EQUALLYWELL 2023 Symposium

Thank you to our wonderful sponsors.

Australian Government
Department of Health and Aged Care

Queensland Government

Queensland Mental Health Commission

Supported by the NSW GOVERNMENT

Australian Government
National Mental Health Commission

neami national Improving Mental Health and Wellbeing

wellways

The Royal Australian & New Zealand College of Psychiatrists | Your Health in Mind

www.equallywell.org.au

THE WORLD JOURNAL OF BIOLOGICAL PSYCHIATRY
https://doi.org/10.1080/15622975.2022.2112074

ORIGINAL INVESTIGATION

OPEN ACCESS Check for updates

Clinical guidelines for the use of lifestyle-based mental health care in major depressive disorder: World Federation of Societies for Biological Psychiatry (WFSBP) and Australasian Society of Lifestyle Medicine (ASLM) taskforce

Wolfgang Marx[a], Sam H. Manger[b,c], Mark Blencowe[c], Greg Murray[d], Fiona Yan-Yee Ho[e], Sharon Lawn[f,g], James A. Blumenthal[h]*, Felipe Schuch[i], Brendon Stubbs[j], Anu Ruusunen[a,k,l], Hanna Demelash Desyibelew[m], Timothy G. Dinan[n], Felice Jacka[a], Arun Ravindran[o], Michael Berk[a] and Adrienne O'Neil[a]*

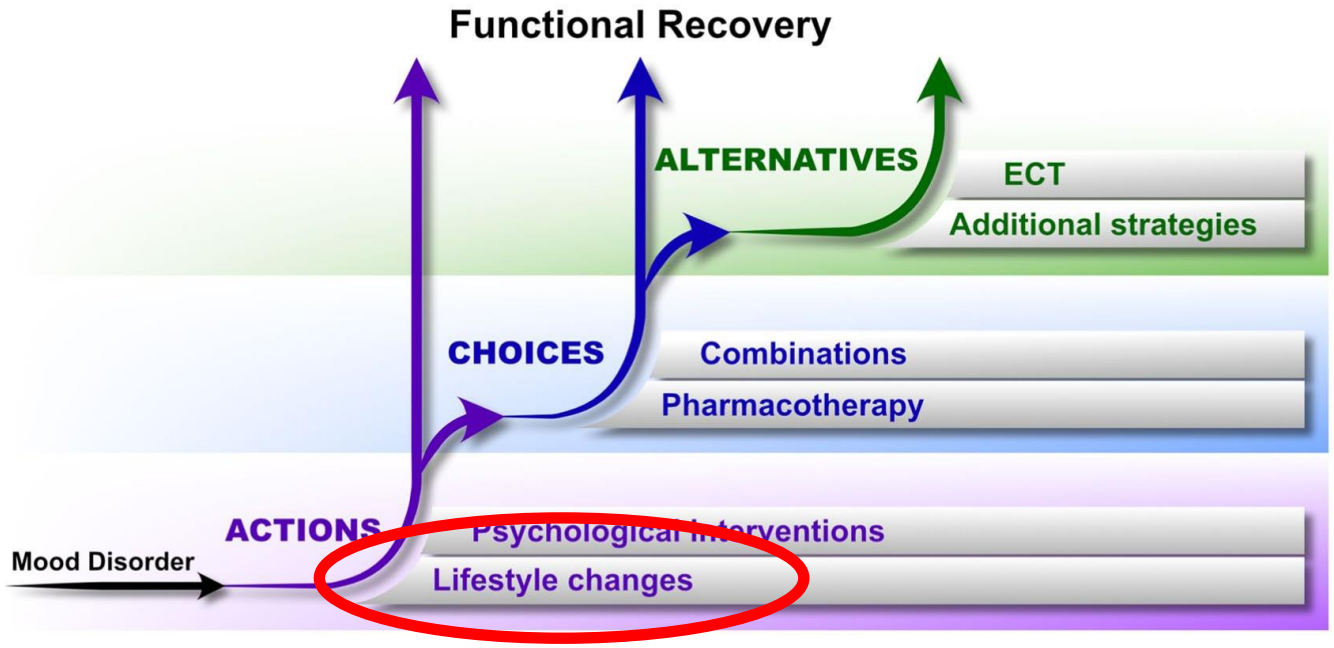
Evidence for lifestyle-based mental health care is compelling

A meta-review of "lifestyle psychiatry": the role of exercise, smoking, diet and sleep in the prevention and treatment of mental disorders

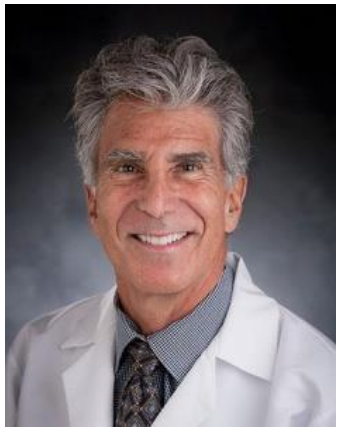
Joseph Firth, Marco Solmi, Robyn E. Wootton, Davy Vancampfort, Felipe B. Schuch, Erin Hoare, Simon Gilbody, John Torous, Scott B. Teasdale, Sarah E. Jackson, Lee Smith, Melissa Eaton, Felice N. Jacka, Nicola Veronese, Wolfgang Marx, Garcia Ashdown-Franks, Dan Siskind, Jerome Sarris, Simon Rosenbaum, André F. Carvalho, Brendon Stubbs ... See fewer authors

"For clinical settings, the findings presented above add to the growing rationale for broad-scale provision of lifestyle interventions within primary and secondary care services for people with mental disorders"

Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders



Lifestyle is now ‘first-line’, ‘non-negotiable’ treatment for mood disorders

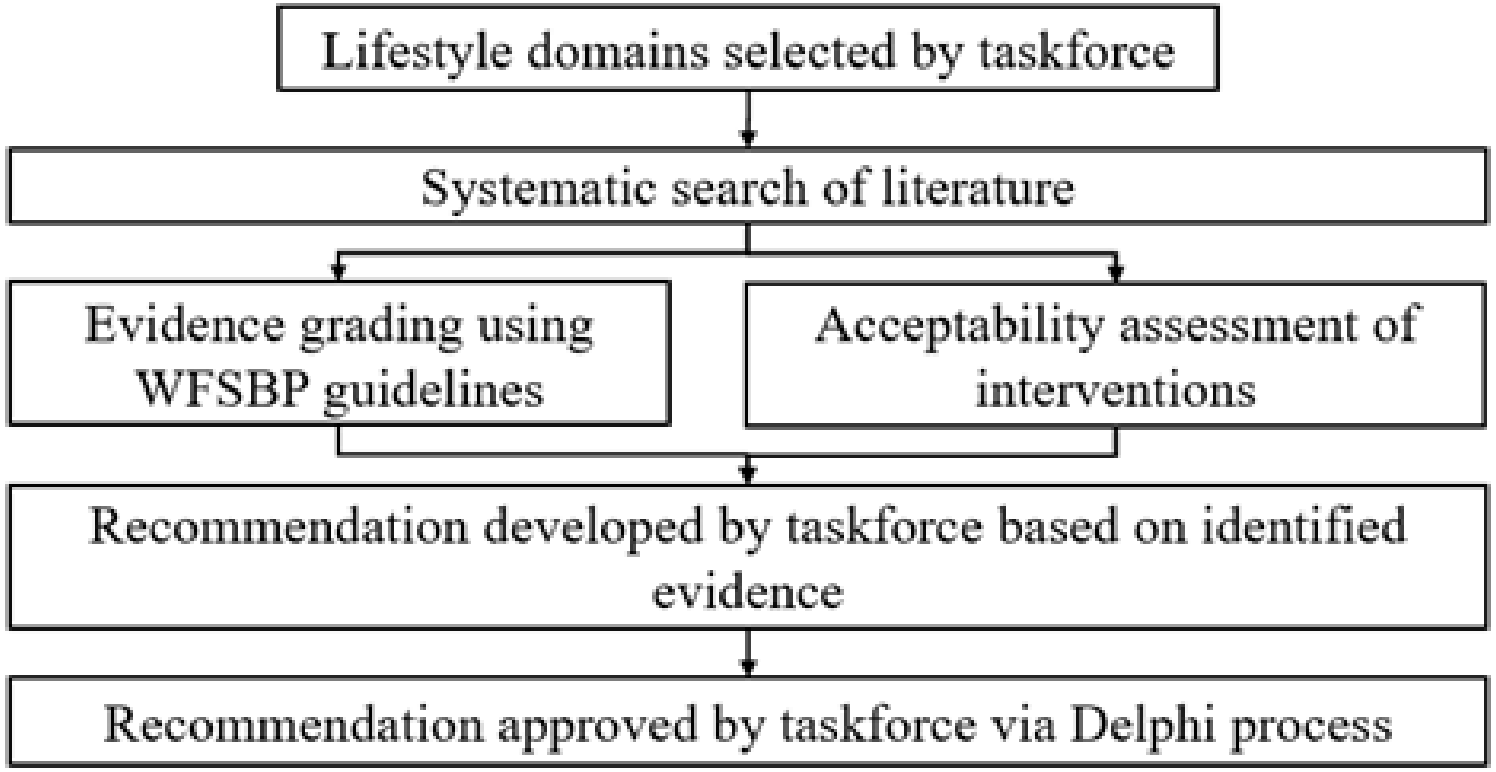








World Federation of Societies of Biological Psychiatry & Australasian Society of Lifestyle Medicine Lifestyle-Based Mental Health Care Clinical Guidelines for the management of depression



Years to complete	Meetings had	Papers screened	Words written	Total Pages	Total references
2.5	120	10,456	38,024	151	364

Strength of supporting evidence / *evidence statement phrasing*
Grade B / *could*
Grade C1 / *may*
Grade C3 / *may*

Domain	**Recommendation statement**	**Level of evidence**	**Recommendation Grade**
5.1 Physical activity and exercise interventions	Physical activity and exercise interventions could be used to reduce depressive symptoms in people with Major Depressive Disorder	Limited; Grade B	2
5.2 Smoking cessation interventions	Smoking cessation interventions that involve nicotine replacement, standard smoking cessation techniques, and/or counselling may be used to reduce depressive symptoms in current smokers with Major Depressive Disorder	Low; Grade C3	3
5.3 Work-directed interventions	A combination of work focused counselling and work-directed interventions could be used to reduce depressive symptoms in people with Major Depressive Disorder	Limited; Grade B	2
5.4 Mindfulness-based and stress management interventions	Mindfulness-based therapies (e.g., Mindfulness Based Cognitive Therapy [MBCT] and Mindfulness Based Stress Reduction [MBSR]) could be used to reduce depressive symptoms in people with Major Depressive Disorder	Limited; Grade B	2
	Stress management and relaxation techniques (e.g., breathing techniques, progressive muscle relaxation, coping skills training) could be used to reduce depressive symptoms in people with Major Depressive Disorder	Limited; Grade B	2
5.5 Dietary interventions	Dietary counselling to improve nutritional habits that is in line with healthy dietary guidelines and/or nutrient-dense dietary patterns may be used to reduce depressive symptoms in people with Major Depressive Disorder	Low; Grade C1	3
5.6 Sleep-related interventions	Cognitive behavioral therapy for insomnia (CBT-I) could be used to reduce depressive symptoms in people with Major Depressive Disorder	Limited; Grade B	2
5.7 Loneliness and Social support- related interventions	Improving social support and reducing loneliness may be used to reduce depressive symptoms in people with Major Depressive Disorder	Low; Grade C3	3
5.8 Green space interventions	Support regarding individualized interaction with green spaces or participation in a green space-focused program may be used to reduce depressive symptoms in people with Major Depressive Disorder	Low; Grade C1	3

Statement: Dietary counselling to improve nutritional habits that is in line with healthy dietary guidelines and/or nutrient-dense dietary patterns may be used to reduce depressive symptoms in people with Major Depressive Disorder

Recommendation Grade: 3
Strength of evidence: Low; Grade C1
Acceptability: Good
Clinical recommendation was based on: 4× randomised controlled trials ($N = 395$ participants) (Jacka et al. 2017; Parletta et al. 2018; Francis et al. 2019; Bayes et al. 2022)
Effect size: Moderate to large (Standardized mean difference = 0.65 − 1.16)
Risk of Bias assessment: High Risk of Bias

Box 6. Clinical advice and tips for diet.

- Encourage adherence to nutrient-dense, minimally processed dietary patterns, such as the Mediterranean diet
- Incorporate joy, social connection, and mindfulness into the 'food experience' where possible
- Where required and available, refer to a trained dietician
- Increase consumption of fruits, vegetables, legumes, wholegrains, nuts, seeds, herbs and spices as tolerated
- Cooking in bulk and freezing, planning meals in advance, and buying frozen vegetables, canned and dried legumes, and tinned fish can be affordable, convenient, and nutrient dense
- Include a high consumption of foods rich in omega-3 polyunsaturated fatty acids and fibre
- Limit intake of ultra-processed foods and discretionary foods, and replace ultra-processed foods with minimally processed nutritious foods
- Consume red meat in moderation and opt for lean sources rather than processed and/or fatty cuts, considering the individual's cultural-religious background
- Include extra virgin olive oil as the main source of cooking and added oil
- Consume the daily recommended water intake
- Avoid excessive alcohol consumption

Partially adapted from Opie et al. *(2017)*

4.3.3. Clinical considerations

4.3.3.1. Determine role of work-related and other factors in MDD. Determining the role of an individual's employment in contributing or causing depressive symptoms is an important initial step in clinical management. This assessment will inform work-related management strategies such as if graded work-directed interventions are available and appropriate. This determination can be made by clinical judgement based on a comprehensive clinical assessment and may be apparent in instances where clinical care has been sought due to mental or psychological injury being reported or where work compensation claims are sought. While there is a lack of appropriately validated tools to assess this, the use of tools such as the Workplace Stressors Assessment Questionnaire and the Work Environment Scale may help guide clinical assessment (see Table 3 in the Implementation Consideration section for further details on assessment tools) (Mazza et al. 2019). Conditions that are commonly comorbid with work-related MDD include musculoskeletal pain, trauma, and substance use (IsHak et al. 2018). Interventions should assess for, and where appropriate, manage these conditions as they may exacerbate and/or prolong depressive symptoms. Please see section 6.2 for further information regarding assessment of lifestyle factors in clinical care.

4.3.3.2. Consider partial return to work where possible. Extended unemployment increases the risk of and may exacerbate existing adverse conditions of unemployment including increased MDD, alcohol abuse, isolation, hopelessness, decreased self-esteem, suicide, financial debt, and diminished social status (Bond et al. 2017; Audhoe et al. 2018). To compound this further, research demonstrates that the probability of returning to work decreases as the length of time since employment increases (Audhoe et al. 2018). Therefore, partial return to work and related strategies such as temporarily reducing work hours, graded exposure to returning to full work capacity, or seeking deployment to achievable duties, should be considered to avoid extended absenteeism (Australasian Faculty of Occupational Environmental Medicine 2010; Mazza et al. 2019).

4.3.3.3. Need for work directed interventions combined with psychotherapy. A recent Cochrane review found that a combination of psychotherapy and work-targeted interventions may be more effective for the management of MDD than work-targeted interventions alone (Nieuwenhuijsen et al. 2020). Work-directed interventions may include modifying expected duties of the role, work routines and work environment, mentor support programs, and education regarding coping skills and compensatory work strategies (e.g. stress management strategies, memory aids) (Lerner et al. 2020; Nieuwenhuijsen et al. 2020). People with higher self-efficacy are more likely to return to work and incorporating interventions that improve self-efficacy may aid in work-directed interventions (Mazza et al. 2019). Additional considerations include addressing perceived work quality (Butterworth et al. 2013), as jobs with a high number of adverse factors (e.g. job insecurity, psychological demands) have a comparable risk of MDD relating to unemployment (Australasian Faculty of Occupational Environmental Medicine 2010). There are now Mental Health First Aid programs that are available in many countries around the world that are designed to assist managers, peers, friends, family and colleagues in responding to mental health concerns. They are increasingly being adapted and delivered in the workplace setting (e.g. (Mental Health First Aid International 2022)).

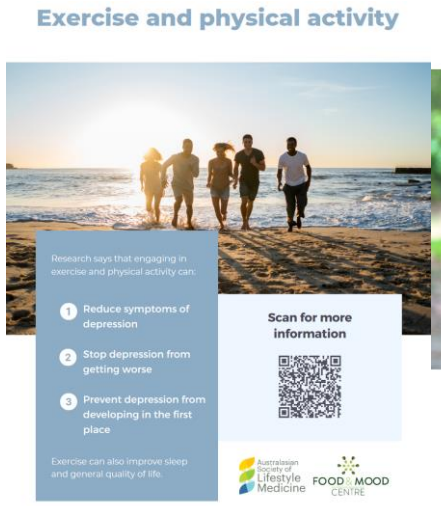
4.3.3.4. Engagement with workplace and occupational therapists. Where possible and with consent from the individual, communication with the employer can assist with treatment through management of work environment-related factors that may be exacerbating symptoms (Pomaki et al. 2010). Relaying concerns of the individual regarding returning to work, perceived barriers, and suggested alternative arrangements to the employer may facilitate work-directed interventions. Furthermore, collaboration with the employer may allow for additional intervention strategies that are difficult to implement without engagement from the workplace. Examples of such work-targeted interventions include partial return, temporary reduction of job demands, and delegating tasks (Finnes et al. 2019). Working with workplace rehabilitation providers, when available, can provide further clinical support, help coordinate, and aid in delivering individualised work-directed strategies and education (Schene et al. 2007; Hees et al. 2013). Further considerations can be seen in Box 4.

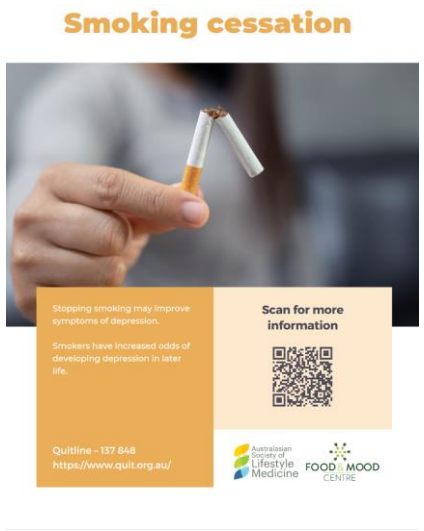
4.3.3.5. Volunteering. Volunteering may be a related avenue where paid employment may not be attainable, feasible, or necessary (e.g. post-retirement). A systematic review of health benefits of volunteering found mixed evidence of positive impacts on MDD, though a greater number of the cohort studies reported reduced levels of MDD than those reporting no benefits (Jenkinson et al. 2013). Heterogeneity across studies makes it difficult to synthesise clear advice, though type of volunteering did not appear to

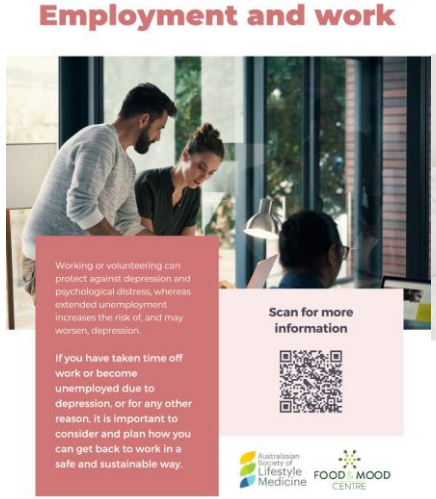
4.5.4. Resources

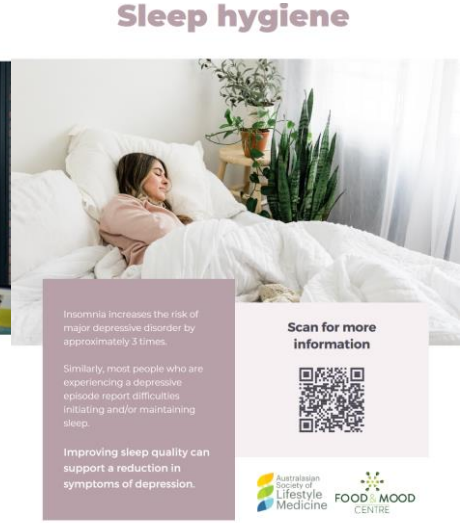
- *The International Society of Nutritional Psychiatry Research (ISNPR) (ISNPR – International Society for Nutritional Research 2021).* The ISNPR is a global network for researchers that aims to promote the generation and translation of high-quality evidence for nutritional approaches to the prevention and treatment of mental disorders.
- *A modified Mediterranean dietary intervention for adults with major depression: Dietary protocol and feasibility data from the SMILES trial (*Opie et al. 2018*).* This publication provides a detailed guide of the dietary intervention used for the SMILES trial and may serve as a valuable reference for future clinical trial design as well as a guide to providing dietary interventions in clinical practice.
- *Food and Mood: Improving Mental Health Through Diet and Nutrition (*FutureLearn 2021*).* A free online course available to the general public on the current evidence regarding dietary interventions in mental health.
- *Feeding melancholic microbes: MyNewGut recommendations on diet and mood (*Dinan et al. 2019*).* Further information regarding specific components of healthy dietary patterns and current evidence for their potential role in MDD.
- *Clinician guidelines for the treatment of psychiatric disorders with nutraceuticals and phytoceuticals: The World Federation of Societies of Biological Psychiatry (WFSBP) and Canadian Network for Mood and Anxiety Treatments (CANMAT) Taskforce (*Sarris et al. 2022*).* Recently published clinical guidelines on dietary supplement interventions in mental disorders

Consumer-friendly resources









- Consumer Resource - Food & Mood
- Consumer Resource - Physical Activity
- Consumer Resource - Sleep
- Consumer Resource - Social Connection
- Consumer Resource - Smoking Cessation
- Consumer Resource - Employment & Work
- Consumer Resource - Green & Blue Spaces
- Consumer Resource - Mindfulness & Stress Management

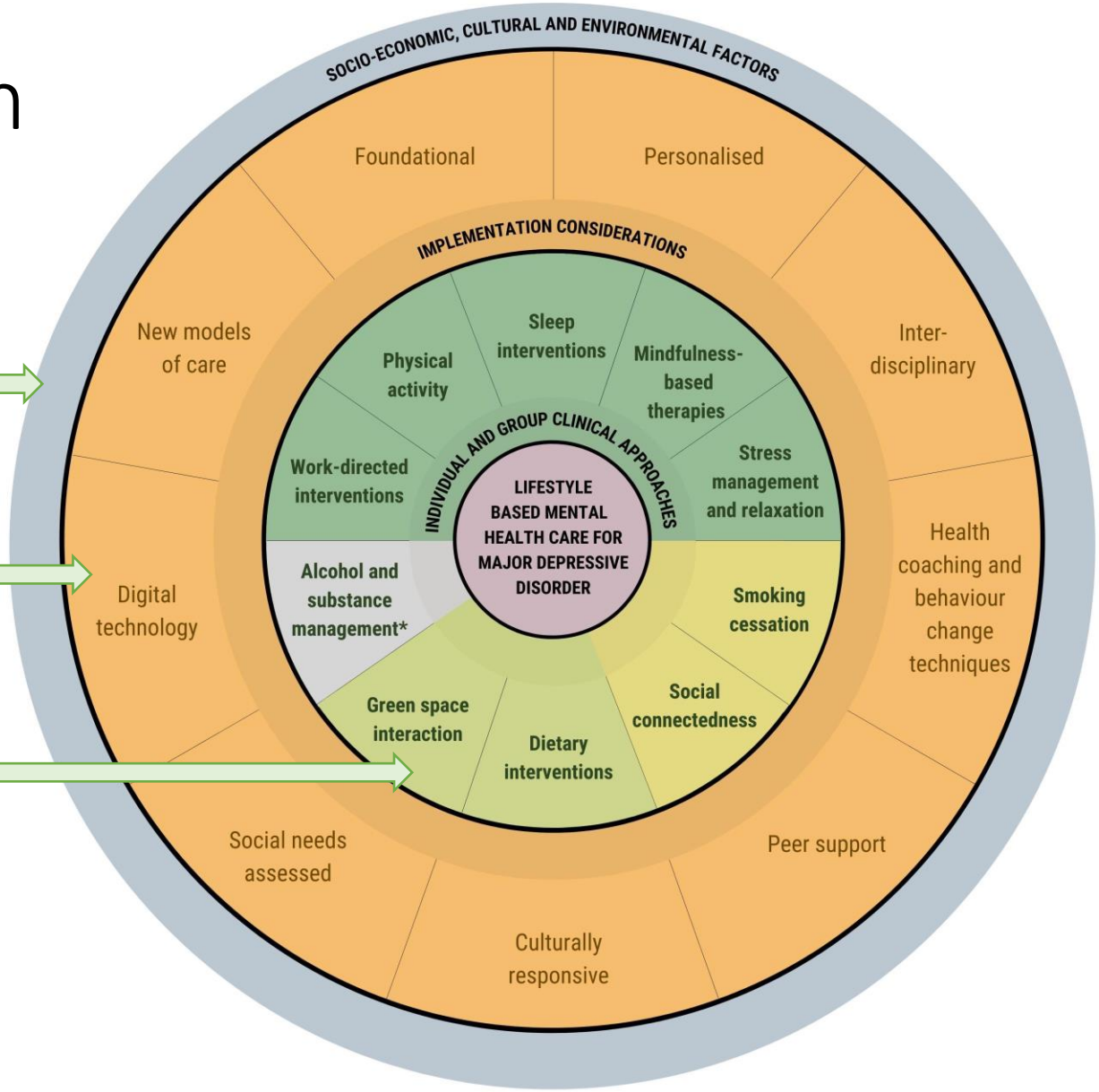
https://foodandmoodcentre.com.au/resources

Options for implementation at each level

Socio-Environmental Advocacy

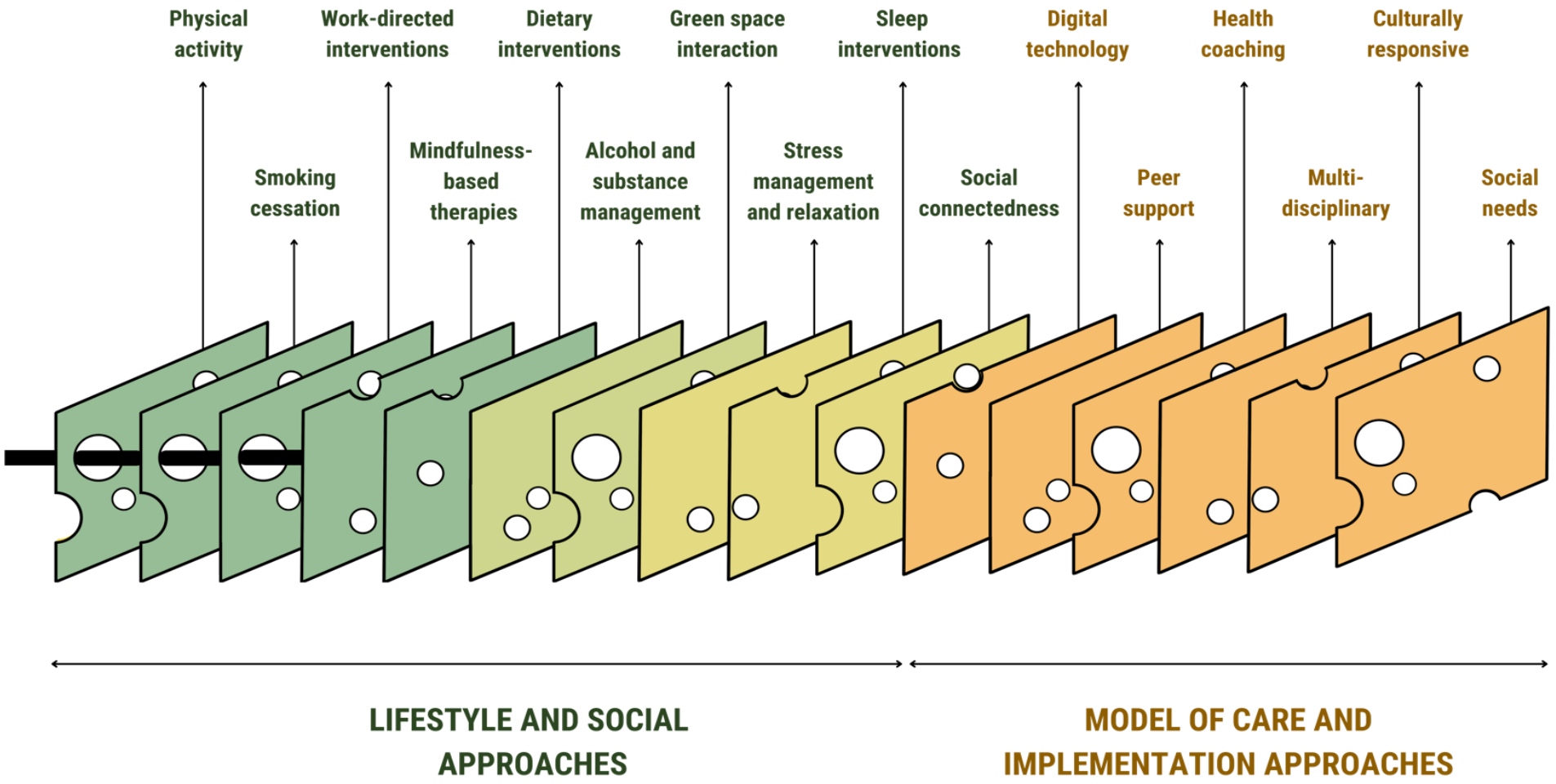
Micro-environments: Clinical and settings models of care innovation

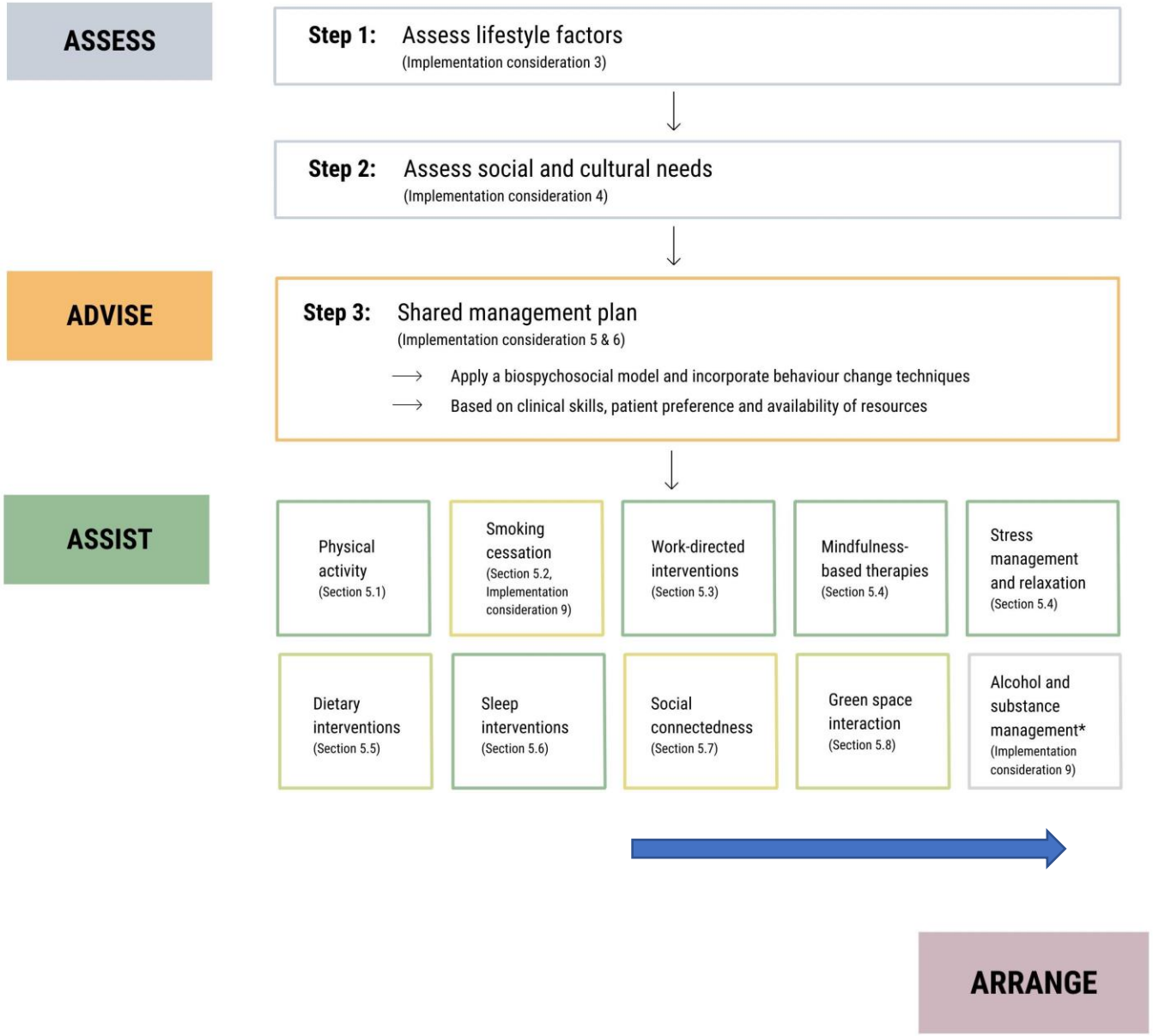
Individual/group knowledge and skills



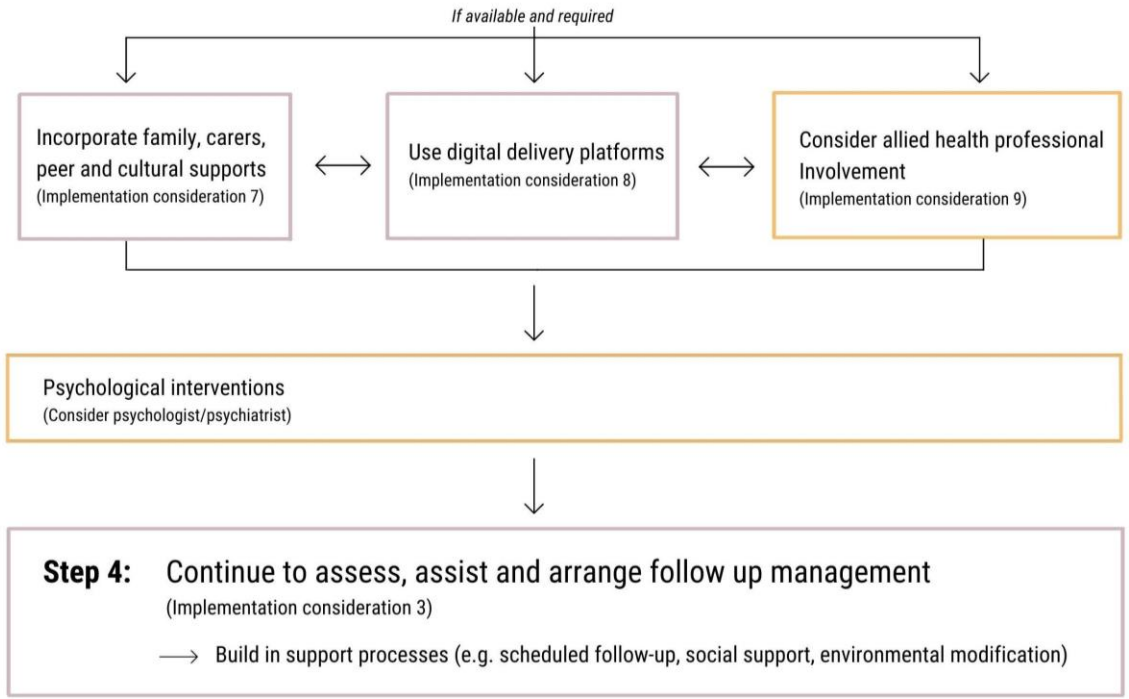
*Not graded as part of these guidelines (we recommend use of complementary AOD guidelines)

Many layers of LM that can make it **effective**





1. Assess
2. Advise: Normalise lifestyle approaches help MH
3. Assist: I am curious to hear your thoughts on what small steps we can make?
    1. *“Can I make a suggestion?” “some ppl find …”*
    2. Reaffirm their values and good choices
4. Arrange:
    1. Refer and resource (local, online)
    2. Accountable - Clinical, social, digital?



Marx W, Manger S, O’Neill A, et al, Clinical Guidelines for the Use of Lifestyle-based Mental Health Care in Major Depressive Disorder: The World Federation of Societies fo Biological Psychiatry and Australasian Society of Lifestyle Medicine Taskforce, The World Journal of Biological Psychiatry, 2022

Do we need new and scaled models? Yes

Image source: pexels

Create space, time, culture

Image source: Dr Sam Manger

Many examples of success

Any questions?