COUNTRY PROFILE

Analysis for mental health campaigning and advocacy

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THE PURPOSE

of these profiles is to inform effective mental health advocacy by identifying and documenting national priorities for mental health campaigning efforts. This country profile is the culmination of desk research and interviews with experts in Peru. Based on the PESTLE[1] framework of analysis, covering Political, Economic, Social, Technological, Legal and Environmental factors, it seeks to outline issues relevant to mental health, identifying resource gaps, challenges, opportunities and priorities of people affected, leading to recommendations for key actors working in mental health campaigning and advocacy in Peru. The development of country profiles was implemented through a partnership between the Speak Your Mind Campaign and the Mental Health Innovation Network.

1 Perera R. 2017. The PESTLE analysis.

Photo: Municipal Palace of Lima, LINK

Political Factors

Institutional Framework: The State of Peru is formed by the Executive, Legislative, and Judicial Branches, as well as the autonomous constitutional bodies. The Executive Branch promotes all national policies and is organized at the national, regional and local levels. In addition, it is in charge of the 18 existing ministries in Peru, including the Ministry of Health (MINSA), which has the mission of promoting health, preventing diseases and guaranteeing health care for all the country's inhabitants; proposing and directing health policies. The Mental Health Directorate sits within MINSA and Yuri Cutipé is the current Acting Director.[2]

Mental Healthcare System: The Directorate's structure for services is divided across multiple levels. At the first level, there are primary health centres (PHC), which care for a variety of health conditions.

2 Gob.pe Plataforma digital única del Estado Peruano. LINK

PHC is further subdivided based on the availability of professionals at the centres. The I-3 and I-4 centres are the most specialized (e.g. some include psychology and/or psychiatry services). PHC also works with Community Mental Health Centres (CMHC), Psychosocial Rehabilitation Centres, Occupational Rehabilitation Centres and Protected Homes and Residences.

The CMHCs[3] are specialized mental health centres, which have a psychiatrist and provide specialised services for children, adolescents, adults, older adults, as well as for people with addictions. The Psychosocial Rehabilitation Centres[4] are institutions for people with mental disorders and disability, which allow them to regain their autonomy and promote their integration into the community. Occupational Rehabilitation Centres[5] are institutions where people can recover or acquire the necessary skills to get and keep a job. Finally, the Protected Homes and Residences[6] are places that provide temporary residence for people with mental, intellectual and/or psychosocial disabilities who cannot live independently and do not have the necessary family support.

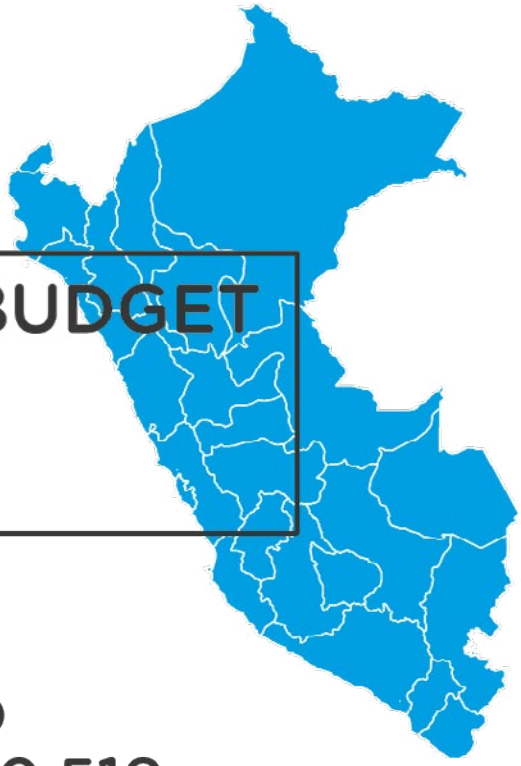
The second level of care includes general hospitals, which usually have psychology and/or psychiatry services. As part of the Mental Health Reform, specialised hospitals (from category II-2) have Mental Health and Addiction Hospitalization Units[7]. Finally, on the third level, there are hospitals specialised in mental health. Peru has 3 of these psychiatric hospitals nationwide, all located in Lima, the country's capital.

Economic Factors

BREAKDOWN OF MENTAL HEALTH SERVICES AND RESOURCES[8]

MENTAL HOSPITALS	3
PSYCHIATRIC UNITS IN GENERAL HOSPITALS	12
COMMUNITY MENTAL HEALTH CENTRES[9]	134
GENERAL MENTAL HEALTH STAFF (rate per 100,000 of the population)	Psychiatrists: 0.76 Other medical doctors: 5.55 Psychologists: 5.06 Social workers: 0.22 Nurses: 6.09 Occupational Therapists: 0.21 Other mental health workers: 4.54

3 MINSA 2017. Norma Técnica de Salud. Centros de Salud Mental Comunitarios. LINK
4 El Peruano 2015. Decreto Supremo 033-2015-SA LINK
5 El Peruano 2015. Decreto Supremo 033-2015-SA LINK
6 MINSA 2018. Norma Técnica de Salud. Hogares Protegidos LINK
7 MINSA 2018. Plan Nacional de Fortalecimiento de Servicios de Salud Mental Comunitaria 2017 – 2021 LINK
8 WHO 2014. Mental Health Atlas country profile 2014 LINK
9 PAHO 2020. Perú continúa con la implementación de centros de salud mental comunitarios. LINK



THE NATIONAL BUDGET FOR 2020 IS $51,815,146,854[10]

10%

of the national budget is devoted to healthcare services.

AROUND **$102,300,519** goes towards **MENTAL HEALTH**

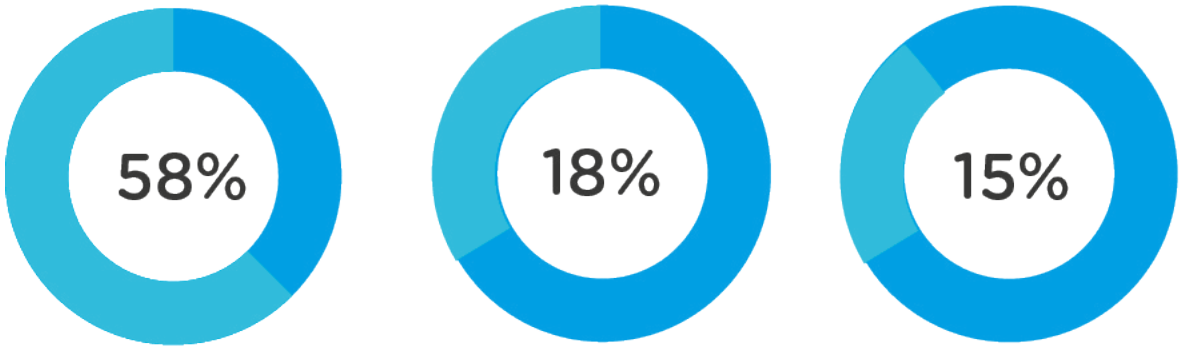
Which represents **2%** of the health budget

└ **0.2%** of the national budget.[11]

In terms of the economic burden of mental disorders,[12] using a hypothetical cohort, it was estimated that in **2015 mental disorders** represented a total cost of **$21,893,108**

└ **91.3%** of the budget allocated for the mental health budget program for that year.

In the breakdown by disorder, most of the resources went towards managing



Depression **Alcohol abuse** **Schizophrenia**

10 Decreto de Urgencia N 014-2019 LINK
11 Decreto de Urgencia N 014-2019. LINK
12 Mosqueira-Lovón, et al. 2015. Costo De Enfermedades Mentales Prevalentes En Perú.

Photo LINK

Social Factors

Mental disorders represent the largest cause of disability[13] in the country, followed by unintentional injuries and cardiovascular disease. It is estimated that about 30% of the Peruvian population[14] will experience a mental disorder at some point in their life. Annually, approximately 20% live with a mental disorder[15]. The most prevalent disorders are anxiety disorders (14.9%), mood disorders (8.2%), impulse control (8.1%) and substance use disorders (5.8%). The age of onset[16] for mental disorders was found to be 15 years old for anxiety disorders, and 20 years old for impulse control disorders. Similarly, in the case of children and adolescents[17], the prevalence of any mental health problem is between 14.7% and 20.3%.

Despite the high prevalence of these disorders, and the high disability that they cause, the treatment gap is still between 69-90%[18] in different regions of the country. Among the main barriers to accessing mental health treatments, an interviewed user mentioned some important limitations:

13 MINSA 2018. Carga de Enfermedad en el Perú. LINK
14 Fiestas & Piazza. 2014. Lifetime prevalence and age of onset of mental disorders in Peru: results of the World Mental Health Study, 2005. RPMESP, 31(1), 39-47.
15 MINSA 2018. Plan Nacional de Fortalecimiento de Servicios de Salud Mental Comunitaria 2017 – 2021. LINK
16 Fiestas & Piazza. 2014. Lifetime prevalence and age of onset of mental disorders in Peru. LINK
17 MINSA 2018. Plan Nacional de Fortalecimiento de Servicios de Salud Mental Comunitaria 2017 – 2021. LINK
18 Ibid.

1) the amount of paperwork and difficulty of the procedures to arrange an appointment and/or to obtain a health insurance, including the lack of guidance on how to carry this out; and **2)** the poor treatment received by health workers, including mistreatment, and the perception that health workers usually give more importance to the reports of family members than to those from users. The interviewee recommends that mental health services should provide a good atmosphere, allowing users and family members to feel welcomed.

The psychiatrist is sometimes more mindful to the information given by the family member than the user. [...] The doctor must be reminded that he must take into account what the patient says.

Interview with User Organization Leader

Regarding associations of users and family members of mental health, Peru has a National Association of Users and Family Members (Ayni Peru)[19], which has representatives from different regions of the country. There are also associations at the regional level (such as Misky Puquio in La Libertad)[20] and at the district level (such as Asumen[21] in San Martín de Porres, Lima). Recently, and as a response to the new Mental Health Law, the Coalition for Mental Health and Human Rights was formed with individual and collective members from the civil society.

Another important aspect in the Peruvian context is the lack of autonomy and the presence of stigma towards people with psychosocial disabilities. One of the interviewees commented that as part of a study -not yet published-, it was found that many people did not have the keys to their houses to be able to leave freely, and their interaction with others was restricted because they were considered "dangerous". The interviewee also commented that people with mental disorders have greater barriers to accessing education and formal employment:

In the [legal] clinic we see many cases of children who do not even have a diagnosis, but because of the atypical behavior, the alarms go off in the centers and houses of other children so that those children are expelled and their education is restricted because they consider them as a danger. At the university level it is the same, if it affects the security of the university community. [...] Inclusion [in the workplace] is very poor and their [working] conditions are precarious, with short or no contracts, and employers include psychological evaluation in the medical examination, which is once a year, but what it does is that when identifying cases, there is a job separation. So they don't hire them and there's a big chance of discrimination.

Interview with Lawyer

19 MINSA 2019. Minsa promueve conformación de asociaciones de usuarios afectados en Salud Mental. LINK
20 MINSA 2017. La Libertad: Crean primera asociación regional de familiares y usuarios con problemas en salud mental. LINK
21 Gamarra 2011. Una visita a la Asociación de Usuarios de Salud Mental de San Martín de Porres. LINK

Technological Factors

The use of information and communication technologies in Peru[22] is high, as 92.8% of households have landlines, cell phones, Internet or cable television. It is also estimated that 73% of people who had internet access[23] were active on social networks and that 70% use social networks on cell phones. Technology has been used to convey messages about mental health at both the individual and social levels. At the individual level, a research study[24] in Lima created text messages to encourage people to actively seek mental health help, if needed. At the social level, certain organisations have used the media to spread messages about mental health. For example, the Colectivo Descosidos worked with inpatient and outpatient users of a psychiatric hospital by conducting radio workshops that sought to reduce internalised and social stigma. On the other hand, De-Mentes, a non-profit organisation, has developed awareness campaigns against stigma towards mental health through social media and community activations. Finally, the Ministry of Women and Vulnerable Populations launched the "Violence disguised as love" campaign, aimed at recognizing warning signs of gender violence. This campaign is broadcast through radio and television spots and also has an interactive website.

The production of research on mental health[25] in Peru is scarce. For example, between the years 2011 and 2013, Peruvian research was found to be lower than in Brazil, Chile, Argentina and Colombia and, from the publications found, 56% of authors were from researchers outside of Peru. Some of the research carried out includes screening in primary care[26], mobile applications to reduce symptoms of depression[27], implementation of sheltered homes for women with schizophrenia[28], associations between tuberculosis and mental health[29], and maternal mental health[30].

Legal Factors

The Political Constitution of Peru recognizes the universal right to health. Since 2004, mental health has gained importance in policies and regulations, which was reflected in the publication of the MINSA Guidelines for Action in Mental Health. Peru was also one of the first States to sign the United Nations Convention for the Rights of Persons with Disabilities in 2007 and ratified it in 2008[32].

In 2012, with the approval of the Law 29889[33] (which modifies the article 11 of the Law 26842, the General Health Law), the provision of mental health services at the primary and secondary care levels were officially acknowledged, and introduced support

22 INEI 2018. Estadísticas de las Tecnologías de Información y Comunicación en los Hogares. LINK
23 Yi Min Shum 2019. Situación digital y social media en Perú 2019.LINK
24 Toyama et al. 2018. Design and content validation of a set of SMS to promote seeking of specialized mental health care within the Allillanchu Project. Global Health, Epidemiology and Genomics, 3, e2. doi:10.1017/gheg.2017.18
25 Luna-Solís 2015. Producción científica en salud mental en Perú: Reto en tiempos de reforma de salud. AMP. 32(1), 36-40.
26 Diez-Canseco et al. 2018. JMIR 20.3: e100.
27Brandt et al. 2019. JMIR 6.6: e11701.28
28 Socios en Salud 2017 LINK
29 Acha et al. 2007. Global Public Health. 2.4: 404-417.
30 Eappen et al. 2018. Global Mental Health. 5.
31 Constitución Política del Perú 1993. LINK
32 Naciones Unidas 2008. Convención sobre los Derechos de las Personas con Discapacidad. LINK
33 El Peruano 2012. Ley 29889. LINK

services for user's recovery and to promote their reintegration into society. In that same year, the General Law on Persons with Disabilities was published, Law 29973[34], which aims to establish the legal framework for the promotion, protection and realization of the rights of People with Disabilities, promoting their development and full and effective inclusion in political, economic, social, cultural and technological life.

In May 2019, with the publication of a new Mental Health Law (Law 30947[35]), the Law 29889 was repealed and it recognized the legal capacity of People with Disabilities, and contemplated the community approach, deinstitutionalization and community life, among others. Although the enactment of this Law meant a great advance and alignment with the CRPD, there are still difficulties regarding the viability of protected homes and the involuntary admission of people with psychosocial disabilities.

The legislation has made positive progress, both in the law and its regulations. They are quite aligned with the CRPD, especially with respect to deinstitutionalizing, restricting admission to psychiatric hospitals, and promoting a community-based model of care. [Yet], there are two points in the current legislation to observe.
One is regarding involuntary hospitalization [arguable] and the other regarding hospitalization ordered by dangerousness, without medical purposes [unacceptable].

Interview with Lawyer

An important element of the Peruvian Mental Health Reform community-based model of care is to enable users to participate in the implementation processes of mental health care. However, the interviews showed that this participation is still incipient. One user interviewed commented that there are no open consultation processes to discuss the laws or regulations, and that when they do exist, there are important limitations to access these spaces.

It is not a complaint. On the one hand, I think they have not taken us into account. On the other hand, I think they have invited us, but sometimes the invitations have not arrived, they have not tried to take the time to adequately contact users so that they are present. For example, some have difficulties to access, due to mobility issues, orientation, accompaniment required, effects of medication, etc. As a consequence, there are no users present at such assemblies or meetings.

Interview with User Organization Leader

In addition, the lawyer interviewed added that, in many cases, the consultation processes are only to receive comments when the document is already finished.

34 El Peruano 2020. Ley 19973.LINK
35 El Peruano 2019. Ley 30947. LINK

Photo: Pedro Szekely. Colca, Peru, 2007 LINK

The consultation processes in Peru, and especially those for people with disabilities, are very bad. [...] The Government understands that they just post the document on the website and receive comments, or they hold a large event where 500 people gather, they tell what they are going to do, but they cannot listen to everyone, so in the end it is just a mere formality, in that they even do it when the document is already finished, so there is no real consultation.

Interview with Lawyer

The interviewee commented that the National Human Rights Coordination in Peru created a platform for organizations of People with Disabilities, which sent comments when the Mental Health Law was launched, but these were not implemented. The interviewee considers that it set a record, but there were no changes in the law. She also pointed out that they have seen the regulation and its new versions thanks to internal contacts, but not through formal spaces where opinions have been socialized and collected.

The most updated regulation for mental health care in Peru is the National Plan for Strengthening Community Mental Health Services 2018-2021[36], which describes the problems identified by the State in the field of mental health and the actions that will be carried out to overcome them. The CSMC technical health norm[37] specifies the objectives, organization, roles and activities within the CSMC.

Environmental Factors

Bicentennial Anniversary: In 2021 the Bicentennial will be celebrated, commemorating the 200th anniversary of the proclamation of the independence of Peru[38]. The Peruvian government is carrying out various activities and has set several goals for this celebration. One of them is to implement 281 CMHC nationwide. As part of this effort, and in view of the concern for the mental health of university students, in 2019 the first university CSMC was inaugurated at the Universidad Nacional Mayor de San Marcos.

Political violence victims: Peru owes a debt to the victims of the internal armed conflict that took place between 1980 and 2000. In 2016, MINSA published guidelines for the mental health care of people affected by violence during this period to guarantee the access and quality of mental health services, the strengthening of human resources and the implementation of clinical and community interventions targeting this population.

Gender violence: Peru struggles with a rising incidence of gender violence, especially towards women and LGBTI population. In 2017, MINSA published a technical guide[39]

36 MINSA 2018. Plan Nacional de Fortalecimiento de Servicios de Salud Mental Comunitaria 2017 – 2021. LINK
37 MINSA 2017. Norma Técnica de Salud. Centros de Salud Mental Comunitarios. LINK
38 Gobierno del Perú. Bicentenario Perú 2021. LINK
39 MINSA 2017. Guía Técnica para la atención de salud mental a mujeres en situación de violencia ocasionada por la pareja o expareja. LINK

for providing mental health care to women affected by violence caused by their partner or ex-partner, which aims to establish identification, diagnosis and treatment procedures.

Natural disasters: Peru is in an area prone to natural disasters. Currently, there is no specific clinical practice guide[40] for mental health in disaster situations. However, the emergency health guide specifies that there must be community mental health care in these situations to alleviate or control the effects of trauma and to avoid re-victimization.

COVID-19 Response: Recently, in the face of the crisis caused by the coronavirus pandemic, although the Peruvian government has not neglected mental health, the shortcomings of the system have become evident. After the mandatory lockdown began, MINSA distributed two technical guides for mental health care, targeting the mental health of health staff[41] and affected populations, families and communities[42]. Some special measures taken in the context of the pandemic were to authorize, at first, the short walks of people with autism spectrum disorder[43] - albeit only for 15 minutes - and, later, to children and adolescents under 14 years old[44]. Despite public health measures, it has become known that institutionalised populations are exposed, both in psychiatric hospitals[45] and in prisons[46], to a higher risk of contagion given the precarious conditions in which they live.

The consultation processes in Peru, and especially those for people with disabilities, are very bad. [...] The Government understands that they just post the document on the website and receive comments, or they hold a large event where 500 people gather, they tell what they are going to do, but they cannot listen to everyone, so in the end it is just a mere formality, in that they even do it when the document is already finished, so there is no real consultation.

Interview with Lawyer

40 MINSA 2017. Documento Técnico. Lineamientos para la implementación del proceso de rehabilitación y del proceso de reconstrucción en los servicios de salud frente a emergencias y desastres. LINK
41 MINSA 2020. Guía Técnica para el Cuidado de la Salud Mental del Personal de la Salud. LINK
42 MINSA 2020. Guía técnica para el cuidado de la salud mental de la población afectada, familias y comunidad, en el contexto del COVID-19. LINK
43 MINSA 2020. Documento Técnico: Orientaciones para el cuidado integral de la salud mental de las personas con Trastorno del Espectro Autista LINK
44 MINSA 2020. Alerta Epidemiológica AE-017-2020. LINK
45 Sucesos 2020. COVID-19: la silenciosa muerte de los pacientes del Larco Herrera. LINK
46 IDL. 2020. El espejo cóncavo. Sobre el coronavirus y las prisiones. LINK

LOCALLY-LED AND EVIDENCE INFORMED RECOMMENDATIONS FOR PERU'S MENTAL HEALTH CAMPAIGNING EFFORTS

1 Establish a central coordinating mechanism to support mental health associations

While there are a number of family and users' associations in Peru, they are still limited considering the population in need that requires representation. According to key informants, the work carried out by existing associations is highly variable, they are self-sustained (do not have an external budget assigned), and they are made up of small groups, which limits the real representation of the country's mental health users. Each CSMC should promote the creation of local user associations and provide them with the support required to maintain activities[47].

2 Increase the national mental health budget

Although mental health investment is increasing and being better distributed, it is still insufficient to cover all the population needs. Hence, we recommend raising the investment in mental health services to at least 5% of the total health budget.

3 Tackle stigma towards people with mental disorders

Mental health stigma is an enormous problem in Peru and it has a negative impact on the people with psychosocial disabilities autonomy and exercise of human rights. It is highly needed to conduct a campaign that tackles inaccurate beliefs about mental health, such as perceiving people with mental health problems as dangerous, and to raise awareness about the negative effects of excluding them from the society.

4 Promote the autonomy and exercise of human rights

The exercise of human rights and autonomy has historically been limited among people with mental illness. It is important to strengthen the prevention and promotion of mental health, as a means to avoid developing severe symptoms that might negatively impact on the person's decision-making. It will be crucial to educate users and family members about the ways of ensuring respect for human rights when a crisis arises, such as the use of advanced directives, which are a permit the service user gives to a person they trust to make decisions about their treatment based on their pre-specified conditions.

47 MINSA 2018. Plan Nacional de Fortalecimiento de Servicios de Salud Mental Comunitaria 2017 – 2021. LINK

5 Nothing about us without us: Assure the active participation of people with psychosocial disabilities

Legislation and policies regulating the health of people with psychosocial disabilities must be responsive to their needs. Therefore, it is crucial that decision-makers successfully work collaboratively with people with psychosocial disabilities. This not only means inviting them to join the conversation but to guaranteeing their active participation and the explicit inclusion of their views, concerns, needs and demands at all stages, including conceptualisation, drafting, debating and enactment.

6 Take advantage of the momentum that mental health is gaining in Peru

It is a key moment for mental health advocacy. The sum of legislation efforts to improve the current law, the Bicentennial celebrations aiming to increase the number of CMHC, and the evidence suggesting how the lockdown due to COVID-19 will affect the mental health of the population, represent a window of opportunity for mental health. We need to strengthen our current initiatives (i.e. targeted policies, deployment of CMHCs nationwide, increased budget), and work towards better quality of care in public health services, improve the initiatives at the community level, promote the participation of local civil organizations, and encourage the involvement of people with psychosocial disabilities.