Implementing Lifestyle Interventions in Mental Healthcare: Key Findings from the Third Report of The of The Lancet Psychiatry Physical Health Commission, Commission, Published August 2025

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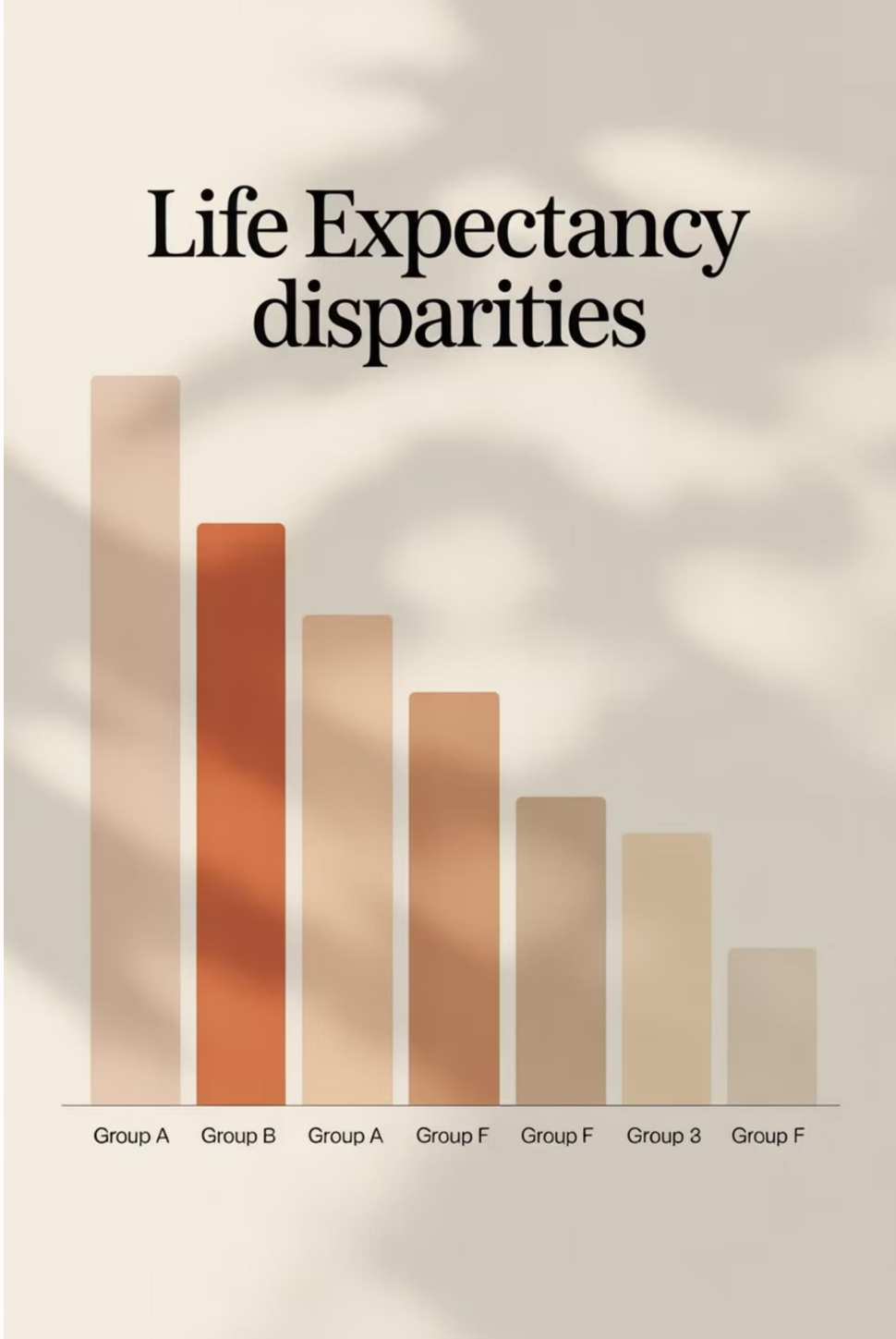
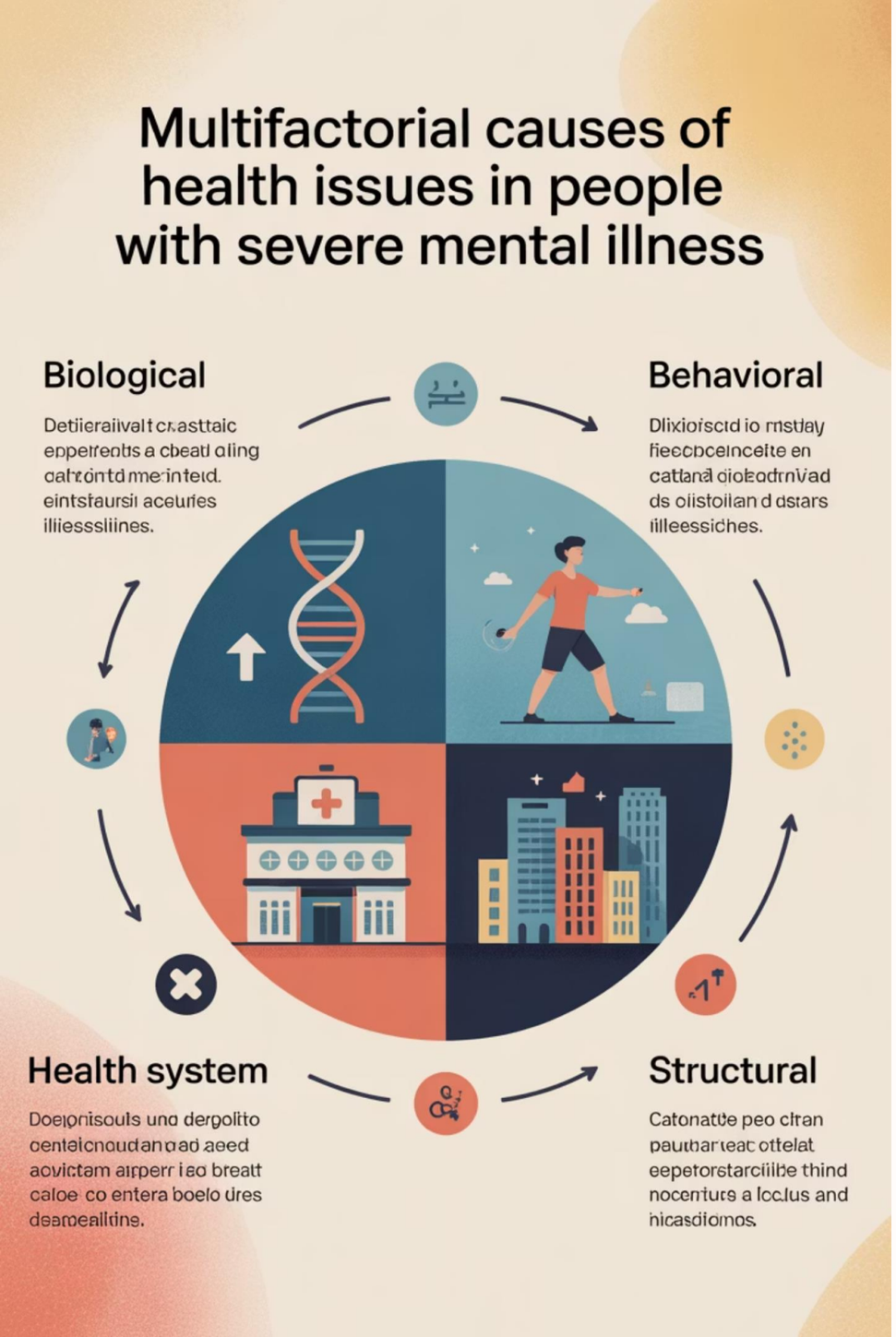
2019 Lancet Psychiatry Commission Overview

Physical health in severe mental illness illness — context for the 2025 Third Third Report

Why It Mattered (2019)

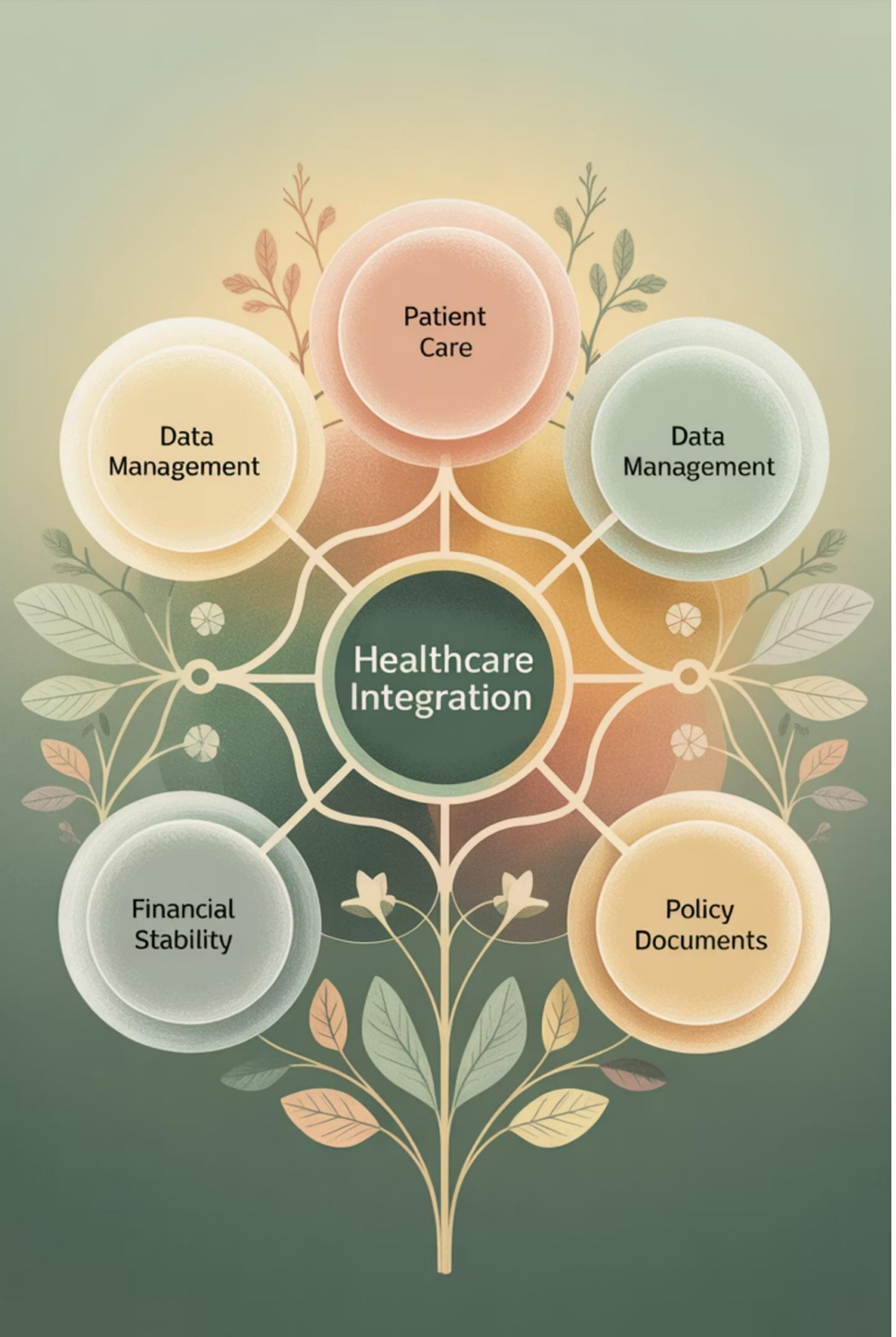
- People with severe mental illness (SMI) die 10–20 years earlier than the general population.
- Approximately 70% of premature deaths are due to preventable physical conditions (CVD, diabetes, cancer, respiratory disease).
- Described as a 'scandal of premature mortality’ an equity and human rights issue.





Key Findings (2019)

- People with SMI have 1.4–2× higher risk of cardiometabolic disease.
- Multifactorial causes:
  - Biological: medication side-effects.
  - Behavioural: smoking, poor diet, inactivity, poor sleep.
  - Health system: under-detection and undertreatment of physical illness.
  - Structural: poverty, stigma, social exclusion.



2019 Recommendations (Themes)

- Integrate physical & mental health care.
  - Screening, prevention, lifestyle interventions in psychiatric services.
- Universal lifestyle targets.
  - Smoking, diet, physical activity, sleep, substance use.
- Policy & system change.
  - Prioritise SMI physical health; fund, incentivise, embed in guidelines.
- Equity.
  - Reduce disparities; extend evidence base to LMIC/Global South.

2019 Report's Core Recommendations

Multiprofessional Clinical Care Care

Promote integrated care models that seamlessly blend physical and mental health expertise within multidisciplinary teams

Health Promotion Priority

Prioritise prevention strategies and health promotion initiatives as fundamental components of mental health treatment

Social Determinants

Address broader social determinants and economic contexts that contribute to lifestyle risk factors and health inequities

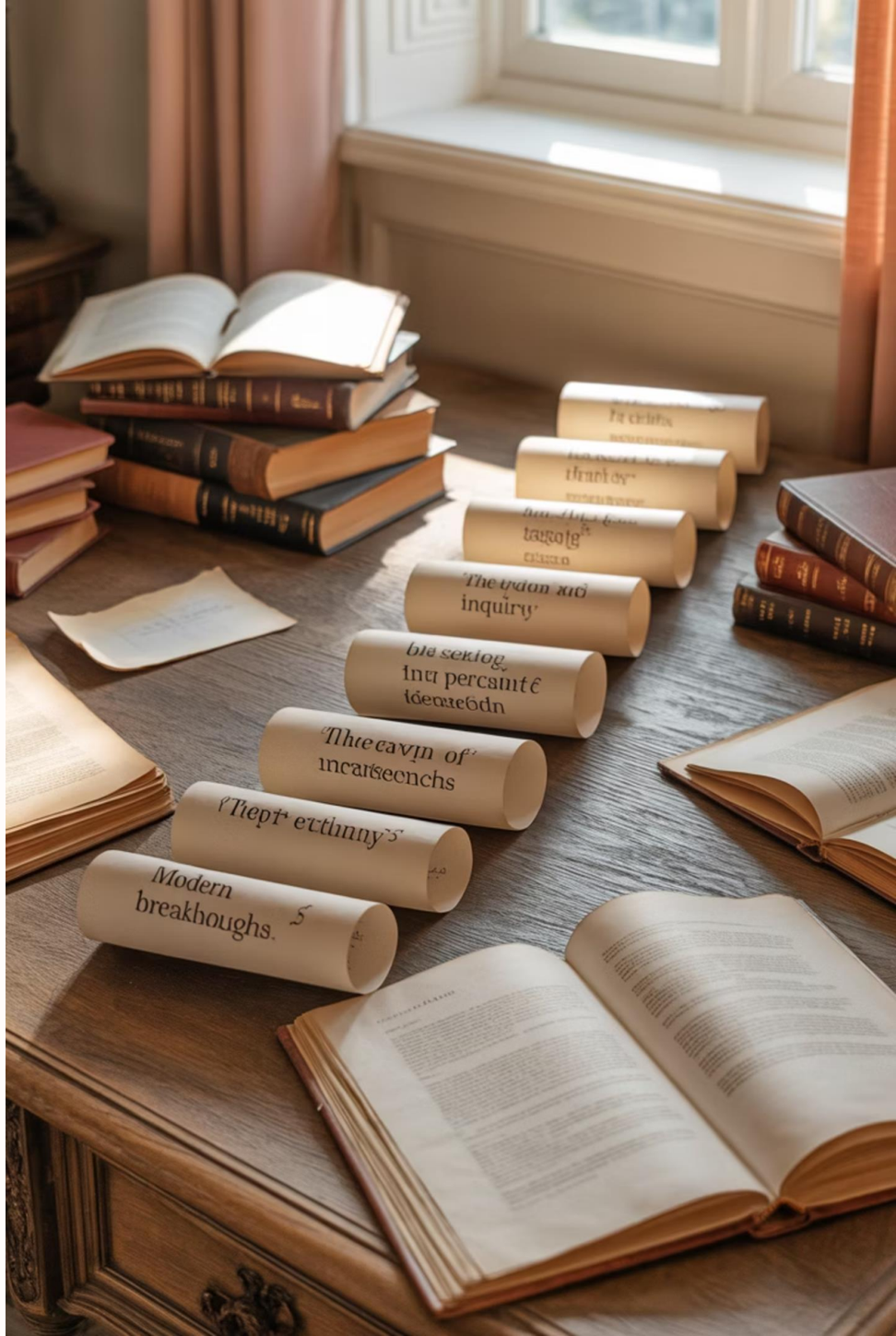
Implementation Research

Call for focused research on effective implementation of lifestyle interventions in real-world clinical settings

Why Move to 2025 (Third Report)?

- 2019 set the mandate, but implementation gaps remained.
- Evidence base has expanded (2018–2023: 99 new reports).

- 2025 shifts focus: from 'what should we do' → 'how do we implement at scale, sustainably, equitably.'



Part 1: What was the effect of the 2019 *Lancet Psychiatry* Commission Commission on the field of lifestyle lifestyle interventions in mental health care?

They analyzed policy documents and journal articles related to lifestyle that cited the 2019 *Lancet Psychiatry* Commission.

As of March 2024, the 2019 *Lancet Psychiatry* Commission had been cited in **17** policy documents and guidelines; **and 319** journal articles that discussed lifestyle interventions.

Aim of Part 1

To assess how much influence the 2019 Lancet Psychiatry Commission (the one on protecting the physical health of people with mental illness) has had. In other words: since that report, **what changes have occurred in terms of policy, research, guidelines, and awareness?**

Methods Used

- They used citation mapping, looking at how often and in what way the 2019 report is cited in policy documents, guidelines, consensus/position statements, and journal articles.
- The cut-off date for data collection was March 2024.

Key findings

Focus of citations

- Many of the journal articles focus on physical activity or a combination of lifestyle factors.
- The policy/guideline documents often reference the 2019 report in terms of acknowledging life expectancy gaps and physical health disparities in mental illness. However, fewer of them explicitly discuss lifestyle interventions in detail (i.e., how to implement them).

Geographical spread and inequalities

- A large majority of the citations and intervention studies are from high-income countries. For example, ~88% of the cited journal articles had lead authors from high-income settings.
- Very few are from low-income or Global South settings, indicating a gap in representation.

Translational / real-world outcomes

- Some concrete changes are noted: inclusion of healthy lifestyle promotion in international psychiatry action plans (e.g., the World Psychiatric Association's Action Plan 2023-2026) and the establishment of special interest groups (e.g., in the American Psychiatric Association) dedicated to lifestyle psychiatry.
- But even with citations, many of the references are more about acknowledging the issue rather than the deep implementation of lifestyle interventions. There are gaps between "we talk about it" and "we do it."

Implications / What This Means

- The 2019 Commission raised awareness and had measurable influence: more research, more policy acknowledgment, and more referencing in guidelines. That's good; the field is moving.
- However, there is a **significant evidence-implementation gap**: simply citing or recognizing the problem is not enough. The challenge lies in turning that into effective, sustainable practice.
- There is a serious lack of diversity in settings (Global South, low-income) both in who produces the research and where interventions are being applied. This means many populations may not benefit equally.

Part 2: What do lifestyle interventions in in mental health services currently look look like?

We investigated how recent lifestyle interventions are being conducted. We present six case studies of grassroots interventions covering physical activity, nutrition, and smoking cessation across both inpatient, community, and outpatient settings in the Global North and Global South.

> Lifestyle interventions were included if they targeted people living with mental illness and focused on multiple modifiable lifestyle risk factors (e.g., physical activity, nutrition, smoking cessation, and sleep), as well as those targeting a single modifiable lifestyle risk factor (e.g., solely physical activity;.

Part 2 — Aim & Scope

- Systematically scoped articles describing lifestyle interventions (Jan 2018 – Aug 17, 2023).
- 99 reports ↔ 89 unique interventions in mental health populations.
- Purpose: map what interventions currently look like and illustrate with 6 case studies (Global North & South).

Lifestyle Interventions in Mental Health Care, Published Between Between Jan 1, 2018, and Aug 17, 2023

Study Characteristics

All but one of the 89 (99%) interventions were conducted in high-income countries. Thirty interventions were from the USA (34%), eight from Spain (9%), eight from Australia (9%), and the remaining interventions were from the UK, Denmark, Sweden, Netherlands, Germany, Switzerland, Italy, and China. The median sample size was 152 participants (IQR 224.25). The duration of these interventions varied widely, with the most common being 3 months (20 studies [22%]), 12 months (15 studies [17%]), and 2 months and 6 months (nine studies [10%] each).

Intervention Type

The types of interventions explored in these studies varied. Fifty-seven interventions (64%) included physical activity as a key intervention component, often implemented through structured aerobic exercise programs. Thirty-seven interventions (42%) incorporated dietary interventions or included nutrition as part of a multicomponent approach. Smoking cessation was addressed in 34 interventions (38%). Sleep interventions, which targeted sleep hygiene or incorporated sleep as part of broader health initiatives, were included in 15 interventions (17%).

Delivery

Involvement of individuals with lived experience of mental illness in the design or development of the interventions was reported for only five interventions (6%), and peer-delivery methods were used in five interventions (6%), predominantly in community settings. Forty-one interventions (46%) exclusively used individual sessions; 25 interventions (28%) used mixed delivery, combining individual and group sessions.

Adherence, attrition, and intervention fidelity

Attrition rates were documented in 64 interventions (72%), with the most common level being low attrition (<20%), observed in 28 interventions (31%). Moderate attrition (20–40%) was reported in 11 interventions (12%), and high attrition (>40%) was observed in seven interventions (8%). Several interventions indicated mixed patterns, such as increasing attrition over time or differences between intervention and control groups.

Adherence was reported for 32 interventions (36%), with high adherence (>80%) noted in 16 interventions (18%), and low or moderate adherence observed in six interventions (7%). Long-term post-intervention follow-ups often revealed substantial drops in adherence, suggesting strong initial adherence during the active study phase, but challenges in maintaining participant engagement over time. Fidelity was reported for only four interventions (4%). The inadequate reporting on adherence to interventions and intervention fidelity emphasises the necessity for improved documentation in future trials of lifestyle interventions for people living with mental illness in accordance with reporting guidelines, such as the CONSORT 2025 statement.

Effectiveness

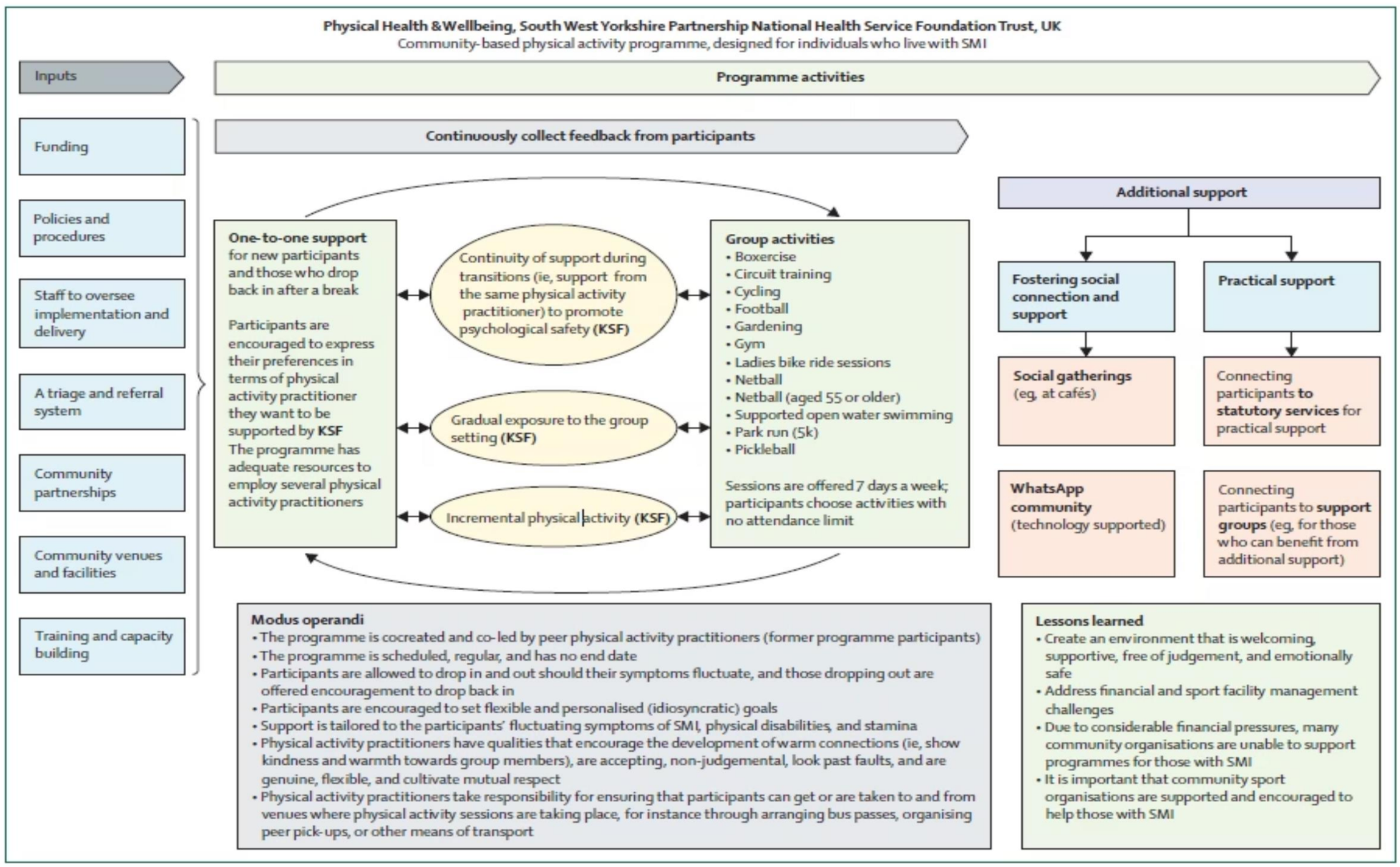
The studies involved the assessment of a wide range of outcomes, including psychiatric, health behaviour, cognition, cardiometabolic, and cost-effectiveness outcomes. Psychiatric and quality-of-life outcomes were reported in 34 studies, with 29 studies (85%) showing positive effects. Of the 26 studies that considered cardiometabolic outcomes, 15 (58%) showed improvements. Other commonly reported outcomes included improvements in smoking cessation and alcohol use (20 [80%] of 25 studies), physical fitness and activity (19 [83%] of 23 studies), sleep (nine [69%] of 13 studies), and dietary knowledge and behaviour (nine [100%] of nine studies). All three studies with cognitive outcomes reported favourable between-group effects.

The evidence base is active and promising across multiple outcomes.

- Reporting gaps (fidelity/adherence) and mixed attrition make it harder to scale reliably.
- Cost-effectiveness data are encouraging but limited; mostly from high-income settings.
- Priorities: better reporting per CONSORT 2025; long-term engagement strategies; more Global South data; include economic evaluations alongside effectiveness outcomes.

Physical Health & Wellbeing, South West Yorkshire Partnership National Health Service Foundation Trust, UK

Community-based physical activity programme, designed for individuals who live with SMI



Modus operandi

- The programme is cocreated and co-led by peer physical activity practitioners (former programme participants)
- The programme is scheduled, regular, and has no end date
- Participants are allowed to drop in and out should their symptoms fluctuate, and those dropping out are offered encouragement to drop back in
- Participants are encouraged to set flexible and personalised (idiosyncratic) goals
- Support is tailored to the participants' fluctuating symptoms of SMI, physical disabilities, and stamina
- Physical activity practitioners have qualities that encourage the development of warm connections (ie, show kindness and warmth towards group members), are accepting, non-judgemental, look past faults, and are genuine, flexible, and cultivate mutual respect
- Physical activity practitioners take responsibility for ensuring that participants can get or are taken to and from venues where physical activity sessions are taking place, for instance through arranging bus passes, organising peer pick-ups, or other means of transport

Lessons learned

- Create an environment that is welcoming, supportive, free of judgement, and emotionally safe
- Address financial and sport facility management challenges
- Due to considerable financial pressures, many community organisations are unable to support programmes for those with SMI
- It is important that community sport organisations are supported and encouraged to help those with SMI

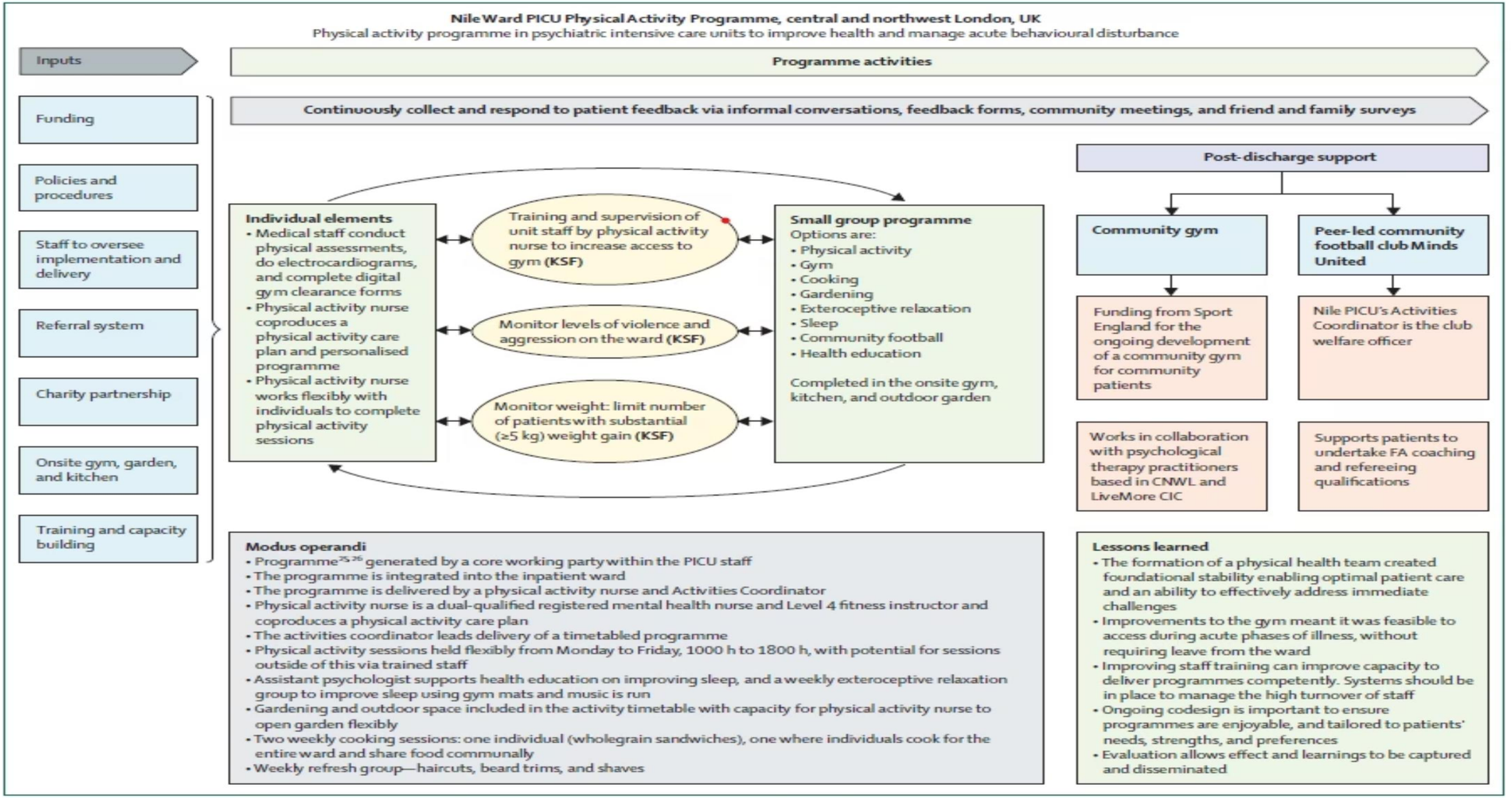


Figure 3: **Case study describing implementation and delivery for the Nile Ward PICU Physical Activity Programme**
Key success factors were determined by both those internal to the programme and Commission authors after the original written submission and during the creation of the figure. CNWL=central and northwest London. CIC=community interest company. FA=Football Association. KSF=key success factor. PICU=psychiatric intensive care unit.

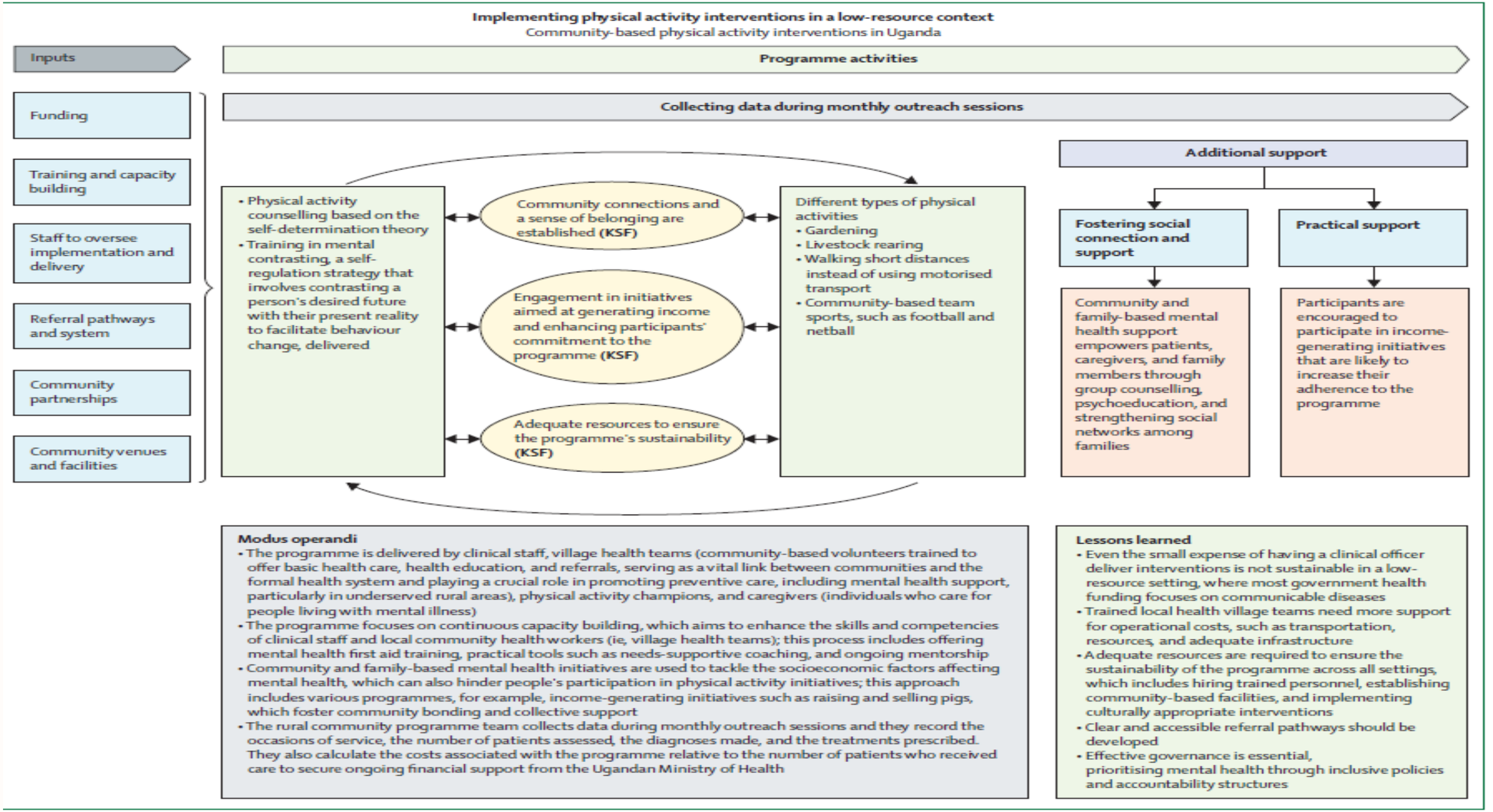


Figure 5: **Case study describing the implementation of physical activity interventions in a low-resource context**
Key success factors were determined by both those internal to the programme and Commission authors after the original written submission and during the creation of the figure. KSF=key success factor.

Part 3: What are the effective components of of lifestyle interventions interventions in mental mental health care?

- We examined a meta-analyses of lifestyle interventions to understand which aspects or elements were more likely to generate beneficial effects on mental and physical health outcomes for people with mental illness.

- We generated eight recommendations that were reviewed by the lived experience groups, the Global South Advisory Group, and a broader authorship team, and modified where appropriate.

What Works — Key Effect Sizes & Components

Theory of Behavior Change (Exercise)

- Interventions grounded in motivational theory (e.g., self-determination, social cognitive, self-efficacy, transtheoretical) improved: (Romain and colleagues)
  - Physical activity: g = 0.27 (k=8)
  - Weight: WMD = −1.87 kg (k=10)
  - BMI: WMD = −0.82 kg/m² (k=11)
  - Waist: WMD = −1.91 cm (k=9)
  - Fasting glucose: g = −0.17 (k=7)

Using one theory outperformed multiple motivational theories (PA: g = 0.34 vs 0.10; weight: −2.51 kg vs −1.72 kg).

Behavior Change Techniques (BCTs)

Goal-setting/planning showed a small 'borderline' PA effect (g≈0.29, k=6). (Romain and colleagues)

- Studies without "social support" and "shaping knowledge" BCT bundles showed larger PA effects (g≈0.26 and 0.45, respectively).
- Vancampfort and colleagues found that fewer participants dropped out of exercise interventions that used autonomous motivation strategies (self-determined, consistent with participants' intrinsic goals) compared with those that did not use autonomous motivation strategies (k=7; 7.2% [95% CI 4.2–12.3] vs k=9; 30.4% [23.6–28.2]).
- Similarly, fewer people dropped out of studies that did not use controlled motivational strategies (non-self-determined, external reasons; e.g., perceived approval) compared with studies that did use controlled motivation strategies (k=12; 12.2% [7.1–20.2] vs k=4; 26.5% [13.8–44.9]).

Mode, Provider, Intensity (Practice-Facing)

- Fernández-Abascal and colleagues found that lifestyle interventions that included individual or group components had similar effects on standard anthropometric and metabolic biochemical parameters; however, the group-based approaches showed **large effects on BMI** (k=18; g=–1.02), whereas individual interventions had a small effect (k=6; g=–0.43).
- Mucheru and colleagues found that lifestyle interventions that offered personalization and consistent progress reviews (i.e., a structured approach) had **larger effects on body weight** (k=4; ES [effect size]=–5.36). In contrast, non-structured approaches did not have a statistically significant effect (k=8; ES=0.39).
- Speyer and colleagues found that lifestyle interventions **delivered as individual sessions had the largest effect on BMI** (k=10; PE=–1.28 kg/m²), followed by combined group and individual approaches (k=15; PE=–0.43 kg/m²). For exercise-specific interventions, **findings were mixed;** both individual and group sessions conferred benefit.
- For nutrition-specific interventions, individual sessions **effectively reduced BMI** (k=3; SMD [standardized mean difference]=–0.30). In contrast, there was no overall effect when including **individual, group, and mixed dietary interventions (k=10; SMD=–0.11).**

Mode, Provider, Intensity (Practice-Facing)

- Mode: Offer both individual and group formats to match heterogeneity in readiness/motivation.
- Provider: Embed exercise/nutrition specialists (with MH training) in services. Where unavailable, upskill MH clinicians/peer workers with supervision.
- ***Rocks and colleagues*** *found that nutrition interventions delivered by dietitians had statistically significant and clinically relevant effects on body weight (k=5; SMD=−0·28). In contrast, there was no overall effect when including both dietitian- and non-dietitian-delivered studies (k=10; SMD=−0·11).* ***Lederman and colleagues*** *reported that exercise interventions that were supervised by qualified exercise professionals had considerably larger effects on sleep quality (k=6; g=1·00) compared with those delivered by less qualified supervisors (k=2; g=0·16). Dropout rates from exercise interventions were lower when they were delivered by qualified exercise experts.* These findings suggested that different types of exercise conferred different benefits and that programmes should be guided by participant preference.
- Intensity: Start manageable; progress to ≥3 supervised sessions/week; integrate health coaching and motivational interviewing.

- ***Pape and colleagues*** **-**interventions that included mainly structured, high-intensity physical activity had a large effect on quality of life (k=5; g=0·92) and higher rates of attendance in lifestyle interventions had a larger effect on quality of life (k=8; g=0·46) than lower attendance rates (k=8; g=−0·02).
- ***Chen and colleagues*** *explored the elements of precision exercise in adolescents with depression. Exercising three times (k=7; SMD=−0·84), or four or five times (k=4; SMD=−0·63), per week rather than once or twice (k=1; SMD=−0·14) and having sessions of 45–50 min (peak: k=4; SMD=−0·93) or 60–75 min (k=3; SMD=−0·65) rather than 30–40 min (k=4; SMD=−0·47) were more effective; and that varying exercise intensities had similar effects.* In other studies that explored intervention intensities, moderate-to-vigorous aerobic exercise and high-intensity interval training, and having at least three sessions per week, had larger effects on various outcomes than lower intensity and fewer sessions.

- **Vancampfort and colleagues** found that dropout rates were similar across intensity levels, but lower for interventions that comprised sessions of **shorter duration** (16 mins, *k*=2; 5% [95% CI 4·2–35·0]; 30 mins, *k*=4; 16% [5·4–39·0]; 60 mins, *k*=2; 20% [5·0–53·9]; 90 mins, *k*=3; 14% [3·7–40·4]).

- Exercise interventions of short **duration (≤10 weeks)** seemed to have a greater effect on mental health outcomes than those with a longer duration. Meta-analyses of exercise interventions offered to people with depression, alcohol use disorder, and severe mental illness found that programs of shorter duration (≤10 weeks) were more effective for various mental health outcomes.

Population & Setting

Offer lifestyle interventions to everyone engaged with MH services (prevention & treatment), not only those with physical comorbidity.

- Inpatient & community both beneficial; e.g., waist circumference reductions were larger in inpatient (k=3, g=−0.69) vs. outpatient (k=10, g=−0.09) settings. ***Fernández-Abascal and colleagues explored the effect of multiple lifestyle intervention elements for people with serious mental illness according to setting. The authors found no clear differences in effect for standard anthropometric or metabolic biochemistry measures***

- Access to a gym or clinic-based exercise facility is important for both outpatient/community and inpatient services, given the potential for larger effects, with home-based regimens potentially able to complement onsite facilities.

- **Speyer and colleagues** found similar effect sizes for lifestyle interventions on BMI by stage of illness (for prevention studies, k=8; PE=–0·56 kg/m²; for intervention studies, k=32; PE=–0·64 kg/m²). **Fernández-Abascal and colleagues** found large effects for lifestyle intervention on BMI and blood glucose during early psychosis (for BMI, k=2; g=–3·66; for glucose, k=1; g=–1·63).

- Early psychosis shows bigger functional gains (g≈0.80, k=2) than persistent schizophrenia (g≈0.36, k=15).

Sleep

Two meta-analyses examined sleep deprivation for depression; broader sleep components (e.g., CBT-I within MH services) remain under-synthesised ---------- a clear evidence gap.

For other outcomes, there were **large effects** of lifestyle intervention on the Positive and Negative Syndrome Scale scores for schizophrenia (*k*=13; *g*=–0·79), a medium effect in first-episode psychosis (*k*=3; *g*=–0·55), and small non-significant effect in schizophrenia spectrum disorders (*k*=5; *g*=–0·27).

There was a large effect on negative symptoms in first-episode psychosis (*k*=3; *g*=–1·00), a moderate effect in schizophrenia (*k*=19; *g*=–0·52), and a small non-significant effect in schizophrenia spectrum disorders (*k*=3; *g*=–0·17). ***Korman and colleagues*** *found a large effect of exercise intervention on global functioning in participants with early psychosis (k=2; g=0·80) and a small-to-moderate effect in persistent schizophrenia (k=15; g=0·36)*. Lifestyle interventions should be offered to all people who are engaged with mental health services, and not solely for the treatment of chronic physical health conditions.

Evidence-based recommendations from meta-research

- Base exercise interventions on a single motivational theory. Include each component of the theoretical model, aim to foster autonomous intrinsic motivation, and avoid using controlled motivational strategies.
- Offer both individual and group-based interventions that can cater to heterogeneous presentations in terms of age, gender, illness severity, readiness, and motivation to change.
- Offer a range of intervention approaches that consider individual needs and preferences to improve adherence and reduce dropout rates.
- Integrate health coaching, behavior change techniques, and the foundational principles of motivational interviewing; this combined therapy can be delivered by upskilled exercise and nutrition practitioners, peer workers, or other healthcare workers.
- Integrate exercise and nutrition specialists (with nationally or internationally recognized qualifications) into mental health services to increase the effectiveness of lifestyle interventions and reduce dropout rates, and train these professionals in mental health; in the absence of specialists, delivery by mental health clinicians and peer workers with additional support, supervision, and training might be effective.
- Start exercise interventions at a manageable level, focus on addressing barriers, consider open goals (based on Swann and colleagues' definition, 'open goals' refer to non-specific, exploratory goals that are often phrased 'See how well I can do...'), and progress intensity and frequency over time, ideally aiming for three or more times per week, and supervised where possible.
- Lifestyle interventions should be prevention-focused and offered to everyone engaged with mental health services (and individuals with an eating disorder should be offered specialist eating disorder treatment); given the systemic health benefits, implementing these interventions early in the illness presents a crucial opportunity to prevent the deterioration of physical and mental health.
- Offer lifestyle interventions in both inpatient and outpatient or community settings.

Part 4: What are the barriers and enablers to the implementation and delivery of lifestyle interventions in mental health settings?

Aim

To systematically map barriers and enablers to implementing lifestyle interventions in mental health services.
Sources: 118 studies (from 2018–2023) across different regions and populations, plus case studies and stakeholder consultations.
Structured using the Consolidated Framework for Implementation Research (CFIR) domains.

Methods

Systematic scoping review of qualitative and mixed-methods studies.
Data coded into CFIR domains:

- Intervention characteristics
- Inner setting (within organisations)
- Outer setting (policy, funding, system-level)
- Characteristics of individuals (service users & staff)
- Process (training, planning, evaluation)

Equity focus: attention to under-represented groups and low-resource contexts.

Key Barriers Identified

Intervention characteristics

- Lack of adaptation to individual needs (one-size-fits-all doesn't work)
- Time intensity and long duration deter uptake
- Limited evidence in real-world settings; lack of fidelity monitoring

Inner setting (organisational)

- Staff shortages, workload pressures
- Lack of leadership buy-in and organisational prioritisation
- Competing demands → lifestyle interventions often sidelined

Outer setting (system-level)

Funding gaps for non-pharmacological interventions.

Policy frameworks acknowledge importance but often don't provide resources.

Reimbursement structures favour medication, not lifestyle care.

Individuals (service users & staff)

Service users: motivational challenges, stigma, comorbidity burden.

Staff: lack of training, confidence, and role clarity.

Process

Poor planning and coordination.

Inconsistent monitoring and evaluation.

Few implementation toolkits or protocols.

Key Facilitators Identified

Co-design with service users → boosts acceptability and engagement.

- Embedding interventions into routine care rather than add-ons.
- Training + supervision for staff, especially task-shifting to nurses/peer workers.
- Leadership support at service and system level.
- Integration with community resources (e.g., gyms, dietitians, quit-smoking services).
- Digital/remote delivery as a supplement (not replacement).

	Providers' perspective	Participants' perspective
Macro	Broad structures that shape health care delivery, such as policy, regulatory mechanisms, and demographics	External factors, such as policy, economic conditions (e.g., recession), societal values, and cultural norms
Meso	Organizational factors, such as leadership, culture, resource availability, data systems, training, and organizational support	Social and environmental contexts affecting participants (e.g., obesogenic hospital environments, stigma, limited resources, and community safety concerns)
Micro	Clinical team-level factors, such as knowledge of lifestyle interventions, familiarity with the evidence base, motivation, and opportunities for action	Individual-level factors, including biological (e.g., mental health symptoms and energy levels), psychological (e.g., motivation and fear), and social or economic constraints

Definitions relevant to the providers' perspective adapted from Fulop and Robert.[56] Definitions relevant to the participants' perspective developed for this Commission report and informed by Leyland and Groenewegen.[57]

Different system levels from the providers' and participants' perspectives

How (can) lifestyle interventions can be implemented in ways that address the needs of people with mental illness?/.

Part 5: Recommendations for implementing lifestyle interventions interventions in mental health services

These recommendations describe the evidence that supports the implementation and delivery of lifestyle interventions in mental health services.

Provide actionable recommendations for implementing lifestyle implementing lifestyle interventions.

- Built from Parts 3–4 evidence + lived experience + Global South input.
- Iterative development:
  - Drafted from 2019 Commission items.
  - Feedback from Global South Advisory Group (n=10) & Lived Experience Groups (n=8).
  - Focus groups (n=8) + GSAG roundtable (n=13).

Perspectives from people with lived experience

Regarding lifestyle interventions, participants acknowledged that the framing of lifestyle in this Commission report was narrow. The **targeted nature was seen as overlooking many fundamental challenges to people's health and well-being**. The effects of disadvantage, inequality, exclusion, and trauma throughout one's life, and intergenerationally, were frequently referred to as the most fundamental issues for people and the **root causes of unhealthy behaviors**. Some participants believed these fundamental issues needed to be solved before other lifestyle options were considered, whereas others recognized the broad value of these approaches at all stages of an individual's journey.

Participants preferred health and well-being to be framed **beyond a biomedical perspective**, emphasizing the importance of tailoring interventions to the diverse needs of target populations (e.g., specific ethnic groups), as well as structural (e.g., type of activity) and contextual (e.g., social support) elements. **Examples included women-only activities**, co-delivering interventions with community members, using convenient locations within the participants' communities, and adapting the content of intervention materials to their faith.

Expand focus beyond individual behavior → consider poverty, inequality, trauma, stigma.

- Relational care: empathy, autonomy, belonging, community connection.
- Authentic co-production: not tokenistic; resourced and meaningful.
- Address discrimination in routine interactions.
- Human connection and supportive relationships as vital as technical content.

Considerations for Global South contexts

In high-income countries, only one in five people receive minimally adequate treatment for depression. This statistic is even worse in low-income and middle-income countries, with only one in 27 people receiving adequate treatment.

In many Global South contexts, high costs and inequitable access to services might result in people seeking alternative care from, for example, religious leaders or traditional healers.

Several factors should be considered for effective lifestyle interventions to be sustainably implemented and scaled up in mental health services across countries considered part of the Global South.

These include resource availability, the potential for task shifting or delivery by lay members of the community (i.e., not only by specialists or clinicians), and the possibility of using other community resources, such as existing mental health programmes.

Addressing macro (system), meso (organisational), and micro (front-line service, individual) level barriers will require engaging policymakers, organisational leaders, clinical staff, people with lived experience, and community leaders (e.g., religious leaders and traditional healers) in the cocreation and codevelopment of lifestyle interventions.

Engaging stakeholders beyond the health-care system will allow for culturally responsive and acceptable lifestyle interventions while fostering sustainable implementation across mental health services. The asymmetry in evidence for the Global South compared with the Global North means there is an urgent need for Global South research to ensure that the allocation of funds matches population needs.

Panel 7: Recommendations for implementation and delivery of lifestyle interventions in mental health services

Implementation

Strategic alignment

- Align priorities for integrating lifestyle interventions with organisational strategy: mission, priorities, and target population
- Develop organisational policies that support the effective implementation and delivery of these interventions

Processes

- Install clear and flexible intervention processes that allow staff sufficient flexibility during implementation and intervention delivery to respond to local and individual needs
- Introduce coordination activities to support implementation efforts and ensure there is adequate capacity within the team to deliver them
- Where feasible, ensure sufficient funding, reimbursement mechanisms, and payment models; attract investment beyond the health-care system by applying for grants from charitable foundations and sponsors
- Conduct ongoing monitoring and evaluation to build confidence in intervention outcomes; the complex nature of the implementation and delivery of interventions in mental health-care settings necessitates a shift from a static, one-off evaluation, to continuous developmental evaluation that facilitates adaptations of interventions as they are being implemented

Culture

- Champion and lead culture change through, for example, mobilising leaders with a mandate to advocate for the integration of lifestyle interventions or advance the steps that leaders should take to ratify the implementation of lifestyle interventions

Skills

- Inspire action through education by dedicating resources and time for staff training, supervision, and education
- Organise regular workshops and seminars for all staff members on lifestyle interventions and their implementation
- Build collaborative learning communities, such as interest groups
- Formally integrate the role of dietitians, exercise professionals, and smoking cessation specialists into mental health services and implement job shadowing to facilitate learning
- Ensure that exercise, nutrition, and smoking cessation

Attitudes

- Foster positive characteristics and attitudes among the personnel who deliver interventions
- Foster a willingness and capability among staff to prioritise lifestyle interventions
- Promote positive attitudes toward different delivery methods for lifestyle interventions, such as telehealth

Implementation aids—facilities, tools, and technology

- Ensure appropriate facilities for delivering lifestyle interventions
- Provide tools for metabolic monitoring and lifestyle assessments
- Use the opportunities presented by telehealth and technology
- Use digital systems to integrate lifestyle interventions into day-to-day care delivery through for example, the use of digital physical health screening forms that prompt referral to physical health professionals
- Use data and information systems to facilitate monitoring of the completion of intervention-related tasks (eg, physical health screening)

Implementation aids—team capacity and capabilities

- Enhance staff capacity to support implementation and delivery efforts by appointing internal implementation leaders and multiple staff members, whose sole role would be to address the physical health of participants or who would be able to dedicate a proportion of their time to the delivery of the interventions
- Weigh the pros and cons of having current members of staff delivering lifestyle interventions versus employing new team members (eg, exercise professionals and dietitians)
- If practicable, offer staff an option to volunteer for the role rather than assigning them to deliver interventions, as this might facilitate ownership and commitment
- Allocate funding for new staff members who will deliver lifestyle interventions (eg, exercise professionals); if required, subcontract the delivery of interventions, or their elements (eg, physical activity sessions), to external providers
- Ensure that management support is available at the front-line team level

External support to enhance the success of implementation efforts

- Include collaborative governance, whereby the capacity for lifestyle interventions for people with mental illness is built through joint decision making and collaborative working

implemented

Culture

- Champion and lead culture change through, for example, mobilising leaders with a mandate to advocate for the integration of lifestyle interventions or advance the steps that leaders should take to ratify the implementation of lifestyle interventions

Skills

- Inspire action through education by dedicating resources and time for staff training, supervision, and education
- Organise regular workshops and seminars for all staff members on lifestyle interventions and their implementation
- Build collaborative learning communities, such as interest groups
- Formally integrate the role of dietitians, exercise professionals, and smoking cessation specialists into mental health services and implement job shadowing to facilitate learning
- Ensure that exercise, nutrition, and smoking cessation specialists who provide lifestyle interventions receive foundational mental health skills training
- Use task shifting or delivery by upskilled lay members of the community in lower-resource settings
- Train mental health practitioners in the delivery of lifestyle interventions (eg, metabolic monitoring and lifestyle assessments)

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External support to enhance the success of implementation efforts

- Include collaborative governance, whereby the capacity for lifestyle interventions for people with mental illness is built through joint decision making and collaborative working
- Engage in proactive outreach and engagement efforts: engage external stakeholders from various sectors at local, national, and international levels to facilitate support for best-in-class efforts that drive the implementation and delivery of lifestyle interventions

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Delivery

Components

- Offer routine metabolic monitoring and follow-up referral to relevant clinical services, in accordance with health service or national guidelines
- Implement multicomponent interventions that include, for example, physical activity, nutrition, and smoking cessation; encourage patients to choose options that meet their needs and preferences
- Integrate health coaching, behaviour change techniques, and the foundational principles of motivational interviewing; this approach can be delivered by upskilled exercise and nutrition practitioners, peer workers, or other health-care workers
- Empower participants through education

Delivery methods

- Offer lifestyle interventions in both inpatient and outpatient or community settings
- Integrate exercise and nutrition specialists into mental health services to increase effectiveness of lifestyle interventions and reduce dropout rates; in the absence of specialists, delivery by mental health clinicians and peer workers with additional support, supervision, and training, might be effective
- Start exercise interventions at a manageable level and increase over time, ideally to three or more times per week
- Offer both individual and group-based interventions that can cater to heterogenous presentation in terms of age, gender, illness severity, readiness, and motivation to change
- Create a safe environment to foster psychological safety
- Provide personalised and flexible services (eg, offer diverse intervention strategies tailored to individual needs and preferences)
- When applicable and desirable, involve the patient's primary social ties, such as family members and friends
- Value the importance of peer-led or peer-delivered lifestyle interventions
- Offer resources to support transitions to healthier lifestyles, such as free nicotine patches, transport for participants to the venue, and resources to support food security

Characteristics

- Provide the necessary support for participants to initiate and maintain lifestyle changes
- Lifestyle interventions should be prevention focused and offered to everyone engaged with mental health services
- Those with an eating disorder should be offered specialist eating disorder treatment

Crafting—key principles for success

- Ensure interventions are culturally responsive
- Ground exercise interventions in a single motivational theory and include each component of the theoretical model
- Aim to foster autonomous intrinsic motivation and avoid controlled motivational strategies (ie, non-self-determined or for external reasons, such as perceived approval)

CONCLUSION

- Lifestyle interventions must move from being optional add-ons → to being routine, core components of mental health care.
- Successful implementation requires:
  - Multi-level action (macro–meso–micro).
  - Sustained investment and workforce planning.
  - Better reporting of reach, adherence, fidelity, attrition, and outcomes.
  - Embedding co-production with service users and carers.
- Equity and cultural adaptation are critical, especially for the Global South.
- The Commission's message: Lifestyle care is not "nice to have" — it is essential, feasible, and a matter of parity and human rights.

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