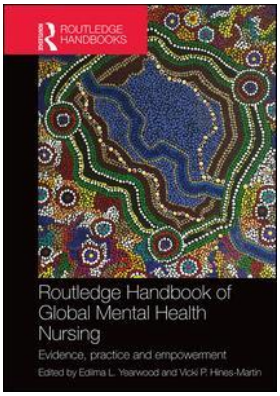

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GLOBAL HEALTH ETHICS AND MENTAL HEALTH

Wendy Austin

Introduction

If ethics is "aiming at the 'good life' with and for others in just institutions," as suggested by philosopher Paul Ricoeur (1992, p. 192), how might we envision ethical action in a global community? What constitutes ethical health care when the moral horizon embraces the entire world? How do health professionals striving to be ethical re-orientate themselves to this broader understanding of their duties and responsibilities? The paramount risks to human health and well-being are now global ones with worldwide effects (Austin, 2001a). The undeniable interconnectedness of the global community, "There is no us and them anymore" (Ward, 2012, p. 6), requires a new way of thinking. The twenty-first century demands a global health ethic.

Within this new ethic, mental health may come "out of the shadows at last" (Kirby & Keon, 2006) and be recognized for its importance to human health and the global society. There is opportunity in this time of change to challenge the devastating discrimination associated with mental disorders that exists worldwide, injures the lives of many, and reaches to the level of governmental policy and funding. Health professionals can play a significant role in such a challenge. They will require an understanding of the language of global health ethics, of the current status of global mental health care, and of pressing ethical issues in the field of mental health. The goal for this chapter is to assist health professionals by identifying core concepts and key trends in global health ethics, relating them to mental health care, and providing some recommendations for action. It opens with an answer to what is global health ethics?

Global health ethics

"Global health ethics" is used with the emphasis on "global" to characterize health ethics issues related to global health phenomena and/or those that require action at a global level (Hunter & Dawson, 2011; Stapleton, Schröder-Bäck, Laaser, Meershoek, & Popa, 2014). Pandemics are a good example of such an issue. Global health ethics is also used with the emphasis on "ethics" to refer to a field of study within bioethics (Hunter & Dawson, 2011). This field's interests are wide-ranging, from health inequities to human cloning. Neither of these conceptualizations of global health ethics, however, fully embraces the reality that the world has become one community, a global village (McLuhan & Powers, 1989). The view from space has dramatically shown us that we reside together with other living things on one small planet.

Globalization is essentially a social process in which the social and cultural aspects of life are no longer powerfully shaped by geographical boundaries and constraints (Waters, 1995). Economic globalization has become a force impacting every nation (Friedman, 1999); the diversity created by the migration of people across the globe is transforming societies (Robertson, 2003). Threats to well-being in one part of the world (e.g., poverty, armed conflicts/terrorism, environmental degradation, political crises, corruption, as well as epidemics) can have significant consequences for others geographically distant. The key question of law—"What rules do we need to promote a peaceful and fair society?"—now requires a global answer (Andorno, 2009, p. 224). The World Economic Forum's *Global Risks* (2013) identifies water and food crises, increased incidence of extreme weather events, severe income disparity, and high un/under-employment as among the top 10 risks facing the global community. These are all threats to human health and health is high on the world's political agenda (Harman, 2012).

A global health ethics is needed that can provide moral guidance to world health systems and governance (Velji & Bryant, 2014). Is it possible, however, to achieve such an ethic given the diversity of human languages and cultures and the disparities in wealth and health? How may the current deficiencies in global governance be overcome? Finding answers will require significant worldwide dialogue and exploration. There are core concepts that are key to the vocabulary of global health ethics and to its evolution. They are introduced in the next section.

Core concepts in global health ethics

Although telecommunication allows us to connect quickly across great distances (at least for those with access), genuinely connecting across the diverse cultural, political, religious, and language differences of the global village remains highly challenging. There are, however, some elements that have significance across diversity and that are serving as components of a framework for a global health ethic. These include human dignity, human rights, social responsibility, social justice, and global health governance.

The universality of human dignity

The fundamental unity of human beings—made scientifically evident by the decoding of the human genome—and the inherent dignity of each member of the human family have been primary assumptions in international rights and ethics documents. Law and ethics scholar, Roberto Andorno (2009) finds that, when paired with human rights (which are grounded upon human dignity), the overarching principle of respect for human dignity provides a practical way to address bioethics issues at a global level. It is the best grounding for international biomedical legal standards. Nevertheless, the notion of "human dignity" is not universally accepted. It is considered by some health ethicists as a "useless concept" because it is "hopelessly vague" (Macklin, 2003, p. 1420). To date, there is no broadly accepted definition of human dignity in the global health ethics literature. Mark Lagon and Anthony Arend (2014), however, have developed a working definition by drawing from the many traditions that acknowledge human dignity: it is "the fundamental agency of human beings to apply their gift to thrive" (p. 16). It rests, they note, on the notions of "agency" (i.e., the capability of achieving one's potential) and "respect" (i.e., recognition that each person has inherent worth and a claim to equal opportunity). For human dignity to be meaningful, they argue, it must be "institutionalized in practice and governance" (Lagon & Arend, 2014, p. 16). Human dignity is fundamental to the concept of human rights.

Human rights

Human rights have become a language that makes engagement across the human community on fundamental issues possible (Ignatieff, 2001). "Human rights" reflect values that are based on the assumption that every human being has natural rights; that is, human individuals can make certain claims based entirely on their humanness (Austin, 2001b). In 1948 the United Nations' (UN) Universal Declaration of Human Rights (UDHR) formalized the recognition of every person's inherent freedom and equality in dignity and rights (UN General Assembly, 1948). The UDHR makes the respecting, protecting, and fulfilling of human rights the responsibility of nation states.

Within the UDHR, health is conceptualized as a right, moving it beyond a narrower medical perspective and emphasizing its social determinants. In Article 25 of the UDHR, the *right to health* is described as:

> The right to a standard of living adequate for the health and well-being of him [or her] and his [or her] family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his [or her] control.
>
> *(UN General Assembly, 1948)*

Once a nation ratifies (i.e., formally approves) the UDHR, it is required to report to the UN on the ways in which it promotes the health of its people. In many respects, the UDHR remains aspirational. Although it is considered binding and nations are to monitor their progress in upholding the rights of their people, it is difficult to hold nations accountable. The UDHR lacks "enforcement machinery" (Benatar, 1998, p. 297). It does have rhetorical force, given that violations of the rights proclaimed within it are imbued with shame (Austin, 2001b).

Additional human rights instruments continue to be created. For instance, the International Covenant on Economic, Social and Cultural Rights (ICESCR) (UN, 1966) addresses not only the "right of everyone to the highest attainable standard of physical and mental health" (Article 12), but the right to many of the social determinants of health, such as an adequate standard of living, education, and social security. Freedoms related to health (e.g., right to be free from non-consensual or degrading treatment) and entitlements (e.g., access to essential medicines; right to have diseases prevented, treated, and controlled; equal and timely access to basic health services) are identified (OHCHR & WHO, 2008). A basic issue with such instruments is that they are not necessarily ratified (i.e. formally approved) by all nations. The United States, for example, signed the ICESCR in 1977, but has never ratified it.

Direct references to the right to health appear in the 1989 Convention on the Rights of the Child (e.g., the right to treatment and rehabilitation facilities; the requirement that states take measures to abolish traditional practices prejudicial to children's health). The 2006 Convention on the Rights of Persons with Disabilities, grounded upon a social model of disability, identifies what societies need to do to address social exclusion and defines the entitlements of persons living with disabilities, including psychosocial disability (UN, 2006). The Universal Declaration of the Human Genome and Human Rights, endorsed by the UN in 1998, addresses such issues as the potential for genetic discrimination and the implications of interventions (e.g., research, treatment, diagnosis) on a person's genome. The fact is that most, perhaps all, human rights instruments are relevant to the right to health: health is dependent on rights fulfillment.

The Declaration of Bioethics and Human Rights

In 2005, the Declaration of Bioethics and Human Rights (DBHR) was developed by the UN's Educational, Scientific and Cultural Organization (UNESCO) (UNESCO, 2005). Created by using principles of bioethics within a human rights framework, it is a legal (but nonbinding) instrument that addresses "ethical issues related to medicine, life sciences and associated technologies as applied to human beings, taking into account their social, legal and environmental dimensions" (UNESCO, 2005, p. 76). Upheld are the equality of all human beings in dignity and rights, their right to be treated justly without discrimination, the solidarity of the human community, and respect for diversity and pluralism. Humanity's interconnection with other living things is addressed along with its role in protecting the environment. There is emphasis on the sharing of scientific and technological benefits and specific goals related to access to quality health care and essential medicines. Reaction to this Declaration has ranged from appreciation of its achievement to profound doubt of its (Andorno, 2009) or any universal declaration's (Benatar, 2005) value. Specific articles are challenged, such as Article 3b, which states that the interest of individuals are of greater importance than the interests of science and society, a claim that is not universally accepted (Landman & Schüklenk, 2005) and that can be perceived as counter to some public health initiatives, like quarantine.

Social responsibility

Responsibility can be defined as "a moral obligation to behave correctly towards or in respect of a person or thing" ("Responsibility," 2014). The concept of social responsibility resides in the belief that individuals, organizations, communities, and governments have an ethical obligation to act in ways that support, not harm the well-being of their society. In a global society, how is social responsibility understood? The *cosmopolitan* perspective considers every individual as a world citizen who has a moral duty to assist others in need without proximity or nationality being a factor. The opposing or *anti-cosmopolitan* perspective regards morality as local and specific, delimited within a culture or community (e.g., a nation), although peaceful co-existence has moral worth (Stapleton *et al.*, 2014).

These perspectives are reflected in approaches to social responsibility known as the *humanitarian approach* and the *statist approach* (Toumi, 2014). The latter is congruent with the anti-cosmopolitan perspective: governments' responsibilities are for the well-being of their own citizens. It is acknowledged that interactions between states can create moral obligations, such as when one state's actions negatively impact the citizens of another (e.g., an oil spill caused by one state's shipping affects the environment of another). There is a "negative duty" not to harm the other, but there can be no expectation (i.e., "positive duty") that one state should help another, such as during a natural disaster. To do so is supererogatory (i.e. charity): no moral duty exists (Toumi, 2014). What is not acknowledged in this approach is the interdependence of contemporary states (Toumi, 2014). In the humanitarian perspective, location is not a factor (Lowry & Schüklenk, 2009). Those who are prosperous and able to do so have a moral obligation (a positive duty) to help those in need, as the dignity and worth (i.e., moral status) of each person is the same. Not acknowledged is the reality of competing interests, exploitive actions, and mutual hostilities that currently occur between nations (Toumi, 2014).

The drowning child in a shallow pond

Moral philosopher, Peter Singer (1997) created a scenario for his students to imagine. One morning on their way to class as they pass a shallow pond, they see a child is drowning.

Do they have any obligation to rescue the child? His students invariably believe that they do: there is no excuse not to do so. Muddy shoes and being late for class are trivial in comparison. Singer points out that everyone is in this position: we can save the lives of distant children at risk of dying of hunger or illness at little cost and no danger to ourselves by contributing to humanitarian aid. Why is this rescue not as morally necessary? Singer's scenario has become a classic metaphor regarding global moral obligation.

Singer's humanitarian position—that those who have "surplus" resources should use them to help those living in poverty—is supported by others like Peter Unger, author of *Living High and Letting Die: Our Illusion of Innocence* (1996), but some reject it entirely (Wisor, 2011). Neera Badhwar (2006), for example, finds the expectations of Singer and Unger to be "incompatible with that which makes life worth living: the pursuit of happiness" (p. 74) and against common sense. But what if we have metaphorically pushed the child into the pond? Thomas Pogge (2002) argues that this is the real case and thus responding with aid is a negative duty. He finds that systemic economic and political strategies have created poverty and that, not only should we harm less but we should help more, given that about one-third of the 18 million human deaths each year are due to preventable, poverty-related causes such as poor nutrition, unsafe water, and lack of vaccines, antibiotics, and other medicines. Globally, severe poverty could be eradicated with little economic cost: the rich half of the world's population would have to make do with 1 percent less of the global household income (96 percent rather than 97 percent). That this does not happen is to Pogge "morally indefensible" (2002, p. 241).

Solidarity

Solidarity has been named as the most important of all values for global health ethics (Benatar, Daar, & Singer, 2003). Without an attitude of unity, caring, and mutual support, it is possible that distant indignities, rights violations, injustices, and disparities will be ignored. A sense of solidarity evolves as we expand our capacity for empathy, that is, our ability to recognize the pain, degradation, and suffering of others and know that it matters to us (Rorty, 1999; Benatar, Daar, & Singer, 2003). The "sentiments of mutual belonging and of shared responsibility for the common future" and the "willingness to find amicable and enduring solutions" to conflicts are essential aspects of human solidarity (Bauman, 2008, p. 250). The sociologist, Zygmunt Bauman (2008) notes that acknowledgement of "the logic of global responsibility" is necessary to the addressing of planet-wide problems, but it takes us to where humankind has never been (2008, p. 252). As well, this necessary but formidable shift in thinking needs to take place in the early twenty-first century at a time when market capitalism is dominating most societies. The corporatization of society—termed "The McDonaldization of society" by sociologist George Ritzer (1993)—supports, at most, non-cosmopolitan approaches to responsibility. The worth of solidarity is negated. It seems that, for the vision of global solidarity among strangers to be realized as called for in the DBHR, the notion of the world as a collection of individual consumers must first be overcome.

Social justice

Social justice is fundamentally "the fair distribution of society's benefits and responsibilities and their consequences" (CNA, 2006, p. 7). Although not made an explicit goal of the UN until 1990, social justice has always been a prime concern, as evidenced in the articles of the UDHR. It needs to be: "Social injustice is killing people on a grand scale" (CSDH, 2008, p. 26). It creates risk for all, leading as it may to serious conflict within and between nations and/or the

impediment of meaningful societal progress. Examination of social justice involves determination of the extent of population disparities, their causes, and potential strategies to eliminate them (CNA, 2006). Poverty is a crucial measure. It is estimated, based on multidimensional measures of poverty that 1.5 billion people in 91 countries live in poverty, along with the associated deprivations in living standards, health, and education (UN Development Programme, 2014). There exists great and rapidly growing economic disparity in the world: "The wealth of the world is divided in two; almost half going to the richest 1 percent; the other half to the remaining 99 percent" (Oxfam, 2014, p. 1). This widening of disparities is a major global trend that threatens social stability within nations, as well as global security (World Economic Forum, 2013). This widening gap between rich and poor is in urgent need of solutions. It underscores the call for international consensus on achieving universal social protection that is the focus of the 2014 UN Development Report.

Health equity

Equity is about fairness and "the just treatment of individuals in their own social context" (CNA, 2006, p. 8). Equity in health is about the fair opportunity to obtain one's full health potential. Although differences in health potential will always exist due to biological causes (e.g., genetics, age, gender), other differentials in health are preventable or remediable. Equity in health care is about "equal access to available care for equal need"; "equal utilization of care for equal need," and "equal quality of care for all" (Whitehead, 1992, p. 221). Inequity in health care is highly visible as when individuals who are members of a high-income population receive prolonged biomedical treatments supported by advanced technology to sustain their lives even when such treatments are of little benefit or futile, while others with less income struggle to meet basic needs or sustain their health (Benatar, 2013).

Addressing inequities in health and health care can be difficult. The Global Strategy of Health for All by the Year 2000, initiated by the World Health Assembly in 1981, failed to achieve its goals. Although the greatest threats to health are poverty, population growth, depletion of natural resources, global warming, and new and emerging infectious diseases, too often an international health approach (i.e., focused predominately on biomedical health care assistance) is taken in addressing health inequities, rather than a global health approach with its focus on health for all (Benatar, 2013). In 2008, the WHO's Commission on the Social Determinants of Health recommended three strategies be implemented for "Closing the Gap" in health equity: "improve daily living conditions"; "tackle inequitable distribution of power, money, and resources"; "measure and understand the problem and assess impact of action" (CSDH, 2008, p. 2).

Research is vital for closing the gap in health equity, but the reality is that significant imbalances and gaps exist in the field of health research itself (Pang, 2011). In 1990 the Commission on Health Research for Development reported results of a worldwide survey of health research, coining the term "10/90 gap" for the disparities found: only 10 per cent of the world's health resources are used for research into 90 per cent of the world's health problems (Ramsay, 2001). A decade later, The Global Forum for Health Research, the worldwide research network created as a response to the report, found that despite total funding increases, the disparities gap remained much the same (Ramsay, 2001). Although the "10/90 gap" is not currently accurate in a quantitative sense, the resources for health research on the needs of low- and middle-income countries remain extremely inadequate (Global Health Forum, 2011). Disparities exist, not only in funding for health, but disparities in access to the benefits of research, opportunities for using research outcomes effectively, and in research capacity development (Pang, 2011). Tikki Pang

(2011), Director of Research and Cooperation at the WHO argues for a new global health research agenda, one guided by key criteria that include: inclusiveness in setting priorities, balance between generation/utilization of knowledge and between new interventions/improvement of health systems, and equitable access to "the fruits of research" (p. 288). To make this agenda a reality will be a matter of good governance (Pang, 2011).

Global governance for health

Global governance for health has evolved over the last three centuries. It has moved from international standards developed to oversee sanitation and trade-related health issues and the work of non-governmental agencies in times of emergencies and conflicts (e.g., International Committee of the Red Cross) to institutions formed at the end of WWII (e.g., the World Health Organization (WHO), other UN agencies like UNICEF, and the World Bank) (Harman, 2012). The WHO has been the primary UN institution overseeing global health, with all nations as members. For global health issues, the WHO has "unrivalled normative authority, global influence, and legal powers" (Sridhar & Gostin, 2014, p. 117).

Governance for global health and global health research, however, increasingly involves complex public–private partnerships, such as The Global Fund, based in Geneva, which includes governments, civil society, and the private sector in a fight to end AIDS, TB and malaria (Harman, 2012). While these new partnerships mobilize awareness, monies, and expertise, they tend to focus predominately on one disease and are responsible only to their funders. Like celebrities, also new actors in global governance for health, they are not the best source for global health agenda setting (Harman, 2012), which requires addressing human resources, global health infrastructure, and the social, economic and environmental determinants of disease (Cooper, Kirton, & Stevenson, 2009). The WHO is having to adapt to a shifting global environment and the reality that health is critically influenced by policies made in other areas, such as environment, trade, and migration (Frenk & Moon, 2013). It may be losing its ability to set the global health agenda (Lidén, 2014).

Julio Frenk and Suerie Moon (2013), experts in global governance for health, identify four essential functions of the global health system: "production of global public goods" (e.g., research and development; standards); "management of externalities across countries" (e.g., surveillance and information sharing); "mobilization of global solidarity" (e.g., financing, technical cooperation); and "stewardship" (priority setting, mutual accountability) (p. 940). Their indicators for good governance in this area are "effectiveness, equity, efficiency in achieving outcomes" along with "credibility and legitimacy" in how decisions are made (Frenk & Moon, 2013, p. 939). A critical issue for current global governance is that there is no global government. The tools for collective action at national levels (e.g., taxation, democratic procedures, law enforcement), for the most part, do not—as yet—exist for the global village (Frenk & Moon, 2013).

Global health diplomacy

With the recognition that political and economic stability requires healthy populations, health has increasingly become a priority in states' foreign policy, security, and trade concerns. This has fostered the WHO's concept of *global health diplomacy*. This form of diplomacy encompasses negotiations about key systemic changes that impact global public health and is based on understanding health as a human right and as global public good. It offers a new lens through which to perceive the landscape of global health and foreign relations (Kickbusch, Novotny, Drager, Silberschmidt, & Alcazar, 2007).

Ethics and global mental health

Consideration of the core concepts of global health ethics in their application to mental health and mental health care allows for a portrait of the current global ethical issues in this area to be created. Thus, human dignity, human rights, social responsibility, social justice, and global governance for health will frame the following discussion of the status of the ethics of global mental health (GMH). Prior to this discussion, however, it is important to note that consensus has not been achieved on the worth of a global approach to mental health. Against the scientific arguments (from human biology, epidemiology, evidence-based medicine) and the ethical arguments (universality of human dignity and rights, health equity) for a global frame of reference in mental health are opposing perspectives that claim GHM primarily supports the expansion of Western psychiatry, medical empiricism, and the pharmaceutical industry (Summerfield, 2012) and/or that mental health is so contingent upon the "local" (i.e., ethno-cultural, social, community aspects) that a global approach is highly inappropriate (Bemme & D'souza, 2014). In their cogent presentation of such arguments regarding GMH, Doerte Bemme and Nicole D'souza (2014) move beyond them to suggest that GMH, conceived as situated within global health (not psychiatry) with a pluralistic vision of knowledge, an understanding of "community" as varying in scale (i.e., local to global), and emphasizing multidisciplinarity, may be explored for meaningful responses to a suffering humanity. The Movement for Global Mental Health (a coalition of institutions and individuals in over 100 countries) stipulates that appropriate mental health services are essential to every prosperous and humane society and that ensuring the rights of persons with mental disorders must become a top priority (Patel, Boyce, Collins, Saxena, & Horton, 2011). Ensuring the right of persons with mental disorders to lives of dignity is fundamental to global health ethics.

Human dignity

Persons with mental health challenges and disorders face—even in high-income countries—social exclusion, violations of their human rights, barriers to accessing effective care, and challenges in sustaining or improving their standard of living. This situation has been called "a global emergency on a par with the greatest human rights scandals" (Patel, 2011, p. 1441) and "a failure of humanity" (Kleinman, 2009, p. 603). Recognition that this failure is fundamentally a matter of ethics will be important to success in addressing it. In fact, Arthur Kleinman, a global mental health expert, argues that it will require a "moral transformation" as it is due to "prejudice, discrimination and lack of political will to commit adequate resources" (Kleinman, 2009, p. 603).

Research on mental health stigma in the global context (across 16 countries) reveals that, even in countries with low overall stigma, prejudice was associated with issues dealing with intimate settings (e.g. the family), vulnerable groups (e.g., children), and self-harm; there was unwillingness to have persons with mental disorders in positions of authority, uneasiness about interactions with them and about potential for violence. The researchers concluded that anti-stigma initiatives need to address tolerance and inclusion at a cultural level (Pescosolido, Medina, Martin, & Long, 2013). This appears to be true within the culture of health care services itself (see Chapter 5 for additional information about stigma).

Many persons with mental disorders, in numbers sufficient to form national and international organizations, call themselves "survivors." They are not referring to surviving their illness, as a person with cancer or cardiac disease may, they are saying that they have survived their treatment and care (Austin, Bergum, & Nuttgens, 2004). Responsive mental health services must evolve

so that the changing needs of persons with mental disorders, from in-patient services for acute symptoms to community support for dealing with life constraints are addressed (Frese, Stanley, Kress, & Vogel-Scibilia, 2001). A review and synthesis of consumer literature (Horsfall, 2003), however, indicates that there is insufficient inclusion of health services requested by persons living with mental disorders and that persons using existing health services feel that professionals define them primarily by their diagnosis (Horsfall, 2003). Quality relationships with helpers is a key concern, as are related concerns of choice, individuality, and information (Edwards, 2000). Users of mental health services want to be heard (Hamilton & Roper, 2006; Happell, Manias, & Roper, 2004) and to be taken seriously (Edwards, 2000). The WHO asserts that primary care for mental health can reduce stigma and discrimination as persons with mental disorders are treated like those with other conditions and see the same health workers. Such commonality affects the perception of mental health problems and disorders by the persons experiencing them, their families and community, and by health workers who have become better educated and experienced in their care and treatment (WHO & Wonca, 2008).

The incarceration of persons with mental disorders in prisons and jails is a serious problem across the globe, with the mentally ill prisoner being doubly stigmatized (Chaimowitz, 2012). Treatment within correctional institutions can be poor or nonexistent. Correctional officers are usually not trained to provide mental health care; and some prisoners with mental disorders may be unable to adjust to a highly structured, rule-driven environment. Too often the strategies available for keeping the mentally ill prisoner safe involve segregation, seclusion, or restraints (Peternelj-Taylor, 2008). Persons with psychosocial disability are made incredibly vulnerable within prisons and jails; they need to be treated by the least restrictive means and their dignity preserved (Okasha, 2004). If societies are judged on their treatment of their most vulnerable members, then the mentally ill person under forensic purview will be a touchstone for evaluating the state of the global society as it evolves.

Embracing human dignity as a true value in global mental health care, rather than as a platitude, has the potential to support mental health professionals to work in genuine partnership with persons with mental disorders, their families and communities. Through mutual respect, the moral transformation called for by Kleinman (2009) can begin to be realized at the grassroots level. To secure the necessary political will to overcome the threats to human dignity from prejudice and discrimination, such stigma may need to be conceived and confronted as a human rights issue (Mehta & Thornicroft, 2014).

Human rights

Health law scholar, Lawrence Gostin (2001) points out that human rights is an important approach to global mental health because it encompasses two fundamental ideas: "human rights is the only source of law that legitimizes international scrutiny of mental health policies and practices within a sovereign country" and "human rights do not rely on government beneficence" (p. 264). As rights are possessed on the basis of one's humanity, a government cannot grant nor deny them but can be made accountable for violations of rights under international law. Gostin proposes that using human rights doctrine is a stronger response to advancing the dignity and welfare of persons with mental (psychosocial) disability than a health approach, as it is enforceable. He underscores three connections between mental health and human rights: human rights can be violated by mental health policies, programs, and practices; mental health is adversely affected by rights violations; and rights and mental health are complementary approaches to a flourishing human life (Gostin, 2001). As well as an instrument for advancing the civil and political rights and freedoms of persons with mental disability (e.g., areas related to liberty, privacy, and

autonomy), human rights can support "the right to health" (Gostin, 2001). As noted previously in this chapter, duties related to upholding economic, social, and cultural rights, including the right to health, are imposed on nations by the ICESCR. For the right to health to be globally generalized, governments who have yet to ratify this covenant will need to do so.

Assistance for governments in developing and adopting strategies to protect the rights of people with mental disorders, particularly through mental health legislation, is provided by WHO through the Mental Health and Human Rights Project. Guidance materials include an international network of experts, a "checklist" for reviewing existing laws, technical support to countries, and a WHO (2005) *Resource Book on Mental Health, Human Rights and Legislation*. The latter is primarily a resource for those working with legislation, but is an excellent resource for health professionals as it includes details of human rights instruments and standards relevant to mental health. Mental health law can enable health policy to be developed, conceptually framed, and enforced, thus helping to ensure

> the establishment of high quality mental health facilities and services; access to quality mental health care; protection of human rights; patients' right to treatment; the development of robust procedural protections; the integration of persons with mental disorders into the community; and promotion of mental health throughout society.
>
> *(WHO, 2005, p. 4)*

Advocacy for the rights of persons living with disability is a global priority, recognized by the UN with the *Convention of the Rights of Persons with Disability* (UN General Assembly, 2007), an explicit acknowledgement of rights to respect, dignity, and an optimal quality of life. From the WHO's perspective, mental disorders are not synonymous with disability but persons with mental disorders may be considered to have a disability if they are experiencing the disorder as a long-term impairment that negatively affects their societal participation because of physiological and/or social constraints (WHO, 2005).

What do human rights mean to persons who have a psychosocial disability? Users of mental health services in low- and middle-income countries, self-identified as having a mental or psychosocial disability, describe human rights as ensuring "basic needs" are met, "human dignity" respected, and "freedom" to have a "decent life" as participants in society are upheld (Drew *et al.*, 2011, p. 1665–6). Their major concerns were identified as lack of access to basic mental health care and "ill treatment and abuse by health workers" (Drew *et al.*, 2011, p. 1664). Alleged human rights violations in mental health care reported to the Office of the United Nation's High Commissioner for Human Rights (OHCHR) include: poor conditions in psychiatric facilities, inadequate nutrition and sanitation, abusive treatment of patients, and persecution of health professionals due to their professional activities (OHCHR & WHO, 2008, p. 39). Further, the Pan American Health Organization (PAHO) finds that problems in psychiatric institutions in many countries involve "completely unregulated involuntary admission of patients"; "little control over the use of physical restraints or isolation of patients"; and "problems with court-ordered confinement of people with supposed mental disorders who have committed unlawful or criminal acts" (PAHO, 2009, p. 7). These are very serious threats to or violations of human rights. Yet, across low-, middle-, and high-income countries, the physical, mental, and emotional abuse of persons with mental disorders in hospitals and social care facilities goes underreported, making it "a hidden human rights emergency" (WHO, 2012,¶1). Such a state of affairs requires an urgent response by governments.

To support effective response, the WHO has initiated "WHO QualityRights: act, unite and empower for mental health" and a "QualityRights Toolkit" to assess and improve care and

human rights in health and social care facilities (O'Hara, 2012). The focus is on five human rights: the right to an adequate standard of living and social protection; enjoyment of the highest attainable standard of physical and mental health; to exercise legal capacity and to personal liberty and the security of person; as well as freedom from torture or cruel, inhumane or degrading treatment or punishment and from exploitation, violence and abuse; and the right to live independently and be included in the community (WHO, 2012, Table 3, ¶2).

In 2013 on Human Rights Day, December 10 another WHO resource for mental health was launched: MINDbank (WHO, n.d.). Part of the Quality Rights initiative, it is an online platform with national and international resources related to mental health, addiction, disability, and human rights. Its purpose is to facilitate dialogue, advocacy, and research that support nations' reform of policies, laws, and service standards so that they are in line with international best practices and human rights.

The global acknowledgement of the grave situation in mental health care with regards to human rights violation and the new resources being developed to enable governments to address them are creating a more hopeful future for persons with mental disorders and their families and for the health professionals who strive to work in partnership with them to provide appropriate quality care.

Social responsibility

Social responsibility in a global society encompasses, at the very least, all of humanity. The Global Health Movement holds the assumption that humanity transcends geographical, statist, cultural boundaries, and that it is a moral imperative to act in response to the prejudice, discrimination, and inequities that threaten the dignity and rights of persons with mental disorders (Bemme & D'souza, 2014). Yet such responsibility may be staggering in its scope. Moral responsibility can be, as Bauman says, "cumbersome, incapacitating, joy-killing," and "insomnogenic" (1993, p. 242). When one recognizes the depth and span of social injustice, it can be "deeply unsettling," and "disorientating" (Harbin, 2014, p. 162). The philosopher, Ami Harbin (2014) points out that when responsibilities are very complex, require moral action at many levels, and when there is no assurance that a sufficient response exists, the ordinary agent may be overwhelmed and lose motivation to act. But disorientation does not need to overwhelm, she argues, when one can identify projects suiting one's capabilities, learn how to negotiate calls to act, and discover how to sustain one's motivation for doing so.

It may be that accepting the essential messiness of the ethical demand is a necessary wisdom, particularly for the global citizen. That wisdom and the knowledge that social responsibility is about interdependence and collectivity may sustain health professionals as they attempt to respond locally to global social injustice. They possess the asset of being experienced agents of social change. For example, nursing, like other health professions with a fiduciary (faithful) relationship with the public, has always held social responsibility as an obligation (Tyer-Viola *et al.*, 2009).

A tool for health professionals who are resisting disorientation at the extent of mental health injustices is Iris Young's (2006) social connection model of responsibility. Responsibility in this model is delineated by virtue of social roles (e.g., nurse, teacher, physician, citizen) and understood as shared with others. Young advises individuals to reflect upon structural injustices (i.e., morally unacceptable conditions) and decide what they can do. She offers a guide to such reflection: consideration of *interest*, *power*, *privilege*, and *collective ability*. One needs to choose where one's interest for action most strongly lies. What injustice seems most urgent to remedy? It might be the lack of mental health literacy in one's community or the need for housing for

persons with a severe and persistent mental disorder. Both are global issues that can be impacted by local actions. What is one's potential to influence or effect positive change in this chosen interest? While a celebrity like Bono (singer and rock music group lead) is able to meet with world leaders and Angelina Jolie (movie star) can access the media to speak to millions, an individual health professional's options—writing a letter to the editor of a local or national newspaper, addressing the members of one's professional organization, contacting a government representative, or joining others to act collectively—may be more limited but can still be effective in making a difference. In what way is one privileged, that is, able to act without deprivation or negative consequences? For example, has one's education provided the knowledge and skills to support persons with psychosocial disability and their families to act themselves to effect change? Is a particular issue of injustice more readily addressed than another due to one's existing roles, connections, influence, or organizational membership? A group of nurse educators in a high-income country, for example, may be able to partner with nurse educators in a low- or middle-income county to assist them in developing particular mental health skills, resources, or research and, in turn, learn from them about their situation and challenges. This social connection approach can be a platform for health professionals to act on their social responsibility for mental health in a realistic, sustainable, and hopeful way.

Social justice

Mental, neurological, and substance (MNS) disorders are estimated, using the 2010 Global Burden of Disease (GBD) data, to be the leading cause of Years-Lived-with-Disability (Whiteford *et al.*, 2013). The GBD is an economic parameter calculated using the DALY (disability-adjusted-life-year), a measure of years of life lost to premature death and to time lived without full health (Murray & Lopez, 1996). Because mental health problems and disorders are nearly invisible when mortality rate is the statistic used, the GBD has been of major import in measuring the true toll of mental disorders in national and global contexts (Desjarlais, Eisenberg, Good, & Kleinman, 1995). It is now known that MNS disorders contribute nearly 14 percent of the GBD (Kleinman, 2013). The startling fact remains, however, that MNS disorders still receive less than 1 percent of health care services funding in most low- and middle-income countries, The *mental health treatment gap* (i.e., the difference between the prevalence of a disorder and the proportion of persons with it who receive treatment) remains large, even in high-income countries, where it is estimated that only one-third of persons with mood disorders get treated; in low-income countries the estimate is 1 in 10 (Eaton, De Silva, Rojas, & Patel, 2014).

The degree and effect of insufficient resources can be seen by examining a core component of mental health care—human resources. When the human resources for mental health were analyzed in 58 low- and middle-income countries, all but three had insufficient numbers of nurses in mental health settings and 93 percent of low-income countries and 59 percent of middle-income countries had a shortage of psychiatrists (Scheffler, 2011). Often those working in mental health services lack training in psychiatric clinical skills and ethics, making quality of care a serious problem (Kleinman, 2013). Investment in the global mental health workforce is urgently needed and represents a significant gap that must be addressed.

Unfortunately, mental health remains at the bottom of public health priorities everywhere, its importance unrecognized by policy makers, funders, and the public, mainly due to the stigma associated with mental illness (Caldas de Almeida, Minas, & Cayetano, 2014). Along with this substantial barrier and lack of trained workforce, other barriers to progress on just access to humane, effective mental health care include: the "complexity of and resistance to decentralization of mental health services," challenges to mental health integration into primary care

settings, and insufficient public health perspectives in mental health leadership (Saraceno *et al.*, 2007, p. 1164).

According to the WHO, health systems must strive to meet legitimate expectations on the non-health aspects of health care across the domains of dignity, prompt attention, autonomy, choice of health care provider, clear communication, confidentiality, quality of basic amenities, and access to social support networks. Although *responsiveness* is highly relevant to mental health care services because of the "specific dependency and vulnerability" of its users, (Bramesfeld, Klippel, Seidel, Schwartz, & Dierks, 2007, p. 880), it may be a greater challenge to achieve there than anywhere else, given the prevailing barriers to care.

The increased vulnerability of users of mental health services is related not only to the devastating effect of mental health problems and mental disorders, and the associated stigma, but often also due to poverty. Poverty appears to be both a determinant and a consequence of poor mental health. Vijaya Murali & Femi Oyebode (2004) note that psychiatric conditions occur at higher rates in the world's poorest, with unemployment significantly increasing the risk for psychiatric disorders. There is epidemiological evidence that an inverse relationship exists globally between social class and mental illness. The reasons for this may be the downward social drift caused by the consequences of having a mental disorder; that the socio-economic adversity of lower-class living precipitates mental illness; or that persons from the lower social class have less mental health literacy and/or less access to effective treatment and services compared to those in higher social classes (Murali & Oyebode, 2004). There is evidence that "low education, food insecurity, inadequate housing, low social class, low socio-economic status and financial stress" are positively correlated with some mental disorders (e.g., depression, anxiety disorders) (Lund, 2014, p. 136).

The neglect of mental health in the global health arena is so extreme as to be unconscionable. It is noteworthy that Sophie Harman in her work, *Global Health Governance* (2012), when arguing that issues like HIV/AIDS and pandemic flu dominate global health to the neglect of other health priorities, fails to even mention mental health in her chapter, "Neglected Health." Despite the WHO slogan, "there is no health without mental health," authentic acceptance of this fact continues to be elusive. Indeed, it was in 1948 that the WHO's first director, Dr Brock Chisholm, a psychiatrist, stipulated that without mental health there is no true physical health (Kolappa, Henderson, & Kishore, 2013). Although it can be challenging to remain optimistic regarding positive change in this arena, strong and effective global governance for health offers a pathway to hope.

Global governance for health

Barriers to actualizing ethical, quality mental health care across the globe can seem insurmountable. However, much will be accomplished if the WHO Mental Health Action Plan 2013–2020 is fully enacted and its objectives met. These objectives involve strengthening leadership and governance; providing comprehensive, integrated, and responsive mental health and social care in community-based settings; implementing promotion and prevention in mental health; and strengthening information systems, evidence, and research (WHO, 2013). In the last two decades, resources have been created that can support the Action Plan, including *The World Health Report 2001: Mental Health: New Understanding, New Hope* (WHO, 2001); mhGAP intervention guidelines (WHO, 2010); informed calls for action by world experts in mental health (see *The Lancet* series on global mental health in 2007, 2011); the Grand Challenges in Mental Health research initiative (Collins *et al.*, 2011, 2013); and the Movement for Global Mental Health (Patel *et al.*, 2011). A major factor will be whether or not mental

health is included in the post-2015 Sustainable Development Goals and whether governments commit to increased mental health budgets, particularly human resources (Lund, 2014). Ultimately, it will be political will and public advocacy that will determine the global governance for health's response to the emergency of failing mental health care.

Recommendations to health professionals

Develop a global state of mind

Crucial to global health ethics is "a global state of mind about the world and our place in it" (Benatar *et al.*, 2003, p. 129). This will require imagination. The philosopher, Charles Taylor (2004) explains that the social imaginary (i.e., the way one's life with others is perceived) is shaped by myths, tales, and images: what is (and is not) encountered in books, the press, and other media shapes how individuals understand their place in the world. These influences on social life will affect how (or if) a global society is envisioned. It may be pictured as individual consumers residing in a global shopping center or as global citizens living in an interconnected world. Metaphors are central to imaginative thinking. They allow perceptions to shift and the self and world to be seen in new ways (Lakoff & Johnson, 2003). The "global village" of Marshall McLuhan, for instance, suggests a re-vision of the world as local space (McLuhan & Powers, 1989). Imagined as a moral community that is evolving to become harmonious and just, the global village has possibilities as a healthy and safe home. People can come together, in the words of Richard Rorty in *Philosophy and Social Hope* (2003), through "an image of themselves as part of a great human adventure, one carried out on a global scale" (pp. 238–239), he was writing, however, about democracy.

Re-orientate one's vision of health and health ethics to encompass the global community

A global attitude to health and health ethics is necessary if they are to be understood in their full context. Questions need to be raised about what changes for ethical practice when "global" becomes a significant frame of reference (Austin, 2001a). What will it mean for resource allocation? For service delivery? For health systems development? This global attitude brings an expansion of moral responsibility. Fortunately, such responsibility is shared and trans-disciplinary in nature. It can be acted upon locally. And the basis of a global attitude is foundational to the health disciplines: ethical care is without discrimination related to race, religion, politics, gender, age, or other such attributes. It is moral space that is changing for health professionals, not values.

Raise consciousness of all regarding dignity and human rights in health care

Attentiveness to the dignity of all persons does much to support equality and to prevent or overcome discrimination in health care. This is particularly important in mental health due to the extensive prejudice and discrimination that can be the most devastating aspect of a psychiatric diagnosis. The promotion of right to health can be accomplished by helping patients/families and colleagues understand their rights, by helping the public to query and monitor health systems and services, and by influencing policy development through proactive contributions and critique and the mobilizing of professional associations (Austin, 2001b). Rights can be protected by health professionals through identification, documentation, and testimony about

rights violations. Such action, however, can be dangerous. Health workers have been attacked for treatment and care of politically unpopular groups or for witnessing human rights violations. In 2013, for example, the UN Human Rights Council was called upon by the Safeguarding Health in Conflict Coalition, and other human rights groups to strengthen documentation and accountability for attacks on health workers, an increasing phenomenon (Physicians for Human Rights, 2013). One can keep informed and contribute support for human rights through groups such as Physicians for Human Rights, Global Lawyers and Physicians, and Human Rights Watch.

Acquire and/or contribute to capacity building for global health ethics

Knowledge regarding human rights, particularly as related to health, is necessary if one is to competently play a part in advocating for those with rights at risk. The need for education for global citizenship in the health disciplines is increasingly recognized, with considerable agreement existing in relation to the necessary competences. Actualization of such education, however, is not as common. A Brazilian study of nurse educators found that, while there was agreement about competencies to be included in global citizen curricula—"GBD," "health implications of migration, travel, and displacement," "social and environmental determinants of health," "health care in low-resource settings," "health as a human right and development resource," and "globalization of health and health care"—inclusion was not necessarily occurring (Ventura *et al.*, 2014, p. 182). Yet, if local and global health realities are to be transformed, the nascent clinician must be prepared for practice in a globalized world (Ventura *et al.*, 2014).

One popular strategy in the education of health professionals, particularly in high-income countries is the practicum abroad. Although this strategy can prove highly educational, it can be "morally problematic" (Dwyer, 2011, p. 325). Students may be ill prepared, stay for too brief a time, and disrupt the host health care system rather than benefit it (Dwyer, 2011). James Dwyer offers some points for reflection by students considering an out-of-country experience, including: knowledge of the language used in host region; knowledge of its history, culture, and social structures; appropriateness of length-of-stay and of their stage of training; the worth of the proposed project (a respectful partnership?; benefits and burdens fairly shared?); and motivation for going (2011, pp. 325–326). He raises an important question: Are there ways at home to promote global health? (2011, p. 326). Also helpful is Andrew Pinto's and Ross Upshur's (2009) global health ethics framework for educators of students going abroad for experience in a developing nation: the principles of humility (e.g., recognize own limitations); introspection (e.g., examination of motives, privileges); solidarity (e.g., consider the "global commons" and "global health goods); and social justice (e.g., equity, human rights, and the forces of globalization) (pp. 7–9).

Reflect upon your social responsibility as a health professional in a global community

What social injustices and health inequities inspire you to act? Consider this interest realistically and determine your best options for acting upon it. What group, association, or community offers a potential collective for activating your chosen action or project? If your talents, privileges, and connections are in the mental health arena, not only are there a myriad of injustices requiring remedy, but the time is ripe for change. There is opportunity to be part of a moral movement that will advocate for policies, funds, and sustainable programs in mental health, and for the research to support them (Kleinman, 2013).

Conclusion

The questions posed at the onset of the chapter—How might we envision ethical action in a global community? What constitutes ethical health care when the moral horizon embraces the entire world? How do health professionals striving to be ethical re-orientate themselves to this broader understanding of their duties and responsibilities?—remain open. They are questions humankind has not raised before and we will need to live through to the answers.

Some of the key concepts of a global health ethic, such as human dignity and human rights can appear to be too vague to be very useful. Yet most people intuit their meaning and understand their worth to human lives. These concepts form a basis for global dialogue. The DBHR, as imperfect as it is, offers a beginning and a basis for conversation about health ethics within a global society. The vision of a just world in this landmark document calls for respect and concern regarding "the interconnection between human beings and other forms of life," and our role in "the protection of the environment, the biosphere, and biodiversity" (UNESCO, 2005, Article 17).

Is there any reasonable basis for optimism that a just, harmonious, and healthy society is in the future of our planet? James Orbinski (2009), in his work *An Imperfect Offering: Humanitarian Action in the Twenty-First Century*, notes that he is frequently asked: "Are you still optimistic about the future?"; "How can you still have hope?"; and "What can we do?" His answer, learned from the writings of Vaclav Havel, former president of Czechoslovakia is: "While I am sometimes optimistic, I always try to be hopeful" (2009, p. 397). Orbinski concludes that, "Concretely, the most important thing we can do is actively and pragmatically assume our responsibility as citizens for the world in which we live" (2009, p. 400). This is what is demanded of the contemporary, ethical, mental health professional.

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