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ETHICAL PRINCIPLES IN GLOBAL MENTAL HEALTH

What core ethical principles can organizations apply to ensure that global mental health policies and practices do no harm?

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Key Takeaways

- ✔ Core ethical principles associated with mental health practice are incorporated under wider humanitarian principles of autonomy, beneficence, nonmaleficence (i.e., "do no harm"), and justice.
- ✔ Ever since the adoption of the 2007 Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings, which promoted refraining from causing harm, many humanitarian organizations have promoted the "do no harm" principle.
- ✔ Implementing the "do no harm" principle in global mental health settings poses a number of challenges, including:
  - o Inadvertent harms associated with poor coordination of services
  - o Poor service quality
  - o Lack of cultural specificity and tailoring,
  - o Lack of independence
  - o Short-term aid structures
  - o Difficulties with informed consent related to external and internal power dynamics
  - o Individualistic versus collectivistic societal orientations
  - o Targeting of vulnerable populations to receive support
  - o Creating dependency
  - o Undermining comprehensive service development through siloed approaches.

Promising Approaches

Given the findings of this review, we recommend professional and international aid organizations move beyond the incorporation of "do no harm" and safety principles to construct ethical relationships that proactively encourage justice and promote the capacities of individuals, families, and communities globally.

The following actions may be beneficial for professional and humanitarian aid organizations and other practitioners working in international contexts:

Explicitly recognize and name common unintended consequences of mental health interventions that occur when working across cultures. Encourage mental health professional associations to incorporate language about the application of ethical principles to guide global approaches, interventions, and services to avoid unintentional harm.

Provide education and training materials for members of all professional bodies on ethical considerations and modifications needed to provide competent practice in global settings. This should include guidelines to navigate how a human rights-based approach to mental health provision may conflict with other ethical principles such as self-determination. This is particularly important for professions that do not currently require practitioners to be accredited or licensed for international practice.

Involve people with lived experience, community members, and local mental health professionals from low- and middle-income countries (LMICs) in consultations to develop and/or revise codes of ethics to ensure ethical principles are culturally appropriate, build on local knowledge, and are sensitive to needs of diverse populations.

Conduct ongoing and continuous review of ethical principles across settings. Include diverse stakeholders, local partners, and individuals with lived experience to contextualize these mental health policies and practices, which will increase applicability and reduce the risk of harm.

Establish policies to encourage inter-professional and inter-sectoral collaborations, including suggestions for establishing common ethical principles, defining and articulating common outcomes, and incorporating mutually reinforcing or joint strategies to incorporate ethical principles beyond "do no harm" into guidelines that can address a broad array of professional and humanitarian organizations.

By explicitly adapting core organizational and professional ethical principles, these essential standards can be applied more effectively reduce the chances of harm. It is important to recognize that the modification of standardized principles for mental health practice will require vigilant contextualization to apply them effectively in different settings.

Introduction

Background

Mental health has become integral to global health, international development, and humanitarian work. Increased awareness of the importance of mental health has expanded the delivery and integration of services and interventions. Consequently, it is increasingly recognized that mental health interventions, services, and approaches may lead to unintentional harm. Professional organizations have developed principles to govern the ethical standing and soundness of services and interventions; however, much of this guidance is not intended for application in international settings. Efforts at adapting these standards and principles to account for the myriad of challenges practitioners, organizations, and researchers may face working in LMICs in development and humanitarian settings are not well documented. The goal of this review is to inform the following questions:

- How is the ethical principle of nonmaleficence or "do no harm" understood among academia and global mental health practitioners and organizations?
- How have core ethical principles been translated into guidelines to reduce or avoid unintentional harm?
- How have ethical principles been applied to better guide ethical decision-making among mental health practitioners or organizations?
- How can practitioners and organizations better crystalize these principles in policies and practices going forward?

Search Strategy

Google Scholar, PsycINFO, EBSCO, and Scopus were used as search engines. The following combination of terms were used for this search: "do no harm" and "global mental health" or "LMIC," "ethical standards," and "global mental health" or "LMIC," "mental health" and "ethical standards," "global or international mental health" and "non-malfeasance," "risk of harm" and " mental health," "Community Advisory Board" and "mental health" and "global mental health research" and "ethical guidelines" or "ethical standards". Resources gathered throughout a series of mental health consultation sessions were also incorporated into the search. Upon review of titles and abstracts, a total of 26 manuscripts, reports, and books were included in this brief.

Findings

How have global development and humanitarian agencies applied the principle of "do no harm" into policy documents?

Most organizations reference the "do no harm" approach developed by Mary B. Anderson in the 1990s.[1–5] These organizations included OXFAM, UNHCR, and UNICEF. While many have adapted this approach to fit their needs, the general principle involves a seven-step process requiring practitioners and organizations to evaluate the context, the dividers, the connectors, how the intervention interacts with these parameters, the patterns of impact, alternative strategies, and the anticipated effects. Figure 1 visualizes OXFAM's "do no harm process."

In this review, few organizational policy documents defined "do no harm" as an approach to mental health service delivery. As Patel[6] notes, among international organizations, "do no harm," or not causing further physical or psychological harm, or creating further risk, is a dominant principle. However, few international organizations reviewed for this brief unpacked this principle beyond considering protection responses to a range of refugee protection concerns such as child labor, exploitation, neglect or abuse, gender-based violence, and the protection of others considered vulnerable (e.g., those with mental health conditions, special needs, or disabilities)[6].

Challenges of implementing the "do no harm" approach:

- Obtaining informed consent
- Contextualization of interventions
- Avoiding cross-cultural misunderstandings
- Addressing power asymmetries and conflicts of interest
- Avoiding dependency
- Addressing potential harm to staff members.[6–10]

How have different professions applied ethical principles such as "do no harm" into global mental health practice?

Most literature that discusses applied ethical principles for mental health work globally comes from humanitarian organizations under wider discussions of humanitarian principles (autonomy, beneficence, nonmaleficence, and the principle of justice)[6,9,11] or the Inter-Agency Standing Committee (IASC) guidelines issued in 2007.[12] Appendix 1 contains a summary of these core principles. This body of literature highlights the need for contextualization and cultural adaptation to make these principles workable in different settings.[7–11,13–15]

While the American Psychological Association (APA),[16] Australian Psychological Society (APS),[17] and British Psychological Society (BPS),[18] all offer their own code of ethics, none explicitly mention "global mental health" or discuss how to apply or adapt these ethical principles in international or humanitarian contexts. APA and BPS have statements about working cross-culturally; however, they primarily refer to working with diverse ethnic groups within their discrete countries (i.e., immigrants). They do not explicitly acknowledge the ethical difficulties or nuances of working in development contexts or humanitarian settings. These professions, however, have a long history of addressing and refining their ethical codes. Relevant lessons learned may be applied to global mental health ethical principles.

Several authors from different professions have discussed ethical principles in global mental health research.[19–23] These principles include scientific merit, engaged participation, informed consent, guarantees of privacy and confidentiality, safety, neutrality, cultural competency in research, and clear purpose and benefits from research. Appendix 2 provides additional information about applying these principles when researching in global contexts. Additional insights regarding ethical principles across mental health professions are available in a separate brief.

Figure 1. The Do No Harm Process[3]

Analyze the Context
Examine the situation and background information in order to gain a better understanding of the context.

Effects of other Options
What other Options are there? How do these Options affect the Dividers? How do they affect the Connectors?

Discover Patterns of Impact
What are the Patterns of Impact? How do these interact with the other elements?

Understand the Dividers*
What are the Dividers? Which of these Dividers are the strongest? Which are the most divisive?

Understand the Connectors*
What are the Connectors? Which Connectors can we influence?

*Dividers and Connectors refer to the experiences, institutions, or values, that either create divisions among people (leading to conflicts and mistrust) or foster connections among people (enhancing collaboration and trust).

Analyze the Intervention's Interactions
How do elements of our intervention interact with the Dividers and the Connectors?

Source: Adapted from Oxfam International. The Do-No-Harm Approach: How to ensure that our work contributes to peace & not conflict. 2018.

What guidance have different organizations provided to apply ethical principles (i.e., do no harm) internationally?

Most documents reviewed for this brief discussed the guidelines issued by the IASC, which mentioned ethics in the context of larger humanitarian values.[5–7,11–13,15] Cherepanov,[19] notes that while many of these values and principles vary slightly across organizations, they are largely based on, and closely related to, the International Federation of the Red Cross and Red Crescent Societies (IFRC) fundamental principles, written in 1965.[19,20] These principles include humanity, impartiality, neutrality, independence, voluntary service, unity, and universality. While many organizations reference these principles, few apply them specifically to mental health services or interventions.

Scholars have recommended two overarching themes for mental health professionals to consider in delivery of ethical global mental health programs and practices:[10]

1. ***Consideration of culture and context*** when delivering mental health interventions which include:
    - **Cultural relevance** or the crafting of global mental health programs that have meaning, value, and feasibility in identified communities and contexts;
    - **Cultural competence,** or being aware of and respecting a particular culture's perception of mental health needs;
    - **Recognizing similarities and differences**, and learning to identify them, particularly in terms of the psychological distress inherent in lived human experience and actual manifestations of mental illness.

Cultural and contextual variables that may affect the ethical implementation and effectiveness of approaches to mental health, include:

- **Cultural beliefs** and attitudes towards mental health conditions;
- **Language and communication** barriers among persons with mental health conditions and trained mental health professionals who work internationally;
- **Stigma and discrimination** of mental health services;
- **Socioeconomic barriers** that exacerbate mental health issues, such as poverty, unemployment, and low education, political instability and poor governance;
- **Weak legal protections** for people who experience human right violations, potentially traumatizing and other events that can contribute to the development or exacerbation of mental health conditions which perpetuates disempowerment and instability;
- **Traditional and alternative healing practices** not yet mainstreamed or as socially accepted or accessible as western-style mental health services; and
- **Health systems** that are not well-equipped to provide adequate mental health services.

2. ***Collaboration*** with diverse stakeholders, local partners, and service users to support ethical soundness of mental health interventions which include:
    - **Relationship building** on local and systems levels to improve the sustainability of mental health programs and practices;
    - **Reciprocity** which includes working with individuals on the ground and building on local knowledge and expertise to increase relevance, mutual understanding, and reduce risk of harm; and
    - **Consistent communication** between stakeholder groups and across disciplines to increase the relevance and efficacy of mental health services and interventions. This includes active listening to increase mutual respect and engaging in difficult or uncomfortable dialogue which can increase learning of the needs of the local communities.

Table 1. Summary of Ethical Issues in Global Mental Health

THEME	ETHICAL PITFALL
Fragmentation	• Poor coordination of care • Providing care in a silo/lack of holistic care • Poor quality of care
Dependence	• Raising local expectations of continued support • Lacking adequate preparation and training • Creating dependencies within the local population
Cultural Considerations	• Violating cultural and social norms • Using culturally inappropriate methods • Imposing western practices despite local customs • Overusing local resources • Individualistic vs. collective approaches
Security/Safety	• Using aggressive methods • Using aid as a weapon • Excessive targeting of vulnerable groups • Facing informed consent issues
Deficit Model	• Focusing only on clinical diagnoses • Lacking prevention oriented thinking • Adopting a deficit focus approach

Wessels[7] offered a reflection on some pitfalls that emerge when humanitarian agencies provide psychosocial services in emergency contexts. He notes that "parachuting" (i.e., the arrival of outside "helpers" who lack ongoing relationships with relief efforts, agencies, and affected populations) may unintentionally cause harm by consuming scarce resources, violating cultural and social norms, employing culturally inappropriate methods, increasing security burdens, using aggressive methods, and raising local expectations of continued support. Other potential practices that may cause harm include poor coordination of care, non-holistic care, failure to secure informed consent, excessive targeting of vulnerable groups to the point of triggering jealousies leading to reverse stigmatism and social tension, a deficit focus, imposing Western practices despite local customs (i.e., cultural incompetency), inadequate preparation and training, the creation of dependencies, and poor preventative intervention.[7]

With a few exceptions, direct policy recommendations to better implement common ethical principles of autonomy, beneficence, cultural competence, impartiality, neutrality, or "do no harm" were scant in the literature. Pate[16] suggests organizations and other service providers conduct regular and sustained analyses of power within their organizations and reconfigure healthcare responses as integrative "care services." Figure 2 provides Patel's[6] framework to assist in organizational analyses. Although this example emphasizes how differences in power and interests may impact psychological and mental health care services for refugees, they could also be applied with other vulnerable populations in humanitarian and development contexts.

Figure 2. Power and Interest: Psychological, Mental Health and Social Care for Refugee People[6]

Refugee Communities

- Ongoing concerns of safety and lack of security
- Experiences of powerlessness and coping, and impact on health and wellbeing
- Lack of access to Justice, reparation, and rehabilitation
- Lack of genuine participation and inclusion in service design, development, and delivery

Staff Members

- Local staff trained on Eurocentric models and interventions
- Expertise of local staff, local expertise is neglected: and axiom of 'West is Best'
- Lack of genuine participation and inclusion of local staff and experts in service design, development, and delivery
- Differential working conditions and salaries
- Absence of, or inadequate, staff care
- Staff experiences mirroring experiences of refugee people

International Organizations

- Historical, political, and economic interests in funding choices of international organizations
- Short-lived services restricted by resources, geography, political, and economic instability, Lack of security
- Reliance on 'international' experts and consultants, over local advisors
- Absence of effective state health and social care services
- Funding competition and financial instability

Concepts and Models

- Artificial distinctions between psychological problems and 'mental disorders'; and between 'basic support' and 'specialist support'
- Medicalization of distress
- Eurocentric concepts, models, and methods
- Rejection of culturally acceptable approaches to health and well-being, considered as primitive or not evidence-based

Source: Adapted from Patel N. The mantra of 'do no harm' in international healthcare responses to refugee people. In: An Uncertain Safety. Springer, 2019:155-183.

Shah[9] recommends that developing ethical cultural adaptation protocols can mitigate the chances that interventions will suffer from under-adaptation, unilateral decisions, confusion, or "re-inventing the wheel" with each project. These recommendations were situated within the larger argument for ethical cultural adaptation of protocols, rather than specifically contextualized for mental health. These recommendations aligned with the larger focus on cultural competency discussed by several authors. [7,9,12]

APPENDIX

Appendix 1: IASC Guidelines Core MHPSS Principles

1. Human rights and equity for all affected persons ensured, particularly protecting those at heightened risk of human rights violations.
2. Participation of local affected populations in all aspects of humanitarian response.
3. Do no harm in relation to physical, social, emotional, mental, and spiritual well-being and being mindful to ensure that actions respond to assessed needs, are committed to evaluation and scrutiny, supporting culturally appropriate responses and acknowledging the assorted power relations between groups participating in emergency responses.
4. Building on available resources and capacities by working with local groups, supporting self-help, and strengthening existing resources.
5. Integrated support systems so that MHPSS is not a stand-alone program operating outside other emergency response measures or systems (including health systems).
6. Multilayered supports, acknowledging that people are affected by crises in different ways and require different kinds of support. Multilayered supports are ideally implemented concurrently (though all layers will not necessarily be implemented by the same organization). These are commonly represented by the IASC "intervention pyramid."

Source: Inter-Agency Standing Committee, IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. 2007.

Appendix 2: Ethical Principles in Global MHPSS Research[22–25]

ETHICAL PRINCIPLE	MEANING
Scientific Merit	As a precondition of research, researchers are responsible for evaluating the selection of research questions in light of their personal biases, the neutrality of their question under examination, the risk and benefit of the research to participants and the field, their proposed methodological approach in terms of rigor, transparency, and fidelity, and their exercise of continuous ethical reflexivity and promote collective learning.
Participation	Researchers are responsible for ensuring that all stakeholders have a shared understanding of the research question and process as well as that participants are fairly selected in line with research objectives and informed by local knowledge.
Informed Consent	Researchers are responsible for undertaking culturally responsible informed consent and disclosure of any study policies and procedures. This includes tailoring informed consent processes to local and cultural contexts and ensuring participant comprehension and the voluntariness and autonomy of their decisions by evaluating factors that may influence decision making. These include potential coercion, exploitation, and normative beliefs around decision making capacity.
Privacy and Confidentiality	Researchers need to ensure privacy and confidentiality within the limits of the context by evaluating potential harms and developing culturally valid criteria for disclosure/referral systems.
Safety	Researchers are responsible for ensuring the safety of participants, the research team, and themselves as relating to various environmental, political, and health risks, and for having adequate procedures to respond. This includes being accountable for adequate training, referrals, resources, and preparation to accommodate adverse events.

ETHICAL PRINCIPLE	MEANING
Neutrality	Researchers should seek to remain neutral in terms of their interactions with target populations and communities by thoroughly evaluating and being transparent about power and knowledge asymmetries both with populations, gatekeepers, and other collaborators. Coordination with other researchers and organizations should be optimized and networked within emergency situations to reduce waste and founded in principles of mutual respect and trust.
Cultural Competency	Researchers, in designing a study, should take into account assets and resilience as well as cultural and contextual factors that may influence responsiveness to treatment and/or research participation. Close collaboration with a "culturally competent advocate" from the community where research will take place throughout the design and implementation of the study and cultural feasibility studies in preparation for clinical trials are among ways to ensure adequate consideration of ethical and social issues in the design of cross-cultural studies. Some scholars advocate for inclusion of "the religious, spiritual, and/or traditional principles that characterize a local population" into international ethical guidelines for the conduct of Global Mental Health Research.
Purpose and Benefits	Researchers should evaluate and plan for how populations under study can derive sustainable benefit from the research, who is entitled to the results of the study, how results will be disseminated, the risk of sharing results for both participants, communities, and collaborators, and the overall ethical review strategy of the study.

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