

# Integrated Behavioral Healthcare: Paving the Future of Mental Health in India

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## Abstract

This research paper explores the concept of integrated behavioral healthcare (IBHC) and its potential as a transformative approach to the future of mental health services in India. This paper explores how integrated care can bridge the gap between physical and mental health, enhance access to services, and improve outcomes by recognizing the unique challenges and opportunities in the Indian healthcare landscape. This paper presents a comprehensive overview of the subject and discusses policy implications for the Indian context towards improving mental health outcomes and healthcare delivery.

**Keyword:** Mental health, Suicide, dementia, anxiety disorders, substance use disorders, Schizophrenia, Integrated Behavioral Health Care, National Mental Health Survey, healthcare utilization, service use, impact, disability of mental disorders, biological, psychological, social needs, coordinated care, Collaborative Care, patient-centered and health information technology, WHO, National Mental Health Program, District Mental Health Program, primary and community health centers, Emotional expression, Shame, Power Distance, Collectivism, unique health identification, spirituality and religion, Data Privacy, telehealth and teletherapy

## Introduction

Our capacity to think clearly, make wise decisions, and cope with everyday challenges is strongly influenced by our mental health, which is an essential aspect of our total wellness. We can build and maintain healthy relationships, be successful at work, and take pleasure in our free time when our mental health is in good shape. However, a number of variables, including our biological makeup, socioeconomic circumstances, and environment, might harm our mental health. Exposure to these risk factors can lead to a range of mental health problems, which account for 13% of all diseases worldwide and one in every ten years of lost health internationally. These problems have a considerable impact on the global disease burden. Globally, 300 million people suffer from depression, 800,000 people commit suicide each year, and dementia is one of the top 10 killers on the globe. [1]

Mental illness is a serious public health concern in India. According to the 2015–16 National Mental Health Survey, almost 15% of Indians are living with mental health issues. Depression, anxiety disorders, substance use disorders, and schizophrenia are examples of common disorders. [2]

Traditional healthcare practices frequently separate physical and mental health, which leads to a lack of access to care and cultural stigma. A paradigm called Integrated Behavioral Health Care (IBHC) combines physical and mental healthcare treatments. IBHC clinicians work together to serve patients with both physical and mental health needs with integrated treatment. IBHC can increase access to care, lessen stigma, and improve patient outcomes for people with mental health disorders, which bodes well for the future of mental health care. This study aims to investigate the potential of IBHC as India's next-generation provider of mental health services.

**Keywords-** Mental health, Suicide, dementia, anxiety disorders, substance use disorders, Schizophrenia, Integrated Behavioral Health Care

## Research Methodology

The literature search strategy involved a comprehensive approach to identifying relevant studies on mental health problems in India, with a focus on IBHC. Multiple databases, including World Health Organisation(WHO), PubMed, PsycINFO, and Google Scholar, were searched using a combination of keywords such as "mental health," "India," "prevalence," "burden," "access to care," "mental health disorders," and "integrated behavioral healthcare." The search was conducted without any language or date restrictions to ensure the inclusion of a wide range of studies. In addition to academic literature, reports from government agencies, international organizations, and non-governmental organizations were reviewed to capture a holistic understanding of the topic.

To ensure the selection of appropriate studies, specific inclusion and exclusion criteria were applied. Inclusion criteria included studies on mental health problems in India, prevalence rates, types of mental health disorders, access to mental healthcare, social and cultural factors influencing mental health, and mental health policies and initiatives in India, with a focus on IBHC. Both quantitative and qualitative studies were considered. Studies that provided insights into the challenges, current practices, and future directions for IBHC in India were prioritized. Exclusion criteria involved studies that were not specific to mental health or did not pertain to the Indian context, as well as studies that did not focus on IBHC. Studies with insufficient data, case reports, editorials, and opinion pieces were also excluded. The focus was primarily on peer-reviewed articles, systematic reviews, meta-analyses, and research reports that provided substantial evidence and analysis of mental health problems in India in the context of IBHC.

The selection of studies involved a two-step process. Initially, titles and abstracts were screened to assess their relevance to the research topic. Subsequently, full-text articles were reviewed based on the inclusion and exclusion criteria.

This research methodology will help identify the best practices for IBHC in India and develop recommendations for improving the delivery of mental health services in the country.

## 4 The Current State of Mental Health in India

### 4.1 Prevalence of Mental Health Disorders

In India, mental health issues are a major public health concern. The National Institute of Mental Health and Neurological Sciences (NIMHANS), Bengaluru, collected an enormous amount of data for the National Mental Health Survey (NMHS) in 2015–2016, including information on the prevalence and

burden of mental disorders as well as the treatment gap, patterns of healthcare utilization, service use, impact, and disability of mental disorders. Only 12 states, one for each Indian region, were included. Nearly 15% of Indians, according to the NMHS, are affected by mental health issues. Depression, anxiety disorders, substance use disorders, and schizophrenia are examples of common illnesses. With over 15% of the population suffering from mental health illnesses, India has a serious public health challenge.

Urban dwellers and women are more susceptible to being impacted. However, There are few mental health resources available, especially in rural areas. As a result, there is a significant treatment gap, with just 10–12% of people with mental health illnesses receiving any kind of care. In India, stigma and discrimination related to mental health are still pervasive. This may discourage people from asking for assistance even when they are in need. Alcohol use disorders and drug use disorders, respectively, affect 1.8% and 0.6% of the population, making substance use disorders a serious issue in India. In people with mental illness, the suicide rate is 36.4 per 100,000 people, which is much higher than the rate in the general population. This demonstrates the importance of early detection and action to stop suicides. Many people who suffer from mental health illnesses turn to unofficial sources for support, including friends, family members, religious healers, and traditional healers. Few people seek professional mental health care, on average. This shows that there is a need to improve access to professional mental health treatments and raise awareness of mental health illnesses. [2]

#### 4.2 Challenges in Mental Healthcare Delivery

Two important factors that are linked to mental diseases are poverty and educational attainment. High-risk groups include those with lower levels of education, income, and access to necessities. The majority of uneducated and unemployed persons suffer from affective disorders, panic disorders, generalized anxiety disorders, particular phobias, and substance use disorders. Suicidal conduct is more prevalent in women, those with unfavorable job conditions, little discretionary authority, premarital sex, physical or sexual abuse, persistent pain, and stress. Significant associations between suicide, recent breakups, and living alone were also found. Environments at work, school, and at home are significant factors in the development of mental diseases. Due to fast social change, gender discrimination, social marginalization, and domestic abuse, females are more susceptible to mental problems. Domestic violence is a major problem in India, and women are more likely to suffer from it.

Psychological factors such as headaches, body aches, sensory symptoms, and tiredness also make people vulnerable to mental disorders. Biological factors include genetics, abnormal physiology, and congenital defects. Disasters can also lead to mental health problems, such as post-traumatic stress disorder, generalized anxiety disorder, and panic disorder. Stigma related to mental disorders, lack of awareness, delayed treatment-seeking behavior, lack of low-cost diagnostic tests, and lack of easily available treatment are the main hurdles in combating the problem of mental health in India. Factors pertaining to traditional medicine and beliefs in supernatural powers in the community also delay diagnosis and treatment. India has focused its attention mainly on maternal and child health and communicable diseases, which has led to a lack of political commitment to non-communicable diseases, further aggravating the load of mental disorders. [3]

### 4.3 IBHC Concept and Benefits

Decades after the Alma Ata Declaration on primary health care was adopted, its key principles remain fundamental building blocks for improved global health. The first principle of the Declaration reaffirms the Constitution of the World Health Organization (WHO): health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. [4] All people's lives are fundamentally reliant on their mental health. It affects our thoughts, emotions, and behaviors. It supports our capacity to decide, form connections, and influence the environment in which we live. Another fundamental human right is mental health. Additionally, it is essential for socioeconomic, communal, and personal development. It is always a part of us, even when we are not aware of it. Our physical and mental well-being are equally vital. When we have good mental health, we can handle life's stresses, recognize our own potential, learn and function well, and actively participate in our communities. We are better equipped to connect, function, cope, and thrive when we are in good mental health. [5]

Numerous millions of individuals are impacted by mental illnesses, which lead to significant suffering, incapacity, and financial loss. Although mental diseases may be successfully treated, only a small portion of those in need receive even the most basic care. The best practical strategy to close the treatment gap and guarantee that patients receive the mental health care they require is to integrate mental health services into primary care. Primary mental health treatment is inexpensive, and investments may yield significant returns. It is crucial that primary care practitioners are well-trained and supported in their mental health work because certain skills and abilities are necessary to screen, diagnose, treat, support, and refer people with mental disorders. [6]

### 4.4 Definition of IBHC

According to the American Psychological Association, "Integrated health care, often referred to as inter-professional health care, is an approach characterized by a high degree of collaboration and communication among health professionals. What makes integrated health care unique is the sharing of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological, and social needs of the patient. The inter-professional health care team includes a diverse group of members (e.g., physicians, nurses, psychologists, and other health professionals), depending on the needs of the patient." [7]

IBHC's guiding principles are predicated on the idea that physical and mental health are intertwined. IBHC programs seek to offer thorough, coordinated care for illnesses affecting both physical and mental health. Universal health coverage, compliance with the Convention on the Rights of Persons with Disabilities, the use of scientific evidence and best practices, taking cultural considerations into account, the adoption of a life course approach that takes into account health and social needs at all stages of life, and partner participation are some of the fundamental principles of IBHC. [6], [8]

### 4.5 Components of IBHC

IBHC entails coordinating and integrating primary care and mental health services under a single system. The fundamental elements of IBHC cover a range of elements that go into a patient-centered, all-encompassing approach to healthcare. Collaborative Care Teams are the essential elements of IBHC that benefit stakeholders. Multidisciplinary teams are essential to IBHC. These teams often include care coordinators, behavioral health experts (such as psychologists, psychiatrists, and social workers), and

primary care physicians, nurse practitioners, and physician assistants. In order to give patients comprehensive care, collaborative care teams collaborate. Care that is patient-centered is tailored to the patient's needs, preferences, and objectives. Patients actively participate in their care, and decision-makers value their opinions. Coordinated care entails the healthcare team's members effectively communicating and exchanging information. It guarantees that patients receive interdisciplinary treatment for both physical and mental health concerns. Screening and assessment aid in the early detection of mental health problems, especially in primary care settings, and guarantee the quick implementation of the necessary interventions. Medical, behavioral, and psychosocial therapy may all be a part of the treatment plans and initiatives. Treatments supported by evidence are frequently used to direct care. In Shared Decision-Making, Patients actively work with medical professionals to choose amongst available treatments while addressing any worries or queries they may have. Patient outcomes are evaluated using standardized methods, and changes to the treatment plan are made in accordance with these data, which is a hallmark of IBHC. Healthcare organizations that practice population health management investigate and address prevalent mental health problems that afflict particular patient demographics, such as depression in elderly people. Access to Care is ensured by providing treatments in primary care settings, which are more easily accessible to patients. IBHC hopes to lower obstacles to getting mental health treatment. Healthcare professionals in the IBHC are taught to be sensitive to the various cultural backgrounds and beliefs of their patients and to deliver care that respects and takes these elements into account. IBHC frequently makes use of health information technology to support team member communication and care coordination. In order to improve their mental and physical health, patients are given continued care and follow-up even after the initial treatment phase. [9],[10]

Keywords - National Mental Health Survey, healthcare utilization, service use, impact, disability of mental disorders, biological, psychological, social needs, coordinated care, Collaborative Care, patient-centered and health information technology

**5 Model of Behavioral Healthcare in India**

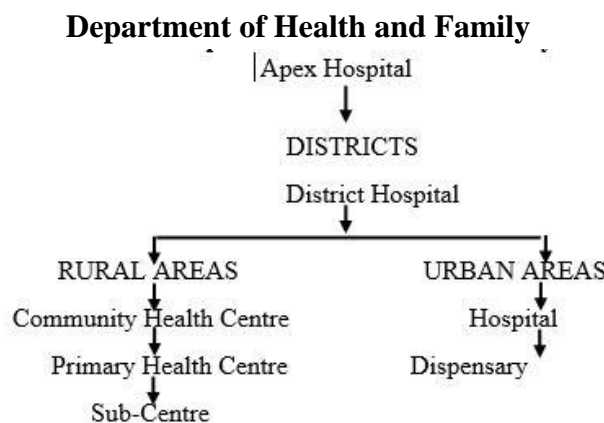
**5.1 Broadly, the public healthcare system in India[11],[12] can be summarized as shown in the chart below:**

**The Healthcare System in India**

**NATIONAL LEVEL**

**Ministry of Health and Family Welfare(MoHFW)**

**STATE & U.Ts**





The WHO emphasized the importance of providing mental health care to developing nations during a 1974 expert committee conference in Addis Ababa. In 1982, India became a leading emerging nation by implementing the National Mental Health Programme (NMHP) in accordance with WHO recommendations and making use of the pre-existing general healthcare infrastructure. Over the course of the last few decades, NMHP has experienced numerous changes. These include the enhancement of mental health services provided by primary and community health centers (PHCs and CHCs), the implementation of the District Mental Health Programme (DMHP), which treats each district as a separate entity, and the pairing of DMHP with the National Rural Health Mission (NRHM) to further enhance program implementation. [13]

### 5.1 NMHP

PHCs and CHCs served as the service delivery unit under NMHP. Nevertheless, there were numerous implementation and management challenges with this concept. As a result, the scope of the services was constrained. The initiative had certain fundamental conceptual faults, such as the absence of any budgetary estimation or provision, and uncertainty about who should pay for it—the Indian central government or the state governments, who were always short on funding for healthcare. Moreover, psychiatrists' reactions to the program were unwelcoming, to the point of its outright rejection. [13]

### 5.2 DMHP

The MoHFW is responsible for implementing DMHP in India. It was launched by the GoI in 1996 to overcome the limitations of NMHP. Under the DMHP, each district is designated as a mental health district, and a team of mental health professionals (psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, and community health workers) is established to deliver services within that district. The specific organization and implementation of the DMHP may vary from state to state, as the program is implemented by the respective State Health Departments in collaboration with the MoHFW. The primary objectives of the DMHP are to ensure the availability of mental health services at the district level, reduce the treatment gap for mental health conditions, promote community participation, and strengthen the overall mental health infrastructure in India. DMHP has evolved greatly in the last 15–20 years under the Five Year Plans. The DMHP was launched on the premise of the positive outcome of the Bellary project which showed that the district could be a robust model for service delivery, implementation, and scale-up of the program; because the Bellary district has more outreach mental health treatment facilities than the rest of the nation, it was determined that the district selected for this reason was not representative of districts across the entire nation. Furthermore, the approach entirely disregarded psychosocial therapies in favor of a pharmaceutical framework. Furthermore, the program's poor performance was caused by its top-down methodology, which excluded local input from its design and execution. Political neglect, insufficient leadership at the federal, state, and local levels, a lack of funding, and poorly executed service delivery (including low staff retention, motivation, and training) at the district and community levels have all been significant obstacles to the DMHP's implementation. [14]

### 5.3 Adaptations for the Indian Context

Most of psychiatry and psychology have emerged from cultural traditions and understandings of human conditions as existing in the Western world. They have provided theories and frameworks for the

treatment of mental distress; however, their application becomes erroneous at times when applied in cultures other than Western cultures due to the complexity that working across cultures brings with it. India is culturally diverse across its length and breadth, and the same has a significant impact on the many aspects of mental health, ranging from the ways in which health and illness are perceived to the health-seeking behavior and attitudes of the patients as well as the practitioners and mental health systems. Hechanova and Waeldle[15] suggest that there are five key components of diverse cultures that have implications for mental health professionals. While the authors make their arguments in the specific context of disaster situations in Southeast Asia, their comments provide a framework to identify issues related to cultural diversity and mental health. Emotional expression is an aspect in which it may be perceived that talking about painful issues would lead to further painful feelings. Shame is another key element in this context because of the significant role that family plays in the lives of Asian individuals with mental health issues. The third element that they bring out is power distance, or the large differences in power that may exist between therapists and which may have implications in terms of autonomy or lack thereof in the therapeutic relationship. Fourth, they discuss the nature of collectivism and its impact as a supportive factor for resilience and coping. Finally, they discuss spirituality and religion from the point of view of attribution as well as in terms of coping with disease. [15],[16]

Considering the many cultural elements, the integration of behavioral healthcare in India is a challenging task. Indian cultures differ significantly in how they express their emotions. Mental health practitioners must modify their therapy approaches in light of these variances. Health practitioners can try to lessen the stigma associated with mental health difficulties in India by spreading the belief that asking for treatment is a sign of strength rather than weakness and by increasing awareness of these issues. Healthcare providers must make an effort to lessen power distance and foster an atmosphere where patients feel free to voice their concerns. By highlighting the significance of each person's well-being for the general well-being of the community, mental health practitioners can combat collectivism. Health practitioners might use religiously-aligned practices such as prayer or meditation in their treatments. [17]

### **5.3 Challenges of Integration of Behavioral Healthcare**

The main challenge to the integration of mental health services into PHC is the acute shortage of mental health professionals, as without some form of supportive supervision by specialist mental health professionals, it is not possible to achieve sustainable integration of mental health care into PHC of adequate quality. Non-availability of a multidisciplinary workforce trained to provide psychosocial care because public sector psychologists, social workers, counselors, and support workers are in short supply. Beliefs that mental illness was strange behavior and more difficult to diagnose than other illnesses and that traditional healers were more effective than modern medicine practitioners, with strong reliance on self-help, informal healing approaches, and more formal traditional and religious healing, beliefs that anyone who had mental illness should be avoided because it is difficult to work with such people, and so, they should be kept behind locked doors and excluded from the public, that patients respond to screening in a dishonest manner, would not comply with the provider's recommendations including accepting to receive the diagnosis or treatment at the primary care level, and that there was a likelihood of legal liability for charting a wrong diagnosis and the PCPs were unsatisfied with the level of knowledge they had in mental health and did not regard managing mental illnesses as their primary role. They left counseling to the few specialists on the ground, which, in their view, tended to be

unsuccessful. The challenges related to the healthcare professional's knowledge and skills in the integration of behavioral healthcare included the inability to diagnose and treat mental illnesses, limited mental health awareness in the community, increased workload, and limited time, which are motivation-related barriers to the integration of behavioral healthcare services into PHC. The availability of funds is another important aspect that poses a challenge in scaling up existing facilities as well as training PHC staff to identify, diagnose, and treat behavioral health issues.[18],[19]

#### 5.4 Data Privacy and Technology

The landmark Mental Health Care Act of 2017 intends to enhance mental health services provided in India while safeguarding the rights of those who suffer from mental disease. Nonetheless, the paucity of research on digital data privacy has led to its low priority in India's nascent digital mental health programs. The Indian government is working methodically to make sure that every patient receiving health services has a unique health identification (UHID), a digital identity that is connected to "Aadhaar" number and is issued by healthcare providers to track individuals and obtain pertinent medical records. People with mental illnesses must have their digital data privacy protected in order to lessen the likelihood that they will be stigmatized, judged, or face other negative outcomes in their personal or professional connections. [20]

Biometric and demographic data stored in a central database, such as under the Aadhaar system, can pose a significant threat to the data privacy of individuals with potentially stigmatizing conditions like behavioral health disorders. The use of artificial intelligence in digital solutions, including health interventions, can further complicate the situation and potentially compromise data privacy. Patient exclusion in the development of artificial intelligence systems in mental health research and clinical practice is a common issue. There is a risk of unauthorized or unintended disclosure of an individual's mental illness or other stigmatizing conditions, which can lead to denial of access to crucial services or perpetuation of stigma. Individuals may experience discrimination by insurers or financial institutions if they have to reveal their sensitive health information, leading to potential denial of services. Increasing awareness of data privacy among individuals with mental health conditions and their families is crucial, and privacy rights and advisories should be included in all digital mental health program materials and in the training curricula for medical and engineering graduates. [20],[21]

Further, the technology will enable the development and implementation of IBHC interventions, providing accessible and convenient support to the clientele. It will combine mental health services with primary care, other medical specialties, and social services. Technology can be used to support IBHC for (a) digital mental health interventions to provide self-help and support to individuals with behavioral health conditions, as well as to deliver therapeutic services remotely. For example, mobile applications can provide tools for mood tracking, cognitive-behavioral therapy exercises, and virtual support groups. (b) Telehealth and teletherapy services will allow individuals to access mental health services from the comfort of their own homes, which can be especially beneficial for people who live in rural areas or who have difficulty traveling to traditional in-person appointments. (c) Data linkage and analysis can be used to link and analyze data from different sources, such as electronic health records, social media, and wearable devices. This data can be used to better understand mental health conditions and develop more effective interventions. [20],[21]



Keywords – WHO, National Mental Health Program, District Mental Health Program, primary and community health centers, Emotional expression, Shame, Power Distance, Collectivism, unique health identification, spirituality and religion, Data Privacy, telehealth and teletherapy

## **6 Policy Implications**

### **6.1 National Mental Health Policy**

The Government of India, National Mental Health Policy has shown alignment with integrated care principles to some extent. The policy recognizes the need for integration of mental health into primary care and emphasizes the importance of collaboration and integrated care. [22] Efforts have been made to address barriers in mental health service provision, such as the shortage of manpower and specific psychiatric problems faced by vulnerable populations. [23] However, there are still gaps in understanding the challenges of increasing access to and improving the quality of mental health care throughout the country.[24] The policy has undergone modifications over time, with the inclusion of daycare and long-term continuing care centers, financial support, and the implementation of the Mental Health Care Act. [25] Overall, while the policy has made progress in aligning with integrated care principles, there is still room for improvement in terms of addressing resource constraints, increasing trained personnel, and conducting context-specific research.[26]

### **6.2. Regulatory Framework**

The Mental Healthcare Act, 2017 (MHCA 2017) is a significant step forward for mental healthcare in India.[27] However, there are a number of areas where the Act can be improved to support IBHC in India. The MHCA 2017 was signed into law by the President of India in April 2017 and took effect on April 7, 2018. It provides mental health care and services to people with mental illness and protects and promotes their rights while they are receiving these services. It replaced the Mental Health Act, 1987 (MHA 1987). The definition of mental illness in the MHCA 2017 is too restrictive and needs to be revised to include all mental illnesses that are recognized by the International Classification of Diseases (ICD 10). Clarity is required on whether the definition of mental illness in the MHCA 2017 should be used to determine who is eligible for mental healthcare services. MHCA 2017 does not allow for admission to a mental health establishment (MHE) for observation and serial mental status evaluation. The act makes it difficult to admit and treat people with mental illness (PWMI) before their condition becomes severe. This is because admissions are only possible under certain sections of the act, which have strict criteria. This can be a time-consuming process, and it may delay life-saving treatment. The psychiatrist should have the final say on admission of PWMI for observation or treatment, even if it is involuntary. The psychiatrist should also be able to override advance directives in certain cases, such as when the PWMI is suicidal. The act also places an unfair burden on psychiatrists by requiring them to assess the capacity of PWMI periodically and treat them according to the advance directive/consent of the nominated representative (NR). This is time-consuming and resource-consuming, and it can hinder patient care. The act may be amended to allow for admissions for observation and serial mental status evaluation, and it should make it easier to admit and treat PWMI before their condition becomes severe because IBHC models often rely on early intervention and support, so it is important to make it easier for people with mental illness to access the care they need before their condition becomes severe. The act should also give psychiatrists more flexibility in overriding advance directives and assessing the capacity of PWMI. Section 20 of the MHCA 2017 prohibits compulsory toning of people with

mental illness (PWMI). However, some PWMI may be found in a disheveled state, wandering on the roads, and without the capacity to give consent, make decisions for themselves, or have an advance directive (AD) or nominated representative (NR). It can be difficult to manage such patients in this situation. Section 20 also gives PWMI the right to wear their own personal clothes if they wish and not to be forced to wear uniforms. However, uniforms promote uniformity, make it easier to identify PWMI, and help to prevent suicidal attempts. The MHCA 2017 requires psychiatrists to hire lawyers for Mental Health Review Board (MHRB) proceedings, which is costly. It also clubs electroconvulsive therapy (ECT) for minors with prohibited procedures, requiring prior permission from the MHRB, which delays treatment and worsens the stigma towards ECT. The MHCA 2017 should be amended to exempt psychiatrists from having to hire lawyers in MHRB proceedings and to remove the requirement for prior permission from the MHRB for ECT for minors. This would ensure that people with mental illness have access to the care they need and that psychiatrists are not penalized for providing that care. The Act requires general hospitals providing psychiatric services to register as mental health establishments (MHEs). This can be a challenge for psychiatrists, as they must decide whether to treat patients in unregistered hospitals or risk legal consequences. There is a need to amend the MHCA 2017 to address this issue and reduce the stigma around mental illness. This would ensure that people with mental illness have access to the care they need, are treated with dignity and respect, and integrate behavioral healthcare. [27],[28]

Keywords – National Mental Health Policy, Rights, Person with mental illness, trained professionals, Mental Health Review Board

## 7. Future Prospects - Telehealth and Digital Interventions

Telehealth and digital interventions have the potential to improve access to integrated behavioral healthcare in India. The COVID-19 pandemic has highlighted the importance of telehealth in increasing healthcare accessibility and quality[21] Digital healthcare can help address the challenges faced by the Indian healthcare system, such as limited healthcare facilities in rural areas and a high teledensity.[29] Telehealth services can be particularly beneficial for individuals with functional gastrointestinal disorders, as multidisciplinary treatment involving nutrition therapy and psychogastroenterology is often needed.[30] Additionally, digital gaming-based interventions can be used to deliver psychotherapy, cognitive training, and behavioral modification for mental health conditions. Telehealth and digital interventions have the potential to transform the healthcare ecosystem in India, especially in the post-COVID-19 era. [31]

Keywords - Telehealth and digital interventions

## 8 Conclusion

By addressing the historical division between physical and mental health, IBHC offers a promising way to transform mental health treatment. It has a well-established track record of lowering expenses, increasing access, and improving patient outcomes. Even if there are still obstacles to overcome, continued legislative backing and technical developments suggest that integrated behavioral healthcare is set to revolutionize mental health services in the future.

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