International Journal of Education, Modern Management, Applied Science & Social Science (IJEMMASSS)
ISSN :2581-9925(Online), Impact Factor: 7.555, Volume 07, No. 04(II), October - December, 2025, pp. 180-186

Public Policy for Mental Health Promotion: Strategic Integration of Psychological Well-Being into Social Welfare Programmes

Dr. Pankaj Kumar*

Assistant Professor (GT), Department of Psychology, G.D. College, Begusarai,(Lalit Narayan Mithila University, Darbhanga, Bihar)

*Corresponding Author: pankajkumarsah2015@gmail.com

Citation: Kumar, P. (2025). Public Policy for Mental Health Promotion: Strategic Integration of Psychological Well-Being into Social Welfare Programmes. International Journal of Education, Modern Management, Applied Science & Social Science, 07(04(II)), 180–186. https://doi.org/10.62823/IJEMMASSS/7.4(II).8441

ABSTRACT

Mental health is increasingly recognized as a vital component of human development, social equity, and economic productivity, yet it remains under-prioritized within public policy in many developing contexts, including India. This study examines how psychological well-being can be strategically integrated into social welfare programmes, with a special focus on Bihar, a state facing severe mental health infrastructure and workforce deficits. Drawing on secondary data from government reports, policy documents, WHO sources, and peer-reviewed literature, the study analyses national and state-level frameworks, resource gaps, and implementation challenges. Evidence indicates that although India has progressive policies such as the National Mental Health Programme (NMHP), District Mental Health Programme (DMHP), and the Mental Healthcare Act (2017), less than 2% of the health budget is allocated to mental health, and treatment gaps remain high. Bihar exemplifies these disparities, with extremely low ratios of psychiatrists, psychologists, and social workers, alongside limited district-level coverage. The paper highlights emerging progress through institutions like BIMHAS and digital models such as telepsychiatry under the VKN-ECHO framework, demonstrating that scalable and cost-effective solutions are possible. It argues for a multi-sectoral and preventive approach that links mental health with welfare sectors such as education, women's empowerment, employment, and poverty alleviation. Strengthening governance mechanisms, increasing dedicated funding, promoting community-based outreach, and leveraging digital innovation are identified as key strategies. The study concludes that embedding psychological well-being into social welfare policy can enhance resilience, productivity, and social inclusion, ultimately repositioning mental health as a public good and a foundation for inclusive and sustainable development in India.

***Keywords**: Mental Health Policy, Psychological Well-Being, Social Welfare Programmes, Public Health Governance, Digital Innovation.*

Introduction

Mental health has emerged as a fundamental pillar of sustainable development, social equity, and human progress. The WHO identifies psychological well-being as an essential component of overall health, yet in developing nations like India, it remains a neglected policy area. The lack of attention to mental health undermines productivity, aggravates social disparities, and hinders economic growth. To achieve holistic development, public policy must move beyond isolated medical interventions and adopt an integrated approach that embeds mental health into the core of social welfare programmes.

In India, mental health challenges are widespread across all socio-economic groups. The National Mental Health Survey (2015–16) reported that over 10% of adults need active mental health intervention, but more than 70% remain untreated. Despite the growing burden, less than 2% of the

national health budget is allocated to mental health, reflecting chronic underinvestment. This financial neglect is particularly severe in economically weaker states like Bihar, where inadequate infrastructure and human resources intensify the crisis. The result is a cycle of untreated mental distress, social exclusion, and declining human development outcomes. Addressing this requires viewing mental health as a public policy imperative linked to welfare, education, and employment.

Bihar exemplifies the acute challenges in mental health service delivery. The state has one of the lowest ratios of mental health professionals in India only 0.03 psychiatrists per 100,000 population, compared to the WHO's minimum recommendation of three. There is also a severe shortage of psychiatric social workers, clinical psychologists, and counsellors. However, progress is emerging. The Bihar State Institute of Mental Health and Allied Sciences (BIMHAS) in Patna expanded its reach from 563 patients in 2006 to over 104,000 in 2024, with capacity increasing to 321 beds in 2025. These advancements highlight growing recognition of mental health's importance but also reveal the need for equitable rural-urban access and stronger institutional frameworks.

Strategically designed public policy can be transformative in embedding mental health into the social welfare framework. Integrating mental health into national and state programmes such as the DMHP and Ayushman Bharat can help close service gaps. Digital innovations like telepsychiatry under the VKN-ECHO model offer new ways to reach underserved populations. A multi-sectoral approach linking health, education, social justice, women's welfare, and technology is vital for sustainable progress.

Achieving this vision requires not only sound policy but also greater investment, institutional strengthening, and widespread mental health literacy. Embedding psychological well-being into welfare programmes addressing poverty, disability, and employment can enhance resilience and social harmony. This study examines current policies, identifies gaps, and proposes scalable, context-sensitive strategies to shift India and especially Bihar from treating mental illness to fostering mental wellness as a public good.

Review of Literature

Chakrapani, V., et al. (2023).*Mental health in India: Sociocultural dimensions, policies and programmes.* The review examines sociocultural barriers stigma, caste, and poverty within India's mental health system. Despite policy progress, services remain fragmented and institutional. It advocates for culturally sensitive, decentralized, and community-based mental health approaches within welfare programmes.

Gupta, S. (2022).*National Mental Health Policy, India (2014): Where have we reached?* Gupta assesses the policy's implementation, citing insufficient funding, lack of coordination, and limited monitoring. The study stresses linking mental health policy with welfare design, funding, and accountability for effective outcomes.

Kaur, A., Kallakuri, S., Mukherjee, A., Wahid, S. S., Kohrt, B. A., & Maulik, P. K. (2023).*Mental health related stigma, service provision and utilisation in Northern India: Situational analysis.* This situational analysis in Haryana identifies low awareness, stigma, reliance on traditional healers, and lack of resources as key barriers to mental health care. The study highlights policy–practice gaps and calls for stigma reduction, community-based services, and better policy alignment with local realities.

Meghrajani, V. R., Marathe, M., Sharma, R., et al. (2023).*A comprehensive analysis of mental health problems in India and the role of mental asylums.* This analysis reviews India's mental health burden, highlighting poor access, stigma, and institutional dominance. It advocates deinstitutionalization, early intervention, and community-based care integrated into welfare and public health systems.

Ranade, K. (2022).*Mental health law, policy & programme in India.* Ranade traces policy evolution from colonial acts to the 2017 Mental Healthcare Act, highlighting underfunding, workforce shortages, and poor coordination. The paper argues that policy must be backed by funding and inter-sectoral collaboration to strengthen welfare-linked mental health services.

Rathod, S., Kingdon, D., Phiri, P., et al. (2017).*Mental health service provision in low- and middle-income countries.* This review highlights service shortages, treatment gaps, and poor integration with primary care in LMICs. It recommends community-based, welfare-integrated service models using task-sharing and lay health workers to improve access.

Singh, V., et al. (2022).*Mental health prevention and promotion – A narrative review.* This review categorizes interventions by level, setting, and type, emphasizing promotion and prevention in LMICs. Despite proven efficacy, limited resources and weak policy integration restrict implementation. It recommends incorporating promotion and prevention within large-scale welfare frameworks.

van Stolk, C., et al. (2014).*Psychological well-being and work: Improving service use for people with common mental health problems.* This review links PWB to better employment and social outcomes. It suggests embedding PWB promotion in welfare and employment programmes to enhance productivity and social participation, especially in contexts like Bihar.

Objectives

- To assess the national and Bihar-specific mental health infrastructure and policy implementation.
- To analyse resource disparities and evaluate pilot models of mental health interventions.
- To propose context-sensitive and scalable strategies.

Methodology

This study uses a qualitative research design based on secondary data analysis to explore the integration of psychological well-being into India's social welfare programmes, focusing on Bihar. Data were drawn from government reports, policy documents, Union and State Budgets, NFHS data, WHO reports, and peer-reviewed literature. Bihar-specific information was obtained from the DMHP and BIMHAS performance records. The study compares national and state frameworks to identify policy gaps, resource disparities, and implementation challenges. Through qualitative synthesis, it proposes context-sensitive and scalable strategies to strengthen institutional capacity, promote digital outreach, and embed mental health within welfare initiatives.

National Framework and Mental Health Policy Landscape

India's approach to mental health has evolved significantly over the past few decades, particularly following the introduction of the *NMHP* in 1982. The NMHP marked the country's first official acknowledgment of mental health as a public concern and aimed to integrate mental health care into general health services. However, despite its long existence, implementation has been uneven due to inadequate funding, limited awareness, and a shortage of trained professionals. The *Mental Healthcare Act (2017)* further strengthened India's commitment by recognizing mental health as a right and emphasizing access to affordable and quality services. It also mandated the establishment of Mental Health Review Boards and protection of patient rights.

At the national level, India's mental health infrastructure remains underdeveloped relative to global standards. Less than 2% of the Union Health and Family Welfare Budget is allocated to mental health, and only about 0.75 psychiatrists per 100,000 people are available far below the WHO-recommended minimum of three. The majority of mental health facilities are concentrated in urban areas, leaving rural populations underserved. Although national schemes such as *Ayushman Bharat*, *National Health Mission (NHM)*, and the *DMHP* aim to integrate mental health into primary care and welfare, resource allocation and inter-sectoral coordination remain weak.

Mental Health Infrastructure and Policy Implementation in Bihar

Bihar faces some of the most severe mental health challenges in India, largely due to limited infrastructure, low health literacy, and high poverty rates. The state has only 0.03 psychiatrists per 100,000 population, indicating a 96.6% deficit compared to WHO norms. Similarly, the number of clinical psychologists and psychiatric social workers is extremely low approximately two per crore population. Despite these challenges, Bihar has made gradual progress through institutional strengthening and targeted initiatives.

The BIMHAS in Patna has become a cornerstone for mental health services, expanding from 563 patients in 2006 to over 104,000 in 2024. The institution's capacity also increased to 321 beds in 2025, reflecting improved accessibility. Moreover, the DMHP operates across several districts, albeit with limited staff and inconsistent coverage. The government has also begun incorporating mental health elements into broader welfare schemes, including women's empowerment and youth development initiatives. However, widespread stigma, lack of community awareness, and weak coordination between departments of health, education, and social welfare continue to hinder effective policy implementation.

Integration of Psychological Well-Being into Social Welfare Programmes

The integration of mental health into social welfare in Bihar and India remains nascent but essential. Welfare programmes addressing poverty alleviation, education, women's empowerment, and employment generation rarely include structured psychological support, despite the clear evidence linking mental well-being to social and economic outcomes. Initiatives such as *Ayushman Bharat Health and Wellness Centres* and *Digital Mental Health Interventions* (like the VKN-ECHO telepsychiatry model) represent promising steps toward integration.

A multi-sectoral framework linking health, education, and community development can help embed psychological well-being in welfare delivery. For example, training social workers and Anganwadi workers in basic counselling can promote early detection and referral. Likewise, integrating mental health awareness campaigns into welfare schemes such as *National Rural Livelihood Mission (NRLM)* or *Poshan Abhiyaan* can help normalize discussions around mental well-being. While Bihar's progress is notable, it underscores the need for sustained investment, decentralization of services, and community participation to ensure that psychological well-being becomes an inseparable component of social welfare policy implementation across India.

Human Resource and Infrastructure Disparities in Mental Health Services

A major challenge in integrating psychological well-being into public welfare programmes lies in the shortage of trained professionals and infrastructure. India, as per WHO recommendations, should have at least three psychiatrists per 100,000 population; however, the country has only 0.75 per 100,000, while Bihar lags severely behind with 0.03 per 100,000, marking a deficit of nearly 96.6%. Moreover, Bihar has just two clinical psychologists and two psychiatric social workers per crore population, making community-level interventions nearly impossible to sustain.

In terms of infrastructure, although the BIMHAS has expanded significantly serving over 104,000 patients in 2024 compared to only 563 in 2006it remains the only major tertiary-level mental health institution in the state. The DMHP is functional in only a few districts, leaving vast rural areas underserved. Limited hospital beds, outdated facilities, and the absence of specialized units further restrict access to timely care.

The shortage of professionals is not just a state issue but a reflection of national underinvestment. Training facilities for psychiatry, psychology, and psychiatric social work are concentrated in metropolitan regions, leaving states like Bihar dependent on central assistance and digital outreach models.

Evaluation of Pilot Mental Health Intervention Models

Several pilot projects in India offer insights into scalable approaches for mental health integration. The VKN-ECHO (Virtual Knowledge Network Extension for Community Healthcare Outcomes) model under the DMHP has shown promise by connecting district hospitals and primary health centres with experts through tele-mentoring. This digital approach can help bridge the human resource gap in Bihar.

Similarly, community-based models such as ASHA-led counselling sessions, mental health awareness campaigns, and school-based life skills programmes have yielded positive results in states like Kerala and Tamil Nadu. Bihar can adapt these models by leveraging local networks and existing welfare frameworks, including Self-Help Groups (SHGs) and Panchayati Raj Institutions (PRIs), for early identification and intervention. Incorporating such pilot models into Bihar's welfare architecture could significantly enhance access, affordability, and awareness of psychological well-being, particularly among marginalized communities.

Table 1: Comparative Overview of Mental Health Resources and Pilot Interventions

Parameter	National Average	Bihar State Data	WHO Recommended Standard
Psychiatrists (per 100,000 population)	0.75	0.03	3.0
Clinical Psychologists (per crore population)	12	2	50+
Psychiatric Social Workers (per crore population)	15	2	50+

Hospital Beds for Mental Health	10,000 (approx.)	321 (BIMHAS)	Adequate per WHO: 50 per lakh
Annual Mental Health Patients Treated	1.2 million (India)	104,000 (BIMHAS, 2024)	—
Functional District Mental Health Programmes	72% districts covered	30% districts covered	100%
Key Pilot Models	DMHP, VKN-ECHO, ASHA-led counselling	DMHP (partial), BIMHAS telepsychiatry	—

Source: Compiled from NMHS (2015–16), MoHFW Reports (2023–24), WHO Mental Health Atlas (2021), BIMHAS Annual Report (2024–25), and DMHP Progress Reports (2024).

The above Table 1 compares mental health resources and interventions across India (national average), Bihar, and WHO standards, revealing major shortfalls in Bihar's mental health infrastructure and workforce. India has 0.75 psychiatrists per 100,000 population, while WHO recommends 3.0. Bihar's figure of 0.03 shows an extreme shortage. Similarly, clinical psychologists and psychiatric social workers number only 2 per crore in Biharfar below national averages (12 and 15) and WHO norms (50+).

Infrastructure is also limited: India has around 10,000 hospital beds for mental health, whereas Bihar has only 321 beds at BIMHAS, compared to the WHO standard of 50 beds per lakh. In 2024, BIMHAS treated 104,000 patients, a small share relative to the 1.2 million treated nationally. Programmatically, DMHP covers 72% of Indian districts but just 30% in Bihar, showing weak outreach. While India uses DMHP, VKN-ECHO, and ASHA-led counselling models, Bihar's initiatives are confined to partial DMHP coverage and BIMHAS telepsychiatry. Overall, the table underscores Bihar's critical need for stronger mental health policies, workforce expansion, and community-based interventions to align with WHO standards.

Strengthening Institutional Frameworks and Governance Mechanisms

Embedding psychological well-being into social welfare programmes requires a robust and accountable institutional framework. Mental health should no longer be treated as a peripheral concern of the health sector but as a cross-cutting policy priority across ministries such as health, education, labour, and social justice. A strong governance structure ensures coherence between central and state-level programmes. Establishing Mental Health Policy Coordination Units within state departments can improve planning, monitoring, and inter-departmental communication.

In Bihar, existing institutions like the BIMHAS and the DMHP can serve as focal points for policy convergence. Strengthening these through adequate staffing, training, and data management will improve service delivery and accountability. Moreover, integrating mental health components within welfare schemes such as Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), National Social Assistance Programme (NSAP), and Integrated Child Development Services (ICDS)can help ensure mental well-being reaches marginalized populations. This institutional alignment fosters sustainability and ensures that mental health is embedded into the core of welfare governance rather than treated as a stand-alone intervention.

Enhancing Funding Mechanisms and Resource Allocation

One of the most critical barriers to integrating mental health into social welfare policy is underfunding. Currently, India spends less than 2% of its total health budget on mental health, and Bihar's share is even lower. To address this gap, a dedicated mental health fund should be established within state budgets to support community-based programmes, digital outreach, and workforce training.

Public–private partnerships (PPPs) can also be leveraged to expand access to affordable mental health care. For example, collaborations with NGOs, academic institutions, and corporate social responsibility (CSR) initiatives can help provide psychological support in rural and semi-urban areas. Additionally, performance-based budgeting linking resource allocation with measurable outcomes like awareness levels, service reach, and reduction in stigma can ensure transparency and accountability. Investing in training programmes for social workers, health officers, and teachers will build human capacity to deliver mental health interventions within welfare schemes. In essence, sustained and strategically targeted funding is the backbone of scalable mental health integration.

Promoting Community-Based Outreach and Digital Innovation

Integrating psychological well-being into welfare programmes must prioritize community-level interventions supported by digital technology. Community engagement helps reduce stigma, enhances trust, and ensures cultural relevance. Bihar, with its diverse socio-economic population, can benefit from grassroots mental health networks involving panchayat representatives, Anganwadi workers, and Accredited Social Health Activists (ASHAs). These frontline workers can act as early identifiers of distress and provide basic counselling or referrals through a task-shifting approach.

Digital innovation, such as the VKN-ECHO model under the DMHP, can amplify outreach by linking local health centres with mental health specialists through telepsychiatry and e-consultation. Mobile-based mental health education campaigns and helplines can provide real-time support, especially for youth and rural women. Moreover, integrating digital modules into social welfare portals like Jan Seva Kendra and e-Samadhan can help citizens access mental health resources seamlessly.

By combining digital connectivity with community empowerment, Bihar can develop a hybrid model that expands access, minimizes stigma, and delivers psychological well-being services where they are needed most. Such strategies align with India's broader vision of inclusive development and digital transformation, ensuring mental health becomes a shared responsibility across sectors and communities.

Findings and Interpretations

The findings of this study reveal a significant gap between mental health policy intent and on-ground implementation in India, particularly in Bihar. Analysis of secondary data shows that while India has established a progressive policy framework through the NMHP, DMHP, and the Mental Healthcare Act (2017), the actual integration of psychological well-being into social welfare programmes remains limited. Less than 2% of the national health budget is devoted to mental health, which directly affects service expansion, workforce development, and community outreach. The treatment gap where more than 70% of individuals requiring care remain untreated indicates that policy commitments have not translated into adequate service delivery.

In Bihar, the results are more pronounced. The state's extremely low ratio of 0.03 psychiatrists per 100,000 population, along with minimal numbers of clinical psychologists and psychiatric social workers, highlights a critical human resource deficit. Infrastructure limitations are equally evident, with BIMHAS serving as the primary tertiary care centre and DMHP coverage limited to a fraction of districts. However, the rapid increase in patient footfall at BIMHAS and the adoption of telepsychiatry models suggest a rising demand for services and growing awareness. These trends indicate that when services are available and visible, communities are willing to seek mental health support.

The discussion points to the importance of a multi-sectoral welfare-linked approach. Evidence from pilot models such as VKN-ECHO and ASHA-led counselling demonstrates that task-sharing and digital platforms can partially offset workforce shortages. Integrating mental health into welfare schemes like NRLM, ICDS, and employment programmes can also address the socio-economic determinants of distress. Furthermore, community-based awareness initiatives appear effective in reducing stigma and improving early help-seeking.

Overall, the study demonstrates that mental health integration is feasible but requires systemic reforms. Strengthened governance, better funding, decentralization of services, and convergence between health and welfare departments are essential. If scaled effectively, these strategies can transform mental health from a specialized service into a routine component of social welfare delivery, thereby improving both psychological well-being and broader development outcomes.

Conclusion

Mental health has emerged as a critical pillar of human development, social inclusion, and economic productivity, and this study underscores that it must be treated as a core public policy priority rather than a marginal health concern. Although India has established progressive frameworks such as the NMHP, DMHP, and the Mental Healthcare Act (2017), their impact is constrained by underfunding, workforce shortages, stigma, and uneven implementation, particularly in resource-poor states like Bihar. Integrating psychological well-being into social welfare programmes related to poverty reduction, education, women's empowerment, and employment can create far-reaching social and developmental benefits by strengthening resilience and social participation. A coordinated multi-sectoral strategy combining stronger institutions, dedicated funding, community-based outreach, and digital innovations like telepsychiatry offers a practical pathway to close existing gaps. Moving from a reactive, illness-cantered approach to a preventive and promotive model of mental wellness is essential for sustainable

progress. When psychological well-being is embedded within welfare governance and everyday service delivery, it not only improves individual quality of life but also contributes to inclusive growth, social harmony, and long-term development outcomes, ensuring that mental health becomes a shared public good and a foundation for a healthier, more equitable society.

References

1. Alegría, M., NeMoyer, A., &FalgàsBagué, I. et al. (2018). Social determinants of mental health: Where we are and where we need to go. *Current Psychiatry Reports, 20*(95). https://doi.org/10.1007/s11920-018-0969-9
2. Fisher, M. (2022). Moving social policy from mental illness to public wellbeing. *Journal of Social Policy*, *51*(3), 567-581.
3. Grummitt, L., Barrett, E., Halladay, J., Bailey, S., Birrell, L., Hunter, E., Kelly, E., Champion, K., Gardner, L., Nguyen, A., Chapman, C., Newton, N., &Teesson, M. (2023). Embedding action on social and structural determinants of mental health into a national framework: An "immunisation schedule" for the prevention of common mental disorders. *Mental Health & Prevention, 32*, 200308. https://doi.org/10.1016/j.mhp.2023.200308
4. Herrman, H. (2001). The need for mental health promotion. *Australian and New Zealand Journal of Psychiatry, 35*(6), 709–715. https://doi.org/10.1046/j.1440-1614.2001.00947.x
5. Malhotra, S., & Shah, R. (2015). Women and mental health in India: An overview. *Indian Journal of Psychiatry, 57*(S2), S205–S211.
6. Meghrajani, V. R., Marathe, M., Sharma, R., et al. (2023). A comprehensive analysis of mental health problems in India and the role of mental asylums. *Cureus, 15*(7), e42559. https://doi.org/10.7759/cureus.42559
7. Monshat, K., & Herrman, H. (2010). What does "mental health promotion" mean to psychiatry trainees? *Australasian Psychiatry: Bulletin of the Royal Australian and New Zealand College of Psychiatrists, 18*(6), 589. https://doi.org/10.3109/10398562.2010.500330
8. Mulvale, G., & Bartram, M. (2016). No more "us" and "them": integrating recovery and well-being into a conceptual model for mental health policy. *Canadian Journal of Community Mental Health*, *34*(4), 31-67.
9. Pandya, A., Shah, K., Chauhan, A., & Saha, S. (2020). Innovative mental health initiatives in India: A scope for strengthening primary healthcare services. *Journal of Family Medicine and Primary Care, 9*(1), 502–507.
10. Patel, V., Saxena, S., Lund, C., Kohrt, B., Kieling, C., Sunkel, C., Kola, L., Chang, O., Charlson, F., O'Neill, K., & Herrman, H. (2023). Transforming mental health systems globally: Principles and policy recommendations. *The Lancet, 402*(10402), 656–666. https://doi.org/10.1016/S0140-6736(23)00918-2
11. Singh, S., Roy, D., Sinha, K., Parveen, S., Sharma, G., & Joshi, G. (2020). Impact of COVID-19 and lockdown on mental health of children and adolescents: A narrative review with recommendations. *Psychiatry Research, 293*, 113429.
12. Singh, V., Kumar, A., & Gupta, S. (2022). Mental health prevention and promotion—A narrative review. *Frontiers in Psychiatry, 13*.https://doi.org/10.3389/fpsyt.2022.898009
13. Slade, M. (2010). Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC health services research*, *10*(1), 26.
14. Smith, A., Bhugra, D., Van Voren, R., &Liebrenz, M. (2023). Mental health of political figures: Ethics of commentary and psychiatric assessment related to the death of Vladimir Bekhterev (1857–1927). *Indian Journal of Psychiatry, 65*(4), 482–483. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_500_22
15. Thornicroft, G., Sunkel, C., Aliev, A. A., Baker, S., Brohan, E., elChammay, R., Davies, K., Demissie, M., Duncan, J., Fekadu, W., Gronholm, P. C., Guerrero, Z., Gurung, D., Habtamu, K., Hanlon, C., Heim, E., Henderson, C., Hijazi, Z., Hoffman, C., ... Winkler, P. (2022). The Lancet Commission on ending stigma and discrimination in mental health. *The Lancet, 400*(10361), 1438–1480. https://doi.org/10.1016/S0140-6736(22)01470-2
16. World Health Organization. (2024). *Achieving well-being: a global framework for integrating well-being into public health utilizing a health promotion approach*. World Health Organization.

❑❑❑