Universal Ethical Framework for Mental Health Practitioners

Morality as imaginative identification which humanises and identifies with the dignity of the other.

— Breyten Breytenbach

Introduction: Why a Universal Framework Is Needed Now

In the aftermath of the Second World War, the international community recognised that professional ethics grounded solely in national, institutional, or technical norms had failed catastrophically. The Universal Declaration of Human Rights (1948), the Geneva Conventions, and subsequent international covenants emerged from the recognition that silence, professional neutrality, and institutional obedience had enabled mass atrocity.

Mental health professions were not exempt. Psychiatry and psychology had been used to legitimise eugenics, forced sterilisation, torture, racial hierarchy, political repression and colonial domination. These harms were enacted not only through participation, but through compliance, rationalisation, and silence.

Today, mental health practitioners face a convergence of risks that again test the limits of existing ethical codes:

- genocide, armed conflict, war crimes, and crimes against humanity
- colonialism, occupation, apartheid, militarisation, and cross-border power asymmetries;
- mass displacement, statelessness and forced migration
- patriarchy, gender-based violence, and reproductive coercion;
- structural racism, surveillance and authoritarian erosion of law;
- climate breakdown and ecological collapse;
- economic inequality and precarity;
- carceral and detention systems;
- digital environments shaping psychological life.

At the same time, many prevailing professional codes:

- restrict mental health to the individual psyche
- treat political, historical, and ecological violence as “context” rather than determinants of mental health

- frame ethical engagement as “activism” and “political” and therefore suspect
- ·uphold a conception of neutrality that may be used to shield power and prioritise institutional stability over acknowledgement of structural harm

This Framework asserts that, as in the post-war period, the field requires a collective ethical orientation that exceeds narrow institutional boundaries and supports ethical clarity across borders.

Purpose and Scope

This Framework:

- legitimises a broad conception of mental health that includes social, political, gendered, economic, technological, and ecological determinants;
- recognises colonial domination, interstate war, and structural power asymmetries as present-day mental health risk factors;
- affirms advocacy, prevention, and ethical speech as legitimate professional responsibilities;
- affirms that silence constitutes ethical complicity where it enables foreseeable harm;
- affirms solidarity among mental health practitioners worldwide;
- provides ethical legitimacy for challenging restrictive institutional or national policies;
- supports independent accountability and protection for ethical dissent.

While urgently relevant to contemporary crises, this Framework is not crisis-specific. It is intended as a durable ethical instrument for present and future harms affecting psychic life globally.

Preamble: Authority, Responsibility, and Non-Complicity

Mental health practitioners hold authority over diagnosis, narrative, credibility, and care. This authority shapes what suffering is recognised, legitimised, or rendered unspeakable.

Ethical responsibility therefore extends beyond individual treatment to the conditions that make psychological life possible or impossible, including:

- war, occupation and militarisation;
- colonial domination and structural injustice;
- patriarchy and gender-based violence;
- racial discrimination and economic deprivation;
- environmental devastation;
- carceral confinement and detention;
- digital and informational environments;
- enforced silencing and denial.

This Framework is grounded in:

- international human-rights law;
- WHO mental health policy;
- medical ethics declarations;
- research on social and structural determinants of health;
- climate and disaster mental health scholarship;
- the principle of non-complicity, including through silence.

Neutrality that functions to deny, obscure, or normalise mass harm is not ethically neutral. International ethical instruments reject neutrality in the face of torture, genocide, and crimes against humanity.

Article 1 — Structural Determinants of Mental Health

Mental health is inseparable from social, political, economic, gendered, technological, historical, and ecological conditions.

Practitioners shall recognise that:

- genocide, war and armed conflict produce collective trauma and moral injury
- militarisation, settler colonialism and apartheid, occupation and siege, racialised border regimes and mass displacement generate chronic and intergenerational psychological harm
- gender-based violence, and restrictions on sexual and reproductive autonomy undermine bodily integrity, dignity, and psychic integration
- racism, patriarchy, systemic marginalisation and dispossession undermine dignity, agency and erode subjectivity
- economic inequality, precarity, and material deprivation are powerful predictors of psychological distress;
- carceral and detention systems, including the use of torture, generate predictable and preventable psychological harm;
- digital and algorithmic environments shape identity, perception, and exposure to harm;
- climate breakdown and environmental degradation produce anticipatory trauma, grief, and intergenerational anxiety;
- collective trauma is not reducible to individual pathology.

Mental health practice must not sanitise, euphemise, or depoliticise these realities where they shape psychological suffering. Recognition of these structural determinants calls for a clinically reflective sensibility, one that is attentive to, and strives to bear, the traumatic impact of social, political, and environmental conditions; avoids pathologizing understandable psychological responses to such harms; and resists reducing treatment to adaptation to harmful or dehumanising circumstances.

Mental health practice includes the prevention of foreseeable harm, not only treatment after injury. Advocacy aimed at reducing mental health risks arising from such structural determinants does not constitute unethical politicisation. Failure to recognise these realities risks reproducing epistemic violence within clinical and institutional settings.

Article 2 — Silencing, Neutrality, and Ethical Harm

Practitioners shall recognise silencing as an ethical harm in its own right.

Silencing may occur through:

- pathologizing responses to structural violence
- discouraging ethical speech or debate
- invoking neutrality to foreclose recognition
- the adoption or interpretation of institutional policies, regulations and communication protocols that prioritise reputational risk management or institutional comfort over protected ethical discussion
- an unexamined dynamic of organisations prioritising survival over ethical thinking and acknowledgement of lack or failure

Silence constitutes ethical complicity where it enables denial, dehumanisation and foreseeable harm.

Article 3 — Dignity, Equality, and Protection of Debate

All persons are entitled to dignity, equality, and freedom from discrimination.

Practitioners shall recognise gender diversity and gender-based marginalisation as relevant determinants of mental health.

Institutions shall:

- protect members who raise ethical concerns;
- provide structured spaces for internal debate;
- tolerate good-faith, evidence-informed professional disagreement without retaliation.

Open, evidence-informed professional debate concerning models of care must be protected. Ethical disagreement is not a threat to professionalism. The absence of debate increases the risk of collective denial and institutional complicity.

Article 4 — Documentation and Institutional Integrity

Practitioners shall document exposure to:

- violence, including sexual and reproductive violence;
- displacement;
- economic deprivation;
- carceral and detention conditions;
- environmental disaster;
- digital harassment or systemic manipulation;
- state or corporate harm;

accurately and without institutional sanitisation.

Institutions must protect whistle-blowers and ethical dissenters in accordance with international principles. Suppression of ethical concern undermines both clinical integrity and public trust.

Article 5 — Global Solidarity and Shared Ethical Responsibility

Mental health practitioners have ethical obligations that extend beyond national and institutional boundaries.

Global solidarity:

- counters isolation and silencing
- supports practitioners under repression or censorship
- affirms the protection of mental health practitioners and all health personnel under international humanitarian and human-rights law, and expresses solidarity with those subjected to violence, intimidation, detention or persecution
- affirms shared commitments to human dignity

Where international law is undermined, ethical clarity depends on collective professional conscience.

Article 6 — Education, Oath and Accountability

Training programmes shall include:

- human-rights law;
- colonial, gendered, and political histories of mental health;
- social, economic, and technological determinants of psychological well-being;
- climate and disaster mental health;
- ethics of non-complicity and ethical speech.

This Framework implies an ethical oath:

I will not remain silent where silence enables harm.

Independent mechanisms should be developed to review ethical breaches, investigate complicity, and protect practitioners acting in accordance with this Framework.

Closing Statement

Mental health practice cannot be neutral between:

- dignity and dehumanisation;
- truth and denial;
- life and preventable destruction.

In a world shaped by war, structural domination, ecological collapse, and mass harm, ethical clarity, protected debate, and global solidarity are conditions of professional integrity

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Healing begins when we name the injustice, not silence it.

- Dr Samah Jabr