



UNIVERSAL
ETHICAL
FRAMEWORK

Universal Ethical Framework for Mental Health Practitioners

The Statement

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

The Universal Ethical Framework for Mental Health Practitioners (UEF)

(<https://ukpalmhn.com/pvp/universal-ethical-framework-for-mental-health-practitioners/>) evolved from concerns that existing professional ethical frameworks, while providing substantial ethical foundations, vary in the extent to which they explicitly address the mental-health consequences of large-scale social, political and environmental harms, and particularly questions of institutional responsibility, silencing, denial or normalisation of such harms. It draws inspiration in part from Doctors Against Genocide (DAG) and its preventative understanding of the principle of *do no harm*: that professional ethical responsibility extends beyond avoiding harm in individual practice to recognising, speaking out about and seeking to prevent foreseeable harms to communities and populations.

The UEF develops this principle across the mental-health professions, supplementing rather than replacing established clinical ethics, and recognising mental-health professionals and their organisations as participants in civil society with responsibilities towards human rights, democratic freedoms and the prevention of harm. Grounded in international human-rights and humanitarian principles and informed by interdisciplinary understandings of mental health, trauma and human development, it addresses structural determinants of mental health alongside war, occupation, apartheid, genocide, crimes against humanity, torture, displacement and other forms of collective violence.

Its core principles include recognition of suffering and its social context, truthful engagement with evidence, non-discrimination and non-dehumanisation, protection of open professional inquiry and free expression, ethical non-complicity, global solidarity, and a clinically reflective stance that resists both pathologising responses to oppression and using neutrality to evade ethical responsibility.

This Information Pack is offered as a resource for anyone wishing to understand the context and thinking behind the Universal Ethical Framework's development, its evolution, and ways in which it might be engaged with. It includes a Q&A section addressing questions that may arise in relation to the Framework.

The Information Pack is intended to remain under continuing review and is being circulated at this stage as a draft for further consultation. Contributions, including critical responses, are welcomed so that it may be tested, refined and enriched by diverse perspectives from across the globe, as well as by multidisciplinary and theoretically varied sources and traditions. We particularly welcome reflections on its scope, assumptions and language; areas that may require further development; perspectives or bodies of knowledge that may be insufficiently represented; and its practical relevance across differing professional, cultural and social contexts. Participants are encouraged to draw on, adapt and personalise the material in developing their own resources, informed by their particular contexts, perspectives and priorities. Everyone is welcome to use the Information Pack in whatever ways they consider most helpful in supporting the consultation, discussion, dissemination and further development of the Framework.

1. Introduction and Context

We have been witnessing what Palestinians, a substantial body of genocide scholarship, international human-rights organisations, UN experts and health - professional organisations have identified as genocide against the Palestinian people in Gaza, with devastating consequences for the mental health of survivors and for generations to come. These assessments include findings by the UN Special Rapporteur on the occupied Palestinian territory, Amnesty International, the International Association of Genocide Scholars, B'Tselem and Physicians for Human Rights-Israel. The International Court of Justice, while not yet having determined the genocide case on its merits, has found that Palestinians in Gaza have plausible rights to protection from acts of genocide under the Genocide Convention and has repeatedly ordered provisional measures for their protection.

At the same time, despite extensive evidence of crimes against humanity, many of us have experienced profound difficulty within our professional organisations in raising concerns, expressing solidarity, or opening discussion about these realities. Such engagement has frequently been characterised as "political" and therefore as falling outside the legitimate remit of professional ethics. In the UK, for example, it has been argued that such activities do not, for this reason, fall within charitable objectives. Legal action or referral to the Charity Commission is threatened or progressed and so the line of least resistance is often taken. Appeals to neutrality have appeared to prioritise institutional stability and reputational management over ethical recognition of structural harm.

Accusations of antisemitism have at times been deployed in ways that conflate antisemitism with legitimate criticism of state violence or opposition to violations of international law, some of which, including genocide, torture, crimes against humanity, war crimes and severe forms of persecution occupy a distinct and exceptionally grave legal status because they involve deliberate or systematic attacks upon human life, dignity, or group existence. Some

of the underlying prohibitions, including those against genocide and torture, are recognised as peremptory norms of international law from which no derogation is permitted. This does not diminish the seriousness of antisemitism itself, which, like all forms of racism, discrimination and dehumanisation, must be opposed.

Colleagues speaking about Palestine have nevertheless experienced harassment, disciplinary processes or exclusion. Meanwhile, Palestinian doctors and health workers have themselves been subjected to detention, torture and killing while attempting to preserve life.

These experiences have brought a larger ethical question into focus: **What responsibilities do mental health professionals and their professional institutions have when confronted with credible evidence of catastrophic and foreseeable harm?**

The **Universal Ethical Framework for Mental Health Practitioners** (<https://ukpalmhn.com/pvp/universal-ethical-framework-for-mental-health-practitioners/>) has been influenced by the harrowing testimonies of health practitioners and citizens experiencing mass violence in Palestine and elsewhere, including Sudan, the Democratic Republic of the Congo or Myanmar. It has also taken inspiration from Doctors Against Genocide's development of a medical and public-health approach to genocide, which emphasises early recognition, prevention and the observable consequences of mass violence rather than regarding genocide solely as a legal determination made after extensive adjudication.

Central to this approach is a further proposition of particular relevance to the Universal Ethical Framework: that **the traditional medical commitment to *do no harm* cannot end at the doors of the clinic**. Where healthcare professionals are confronted with credible evidence of genocide or other mass atrocities, the responsibility to protect life may also entail a heightened responsibility to consider how, within the limits of professional knowledge, role and capacity, they might bear witness, speak or otherwise contribute to efforts to prevent further harm.

Ordinarily, *do no harm* is understood primarily in relation to the conduct of the practitioner towards the individual patient. But in circumstances of catastrophic, foreseeable and potentially preventable harm, professional ethics may also require us to consider the consequences of silence and inaction. If healthcare professionals possess relevant knowledge about the destruction of health, the infliction of trauma, the targeting of healthcare systems or the conditions producing mass suffering, then ethical question cannot be confined to what happens within individual clinical encounters.

This does not mean replacing or modifying the legal definition of genocide, nor suggesting that mental health practitioners should assume the role of international courts. Rather, it requires an important distinction between legal adjudication and preventive health ethics. Legal processes determine whether the evidential requirements for establishing genocide or other international crimes have been met. Preventive ethics asks a different and more immediate question: **when credible evidence indicates a serious risk of catastrophic or**

potentially genocidal harm, what responsibilities arise before a final legal determination has been reached?

From a health perspective, waiting for retrospective certainty may itself carry consequences. Prevention necessarily involves recognising warning signs, assessing credible evidence and responding proportionately before harm becomes irreversible. This is familiar territory within healthcare: the purpose of identifying risk is precisely to make intervention possible before harm becomes irreversible.

Mental health professionals have particular knowledge to contribute. We understand something of the psychological consequences of dehumanisation, persecution, forced displacement, deprivation, collective violence and the destruction of families and communities. We also understand that such harms may extend across generations. Bearing witness to these realities, resisting their denial or distortion, and speaking when silence risks normalising or enabling grave harm may therefore be understood not as departures from professional ethics, but as expressions of them.

This does not imply a duty to make pronouncements on every political conflict, nor does it prescribe one form of advocacy for every practitioner. Responsibility may be considered proportionately in relation to the gravity, credibility, foreseeability and preventability of the harm and to the practitioner's knowledge, role and capacity. But genocide, crimes against humanity and other mass atrocities represent the most extreme end of that continuum. In such circumstances, the injunction to *do no harm* may reasonably encompass not only a duty not to inflict harm ourselves, but a heightened responsibility to speak and act, within the limits of our knowledge and professional capacities, for its prevention.

From Palestine to a Universal Ethical Framework

The ethical questions raised by Palestine extend beyond this particular context, exposing a broader challenge for the mental health professions: **what should a genuinely Universal Ethical Framework for mental health practitioners look like?**

War, occupation, forced displacement, racism, discrimination, poverty, ecological crisis and other forms of structural violence are well-established determinants of mental health. If these conditions contribute directly to psychological suffering, can they be excluded from professional ethical concern simply because they are politically contested? Or does the ethical responsibility of mental health practitioners necessarily extend beyond the consulting room to include the prevention of foreseeable harm and the conditions that produce it?

A Universal Ethical Framework for Mental Health Practitioners

(<https://ukpalmhn.com/pvp/universal-ethical-framework-for-mental-health-practitioners/>)

The Universal Ethical Framework for Mental Health Practitioners (UEF) evolved from concerns that existing professional ethical frameworks, while providing substantial ethical foundations, vary in the extent to which they explicitly address the mental-health

consequences of large-scale social, political and environmental harms, and particularly questions of institutional responsibility, silencing, denial or normalisation of such harms.

Its central proposal is therefore that mental health ethics should attend not only to individual clinical conduct but also to the social, structural, institutional, and political conditions that produce or normalise psychological suffering.

It seeks to articulate a broader ethical orientation encompassing:

- structural determinants of mental health;
- human dignity, equality and freedom from discrimination;
- prevention of foreseeable harm and non-complicity;
- overcoming silencing and suppression of ethically relevant discussion;
- institutional responsibility and accountability;
- protected debate and good-faith disagreement;
- global solidarity and shared ethical responsibility; and
- the implications of these principles for clinical practice, training and ethical formation.

The Framework draws upon internationally recognised human rights instruments, international humanitarian law, established principles of medical ethics and contemporary public mental health. These represent, however imperfectly, humanity's sustained attempt to articulate minimum protections for human dignity and to learn from historical circumstances when silence, professional obedience, institutional silence and failures of ethical responsibility accompanied grave abuses.

To ground the Framework in such principles also provides a shared language through which practitioners from different countries, disciplines and traditions can engage in meaningful dialogue despite differences in political outlook or theoretical orientation. A universalist approach can help guard against ethical judgement becoming determined primarily by national interests, institutional pressures or changing political climates. It may also make it more difficult for concerns about structural violence or mass civilian harm to be dismissed as political partisanship.

Universal does not mean uniform. The Framework does not ask practitioners to subscribe to a particular political ideology or adopt a single moral vocabulary. It aims instead to establish sufficient common ground – human dignity, protection from harm, equality, critical openness and truthful engagement with evidence – to permit ethical principles to be considered consistently across contexts while protecting good-faith disagreement and professional debate. It is vital to keep in mind questions as to who determines what constitutes the common ethical ground, and how the reproduction of dominant professional or Global North assumptions in deciding what is universal are to be avoided. Its universality therefore cannot simply be asserted. It needs to be developed through dialogue among different professions, cultures, theoretical traditions and lived experiences, contestation and plural participation, remaining open to challenge, evidence and revision.

Central to this is the proposition that silencing becomes ethically problematic where it contributes to denial, dehumanisation or foreseeable harm. Advocacy, prevention, ethical speech and protected debate may therefore constitute legitimate dimensions of professional responsibility, rather than departures from it.

Palestine is not an exception to these principles; it is one of the clearest contemporary tests of whether we are prepared to apply them consistently.

This Framework has emerged partly from the experience of silencing, suppression of solidarity and increasing pressures that have been faced in speaking out about Palestine. Appeals to broader principles may help us to respond to accusations of political partisanship, lack of neutrality and overextension of our roles while the sense of powerlessness within our individual associations and groups may be mitigated by the mobilisation of a wider mental health community around such principles. But the Framework is not offered as a prescription or a finished ethical code. It is a discussion document and invitation to collective ethical thinking. If our concern arises from a commitment to the equal dignity of all human beings, the principles we invoke must be capable of extending beyond any single conflict, community or historical moment.

If we are able to generate conversations about this it may be harder to exceptionalise Palestine, or any other such situation, and it may help to consolidate the moral basis for speaking out and standing in solidarity, particularly when mass harms are being perpetrated and mental health is at grave risk.

This is particularly important at a time of increasing authoritarianism, political corruption, misinformation, intimidation and pressures upon freedom of speech and truthful enquiry. Law, justice and accountability themselves are under strain. Isolation and fragmentation within and between professional communities provide little protection against these developments. The mental health field requires forms of ethical solidarity capable of crossing institutional and national boundaries while remaining critically reflective about inequalities of power, including the historical and structural relationships between the Global North and Global South.

The Framework is intended to strengthen our capacity to uphold the civil liberties necessary for the free development of our disciplines and to contribute, as members of civil society, to the preservation of open, pluralistic and democratic cultures. It seeks to contribute to an ethical architecture capable of supporting protected debate, principled solidarity, prevention of foreseeable harm and professional clarity wherever human dignity and mental health are at risk. It is a shared endeavour rather than something owned by any individual or organisation.

We hold in mind Lama Khouri's words and imagery:

'Transnational solidarity is the lived recognition that liberation is indivisible. The gathering is real. The convergence is real. Every post you write that refuses the official silence, every conversation you refuse to drop, every moment you say the

word genocide in a room that wants you not to: that is a stream finding another stream'. <https://yuiad.substack.com/p/shallal-on-water-palestine-and-the>

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2. Evolution of the Universal Ethical Framework for Mental Health Practitioners

The idea of a Universal Ethical Framework arose from discussions at the Psychoanalytic Voices for Palestine (PVP) hybrid Conference in October 2025.

Inspiration was drawn from Doctors Against Genocide (DAG)'s development of a medical and public health approach to genocide and its insistence that the commitment "to do no harm" carries responsibilities for prevention as well as treatment. The Framework was initially developed by PVP members, with a first draft and discussion forum published on the PVP webpages.

In May 2026, a joint online meeting was held between PVP and Group Analysts for Palestine (GA4PAL) following an approach from GA4PAL recognising the Framework as an important opportunity to bring different networks together to reflect on themes of human suffering and the roles and responsibilities of the healing professions. We felt jointly enlivened by the

possibility of opening up wider debate through this work. The discussion generated a shared commitment to widen the conversation by engaging other mental health networks, groups and individuals. A UEF working group and a UEF Google group (uef4mhp@googlegroups.com) were subsequently established.

Following feedback, the UEF Framework was revised and published on the PVP webpage in its current form. A further online meeting for allied mental health groups was held in July 2026 opening broader dialogue around silencing, structural determinants of mental health, and professional ethical responsibility. Participants expressed considerable enthusiasm for developing the initiative further and broad consensus emerged around a co-ordinated campaign for wider dissemination.

A Q&A discussion document, examining the evidence and conceptual foundations of the Framework, to assist in its engagement, has been developed and is included in this pack. Further opportunities for engagement include discussion at the Group Analysts' Summer Symposium in August 2026 and the PVP Conference on 10 October 2026 which will be underpinned by the Framework and will provide an opportunity to consider both why a Universal Ethical Framework is needed and how it might be used in practice. The development of illustrative clinical case studies is encouraged and the Home for Liberatory Mental Health has proposed adopting the UEF.

3. Engaging with the Universal Ethical Framework in Practice

The Universal Ethical Framework is intended not only to be read, cited or endorsed, but to be used as a living resource for ethical reflection, professional dialogue and collective action. Engagement may take different forms depending on a practitioner's role, setting, jurisdiction and capacity. It does not require uniform political agreement or identical forms of public action. Rather, it invites practitioners and institutions to consider how the principles of the Framework might illuminate the ethical questions they encounter in practice.

a) Professional Discussion and Ethical Deliberation

The Framework can provide a shared language for discussing questions that may otherwise become polarised, personalised or dismissed as "political". It may be used in professional forums, reading groups, conferences, supervision, ethics committees and interdisciplinary discussions.

Rather than requiring agreement on a particular position, discussion might begin with questions such as:

- What aspects of this situation engage our professional ethical responsibilities?
- What forms of suffering or structural harm are present?
- Whose experiences or perspectives may be insufficiently heard?
- Are universal ethical principles being applied consistently?

- What credible evidence is available, and how are we distinguishing evidence from assumption, interpretation or misinformation?
- What might be the consequences of speaking, remaining silent or adopting a position of neutrality?
- How can disagreement be protected without permitting dehumanisation, discrimination or denial of serious harm?

The Framework may therefore function less as a source of predetermined answers than as a means of improving the quality and ethical depth of professional deliberation.

b) Education and Training

The Framework may also be incorporated into professional education, clinical training and continuing professional development.

Training might use case material to explore the relationship between individual psychological suffering and wider social, political, economic, cultural and environmental conditions. It could encourage practitioners to consider how war, displacement, racism, poverty, discrimination, ecological crisis, repression or other structural conditions enter the consulting room and influence both patient experience and professional practice.

For example, trainees might be invited to consider a patient experiencing profound distress following forced displacement. Alongside questions of diagnosis and treatment, they could be asked:

- What aspects of the patient's distress represent understandable responses to their circumstances?
- What would be lost if the problem were conceptualised solely as individual psychopathology?
- How might cultural, historical and political context affect formulation?
- What ethical responsibilities arise in relation to advocacy, access to services or prevention of further harm?
- Where are the limits of the practitioner's role?

Such discussion can help develop a clinically reflective sensibility that neither reduces psychological suffering to politics nor separates it artificially from the conditions in which it arises.

c) Ethical Reflection in Clinical Practice

Individual practitioners may use the Framework as a reflective aid when confronting difficult situations.

A practitioner might ask:

- What are the relevant structural determinants of mental health in this situation?

- Am I sufficiently attentive to the social and historical context of this person's suffering?
- Am I inadvertently pathologising an understandable response to oppression, violence, loss or insecurity?
- Are assumptions arising from my own cultural, professional or political position influencing my understanding?
- What power relationships are operating?
- Is there foreseeable harm that might reasonably be prevented?
- Does my professional responsibility extend beyond treatment in this instance?
- If I decide not to speak or act, what are the ethical reasons for that decision?

The purpose is not to prescribe activism but to make the question of responsibility available for conscious ethical consideration.

d) Advocacy and Prevention

The Framework recognises advocacy and prevention as legitimate dimensions of professional ethical responsibility where social or structural conditions create significant foreseeable harm.

Advocacy may take many forms: contributing professional expertise to public debate; supporting affected communities; challenging discriminatory practices; writing or signing professional statements; contributing evidence to consultations; supporting humanitarian or human-rights initiatives; or advocating within one's own institution. The appropriate response will depend upon the seriousness of the harm, the strength of the evidence, the practitioner's expertise and position, and what action is realistically possible.

The Framework does not suggest that every practitioner must respond publicly to every injustice. It does, however, invite consideration of whether there are circumstances in which professional knowledge creates a responsibility not merely to treat the consequences of harm but to contribute to its prevention.

e) Organisational Reflection and Endorsement

Professional organisations may engage with the Framework at different levels. Formal endorsement is one possibility, but it need not be the starting point. An organisation might first circulate the Framework to its members, organise a webinar or roundtable, invite written responses, refer it to an ethics committee, or use it to review its existing ethical policies.

Institutions might ask:

- Does our ethical code adequately recognise structural determinants of mental health?
- Do our policies enable members to raise concerns about serious human suffering and potential ethical breaches?

- How do we distinguish inappropriate partisanship from legitimate professional ethical speech?
- Might appeals to "neutrality" beyond the clinical relationship or scholarly context inhibit recognition or discussion of ethically significant harm?
- Do our procedures protect good-faith disagreement?
- Could our rules inadvertently silence marginalised voices or inhibit discussion of serious harm?
- How do we respond when credible evidence of grave violations of human rights or humanitarian law emerges?
- Do we have mechanisms for considering prevention and non-complicity as well as treatment?
- How do we protect practitioners who raise legitimate ethical concerns?
- Are there circumstances in which compliance with official or governmental policies might conflict with our professional ethical responsibilities?

Endorsement should therefore be understood not simply as attaching an organisation's name to the Framework, but as an opportunity for meaningful institutional self-reflection, particularly given that the Framework itself arose partly in response to inadequate professional responses to genocide and mass atrocity.

f) **Using the Framework to Examine Difficult Cases**

Short illustrative scenarios may make the Framework more accessible.

- **Silencing:** Members of a professional organisation request discussion of the mental-health consequences of a current conflict. The organisation declines on the grounds that the matter is "political". The Framework invites consideration not simply of whether the organisation should issue a political statement, but of whether preventing discussion is compatible with its responsibilities towards ethical enquiry, professional knowledge and protected debate.
- **Structural harm:** A clinician repeatedly encounters severe distress among people living under insecure immigration conditions. The Framework invites reflection on both individual treatment and whether professional knowledge of the recurring structural source of harm creates wider responsibilities.
- **Institutional complicity:** A professional body is asked to participate in an activity involving an institution credibly alleged to be contributing to serious human-rights violations. The Framework may provide a structure for examining evidence, proportionality, professional responsibilities, risks of complicity and possible courses of action.
- **Contested evidence:** Practitioners strongly disagree about a politically charged event. Rather than requiring ideological consensus, the Framework directs attention towards credible evidence, truthful representation, universal principles, protection against dehumanisation, and the capacity to sustain disagreement without silencing.

- **Mass atrocity:** Credible international bodies warn that a population may be at risk of genocide or crimes against humanity. The Framework invites consideration of whether the gravity and preventability of the potential harm create responsibilities beyond those arising in ordinary political disputes.

These examples are intended to generate questions rather than predetermined conclusions.

g) A Framework for Questions, not a Test of Correctness

Engagement with the Framework should not become a means of determining who is ethically "good", politically acceptable or sufficiently radical. That would reproduce precisely the forms of certainty, conformism and exclusion the Framework seeks to resist.

Its value lies instead in helping practitioners and institutions ask better questions:

- What is happening?
- Who is suffering?
- What do we know, and how do we know it?
- Whose voices are being heard and whose are absent?
- What universal ethical principles are engaged?
- What are the foreseeable consequences of action and inaction?
- What responsibilities arise from our particular professional knowledge?
- What can reasonably be done?
- And how can we remain open to evidence, disagreement and revision while refusing indifference to serious human suffering?

Used in this way, the Universal Ethical Framework becomes neither a political manifesto nor a static professional code. It becomes a **reflective ethical resource**: a means of connecting clinical knowledge, human rights, public mental health, prevention, truthful enquiry and professional responsibility.

Its success should therefore not ultimately be measured by how many organisations endorse it, but by whether it helps create professional cultures in which difficult realities can be thought about more honestly, suffering can be recognised more fully, disagreement can be held more safely, and practitioners and institutions are better able to consider what ethical responsibility requires of them.

4. Questions and Answers: Evidence and Conceptual Foundations for the Universal Ethical Framework for Mental Health Practitioners

(1) Introduction

What is the purpose of this Q&A document?

This document accompanies the Universal Ethical Framework for Mental Health Practitioners and is intended to assist in answering questions, with references, that may be raised when engaging with the framework.

Why do we need a framework?

The Framework has emerged from the recognition that silence, professional neutrality and professional compliance have repeatedly accompanied mass atrocity, continue to do so in the present and risk doing so in the future.

It arises from concern in this context that prevailing professional ethics frameworks often remain more developed in relation to individual clinical conduct than in relation to structural determinants of mental health, institutional silencing, mass atrocity, ecological crisis, or conditions of collective harm. While many professional bodies increasingly acknowledge social determinants of mental health, these factors frequently remain secondary to intrapsychic and individualised models of distress and care.

The Framework's core proposal is therefore that mental health ethics not be limited to individual clinical conduct, but also attend to the social, structural, institutional, and political conditions that produce or normalise psychological suffering.

The Framework seeks to articulate a broader ethical orientation encompassing structural determinants of mental health, silencing as an ethical harm in its own right, the entitlement of all to dignity, equality and freedom from discrimination, the ethical responsibilities and accountability of institutions, the need for global solidarity and shared ethical responsibility as well as the implications for training and ethical formation.

It is grounded in:

- International human rights law
- WHO public mental health approaches
- Medical ethics declarations
- Social psychiatry and trauma research
- Psychoanalytic and relational traditions
- Liberation and decolonial psychologies
- And the principle of non-complicity

Key References

- Universal Declaration of Human Rights (1948)
- International Covenant on Economic, Social and Cultural Rights (1966)
- WHO World Mental Health Report (2022)
- WHO & Calouste Gulbenkian Foundation, Social Determinants of Mental Health (2014)
- Belkin, G. & Thompson, K.S. (2026). "The Health of Democracy Is Psychiatry's Business." *Psychiatric News*, 61(6)

What do we mean by "Universal"?

The term "Universal" refers to the Framework's grounding in principles intended to apply across national, cultural, institutional, and professional contexts while remaining open to critical reflection and revision. It draws particularly on internationally recognised human

rights standards, public health principles, and ethical commitments to human dignity, non-discrimination, and protection from harm. The term does not imply uniformity of belief, political consensus, or the erasure of cultural differences; rather, it reflects an aspiration to identify ethical responsibilities that transcend institutions, jurisdictions or ideological positions.

Is this document intended to be a definitive statement?

This document is not intended as an exhaustive literature review, nor does it claim that all propositions within the Framework are empirically settled or uncontested. Some elements derive from epidemiological evidence and public-health research; others arise from ethical reasoning, historical reflection, psychoanalytic understanding, or evolving legal and political debate.

(2) Historical Foundations: Human Rights, Medicine, and Professional Responsibility
How did modern human rights principles influence professional ethics?

The modern human rights framework emerged partly in response to recognition that professional neutrality, bureaucratic obedience, and institutional silence had enabled mass atrocity during the Second World War.

The Universal Declaration of Human Rights (1948), the Genocide Convention (1948), the Geneva Conventions, and subsequent international covenants reflected an understanding that ethical responsibility extends beyond passive adherence to institutional authority. The Nuremberg trials and Nuremberg Code established that professional obedience does not absolve ethical responsibility where grave harm is concerned.

Key References

- Universal Declaration of Human Rights (1948)
- Convention on the Prevention and Punishment of the Crime of Genocide (1948)
- Nuremberg Code (1947)
- Annas, G. & Grodin, M. (1992). The Nazi Doctors and the Nuremberg Code

How have mental health professions been implicated in historical abuses?

Mental health professions were implicated in several forms of abuse during the twentieth century, including:

- Eugenics programmes
- Forced sterilisation
- Racial hygiene policies
- Political psychiatry
- Participation in torture or coercive interrogation
- Colonial systems of classification and governance

Illustrative References

- Lifton, R.J. (1986). The Nazi Doctors
- Friedlander, H. (1995). The Origins of Nazi Genocide
- Bloch, S. & Reddaway, P. (1984). Psychiatric Terror

- Lombardo, P. (2008). Three Generations, No Imbeciles
- Keller, R. (2007). Colonial Madness

(3) Social and Structural Determinants of Mental Health

What evidence supports the importance of social determinants of mental health?

A substantial body of research demonstrates that mental health is shaped not only by individual psychology, but by social, economic, political, environmental, and historical conditions.

The WHO identifies social determinants of mental health as including:

- Poverty
- Inequality
- Violence
- Displacement
- Discrimination
- Housing insecurity
- Unemployment
- Environmental instability
- Social exclusion

Key References

- WHO World Mental Health Report (2022)
- WHO & Calouste Gulbenkian Foundation (2014). Social Determinants of Mental Health
- Marmot, M. (2020). Health Equity in England: The Marmot Review 10 Years On

Which social conditions are associated with mental distress?

Research demonstrates associations between mental distress and:

- Economic precarity and inequality
- Racism and discrimination
- Gender-based violence
- War, forced displacement and exile
- Detention and incarceration, including torture and torture by proxy
- Climate-related disruption
- Harmful digital environments.

Selected References

- Lund et al. (2018). Lancet Psychiatry
- Wilkinson & Pickett (2009). The Spirit Level
- Williams & Mohammed (2013). "Racism and Health"
- WHO Violence Against Women Estimates (2021)
- Fazel & Baillargeon (2011). The Lancet
- Clayton et al. (2017). Mental Health and Our Changing Climate

Why does the Framework distinguish between structural determinants and mass atrocity crimes?

The Framework recognises that structural determinants of mental health operate across differing scales and degrees of ethical, legal and humanitarian gravity.

Many conditions identified within the Framework — including poverty, discrimination, economic inequality, environmental degradation, gender-based marginalisation, detention systems and harmful digital environments — are significant determinants of mental health and contribute to psychological distress across populations. They therefore warrant ethical attention from mental health practitioners and institutions.

At the same time, certain forms of harm occupy a distinct and exceptionally grave status under international law because they involve deliberate or systematic attacks upon human life, dignity or group existence. These include genocide, torture, crimes against humanity, war crimes and severe forms of persecution.

The Framework therefore does not treat all harms as equivalent. Rather, it seeks to recognise the continuum through which structural conditions may contribute to psychological suffering, while acknowledging that mass atrocity crimes occupy a distinct level of ethical and legal gravity. Some of the underlying prohibitions, including those against genocide and torture, are recognised as peremptory norms of international law from which no derogation is permitted.

Recognising broader determinants of mental health does not diminish the gravity of genocide or torture. Equally, recognising the exceptional gravity of such crimes does not negate the importance of addressing the structural conditions that undermine mental health in everyday life.

Where might the limits of professional responsibility lie?

The extent of professional responsibility may be considered proportionately. Practitioners may speak about matters of concern as citizens and professionals, and reflection on social and political conditions would be recommended when these have clear implications for mental health, access to care, safety, dignity or the equitable distribution of resources. Stronger ethical obligations may arise where harms are grave, foreseeable, preventable or systematically imposed, particularly when they affect populations whose vulnerability is compounded by discrimination, displacement, deprivation or violence. In such circumstances, professional responsibility may extend beyond private reflection or clinical response to include a duty to identify, document, and where appropriate, challenge practices and structures that produce or sustain serious harm.

The relevant question is whether the scale, severity and mental health consequences of the harm engage the profession's core commitments to human dignity, non-maleficence, justice and care.

Key References

- Convention on the Prevention and Punishment of the Crime of Genocide (1948)
- Convention Against Torture (1984)

- Rome Statute of the International Criminal Court (1998)
- WHO World Mental Health Report (2022)

Why does the Framework include climate change and ecological crisis?

Climate change is increasingly recognised as a significant threat to mental health. Research has documented associations between climate-related events and:

- Anxiety
- Depression
- Trauma
- Grief
- Displacement
- Loss of community
- And increased psychological vulnerability

Climate change may affect mental health both directly, through exposure to disasters such as floods, fires, droughts, and extreme weather events, and indirectly through economic insecurity, displacement, ecological degradation, and concerns about the future. Researchers have also identified experiences such as climate grief, eco-anxiety, and solastalgia—the distress associated with the loss or transformation of familiar environments.

The Framework recognises that many emotional responses to ecological crisis are understandable responses to real and foreseeable threats rather than signs of individual pathology. It therefore supports approaches that combine clinical care with prevention, adaptation, and broader attention to environmental determinants of wellbeing.

Key References

- Intergovernmental Panel on Climate Change (IPCC) Sixth Assessment Report
- WHO (2022). Mental Health and Climate Change
- Clayton et al. (2017). Mental Health and Our Changing Climate
- Albrecht, G. (2005). Original formulation of solastalgia

Why does the Framework include gender, sexual and reproductive health?

A substantial body of evidence demonstrates that gender-based violence, discrimination, exclusion, and restrictions on sexual and reproductive autonomy can have profound consequences for mental health.

These consequences may include:

- Trauma
- Depression
- Anxiety
- Shame
- Social exclusion
- Increased vulnerability to abuse
- And barriers to accessing care

The Framework therefore recognises gender diversity and gender-based marginalisation as relevant determinants of mental health. It further recognises that restrictions on sexual and reproductive autonomy, conflict-related sexual violence, and systemic discrimination may contribute significantly to psychological suffering.

At the same time, the Framework affirms the importance of protected, evidence-informed professional debate concerning models of care, clinical practice, and emerging areas of knowledge. Recognition of dignity and protection from discrimination are not incompatible with thoughtful professional discussion.

The aim is to support both human dignity and intellectual openness.

Key References

- WHO Violence Against Women Estimates (2021)
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
- Yogyakarta Principles (2007)
- WHO reports on gender, sexual health, and mental health

(4) Colonialism, Structural Violence, and Mental Health

What is the relationship between colonialism and mental health?

A growing body of scholarship examines the relationship between colonialism, structural violence, and mental health. Thinkers such as Frantz Fanon and Ignacio Martín-Baró argued that psychological suffering may be shaped by:

- Racial domination
- Occupation
- Dispossession
- Political repression
- Internalised structures of inferiority and exclusion

Foundational References

- Fanon, F. (1952). *Black Skin, White Masks*
- Fanon, F. (1961). *The Wretched of the Earth*
- Martín-Baró, I. (1994). *Writings for a Liberation Psychology*

What does contemporary scholarship say?

Contemporary scholarship has examined:

- Colonial legacies in psychiatry
- Racialised diagnostic practices
- Institutional mistrust
- Structural inequality and distress
- The psychological and developmental effects of occupation, surveillance, dispossession and political violence

Nadera Shalhoub-Kevorkian's concept of "**unchilding**" offers a particularly important example of how structural and political violence may enter the developmental world of children. Drawing on her research into Palestinian childhood under conditions of occupation

and settler colonialism, she describes processes through which children may be constructed as threatening or dangerous and thereby displaced from the protections ordinarily associated with childhood. Her work draws attention not only to direct experiences of violence, detention and surveillance, but to the wider political conditions that shape children's experiences of safety, vulnerability, family life and development.

This is relevant to mental health practice because it illustrates how psychological suffering cannot always be adequately understood by separating the child from the social and political environment in which development takes place. It also raises ethical questions about dehumanisation: when children cease to be socially recognised as children deserving protection, conditions that would ordinarily be understood as intolerable threats to childhood may themselves become normalised.

Key References

- Mills, C. (2014). *Decolonizing Global Mental Health*
- Fernando, S. (2017). *Institutional Racism in Psychiatry and Clinical Psychology*
- Farmer, P. (2004). "An Anthropology of Structural Violence"
- Mamdani, M. (1996). *Citizen and Subject*
- Kirmayer et al. (2014). Indigenous mental health and resilience
- Shalhoub-Kevorkian, N. (2019). *Incarcerated Childhood and the Politics of Unchilding*. Cambridge: Cambridge University Press
- Berger, E., Hinnawi, Z. & Jabr, S. (2026). "Ethics in Mental Health Under Political Violence: The Case of Palestine." *International Journal of Applied Psychoanalytic Studies*, e70065

(5) War, Mass Atrocity, and Collective Trauma

What are the mental health consequences of war and mass atrocity?

Extensive research demonstrates profound mental health consequences arising from:

- War
- Genocide
- Ethnic cleansing
- Siege
- Forced displacement
- Torture and torture by proxy (the impact on the families of those tortured/disappeared/left unrecovered/unidentified)
- Mass civilian destruction

Key References

- Herman, J. (1992). *Trauma and Recovery*
- Van der Kolk, B. (2014). *The Body Keeps the Score*
- WHO Mental Health in Emergencies resources
- Danieli, Y. (Ed.). (1998). *International Handbook of Multigenerational Legacies of Trauma*. Plenum Press
- Kienzler, H., Daniel, G., Hammoudeh, W., Nashashibi, R., Abu-Jamei, Y. & Giacaman, R. (2024). "Unbearable suffering: mental health consequences of the October 2023 Israeli military assault on the Gaza Strip." *BMJ Global Health*, 9

How are genocide and crimes against humanity to be distinguished?

Genocide and crimes against humanity are distinct categories of international crime, each defined by particular legal elements under international law.

Both are among the gravest violations of international law, while the prohibition of genocide is also recognised as a peremptory norm from which no derogation is permitted. Genocide requires the specific intent to destroy, in whole or in part, a protected group as such, whereas crimes against humanity concern specified acts committed as part of a widespread or systematic attack directed against a civilian population.

Key References

- Genocide Convention (1948)
- United Nations Office on Genocide Prevention
- Power, S. (2002). *A Problem from Hell*
- Staub, E. (1989). *The Roots of Evil*

(6) Silencing, Institutional Dynamics, and Ethical Harm

What does the Framework mean by silencing?

The Framework identifies silencing as a potential ethical harm where it contributes to denial, dehumanisation, or foreseeable suffering.

Silencing may be defined as the active suppression, penalisation, delegitimisation, exclusion or systematic avoidance of ethically relevant suffering, rather than simply the absence of speech. The concept therefore concerns the conditions under which speech and enquiry are permitted, rather than an entitlement to agreement or institutional endorsement. Disagreement, uncertainty, institutional caution, clinical neutrality, or a decision not to comment publicly on every issue are not in themselves necessarily ethically harmful.

What evidence exists regarding institutional silencing?

Research concerning organisational life demonstrates that institutions may defensively regulate ethical concern under conditions of anxiety, conflict, or reputational threat.

Key References

- Menzies Lyth, I. (1960). "Social Systems as a Defence Against Anxiety"
- Obholzer & Roberts (1994). *The Unconscious at Work*
- Freyd, J. (2018). *Blind to Betrayal*
- Smith & Freyd (2014). "Institutional Betrayal"
- Berger, E., & Jabr, S. (2020). "Silencing Palestine: Limitations on Free Speech Within Mental Health Organizations." *International Journal of Applied Psychoanalytic Studies*, 17(2), 193–207. [DOI](#)

Does the Framework reject neutrality?

No. It questions forms of neutrality that may inhibit ethical recognition of structural harm or foreclose protected debate. It cautions against external political, governmental, media or lobbying pressures which may insist that the correct ethical stance is silence, justified as

“neutrality” or “non-partisanship”. It recognises that neutrality may be a legitimate clinical and scholarly stance.

Key References

- Arendt, H. (1971). Thinking and Moral Considerations
- Fricker, M. (2007). Epistemic Injustice
- Honneth, A. (1995). The Struggle for Recognition

(7) Existing professional ethical codes

Does the Framework duplicate existing professional ethical codes, and what gap is it intended to address?

No. The Framework builds upon rather than replaces existing professional ethical codes and international guidance. Major frameworks across psychotherapy, counselling, psychoanalysis, group analysis, psychology, medicine and mental health already establish important principles including non-maleficence, beneficence, respect for dignity and human rights, justice, non-discrimination, professional integrity and protection from abuse. Some extend further into social responsibility, inequalities, organisational pressures, human-rights violations and particular forms of professional complicity.

The gap addressed by the Framework is therefore not an absence of ethical concern with human rights, social responsibility or the prevention of harm. Nor does the Framework suggest that psychotherapy and related disciplines have historically been concerned only with the individual or the consulting room. Some traditions, including group analysis, have long emphasised the relationship between individual psychological life, groups, institutions and the wider social world.

Rather, relevant ethical and theoretical resources are dispersed across different professional traditions and developed to differing degrees. Ethical codes within psychotherapy and related professions have understandably tended to elaborate most fully the responsibilities arising within clinical and other direct professional relationships. Wider medical, psychological, public-health and human-rights frameworks extend further into social determinants, population health, inequality, armed conflict and human rights. What remains comparatively less developed is an integrated, cross-disciplinary account of what these principles mean when serious mental-health harms arise from structural, political, economic, environmental or collective conditions beyond the immediate clinical relationship.

A **selective comparison** illustrates both the substantial foundations already available and the areas the Framework seeks to develop further.

Framework

British Psychoanalytic Council (BPC), Standards of Conduct, Practice and Ethics

Existing contribution

Establishes standards governing psychoanalytic and psychodynamic practice, including patient welfare, protection of the public, professional integrity, boundaries, competence, confidentiality and responsible use of professional relationships and authority.

Area the UEF seeks to develop further

Principally concerned with ethical conduct within clinical and professional practice. Less developed is the application of these principles to structural and collective harms and the responsibilities of psychoanalytic institutions as participants in wider civil society, including questions concerning institutional silence, neutrality, affiliation, legitimisation or suppression of professional discussion.

Framework

Institute of Group Analysis (IGA), ethical and professional standards

Existing contribution

Establishes ethical standards for group analytic and psychotherapeutic practice, including responsibilities towards patients and group members, confidentiality, boundaries, competence, integrity, avoidance of exploitation and discrimination, and responsible use of professional authority. The wider group-analytic tradition provides important conceptual resources for understanding relationships between individuals, groups, institutions and their social contexts.

Area the UEF seeks to develop further

The ethical provisions are developed principally in relation to therapeutic groups, patients, practitioners and professional conduct. The wider social orientation of group analysis is less fully translated into explicit ethical guidance concerning structural and collective harms, war or mass atrocity, the civil-society responsibilities of professional organisations, or circumstances in which institutional silence, neutrality, legitimisation or suppression of discussion may become ethically significant.

Framework

British Association for Counselling and Psychotherapy (BACP), Ethical Framework for the Counselling Professions

Existing Contribution

Provides a developed relational ethical framework grounded in values, principles and personal moral qualities, including respect for human rights and dignity, alleviation of distress and suffering, wellbeing, justice, non-maleficence and fair provision of services.

Area the UEF seeks to develop further

Provides substantial foundations for socially responsive practice but develops these most fully in relation to clients and professional relationships. Less systematically elaborated are responsibilities arising from serious collective or structural harms outside the therapeutic

setting and the distinction between legitimate professional engagement, wider ethical responsibility and stronger ethical duty.

Framework

UK Council for Psychotherapy (UKCP), ethical standards

Existing Contribution

Emphasises client welfare, dignity, autonomy, confidentiality, boundaries, competence, equality, avoidance of discrimination, professional integrity and protection from harm and exploitation.

Area the UEF seeks to develop further

Provides less detailed guidance concerning practitioners' and professional institutions' responsibilities in relation to structural violence, war, mass atrocity and other collective harms, or the circumstances in which institutional silence, neutrality or professional legitimisation may acquire ethical significance.

Framework

British Psychological Society (BPS), Code of Ethics and Conduct

Existing Contribution

Extends ethical concern beyond individual practice through principles including Respect, Competence, Responsibility and Integrity, providing important foundations for considering professional power, human rights, discrimination, harm and wider responsibilities associated with psychological knowledge and practice.

Area the UEF seeks to develop further

Does not comprehensively integrate these principles into guidance concerning professional responses to war, mass atrocity and other large-scale collective harms, or provide a developed account of when institutional silence, neutrality, affiliation or legitimisation may constitute forms of complicity.

Framework

American Psychological Association (APA), Ethical Principles of Psychologists and Code of Conduct

Existing contribution

Establishes beneficence and non-maleficence, justice, respect for rights and dignity, safeguards against misuse of psychological influence and important prohibitions concerning participation in torture and serious human-rights violations.

Area the UEF seeks to develop further

Provides strong foundations concerning professional conduct and specified forms of complicity but less systematic guidance concerning collective and structural sources of mental-health harm and the graduated responsibilities of practitioners and professional institutions in responding to them.

Framework

World Medical Association (WMA), International Code of Medical Ethics and related guidance

Existing contribution

Extends medical responsibility beyond individual patients to populations and society; addresses health inequalities and their determinants, human rights, organisational pressures and professional participation in torture. WMA guidance concerning armed conflict explicitly recognises that war and political violence can engage professional ethical responsibilities.

Area the UEF seeks to develop further

Goes considerably further than many profession-specific codes and provides an important foundation for the UEF. However, these provisions do not constitute an integrated, cross-disciplinary mental-health framework for assessing when silence, neutrality, institutional affiliation, legitimisation or concealment in relation to collective harms becomes ethically significant.

Framework

World Health Organization (WHO), rights-based mental-health guidance

Existing Contribution

Places mental-health services within an explicit international human-rights framework and recognises the importance of social determinants and connections with housing, education, employment, social protection and community life.

Area the UEF seeks to develop further

Strong on human rights, social determinants and systems of care, but not primarily a professional ethical framework. It therefore provides less guidance concerning the responsibilities of individual practitioners and professional organisations when serious harms arise from wider social, political or institutional conditions.

What does the comparison suggest?

The comparison suggests that the Framework is not introducing social or human-rights concerns into professions from which they have previously been absent. On the contrary, substantial ethical and theoretical resources already exist within psychotherapy, psychoanalysis, group analysis, psychology, medicine and international mental-health

guidance. Some traditions, including group analysis, have long emphasised the relationship between individual psychological life, groups and the wider social world.

The Framework seeks to **connect, make explicit and develop these existing resources**, particularly where their implications for professional ethics beyond the immediate clinical relationship remain fragmented or unevenly articulated. Its distinctive contribution lies particularly in bringing together consideration of **structural and collective harm, institutional responsibility, professional authority and non-complicity** within a common mental-health ethical framework.

It asks, in particular: when do structural, political, economic, environmental or collective conditions affecting mental health become a **legitimate dimension of professional ethical concern**? When does awareness of serious and foreseeable harm generate an **ethical responsibility to consider whether and how to respond**? When might a stronger **ethical duty** arise? How should professional organisations consider their own actions, affiliations and use of professional authority? And under what circumstances might facilitation, legitimisation, concealment, silence or claims to neutrality themselves acquire ethical significance?

The UEF seeks to provide a common framework within which these questions can be considered across mental-health disciplines and across differing forms and scales of harm. It does not claim that existing professional ethics are silent on these matters, nor that every practitioner or organisation acquires identical obligations. Rather, it seeks to make more coherent and explicit ethical responsibilities already implicit or partially articulated within existing professional traditions.

This includes distinguishing between recognising an issue as a **legitimate dimension of professional practice**, accepting a **responsibility to consider whether and how to respond**, and identifying circumstances in which a stronger **ethical duty** may arise. The nature and weight of responsibility will vary according to context, including the gravity and foreseeability of harm, the strength of available evidence, professional role and authority, proximity to the harm, capacity to influence it, and the risks and likely consequences of action or inaction.

(8) Non-Complicity and Ethical Speech

What is the principle of non-complicity?

The principle of non-complicity holds that ethical responsibility extends beyond direct participation in harm to forms of facilitation, legitimisation, concealment, or silence that enable, sustain or contribute to foreseeable serious harm.

Key References

- International Code of Medical Ethics (WMA, 2022)
- WMA Declaration of Tokyo
- Convention Against Torture (1984)
- UN Principles on Human Rights Defenders
- Irfan, B., Venugopal, K., Cohen, M. A., Soni, A., Sirvent, R. D., Ge, Y., Arraf, H., Kuemmerle, K., Jboor, N., Hawwash, M., & Abu Alamrain, A. (2025). "People-Centered

Accountability amid the Gaza Genocide: Doctors Against Genocide, Healthcare Workers Watch, and the Freedom Flotilla Coalition.” Health and Human Rights, 27(2), 27–38.
<https://pmc.ncbi.nlm.nih.gov/articles/PMC12799028/>

How does the Framework apply this principle?

The Framework extends this principle to broader institutional contexts, arguing that silence may constitute ethical complicity where it enables foreseeable harm, denial, or dehumanisation.

The Framework distinguishes between recognising an issue as a **legitimate dimension of professional ethical concern** and concluding that every practitioner has an **ethical obligation to take a particular form of action**. Its purpose is not to prescribe uniform political or public advocacy.

At a first level, the Framework affirms that engagement with the social, political, economic and environmental conditions affecting mental health falls legitimately within the scope of professional reflection and practice. Practitioners and professional bodies may therefore speak, organise, educate, advocate or contribute their expertise in these areas without such engagement being dismissed simply as “political” or as falling outside professional competence.

A stronger level of **ethical responsibility** may arise where serious or foreseeable harm is involved, particularly where practitioners or institutions possess relevant knowledge, professional authority, influence or a particular relationship to those affected. Responsibility does not necessarily prescribe one response. It may be discharged in different ways — through clinical work, education, research, testimony, organisational action, advocacy, support for affected colleagues and communities, or other contextually appropriate forms of engagement.

The language of **ethical duty** is reserved for circumstances in which the obligation is substantially stronger: for example, where professional conduct would itself facilitate, legitimise, conceal or contribute materially to serious harm; where there is a clear obligation to protect patients or others within one’s professional responsibility; or where fundamental professional and human-rights norms are directly engaged. Even here, what can reasonably be required of an individual must take account of role, knowledge, capacity, proximity, personal and professional risk, and the likely consequences of action or inaction.

The Framework therefore proposes a **graduated conception of ethical engagement**. Some forms of engagement are professionally legitimate; some circumstances generate a responsibility to consider whether and how one should respond; and more limited circumstances may create a stronger ethical duty to act, or to refrain from conduct that would contribute to serious harm. It does not imply that every mental health professional has a duty to engage in public advocacy, issue statements, join campaigns or adopt identical positions.

Nor does the Framework suggest that every association, omission or failure to speak constitutes complicity. Whether facilitation, legitimisation, concealment or silence becomes ethically significant depends upon context. Relevant considerations may include the nature,

scale and severity of the harm; the credibility and strength of the available evidence; whether the harm is known or reasonably foreseeable; the proximity of an individual's or institution's actions to it; and the degree of professional authority, influence or capacity to act.

Particular attention may be needed to the **function** performed by an action or omission: whether, for example, it materially assists harmful practices, lends them professional or institutional legitimacy, obscures credible evidence, minimises or rationalises suffering, inhibits scrutiny or discussion, or contributes to the normalisation of conduct that might otherwise be recognised as unacceptable. Silence or claims to neutrality may become especially significant where they operate within substantial inequalities of power, where those experiencing harm have limited capacity to make themselves heard, or where professional authority is invoked selectively in ways that protect more powerful actors from scrutiny.

Assessment should also take account of legitimate constraints, including clinical responsibilities, confidentiality, personal safety, organisational role, and the proportionality and likely consequences of possible action. The question is therefore not simply whether a person or organisation has spoken or remained silent, but whether, in the circumstances, its actions, affiliations, professional authority or omissions can reasonably be understood as contributing to the facilitation, legitimisation, concealment or continuation of serious and foreseeable harm. As the gravity and foreseeability of the harm, the strength of the evidence, proximity to it and capacity to influence it increase, so too may the weight of ethical responsibility.

(9) Politics, Prevention, and Professional Responsibility

Is the Framework encouraging the politicisation of mental health practice?

The Framework does not argue that mental health practitioners should become partisan political actors, nor that professional disagreement should be replaced by political consensus.

Rather, it recognises that many of the conditions known to affect mental health — including war, displacement, racism, poverty, gender-based violence, environmental degradation, detention, discrimination, and other forms of structural harm — are frequently described as “political” and therefore treated as lying beyond the legitimate scope of professional concern.

The Framework challenges this assumption. It argues that where social, economic, environmental, or political conditions are significant determinants of psychological suffering, recognising and addressing their impact is consistent with the ethical responsibilities of mental health practitioners.

Why might the use of the term “political” be questioned?

The label “political” may at times be used to dismiss, marginalise, or silence discussion of conditions that are directly relevant to mental health and human wellbeing.

Many issues now widely recognised as legitimate concerns for mental health practitioners — including domestic violence, racism, poverty, discrimination, LGBTQ+ rights, disability

rights, child protection, refugee welfare, and climate change — have at various times been dismissed as “political” rather than understood as matters affecting psychological health and human dignity.

The Framework therefore encourages critical reflection on how and why certain forms of suffering come to be recognised as legitimate objects of professional concern while others are excluded from discussion.

Should mental health practitioners speak publicly about human rights concerns?

The Framework does not suggest that mental health practitioners have a duty to comment on every political controversy or public policy issue.

However, mental health practitioners possess expertise concerning the causes, consequences, and prevention of psychological suffering. Where serious threats to mental health arise from violence, discrimination, displacement, environmental disaster, or other structural conditions, practitioners may have legitimate professional grounds for contributing to public discussion.

Throughout history, mental health professionals have played important roles in documenting the effects of torture, racism, war, poverty, domestic violence, child abuse, and institutional neglect. Such contributions have often informed public understanding, policy development, and harm prevention.

The Framework therefore recognises that public ethical speech may constitute a legitimate dimension of professional responsibility when grounded in professional expertise, concern for human wellbeing, and the prevention of foreseeable harm. This does not require partisan alignment or political unanimity. Rather, it reflects the view that professional responsibility may sometimes extend beyond the consulting room when conditions affecting mental health are themselves matters of public concern.

Key References

- World Medical Association (2022). International Code of Medical Ethics
- WHO World Mental Health Report (2022)
- Patel et al. (2018). Lancet Commission on Global Mental Health and Sustainable Development
- United Nations Declaration on Human Rights Defenders (1998)

What role do prevention and ethical reflection play?

The prevention of foreseeable harm has long been recognised as a core professional responsibility. This includes not only responding to distress after it occurs, but also identifying and, where appropriate, speaking about conditions that contribute to its production.

The Framework therefore affirms that advocacy, prevention, public education, and ethical speech may constitute legitimate dimensions of professional responsibility where substantial and foreseeable harms to mental health are evident.

Why does the Framework refer to harmful social norms?

Mental health practitioners routinely encounter the psychological consequences of social norms, institutional practices, and cultural assumptions. History demonstrates that societies may normalise beliefs, policies, and practices that are discriminatory, dehumanising, exclusionary, or psychologically harmful.

The concept of “unchilding” (Shalhoub-Kevorkian, 2019) provides a particularly stark illustration of such normalisation, describing processes through which racialised or colonised children may come to be represented as threatening and consequently treated as less entitled to the protections ordinarily accorded to childhood.

Other examples include:

- Racial segregation and scientific racism
- Eugenics and forced sterilisation
- Criminalisation of homosexuality
- Gender discrimination and gender-based violence
- Political repression
- Torture and cruel treatment

The Framework therefore argues that professional ethics require a capacity for critical reflection on prevailing social norms, rather than assuming that what is socially accepted is necessarily ethically justified.

Does this mean that practitioners must share the same political views?

No. The Framework explicitly protects good-faith, evidence-informed disagreement, and ethical pluralism. Its purpose is not to prescribe political positions, but to support recognition of structural determinants of mental health, encourage critical ethical reflection, and protect the capacity of practitioners to speak and think about conditions that contribute to human suffering.

The aim is not to collapse mental health practice into politics, but to ensure that professional ethics remain capable of recognising structural causes of distress, challenging harmful forms of normalisation, and contributing to the prevention of avoidable harm.

Key References

- World Health Organization (2022). World Mental Health Report
- World Health Organization & Calouste Gulbenkian Foundation (2014). Social Determinants of Mental Health
- Martín-Baró, I. (1994). Writings for a Liberation Psychology
- Fanon, F. (1961). The Wretched of the Earth
- Marmot, M. (2020). Health Equity in England: The Marmot Review 10 Years On
- Patel et al. (2018). The Lancet Commission on Global Mental Health and Sustainable Development
- Arendt, H. (1971). Thinking and Moral Considerations
- World Medical Association (2022). International Code of Medical Ethics

(10) Ethical Pluralism and Protected Debate

Why does the Framework emphasise protected debate?

The Framework affirms:

- Open ethical discussion
- Good-faith disagreement
- Academic freedom
- Institutional tolerance of dissent

Key References

- Mill, J.S. (1859). On Liberty
- Arendt, H. (1963). Eichmann in Jerusalem
- Bion, W.R. (1962). Learning from Experience

How does the Framework balance debate and ethical responsibility?

The Framework seeks to avoid ideological conformity while resisting institutional conditions in which important forms of suffering become professionally unspeakable. Ultimately, the members of a mental health association share responsibility for constructing and maintaining such a culture.

(11) Clinical Orientation: A Reflective Sensibility

What clinical orientation does the Framework propose?

The Framework proposes a clinically reflective sensibility attentive to:

- Structural conditions
- Trauma
- Social suffering
- The interaction between psychic and social life

Key References

- SAMHSA (2014). Trauma-Informed Care in Behavioural Health Services
- Mitchell, S. (1988). Relational Concepts in Psychoanalysis
- Orange, D. (2011). The Suffering Stranger
- Patel et al. (2018). The Lancet Commission on Global Mental Health and Sustainable Development
- Jabr, S., & Berger, E. (2015). "An Occupied State of Mind: Clinical Transference and Countertransference Across the Israeli/Palestinian Divide." *Psychoanalysis, Culture & Society*, 21(1), 21–40.

What does this orientation seek to achieve?

It seeks to avoid pathologising understandable responses to violence, deprivation, exclusion, ecological crisis, and social disintegration while maintaining clinical seriousness and ethical complexity.

(12) Conclusion

What is the central concern motivating the Framework?

The Framework arises from concern that important ethical resources concerning collective harm, structural violence, ecological instability, institutional silencing, and mass trauma exist across the mental-health professions but remain unevenly developed and insufficiently integrated.

What is the Framework's central claim?

Its central claim is that mental health ethics cannot be fully separated from questions of human dignity, structural violence, protected debate, and collective responsibility. It does not aim to impose a single moral vocabulary, but instead grounds itself in dignity, protection from harm, and critical openness across contexts.

How should the Framework be used?

The Framework is intended as an ethical and educational resource rather than a regulatory code. We hope others will critique it, strengthen it, challenge it and help reshape it. Its universal legitimacy will be derived from its development through professions, cultures and lived experience.

It may be used:

- As a basis for professional discussion
- Within training and educational programmes
- To support ethical reflection concerning structural determinants of mental health
- To encourage protected debate within institutions
- As a resource for advocacy concerning mental health and human rights
- And as a potential basis for organisational endorsement or adoption

The Framework does not seek to replace existing professional ethics codes. Rather, it seeks to complement them by addressing areas that are often underdeveloped, including structural determinants of mental health, institutional silencing, ethical speech, prevention, and non-complicity.

As a living document, it is intended to remain open to revision, critical engagement, and development in light of emerging evidence, changing social conditions, and ongoing professional dialogue.

How should the Framework be understood going forward?

The Framework should be understood as an invitation to ongoing professional reflection, debate, revision, and solidarity across differing traditions and perspectives.

Key References

- World Health Organization (2022). World Mental Health Report
- Martín-Baró, I. (1994). Writings for a Liberation Psychology
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