HCPs often lack the training and skills necessary to address patients’ rapid weight gain caused by antipsychotic medications and stigma due to negative body image. Siloed healthcare that separates physical and mental healthcare can make it more challenging for HCPs to holistically address patients’ healthcare needs. HCPs’ professional values may be compromised when they are unable to comprehensively address patients’ healthcare concerns. When they begin with early weight management conversations, HCPs are more likely to establish trusting, sustained therapeutic relationships by co-developing individualised goals and care plans based on patients’ interests and available, local resources. HCPs are more likely to engage with and educate family and informal carers when they believe these supports can help patients on their recovery journeys. HCPs also value input from PSWs and groups with shared, similar lived experiences that empower patients, although they also recognise barriers, such as lack of formal recognition, which can disrupt sustained help from peer supports. CMOC 1: lack of training When HCPs have not received adequate training to manage the physical and mental healthcare needs of patients with SMI and AIWG (C), they are less likely to provide holistic care (O), because they lack confidence in how to initiate and navigate sensitive conversations involved in managing complex needs (M). CMOC 2: siloed care When HCPs work in narrow siloed systems with limited connections to other HCPs or services (C), this is likely to lead to disjointed or incomplete care that fails to address the full range of patient needs (O), because the HCP does not think that working across systems is their responsibility (M). CMOC 3: professional value compromise When HCPs are repeatedly unable to provide care that is consistent with their professional values owing to systemic constraints (C), they may disengage, become cynical or emotionally shut down, or leave their roles (O), because they reason that the system sets them up to fail by making meaningful care for physical health conditions including weight gain feel like an unreachable goal (M). CMOC 4: meeting patient needs When HCPs spend time building rapport to better determine a patient’s needs, values and locally available resources (C), they are more likely to collaboratively develop achievable and sustainable individualised goals and care plans (O), because they believe that goals co-developed around each patient’s own priorities and locally available resources are more likely to be meaningful and sustained (M). CMOC 5: early weight management conversations When HCPs appreciate the impact of rapid weight gain on patients’ self-esteem (C), they are more apt to have early and ongoing conversations about these side-effects of antipsychotics (O), because they are concerned about damaging trust and the therapeutic alliance (M). CMOC 6: motivating and supporting lifestyle changes When HCPs recognise that SMI will affect the motivation of patients to make lifestyle changes (C), they are more apt to help patients to identify meaningful interests and to co-develop structured routines that build confidence (O), because they believe this type of support will be more acceptable and sustainable to patients (M). CMOC 7: family and/or carer support for patients When HCPs determine that family members have insight into needs and challenges faced by patients (C), they are more likely to engage families in lifestyle planning and provide family support and ongoing education and/or training (O), because they believe family members can be helpful to patients’ recovery (M). CMOC 8: non-professional support from peer support and/or peer groups When HCPs are aware of the unique benefits that peer support can offer patients seeking lifestyle change (C), they are more likely to recommend PSWs and/or groups (O), because they believe that peers with shared lived experience carry a form of trust and credibility with patients that clinical relationships cannot replicate (M). CMOC 9: peer support concerns When the healthcare system does not consistently employ PSWs as members of the team (C), HCPs are less likely to involve them (O), because they are concerned about PSWs’ ability to provide sustained and reliable support for patients (M). CMOC, context–mechanism–outcome configuration; HCP, healthcare professional; PSW, peer support worker; SMI, severe mental illness; AIWG, antipsychotic-induced weight gain.

is a national scandal . . . the way we treat people with serious mental illness.’ (HCP 3)

‘ . . . [I]t’s just more about getting the bare bones done even though you want to go above and beyond and support in whatever manner you can, you just know that you’re just not going to have the time to do it . . . part of the reason why I left psych liaison is because you don’t have the capacity to be able to give the care you want . . . ’ (HCP 7)

Strategies to enhance individualised and meaningful support

CMOCs 4–6 described strategies that HCPs associated with more meaningful, effective support for people experiencing AIWG. In CMOC4, HCPs emphasised the importance of investing time in building rapport, understanding what matters to each patient and co-developing realistic, personalised goals. Without this, care plans risked becoming generic and poorly matched to individual needs.

‘ . . . [F]irst and foremost it needs to be what the patient’s goals are, what do they want to happen from this and what’s the

timescale they want it to happen in . . . some care plans are not particularly tailored for the individual, some are quite generic.’ (HCP 7)

In CMOC5, HCPs described how recognition of the emotional impact of SMI and AIWG – particularly on identity and self-esteem – encouraged early, pro-active conversations about side-effects. These discussions were acknowledged as difficult, but delaying them risked harming trust and the therapeutic relationship. HCPs described balancing timing with the impact of early weight gain.

‘ . . . [T]he weight gain is – and the impact of the drugs on the hunger is imminent, it happens very, very, very quickly, and the other reason why you want to do that is you want to make sure you’ve got the trust of your patients . . . for the majority of patients . . . it does matter because it is part of their identity and not telling somebody about a side-effect that happens so quickly and is of such a magnitude . . . we’re not meeting that responsibility.’ (HCP 5)

CMOC 6 related to HCPs’ recognition that amotivation, which is common in individuals with SMI, often undermines capacity to

initiate and sustain lifestyle change. Rather than interpreting disengagement as unwillingness, HCPs highlighted the importance of building routine gradually, identifying personal interests and supporting confidence.

‘Amotivation is a symptom of schizophrenia... it’s about helping people have confidence to build that routine. That’s more likely to be sustained... it’s how we support people to have routine and to be motivated with a reasonable expectation... other than a realisation that anyone that’s like had periods in hospital and been ill with any type of illness is going to lack confidence, lack ability to have routine... lack motivation and it’s about how you engage them in building those kind of tools in order to then like kind of move forward.’ (HCP 2)

The role and limitations of non-professional support

CMOCs 7–9 described how non-professional support influenced engagement with lifestyle change. In CMOC 7, HCPs discussed the potential benefits and challenges of involving family members. They were more likely to include families when their support was balanced, informed and aligned with patient autonomy, but they also recognised how over-involvement or limited understanding could hinder progress. HCPs emphasised the need for families to receive education about SMI and medication-related side-effects.

‘... [F]amily can be helpful, again it depends how engaging the family are, it depends on the family dynamics... if they’re quite involved shall we say, which can be quite negative sometimes, or quite controlling, or if they just don’t, if they’re quite lackadaisical, again that can be quite negative. As long as they have the knowledge base behind it and they’re given education behind... then I think they can be quite helpful.’ (HCP 7)

In CMOC 8, HCPs highlighted the value of peer support workers (PSWs) and peer groups. They described peer relationships as offering a level of connection, credibility and influence that could exceed professional input. Seeing others with similar experiences was viewed as empowering and motivating for patients.

‘... [W]hole peer dynamics are absolutely crucial to our guys making progress generally. And it’s like that is so much more powerful than anything I could ever say to the patient... as well where there’s that sort of real peer reflection and accepting things from their peers that they would never accept from a professional.’ (HCP 9)

In CMOC 9, HCPs described systemic issues that limited the impact of PSWs. Although highly valued in principle, PSWs were often inconsistently employed, poorly supported or embedded within restrictive service models. These conditions reduced HCPs’ confidence in relying on peer support as a dependable part of care planning.

‘Most of the staff are peer staff and they’re great... They are poorly managed and... unsupported. Everybody leaves and they can’t keep hold of staff... No one supports you and so they get unwell and leave... If you’ve got someone who has chronic schizophrenia and loads of negative symptoms, ten sessions of peer intervention is not going to touch it. They need someone two or three times a week to go out, take them

wherever it is they need to go, support them to do that cooking, go to Weight Watchers or Slimming World... to the GP. They need that long term and we haven’t got that anymore.’ (HCP 20)

Discussion

Summary of findings

This realist evaluation explored how HCPs support people with AIWG and identified nine CMOCs explaining how contexts and mechanisms shape practice. CMOCs 1–3 described system-level constraints: limited training in physical health; fragmented communication and unclear responsibilities across services; and the effects of under-resourcing on morale. CMOCs 4–6 related to relational and behavioural approaches and highlighted the need for tailored support, early and open conversations about medication side-effects, and routines aligned with patient interests. CMOCs 7–9 addressed non-professional support, showing how family and peers could facilitate or hinder engagement depending on alignment with patient goals and service integration. The shift in interview focus from AIWG interventions to decision-making and gaps in provision arose directly from what participants reported: structured non-pharmacological provision was largely absent, and understanding why became the more pressing question. Together, these findings show how HCPs navigate intersecting systemic, relational and organisational influences when supporting people with AIWG.

Systemic and professional challenges

HCPs described significant systemic and organisational barriers that limited their ability to support people with AIWG, consistent with evidence linking structural underinvestment to the 13- to 15-year mortality gap.¹ Many reported limited confidence in addressing the physical consequences of antipsychotic treatment, contributing to delays or avoidance despite guidance recommending early intervention.^{3,17} Existing weight management frameworks such as the 5As and the 4Ms^{27,28} do not meet challenges posed by SMI, including amotivation, cognitive impairment, persecutory ideation and medication side-effects, which complicate non-pharmacological interventions.^{1,3,6}

These gaps reflect broader limitations in healthcare education.^{29,30} Mental health professionals receive limited training in physical health, and general health training often pays insufficient attention to SMI.^{29,30} A lack of visible, experienced clinicians who can confidently integrate physical and mental healthcare in everyday practice and of clinical placements supporting joined-up practice, as well as limited post-graduate opportunities, further impedes integration in practice.³¹ Hidden curricula may also reinforce stigmatising assumptions about obesity and mental illness.³² Although HCPs wished to provide holistic care, many lacked the language, confidence or organisational support to do so. Some authors advocate embedding trauma-informed care and motivational interviewing into professional development,³³ although uptake is inconsistent. Early silence around weight gain may damage trust and contribute to disengagement.¹ HCPs echoed patient concerns.

Fragmentation across the care pathway (CMOC2) was a recurring concern. Participants described siloed services, unclear responsibilities and poor coordination among primary, secondary and community care, which disrupted continuity and left patients navigating services alone. Although integrated care models are intended to bridge such gaps, implementation remains challenging.^{29,34} HCPs in our study described how system fragmentation obstructed shared-care planning, communications and long-term follow-up. These pressures also contributed to emotional strain and

reduced morale (CMOC3). The wider literature has linked such experiences to professional distress when HCPs feel unable to provide care aligned with their professional and ethical values.^{35,36} Several HCPs described a cumulative emotional burden and a sense they were letting patients down despite best intentions. Recommended mitigations include reflective practice, talking therapies and dedicated peer support spaces.³⁶ In line with the wider findings from RESOLVE, these interviews with HCPs highlight a need for organisational change to enable coordinated, relationally anchored care. Potentially, patients may interpret these structural failures as neglect or abandonment.

Strategies to enhance individualised and meaningful support

Despite systemic constraints, HCPs also identified practical ways to strengthen support. CMOC4 demonstrated the importance of goals tailored to patient interests and values. Investing time to understand what mattered to patients supported the development of relevant, realistic care plans, consistent with recovery-oriented principles that emphasise autonomy and shared decision-making.³⁷ Evidence shows that involvement of patients in treatment decisions improves outcomes.³⁸ Guidelines on antipsychotic prescribing stress shared decision-making,^{13,17} although implementation remains uneven.³⁹

CMOC5 stated that delaying conversations about AIWG risked eroding trust. Early, clear and repeated messaging was considered to be essential, consistent with evidence that patients often need time to process health changes⁴⁰ and may avoid discussions owing to perceived judgement or stigma.⁴¹ Following the patient's lead, pacing conversations and emphasising benefits rather than risks would align with evidence that supportive, person-centred approaches enhance engagement.⁴²

CMOC6 focused on the need for patience, flexible pacing and relational continuity. Behaviour change approaches are most effective when HCPs consider identity, readiness and coping strategies.⁴³ Motivational interviewing provides a structured approach for exploring ambivalence³³ and may improve accessibility for front-line staff.⁴⁴ Overall, small, tailored steps and opportunities for self-inquiry are required.

Role and limitations of non-professional support

CMOC7 described how family involvement could help or hinder weight-related support. Families facilitated progress when they reinforced healthy routines, respected autonomy and were aligned with patient goals; however, limited understanding of SMI or controlling behaviours undermined engagement. These findings are consistent with wider evidence on family-inclusive practice, in which strengths-based collaboration and education enhances outcomes.⁴⁵ Without adequate training, leadership and supportive organisational culture, family involvement may be inconsistent or ineffective.⁴⁶

CMOC8 identified peer support as uniquely motivating owing to shared lived experience, offering connection, hope and motivation in ways that clinical relationships could not replicate. This reflected recovery-oriented models emphasising identity reconstruction and empowerment⁴⁷ and was consistent with research on self-management and engagement.⁴⁸ However, CMOC9 reflected concerns about the sustainability of peer support roles. PSWs often faced inconsistent funding, weak integration and limited supervision, creating uncertainty for HCPs. Evidence shows that unclear role definitions and limited career pathways undermine the long-term impact of peer support.^{48,49} The RESOLVE realist synthesis⁶ likewise found that peer-led approaches showed promise but were often absent from formal pathways owing to fragmentation and lack of strategic oversight. Collectively, these findings suggest that the potential of peer support requires structural investment, supervision and integration.

Without such supports, HCPs confront AIWG without the relational scaffolding needed for sustained behaviour change.

Strengths and limitations

This study provides valuable insights into how HCPs understand and respond to AIWG in SMI. The CMOCs enabled exploration of why approaches work differently across settings. The study also benefited from involvement from clinical, academic and lived experience stakeholder groups, supporting the relevance and interpretive rigour of the analysis. Alongside the realist synthesis,⁶ this paper offers a detailed account of HCP perspectives to inform future service design.

Limitations include the possibility of selection bias, as participating HCPs may have been more attuned to AIWG. Although the multidisciplinary sample enriched the data-set, perspectives varied across roles. Most participants were based in England, which limits the transferability of the results. Some CMOCs were developed solely from HCP interview data without triangulation across sources; however, several, including those regarding shared decision-making and fragmented care, were consistent with wider findings from RESOLVE. Although designed sequentially, the synthesis and evaluation overlapped in practice, meaning that IPTs were not fully available to inform early interview design. Mitigations applied to develop and refine CMOCs throughout included use of the emerging synthesis findings to inform the interview questions, retroductive reasoning to guide the analysis and extensive stakeholder engagement (involving both the lived experience group and the practitioner group).

Future research

Further research should examine how training, motivational interviewing and anti-stigma education can support early, confident conversations about AIWG. Studies should explore how different professional groups enact their roles in supporting physical health, recognising variation in training and organisational context. There is also a need to develop and evaluate preventive approaches focusing on early intervention, shared decision-making and relational continuity, including how and when lifestyle and risk-reduction strategies can be introduced. Realist approaches are well suited for clarification of how integrated, preventive care operates for patients. Further attention is needed to understand how coordination between mental and physical health services is achieved in practice, and how shared planning, role clarity and sustained follow-up can be embedded into everyday care. Finally, participatory approaches involving patients, family carers and PSWs are essential for co-designing feasible and effective interventions from the outset.

Implications

According to this realist evaluation of how HCPs navigate complex individual, relational and systemic factors when supporting people with AIWG, structural constraints and gaps in training left many feeling underprepared, yet they remained committed to person-centred, relational approaches. Trust, timing and tailoring were central to meaningful engagement. Implications arise at multiple levels: training programmes must better equip HCPs to recognise and respond to physical health needs in SMI; national guidance should provide explicit standards for early conversations, care planning and access to tailored interventions; and at the systems level, integrated care requires investment in relationships, roles and resources. Embedding family and peer support within pathways may strengthen engagement and sustain motivation. Without clear pathways and sustained infrastructure, responsibility for AIWG is easily overlooked, leaving HCPs, patients and family and informal carers to manage complex health issues in isolation.

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Supplementary material

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Data availability

Owing to the sensitive nature of the qualitative data generated, data sharing would not be appropriate.

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Author contributions

Conception or design of the work: J.H., M.M., G.W., S.O., A.E.L.W., S.H., K.A., A.L.A., R.U. and I.D.M. All authors met all four ICMJE criteria for authorship; contributed to acquisition, analysis or interpretation of data for the work; drafted and reviewed the paper and approved the final version.

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Declaration of Interest

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