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EDITORIAL

Examining Institutional Corruption in Mental Health: A Key to Transformative Human Rights Approaches

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Introduction

At a time of unprecedented upheaval in the world order triggered by the Trump administration's withdrawal of funding and institutional engagement, this special section adds to broader conversations regarding how human rights praxis might contribute to a more democratic political economy of global health, particularly global mental health. These conversations are occurring against a backdrop of dramatically reduced policy space across global health, as a result of cuts in development finance from the United States and other countries, as well as debt servicing and illicit financial flows. Today, the Global South loses more than US$1.7 trillion annually to tax evasion, avoidance, and illicit financial flows, and as of 2024, developing countries' external debt was almost US$12 trillion, which translates into 90% of export revenues. The United Nations Conference on Trade and Development estimates that 54 countries spend more on debt servicing alone than on health care.[1] In this context, when there are strong pushes to increase private financing and provision, and to implement cost-cutting in health systems, the papers collected here present a cautionary tale for policy makers and human rights activists alike.

Looking back at the last 40-plus years, the pieces in this special section make clear that the architecture of global governance in mental health has long been marked by the concentration of economic and epistemic power in private actors, driven by knowledge hierarchies favoring biomedical approaches, and trapped in colonialist dynamics and mentalities.[2] Despite significant progress in creating enforceable normative standards, especially since the entry into force of the landmark United Nations Convention on the Rights of Persons with Disabilities, and in elaborating the contents of human rights-based approaches

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Competing interests: None declared.

(HRBAs) to health, these efforts have not produced transformative change in practice. There are many factors that have stymied progress, but here we identify *institutional corruption* as a significant barrier to the promotion of rights related both to mental health and psychosocial disabilities.

In human rights praxis, corruption is often framed in terms of "leakage," or abuse of entrusted public power for private gain, which leads to mapping perpetrators, victims, and potential reforms. The underlying presumption is that corruption is an illicit deviation from the legal norm. In the context of neoliberal globalization, an uncritical focus on corruption in the public sphere has been aligned with global and national policies promoting the privatization of health services, including mental health services. At a time when human rights are under attack not just from conservative populists but also progressives who argue that the human rights movement has been either complicit in the rise of neoliberalism or ineffectual at constraining its devastating consequences, we should take the consequences of these inadvertent alignments seriously.[3]

In analyzing the connections between mental health, human rights, and corruption, the papers collected in this special section adopt a different starting point that does not take as a given that the problem of corruption lies exclusively in public officials' conduct—or that the obvious remedy is to privatize to diminish opportunities for such malfeasance. Here, we focus on *institutional corruption*. We adopt Lawrence Lessig's definition of institutional corruption as

> *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.*[4]

When applied to mental health, focusing on institutional corruption allows us to better understand how public and private organizations alike may "deviate from their mission by engaging in activities that endanger it, even if these activities are not illegal."[5]

Highlighting institutional corruption in mental health in no way negates the rampant problem of regular corruption. It does, however, call for a critical examination of prevalent recommendations of best practices for public policies made without due consideration of socioeconomic context and health system capacity. These include scaling up mental health coverage without adequate attention to the content and quality of that care; privatizing services for mental health that may produce unequal treatment through dual practice, among other things; and proliferating "cost-effective" pharmaceutical approaches in a global context in which the social determinants of mental health, as well as public funding for health systems, are being hollowed out.

Reexamining the application of human rights to mental health today could not be more urgent, given the widespread attention placed on a global mental health crisis. Alarm bells over the "crisis in mental health" have been ringing for some time. For example, suicide rates in the United States rose 30% from 1999 to 2016, representing an increase among both sexes, all racial and ethnic groups, and all urbanization levels.[6] After the COVID-19 pandemic, *The Lancet* published a study finding an additional 53.2 million cases of major depressive disorder and 76.2 million cases of anxiety disorder globally due to the pandemic.[7] In recent years, *The Lancet* has devoted a commission to global mental health and has published multiple series, including on adolescent psychiatry, transforming mental health implementation research, and climate change and mental health.[8] While structural issues are often mentioned, the focus in these reports and in the Movement for Global Mental Health still tends to be on scaling up and securing equitable access to care within and across countries. Frequently, the human rights principles of nondiscrimination and equality have been invoked in these calls.

HRBAs also highlight the need to address how the social determinants of health and well-being impact the prevalence of mental health issues,

which are distinct from but overlap with some psychosocial disabilities. A key insight of HRBAs is that institutional arrangements, and the laws that structure them, can be changed to modify the social determination of mental health, as well as the social creation of disability. The papers collected here go a step further, focusing on the role of evolving political economies that have fostered institutional corruption and prevented such changes from being implemented in practice. In so doing, they denaturalize the economic order as a given and examine how it interacts with mental health policy and the practice of psychiatry in middle-income and lower-middle-income countries.

For example, in the United States, prolonged declines in wages, barriers to education (and the instrumentalization of education as the sole key to social mobility), the deterioration in job quality, and subsequent alienation from the labor force are all underlying determinants of the increase in suicides and "deaths of despair," and they are simultaneously consequences of the United States' political economy as increasingly dominated by the interests of the wealthiest and a discourse of meritocracy that blames poverty on moral failure.[9] While human rights analyses on mental health that focus on socioeconomic issues directly related to treatment or health care access, or specific policies on issues such as housing, are important, they fail to capture the broader structural drivers that shape the possibilities for well-being.

If we extend this broader focus to the rest of the world, it becomes even more urgent to situate our human rights analyses and claims in the context of neoliberal economic orders and examine how they institutionalize, legitimate, and reproduce regimes that drive systemic mental health issues—as well as individualized biomedical remedies for those problems.

As detailed in several papers in this special section, the prioritization of medication as treatment for mental health—which began in the 1980s and has greatly expanded treatment in high-income and middle-income countries alike—exists in this broader context of the hegemonic neoliberal ethos that pervades academic and public conceptions of mental health care, and which magnifies narratives of mental health as a biological issue and an individual responsibility.[10] The special section further considers who the actors are that are promoting and profiting from these global discourses, which are then transferred to local contexts. Analyzing how the multinational pharmaceutical industry has profited from the guild interests of professional psychiatry calls attention to how specific actors systematically extract gains that may be unrelated to or even undermine the health and well-being of patients and the public in general. Those entrenched interests, and the political control they exercise, help explain the systematic marginalization of social determinants of mental health in setting priorities for action, and hold lessons for moving forward.

Different regions, disciplinary perspectives, and issues

The collected papers span geographic contexts and histories, as well as aspects of psychosocial and mental health. To explicate the political economy of mental health, which is concerned with both institutions and governance (i.e., formal institutions and informal rules; capacity of public administration), almost all the papers situate their arguments in the structural and socio-historical context in which particular national mental health systems were constructed. Former Eastern Bloc countries with histories of Soviet psychiatry, such as Serbia, naturally differ substantially from other countries such as South Africa or Peru. Other papers address specific issues within mental health to examine the dynamics of economies of influence exercised by the pharmaceutical industry, such as obesity medications and drugs to treat postpartum depression.

It is not a coincidence that many of these papers are written by authors from different disciplines or deploy multidisciplinary methods, including empirical studies and normative frameworks. Challenging disciplinary orthodoxies—not just in biomedicine and public health but also in human rights praxis—frequently calls for an external or fresh gaze in order to unsettle ways of

understanding the world that are taken for granted within a specific professional tribe. While these papers adopt different approaches to considering how HRBAs might contribute to meaningful reform, they collectively point to the need to situate our human rights analyses and advocacy in specific contexts, and to render visible the global and national forces that have shaped those particular settings when designing reforms.

In the first piece, "Institutional Corruption in the Political Economy of Global Mental Health: Challenges for Transformative Human Rights Praxis," Alicia Ely Yamin and Camila Gianella Malca set out the theoretical anchor for the special section, in which they challenge the standard understanding of HRBAs in three ways. First, they suggest that transformative human rights approaches need to be attentive to the epistemic architectures of both biomedicine and neoliberal economies in which mental health rights are advocated. Improving technical interventions is crucial, but broader structural and institutional arrangements that entrench asymmetries at the micro level between clinicians and patients and at the macro level in national health systems are too often not just displaced by biomedicine but obscured or distorted by the premises built into the model. Second, accepting the prevalent human rights construction of corruption as "bad apples" that engage in bribery or the embezzlement of public funds destines remedies to reinforce structures that systematically privatize wealth and deprive states of the capacity to uphold mental health rights. If those premises are accepted in HRBAs, applying rights to mental health may stymie more than facilitate structural reforms. Rather, our understanding of corruption in mental health needs to extend to institutional corruption that entails structural and systemic drivers of private gain at the expense of the public good, which are imbricated in economies of influence between academic psychiatry and the pharmaceutical industry and spread through the globalization of Western biomedical frameworks and the neoliberal consensus across the globe. Third, they add to the literature on the psychiatrization of the world by placing it in historical context, noting the intertwined impacts of the spread of biomedical approaches to mental health and neoliberal globalization since the 1980s and the differential impacts across the world.

This anchor piece, together with the remainder of the papers, suggests that human rights needs to be attentive to both universal trends in global and national political economies and the plurality of lived experiences in national settings. A series of papers then delve into greater detail with respect to how institutionalized corruption spreads discourses and practices across borders. In "Addressing the Global Mental Health Crisis: How a Human Rights Approach Can Help End the Search for Pharmaceutical Magic Bullets," Lisa Cosgrove argues for a shift away from the dominant pharmaceutical paradigm in global mental health, advocating instead for an HRBA that recognizes how emotional distress is often rooted in social, political, and economic conditions. Using the specific example of zuranolone, a recently approved treatment for postpartum depression, Cosgrove argues that institutional corruption, manifested through conflicts of interest and guild influence, undermines scientific integrity and public trust. She situates this critique within the broader context of neoliberal frameworks that medicalize distress and obscure structural drivers such as inequality, discrimination, and lack of social support. Cosgrove emphasizes the importance of moving beyond binary debates (pro- or anti-psychiatry) and fostering more nuanced narratives that critically examine who benefits (and who does not) from current models of care.

In "Without Informed Consent: The Global Export of a Failed Paradigm of Care," Robert Whitaker argues that the way in which the US biomedical model of psychiatry was exported globally alongside psychiatric medications failed to provide patients and the broader public with adequate information about the limitations and risks of this approach, which would have been necessary for "informed consent." He argues that the chemical-imbalance narrative, used to justify the disease model, was never scientifically validated and that research consistently fails to demonstrate long-term improved recovery with psychiatric drugs.

Whitaker contends that institutional corruption, which is rooted in guild interests, led US psychiatry to misrepresent its own evidence base and that this misrepresentation influenced World Health Organization-endorsed global mental health frameworks. As a result, he asserts, a paradigm of care grounded in inaccurate claims of efficacy and safety was disseminated worldwide, contributing to worsening public mental health outcomes.

Ximena Benavides's paper, "Too Big to Lose Weight: How Pharmaceuticalization Corrupts the Right to Health," considers the political economy of health through the lens of obesity and comorbidities in mental health, arguing that "the pharmaceuticalization of obesity carries wide-ranging implications for public health—from its intersections with mental health and diabetes to its structural effects on the health care system." Noting that reliance on glucagon-like peptide-1 receptor agonists has generated market distortions, Benavides examines the financialization of health care, focusing on how policy choices allocate power to dominant pharmaceutical manufacturers operating in highly concentrated markets. She then describes institutional corruption as the transfer of governance to private actors that favors self-interested exercises of governing power in drug commercialization and redefines medical progress in terms of market expansion and control. Benavides argues that these dynamics disregard the social determinants of obesity and weaken the protection of fundamental rights to health and health care.

The remainder of the special section focuses on middle-income countries and regions with very different historical trajectories regarding mental health: Eastern Europe, Peru, and South Africa.

In "Reflections on Institutional Corruption in Mental Health Policy Implementation: Global Insights and the Eastern European Experience," Dainius Pūras and Julie Hannah reflect on the missed opportunities for transformation in Eastern Europe following the fall of the Soviet Union. Hannah worked closely with Pūras while he was the United Nations Special Rapporteur on the right to health, and much of their focus at the time was on mental health and the obstacles posed by the biomedical model. In this piece, they recount—based on the authors' own experiences—that although the collapse of totalitarian regimes brought hope for more human rights-centered mental health systems, the convergence of neoliberalism with remnants of totalitarian institutional cultures instead led to the renewed medicalization of mental health challenges. Their paper highlights this experience in Central and Eastern European countries and raises important questions about authoritarian dynamics in many mental health care institutions that play out between providers and patients. By underscoring the critical role of institutions as a major barrier to the adoption of truly human rights-based mental health reforms, the authors call on the global mental health movement to move beyond a narrow focus on mental health goals such as reducing treatment gaps and to recognize the need for transformation of the system itself—ensuring that care is accessible, non-coercive, and rights based—and to address institutional corruption as both a consequence and a cause of institutional flaws.

Milutin Kostić and Danilo Vuković, the authors of "Regression of Hard-Won Advances in Socialized Medicine: The Emergence of the Private Sector in Health Care in Serbia," examine how the emergence of dual practice in post-socialist Serbia, where the majority of physicians work simultaneously in public hospitals and private clinics, has weakened the public health system and produced conditions that foster institutional corruption. They argue that dual practice creates direct financial incentives for physicians to conserve time and effort in the public sector and to encourage patients to seek care privately, which turns access to timely and respectful treatment into a matter of ability to pay. As the authors explain, this model "breaches equality and access to rights and services" by producing a two-tiered system in which wealthier patients often receive more care (and sometimes unnecessary care, including prescriptions), while those dependent on the public system encounter declining quality and access. Limited state investment in public health facilities further exacerbates this dynamic, accelerating the shift of patients who can afford to do so toward private providers. Kostić

and Vuković propose eliminating dual practice in mental health and beyond in order to address structural inequity and protect the right to health.

The two papers on Peru—written by Alberto Vásquez and Camila Gianella, respectively—illustrate what happens when global mental health discourses are transferred into local contexts with weak institutional capacity that refracts the steep socioeconomic inequalities and social fragmentation of the broader society. Each study examines different aspects of the implementation of an ambitious mental health reform over the past decade. While both authors highlight some positive outcomes of the reform, they also note how structural factors—such as a weak and underfinanced health system, the dominance of a biomedical approach to mental health, the lack of regulation of private actors, and weak oversight of the commercialization of drugs, including psychiatric medication—can undermine the effects of mental health policy reforms and contribute to maintaining and even reinforcing institutional corruption.

Vásquez's paper, "A Hard Pill to Swallow: Pharmacy Chain Dominance and the Commodification of Mental Health in Peru," examines how chronic underinvestment and uneven implementation of community-based reforms have allowed private pharmacy chains to become central providers of mental health care in Peru. He argues that persistent medication shortages and limited access to public services lead many people to self-medicate and rely on pharmacies as their primary point of care. Further, in this context, pharmacy conglomerates shape which psychotropic medications are available and at what price, often prioritizing high-profit products and limiting access to affordable generics. This model exemplifies institutional corruption in that it privileges profit over the public purpose of health institutions. Using the framework of institutional corruption, Vásquez shows how these dynamics undermine the availability, accessibility, acceptability, and quality standards required by the right to health. He calls for stronger public investment and rights-based reforms to ensure "that private actors operate within clearly defined legal and ethical boundaries."

In "When Scaling Up Isn't Enough: The Impacts of Peru's Mental Health Care Reform on Adolescents," Camila Gianella Malca also deploys the human rights framework of availability, accessibility, acceptability, and quality of facilities, goods, and services to examine the effectiveness of Peru's mental health reform with respect to a specific population: adolescents. Gianella notes that the reform was intended to incorporate a human rights-based approach. Yet based on a qualitative study conducted across four regions of Peru, Gianella is able to provide granular insights into where the rhetoric of human rights has fallen short in practice. Through a combination of policy analysis and qualitative interviews, Gianella shows how the reform's focus on scaling up access to pharmaceutical treatment neglects critical issues such as health system capacity, the availability of trained personnel, the need for intercultural and youth-centered approaches tailored to diverse adolescents, and information systems that adequately monitor policy impact. Gianella's analysis also highlights how a reform that promotes pharmacological treatment creates risks of abuse by private actors involved in the marketing of psychiatric medications.

Finally, Sasha Stevenson's paper, "South Africa's Life Esidimeni Disaster and the Institutional Corruption That Opened the Door to It," offers a chilling case study on the impacts of institutional corruption on human rights, including the rights to health and life. Stevenson examines the Life Esidimeni case, which shows how a policy reform portrayed as aligned with international standards, in a country with expansive human rights protections in its constitution, can still cause enormous damage to vulnerable populations when private nongovernmental actors are engaged without sufficient oversight. In this case, 144 patients in the care of nongovernmental organizations died in grotesque conditions of neglect—undernourished, dehydrated, unmedicated, and sometimes suffering from bedsores and gangrene. Stevenson argues that the Life Esidimeni tragedy "must be seen as a large-scale human rights violation within the context of institutional corruption: caused by inappropriate political involvement in the administration of

health and the drive for cost-saving, disguised as deinstitutionalization." As with the papers from Peru, the Life Esidimeni case reveals the shortcomings and potential harms of involving private actors in the supply and administration of health services in contexts characterized by weak state capacity to oversee the quality of care and by structural violence against vulnerable populations. Stevenson's paper also goes on to document the "public and legal processes undertaken to expose the disaster, to secure accountability, and to begin to deconstruct the conditions that allowed one of South Africa's most shameful human rights violations of the democratic era."

Conclusion

The papers in this special section offer three important contributions at a time when there is simultaneously a renewed focus on the "crisis in mental health" and a major disruption in global health governance, including in mental health, as a result of changes in US policy and their follow-on effects. Amid the intensifying calls to move toward greater private financing and provision of health services to fill gaps created by sharply reduced development finance as well as renewed austerity, the papers collected here suggest the need for different approaches.

First, these papers make a compelling argument that addressing corruption as a barrier to progress in mental health systems requires moving beyond narrow understandings of illegal misconduct by public officials to also consider the role of private actors (including the pharmaceutical industry's interactions with academic and professional psychiatry), the adoption of dual practice models and public-private partnerships, the role of trade liberalization and intellectual property regimes, and the increasing financialization of aspects of health care systems, including pharmaceutical medications. The papers here collectively explicate how this *institutional corruption* is embedded within broader political, economic, and historical contexts that shape priorities, allocate resources, and determine experiences of care.

Second, taken together, the pieces in this special section call for a rethinking of the architecture of global mental health through a political economy lens that recognizes how epistemic and economic power at the global level operates to legitimate specific forms of mental health care in middle-income and lower-middle-income countries. Evidence presented here of how these models are transferred to specific country contexts suggests that the increasingly frequent rhetorical incantations regarding the importance of "decolonizing mental health" or "social determinants of mental health" are unlikely to produce meaningful change without challenging both the narrow frameworks and authority of Western psychiatry and the neoliberal globalization that facilitates the spread of that individualized, abstracted understanding of emotional distress.

As should be clear from the data presented throughout the special section, this is in no way an anti-scientific stance or a simplistic rejection of psychopharmacology. It is rather an acknowledgment that while the health sciences are often taken as technical and accessible only to specialized expertise, the frameworks in which they operate are not free of cultural premises and interact with the political economies that we inhabit and which deeply affect our diverse lived realities.

Finally, the pieces collected here call for us to reflect on how human rights approaches can meaningfully contribute to confronting the structural conditions that sustain institutional, as well as regular, corruption and systematically perpetuate violations of dignity and well-being across social determinants of mental health as well as in care. Facing this challenge in human rights could not be more urgent in our current period of radical upheaval. Applying human rights to any health issue in transformative ways requires destabilizing ways of framing the world that stem from disciplinary orthodoxies and naturalized practices in medicine and public health. But a robustly transformative praxis of human rights equally calls for recognizing that the meaning—and meaningfulness—of applying human rights to mental health cannot be autonomous from our socioeconomic contexts—or abstracted from the colonial and other socio-his-

torical processes that have created them.

Acknowledgments

This project received support from the Brocher Foundation. The Brocher Foundation's mission is to encourage research on the ethical, legal, and social implications of new medical technologies. Its main activities are to host visiting researchers and to organize workshops and summer academies. More information on the Brocher Foundation is available at www.brocher.ch. We are grateful for the additional support provided by the Harvard Global Health Institute, which was crucial for enabling both a pre-workshop convening and travel to a workshop at the Brocher Foundation, as well as the Chr. Michelsen Institute, which provided both financial and project management support.

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