HHR Health and Human Rights

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Institutional Corruption in the Political Economy of Global Mental Health: Challenges for Transformative Human Rights Praxis

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Abstract

Through an exploration of the impacts of institutional corruption in global mental health, we argue here that deploying human rights-based approaches to health must go beyond rhetoric regarding equity in access to treatment to address power structures that systematically perpetuate harm against diverse people in specific contexts. First, applying human rights to mental health in transformative ways requires upending the biomedical paradigm that both locates mental health within people's brains and imbues psychiatric expertise as an unchallengeable authority in defining mental health conditions. Second, such change in approaches to mental health has proved challenging due in significant measure to institutional corruption, defined as a systemic, legal influence that diverts the institution from its purpose. We focus on institutional corruption driven by financial influences of the pharmaceutical industry in combination with the guild interests of the psychiatric profession. Third, we sketch the relation between institutional corruption and the spread of neoliberal policy imperatives on the financing and organization of mental health services in lower-middle and middle-income countries. Finally, we question the metrics deployed in global health that reaffirm existing presumptions in mental health systems, such as coverage, which can foster institutionalized corruption. We conclude that focusing on institutional corruption allows us to understand the need for new forms of health governance aligned with transformative human rights praxis.

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Competing interests: None declared.

Introduction

Through an exploration of the impacts of institutional corruption in global mental health, we argue in this paper that deploying human rights-based approaches to health (HRBAs) must go beyond rhetoric regarding equity in access to treatment to address power structures that systematically perpetuate harm against diverse people in specific contexts. First, we assert that applying human rights to mental health in transformative ways requires upending the biomedical paradigm that both locates mental health within people's brains as a stochastic phenomenon and imbues psychiatric expertise as an unchallengeable authority in defining mental health conditions. Likewise, the landmark United Nations (UN) Convention on the Rights of Persons with Disabilities, which 191 states and the European Union have ratified, explicitly rejects the medical model of disability in favor of a social model.[1] Under this convention, psychosocial disability is understood to be created through the interaction between a person's impairment and the social, civic, political, and economic environments that contain physical, attitudinal, and communication barriers.[2]

Mental illness and disability overlap to some degree but are not synonymous. However, the effective enjoyment of health and disability rights always requires a just arrangement of institutions, and in both cases the need to move beyond a biomedical model and acknowledge the role of laws, policies and practices has been repeatedly emphasized by various UN bodies and human rights institutions.

Second, we assert that although normative standard-setting has proceeded rapidly in both health and disability rights, implementation and systemic change in approaches to mental health have proved challenging due in significant measure to institutional corruption, which is directly related to the privileging of psychiatric expertise in the biomedical model. Following Lawrence Lessig, we define institutional corruption as

> *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.*[3]

In this context, Lisa Cosgrove and Robert Whitaker have used the term "economies of influence" to describe the institutional corruption in psychiatry that is driven by financial influences of the pharmaceutical industry in combination with the guild interests of the psychiatric profession.[4] Thus, institutional corruption is not a glitch in current mental health systems but a feature that is woven into their design.

Third, noting that the rise of an understanding of mental illness as an imbalance of chemicals naturally found in the brain overlaps with political economies shaped by coloniality in global health, together with the neoliberal globalization that began to sweep the world in the 1980s, we sketch some of the dramatic impacts of structural adjustment programs and successive implementation of neoliberal policy imperatives on the financing and organization of mental health services in lower-middle and middle-income countries. Here, we focus on two processes. First, the coloniality of knowledge production in global health enabled the research premises advanced through the National Institute of Mental Health and the categories of the DSM (Diagnostic and Statistical Manual of Mental Disorders) and ICD (International Classification of Diseases) to spread throughout the rest of the world.

This dimension of the paper contributes to other critical accounts of psychiatrization by emphasizing the significance of neoliberal globalization's impact on social determinants and health care reforms worldwide, which has exponentially expanded the reach of biomedical and pharmaceuticalized approaches and, in turn, institutional corruption.[5] The application of neoliberal policy imperatives drove health reforms that included targeting the needy and reducing universal services. These reforms also involved cutting social protections that support psychosocial needs, expanding intellectual property protections for pharmaceuti-

cals, and privatizing or engaging in public-private partnerships to provide mental health care. Moreover, throughout, we emphasize that human rights principles have often been invoked to spread psychiatric treatment and pharmaceuticalization to lower-middle and middle-income countries out of concerns for equal access to pharmaceutical treatment.

Finally, looking ahead to what can be done, in addition to suggesting the need for broader systems change, we question the metrics deployed in global health—particularly the focus on coverage abstracted from context—which reaffirm existing presumptions in mental health systems and which can foster institutionalized corruption. We conclude that focusing on institutional corruption allows us to understand the need for new forms of health governance aligned with more transformative human rights praxis.

In proposing changes to human rights theory and practice, this paper draws on two non-exhaustive reviews of public health research (PubMed), social science and legal databases, and gray literature on (1) corruption and mental health, and (2) human rights (including disability rights) and mental health. These reviews were performed during 2023–2024. Although most of the secondary literature dates from the last 10 years, key legal and institutional documents from as early as the 1970s were essential to examine to establish the context for the arguments we make. Further, additional literature reviews on privatization and public-private partnerships in health, as well as on the use of global indicators, were performed by this paper's authors for other studies and, in turn, inform this work as well.

Beyond the biomedical model[6]

The starting point for applying human rights to mental health in a transformative way requires understanding how defining mental health and psychosocial disability in terms of rights challenges the biological individualism of mainstream psychiatry, which defines conditions in terms of personal defects or abnormalities.

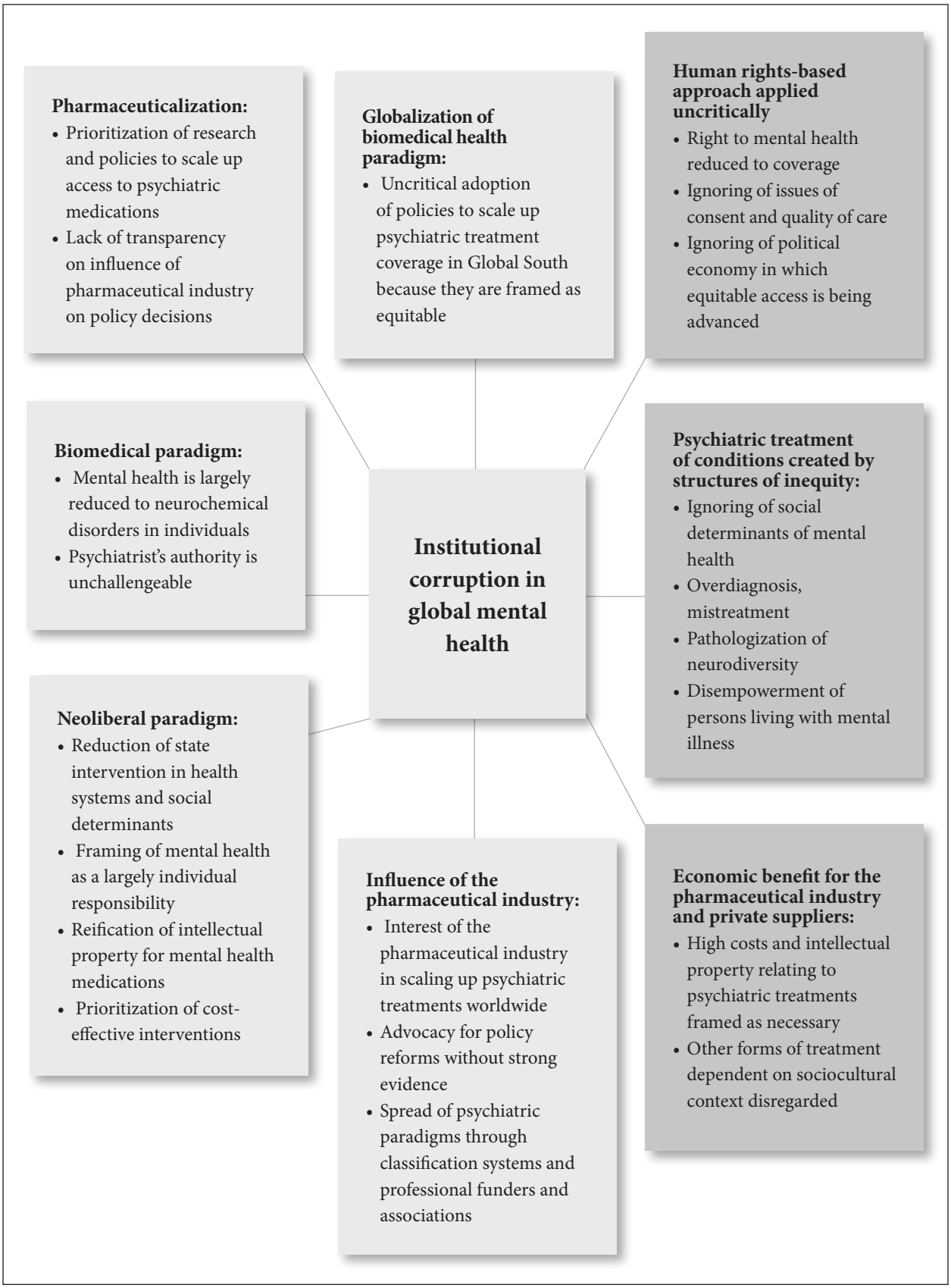
In the biomedical paradigm, health is defined as the absence of disease—for example, a "normal" result on a cholesterol or other function test. This negative definition of health, including mental health, is simultaneously (1) abstracted from social context (and therefore permits standardization in research and classification of disease, however questionable that is in mental health); and (2) appraised exclusively through a specialized scientific expertise. In the case of mental health, many mental health problems have been reduced to an imbalance affecting neurotransmitters, and psychiatric drugs as the solution to balance the chemicals naturally found in the brain.[7]

By contrast, conceptualizing mental health as a right requires accepting that (1) mental health has special moral value because of its relationship to dignity—variously and not mutually exclusively understood as self-governance, a preservation of a range of opportunities, and the ability to participate fully in one's community and society; and (2) mental health is *not* merely an individual biological or biochemical issue. On the contrary, understanding mental health in terms of rights requires recognizing health, including mental health, not as a natural good but as a social good dependent on the just arrangement of essential social institutions, including health systems.[8] Just as with disability in a rights paradigm, our conception of mental (ill) health in a rights framework is also constructed in interaction with social and cultural norms.[9]

This broader understanding has been well-diffused in international legal frameworks since the entry into force of the UN Convention on the Rights of Persons with Disabilities. In 2017, the UN Special Rapporteur on the right to health argued for a more expansive understanding of mental health that encompasses social determinants.[10] In 2023, the UN General Assembly adopted a resolution underscoring the need to frame mental health not only as the presence or absence of a psychiatric disorder or cognitive condition but rather as the result of

> *an environment that enables persons to live a life in which their inherent dignity is respected, with full enjoyment of their human rights, and in the*

FIGURE 1. Institutional corruption in global mental health



> *equitable pursuit of their potential, and that values both social connection and respect through non-violent and healthy relationships, and recognizing that discriminatory laws policies, practices and attitudes undermine well-being and inclusion.*[11]

In addition to focusing on the social determinants of mental health, transformative human rights praxis calls for changing the epistemic paradigm of biomedicine that privileges the technical expertise of psychiatrists. In the biomedical model, the technical language of scientific "expertise" cloaks the deeper political implications of decisions made in biomedical research and clinical practice, guiding narratives of social beings, human bodies, sexuality, (dis)abilities, race, and the like. In the case of mental health, this dominant model feeds on and facilitates harmful stereotypes: people with mental conditions "continue to be falsely viewed as dangerous," they are "labelled incompetent," "their capacity to make decisions is questioned," and they are "denied the right to make decisions for themselves."[12]

While power asymmetries between health professionals and health care users are prevalent across health services and conditions, in the case of mental health, they are exacerbated. Historically, in psychiatry, objective "scientificity" as a form of categorization has served as a pretext to regulate populations in society for deviance from norms and standards of being or behavior.[13] In some places, political dissent was defined in terms of mental disorders (e.g., "sluggish schizophrenia" under Soviet psychiatry); in others, feminist discontent with social roles was labeled "hysteria." These categorizations have changed over time, and with context.

When the DSM-3 conceptualized psychological disorders as primarily brain-based diseases, psychiatrists' special medical expertise became essential to diagnose and treat these conditions, despite dissent from the beginning as to the appropriateness of categorizing mental distress in this way.[14] Over the last 40 years, the American Psychiatric Association and academic psychiatry in the United States and other countries have touted pharmaceutical treatments in addressing mental illness, which has greatly expanded markets for psychiatric medications.[15]

The ICD, the most widely used classification of diseases for low- and middle-income countries, also quickly adopted the neurochemical account of mental disorders. While many have pointed to the lack of diagnostic reliability and the lack of cultural appropriateness, and disability rights activists have argued that the medical model pathologizes neurodiversity, the predominant approach to mental health has been the biomedical one. And pharmaceutical interventions have been prioritized as a first-line therapy worldwide.[16]

The medicalization of mental illness has had direct effects on widespread diagnoses of mental illness as institutional responses to "deviant behavior."[17] Making mental illness into an issue largely of brain chemistry and presenting psychopharmacology as a solution enabled an extraordinary arrogation of power to psychiatrists to control both the supply and demand of mental health care. Mental health diagnoses based on genetics and neuroscience captured the fervor of academic and clinical psychiatry in the late 20th century and the beginning of the 21st century around the world, even after they were shown to have limited clinical utility and began to be questioned in the Economic North.[18]

Institutional corruption

The standard approach to corruption in human rights is to treat it as a leakage—that is, a drain on resources that could otherwise go toward fulfilling, in this case, mental health care. Traditionally, that leakage is construed as misfeasance or malfeasance by *public* officials. In some legal regimes, such as the United States, corruption is explicitly limited to quid pro quo cases—for example, where there is a direct exchange between a public official and some kind of donor, where an official takes a specific official action in return for a benefit, or where a donor's influence can be proven to have impacted the official's judgment unduly, or if there is a strong appearance of such influence.[19] Dennis Thompson argues that *institutional corruption* can be applied more generally to "political gain or benefit by a public official under conditions that in general tend

to promote private interests."[20] However, this focus on public officials is unduly narrow. Just as we have expanded our understanding of infringements of rights beyond the direct actions of state agents, it is time to broaden our view of corruption beyond actions by state officials, and explore how institutional arrangements across both public and private sectors foster a more insidious form of *institutional corruption*.

As noted above, we adopt Lessig's definition of institutional corruption: "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." Cosgrove and Whitaker identify the release of the DSM-3 as an inflection point in mental health care, after which pharmaceuticalization exponentially expanded. Subsequent versions of the DSM and ICD have generally reinforced this trend.[21]

Nonetheless, the drivers of inappropriate measures go far deeper than isolated bad practices, as the default becomes pharmaceuticalization.[22] Normative guidance that fails to account for institutional corruption is likely to be ineffective. That is, the inherent indeterminacy of international standards, the prioritization of a biomedical understanding of mental health, an overemphasis on scaling up treatment coverage, and the incompleteness of formal human rights norms regarding mental health care open the space for informal and background rules to play a significant role in everyday behavior within mental health systems.[23] In this context, informal rules relate to how conditions for exercising entitlements to mental health care are deliberately restricted to impose a default of pharmaceuticalization, as well as coercion. Background rules, in turn, relate to how health institutions function with respect to such factors as staffing and information sharing, which also play a significant role in erecting barriers to non-pharmaceutical, non-biomedical forms of mental health care in practice.[24]

The current for-profit schema of research and development has strengthened the ties between academic researchers and pharmaceutical companies, as well as the prevalent sponsorship of clinical trials by the industry, imbricating institutional corruption ever more deeply into practice.[25] Since DSM-5, the American Psychiatric Association has had an official policy of declaring conflicts of interest (defined as receipt of US$10,000 from pharmaceutical companies per year, with the exception of unconditional grants). However, in practice, more than half of psychiatrists on review committees maintain close relationships with the pharmaceutical industry, in particular in relation to mood, sleep, and psychotic disorders, and research on randomized controlled trials has found evidence in support of conflicts of interest as a potential bias in the outcomes of such trials conducted for antidepressants.[26]

In turn, the permeation of pharmaceuticalization in medical knowledge and training has become so normalized that its impact on clinical treatment is not generally questioned by individual patients, providers, or the general public in most of the world.[27] Indeed, the pharmaceuticalization of mental illness has been so widely exported around the world that even where social causes, such as austerity, are understood to cause emotional distress (including depression and anxiety), the response is still too often to treat this distress at a biochemical level.[28]

The WHO currently explicitly recommends that national action plans "evaluate and monitor the use and costs of psychotropic medication, psychological interventions, and other treatments in mental health and social services in primary care" and calls for "a significant increase in investment in research and evaluation" of alternatives to psychopharmacology.[29] Yet the biomedical framework is still disseminated through prominent medical and public health journals, at universities, at academic and professional conferences, and through the direct lobbying of the pharmaceutical industry worldwide.

Research agendas have been crucial to propagating this epistemic framework, and agencies such

as the National Institute of Mental Health (NIMH) in the United States have played a significant role in shaping the global understanding of mental health issues. Until the Trump administration took office in 2025, the NIMH, and its parent institution the National Institutes of Health, funded more basic research on mental health than any other institution in the world. The NIMH has overwhelmingly prioritized the funding of biomedical research over social science research on structural causes or population effects over time.

Institutions that frame thinking as well as funding in global health have also contributed to these policies. For example, in 2007, *The Lancet*, a leading global health journal, published an influential series on mental health, which further disseminated the idea of pharmaceutical treatment as cost-effective worldwide.[30] In 2016, the World Bank published a report estimating global burdens of mental illness and disability and calling for making mental health a global development priority.[31]

Professional associations such as the World Psychiatric Association have also urged scaling up the availability and use of psychiatric drugs and adopting standardized approaches and categories of diseases.[32] In this regard, the ICD, the most widely used system of medical classification worldwide, provides practitioners with a universal, free, and accessible classification system that can be utilized by non-psychiatrists working even in low-income settings and which has been critical for spreading the Western biomedical model of mental health around the world.

Human rights arguments have often been key in spreading the biomedical model of psychiatry beyond the United States and Western Europe to the rest of the world. Article 25 of the Convention on the Rights of Persons with Disabilities calls for state parties to take all appropriate measures to ensure access for persons with disabilities to health services, which include providing persons with disabilities "the same range, quality and standard of free or affordable health care and programmes as provided to other persons," as well as "*those health services needed … specifically because of their disabilities*, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities."[33] Although it has shifted positions, WHO itself encouraged the global dissemination of psychopharmacological treatments in its 2001 edition of its flagship *World Health Report*—whose title was *Mental Health: New Understanding, New Hope*—as a response to the vast unmet need for mental health care in lower-middle and middle-income countries.[34] In arguing for redressing discrimination in mental health, prominent human rights advocates have pointed to WHO studies that have shown "a huge and growing proportion of morbidity and mortality from mental disorders with significant underdiagnosis and treatment compared to physical disorders."[35]

The Movement for Global Mental Health has consistently used nondiscrimination and human rights arguments to argue for "scaling up" access to psychiatric treatments worldwide, including pharmaceuticals, available in the Economic North.[36] For example, Vikram Patel, a leading proponent, analogizes the situation to inequitable access to HIV/AIDS drugs:

> *Consider the moral argument that persons with HIV/AIDS in developing countries had the right to access antiretroviral drugs, that the state has to provide them for free, that drug companies had to reduce prices … that discrimination against people with HIV/AIDS had to be combated vigorously, and that knowledge about HIV/AIDS was the most powerful tool to combat stigma. These arguments were human rights based … We believe that the time is ripe for such a [global mental health] advocacy initiative that makes the moral case for the mentally ill.*[37]

Of course, a human rights framework requires that access to treatment be universally available, and there is no question that in too many countries the lack of access to appropriate mental health care causes tremendous suffering. However, the actual quality of care and agency of persons must be part of the equation. The reductive analogy fails on multiple dimensions, including the unreliability of diagnostic categories, the lack of evidence regarding the effectiveness of psychotropic medication,

the displacement of social determinants, and the equally important right of persons across the world to refuse treatment. Health rights cannot be constructed in a vacuum; in this case, a psychiatrized vision constructed through colonialist architectures of knowledge production has been applied through ostensibly universal models that omit and distort important features of the experience of emotional distress in specific local contexts.

The push to spread a pharmaceuticalized model of psychiatric treatment to the rest of the world has not been without critique. It has been accused of psychiatric colonialism—of "exporting western illness categories and treatments that would ultimately replace diverse cultural environments for interpreting mental health."[38] Others have pointed out that prevalent models in mental health care are based on neocolonial power structures that permeate public health, effectively marginalizing traditional Indigenous knowledges in favor of allopathic health treatments. As China Mills writes, "to export psychiatry globally is to begin to reframe an enormous variety in expression of personal and social distress into an illness model, treatable by drugs." She concurs with other scholars who have argued that because this approach is devised in a particular Western culture that is alien to many, it constitutes a kind of psychiatric imperialism that may be less stark than military domination but is no less destructive to the populations around the world.[39]

Neoliberal globalization and the political economy of global mental health

Epistemic frameworks travel through the arteries of power. Sometimes these are professional associations and journals; sometimes they are rooted in the economic ordering of societies. Just as the biochemical understanding of mental illness was becoming embedded in mental health practice in the 1980s, neoliberal globalization began sweeping the globe, with extraordinary impacts on health systems, including mental health systems. The two processes were deeply intertwined. Divorcing all health, including mental health, from social meaning enormously facilitated the commercialization of health care.[40] It is not just that in isolation, the answer to depression was to prescribe a psychotropic medication, and the answer to the side effects of that medication was then to prescribe yet another pharmaceutical. Health systems came to be understood as apparatuses for delivering technical interventions to address individuals' biological conditions—as determined by clinical judgments—as opposed to social institutions at the interface of society and the state. Furthermore, those apparatuses were to be reformed in the most cost-effective way, which often facilitated the privileging of pharmaceuticals over talk therapy and relational approaches to psychosocial health in traditional medicine.

The web of negative experiences that deeply affect both mental and physical health includes historical experiences of colonization, enslavement, and marginalization, as well as adverse early life exposures, such as exposure to family and community violence, discriminatory employment patterns, economic insecurity, poverty, lack of education, and homelessness. But in a highly individualized technical health care delivery system, these social, political, and historical determinants could be shunted aside.[41]

Various guidelines from WHO, as well as its Comprehensive Mental Health Action Plan 2013–2030, now call for actions across health, education, labor, housing, and other arenas to deliver a coordinated response as opposed to merely increasing access to psychiatric medications.[42] Yet the past four decades have driven health systems across most of the world in precisely the opposite direction.

The diffusion of a menu of neoliberal policies to lower-middle and middle-income countries proceeded rapidly from the 1980s onward through various social processes, including policy imitation, the adoption of new ideas, and the need to compete in global markets.[43] Additionally, as Alex Kentilkenis and Sarah Babb argue, "Coercion was also a key diffusion mechanism: powerful global institutions could use their resources to leverage free-market reforms."[44] The World Bank and International Monetary Fund—

pushed by powerful shareholders, particularly the United States—developed a set of interventions in the internal governance and economies of countries across the Global South to address perceived debt default threats. In exchange for rescue from default, countries were forced to adopt "structural adjustment policies," which generally included privatization and deregulation; trade liberalization to open markets to foreign investment; and the reduction or elimination of social subsidies to balance budgets, which then entailed imposing user fees for health services, among other things.[45]

In the logic of neoliberalism, the public sector was cast as the locus of corruption in overseeing clientelistic and poor regulatory practices, and shrinking that potential for abuse through privatization has been a prevailing response from international financial institutions.[46] Spreading the understanding of corruption as bad apples "abusing entrusted power for private gain" has been a key pillar of promoting privatization and deregulation, which, not ironically, has fostered conditions for the appropriation of public power for private economic and political gain.[47]

Given limited space, we highlight two prominent effects of neoliberal globalization: (1) the shrinking of public health capacity and turn toward private provision of care or public-private partnerships; and (2) the role of trade liberalization, and heightened protections for intellectual property, in propelling expansion of the pharmaceutical industry into the Global South.

First, these market-friendly reforms prioritized fiscal discipline and balanced budgets, and almost always involved replacing broad universal social programs in health and beyond (often largely aspirational at the time) with targeted programs for the neediest, to meet "basic needs." More than 40 years later, waves of adjustment and austerity have been imposed on much of the Global South, which have hampered the capacity of states to adequately fund health systems, as well as invest in social protection, education, and other common goods that are directly related to psychosocial well-being.[48]

Responding to gaps in public finance and capacity in health systems, lower-middle and middle-income countries governments often expand privatized care alongside public health care for the poor, seeking partnerships with the private sector and establishing public-private partnerships (PPPs) in mental health, long-term care, and other aspects of health delivery. In the logic of neoliberalism, PPPs are often politically attractive for moving public spending off the government balance sheet. Yet evidence on health PPPs is patchy at best; PPP contracts can be expensive and inflexible, and PPP facilities can systematically exclude "expensive patients" to limit costs and meet targets.[49] Further, contrary to arguments about privatization reducing abuse-of-power corruption, PPPs are often unaccountable to the public and are involved in egregious violations of patients' rights in mental health facilities.[50] Despite the lack of robust evidence on the positive impacts of health PPPs, and evidence of corruption on health infrastructure PPPs, neoliberal ideology has displaced public policy debates about whether the private sector is needed and whether it is more efficient; instead, the sole question is when and how private funding can be sourced and de-risked.[51]

Another key structural aspect of privatizing public goods for private gain occurred through neoliberal trade liberalization and the expansion of intellectual property protections, including for pharmaceuticals. The Agreement on Trade-Related Aspects of Intellectual Property Rights required the adoption of far more invasive rules for patents on medications, among other things, which largely did not exist in the Global South, in contrast to "freeing up" trade in goods by eliminating tariffs.[52] Intellectual property became a major source of wealth transfer from the Global South to pharmaceutical corporations in the North.[53]

The liberalization of trade and the introduction of greater intellectual property protections for pharmaceuticals opened vast markets for the industry, as clinicians were being introduced to the biomedical view of psychological distress and governments were reducing budgets for social protections and non-pharmaceutical care in health systems. Pharmaceutical companies modified some of their marketing techniques in situations where it

was clear that people understood their distress to be caused by economic austerity, such as in Argentina, so that anti-anxiety and antidepressant medications were promoted as biochemical interventions for social problems.[54]

Currently, neoliberal imperatives of privatization and increasing financialization of health care and commodities, including pharmaceuticals, reinforce both the biological individualism underpinning psychiatrization and the social inequalities that foster emotional distress.[55] On a global level, the effects of receding fiscal space and, in turn, the political capacity of many states—especially those in the Global South—hollow out the possibilities for fulfilling meaningful claims for health and social protection by persons with mental illness and psychosocial disabilities, and more broadly.

If we understand corruption in mental health as institutional, HRBAs have to address not only how neoliberal globalization has shaped legal and policy frameworks that deprive states in the Global South of the capacity to construct other forms of mental health treatment, but also how neoliberal social policy has exacerbated gaping wealth gaps.[56] This includes reforming intellectual property regimes, advancing an international framework for tax cooperation to stem massive interstate tax avoidance and evasion, and addressing unsustainable sovereign debt. Without concrete measures that address institutional capacity and political economy factors, invoking the importance of social determinants in scholarly articles and national policy documents offers hollow hope.

Measuring progress in health systems: The need for new metrics

Addressing institutional corruption calls for a broad set of legal and policy reforms at national and international levels and change in educational approaches and training incentives for providers. It also calls for different metrics. Metrics drive funding and priorities; they create incentives for behavior change and performance standards. In neoliberalism, the performance standards and behaviors are individualized. By changing metrics, we can begin to redefine the framework for understanding mental health and illness, and the goals of health systems in addressing mental health can begin to be more aligned with demands from people with lived experience.[57]

Both the Sustainable Development Goals, which set out universal health coverage as a principal target under the goal of "improvement of health and well-being," and national planning targets emphasize *coverage* as an indicator of progress in health, including mental health.[58] The use of coverage under universal health coverage has been successful in cultivating a sense of urgency and shared understandings of the aims of health systems across many countries, including catalyzing a sense of urgency around a Movement for Global Mental Health, to which some HRBAs have contributed.

However, as noted above, HRBAs in the context of mental health can actually foster pharmaceuticalization by focusing on measurements of equity of access without interrogating the relationship between accessibility of treatment and outcomes.[59] If our starting presumption is that over-pharmaceuticalization is a manifestation of institutionalized corruption, we cannot rely on the traditional public health measures of inputs (e.g., drug supply) and outputs (e.g., patients attended or medications distributed) to assess progress in mental health, much less in combating corruption in mental health.[60]

Increasing coverage in mental health in isolation from quality of care and adequate evaluation of outcomes is not a solution and may drive institutionalized corruption further. Let us recall that providers determine both the supply and demand for pharmaceutical treatments, and the evidence that expanding coverage improves population mental health is not robust. Data on psychiatric conditions over time on a population-wide basis reveal that the number of people taking antidepressants has risen exponentially and continues to rise; for example, antidepressant prescriptions virtually doubled in England in the last decade, rising from 47 million in 2011 to more than 85 million in 2022/23, and these trends are set to continue.[61] Fur-

ther, the average duration that any one person takes an antidepressant has also doubled over the last 15 years or so, with approximately half of patients being classified as long-term users. These data should raise alarm bells over how we assess "progress."

Further, qualitative research reveals that prioritizing pharmacological interventions over other types of interventions has often been based on questionable evidence.[62] The truth is that the little information we have on the connections between prescription coverage and outcomes from varied contexts does not support widespread pharmaceuticalization as the adoption of "all appropriate measures" under international law.[63] Systematic reviews of studies that attempt to model the clinical and cost effectiveness of various treatment forms have uncovered difficulties in evaluating such effectiveness, given contested assumptions regarding the nature of clinical benefits of multiple treatments.[64] Further, significant disparities in studies that measure clinical versus cost-based effectiveness underscore the difficulty in evaluating treatment based on such siloed efficacy metrics.[65]

In short, if we want to meaningfully assess progress in mental health, and combat institutionalized corruption, an important first step is to adopt different metrics, which in turn would suggest adopting different understandings of the aims of mental health care. Indicators that are fit for purpose would ideally combine issues relating to institutional practice (e.g., numbers of health facilities with protocols for supported decision-making; staffing of social workers) with outcome indicators (e.g., percentage of patients treated for psychological conditions who finish treatment and do not relapse within a certain period; suicide rates). In keeping with human rights concerns about nondiscrimination, these data should be disaggregated by sex, race, ethnicity, socioeconomic class, region, and age, and include both PPPs and private facilities. Further, quantitative indicators should always be supplemented by qualitative research to assess people's lived experiences at the national and subnational level, and to account for cultural differences as well as socio-historically constructed understandings of emotional distress from colonialism. To advance systems that uphold the rights of diverse persons suffering from psychosocial distress, we require far more data that are reliable and actionable, and tailored to specific social and cultural realities. Finally, legal and regulatory frameworks have been included previously in Sustainable Development Goal indicators (e.g., indicator 5.6.2); in this case, it is imperative for transparency laws regarding the pharmaceutical industry's support to universities, health authorities, and providers to be incentivized through monitoring processes that can drive actions.

Conclusion

In this paper, we have challenged the standard understanding of HRBAs in relationship to mental health in three ways. First, we have suggested that transformative human rights approaches need to be attentive to these epistemic architectures of biomedicine and neoliberal economies in which mental health rights are advocated. Improving technical interventions is of course essential, but 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 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. We have argued here for a conception of institutional corruption in mental health 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 lower-middle and middle-income countries. Third, we have added to the literature on the psychiatrization of the world by placing it

in socio-historical context, noting the growing impacts of neoliberal globalization, which began to colonize our collective imaginations just as the Cold War was thawing and other modes of mental health practice began to wane in power.

Rethinking epistemic paradigms in science as well as economic organization may appear to be an overwhelming task, but, along with legal and policy advocacy, we have argued that shifting our measurement of progress in mental health can facilitate such reimagining and foster consideration of different sorts of governance. Coverage in access to psychiatric treatment, while important, cannot be the gold standard for assessing health systems and the right to health. Governments should produce disaggregated data—both qualitative and quantitative—focusing on measuring successful outcomes rather than inputs. These different forms of data are critical to understanding and assessing the real effectiveness of prioritized interventions and to being accountable to local populations, especially marginalized ones, regarding what interventions are useful in specific contexts.

Ultimately, effectively addressing institutional corruption in mental health requires different forms of global governance for mental health, understood as the mechanisms through which various historical configurations of actors utilize legislation, economic incentives, direct coercion, and epistemic framings to produce, monitor, and control behaviors and practices related to mental health and well-being. Biomedicine depends on what Sheila Jasanoff has termed "technologies of hubris" to "keep the wheels of science and industry turning," whereby a series of predictive methods are designed to facilitate management and control by experts invested with technical authority, even in areas of high uncertainty, such as mental health. Neoliberal globalization has relied on other technologies of hubris, whereby economic policies are dictated from afar by international financial institutions based on abstract metrics, such as fiscal discipline and debt-to-GDP ratios. Development frameworks, such as the Sustainable Development Goals, similarly rely on abstracted indicators that determine knowledge and governance discourses about the meaning of progress in mental health, and health more broadly, across widely varying cultural and social contexts. Addressing institutional corruption and advancing mental health *rights* for all calls for shifting to technologies of humility, which Jasanoff describes as "social technologies [that] would give combined attention to substance and process, and stress deliberation as well as analysis." Such technologies of humility would "engage the human subject as an active, imaginative agent, as well as a source of knowledge, insight, and memory."[66] As Jasanoff suggests, these concepts alone are insufficient to drive serious institutional change. However, they can offer starting points for a deeper public debate on addressing the scope of institutional corruption and the future of human rights in mental health.

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