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Author Contribution
All authors contributed to formulating the research question and study/workshop design. RO and WM organised and conducted the symposium. LKR consolidated and analysed response data and wrote the manuscript, which was approved by all authors.

Data Availability
Data relevant to this article is presented within the manuscript and its supplementary materials. Any additional information can be made available from the corresponding author [LKR] upon request.

Abstract

Background: Evidence supporting lifestyle-based mental healthcare has expanded, but translation into routine services requires coordinated research on effectiveness, safety, implementation, scalability, and equity. A shared research agenda could help guide this work in Australia.

Aims: To identify researcher- and clinician-informed priorities for advancing lifestyle psychiatry in Australia over the next decade.

Method: A modified nominal group technique was used with 58 researchers and clinicians at the inaugural Australian Lifestyle Psychiatry Symposium in Melbourne on 19 March 2026. Independent priority generation, facilitated discussion, and two anonymous voting rounds informed thematic synthesis. Previously co-developed lived experience priorities informed deliberations, and the final agenda was circulated to attendees for review and approval.

Results: 58 participants voted in round one on 39 group-generated priority statements. The top 18 priorities were shortlisted and consolidated into 16 for a second vote completed by 43 participants. Eleven priorities were selected, retaining both statements tied at 10th place, and grouped into four themes: identifying high-quality standardised evidence; evaluating and actioning implementation; understanding scalability; and identifying equitable implementation strategies. Priorities addressed effectiveness, tailoring, harms, workforce training, routine-care implementation, digital delivery, economic evaluation, partnerships, and adaptations for disadvantaged communities, diverse populations, and reproductive stages.

Conclusions: The priorities provide an Australian researcher- and clinician-informed agenda for studying effective, sustainable, and equitable lifestyle psychiatry. Broader stakeholder involvement and periodic reassessment are needed to strengthen its relevance and support coordinated research investment.

Introduction

Lifestyle psychiatry has progressed from evidence linking health behaviours with mental health towards questions of their translation into practice. Recently, an international conceptual framework sought to establish a shared understanding of lifestyle psychiatry and its application within mental health care, emphasising person-centred, recovery-oriented, and context-sensitive practice (Deenik et al., 2025). Calls to move "from impact factors to real impact" have consequently emphasised the need to study implementation alongside intervention effectiveness and to account for the workforce, organisational, and policy conditions required for routine delivery (Deenik et al., 2020). The third report of the *Lancet Psychiatry* Physical Health Commission similarly identifies implementation as a central challenge for integrating lifestyle therapies into mental healthcare and highlights the importance of multilevel action across individuals, workforces, organisations and systems (Teasdale et al., 2025). The field-level gap addressed here concerns how Australian researchers and clinicians collectively prioritise the evidence and implementation work needed to advance this agenda.

At the same time, lifestyle psychiatry spans multiple behavioural domains, disciplines, populations, intervention types, and service settings. This breadth creates substantial opportunity, but also a risk of fragmented terminology, duplicated effort, and research that is difficult to compare or translate. Coordinated research priority setting can help direct limited resources towards questions considered important by relevant stakeholders and make the values and assumptions informing an emerging research agenda more explicit. Transparent reporting is particularly important because priority setting is not value-neutral: its outputs depend on who participates, the criteria participants are asked to consider, how candidate priorities are combined, and how final decisions are made (Tong et al., 2019). Structured consensus methods such as the nominal group technique can support broad idea

generation and reduce the influence of dominant voices by combining independent generation, facilitated discussion, and individual voting (McMillan et al., 2016).

Internationally, the LifePsych Society identified priorities and opportunities in lifestyle psychiatry spanning research innovation, inclusivity, clinical implementation, and global collaboration (Firth et al., 2025). Within Australia, however, there has been limited opportunity for researchers and clinicians working across lifestyle domains to collectively identify nationally relevant priorities, particularly those concerned with implementation, equity, and translation into practice. The inaugural Australian Lifestyle Psychiatry Symposium (ALPS) was convened to provide such a platform. It aimed to align research efforts, foster collaboration, and define a shared agenda capable of informing future research initiatives, working groups, and funding discussions.

The aim of the priority-setting exercise within the symposium was to identify a concise set of ten research priorities for advancing lifestyle psychiatry in Australia over the following decade. This article reports the methods and resulting agenda and critically interprets the themes that emerged.

Methods

Design and Setting

A structured, multi-stage research priority-setting workshop was conducted as part of the inaugural ALPS, attended by 58 researchers and clinicians on 19 March 2026 in Melbourne, Australia. A modified nominal group technique (Wiggins et al., 2020) was used to combine independent idea generation, small-group deliberation, whole-group discussion, iterative refinement, and anonymous voting. The approach was modified to accommodate the number of participants and the broader symposium format, including the use of an audience-

response platform, table-based group work, an expert panel, and a post-symposium online voting round.

The exercise was designed to identify 10 high-priority research priorities capable of advancing lifestyle psychiatry in Australia during the next decade. Participants were asked to consider all lifestyle psychiatry pillars, clinical and non-clinical populations, and potential settings. Throughout the process, they were prompted to consider feasibility, potential impact, translation into practice, scalability, and equity. These criteria were intended to direct attention towards priorities that were not only scientifically important but also capable of informing meaningful policy, practice, or population benefit. Reporting was informed by principles for structured consensus methods and transparent priority-setting research (McMillan et al., 2016; Tong et al., 2019).

Participants, priority generation, and discussion

Participants comprised a purposive national sample of 58 researchers and clinicians with expertise relevant to lifestyle psychiatry. Attendees represented universities, health services, research institutes, and not-for-profit organisations. They brought experience across lifestyle domains, disciplinary backgrounds, populations, clinical settings, and career stages. Participation in the symposium and priority-setting workshop was advertised online through the International Society for Nutritional Psychiatry Research (ISNPR) and Deakin University, and shared between researcher communities on LinkedIn, with a registration cost of AUD$70. Priorities previously co-developed with seven people with lived experience were presented before the workshop to inform deliberation; these were not combined numerically with the researcher and clinician voting data.

Participants independently submitted two to three candidate priorities through Mentimeter (an online audience-response platform), generating 122 statements. Facilitated small-group discussions then considered the importance of the proposed priorities and gaps

across populations, settings, and lifestyle domains. An expert panel and plenary discussion then considered implementation challenges, translation, and equity (See Supplementary Materials for program). Participants then returned to their small groups and collectively submitted their three highest priority statements, resulting in 39 priorities. Throughout the exercises, participants were encouraged to consider feasibility, potential impact, scalability, translation into practice, and equity.

Voting and refinement

Fifty-eight participants completed the first anonymous in-person vote on 39 candidate statements, each allocated five unranked selections. The organising team aimed to retain the upper 50% of the first-round ranking. The statement at the 18th position received seven votes, whereas the statements at the 19th and 20th positions each received six votes. The shortlist was therefore closed at the 18th position, retaining all 18 statements receiving at least seven votes (12.1% endorsement from first-round voters; 46.2% of the 39 candidate statements). Clarifying wording and combining overlapping statements then produced 16 distinct candidates for the second vote, grouped under four themes (see Table 1).

The 16 refined priorities were circulated electronically for a second anonymous vote, completed by 43 participants through Mentimeter two weeks after the symposium took place. Participants could choose five unranked selections from this shortlist. The second round determined relative priority among the refined statements; votes from the two rounds were not pooled. The organising team sought a concise set of ten leading priorities. The cutoff intersected a tie, with two statements each receiving ten votes (23.3% of second-round voters) at the tenth-place boundary. Both were retained, yielding 11 top priorities and avoiding an arbitrary distinction between equally supported candidates (as in CCAA, 2026; Cochrane Hypertension, n.d.).

The resulting priority set and wording were circulated to symposium attendees for review and approval before they were finalised (Supplementary Materials). This provided an opportunity to identify omissions or changes in meaning introduced during refinement.

Ethical approval and consent

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. The researcher priority-setting exercise was approved by the Deakin University Human Research Ethics Committee (project 2025/HE001221). The separate lived-experience priority-setting activity conducted by the ALPS team was approved under project 2025/HE001120. Written informed consent for publication of aggregate de-identified data was obtained when participants registered for the workshop and symposium.

Results

Participant characteristics

ALPS brought together 58 researchers and clinicians from four Australian states: Victoria, Queensland, New South Wales, and South Australia. Participants represented universities, health services, research institutes, and not-for-profit organisations, and included students and early-, mid- and established-career researchers and clinicians. 43 participants identified as female, 14 as male, and one as non-binary. 13 participants (22.4%) resided in regional areas, and 53.4% reported personal lived experience of mental health challenges. This latter characteristic indicates that lived experience was present within the symposium community, although most participants contributed principally in researcher or clinician roles rather than as formally recruited lived-experience representatives.

Priority consolidation

The priority-setting process produced 11 final priorities, which were organised under four overarching themes: identifying high-quality standardised evidence; evaluating and actioning implementation; understanding scalability; and identifying equitable implementation strategies. Table 1 shows the number of votes received for each priority during the first and second rounds, and the percentage of participants who endorsed them (five votes per participant). The final 11 priority statements are highlighted and include both statements tied at the tenth-place cutoff, each with ten selections (23.3%).

Table 1.

Australian lifestyle psychiatry researcher priorities

First vote n (%) N = 58	Workshop Priority	Refined Priority[$]	Second vote n (%) N = 43
Identifying High-Quality Standardised Evidence			
17 (29.3%)	Large scale 'hybrid' trials that have diverse populations and that allow for subgroup analysis and inform tailoring.	**Determine real-world effectiveness and inform lifestyle psychiatry intervention tailoring through large scale hybrid trials with diverse populations that allow for subgroup analysis.**	**28 (65.1%)**
9 (15.5%)	To identify minimum data quality indicators and links with data capture infrastructure, with the purpose to inform national standards and data collection procedure.	Determine minimum data quality indicators and appropriate collection infrastructure to inform national standards and data collection procedures.	9 (20.9%)
8 (13.8%)	Determine the efficacy of lifestyle psychiatry principles across all populations (not just those experiencing mental health illness).	Determine the efficacy of lifestyle psychiatry interventions across all populations, including those not experiencing any mental health conditions.	8 (18.6%)
7 (12.1%)	Identify the unintended harms of lifestyle focused interventions (eating disorders, exercise addictions, body dysmorphia, self-harm).	**Identify the unintended harms of lifestyle focused interventions (eating disorders, exercise addictions, body dysmorphia, self-harm).**	**11 (25.6%)**
Evaluating and Actioning Implementation			
15 (25.9%)	Evaluate and develop effective training in lifestyle psychiatry for all multidisciplinary staff, including allied health professionals.	**Evaluate and develop effective training in lifestyle psychiatry for multidisciplinary staff, including mental and allied health professionals.**	**28 (65.1%)**
12 (20.7%)	Determine how best to leverage technology to deliver scalable personalised digital lifestyle interventions.	**Determine how best to leverage technology to deliver scalable personalised digital lifestyle psychiatry interventions.**	**10 (23.3%)**
10 (17.2%)	Develop effective implementation strategy evaluations that capture barriers, enablers, and harms, to	**Understand for who lifestyle psychiatry interventions work and why using implementation evaluations**	**12 (27.9%)**

	identify what works for who and why.	**that capture barriers, enablers, and harms.**	
8 (13.8%)	Understand the steps towards closing the gap between research and real-world implementation	**Understand the steps towards closing the gap between research and real-world implementation of lifestyle psychiatry, by implementing and evaluating lifestyle interventions within routine care.**	**21 (48.8%)**
7 (12.1%)	Implementation and evaluation of sustainable lifestyle interventions within usual care/real-world settings and routine care.		
Understanding Scalability			
14 (24.1%)	Implement meaningful partnerships (e.g. between doctors, policy makers, lived experience/peer-support, allied health) that enable holistic approaches to mental health.	**Identify meaningful partnerships (e.g. between doctors, policy makers, lived experience/peer-support, allied health) that will enable holistic mental healthcare.**	**12 (27.9%)**
11 (19.0%)	Conduct health economic modelling that considers context and population, to inform policy and funding, through understanding the cost-effectiveness of lifestyle psychiatry interventions.	**Evaluate the cost-effectiveness of lifestyle psychiatry interventions across diverse populations and contexts to inform policy and funding decisions.**	**15 (34.9%)**
7 (12.1%)	Understand how to influence environmental determinants to effectively improve lifestyle behaviours.	Identify methods to modify environmental determinants to enable and sustain population-level improvements in lifestyle behaviours.	5 (11.6%)
7 (12.1%)	Determine the best way to leverage and integrate peer support workers to deliver lifestyle interventions in mental health services.	Determine the best way to leverage and integrate peer support workers to deliver lifestyle interventions in mental health services.	7 (16.3%)
Identifying Equitable Implementation Strategies			
13 (22.4%)	Understand how inclusive (neuro-affirming, culturally sensitive, accessible) lifestyle psychiatry can be implemented across health settings and life stages.	**Understand how inclusive (neuro-affirming, culturally sensitive, accessible) lifestyle psychiatry interventions can be implemented across health settings and life stages.**	**14 (32.6%)**
10 (17.2%)	Determine implementation strategies for lifestyle psychiatry in low socioeconomic settings.	**Identify how to adapt lifestyle psychiatry implementation strategies to ensure effectiveness and access equity for marginalised and low SES communities.**	**17 (39.5%)**
8 (13.8%)	Identify how to adapt lifestyle interventions to ensure equity of access for communities experiencing marginalisation.		
9 (15.5%)	Understanding which aspects of lifestyle psychiatry are priorities for populations who we are not reaching within our current services and service models.	Understand which aspects of lifestyle psychiatry are priorities for populations who we are not reached within our current services and service models.	8 (18.6%)
7 (12.1%)	Determine how lifestyle psychiatry is implemented across key reproductive stages for women and girls.	**Determine how lifestyle psychiatry implementation can be adapted across key reproductive stages of women and girls.**	**10 (23.3%)**

Note. Endorsement was defined as the proportion of voters in a given round selecting an item. Values are numbers of selections and percentages of voters in each round. Two overlapping pairs from the first-round shortlist were consolidated, leaving 16 candidates for the second vote. First-round counts for merged statements are not added because the same participant may have selected both. As the sample differed between rounds, changes in

endorsement percentages are not evidence of increasing agreement or changing preferences within individuals. [$]The final set of refined priorities are bolded.

Discussion

Principal interpretation of the agenda

The ALPS priorities reflect a field seeking to progress from accumulating evidence of association and efficacy towards establishing real-world, equitable, and sustainable application. This direction is consistent with international lifestyle psychiatry priorities and health-system frameworks, which emphasise inclusive research, improved clinical implementation and collaboration, and multilevel integration into mental healthcare and support (Deenik et al., 2025; Firth et al., 2025; Teasdale et al., 2025). Importantly, this translational emphasis does not mean that efficacy questions have been resolved across every lifestyle domain or mental disorder. Effectiveness research should continue, but be designed to yield information about implementation, variation in response, and equity. This would offer significant value to the field compared to treating these concerns as something that can be deferred until after efficacy has been established.

Large, diverse hybrid trials can support analysis of differential outcomes, but only if benefit, harms, and implementation outcomes are prospectively specified and measured. Routine-care evaluation may improve external validity, but it does not produce equitable implementation unless recruitment pathways, service access, and adaptations are examined across social and population groups. Similarly, identifying barriers and enablers has limited translational value unless findings inform the selection and testing of implementation strategies. The agenda therefore supports a cumulative research program in which effectiveness and implementability are examined together and re-evaluated as lifestyle therapies move between populations and service contexts.

The four themes provide a structure for interpreting the full agenda. Identifying high-quality standardised evidence concerns effectiveness, variation in response, and safety; evaluating and actioning implementation concerns workforce preparation, routine-care delivery, explanatory evaluation, and technology; understanding scalability concerns economic evidence and partnerships; and identifying equitable implementation strategies concerns structural disadvantage, inclusive practice, and adaptation across reproductive stages. These themes are interdependent: the value of a scalable delivery model depends on whether it can be delivered competently, sustained within available resources, and accessed by the people it is intended to serve.

The following sections focus on the top 11 priorities by theme and in the order in which they appear in Table 1.

Identifying high-quality standardised evidence

Priority: "Determine real-world effectiveness and inform lifestyle psychiatry intervention tailoring through models such as large-scale hybrid trials with diverse populations that allow for subgroup analysis".

This priority links three needs that have often been addressed separately: testing effectiveness under conditions resembling practice, examining how implementation operates in those conditions, and generating evidence capable of informing tailoring. Effectiveness–implementation hybrid designs were developed to integrate clinical and implementation questions within a single program of research, with the balance between these aims varying across three broad hybrid types (Curran et al., 2012). Subsequent reflections have emphasised that a study should not be labelled hybrid simply because it reports a small number of feasibility measures; clinical and implementation aims, outcomes, and design features should be specified prospectively and supported by appropriate implementation theory and methods (Curran et al., 2022).

As lifestyle therapies are often complex and adaptable, they may be delivered by different health professionals, with outcomes depending on participant motivation, material resources, social support, and local service structures. Consequently, average symptom change observed in a controlled trial provides limited information about whether delivery can be reproduced, who is reached, which adaptations are necessary, or what resources implementation requires. Hybrid research offers a means of studying these questions without maintaining a rigid separation between effectiveness and implementation. Examples are emerging (Smit et al., 2022) but remain comparatively limited relative to the breadth of the lifestyle psychiatry evidence base.

The priority's emphasis on diverse populations and subgroup analysis is also consequential. Diversity in participant recruitment is necessary for relevance and equity, but diversity alone does not ensure that a trial can reliably identify differential benefit. Subgroup and predictive analyses require adequate sample sizes, prespecified hypotheses where possible, and methods capable of distinguishing prognostic factors from genuine treatment-effect modification. The PATH Statement cautions that analyses of treatment-effect heterogeneity can generate unstable or misleading findings when data-driven subgroups are examined without appropriate modelling, validation, and attention to absolute effects (Kent et al., 2020). Large-scale hybrid trials should therefore be designed not merely to include diverse participants, but to support sufficiently powered, theoretically justified, and externally validated analyses.

Priority: "Identify the unintended harms of lifestyle focused interventions (eating disorders, exercise addictions, body dysmorphia, self-harm)".

Lifestyle therapies may be perceived as intrinsically low risk because they involve behaviours commonly promoted for general health. This assumption can obscure the need for systematic safety planning, measurement, and reporting. Physical activity interventions may

produce injuries or physiological complications, while dietary, weight-, or exercise-focused content may interact adversely with disordered eating, compulsive exercise, or body-image concerns. Mental health symptoms may also deteriorate during an intervention without the event being caused by the intervention being evaluated. A defensible safety evaluation must therefore distinguish events occurring during treatment from harms plausibly attributable to treatment, while capturing both anticipated and unanticipated events.

Evidence from physical activity interventions for mental health conditions has previously shown inconsistent adverse-event reporting, limiting conclusions about safety despite evidence of benefit (Czosnek et al., 2019). This reflects a broader methodological problem in trials: incomplete specification of how harms were defined, elicited, coded, and analysed can systematically understate risk. It is consequently recommended that randomised trials report how harms were defined and collected, identify withdrawals attributable to harms, and present denominators and results transparently (Junqueira et al., 2023). These principles are applicable to non-pharmacological and behavioural trials even where serious intervention-related events are expected to be uncommon.

Within lifestyle psychiatry, safety should consequently be treated as part of implementability rather than as a peripheral clinical outcome. The monitoring burden and competencies required to identify emerging risks may influence whether a lifestyle therapy can be responsibly delivered in a particular population or setting.

Evaluating and actioning implementation

Priority: "Evaluate and develop effective training in lifestyle psychiatry for multidisciplinary staff, including mental and allied health professionals".

Training is an implementation question as well as an educational one. Reviews of therapist training in evidence-based mental healthcare indicate that improvements in knowledge following brief workshops do not necessarily produce sustained changes in

clinical practice, while more intensive approaches incorporating consultation and supervised practice show promise (Frank et al., 2020). For lifestyle psychiatry, evaluating a training program should consequently extend beyond attendance, satisfaction, or self-reported confidence to observed competencies, referral behaviour, intervention fidelity, and sustained use within services. The distinct duration, format, supervision, and organisational support needed for different professional roles should also be considered. This would complement calls for workforce development and multidisciplinary integration (Teasdale et al., 2025), while testing whether training changes what services actually provide and whether its effects persist as staff and service conditions change.

Priority: "Understand the steps towards closing the gap between research and real-world implementation of lifestyle psychiatry by implementing and evaluating lifestyle interventions within routine care".

This priority makes routine care both the setting and subject of inquiry. Delivery within routine services exposes questions that supported trials can partially conceal: who identifies and refers eligible participants; whether clinicians have the necessary knowledge and time to deliver lifestyle therapies; how lifestyle therapists communicate with existing treatment teams; which resources are essential; how adaptations are governed; and whether delivery can be maintained after research support is withdrawn. Earlier lifestyle intervention research in mental health care has identified barriers and facilitators spanning organisational culture, staffing, professional attitudes, leadership, implementation processes, and intervention characteristics (Deenik et al., 2019). More recent field-level recommendations likewise emphasise workforce development, multidisciplinary collaboration, implementation strategies, organisational support, and policy and financing mechanisms (Teasdale et al., 2025).

Routine-care research also requires outcomes beyond clinical effectiveness. Reach, acceptability, appropriateness, feasibility, fidelity, adoption, cost, penetration, and sustainability answer different questions and operate at different levels. A clinically effective therapy cannot be presumed implementable because participants who entered and completed a trial reported positive outcomes. Conversely, an intervention may be acceptable under trial conditions while still requiring resources or workflows that are unavailable in ordinary services. Evaluations should therefore specify which implementation outcomes can be inferred from the design and whose perspectives they represent.

Priority: "Determine who benefits from lifestyle psychiatry interventions, and why, using implementation evaluations that capture barriers, enablers, and harms".

This formulation is notable because it does not treat differential benefit solely as a statistical question. It connects participant outcomes with implementation processes and context. Variation in benefit may reflect baseline prognosis, treatment engagement, accessibility, implementation fidelity, the fit between recommendations and an individual's circumstances, or the support available to enact change. Similarly, greater safety-event burden may indicate clinical complexity, exposure to intervention-related risk, or background events unrelated to treatment. Quantitative predictor analyses can identify candidate characteristics associated with outcomes, but mixed-methods are needed to investigate plausible mechanisms and contextual explanations.

The distinction between prognostic prediction and treatment-effect moderation is important. A characteristic associated with improvement among all recipients is not necessarily evidence that the lifestyle therapy works better for people with that characteristic than an alternative treatment would. Confirming differential treatment effects requires appropriate interaction analyses, adequate power, and preferably external validation (Kent et al., 2020). Exploratory predictors should therefore be interpreted as hypothesis-generating

targets for tailoring, support, or monitoring rather than criteria for treatment allocation. The combined purpose is to identify candidate targets for subsequent testing and to show why tailoring should extend beyond intervention content to the intensity of professional input, monitoring, and clinical oversight.

Priority: "Determine how best to leverage technology to deliver scalable, personalised digital lifestyle psychiatry interventions".

Digital delivery offers a potential route to extending reach, but the relevant question is which combinations of technology, professional support, and service integration work for whom. A systematic review of digital lifestyle interventions found improvements in depression, anxiety, and stress across adult populations (Brinsley et al., 2025). These findings support further evaluation of digital delivery, but do not establish that every platform, level of automation, or personalised feature improves outcomes or can be sustained in routine care. Digital mental health research has accordingly emphasised designing and evaluating the technology together with the service and implementation arrangements needed to support its use (Mohr et al., 2017).

This priority therefore connects directly with workforce preparation, routine-care evaluation, and equity. Evaluation should also capture uptake, sustained engagement, staff workload, accessibility, data governance, and arrangements for responding to deterioration. Digital access, literacy, language, disability, and privacy needs should be assessed alongside clinical outcomes, with supported or non-digital routes available where required.

Understanding scalability

Priority: "Evaluate the cost-effectiveness of lifestyle psychiatry interventions across diverse populations and contexts to inform policy and funding decisions".

Clinical benefit does not itself establish value for money. A systematic review of physical activity interventions for people with schizophrenia or bipolar disorder found mixed

cost-effectiveness results for multicomponent lifestyle programs, with differences across intervention models, populations, and economic methods (Jin et al., 2023). This limits the extent to which a favourable evaluation of one program can support funding for lifestyle psychiatry as a whole.

Economic evaluation should therefore be planned alongside effectiveness and implementation research, with explicit attention to the comparator, analytical perspective, time horizon, and uncertainty. Relevant costs include training, supervision, allied-health input, digital infrastructure, coordination, and ongoing support, alongside participant and carer costs where the perspective includes these. Cost-effectiveness should also be considered alongside budget impact: an intervention may represent good value while remaining difficult for a particular service to afford at the proposed scale (Sullivan et al., 2014).

Priority: "Identify meaningful partnerships (e.g., between doctors, policy makers, lived experience/peer-support, allied health) that will enable holistic mental healthcare".

Partnerships are not simply a means of disseminating a completed intervention. They can shape the research question, delivery model, referral pathways, workforce responsibilities, and funding arrangements from the outset. Work on co-creation in community-based health services emphasises that its value depends on relationships, governance, facilitation, and attention to the wider system (Greenhalgh et al., 2016). For lifestyle psychiatry, this suggests evaluating how partnerships between clinical services, allied health, policymakers, and lived-experience or peer-support contributors affect implementation and continuity of care.

Research should specify partners' roles, decision-making authority, remuneration, and arrangements for managing different priorities, then examine whether the partnership improves coordination, referral completion, reach, or sustainability. Peer involvement should be distinguished from specialist clinical or allied-health expertise. Together, this priority and

the one prior positions scalability as the capacity to deliver and sustain an intervention within functioning care systems, supported by viable funding and shared responsibility, not simply increasing participation and client reach.

Identifying equitable implementation strategies

Priority: "Identify how to adapt lifestyle psychiatry implementation strategies to ensure effectiveness and access equity for marginalised and socioeconomically disadvantaged communities".

This priority appropriately distinguishes adapting the implementation strategy from modifying the clinical content alone. Inequitable access may be produced by referral systems, intervention cost, transport, digital exclusion, work and caring responsibilities, language, cultural safety, service location, and an individual's capacity to undertake lifestyle change. A lifestyle therapy may therefore be clinically adaptable yet remain inaccessible because the strategy used to recruit, refer, fund, or deliver it does not address structural barriers.

Equity-focused implementation frameworks encourage simultaneous assessment of implementation determinants and the social and healthcare-system conditions that generate disparities (Woodward et al., 2019). This extends implementation inquiry to culturally relevant factors, content of clinical encounters, and wider societal influences. These factors can later support adaptation of both interventions and implementation strategies. More recent calls for equitable implementation science also emphasise community and multisector partnerships, equity-relevant metrics, and accountability for whether evidence-based interventions are adopted and sustained among populations facing structural disadvantage (Shelton & Brownson, 2024).

This has two implications for lifestyle psychiatry research. First, representativeness should not be treated as a descriptive footnote. Reach and outcomes should be examined across relevant social groups, alongside the recruitment and service mechanisms that

determine participation. Second, tailoring must not become a mechanism for excluding people with greater clinical or social complexity. Adaptation should instead reduce avoidable burden and enable participation, while preserving essential therapeutic functions and appropriate safeguards. The priority therefore primarily identifies an evidence boundary when research is conducted in homogenous populations, alongside a direction for prospective research involving marginalised communities as partners in intervention and implementation design.

Priority: "Understand how inclusive (neuro-affirming, culturally sensitive, accessible) lifestyle psychiatry interventions can be implemented across health settings and life stages".

Inclusivity requires more than recruiting a heterogeneous sample or offering the same materials to everyone. A co-produced systematic review of mental healthcare for autistic adults identified potentially useful intervention and service adaptations, but also important gaps in robust evaluation (Loizou et al., 2024). This supports testing how communication, sensory environments, appointment structure, and delivery formats can be adapted to individual needs. Evidence from autistic adults should not be assumed to represent all neurodivergent people or developmental stages.

Cultural responsiveness and accessibility likewise need to be built into how interventions are designed, delivered, and evaluated. Within Australia, research should involve Aboriginal and Torres Strait Islander communities in decisions about culturally safe care and community priorities, and work with culturally and linguistically diverse communities to examine language, food practices, and understandings of health. Across life stages and settings, priorities may differ in relation to autonomy, family involvement, disability access, and available support. These are questions for co-designed evaluation rather than fixed assumptions about demographic groups. A common therapeutic purpose may be

retained, while the content, communication, and conditions of delivery are adapted, consistent with person-centred lifestyle psychiatry and equity-focused implementation (Deenik et al., 2025; Shelton & Brownson, 2024).

Priority: "Determine how lifestyle psychiatry implementation can be adapted across key reproductive stages of women and girls".

The explicit focus on reproductive stages recognises that an inclusive approach must also examine changes in clinical needs and delivery conditions within populations. For example, evidence that prenatal exercise can reduce prenatal depressive symptoms does not establish equivalent effects during the postpartum period (Davenport et al., 2018). Guidance on perimenopausal depression similarly highlights the need to assess reproductive stage alongside psychiatric symptoms, sleep disturbance, and psychosocial circumstances (Maki et al., 2018). These examples support stage-specific evaluation rather than assuming that findings from general adult samples apply throughout reproductive transitions.

Research should examine how lifestyle psychiatry can be adapted across puberty, menstrual and reproductive experiences, pregnancy, the postpartum period, and the menopausal transition, including where delivery intersects with maternity, primary, specialist mental health, or menopause services. Relevant implementation questions include the timing and safety of recommendations, competing care demands, access to appropriate professional input, and how to distinguish intervention effects from concurrent treatment or stage-related changes. Women and girls should inform which outcomes and delivery arrangements matter at each stage.

Strengths and limitations

The priority-setting exercise had several strengths. It convened a multidisciplinary national group at different career stages and used a structured sequence that combined independent idea generation with deliberation and anonymous voting. Independent

submission and anonymous ranking reduced the influence of hierarchy or dominant speakers. The initial 122 submissions provided a broad pool from which group discussion and two voting rounds progressively refined an actionable agenda. Participants were explicitly asked to consider feasibility, scalability, impact, translation, and equity rather than scientific novelty alone. Retaining the full final-stage candidate list preserves research topics and allows readers to understand the selection boundary. The resulting agenda can support coordination between researchers and clinicians, identify opportunities for collaboration and funding, and provide a concrete starting point for consultation with a broader range of stakeholders. Its usefulness can subsequently be assessed through its influence on research partnerships, study development, and investment decisions.

Several limitations qualify the resulting agenda. First, participants were purposively drawn from an existing Australian lifestyle psychiatry research and clinical community and represented four states. The priorities should therefore be interpreted as researcher- and clinician-informed rather than as a comprehensive national consensus across all jurisdictions and stakeholder groups. Consumers, carers, First Nations communities, culturally and linguistically diverse communities, policymakers, service leaders and funders were not all represented as distinct stakeholder groups within the voting exercise. Although more than half of attendees reported lived experience of mental health challenges and priorities from seven formally recruited lived experience participants were presented, personal lived experience among professional participants is not equivalent to participation in a designated consumer or lived-experience role.

Second, the modified nominal group process occurred principally within a single symposium. Time constraints may have favoured broad, readily communicable priorities over more specific research questions, and dynamics during the table discussions may have influenced which ideas progressed from the independent pool. The panel discussion and

prioritisation criteria may also have contributed to the strong implementation and translation orientation of the final agenda. This was consistent with the purpose of the symposium but should be recognised when interpreting the relative absence of other basic, mechanistic, or intervention-development questions.

Lastly, the final priorities reflect the preferences of the participants completing the second vote, where participation was lower than in the first round. The cutoff defined a concise communication output and should not be interpreted as a statistically significant difference in importance between statements immediately above and below it. The agenda provides a context-specific basis for research coordination and broader stakeholder consultation, rather than a population-representative national consensus. Broader stakeholder representation and a future international Delphi process would strengthen outcomes and identify priorities that are nationally distinctive or internationally shared.

Conclusion

The inaugural ALPS priority-setting exercise produced an Australian research agenda oriented strongly towards the real-world translation of lifestyle psychiatry. Considered together, they indicate that the promise of lifestyle-based mental health care will not be realised through efficacy evidence alone. Translation requires research that identifies defensible intervention targets, anticipates heterogeneity and harm, examines delivery within actual service contexts, and evaluates whether implementation is both effective and equitable. We also requires evidence on workforce preparation, technology-supported delivery, economic value, and the partnerships needed to sustain care. Inclusive implementation must account for neurodivergence, culture, accessibility, life stage, and reproductive transitions. These priorities together provide a basis for coordinated research that simultaneously tests how and for whom lifestyle psychiatry interventions work, along with how services can deliver them responsibly, sustainably, and equitably.

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