

# 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, thereby potentially facilitating the internalisation of unethical societal norms
- uphold a conception of neutrality that may be used to shield power and prioritise institutional stability over acknowledgement of structural harm

This Framework proposes 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. It is intended to strengthen our capacity to promote civil liberties required for the free development of our disciplines and help us contribute to vibrant civil societies promoting democratic and universalist values.

## 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
- 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**

We believe that mental health is inseparable from social, political, economic, gendered, technological, historical and ecological conditions.

As practitioners, we recognise that:

- genocide, war and armed conflict produce collective trauma and moral injury
- militarisation, settler colonialism, apartheid, occupation, and siege, racialised border regimes and mass displacement generate chronic and intergenerational psychological harm

- gender-based violence, including transgender discrimination, and restrictions on sexual and reproductive autonomy undermine bodily integrity, dignity and psychic integration
- racism, patriarchy, systemic marginalisation, and dispossession undermine dignity, agency and subjectivity
- economic inequality, precarity and material deprivation are powerful predictors of psychological distress
- carceral and detention systems, including 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.

We recognise that structural determinants of mental health operate across differing scales and degrees of ethical, juridical, and humanitarian gravity, including harms prohibited absolutely under international law.

We believe that good mental health practice requires that we do not sanitise, euphemise, or decontextualise these realities where they shape psychological suffering.

Recognition of these structural determinants calls for a clinically reflective sensibility that is attentive to, and capable of bearing, the traumatic impact of social, political, and environmental conditions; avoids pathologizing understandable responses to such harms; and resists reducing treatment to adaptation to harmful or dehumanising circumstances.

We believe that mental health practice includes the prevention of foreseeable harm, not only treatment after injury. Advocacy aimed at reducing mental health risks arising from structural determinants does not constitute unethical politicisation.

Failure to recognise these realities risks reproducing the silencing, invalidation, or erasure of lived experience within clinical and institutional settings.

## **Article 2 — Silencing, Neutrality, and Ethical Harm**

As practitioners, we recognise that silencing constitutes 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 rather than as a legitimate clinical or scholarly stance
- institutional policies and communication protocols that prioritise reputational risk management or institutional comfort over ethical discussion
- organisational dynamics that privilege survival, comfort, or cohesion over ethical reflection and accountability
- Visa dependence, precarious contracts and institutional hierarchies may shape who can speak and at what cost.

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.

We call on institutions to:

- 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 or scholarly disagreement is not a threat to professionalism. The absence of debate increases the risk of collective denial and institutional complicity.

### **Article 4 — Institutional Integrity, Ethical Dissent and Accountability**

We believe that institutions have a responsibility to create conditions in which ethical concerns can be raised, discussed, and examined without fear of retaliation.

Mental health organisations should foster cultures that encourage critical reflection on institutional practice, acknowledge ethical failures where they occur, and remain open to challenge from members acting in good faith.

Institutions must protect whistle-blowers and ethical dissenters in accordance with recognised principles of justice, due process and freedom of expression. They have a duty to act on information to prevent harm.

Institutions should support practitioners without institutional sanitisation in accurately documenting the professional witnessing of societal conditions posing risks to mental health as well as the recording of clinically relevant social, political, environmental, and conflict-related determinants of mental health, with due regard for clinical judgement, confidentiality, safeguarding, legal obligations, or patient autonomy.

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

Suppression of ethical concern undermines both clinical integrity and public trust.

## **Article 5 — Global Solidarity and Shared Ethical Responsibility**

We believe that mental health practitioners have ethical obligations that extend beyond national and institutional boundaries. We recognise the responsibilities of practitioners located in the Global North with its structural and historical role in harms perpetrated in the Global South. ‘

Global solidarity:

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

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

## **Article 6 — Education and Ethical Formation**

### **Training**

We believe training programmes should include:

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

### **Ethical Commitment**

This Framework invites practitioners to adopt the following ethical commitment

**I will not remain silent where silence enables harm.**

### **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.

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

— **Samah Jabr**