

# Interventions in Everyday Life to Improve Mental Health and Reduce Symptoms of Psychiatric Disorders

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The high prevalence rates of mental disorders worldwide and the paucity of services constitute a mental health crisis. The vast majority of people in low-, middle-, and high-income countries do not receive any intervention for their symptoms of mental disorders, despite enormous advances in developing evidence-based psychosocial treatments and medications. The article proposes greater utilization of interventions in everyday life as an addition to the more traditional and commonly used mental-health interventions. The article delineates criteria to help identify what such interventions ought to include to permit accessibility, scalability, and reach to special populations. Physical activity, contact with nature, and yoga are examples to illustrate the class of everyday interventions that have evidence attesting to their impact on mental health and symptoms of psychopathology. The challenge is to integrate such interventions in mental health practices to better promote these at the population level and to monitor the impact. Many components of what is needed are in place but are not coordinated in an effective way to have widespread impact on mental health.

## *Public Significance Statement*

Most individuals with mental disorders receive no treatment. This article focuses on activities in everyday life that can improve mental health, decrease psychiatric symptoms, and surmount many of the barriers that impede obtaining treatment. The activities are posed to promote a class of interventions known to improve mental health, are readily available, and overcome many of the barriers to receiving mental health services.

**Keywords:** everyday life interventions, mental health, reducing the treatment gap

There is a mental illness crisis worldwide that consists of relatively high prevalence rates of psychiatric disorders and a paucity of treatment services that are provided to those in need. Interestingly, there have been enormous advances in developing evidence-based treatments for mental disorders. Yet, the treatments are not reaching most individuals in need of services worldwide. A variety of well-studied structural and attitudinal barriers impede bringing treatments to people and people to treatments. Add to that the fact that many people do not see psychotherapy or medication as something worthwhile, despite the problems they may be experiencing. While there are many efforts to facilitate and extend the delivery of treatment, is there more we could do to improve

the mental health more broadly than the reach of current treatments that would not have the barriers that impede participation in treatment? In everyday life, there are several practices and activities that can reduce the symptoms of mental illness and improve overall mental health, well-being, and the quality of life. These practices do not require seeking mental health services, going to therapy, taking medications, or even viewing oneself as having a mental disorder.

The purpose of this article is to discuss familiar interventions that can have impact on mental health. Among them are physical activity, contact with nature, and yoga. There are others I mention but present three to illustrate and represent a class of interventions that can be more strategically used and promoted. The article begins by providing an overview of the mental health crisis and conveying how and why traditional treatments do not reach people in need. The discussion then describes the importance of expanding the range of options with specific attention to lifestyle practices. Criteria are outlined to guide selection of such practices. Familiar intervention options in everyday life are illustrated with their pertinent evidence related to improving mental health and

This article was published Online First April 20, 2023.

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The author reports no conflict of interest in relation to this article.

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alleviating symptoms of mental disorders. Finally, the article conveys the challenges, strategies to promote, and means of evaluating whether interventions are in fact having the desired impact on improving mental health in the population.

## Background and Contexts

### The Mental Health Crisis

The crisis encompasses two components. The first is the prevalence of disorders and the second is the delivery of services for people with these disorders. These two issues are brought together in the concept of the *treatment gap*, which refers to the difference in the proportion of people who have disorders or a specific disorder (prevalence) and the proportion of those individuals who receive care. The gap is well documented in research spanning the globe, mental disorders, age groups, and time periods (e.g., [Andrade et al., 2014](#); [Kessler et al., 2022](#); [Steel et al., 2014](#)).

### Prevalence of Mental Disorders

Several large-scale surveys have attested to the high prevalence of mental disorders. Consider two examples among the many available studies. First, an evaluation in the European Union (EU) included data from all member states ( $N = 27$ ) plus Switzerland, Iceland, and Norway ([Wittchen et al., 2011](#)). In a given year, 38.2% of the EU population suffered from a mental disorder. That corresponded to approximately 165 million people from childhood through older adults. Second, in the United States, from reports of the National Comorbidity Study, we have learned that 26% of the U.S. population met the criteria for a psychiatric disorder within the past 12 months ([Kessler, Chiu, et al., 2005](#); [Kessler et al., 1994](#)). This increased to 46% of the population over

the course of life ([Kessler, Berglund, et al., 2005](#)). For ease of computation, consider that approximately 25% of the U.S. population experience a psychiatric disorder during a given year and 50% in their lifetime. From a U.S. population of approximately 333 million, this translates to approximately 83 and 167 million people, respectively. Additional surveys across multiple countries present a similar picture (e.g., [Solmi et al., 2022](#)).

Any effort to be precise about the exact prevalence rates must be qualified. The rates are a moving target due to changes over time in the diagnostic criteria and disorders, different methods of assessment, and type of study (e.g., retrospective vs. prospective). In addition, the estimates may be conservative because some disorders (e.g., schizophrenia) and populations with high rates of mental disorder (e.g., individuals in prisons or homeless) often are excluded. Moreover, evidence points to increases in the rates of disorders in the past 10–20 years (e.g., [Lebrun-Harris et al., 2022](#); [Patalay & Gage, 2019](#); [Twenge et al., 2018](#)). Notwithstanding the dynamic nature of documenting prevalence, the conclusion remains, namely, mental disorders are prevalent worldwide.

### Receipt of Services for Mental Disorders

The second facet of the treatment gap pertains to the proportion of those with mental disorders that receive services. Examples from a large literature illustrate the point. Surveys of over 60,000 adults in 14 countries in the Americas, Europe, Middle East, Africa, and Asia found that respondents who received treatment for emotional or substance-use disorders during the previous 12 months ranged from a low of 0.8% (Nigeria) to a high of 15.3% (United States; [World Mental Health Survey Consortium, 2004](#)). These percentages refer to those who received treatment among those in need. These numbers convey that the vast majority (99.2% and 84.7%, respectively, by subtracting the above percentages from 100%) of individuals in need did not receive treatment. A more recent review evaluated the treatment gap in relation to depression among 21 countries ([Thornicroft et al., 2017](#)). In high-income countries, one in five (20%) individuals with depression received treatment. In low- and middle-income countries, one in 27 (3.7%) received treatment. Overall, among many countries, disorders, time frames, and measures, the conclusion remains that most people with a diagnosable psychiatric condition do not receive treatment.

Focusing on one country reveals within population variation. For example, in the United States, ethnic minority groups (e.g., African, Hispanic, and Native Americans) have much less access to care than do European Americans (e.g., [Alegria et al., 2010](#); [McGuire & Miranda, 2008](#)). African Americans are less likely to have access to services than European Americans (12.5% vs. 25.4%), and Hispanic Americans are less likely to have adequate care than European Americans (10.7% vs. 22.7%; [Wells et al., 2001](#)). In the United States,

123 million people (approximately 37% of the population) reside in federally designated as Mental Health Professional Shortage Areas due to their lack of access to professionals who provide services (Smith-East & Neff, 2020). Thus, even the sparse services are allocated with great disparities across ethnic groups and rural and urban areas. No doubt, each country has its groups (e.g., individuals in rural areas, Indigenous people, immigrants, individuals with physical or intellectual disabilities) that are especially unlikely to receive mental health services. The lack of available services for most people and systematic disparities among those services underlie the importance of expanding the options for improving the scale of interventions that can improve mental health.

In evaluating the treatment gap, research typically focuses on the extent to which treatment is provided to individuals who meet criteria for a psychiatric diagnosis. Yet, 10%–16% of individuals who do not meet current or lifetime criteria for a disorder (subsyndromal disorder) receive treatment services (Bruffaerts et al., 2015; P. S. Wang et al., 2007). This is important to mention because it reflects that the need for treatment, as perceived by clients, extends beyond those who meet criteria for a psychiatric disorder (Jorm et al., 2017). Also, the percentages (10–16) are small but, at the population level (in absolute numbers), this is a large group of people that utilizes services.

### Why so Few People in Need of Services Receive Them

Consider two related sets of impediments to help explain why proportionally few people in need of services actually receive them. First, there are daunting steps usually required to obtain treatment. Second and related is the well-researched area on the barriers to treatment participation.

### The Path From Symptoms to Services

There are multiple steps one must traverse to receive health care services in general, but these steps may be less straightforward in relation to seeking mental health services. The steps include:

1. experiencing psychological symptoms;
2. identifying those as symptoms rather than something momentary or transient;
3. deciding whether action is needed to do something about them;
4. identifying the options for intervention (e.g., a psychosocial treatment, medication, religious counseling, personal coaching);
5. seeking and actually obtaining treatment, if that is the option selected;
6. beginning and remaining in treatment; and
7. with ineffective treatment, recurrent disorders, or relapses, traversing parts of the process again.

Multiple obstacles at each step can impede or prevent the individual from moving forward and receiving care (e.g., Jorm, 2012; Stagnaro et al., 2019). When the process does unfold, there are remarkable delays. For example, many years (~8 years) often elapse from identifying a psychological problem to seeking help (Thompson et al., 2008; Wang et al., 2005). For many people, even beginning the process of seeking help is not perceived as worthwhile. For example, a survey in six European countries indicated that one third of individuals believed that professional mental health care is worse than or equal to no help at all (ten Have et al., 2010). A more recent survey of seven countries in the Americas found that 43% of individuals with a mental disorder did not feel there was a need for treatment (Orozco et al., 2022). Thus, initial reticence in beginning the steps I have listed is an obstacle to receiving services.

Let us assume for a moment that we can surmount the reticence for entering treatment and a person begins treatment. Among those who begin treatment, that first treatment may not prove to be helpful (Kessler et al., 2022). Most people do not persist if their treatment was not perceived as very helpful. In short, the path from identifying the need for treatment, receiving care, and viewing treatment as having helped is a road laden with obstacles that help to explain why only a relatively elite few receive treatment.

### Barriers to Treatment Participation

Many of the barriers that impede or prohibit a person from receiving care have been well described (Andrade et al., 2014; Byrow et al., 2020; Goodcase et al., 2022). Two broad categories are often defined based on the source of the barrier: system-level factors (e.g., financial costs, whether a service is available, and policy issues) and attitudinal factors (e.g., stigma, mental health literacy, views that treatment will not be of much help). I have summarized key barriers in Table 1 to recognize obstacles that need to be surmounted, minimized, or by-passed in some way if we are to reach more people in need.

Less frequently discussed are characteristics of clinical practice, the oversight of mental health professions, and policy and laws that can influence the reach of mental health services. In relation to clinical practice, I refer to the way in which treatment is usually delivered. Individual therapy,

**Table 1**  
*Barriers to Mental Health Care*

| Barrier type                          | Brief description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| System factors                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Cost of mental health services        | Treatment is not affordable because services are not covered by insurance of the client, not completely covered, or the out-of-pocket costs are too expensive. The complexity of understanding what is and is not covered or negotiating all of this (reimbursement forms, appealing after a claim has been refused) can be daunting.                                                                                                                                                                                                                                                 |
| Policy and legal constraints          | Government policies (e.g., federal, state, province) as well as third-party payers may restrict what conditions can be treated and reimbursed or for how long treatment can be provided (e.g., number of sessions, days) and still be reimbursed. These constraints also include limited financial resources as a matter of government budgets, policy, or law that provides too few services and therefore less accessible services.                                                                                                                                                 |
| Too few providers to deliver services | Mental health professionals are not available in sufficient numbers to provide services to meet the need. This is a worldwide problem in developing (low and middle income) and developed (higher income) countries as well. In the United States, trained professionals are insufficient in number to treat all those in need and are concentrated in urban areas. Too few meet the ethnic demographic of the nation or do not focus on clinical populations where the unmet need is especially great (e.g., children, older individuals, and others, as noted in the text).         |
| Attitudinal factors                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Stigma                                | Stigma refers to negative beliefs and practices by a group about a condition—in this case, mental disorders. Concerns among potential clients or consumers of treatment with being labeled (diagnosed) with a mental disorder or by being associated with treatment for a mental disorder. Stigma can lead to genuine discriminatory practices and domains of rejection (e.g., employment, promotion). Also, individuals may view their own dysfunction with stigma (self-stigma), which can interfere with identifying themselves as having a mental disorder and seeking treatment. |
| Mental health literacy                | Information individuals have and what they know about mental disorders, whether one has symptoms or a disorder that warrants treatment, what the options are for treatment, and how to pursue those options and obtain treatment.                                                                                                                                                                                                                                                                                                                                                     |
| Cultural and ethnic influences        | Individuals of cultural and ethnic minorities have less access to services for health care in general, including mental health care. Views about whether psychological problems warrant treatment, entry into any health care service, or seeking treatment can vary widely. Some problems (e.g., anxiety, depression) may not be seen as a reason to seek “treatment” or to be involved with a health care system. This is not the same as mental health literacy, which is more about knowing, but rather is more firmly rooted in cultural practices and beliefs.                  |

whether in person or online, can greatly limit treatment because of the relatively small number of mental health professionals in relation to the need for treatment, the specialization of most treatment providers in the treatment of adults (e.g., as opposed to children, adolescents, and older adults individuals), the geographical locale of the majority of providers (urban areas), and lack of ethnic and cultural representation of providers in relation to the clients in need of care (Kazdin, 2018).

Considerable evidence shows that lay individuals can be effective in treating psychiatric disorders (Barnett et al., 2018; Kohrt et al., 2018; Patel et al., 2017; Singla et al., 2017). The mental health professions (psychiatry, psychology, social work) understandably have licensing, training, and credentialing standards regarding who can legitimately deliver mental health services. Many of the standards and restrictions on who can provide service are designed to protect the public, something to which one cannot object. At the same time, there is a potential pool of lay providers we have yet to train and integrate to help with the treatment gap.<sup>1</sup> As for policies, one of the most critical factors in whether a person who receives services for their mental disorders has insurance to cover their care and this applies to low-, middle-, and high-income countries (e.g., Hampton & Lenhart, 2022; Vigo et al., 2022). Insurance agencies (public and private)

follow professional and legal guidelines and might not reimburse treatment by lay individuals.

In summary, the obstacles to obtaining treatment are many, and they often come in packages. That is, it is not one barrier (e.g., lack of insurance *or* no treatment service nearby) but multiple barriers that come together (e.g., mental health illiteracy, self-stigma). Efforts to reduce barriers typically focus on one or two and look for changes in knowledge and attitudes (e.g., Ebert et al., 2019; Thornicroft et al., 2016). While important, this is quite separate from showing the next step, namely, that utilization of care has increased. Also, because barriers come in packages, evidence of reducing one barrier might not even be expected to increase the utilization of services.

### Multiple Efforts to Extend the Reach of Psychosocial Interventions

Several efforts have focused on increasing utilization of mental health services to reduce the treatment gap. I highlight four of these.

<sup>1</sup> The use of lay individuals to deliver mental and physical health care services is an extensive literature with critical issues regarding the scope of the evidence, training issues, ethics, cross cultural issues, and others. These are beyond the scope of the present article and nicely covered elsewhere (e.g., Connolly et al., 2021; Mabunda et al., 2022; Shorey & Chua, 2022).

### ***Engaging Clients in Therapy***

Many individuals who do have access do not seek treatment, among those who actively seek treatment, many never show up for the initial session, and among those who do show up and enter treatment, the dropout rates often are high (Becker et al., 2018; Gmeinwieser et al., 2020; Krendl & Lorenzo-Luaces, 2022). An important area of research to address the matter focuses on engagement of clients. Engagement refers to attending treatment, being committed to treatment, remaining in treatment, and engaging in the prescribed practices and activities (e.g., Constantino et al., 2010; Gonzalez et al., 2018; Seidler et al., 2018). A comprehensive review of 40 years of engagement research focused on utilization and participation of parents in child mental health services (Becker et al., 2018). Engagement encompassed several domains of participation in treatment, including the relationship with the therapist, expectancies for change, attendance, understanding the treatment, and adhering to tasks in and outside of treatment. Accessibility promotion, which used strategies to convey that services are convenient and that made them accessible (e.g., via on-site childcare, taxi vouchers, and bus tokens), was among the highest impact strategy to improve engagement. Additional elements that were most frequently drawn upon to improve engagement were assessment of the client's strengths and needs, psychoeducation, focus on barriers to treatment, and goal setting.

I have only sampled the category of engagement strategies to make the broader point. We might better optimize the utilization of existing treatment resources with more attention to evidence-based engagement strategies. Invariably, more services are needed. Yet, currently, we may not be optimizing the use of services we already have in place.

### ***Dissemination of Treatment***

Dissemination of treatment usually refers to closing the *research-practice gap*, which focuses on extending treatments developed in research to clinical practice. Yet, there are important exceptions where dissemination of interventions to clinicians and an increase in the number of individuals seen in treatment are both addressed. A now well-known model that addresses both the research-practice and treatment gaps is the program referred to as Improving Access to Psychological Therapies. This is a large-scale government-based program in England designed to greatly increase the availability of effective psychological treatment for depression and anxiety (Clark, 2018; Wakefield et al., 2021). The program, within the English National Health Service, has been hugely successful both in recruiting and training new therapists and in scaling treatment to reach many more patients than had been seen in prior years. Improvements in clinical outcomes were documented early in the program. Moreover, treatment was shown to have paid for itself (and more) in terms of government savings (e.g., for sick pay or state

benefits). The program continues with further government funding and extensions in training of therapists, the client populations treated (e.g., children, older adults), and the range of interventions (e.g., mindfulness) and how they are delivered (e.g., via the internet; Clark, 2018; Flygare et al., 2022; Wakefield et al., 2021).

There are other efforts to train practitioners in evidence-based interventions and to do so on a large scale. In the United States, for example, large federal government organizations (Veterans Health Administration), private health care systems (Kaiser Permanente Health Care System), and local communities are involved in such work (e.g., Karlin & Cross, 2014; Karlin et al., 2019; Stuart et al., 2018). More such efforts are needed along with assessment to ascertain whether more people in need of services are reached.

### ***Integrated Care: Primary Care and Behavioral Health***

Traditionally, physical health is handled in primary care facilities that are devoted exclusively to medical concerns. Integrated care is a model of bringing together multiple resources to address the range of physical, mental health, substance use problems, and lifestyle practices (see Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). Although the concept of integration of services is not new (e.g., Starfield, 1992; World Health Organization [WHO], 2001), there is renewed attention to the importance of integration and accelerated efforts to facilitate the changes in health care delivery (e.g., Kaur et al., 2022; Kazak et al., 2017).

The rationale for integration of services is based on multiple considerations:

- Mental and physical health problems go together (e.g., SAMHSA, 2017; Scott et al., 2016); a mental health problem is likely to be associated with a physical health problem, and vice versa.
- When individuals with mental disorders do go for treatment, they are likely to go to a primary care (e.g., internal medicine) service. Yet, many of these patient visits (30%–40%) are for the treatment of a mental disorder (Ansseau et al., 2004; Wittchen et al., 2022).
- The barriers (e.g., stigma of going to a mental health service) can be reduced by integrating care of multiple types in a primary care facility that people are more likely to attend.
- While receiving care for physical health, assessments can identify psychiatric problems (e.g., depression, suicide risk) that otherwise would be neglected (Lanzillo et al., 2019).

- The critical role of behavioral health (e.g., lifestyle practices, stress management) can be more readily addressed as part of physical and mental health care when integrated into a single setting (Wulsin et al., 2022).

Integration provides greater opportunity to reach a segment of the population that seeks physical health care and, in the process, will have access to mental health care as well. Many people do not seek or obtain physical health care. And, in relation to mental health, too few professionals are available to treat the vast majority in need whether in integrated care or clinical practice. Consequently, most integrated care facilities are limited in the range of psychiatric conditions they can accommodate. In addition, the integration and training of different health care professions and complexities of sharing information across disciplines present their own obstacles (e.g., Petersen et al., 2019). Even so, integrated care clearly has been a positive move in extending treatment and in ways that reduce some of the barriers of seeking and obtaining mental health services.

### ***Digital Mental Health Services***

These services refer broadly to a wide array of interventions that are delivered online, via mobile devices, utilize social media, or draw on other technologies (e.g., Lattie et al., 2022; Magnavita, 2018; Tal & Torous, 2017). Included in this is telemedicine, which refers to the use of communication and information technology to extend the reach of medical practice and has been in use for many decades (Bashshur & Shannon, 2009; Shirzadfar & Lotfi, 2017). In relation to psychological treatments, telemedicine is a very active area of research and practice, bolstered even more by the recent COVID pandemic and the increased isolation and confinement of both clients and practitioners. Technological developments have provided additional ways of delivering services. Smartphones, watches, tablets, smart clothing, virtual reality, various other sensors (e.g., in one's car, at home), and social robotics that bring interventions to individuals in their everyday lives (e.g., Emmelkamp & Meyerbröker, 2021; Rabbitt et al., 2015; Witte & Zarnekow, 2019; Zwiebach et al., 2018).

Online delivery of treatment can include many options (Spijkerman et al., 2016). These programs often include the same components of in-person treatment and address a broad range of psychological problems (e.g., Karyotaki et al., 2017; Lattie et al., 2022; Pearcy et al., 2016). These interventions can leap over many of the usual barriers of receiving treatment and expand on the model of in-person, individual psychotherapy at a clinic. Indeed, examples convey that large numbers of individuals can be treated with online delivery of interventions (e.g., Muñoz et al., 2016; Titov et al., 2020).

Although a goal of technologically based treatments is to reach more people who are not otherwise served, this is not

invariably the case. For example, extensions of telemedicine for mental health services have increased rates of services for White patients but decreased the use of services for underrepresented groups (Lattie et al., 2022). Yet, many of the interventions (e.g., smart clothing, watches, virtual reality, social robotics) might exclude marginalized persons due to cost and accessibility. Fortunately, there are now many efforts to extend digital intervention to underrepresented and marginalized groups and countries where health care infrastructure is limited (e.g., Li & Brar, 2022; Schueller et al., 2019; Titov et al., 2019; Wambua et al., 2022). Diverse groups (e.g., rural, homeless, indigenous individuals, older adults) and countries represent different challenges. Even so, considerable evidence indicates that digital variations of psychosocial treatments can be extended to populations and places that are not otherwise reached (see Tal & Torous, 2017; Teachman et al., 2022).

### ***General Comments***

I have highlighted four efforts to extend psychosocial treatments to reach people in need of mental health services. There are other efforts as well, such as the use of lay individuals as therapists, community-based programs, and mobile treatments where therapists drive to locales that do not have clinics (e.g., Connolly et al., 2021; Gibbons et al., 2022). Also, abbreviated interventions (e.g., self-help, single-session treatments) have been suggested as ways of reaching communities with less developed mental health care systems (WHO, 2014). As these comments suggest, multiple avenues of intervening have been suggested and often implemented.

Even with advances in evidence-based treatments and innovations in extending treatments, it is still the case that most people in need do not receive mental health services. The treatments and available methods of extending them have yet to be scaled sufficiently to reduce the prevalence of mental disorders or to close the treatment gap. Many calls have been made for new approaches toward treatment delivery as well as different (e.g., more holistic) approaches that focus on health and adaptive functioning more generally rather than on psychiatric disorders (Firth et al., 2020; Insel, 2022; Kazdin, 2018).

### ***Interventions From Everyday Life***

Efforts to extend the use of therapy are welcome additions to bring the treatments to people in need and bring people in need to the treatments. With these additions in place, some for many years, there are no signs that the treatment gap is closing. With the scope of mental illness and the difficulty in reaching people, is there more we might integrate into mental health care?

Lifestyle practices refer to activities in everyday life that affect health (e.g., Firth et al., 2020; Marx et al., 2021). There are many familiar practices, and some of these have an

evidence base that shows they can improve mental health and reduce symptoms of psychiatric disorders. The purpose of discussing lifestyle practices is not to advocate for any specific one. Rather, the goal is to promote a class or type of interventions that can be more systematically integrated into mental health care. This type of intervention is not part of the traditional mental health services but could greatly improve mental health and its reach.

It is useful to consider more systematic criteria one might use to select such interventions. The reason is that once one enters the arena of everyday life, there are scores of practices promoted to improve mental and physical health, longevity, love lives, and so forth. The criteria I highlight help to select among the many available practices and experiences that can improve mental health. Explicit criteria may also prompt consideration of additional interventions (and criteria) beyond those I highlight here.

### Criteria for Identifying Interventions

The goal is to expand the range of available interventions that are considered, promoted, and used as additional means to improve mental health. Several criteria are presented to make clear the bases for identifying such interventions (see Table 2). First, of course, we would want interventions that are *evidence-based*. The criteria to designate treatment as evidence-based vary among multiple disciplines (e.g., psychology, psychiatry, social work), diverse professional organizations, and private and public agencies within and among countries (e.g., in the Americas, European Union). Invariably, the common feature is that the intervention has empirical support, usually based on results from randomized controlled trials and where the effects have been replicated.

There are now scores of psychosocial treatments and medications that have an evidence base (see Barkham et al., 2021; Kazdin, 2018). Any other interventions to be added ought to meet the current criteria for efficacy. In relation to the present focus, the evidence should relate to improving mental health.

Second, the interventions should be *available in everyday life* and not require attendance to or participation in health care services and settings. Availability will vary by country, culture, locales within a given country, and so forth, with finer grained distinctions (e.g., areas within a given city). However, the criterion focuses on an intervention in which people can draw on or engage on their own without participating in mental or physical health care.

Third, *scalability* is a pivotal criterion to address the treatment gap and hence for identifying interventions. That is, we need interventions that can reach large numbers of individuals in need of help since we know that most individuals in need of services receive none. Fourth, *reach* as a criterion overlaps with but is distinguishable from scalability. Many groups are especially excluded from treatment and for a variety of reasons. For example, in the United States, these groups include children and adolescents, older adults, ethnic minority and underrepresented groups, single-parents, victims of violence, individuals with intellectual and physical disabilities, of lower income, living in rural areas, prisoners, and the list goes on. Scaling interventions so that more people receive them does not necessarily redress disparities in providing care. We could be scaling up to reach more of the people (e.g., majority group members, living in urban areas). Reach extends the criterion of scalability to ensure that those groups least likely to receive care are included.

**Table 2**

*Key Criteria for Identifying Interventions in Everyday Life to Better Address the Treatment Gap*

| Characteristic                                                                 | Defined                                                                                                                                                                                                                        |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Evidence-based                                                                 | We want interventions that have evidence on their behalf.                                                                                                                                                                      |
| Available in everyday life                                                     | An intervention that is available as part of everyday life and does not require attendance to or participation in health care services.                                                                                        |
| Scalability                                                                    | The capacity of the intervention to be applied in a way that reaches a large number of individuals.                                                                                                                            |
| Reach                                                                          | Capacity to extend treatment to groups likely to experience disparities in care, that is, less likely than others (e.g., in their country, city, setting) to receive mental health services.                                   |
| Free or relatively free of <i>system barriers</i>                              | Few or none of the system barriers with seeking mental health services. Affordability and reimbursement for care are not part of these interventions.                                                                          |
| Free or relatively free from <i>attitudinal barriers</i> of mental health care | Few or none of the attitudinal barriers associated with seeking mental health services. The barriers include stigma and self-stigma and mental health illiteracy, as primary examples.                                         |
| Multiple variations of the intervention are available                          | More than one variation of the intervention is available to allow flexibility and choice to accommodate different groups, cultures, and individuals and to provide choice of individuals and changes in that choice over time. |
| Acceptability of the intervention to potential consumers (clients)             | The intervention is acceptable to potential consumers. This refers to judgments by laypersons, clients, and others of whether the intervention procedures are reasonable activities in which to engage.                        |

Fifth, the interventions *remove or minimize the system barriers* (noted previously in Table 1). This begins with the idea that the interventions are *affordable* or, if possible, free. Among the system, barriers are lack of mental health facilities and professionals in the locales where they are needed and the inability of potential clients to pay for the treatment. A criterion for selection for present purposes is the removal or, more likely, minimization of system obstacles.

Sixth and related, the interventions should *minimize or eliminate the attitudinal barriers* often associated with seeking and attending mental health services. These include stigma, self-stigma, and mental health illiteracy, as primary examples. That is, we want activities or practices that are not pursued or sought based on individuals experiencing “symptoms” and traversing the many steps leading to treatment at a mental health facility. This criterion reduces or eliminates the attitudinal barriers that deter individuals from seeking services even when such services are available.

Seventh, the intervention ideally should have *multiple variations* that allow individuals to select among options. Thus, the intervention can be individualized by each person’s tastes and preferences. Also, resources to engage in activities in everyday life can vary among communities and areas within a city or country and hence multiple options are needed.

Finally, the intervention should be *acceptable* to consumers. Acceptability refers to people’s evaluation of the procedures, that is, what actually is done or required and has been evaluated in the context of psychotherapy, medications, hospitalization, and other interventions. Acceptability influences the likelihood that individuals will seek, continue in, or drop out of the intervention and whether clients carry out the procedures prescribed during the intervention (e.g., Carter, 2007; Vazquez et al., 2019; Wierenga et al., 2018). We want interventions that will be evaluated favorably and seen as viable activities in which to engage, independently of any connection to mental health services.

With these criteria in mind, I highlight three examples. They are readily familiar, but not usually actively promoted or integrated with other mental health interventions. They vary in the extent to which they meet or fully meet the criteria I have outlined and invariably will have their own limitations.

### Three Illustrations of Interventions Available in Everyday Life

#### Physical Activity and Exercise

##### Overview

Physical activity is well researched, very familiar, and already has a history of international and national organizations

lobbying for its widespread public adoption. Even so, it is not generally incorporated into recommendations as part of mental health and alleviation of symptoms of mental disorders. Physical activity refers to engaging in movement or action that is sustained for a specific period of time. Over the years, what constitutes health-promoting physical activity has expanded well beyond exercising. Both structured activities (e.g., games, sports, exercise classes) and unstructured activities (e.g., going for walks, doing household chores, gardening) are included among the physical activities that have many beneficial effects (e.g., Chen et al., 2022; Nguyen et al., 2022; Sheehan & Li, 2020).

Along with the expansion of what “counts” as activities that produce beneficial effects has been clarification of the duration requirements to reap the key benefits. Recommendations include exercise for a few times a week and of a specific duration. For example, in the United States, the recommended weekly dose for adults is 150 min of moderate-intensity physical activity and 2 days of muscle-strengthening activity (Centers for Disease Control and Prevention [CDC], 2021, 2022; United States Department of Health and Human Services [USDHHS], 2018). However, the health beneficial effects can be obtained with much less time.

Physical activity has been studied over a period spanning decades in relation to physical and mental health, cognitive impairment (e.g., among older adults), subjective well-being, stress reduction, quality of life, and related domains. Multiple reviews and meta-analyses indicate that exercise can both reduce the symptoms of anxiety disorders, including obsessive-compulsive disorder, affective disorders, eating disorders, substance use disorders, schizophrenia/psychosis, and cognitive impairment (e.g., Fernández-Abascal et al., 2021; Morres et al., 2019; Zschucke et al., 2013). The research includes both concurrent observational and prospective longitudinal studies and randomized controlled trials. Also, the studies have encompassed mild and severe psychopathology and treatment as well as prevention.

As an example, a recent meta-analysis evaluated the effects of physical activity on clinical depression among 15 studies (Pearce et al., 2022). The results revealed significant benefits of physical activity. The benefits were especially marked among those who had not previously engaged in physical activity, but the benefits were not limited to this group. The authors estimated that if individuals who had not engaged in exercise began an exercise regimen, this would reduce the prevalence of the disorder by 11.5%. Interestingly, minimal amounts of physical activity were beneficial below (e.g., half of the) the recommended standards. Other reviews have also concluded that physical activity can reduce the risk of onset of depression and symptoms of depression among those with the disorder (e.g., Firth et al., 2020).

### *Special Features and Considerations*

Several criteria were mentioned (and listed in [Table 2](#)) for identifying interventions in everyday life to add to the means of improving mental health. Exercise fares well on these criteria.<sup>2</sup> This is an evidence-based intervention with now scores of studies and reviews attesting to the effects on symptoms of psychopathology and mental health. Physical activity can take many forms and is available in everyday life. In principle, scalability and reach are met because no special facilities or equipments are needed. System and attitudinal barriers are minimal because the intervention is not part of services for mental health and special settings, while valuable (e.g., gyms, walking, jogging, and bicycling paths) are desirable, they are not needed. There are of course multiple variations and varieties of exercise so there is a plethora of options from individuals of all ages to select for physical activity and exercise. Finally, in relation to the criteria, the intervention is likely to be acceptable in large part because it is recognized as part of self-care in general and not a specific “treatment” for mental disorders.

There are additional features of exercise that are noteworthy as an intervention for mental disorders and mental health. First, as I mentioned, the range of activities that “count” as exercise is vast. Among the consequences, one can exercise in one’s home, by oneself, and with others. Also, over the course of a person’s week or life, one can change activities and still be involved in physical activity. Second, no special equipment, clubs, or settings are required but of course, these are options as well. Walking, gardening, and doing chores, already mentioned, can suffice. Thus, there is no necessary monetary cost of the activity for the individual or health care payers. Third, the benefits have been demonstrated across the age spectrum (e.g., children, adolescents, adults, and older adults). This has been facilitated by the prior point that diverse types of exercise are available and can be suited to the interests and abilities of individuals of different ages and abilities. Fourth, opportunities for exercise can be integrated into multiple settings (e.g., schools at all levels, the workplace, assisted-living facilities). Indeed, many settings (e.g., large corporations, universities) often have exercise facilities that can be used by employees. Finally, and most obviously, exercise can have broad benefits beyond mental health. Large-scale studies have shown that physical activity reduces the risk and onset severity of many disorders and medical conditions (e.g., cancer, hypertension, diabetes) and morbidity and mortality (e.g., cardiovascular disease, all-cause mortality; [Hart & Zernicke, 2020](#); [Sheehan & Li, 2020](#); [M. Wang et al., 2020](#); [USDHHS, 2018](#); [WHO, 2020](#)).

Nationally and internationally, exercise has been extensively promoted, mostly in the context of physical health, in keeping with the research emphasis. Expanded promotion is needed in the context of treatment, prevention, and reduction of symptoms of mental disorders. Despite major efforts to

promote exercise, there is great room for improvement in the proportion of people who engage in minimally adequate physical activity. For example, a large-scale survey in the United States spanning 1998–2018 indicated that the proportion of adults meeting recommended activity guidelines increased from 26% to 37.4% ([Whitfield et al., 2021](#)). This indicates progress over time but certainly the rates could be improved. Moreover, the survey revealed disparities in exercise rates and progress over the 21-year period. Various subgroups (e.g., ethnic minorities, older adults, adults with less than a college education) showed less progress in rate of exercise over time. The rates of engaging in exercise might be viewed in the context of many government agencies already actively promoting exercise, providing guidelines and toolkits to guide agencies, schools, communities, and businesses. These efforts or additional and perhaps different types of efforts are needed to increase the base rates.

Apart from the special features of physical activity, there are qualifiers worth noting. First, exercise is not suitable for everyone, in terms of interest or physical ability. Even so, the vast range of options that constitute physical activity and the wide age range that can be accommodated are clear advantages. Second, the opportunities are quite varied in terms of facilities (e.g., parks with exercise equipment), but even seemingly readily available opportunities (e.g., going for walks, jogging) are not feasible or safe in areas of many cities. Third, the benefits cannot be assumed to uniform across all individuals, mental disorders, cultures, and other potential moderators. Indeed, individuals with various chronic conditions might not be candidates or might not be able to engage in even the minimal exercise requirements. Fourth, in fact, there are barriers for some individuals. For example, one barrier to participation in exercise among adolescents is poor body image, low self-esteem, and concerns about peer reactions during exercise at school ([Martins et al., 2015](#)). However, such barriers might be mitigated with apps and exercise regimens available online and for private use in one’s home.

Finally, exercise can have deleterious effects. Overexertion, exhaustion, and excessive exercise can lead to physical harm. In addition, there are less obvious adverse consequences as well. For example, engaging in exercise, in combination with a specific genetic characteristic, increases the risk of amyotrophic lateral sclerosis, a degenerative motor neuron disease ([Julian et al., 2021](#)). Also, compulsive exercise in many individuals is considered to maintain eating

<sup>2</sup> I discuss whether interventions meet the criteria outlined earlier in the article as the basis for selecting interventions. It is important to acknowledge that each criterion might be viewed as on a continuum and hence to be evaluated as the extent to which the criterion is well met. Related, the applicability of a criterion (e.g., scalability, reach) might vary by some other moderator (e.g., ethnic minority, rural vs. urban settings). These points are important to acknowledge and also apply to more traditional mental health interventions when deciding whether a variation of psychotherapy is evidence-based.

disorders (Hallward et al., 2022). Cautions are important to note and evaluate for any intervention. However, the weight of the evidence and recommendations suggest that “physical activity is safe for almost everyone” (USDHHS, 2018, p. 89).

These qualifiers and objections must be viewed in context. Physical activity is highlighted here as one strategy to extend interventions that could reduce mental disorders and improve mental health. Among individuals without diagnosable mental disorders, the benefits are critically important. As I mentioned, many people with subclinical disorders utilize mental health services and perceive themselves in need of treatment. Also, these individuals are at risk for diagnosable disorders, and exercise might reduce that risk.

It is important to reiterate that I am not suggesting that exercise is *the* solution we need for the treatment of mental disorders or, by itself, will close the treatment gap. Exercise is a viable and underused intervention in everyday life that could have palpable impact on mental health, a finding already well supported. The challenges are to recognize the role exercise could play as part of the range of interventions for mental health, integrate the intervention in a way so it can be part of services, and foster practices (e.g., in schools, in the workplace, in more community settings) that will scale up its use.

## Contact With Nature

### Overview

Contact with nature is a broad term that encompasses interaction with some facets of the natural environment including the wilderness, mountains, forests, and other open areas. One usually thinks of trips to the country and locations that are away from urban areas but gardens and parks with foliage, animals, and in general the sights, sounds, fragrances, and ambience of the outdoors are central features, whether in a city or a wilderness setting (Hartig et al., 2014). In addition, access to oceans, beaches, and lakes (so-called blue space) serves as contact with nature (Hermanski et al., 2022). The definitions and scope of all that is included need not detain us but of course they become important when investigating precisely which among the vast types of contacts if any produce mental health benefits.<sup>3</sup>

The centrality of contact with nature has been a topic of cultural and religious practices over the course of history (Hartig et al., 2014; Kazdin & Vidal-González, 2021; Maller et al., 2009). Related but distinguishable from these traditions and their respective literature are the scientific underpinnings of contact with nature in relation to mental and physical health. Scores of investigations attest to the benefits of contacts with nature and these benefits have been demonstrated in multiple ways. First, in laboratory studies, showing people scenes of nature versus control scenes (e.g., urban areas), reveal the benefits of exposure to nature. For example, in one study, adults were given a task known to induce stress (Brown et al., 2013). At different points, randomly ordered,

individuals viewed nature or urban scenes. Merely viewing nature scenes led to more rapid recovery from the induced stress, as measured by indices of arousal (cardiovascular measures). There are multiple studies of the same type showing that people who view scenes of nature respond better and show more positive mood, less repetitive thinking, and other benefits under these highly controlled laboratory conditions.

Second, many observational (concurrent and prospective) studies outside of the laboratory evaluate individuals who vary in exposure to nature in the past or present and compare them to individuals with little or no such exposure. For example, a longitudinal study in Denmark evaluated all individuals (943,027) born between 1985 and 2003 and examined the extent to which exposure to green space (vegetation) during childhood contributed to mental health during adolescence and adulthood (Engemann et al., 2019). The greater the exposure to green environments where the children grew up during childhood, the lower the risk for a variety of mental disorders later in adolescence and adulthood. Several factors that might plausibly account for the effect (e.g., urbanization of living situation, socioeconomic factors, parental history of mental disorders, and parent age) were controlled and could not explain or account for the effects. Many other naturalistic and observational studies have shown the connection between exposure to nature and a variety of beneficial mental health outcomes (e.g., Bratman et al., 2019; Pouso et al., 2021).

Finally, randomized controlled trials have also demonstrated the benefits. For example, in one study adults were assigned randomly to walk in a natural setting (e.g., green space with grassland, trees, and shrubs) or to walk for the same duration but in an urban area (a walk on a road with a stream of traffic; Bratman et al., 2015). After the 90-min experience, individuals were evaluated using self-report and neuroimaging measures. Those randomly assigned to the nature experience showed lower ruminative thinking (maladaptive attentional focus related to depression and other mental disorders) and reduced brain activation in a region (subgenual prefrontal cortex) known to be active with that type of thinking. The findings are striking because this was a single-exposure experience and the beneficial effects were demonstrated. Other such trials provide similar support (e.g., Fyfe-Johnson et al., 2021).

<sup>3</sup> Many recognized mental health interventions include contact with nature as a key ingredient (e.g., wilderness therapy, bush adventure therapy, adventure-based therapy, nature-assisted therapy). Although there are many variations, typically individuals participate in a nature camp-type setting, with other components that may vary (e.g., learning practical skills; receiving individual, group, and family therapy; structured and unstructured social interaction experiences). These interventions are excluded from the present discussion because they require many special therapeutic settings and arrangements, are recognized as mental health treatments, and are not publicly accessible.

Contact with nature often includes walking, hiking, or bicycle riding through parks, the wilderness, or some other natural setting. Each of these activities is a form of exercise and even light exercise is associated with many mental and physical health benefits. Perhaps the benefits of exposure to nature merely reflect the effects of exercise. Yet, research has suggested that exercise is not a suitable explanation because many ways of exposing people to nature (e.g., as in the laboratory studies) do not involve exercise. On the other hand, direct tests have been inconsistent in showing that “green exercise” (engaging in the exercise in nature) surpasses the benefits than doing the identical exercises without exposure to the natural environment (Barton & Pretty, 2010; Lahart et al., 2019; Pretty et al., 2005).

There are now multiple narrative and meta-analytic reviews of research and large-scale surveys attesting to the beneficial effects in relation to mental health (Bratman et al., 2021; Frumkin et al., 2017; Hung & Chang, 2021; Maller et al., 2009; Moens et al., 2019; Pouso et al., 2021). The many beneficial effects of contact with nature have included improved mood, happiness, subjective well-being, sleep, self-esteem and cognitive functioning (as reflected in memory and paying attention), and reduced distress, feelings of isolation, ruminative thinking, depression, and anxiety. It is encouraging to note that, the benefits have been shown for children, adolescents, and adults and for men and women, and across many different countries.

Many psychological benefits of contact with nature reflect key ingredients related to psychopathology (e.g., rumination, depressed mood, and stress). However, little attention has been given to the impact on symptoms of psychopathology in clinical populations. The benefits (e.g., in mood, memory) have been evident in clinical samples (e.g., adults with clinical depressed, children diagnosed with attention deficit hyperactivity disorder), but with little attention to impact on the disorder, its key symptoms, or social functioning in everyday life (e.g., Berman et al., 2012). More direct tests are needed to establish the impact on symptoms of mental disorder. Yet, even without that, it is reasonably clear that contact with nature can improve subjective well-being and the quality of life.

### ***Special Features and Considerations***

Contact with nature satisfies several criteria noted previously (Table 2). These include the fact that such contacts have an evidence base in relation to mental health. Diverse criteria have been used across studies including subjective well-being, key characteristics of mental disorders, and symptoms. In terms of scalability, contact with nature with its diverse options is widely available in parks and other such settings and in both urban and rural areas. At the same time, the reach of contacts may have limits. Yet, contact may be less available for people we want to reach (e.g., in inner cities, in neighborhoods with

high crime rates) or when available may have impediments such as safety that limit utilization. In terms of barriers, contact with nature is relatively free from system barriers insofar as access to parks and the countryside is widely available and does not necessarily have any costs for entry or use. Perhaps more clearly, the attitudinal barriers are nicely addressed because contact with nature is not seen as connected to mental health care. Generally, there are multiple options and variations (e.g., parks, gardens, lakes, rivers, and oceans) so that criterion is nicely met. Individuals can select which among these options might be desirable and can vary the options over time, depending on local availability. Finally, contact with nature is likely to be acceptable as the activity in part because it is very familiar and has no relation to mental health services. Moreover, contact with nature does not require special skills. Indeed, an idiom in American English to convey that something is easy is to say, “It’s like a walk in the park.”

A plethora of critical questions remains regarding contact with nature and its role in improving mental health. First, “contact with nature” includes many components, settings, and interventions. Insufficient attention has been given to any one form (e.g., walks in nature) to identify critical parameters (e.g., duration, frequency) and whether some types of contacts and settings are more beneficial than others (e.g., de Vries et al., 2021). Second, the mechanisms through which the beneficial effects occur are largely unknown. This point might be made in relation to most interventions directed toward improving mental health, whether traditional mental health treatments or those everyday activities that serve as the impetus for this article. However, contact with nature often includes multiple components (e.g., reduced air pollution in nature, physical activity, socialization), each of which is already known to relate to health (Hartig et al., 2014). Isolated studies have separated these influences by controlling for one (e.g., physical activity, socialization) but more work is needed. Third and most relevant for the present discussion is the systematic evaluation of contact with nature on alleviation of symptoms of mental disorders. We know that the benefits include psychological factors that relate to, promote, and predict mental disorders but more direct tests are needed.

The health benefits of contact with nature have been studied for a period spanning decades. There have been many policy statements and recommendations to expand opportunities for contact with nature to promote public health in communities (e.g., WHO, 1986, 1997). What is new and maybe improved is the quality of the evidence showing the health benefits both in psychological and physical domains.

There are special challenges of providing contact with nature as a readily available resource. First, there are disparities in access. For example, in the United States, 75% of all non-White families with children live in neighborhoods with less natural land than the average for the state in which they live (Borunda, 2020). Urban planning routinely includes access to parks and nature, but the disparities remain. Second,

climate change and its consequences (e.g., desertification, forest fires) and commercial use (e.g., loss of natural settings and habitats) for farming, mining, and logging, decrease natural settings and habitats. In cities, restrictions in the use of water and in some cases fire hazards limit access to areas in nature.

Finally, the open outdoors away from urban life has changed in many places now with crowds and over tourism (e.g., Nickerson, 2016; Sæþórsdóttir & Hall, 2020). People in urban areas escape to the wilderness, national parks, or local forests (e.g., on the weekends or vacation breaks) only to find crowds and efforts to manage and control access. As summed up nicely, “tourists are loving nature to death” (Simmonds et al., 2018, *Crisis in Our National Parks: How Tourists are Loving Nature to Death*). In short, in addition to the research questions about the effects of contact with nature, attention is needed to ensure the availability of a way in which these benefits can be realized. What an irony it would be if the mental health benefits were achieved by remaining in the city on the weekends while most other people fled to the wilderness.

Even with the qualifications noted, it remains important to draw attention to the potential utility of contacts with nature. In fact, many people do have access and if utilization could be fostered, the benefits are noteworthy. Attention is needed to evaluate the impact more formally on subclinical and diagnosable disorders and whether the benefits are enduring.

## Yoga

### Overview

Yoga is spiritual discipline and set of practices designed to bring harmony between the mind and body. The discipline has a history beginning in India and extending thousands of years (Basavaraddi, 2015). Over the years, the practice has become global (Raghuwanshi, 2011). Yoga encompasses many components that include a variety of movements, postures, breath control, relaxation, mindfulness, and meditation. The many styles of yoga vary primarily in their emphasis on these different components. Most common are versions that focus on various postures, breath control, and concentration (meditation; e.g., de Manincor et al., 2015; Matko et al., 2021).

The many styles of yoga are not covered here for two reasons. First, much of the research does not specify the type of yoga that was included (Wieland et al., 2021). Second, when different styles are evaluated, consistent differences in outcomes do not emerge. For example, in an extensive review of over 302 randomized controlled trials and 52 styles of yoga, differences did not emerge in favor of one style versus another (Cramer et al., 2016). Admittedly, there are very few direct tests of different types. In any case, for present purposes, distinctions will not be made about types of yoga in terms of mental and physical health outcomes. There might well be differences in the extent to which variations are disseminable and acceptable.

There are now hundreds of reviews (>300) of the effects of yoga on mental and physical health (e.g., Klatte et al., 2016; National Library of Medicine, National Center for Biotechnology Information, 2022; Wieland et al., 2021). In relation to mental disorders, the strongest evidence appears for the reduction of depressive symptoms (Bridges & Sharma, 2017; Meister & Becker, 2018; Uebelacker et al., 2010). For example, one meta-analysis focused on depressive symptoms but included participants with a range of diagnosable mental disorders (Brinsley et al., 2021). The studies included many control and comparison conditions commonly used in psychotherapy research trials (e.g., no-treatment, waitlist, or treatment-as-usual). Overall, yoga was superior to comparison conditions in reducing depressive symptoms.

Beyond depressive symptoms, other work has shown positive benefits among individuals diagnosed with schizophrenia, eating disorders, substance abuse, obsessive compulsive disorders, and others (Cramer et al., 2016). Subjective well-being, cognitive functioning, and stress too have benefited from yoga. Many individuals seek yoga for physical health reasons, and the research has shown that yoga has been helpful for a variety of medical conditions including chronic pain, arthritis, multiple sclerosis, asthma, hypertension, and others (National Library of Medicine, National Center for Biotechnology Information, 2022; National Institutes of Health, National Center for Complementary and Integrative Health, 2022).

### Special Features and Considerations

Yoga fares well on the several criteria noted previously (Table 2). There is an evidence base showing the benefits in relation to mental health including both multiple indices of mental health and symptoms of mental disorders. Yoga is scalable and already is practiced in many countries, although typically by only 10%–15% of the adult population, as documented later. Perhaps more could be done with digital technology and apps to extend this. In terms of research, it is not clear that yoga is practiced equally or available equally across marginalized groups outside of the countries and cultures where yoga has developed. In terms of barriers, yoga is likely to be free from many of the system barriers (e.g., insurance, special facilities). However, there is training that is required and the availability of training and trainers can restrict use. On the other hand, the attitudinal barriers are probably little or no problem. Yoga by tradition and current practice is not seen as a “treatment” or designed for “mental disorders.” As to variations, the widespread use of yoga may be facilitated by the many options and types that are available. In principle, individuals can select a variation in keeping with their goals, interests, and physical ability. In practice, probably a large sample of variations of yoga are simply not available in any given local to provide a menu of sorts. That can be addressed also by digital technology to

extend the reach. In terms of criteria I have highlighted, yoga is likely to be acceptable as the activity in part because it is very familiar and more related to well-being rather than an intervention for mental health problems. Finally, although yoga does require special skills and practices, the requirements can be modified and adapted to accommodate individuals and their physical conditions.

There are many strengths of yoga as an intervention to improve mental health. First, is the fact that the intervention already is in widespread use. Surveys in the United States, for example, find that between 10% and 14% of the population practice yoga (e.g., [Clarke et al., 2018](#); [Schröter & Cramer, 2021](#)). Similarly, surveys in India encompassing rural and urban areas indicate approximately 12% of the population report the use of yoga. The percentages of use in other countries (e.g., Australia, Germany) fall within the same range ([Cramer, 2015](#); [Xue et al., 2007](#)). While the percentages are small, they encompass millions of people worldwide.

Second, people see yoga as relevant to their lives and useful for many reasons ([Cramer et al., 2016](#)). Primary among the reasons, in order of preference, have been general wellness (81%), physical exercise (80%), stress management (73%), seeking a spiritual experience (37%), alleviate a health condition (28%), personal recommendation (25%), illness prevention (23%), seeking a hobby (18%), social interaction (16%), and others ([Quilty et al., 2013](#)). Whatever the initial primary reason, one survey showed that nearly 2/3 of individuals changed their primary purpose. The top shift was to spirituality as the goal ([Park et al., 2016](#)). Overall, the many reasons for which yoga is used might facilitate recommendations for widespread promotion and adoption. Third and related, the widespread use of yoga may be facilitated by the many variations that are available. Individuals can select a variation in keeping with their goals, interests, and physical ability. Finally, occasionally negative effects are reported (e.g., soreness/pain, new injury, overexertion). However, these effects are exceptions and as one review noted, the data support the “overwhelmingly positive benefits” ([Park et al., 2016](#), p. 276).

Several criteria were mentioned as the basis for identifying interventions that are disseminable and outside the usual domain of mental health services. Yoga was selected because it fares well on the criteria ([Table 2](#)).

There are limitations of yoga in relation to the goals of this article. First, the empirical literature underscores the effects on well-being, although I mentioned depressive symptoms as a strong area too. Yet, more is needed in relation to the effects on symptoms of mental disorders with individuals who meet varying degrees of a disorder (e.g., meet criteria or subsyndromal in relation to specific disorders). Second, further component analyses are needed given that yoga includes other interventions (e.g., meditation, exercise). Finally, yoga may reflect a cultural practice that is a strength for some groups but possibly a limitation. Yoga is practiced worldwide

so perhaps that is less of a concern. Yet, at a more local level, various marginalized or ethnic groups, as a matter of orientation and philosophy, may not see yoga as acceptable as, for example, exercise and contact with nature. These concerns all are excellent bases for further research. Even so, at this point, based on evidence of the broad effects and widespread use on mental and physical states, yoga represents a viable intervention to extend widely and with benefits that extend to both mental and physical health.

## General Comments

I have highlighted three interventions to identify a class of activities that are available in everyday life. Each can have impact on mental health and indeed has evidence attesting to that. Other interventions in everyday life might have been included. For example, I mentioned yoga but other mind-body interventions might have been mentioned such as tai chi and Qigong, each with supportive evidence in relation to mental health (e.g., [Liu et al., 2020](#); [C. Wang et al., 2010](#)). In addition, many other practices might have been included, such as special diets, pet ownership, listening to music, and dancing. Each of these is often promoted as contributing toward mental health and has some supportive evidence (e.g., [Aalbers et al., 2017](#); [Chang et al., 2021](#); [Hui Gan et al., 2020](#); [Jacka et al., 2011](#); [Zhu et al., 2021](#)). Many other interventions of everyday life (e.g., photography, crafts, board and card games, woodwork) address various hobbies and pastimes might extend the list even further. Extending the list conveys the importance of having criteria in advance for their inclusion. Evaluating interventions goes beyond the significant challenging of carefully establishing if they are evidence-based to address the other criteria (e.g., scalability, reach) that convey their utility in having impact on reducing the burdens of mental disorders and related (e.g., subsyndromal) conditions. Ideally, there might be a portfolio of interventions that I have delineated as a category with only three of the more well-established examples.

I did not elaborate these other interventions for two reasons. First and foremost, the goal was to represent the class of intervention available in everyday life. Examples were designed to convey the point rather than to exhaust all possibilities. Second, those I omitted do not meet many of the criteria ([Table 2](#)) or have other obstacles. For example, diet can contribute to mental health. However, this consists of healthful eating (e.g., fresh vegetables, fish, olive oil), which tends to be expensive and not as readily available on a large scale despite efforts to do so in many creative ways (e.g., [Brownell & Frieden, 2009](#); [Niebylski et al., 2015](#)). Moreover, worldwide, the lack of food is endemic, with an estimated 25,000 people *daily* worldwide dying from lack of food ([Holmes, 2022](#)). Promoting special diets is a luxury—our first social task would be to feed our population. Another facet of diet, less frequently promoted, is special dietary

supplements (micronutrients) that can reduce psychopathology, as demonstrated in multiple randomized controlled trials (e.g., Blampied et al., 2020; Rucklidge & Kaplan, 2013). Yet, these supplements are not readily available, are not well known, and are not likely to be scalable or widely acceptable at this time.

I mention other interventions in passing that might have been included. I am not in any way asserting that they do not have significant benefit. Rather, I have selected interventions from everyday life that are more readily accessible and have a developed research base showing the connection between engaging in a practice and favorable mental health outcomes. It is important to reiterate, I am not promoting any specific intervention but rather raising the class of interventions that are evidence-based and meet the other criteria that would permit their widespread use.

Although I emphasized the interventions, it is important to recognize the manner of delivery and aids that can facilitate their use. I refer to technology such as various applications and programs that can bring exercise, virtual walks in nature, and yoga instruction and classes online. Online options extend enormously the possibilities of reaching individuals insofar as smart devices (phones, tablets, televisions, interactive speaking devices in the home) are part of daily life. As I mentioned earlier, traditional mental health interventions (e.g., cognitive therapy, self-help interventions) as well as interventions available in everyday life can be bought to individuals in their own home. This can help scale the intervention to reach more people. For example, in 2023, an estimated 6.8 billion people in the world (or approximately 85%) will have access to smartphones (Oberlo, 2022). Moreover, the percentage grows annually. Of course, this still excludes many people and disproportionately from low-income countries. Even so, the potential for reaching people with interventions to improve mental health is obviously enormous.

Not in the criteria for selecting these interventions in everyday life was the scope of impact that the interventions share. For physical activity, contact with nature, and yoga, the benefits extended to physical and mental health. The broad effects of the interventions are a huge advantage because physical and mental health are intricately intertwined (WHO, 2019). Having one type (physical or mental disorder) greatly increases the likelihood of having a disorder of the other type (Goodell et al., 2011). The relation of mental disorders and physical health is perhaps most poignantly conveyed by noting their relation to mortality. Large-scale studies (e.g., >270,000) have shown that individuals with a mental disorder die much earlier than their life expectancy if they did not have a disorder (Nordentoft et al., 2013).

Interventions that can improve both mental and physical health might be seized upon as the highest priorities in health care for both treatment and prevention. Indeed, there are many ways in which they have been recognized as pivotal. The World Health Organization, for example, has noted in

several policy documents the importance of physical activity over the life span and the promotion of physical activity is one of the 2030 Sustainable Development Goals (WHO, 2019). Many countries have their health organization promoting physical activity in a similar way (e.g., CDC, 2020; National Institute for Health and Care Excellence, 2019).

In summary, the value of the interventions, or at least some of them, is recognized widely. That part is not so new, although contact with nature and its effects are less commonly known. What is new is the need to recognize the interventions as viable options to improve mental health and to integrate them into general practice and activities more universally and commonly in everyday life. In other words, what needs to be new are the ways in which interventions in daily life are fostered, promoted, implemented, and evaluated, topics considered next.

## Directions for Research

### Fostering Uptake, Utilization, and Maintenance

Novel ways are needed to promote utilization of the everyday interventions. The point can be underscored by considering physical activity, which has had many programs to promote its use. Several countries have provided concrete guidelines for the public. These include as examples, Australia, Canada, the European Union, the United Kingdom, and the United States (Australian Department of Health, 2021; European Union, EU Working Group, Sport & Health, 2008; Piercy et al., 2018; Tremblay et al., 2016; UK Chief Medical Officers, 2011). Many of these guidelines provide materials (e.g., tool kits) for communities, schools, work settings, and provide support for changes in local policies. Moreover, psychiatric associations of various countries (e.g., Australia, New Zealand, Europe) have provided guidelines for physical exercise as a first line of attack for the treatment of mental disorders, including severe mental illness (e.g., Malhi et al., 2015; Stubbs et al., 2018). These guidelines have been a huge and uniform step toward advancing exercise. Even so, international studies consistently show that the minimal standard of physical activity is infrequently met (Bauman et al., 2009; Hale et al., 2021; Wilson et al., 2021). As noted by the National Physical Activity Plan, a coalition of multiple organizations in the United States, "Significant progress has been made worldwide in establishing physical activity as a public health priority. Yet, success in increasing physical activity at the population level has been very limited." (p. 1 of <https://www.physicalactivityplan.org/#nonnumbered>). Additional efforts are needed to increase adoption of the lifestyle interventions of the Type I have noted and to be sure any efforts encompass those groups already experiencing health care disparities.

The research and application tasks are to identify the best strategies to increase utilization of the interventions. In one meta-analysis, multiple structured interventions were evaluated

that included group and individual programs and procedures such as instructions, modeling, social support, goal setting, graded tasks, and others. There was minimal impact of the interventions, with effect sizes hovering  $<.2$  in initiating exercise or obtaining continuation after training (e.g., Willinger et al., 2021). The review serves as an excellent base for conveying that much more is needed and that evaluation is central for any effort to increase utilization.

In passing it is important to acknowledge a common practice for fostering lifestyle changes. Typical among these are government and nongovernment agencies making recommendations, highlighting various practices or disorders (e.g., CDC, National Institutes of Health, American Medical Association). The rationale for presenting information and guidance is sound. There is widespread physical and mental health illiteracy, which refers to the absence of information in several domains, including recognition of a physical or psychological problem (e.g., symptoms), resources that can be used to ameliorate them, and how to access these resources. Clearly, basic information on what to do to sustain mental health is needed to redress illiteracy. Yet, the vast majority of educational and information appeals are never evaluated empirically, and their impact on the uptake of recommended practices is largely unknown. We know from many different areas of research that rational appeals, providing information, and doling out advice are relatively weak ways of changing human behavior (e.g., Anderson & Whiston, 2005; Maher et al., 2014; Snyder et al., 2004; Sweeney & Moyer, 2015). They raise awareness and might even change knowledge and attitude, but these changes often do not translate to changes in overt behavior.

Although informational and educational appeals often are weak in terms of the number of individuals affected, they can be delivered inexpensively and reach large numbers, including individuals who otherwise might not receive treatment. Having some impact on clients with the use of the media and web-delivered messages, for example, would be great because relatively little in the way of effort is required. In other words, often weak interventions are inversely related to cost and positively related to scalability. If the intervention is a message, there are vast options (e.g., web, social media, smartphones, and watches) to reach many people in need of services and ways to ensure the messages reach the intended people (e.g., via social networks). Instructional, educational, and other such appeals are valuable for the reasons I noted. Yet, they infrequently rely on psychological findings from how to provide messages to optimize their impact on behavior (e.g., the use of message framing, social norming, nudging, choice architecture; e.g., Gallagher & Updegraff, 2012; Hansen et al., 2016; Thaler & Sunstein, 2008).

There are many other interventions that could promote behaviors related to physical and mental health. The use of technology can and already do play a critical role in lifestyle practices. “Apps” and wearable devices (e.g., wristbands,

smartwatches) might give messages but also animated figures or even interactive video and virtual games that involve physical activity could promote mental health-related behaviors. Social robots, even though still costly, already play a role in the delivery of mental health services and can reach many people who otherwise receive very little care (e.g., older adults; Rabbitt et al., 2015). More can be expected from devices with which we interact for more topics than questions about weather, time, and the news (Siri, Alexa, Cortana, Bixby). I am not suggesting any such devices are substitutes for mental health treatment, although that is a topic in its own right. The question is what can be mobilized to foster engaging in those everyday lifestyle activities that are known at this time to have impact on mental health.

Certainly, access to activities and incentives to utilize them can be better aligned. For example, in the United States, many states have laws that require some level of physical education (activity) in elementary school through the 12th grade. The laws vary in what is required, and research shows that the extent of physical activity of youth is highly related to the level of activity required by those laws (Piekarz-Porter et al., 2021). States with few or minimal requirements tend to have significantly lower rates of exercise among school children. This is ironic for other reasons, including findings that physical activity of youth is associated with improved academic performance and attendance (e.g., Richards & Smith, 2016; Taras, 2005).

Many workplaces have exercise facilities or provide access to other facilities nearby for their employees. Incentives for using these might be increased. In some work settings (e.g., business, universities), health care costs (insurance) are charged to or shared with employees, and there is also a separate unrelated fee for using exercise facilities. These seem to be competing. It would seem wise to provide free or very low-cost access to exercise and gym facilities and then to evaluate whether costs would be recovered by fewer health care visits, absenteeism, and other employer costs.

Access to interventions can be extended from existing programs. For example, for older adults in the United States, there is an insurance-based program referred to as Silver Sneakers in which elderly individuals are given free access to exercise facilities throughout the country. Ideally, such a program might be provided more widely or perhaps provided to those individuals least likely to receive health care services or at greatest risk of physical and mental disabilities.

Apart from interventions emanating from government and health care agencies and resources, more could be done culturally by mobilizing other domains of influence. For example, consider the widespread viewing of movies and services that stream unlimited movies in the home. What might be done to foster interventions or rather activities of the type I have illustrated? Years ago, select unhealthful practices (e.g., cigarette smoking) were reduced in modern movies. Similarly, safety practices were occasionally introduced

(e.g., seat belt use; Jacobsen et al., 2001).<sup>4</sup> These were background factors and, of course, rarely part of any movie plot. Similarly, routine practices including exercise, walks in nature, yoga, and other activities of the same type, could play an ancillary role in movies. Strategic placement of activities is not a departure from what many movies do by strategically placing branded projects (e.g., various named beverages, airlines, and specific brands of assorted products). I am not suggesting that changing the background of occasional activities in movies will reduce the burdens of mental illness. Yet, a united cultural front in which mental health-promoting activities were more ever-present might have a synergistic effect in terms of the background of a given cultural. This would mobilize government and nongovernment agencies and cultural groups to move toward the shared goals of improving mental and physical health.

A broad perspective may be needed to integrate everyday practices so they are more easily and readily adopted. There are many different disciplines relevant to the challenge, including psychology, psychiatry, implementation science, occupational therapy, law and social policy, government (at multiple levels), and many facets of society (e.g., educational systems, business and industry, and entertainment and media). The idea is to mobilize as many facets as possible of a given culture in collaboration to facilitate, promote, encourage, and nudge, but not force, engaging in health-promoting behaviors.

### Evaluation of Mental Health-Related Outcomes

An initial priority for research would be more direct tests and randomized controlled trials of the interventions to elaborate the impact on mental health and symptoms of mental disorders. We might not expect these lifestyle changes to exert the same impact as standard treatments (e.g., cognitive therapy, transdiagnostic therapies). Yet, we would want a clear picture of how these interventions fare in relation to well-established evidence-based interventions. A handful of benchmarking studies with the conditions commonly used in randomized controlled trials of psychosocial treatments would add perspective on where these lifestyle activities might fit (e.g., for whom, in a stepped-care regimen).

A second priority would be the preventive role of the interventions. We know that the interventions I mentioned improve mental and physical health, subjective well-being, and social functioning. Yet, we now need longitudinal work to identify the extent to which engaging in these activities reduces or delays the onset psychiatric disorders, reduces the severity of disorders, or prevents or delays the likelihood of relapse of an episodic mental disorder. Also, we know that many individuals with psychiatric disorders can be functioning well (Devendorf et al., 2022). Consequently, if engaging in physical activity or other activities has little or no impact on the onset of psychiatric disorders, it might still have

palpable implications on daily functioning among those with disorders.

A third priority might be accorded to the study of moderators, that is, those variables that can influence the magnitude or direction of the relationship between treatment and therapeutic change. The case can be made for the study of moderators in general, especially in an age of precision treatments, in which the goal is to match clients to treatments from which they will likely profit. However, in the case of those interventions available in everyday life, we do not know for whom they might be effective or sufficiently effective to improve life in palpable ways. If, for example, one or more of these interventions was especially effective with individuals with subclinical (subsyndromal) disorders (e.g., depression, anxiety), that would be important to know. Such individuals experience impairment in daily functioning, are seen in mental health services, and utilize treatments that might be reserved for individuals with more severe psychopathology or impairment.

Finally, for many practical reasons (e.g., policy, insurance, business practices), we would want to know the costs and cost savings of fostering physical activity and the other interventions in daily life. Programs that effectively increase utilization of everyday interventions obviously will have costs. We will want to know these and evaluate the extent to which they lead to cost recovery elsewhere. The cost savings might well be reflected in the reduced use of physical and mental health services, absenteeism from work and school, lower costs for unemployment and disability payments, and other such indices. Indeed, the likelihood that such interventions would continue to be promoted on a broad scale would be influenced by cost savings and benefits.

Needless to say, I have not exhausted the research questions that would elaborate the impact of interventions in everyday life. The priorities I have selected focus on establishing impact in the context of both treatment and prevention, the possibility of identifying subgroups for whom the interventions might be especially effective, and evaluation of the benefits and cost or cost savings that might result. Moreover, the collaboration of multiple disciplines adds depth and richness to addressing these questions.

### Evaluation and Monitoring of Impact

I have highlighted two areas that include adoption and utilization of the interventions available in everyday life and the impact that these have at the individual and population

<sup>4</sup> It turns out that movies often are credited with modeling all sorts of unhealthful and dangerous prevention activities (e.g., smoking, use of drugs, use of weapons) and not modeling actions that would prevent or minimize injury (e.g., use of helmets among bike riders, use of crosswalks among pedestrians; e.g., Jacobsen et al., 2001; Pelletier et al., 2015). Clearly, there are missed opportunities to promote activities that are beneficial, including those activities discussed in this article.

levels (e.g., prevalence, cost). Evaluation and monitoring of impact are essential ingredients in both the areas I discussed. That is, we would want to know that we could increase utilization of physical activities and other activities and that this made a difference in outcomes at the population level.

Assessment is well recognized as critical to global mental health apart from any specific type of intervention. For example, Grand Challenges in relation to both physical and mental health have identified the central nature of evaluation that includes mental health and monitoring progress at the population level (*Global Grand Challenges, 2003–2022; Varmus et al., 2003*). Moreover, there are many models in place to monitor health both within countries and at the international level (e.g., via the World Health Organization). Thus, extensions to monitor utilization of everyday interventions I mention and their the short- and long-term outcomes with which they are associated are feasible.

Two examples in the United States illustrate available models in place already. The National Health Interview Survey has been used to monitor the health of the U.S. population since 1957 and on a variety of health domains (see *USDHHS, 2010*). This is the main means of monitoring the health of the nation. The data for the measure are collected through personal household interviews (35,000–40,000 and encompassing 75,000–100,000 individuals). The U.S. Census Bureau serves as the agency that collects data for this measure and tracks health status, access to health care, and the extent to which health objectives are achieved.

Another large-scale surveillance measure in place is the National Survey on Drug Use and Health. This survey is administered nationwide in the United States and samples approximately 70,000 individuals (age 12 and older; *USDHHS, 2018; <https://nsduhwebesn.rti.org/resweb/homepage.cfm>*). The survey provides data on the level and patterns of alcohol, tobacco, and illegal substance use and abuse; track trends in use and abuse, assess the consequences, and identify groups at high risk. In addition to substance use and abuse psychopathology (e.g., depression), impairment, and service use are assessed. The interview has had different formats over the course of its use began in 1988, including personal interviews, computer-assisted personal interviews, and audio computer-assisted self-interviews. The measure is relied heavily by diverse federal and state government agencies to make decisions and track trends in various groups (e.g., youth) or specific domains of use and abuse (e.g., alcohol). There are of course many other surveys and span countries throughout the world.<sup>5</sup>

The assessment of utilization and impact of intervention outcomes is a weighty topic because of the range of measures and outcomes that are available and relevant at the individual and population level. Yet, for present purposes, the key goals relate to the treatment gap. Can we scale up interventions to reach more people in need and reach individuals who are least likely to receive services? When scaled in this way, can we

reduce the prevalence of mental disorders, improve the adaptive functioning of those with continued disorders, and increase the mental health and quality of life of a nation? Evaluation and monitoring of both the activity (e.g., exercise) and outcomes over time are essential.

### Closing Comments

Interventions in everyday life can be added to the options to improve mental health and reduce the symptoms of psychopathology. Understandably, it might be easy to misinterpret what is being advocated, and hence it is important to dispel potential concerns. First, I am not suggesting that the interventions in everyday life are substitutes for, nor even necessarily the intervention of first choice, for the treatment of mental disorders. A misreading and straw(man)person argument against what I propose would be to suggest that a suicidal patient should begin a regimen of jumping jacks or take a walk in the park as the means of addressing the clinical problem. Second, I am not stating that any one intervention is a panacea. We know from research on virtually any intervention (e.g., in medicine, psychology, education) that no one intervention will work with all individuals. Third, I gave three examples of interventions available in everyday life that met criteria that would favor their scalability and minimize the traditional barriers to mental health care. My goal was to raise a class of interventions and with criteria to help exclude the sea of everyday recommendations to improve life and well-being, but with little more than anecdotal information and the proverbial “clinical evidence” often promoted in advertisements. In raising a class of interventions, there was no effort to be exhaustive. Indeed, a goal of the article is to foster broader consideration of what might be used to improve mental health and reduce psychopathology that goes beyond our traditional conceptualizations of what can be done to address the treatment gap.

Finally, the interventions I have illustrated have their own barriers that limit accessibility, even though many of the usual barriers to obtaining mental health care are mitigated or avoided. For example, contact with nature, as reflected in parks and open areas, is not readily available in many areas, even though they are often included in urban planning. Similarly, exercise facilities are not routinely available if this refers to membership in a business that offers access to facilities but for a price. More would need to be done within a given culture and government to facilitate access to and foster use of such interventions.

<sup>5</sup> There are scores of surveys worldwide. Among them is the World Health Survey Plus that encompasses approximately one third of member countries (*WHO, 2022*), the European Health Interview for member countries (*Eurostat, 2022*), the National Health Survey in Australia (*Australian Bureau of Statistics, 2022*), the China Health and Nutrition Survey (*UNC Carolina Project, 2022*), the Mexican National Health and Nutrition Surveys (*Shamah-Levy et al., 2019*), and several others spanning Asia, South America, and Africa.

With these caveats in mind, it is important to recount the original goal, namely, reduce the enormous gap in services provided to people with mental health problems. As I have noted previously, despite advances of all sorts in developing treatments and devising creative ways of delivering them, the most common treatment condition for individuals with mental disorder in low-, middle-, and high-income countries is no treatment. Interventions in everyday life need to be rigorously evaluated in the context in which I have raised them, namely, their short- and long-term impact on mental health and in the context of treatment and prevention. The evaluation is critical for any intervention, but in the case of those I have suggested, there are additional issues because the goal is to scale these at the level of the population. There are important cost issues, even though the interventions themselves are readily available. What additional funds are needed to effectively promote utilization of these interventions and develop infrastructure (e.g., local, federal) to maintain effective promotion strategies. The costs would include those related to monitoring the population impact of such interventions on a regular basis. Also, we would want to know about cost recovery. That is, are the costs of effectively promoting and monitoring use of such interventions recovered by reductions in the cost of health care (e.g., hospital visits, absenteeism from school and work, disability payments) due to the mental and physical health benefits of these everyday activities? The initial task is to consider expanding the conceptualization of what interventions can be used to promote mental health and contribute to the reduction of the treatment gap. These everyday interventions have the potential of raising the overall level of mental health at the population level and reducing the need or intensity of specialized treatment. The current research emphasis on interventions for mental health focuses on models of treatment to which most people do not have access. Could interventions in everyday life help to ameliorate the treatment gap? The critical next steps are needed both to increase utilization and to monitor impact.

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Received November 9, 2022

Revision received January 23, 2023

Accepted February 16, 2023 ■