

Mental Health reform 2.0: Learning from the Global South

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Over the last two decades, mental healthcare has undergone significant global changes. Since the UN Convention on the Rights of Persons with Disabilities in 2006(1), “a new era” for mental healthcare centered on patients’ rights and autonomy (2) has emerged, referred to by the authors as Mental Healthcare Reform 2.0. The first reform involved the abolition of asylums at large scale in much of the Global North in the 60s and 70s, but also in Global South countries, such as Brazil. The second reform heralds a new healthcare culture based on patient empowerment and community participation.

Despite constrained resources, the Global South has been at the forefront of developing innovative, cost-effective, and community-based mental health and psychosocial support (MHPSS) interventions. These approaches offer valuable insights that can inform and be integrated into our call for action towards Mental Healthcare Reform 2.0 globally. These lessons can, thus, guide reforms to build more resilient and equitable mental health systems.

This commentary highlights key actions on *who* needs to be involved in the Mental Health Reform 2.0, *what* approaches should be embedded, and *how* to ensure a successful culture shift in mental healthcare (Table 1).

WHO: A change in Human Resources

Task shifting

Countries like India (3) Pakistan (4), and Brazil (5) have successfully implemented task-shifting models, where non-specialist health workers deliver mental health interventions. The Friendship Bench in Zimbabwe trains lay health workers to provide evidence-based talk therapy, reducing depression and anxiety (6). The Global North can adopt similar models by training non-specialists to expand access to care and mitigate power imbalances to empower local resources.

Participation of people with lived experience

An inclusive mental health system must recognize the value of involving individuals with lived experience in service delivery and policy development. Their invaluable insights can contribute effective and compassionate care models (7). Peer-led psychosocial support programs have demonstrated evidence of success (8). Mental Healthcare Reform 2.0 should formalize mechanisms for engaging individuals with lived experience in decision-making processes, from designing care pathways to recovery and evaluation of service effectiveness.

WHAT: A change in the Approach

Culturally informed interventions

Many Global South countries use culturally relevant and low-cost interventions, leveraging local languages, traditions, and informal support systems (9). The narrow, binary framing of mental health in biomedical terms fails to encounter the fundamental dimensional nature of mental health which is related to the different ways individuals understand their own mental health. Community care sets the foundation for early interventions, preventing escalation and relapse. A compelling example is the adaptation of WHO's Doing What Matters in Times of Stress (DWM) in Kenya, where the program was implemented in barbershops within informal urban settlements. Barbers—trusted and embedded figures within the community—were trained to recognize signs of psychological distress and deliver basic psychosocial support using the DWM framework. Delivered in local languages and embedded within everyday spaces, this initiative highlights how community care can enable early intervention, reduce stigma, and prevent the escalation or relapse of mental health conditions. It also underscores the potential of informal settings to serve as accessible and culturally attuned mental health entry points in contexts where formal services may be limited or stigmatized (<https://www.mhinnovation.net/innovations/we-matter-too-mental-health-intervention-adolescent-men-using-african-hiphop-bongo>).

The context of psychiatric reform in Brazil is another example. The therapeutic companion (acompanhante terapêutico, AT) is a health professional who works with individuals facing emotional, behavioral, or social adaptation difficulties, primarily within the context of mental health. These professionals are responsible for providing guidance and emotional support to patients, promoting patient autonomy, and facilitating social reintegration into the community (10).

Equitable e-mental health approach

While technological advancements such as teletherapy, AI-driven diagnostics, and mental health apps have gained momentum in the post-COVID-19 and demonstrated potential to enhance service accessibility, digital solutions should be integrated thoughtfully, addressing digital disparities in remote and underserved populations (11). Ethical concerns surrounding data privacy, digital equity, and biases in AI-based mental health tools must be considered to prevent harm.

Addressing social determinants of mental health

Mental health programs in the Global South integrate social interventions, recognizing that poverty, unemployment, and violence can worsen mental health outcomes. The BasicNeeds Model in Uganda and Kenya combines mental health support with livelihood programs, improving both mental well-being and economic resilience (12). The Brazilian mental health reform introduced the Therapeutic Residential Service (SRT) - houses in urban areas for people discharged from long-term hospitalizations - and the “Back home program” (programa de volta para casa –PVC), which consists of a financial aid that aims to facilitate the process of deinstitutionalization and social reintegration in their communities of its beneficiaries. Both programs which follow WHO and PAHO recommendations tackle the social and structural determinants of health and represent innovative technologies for social protection and support for resocialization, enhancing users’ emancipation and autonomy (13). The successful implementation of Reform 2.0 calls for interventions that do not only focus on symptoms and diagnosis but also address social and structural determinants that perpetuate mental health challenges.

HOW: A change in Ethics

Reinforcement of autonomy for people living with mental health conditions

Autonomy is a cornerstone of ethical mental health care. Individuals should have the right to make informed decisions about their treatment (14). Reform 2.0 must promote strategies enhancing self-determination through shared decision-making models, information provision about rights, and self-advocacy skills training that strengthen autonomy and improve outcomes. An example of an autonomy-producing initiative is the ‘autonomous medication management’ in Canada and Brazil (collaborative management in Spain) that promotes open communication between patients, physicians, and family, and helps patients regain control over their treatment (15).

Rights of patients and caregivers

A rights-based approach ensures humane, equitable and non-discriminatory mental healthcare (16). Mental Healthcare Reform 2.0 must uphold laws protecting individuals from involuntary hospitalization, coercive treatment, and other practices that erode autonomy. Additionally, caregivers, who play a vital support, often face significant emotional and financial strain. Policies must provide adequate support systems for them too.

Intangible elements in monitoring and evaluating mental health services

Effectiveness of mental health services extends beyond quantifiable metrics like treatment success rates. Intangible elements, such as patient satisfaction and participation, therapeutic alliance, and cultural appropriateness, are crucial in evaluating care quality. In fact, quality services are those that help to promote meaningful quality in people’s lives. Trust between patients and providers, dignity in care experiences, and adaptability to diverse backgrounds and ongoing changes define effective interventions. Qualitative research should then complement quantitative measures for comprehensive evaluations.

The Inter-Agency Standing Committee (IASC) guidelines on Monitoring and Evaluation of Mental Health and Psychosocial Support (MHPSS) (2021) underscore a multidimensional conceptualization of effectiveness, recognizing that conventional quantitative indicators alone are insufficient to fully assess the quality and impact of interventions. The guidelines advocate for participatory, culturally sensitive, and contextually grounded evaluation frameworks that reflect the complexities of individuals’ lived experiences in emergency settings. Central to this approach is the integration of qualitative methodologies—such as narrative inquiry, focus group discussions, and participatory appraisal techniques—which enable the capture of subjective dimensions of care, including perceptions of trust, dignity,

relevance, and empowerment. By complementing quantitative measures, this comprehensive evaluative model enhances the validity, responsiveness, and ethical grounding of MHPSS assessments, thereby aligning with core humanitarian values and improving the relevance and sustainability of mental health interventions in diverse emergency contexts (17).

Conclusion

While many effective interventions exist spanning across medication, psychological and social interventions for the whole range of mental health conditions across the life course, the challenge remains in implementing them in a just and equitable way. While mental health suffering remains, Mental Healthcare Reform 2.0 presents a historic opportunity to reimagine mental healthcare, addressing both tangible and intangible elements that shape its effectiveness and ethics. Lessons from the Global South offer valuable insights into *who* should be involved, *what* approaches should be adopted and *how* to ensure a just and equitable Reform -building a new culture of care.

About the authors

Since 2009, SE has lived, worked and taught in humanitarian settings in Sub-Saharan Africa, Latin America, North Africa and the Middle East as community-based mental health advisor. Currently, she works in Monitoring & Evaluation programs of mental health and psychosocial interventions in North Africa and further, she supports community-based interventions in Kenya. FO has lived and taught collective and public health at the State University of Rio de Janeiro, in Brazil, for more than 20 years. AMH co-led global south-oriented projects such as Health for All in Latin America and has taught and conducted fieldwork in different parts of Brazil.

Conflicts of Interest

Authors report no conflicts of interest

Author contributions

SE, AMH and DO contributed equally to this work

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