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Avoidable Ignorance and the Politics and Ethics of Whistleblowing in Mental Health

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Abstract

Ethical obligations of professionals require minimizing avoidable harms, if necessary, by bringing these to the attention of others; there is a duty to know and to act -- a duty to "blow the whistle." There is a duty to be politically active in challenging sources of authority such as administrators who compromise client safety. Harming in the name of helping occurs in all helping professions. Harms often continue because of a lack of due diligence to discover harms (culpable ignorance) and reluctance to act to try to prevent them. Examples include avoidable misunderstandings regarding the causes of client concerns, and resulting recommendations of ineffective and/or harmful assessment, intervention, and evaluation methods. Marketing efforts of corporations, organizations, and professional education programs involved in the mental health industry may mislead rather than inform professionals and clients about how to minimize harms, resulting in avoidable miseries often by imposed secrecy. Suggested preconditions for whistleblowing include caring, empathy, moral courage, critical thinking values, skills and knowledge, and assertion and emotion management skills. Contributors to success are described as well as potential negative consequences for whistle-blowers. Creation of a client-focused culture is suggested as a remedy, together with cultivation of a moral compass that minimizes culpable ignorance. Valuable websites and other sources of guidance are noted.

Whistleblowing involves efforts to make transparent and alter what someone or some group views as a harmful practice, policy, and/or law including use of misleading assessment, intervention, and evaluation methods and bogus claims in research reports. Every profession has a history of harming in the name of helping, both avoidable and not, encouraged by false claims regarding effectiveness and misuse of funds that contribute to harm. Ethical obligations of professionals to help, to avoid harm, and to involve clients as informed participants make whistleblowing a key responsibility of all those involved in the helping professions including educators, researchers, administrators, policy and advocacy organizations, and practitioners. Legal regulations may also apply.

The need for whistleblowing includes situations in which ineffective and/or harmful services are offered and effective services are not provided. Wrongdoing may include stealing, waste, mismanagement, avoidable safety problems, sexual harassment, and unfair discrimination (Miceli & Near, 1992). Whistleblowers bring to other's attention practices and policies of their employing organizations they believe to be "illegal, inefficient, immoral or unethical" (Perruci, Anderson, Schendel, & Trachtman, 1980, p. 149) including waste (Shrank, Rogstad, & Parekh, 2019). Services offered may not match requirements for successful implementation of a practice and/or policy. It is estimated that 20 to 50 percent of healthcare services in the United States are inappropriate (Ioannidis, Stuart, Brownlee, & Strite, 2017). Examples of harmful omissions include failure to provide follow-up services and failure to involve clients as informed participants (e.g., Antidepressant Withdrawal, 2018; Davies & Read, 2018). Underuse of effective interventions and overuse of ineffective ones are common (Hochman, 2014; Prasad & Ioannidis, 2014). The history of psychiatry includes inflicting various forms of confinement, overmedication, and torture, including unnecessary removal of teeth and intestines from depressed women (Scull, 2005; 2015). Harmful administrative practices including stonewalling when confronted with clear evidence of harming in the name of helping.

For occasions calling for whistleblowing, we can ask how many are acted on compared to how many are ignored and, to what effect on clients? We can explore who knew what and when. For each, we can ask how much money is wasted on views that diminish rather than contribute to quality of life for clients? For each, we can ask which ones are in play in my agency/professional educational setting? If in play, do they harm clients, for example, by providing inaccurate views of client problems and related hoped-for outcomes and how they can be achieved? Motivation for whistleblowing may include integrity, altruism/public safety, minimizing injustice, and/or self-preservation (Kesselheim, Studdert, & Mello, 2010).

Wikipedia defines a whistleblower as “a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organization that is either private or public” and cites Vandekerckhove (2006). Near and Miceli (1985) define whistleblowing as “the disclosure by organizational members (former or current) of illegal, immoral, or illegitimate practices under the control of their employers to persons or organizations that may be able to effect action” (p. 4). It is a form of criticism and thus subject to common reactions to criticism, including denial. As Santaro and Kumar (2018) note, “whistleblowing in its historical origin is a form of fearless speech [parrhesia] that disclosed misdeeds in governments and organizations” (p. 14); It ‘shares with parrhesia the moral ideals of truth-telling, courage, non-compulsion, sense of duty, and helping others” (p. 15). Whistleblowing may be internal (within an organization) and/or external (reports outside of an organization such as to a newspaper). It can be viewed as a kind of client advocacy (Green & Latting, 2003). Some reserve the term only for external revelations. Miceli, Dreyfus, and Near (2014) use the term “bell-ringers” to refer to “individuals who are not now and never were members of an organization” (p. 71) to distinguish such people from whistleblowers. I use the term to refer to either source.

Whistleblowers bring to others’ attention policies and practices they view as harmful. These are often in direct contradiction to the professed goals of an agency as illustrated by institutional corruption:

> “Institutional corruption is manifest when there is a systemic and strategic influence which is legal, or even currently ethical, that undermines the institution’s effectiveness by diverting it from its purpose or weakening its ability to achieve its purpose, including, to the extent relevant to its purpose, weakening either the public’s trust in that institution or the institution’s inherent trustworthiness” (Lessig, 2013, p. 2).

Lessig (2018) argues that academic corruption now flourishes because of the influence of money. Revenue maximization policies initiated by state legislators, and facilitated by large corporations, are a striking example of institutional corruption in child welfare, including diversion of funds from foster children to run state government (Hatcher, 2016). Only through whistleblowing may harms, frauds, scams, and related propaganda ploys be revealed and stopped (Dukes, Braithwaite, & Moloney, 2014). Jaydeen Vicente, a former Eli Lilly sales representative, described years of what she said were illegal Zyprexa [an antipsychotic] marketing efforts regarding sedation of unruly nursing home patients to save nursing time and effort, and the treatment of disruptive children (Harris & Berenson, 2009). Lawsuits may be necessary to stop harmful practices such as overmedication of children in foster care

(Kessel, Guinto, Ciccone, & Gewargis, 2019). Clearly, good intentions and professional degrees are not enough to avoid harm.

Journalists often reveal harmful practices and policies (Levy, 2003, 2004). Former users of mental health services have been active in documenting harms (Whitaker, 2010; Whitaker & Cosgrove, 2015). Moran (1998) argues that the essence of science is whistleblowing; long held beliefs are often shown to be inaccurate. Consider critiques of accepted but harmful practices (Hochman, 2014) including giving infants oxygen at birth resulting in the blinding of thousands of infants (Silverman, 1980). Individual practitioners/academics may mount a concerted effort to blow the whistle about practices they view as harmful as illustrated by the decades long publications of Szasz (1961, 2007), recent publications by Moncrieff (2008a, 2008b) and the work of Kirk and his colleagues (e.g., Kirk, Gomory, & Cohen, 2013).

Promotion of pseudoscience in social work, psychology, and psychiatry has been critiqued (Jacobson, Foxx, & Mulich, 2016; Lilienfeld, Lynn, & Lohr, 2015; Thyer & Pignotti, 2013). Organizations such as ProPublica are active in revealing avoidable harms. (See also National Whistleblower Center (NWC); Critical Psychiatry Network, http://www.criticalpsychiatry.co.uk, Reveal Center for Investigation Reporting, http://www.revealnews.org; PharmedOut; Speaking Up For Science [2018]). Whistleblowers play a key role in exposing data fabrication and predatory journals (http://retractionwatch.com). Efforts to silence scientists both within and outside of scholarly contexts are common (Bauer, 2004). Over the past decades, greater attention has been given to blowing the whistle on flawed publications, scientific misconduct, and waste regarding research (Ioannidis, 2005, 2016; Young, Ledford, Van Noorden, 2013). The process of evidence-based practice is a form of whistleblowing in terms of emphasizing the importance of critically appraising claims that affect clients' lives (Gambrill, 2019; Straus, Glasziou, Richardson, & Haynes, 2011).

> Whistleblower disclosures can save lives as well as taxpayer dollars. They play a critical role in keeping our Government honest, efficient, and accountable. Recognizing that whistleblowers root out waste, fraud, and abuse, and protect public health and safety, federal laws strongly encourage employees to disclose wrongdoing (National Science Foundation, n.d.).

Whistleblowing and Ignorance: Intimate Companions

Whistleblowing is about making the veiled transparent; it is closely tied to ignorance, both culpable (Smith, 1983; Medina, 2013) and not. Examples of avoidable ignorance in mental health include outcomes of practices and policies (exactly what is done and to what effect) and errors/mistakes, their frequency, causes, and consequences. For example mental health agencies rarely (if ever) clearly describe the track record of their agency in addressing client problems on their website. The term "agnotology" refers to the cultural production of ignorance (Proctor & Schiebinger, 2007). The field of agnotology, also referred to as the sociology of ignorance, highlights the social construction of ignorance, for example by the creation of doubt and censorship. Uncertainties related to ignorance may be avoidable or not. They may be related to many factors including error and limitations of knowledge (Smithson, 1989). The term "forbidden knowledge" refers to "knowledge considered too sensitive, dangerous, or taboo to produce" (Kempner, Merz, & Bosk, 2011, p. 476).

Hiding vital information is often carefully planned and maintained; it is strategic – used to hide harms on the part of individuals who, and/or organizations which, benefit from maintaining secrecy (McGoey, 2007; 2012). This may be encouraged by: media neglect; misleading publications in the professional literature; administrative practices and policies and related lapses; lack of critical thinking, knowledge, skills, and values; and a disregard for epistemic responsibility. Whistleblowing was never mentioned in my education as a social worker and psychologist; this seems to be one of the taboo topics in professional education programs. A lens of ignorance invites us to ask: "What important questions remain unanswered?" "What are important uncertainties?" "What practices and policies are in need of whistleblowing?" Ignorance may be avoidable or not. It may matter or not in terms of harm to clients. What are the sources and kinds of avoidable ignorance concerning "mental health" practices and policies that harm clients? Who are its promoters and what are their methods?

Socially constructed ignorance influences risk to clients in many ways including making decisions based on inaccurate claims about the effectiveness of assessment, intervention, and/or evaluation methods and allowing avoidable harms to continue. Contraindicated interventions may be used and effective methods overlooked. McGoey (2007) argues that strategic ignorance helps regulating agencies to avoid carrying out their key functions. In the helping professions, our guard may be down for deception; who would promote policies and practices that harm vulnerable people? Causes of avoidable ignorance include clashes between professionals' interest to keep a job and client interests (receiving valuable services) and lack of skills in critically appraising claims and related

evidence (Ioannidis, Stuart, Brownlee, & Strit, 2017). Flaws in the peer-reviewed literature as well as out-of-date texts used in professional education programs contribute to avoidable ignorance (Gray, 2001; Ioannidis, 2016). Causes of information avoidance include minimizing challenges to existing beliefs, time needed, and biases such as risk and regret aversion (Golman, Hagmann, & Loewenstein, 2017).

Active Ignorance

To be “active,” Golman et al. (2017) suggest two criteria: (1) we must be aware that the information is available, and (2) have free access to the information or avoid the information even if we have free access to it. Codes of ethics obligate those involved in helping professions to "know about" harms and to take action. However, many do not; there is a disconnect between what should be done and what is done. Under the heading, “The Sound of Silence” (p. 79), Ash (2016) describes the results of a survey of 1400 managers and 200 other employees across a variety of organizations and sectors.

> “(This) did not paint a hopeful picture of the ethical climate of those private and public sector organizations. Half of those surveyed had observed misconduct; one third did not report it, mostly because they did not think anything would be done about it, or because they believed they would suffer reprisal if they did… One in five respondents did not expect their organization to treat people fairly; this lack of trust and avoidance of accountability were seen as the key blocks to organizational development and change. And four out of ten said there was a disconnect between the public values of the company and its real time behavior towards its employees and its business” (Lucy, Poorkavoos, & Wellbelove, 2014).

Medina (2013) suggests three epistemic vices that support active ignorance: epistemic arrogance, laziness, and, closed-mindedness. Epistemic arrogance refers to a cognitive-superiority complex in which we assume we are entitled to credibility. As he notes, this makes it difficult or impossible to learn from mistakes and to learn about biases and/or assumptions.

> “The epistemic vices of arrogance, laziness, and closed-mindedness greatly contribute to the production of a particular form of ignorance: *active ignorance*, an ignorance that occurs with the active participation of the subject and with a battery of defense mechanisms, an ignorance that is not easy to undo and correct, for this requires

> retraining—the reconfiguration of epistemic attitudes and habits—as well as social change. Those who are epistemically arrogant, lazy and closed-minded are *actively ignorant*. Actively ignorant subjects are those who can be blamed not just for lacking particular pieces of knowledge, but also for having epistemic attitudes and habits that contribute to create and maintain bodies of ignorance. These subjects are at fault for their complicity (often unconscious and involuntary) with epistemic injustices that support and contribute to situations of oppression" (Medina, 2013, p. 39).

Propaganda: Integral to the Promotion of Avoidable Ignorance

The term "propaganda" refers to encouraging beliefs and actions with the least thought possible (Ellul, 1965). It encourages and creates avoidable ignorance via censorship, distortion, creation of confusion, distraction, and fabrication (Gambrill, 2012). Many harms are hidden by obscure language, a key form of propaganda (Orwell, 1958). For any harm for which whistleblowing is called for, we can examine strategies used to hide it including hiding information that if made public, could decrease purchase of a product such as a mental health service. We can use Rank's (1984) four-part analysis to identify the kinds of propaganda used such as hiding the harms of an intervention and exaggerating the benefits. Examples of propaganda strategies used to hide sexual grooming of young girls in Rotherham, England included refusal to acknowledge, discrediting the source, doublespeak, and bullying (Ash, 2016, p. 90-91).

Missing or vague data regarding what is done and to what effect (lack of transparency) is a key source of the need for whistleblowing. For example, websites of agencies rarely give specific details regarding the evidentiary status of services offered, with what fidelity they are offered, and to what effect (censorship). The evidentiary status of claims is often misrepresented (e.g., claims of effectiveness are not warranted because of distortion and fabrication), for example. Accurate descriptions of such information are needed to involve clients as informed participants. There are increasing revelations of bogus claims in the peer-reviewed literature, including systematic reviews (Ioannidis, 2005, 2016). Examples include reversals of established medical practices (Prasad, Cifu, & Ioannidis, 2012) and bogus claims of effectiveness (e.g., of antidepressants, Ioannidis, 2008). (See http://retractionwatch.com.)

The Context

Only by considering the interlinked participants and related contingencies involved in harming clients in the name of helping in the mental health industry – only by understanding the "big picture" – may practices, policies, and related legislation that negatively affect client welfare be identified and informed plans made to try to minimize harms. Perruci and his colleagues (1980) view whistleblowing as "an act of collective opposition to authority taking place within a context of political conflict" (p. 149). There is a "resistance to organizational authority" (p. 149). Secrecy is a key method used by bureaucrats to create and maintain authority (Weber, 1922/1985). As Bok (1981) points out, authoritarian regimes may regard dissent of any form, including policy differences, as whistleblowing, rendering whistleblowing an often heroic practice. Whistleblowing is a subversive activity in mental health agencies in which provision of effective services is not pursued as a top priority (Olsson, 2016). Administrators may use (and have used) their power to force whistleblowers to undergo psychiatric examinations (Kenny, Fotaki, & Scriver, 2019). Silence in the face of avoidable harm because of loyalty to an organization contributes to institutional corruption in which an agency loses sight of its professed goal – to help clients. Encouraging disparate views is needed to counter biases such as groupthink (Dungan, Waytz, & Young, 2015).

The mental health industry is a multi-billion dollar one including psychiatric hospitals, outpatient addiction and mental health centers, the pharmaceutical industry (the most lucrative), the professional education industry, advocacy groups, research centers, think tanks, and regulatory and licensing agencies (http://IBISWorld.com; Levine, 2017). Revenues are "projected to increase from $147 billion in 2009 to $239 billion in 2020" (SAMHSA Spending Projections, 2010-2020, p. 18). The mental health, poverty, and child welfare industries overlap. The addiction treatment industry is estimated to be $35 billion (Munro, 2013; SAMHSA, 2014). This includes residential centers, outpatient treatment centers, and services by individual practitioners. Residential psychiatric facilities for youth and nursing homes are multimillion-dollar businesses.

Profit making is a key aim of for-profit, and many (supposedly) nonprofit organizations in the mental health industry. Concern for profit rather than service is reflected in the mistreatment of clients in order to make money such as use of excessive restraints, unneeded medication and hospitalization, and lack of effective services (U.S. Government Accountability Office, 2014). Regulatory agencies may fail to guard the gate including ill-advised approval of psychotropic medications encouraged by conflicts of interest, including involvement of researchers who receive money from pharmaceutical

companies (Dukes, Braithwaite, & Molony, 2015; Gotzsche, 2013; McGoey, 2007). Professional education may miseducate (Lacasse & Gomory, 2003). The sheer size and economics of the mental health industry pose a formidable obstacle to transparency. Included in the industry are research centers, individual researchers, publishers, publications, both for-profit and not-for-profit agencies, think tanks, advocacy groups, foundations, professional education programs, governmental regulators, and oversight agencies. Given the extensiveness of the mental health industry, practices and policies in need of whistleblowing may occur in multiple sites. In each case we can ask, "Is there more good than harm done and is it possible to increase the good and to decrease the harm and, for every dollar spent, how much actually contributes to the well-being of clients and how can we improve this amount?" Administrative policies and practices influence what is shared and what is not.

Examples of Whistle-blowing in Mental Health

Under the provisions of the Federal False Claims Act (1846), any citizen can request the U.S. Government to begin an investigation given concerns about how government funds are attained or being used. This may include contracts that were bid illegally, kickbacks, selling of defective products, and overcharging the state or federal government (Kohn, 2017). Later amendments allow whistleblowers to file confidentially and provide financial awards following successful suits (Kohn, 2017). Billions of dollars are obtained each year under this Act, including from providers of mental health care – $53 billion in 2016. Most states also have false claims statutes (http://wikipedia.org; Kohn, 2017). Examples of successful fraud allegations brought under The False Claims Act include:

- $7 million ruling against Region 8 Mental Health Services by Department of Justice, U.S. Attorney's Office, Southern District of Mississippi, December 14, 2017, http://www.justice.gov/
- New London Psychiatrist and Mental Health Clinic pay over $3.3 million to Settle False Claims Act Allegations, U.S. Attorney's Office, District of Connecticut, Department of Justice, March 15, 2019
- Whistleblower case against Oxford County Mental Health Services in Maine brought under The False Claims Act, Maine's Whistleblower Protection Act and the Human Rights Act because of failing to update patient's care plans, lack of access to counseling, or other necessary services listed in their care plans (Berger Montague, n.d.)

- False Claims Act lawsuit brought against South Bay Mental Health Center, Inc., Massachusetts for overbilling and using unlicensed and unsupervised personnel (Turcotte & Hutcheson, 2018).

Misleading problem framing, offering harmful or ineffective methods and not providing effective ones call for whistleblowing.

Misleading Problem Framing

There are great stakes in how problems are framed, and people with vested interests devote considerable time, money, and effort to influence what others believe (Loeske, 1999). Selection of assessment and intervention methods is influenced by how problems are framed. Problem framing is controversial and professionals have an obligation to be accurately informed about the evidentiary status of related claims. Sociological, psychological, medical, behavioural, and integrative views compete for attention influenced by special interests of involved industries including the pharmaceutical industry, the psychiatry industry, the counseling industry, the assessment industry, and the professional education industry (e.g., Gambrill, 2012). Sociologists emphasize the social construction of problems—the framing of political concerns such as equality of rights and freedom from unwanted control into personal ones over which the state has power (Mills, 1959). They have long critiqued the attribution of problems-in-living to individual characteristics (Conrad, 2007). Defined as political problems, protests to alter related social conditions may result (Moncrieff, 2008b). Defined as existential problems, religious, evolutionary, and/or philosophical views are emphasized. A behavioural approach informed by the science of behaviour focuses on identifying related contingencies and increasing alternative behaviours in pursuit of hoped-for outcomes (Layng, 2009; Madden, 2013).

The term “mental health” suggests a biological framing that has long been critiqued, for example, by Szasz (1961, 2007) as well as by many others (e.g., Conrad, 2007). Defined as medical problems, medication is emphasized (Szasz, 2001). The biomedical industrial complex, including institutional psychiatry and the pharmaceutical industry has been very successful in forwarding definitions of problems-in-living as mental illnesses. Diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders* have increased from 80 in 1980 to 500 in 2013 (Kirk, Gomory, & Cohen, 2013). The boundaries around categories of alleged disorders continue to expand. Common variations in behaviour are transformed into potential risk factors dubbed “unhealthy” and in need of treatment.

Disease mongering refers to expanding the diagnostic boundaries of illnesses and promoting awareness to enhance markets to sell related products (Payer 1992). At a conference on "Selling Sickness: People Before Profits" (2013) held in Washington, D.C., a roundtable on "Whistleblowers and Selling Sickness" was described as follows:

> At great personal cost, whistleblowers are often crucial to exposing the nature and extent of corporate, government, health and academic misconduct and fraud. In recent years the public has learned much about disease mongering from government and corporate insiders such as those on this panel (p. 13).

The promotion of the belief that deviant or troubling behaviours are caused by an illness (a brain disease/chemical imbalance) has spawned scores of industries and thousands of mental health agencies, hundreds of research centers, and thousands of advocacy groups which forward this view. The term "mental health" is used ubiquitously. A biopsychiatric approach focuses on identifying "disorders" of clients – what is "wrong with them." Psychiatrists have the power to coerce people to participate in interventions "for their own good" as in use of outpatient commitment defined as "treatment." It is often assumed that certain behaviours are related to too much or too little of certain biochemical substances (chemical imbalances). (See critique by Moncrieff, 2008a & 2008b.) The pharmaceutical industry promotes the view of depression and anxiety in social situations as biochemical illnesses requiring medication (e.g., Clarke, Mamo, Fosket, Fishman, & Shim, 2010; Moynihan, & Cassels, 2005). Environmental contributors to distress such as poverty, pollution, lack of health care, and lack of jobs that pay a living wage (e.g., Gong, Palmer, Gallagher, Marsden, & Fone, 2016) are often ignored as illustrated by the literature describing the medicalization of distress (e.g., PloS Medicine Editors, 2013 and Selling Sickness Conferences). The term "medicalization" refers to viewing problems-in-living as medical conditions (Bell & Figert, 2012; Conrad, 1992).

Evidentiary Status of Assessment Methods

How are problems framed and how do they shape selection of assessment and intervention methods? Assessment frameworks differ in how compatible they are with empirical data regarding how behaviour develops, changes, and is maintained. Views may be accepted that limit opportunities to help clients. Consider controversies concerning attention deficit hyperactivity disorder (ADHD) (Olfman & Robbins, 2012). Some assume related behaviours are caused by brain dysfunctions. Others emphasize the role of environmental circumstances such as limited educational opportunities

and poverty (Timimi, 2008). Without a contextual understanding of behaviour (e.g., Layng, 2009), it is easy to fall into "blaming clients" and focusing on "changing them" or giving them a rationale for their misery rather than working together with others to alter related environmental conditions. Approaches that focus on alleged pathologies of clients (eliminative approaches) may result in overlooking client strengths (Gambrill, 2014). A contextual-constructional approach attends to both client characteristics and circumstances including alternative behaviours that may compete successfully with undesired ones (Layng, 2009).

Evidentiary Status of Intervention Methods

Are intervention methods those most likely to help clients attain hoped-for outcomes? Consider the use of neuroleptic medication with the elderly. Goetsche (2013) argues that this kills over 500,000 people 65 years and older each year and disables tens of thousands more. Overmedication of children, especially those involved in the child welfare system, is common (U.S. Government Accountability Office, 2014). Past as well as current research highlights lapses in helping poor vulnerable clients, including failure to offer needed support services both in mental health and child welfare settings (Fuller & Nieto, 2014).

Accuracy and Transparency of Evaluation Methods

How is outcome evaluated by staff? Are surrogate outcomes used (e.g. how many sessions were attended) that may not reflect change or its lack thereof? Are hoped-for outcomes monitored over time? Are follow-up data collected? Are related data available on agency websites? Is this accurate?

The Ethics of Whistleblowing

Who blows the whistle about what and how in mental health contexts? Of all who know about ineffective and/or harmful services offered to clients, only some make efforts to bring this to the attention of others. Dubious claims about what is effective, and what is not, abound. Of all the situations in need of whistleblowing, what percentage are acted on and to what effect? Who is in a position to know? Who knew what and when? When do professionals have a duty to know about and reveal avoidable harm that diminishes quality of care? Who is responsible for critically appraising practices and policies that affect client welfare – for epistemic vigilance (Corlett, 2009; Origgi, 2010).

When does loyalty to clients require loyalty to agency's manifest goal to help clients rather than its hidden main goal to survive and make money? What must be done to catch and counter the "three wise monkeys: hear no evil, see no evil, and speak no evil" (Ashworth, 2018).

Professionals differ in their attention to, and concern about, harming in the name of helping. They differ in the extent to which they rely on logic and evidence in reviewing moral obligations (Stahl, Zaal, & Skitka, 2016).

> The whistleblower acts on *principle*. Conflict occurs within that individual between obedience, on principle, to the immediate authority (usually the employer), and what the whistleblower regards as a higher authority – concepts such as "truth," "justice," "the public interest," or God. The reaction that occurs is *organizational*, in that it arises from what is seen as a challenge to the organization's authority from someone who, being within the organization, is regarded as a traitor. The whistleblower *dissents* from the accepted culture, internal principles and practice of the organizations." (Leanne, 2012, p. 249).

Obligations described in professional codes of ethics to help, to avoid harm, to involve clients/patients as informed participants, call for practitioners to bring harmful practices and/or policies to the attention of others. What percent do so? Avoidance of public disclosure of avoidable harm is of high interest to organizations, thus providing in-house routes to identify and correct harms should be valued (McDougell, 2015).

Helping professions differ in attention to circumstances in need of whistleblowing. For example, medicine and nursing are more highly developed in attention to errors compared to social work and psychology (Goetsche, 2013; Ioannidis, 2008). Only fairly recently has social work devoted more attention to whistleblowing (Mansbach & Bachner, 2009; Skivenes & Trygstad, 2010). Loyalty to an organization may contribute to ignoring harmful policies and practices although this would only be true in an organization favoring secrecy regarding harms. Different people may be involved in any given instance and may have different reasons for avoidable ignorance or, if "in the know," for not sharing related information with others. Many may share similar concerns but remain silent (Kuran, 1995).

> "Whistleblowing – the act, the response, as well as the deafening silence of those who stand by in the face of wrongdoing – touches some very deep recesses of what it is to be human, to bear witness to wrongdoing, or to turn away. Most employees have observed wrongdoing. But most employers do not act to stop wrongdoing they know is

going on (Miceli, Near, & Dworkin, 2008)" (Ash, 2016, p. 12).

Whistleblowing is closely related to informed consent issues (e.g., Antidepressant Withdrawal, 2018; Davies & Read, 2018). Consider the following examples in which clients are not informed: 1) prescribing medication to children shown to do more harm than good; 2) referring clients to services of unknown effectiveness; 3) failing to monitor progress in an on-going manner which would allow timely detection of ineffective or harmful results; 4) failing to plan for the generalization and maintenance of hoped for outcomes; 5) false claims of effectiveness on agency websites; and 6) failing to monitor quality of process during counseling.

As with other moral obligations, excuses may be offered for failure to "do the right thing" (McDowell, 2002), such as "I was not sure so said nothing," "It would get me in trouble," "Others should (will) reveal it," "It would not do any good -- nothing would change," "Someone else will do it," "I don't have time," "I don't want the aggravation," "She/he doesn't mean to do it," "Perhaps it does no harm," and "We will lose money". Good intentions may be confused with good outcomes. People differ in their skill and knowledge in critically appraising claims about the effectiveness of practices and policies. Critical appraisal skills may be lacking among both helpers and clients. Enhancing such skills is key in the process of evidence-based practice (Gambrill, 2019). People also differ in their circumstances; for example, would a social worker lose her job and thus place her children at economic risk by revealing harming in the name of helping?

Duty to Know: The Obligation to be Informed

Ethical obligations of professionals to help and not harm, and to involve clients as informed participants, highlight their obligation to be accurately informed concerning the evidentiary status of practices and policies that affect client welfare, including injustices as a result of lack of access to vital resources such as legal help (Sandefur, 2016), and to minimize culpable ignorance. These obligations require being informed about influences on problem framing including biases and propaganda ploys such as misrepresentations of the evidentiary status of practices and policies. Are important lapses in service being ignored? Are clients being abused? What are the gaps between practices and policies used in an agency and what does research suggest is effective? Professionals have a duty not to be deceived by false claims. Are practices used that are counter-indicated by related research, such as ineffective parent training methods, harmful prescribed medication, and focusing on individuals as the cause of their problems, and ignoring related environmental causes such as poverty and pollution?

Ash (2016) describes the consequences of "ignoring and blind-eyeing in relation to the Rotherham Scandal where many insiders knew of the sexual exploitation of adolescents for years and did nothing" (Casey Report, 2015). If Gotzsche (2013) is accurate in his description of harms of prescribed psychotropic mediation for the elderly, who should know about this? Certainly, elderly people and their significant others, as well as professionals who work with them and managers who oversee such professionals, should be informed and take action. What has each involved group done and to what effect? Are user-friendly decision aids available and used to guide elderly people and their significant others to make informed decisions about whether to take a prescribed medication (Elwyn, Edwards, & Thompson, 2016)?

Discoverability as an Obstacle

Harmful practices and policies differ in their discoverability. Some are easily discoverable, especially if related skills and knowledge are available; for example how to critically appraise claims (see http://testingtreatments.org). Harms may be obvious to anyone who looks and cares. Agency practices can be compared with what well-designed research suggests is effective. The Internet provides sources relevant to whistleblowing in mental health contexts such as Critical Psychiatry Network (CPN). These may reveal bogus claims of effectiveness and promotion of harmful practices and policies. Consumer and advocacy groups offer other channels for transparency, such as http://www.hearing-voices.org. Discovery of accurate accounts may be difficult because of lack of integration of different areas of inquiry including psychiatric, sociological, behavioural, anthropological, and biological theories and related data. Individuals and organizations with vested interests in obscuring harms and, perhaps their direct role in creating them, will be vigilant and active in hiding information showing the ineffectiveness and/or harmful effects of interventions (Gotzsche, 2013; Olfman & Robbins, 2012). (See earlier discussion of strategic ignorance.)

We cannot blow the whistle on harms we do not see. Not seeing is related to self-censorship, either conscious or unconscious, which may be encouraged by a dysfunctional organizational culture in which those who raise questions about services are punished. (See discussion of information avoidance by Golman et al., 2017 and later discussion of responsibilities of administrators.) False consciousness and mystification refer to beliefs that obscure or distort rather than reveal what is true about the world, such as who benefits from certain practices and policies. The view promoted in many professional education programs reflects the dominant medicalized view of deviant behaviour and,

thus, students are likely to carry it on in the agencies in which they work (Lacasse & Gomory, 2003). Fricker (2007) uses the term "epistemic injustice" to refer to "a wrong done to someone specifically in their capacity as a knower" (p. 1). For example, if someone views those labeled as “mentally ill” as irrational, they may not believe what such individuals report (e.g., Carel & Kidd, 2010). She refers to this as testimonial injustice. In hermeneutical injustice, "a gap in collective interpretative resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (p. 1). Fricker (2007) offers the example of experiencing sexual harassment in a society in which the concept of harassment does not exist. (See earlier discussion of problem framing.)

Those in the helping professions are obligated to minimize epistemic injustices; they are obligated to use epistemic vigilance (for example, to critically appraise claims that affect client welfare) (Gambrill, 2019; Sperber, Clement, Heintz, Mascaro, Moncrief, Briggs, & Wilson, 2010). Do professional education programs attend to such obligations? For example, social work students rarely learn about the science of behaviour in professional degree programs; instead, they are often indoctrinated into the "mental health" paradigm, including an unskeptical reliance on the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Gambrill, 2014; Thyer, 2005). Failure to acquire knowledge that contributes to helping clients results in harm when such knowledge and related skills are needed to prevent harm and to help clients.

Duty to Act to Minimize Avoidable Harms

The nature of, and reasons why, practices and policies that harm clients are used should inform related actions to decrease them. Some harmful practices/policies, such as lack of information concerning the evidentiary status of services used on agency websites, including track records of success of staff who provide them, are common practice and will take considerable efforts to rectify. Learning opportunities may be lacking in an agency via journal clubs, rotating responsibilities as a knowledge manager and gathering and reviewing client feedback about quality of services and taking corrective actions. Ethical obligations to involve clients as informed participants can be highlighted and advantage taken of decision aids (http://decisionaid.ohri.ca). In each case, we can identify interested parties as well as parties who have an ethical obligation to “know” and to act. Perhaps staff are unaware of the questionable evidentiary status of services offered in their agency as well as in agencies to which they refer clients. These are failures of epistemic due diligence. Journal clubs could be set up to review the quality of research regarding services offered in an agency (ACP journal club).

If such efforts to enhance quality of care are not successful, other routes can be pursued, including sharing information with the media and filing under the False Claims Act. Staub (2015) describes "the costs of passivity in the face of others' needs" (p. 22), including decreasing "our openness to them, our capacity for empathy with them and in our ability to grow as a person" (p 23). The more we remain passive in the face of harm, the more we may do so in the future. Exposing harm may encourage others who share a whistleblower's concern but who have remained silent to speak up, thus encouraging important changes.

Personal Preconditions for Whistleblowing

Both personal and environmental characteristics, such as administrative encouragement of transparency, influence the likelihood of whistleblowing as well as its effects. Related policies and practices in different countries may influence whistleblowing (Skivenes & Trygstad, 2010). Staub (2003, 2015) suggests three requirements for acting to prevent/stop harm to others: caring, empathy, and moral courage. Critical thinking knowledge, skills, and values (including those involved in appraising claims) as well as assertion and emotion management skills are also required. This applies to all players in the system of care, including administrators.

Caring/Empathy

Caring about minimizing harm and maximizing help is one precondition. Caring is encouraged by empathy. Both encourage attentiveness to avoidable harm, including harms to organizations, which highlights the importance of accuracy of the grounds on which accusations are made (as emphasized by Bok 1981). She argues that dissent, breach of loyalty, and accusation "impose certain requirements of accuracy and judgment in dissent … exploring alternative ways to cope with inappropriateness that minimizes the breach of loyalty; and a fairness in accusation" (pp. 210-211). Ash (2016) highlights the importance of attentiveness, responsibility, competence, and responsiveness as integral to an ethics of care. Staub (2015) suggests that empathy includes both a cognitive response (understanding other peoples' environments) and an emotional reaction (feeling what they may feel). Not all helpers give first priority to client welfare. Competing goals may include maintaining and gaining status by appearing more expert than is the case and gaining money. If there is no caring, we are unlikely to attend to, and attempt to, decrease avoidable harms. One might ignore even blatant inappropriate behaviour such as staff members slapping residents. Arrogance, laziness, and closed-mindedness

contribute to a lack of caring.

Caring and empathy encourage looking rather than avoiding; knowing rather than ignorance. Indeed, professional codes of ethics require this. Caring is encouraged by understanding and valuing ethical obligations to help clients, provide informed consent, and forward social justice (e.g., work together with others to minimize inequalities that contribute to personal problems, such as contaminated water). Increasing caring may require resetting our "ethical compass" – sensitivity to the miseries and/or injustices others endure. It may require resetting our "outrage meter." It will require critically appraising claims that influence practices and policies, for example the claim that mental illness is the cause of troubled, troubling, and very dependent behaviours (Szasz, 2007).

Moral Courage

Staub (2003) defines moral courage as "the ability and willingness to act according to one's important values even in the face of opposition, disapproval and the danger of ostracism" (p. 8). Such courage is required as illustrated by consequences for whistleblowing (see later discussion). To the autocratic and powerful, raising questions threatens their power to simply "pronounce" what is and is not without taking responsibility for presenting well-reasoned arguments, involving others in decisions, and considering the consequences of actions and inactions. Even when questions are tactfully posed, those in authority may become defensive, hostile, or angry when their claims are questioned. Socrates was sentenced to death because he questioned other people's beliefs. (See Plato's *Apology*.) To those who uncritically embrace a "doing good ideology," asking that verbal statements of compassion and caring be accompanied by evidence of helping may seem disloyal or absurd. However, history shows otherwise, as discussed earlier (e.g., Scull, 2015). Evolutionary history highlights the powerful role of status (Gilbert, 1989; Goode, 1978). Thus, the student who questions a professor or supervisor may be viewed as a threat, rather than a source of knowledge that may contribute to provision of high quality care for clients. An understanding of social hierarchies and how ranking maintains them contributes to viewing such reactions in their historical and biological context (Gilbert, 1989).

Critical Thinking, Knowledge, Skills, and Values

Harms calling for whistleblowing may be so obvious that critical appraisal skills are not needed. Staff may witness physical abuse of residents; they may see youth not being fed or clothed appropriately. They may be aware of impossible tasks imposed on staff and/or clients which

compromise care. In other circumstances, discovering harms in need of correction may require critical appraisal skills to evaluate the accuracy of claims about what helps clients and what harms them (Ioannidis, Stuart, Brownlee, & Strite, 2017). Clarifying and critically examining claims and basic assumptions is a key component of critical thinking. For example, who benefits from emphasizing lack of "self-esteem" as a cause of problems? Who loses (Baummeister, Campbell, Kruger, & Vohs, 2003)? Critical thinking involves arriving at well-reasoned beliefs and actions. It encourages us to think contextually (to consider the big picture and connect personal troubles to social issues). Related values suggested by Paul (1993) include intellectual integrity, humility, courage, curiosity, empathy, and perseverance. (See also Paul & Elder, 2014.) Every agency makes claims about what it accomplishes. Are they true? Are evaluation methods sound? What sounds good may not be good. Keep in mind that both for-profit and not-for-profit agencies and involved corporations maintain or increase funds by claiming that they help people. Health literacy has been defined as "the degree to which an individual has the capacity to obtain, communicate, process and understand basic health information and services to make appropriate health decisions" (Ratzan & Parker, 2001; Patient Protection and Affordable Care Act of 2010, Title V). (http://www.cdc.gov). The Internet has brought us not only a plentitude of dubious claims, but also sources that can help us to learn how to critically appraise claims (http://testingtreatments.org, available in twelve languages) and to locate valuable information. It also provides a channel for whistleblowing (Lewis, Brown, & Moberly, 2014). Decision aids designed for many health concerns should be available to all involved parties (see Center or Shared Decision Making).

Without critical thinking, knowledge, skills, and values, avoidable harms such as incompetent services are less likely to be noticed or, if noticed, acted on. We are less likely to recognize and avoid common biases such as confirmation biases and social psychological persuasion strategies and less likely to detect flaws in published research and guidelines. Critical thinking is an antidote to epistemological arrogance and one-sided thinking (Baron, 2017). It is an antidote to being propagandized by others or by oneself in ways that decrease opportunities to help clients. Thinking critically about problems and proposed remedies commits us to the effort required to develop critical appraisal skills and question popular assumptions, including underlying points of view. Unless we have grown up in an environment in which critical thinking is valued and modeled, we may feel personally attacked when someone disagrees with or questions what we say.

Recognizing underlying goals and points of view is not easy; they are often implicit rather than

explicit. They may be part of the basic social fabric and related belief systems in which we live, perhaps unquestioned. (See prior discussion of problem framing.) They may be deliberately suppressed. Related facts and figures may be hidden or distorted. The essence of self-deception is not being aware that you deceive yourself (Baron, 2000). Many scholars, although vastly disparate in their views, emphasize empowerment through self-education (including Freire, 1973; Popper, 1994; Skinner, 1953). A key part of this self-emancipation through knowledge is the critical appraisal of accepted views – the epistemic obligation to be informed about injustices and contributors to them and to take action (Medina, 2013).

Assertion and Emotion Management Skills

Whistleblowing requires action (e.g., asking questions, raising concerns, persistence in the face of "brush-offs" and abuse – assertive skills). Effective skills in raising concerns will contribute to success as will emotion management skills for handling negative reactions (e.g., Speed, Goldstein; Goldfried, 2017). Ineffective skills in dealing with burnout may hinder effective action. Thus, practitioners have an obligation to address burnout that results in harm to clients.

Contributors to Success

Whistleblowers decide how to document harms, how to bring these to the attention of others (by what means), and whether to act alone or in concert with others (Kohn, 2017; Martin, 2013). Agency whistleblower policy and suggested routes will influence choices. The Internet and on-line groups provide possible routes (Wilke, 2013). Whistleblowing will be easier in some settings than in others. Does management welcome critical feedback? Are guidelines available (Openness and Honesty when things go wrong, 2015; Freedom to Speak Up Review Tool, 2019; PSS whistle-blowing and passing on concerns - Psychiatrists' Support Services)? Avoidable harms could be revealed by requesting referral agencies to provide clear data regarding the evidentiary status of services provided. Choice of strategy should be informed by the nature of the claimed harm. For example, revealing corrupt financial accounting may require a different approach compared to revealing use of ineffective and/or harmful services. The latter may be easy to reveal and obvious to all who care. The former may require a much more strategic approach to gain related evidence including obtaining documents under The Freedom of Information Act. Kohn (2017) warns potential whistleblowers not to use agency hotlines.

Martin (2013) highlights the importance of knowledge of context and encourages whistleblowers to discover this by talking to knowledgeable people, seeing if there is any related research, and carrying out an investigation. He argues that seeking change through official channels is seldom effective, including appeal to internal grievance procedures and regulatory agencies.

> "A very important piece of advice for whistleblowers, which they ignore at their peril, is never to use an official, internal "anti-corruption" body for anything but the most trivial matter, and preferably not to risk using it even then" (Lennane, 2012, p. 256).

Suggestions Martin (2013) offers for gaining support include: preparing a written document, approaching individuals, forming support/action groups, writing letters, creating a website, and/or approaching the media. Mistakes he suggests include trusting too much, not having enough evidence, using the wrong style, not waiting for the right opportunity, not building support, playing the opponent's game, and not knowing when to stop. (See also Kohn, 2017; Thomas, 2018.) Guidelines suggested by Ash (2016) include:

- Disabusing yourself that you will be viewed as a hero for disclosing concerns;
- Getting the facts, dates, times, observations about concerns written down in detail;
- Checking out concerns with others at work;
- Seeking professional, preferably legal, advice; and
- Understanding that trade unions may or may not be your friend.

State and federal laws have been passed to encourage and protect whistleblowers including the Whistleblower Protection Act to protect federal employees. State whistleblower laws can be found on http://www.ncsl.org (National Conference of State Legislators [NCSL]). Federal and state agencies have inspector generals to investigate whistleblower disclosures concerning fraud and waste, for example. Hiring an experienced attorney may be vital for success and for your own protection (http://www.pogo.org).

The Importance of Careful Documentation

Martin (2013) highlights the importance of documentation; "The bigger and more serious the problem, the more evidence you need" (p. 68). Unless harms are clearly and accurately documented with facts, figures, and perhaps pictures/videos that can be shared and authenticated, successful action to minimize harms is unlikely to be successful. Draw on state and federal regulations in documenting harms. (See description by Kohn, 2017.) As Kohn (2017) notes, "documentary evidence

is vital" (p. 265). This is needed to resist efforts to deny concerns including destruction of documents, lying, creation of false documents, and frame-ups (Martin, 2013, p. 68). Detailed documentation decreases the likelihood of being ignored, attacked, receiving empty reassurances, and increased secrecy concerning what is done and to what effect, and/or making superficial changes (p. 74).

Involve Others

> There are many possible "others." Martin (2013) emphasizes the importance of carefully choosing advocates. They may be from inside and/or outside the organization. "It is very important for whistleblowers, when considering making a complaint, internal or external, to line up support for themselves before they start. The most reliable support will come from outside the organization – support from within is likely to crumble once a typical employer reaction starts. A body such as Whistleblowers Australia is useful, not only for general support and advice, but also in some cases to take whistleblowers' information to the media or outside agencies, rather than them having to take the risk of doing it themselves…" (Leanne, 2012, p. 256).

In wooing compatriots, appeal to shared goals, such as offering clients effective services (Fisher & Ury, 2008). If such appeals are successful, alternatives to harmful practices can be pursued.

Tenacity

Ongoing efforts on a large scale may be needed. Changing harmful/ineffective practices may require continuing exposure over time, even years.

Consequences of Whistleblowing to the Whistleblower

"There are tangible legal, financial, social, emotional, and physical tolls to whistleblowing" (Garrick, 2017, p. 39). Those involved such as administrators have an option of how to respond to whistleblowing. Questioning accepted policies and practices may be met with attempts to discredit (or cajole) those who raise concerns, including filing lawsuits against "bell-ringers" or declaring them mentally ill. Promises of changes needed may be empty. Retaliation against whistleblowers is common to silence the whistleblower, prevent public knowledge of a complaint, discredit the whistleblower, and/or discourage other potential whistleblowers (Near & Miceli, 1995). Blowing the whistle often results in immediate harmful effects for the whistleblower. A survey of 233 whistleblowers

in the United States (McMillan, 1990) reported that 90 percent lost their jobs or were demoted, 27 percent faced lawsuits, 25 percent got into difficulties with alcohol, 17 percent lost their homes, 15 percent were divorced, 10 percent attempted suicide, and 8 percent went bankrupt (p. 250). Near and Miceli (1995) suggest that consequences for the whistleblower are influenced by the whistleblower's credibility, power, and anonymity as well as the wrongdoer's credibility and power. They also suggest the influence of the nature of the wrongdoing, strength of related evidence, legal basis of accusations, and climate supporting the whistleblower.

Reputations may be damaged by "bullying; mobbing (asking other employees to monitor and report on the activities of the whistleblower); ostracizing the employee from the team; devaluing the contributions or the performance of the whistleblower; blackballing from other jobs and opportunities; double-binding with difficult tasks to complete; gaslighting by calling into question the memory of the whistleblower; questioning accuracy or its scope; and marginalization" (Garrick, 2017, p. 39). Regulatory agencies may or may not protect people from harmful practices; indeed they may foster problems via conflicts of interests of participants as described by Gotzsche (2013).

Leanne (2012) reported that if the whistleblower remained in his or her job, punitive and informal tactics were typically used. In a study sponsored by Whistleblowers Australia (WBA) (1993), reported in Leanne (2002), these included:

1. Isolation: from the usual channels of information and consultation (49 percent); or physical isolation (23 percent);
2. Removal of normal work (43 percent);
3. Abuse and denigration, usually by supervisors, who may also encourage others to give the whistleblower a hard time (43 percent);
4. Minute scrutiny of timesheets and work records, inspections, and adverse reports sought from previous employer (34 percent);
5. Demanding or impossible orders (26 percent);
6. Referral for psychiatric assessment/treatment (37 percent); attempts to do so in another 9 percent;
7. Threats of disciplinary action (20 percent) (Leanne 2012, p. 251).

Effects reported less frequently included death threats, fines, and falsification of records. (See also Vandekerckhove, James, & West, 2013.) Alford (2016) notes that "a troubling aspect of the retaliation

that whistleblowers receive is that much of it comes from their peers" (p. 1). Loss of peer support is common; peers shun whistleblowers who are viewed as "the other."

Obstacles to Whistleblowing

Both individual and contextual factors may pose an obstacle. Lack of critical thinking, knowledge, skills, and values may contribute to culpable ignorance such as a lack of due diligence. Fear of potential negative consequences is based on reality. Institutional corruption in which an organization is diverted from its purpose may flourish. Regulatory agencies may not support whistleblowing; they themselves may be the target of whistleblowers who allege conflicts of interest (Cosgrove, Vannoy, Mintzes, & Shaughnessy, 2016). Whistleblowing takes time and requires psychological and moral fortitude to weather kickback. Related whistleblower policies and regulations may not fully protect confidentiality and freedom from retaliation (Caught Between Conscience and Career, 2019, http://www.pogo.org). Managerialism may flourish (Rogowski, 2010) including "meaningless managerial mantras given by managers" (Ash, 2016, p. 137). Bolsin and his colleagues (2011) argue that "the emphasis on financial goals, the lack of effective responsibility for the outcomes of care and on the widely accepted code of ethics for medical managers (in the National Health Service [NHS]) makes it unlikely that they can currently catalyze the necessary change" (p. 280). Changes in management practices may be viewed as effective simply because there was a change (Stivers, 2001). There may be "mindless pursuit of administrative efficiency" (Adams & Balfour, 1998). Ash (2016) views "the undiscussables of organizational life as a major obstacle to organizational learning" (p. 56).

> "Conspiracies of silence, keeping quiet, not rocking the boat and absence of hope that anything will change are all reasons why people don't speak up about what they see, hear, or sense is wrong. Dread of being labeled as trouble maker or moaner, fear of loss of trust, respect and relationship, of retaliation, punishment, loss of job, and feelings of futility are all reasons those keeping quiet have given for their silence. These all reside in the basic requirement of the workplace that employees obey rules, directives, and authority" (p. 82).

New staff may be unsure about how to react.

> "Carlos first worked as a residential care worker when he observed a senior colleague physically assaulting a non-verbal resident who had an intellectual disability and

> therefore could not tell anyone what had happened: ….Because I was so young, it took me ages to actually say to the manager what the bruising was on this person's face … It took me probably two or three weeks" (Raymond, Beddoe & Staniforth, 2017, p. 23).

Ash (2011) suggests that "Turning the blind eye or not seeing has the effect of normalizing wrongdoing. Its perpetrators and observers are socialized to cease to regard the practice as wrong. They no longer see it" (p. 61). Devices of denial used in the Rotherham Scandal described by Ash (2016) include:

1. "It's not happening"; refusal to acknowledge
2. Discrediting the source, blaming the messenger
3. Window dressing and false comfort
4. Double speak
5. Focusing on the process, not outcomes
6. Blaming, bullying, and no bad news (pp. 50-91)

In *The Freedom to Speak Up Review* (Francis, 2015), people in the National Health Service (NHS) in England who were interviewed "spoke of the *disincentive* to speak out, and of not having the stomach to raise concerns because they had seen what had happened to others who had done that before them, or that the bullying culture itself blocked expression of concerns they had" (Vandekerckhove & Rumyantseva, 2014, p. 60). This publication was followed by hundreds of reports of concerns by those in the medical health care system.

Remedy: Create a Client Focused Culture/Climate

In the best of worlds, whistleblowing would not be necessary. Policies and practices would be in place which provide a culture and climate of transparency and honesty which encourages catching and countering practices and policies that detract from rather than contribute to helping clients and minimizing harm (Openness and Honesty whenever things go wrong, 2018; Vincent, 2010; Vandekerckhove, Fotaki, Kenny, Humantito, & Kaya, 2016; Association of Chartered Certified Accounting [ACGA], http://www.esrc.ac.uk). Valid decision support tools would be in use (e.g., Durand, Witt, Joseph, Williams, Newcombe, Politi, Sivell, & Elwyn, 2015; Langer, Mooney, & Wills, 2015). Staff, including interns/trainees, would have legal protection if they report problems (Cohen, 2018).

> "Neither the carrot of cash incentives to whistleblow, nor the stick of the duty to report, really comprehend the influence of the organizational culture, and cultures, on trust in the workplace, and on the behavior and actions of those who work in it. Most employees who observe wrongdoing in organizations do not report it to someone who can take corrective action. They will be more likely to do so when they work in an organizational culture they experience as reasonable and fair, one they can trust. In settings like this where managers observably and demonstrably take action to stop poor practice and right wrongdoing, employees feel more supported and regard the organization as more just" (Ash, 2016, p. 123).

The greater the transparency of what is done and to what effect, and the use of these data to improve the quality and safety of services, the less the need for whistleblowing. Assessment methods used by agency staff should be routinely reviewed to determine their evidentiary status. For example, do assessment theories and related measures used provide valid data that contribute to informed decisions? Do staff in child welfare agencies refer clients to mental health agencies that employ effective interventions? Websites of mental health agencies should include information that would allow users of services to arrive at informed decisions regarding the effectiveness of services offered. If candid, here is what may be said:

> Our agency uses programs said to be effective by others. We have not examined the rigor with which such determinations are made. In addition we do not review the fidelity of services offered due to a lack of money and time. We use process measures to evaluate the outcome of our services, that is, how many sessions a client attends. We do not know whether this reflects improvement in hoped-for outcomes. We refer our clients to psychiatrists when medication is needed but we do not review the appropriateness of prescriptions given or possible harmful consequences.

The process of evidence-based practice encourages accurate description of the evidentiary status of assessment, intervention, and evaluation methods and involving clients as informed participants in decisions made (Straus et al., 2011). Related critical thinking values, knowledge, and skills, including health literacy, should be acquired during professional education programs. The NHS of the UK has published a checklist to encourage speaking up (Freedom to Speak Up Review tool for NHS trusts and foundation trusts, July 2019).

Conclusion

Practices and policies, both past and present, illustrate the need for whistleblowing when efforts made via other channels are not effective. Whistleblowing is an ethical duty of all those involved in the mental health industry. Silence in the face of avoidable harm is not an ethical option. Whistleblowing entails bringing to others' attention harmful practices and policies and related circumstances others may not be aware of, or, if aware, may dismiss as unimportant, benefit from them, or choose to remain silent about them. This requires scrutiny of one's own ethical standards, including duty to know; professional integrity requires recognizing avoidable ignorance that contributes to harm to clients and acting to reveal and decrease this. Epistemic vigilance is needed (Sperber et al., 2010). Lack of moral integrity, organizational characteristics, and regulatory lapses all contribute to the need for whistleblowing.

For every known harm, there are many more. For every instance of avoidable ignorance that perpetuates dismal circumstances, there are more. Yet, even known harms often remain in the shadows, encouraged by uncritical professional education programs, misleading research reports, avoidable ignorance, media neglect, and misleading discourse and tactics of those who benefit from ignorance. The enduring influences of conformity, fear, self-interest, and biases including group think, combined with a lack of critical thinking, values, knowledge, skills, and assertion skills hinder whistleblowing. Concerns about protecting economic gain and power may loom larger than helping people and "telling the truth."

If the recent past is an indicator of the future, including exposure of bogus claims in the peer-reviewed literature, whistleblowing will become more common, taking advantage of the Internet (http://retractionwatch.com). Promising trends include the push for transparency concerning quality of published research, exposure of conflicts of interest, increased availability of websites bringing culpable harm to our attention, and user-friendly websites such as http://testingtreatments.org to facilitate acquisition of critical appraisal skills. The process of evidence-based practice is designed to reveal important uncertainties, including questionable grounds for using certain practices and policies. Some professions are more advanced than are others in revealing harming in the name of helping and developing aids for, and encouraging, whistleblowing, including decision aids for specific concerns (medicine compared to social work). Caring, empathy, and embracing ethical obligations may push even the fearful to reveal culpable ignorance.

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