HHR Health and Human Rights

DREXEL UNIVERSITY Dornsife School of Public Health

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Reflections on Institutional Corruption in Mental Health Policy Implementation: Global Insights and the Eastern European Experience

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Abstract

Existing evidence shows that mental health policies and services are especially vulnerable to ineffective and corrupt practices. Systemic obstacles, such as the overuse of the biomedical model, power asymmetries, and selective evidence, undermine both the realization of the right to health and the rights-based implementation of policies in practice. This paper draws on the personal experience of the authors alongside global insights to examine the relationship between institutional corruption and the right to mental health, with a focus on Central and Eastern Europe as a bellwether. Following the societal transitions of the 1990s and beyond, prolonged psychosocial stress contributed to widespread self-destructive behavior and high mortality rates, particularly among rural, middle-aged men. In response, foreign consultants frequently advised governments to prioritize diagnosing clinical depression and prescribing new-generation psychiatric medications as the principal strategy. We argue that this narrow biomedical focus, reinforced by biased evidence, represents a form of institutional corruption: it distorts problem framing, entrenches biomedical dominance, sidelines community and social responses, and ultimately compromises the right to health. Recognizing and addressing these dynamics is essential to align mental health policy with rights-based, context-responsive care.

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Competing interests: None declared.

Introduction

This paper explores global failures and missed opportunities to reform mental health systems in line with modern, rights-based approaches. These global obstacles are reflected in the experience of Central and Eastern Europe (CEE), where authoritarian legacies left deep imprints on mental health systems. Even after the collapse of the Soviet Union, the region struggled to dismantle outdated practices. As a result, it failed to seize the opportunity to implement transformative, rights-based reforms during the post-Soviet transition.

The paper draws on the personal experiences of its authors, Dainius Pūras and Julie Hannah. Pūras served as the United Nations (UN) Special Rapporteur on the right to physical and mental health from 2014 to 2020. During this period, he was supported by Hannah, a human rights expert and advocate from the University of Essex, who played a key role in shaping the mandate's work on the right to mental health. The paper draws from the tradition of participant observation as a methodological foundation, reflecting on insights gained through the authors' active involvement in policy processes, advocacy, and institutional reform at both regional and global levels.[1] In this way, the authors offer an experiential account that bridges personal engagement with a broader analysis of systemic challenges.

The first half of the paper focuses on Pūras's earlier experiences in CEE—before, during, and after the profound political and social transformations of the late 20th century. In particular, it highlights how mental health systems were shaped by Cold War dynamics on both sides of the Berlin Wall and examines the missed opportunities to invest in a human rights-based approach following its fall. This regional account informs the paper's second part, which presents reflections on global challenges in the field of mental health and human rights, grounded in the experience of the Special Rapporteur and the positions advanced by the UN right to health mandate during his tenure.

Underpinning these reflections is the regional case of CEE, which illustrates the varied roots of institutional corruption in mental health care, with lessons that are globally relevant.

Existing evidence indicates that mental health policies and services are especially susceptible to ineffective and corrupt practices.[2] This is a concern echoed by Robert Whitaker and Lisa Cosgrove, who describe the institutional corruption of psychiatry as rooted in systemic distortions that prioritize commercial and professional interests over patient well-being.[3] When viewed through Lawrence Lessig's lens on institutional corruption, where legal but ethically compromising influences distort an institution's core purpose, mental health systems can be seen as structurally vulnerable to such corruption.[4] In this context, policy implementation is often shaped less by public health priorities and human rights obligations than by entrenched financial, professional, and political dependencies, which systematically undermine efforts to scale equitable, community-based mental health services. The roots of such institutional corruption lie in embedded systemic obstacles, including an overreliance on the biomedical model and pharmacological interventions, entrenched power asymmetries, and the production and use of biased evidence.[5] These factors remain pervasive across all levels of mental health governance, distorting priorities away from people's actual needs and undermining a delivery of care that is equitable, evidence-based, and responsive to context. As a result, even when mental health policies appear to reflect modern human rights and public health frameworks, their implementation often fails to uphold the core principles of the right to health.[6]

In CEE, despite clear evidence that high rates of suicide and common mental health conditions in the late 20th century were linked to the stresses of profound societal transition and widespread patterns of destructive and self-destructive behavior, mental health policy and service development followed a largely medicalized path. Depression and other mental health conditions were treated mainly as biomedical issues, attributed to chemical imbalances in the brain rather than as outcomes of social and structural distress. Framing this situation as a case of institutional corruption, where systems are designed to serve entrenched professional and

political interests instead of well-being, the discussion turns to global developments in mental health policy, with particular attention to these structural obstacles that continue to undermine the full realization of the right to mental health for all.

Reflections on the Central and Eastern European experience

This section outlines the state of mental health policies and services in CEE before and after the fall of the Soviet Union, during a time of profound societal transition. It explores the interaction between distinct mental health systems shaped by differing political, economic, and ideological contexts during the Cold War. With the collapse of the Soviet Union in the 1990s, these once-separated systems began to converge, bringing both new opportunities and complex challenges for developing effective, transparent, and rights-based mental health care. To understand the transformations of the 1990s, we first examine the state of mental health policy and services in the region before that period.

The Soviet era of psychiatry in Central and Eastern Europe

CEE is a unique region shaped by 50–70 years under a Soviet-style totalitarian legacy. Following the collapse of the Soviet Union in the early 1990s, many CEE countries became known for their peaceful revolutions and transitions toward national independence and democracy. This historical turning point raised important questions: What were the opportunities and obstacles to introducing and adapting evidence and human rights-based mental health care practices in the region? How does the CEE experience differ from that of other regions?

All regions today face significant challenges in addressing global mental health issues, especially amid a shifting paradigm in mental health thinking. In this regard, it is often said that all countries may be considered "developing." Yet regional context matters, particularly when it concerns the institutional legacies from which such regions are building their reform trajectories. They shape not only existing structures and professional cultures but also public trust, governance capacities, and openness to reform. For this reason, the historical, political, and social specificities of regional context must be carefully considered when formulating and implementing national mental health policies, as they can profoundly influence both the process and the outcomes of reform.

It is important to highlight that the Soviet school of psychiatry was deeply influenced by the postwar and Cold War context. High-level political decisions made in Moscow positioned psychiatry and mental health care as strategic tools of ideological confrontation with the West. Several psychiatric research institutes, based primarily in Moscow, were tasked with constructing the theoretical foundations of Soviet psychiatry as both a science and a practice.[7]

A central message promoted by the political leadership was that, with the defeat of capitalism and the progression toward a society of "mature socialism," all social and psychosocial causes of mental health issues had supposedly been eradicated within the Soviet Union. This message, rooted in ideological propaganda and wishful thinking, became a dominant narrative. The role of scientific institutions and academia was, in effect, to generate so-called evidence in support of this politically driven claim. An example of this was the development of the concept of "sluggish schizophrenia"[8] by Soviet psychiatric authorities, which served to justify and reinforce the regime's political narrative. Such a diagnosis was used to pathologize dissent and frame political nonconformity as a type of "mental illness," aligning psychiatric practice with the objectives of the totalitarian state.

The narrative developed by the Soviet school of psychiatry emphasized that in the Western world—particularly in the United States and Western Europe—violations of economic and social rights under capitalism were the primary causes of widespread mental health conditions. By contrast, according to the Moscow school of psychiatry, such issues existed in the Soviet Union and its satellite states only to a much lesser extent.

At the highest political levels, it was decided that in the Soviet Union, incidents such as suicide,

violence, heavy drinking, and other forms of behavior deemed inappropriate could be explained only as manifestations of a mental health condition rooted in brain pathology. Leading psychiatric research institutes in Moscow determined that these cases were most often to be classified as forms of schizophrenia. To support this position, diagnostic criteria for schizophrenia were significantly broadened.

Meanwhile, Soviet psychiatric authorities maintained that if similar behaviors or psychological conditions emerged in the United States or other capitalist countries, they were to be interpreted as the inevitable outcomes of exploitation and alienation caused by the oppressive capitalist system. This double standard served to align psychiatric theory and diagnosis with ideological propaganda, reinforcing the notion of the superiority of Soviet socialism and the pathology of dissent under capitalism.

For those without lived experience of the Soviet system, this way of thinking may appear logical. After all, there is substantial evidence that inequality, particularly under capitalism and neoliberal policies, can have harmful effects on mental health and societal well-being.[9] This understanding may explain why many experts familiar only with the shortcomings of capitalism are not sufficiently critical of the effects of Soviet-style socialism.

In practice, however, the Soviet system evolved into an Orwellian society, marked by widespread institutional corruption, including within the health care sector. Psychiatry was no exception.[10] Mental health care and decision-making was deeply affected by a disconnect between two co-existing realities: the official narrative presented in documents and propaganda, and the lived reality of everyday practice. As in Orwell's novel, while the system claimed equality, in reality, "some [were] more equal than others."[11]

This legacy, rooted in a totalitarian system that left no room for democratic oversight or civil society, produced deeply harmful effects on mental health care and outcomes.[12] Psychiatric training emphasized a strictly biological model, reinforced by a strongly paternalistic approach. For example, a disturbing marker of professional competence was the ability to persuade the parents of children with intellectual disabilities or autism to relinquish custody, or to convince the spouse of a person diagnosed with a mental health condition to seek divorce. Treatment practices relied heavily on high doses of psychotropic medications, prolonged inpatient care in large psychiatric hospitals, and the widespread use of institutionalization for individuals deemed "treatment resistant." Receiving a psychiatric diagnosis often resulted in the loss of fundamental rights, with little to no legal protection or recourse.

The post-collapse period

In the late 1980s and early 1990s, the entire CEE region underwent a dramatic transformation. Countries that had been occupied or dominated by the Soviet Union regained their independence and began transitioning toward democracy and a market-based economy.

There was widespread enthusiasm to reform areas that had been suppressed under the former system, and mental health care was among them. Efforts were made to introduce previously marginalized elements such as psychotherapy, psychosocial interventions, modern public health approaches, and human rights principles.[13] These reforms aimed to restore balance within the bio-psycho-social model, countering the narrow biomedical focus imposed during the Soviet era.

Although there was optimism across CEE countries in the early 1990s, the societal transition also brought serious negative consequences. One of the most significant was a surge in premature deaths across the region during the last decade of the 20th century. According to Giovanni Cornia and Renato Paniccià, the abrupt and intense psychosocial stress caused by the transition from a centrally planned system to a radically different political and economic model led to a sharp rise in morbidity and mortality among large swaths of the population.[14] It is estimated that approximately four million more people died than should have been expected in a region of around 400 million inhabitants.

Government responses to the region's stress-induced crisis of mortality

The last decade of the 20th century marked a pivotal moment for the global community. With the end of the Cold War, there was widespread hope that countries and regions, including Europe, would fully embrace a human rights-based approach, particularly in the field of mental health. As history has shown, the right to mental health can be meaningfully realized only when all human rights are upheld equally and without exception. However, during the Cold War, both ideological blocs misused the concept of human rights, applying it selectively to serve political aims. In the "capitalist West," economic and social rights were often neglected, while in the "socialist East," civil and political rights were suppressed. In both cases, this selective application of human rights had a detrimental impact on societal mental health.

In the 1990s and into the early 2000s, there were strong expectations that the CEE region would become a fertile ground for the implementation of modern, rights-based approaches across sectors such as health, mental health, social welfare, and education. In the field of mental health specifically, it was hoped that Western consultants would encourage the new democracies to adopt public health strategies, human rights-based frameworks, and modern psychosocial interventions—tools seen as essential for addressing the region's high suicide rates and widespread challenges to societal mental well-being.

To the surprise of many local mental health professionals, consultants from academic centers in the Global North who arrived in the CEE region after the collapse of the Soviet Union did not prioritize psychosocial, community-based interventions, public health strategies, or human rights-based approaches.[15] Instead, their main recommendation was to invest in the biomedical model—specifically, to ensure coverage for the widespread use of new-generation psychotropic medications. Prominent psychiatrists from Europe and North America visited Lithuania and other newly independent states to advise governments that these medications should be the first-line treatment for conditions such as depression and schizophrenia, and were essential to reducing high suicide rates.[16]

Unfortunately, many of these consultants overlooked the broader social determinants of mental health and failed to recognize that, unlike in the West, the CEE region had not been shaped by psychodynamic or other psychological traditions. On the contrary, the region had long been heavily reliant on the biomedical model—an approach that had already contributed to a narrow, medicalized view of mental health care.

The trajectory of psychiatry and mental health care in Lithuania over the past few decades offers a complex snapshot. While the country has made significant progress in areas such as democratic governance, the rule of law, and the development of a vibrant civil society—especially since joining the European Union in 2004—these positive changes have had a limited impact on the mental health sector.

Following the advice of foreign consultants, Lithuania generally chose not to radically reform its mental health system but instead to invest in improving the existing model. As a result, after more than three decades, the system still relies on the same outdated infrastructure.[17] Despite considerable investment, only the facade of the mental health system has been redecorated, while its institutional culture continues to be marked by social exclusion, institutionalization, overmedicalization, and discriminatory practices.[18] Independent human rights monitoring in psychiatric facilities faces ongoing resistance. Institutional care remains in high demand, and large residential institutions remain full due to the lack of a diverse and adequately resourced network of community-based services.

Officially, Lithuania has more than 100 outpatient mental health centers serving a population of 2.7 million—an impressive ratio on paper. However, there is insufficient recognition among key stakeholders that these centers often fail to address core issues, such as the need to prevent institutionalization and to reduce the excessive use of psychotropic medications. Thus, these services are not functioning as truly comprehensive, community-based alternatives. Resistance to meaningful

change comes not only from government authorities but also from influential figures within the psychiatric profession.

In response, Mental Health 2030, a nongovernmental and expert coalition, has repeatedly called on national authorities to critically examine the current, ineffective infrastructure and begin implementing World Health Organization recommendations and human rights obligations, particularly those related to the development of quality, rights-based outpatient services.[19]

What preliminary conclusions can we draw from the development of mental health policies and services in the CEE region? An opportunity for reform was missed. Ironically and paradoxically, it was Western experts who advised investment in the existing, harmful status quo—reinforcing overreliance on the biomedical model by medicalizing issues rooted in the profound societal stress of the transition period, such as high suicide rates.

This outcome may be explained in part by the timing of two overlapping processes in different parts of the world. Just as CEE countries were emerging from decades of repressive, biologically driven psychiatry, the West was experiencing the "Prozac era," marked by disillusionment with psychotherapy and a renewed emphasis on pharmacological treatment. As a result, the CEE region, instead of moving toward a more balanced approach, entered a new phase of overmedicalization.

The effects of this trend remain visible today. The institutional corruption of the Soviet era did not disappear—it adapted and intertwined with new forms of influence.[20] The old Orwellian-style control evolved into a different kind of corruption, generously fed by the influence of the pharmaceutical industry and its close ties to the psychiatric establishment within the new environment of neoliberalism.

These historical and regional insights are essential when considering global mental health developments, including the harmful effects of totalitarianism, neoliberalism, and deepening social inequalities.

Bridging perspectives: From Central and Eastern Europe to global recognition of reform imperatives

We now turn to examine the broader global landscape of mental health over the past several decades. The first quarter of the 21st century has been marked by growing efforts to identify and dismantle systemic obstacles that have hindered meaningful reform in mental health care. Much has taken place in the field of mental health policy and services during these first 25 years, revealing both progress and challenges.

To understand this period, it is essential to recognize the dominant narrative that prevailed at the end of the 20th century: a widespread belief in the triumph of the biomedical model. The promise appeared bold and compelling—that advances in neuroscience and neuroimaging would soon identify biomarkers for major mental health conditions, enabling more precise diagnoses and the development of effective, evidence-based biomedical interventions that would significantly improve outcomes.

This scientific optimism was reflected by Edward Shorter, a renowned historian of psychiatry, who wrote at the turn of the century:

> *If there is one central intellectual reality at the end of the twentieth century, it is that the biological approach to psychiatry … has been a smashing success.*[21]

Shorter's observation also reflected the prevailing consensus of the time and shaped the direction and priorities of mental health systems moving into the 21st century. This optimism and consensus aligned with powerful professional, commercial, and bureaucratic incentives, channeling resources toward a narrow basket of biomedical solutions in service of these vested interests rather than the public good.

However, it did not take long for skepticism to darken the promise of the biomedical paradigm. Breakthroughs failed to materialize: biomarkers for mental health conditions remained elusive, and the effectiveness of new psychotropic medications fell

short of expectations. Despite initial enthusiasm, many of these medications did not deliver the transformative impact claimed by pharmaceutical companies and endorsed by leading figures in academic psychiatry. Meanwhile, other essential components of modern mental health care were underfunded, including psychosocial support, prevention and promotion strategies, and rights-based approaches.[22]

Importantly, this biomedical optimism undermined the full and effective realization of a human rights-based approach to mental health. The dominant logic held that if effective medications were now available, they should be accessible to everyone. When individuals diagnosed with conditions such as depression or schizophrenia refused treatment, coercive or involuntary measures were often framed as justifiable. In practice, the rise of the biomedical model did not lead to improved human rights protections. On the contrary, it became clear (globally) that this paradigm carried serious side effects, both in terms of clinical outcomes and in its implications for autonomy, dignity, and systemic equity.[23]

The adoption of the *Convention on the Rights of Persons with Disabilities* (CRPD) in 2006 marked a transformative moment in global mental health discourse.[24] It introduced clear principles for the protection of the rights of persons with disabilities, including those with psychosocial and intellectual disabilities, and sent an unequivocal message: realizing these rights requires moving away from a purely medical model and embracing a human rights-based, social model of care and support.[25]

This shift in the normative framework and a growing international consensus on the need to move beyond the status quo is reflected in key international documents. These include multiple UN Human Rights Council resolutions, as well as reports by the UN Special Rapporteur on the rights of persons with disabilities, the UN High Commissioner for Human Rights, and the UN Special Rapporteur on the right to health.[26]

The UN Special Rapporteur on the right to health identified three major systemic obstacles to the realization of the right to mental health, including an overreliance on the biomedical model and biomedical interventions; persistent power asymmetries; and the biased use of evidence and knowledge. The combined weight of these barriers continues to exert a powerful influence on decision-making processes at all levels of mental health systems. Together, they impede transformative change and contribute to what can be described as institutional corruption within mental health care.

These normative positions are complemented by three recent documents from the World Health Organization.[27] Together, they reflect an evidence-based call to action to invest in services that uphold human rights, eliminate coercion, and empower those who use mental health services.[28]

Is there sufficient evidence to support the claim that the status quo in mental health care is no longer working and increasingly doing more harm than good? We believe that the answer is yes. This growing body of evidence and international consensus points to the urgent need to move away from traditional models of mental health care and psychiatry that rely heavily on coercion, discrimination, and overmedicalization.

Since the adoption of the CRPD, advocates have called on UN member states and other stakeholders to abandon the entrenched status quo in psychiatry. The central debate among experts is no longer whether coercive measures are effective, but whether they should be substantially reduced or banned outright, with a view toward their full elimination.[29]

A robust and growing evidence base further undermines the legitimacy of the status quo. Research increasingly shows that systems overly focused on biomedical interventions, particularly psychotropic medications and nonconsensual measures, are not achieving improved mental health outcomes.[30] Just as important, civil society movements led by users and former users of mental health services, as well as organizations of persons with disabilities, have played a central role in exposing systemic failures.[31] Many of these advocacy efforts originated in CEE.[32] These movements have challenged the underlying causes of human rights violations, proposed alternative approaches, and

helped shift the global narrative on mental health toward one centered on dignity, autonomy, and social inclusion.

The failures of the status quo manifest differently across global contexts. In the Global South, the primary challenge remains the lack of access to acceptable, community mental health services. In contrast, the Global North faces a different kind of crisis. Here, the biomedical model has dominated for decades and coercive measures have not only persisted but are on the rise in many countries.[33] Ironically, this entrenched infrastructure often presents a greater barrier to reform than in lower-resource settings, leading some experts to suggest that transformative change may be more feasible in the Global South.[34]

Proponents of the biomedical (neurobiological) model have long claimed that effective treatment with psychotropic medications would help reduce stigma. However, this promise has not been fulfilled. On the contrary, the dominance of the biomedical paradigm has reinforced the use of involuntary treatment, often linked to higher doses of medication and the widespread practice of polypharmacy.[35] In many settings, refusal to take medication remains one of the most common justifications for coercive interventions. As a result, overreliance on medication-based treatment has likely contributed to the continued rise of involuntary practices, even in economically advanced countries. Instead of diminishing stigma and discrimination, these outcomes have created conditions in which they continue to thrive.

In many countries, coercion remains widespread in mental health care services. Evidence indicates that the use of coercive measures is not only persistent but increasing, despite substantial investments in mental health systems and stated commitments to use involuntary interventions only as a last resort.[36] For example, in the United Kingdom, the use of coercion under the Mental Health Act rose by 43% between 2006 and 2017.[37] Similar upward trends have been reported in other European countries, such as Scotland, Ireland, Belgium, and France.[38] Moreover, a consistent pattern of human rights violations in psychiatric institutions across Europe has been documented.[39]

To a large extent, this systemic global failure in mental health services is rooted in the routine use of nonconsensual measures, which providers are legally permitted to apply. At the clinical level, coercion corrupts the therapeutic alliance and undermines a core ethical principle of "do no harm." Although mental health laws in many countries are intended to safeguard the rights of persons with psychosocial disabilities, in practice these laws are frequently used to override those rights. What is legally framed as an exception is, in reality, too often treated as the rule.

To conclude this analysis, we return to the work of esteemed historian Edward Shorter. While in 1997, he confidently declared the triumph of biological psychiatry, by 2021 his assessment had shifted dramatically. In *The Rise and Fall of the Age of Psychopharmacology*, Shorter offers a sobering historical account, ultimately concluding that the story of psychopharmacology is one of public health failure.[40] He argues that psychiatry's diagnostic systems and therapeutic interventions have largely failed and that the field has retreated significantly from its earlier aspirations.

This stark reassessment reflects a broader reality: psychiatry, under the dominance of the biomedical paradigm, has not only lost its scientific footing but now appears to find itself in a profound crisis of both evidence and of values.

Moving beyond the impasse: Structural changes for sustainable mental health reform

A growing body of evidence supports the conclusion that the continued dominance of the biomedical model does more harm than good. Despite these calls and the accumulation of data, signs of meaningful change remain limited. In many regions and countries, the status quo in psychiatry, when actual practices are examined, continues to be firmly grounded in the biomedical paradigm.[41]

Nearly three decades after the ambitious *World Health Report 2001*, progress has been slow, if not stagnant. Throughout the 2010s and into the

2020s, effective, rights-based, and scalable alternatives have remained on the margins of mental health systems. In many countries, these noncoercive, community-based services are still absent from national plans, while in others, existing alternative models face growing pressure to shut down in favor of a return to the monopoly of mainstream psychiatry.

In several regions, including parts of Europe, substantial human and financial resources continue to be funneled into large residential institutions for the long-term care of persons with psychosocial disabilities. Medical education, particularly in psychiatry, continues to emphasize biomedical interventions as the first-line response, reinforcing the existing paradigm. Despite long-standing recommendations by the World Health Organization to move away from institutional psychiatric hospitals, these facilities still receive priority investments in many countries and often remain closely tied to academic psychiatry.

Mental health laws, while often framed in humanistic language invoking dignity and rights, frequently serve to legitimize the opposite. They continue to undermine the legal capacity and equal protection of persons with psychosocial and intellectual disabilities by permitting involuntary placement and treatment. Even when international funding is available, it often goes toward renovating psychiatric hospitals or large institutions, effectively reinforcing outdated systems and undermining the potential for structural reform.[42]

To enhance the quality of the global discourse on the present and future of mental health care, it is essential to include a diversity of voices and perspectives. However, a recent study found that the global mental health field continues to be shaped predominantly by elite, Western, and medicalized viewpoints.[43]

The psychiatric profession remains a central actor in shaping both global discourse and national mental health policies and services. Yet many influential psychiatric associations have so far resisted emerging reforms and continue to support the status quo. In this context, a study analyzing responses from major psychiatric organizations to the 2017 report of the UN Special Rapporteur on the right to health is particularly revealing.[44] Many prominent psychiatrists maintained that psychiatric expertise should remain the guiding force in mental health care, regardless of a person's consent, and that the protection of the right to health and restoration of dignity through clinical intervention must precede the exercise of other human rights.

This position reflects a hierarchical understanding of human rights that stands in direct opposition to the principles of the CRPD and the interpretation offered by the UN Committee on the Rights of Persons with Disabilities and many other international bodies and experts. Nearly two decades after the CRPD's adoption, there remains a significant divide between the psychiatric establishment and those advocating for a human rights-based approach to mental health. This enduring divide has been characterized as an "impasse," highlighting deep disagreements over coercion, legal capacity, and systemic discrimination.[45]

Academic psychiatry plays a particularly influential role, given its control over medical education and research agendas. Calls for reform have come not only from external critics but also from within academic psychiatry itself, where some members have acknowledged the urgent need to rebalance priorities in training, service delivery, and evidence production.[46] Nevertheless, with some exceptions, academic psychiatry continues to largely uphold the status quo.

The medicalization of public mental health has been driven in part by a lack of transparency and accountability in medical education and research, leading to biased evidence being embedded into clinical practice on a global scale. This trend has affected all regions, including CEE, as previously discussed. It must be met with strong corrective action by states and international organizations to ensure that mental health policies are grounded in non-biased evidence and a human rights-based approach. This obvious crisis in academic psychiatry, compounded by questionable ties with the pharmaceutical industry, has contributed to a "corruption of knowledge" in the mental health field. This crisis should be seen as a warning for psychiatry and

mental health care, as well as for the broader health sector.[47]

Overall, a significant portion of the psychiatric profession, including many leaders within academic psychiatry, continues to oppose the CRPD framework and the positions articulated by the Committee on the Rights of Persons with Disabilities, particularly in General Comment 1 on legal capacity.[48] However, there are encouraging signs of change. Influential figures within academic psychiatry and the leadership of the World Psychiatric Association have recently begun to adopt more progressive stances. Notably, respected psychiatrists have co-authored publications advocating for a rights-based approach that centers people with lived experience and promotes alternatives to coercion and violence in care settings.[49] Furthermore, the World Psychiatric Association has launched a campaign and issued a position statement on the reduction of coercion in mental health services.[50] This is a clear signal that the psychiatric community, albeit cautiously, is beginning to align with broader efforts to reform mental health care.

The strengthening of social psychiatry may offer a promising pathway forward, helping the psychiatric profession address its crisis of evidence and values while building common ground with a global coalition of stakeholders committed to advancing rights-based mental health systems.[51]

Conclusion

Mental health services worldwide remain anchored in laws, practices, and institutional cultures that obstruct the full realization of the right to mental health and the foundational principles of the CRPD. Even in light of authoritative calls for reform, including from the World Health Organization, systemic transformation remains elusive across both high- and low-income settings. For such changes to happen, there is need for a unified coalition of powerful stakeholders committed and willing to be active participants.

The reflections presented in this paper, drawn from both regional and global perspectives, highlight the systemic obstacles that continue to impede the implementation of modern, rights-based mental health policies and services. The most critical elements—overreliance on the biomedical model and interventions, entrenched power asymmetries, and the biased use of evidence—interact to sustain a vicious cycle of discrimination, coercion, disempowerment, and helplessness. Likewise, these factors together contribute to the sustained presence of institutional corruption, where legal, policy, professional, and health systems consistently serve entrenched interests.

These factors do not exist in isolation. They reinforce one another and together perpetuate a crisis of both evidence and values in mental health care. Left unchallenged, they present a universal barrier to realizing the right to mental health and are relevant across all regions, irrespective of economic status. The experience of CEE serves as a cautionary tale, where post-transition opportunities for reform were lost to ineffective investments and the reinforcement of outdated and harmful systems.

Going forward, the international mental health movement must prioritize dismantling these systemic barriers. The primary goal should no longer be only the reduction of a "treatment gap" but rather the transformation of the system itself, ensuring that care is accessible, noncoercive, and rights based. Addressing institutional corruption—as both a cause and a consequence of systemic failure—is central to this effort.

Acknowledgments

We dedicate this paper to the late Bhargavi Davar, Gábor Gombos, Saulius Pečiulis, and Jolijn Santegoeds—scholars, organizers, and truth-tellers. Any light in these pages is theirs; any errors are ours.

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