

Mental health and lifestyle – Essential skills for healthcare professionals

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The influence of lifestyle on mental health

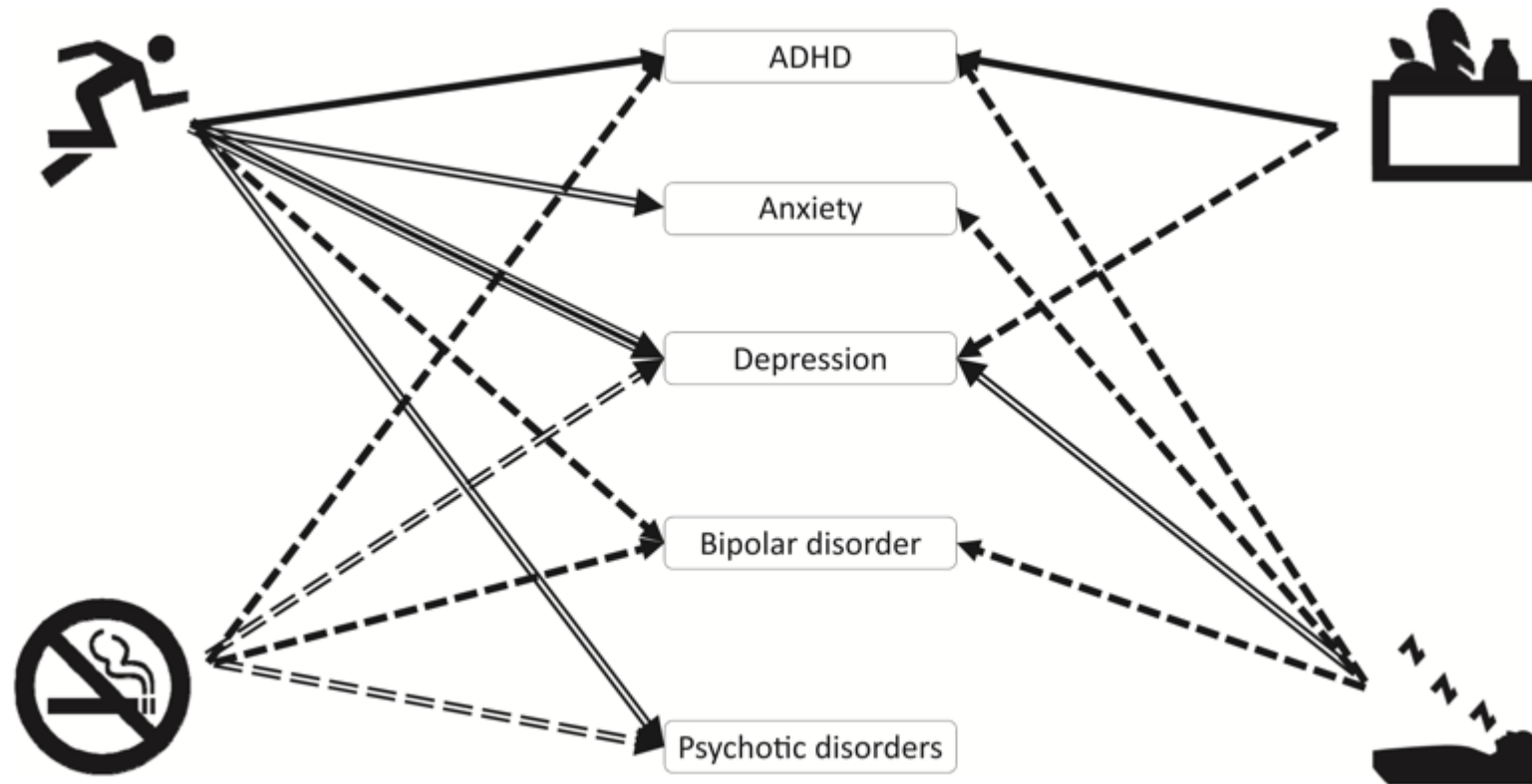
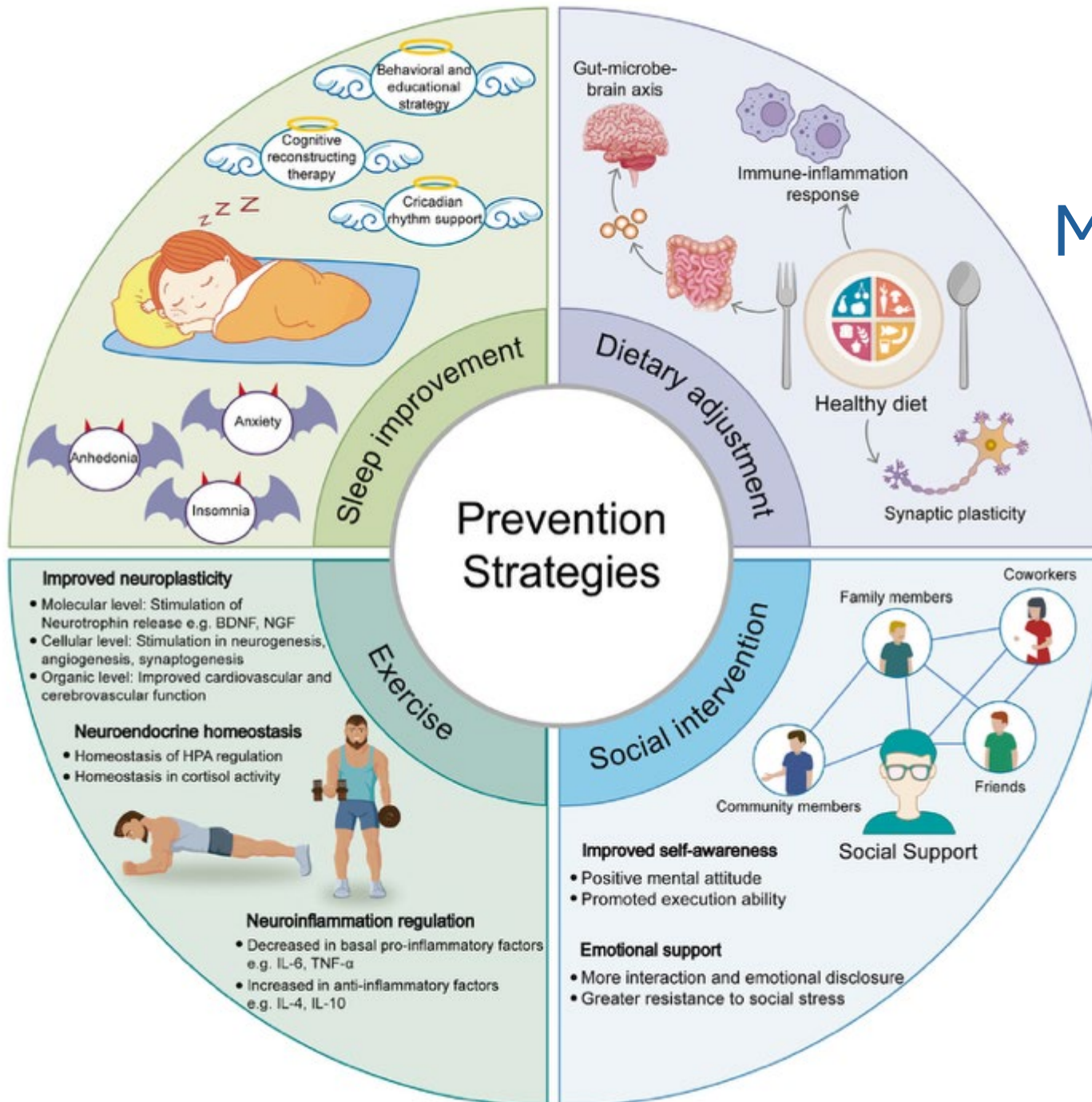


Figure 1 Lifestyle factors in the prevention and treatment of mental illness. The dashed line indicates evidence for protective benefit from either prospective meta-analyses (P-MAs) or Mendelian randomization studies (MRs). The double-dashed line indicates evidence for protective effects from both P-MAs and MRs. The solid line indicates evidence for efficacy in treatment of mental illness from MAs of randomized controlled trials (RCTs). The double solid line indicates convergent evidence from MRs or P-MAs with MAs of RCTs. The treble solid line indicates convergent evidence from all three (P-MAs + MRs + MAs of RCTs). ADHD - attention-deficit/hyperactivity disorder.

Lifestyle Psychiatry for Prevention Major depressive disorders



Cui, L., Li, S., Wang, S., Wu, X., Liu, Y., Yu, W., ... & Li, B. (2024). Major depressive disorder: hypothesis, mechanism, prevention and treatment. *Signal transduction and targeted therapy*, 9(1), 30.

Prevalence of behavioural risk factors

Table 2. The prevalence of various behavioural risk factors across different mental health diagnoses.

	Alcohol	Tobacco use	Physical Activity	Sedentary Behaviour	Poor Diet	Poor Sleep
Major Depression	Around 30% have/had alcohol use disorder. ⁴⁵¹	More likely to smoke, be nicotine dependent, less likely to quit, and more likely to relapse ⁴⁵²	Around 60-70% do not meet physical activity guidelines. ^{60,453}	Sedentary for 8.5 hrs per day. ⁴⁵³	Significantly higher food intake and poorer diet quality than general population. ⁸³	Significant poorer continuity of sleep and reduced sleep depth compared to healthy controls. ⁴⁵⁴
Anxiety Disorders	17.9% have alcohol dependence/abuse. ⁴⁵⁵	Heightened risk of regular smoking (+41%) and nicotine dependence (+58%). ⁴⁵⁶	Individuals with panic disorders, social phobia and agoraphobia report significantly less activity. ⁴⁵⁷	Inconsistent evidence for increased sedentary time in people with anxiety. ⁴⁵⁸	Insufficient evidence on diet in anxiety disorders.	Anxiety disorders, ^{454,459} and OCD ⁴⁶⁰ are associated with reduced sleep quality
Bipolar Disorder	1 in 3 have/had alcohol use disorder. ⁴⁶¹	Elevated rates of current smoking; higher than MDD but lower than schizophrenia. ⁸⁶	Majority meet PA guidelines and no different to general population. ^{30,60}	Sedentary over 10 hours per day. ^{30,60}	Consume ~200 calories more than general population per day. ⁸⁷	Even between episodes, people with bipolar disorder have elevated sleep-wake disturbance, similar to insomnia patients. ⁴⁶²
Schizophrenia	1 in 5 have/had alcohol use disorder. ⁴⁶³	Significantly higher rates of current smoking, heavy smoking and nicotine dependence. ⁸⁴	Majority do not meet physical activity guidelines. ^{35,60}	Sedentary for ~11 hrs per day. ⁴⁶⁴	Consume ~400 calories more than general population per day. ⁸⁷	Significantly reduced sleep time & quality of sleep. ^{454,459}
First-Episode Psychosis	27% have/had alcohol abuse/dependence. ⁴⁶⁵	58% are tobacco users, significantly higher than matched controls ⁴⁶⁶	Less active than long-term schizophrenia. ³⁵	Insufficient evidence on sedentary behaviour in early psychosis.	Insufficient evidence on diet in early psychosis.	Significantly reduced sleep time & quality of sleep. ⁴⁵⁹
Post-Traumatic Stress Disorder	Elevated rates of comorbid alcohol misuse compared to general population (10-61%). ⁴⁶⁷	22% more likely to be current smokers than general population. ⁴⁶⁸	9% less likely to be physically active than general population. ⁴⁶⁸	Insufficient evidence on sedentary behaviour in PTSD.	5% less likely to have a healthy diet than general populations. ⁴⁶⁸	Significant poorer continuity of sleep and reduced sleep depth compared to healthy controls ⁴⁵⁴

Red = Multi-national meta-analysis

Purple = Systematic review of case-controlled, clinical and/or epidemiological research

Blue = Large-scale epidemiological studies

Note: 'Significantly' refers to p<0.05 compared to general population.

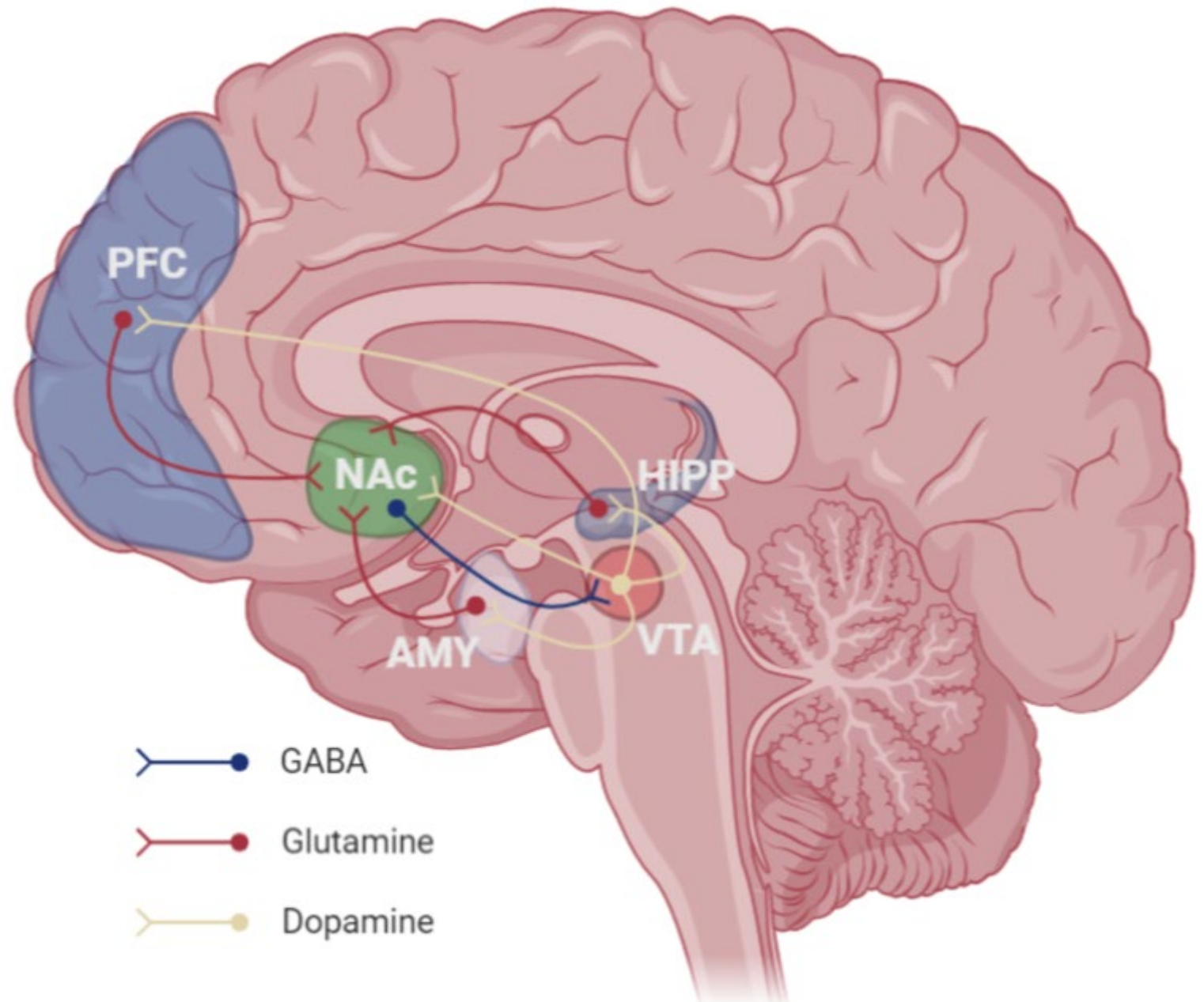
Firth, J., Siddiqi, N., Koyanagi, A. I., Siskind, D., Rosenbaum, S., Galletly, C., ... & Stubbs, B. (2019). The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. *The lancet psychiatry*, 6(8), 675-712.

EPA guidance on lifestyle interventions for adults with severe mental illness

Recommendation (Grade A)

Lifestyle interventions that combine behaviour change techniques, dietary modifications, and physical activity should be offered to individuals with SMI for reducing weight and other metabolic syndrome components, as well as depressive and anxiety symptoms.

Reward system





Habit formation

Who brushed
their teeth
today?





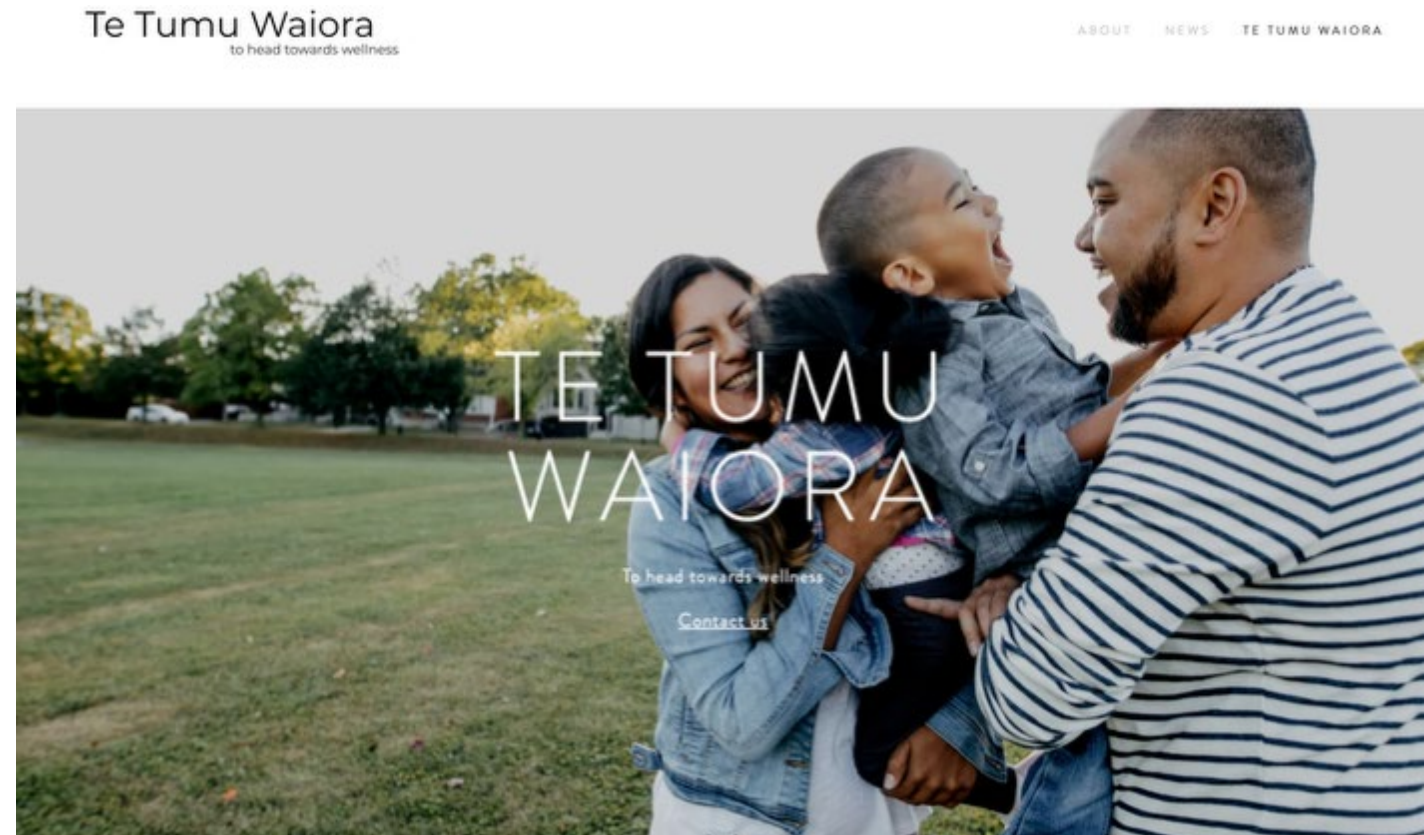
Key stimulus

Automated habit

Example: Te Tumu Waiora

Key Features

- Deliver accessible, community-based care integrating physical, mental, and social health.
- Focus on prevention, and empowerment.
- **Health coaches:** Support individuals in achieving their goals - improved mental wellbeing, healthier lifestyles, and positive behaviour change.



Essential skills for healthcare professionals

Psychologist

Nurse

Physical therapist

Social worker

Physician Assistant

Physician

- Interprofessional competence
- Competencies for teaching health literacy and habit formation
- Specialized knowledge in the field of prevention and lifestyle
- Competencies for supporting people with severe mental illness



Mangere Health Centre Health Coach Renee Henry spends time with her regular walking group.

<https://www.tetumuwaioa.co.nz>, access date 17.10.2025

Essential skills for healthcare professionals

- Interprofessional approach
- Mental health as a common goal
- Shared understanding of the importance of a healthy lifestyle and approaches to behavioral change



Thank you for listening

