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Editorial

Dignity in mental health practice & research: Time to unite on innovation, outreach & education

Dignity has been described as 'the inherent and inalienable worth of all human beings irrespective of social status such as race, gender, physical or mental state'[1]. Dignity is, therefore, at the core of psychological well-being, social connection and humanity. Mental health interventions that explicitly promote and preserve dignity for people experiencing mental distress are growing in clinical practice and research in the USA, India, Europe and elsewhere [2]. However, there is a need for more research and policy supporting the implementation and evaluation of these initiatives. Here, we highlight some of these programmes and make recommendations on how to further integrate dignity in mental health research, practice, outreach and education in India and the world.

Advocating for dignity in the context of mental distress and isolation requires a redoubling of effort to engage a person who may feel disconnected, to communicate even when a person seems uncomprehending and to connect when a person's perceptions and understanding are different from one's own. Dignity should be afforded to all, and evidence is accruing that recovery-oriented support and mental health first aid in the community and in treatment settings make a difference. These efforts not only create a positive experience for the person at the centre of concern, the family and support network, clinicians and the public but also lead to real dialogue, person-centred care, reduced stigma and broader social and recovery capital.

Protecting and promoting dignity plays a central role in the UNESCO Universal Declaration on Bioethics and Human Rights[3]. This goal must include strategies that support psychological and mental health first aid for all, including awareness of issues faced by people experiencing mental distress and isolation[4]. Dignity is fundamentally a social construct and people require a sense of connection in their society to create meaning, purpose and self-worth. Social isolation and loneliness are often at the core of mental distress, and interventions to increase a person's sense of dignity and belonging buffer against psychological and social stressors that otherwise precipitate or worsen mental distress[5]. Conversely, prejudice, stigma, discrimination and disrespect can thwart a person's sense of belonging and hinder help-seeking from their social network, community or clinical services during times of mental distress[6]. To overcome these attitudinal barriers, interventions need to be implemented flexibly and sustainably such as using gatekeepers, peers, train-the-trainer models, cell phone- and internet-based strategies, community pairing partnerships and other low-cost community-based approaches.

Dignity in global mental health

The challenges and solutions associated with promoting dignity in mental health can vary as a function of culture and geography. For example, rural mental health has become a growing concern throughout the world, especially given the low provision of mental health services in these areas. India, like many countries, is a complex nation of contrasts where geographical barriers to mental health care can be seen in sharp focus. Seventy per cent of India's population lives in rural areas, where there are higher rates of affective disorders, particularly among the elderly[7] and about four psychiatrists serve every one million Indian citizens, tending to work in urban areas[8]. Due to the lack of resources, stigma and a shortage of education around mental health, people in rural areas remain isolated and at risk for suicide[9]. Such barriers need innovative solutions that incorporate recovery-orientated approaches involving primary

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care practitioners, caregivers, community members and people with lived experience of mental health problems. In rural areas, there is an additional need to develop a workforce that has the skills to provide evidence-based approaches in a manner that supports dignity, engagement and empowerment.

Psychological and mental health first aid for all

How can we better promote and protect dignity in mental health for all? How can we encourage more dialogue and support in day-to-day clinical practice? How do we encourage tolerance and curiosity to foster lasting connections? As a starting point, humble inquiry increases clinicians' listening abilities and sense of connection and dignity. Mindful communication can also support deep listening with dignity while building personal resilience and compassion for self and others. Through meditation and yoga practices, individuals increase self-awareness to their immediate experience in a purposeful manner (*i.e*., to their breath, body sensation and feelings) with curiosity and without judgement[10]. These skills and way of being are enhanced through formal and informal practices that increase self-awareness and emotional intelligence[11].

Specific programmes such as Mental Health First Aid, Emotional CPR, Alcoholics Anonymous (and other 12-Step Fellowships) and Open Dialogue can serve to expand psychological support in ways that enhance dignity and respect for all. Mental Health First Aid is a widely implemented and evidence-based approach that is applied at a community level. Through brief gatekeeper training, members of the general public are educated about mental health and equipped with skills to intervene with those who are distressed or suicidal. A systematic review[12] demonstrated a large effect of the intervention on knowledge and medium-sized effects on both attitudes and help-providing behaviours. Starting with the Mental Health First Aid model as a template, Delphi consensus studies in India[13], as well as Japan[14] and the Philippines[15], succeeded in generating culturally tailored guidelines of actions for members of the public to use when they encounter a suicidal person. Rural and urban areas in the USA are implementing Mental Health First Aid, and smaller Eastern European countries such as Latvia are using videos of individuals with lived experience of depression, schizophrenia and dementia in an effort to reduce stigma and isolation[16].

There are numerous other examples of programmes designed to reduce stigma which involve people with lived experience. The voices of people with lived experience can mental health services to be more aware and supportive of dignity in mental health. The innovative Emotional CPR intervention, which was developed by an international team of persons with lived experience, teaches specific principles for people to embody when helping someone in emotional distress including full listening, authenticity, non-judging attitude, making connection and empowerment as a means of restoring dignity[17]. Twelve-Step Fellowship programmes[18] and Hearing Voices[19] are other examples of peer support that foster hope and recovery.

Open Dialogue prioritizes respect and dignity for people experiencing severe mental distress and seeks to understand the person and his/her family in the broader personal, social and cultural context[20]. This recovery-oriented approach quickly brings together the person at the centre of concern with the family or support network and multiple clinicians. In network meetings, clinicians engage in natural conversation in an attempt to understand the multiple perspectives of the current situation by listening to people's stories (over their symptoms) and creating space for all to be heard. The approach is fully transparent, with shared treatment planning discussions occurring only in the presence of the individual at the centre of concern. The individual and support network engage in a dialogue which includes responding to reflections that clinicians express amongst themselves. Initial studies have shown promising results in preventing relapse, improving quality of life, as well as increased satisfaction for patients, families and clinicians[21,22].

Having multiple mental health problems such as co-occurring mental illness and addiction (co-occurring disorders) can worsen stigma[23] and requires integrated holistic care that provides hope and empowerment[24]. Co-occurring disorders become more complex when these occur in the context of homelessness and recent incarceration. Homelessness and incarceration experiences in themselves often involve the degradation of dignity through the loss of privacy and autonomy. The MISSION model targets homeless veterans, often with co-occurring disorders, in the USA through a network of clinicians and peer support specialists in a manner that promotes dignity and has resulted in improved treatment engagement and outcomes[25].

There are numerous other community-based recovery-oriented interventions that promote dignity

and social integration. The Clubhouse model, implemented in 33 countries, provides integrated therapeutic working communities for people with severe mental health problems and members work (in transitional, supported or independent employment) in an approach that emphasizes individuals' strengths and relationships. A recent systematic review found that the intervention was effective in promoting employment, reducing hospitalizations and improving quality of life[26]. The broadest application of a community-based approach can be seen in the phenomenon of 'therapeutic towns' such as Geel (Belgium)[27] and Sopo (Colombia)[28]. These towns serve to create a 'foster community' where those with mental health problems are integrated into community and working life.

In rural India, the MINDS Foundation operates in Gujarat using a grassroot approach which implements screening and intervention for mental illness through health worker training, community education and engagement and direct service delivery. Through assessment of the communities' attitudes and knowledge of mental health, MINDS has been able to formulate targeted mental health education programming and successfully train community health workers in identifying mental health symptoms, providing initial screening and being a resource for continued holistic mental health care[29]. This model has reduced stigma and promoted help-seeking by identifying those in need and connecting them in a respectful and dignified manner to appropriate affordable care.

Recommendations and conclusions

There are many additional opportunities to further develop, implement and evaluate psychological and mental health first aid approaches that support dignity in mental health. However, policymakers and healthcare leaders must prioritize and support this area of work. There is a need for people with lived experience, researchers and clinicians to work together and further develop and study interventions that integrate dignity as a core principle of therapeutic practice. Engaging a broader group of stakeholders would include families, community leaders and educators. Ethical frameworks already aim to protect dignity in research by emphasizing respect for autonomy, beneficence, non-maleficence and justice in research procedures[30]. To take this aim one step further in mental health research, dignity could be integrated as a measurable process and outcome in intervention development and evaluation, through the adaptation of existing psychometric instruments or through linguistic and behavioural observation coding. Such approaches have previously been applied with constructs of recovery and therapeutic alliance.

Research on how clinicians and people with lived experience engage and connect with others through web-based and mobile mental health interventions also requires further study. There are several well-established web-based interventions for mild depression such as MoodGym[31] and iFightDepression[32], operating in Western countries that could be tailored for Asian settings as needed. In rural India, the MINDS Foundation collaborates with Medic Mobile, Inc., to deliver a simple 22-question survey through an SMS mobile device in an effort to better identify those in need of mental health care. These approaches reduce barriers of cost, geography and limited trained professionals[33] and promote self-management and patient empowerment that can enhance dignity.

Improved integration of mental health care into primary care will further improve mental health outcomes for all, especially in the context of a supportive and respectful primary care clinician-patient alliance. Primary care programmes can benefit from using change management strategies from implementation science or quality improvement approaches in order to change their treatment culture and integrate mental health evidence based approaches. The aim of dignity and respect for all should be explicitly identified in health providers' mission statements and other policies. More importantly, these should be upheld in daily communication and interactions at all levels. These concepts (and their associated skills such as respectful communication, deep listening and patience) also need to be enshrined in curricula for clinical training and maintained through continuing education.

In broader society, politicians, media, schools and communities all have a role to play in tackling mental health-related stigma and promoting dignity through education, policies and action. The isolation of mental distress can be a very painful experience. With societal and organizational support, dignity and respect can help bring healing and recovery one step closer for all.

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