PREKURE CLINIC

THE PREKURE CLINIC APPROACH · MENTAL FITNESS

Mental fitness: lifestyle, skills, therapy and medicines

Running on empty isn't a character flaw.

Mental fitness is what you need to handle the psychological and physical ups and downs of life. We help you build it, and we treat depression and anxiety as part of the same approach.

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The PREKURE Clinic · Lifestyle medicine · Metabolic medicine · Behavioural medicine · Updated November 2026

PART 1

The PREKURE Clinic approach at a glance

What we mean by mental fitness. Mental fitness is what you need to negotiate the psychological and physical ups and downs of life, and to recover from them: skills, habits and physical foundations. Like physical fitness, everyone has some and it can be built, but it does not make you immune. Fit people still get injured, and they tend to recover better. "Mental health" could mean the same thing, but in everyday use it has come to mean diagnosis and treatment. Depression and anxiety are common and important, and we treat them, but they sit inside this wider picture: you can have a diagnosis and be doing well, or have no diagnosis and be struggling. We prefer "fitness" because it puts the focus on behaviours and skills that anyone can build.

Load and capacity. As with metabolic health, the question is whether load outruns capacity. Load includes stress, poor sleep, loneliness, money worries, illness and big life changes. Capacity is built by sleep, movement, food, connection, purpose and psychological skills. People come to us feeling stretched, flat, anxious, exhausted or not themselves, with or without a diagnosis.

The foundations. In trials, regular exercise reduced depression by about as much as talking therapy, though the evidence is low certainty. Treating insomnia halved new or recurrent depression in older adults. Diet trials are small but encouraging. Easy, always-available rewards such as scrolling, gaming and alcohol can crowd out sleep, movement and connection, and cutting back social media gives small gains. Broad-spectrum vitamin and mineral supplements, studied mainly in New Zealand by Professor Julia Rucklidge's team, help some groups, most clearly children with ADHD and emotional outbursts.

The skills. Sadness, worry and grief are part of a full life, not signs that something is broken. Cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT) began as treatments, but their core skills are everyday tools anyone can learn: noticing how thoughts, feelings and actions connect, stepping back from unhelpful thoughts, making room for hard feelings, and taking small steps towards what matters. They help at work, at home and through a hard week, not only in illness. As treatments, they work about as well as antidepressants for depression, and their benefits last longer after treatment stops.

When it is more than ups and downs. In 2024/25, 14.3% of New Zealand adults reported high psychological distress, up from 6.2% a decade earlier, and 22.9% of those aged 15 to 24. Depression and anxiety are leading causes of disability worldwide. Most distress is mild to moderate, and most of it responds to care. In line with the Royal Australian and New Zealand College of Psychiatrists (RANZCP), lifestyle change, education and psychological skills are the foundation of care for everyone, with medicines added when these are not enough.

Antidepressants. On average, SSRIs beat placebo by about 2 points on the 52-point Hamilton depression scale, below the 3 points patients start to notice, and less in milder depression. About 7 to 8 people take an SSRI for 6 to 8 weeks for one extra person to have their symptoms halved. For every 5 people treated, one more has sexual side effects when asked directly, and for every 7 who stop, one

more has withdrawal symptoms. Antidepressants help many people with more severe depression, especially alongside therapy. Stopping should be planned and gradual.

Get help urgently for thoughts of suicide or self-harm, being unable to function, or unusual experiences such as hearing voices: call or text 1737, or 111 in an emergency.

Our stance

1. Mental fitness can be built by anyone, with or without a diagnosis.
2. Sleep, movement, food, connection, purpose and less alcohol are the foundation for everyone, and exercise is a core treatment, not an add-on.
3. Psychological skills are taught as part of care, not left to chance.
4. Following RANZCP, lifestyle, education and psychological support come before medicines for most people with mild to moderate symptoms.
5. Antidepressants have a place. We support informed decisions, discuss withdrawal before starting, and taper slowly when stopping.
6. Severe depression, suicidal thoughts, psychosis and bipolar disorder need specialist care, and we refer promptly.
7. We track distress with the K10 and publish our results.

PART 2 · THE EVIDENCE

What mental fitness is

There is no single agreed definition of mental fitness, but it rests on well-established ideas.

Two separate scales. In a national sample of 3,032 US adults, mental illness and positive mental health formed two related but distinct dimensions (Keyes, J Consult Clin Psychol 2005). People without a disorder who were not flourishing still reported poorer emotional health and more limits on daily life than those who were (Keyes, J Health Soc Behav 2002). Removing illness is not the same as building wellbeing.

Psychological flexibility. The ability to adapt, shift perspective and keep acting on what matters is linked to better mental and physical health, and it is what ACT trains (Kashdan and Rottenberg, Clin Psychol Rev 2010).

A broad definition. The World Health Organization defines mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community" (WHO 2022). Mental fitness is our practical version: the parts people can build.

How we measure it. Our Metabolic Map uses the Kessler 10 (K10), the distress measure in the New Zealand Health Survey, so clients can compare themselves with national figures and track change. It is a screening tool, not a diagnosis.

Depression and anxiety: how common and how serious

Measure	Finding	Source
High psychological distress, NZ adults	14.3% in 2024/25 (6.2% in 2014/15); 22.9% aged 15 to 24; Māori 22.5%; Pacific 23.8%; most deprived areas 21.4%	Te Hiringa Mahara 2026
Unmet need for mental health care, NZ	10.5%; Māori 16.1%; Pacific 16.2%	Same
Disability worldwide	Depression 2nd and anxiety 8th among causes of years lived with disability	GBD 2019, Lancet Psychiatry 2022
Death and heart disease	About 1.5 times the death rate and 30% higher heart disease risk with depression (observational)	Cuijpers, Am J Psychiatry 2014; Gan, BMC Psychiatry 2014
Recurrence	28% of past depressive and 26% of past anxiety disorders came back over 9 years	NEMESIS-2, Int J Methods Psychiatr Res 2026

Common drivers include poor sleep, stress, loneliness, low activity, alcohol, money worries, physical illness and life transitions, and most can be changed. The popular idea that depression is a "chemical imbalance" of low serotonin is

not supported (Moncrieff, Mol Psychiatry 2022), and whether antidepressants help does not depend on it.

The foundations: lifestyle

Approach	What it does	Evidence
Exercise	Reduced depression against active controls: walking or jogging (effect size 0.62), yoga (0.55), strength training (0.49), similar to CBT (0.55)	Low certainty, most trials unblinded (Noetel, BMJ 2024)
Treating insomnia	New or recurrent depression 12 against 26 in 100 in older adults	Moderate (Irwin, JAMA Psychiatry 2022)
Mediterranean-style diet support	Remission 32 against 8 in 100 at 12 weeks (67 people)	Low: small, unblinded (SMILES, BMC Med 2017)
Diet across trials	Small benefit for depression symptoms; supplements did not prevent depression	Moderate (Firth, Psychosom Med 2019; MooDFOOD, JAMA 2019)
Alcohol, smoking, social connection	Recommended by guidelines; little trial evidence in depression specifically	Expert opinion

The international lifestyle psychiatry guideline calls lifestyle "a foundational component" of care (Marx, World J Biol Psychiatry 2023). Exercise is strong enough to offer on its own for mild to moderate depression, but calling it "as effective as antidepressants" overstates lower-certainty evidence.

Broad-spectrum micronutrients. These formulas combine most vitamins and essential minerals in several capsules a day. In placebo-controlled trials, they improved ADHD symptoms in adults (Rucklidge, Br J Psychiatry 2014) and overall functioning and emotional regulation in children with ADHD in New Zealand and North America (clinician-rated responders 54% against 18%; Rucklidge 2018; Johnstone 2022). In adults with anxiety or depression, people improved faster but responder rates were similar by 10 weeks (Blampied 2023), and in pregnant

women with depressive symptoms there was no difference (Bradley 2024). Trials are careful but small and mostly from one group. We discuss micronutrients as an option alongside diet, sleep and activity, and anyone on psychiatric medication should use them only with their doctor involved.

Reward, habits and screens

Loss of interest and pleasure is a core feature of depression, linked to blunted reward circuits (Pizzagalli 2014). At the other end, easy, always-available rewards can crowd out the activities that sustain mood. Across the population, social media explains very little of the difference in teenage wellbeing (Orben 2019), but heavy use matters: girls using it 5 hours or more a day had 50% higher depression scores, largely through harassment, poor sleep and body image (Kelly 2018). Trials of cutting back show small, short-term gains in wellbeing and mood, and one meta-analysis found no effect on mood (Burnell 2025; Lemahieu 2025).

Claim	Our rating
Rebuilding rewarding activity improves depression	Well supported
Cutting back heavy social media use improves mood	Small, short-term benefit
Smartphones caused the youth mental health crisis	Plausible contributor, especially for heavy-using girls; not proven as the main cause
Drugs of addiction reset the brain's reward balance	Well supported (Koob and Le Moal 1997)
Phones "hijack dopamine" like drugs, and "dopamine fasting" resets it	Not supported; no trials

The skills: tools anyone can learn

CBT and ACT began as therapies, but their core skills are tools for understanding and working with yourself in everyday life: at work, with family, with sleep or food, and through a hard week. They build the psychological flexibility described above, and coaches can teach them.

Notice how thoughts, feelings and actions connect (CBT). When your mood drops, catch what you are telling yourself ("I always stuff this up"), check it against the evidence or what you would say to a friend, and test it with a small experiment rather than assuming the worst.

Step back from thoughts and make room for feelings (ACT). "I'm having the thought that I'm useless" is a thought, not a fact or an order. Let hard feelings rise and fall without fighting or feeding them. The aim is to stop them running the show, not to get rid of them.

Choose towards moves (ACT). The "choice point", from Russ Harris's practical guide to ACT, is the moment a hard thought, feeling or urge shows up. Pause, name it, and choose a towards move, one small action in line with your values (such as whānau, health, learning or contributing), over an away move.

Act first and let mood follow (behavioural activation). Plan small, rewarding or meaningful activities even when motivation is low, and tackle problems one step at a time.

What the evidence shows. The strongest evidence comes from treatment. Psychotherapy works as well as medication for depression, combined treatment works better than either alone, and people prefer psychotherapy (Cuijpers, World Psychiatry 2020). For every 5 people who had CBT, one fewer relapsed than among people whose medication was stopped (Cuijpers, BMJ Open 2013). ACT has effects similar to CBT (Gloster 2020), and mindfulness-based therapy reduces relapse in recurrent depression (Kuyken 2016). Behavioural activation has a large effect on depression, though most trials are low quality (Ekers 2014). In the COBRA trial, junior workers with 5 days' training delivered it as well as therapists delivered CBT (Richards, Lancet 2016), which makes it a strong fit for health coaches. As prevention, the evidence is real but more modest: across 50 trials, psychological interventions cut new cases of depression by about a fifth over a year, with about 21 people taking part to prevent one case (Cuijpers, Clin Psychol Rev 2021). Guided online CBT works well, and free New Zealand courses are available through Just a Thought.

Antidepressants

What we count as meaningful. At least 3 points on the 52-point Hamilton scale, the lower end of published estimates of the smallest change patients notice (Hengartner and Plöderl 2022). The average SSRI benefit is about 1.75 to 2 points (Stone, BMJ 2022), smaller in milder and larger in very severe depression (Fournier, JAMA 2010). An NNT (number needed to treat) of 8 means eight people take the drug for one extra person to respond, not that one in eight benefit and the rest gain nothing.

Outcome	On drug	On placebo	NNT or NNH (number needed to treat or harm)	Source
BENEFITS				
Symptoms halved, SSRIs, 6 to 8 weeks			NNT 7 to 8	Arroll, Cochrane 2009
Remission, SSRIs	35%	26%	*NNT 10	Jakobsen, BMC Psychiatry 2017
Mild (minor) depression			No significant benefit	Barbui, Br J Psychiatry 2011
Generalised anxiety or panic, response			NNT 7	Kopcalic, Cochrane 2025; Bighelli, Cochrane 2018
HARMS				
Sexual problems, asked directly	36%	15%	*NNH 5	Clayton, J Clin Psychiatry 2006
Nausea	21%	9%	*NNH 9	Jakobsen 2017

Outcome	On drug	On placebo	NNT or NNH (number needed to treat or harm)	Source
Withdrawal symptoms on stopping (severe: 2.8% against 0.6%)	31%	17%	*NNH about 7	Henssler, Lancet Psychiatry 2024
Suicidal thoughts or worse, under 25	1.34%	0.80%	*NNH about 190	Stone, BMJ 2009
Relapse within a year if long-term users stop	56%	39% (continue)	*about 6	ANTLER, NEJM 2021
Falls in a year, age 65 and over (observational)	5.7%	3.5%	*NNH about 45	Coupland, BMJ 2011
Serotonin syndrome, mostly when combined with another serotonergic medicine; tramadol with an SSRI or SNRI is a high-risk combination			Rare, but can be life-threatening	Medsafe 2022
Low blood sodium, mostly in older adults (studies without placebo)	5.6% SSRIs; 7.4% SNRIs; 1.0% mirtazapine		Odds about 3 times higher than without antidepressants	Gheysens, Eur Psychiatry 2024
Upper gut bleeding (observational); about 4 times the odds when taken with anti-inflammatories such as ibuprofen			NNH about 3,200 at low risk; about 880 at high risk	Anglin, Am J Gastroenterol 2014

Outcome	On drug	On placebo	NNT or NNH (number needed to treat or harm)	Source
Heart rhythm change (QT prolongation), citalopram			Dose-related; maximum 20 mg a day in older people and those with liver problems	Medsafe 2015

Figures marked * are our arithmetic from published rates. Short trials undercount side effects.

Other antidepressants. SSRIs are usually tried first, but SNRIs such as venlafaxine, and mirtazapine, are also widely used. Across 522 trials, all 21 antidepressants studied beat placebo, and the differences between them were modest (Cipriani, Lancet 2018). Mirtazapine is sedating and is one of the antidepressants most linked to weight gain (Serretti, J Clin Psychiatry 2010), which matters in metabolic care. Venlafaxine is among those with more frequent and more severe withdrawal symptoms (Henssler, Lancet Psychiatry 2024). Tricyclics are now rarely used for depression. Bupropion is approved in New Zealand only to help people stop smoking, so using it for depression is off-label (Healthify).

One yardstick for every treatment. Against a pill placebo, psychotherapy scored about 2.7 Hamilton points better, comparable to antidepressants and also below the 3-point threshold (Cuijpers, Psychol Med 2014). No treatment for mild to moderate depression is a sure thing, which is why we offer choices, track progress and change course when needed.

Withdrawal. About 1 in 3 people get symptoms after stopping, mostly mild and short, but a few are severe or last months (NICE NG222). Antidepressants do not cause craving, so "addictive" is the wrong word, but dependence and withdrawal still happen.

What the guidelines say, and New Zealand

RANZCP makes lifestyle change, education and psychological therapy the foundation of care for everyone with depression. In its words, these "Actions" are "essentially non-negotiable", "in many cases" they "will be sufficient to manage uncomplicated depressive symptoms", and an antidepressant is added if they are not (Malhi, ANZJP 2021). NICE says "Do not routinely offer antidepressant medication as first-line treatment for less severe depression" unless the person prefers it (NICE NG222), and bpacnz says antidepressants are "not routinely prescribed" for mild depression (bpacnz 2017).

Funded antidepressant prescriptions in New Zealand rose 25% from 2019 to 2024, to about 2.4 million (Pharmac OIA 2025). Free supports include 1737 (call or text, any time), Just a Thought and the Groov app.

Finding your pathway

Working out what is driving distress helps people choose a starting point they believe in. The evidence that matching improves outcomes is modest: in one trial of 951 people it raised reliable improvement from 45% to 52% (Delgadillo, JAMA Psychiatry 2022). So we track the K10 every few weeks and change course if things stall.

What seems to be driving it	Signs	Starting pathway	Evidence
Too little reward	Loss of interest, withdrawal, inactivity	Behavioural activation and exercise	Strong
Poor sleep	Insomnia, exhaustion	CBT for insomnia	Strong
Worry and rumination	Anxiety, racing thoughts	CBT, ACT, guided online CBT, mindfulness	Strong
Too much easy reward	Hours of scrolling, late-night use, hard to enjoy ordinary things	Planned cut-back, phone out of the bedroom, time swapped for activity and people	Small benefit

What seems to be driving it	Signs	Starting pathway	Evidence
Alcohol and other drugs	Drinking or using to cope, low mood afterwards	Brief advice and cut-down support; addiction services when needed	Moderate for brief alcohol advice (Kaner, Cochrane 2018)
Stress at work or home	Overload, conflict, exhaustion	Problem solving, workplace changes	Moderate
Disconnection	Loneliness, few close contacts	Group activity, community connection	Expert opinion
Physical health	Pain, menopause, thyroid, metabolic illness, medicines	Medical review	Good practice
Severe symptoms or risk	Suicidal thoughts, unable to function	Urgent medical and specialist care	Essential

Weighing it up: the PREKURE Clinic approach

Situation	Usual starting point
Stretched or struggling, no diagnosis	Foundations and skills with a coach; track the K10
Mild symptoms, first episode	Lifestyle change, guided self-help or brief therapy; review in a few weeks
Moderate symptoms	Psychological therapy plus lifestyle; discuss an antidepressant, especially if function is badly affected or past response was good
Not improving after 6 to 8 weeks of good care	Add or switch treatment; consider an antidepressant and medical review

Situation	Usual starting point
Severe depression, suicidal thoughts, psychosis or mania	Urgent specialist care; call 1737, or 111 in an emergency
Already on an antidepressant and well	Continue, or plan a slow, supported taper

Questions to ask: What might be driving how I feel? What would lifestyle change and therapy involve, and how soon should I expect change? If I take an antidepressant, what benefit and side effects are likely for someone like me, and how would I stop?

What the PREKURE Clinic does

1. Assessment with a doctor, building on the K10 from your Metabolic Map, plus physical health, sleep, alcohol and risk screening.
2. A matched PREKURE health coach for movement, sleep, food, connection, alcohol, stress and purpose.
3. Psychological skills: behavioural activation, CBT and ACT-based tools, guided online CBT, and referral to psychologists or free Access and Choice services.
4. Exercise as treatment: a planned, enjoyable programme of walking, strength or yoga, three or more times a week.
5. Medicine decisions made together, including a check of other medicines such as tramadol and anti-inflammatories, with withdrawal discussed before starting and slow, supported tapering when stopping.
6. Safety netting and prompt referral for severe illness.
7. Regular K10 tracking, with results published.

What the PREKURE Clinic will not claim: that depression is a chemical imbalance; that antidepressants do not work or are addictive; that lifestyle alone is enough for everyone; that exercise is proven equivalent to antidepressants; that mental fitness makes anyone immune to mental illness; or that coaching replaces specialist care for severe illness.

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Lifestyle medicine · Metabolic medicine · Behavioural medicine. Online, anywhere in New Zealand.

This page is general information based on published evidence as at November 2026. It is not personal medical advice. Talk with your doctor or a PREKURE Doctor about what is right for you.

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Figures were checked against primary sources on 30 October 2026. Figures marked as our arithmetic are calculated from published rates. Not yet confirmed: whether bpacnz has updated its 2017 guidance.

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