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Mental health physical therapy: recommendations for practice, policy, and payment

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PERSPECTIVE

Mental health physical therapy: recommendations for practice, policy, and payment

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Abstract: Four out of 5 individuals with mental and/or behavioral health challenges have a comorbid physical condition, and PTs frequently encounter patients with MBH needs. Depression is the leading cause of disability, with a global prevalence of 280 million. Individuals with depression also experience an elevated risk of cardiovascular disease, cancer, respiratory disease, musculoskeletal pain, obesity, metabolic disease, and diabetes. The public deserves accessible, affordable, integrated mental and physical healthcare, and PTs are uniquely positioned to play a critical role in prevention, early detection and intervention. **Objectives**: This perspective paper has 3 objectives: 1) to provide practical, evidence-based, actionable strategies for physical therapists to manage these conditions; 2) to enlist academic and clinical stakeholders to update curricula and provide contemporary clinical training for today's students; and 3) to advocate for legislative and payment reform reflecting the effectiveness of physical therapy in addressing MBH. This paper contains three sections. Section 1 includes the need for MBH PT, the role of the PT as an integrative primary care provider, and MBH models to guide PT care. Section 2 addresses 3 objectives: (1) screening and differential diagnosis, best practices, and research; (2) education and clinical interventions for PTs working in MBH; and (3) legislative and payment recommendations and system-level reforms to support PTs in MBH. Section 3 includes recommendations and future directions for PTs to advance and elevate the profession in support of the people we serve.

Summary Box

This perspective paper highlights methods, models, screening, intervention, and systems reforms for physical therapists to improve the lives of individuals with mental and behavioral healthcare needs. It provides focused recommendations for clinicians as primary care practitioners, and it highlights the urgent need to shift PT education toward a whole-person approach.

Keywords: physical therapy; mental health; behavioral health; practice; policy; payment

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Section 1: The imperative for mental health integration in physical therapy

The American Physical Therapy Association (APTA) and physical therapy professionals globally are actively expanding their role to address mental and behavioral health (MBH) within individuals and communities.[1] Contemporary physical therapist (PT) practice recognizes the strong connection between physical and mental health. The APTA's official position is that "*physical therapist services include the prevention and management of behavioral and mental health conditions, addressing the interconnected physical, psychological, and social health domains to ensure whole-person care*".[1] This perspective discusses how physical therapists (PTs) can expand or work at the top of their scope of practice, the role that PTs play in MBH, and evidence-based models that guide clinical decision making for the PT addressing MBH.

PTs frequently encounter patients with mental health conditions. Notably, 4/5 individuals with MBH conditions have a comorbid physical condition.[2] According to one survey, 41% of PTs in general practice reported daily encounters with patients who had comorbid MBH conditions, while 76% reported weekly encounters.[3] Of all MBH conditions, depression is the leading cause of disability, with a global prevalence of 280 million.[4] Evidence indicates close associations and shared risk factors between depression and cardiovascular disease, cancer, and respiratory disease.[4] People with depression also experience higher rates of somatic symptoms, musculoskeletal pain, sedentary behaviors, obesity, hyperglycemia, metabolic syndrome, diabetes, and disability.[5] Bidirectional associations exist between depression, anxiety, and physical illness, as well as shared etiological, environmental, psychological, and biological factors that contribute to mental and physical health.[6-7]

One hundred and twenty-two million Americans (49%) live in a designated mental health provider shortage area.[8] In addition, the United States is projected to face a shortage of 17,800 to 48,000 primary care physicians by 2034.[8] Physician and MBH provider shortages, along with the burden of MBH and noncommunicable diseases, have caused growing demand for primary care services. People with physical and functional impairments are particularly affected. PTs are well-suited to meet these needs by working alongside other primary health care team members, with increasing credibility and influence.[8] Given provider shortages and increasing primary care burdens within the US, including PT as primary care team members can improve access, optimize care navigation, and reduce overall costs for people with physical and functional needs, particularly among people experiencing depression and anxiety, the two most

common MBH conditions.[8] Overall, PTs can positively influence MBH through patient engagement, motivation, and evidence-based interventions.[9]

While some PTs may be apprehensive about managing psychosocial aspects, the impact of whole-person care and therapeutic alliance improves physical therapy outcomes.[10] The growing burden of MBH conditions, often accompanied by physical health issues, demonstrates a clear need for PTs to address psychological and social determinants of health.[11] These realities underscore the urgent need to integrate MBH into PT practice, not only to improve outcomes but also to redefine the PT's role as a frontline provider in addressing physical, mental, and behavioral health.

Two models guide the PT in a transdiagnostic approach to MBH care. The first, developed by Tatta et al. in 2023, is the Pain Recovery and Integrative Systems Model (PRISM).[12] PRISM supports PTs working at the intersection of pain management and MBH. PRISM is an integrative, salutogenic, and cognitive-behavioral approach that addresses the multidimensional nature of pain.[12] As a resilience-based approach, PRISM aligns with global, psychosocial MBH strategies and positions PTs as key providers in whole-person care. PRISM's processes are based on Level I and II evidence, offering PTs a practical framework that transforms traditional pain and MBH care toward facilitating resilience.[12] It includes 6 domains: (1) *Person Context* acknowledges how pain intersects with social and life circumstances; (2) *Purpose* recognizes that pain disrupts life's meaning and restores values-based action, identity, and autonomy; (3) *Pain Literacy* develops empowered beliefs and safety learning; (4) *Pain Mindset* cultivates a psychologically flexible and behaviorally adaptive response to pain; (5) *Physical Capacity* improves function by resolving impairments with therapeutic movement and embodiment; and finally, (6) *Physiology*, emphasizes physical activity, nutrition, and circadian rhythms. Preliminary operationalization and feasibility testing were undertaken.[13] See Figure 1 for details of the PRISM Model.

The Second model is the Health-Focused Behavior Change Model (HFPTM) developed by Lein et al. in 2017.[14] This validated model provides a framework for PTs to screen for and address health behaviors known to improve physical, mental, and behavioral well-being [14] HFPTM is patient/client-centered and considers individual, behavioral, and environmental factors (Figure 2). The HFPTM has five constructs and related care activities. Step 1 is a needs analysis which prepares PTs to examine the prevalence of MBH needs in the clinic, learn about MBH PT, consider screening tools and resources to provide MBH interventions, create a consultancy network with MBH providers, and establish ongoing program evaluation.

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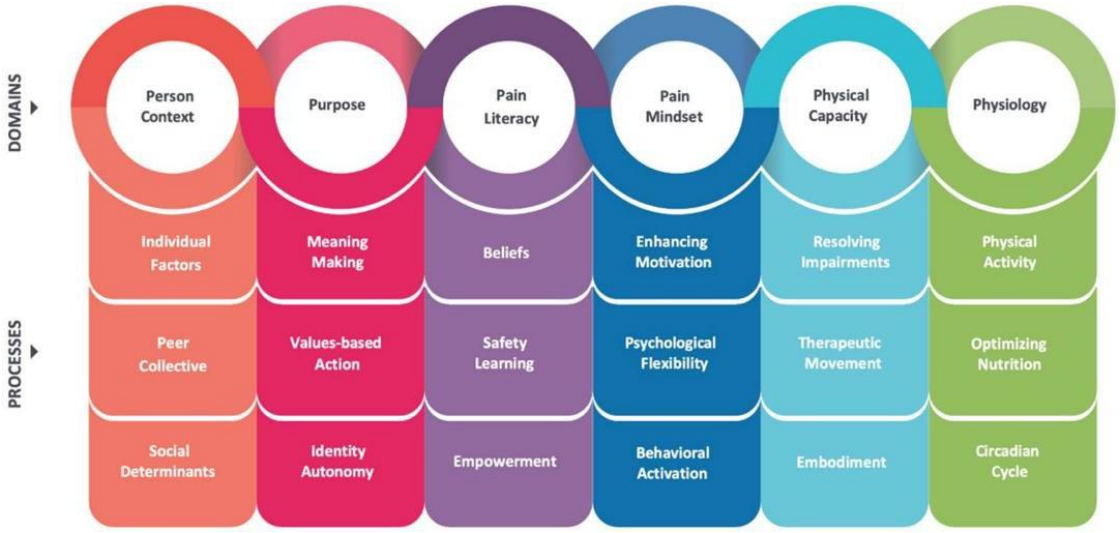

Figure 1. (PRISM) Pain Recovery and Integrative Systems Model[12]

Step 2 determines each patient/client's need for lifestyle behavior change by using valid and reliable measures to screen for MBH challenges. Step 3 involves collaboration with the patient/client about lifestyle and behavior change, and Step 4 involves behavioral interventions such as stress and pain relief, nutrition, physical activity, low-intensity cognitive-behavioral techniques, and/or referring to a mental health provider for co-management.[15] Step 5 requires the PT to assess outcomes, such as treatment concordance for PT MBH interventions and patient satisfaction with PT MBH services. See Figure 2 for details on the MFPTM.

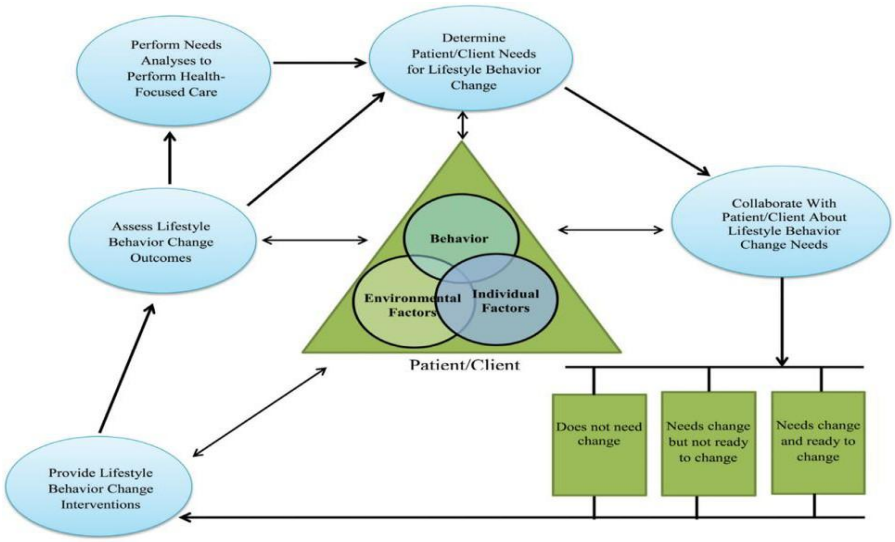

Figure 2. Health Focused Physical Therapy Model[14]

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Section 2: Strategies for practice, education, and policy transformation

The *first objective* for this section is to highlight screening, diagnosis, differential diagnosis, best practices, and research for MBH PT. While MBH concerns can surface during the patient interview, the use of publicly available patient-reported outcome measures (PROMs) can help screen for stress, anxiety, depression, PTSD, and substance use. Identification of these conditions aids the diagnostic process, which is the evaluation of information obtained from the patient's history and physical examination and other available information.[16] Diagnosis is within the professional scope of physical therapist practice in the United States of America (USA).[17] Many PTs serve as entry point providers, and in certain states and jurisdictions are legally recognized as primary care providers.[17]

Since stress is associated with MBH conditions, PTs may ask patients to complete a stress survey first, such as the Perceived Stress Scale (PSS). The PSS is a reliable and valid 10-item tool: scores ranging from 0 to 13 suggest low stress, while scores from 14 to 26 are considered moderate stress. High perceived stress is a score between 27 and 40. Moderate to high scores should prompt the PT to administer either the General Anxiety Scale-7 (GAD-7), Patient Health Questionnaire-9 (PHQ-9), or both based on symptoms detected during the initial examination.[18-20] The GAD-7 is a reliable and valid tool; scores from 0 – 4 are interpreted as minimal anxiety; 5 – 9 = mild anxiety; 10 – 14 = moderate anxiety; 15 – 21 = severe anxiety.[18-19] A score of 8 or higher suggests generalized anxiety disorder and warrants referral to a mental health provider.[20] The 9-item PHQ-9 is a reliable and valid scale to assess depression. PTs should interpret the total score as follows: 0-4 = no depression; 5-9 = mild depression; 10-14 = moderate depression; 15-19 = moderately severe depression; and 20 or greater severe depression.[21] If the PHQ-9 score indicates mild depression, PTs should consider repeating the test and initiating a stress management program, but should consider referring to and co-managing with a mental health provider if the PHQ score is 10 or greater.[21] The PHQ-9 also has a question that screens for suicide risk. If a patient's response is 1 or higher on this question, further testing by a trained professional is critical.

The second objective for this section is to outline education and clinical interventions for the MBH PT. Although people with MBH conditions have lower levels of physical activity, evidence demonstrates the effectiveness of exercise in improving MBH outcomes.[5] Regular exercise modulates the functioning of the hypothalamus-pituitary-adrenal (HPA) axis.[22] Additional benefits include secretion of endogenous opioids and endocannabinoids, which are associated with pleasure, reduced anxiety, decreased pain sensitivity, and

lower systemic inflammation.[22] Exercise can also help mitigate some of the physical side effects associated with antipsychotic medication, such as weight gain, hyperlipidemia, and metabolic syndrome.[22] The psychological benefits of exercise, such as reduced depression and anxiety and improved self-efficacy, likely arise from the dynamic interplay between neurophysiological, behavioral, and social mechanisms.

The International Organization of Physiotherapy in Mental Health (IOPTMH) and the Centers for Disease Control and Prevention (CDC) generally recommend at least 150 minutes of moderate-intensity aerobic activity or 75 minutes of vigorous-intensity aerobic activity per week, along with muscle-strengthening activities twice a week, for adults to improve both physical and mental health. This can be achieved in bouts of 10 minutes spread across the day. Adherence to guidelines for physical activity is strongly associated with both the prevention and improvement of MBH conditions, and exercise is recognized by physicians and MBH providers as an evidence-based option for treating mental health conditions.[23] Despite this recognition, a relatively small proportion of primary care physicians recommend physical activity consistent with national guidelines or refer patients to a PT as an intervention for MBH.[24]

Recent systematic reviews and meta-analyses indicate that exercise and PT intervention successfully address MBH conditions.[25-26] Across people with depression, anxiety, PTSD, schizophrenia, and eating disorders, aerobic and strength training, body awareness, and mind-body techniques improve psychological symptoms, physical health, and overall quality of life. In 2024, the BMJ published a landmark systematic review and meta-analysis of 218 randomized controlled trials, including over 14,000 participants with major depressive disorder, indicating that exercise works well in these patients.[25] Additionally, a substantial body of research has now emerged to explore the mechanisms of mindful movement practices such as yoga, Pilates, Tai Chi, and Qigong. Yoga[27] and Pilates[28] optimize the interaction between neurophysiological regulation, psychological processes, and behavioral change,[29] and offer a viable complementary approach to managing symptoms of stress, anxiety, depression, and PTSD.[30] Several high-quality clinical trials and reviews underscore the therapeutic potential of yoga across a range of mental health symptoms without adverse events.[31] Table 1 illustrates MBH conditions and the corresponding evidence.

Table 1. Research findings in support of exercise for common MBH conditions[25]

Exercise Concept	Evidence
General	• Walking or Jogging: *moderate reductions in depressive symptoms* ○ (Hedges' g = -0.62; 95% credible interval [CrI]: -0.80 to -0.45) • Yoga: *moderate symptom reduction* ○ (g = -0.55; 95% CrI: -0.73 to -0.36) • Strength training: *moderate symptom reduction* ○ (g = -0.49; 95% CrI: -0.69 to -0.29) • Mixed Aerobic Exercise: *moderate effectiveness* ○ (g = -0.43; 95% CrI: - 0.61 to -0.24). • Tai Chi or Qigong: *moderate symptom reduction* ○ (g = -0.42; 95% CrI: - 0.65 to -0.21).
Dose-Response Relationship	Antidepressant effects of exercise were found to be proportional to the intensity prescribed. Vigorous activities yielded more significant benefits.
Acceptability & Adherence	Strength training and yoga are the most acceptable modalities, with lower dropout rates compared to other forms of exercise
Comparative Effectiveness	Exercise interventions showed moderate, clinically meaningful reductions in depressive symptoms in comparison to active controls. Exercise in combination with selective serotonin reuptake inhibitors (SSRIs) or psychotherapy provides additional benefits
Gender Differences	Strength training is more effective for women Yoga or qigong has greater efficacy for men
Age Differences	Yoga is beneficial for older adults Strength training has better outcomes in younger individuals.
Comorbidities & Baseline Depression Levels	Exercise is *equally effective* for individuals with and without comorbidities and across varying baseline levels of depression
Clinical Implications	Exercise, particularly walking or jogging, yoga, & strength training, should be core components in the treatment of depression.

Despite decades of research linking physical inactivity to chronic disease, its impact on MBH is only now being fully recognized. A 2025 umbrella review in the Journal of Psychiatric Research systematically evaluated whether aerobic exercise could serve as a *transdiagnostic* intervention across a range of MBH conditions.[26] Researchers assessed 99 randomized controlled trials (RCTs), which included over 5,600 participants, using the TRANSD criteria for rigor and generalizability of cross-diagnostic treatment effects.

Findings indicated that consistent moderate-to-vigorous aerobic exercise, implemented at the frequency of the American College of Sports Medicine (ACSM) guidelines,[32] is an effective intervention for 11 mental disorders spanning four diagnostic spectra: depression, anxiety, psychotic, and neurodevelopmental conditions.

The benefits of aerobic exercise result in moderate improvements in core psychiatric symptoms, including PTSD,[33] depression,[34] anxiety,[35] schizophrenia,[36] eating disorders,[37–39] and inattention and hyperactivity.[35] Importantly, aerobic exercise improved symptoms of anxiety and depression, where pharmacological treatments often fall short.[40] While more data are needed for quality of resistance-training effects, the existing evidence strongly supports the use of aerobic exercise as a broad-spectrum, low-cost, and low-risk intervention.[26] The underlying mechanisms are multifaceted—ranging from reductions in inflammation and oxidative stress, to influences on the gut-brain axis, the immune system, and increased levels of brain-derived neurotrophic factor.[41]

Evidence also supports lifestyle interventions, including tobacco and nicotine cessation,[23] nutrition,[42] sleep hygiene,[43] and mindful stress management,[44] which can be prescribed by PTs to manage MBH conditions and chronic disease. Additionally, the APTA and World Health Organization (WHO) recommend *low-intensity psychological interventions (LIPIs)*, which are brief, accessible, transdiagnostic treatments focused on self-management skills for lifestyle and behavior change.[45–47]

LIPIs are delivered by non-specialized health care providers and include strategies such as motivational interviewing,[48] shared decision making,[49] cognitive behavioral PT,[50] mindfulness and acceptance-based approaches[43-44], pain neuroscience education,[51] cognitive functional therapy,[52] and pain resilience therapy.[13] The evidence indicates that PTs can effectively and appropriately deliver LIPI as part of a stepped care approach,[53] serving as a first line of treatment, then allowing the patient to “step up” to a mental health provider to address specific diagnostic or treatment needs. Stepped care provides lower intensity and less costly approaches as a first-line treatment, which has shown both efficacy and cost-effectiveness.[16]

The third objective for this section highlights legislative, payment, and system reforms. Several policies and position statements give credibility to the MBH PT movement. These are led by the APTA, whose mission and vision statements connect mental health to physical health.[1] See Table 2 for a description of the organizations and their policies that influence MBH in physical therapy.

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Table 2. Organizations and policies influencing MBH in physical therapy

Domain	Directive	Specific Language for MBH Physical Therapy
APTA House of Delegates policy on the role of the PT in behavioral & mental Health[1]	HOD P07-25-49-19	Physical therapist services include the prevention and management of behavioral and mental health conditions, addressing the interconnected physical, psychological, and social health domains to ensure whole-person care.
APTA House of Delegates on physical therapists' services in primary care[8]	HOD P07-24-05-07	Physical therapists possess clinical expertise in the prevention and management of common health conditions seen in primary care settings. Physical therapists practicing in primary care improve the health of society.
Commission on the Accreditation of Physical Therapy Education (CAPTE)[54]	Required elements to support the PTs role in mental health care across the lifespan: 7A, 7D	7A: Curricular Requirements for diagnosis, differential diagnosis, neuroscience, pharmacology, behavioral science, and psychosocial aspects of health/disability 7D: Screening and Exam for psychosocial and mental health aspects of patient care.
Jurisdictional Physical Therapist Scope of Practice[55]	HOD P06-17-09-16 HOD P06-17-08-07	Defined by state licensure laws and typically includes evaluation and management of the physical, behavioral, and psychosocial factors influencing pain, functioning, disability, health, and well-being. State practice acts that specifically mention MBH as of May 2025 are AL, CT, CA, DC, FL, IL, MI, MN, MS, MO, SC, VA.
APTA Guide to Physical Therapist Practice 4.0[17]	1. Diagnosis 2. Tests & Measures 3. Interventions	• "…to organize and interpret all relevant information collected." • cognitive and mental functions tests to address mental and other psychiatric diagnoses as well as illness or injury influencing mental functions. • Educational & procedural interventions including MI, CBT, mindfulness, pain modulation, and lifestyle health behavior change.
APTA Code of Ethics[56]	HOD S06-20-28-254 Principles 5, 6, 7, 8	The principles obligate us to address MBH through prevention, screening, assessment, and intervention.
APTA Federal Section	Primary Care Special Interest Group	Promotes PTs as universally recognized front-line providers in the primary care arena.
American Council of Academic Physical Therapy (ACAPT)[57]	Dealing with the MBH crisis in higher education includes over 300 PT programs and over 39,000 students.	Address and train students in trauma-informed crisis management, training to recognize and respond to MBH conditions in students, discuss MBH regularly, create safe spaces for MBH, provide mindfulness resources.

There is a need to extend beyond pain neuroscience education and more clearly address MBH conditions using evidence-based curricular design.[2,51] Options for including MBH content into PT curricula include

adding certificate programs in MBH to the DPT degree, adding complex MBH concepts to discussions, patient simulations, and practical exams, and teaching students evidence-based educational interventions such as interoception awareness,[58] meditation,[59] reframing,[60] breathing,[61] and links between alexithymia, alexisomia,[62-63] and wellness.

Similarly, payment models can facilitate or diminish access for individuals with MBH needs. To provide high-quality, reimbursable care, PTs must remain informed about the various payment structures and how they influence service delivery and documentation across settings.[64] The general payer information in Table 3 describes how the common payer types, such as the Centers for Medicare and Medicaid Services (CMS) and private insurers, may reimburse PTservices.

Table 3. Payers' systems that may reimburse for MBH Physical Therapy

Payer Type	Description
Medicare Part A	PT for hospital stay, skilled nursing facility, inpatient rehabilitation, hospice, or home health care. *PTs can elevate patient outcomes and expedite discharge by using MBH interventions.*
Medicare Part B	Pays for medically necessary outpatient PT when a physician, nurse practitioner, or physician assistant certifies it as medically necessary. Coding must be accurate based on documentation of personal factors and body functions, including mental functions. Codes include low (97161), moderate (97162), and high (97163) complexity, and psychological distress or behavior barriers may require additional time, care coordination, or modification to the plan of care.
CMS Integrative Behavioral Health Model	Developed to improve behavioral and physical health outcomes for adults enrolled in Medicaid and Medicare with moderate to severe mental health conditions or substance use disorder (SUD). PT is not covered under this model, but many PTs use alternative diagnoses, like chronic pain, to address underlying MBH factors. While this strategy enables patients to access needed services, it poses the risk of diagnostic overshadowing, a situation where the physical diagnosis (e.g., pain) eclipses the recognition and treatment of co-occurring mental or behavioral health conditions. This practice can negatively affect both patient outcomes and a PTs ability to deliver whole-person care.
Medicare Advantage (Part C)	A privately managed alternative to Medicare. Includes PT with varying coverages.
Medicaid	The US public health insurance program for eligible low-income individuals. Coverage varies by state and includes eligibility standards, payment rates, and PT is often at risk of being cut or limited.
Private Insurance	Wide variability and coverage, limits, and requirements. PTs should verify coverage and billing practices with individual insurance companies.
Cash-Based Services	Patient pays the PT directly, bypassing insurance billing. PTs can establish their fee schedules, including setting a flat rate per session, creating a service-specific fee schedule, or offering packages that provide a discount for multiple visits. Patients may choose to submit receipts to their health savings accounts (HSAs) or flexible spending accounts (FSAs), or even to their private insurers for possible reimbursement after paying out-of-pocket. Therefore, PTs should provide clear documentation of services rendered, including appropriate ICD-11 codes and, when applicable, CPT® codes, particularly if patients intend to seek reimbursement independently.

The successful implementation of the physical therapy management plan relies on system-level support. Health systems should foster interprofessional coordination and collaboration through shared documentation platforms, value-based payment models, and interdisciplinary care. Additionally, policy should support licensure, scope expansion, and payment that enable PTs to participate fully in MBH care delivery. In instances where payment for PTs to participate fully in MBH is lacking, strategic action should be taken by the APTA components and state associations to secure payment in a coordinated effort with other stakeholders. This may be in the form of a "charge" in the context of the APTA House of Delegates. This directs the APTA Board of Directors to allocate resources and act on access to and payment for PTs to participate fully in MBH care delivery.

Section 3: Recommendations and future directions for the profession

While some PTs may be apprehensive about shifting their practice, whole-person care improves outcomes.[2] The trust and rapport cultivated during clinical encounters enhance the likelihood of patient disclosure, so PTs must become trained to recognize signs of psychological distress. Tables 4 and 5 include the clinician and the educator recommendations, with action items to advance the profession on behalf of the patient.

Table 4. Recommendations for clinician stakeholders

Recommendations	Action Items
Use the Health Focused PT Model (HFPT) and/or the Pain Recovery and Integrative Systems Model (PRISM) to guide patient-centered care.	- Routinely assess MBH using validated tools (e.g., PHQ-9, GAD-7, PSS, equanimity scale, tolerance for uncertainty scale, and others)
Enhance Screening & Differential Diagnosis	- Screen for stress, anxiety, depression, post-traumatic stress, suicidality, and ACE scores using validated scales - Use clinical reasoning to determine when to refer to another health service provider
Utilize psychologically informed interventions	- Incorporate cognitive-behavioral principles and techniques such as values-based goal setting, reframing, meditation, and breathing techniques to stabilize the autonomic nervous system
Prescribe exercise and physical activity as part of “first-line” MBH care.	- Provide tailored, evidence-based exercise prescription for depression, anxiety, post-traumatic stress, and other conditions as part of collaborative, team-based care
Incorporate Mindful Movement Practices	- Introduce Yoga, Tai Chi, Pilates, Qi Gong to promote emotional regulation and reduce distress
Facilitate lifestyle interventions for whole-person care	- Address smoking cessation, nutrition, sleep hygiene, & social connectedness
Collaborate and refer appropriately	- Engage in co-management, consultation, and referral pathways with other providers to improve MBH outcomes - Build community partnerships to address social determinants of health and ACE scores.

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Table 5. Recommendations for educator stakeholders

Recommendations		Action Items
Support scope and payment for MBH	-	National and jurisdictional policy should support licensure, scope expansion, and payment that enable PTs to participate fully in MBH care delivery.
Embed MBH into physical therapist/physiotherapist/DPT curricula	-	Include coursework on MBH screening, psychologically informed care, HFPTM, and PRISM frameworks; add MBH interventions, difficult conversations, and MBH diagnoses in simulations, role play, and practical exams for all courses.
Train faculty and students to learn psychologically informed care skills	-	Include training for students in motivational interviewing, shared decision making, strengths-based communication, and trauma-informed care.
Foster competence in low-intensity psychotherapeutic interventions (LIPIs)	-	Prepare students to deliver interventions aligned with WHO guidelines as non-specialized healthcare providers for MBH education and behavior change.
Expand interprofessional education	-	Include interprofessional case studies with an MBH focus
Promote cultural humility	-	Encourage students to have conversations and role play MBH care, including Adverse Childhood Experiences (ACE) scores and social determinants of health
Support advanced competencies in MBH	-	Offer certifications and continuing education focused on MBH

The emergence of the MBH PT reflects an evolution informed by decades of research, advances in PT education, and clinical innovation. Today's PT must move beyond somatic reductionism and the traditional mind-body divide by promoting a whole-person approach to patient care. This aligns with the APTA House of Delegates position, stating that "*Physical therapist services include the prevention and management of behavioral and mental health conditions, addressing the interconnected physical, psychological, and social health domains to ensure whole-person care.*[1] Committing to 1 training in mind-body interventions each year can alter the fabric of PT for all patients and advance our work to new levels of value and longevity.

Equity, Diversity, and Inclusion Statement

The authors affirm their commitment to diversity, equity, and inclusion in all aspects of research. In preparing this manuscript, we prioritized inclusive research practices by considering the needs and perspectives of diverse populations, particularly those underrepresented in clinical research and healthcare systems. Efforts were made to ensure that this work promotes accessibility and respect for individuals across dimensions of race, ethnicity, gender identity, sexual orientation, age, ability, socioeconomic status, and lived experience.

Conflict of Interests

All authors declare that there are no conflicts of interest.

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