UNIVERSITY OF BRASILIA
INSTITUTE OF INTERNATIONAL RELATIONS
POSTGRADUATE PROGRAMME IN INTERNATIONAL RELATIONS

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UNDERSTANDING GLOBAL MENTAL HEALTH GOVERNANCE THROUGH THE REGIMES COMPLEX LENS

Brasilia
2026

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ENTENDENDO A GOVERNANÇA DA SAÚDE MENTAL GLOBAL PELAS LENTES DA TEORIA DOS REGIMES COMPLEXOS

Dissertation presented to the Postgraduate Programme in International Relations of the University of Brasilia as a requirement for the degree of Master (MSc) in International Relations

Advisor: Dra. Ana Flávia Granja e Barros

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“Traigo los ojos con que ella miró estas cosas, porque me dio sus ojos para ver.”

Juan Rulfo

À minha mãe por me emprestar seus olhos para que eu pudesse abrir os meus.

ABSTRACT

This dissertation examines how mental health has been integrated into global health governance by analyzing it as a complex regime composed of overlapping, non-hierarchical arrangements involving states, international organizations, regional bodies, civil society, philanthropic institutions, academia and private sector actors. The study aims to understand how these actors shape the agenda, norms and resource flows that structure global mental health action. Using a qualitative and interpretative methodology based on documentary and discourse analysis, it examines resolutions, policy frameworks, institutional reports and strategic documents produced by the United Nations, the World Health Organization (WHO), the Pan American Health Organization (PAHO) and other relevant institutions. The research identifies how mental health has gradually moved from the margins of international health cooperation to a more institutionalized position, supported by instruments such as WHO's Comprehensive Mental Health Action Plan 2013–2030 and its incorporation into the Sustainable Development Goals. The findings show, however, that despite growing political recognition, global mental health governance remains fragmented, underfunded and marked by asymmetries between the Global North and South. Persistent challenges include weak multilevel coordination, reliance on voluntary contributions, limited enforcement mechanisms, and insufficient integration of social determinants and intersectional inequalities. The research also identifies emerging innovations and collaborative practices, such as community-based care models, digital mental health, multilevel governance arrangements and cross-sectoral coalitions that link mental health to climate resilience, social protection and human rights frameworks. It concludes that advancing global mental health requires strengthening institutional coherence, expanding stable financing, enhancing social participation and adopting governance models capable of addressing the complexity of the Anthropocene. The study argues that mental health must be reframed as a central pillar of sustainable development, and that coordinated action across actors and levels of governance is essential to ensure equitable, human rights-based and scalable responses that effectively leave no one behind.

Keywords: Global Health Governance, Mental Health Policy, World Health Organization, Complex Regimes.

RESUMO

Esta dissertação examina como a saúde mental vem sendo integrada à governança global da saúde, analisando-a como um regime complexo composto por arranjos sobrepostos e não hierárquicos que envolvem Estados, organizações internacionais, organismos regionais, sociedade civil, instituições filantrópicas, academia e atores do setor privado. O estudo busca compreender como esses diferentes atores moldam a agenda, as normas e os fluxos de recursos que estruturam a ação global em saúde mental. A pesquisa adota uma metodologia qualitativa e interpretativa, baseada na análise documental e discursiva, examinando resoluções, marcos normativos, relatórios institucionais e documentos estratégicos produzidos pelas Nações Unidas, pela Organização Mundial da Saúde (OMS), pela Organização Pan-Americana da Saúde (OPAS) e por outras instituições relevantes. O estudo identifica como a saúde mental transitou gradualmente das margens da cooperação internacional em saúde para uma posição mais institucionalizada, apoiada por instrumentos como o Plano de Ação Abrangente em Saúde Mental da OMS 2013–2030 e por sua incorporação aos Objetivos de Desenvolvimento Sustentável. Os resultados indicam, contudo, que, apesar do crescente reconhecimento político, a governança global da saúde mental permanece fragmentada, subfinanciada e marcada por assimetrias entre o Norte e o Sul Globais. Entre os desafios persistentes, destacam-se a fragilidade da coordenação multinível, a dependência de contribuições voluntárias, a limitação de mecanismos de *enforcement* e a insuficiente integração dos determinantes sociais da saúde e das desigualdades interseccionais. A pesquisa também identifica inovações emergentes e práticas colaborativas, como modelos de cuidado comunitário, soluções digitais em saúde mental, arranjos de governança multinível e coalizões intersetoriais que articulam saúde mental com resiliência climática, proteção social e marcos de direitos humanos. Conclui-se que o avanço da saúde mental global requer o fortalecimento da coerência institucional, a ampliação de mecanismos estáveis de financiamento, o aprofundamento da participação social e a adoção de modelos de governança capazes de responder à complexidade do Antropoceno. O estudo argumenta que a saúde mental deve ser reenquadrada como um pilar central do desenvolvimento sustentável e que a ação coordenada entre atores e níveis de governança é essencial para assegurar respostas equitativas e escaláveis, baseadas nos direitos humanos e capazes de efetivamente não deixar ninguém para trás.

Palavras-chave: Governança Global da Saúde, Política de Saúde Mental, Organização Mundial da Saúde, Regimes Complexos.

RESUMEN

Esta disertación analiza cómo la salud mental se ha incorporado a la gobernanza global de la salud, entendiéndola como un régimen complejo formado por arreglos superpuestos y no jerárquicos en los que participan Estados, organizaciones internacionales, organismos regionales, sociedad civil, instituciones filantrópicas, la academia y actores del sector privado. El objetivo es comprender de qué manera estos actores influyen en la agenda, las normas y los flujos de recursos que estructuran la acción global en salud mental. A partir de una metodología cualitativa e interpretativa basada en el análisis documental y del discurso, la investigación examina resoluciones, marcos de política, informes institucionales y documentos estratégicos elaborados por las Naciones Unidas, la Organización Mundial de la Salud (OMS), la Organización Panamericana de la Salud (OPS) y otras instituciones pertinentes. El estudio muestra cómo la salud mental ha transitado gradualmente desde una posición periférica en la cooperación internacional en salud hacia un lugar más institucionalizado, respaldado por instrumentos como el Plan de Acción Integral en Salud Mental de la OMS 2013–2030 y por su incorporación a los Objetivos de Desarrollo Sostenible. No obstante, los hallazgos indican que, pese al creciente reconocimiento político, la gobernanza global de la salud mental continúa siendo fragmentada, insuficientemente financiada y atravesada por asimetrías entre el Norte y el Sur Globales. Persisten desafíos como la débil coordinación multinivel, la dependencia de contribuciones voluntarias, los limitados mecanismos de implementación y rendición de cuentas, y la integración todavía insuficiente de los determinantes sociales y de las desigualdades interseccionales. La investigación también identifica innovaciones y prácticas colaborativas en expansión, entre ellas modelos de atención comunitaria, soluciones de salud mental digital, arreglos de gobernanza multinivel y coaliciones intersectoriales que articulan la salud mental con la resiliencia climática, la protección social y los marcos de derechos humanos. En conjunto, se concluye que avanzar en la agenda global de salud mental exige reforzar la coherencia institucional, ampliar fuentes estables de financiamiento, profundizar la participación social y adoptar modelos de gobernanza capaces de responder a la complejidad del Antropoceno. En este sentido, la disertación sostiene que la salud mental debe replantearse como un pilar central del desarrollo sostenible y que la acción coordinada entre actores y niveles de gobernanza es indispensable para garantizar respuestas equitativas y escalables, basadas en los derechos humanos y capaces de efectivamente no dejar a nadie atrás.

Palabras-clave: Gobernanza Global de la Salud, Política de Salud Mental, Organización Mundial de la Salud, Regímenes Complejos.

LIST OF ABBREVIATIONS

BTTC – Business Council and the Think Tank Council

CAHSM – The Ad Hoc Committee on Mental Health of Mercosur

CAPS – Brazilian Psychosocial Care Centers

CUGH – Consortium of Universities for Global Health

CRPD – Convention on the Rights of Persons with Disabilities

DALYs – Disability-adjusted life years

ECOSOC – The United Nations´ Economic and Social Council

EU – European Union

FCTC – Framework Convention on Tobacco Control

GMHAN – Global Mental Health Action Network

HRC – Human Rights Council

IHR – International Health Regulations

ILO – International Labour Organization

IOs – International Organizations

IOM – International Organization for Migration

ISB – International Sanitary Bureau

LNHO – League of Nations Health Organization

LMICs – Low- and Middle-Income Countries

MDGs – Millennium Development Goals

mhGAP – Mental Health Gap Action Programme

MHPSS – Mental-health-and-psychosocial-support

MSF – Doctors without Borders

NCDs – Noncommunicable Diseases

NDB – New Development Bank (BRICS´ Bank)

NGOs – Non-Governmental Organizations

NIMH – National Institute of Mental Health (United States)

NMH – Pan American Health Organization´s Department of Noncommunicable Diseases and Mental Health

OAS – Organization of American States

OECD – Organization for Economic Co-operation and Development

PAHO – Pan American Health Organization

PHEIC – Public Health Emergencies of International Concern

PPPs – Public–private partnerships

RAPS – Brazilian Psychosocial Care Network

SDGs – Sustainable Development Goals

SSRI – Selective Serotonin Reuptake Inhibitor

SUS – Brazilian Public Health System

UN – United Nations

UNAIDS – The Joint United Nations Programme on HIV and AIDS

UNDP – United Nations Development Programme

UNFPA – United Nations Population Fund

UNGA – United Nations General Assembly

UNHCR – United Nations High Commissioner for Refugees

UNICEF – United Nations Children's Fund

UNODC – United Nations Office on Drugs and Crime

WB – World Bank

WEF – World Economic Forum

WFMH – World Federation for Mental Health

WFPHA – World Federation of Public Health Associations

WHA – World Health Assembly

WHO – World Health Organization

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INTRODUCTION

The Anthropocene, a proposed geological epoch, is defined by the extensive and lasting impact of human activity on Earth's geology and ecosystems. According to Waters et al. (2016), the Anthropocene is functionally and stratigraphically distinct from the Holocene due to the global-scale environmental transformations driven by industrialization, urbanization, and the proliferation of novel materials. Anthropogenic influences, from deforestation and urbanization to poor waste management, have fundamentally modified planetary processes (ZALASIEWICZ et al., 2017). Hallmarks of the Anthropocene include major biodiversity loss, climate change driven by greenhouse gas emissions, widespread ecosystem degradation, and the accumulation of synthetic materials in natural environments (STEFFEN, CRUTZEN; MCNEILL, 2007). These transformations not only reshape ecological systems but also generate profound social and political challenges, requiring interdisciplinary analysis, new governance responses, and policy innovation.

In addition to its geological significance, the Anthropocene serves as a conceptual lens for understanding the deep interconnection between environmental changes, global governance, and human well-being. Scholars across disciplines, including environmental studies, political science, international relations, and public health, have examined how the Anthropocene encapsulates the convergence of these global issues and their urgent consequences, such as the proliferation of interconnected health crises. Environmental degradation, air and water pollution, and the increasing frequency of extreme weather events are not solely ecological concerns; they also have direct and indirect consequences for human populations and constitute growing public health threats, with far-reaching impacts on both physical and mental health (CORVALÁN et al., 2022; WHO, 2022).

As conceptualized by the World Health Organization (WHO), mental health is a basic human right and is not only fundamental to individual well-being but also essential for societal development (WHO, 2025). The World Economic Forum (WEF), in its Global Risks Reports of 2021 and 2023, has also underscored mental health as a critical global issue, recognizing its deterioration as a significant short-term risk that threatens social cohesion and exacerbates other global challenges (WEF, 2021; 2023).

This increasing recognition of mental health as a global concern stands in contrast to its historical marginalization within global governance frameworks (PATEL et al., 2018), particularly in health agendas that have traditionally prioritized infectious diseases and physical health conditions (BEMME; D'SOUZA, 2014; VIGO, THORNICROFT; ATUN, 2016). At the same time, the evolution of global health governance reflects a broader and ongoing transformation: a shift from addressing public health issues as hygiene, tropical medicine, and infectious disease control to adopting more globalized approaches that conceptualize health as a transnational concern and an essential element of international cooperation and development (FIDLER, 2001). This shift has been shaped by processes of globalization, epidemiological transitions, and the growing understanding of health not only as a development issue but also as a matter of human security, political relevance, and socioeconomic resilience (KICKBUSCH; GLEICHER, 2025; GOSTIN, 2014).

Within this broader reconfiguration of priorities and governance mechanisms, initiatives led by the WHO and transnational advocacy networks have increasingly sought to include mental health in global policy frameworks. These initiatives emphasize its relevance to sustainable development and the protection of human rights (BENNETT; IREDELL, 2020). The incorporation of mental health targets into the United Nations Sustainable Development Goals (SDGs), especially under SDG 3.4, illustrates this shift and signals a growing international commitment to addressing mental health as an integral component of global well-being (PATEL et al., 2018).

This growing visibility, however, has unfolded amid mounting global challenges that further expose structural fragilities. The COVID-19 pandemic has exposed the vulnerability of mental health systems and underscored the need for resilient, globally coordinated responses (WHO, 2022; SANTOMAURO et al., 2021). Beyond its epidemiological impact, the pandemic revealed how mental health is deeply embedded in broader socio-political and economic structures, reinforcing the necessity of integrating mental health into public health emergency preparedness and response strategies (KOLA et al., 2021). It also sheds light on critical gaps in perinatal mental health support for postpartum people, which contribute to higher rates of maternal suicide, neonatal malnutrition, and illness among newborns (PROJECT HOPE, 2024, p. 13). These dynamics renewed global attention to workforce

protection, equity in service access and provision, and the interdependence between mental health and other systemic determinants.

This thesis is guided by the following research questions: How have global health governance frameworks incorporated mental health? What roles do the main actors play in shaping this agenda? Which political and institutional challenges continue to hinder the development of an effective global mental health governance framework? What innovative policy strategies and approaches have emerged in this field, and how can they contribute to advancing and scaling mental health within global health governance?

Addressing these questions requires a multidimensional analytical approach that bridges public health, international relations, and global political economy. By examining the positioning of mental health within the broader architecture of global governance, this study seeks to contribute to ongoing debates on how international cooperation can support the development of more inclusive, sustainable, and equitable global health policies.

The research adopts a qualitative and interpretative design, grounded in documentary analysis of institutional, legal, and policy materials. The empirical corpus combines primary and secondary sources, including resolutions, constitutions, conventions, global strategies and action plans, ministerial declarations, technical guidelines, monitoring reports, and strategic documents produced by international and regional organizations. These are complemented by analytical reports from international agencies and think tanks, as well as scholarly literature from public health, global governance, and international relations. Documents were selected according to their relevance for understanding how mental health is framed institutionally, how it enters agenda-setting processes, and how norms and instruments for its governance are constructed and implemented. Moreover, visual analytical tools, including AI-assisted visualization, were used to synthesize complex institutional relationships and support interpretative analysis, without replacing documentary or theoretical examination.

Methodologically, the study combines institutional and discourse analysis. First, an interpretative institutional analysis is used to identify the mechanisms, procedures, and decision-making dynamics through which mental health has been progressively integrated into the global health governance system. This involves mapping actors, arenas, instruments, and rules that structure the field, and examining how these elements interact across global,

regional, and national levels. Second, discourse analysis is employed to explore how mental health is represented and constructed in official narratives, policy frameworks, and institutional reports, with particular attention to the linguistic, ideological, and political dimensions that underpin global strategies (SCHMIDT, 2008). Through this interdisciplinary and interpretative lens, the research seeks to understand how mental health has been positioned within the global health agenda and how global players interact and shape mental health frameworks.

Analytically, the thesis scrutinizes the research questions through the theoretical lens of Regime Complex Theory, complemented by insights from global governance theory and the notion of organizational autonomy in international organizations (BARNETT; FINNEMORE, 2004; ZELLI et al., 2021). Regime complexes are understood as constellations of partially overlapping and non-hierarchical institutions, in which authority, norms, and agendas are continuously negotiated among diverse actors (ORSINI et. al., 2013). This perspective is combined with global governance approaches that emphasize the plurality of actors and sites of authority beyond the state, including international organizations, transnational networks, and private and philanthropic actors (BENNETT; SATTERFIELD, 2018). The concept of organizational autonomy highlights how international organizations such as WHO and PAHO develop their own preferences and practices, sometimes extending beyond or reshaping the interests of member states (BARNETT; FINNEMORE, 2004).

While regime complex theory has been widely applied to areas such as climate change, trade, security and environmental governance, its application to global health, and particularly to mental health, remains comparatively underexplored. Classical regime theory, as originally formulated, presupposes a relatively stable constellation of rules, shared expectations and a limited number of central institutions. This assumption is increasingly inadequate to capture the fragmented, multi-actor and dynamically evolving landscape of global health governance in the Anthropocene.

In the field of mental health, governance does not operate through a single treaty-based regime or a clearly delimited institutional hierarchy. Instead, it emerges through overlapping mandates, partially coordinated strategies, and dispersed authority across international organizations, regional bodies, state actors, philanthropic institutions, civil society networks, academic communities and private sector stakeholders. These arrangements

coexist without a central coordinating authority and frequently pursue intersecting, yet not always convergent, objectives. Regime complex theory is therefore particularly well suited to analyze global mental health governance, as it allows for the examination of both cooperation and contestation, complementarity and fragmentation. Moreover, adopting a regime complex lens enables the analysis of governance dynamics beyond formal institutional design. It captures informal practices, discursive convergence, soft-law instruments, funding mechanisms and policy diffusion processes that shape mental health governance in practice. Rather than assuming coherence or linear institutional evolution, this framework foregrounds processes of negotiation, adaptation and strategic interaction among actors with asymmetrical power and resources.

In contrast to more generic approaches to global governance, regime complex theory provides analytical tools to examine how authority is distributed and reconfigured across institutional sites, how actors navigate overlapping jurisdictions, and how gaps and redundancies emerge within governance architectures. This perspective is especially relevant in mental health, where responsibilities are frequently dispersed across health, social protection, education, justice and humanitarian sectors, resulting in coordination challenges and uneven policy implementation. By applying this framework, the dissertation conceptualizes global mental health governance not as a consolidated or fully coherent regime, but as an evolving and contested configuration. Mental health is thus understood as a policy domain that operates at the intersection of multiple regimes, including health, human rights, development, disability and humanitarian governance, while progressively consolidating its own agenda, norms and institutional practices.

Building on Orsini's (2019) advocacy for a complexity-oriented approach in international relations, the study conceptualizes global mental health governance as a multidimensional regime composed of intersecting actors, policies, and institutional mechanisms. These complexities are further analyzed through global governance debates that examine misalignments between state preferences, international institutions, and transnational actors in shaping health policies and resource allocation (ALTER; MEUNIER, 2009; ZÜRN, 2018; RANDALL HENNING; PRATT, 2023). Through critical engagement with resolutions, strategic frameworks, and policy instruments, the research investigates how fragmented

governance structures influence the prioritization and framing of mental health within international policy arenas.

This study acknowledges its inherent limitations in qualitative document analysis, such as the lack of access to internal deliberations or confidential data, and the potential for institutional bias in official reports. These are mitigated by critical reading and cross-comparison of multiple sources.

Ultimately, the thesis aims to contribute to the emerging field of global mental health governance by offering a critical reflection on the ways in which political, economic, and institutional forces interact to shape global priorities and by identifying possibilities for more equitable, scalable, and coordinated responses.

Lastly, the dissertation is structured into three chapters, each addressing distinct yet interconnected dimensions of global mental health governance.

Chapter 1 traces the evolution from international to global health, highlighting the shift from early efforts focused on infectious disease control to a broader agenda that incorporates mental health. Milestones include large-scale campaigns against malaria, tuberculosis, and smallpox, the rise of social determinants of health, and the creation of governance structures such as the WHO in 1948 (FIDLER, 1997; BROWN, CUETO, FEE, 20066; WHO, 1948). The chapter then examines mental health's growing prominence, driven by evidence of its global burden (PATEL et al., 2013; PRINCE et al., 2007), its inclusion in the SDGs, and the principle that "there is no health without mental health" (UN, 2015). Finally, it addresses mental health as a human rights issue, emphasizing the shift from institutionalization to community-based care under the CRPD (UN, 2006) and the deinstitutionalization movement, which advanced dignity and freedom (FREEMAN, 2015; THORNICROFT; TANSELLA, 2004). These developments underpin mental health's integration into global health governance.

Chapter 2 will examine the institutionalization of global mental health, analyzing it through the lens of complex regimes theory and focusing on the key actors and frameworks that have shaped this domain, including international organizations, national governments, non-governmental organizations (NGOs), and private sector stakeholders.

Chapter 3 begins by examining the persistent challenges and gaps that hinder the advancement of the global mental health agenda and the effective implementation of related policies, including resource allocation and innovation. These obstacles, such as insufficient and unstable funding, continue to impede the translation of political commitments into concrete and sustained actions. In this context, the chapter analyzes innovation, best practices and how initiatives can further be scaled up through cooperation, addressing the social determinants of health that shape access to mental health services and the quality of care, such as gender, poverty, racism, education degree, and living conditions. Finally, the chapter will offer policy recommendations and outline future directions for global mental health governance.

This historical and conceptual reconstruction is essential to understanding how mental health became legible as a global governance issue. *Chapter 1* therefore traces the evolution from international to global health as the structural and normative precondition for the emergence of global mental health governance.

CHAPTER 1: THE EVOLUTION OF GLOBAL HEALTH: PAVING THE WAY FOR MENTAL HEALTH

The origins of what would later be conceptualized as international health can be traced back to the late 19th and early 20th centuries, a period in which health-related initiatives across borders were primarily driven by concerns with hygiene and tropical medicine. These fields emerged in response to the challenges posed by infectious diseases in colonial settings, especially in tropical regions affected by European imperial expansion. Tropical medicine developed as a distinct discipline during this period, with a focus on diseases such as malaria, tuberculosis, and yellow fever, illnesses that disproportionately affected colonial administrators, soldiers, and local populations and were perceived as threats to colonial governance and economic productivity (PACKARD, 2016). Public health interventions, in this context, were largely instrumental, aimed at maintaining colonial authority rather than promoting health as a universal right (BALDWIN, 1999).

By the turn of the 20th century, health initiatives were increasingly framed not only in terms of colonial management but also as issues of international concern requiring technical cooperation and cross-border regulation. The growing interconnectedness brought about by trade, migration, and technological development reinforced the idea that disease control could no longer be managed solely within national borders. Cholera, yellow fever, and plague outbreaks traveled along maritime and land routes, threatening cities and trade networks far beyond their points of origin. This led to the emergence of early multilateral mechanisms aimed at disease surveillance and quarantine coordination, as evidenced by the International Sanitary Conferences (BALDWIN, 1999; FIDLER, 2001). These developments laid the groundwork for viewing health as a matter of collective security, diplomacy, and international cooperation — themes that would later become central to the architecture of global health governance (HOWARD-JONES, 1975; CUETO, BROWN; FEE, 2019).

At the same time, shifts in political thought and scientific knowledge were reshaping the understanding of health and its social function. The rise of bacteriology and germ theory, championed by figures such as Louis Pasteur and Robert Koch, provided a scientific rationale for controlling infectious diseases and justified greater state intervention in public health (LATOUR, 1988; GRADMANN, 2009). Meanwhile, the early socialist and labor movements in Europe, along with philanthropic reformers, were increasingly advocating for state

responsibility in addressing the health conditions of the working and poor classes (ROSEN, 1994; PORTER, 1999). This convergence of science, politics, and moral responsibility gradually expanded the idea of health beyond the elite and colonial administrative classes to broader populations, setting the stage for more inclusive public health systems. These dynamics would later influence both the institutional design of health governance and the normative frameworks underpinning international cooperation in health (LEE; COLLIN, 2005; BIRN, 2009).

A Historical Perspective for International Health and Global Health

This historical context shaped the early development of international health, which was grounded in an emerging public health centered on controlling infectious diseases and improving environmental conditions. In the late 19th century, public health began to be conceptualized not merely as the treatment of individual illnesses but as a collective endeavor aimed at improving the sanitary conditions of populations, particularly in rapidly industrializing urban centers plagued by poverty, overcrowding, and poor sanitation. The sanitary movement, as described in public health literature, emphasized interventions such as waste removal, clean water supply, and urban drainage systems as essential to preventing disease (ROSEN, 1994). Reformers like Edwin Chadwick in England and Louis-René Villermé in France documented the direct relationship between poor urban infrastructure, low pay, child labor, and high rates of disease and mortality (CHADWICK, 1842; VILLERMÉ, 1840). These early conceptions of health were closely linked to social hygiene and state responsibility, laying the foundations for what would become modern public health systems.

Literature from this period played a crucial role in documenting and denouncing the social conditions that contributed to illness. Novels such as Germinal by Émile Zola (ZOLA, 1885) and Oliver Twist by Charles Dickens (DICKENS, 1838) exposed the degradation, child labor, malnutrition, and insalubrity endured by working-class populations in France and England. In Latin America, *O Cortiço* by Aluísio Azevedo (AZEVEDO, 1890) vividly portrayed the overcrowding, lack of sanitation, and moral stigmatization of the urban poor in late 19th-century Brazil. These narratives reveal how literature captured the intimate relationship between social inequality, environmental degradation, and health, reinforcing a

sanitary-focused bias behind early public health interventions. This conceptual development then culminated in the early 20th century with Charles-Edward Amory Winslow's seminal definition of public health as "the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts," highlighting the role of intersectoral actions and civic engagement in improving population health (WINSLOW, 1920).

The International Sanitary Conferences, initiated in 1851, represented one of the first multilateral efforts to address health issues and challenges across borders. These conferences aimed to harmonize quarantine protocols and control the spread of transboundary diseases such as cholera, yellow fever, and plague. Their culmination led to the adoption of the International Sanitary Regulations in 1903, establishing an early legal framework for international cooperation in health (BROWN, CUETO, FEE, 2006). In the Region of the Americas, the creation of the Pan American Health Organization (PAHO) in 1902 marked a significant institutional development in the field. As the oldest continuously active international public health agency, PAHO played a pivotal role in strengthening regional cooperation and health infrastructure. These developments, combined with the devastation caused by the Spanish flu pandemic of 1918–1919, which resulted in an estimated 50 million deaths worldwide, starkly revealed the limitations of nationally fragmented health responses and underscored the necessity of more coordinated international cooperation. In the wake of this crisis, the international community recognized the urgent need for a structured global health governance mechanism, which led to the establishment of the League of Nations Health Organization (LNHO) in 1921, as a technical body within the League of Nations (1920–1946).

The LNHO played a foundational role in shaping modern international health governance by advancing standardized disease surveillance, promoting scientific research, and fostering cross-border collaboration to address shared health threats (WEINDLING, 1995; BOROWY, 2009; HOWARD-JONES, 1975). Among its key contributions were the standardization of vital statistics, the development of epidemiological intelligence networks, and the creation of mechanisms for the exchange of health data among member states. These initiatives marked a gradual shift from a colonial and regionally bounded approach to a more cooperative and globally oriented vision of health. At the same time, the League of Nations'

institutional decline during World War II and its eventual dissolution, followed by the creation of the United Nations, reshaped the broader architecture of multilateral cooperation. This political and institutional reconfiguration created the conditions for a more universal and formally coordinated health agency, building on the LNHO's technical legacy while relocating health governance within the emerging UN system (LEE; COLLINS, 2005).

In 1948, the World Health Organization (WHO) was established as a specialized agency of the United Nations during the first World Health Assembly in Geneva, with the participation of 52 member states. Its Constitution defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1948), thereby expanding the international health agenda to include a holistic understanding of well-being. This foundational moment also marked the formal recognition of health as a human right and highlighted the need for international coordination to promote it (LEE; COLLINS, 2005).

In the decades that followed, international conferences on health, development, and human rights helped to consolidate this broader vision. The Alma-Ata Declaration of 1978 advocated for primary health care as the key strategy to achieve "health for all," emphasizing community participation, intersectoral action, and the role of social, economic, and political determinants in reducing health inequalities (WHO, 1978; CUETO, 2004). Building on this momentum, the Ottawa Charter for Health Promotion in 1986 further advanced the recognition of health equity and individual and collective empowerment as essential to improving population health (WHO, 1986; BIRN, 2009). This paradigm shift fostered renewed multilateral cooperation and laid the groundwork for major global efforts such as the eradication of smallpox in 1980, a landmark achievement led by WHO in partnership with national governments (FENNER et al., 1988), and the revision of the International Health Regulations (IHR). Initially adopted in 1969 and revised in 2005, the IHR aimed to strengthen preparedness and global health security in response to emerging threats, establishing a normative framework for the detection, notification, and coordinated response to public health emergencies of international concern (PHEIC), while seeking to minimize unnecessary disruption to international trade and travel (WHO, 2016; FIDLER, 2001; FIDLER, 2005), highlighting how the IHR became a central instrument in debates on global health security and governance challenges.

By the latter half of the 20th century, the field of international health had begun to evolve into what would later be conceptualized as “global health”, a paradigm defined by its emphasis on equity, social determinants of health, and the intersection of health with broader themes such as development, human rights, security, and globalization (BROWN, CUETO, FEE, 2006). This conceptual transformation reflected the growing recognition that health challenges are inherently interconnected and transcend national borders, catalyzed by the rise of noncommunicable diseases (NCDs), the persistence of pandemics such as HIV/AIDS, and the emergence of novel infectious threats like SARS, H1N1, and COVID-19.

In the 1990s, the concept of global health gained increasing prominence in both academic and policy discourse, emerging as a comprehensive framework to address communicable and noncommunicable diseases alike, reduce global health disparities, and promote shared responsibility for health outcomes across countries and regions (KOPLAN et al., 2009). These developments exposed the limitations of vertical, disease-specific approaches and underscored the need for integrated strategies capable of addressing the root causes of ill-health (FRENK et al., 2013; GOSTIN; FRIEDMAN, 2015). As part of this response, global health governance increasingly adopted multisectoral approaches and embraced a broader range of stakeholders, including states, international organizations, civil society, philanthropic foundations, academic institutions, and the private sector, in efforts to build resilient and equitable health systems (KICKBUSCH et al., 2012; KICKBUSCH; SZABO, 2014; YOUDE, 2012). This transition marked a departure from a state-centric model of international health to a more complex and pluralistic governance arrangement, consolidating global health as a field requiring inclusive, accountable, and justice-oriented governance frameworks.

After this process, global health became increasingly shaped by interconnected transnational dynamics such as climate change, migration, geopolitical conflict, and economic interdependence. These challenges have deepened the understanding that health outcomes are not solely determined by biomedical factors, but are profoundly influenced by structural, social, and political determinants, thereby demanding governance models that are not only technically sound but also inclusive, transparent, and equity-oriented (GOSTIN; SRIDHAR, 2014; YOUDE, 2012). Therefore, while both international health and global health seek to address transnational health challenges, the latter represents a more integrated,

interdependent, and equity-oriented paradigm. It emphasizes sustainability, shared responsibility, and the construction of resilient health systems capable of addressing both immediate health threats and long-term structural determinants, particularly those affecting historically marginalized groups. The conceptual and institutional shift from international to global health reflects a broader reconfiguration of global governance, marked by the growing involvement of diverse actors, the consolidation of multilateral frameworks, and the normative recognition of health as a multidimensional concern linked to human rights, development, and social justice, linked to human rights, development, and social justice (GOSTIN; MEIER, 2022; GOSTIN; SRIDHAR, 2014; KICKBUSCH et al., 2012). The rise of global health has therefore entailed not only a change in terminology, but also a transformation in the ways health is understood, financed, governed, and integrated into international cooperation agendas. In this expanding and more inclusive framework, mental health has increasingly been recognized as a cross-cutting issue in broader health and development strategies.

In this context, the adoption of the Millennium Development Goals (MDGs) by the United Nations in 2000 marked a turning point in the trajectory of global health governance. As part of a broader strategy to eradicate poverty and promote sustainable development, the MDGs established time-bound targets to reduce child mortality, improve maternal health, and combat major infectious diseases such as HIV/AIDS, malaria, and tuberculosis (UNITED NATIONS, 2000). These goals galvanized international attention and political will, fostering an unprecedented wave of multilateral cooperation, resource mobilization, and the expansion of public–private partnerships. The global health architecture experienced a proliferation of new actors and funding mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance, reflecting a growing emphasis on results-based financing and performance indicators.

The MDGs contributed to substantial improvements in health outcomes, including a decline in the annual number of deaths of children under five from 12.7 million in 1990 to 6.3 million in 2013 – a reduction of about 49% in the under-five mortality rate – and a significant drop in the global number of maternal deaths over the same period (WHO, 2018). Despite persistent regional disparities and criticisms regarding the verticalization and selectivity of health goals, the MDG era laid the foundation for a results-oriented and accountability-driven

approach to global health policy. It also reinforced the strategic role of diplomacy, governance mechanisms, and multistakeholder coordination in shaping health as a core dimension of development.

Building on the momentum of the MDGs, the United Nations adopted in 2015 Resolution A/RES/70/1, Transforming our World: The 2030 Agenda for Sustainable Development, which called on all Member States to promote human rights, reduce inequalities, and foster inclusive development worldwide (UN, 2015). This experience directly informed the formulation of the Sustainable Development Goals (SDGs), which integrated health into a comprehensive and multisectoral framework for advancing global equity and sustainability (UN, 2015; SACHS, 2012). In this normative and institutional shift, health was positioned as a central pillar of a universal agenda for social justice, inclusion, and sustainable development, articulating an ambitious vision that explicitly links well-being to structural and social determinants.

Within this framework, SDG 3 – "Ensure healthy lives and promote well-being for all at all ages" – explicitly includes a target to reduce by one-third premature mortality from noncommunicable diseases (NCDs) through prevention and treatment, while also promoting mental health and well-being. This inclusion marked a critical expansion of the global health agenda beyond traditional disease control, incorporating the social, emotional, and psychological dimensions of health. Moreover, SDG 3 reinforces the need for cross-sectoral collaboration and the integration of health across development strategies, reaffirming the interdependence between health outcomes, social equity, and sustainability.

From a governance perspective, this reorientation has been interpreted by scholars as requiring new balances between national sovereignty and global solidarity. Authors such as Ilona Kickbusch and colleagues (2012) and Gorik Ooms (2008) emphasize the importance of accountability, participation, and fairness in global health decision-making, highlighting the political dimensions of health governance (KICKBUSCH et al., 2012; OOMS, 2008). In parallel, the Commission on Social Determinants of Health underscored that health equity cannot be achieved without addressing material conditions, education, employment, and access to services, calling for intersectoral policies and structural change (MARMOT et al., 2008).

These debates converge with the global push for Universal Health Coverage (UHC), as promoted in the WHO's World Health Report (2010) and further articulated by Sridhar and Woods (2013). Framed as both a technical and normative objective, UHC reflects a growing consensus that health constitutes a global public good and a foundational component of sustainable development, reinforcing the need for governance arrangements capable of aligning equity, universality, and long-term resilience.

Later, the COVID-19 pandemic served as a powerful catalyst, amplifying the recognition of health as a major international concern and exposing the fragility of global health systems. In particular, it brought unprecedented attention to the mental health crisis, both by exacerbating pre-existing conditions and by generating new layers of psychological distress across populations. This alarming scenario underscored the urgent need for targeted mental health services for essential workers, particularly during public health emergencies, and highlighted systemic failures in providing sustainable psychosocial support within health systems (WHO, 2022; KOLA et al., 2021). Moreover, the pandemic also magnified social inequalities and exposed the cumulative impact of structural determinants on mental health. Poverty, unemployment, precarious housing, food insecurity, and systemic discrimination, including racism and gender inequality, were all intensified during the crisis, disproportionately affecting already vulnerable populations (LUND et al., 2018; WHO, 2022). The syndemic nature of COVID-19 thus revealed how mental health cannot be disentangled from broader social, economic, and environmental conditions.

These stressors were further compounded by emerging and interconnected global challenges. Climate change, for instance, has become increasingly recognized not only as an environmental and health issue but also as a major psychological stressor. The phenomenon of climate anxiety, particularly among youth and communities in disaster-prone or environmentally degraded areas, reflects growing mental distress linked to uncertainty about the future and feelings of helplessness (CUNSOLO; ELLIS, 2018). Economic instability, geopolitical tensions, forced displacement, and digital dependency have similarly intensified the complexity of mental health needs, revealing the inadequacy of fragmented approaches and reinforcing the urgency of comprehensive, multisectoral responses. In this context, the COVID-19 pandemic served as a critical juncture by amplifying these vulnerabilities and repositioning mental health at the core of international health debates, not as a peripheral

concern, but as a fundamental dimension of human development, social cohesion, and resilient public health systems.

Together, these developments helped catalyze institutional, political, and normative changes within global health governance, setting the stage for the consolidation of mental health as a distinct agenda. The following section examines this process in greater depth, showing how mental health has moved from the margins of global health to a more structured and institutionalized domain. While it remains embedded within the broader global health architecture, it has increasingly developed its own agenda, instruments, and governance dynamics, laying the groundwork for the analysis developed in *Chapter 2* and *3*.

Global Mental Health: From the Margins of Global Health to its own Agenda

As mental health gained normative and political visibility, it also began to take shape within institutional frameworks, technical guidelines, and international cooperation mechanisms - and to have a framework of its own. Thus, this section examines the processes through which mental health has been progressively institutionalized within global health governance.

In this sense, the Declaration of Caracas (1990) marked a turning point in the regional and global governance of mental health, especially in the Americas as it became a landmark for the later movement of psychiatric reform, further addressed in this section, as it called for the protection of the rights of individuals with mental disorders and the reorganization of mental health systems based on decentralization, community participation, and the promotion of care in the least restrictive environments. Rooted in the principles of social medicine and influenced by earlier experiences of psychiatric deinstitutionalization in countries like Italy and Brazil, the Declaration reflected growing awareness of the abuses and inefficiencies inherent in asylum-based models, advocating instead for integrated, rights-based care at the community level (AMARANTE, 1995).

The WHO and other multilateral actors have increasingly acknowledged the substantial impact of mental health on individuals, communities, and economic systems. As Thornicroft et al. (2017) emphasize, mental health is inseparable from overall well-being and

influences physical, emotional, and social dimensions of health. This evolving recognition has been shaped not only by data on disease burden but also by sustained advocacy from researchers, civil society organizations, and people with lived experience, particularly in low- and middle-income countries (LMICs), where mental health systems have historically been underdeveloped and inequities in care most pronounced (VIGO et al., 2016; WHITEFORD et al., 2013). Emerging scholarship has also advocated for decolonial approaches to global mental health, challenging biomedical and Western-centric paradigms and emphasizing culturally grounded, community-based responses (MILLS, 2014; KIRMAYER; PEDERSEN, 2014).

This shift in recognition was accompanied by a series of normative and institutional developments. A landmark moment came with the publication of the *World Health Report 2001 – Mental Health: New Understanding, New Hope*, which positioned mental health as a global public health and social priority requiring policy-driven action and integration into national health systems (WHO, 2001). The report brought renewed attention to the global burden of mental disorders, emphasizing that conditions such as depression, anxiety, and schizophrenia were among the leading contributors to disability-adjusted life years (DALYs) worldwide (WHO, 2017). It also outlined ten strategic recommendations for strengthening mental health systems, especially in LMICs. These included the enactment or reform of mental health legislation, the promotion of community-based care models, the expansion of education and training for health professionals, increased investment in human resources, and the advancement of mental health research (WHO, 2001).

The adoption of the Convention on the Rights of Persons with Disabilities (CRPD) in 2006, and its subsequent ratification by a majority of UN member states, also marked a watershed moment in the reorientation of mental health policy toward dignity, autonomy, and community-based alternatives to institutionalization (UN, 2006). Article 25 of the Convention explicitly recognizes the right of persons with disabilities to the enjoyment of the highest attainable standard of health, without discrimination, including those with psychosocial and intellectual disabilities. It has been instrumental in shifting international discourse toward deinstitutionalization, community-based care, and the protection of autonomy and dignity for persons with mental health conditions. The document mandates states to ensure access to quality mental health services, promote full social inclusion, and eliminate coercive practices

and discrimination in health care (UN, 2006). Its emphasis on legal capacity, informed consent, and participation has catalyzed a growing movement advocating for peer support, service-user leadership, and the recognition of lived experience in mental health governance (DREW et al., 2011; MINKOWITZ, 2006). These normative advances challenge the dominance of biomedical and paternalistic models, fostering the development of more participatory, rights-based, and culturally responsive systems of care (KIRMAYER; PEDERSEN, 2014; MILLS, 2014). In this regard, the CRPD functions not only as a human rights instrument, but also as a normative driver for reforming mental health systems globally, aligning public policies with international obligations and ethical standards (DREW et al., 2011).

This momentum was further reinforced by *The Lancet Global Mental Health Series* (2007), which introduced the concept of the "treatment gap" and the significant proportion of individuals with mental disorders who do not receive appropriate care, particularly in low- and middle-income countries (LANCET GLOBAL MENTAL HEALTH GROUP, 2007). Another milestone in the process of greater institutionalization of global mental health was the adoption of Resolution WHA65.4 by the World Health Assembly in 2012, which called for a comprehensive, coordinated response to mental disorders at country level, with special emphasis on LMICs (WHO, 2012). This resolution laid the groundwork for the Comprehensive Mental Health Action Plan 2013–2020, subsequently extended to 2030, which established four strategic objectives: to strengthen effective leadership and governance for mental health; to provide comprehensive, integrated, and responsive mental health and social care services; to implement strategies for promotion and prevention; and to reinforce information systems, evidence, and research (WHO, 2013; WHO, 2021). The action plan marked a shift toward framing mental health not only as a technical health priority, but also as a policy and governance issue requiring intersectoral coordination, community engagement, and rights-based approaches.

This institutional effort helped to culminate in the inclusion of mental health and well-being within the 2030 Agenda for Sustainable Development, notably under SDG Target 3.4, which commits to reducing premature mortality from noncommunicable diseases and promoting mental health (UN, 2015), which included death by suicide. This discursive and normative inclusion signaled a broader understanding of mental health as inseparable from

global equity, human capabilities, and sustainable development. In addition, recent resolutions of the United Nations General Assembly have increasingly recognized mental health and psychosocial well-being as integral to sustainable development and human rights, encouraging community-based, rights-oriented services in line with the CRPD. This integration reflects a growing consensus that addressing mental health is essential to achieving health equity, breaking cycles of poverty, and advancing inclusive development.

The 2021 Global Risks Report, issued by the World Economic Forum (WEF), highlighted mental health deterioration as one of the most significant short-term global risks and a major blind spot for both governments and international institutions. It identified youth mental health deterioration as the second most pressing emerging crisis, emphasizing the compounded vulnerabilities faced by young people due to environmental degradation, economic instability, rising inequality, and educational disruptions (WEF, 2021). These concerns were reinforced in the World Mental Health Report 2022, issued by the World Health Organization (WHO), which provided a comprehensive global overview of mental health, highlighting persistent treatment gaps, the growing burden of mental disorders, and the continued need to integrate mental health into universal health coverage systems (WHO, 2022). Building upon this trajectory, the 2023 Global Risks Report reaffirmed the systemic nature of mental health challenges, placing them at the intersection of social resilience, public trust, and economic recovery (WEF, 2023).

However, this multifaceted process is shaped not only by shifting paradigms in global governance, international dynamics and social determinants, but also by historical struggles surrounding the meaning of mental illness, the evolution of psychiatric care, and the political demand for reform. While much of the current debate centers on the integration of mental health into global frameworks for development and human rights, these normative advancements cannot be fully understood without revisiting the socio-historical trajectory of psychiatry and the contestation of its most exclusionary practices.

Historically, the term “madness”, often used synonymously with mental illness, served as a category of exclusion, constructed to designate individuals who deviated from socially acceptable norms. As Foucault (1972) demonstrated in *Histoire de la folie à l’âge classique*, the rise of the modern asylum system in Europe during the seventeenth and eighteenth centuries marked a shift from community-based responses to madness to systems of

confinement and segregation. In this context, madness was no longer interpreted solely through religious or moral lenses but became medicalized, institutionalized, and subjected to the control of emerging state apparatuses. These institutions, rather than offering care, often functioned as sites of social abandonment, spaces where the "insane," the poor, the deviant, and the undesirable were collectively confined. Goffman (1961), in his seminal ethnography of mental institutions, referred to such settings as "total institutions," where individuality was stripped away, and the institutional logic overruled the person's autonomy.

This apparatus of confinement also intersected with broader systems of colonial domination and racial exclusion. In colonized societies, psychiatric institutions were frequently used to pathologize political dissent and reinforce racial hierarchies. As Frantz Fanon observed in his work as a psychiatrist in colonial Algeria, psychiatry became a tool for silencing anti-colonial resistance, labeling insurgents as mentally ill to depoliticize their struggles (FANON, 1968). The dehumanization of colonized populations through psychiatric practices mirrored the broader logics of racialized control inherent in colonial regimes. Building on this critique, Achille Mbembe (2021) describes these dynamics as part of a necropolitical system, wherein entire populations were relegated to zones of abandonment, both socially and institutionally, with psychiatric hospitals often becoming carceral spaces of social death for Black, Indigenous, and colonized peoples.

Throughout the twentieth century, psychiatric hospitals became symbols of exclusion and chronic neglect, particularly in countries with authoritarian or colonial histories, where the delivery of psychiatric care was often entangled with state repression and the absence of human rights guarantees. In Chile, for instance, the long and oppressive military regime (1973–1990) dismantled emerging efforts toward the deinstitutionalization of psychiatric care and imposed a neoliberal constitutional framework that curtailed the state's role in health and social protection. Community-based mental health work, politically associated with socialism, was banned, and many progressive psychiatrists were silenced through torture or exile. Yet, despite this repressive context, certain therapeutic initiatives persisted, such as the "Protected Commune", which sought to recreate a small town within the institution's gates through democratic roles, self-governance structures and everyday community life (MONTENEGRO, 2024, p. 680). In Brazil and many other Latin American countries, psychiatric institutions operated under a logic of reclusion, moral judgment, and medical paternalism, with patients

subjected to inhumane treatments, overmedication, and isolation from society. The psychiatry movement of reform and anti-asylum, emerging in the 1960s and 1970s, challenged this paradigm, criticizing the coercive and hierarchical nature of psychiatry and calling for alternative models based on dignity, freedom, and community care" (SZASZ, 1961).

One of the most influential movements in this regard was the Italian psychiatric reform led by Franco Basaglia. His critique of psychiatric institutions as mechanisms of social control rather than healing culminated in its national Law 180/1978, which led to the gradual dismantling of asylums in Italy and the creation of community-based mental health services. Basaglia's work emphasized the social determinants of mental suffering and the need to reconstruct psychiatric care around the person rather than the diagnosis (BASAGLIA, 1985). His ideas inspired reform movements across Latin America, especially in Brazil, where the slogan for "care in freedom" (free translation from the Portuguese "cuidado em liberdade") became central to defining the model of care and is still present as one of the foundations of mental health policy.

In Brazil, the psychiatric reform movement emerged in the 1980s in the context of re-democratization and broader struggles for universal health, human rights, and social justice. Anchored in the ideals of the Sanitary Reform and the creation of the Brazilian Unified Health System (from the Portuguese acronym SUS), the movement advocated for the closure of asylums and the construction of a psychosocial care network centered on territorial services, deinstitutionalization, and user participation. The enactment of its national Law 10.216 in 2001 formalized these principles by guaranteeing the rights of people with mental disorders and establishing guidelines for community-based mental health care. In that sense, scholars such as Amarante (1995) and Amarante and Nunes (2018) emphasize that the reform in Brazil represented not only a reorganization of services but a profound epistemological and ethical shift, a move away from institutional violence and toward a recognition of mental health as a social, cultural, and political phenomenon.

These local and national reform processes have deeply influenced the discourse and practice of global mental health governance as they established legal and normative foundations for the advancement of mental health policies, facilitating international cooperation, strengthening accountability, and encouraging states to adopt rights-based and inclusive approaches to mental health governance. Despite these tensions, the

deinstitutionalization movement, together with advocacy by service users and civil society, challenged the dominance of biomedical, hospital-centered models and pushed for care strategies based on freedom, inclusion, and participation. As Bemme and D'souza (2014) argue, global mental health cannot be merely a technical response to disease burden; it must contend with the legacies of exclusion, the politics of care, and the situated knowledge of those who have been marginalized by psychiatric systems. Thus, the institutionalization of global mental health is not a neutral or linear process. It is the outcome of contestations, resistances, and reformist agendas that span local and global arenas. It reflects a growing consensus that mental health governance must be grounded in human rights, community engagement, and cultural responsiveness, principles that echo both the demands of psychiatric reform and the broader objectives of global health equity.

Despite these tensions, the deinstitutionalization movement, together with advocacy by service users and civil society, challenged the dominance of biomedical, hospital-centered models and pushed for care strategies grounded in freedom, inclusion, and participatory governance. These mobilizations emerged not only from legal or policy frameworks but also from resistance to long-standing experiences of coercion, invisibility, and institutional violence. Survivor-led organizations, peer-support networks, and rights-based movements played a pivotal role in reframing mental health as a domain of citizenship, agency, and collective care. As Bemme and D'souza (2014) argue, global mental health cannot be understood merely as a technocratic solution to disease burden. Rather, it must contend with embedded historical legacies, including colonial psychiatry, epistemic injustice, and social control, and with power asymmetries that persist in the design and delivery of mental health systems. These actors have brought forward epistemologies from the margins, contributing to the transformation of global debates and to more pluralistic, accountable, and culturally responsive governance frameworks.

However, the global diffusion of mental health norms has not been without critique. Scholars such as Derek Summerfield (2008) and China Mills (2014) have warned against the uncritical exportation of Western psychiatric models to the Global South under the banner of "Global Mental Health." They argue that such practices risk epistemic violence by marginalizing indigenous, local, and culturally distinct understandings of mental suffering. These critiques emphasize the need to question whose knowledge counts in defining mental

health and to remain attentive to the ways in which global mental health agendas may reproduce colonial power dynamics under the guise of humanitarianism. Mills, for instance, interrogates the role of philanthropic capitalism and global governance in shaping mental health policies that, while well-intentioned, often overlook structural violence, poverty, and historical trauma.

Building upon these struggles and normative transformations, this process has laid the foundations for a more structured global mental health governance architecture with its own agenda. In light of these developments, the notion of global mental health has emerged not only as a field of scientific inquiry, but also as a domain of policy and practice aimed at promoting equity in mental health outcomes across countries and populations. The internationalization of mental health thus represents a paradigmatic shift in both the discourse and the governance of global health. Against this backdrop, the next chapter explores this governance configuration in greater depth. These developments created not only normative recognition, but also an increasingly dense institutional environment. Understanding how this environment operates requires shifting the analysis from historical trajectories to the configuration of actors, mandates and power relations that structure global mental health governance today. *Chapter 2 e*xamines, in a non-exhaustive way, the main actors that exist and coexist within the emerging global mental health governance regime.

CHAPTER 2: THE REGIME COMPLEX OF GLOBAL MENTAL HEALTH GOVERNANCE: KEY ACTORS AND INSTITUTIONAL ROLES

While mental health remains largely embedded within the broader global health regime, sharing institutions, normative frameworks, and policy spaces with adjacent health agendas, this configuration will be treated for this research's purpose as a subsystem of the general global health agenda. Yet, this subsystem must be more thoroughly examined to reinforce its significance in shaping the health agenda, as it is shaped by its own constellation of actors, institutional mechanisms, funding instruments, and discursive practices. Then, the theory of complex regimes offers a compelling analytical framework as it highlights how overlapping, non-hierarchical, and polycentric governance arrangements operate simultaneously within global issue areas (ORSINI, MORIN, YOUNG, 2013).

From this perspective, global mental health governance can be understood as an emergent regime complex: a constellation of institutions, actors, and norms that interact with, but are not fully subsumed by, the broader global health system. It reflects a hybrid governance structure, simultaneously embedded in the general global health framework and consolidating itself as a specialized domain with growing agenda-setting capacity, normative influence, and operational reach. This chapter therefore draws on regime complexity theory to explore the institutional architecture of global mental health governance by analyzing the key and main actors involved.

In international relations, regimes are classically defined as sets of implicit or explicit principles, norms, rules, and decision-making procedures around which actors' expectations converge in a specific issue area (KRASNER, 1983). This conceptualization has been fundamental for understanding cooperation and institutional design in global governance. However, when applied to contemporary health governance, and especially to mental health in the Anthropocene, classical regime theory reveals important limitations. It presumes a level of coherence and stability that rarely reflects the complexity of global dynamics and its constant shifts, often neglecting the multiplicity of actors, the fluidity of institutional arrangements, and the fragmentation of authority that characterize present-day configurations.

In response, the concept of regime complexity has gained prominence as a more adequate analytical tool. As articulated by Orsini et al. (2013) and expanded by Zelli et al.

(2020), complex regimes consist of partially overlapping, non-hierarchical, and often functionally specialized arrangements. These bring together a diverse range of actors such as states, international organizations, NGOs, civil society, the private sector, and research communities - that includes Big Pharma -, whose interactions collectively shape governance outcomes, a topic to be addressed in *Chapter 3*. This approach is particularly pertinent to the mental health domain, where governance does not emerge from a centralized authority but from a dense network of interdependent initiatives, legal frameworks, financial flows, and advocacy coalitions operating across multiple scales.

To analyze this configuration, the chapter mobilizes key concepts from global governance studies, particularly those that emphasize the multiplicity of authority and the expanding role of non-state actors (ROSENAU, 1995; DINGWERTH; PATTBERG, 2006). It also draws on three governance typologies: hierarchical governance is represented by intergovernmental organizations, such as WHO and PAHO, which set norms, coordinate global strategies, and influence national policies; multilevel governance links national, regional, and global processes through network governance and , in turn, is characterized by horizontal, flexible, and often issue-specific arrangements among NGOs, philanthropic foundations, academic networks, and social participation, as proposed by Kickbusch (2016). These approaches are not mutually exclusive; rather, they coexist and interact in the governance of mental health, producing hybrid forms of authority and collaboration. For example, an actor may simultaneously set agendas, promote norms, and implement programs, depending on context and capacity.

Having established the theoretical and conceptual foundations for understanding global mental health governance, the next step is to deepen into the analysis of the actors that populate this regime complex. Actors are not merely participants in policy processes and they perform differentiated and strategic roles that shape the contours and contents of global mental health governance. As agenda-setters (UN, WHO, PAHO and State Actors), they influence which issues are prioritized, which populations are targeted, and how problems are framed, whether through the lens of disease burden, rights violations, social determinants, or economic productivity. Norm entrepreneurs (WEF and Civil Society) are those who actively promote new standards, values, and paradigms, translating technical knowledge, field experience, or moral arguments into widely accepted governance principles. These include,

for instance, the promotion of deinstitutionalization, community-based care, or lived experience participation. As implementers, actors carry out programs, disburse funds, provide technical assistance, and deliver services at local, national, or transnational levels. Finally, some actors function as gatekeepers by controlling access to financial resources, data, decision-making spaces, or normative legitimacy, determining which perspectives gain visibility and influence (BARNETT; FINNEMORE, 2004; HAAS, 1992; BETTS; ORCHARD, 2014).

International Organizations

International organizations (IOs) are formal, rule-based institutions established by treaties or other instruments of international law, composed primarily of states and endowed with legal personality and specific mandates (PEVEHOUSE et al., 2004; KARNS; MINGST; STILES, 2015). By contrast, more recent and politically salient groupings, although not fully comparable, such as the G7, G20 and the BRICS, lack a constitutive treaty and a clearly defined legal mandate (SOENDERGAARD; BARROS-PLATIAU, 2021). From the standpoint of classical public international law, which traditionally recognizes only states and treaty-based organizations as subjects of international law, these forums are thus not regarded as legal actors *stricto sensu* in the same way as states and IOs (SHAW, 2008), even though contemporary analyses of global governance increasingly treat them as powerful players in agenda-setting and decision-making processes. They operate across national borders to facilitate cooperation, set norms, provide technical expertise, and address issues that transcend the capacity of individual states. In global health, and particularly in the governance of mental health, IOs serve as platforms for collective action and as normative and operational engines shaping policies, agendas, and standards.

These organizations occupy a central position in the governance of global mental health, serving both as arenas for normative debate and as operational platforms for policy implementation. Their influence extends from agenda-setting and the formulation of global strategies to the provision of technical cooperation and capacity-building in member states. In this capacity, they act as hubs for knowledge production, standard-setting, and political negotiation, mediating between the scientific community, national governments, and civil

society actors (BARNETT; FINNEMORE, 2004; LEE, 2009). The institutional legitimacy of these organizations have their formal mandates and, at the same time, they act as conveners of multilateral consensus on complex health issues, including mental health, which increasingly demands cross-sectoral and cross-border solutions. However, their functions can also be blocked by disagreement among member states, a dynamic that helps explain the long-standing marginalization of mental health in global forums, or shaped by the influence of powerful states, particularly in times of crisis, such as during the COVID-19 pandemic.

In the 21st century, the role of international organizations in mental health governance has expanded in both scope and complexity. Agencies such as the World Health Organization (WHO) and its Regional Offices, particularly the Pan American Health Organization (PAHO), have emerged as primary normative and technical authorities, producing global action plans, guidelines, and epidemiological monitoring tools. Meanwhile, institutions beyond the health sector, such as the United Nations Office on Drugs and Crime (UNODC), the World Bank (WB), and the World Economic Forum (WEF), have incorporated mental health into their agendas, linking it to issues of social protection, criminal justice, human capital development, and economic productivity (LUND et al., 2018; VIGO; THORNICROFT; ATUN, 2016).

The following subsections examine in depth the main international organizations shaping the field, beginning with the WHO and PAHO as the core institutional pillars of the global mental health regime, and extending to other multilateral and transnational actors whose mandates intersect with mental health.

The United Nations (UN) and its System

Among these organizations, the United Nations system stands out as a particularly dense and multifaceted institutional environment. The UN is not a monolithic actor but a complex constellation of intergovernmental bodies, programs, and specialized agencies, each with distinct mandates, institutional orientation, and governance frameworks. This intricate architecture is commonly referred to as the “UN system”, which exemplifies the decentralized and multi-level nature of global governance (BARNETT; FINNEMORE, 2004; UNITED NATIONS SYSTEM CHIEF EXECUTIVES BOARD, 2023). Within this system, mental

health does not fall under the sole purview of a single agency but is addressed through a mosaic of initiatives, reflecting its cross-cutting character and growing political salience.

The United Nations General Assembly (UNGA), as the main deliberative body of the UN, composed of all member states, has increasingly recognized mental health as a key component of both the international human rights framework and the sustainable development agenda. Resolutions such as A/RES/77/300, adopted in 2023, underscore the need to integrate mental health and psychosocial support into pandemic recovery, reinforcing a broader normative shift towards inclusive, community-based, and multisectoral approaches (UN, 2023).

In parallel, the Human Rights Council (HRC) has served as an important platform for framing mental health in terms of dignity, equality, and social justice. Resolutions and debates within the HRC have emphasized the indivisibility of mental health and human rights, calling for the dismantling of structural barriers, the promotion of social inclusion, and the need to challenge coercive or institutionalized psychiatric practices (UN, 2023b; SCHEFFLER-BARLOW et al., 2023). A particularly significant contribution has been the mandate of the Special Rapporteur on the right to the highest attainable standard of physical and mental health, established in 2002. Successive mandate-holders have consistently highlighted mental health as integral to the right to health, advocating for a transition from biomedical and custodial paradigms to community-rooted, participatory, and culturally sensitive care models (UNI, 2017).

Together, these developments reflect a growing political and normative alignment around mental health within the UN system, illustrating how governance operates across interlinked institutions rather than through a centralized authority. This fragmentation, while often seen as a challenge, also allows for the advancement of mental health across diverse agendas, from disability rights and humanitarian response to youth, education, and climate.

Beyond human rights mechanisms, the UN system promotes mental health through an array of specialized institutions and cross-cutting platforms that integrate health into broader agendas of development, humanitarian response, and peacebuilding. The United Nations Development Programme (UNDP) supports countries in integrating mental health into national development strategies, particularly in post-conflict and fragile settings (UNDP,

2021). The United Nations High Commissioner for Refugees (UNHCR) includes psychosocial support in its humanitarian response frameworks, addressing the needs of displaced populations (UNHCR, 2022). The United Nations Office on Drugs and Crime (UNODC) incorporates mental health into policies on drug use, prison health, and criminal justice, promoting rehabilitation (UNODC, 2023). The International Labour Organization (ILO) has advanced the recognition of psychosocial risks in the workplace, particularly after the COVID-19 pandemic, and supports decent work policies that protect mental well-being (ILO, 2022). The United Nations Children's Fund (UNICEF), in turn, addresses child and adolescent mental health through interventions in education, health, social development strategies in collaboration with local governments, other UN agencies and civil society (UNICEF, 2021) with a strong component of youth social participation.

At the intergovernmental level, the Economic and Social Council (ECOSOC) plays a coordination role across the UN system and its subsidiary bodies, including the Commission on Social Development and the Commission on the Status of Women, which have addressed the social and gender dimensions of mental health in the context of poverty eradication, care systems, and post-pandemic recovery. Reports by the UN Secretary-General have further articulated mental health as a cross-cutting issue tied to peacebuilding, climate resilience, gender equality, and inclusive recovery efforts (UN, 2022). These references, found both in formal documents and high-level speeches by the Secretary-General, reinforce mental health as an integral part of the UN development and human rights discourse, with implications for international cooperation and national accountability.

While the WHO remains the primary normative and technical authority in global mental health governance, producing evidence-based guidelines, coordinating action plans, and supporting countries through capacity-building, the broader UN system functions as a governance umbrella. Under this umbrella, mental health is addressed traversally through mandates, with different levels of interconnectedness. This discursive and institutional diffusion illustrates both the complexity of the UN system and the inherently intersectoral nature of mental health within global cooperation.

World Health Organization (WHO)

Within this framework, the WHO plays a pivotal role in consolidating normative guidance, technical leadership, and political momentum for mental health. As a specialized agency of the UN established in 1948, the WHO is constitutionally mandated to promote the highest attainable standard of health for all people, explicitly including mental well-being. Its governance structure includes the World Health Assembly (WHA), which serves as the supreme decision-making body composed of representatives from all Member States; the Executive Board, which consists of 34 technically qualified members elected for three-year terms and tasked with implementing WHA decisions and preparing its agenda; and the Secretariat, headed by the Director-General, which executes the organization's programs and is supported by six Regional Offices, each with considerable autonomy to adapt global directives to regional contexts (WHO, 1948/2006). Over the decades, the WHO has gradually become the central actor for articulating a comprehensive and rights-based approach to global mental health governance, acting both as a driver of national policies and as an agenda pusher.

The WHO's role in global mental health governance is grounded in its normative authority and technical leadership, which have long served as key reference points for national mental health strategies and policy reforms. These functions are reinforced by the Organization's capacity to foster political convergence and intergovernmental coordination through mechanisms such as the World Health Assembly (WHA), where Member States, represented by Ministries of Health and diplomatic delegations, negotiate and adopt resolutions. A landmark example is Resolution WHA65.4 (2012), which called for a comprehensive and coordinated response to mental disorders at the country level. This normative momentum was further consolidated through the adoption of the Comprehensive Mental Health Action Plan 2013–2020, which marked a significant milestone by encouraging Member States to strengthen mental health care systems, reduce stigma and discrimination, and promote mental well-being as an integral component of the broader global health agenda (WHO, 2013).

Inside WHO´s institutional apparatus, mental health is primarily coordinated by the Department of Mental Health, Brain Health and Substance Use, situated under the Division of

Universal Health Coverage for Communicable and Non Communicable Diseases[1]. Over time, the Department has evolved from a relatively peripheral unit into a central actor in the development of normative frameworks, technical guidance, and monitoring tools for global mental health governance. Its mandate was recently expanded to explicitly include brain health, reflecting emerging debates within global health. While brain health is generally defined as a state encompassing cognitive, emotional, and social functioning, and intersects with mental health, it is not synonymous with it. Although recent WHO strategies have begun to frame mental health within a broader neurocognitive continuum, this dissertation focuses specifically on the global governance of mental health, understood in terms of psychological well-being, psychiatric conditions, psychosocial support, and community-based care. The emerging brain health agenda therefore exceeds the analytical scope of this study and will not be examined in detail.

Created in 1999, the Department's institutional trajectory has been shaped not only by its expanding mandate but also by its leadership, which has played a decisive role in redefining WHO's approach to mental health. Under the direction of Benedetto Saraceno between 2000 and 2010, the Department consolidated a shift away from hospital-centered psychiatry toward community-based, rights-oriented models of care, particularly in low- and middle-income countries. During this period, WHO strengthened its work on mental health policy and service development, promoted the integration of mental health into primary care, and supported legislative reforms aimed at dismantling asylum-based systems (SARACENO, 2007; SARACENO et al., 2007). Saraceno also helped lay the groundwork for major initiatives such as the Mental Health Gap Action Programme (mhGAP), which later became a cornerstone of WHO's strategy to scale up care for priority mental, neurological, and substance use conditions in resource-constrained settings (WHO, 2008).

In 2010, Shekhar Saxena succeeded Saraceno as Director and led the department until 2018. A psychiatrist and public health specialist, Saxena further institutionalized evidence-based approaches and global monitoring instruments, overseeing successive editions

[1] World Health Organization Headquarters Organigram, 2023. Available at https://cdn.who.int/media/docs/default-source/documents/about-us/who-hq-organigram.pdf . Access in November 2025.

of the Mental Health Atlas and the operationalization of mhGAP at country level (SAXENA et al., 2007; WHO, 2011). During his tenure, the department strengthened its role in normative standard-setting, including the development and adoption of the aforementioned Comprehensive Mental Health Action Plan 2013–2020, and worked to embed mental health within broader agendas such as universal health coverage, noncommunicable disease strategies and the Sustainable Development Goals (WHO, 2013; WHO, 2018).

Since 2019, Dévora Kestel has served as Director of the Department of Mental Health and Substance Use, at a moment when mental health is both more visible and more politically contested in global governance. With over twenty-five years of field and policy experience across Latin America, Europe and global programs, her leadership has centered on the promotion of rights-based models of care, the expansion of the WHO Quality Rights initiative, and the integration of mental health into emergency and humanitarian responses (WHO, 2020; WHO, 2021). With Kestel being ahead of it, the department has coordinated the World Mental Health Report 2022, intensified its engagement with youth mental health and suicide prevention, and broadened its mandate to encompass *brain health*, reflecting an attempt to align mental health governance with emerging neuroscientific and public health debates, even as the conceptual boundaries of this term remain under construction (WHO, 2022).

Under the leadership of WHO Director-General Tedros Adhanom Ghebreyesus since 2017, mental health has gained greater visibility as an integral component of universal health coverage and pandemic preparedness. Tedros has repeatedly stated that “there is no health without mental health,” positioning the issue as a global public health and development priority (WHO, 2020; WHO, 2022). In 2019, the WHO launched the Special Initiative for Mental Health (2019–2023), an ambitious program designed to expand access to quality and affordable mental health services for 100 million more people by supporting large-scale system reforms in ten priority countries, being them: Argentina, Bangladesh, Cambodia, Ghana, Jordan, Nepal, Paraguay, the Philippines, Ukraine and Zimbabwe (WHO, 2019; WHO, n.d.). Although WHO has not published a consolidated list of selection criteria, its official materials on the Special Initiative for Mental Health, including the program’s web page, FAQs and country case studies, indicate that participating countries were chosen to reflect geographic diversity within the Global South, varying levels of health system

development, demonstrable governmental commitment, and a combination of high mental health needs with opportunities for scalable reforms.

An important reference for WHO's institutional positioning has been the Mental Health Atlas, first published in 2001. This series of reports is updated periodically and constitutes the primary global monitoring tool for assessing country-level progress in mental health system development. The most recent edition, the Mental Health Atlas 2024, based on data from 144 countries, compiles standardized information on legislation, access to services, human resources and financing, offering powerful insights into global and national contexts for policy guidance and coordinated action to address identified gaps (WHO, 2025). The 2024 Atlas also introduces new metrics on telemental health and mental-health-and-psychosocial-support (MHPSS) readiness, underscoring both the technical innovation of WHO and the evolving scope of global mental-health governance. Other materials and tools include the *Comprehensive Mental Health Action Plan 2013–2020*, extended to 2030, which outlines four major objectives: to strengthen effective leadership and governance for mental health; to provide comprehensive, integrated, and responsive mental health and social care services in community-based settings; to implement strategies for promotion and prevention in mental health; and to strengthen information systems, evidence, and research (WHO, 2013a).

The aforementioned initiative mhGAP is a noteworthy tool that WHO has developed to support implementation at country level, which provides evidence-based and training materials for professionals, scaling up care for priority mental, neurological and substance use disorders in diverse and non-health-exclusive settings (WHO, 2008). Furthermore, the WHO *LIVE LIFE* strategy and its guide for implementation offered a comprehensive approach to suicide prevention, structured around four key strategies: limiting access to means; responsible media reporting; fostering socio-emotional life skills; and early identification, assessment, management and follow-up (WHO, 2021).

In addition to the agenda-setting and the development of normative frameworks and technical tools, the WHO convenes global and regional events, facilitates technical cooperation, and supports capacity-building through training, monitoring frameworks, and policy dialogue. These activities strengthen country-level mental health systems, foster South–South learning, and enable multisectoral and public–private partnerships (PPPs) aimed

at stimulating innovation and mobilizing resources. Collaboration with other UN agencies, particularly through the UN Sustainable Development Group, further facilitates the integration of mental health across sectors such as education, social protection, and humanitarian response.

This operational reach is reinforced by the organization's multilevel governance structure. Regional offices, including the Pan American Health Organization (PAHO/WHO) in the Americas, the WHO Regional Office for Europe (WHO/Europe), the WHO Regional Office for Africa (WHO/AFRO), as well as the WHO South-East Asia Region (SEARO) and the WHO Western Pacific Region (WPRO), play a key role in adapting global strategies to diverse epidemiological, political, and socio-economic contexts. This structure allows the WHO to function simultaneously as a central norm entrepreneur and as a facilitator of localized implementation. At the same time, it reflects an inherent tension between global standardization and regional or national adaptation.

The COVID-19 pandemic marked a critical turning point in the public visibility and political relevance of the WHO. The crisis intensified calls for the integration of mental health into emergency response, essential services, and sustainable recovery strategies, elevating the issue within political forums and donor agendas (WHO, 2022). Within Tedros´ administration, mental health was consistently framed as an integral component of universal health coverage and pandemic preparedness, encapsulated in his repeated assertion that "there is no health without mental health" (WHO, 2020; WHO, 2022). Thus, this period was marked by renewed advocacy for scaling up investment, workforce development, and the inclusion of psychosocial support across humanitarian and development interventions.

At the same time, the pandemic exposed enduring structural limitations in the WHO's capacity to ensure equitable implementation, particularly in low- and middle-income countries facing chronic underinvestment in mental health systems. Despite its normative centrality and technical leadership, the Organization operates under persistent financial constraints and fragmented multilateral support. Heavy reliance on voluntary earmarked contributions, often shaped by donor priorities, can undermine institutional autonomy and distort agenda-setting dynamics (GOSTIN; FRIEDMAN; EBELER, 2020), an issue further examined in *Chapter 3*. In recent years, the WHO has also faced political and financial challenges, including the United States withdrawal process, in 2025, followed by Argentina under Milei's

administration. Moreover, tensions with Member States over transparency, the influence of private actors, and crisis-response mechanisms further underscore the Organization's dual vulnerability as both a technical authority and a political arena have also hindered the IO's recent work and how WHO deals with it will determine the future of global health in general.

As the current term of Director-General Tedros Adhanom Ghebreyesus approaches its conclusion in 2027, the future orientation of the WHO's mental health agenda will depend not only on institutional continuity but also on shifting political priorities among Member States, funding arrangements, and the evolving configuration of global health governance. In this sense, the trajectory of mental health within the WHO remains contingent and open-ended, reinforcing the relevance of analyzing global mental health through the lens of regime complexity.

Pan American Health Organization (PAHO)

Established in 1902, the Pan American Health Organization (PAHO) is the oldest specialized international public health agency in continuous operation. Its origin as the International Sanitary Bureau (ISB) marked a pivotal moment in the history of international health cooperation. The ISB was created in response to the need for a coordinated response to epidemics such as yellow fever and cholera, which posed threats not only to populations but also to international trade and travel in the Americas. This institutional milestone laid the foundation for what would later become more structured mechanisms of global health governance (ESPINAL., 2023).

Following the creation of the United Nations in 1945 and the World Health Organization (WHO) in 1948, the Pan American Health Organization (PAHO) was formally recognized as the WHO Regional Office for the Americas. This arrangement, established through a working agreement in 1949 and renewed in 1950, incorporated PAHO into the broader architecture of global health governance while acknowledging its long-standing institutional identity and functions within the inter-American system. As a result, PAHO operates under a dual mandate: it serves simultaneously as the Regional Office of the WHO and as the specialized health agency of the Inter-American System, reporting to the Organization of American States (OAS) since 1958 (PAHO, 2002; CUETO, BROWN; FEE,

2019). From this unique position, PAHO not only supports the implementation of WHO strategies in the Americas but also articulates regional priorities within global health debates and promotes hemispheric cooperation consistent with OAS mandates. This governance arrangement enables PAHO to function as a normative, technical, and political bridge between global and regional levels, facilitating cross-border initiatives, aligning standards, and coordinating collective action among its Member States across both UN- and OAS-related frameworks.

Throughout its institutional trajectory, PAHO played a pivotal role in coordinating cross-border responses to infectious diseases in the Americas, consolidating its technical capacity and legitimacy as a regional health authority. A landmark example of this legacy was the successful eradication of smallpox from the Americas, certified by the WHO in 1971, nearly a decade before global eradication (FENNER et al., 1988). PAHO's leadership in vaccination campaigns and epidemiological surveillance underscored its effectiveness in implementing large-scale disease control strategies across diverse national contexts.

As global and regional health priorities began to shift from a narrow biomedical paradigm to broader understandings of health, including the recognition of its social, political, and economic determinants, PAHO gradually expanded its mandate. Influenced by the principles of the Alma-Ata Declaration in 1978, the organization began to emphasize the right to health and the importance of primary health care as essential to reducing inequalities and achieving universal access (CUETO, 2004). Within this evolving framework, mental health began to appear in its agenda as an important component of integral health. Although initially peripheral to PAHO's core programs, mental health progressively gained normative and strategic relevance within its regional agenda, especially in response to the growing burden of noncommunicable diseases, violence, urbanization, and social isolation in Latin America and the Caribbean.

In this sense, PAHO has significantly intensified its direct support to Member States across the Americas in designing and implementing national mental health policies, plans, and services. In 2023, the 60th Directing Council adopted Resolution CD60/9, Strategy for Improving Mental Health and Suicide Prevention in the Region of the Americas, outlining six strategic action lines for 2024–2030, with a focus on governance, financing, service integration, and intersectorality (PAHO, 2023). On a more operational level, PAHO/WHO has

also partnered with Ministries of Health to roll out mhGAP-based training for non-specialist health workers in primary care, enabling nurses and physicians across primary care networks to integrate mental health into routine services (PAHO, 2025b). Jointly, these examples illustrate PAHO's dual role as a normative and technical actor, working with countries to translate regional strategies into concrete reforms while advancing the integration of mental health into broader health and development agendas.

At the high-level representation, Dr. Jarbas Barbosa, the Director of the Pan American Health Organization (PAHO), has consistently expressed his views on the subject, both in speeches and in his decision-making. In 2023, he released a New Agenda for Mental Health in the Americas as part of the High-Level Commission on Mental Health and COVID-19. This report underscores the enduring mental health crisis exacerbated by the latest pandemic, and highlights longstanding systemic issues within the region. According to PAHO, the pandemic amplified preexisting mental health challenges, leading to significant increases in depression and anxiety. However, these challenges predate COVID-19, as evidenced by a 17% increase in suicide rates over the past two decades and a 2018 regional study indicating that nearly 20% of the population in the Americas experienced a mental health disorder within a 12-month period (PAHO, 2023). These figures illustrate the persistent gaps in mental health care and the urgent need for comprehensive regional strategies.

Moreover, within PAHO the Department of Noncommunicable Diseases and Mental Health (NMH) is responsible for promoting, coordinating and implementing technical cooperation in the field, including the prevention and control of noncommunicable diseases and their risk factors, as well as mental, neurological and substance use disorders, disabilities, nutrition, violence and road safety (PAHO, s.d.). Among the initiatives led by this department, the *Better Care for NCDs* initiative stands out, as it provides a regional platform with guidance for primary health care settings, country data, implementation examples, resources and training tools to improve responses to conditions such as diabetes, cancer, hypertension and common mental health disorders (PAHO, 2023; PAHO, 2024). However, as mentioned before, mental health is still framed mainly as one item within a broader NCD agenda, which may dilute its political visibility and competing claims on resources. To address this, PAHO has convened four key regional instruments: (1) the Strategy for Improving Mental Health and Suicide Prevention in the Region of the Americas; (2) the Policy for Improving Mental

Health; (3) the Plan of Action on Mental Health 2015–2020; and (4) the Brasília Consensus, adopted in Brasília, Brazil, on 15–17 October 2013 (PAHO, 2015; PAHO, 2013; PAHO, 2023a; PAHO, 2023b). Combined, these documents provide a relatively coherent, rights-based and equity-oriented framework that explicitly elevates mental health as a regional priority and aligns with WHO's global plans. Yet their adequacy remains partial: they are non-binding, lack dedicated regional financing mechanisms, and available assessments still point to large treatment gaps, slow progress in deinstitutionalization and uneven integration of mental health into primary health care and social protection systems (TRIANNI, SOUZA, 2023). From a governance perspective, they are therefore necessary but not sufficient — they set the direction and offer tools, but their transformative potential depends on stronger national implementation, accountability and resource commitments.

When analyzing the CD60/9, Strategy for Improving Mental Health and Suicide Prevention in the Region of the Americas (Resolution CD60.R12), the Policy for Improving Mental Health, the Plan of Action on Mental Health 2015 to 2020, and the Brasilia Consensus (2013), it becomes clear that the Pan American Health Organization (PAHO/WHO) has sought to place mental health at the center of the regional public health agenda. These documents collectively promote a shift from hospital-based to community-based care, guided by human rights, social inclusion, and intersectoral collaboration. The Strategy CD60/9 recognizes the growing burden of mental disorders and suicide in the Americas and calls for stronger governance, resource allocation and integrated action (PAHO, 2023). The Plan of Action 2015 to 2020 builds on this by urging countries to strengthen primary care, develop national mental health policies, expand community services, and improve data and research systems (PAHO, 2014). The Brasilia Consensus, in turn, reinforces user participation, the empowerment of people with mental disorders and the importance of civil society involvement (PAHO, 2013).

Despite their shared vision, these frameworks face persistent challenges. The main limitation lies in the gap between political commitment and practical implementation. Many countries have endorsed these goals but continue to struggle with limited funding, a shortage of trained professionals, weak intersectoral coordination, and stigma that hinders access to care (PAHO, 2020). Moreover, these policies did not fully anticipate emerging issues such as the mental health consequences of climate change, forced displacement, and digital inequities.

While suicide prevention remains a central concern, strategies often fail to connect with the broader social determinants of mental health, such as poverty and inequality. In short, these documents represent major milestones in advancing mental health in the Americas, setting a strong normative framework and shared regional vision. Yet, their impact has been limited by resource constraints, governance gaps and the absence of binding accountability mechanisms to ensure sustained and equitable implementation.

World Economic Forum (WEF)

The World Economic Forum (WEF) has progressively assumed a more visible role in shaping the global mental health agenda, particularly within the context of workplace well-being and systemic risk analysis. While the WEF does not operate within an intergovernmental legal framework nor issue binding resolutions, its influence is nonetheless significant. It acts as a strategic convener among governments, private-sector actors, academia, and civil society, fostering multisectoral convergence through high-level summits, public–private dialogues, and analytical tools (ZELINKA, 2022; WEF, 2025). This influence has become particularly evident through its annual *Global Risks Report*, which reaches a broad range of readers because of its high credibility and its open access policy. Also, it has incorporated mental health into its mapping of global vulnerabilities.

The *Global Risks Report 2020* marked the first substantial inclusion of mental health as part of its societal risk landscape, framing the rise of depression and anxiety as an emerging concern linked to long-term health burdens and diminished quality of life. At the time, noncommunicable diseases (NCDs) were already recognized as significant threats, but mental health appeared alongside them as a growing global vulnerability distinct from infectious diseases and acute public-health emergencies (WEF, 2020).

The *Global Risks Report 2021* represented a turning point. Amid the ongoing COVID-19 pandemic, the document examined particularly the deterioration of mental health among youth and young adults. It highlighted the compounded effects of digital disruption, abrupt shifts in educational modalities, unemployment, lack of economic prospects, reduced social mobility, and widening inequalities. This edition introduced the expression “mental health deterioration” within its lists of “top risks by horizon” and “top blind spots” identified

by governments and regional alliances, alongside “tech governance failure” and “youth disillusionment” (WEF, 2021). According to the report, approximately 80 per cent of young people (WEF, 2021, p.45) experienced a worsening of their mental health during the pandemic, underscoring the need for strengthened social assistance and targeted policies to reduce gender gaps as part of the recovery process.

This narrative was reinforced in the *Global Risks Report 2022*, which emphasized that around 53 million additional cases of major depressive disorder had emerged during the pandemic period, placing acute pressure on health systems already under strain (WEF, 2022 p. 13). Mental health deterioration was categorized as a societal risk and grouped with concerns such as “erosion of social cohesion” and “livelihood crises.” The report estimated a 23 per cent worsening in mental health compared with pre-pandemic levels and projected a zero-to-two-year horizon for mental health to become a critical global threat (WEF, 2022 p.24). Moreover, it drew attention to the cross-cutting relationship between mental health vulnerabilities and environmental risk, including pollution and exposure to harmful substances, highlighting the multidimensional nature of these threats.

The *Global Risks Report 2023* broadened this analytical frame by listing “severe mental health deterioration” as the 23rd most severe short-term global risk and the 25th in the long-term horizon (WEF, 2023, p. 11). It connected a spectrum of manifestations, including anxiety, dementia, depression, loneliness, and chronic stress, to potential public-infrastructure failures. This edition underscored structural inadequacies of global health systems in responding to compounding risks and grouped mental distress with vulnerabilities such as antimicrobial resistance, misinformation, and vaccine hesitancy, portraying an interconnected cluster undermining system-wide resilience (WEF, 2023).

The 2024 edition signaled a partial shift in focus, with only limited explicit references to mental health. Nonetheless, mental health remained associated with social cohesion, chronic diseases, climate change, and pollution. This edition prioritized risks related to rising global temperatures, economic uncertainty, and misinformation but maintained mental health within the broader narrative of societal fragility. In its closing reflections on “Responding to Global Risks,” the report highlighted the importance of collective action and multisectoral collaboration to overcome low-cooperation environments (WEF, 2024), preserving coherence with the WEF’s long-standing emphasis on coordinated governance.

In contrast, the *Global Risks Report 2025* contained no explicit references to "mental health," "depression," "anxiety," or "loneliness." This omission does not indicate a withdrawal of the WEF from the mental health agenda, but rather a recalibration toward other dominant global risks. Even so, the broader trajectory of the WEF has been accompanied by the operationalization of practical initiative, particularly in the private sector, focused holistically on workplace well-being and resilience. One illustrative set of actions can be found across WEF's ongoing workplace-well-being platforms, which promote integrative approaches to employee and family health, addressing factors such as stress, burnout, work–life balance, and chronic conditions. Although specific branded initiatives vary over time, the Forum consistently positions mental health as a foundational pillar within discussions on healthy workforces, productivity, and sustainable business practices. These mechanisms have successfully mobilized private-sector actors by stimulating multisectoral dialogue and advocating for coordinated responses that place mental well-being at the center of resilient economic systems.

In 2026, the WEF re-centered mental health as a determinant of societal stability, emphasizing how deteriorating well-being among young people and unemployed populations can intensify risks of anxiety and depression (WEF, 2026, p. 63). A notable innovation in this edition was the explicit linkage between AI companions, loneliness, and the broader ecosystem of online harms, suggesting that digitally mediated "support" may coexist with, or even amplify, exposure to risks such as "online child sexual abuse; online harassment; and cyber-bullying" (WEF, 2026, p. 76). Analytically, this framing reinforces the WEF's tendency to situate mental health within systemic risk narratives, where psychosocial distress is not treated only as a health outcome, but also as a driver of social cohesion, governance legitimacy, and resilience in low-trust digital environments.

Through its reports, convening power, and cross-sectoral platforms, the WEF has emerged as a relevant norm entrepreneur in global mental health governance. Its discourse has created greater awareness about mental health concerns, emphasized the urgency of societal responses, and encouraged governments, corporations, and civil society actors to align policies and financial commitments. Although the intensity and framing of mental health coverage vary across editions, the cumulative effect of the WEF's contributions has been to

anchor mental health within wider debates on global risks, resilience, and sustainable development.

To synthesize this trajectory and highlight shifts in salience, framing and risk categorization, Figure 1 provides a comparative overview of how mental health has been addressed across successive editions of the Global Risks Report between 2020 and 2026.

EVOLUTION OF MENTAL HEALTH FRAMING IN THE WORLD ECONOMIC FORUM GLOBAL RISKS REPORTS (2020–26

Year	Report	Mental Health Framing	Population / Key Focus	Status in Report	Analytical Reading
2020	*Global Risks Report 2020*	Emerging societal vulnerability linked to NCDs	General population	Initial mention	Early insertion; mental health framed as a growing risk but not yet *central*
2021	*Global Risks Report 2021*	Pandemic-linked mental health deterioration	Youth and young adults	'Societal risk" and "Blind spot"	*Discursive shift; mental health passes from marginal concern to visible systemic risk*
2022	*Global Risks Report 2022*	Systemic mental health aggravation	General population, with youth emphasis	Short-term Societal risk	*Crisis consolulation; quantified impact and stronger links to social instability*
2023	*Global Risks Report 2023*	*"Severe mental health deterioration"*	General population	*Global risk (Short- and Long-Term)*	Widened analysis; mental health tied to systemic failures and misinformation
2024	*Global Risks Report 2024*	Indirect references	General population	Cross-cutting Societal Risk	
2025	*Global Risks Report 2025*	No direct reference	–	Not mentioned	Reprioritized agenda; *mental health subsumed* under well-being and productivity
2026	*Global Risks Report 2026*	Mental health as a factor of societal stability	Youth and unemployed populations	Cross-cutting Societal risk	

Figure 1: Table of Evolution of Mental Health Framing in the Global Risks Reports of the World Economic Forum (2020-2026).
Source: Elaborated by the author based on qualitative documentary and institutional analysis of World Economic Forum Global Risks Reports (2020–2026), with visual support generated through artificial intelligence tools for analytical synthesis.

The comparative overview highlights the non-linear and contingent nature of the WEF's engagement with mental health. Rather than following a cumulative trajectory, the salience of mental health fluctuates in response to broader global risk narratives, reinforcing the interpretation of the WEF as a norm entrepreneur whose agenda-setting power is shaped by shifting geopolitical and economic priorities rather than by sustained normative commitment.

State Actors

National governments and Ministries of Health are crucial actors in global mental health governance. They are responsible for integrating mental health into broader health and

development agendas and for ensuring sustainable improvements in mental health outcomes both nationally and globally. Countries are urged to implement policies that not only expand access to services but also prioritize prevention, promotion, and the reduction of stigma. However, many countries still face significant challenges, especially in low-resource settings, where mental health services remain underfunded and heavily stigmatized (PATEL et al., 2013; PATEL et al., 2018).

Despite these constraints, a growing number of countries have made notable progress in mental health policy, aligning with international standards and demonstrating proactive engagement in multilateral forums. Italy, for example, has had a historical impact on psychiatric reform, particularly through Franco Basaglia's work and the approval of Law 180 in 1978, which became a global reference for deinstitutionalization and community-based care (LORA et al., 2012). Similarly, the United Kingdom (UK) has stood out as a prominent advocate, spearheading initiatives such as the Mental Health First Aid program, which promotes mental health literacy and early intervention, and is now implemented in over 20 countries (MENTAL HEALTH FIRST AID ENGLAND, 2024). The UK's Mental Health Strategy also emphasizes the integration of mental health into general healthcare, promoting early intervention and community-based care (DEPARTMENT OF HEALTH AND SOCIAL CARE, 2011).

The United States has made substantial contributions through institutions like the National Institute of Mental Health (NIMH), supporting global research collaborations and advancing evidence-based practices in mental health treatment and policy. The NIMH plays a leading role in funding and coordinating mental health research that informs public policy globally (NIMH, 2020). At the same time, recent U.S. administrations have illustrated the fragility and volatility of leadership shifts. Under President Donald Trump, the United States announced its withdrawal from the WHO and suspended contributions to the Organization, framing multilateral health institutions as inefficient and politically biased, before the decision was reversed by the subsequent administration (GOSTIN et al., 2020). These moves were accompanied domestically by attempts to roll back elements of social protection and health coverage, including efforts to weaken the Affordable Care Act and constrain safety-net programs, which threatened to reduce coverage for low-income populations and, in the U.S. context, many racialized communities already facing structural barriers to care

(OBERLANDER, 2017; GALVANI et al., 2020). This combination of international disengagement and domestic retrenchment underscores how shifts in U.S. foreign and social policy can reverberate across global mental health governance, both by destabilizing multilateral financing and by signaling reduced commitment to rights-based, universalist approaches.

In Asia, China has rapidly expanded its mental health infrastructure since the enactment of its Mental Health Law in 2013, increasing the number of psychiatric hospitals and professionals while also promoting community-based care. This legislation was a landmark in ensuring patients' rights and addressing stigma (WHO, 2019). Japan, in turn, has focused on suicide prevention and mental health in the workplace, introducing community-based mental health programs and establishing a national plan to reduce suicide rates. These efforts reflect a growing national commitment to mental health and wellbeing, particularly in response to social isolation and work-related stress (WHO, 2021).

Among the Scandinavian countries, Denmark is recognized for its comprehensive mental health care system, which is publicly funded and integrated into primary care. The country emphasizes early intervention, especially for children and adolescents, and offers free, easily accessible services across its regions. Its mental health policies are grounded in human rights and focus on social inclusion and cross-sectoral collaboration (OECD/EU, 2017).

In the Global South, Brazil’s pioneering role in mental health, both nationally and internationally, has established it as a key player in global mental health governance. Brazil’s experience has been recognized by WHO and PAHO as a model for integrating mental health into primary health care systems and advancing mental health within broader health and development agendas (WHO, 2013; PAHO, 2019). Brazil’s Mental Health Policy has emphasized deinstitutionalization, promoting the inclusion of individuals with mental health conditions and drug use disorders in society and ensuring their access to community-based services. The 2001 Psychiatric Reform Law (Lei 10.216/2001) and the subsequent establishment of the Psychosocial Care Network (RAPS) in 2011 have provided an integrated framework that addresses social determinants and prioritizes human rights (AMARANTE; NUNES, 2018; LUZIO; L’ABBATE, 2020). In multilateral forums, the country has also advocated for equitable mental health access and contributed to South-South cooperation

initiatives by sharing its expertise with other low- and middle-income countries (RIBEIRO, 2019).

Collectively, these national efforts underscore the diversity of approaches to mental health governance. While contexts differ, common trends include deinstitutionalization, intersectoral coordination, and the incorporation of mental health into broader public health and development strategies. These country-level actions are essential for the advancement of global mental health governance, particularly when they inform multilateral cooperation and support cross-border learning.

Economic Blocs

In this context, multilateral economic groupings have also emerged as an important space for fostering the incorporation of health, and then mental health, into their agendas, from the growing understanding of their role in sustainable development, social protection, and economic resilience, as discussed in *Chapter 1*. Under the light of this new configuration and emerging complex and interdisciplinary challenges. Forums such as the G20, Southern Common Market (MERCOSUR), BRICS countries, and the European Union (EU) gradually expanded their mandates to address global health concerns.

G20

Even the G20, originally an economic forum, has expanded its scope to address global health governance. Following the 2008 financial crisis, the G20 evolved from a platform focused primarily on economic stability to an arena where Heads of State and Government engage with a broader spectrum of global challenges, including public health, education, labor policies, climate change, and sustainable development. In 2017, under the German Presidency, the G20 established the Health Working Group, which brought together health ministers from Members, invited countries and international organizations such as WHO, the World Economic Forum (WEF), the World Bank, and UNAIDS, GAVI, The Vaccine Alliance, and UNICEF (KICKBUSCH; HOLZSCHEITER, 2021).

In the late 2010s, mental health began to appear more explicitly in G20 health discussions and leaders' declarations, particularly in connection with human capital, productivity and social protection, signaling growing recognition of the economic and social costs of mental health conditions (KICKBUSCH; HOLZSCHEITER, 2021). In institutional terms, this agenda-setting pathway typically begins within the G20 Health Working Group (HWG), where technical negotiations and political messaging are consolidated into a Health Ministers' Declaration. While not legally binding, this ministerial declaration functions as an authoritative political instrument that signals shared priorities, frames acceptable policy language and can feed into the broader G20 process. In practice, it helps shape the narrative and policy options available for subsequent endorsement at the high-level leadership, where health-related themes may be incorporated into the Leaders' Declaration as part of a wider commitment package.

During the 2019 Osaka Summit cycle, mental health and well-being were referenced in G20 health and finance discussions, especially in the context of human capital development and universal health coverage, although without a stand-alone mental health action plan. This growing engagement culminated in November 2024 in Rio de Janeiro, when Brazil concluded its G20 Health Working Group and elevated mental health as a priority for global health governance. Under Brazil's presidency, this emphasis was formalized in the Rio de Janeiro Declaration of the G20 Health Ministers, reinforcing efforts to position health, including mental health, as a cross-sectoral issue that can be carried forward into the Leaders' Declaration and broader G20 commitments (BRAZIL G20, 2024).

Further, under Brazil's presidency in 2024, the G20 Health Ministers' Declaration on Climate Change, Health and Equity, and on One Health built on decades of efforts to frame health within global governance by emphasizing the need for resilient health systems capable of withstanding multifaceted threats. The declaration highlights the value of a more integrated approach that connects human, animal and environmental health in order to address the cascading impacts of climate change on global health security. It also prioritizes equitable access to resources and innovations, particularly for populations disproportionately affected by these challenges (BRAZIL G20, 2024), aligning with the Sustainable Development Goals and with WHO's long-standing "Health for All" agenda. By framing health as integral to sustainable development and climate resilience, the declaration advances the view that global

health is inseparable from the stability and progress of international systems. This framing resonates with broader debates on the Anthropocene, where interconnected risks increasingly require comprehensive and multisectoral responses to protect well-being and reduce inequities.

Additionally, the focus on health equity aligns with broader initiatives to decolonize global health systems, emphasizing the integration of local knowledge and community-driven solutions that are culturally responsible. Brazil's leadership in this effort illustrates a shift toward leveraging the experiences to inform and transform global health policy frameworks. In the sequence, to deepen our understanding of global health, it is important to explore its historical origins and the transformation of international health from a colonial focus on hygiene and tropical medicine to today's more inclusive notion of public and international health.

This discussion was continued during the South African presidency through the Outcome Document and the Chair’s Statement, as that presidency did not reach consensus to adopt a ministerial declaration. In December 2025, the United States announced the structure of its presidency and that it would not convene the Health Working Group nor the Joint Finance and Health Task Force. As a result, this topic is not expected to be discussed in 2026.

3.3.2. Southern Common Market (MERCOSUR)

The Ad Hoc Committee on Mental Health of Mercosur (CADSM) exemplifies the bloc’s emerging commitment to regional cooperation in mental-health governance. In September 2025, Brasília hosted the committee’s session, bringing together delegations from Argentina, Brazil, Paraguay and Uruguay, alongside the Pan American Health Organization, to align prevention, care and policy strategies for mental health in the region (BRASIL, 2025). Through this mechanism, Member States collaborate in identifying shared priorities for mental-health care, exchanging best practices and advancing public policies aimed at stigma reduction and improved access to services. The initiative reflects a broader aspiration within Mercosur to integrate mental health into regional health infrastructure, linking it to wider goals such as local production of essential medicines and technologies and positioning mental well-being as a key element of sustainable development and regional equity.

BRICS

The BRICs is an acronym that refers to Russia, China and other emerging countries Brazil, India, members since its foundation in 2006, and South Africa, from 2010 onwards. According to Baylis, Smith and Owens, 2020, p. 84, the term was first coined in the research paper *Building Better Global Economic BRICs, by Jim O'Neill of Goldman Sachs in 2001*. Jim O'Neill has projected that in 40 years, by that time, the BRICs economy together would be larger than the G7 (the most developed countries in the world). During the 2023 Johannesburg Summit, BRICS expanded to include additional members as part of its effort to represent the Global South more broadly, therefore including Egypt, Ethiopia, Iran, Saudi Arabia and the United Arab Emirates, with Indonesia entering in 2024, now being unofficially referred to as "BRICS+". Considering the development of significant emerging States, and the shift of the economic weight, exacerbated by the 2008 financial crises, the BRICs nations realised that, in order to push forward their own global south agenda they must cooperate and act in union.

On that note, BRICS countries operate through a mechanism of political and economic coordination, grounded in consensus, equality, and non-interference in the internal affairs of its members (STUENKEL, 2015; RAEL, 2022). Its structure is composed of several levels of articulation, with the Leaders' Summit serving as the main decision-making body, held annually on a rotational basis among member countries (BRICS, 2024). In addition to the summits, there are periodic meetings of Foreign Affairs, Finance, Health, Trade, and Education Ministers, among others, which aim to deepen sectoral cooperation and define joint strategies on priority issues (LEINER et al., 2022). The technical coordination of initiatives is carried out by sherpas and sous-sherpas, who are responsible for preparing agendas and monitoring the implementation of decisions. In parallel, thematic working groups and expert forums operate to produce reports and policy proposals in areas such as science, environment, and health (BRICS, 2024). Moreover, the creation of a bank, a think tank and a business council allows the BRICS to better align priorities and implement future collective action plans. In 2014, the New Development Bank (NDB) was established, headquartered in Shanghai, to finance infrastructure and sustainable development projects in BRICS countries and other emerging economies (NDB, 2024). The BRICS also includes the Business Council

and the Think Tank Council (BTTC), which promote dialogue between the private sector and academia.

Initial discussion concerning mental health has been on the BRICS agenda. In the Leaders' Declaration of the XVII BRICS Summit held in Rio de Janeiro, for instance, paragraph 108 explicitly supports and recognizes the Fourth High-level Meeting of the UN General Assembly on the Prevention and Control of Noncommunicable Diseases (NCDs) and the Promotion of Mental Health and Well-being. Yet no clear collective commitment or follow-up mechanism on mental health has become a sustained priority for the bloc. This is closely related to the institutional nature of BRICS as an informal, consensus-based forum without a constitutive treaty, permanent secretariat or legally binding decision-making procedures, and which has traditionally been framed as an economic grouping (SOENDERGAARD; BARROS-PLATIAU, 2021; THUDIUM, 2023). With the recent enlargement and the inclusion of members with heterogeneous health systems, fiscal capacities and political priorities, it becomes even more difficult to reach agreement on socially sensitive agendas such as mental health. As a result, BRICS health cooperation tends to gravitate towards less contentious issues, notably communicable diseases, vaccine and pharmaceutical production, and access to health technologies, while mental health remains largely confined to declaratory references within the broader agenda of noncommunicable diseases (LIU et al., 2023).

European Union (EU)

The European Union, created in a post-world war II context, by the treaties of Rome in 1957, and further developed by the Single European Act (1987), and formalized by the Maastricht Treaty (1992), introduced three main pillars for the union: European communities, common foreign and security policies, and justice and home affairs; and created the European citizenship. Since then, the European Union expanded to 27 nations, after Brexit.

Over the past two decades, the European Union has progressively strengthened its mental health policies through a series of strategic documents. The 2005 Green Paper laid the groundwork by identifying mental health as a critical public concern and advocating for multi-sectoral strategies to promote well-being and prevent mental disorders (EUROPEAN

COMMISSION, 2005). Building on this foundation, the 2008 European Pact for Mental Health and Well-Being formalized political commitment, emphasizing cross-sector collaboration, the protection of human rights, and priority action areas such as suicide prevention, depression, and the promotion of social inclusion (EUROPEAN COMMISSION, 2008). More recently, the 2023 Communication on a Comprehensive Approach to Mental Health expanded the framework to include innovative digital tools, multi-sector governance, and the integration of mental health into education, employment, and urban planning, reflecting a more holistic and operational perspective (EUROPEAN COMMISSION, 2023). Complementing these strategic documents, initiatives such as the Council Conclusions on the Mental Health of Young People and the Technical Support Instrument Flagship 2024 translate policy into targeted actions, implementation mechanisms, and monitoring frameworks, particularly focusing on vulnerable populations and practical support for Member States (COUNCIL OF THE EU, 2023; EUROPEAN COMMISSION, 2023a).

The aforementioned Communication from the Commission to the European Parliament, The Council, The European Economic and Social Committee and the Committee of the Regions on a comprehensive approach to mental health, has become the main framework to address mental health, going beyond clinical treatment to encompass prevention, well-being, and cross-sectoral policies. It emphasizes that mental health should be accessible, equitable, and considered across multiple policy areas, including education, employment, digital technologies, and urban planning (EUROPEAN COMMISSION 2023, p. 4).

Three core principles guide the approach. First, the promotion of preventive measures aims to reduce the onset and progression of mental health problems (EUROPEAN COMMISSION 2023, p. 10). Second, high-quality and accessible care is highlighted as essential for supporting individuals throughout their mental health journey (EUROPEAN COMMISSION 2023, p. 11). Third, social reintegration after recovery is emphasized, ensuring that people can participate fully in society through access to education, employment, and community life (EUROPEAN COMMISSION 2023, p. 12). Vulnerable populations, such as children, migrants, and individuals with chronic conditions, receive particular attention (EUROPEAN COMMISSION 2023, p. 13).

Therefore, the EU has been acting as a coordinator, funder, and policy guide rather than a regulator, promoting evidence-based interventions, cross-border cooperation, and mental health promotion across its member states (OECD/EU, 2017).

Non-governmental organizations (NGOs), Philanthropic Institutions and civil society

Non-state actors have become increasingly influential in global health governance. NGOs, foundations, academic institutions, and private sector entities contribute to health research, advocacy, funding, and implementation of health programs. NGOs such as the World Federation of Public Health Associations (WFPHA), World Federation for Mental Health (WFMH), Mental Health Europe, and platforms such as the Global Mental Health Action Network (GMHAN) work in advocacy, research, and the provision of mental health services. They are often involved in raising awareness about mental health issues, conducting research, and advocating for policy changes at the international, national, and local levels. Furthermore, Doctors without Borders (MSF) and the International Federation of Red Cross and Red Crescent Societies (IFRC) work to raise awareness, reduce stigma, and provide support for individuals affected by mental health disorders globally. These NGOs contribute to shaping global mental health policies and initiatives through grassroots advocacy and community-based interventions, especially important in settings where government resources are insufficient, or political will is lacking (PARKER, MOFFATT, 2018).

Philanthropic institutions such as the Bill and Melinda Gates Foundation and the Rockefeller Foundation, for example, have significantly influenced global health through their funding of infectious disease research, vaccine development, and health-systems strengthening. While their mental health commitments have been less visible compared to infectious diseases, recent grant data show the Gates Foundation supporting family-therapy projects and recognising mental well-being as fundamental to health equity (SUZMAN, 2024). The Rockefeller Foundation, which historically contributed to the development of psychiatry in the United States and recently emphasises health system resilience and climate-related health risks, also positions mental health within a broader agenda of global health transformation (THE ROCKEFELLER FOUNDATION, 2022).

Also, historically, civil society organizations played a pivotal role in driving psychiatric reform, especially through deinstitutionalization movements and the promotion of community-based care. In countries such as Brazil, Italy, and Argentina, social participation was fundamental in advancing anti-asylum struggles and promoting human rights-centered approaches to mental health. These movements laid the groundwork for plural, inclusive, and rights-based models of care (AMARANTE, 1995; ROTELLI et al., 2013). In recent years, social participation has expanded further with the development of platforms for formal engagement in health governance. In 2024, the World Health Assembly adopted Resolution WHA77.9 on "Social participation for universal health coverage, health and well-being," encouraging Member States to establish institutional mechanisms to engage civil society in decision-making processes in health. This marked a critical step in recognizing participatory governance as essential to the legitimacy and effectiveness of health systems, including mental health services (WHO, 2024).

Academic institutions

Academic institutions and research organizations also contribute significantly to global mental health governance by generating evidence-based research, evaluating policy effectiveness, and disseminating knowledge. Their contributions help inform best practices in mental health care and policy implementation globally. In the scientific community, Universities and research centers contribute essential data and expertise to inform policy decisions and evaluate the impact of interventions (PATEL; SAXENA, 2014). By generating evidence on effective mental health interventions and best practices, these institutions play a crucial role in shaping global health agendas and driving progress towards achieving mental health equity worldwide (COLLINS et al., 2011). In this context, it can be emphasized the role of the Consortium of Universities for Global Health (CUGH), a global association of academic institutions and other organizations committed in addressing global health challenges around the world, and think-tanks as the EIT health, co-funded by the European Union.

Big companies and Pharma

As for the private sector, giant tech enterprises have started to promote a better standard of living for their employees. Several large technology corporations have launched internal mental health initiatives to promote employee wellbeing and prevent burnout, including access to counselling, employee assistance services and channels and digital tools for monitoring workload and stress. By investing in mindfulness apps, online therapy platforms and workplace-wellbeing programs, these companies contribute to normalizing mental health as a core dimension of corporate responsibility and productivity. For example, Microsoft has developed the Viva Insights platform, which uses data-driven insights to improve employee wellbeing and help organizations proactively address workplace stress and burnout (MICROSOFT, 2024). These corporate actions reflect growing recognition of mental health not only as a component of corporate responsibility but also as an essential factor in maintaining productivity and employee retention. By investing in platforms like Headspace and BetterHelp, and integrating mental health into digital workplace tools, these companies actively contribute to the normalization and prioritization of mental health at work.

The role of major pharmaceutical corporations, commonly referred to as “Big Pharma”, including Pfizer, Johnson & Johnson, Moderna, and Novartis, became undeniably prominent during the COVID-19 pandemic, particularly in the global race to develop and sell vaccines. Their rapid mobilization of research, production, and distribution capacities demonstrated the pivotal role of private stakeholders in global health security and innovation. Beyond infectious diseases, these companies have also made significant contributions to mental health, investing in psychopharmacology research and expanding access to treatment for mental disorders. A historical example is Eli Lilly, the developer of *Prozac* (fluoxetine), launched in 1987 as the first widely marketed selective serotonin reuptake inhibitor (SSRI), which revolutionized the treatment of depression and anxiety disorders (ELI LILLY, s.d.). Collectively, these pharmaceutical leaders have contributed not only to the advancement of medical science but also to improving mental health outcomes worldwide through the development of antidepressants, antipsychotics, and innovative therapies, while simultaneously shaping policy debates around equitable access, affordability, and ethical responsibility in mental health care.

The Constellation of Actors in Global Mental Health Governance

While the previous sections examined the roles of individual actors in global mental health governance, a relational perspective is required to fully capture how authority, resources and influence are distributed across this field. Global mental health does not operate through a linear hierarchy or a single coordinating institution. Instead, it is structured as a constellation of partially overlapping actors, mandates and arenas, in which international organizations, states, philanthropic institutions, civil society, academia and private sector actors interact in non-hierarchical and often asymmetrical ways.

This constellation reflects the core characteristics of a regime complex: fragmented authority, multiple centers of norm production, and dynamic patterns of cooperation and contestation. Visualizing these relationships helps move the analysis beyond institutional descriptions toward a systemic understanding of how global mental health governance is actually produced. The Figure 2 below synthesizes this configuration by mapping the main actors, their relative positions and spheres of influence within the global mental health governance architecture.

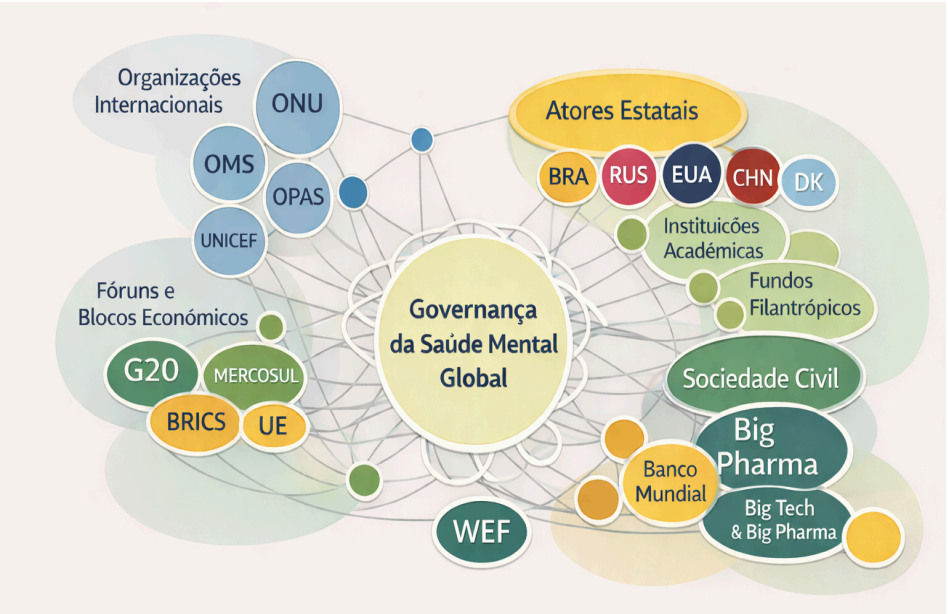


Figure 2: Constellation of Actors in Global Mental Health Governance.
Source: Elaborated by the author based on documentary and institutional analysis, with visual support generated through artificial intelligence tools (2025).

Within this constellation, power and influence are unevenly distributed, shaping how global mental health priorities are defined, funded and implemented. International

organizations such as WHO and PAHO occupy a central normative position, producing standards, action plans and monitoring tools that structure the field. However, their capacity to steer outcomes is constrained by dependence on voluntary and earmarked funding, which amplifies the influence of major donor states and philanthropic actors. In this regard, countries such as the United States play a particularly significant role. Although embedded within the regional context of the Americas through PAHO, U.S. political priorities, financial contributions and regulatory norms frequently reverberate beyond the hemisphere, shaping global agendas, funding flows and policy frames in mental health. Multilateral development banks, especially the World Bank, further reinforce economic and efficiency-oriented approaches by linking mental health to productivity, human capital and labor market outcomes. At the same time, private sector actors, including Big Pharma and digital health companies, exert substantial influence through research investment, market power and public–private partnerships, raising persistent tensions around biomedical dominance, affordability and conflicts of interest. Civil society organizations, user-led movements and academic institutions provide critical counterweights by advancing rights-based, community-oriented and decolonial perspectives, yet their impact remains structurally limited by restricted access to decision-making arenas and financial precarity. Taken together, this constellation reveals that global mental health governance is less a coherent system than a negotiated space of interaction, where outcomes emerge from shifting alliances, competing rationalities and asymmetric power relations rather than from centralized authority.

By synthesizing these actors and their interactions, this chapter demonstrates that the central challenge of global mental health governance lies not only in identifying who governs, but in understanding how governance is produced through fragmented, multilevel and often contested processes. The constellation mapped above helps to explain why mental health has achieved unprecedented normative visibility while remaining chronically underfinanced, unevenly implemented and weakly accountable. It also underscores that governance outcomes are shaped as much by political economy, power asymmetries and institutional incentives as by technical knowledge or formal mandates. Building on this analytical foundation, the next chapter shifts the focus from actors and architectures to the dynamics of coordination, resource allocation and implementation. *Chapter 3* therefore examines how fragmentation translates into concrete governance gaps, but also explores emerging good practices,

innovations and future scenarios that seek to transform interaction within this complex regime into more equitable, effective and accountable global mental health action.

CHAPTER 3: NAVIGATING THE GOVERNANCE FRAGMENTATION OF GLOBAL MENTAL HEALTH AND THE IMPERATIVE FOR NEW COLLABORATIVE MODELS

Mental health outcomes are deeply shaped by the broader social, economic and political conditions in which people live. Rather than being distributed randomly across populations, exposure to mental distress and risk of suicide follows well-established patterns of social stratification, reflecting unequal access to resources, protection and care. Global evidence consistently demonstrates that structural factors such as poverty, precarious employment, forced displacement, urban marginalization and gender-based violence are strongly associated with higher prevalence of common mental disorders and elevated suicide risk, particularly in contexts characterized by weak social protection and limited public services (MENDENHALL et al., 2020; THORNICROFT et al., 2017).

According to the World Health Organization, suicide remains a leading cause of death globally, with rates disproportionately concentrated among young people and populations exposed to social exclusion, violence and economic insecurity (WHO, 2022). While overall suicide trends vary across regions, recent data indicate stagnation or reversal of earlier declines in several countries, underscoring the fragility of progress and the sensitivity of mental health outcomes to social, economic and political shocks. These patterns highlight how gains in mental health are contingent on broader governance arrangements that extend beyond the health sector alone.

The World Mental Health Report further underscores that women are more likely than men to experience depression and anxiety worldwide, reflecting entrenched gender inequalities, unequal care burdens and exposure to violence (WHO, 2022). At the same time, access to mental health services remains profoundly unequal, with large treatment gaps persisting across regions and social groups. These patterns reveal not only service delivery failures, but deeper governance challenges related to prioritization, financing and the distribution of responsibility across sectors and levels of authority.

Building on the historical trajectory reconstructed in *Chapter 1* and the actor mapping developed in *Chapter 2*, this chapter examines three interrelated dimensions. First, it analyzes the political and institutional gaps that limit the effectiveness of global mental health

governance, including fragmented authority, chronic underfinancing, implementation deficits, and persistent asymmetries. Second, it explores how social, economic, and environmental determinants of mental health strain existing governance arrangements and expose their blind spots, particularly in the context of the Anthropocene and intersecting crises driven by structural inequality (MENDENHALL et al., 2020; THORNICROFT et al., 2017). Third, it assesses collaborative models that combine hierarchical, multilevel, and networked forms of governance with multisectoral cooperation and emerging innovations such as digital mental health, examining how these approaches can expand access and strengthen global mental health governance.

Political and Institutional Gaps and Challenges

The contemporary configuration of global mental health governance is marked by a paradox. On one hand, mental health has achieved unprecedented visibility in high-level political forums, scientific publications and advocacy campaigns. WHO's Comprehensive Mental Health Action Plan 2013–2030, the inclusion of mental health in the SDGs and the proliferation of regional strategies attest to a growing normative consensus that mental health is essential for health, development and human rights (WHO, 2013; WHO, 2022). On the other hand, this normative prominence coexists with chronic underinvestment, weak implementation and persistent inequities both within and between countries (SAXENA et al., 2007; PATEL et al., 2018). This gap between discourse and practice reveals structural limitations in the way mental health is governed at global level. Taken together, these dynamics suggest that the central challenge of global mental health governance lies not in the absence of norms or knowledge, but in the political, institutional and distributive conditions that shape how commitments are translated into practice. The following sections unpack these constraints by examining fragmentation, financing, accountability and inequality as interrelated features of the current governance architecture.

Fragmentation and Regime Complexity

From the perspective of regime complex theory, mental health governance is characterized by institutional multiplicity and partial overlap. WHO and PAHO, particularly in the context of the Americas, occupy central positions as technical authorities and norm-setters, while entities such as the World Bank, UNICEF, UNDP and UNHCR incorporate mental health into their sectoral mandates in education, social protection, humanitarian response and development financing (GOSTIN; MEIER, 2022). In parallel, philanthropic foundations, international NGOs, academic consortia and private sector platforms have developed their own programs, metrics and advocacy agendas. These different centers of authority seldom operate in a fully coordinated way, resulting in overlapping mandates, uneven prioritization and competition for resources and visibility. Rather, they reflect distinct constituencies, organizational logics and resource structures. As Orsini et al. (2013) point out, such regime complexes tend to produce both opportunities for experimentation and risks of duplication and incoherence.

Barnett and Finnemore's analysis of bureaucratic authority helps to explain how these institutions shape the mental health agenda. International organizations define what counts as a mental health problem, which populations are prioritized and which types of interventions are seen as legitimate or evidence-based (BARNETT, FINNEMORE, 2004). For example, the widespread diffusion of the mhGAP framework has contributed to privileging scalable, standardized packages of care focused on selected priority conditions in primary care settings (WHO, 2010). This has generated important advances in access to care in LMICs, but has also attracted critiques for insufficiently engaging with local epistemologies, social determinants and community-based models beyond clinical treatment (SUMMERFIELD, 2008; MILLS, 2014). These tensions illustrate how the same instruments that expand coverage can also reproduce narrow problem framings and reinforce vertical, top-down governance.

Underfinancing and the Political Economy of Mental Health

Underfinancing constitutes one of the most persistent and structural constraints on global mental health governance. According to WHO estimates, approximately 15% of the global working-age population lives with a mental disorder, contributing to the loss of an

estimated 12 billion workdays annually due to depression and anxiety alone and generating a global economic burden of around US$1 trillion per year (WHO, 2022). Despite this substantial social and economic impact, and despite mental disorders being among the leading contributors to years lived with disability worldwide, mental health continues to receive a disproportionately small share of health resources at both national and international levels (SAXENA et al., 2007; CHARLSON et al., 2019).

Successive editions of the WHO Mental Health Atlas reveal a striking continuity in patterns of neglect. On average, governments allocate only around 2% of their total health budgets to mental health, a proportion that has shown little meaningful change over the past decade. In low-income countries, per capita spending on mental health remains extremely low, often insufficient to sustain even basic community-based services (WHO, 2021; United for Global Mental Health, 2022). Similar dynamics are observed in development assistance for health: mental health has historically received less than 1% of total health aid, with estimates indicating an average of approximately 0.4% between 2007 and 2013 (GILBERT et al., 2015). These figures point not to episodic neglect, but to a structural pattern of under-prioritization embedded in global and national financing architectures.

Beyond aggregate budget shares, underfinancing in global mental health is also shaped by the way resources are structured, channelled and governed. A significant proportion of mental health funding, particularly in low- and middle-income countries, is delivered through short-term projects, pilot initiatives and externally funded programs rather than through sustained domestic budget lines. This project-based logic fragments service provision, undermines continuity of care and limits the institutionalization of community-based models. From a governance perspective, it reinforces dependency on donor priorities and weakens state capacity to plan, coordinate and scale mental health systems over time, even where political commitment exists.

Hathaway's (2003) concept of the "cost of commitment" offers a useful analytical lens to interpret this pattern. Mental health policies require sustained, long-term and intersectoral investment, yet their benefits, improved productivity, reduced suffering, enhanced social cohesion and resilience, tend to materialize gradually and are difficult to translate into immediate or electorally visible gains. As a result, mental health frequently loses out to policy areas perceived as more urgent, measurable or politically rewarding. Even though economic

modelling demonstrates that every dollar invested in scaled-up treatment for depression and anxiety yields a fourfold return in improved health and productivity (CHISHOLM et al., 2016). Further, accountability is also complicated by the regime complex structure itself. With responsibilities dispersed across international organizations, donors, states, philanthropic actors and private platforms, it becomes difficult to assign clear obligations for financing, implementation and equity outcomes. As a result, accountability tends to be fragmented: actors can claim commitment while deflecting responsibility for delivery, and monitoring mechanisms rarely translate into enforceable demands or financing reforms. This diffusion of responsibility reinforces the persistence of chronic underinvestment and uneven implementation.

From an international relations perspective, this accountability gap is not merely technical but institutional. Unlike regimes such as tobacco control or infectious disease preparedness, mental health lacks binding legal instruments capable of generating enforceable obligations, clearer standards of compliance, or meaningful consequences for persistent inaction. Accountability therefore relies primarily on soft governance tools, including self-reporting, peer review and reputational incentives. While these mechanisms can support transparency and agenda-setting, they often privilege states with greater administrative capacity and political commitment, leaving progress uneven and contingent on domestic cycles, donor preferences and short-term project logics. In practice, this means that the chronic financing gap is not only a resource problem, but also an accountability problem.

These financing constraints are further shaped by the configuration of actors within the global mental health regime complex. International organizations such as WHO and PAHO occupy central normative positions, but their agenda-setting capacity is increasingly constrained by funding structures. Heavy reliance on voluntary and earmarked contributions limits institutional autonomy and creates incentives to align mental health initiatives with donor priorities rather than collectively defined needs (GOSTIN; FRIEDMAN; EBELER, 2020; GOSTIN; MEIER, 2022). This dynamic reinforces power asymmetries between high-income donor countries and philanthropic foundations, on the one hand, and low- and middle-income countries, on the other, which are often positioned as recipients of externally designed programs rather than co-designers of global mental health strategies.

This funding configuration also has important distributive and epistemic effects. Earmarked and voluntary contributions tend to privilege interventions that are easily measurable, scalable and aligned with donor expectations, such as narrow clinical packages or digital tools, while underinvesting in long-term psychosocial care, workforce development and social protection linkages. As a result, financing choices shape not only what is implemented, but also what counts as legitimate mental health action at global level. In this sense, underfinancing operates as a mechanism of governance that indirectly steers priorities, reinforces biomedical framings and constrains the space for alternative, rights-based and community-driven approaches.

State actors also display highly uneven engagement with mental health financing. While some governments act as norm entrepreneurs and invest in rights-based, community-oriented models of care, others engage selectively, prioritizing mental health only when it aligns with broader economic, security or demographic objectives. This heterogeneity contributes to fragmented implementation and undermines the translation of global commitments into stable national policies and budgets. At the same time, civil society organizations, user-led movements and advocacy networks play an important role in challenging dominant paradigms and advancing claims grounded in human rights, lived experience and social determinants. However, their influence over financing decisions remains structurally limited by restricted access to formal decision-making arenas and chronic funding insecurity. Despite their normative relevance, these actors often operate at the margins of institutional authority.

Private sector actors and pharmaceutical companies add another layer of complexity to mental health financing. Their involvement brings resources, research capacity and innovation, but also raises concerns regarding conflicts of interest, biomedical dominance and the prioritization of pharmacological solutions over psychosocial and community-based approaches. In the absence of robust global regulatory mechanisms, these tensions further shape how resources are allocated and which interventions are scaled.

Taken together, these dynamics illustrate that underfinancing in global mental health is not merely a technical problem, but a governance outcome emerging from negotiated interactions within a fragmented regime complex. Overlapping mandates, asymmetric power relations and competing organizational logics produce persistent gaps between normative

commitments and material investment, helping to explain why global mental health governance remains simultaneously more visible yet structurally constrained. Beyond institutional design and financing structures, these governance dynamics also shape how mental health risks and resources are distributed across populations, revealing the deep interconnections between global mental health governance and social inequality.

Social Determinants of Health, Inequalities and Power Asymmetries

Finally, structural inequalities and epistemic hierarchies shape whose voices are heard and whose experiences inform global mental health governance. As decolonial and critical perspectives have argued, much of the global mental health agenda has been driven by institutions, researchers and donors based in the Global North, often exporting diagnostic categories, treatment models and implementation approaches with insufficient attention to local histories, cultures and power relations (BEMME; D'SOUZA, 2014; MILLS, 2014). The result is a tension between the aspiration to universal norms and the need for contextualized, community-driven approaches that respond to lived experiences of racism, gender-based violence, poverty and displacement, reflecting the centrality of social determinants of health and intersecting inequalities.

Beyond its effects at the level of individual exposure and vulnerability, racism operates as a structural feature of global mental health governance itself. It shapes whose suffering is rendered visible, which forms of knowledge are considered authoritative, and how priorities are defined across global, regional and national agendas. In practice, racialized hierarchies influence the allocation of resources, the design of interventions and the circulation of expertise, often marginalizing perspectives rooted in Indigenous, Afro-descendant and other historically oppressed communities. As a result, mental health governance frequently reproduces patterns of exclusion even when it formally adopts equity-oriented language.

Evidence consistently shows that exposure to poverty, precarious work, displacement, urban marginalization and gender-based violence is strongly associated with higher prevalence of common mental disorders and elevated suicide risk, particularly in contexts of weak social protection (MENDENHALL et al., 2020; THORNICROFT et al., 2017). Suicide

remains a leading cause of death globally, disproportionately affecting young people and socially marginalized populations, while women experience higher rates of depression and anxiety linked to structural gender inequalities (WHO, 2022). At the same time, large treatment gaps persist across regions, reflecting enduring failures in the equitable organization and financing of mental health systems.

The WHO´s World Mental Health Report further underscores that women are more likely than men to experience depression and anxiety worldwide, a disparity closely linked to unequal care burdens, exposure to domestic violence and entrenched gender inequalities (WHO, 2022). At the same time, access to mental health services remains profoundly unequal. Globally, a substantial proportion of people living with mental disorders receive no formal care, with treatment gaps exceeding 70% in many LMICs and persisting even in high-income settings among marginalized groups (WHO, 2022).

Racialized populations, including Afro-descendant communities and Indigenous Peoples, often face compounded barriers to care. Experiences of racism within health systems, geographic isolation, under-resourced services and lack of culturally appropriate models of care intensify psychosocial stress while limiting access to prevention, treatment and support (MENDENHALL et al., 2020). In this sense, racism operates not only as a social determinant of mental health but also as a governance issue, shaping whose knowledge is legitimized, which problems are prioritized, and how resources and services are distributed across populations and territories.

Intersectional inequalities are also particularly visible in the mental health of LGBTQ+ populations, revealing how sexual orientation and gender identity intersect with race, class, age and territory to produce compounded forms of vulnerability. Data from the Trevor Project's 2021 National Survey on LGBTQ Youth Mental Health in the United States indicate that 42% of LGBTQ youth reported seriously considering attempting suicide in the previous year, with especially high rates among Native, Indigenous and Black LGBTQ youth (THE TREVOR PROJECT, 2021). These figures illustrate not only elevated individual risk, but also the cumulative effects of discrimination, social exclusion and institutional neglect.

Transgender and gender-diverse young people, in particular, report extremely high levels of psychological distress, frequently associated with exposure to stigma, family

rejection, bullying and physical violence, as well as structural barriers to accessing affirming and competent health services. From a governance perspective, these patterns point to systemic failures in the design and implementation of mental health policies that remain insufficiently attentive to sexual and gender diversity. In many contexts, the absence of inclusive legal frameworks, professional training and data disaggregation renders LGBTQ+ mental health needs invisible within national strategies and global monitoring systems. As a result, inequities affecting LGBTQ+ populations are not only the outcome of social prejudice, but also of governance arrangements that inadequately incorporate intersectionality, participation and accountability into mental health planning and service provision.

Combined, these patterns illustrate that inequity is produced not only by differential exposure to risk, but also by how governance choices allocate resources, organize services and define policy priorities across populations and territories. They also reveal the limits of global mental health governance approaches that focus primarily on service expansion without confronting structural injustice and the distribution of power that sustains it. Without mechanisms that embed equity, participation and accountability into agenda-setting, financing and monitoring processes, commitments to "leave no one behind" risk remaining largely symbolic. Strengthening global mental health governance therefore requires moving beyond normative recognition toward governance arrangements that are enforceable, inclusive and capable of translating political commitments into material investment and equitable implementation.

A central dimension of these inequities concerns the governance of data and information. The systematic absence of disaggregated data on race, ethnicity, gender identity, sexual orientation, disability and territory limits the capacity of global and national institutions to identify disparities, design targeted interventions and monitor progress over time. In this sense, data gaps are not merely technical shortcomings, but political and institutional choices that shape visibility, accountability and resource allocation. When certain populations are not counted, they are less likely to be prioritized, funded or meaningfully included in policy processes. Strengthening global mental health governance therefore requires confronting not only service delivery failures, but also the epistemic and informational infrastructures through which mental health problems are recognized and governed.

In aggregate, the dynamics examined in this section indicate that the central obstacles to advancing global mental health governance are not merely operational or technical, but deeply political and institutional. Fragmentation, chronic underfinancing, weak accountability and persistent inequities are not accidental shortcomings; rather, they emerge from the very structure of a regime complex in which authority, resources and responsibility are widely dispersed across actors and levels of governance. In such a configuration, the proliferation of norms, strategies and initiatives has not been matched by equivalent mechanisms to ensure coordination, sustained financing or enforceable commitments.

From this perspective, the paradox of global mental health governance becomes clearer. The growing normative consensus around the importance of mental health coexists with implementation deficits precisely because commitments are articulated within a governance architecture that relies heavily on soft instruments, voluntary cooperation and project-based funding. This creates a situation in which actors can simultaneously endorse ambitious goals and evade responsibility for delivery, while accountability is diluted across institutions, sectors and scales.

Importantly, these gaps do not imply governance failure in a narrow sense, but rather reflect the inherent tensions of governing a complex, cross-cutting issue within a fragmented global system. Mental health governance thus unfolds in a space marked by overlapping mandates, competing priorities and asymmetric power relations, where progress is uneven and often contingent on domestic political will, donor preferences and short-term funding cycles. Recognising these structural constraints is essential for moving beyond diagnosis toward a more realistic assessment of what kinds of reforms, innovations and collaborative arrangements are feasible. It is against this backdrop that the following sections examine emerging good practices and future scenarios, not as solutions that resolve complexity, but as strategies to navigate it more productively.

Good Practices and Innovations: Intrasectoral, Intersectoral and Multisectoral Approaches

An increasingly important set of good practices in global mental health governance relates to the strengthening of information systems, monitoring frameworks and data

disaggregation. Improving the availability and quality of mental health data, particularly when disaggregated by race, ethnicity, gender, age, territory and other axes of inequality, is a precondition for equity-oriented governance. WHO and PAHO have progressively encouraged countries to enhance mental health information systems not only to track service coverage and workforce capacity, but also to identify disparities in access, outcomes and financing (WHO, 2022; PAHO, 2019). From a governance perspective, such data infrastructures enable more transparent priority-setting, support accountability mechanisms and create the conditions for evidence-informed and rights-based policy design.

From a governance standpoint, data systems are not neutral technical instruments, but key arenas in which priorities are defined, inequalities are rendered visible or invisible, and accountability is either enabled or constrained. In global mental health, the persistent reliance on aggregated indicators has often obscured profound disparities in exposure, access and outcomes across social groups and territories. Without systematic data disaggregation by race, ethnicity, gender, age, disability, socioeconomic status and geography, governance frameworks risk reproducing a formal commitment to universality while failing to address structurally unequal realities.

Recent efforts by WHO and PAHO to strengthen mental health information systems, including through the Mental Health Atlas and guidance on routine monitoring, represent an important step toward addressing this gap (WHO, 2022; PAHO, 2019). When adequately designed, such systems can support more equity-oriented governance by enabling policymakers to identify who is being left behind, where resources are most scarce and which interventions are producing meaningful change. In this sense, data disaggregation becomes a prerequisite not only for better planning, but for rights-based accountability.

At the same time, the expansion of data infrastructures raises critical governance questions. Decisions about which indicators are collected, how categories are defined and how data are used reflect underlying power relations and normative assumptions. Marginalized populations may remain statistically invisible if data collection frameworks do not explicitly incorporate their realities or if political resistance limits the inclusion of sensitive variables such as race or sexual orientation. Moreover, weak institutional capacity and fragmented information systems in many low- and middle-income countries constrain the effective use of data for decision-making.

Strengthening data governance in global mental health therefore requires more than technical harmonization. It demands political commitment to transparency, sustained investment in public information systems and safeguards to ensure that data are used to advance equity rather than surveillance or exclusion. As such, information systems function as a connective tissue between evidence, accountability and participation, linking measurement to governance outcomes.

Moreover, while the previous section highlighted fragmentation, underfinancing and accountability gaps, global mental health governance has also witnessed the emergence of promising practices and institutional innovations that seek to mitigate these constraints. Rather than resolving complexity, these initiatives illustrate how coordination can be strengthened within complex governance settings through pragmatic arrangements that connect global norms to implementation, particularly those promoted by the World Health Organization and its regional offices (WHO, 2022; PAHO, 2019). Analytically, such innovations can be grouped into three interrelated domains: intrasectoral integration within health systems, intersectoral action across policy fields, and broader multisectoral governance arrangements.

At the intrasectoral level, one of the most significant practices has been the progressive integration of mental health into primary health care systems, a core element of WHO's normative guidance since the mhGAP and the Comprehensive Mental Health Action Plan (WHO, 2010; WHO, 2013). Strengthening primary care as the main entry point for mental health services has allowed countries to expand access, reduce stigma and move away from hospital-centered and asylum-based models of care. Task-sharing strategies have enabled trained non-specialist health workers to deliver low-intensity psychological interventions, screening and follow-up within routine services, particularly in low- and middle-income countries (PATEL; SAXENA, 2014; WHO, 2022). From a governance perspective, primary health care functions as a territorial interface between global norms and lived realities, translating international guidance into context-sensitive practices while generating locally grounded data that can feed back into policy formulation and monitoring.

Digital mental health and telemedicine constitute another important axis of intrasectoral innovation. Telepsychiatry, digital screening tools and remotely delivered psychological interventions have expanded significantly, especially following the COVID-19

pandemic, and are increasingly reflected in WHO technical guidance and country-level strategies (WHO, 2022). These tools may reduce geographic inequities and improve system responsiveness, but they also raise governance challenges related to data protection, quality assurance, ethical oversight and digital exclusion. Their contribution to equity therefore depends on their integration into public health systems and regulatory frameworks, rather than their expansion as parallel or market-driven solutions (WHO, 2022).

Intersectoral action represents a second layer of innovation, reflecting growing recognition that many determinants of mental health lie outside the health sector. WHO and PAHO have increasingly emphasized intersectoral action linking mental health with education, social protection, employment, justice and humanitarian response (PAHO, 2019; WHO, 2022). School-based mental health programmes, the integration of psychosocial support into social assistance schemes, and coordination between health and justice sectors illustrate how intersectoral approaches can address upstream drivers of distress. Such initiatives signal a shift from treatment-focused models toward preventive and promotive strategies, although their effectiveness remains contingent on sustained coordination, shared objectives and aligned financing across sectors.

Beyond specific sectoral interfaces, multisectoral governance arrangements have emerged as a more institutionalized pathway for coordination. National mental health plans involving multiple ministries, interministerial committees, and governance bodies with the participation of civil society and service users reflect an effort to institutionalize participation beyond ad hoc consultation and to embed mental health within broader state coordination mechanisms. Such arrangements are explicitly encouraged in WHO and PAHO policy frameworks (WHO, 2013; PAHO, 2019). At the global and regional levels, multisectoral initiatives linking mental health to humanitarian response, climate adaptation and migration governance further reflect this trend, aligning with broader debates on health in the Anthropocene (WHO, 2022).

The adoption of the World Health Assembly resolution on social participation in 2024 further strengthens this governance framework by explicitly positioning participation as a core condition for universal health coverage, health equity and well-being, rather than as a discretionary consultative add-on (WHO, 2024). By urging Member States to institutionalize “regular and meaningful” participation across the policy cycle and to allocate adequate and

sustainable public resources to enable it, the resolution reinforces participation as a governance function closely linked to accountability, transparency and inclusion, including for populations in vulnerable or marginalized situations (WHO, 2024). In the context of global mental health, this normative development is particularly relevant because it provides additional institutional grounding for user-led movements, community organizations and civil society to claim voice in agenda-setting, budgeting and monitoring, precisely the stages where mental health commitments have historically failed to translate into sustained implementation.

For global mental health governance, the 2024 World Health Assembly resolution on social participation carries particularly significant implications. Mental health policies have historically suffered from weak translation between high-level commitments and sustained implementation, especially in budgeting, service organization and monitoring. By framing participation as a core governance function across the policy cycle, the resolution strengthens the normative basis for embedding user and community involvement within national mental health plans, interministerial coordination mechanisms and monitoring processes such as theWHO´s Mental Health Atlas (WHO, 2024).

Operationalizing social participation in mental health governance entails moving beyond episodic consultation toward institutionalized arrangements that enable continuous engagement. This includes the formal inclusion of service users, family networks and civil society organizations in policy design, budget deliberations and evaluation processes. In practice, such mechanisms can contribute to greater policy responsiveness, enhance legitimacy and help ensure that interventions align with lived experiences, particularly among populations disproportionately affected by mental distress and exclusion. Furthermore, participation strengthens accountability by creating additional channels through which gaps between commitments and delivery can be contested. When linked to transparent data systems and monitoring frameworks, participatory governance can support bottom-up scrutiny of implementation and resource allocation. In this sense, the WHA resolution reinforces participation not as an ethical add-on, but as a structural condition for more equitable and effective global mental health governance.

Combined, these intrasectoral, intersectoral and multisectoral innovations demonstrate that global mental health governance is not solely characterized by fragmentation and constraint. They provide concrete entry points for improving coordination and equity within

existing institutional structures. At the same time, their uneven implementation and variable sustainability highlight the limits of technical and organizational solutions in the absence of political commitment, stable financing and inclusive governance frameworks. These tensions inform the analysis of future scenarios and possibilities explored in the following section.

Moving Forward: Scenarios and Possibilities

Despite the structural gaps and tensions identified above, the current moment also presents significant opportunities to reconfigure global mental health governance along more collaborative, equitable and resilient lines. Rather than signaling the emergence of a single central authority, recent developments point to a reorganization of governance through negotiated coordination within a complex, polycentric and fragmented landscape. The growing recognition of mental health as a cross-cutting concern in development, climate governance and humanitarian action, combined with the diffusion of innovative practices at national and subnational levels, has expanded the range of institutional pathways through which such coordination may occur.

Within a regime complex framework, future trajectories of global mental health governance should not be understood as linear or mutually exclusive pathways, but as overlapping and often competing dynamics unfolding simultaneously. Incremental institutional strengthening, network-based experimentation, financing innovations and more transformative cross-sectoral integration are likely to coexist, interact and sometimes clash within the same governance landscape. This plurality reflects the absence of a single center of authority and the heterogeneous interests, capacities and normative orientations of actors involved.

Rather than anticipating convergence toward a unified model, a regime complex perspective highlights the importance of analyzing how different governance pathways shape outcomes across contexts. Some configurations may enhance coordination and equity in certain settings, while reinforcing fragmentation or exclusion in others. Understanding these scenarios as contingent and politically mediated trajectories allows for a more realistic assessment of both opportunities and limits in advancing global mental health governance.

From a regime complex perspective, the central challenge is not to eliminate fragmentation, which is neither feasible nor necessarily desirable, but to govern it more productively. This entails improving alignment among existing actors, clarifying roles and complementarities, and creating institutional mechanisms that allow experimentation while reducing duplication, incoherence and inequitable outcomes. In this sense, scenarios for the future of global mental health governance can be understood as different pathways for organizing interaction, authority and responsibility within an inherently plural system.

One plausible scenario for the future of global mental health governance involves the incremental strengthening of multilevel institutional arrangements that more effectively connect global norms with regional, national, and local policy processes. In this pathway, organizations such as the World Health Organization (WHO) and the Pan American Health Organization (PAHO) continue to exercise normative and technical leadership by setting minimum standards, producing guidance, facilitating peer learning, and coordinating monitoring frameworks, while increasingly supporting co-produced agendas shaped from the outset with Member States, civil society organizations, and people with lived experience of mental distress (PAHO, 2019; WHO, 2022).

Within this scenario, PAHO occupies a particularly strategic position. Although formally a regional organization, its technical expertise, policy innovation, and long-standing convening capacity in the Americas enable agenda-setting effects that extend beyond the hemisphere through policy diffusion, epistemic networks, and demonstration effects. This is especially relevant given the region's strategic weight in global health politics and the presence of high-capacity actors whose domestic policy choices often influence wider global agendas. Strengthening multilevel institutional coordination in this way could enhance policy continuity and institutional resilience in the face of political turnover, while embedding mental health more firmly within national health systems and primary health care as a durable component of universal health coverage.

A second scenario emphasizes network governance and cross-sectoral coalitions organized around specific problems, populations, or policy domains, such as suicide prevention, adolescent mental health, humanitarian emergencies, or digital mental health. In this configuration, coordination is less institutionalized and more horizontal, relying on flexible partnerships involving WHO, PAHO, UNICEF, UNHCR, IOM, academic institutions,

philanthropic foundations, and private-sector actors. When linked to clearly defined objectives, monitoring mechanisms, and time-bound deliverables, such networks have demonstrated potential to accelerate knowledge transfer, promote innovation, and scale interventions across contexts (PATEL et al., 2018; UNICEF, 2020). However, this scenario also entails significant governance risks. In the absence of robust accountability mechanisms and explicit attention to representation and power asymmetries, networked initiatives may reproduce existing inequalities by privileging actors, epistemologies, and policy priorities from high-income countries. Rather than complementing institutional governance, poorly coordinated networks can contribute to further fragmentation, short-term project logics, and uneven implementation, particularly in low- and middle-income settings where institutional capacity is already constrained.

A third set of possibilities centers on financing-driven governance innovations aimed at reducing the persistent "cost of commitment" identified in the previous section. Beyond integrating mental health more systematically into universal health coverage and domestic health budgets, multilateral development banks and global financing mechanisms could embed mental health components within broader investments in primary care, education, social protection, and climate adaptation (WB, 2016; GOSTIN; MEIER, 2022). Blended finance models combining public funding, philanthropic resources, and impact investment may support the expansion of community-based services, task-sharing strategies, and digital tools, particularly in under-resourced contexts. Yet, this scenario depends critically on the existence of strong regulatory safeguards to protect public accountability, equity, and human rights. Without such safeguards, financing-led approaches risk reinforcing market-driven priorities, favoring scalable biomedical or digital interventions over community-based and preventive strategies, and amplifying the influence of private actors in agenda-setting and service delivery.

Technological and service delivery innovations cut across these scenarios as an additional axis of transformation. Digital mental health tools, telepsychiatry, and low-intensity psychological interventions delivered by trained non-specialist workers have shown promise in expanding access and maintaining continuity of care, particularly in the context of climate-related disasters, forced displacement, and recurrent health emergencies characteristic of the Anthropocene (PATEL; SAXENA, 2014; WHO, 2022). Nevertheless, their contribution

to equitable governance depends on integration into comprehensive public systems that address social determinants, ensure data protection, and respect cultural diversity. Without such integration, technological solutions risk becoming fragmented, exclusionary, or overly market-oriented.

A more transformative, cross-cutting scenario would involve the systematic integration of mental health into broader global governance arenas, including climate negotiations, migration compacts, humanitarian frameworks, and sustainable development strategies. As demonstrated throughout this dissertation, the psychosocial consequences of environmental degradation, conflict, and displacement position mental health as both an outcome and a determinant of societal resilience in the Anthropocene (WHITMEE et al., 2015; YOUNG, 2019). Embedding mental health indicators and interventions into climate adaptation plans, disaster risk reduction strategies, and social protection policies could shift mental health from a residual concern to a core component of preparedness, recovery, and sustainable development.

Ultimately, regime complex theory reminds us that global mental health governance should not be assessed against an ideal of coherence or centralization, but rather understood as an evolving configuration shaped by contestation, learning, and persistent power asymmetries (ORSINI et al., 2013; ZELLI et al., 2021). Fragmentation, in this sense, is not merely a governance failure to be corrected, but a structural feature of contemporary global governance in issue-areas that cut across health, development, human rights, climate change, and social protection. The analytical challenge, therefore, is not to design a perfect institutional architecture for mental health, but to cultivate forms of interaction that are productive rather than paralyzing within an inherently plural and polycentric governance landscape.

Across the scenarios examined in *Chapter 3,* three conditions emerge as analytically and normatively central to the future of global mental health governance. First, equity, understood not as a rhetorical commitment but as the active reduction of avoidable disparities in mental health outcomes and access to care across lines of race, gender, class, territory, disability, and migratory status. Equity, in this sense, requires governance arrangements to explicitly confront how resources, authority, and knowledge are unevenly distributed, and how these asymmetries shape who benefits from global mental health initiatives and who remains systematically excluded.

Second, social participation must be conceived not as symbolic consultation or ad hoc engagement, but as meaningful power-sharing with people and communities affected by mental distress throughout agenda-setting, implementation, and monitoring processes. As demonstrated throughout this dissertation, the marginalization of service users, user-led movements, and community organizations has contributed to recurrent implementation gaps and limited policy ownership. Strengthening participation therefore functions not only as a democratic principle, but as a governance mechanism capable of enhancing accountability, legitimacy, and policy effectiveness within a fragmented regime complex.

Third, reflexivity emerges as a critical institutional capacity in the context of global mental health governance. Reflexivity entails the ability of organizations and governance arrangements to interrogate their own assumptions, confront epistemic hierarchies, and remain open to knowledge generated in diverse social, cultural, and political contexts. This is particularly salient in a field historically shaped by Global North epistemologies and biomedical paradigms, where insufficient attention to local histories, social determinants, and lived experience has often undermined the relevance and sustainability of interventions. Reflexive governance is therefore essential to navigating complexity without reproducing domination or epistemic exclusion.

If these principles guide the evolution of mental health governance within the broader global health regime complex, the mental health agenda is more likely to consolidate its own governance space while simultaneously contributing to a more just, effective, and resilient global health system. Rather than competing with other global health priorities, mental health emerges as a cross-cutting domain that exposes the limits of siloed governance and highlights the necessity of integrated, multisectoral responses in the Anthropocene.

At the same time, the operationalization of these principles is conditioned by a volatile political environment marked by competing priorities, fiscal constraints, and ideological contestation. In many contexts, austerity policies, conservative backlash against rights-based agendas, and the securitization or instrumentalization of mental health threaten to narrow policy space. Under such conditions, mental health risks being framed primarily in terms of productivity, risk management, or social control, rather than as a matter of rights, care, and social justice. These dynamics can weaken participatory governance, undermine public investment, and reinforce biomedical or market-driven approaches at the expense of

community-based and preventive strategies. Recognizing these political risks is therefore essential to avoid overly technocratic or optimistic assumptions about future trajectories and to situate governance reforms within broader struggles over power, resources, and meaning.

This chapter's analysis supports the dissertation's central interpretation: global mental health governance operates as a semi-autonomous subsystem within the broader global health regime, shaped by dispersed authority and overlapping mandates. Its consolidation is likely to depend less on institutional centralization or legal formalization than on how effectively coordination, participation, and accountability are cultivated within a fragmented regime complex. In the Anthropocene, where environmental disruption, social inequality, and political instability increasingly intersect, mental health governance also becomes a revealing site for examining whose voices are incorporated into policy, which forms of knowledge are treated as authoritative, and how priorities are translated into practice across unequal contexts.

CONCLUSION

This dissertation examined how mental health has moved from a marginal position to a more central place within global health governance, and how this shift can be analytically understood as the emergence of a field with governance dynamics of its own within an increasingly complex and fragmented international system. Grounded in the analytical context of the Anthropocene, the study approached mental health not as an isolated sectoral issue, but as a cross-cutting concern deeply intertwined with environmental disruption, widening social inequalities, demographic change and the broader crisis of global sustainability. Drawing on regime complex theory and global governance scholarship, the dissertation conceptualized global mental health governance as a semi-autonomous subsystem embedded within the wider global health regime, characterized by overlapping institutions, distributed authority and the absence of a single hierarchical center.

The analysis demonstrated that the incorporation of mental health into global health governance has been neither linear nor uniform. Historically, mental health remained largely absent from early forms of international health cooperation, which focused primarily on hygiene, tropical medicine and infectious disease control. Its progressive institutionalization occurred through a combination of normative developments led by the World Health Organization and its regional offices, the incorporation of mental health into human rights instruments, and national psychiatric reform processes that gradually displaced custodial and asylum-based models in favor of community-based and rights-oriented approaches. This historical trajectory provides the necessary backdrop to understand contemporary global mental health initiatives not as isolated innovations, but as the outcome of cumulative institutional and normative layering.

Mapping the constellation of actors involved in global mental health governance revealed a dense and heterogeneous architecture. WHO and PAHO emerge as central norm entrepreneurs and sources of technical authority, while regional organizations, economic blocs and national governments engage with mental health in uneven and context-dependent ways. At the same time, a growing array of non-state actors, including non-governmental organizations, philanthropic foundations, user-led movements, professional associations, corporate platforms, Big Tech and pharmaceutical companies, actively shape agenda-setting, financing priorities and implementation pathways. Authority, expertise and resources are

therefore widely dispersed, reinforcing the analytical relevance of a regime complex perspective to capture patterns of cooperation, competition and contestation within the field.

Applying this lens allows for a more nuanced understanding of differentiated roles and power asymmetries among actors. While intergovernmental organizations assert normative leadership, other actors exert influence through financial leverage, technological innovation or discursive framing. The World Economic Forum (WEF), for example, has contributed to embedding mental health within broader debates on global risks, resilience and economic sustainability, particularly through its convening power and agenda-setting capacity in the private sector. This layered configuration generates opportunities for innovation and scalability, but also risks reinforcing fragmentation and privileging certain epistemologies and interests over others.

A core analytical finding developed in *Chapter 3* concerns the paradox between the growing normative visibility of mental health and the persistent weakness of its material implementation. Despite the prominence of mental health in WHO action plans, the SDGs and regional strategies, it continues to receive a marginal share of domestic health budgets and international development assistance. From a regime complex perspective, this reflects a condition of institutional proliferation without sufficient integration: declarations and commitments abound, but their translation into sustained and equitable practice remains constrained by non-binding norms, fragmented accountability mechanisms and chronic underfinancing. Overlapping mandates and loosely coordinated initiatives further exacerbate these limitations, rendering progress uneven and highly contingent on domestic political cycles, donor priorities and project-based funding logics.

The dissertation also demonstrated that global mental health governance cannot be adequately assessed without explicit engagement with social and structural determinants. Poverty, precarious labor, racism, forced displacement, gender-based violence and discrimination against LGBTQ+ populations shape both the distribution of mental distress and access to care. Intersectional inequalities mean that Afro-descendant communities, Indigenous Peoples, migrants and gender-diverse youth often bear disproportionate mental health burdens while facing under-resourced and culturally inadequate services. Current governance arrangements have only partially incorporated these realities and frequently

reproduce epistemic hierarchies that privilege biomedical models and Global North perspectives.

Building on these findings, the research argued that more just and effective global mental health governance depends on three interrelated principles: equity, social participation and reflexivity. Equity entails the active reduction of avoidable disparities in mental health outcomes and access to care across lines of race, gender, class, territory and disability. Social participation requires moving beyond symbolic consultation toward meaningful power-sharing with people with lived experience and affected communities throughout agenda-setting, implementation and monitoring processes. Reflexivity refers to the institutional capacity to interrogate power relations, confront epistemic hierarchies and remain open to knowledge emerging from diverse contexts, particularly in the Global South.

In practical terms, this implies strengthening multilevel governance arrangements that connect global, regional, national and local processes in more iterative and reciprocal ways. WHO and PAHO should continue to provide normative and technical guidance, but increasingly through co-produced agendas involving Member States, civil society organizations and service users. Network governance initiatives, thematic partnerships and South–South cooperation platforms can facilitate the diffusion of community-based and rights-oriented innovations, provided they are designed to correct rather than reproduce existing imbalances in representation and voice.

Financing emerged as a second critical implication. The persistent underinvestment documented throughout this research suggests that mental health will not advance without explicit and sustained financial commitments. Integrating mental health into universal health coverage frameworks, strengthening primary health care and social protection systems, embedding mental health within climate adaptation financing, and earmarking resources in development banks and global health mechanisms are essential to reducing the “cost of commitment” and moving beyond pilot initiatives toward durable system strengthening.

The analysis further indicates that regional and bilateral arenas often provide more fertile ground for cooperation and implementation than multilateral settings alone. Within this landscape, PAHO occupies a particularly strategic position by translating global norms into regionally adapted frameworks and facilitating policy diffusion, in the context of the

Americas. The presence of the United States within PAHO gives initiatives developed within it the potential to resonate beyond the hemisphere, influencing broader global debates on mental health financing, service integration and innovation. This reinforces the relevance of regional governance as a bridge between global norm-setting and national implementation.

Situating mental health within Anthropocene governance also requires its systematic integration into policy domains that have traditionally treated it as peripheral. Climate negotiations, migration frameworks, humanitarian response mechanisms and sustainable development forums must incorporate mental health indicators and interventions as core components of resilience and preparedness strategies. Doing so recognizes psychological well-being as an indivisible dimension of health and social sustainability, shaping societies' capacity to adapt to interdependent crises in more equitable and inclusive ways.

This research is not without limitations. It focused primarily on global and regional institutions - particularly in the Americas - and did not include primary fieldwork with service users or policy-makers, which would provide valuable insights into how global norms are negotiated and translated in practice. Moreover, the rapidly evolving nature of mental health governance, particularly in areas such as digital mental health, telehealth, workplace initiatives and climate-related policies, means that some developments extend beyond the temporal scope of this study.

Future research could deepen this analysis through comparative country studies, expanded examination of regional approaches beyond the Americas, and closer attention to user-led movements and decolonial perspectives in reshaping governance agendas. Empirical investigation of emerging financing models, digital interventions and climate-related mental health programs will also be essential to assess whether new collaborative models reduce or reproduce existing inequalities.

Ultimately, this dissertation demonstrates that the future of global mental health will not be shaped by any single institution or instrument, but by the quality of interactions within a fragmented regime complex spanning sectors, scales and epistemologies. The central hypothesis of the research was tested and confirmed: mental health has been incorporated into global health governance as a semi-autonomous subsystem whose consolidation depends less

on institutional centralization than on coordination, equity-oriented design and participatory accountability.

In an Anthropocene marked by accelerating and interconnected crises, global mental health governance holds the potential not only to consolidate its own governance space, but also to catalyze a more equitable, reflexive, and resilient approach to global health governance, one that places people at its center by rethinking how health outcomes are pursued, whose voices are heard, whose knowledge is legitimized, and whose well-being is ultimately prioritized in the pursuit of sustainable and inclusive futures.

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