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**Global mental health (GMH) work reminds us about our professional ideals and mission. GMH specialists conduct research and provide psychosocial and mental health support to populations affected by humanitarian crises around the world. This work exposes these specialists to situations with a high degree of moral ambiguity and no good solutions, where humanitarian accountability takes priority over conflicting values. Self-awareness helps to address the countertransference that confounds complex decision-making and can compromise the health and safety of all involved. The evolving role of GMH as a humanitarian actor underscores the importance of professional competencies in assuring the integrity and standards of practice.**

### Global mental health in a humanitarian context

Global mental health (GMH) professionals respond to ever-increasing humanitarian needs and provide mental health aid and advocacy to populations affected by war, violence, displacement, famine and extreme poverty. GMH forms part of an interdisciplinary humanitarian action which responds to humanitarian crises, conducts humanitarian research, builds capacity, trains specialists and supports relief workers. Some people in this field are working independently, but most are employed by nongovernmental organisations or charitable foundations. The GMH work is carried out in the settings affected by complex emergencies or daily struggles of post-crisis recovery where relief and recovery is complicated by ongoing violence, broken infrastructure and lack of resources.

I define GMH as ‘an area of study and practice that aims to improve mental and psychosocial well-being of populations affected by international humanitarian crises and to support psychological recovery’ (Cherepanov, 2018a, 2018b). Thus, the ethical framework for GMH is the ‘system of professional and multidisciplinary values, competencies, and standards that provide guidance and frame of reference for reasoning the complex professional and moral dilemmas arising within the humanitarian context’ (Cherepanov, 2018a).

Categorising GMH as both a mental health and humanitarian specialisation underscores its integrated nature and determines the scope of services, governing values and interventions.

The humanitarian context of GMH distinguishes it from proxy disciplines, such as international psychology or cultural psychiatry, where their agenda is to form collaborative partnerships and develop policy and sustainable systems. Nevertheless, these terms are still being used interchangeably, creating methodological confusion and leading to professional overreach that goes beyond the mandate of GMH.

### Quest for consistency and standards

The historical perspective of GMH helps to better understand how it has come to be what it is today. Although the humanitarian spirit has always drawn people to help those in greater need, the professional self-determination of GMH can be mostly attributed to the globalisation and professionalisation of humanitarianism. The international experience has broadened the horizons of the profession, demonstrated the power of human resilience and also proven that serving the most vulnerable populations comes with a responsibility that calls for specialised professional competencies.

Summerfield’s uncompromising evaluation of GMH’s core assumptions was a wake-up call that questioned the over-pathologising of human suffering and the ethnocentric and naive convictions about the indiscriminate transferability of professional skills to different cultures and contexts (Summerfield, 2004). This critique underscored the importance of ensuring the standards and integrity of practice. As a result, the GMH that started as voluntaristic and fragmented efforts in the late 1980s had emerged as a vital humanitarian actor without which we cannot imagine contemporary humanitarian action. The *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, issued in 2007 by the Inter-Agency Standing Committee (IASC), has become a major step toward establishing standards and bridging the gap between mental health interventions and psychosocial supports (IASC, 2007).

In humanitarian work where the effectiveness of relief efforts largely depends on coordination, consistency and collaboration, ethical guidance plays an essential role in ensuring accountability and flagging unethical practices. In contrast, the transgression of ethical values undermines the spirit of humanitarianism and the image of the profession, drastically affects the ability of agencies to respond to survivors’ needs and puts both beneficiaries and aid workers at risk.

The professionalisation of humanitarianism prioritises accountability, which is understood as responsible use of power and resources. This accountability calls for ongoing partnerships with stakeholders in needs determination, resource allocation and the implementation of interventions, or 'nothing about us without us!' In this quest, GMH has joined a number of global initiatives that prioritise accountability and quality assurance (Sphere Project, 2011), and my recent book *Ethics for Global Mental Health: From Good Intentions to Humanitarian Accountability* (Cherepanov, 2018a) was written as part of this agenda.

### Ethical dilemmas

Global humanitarian work takes mental health professionals out of their comfort zones and forces them to re-examine everything they thought they knew about the profession, the world and themselves. In their work, they encounter unique moral and professional dilemmas. Their ethics offer professional grounding, set expectations and establish a frame of reference for practice and professional interactions that are consistent with humanitarian values and mission. Ethical dilemmas in GMH are approached as conflicts of underlying paradigms or 'a false opposition' that cannot be directly resolved by deciding 'what professional value is more professional or what moral value is more moral'. Instead, establishing precedence of humanitarian values, accountability and situational relevance becomes a strategy for negotiating competing agendas and values (Cherepanov, 2018a).

In this way, engaging humanitarian principles as the higher-level values helps to reconcile the competing multidisciplinary agendas, like having to choose between allocating resources for children's education versus healthcare, or disaster response versus capacity building. In an ideal world, these agendas would be complementary and not competing. But given that resources are almost always limited, the humanitarian priorities will be different during a public health crisis or post-conflict recovery.

When navigating professional dilemmas, like having to choose between an intervention that benefits an individual and one that benefits the community, exerting accountability as a point of reference helps to establish the primacy of the value in relation to the professional role and the current commitment. This means that this decision may be different depending on the current professional role (e.g. a public health provider, educator or a clinician); the given time and place; the agency's mission, resources and funding; and the demands of the situation. One such dilemma proved to be extremely contentious during the recent Ebola outbreak in West Africa: the providers had to make tough decisions about quarantining suspected cases and risking alienating the communities. Another professional dilemma could involve choosing between using the obsolete assessment tools and practices with

unclear cultural validity or the innovative but experimental approaches.

Reasoning one's way through moral conundrums can be especially emotionally and morally difficult; for example, when having to decide who needs help more or making the decision to abandoning clients in a high security risk situation. Such cases call for a heuristic approach where different levels of problem-solving – which can be emotional, moral, rational or professional – are recognised. Self-awareness helps one to make an informed decision about the choice most appropriate for the situation and the professional role.

### Safety and self-awareness

Humanitarian work exposes you to mass suffering and mortality which may create a perception that life has no value, resulting in neglecting self-care and/or taking unnecessary risks. In humanitarian work, the safety imperative (or the absolute priority of safety) refers to the fundamental premise of how we assess risks and prioritise safety for both the beneficiaries and the providers. When existential despair and survivor's guilt sink in, it is very easy to lose perspective and feel that joining the victims is the only moral choice left. This is why I believe that prioritising safety and self-care in all decisions must be regarded as an ethical responsibility that should be included in the professional codes of ethics.

Unsurprisingly, the professional and personal challenges of humanitarian work affect the mental well-being of GMH providers: they often work in physically demanding and unsafe settings where they have to – under duress – make quick and effective decisions that have a high degree of moral ambiguity.

Wessels emphasised the importance of teaching global psychologists the ethical guidance and critical self-reflection that are essential in avoiding contextual insensitivity to issues such as security and the inappropriate use of various methods including lack of humanitarian coordination; culturally inappropriate interventions; an excessive focus on deficits and victimhood (which can undermine empowerment and resilience); the use of unsustainable, short-term approaches that breed dependency and the imposition of outsider approaches (Wessells, 2009).

Emotional over-engagement affects providers' mental health and confounds their decision-making. Training, supervision and peer support are crucial in managing countertransference and in gaining self-awareness about the power differential and biases. It allows one to recognise and avoid ethically questionable practices such as trauma tourism, acting out the rescuer fantasy or the saviour complex and the contextual incongruence or lacking a 'sense of stage' (Arendt, 1983), meaning that some behaviours or statements can appear inappropriate or tone deaf in the context in which it was presented (for

example, see the 'Barbie Savior' Instagram project: <https://www.instagram.com/barbiesavior>).

## Conclusion

The ethical challenges in GMH humanitarian work have consistently demonstrated the limitations of normative ethics in the unprecedented and morally ambiguous situations that providers encounter in abundance. In contrast to reliance on predetermined norms, standards and protocols, a values-based framework allows for establishing the contextual relevance of professional values and suggests which to prioritise when approaching complex problems. The flexibility and situational congruency of this approach comes with a price: it places more responsibility on the provider in the decision-making process and elevates the roles of professional judgement, professional competency and personal integrity.

The time has come for the professional mental health associations to recognise GMH as a specialisation with its own unique scope of services and

core professional competencies and to establish the standards of training, supervision and practice.

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# Community treatment orders: international perspective

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**The use of community treatment orders (CTOs) is available in more than 70 jurisdictions around the world. Although CTOs are used extensively, their effectiveness remains doubtful. We comment on the existing evidence and focus on components that influence the outcomes of CTOs internationally. It is essential to identify factors that affect the delivery of CTOs, and mixed methodologies may improve our understanding regarding their efficiency.**

## International community treatment orders use and outcomes

Community treatment orders (CTOs) were established with the aim of providing treatment to patients under supervision and outside a hospital setting, even involuntarily. The discussion regarding their efficiency has been an ongoing debate in recent years, yet their use is expanding worldwide without enough empirical evidence to support it. Legislative grounds for CTOs have existed for decades in various regions, including Australia, New Zealand, the USA, Asia, Canada, the UK

and Switzerland, but rates of usage and legislation vary. Generally, the administration of CTOs differs with respect to duration, links to treatment, threshold for compulsion and patient admission history (Dawson, 2005). Their similarities lie in the general practice that is followed; a mental health specialist issues the order, the patient is placed on a CTO, and the order is renewed at specific time-frames over several years (Table 1). Therefore, their differing functions, not only internationally but also area by area, make it impossible to compare between studies.

Important reviews, randomised controlled trials (RCTs) and anecdotal evidence suggest no benefits of CTOs in terms of patients' interests, no reduction in relapse rates or hospital bed days, and no improvement in adherence or quality of life (Steadman *et al*, 2001; Burgess *et al*, 2006; Churchill *et al*, 2007; Kisely *et al*, 2011; Burns *et al*, 2013). The OCTET 3 year follow-up found an association between CTO use and engagement with services, but whether this was due to the effects of the CTO or the severe course of the mental illness was not clear (Puntis *et al*, 2017). Rugkåsa and Burns have pointed out that the problematic nature of CTOs on clinical, ethical, legal, economical and professional