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Guest Editorial

Beyond stigma: reframing antipsychotics as medical treatment

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Summary

Antipsychotic non-adherence, driven partly by stigma, worsens outcomes in severe mental illness. Beyond ameliorating psychosis, evidence shows sustained antipsychotic treatment reduces mortality, cardiovascular risk, suicide, inflammation and cognitive decline, while improving quality of life. Reframing antipsychotics as essential medical care may reduce stigma and improve engagement with patients and clinicians.

Keywords

Antipsychotics; stigma and discrimination; psychotic disorders/schizophrenia; mortality and morbidity; quality of life.

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Beyond stigma: reframing antipsychotics as medical treatment

Poor adherence to antipsychotics remains one of the strongest predictors of relapse and hospital readmission in severe mental illness (SMI). Here, SMI refers primarily to schizophrenia spectrum and severe affective disorders associated with functional impairment and increased medical morbidity. A central but often overlooked barrier to adherence is stigma attached not only to the diagnosis of SMI, but also to antipsychotic medication itself. Because receiving antipsychotics is frequently perceived as a proxy for having an SMI, patients may avoid treatment to escape the social consequences that stigma entails.

This perception could change if patients, clinicians and the wider public recognised that antipsychotics confer therapeutic benefits far beyond the control of psychotic symptoms alone. When used appropriately, they can reduce medical comorbidity, support cognitive and functional outcomes, and improve both quality of life and life expectancy.[1,2] Although these broader therapeutic effects are increasingly recognised, they have not been consistently integrated into a unifying clinical framework. This editorial argues that reframing antipsychotic treatment as an essential component of comprehensive medical care, rather than solely a psychiatric intervention, offers a pragmatic approach that may help reduce stigma and strengthen engagement with treatment.

Antipsychotic prescribing and treatment adherence: a multifactorial problem

Despite clear National Institute for Health and Care Excellence recommendations, antipsychotics remain underused in routine care. A large UK analysis of over 300 000 patients with an SMI found that nearly a third were never offered or prescribed an antipsychotic.[3] Even when treatment is initiated, fewer than half of patients begin or maintain the recommended regimen.[4] Decades after their introduction, reluctance to start and sustain antipsychotic treatment persists as a central clinical challenge.

There are many concurring reasons for this. Illness-related factors – including limited insight, symptom burden and social adversity – interact with cultural beliefs about psychiatric treatment and pervasive stigma surrounding both diagnosis and medication. Antipsychotic treatment is often experienced not simply as therapy, but as confirmation of a stigmatised identity. For many, the prescription of an antipsychotic is perceived and experienced as a social stain that they prefer to avoid. Sadly, this is often validated by the way they can be treated in society, including by the medical profession itself.

Psychiatrists may also contribute, inadvertently or not, to this problem. Suboptimal prescribing, inconsistent messaging in the literature and the persistence of views that antipsychotics merely 'suppress symptoms' can undermine confidence in treatment. Widespread off-label use, such as for insomnia or behavioural disturbance in dementia, may further distort understanding of their primary role. Of note, public attitudes have also been shaped by commercial influences and controversies surrounding psychopharmacology, with both positive and negative consequences.

Concerns about adverse effects are legitimate. Weight gain, cardiometabolic risk, sexual dysfunction, oversedation and extrapyramidal symptoms can all influence adherence. However, antipsychotics are not a homogeneous class: efficacy, tolerability and risk profiles vary substantially and interact with patient-specific factors. Yet prescribing does not always reflect this variation. Agents with well-recognised metabolic liabilities continue to be widely used despite available alternatives; for example, olanzapine remains one of the most frequently prescribed antipsychotics in UK primary care despite its well-documented metabolic burden.[3]

Antipsychotics as medical treatment

To understand why a broader reframing is justified, it is necessary to consider the wider effects of antipsychotic treatment beyond symptom control. Antipsychotic-induced cardiometabolic effects are frequently cited as contributors to excess mortality in SMI. However, robust longitudinal evidence, assessing nationwide samples, demonstrates that adherence to antipsychotic treatment is associated with substantial reductions in all-cause mortality. A 20-year cohort study of patients with schizophrenia found mortality reductions exceeding 50% during periods of antipsychotic use, without evidence of cumulative harm from prolonged exposure.[1]

This apparent paradox can be understood across three interrelated domains. Although symptom severity, social functioning, quality of life and biological outcomes are closely linked, they represent distinct outcome domains that may not necessarily improve in parallel, but may interact at different levels. First, effective control of psychotic symptoms supports behaviours essential for physical health. Untreated illness is associated with poor self-care, increased suicide risk, substance use and social

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withdrawal, alongside reduced engagement with healthcare services. Structural factors, including fragmented services and diagnostic overshadowing, further compound this disadvantage, and patients with an SMI often receive lower standards of physical healthcare, particularly when they relapse and become acutely unwell. Antipsychotic adherence improves engagement with treatment for physical conditions, contributing to reductions in cardiovascular mortality.[5] Moreover, evidence indicates appropriate antipsychotic use in SMI is associated with improvements in social functioning and overall quality of life, particularly in patients receiving long-acting formulations,[2] whereas clozapine has been shown to reduce suicide risk.

Second, repeated episodes of illness may contribute to cumulative cognitive and functional decline. Cognitive impairment is highly prevalent in SMI and strongly linked to poorer long-term outcomes, including reduced capacity for independent living, healthcare-seeking and disease self-management. Sustained, effective treatment may mitigate this trajectory, supporting functional recovery and quality of life. Consistent with this, European Psychiatric Association guidance recognises second-generation antipsychotics as a foundational component in addressing cognitive impairment in schizophrenia.[6]

Third, emerging evidence suggests that inflammatory processes may contribute to both psychiatric and physical morbidity in SMI. Inflammation is seen as part of pathophysiological changes underlying many chronic medical conditions, including those frequently comorbid with SMI, and is discussed here as one illustrative example of broader biological mechanisms that may help explain some of the wider medical effects associated with antipsychotic treatment. If recent findings are any guide, ongoing research is likely to further elucidate the broad medical advantages of consistent evidence-based antipsychotic use, including the therapeutic implications of its anti-inflammatory effects, underscoring how its benefits may extend far beyond the amelioration of patients' mental state.[7]

Taken together, these mechanisms reinforce the view that antipsychotics function not simply as symptom-controlling agents, but as treatments with important medical implications across multiple domains of health.

Reframing antipsychotic treatment

In most areas of medicine, a treatment that reduces mortality and improves quality of life would be regarded as a major therapeutic advance. Yet, despite over seven decades of use, antipsychotics remain widely misunderstood, inconsistently prescribed and frequently declined by those who need them most. Attempts to challenge this situation have, to date, had limited success. An alternative updated and comprehensive approach is required to break this anachronistic impasse.

Reframing antipsychotics as a component of comprehensive medical care offers one such approach. This has practical implications. Clinicians must consistently communicate the broader benefits of treatment, including its impact on physical health, functioning and prognosis, while maintaining transparency about risks. This perspective does not minimise concerns about tolerability or adverse effects. Rather, it integrates them into a balanced, evidence-based discussion in which patient preferences remain central. Patients may conceptualise antipsychotic treatment differently from clinicians, reinforcing the importance of incorporating lived experience and shared decision-making into discussions about treatment.

The psychiatric community has a major role to play on several fronts: clinical, research and educational. First, when prescribing antipsychotics for SMI, psychiatrists should, as part of routine practice, clearly discuss with their patients the medical rationale for evidence-based, continuous antipsychotic treatment. This should include emphasising the long-term physical health risks of untreated illness and the therapeutic benefits of adherence.

Second, clinicians should embrace their responsibility in critically appraising emerging evidence, particularly in identifying and vigorously questioning epidemiological claims that are inconsistent with clinical reality. Interpreting such findings within the broader framework of relapse prevention and morbidity is essential. Recently, during the COVID-19 pandemic, several large database studies generated misleading conclusions about antipsychotic-related medical risk based on incomplete data, omitting key variables such as adherence and age stratification.[8] Such shortcomings can shape misperceptions of antipsychotic treatment and entrench existing biases.

On the same note, it is also important to consider critical literature that takes a more sceptical view of antipsychotic treatment. Studies questioning long-term antipsychotic use, including trials of dose reduction, may raise important issues but do require careful contextualisation. Evidence consistently suggests that reducing treatment without clear clinical rationale increases relapse risk without demonstrable functional benefit. For example, the RADAR trial compared the effects on self-reported social functioning over 2 years between gradual dose reduction and maintenance of antipsychotic treatment in clinically stable patients with an SMI who were living in the community.[9] Although no differences in social functioning were reported, dose reduction was associated with an increased risk and frequency of psychotic relapse, thus again underlying the therapeutic value of long-term treatment maintenance.

Third, the therapeutic landscape has evolved considerably. Modern antipsychotics encompass a range of short-, long- and very-long-acting formulations, and newer agents with distinct pharmacological profiles. This diversity allows for more precise tailoring of treatment to individual patients, improving tolerability, reducing the potential for iatrogenic harm and enhancing acceptability. By offering training in patient-centred, evidence-based prescribing across primary and secondary care settings, practising psychiatrists can help to dispel misconceptions and translate newer advances into practice. This can also prove a legitimate platform to update the medical community and inform the public at large about the role of contemporary antipsychotic treatment in clinical care.

Adherence and medical care

It is time to recognise that the benefits of antipsychotic treatment extend well beyond the control of psychotic symptoms. Evidence demonstrating reductions in mortality, improvements in quality of life and broader effects on physical health supports a fundamental reframing of their role in SMI. Reframing modern antipsychotic treatment as a medical intervention, rather than solely a psychiatric one, offers a powerful opportunity to reshape public and professional perceptions of SMI. This evidence-based reframing warrants further empirical scrutiny, as it has the potential to challenge longstanding misconceptions, reduce medication-related stigma and potentially lessen the stigma associated with mental illness itself.

Presenting antipsychotics as integral to comprehensive medical care enables patients to view adherence not as acceptance of a psychiatric label, but as investing in their overall health and future. This should include lifestyle changes, physical exercise programmes, meaningful social activities, vocational training,

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psychological interventions and open and regular discussions about the rationale for treatment, and the proper balance of risks and benefits it entails, which will vary from one individual to another, and may evolve over time. These discussions should be grounded in shared decision-making and informed by the perspectives and priorities of patients themselves. Such a shift offers the scope for newer psychoeducation and partnership strategies that can strengthen engagement with treatment, improve outcomes and help restore dignity, agency and the prospect of better futures for people living with an SMI.

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