HEALING MINDS, CHANGING LIVES

A MOVEMENT FOR COMMUNITY-BASED MENTAL HEALTH CARE IN PERU

Delivery Innovations in a Low-Income Community, 2013–2016

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WORLD BANK GROUP

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EXECUTIVE SUMMARY

WHAT WILL THIS GREAT VICTORY LOOK LIKE?

The global fight to transform mental health care will be won in ordinary communities, by ordinary people. Won in homes, schools, workplaces, local clinics, and small residential care facilities. Won by families, lay caregivers, nurses, psychologists, and patients providing peer support, as well as by psychiatrists.

What will this great victory look like? It will look like normal life. Like individuals and families living happily, building strong relationships, working productively, where before they could not.

Experts have long known that community-based mental health services are the most effective and efficient way to fight mental, neurological, and substance-use disorders (MNS).[1,2] For decades, however, implementation has lagged. The result is needless human suffering and vast economic costs. Each year, the global economy loses some US$1 trillion in productivity due to depression and anxiety.[3] Now, some countries are fighting back, expanding community-based mental health services with innovative strategies.

One of these countries is Peru. This report explores community-focused change initiatives in the financing, organization, and delivery of mental health services in Peru from 2013 to 2016. It examines the national dimension of reforms but focuses above all on implementation and results in the economically fragile district of Carabayllo, in northern Lima. Marshalling qualitative and quantitative evidence, the report asks three questions:

- **What was achieved during Peru's 2013–2016 mental health care reforms?**
- **What factors appear to have influenced reform successes and shortfalls?**
- **What lessons can be drawn for ongoing efforts to improve Peru's mental health care system, and for mental health agendas in other countries?**

Background

A heavy burden, worst for the poor. Each year, one in five Peruvians will be affected by a mental disorder.[4] These disorders are the country's leading cause of disease burden.[5] Of all chronic diseases in Peru, mental health problems account for the greatest economic costs, far outstripping cardiovascular diseases, cancer, or diabetes. The poorest citizens suffer most. MNS prevalence is highest among the poor and marginalized, further reducing their economic productivity and slowing the nation's progress towards inclusive prosperity.[4]

Care gaps. Despite acknowledgment of the principles of community-based care, mental health services in Peru, as in most countries, have remained largely concentrated in specialized psychiatric hospitals. This model is associated with large, persistent care gaps. In 2012, just 12.8 percent of Peruvians estimated to need mental health services actually received them.[4]

Testing new strategies. From 2013 to 2016, Peruvian health leaders launched a series of community-focused change initiatives to improve mental health care. The low-income district of Carabayllo in northern Lima was one of those where implementers delivered the most complete package of innovations, providing a rigorous road test for reform strategies.

Delivering Community-Based Mental Health Reforms in Carabayllo: What was Achieved?

Broad gains. Four key community-based mental health care modalities were deployed in Carabayllo in 2013–2016. Three scored impressive successes, though with wide scope for further improvement. One initiative failed and requires deep redesign. The overall positive results provide proof of concept for nationwide community-based mental health reform in Peru.

The heart of reform: community mental health centers. Community mental health centers (CSMCs) are the most important component of Peru's mental health care strategy. CSMCs bring mental health services out of psychiatric hospitals and into local settings, where providers engage patients and communities as partners. Twenty-two CSMCs were launched across Peru in 2015, with Carabayllo's the first in Metropolitan Lima. Staffed by an inter-disciplinary team of clinicians and social workers, the Carabayllo CSMC delivered more than 20,000 interventions in its first year and drew patients from far beyond its planned catchment area. Results confirmed large unmet care needs and strong uptake of mental health services in the community. However, heavy patient loads stretched CSMC resources and raised concerns about maintaining quality.

Mental health care in primary care: proof of concept, but more can be done. Reforms sought to foster mental health care delivery in local general health care facilities, a key tenet of community-based mental health.[6] This entailed: (1) mental health training for local primary care providers; and (2) in-service technical support to primary care teams by mental health specialists. By the end of the study period, robust referral networks and collaborative relationships had been established between the Carabayllo CSMC and local primary care centers, and primary care teams showed improved mental health competencies. However, most primary care providers continued to refer patients with mild-to-moderate mental health issues prematurely to the CSMC, rather than treating these patients in the primary-care setting. Maintaining supplies of psychiatric drugs in primary care facilities also posed a persistent challenge.

Healing comes home: a mental health halfway house for vulnerable women. Halfway houses provide temporary residential services to people with serious mental disorders who have been discharged from hospital and have weak family support systems. In Carabayllo, a women's mental health halfway house was implemented collaboratively by the National Institute of Mental Health (INSM), a nongovernmental organization, and the Municipality. The facility operated successfully and at full capacity during the study period, using a minimally restrictive residential care model. Qualitative evidence suggests the approach enhanced residents' wellbeing and accelerated their social reintegration, for example enabling some women to resume interrupted education or earn an independent income, options that previously seemed far beyond their reach.

Failure to establish mental health units in general hospitals. As part of mental health service decentralization, Peru's reform agenda foresees creating short-term mental health hospitalization units in local general hospitals. In Carabayllo, this effort made scant progress. Funds were transferred to the local hospital to implement a mental health and addictions unit, but clinical staff resisted the change. Hospital management facing a generalized budget crisis redirected mental health funding to other priorities. The same pattern played out in other sites around Peru where similar units were planned.

Can Community-Based Mental Health Care Save Money?

Community-based mental health modalities delivered generally promising results for patients in Carabayllo. But are these just "boutique" interventions for a lucky few? Would expanding community-based mental health care nationwide prove prohibitively expensive, or on the contrary might it actually save taxpayers money?

Community-based services: high quality at low cost. Researchers compared the costs of outpatient and inpatient treatment in Carabayllo's community mental health facilities against average costs for the same services in mental health hospitals. Results strongly favor the community approach. In 2016, the average unit cost per outpatient consultation across Peru's three flagship psychiatric hospitals was US$58.96. The unit cost for a standard outpatient consultation at the Carabayllo CSMC was US$11.58, five times less (Table 1). The average patient bed-day cost in mental health hospitals was US$90.86. The per capita daily cost of residential treatment at Carabayllo's halfway house was less than a third as much, US$28.48 (Table 2).

TABLE 1. UNIT COST RATIO FOR OUTPATIENT CONSULTATIONS IN SPECIALIZED HOSPITALS AND CSMCS, 2016

OUTPATIENT TREATMENT	SPECIALIZED HOSPITALS/CSMC, US$			
	INSM	HVLH	HHV	TOTAL
Unit cost - Hospital	75.68	97.54	26.45	58.96
Unit cost - CSMC	11.58	11.58	11.58	11.58
Outpatient treatment cost ratio Hospital/CSMC	6.54	8.43	2.28	5.09

CSMC: community mental health center; INSM: National Mental Health Institute; HVLH: Víctor Larco Herrera National Hospital; HHV: Hermilio Valdizan Hospital.

TABLE 2. UNIT COST RATIO PER INPATIENT DAY IN A SPECIALIZED HOSPITAL VS. PER CAPITA DAILY COST IN A MENTAL HEALTH HALFWAY HOUSE, 2016

HOSPITALIZATION	SPECIALIZED HOSPITALS/HALFWAY HOUSE, US$			
	INSM	HVLH	HHV	TOTAL
Unit cost - of hospitalization	91.02	101.21	69.18	90.86
Daily per capita cost - Halfway house (HH)	24.38	24.38	24.38	24.38
Hospitalization cost ratio – Hospital/HH	3.73	4.15	2.84	3.73

HH: mental health halfway house; INSM: National Mental Health Institute; HVLH: Víctor Larco Herrera National Hospital; HHV: Hermilio Valdizan Hospital.

How much could be saved? Researchers estimated the savings that might hypothetically be obtained by harnessing the cost differentials between hospital-based and community-based mental health treatment. If 90 percent of all outpatient treatments in Lima's flagship psychiatric hospitals were shifted to CSMCs, Peru's health system would save US$7,669,519 annually. This sum would cover the cost of operating 21 community mental health centers. Similarly, if 50 percent of all long-stay hospitalizations took place in halfway houses, the system would save US$7,845,079 and could cover the operating costs of 92 halfway houses.

REFORM AND PERU'S PSYCHIATRIC HOSPITALS

In Peru, as in most countries, large psychiatric hospitals remain the dominant components of the mental health care system today. Can these institutions change, as community-based reforms take hold? As new delivery modalities rolled out in Carabayllo in 2013–2016, Peru's flagship psychiatric hospitals tested their own innovative strategies.

A new financing paradigm. Peru's Comprehensive Health Insurance (SIS) is a public health insurance system for individuals with limited economic resources. Between 2013 and 2014, the SIS changed its mental health care financing framework, increasing fivefold the fees it paid to mental health service providers. This mechanism was introduced in the large psychiatric hospitals, then spread to the CSMCs, spurring dramatic growth in the provision of specialized care. The INSM, for example, multiplied its outpatient numbers fourfold between 2012 and 2016. The financing reform reduced hospital patients' out-of-pocket payments for mental health services from 94 percent in 2013 to 32 percent in 2016.

A new care model. To improve outcomes while boosting efficiency, implementers at the INSM launched an innovative care delivery design called the Short-Term Intervention Module (*Módulo de Intervención Breve*, MIB). For selected patients, the approach prioritized group and workshop treatments that are cheaper and possibly more effective than individual sessions with a psychiatrist. The MIB shows promise to resolve up to 80 percent of cases of mild to moderate complexity. Financed primarily with SIS resources, this treatment model essentially recreates a community mental health center within the hospital.

Hospitals as learning institutions. Community-based and hospital-based mental health care delivery can evolve and advance together. Recent innovations like the SIS and the MIB have not obviated the need for a broad reinvention of the role of psychiatric hospitals. However, these experiments confirm that Peru's flagship hospitals are able to innovate, cooperate, and adapt to new demands.

MENTAL HEALTH REFORM: A POLITICAL PROBLEM

Health benefits and even the evidence of potential cost savings are not sufficient to make change happen, if health policy proposals fail to ignite political support. Key to assessing mental health reform efforts is seeing how such efforts have been managed politically.

To explore this issue, researchers interviewed political decision makers involved in the 2013–2016 reforms. Informants included actors at the national government level (e.g., Ministers of Health and directors of key agencies), as well as local political leaders and health officials in Carabayllo. Informants were asked to identify factors that facilitated political uptake of mental health reform proposals, along with countervailing contextual and political forces.

What helped. Factors widely cited as key political enablers for the reform movement included: (1) a technically robust set of proposed actions aligned with global norms and championed by respected national experts; (2) structural and contextual shifts, especially the changes in Peru's Comprehensive Health Insurance scheme that increased financing for mental health provider institutions; (3) reform proponents' skill in marketing their ideas politically, notably through a positive framing that emphasized ready solutions, not just the magnitude of problems; (4) the argument that mental health action would help address multiple social concerns (e.g., reducing domestic violence and boosting communities' economic productivity); and (5) collaborative, mutually beneficial implementation partnerships spanning national and local levels, within which many stakeholders perceived themselves as net winners.

What hurt. On the negative side, constraints on political uptake identified by informants included persistent misperceptions of the community mental health agenda among some influential stakeholders, together with the stigma attached to mental disorders, which weakened political support and constrained service demand at community level. Reforms also suffered from monitoring and evaluation deficits, notably the absence of indicators to reliably track the impact of innovations on mental health outcomes. Some informants pointed to inadequate mobilization of civil society, academic institutions, and other multi-sectoral partners as a key weakness of reform efforts.

CHOOSING THE FUTURE

Today, Peru's mental health care system stands with one foot in the past and the other in the future. Reform efforts in settings like Carabayllo have shown that community-based strategies can improve the coverage, acceptability, efficiency, and equity of mental health services. As these models expand, they promise transformative health gains for individuals and substantial social and economic benefits for communities.

Mental health in the balance. While recent progress has been impressive, however, several important components of the 2013–2016 mental health reform effort failed to gain traction, and the geographical scale-up even of successful modalities has been slower than anticipated. At the end of our study period, the planned countrywide dissemination of community-based mental health care innovations showed diminished momentum. A downturn in national economic growth spurred budgetary belt tightening and called earlier financing commitments into question. The willingness of the government to continue and ramp up its support for mental health reforms was unclear. For Peru's leaders, the choice between past and future in mental health care remains open.

Fresh challenges. The favorable conditions that facilitated the reform movement during its initial phases will not necessarily continue to operate. Careful strategy and contingency planning will be required going forward. Our report highlights four key challenges reform leaders must negotiate: (1) ensuring sufficient financing to keep reforms on track; (2) coordinating mental health action across provider institutions and territories; (3) adapting mental health reforms to potential broader structural changes in the nation's health system; and (4) navigating a political landscape marked by Peru's policy and institutional reform processes.

How will ongoing reforms be financed? Financing is the most emblematic of these issues. The resource outlook for Peru's mental health agenda is more positive than might be assumed. One reason for this is the results-based budgeting mechanism launched in 2014 to support the roll-out of mental health care innovations. The results-based model establishes a ten-year financing framework for mental health action. The adoption of this mechanism sends a positive signal for the future of reforms. On the other hand, recent threats to the Comprehensive Health Insurance (SIS) framework for low-income citizens could compromise the countrywide expansion of community mental health services.

CONCLUSIONS

What lessons can Peru's recent mental health experiences teach, and what should be done to fulfill the promise of the reforms pioneered in Carabayllo and other settings from 2013 to 2016? The conclusions of this study are the following:

COMMUNITY-BASED MENTAL HEALTH CARE IN PERU: THE BOTTOM LINE

+ **Primary health care in Peru is able to incorporate mental health care. This requires providing primary care workers with training and in-service technical support; making management responsive to conditions in local facilities; and ensuring the continuous availability of psychotropic drugs in primary care services.**[7]

+ **Peru's model for providing specialized mental health services is shifting from psychiatric hospitals to community mental health centers (CSMCs), which already show some evidence of higher levels of productivity, effectiveness, social acceptability, and capacity for innovation to improve care processes.**

+ **Expanded CSMC implementation is feasible under Peru's current national and sectoral conditions. CSMCs have quickly (in less than two years) achieved a cost-benefit advantage compared to the traditional model of care in specialized hospitals.**

+ **In cost-benefit terms, mental health halfway houses are a better alternative for the care of socially isolated people with mental disabilities than keeping these patients in hospitals. Limited qualitative evidence suggests appreciable health and social-integration gains for patients in halfway houses. A network of halfway houses sufficient to serve the current hospitalized population is technically feasible and financially sustainable.**

SYSTEMIC ISSUES AND THE ROLE OF HOSPITALS

+ **The creation of short-term mental health hospitalization units in local general hospitals largely failed during 2013–2016. International norms recognize local general hospitals as a key component of a community-based mental health system.[7] [8] Shaping fresh strategies to resolve this bottleneck is an urgent task.**

+ **The model of Universal Health Insurance associated with Peru's national health reform favored the effective transfer of financial resources for mental health care, significantly reduced out-of-pocket expenses, stimulated the production of mental health care, and revalorized psychosocial work, empowering clients and promoting the exercise of their rights.**

+ **Peru's flagship mental health hospitals have shown a capacity to evolve with the shift to community-based care and to contribute to reform success. Some hospitals have incorporated nurse-led outpatient care modules that essentially reproduce a community-based care approach.**

+ **An efficient, collaborative transfer of competencies from specialized hospitals to CSMCs is possible but will not be automatic. Sustained oversight and facilitation will be required, particularly as substantial human and financial resources begin to be redirected.**

+ **Linking health services through provider-led collaborative networks has high potential to promote a community mental health model but faces resistance from a bureaucratic culture and a tradition of fragmentation and internal competition in the health system.**

REFORM POLITICS

+ From 2013–2016, mental health reform efforts were largely driven by technical experts in the middle-management levels of the Ministry of Health. This enhanced reform proposals' technical strength, but may have limited top-level political support, relative to other agendas that originated in higher echelons.

+ The popular media are capable of redirecting their approaches to mental health issues and can positively influence decision makers, mental health implementers, and the public. The media are becoming allies for community-based mental health reform in Peru. The full potential of this convergence has not yet been reaped.

+ According to frontline implementers, stigma around mental disorders, including among health professionals and patients, remains a major barrier to reforms. Health authorities have attempted to address this problem, but with scant success.

+ Reforms to date show little participation by civil society. The absence of groups representing people directly affected by mental disorders is notable. Partnership with academic institutions has also lagged. This raises concerns for the reform's long-term sustainability, particularly during changes of government.

+ Proactive participation by local political leaders helped spark reform successes in Carabayllo. Grassroots partnerships linking local political leaders and health networks to national reform actors may be catalytic for scale-up.

WHAT CAN BE ACHIEVED

+ Mental health reform can contribute to public health agendas that are important to citizens, including suicide prevention and the control of alcohol and substance abuse.[9 10] Gains in these areas can be promoted by making mental health services more accessible at community level. Positive effects on community quality of life may emerge relatively rapidly.

+ **MNS disorders inflict heavy losses on national economies, including Peru's. Community-based mental health models can go far in reducing these burdens. Access to affordable, quality mental health care improves wellbeing and boosts productivity for individuals, households, and communities. Mental health action promotes social cohesion, builds human capital, and fuels virtuous circles of social and economic development.**[1]

RECOMMENDATIONS

A countrywide community-based mental health care model can succeed in Peru and would bring substantial health, social, and economic benefits to the nation. Making this happen will not be simple. It will require changes in mental health policy, service provision, and financing, along with multi-sectoral action and deeper cultural shifts over time.

This study supports the following specific recommendations. Not an exhaustive reform agenda in themselves, these are selected priority actions derived from the evidence and analyses presented in this report.

SETTING STRATEGY AND REVISING POLICY

+ **A multi-sectoral, multi-year national mental health plan should be designed and implemented, with clear responsibilities and financing mechanisms.**

+ **National, regional, and local governments should rapidly invest in launching community mental health centers and halfway houses throughout the country. The first wave should cover at least one-fourth to one-third of Peru's estimated mental health care need. Specialized mental health hospitals should decentralize their services to these community-based facilities. Financial and human resources should be transferred from specialized hospitals to community facilities along with patients.**

+ **A revised strategy to incorporate mental health hospitalization units in local general hospitals should be developed, with the participation of relevant stakeholders, including those who vigorously resisted the effort in 2013–2016 (e.g., hospital administrators). A new strategy should draw lessons from the previous failure and from international experiences.**

MAKING MENTAL HEALTH FINANCING FAIRER

+ Public and private insurance plans should incorporate mental health benefits that will eliminate out-of-pocket expenses for beneficiaries.

OPTIMIZING COMMUNITY-BASED SERVICES

+ Health authorities and facility managers should ensure that appropriate tools and conditions for mental health care are provided in all first- and second-level health facilities. This includes a reliable supply of psycho-pharmaceuticals.

+ The main risks facing the community mental health center (CSMC) model, such as quality threats due to high patient loads, are basically reflections of CSMCs' success. In Carabayllo, the more than 30,000 interventions delivered at the CSMC during 2016 attest to strong community uptake. Reform coordinators should seek solutions to increase delivery capacity in Carabayllo. They should also plan and budget for large patient flows at future CSMCs.

+ All CSMCs should have a clear territorial delimitation. They should have the mandate and resources to support the first-level general health facilities in their designated area that serve as gateways to the health system.

+ Community health promoters and peer service providers should have a leading role in promoting mental health; detecting mental health problems; early intervention; and the continuity of care. Community and peer health workers involved in mental health action should be adequately rewarded for their work.

CHANGING SECTORAL AND INSTITUTIONAL CULTURES

+ Both standalone mental health facilities such as CSMCs and the mental health units of larger institutions should be integrated in collaborative networks, share resources, have compatible standards, and work together to comprehensively address the mental health of populations.

+ **The universities and systems that train undergraduate and postgraduate students for the health professions should apply the community mental health approach as a theoretical and practical framework. This will support a progressive shift of mindset within the health professions, changing the culture of mental health care and improving outcomes.**

TACKLING STIGMA

+ **A national campaign to destigmatize mental health should be undertaken in partnership with the media. At grassroots level, public education programs and social integration groups organized by CSMCs for patients, families, and community members are promising vehicles to fight stigma.**

BUILDING AN INCLUSIVE MOVEMENT

+ **Communities, local governments, civil society organizations, and businesses should be actively involved in health promotion, disease prevention, and care for people affected by mental disorders. Long-term reform plans should include strategies to engage these partners. Experiences in Carabayllo suggest that the contributions of local government leaders may be especially valuable.**

+ **Patients' organizations and a broad range of civil society groups that promote mental health rights, health equity, social and economic inclusion, and poverty reduction should participate in building a movement for community mental health reform. Reform leaders should foster civil society participation and community voice. The reform movement should also engage academic institutions, which can contribute to research, planning, implementation, and dissemination.**

MEASURING RESULTS

+ **Scale-up of community-based mental health modalities should include an integrated, system-wide plan for monitoring and evaluation, ideally incorporating patient outcomes. Policy makers should engage the expertise of academic institutions and international partners.[4]**

STAYING THE COURSE

+ Consistent political engagement by the Ministry of Health is a prerequisite for completing reforms. Advocates should not downplay the challenges ahead or the political and fiscal efforts required. To ensure lasting success, the Ministry of Health will have to maintain mental health as a priority with a well-structured plan for a minimum of 15 years. The investment of time and resources will be considerable. The rewards will be far more so. Peru's recent establishment of a ten-year performance-based budgeting framework for mental health care and prevention sends an encouraging signal.

A Time to Lead

Mental disorders are not exotic conditions that affect only a handful of citizens, and that can be dealt with by isolating the afflicted from the rest of society. Every year, one in five Peruvians is affected by an MNS disorder. Today, however, only a tiny minority access care. The price of this failure is paid by affected individuals and their families, but also by Peruvian society as a whole. Pervasive untreated mental illness fuels violence, suicide, substance abuse, and instability that weaken social bonds, spur discontent, and undermine citizens' confidence in institutions.[9] [10] [11] Through a multitude of channels, the burden of mental illness weighs on individual productivity and the national economy, slowing development.

Nor are Peru's mental health statistics in any way exceptional. On the contrary, they are typical of what most countries face. This is one reason Peru's reform efforts are so important. Mental health treatment gaps are a global scourge, against which Peru may now be positioned to take leadership. It will do so, if authorities carry forward the efforts described in this report: correcting failures, filling knowledge gaps, supporting continued innovation, and rapidly expanding successful approaches so that more citizens can benefit. As Peru takes its community-based mental health reforms to scale, it will inspire other countries and contribute to the global movement for mental health.

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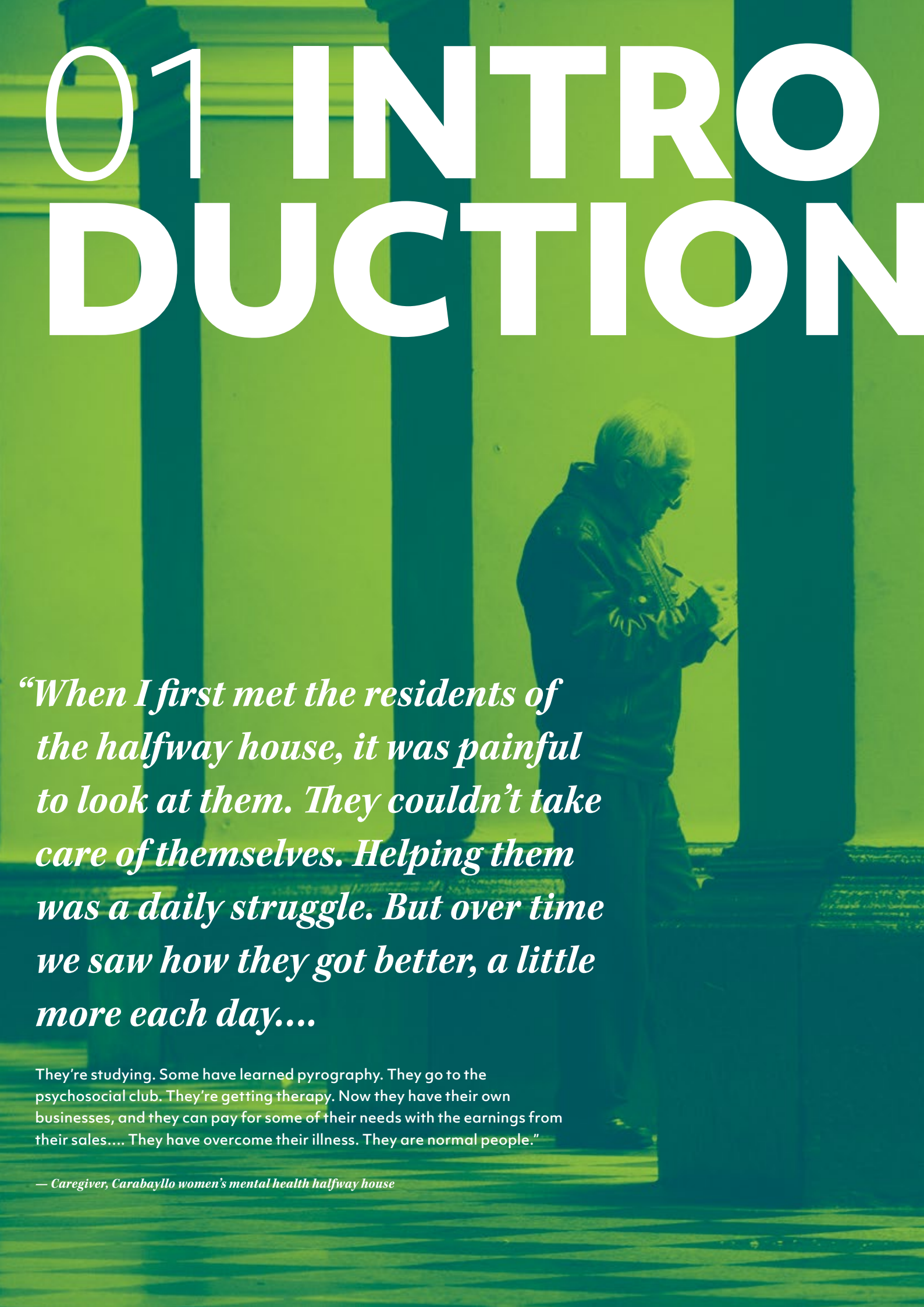
01 INTRODUCTION



"When I first met the residents of the halfway house, it was painful to look at them. They couldn't take care of themselves. Helping them was a daily struggle. But over time we saw how they got better, a little more each day....

They're studying. Some have learned pyrography. They go to the psychosocial club. They're getting therapy. Now they have their own businesses, and they can pay for some of their needs with the earnings from their sales.... They have overcome their illness. They are normal people."

— Caregiver, Carabayllo women's mental health halfway house

The global fight to transform mental health care will be won in ordinary communities, by ordinary people. Won in homes, schools, workplaces, local clinics, and halfway houses. Won by families, lay caregivers, nurses, psychologists, and patients providing peer support, as well as by psychiatrists.

What will this great victory look like? It will look like normal life. Like individuals and families living happily, building strong relationships, working productively, where before they could not. Taken individually, the triumphs will be discreet, almost invisible. But together they will yield a force able to transform communities and dramatically raise the wealth of nations.

Changing Mental Health Care: What is at Stake?

Mental disorders were long seen as rare and shocking individual afflictions, which placed their victims outside of mainstream society. Mental illness touched only a few people, it was generally thought, and those rare, tragic victims were immediately identifiable by their starkly abnormal appearance, speech, and behavior. Such beliefs fed stigma and fear. For generations, they also masked the true prevalence of mental disorders and their social and economic impacts.

Today, the magnitude of these impacts for nations and the global economy is clear. Mental, neurological, and substance use disorders (MNS) account for nine out of the 20 leading global causes of years lived with disability and 10 percent of the global burden of disease. By 2030, depression is projected to be the world's single largest cause of disease burden, surpassing heart disease, injuries, and HIV/AIDS. [1]

Along with vast human suffering, MNS conditions inflict staggering costs on economies. From 2011-2030, global economic output losses due to mental disorders will likely exceed US$ 16 trillion, comparable to losses from cardiovascular diseases and greater than those expected from cancer, chronic respiratory diseases, and diabetes.[2]

In Peru, neuropsychiatric disorders are already the country's leading cause of disease burden. In any given year, one in five Peruvians will be affected by a mental disorder.[3] Mental health problems also account for the largest share of the economic burden of common chronic diseases in the country, far in excess of the costs associated with cardiovascular diseases, chronic respiratory diseases, cancer, or diabetes. Moreover, in Peru as elsewhere, MNS burdens are inequitably distributed. They are highest among the very poor and other marginalized constituencies, complicating their economic and social integration and slowing progress towards shared prosperity.

Community-Based Reforms: A Proven Approach, Poised to Deliver

Social and economic threats on this scale demand a resolute response. Moreover, the nature of the optimal response is clear.

Evidence of the efficacy of community-based mental health care models was already robust in 1990. In that year, Latin American and global mental health leaders gathered in Caracas called on countries to improve the mental health of their people by shifting care progressively from centralized psychiatric hospitals to community settings. A milestone in global mental health, the Declaration of Caracas urged the creation of "decentralized, participatory, integrated, continuing, and preventive community-based care."[4]

More than a quarter-century later, community-based mental health care reforms have progressed in some Latin American and Caribbean countries, confirming the Caracas principles. However, in virtually all countries in the region, large treatment gaps persist.[5,6]

Recently, several countries have begun to carry forward a new wave of community-based reforms that may "change the game" in mental health care in the region and provide an example for the world. One of those countries is Peru.

What this Report Contributes

This report explores change initiatives in the financing, organization, and delivery of mental health services in Peru from 2013 to 2016. It examines the national dimension of reforms but focuses above all on implementation and results in the economically fragile district of Carabayllo, in northern Lima.

The Report Asks Three Questions:

1 **What was achieved during Peru's 2013–2016 mental health care reforms?**

2 **What key factors appear to have influenced reform successes and shortfalls?**

3 **What lessons can be drawn for ongoing efforts to improve Peru's mental health care system, and for comparable agendas in other countries?**

By encompassing both high-level national policy processes and the often-refractory realities of program delivery in a low-income district, the report seeks to shed light on a range of forces that affect the outcomes of community-based mental health reforms. This learning will serve health leaders as they design and implement a new generation of reforms. By detailing aspects of Peru's recent experience, including successes and frustrations, this report may strengthen the evidence base for ongoing efforts to reduce mental health treatment gaps.

The Peruvian Context

Peru's recent mental health reforms have unfolded in a context of rapid economic and social change. With an average annual economic growth rate of 5.9 percent over the past decade, Peru has one of the region's fastest-growing economies, with low inflation, macroeconomic stability, a reduced external debt, and progress in employment and income, which have contributed to poverty reduction and significant advances in social and development indicators.[7] Peru has more than halved poverty and quadrupled its per capita gross domestic product in only two decades.[8] At the same time, following an earlier period of authoritarian rule, armed conflict, and extreme economic instability, the country has returned to and maintained a democratic system.

The wounds of exclusion. While its progress has been remarkable, Peru remains marked by deep economic, social, and cultural inequalities, which are also reflected in the country's health system (Box 1.1).[9] Along with high rotation of government officials, public safety and discrimination pose stubborn governance challenges. A growing sense of national pride and unity contends with forces that deepen fragmentation and exclusion in Peruvian society. Such forces include the stigmatization of mental disorders and the difficulty for people to obtain effective, affordable mental health care.

Box 1.1.
Peru's epidemiological context and health system

Peru is undergoing a demographic and epidemiological transition. Average life expectancy was estimated at 72.53 years for the five-year period 2005-2010, but is expected to increase to 79.1 years by 2025. Nevertheless, communicable diseases such as tuberculosis, malaria, and dengue remain major public health problems, while non-communicable conditions such as obesity, diabetes, cardiovascular diseases, and cancer are also on the rise.[10]

Peru's health system reflects to some extent the segmentation and fragmentation of Peruvian society itself. The system is made up of parallel financing–benefit–access systems that cooperate, compete, and overlap with each other. The social security system is financed by the labor–business sector and administered by an autonomous institution, EsSALUD, under the Ministry of Labor. The public health care system, financed out of the public treasury, consists of a network of health centers and hospitals, which in Lima come directly under the Ministry of Health and in the 25 regions under their respective regional governments.

The private health system is heterogeneous, with, on the one hand, integrated and expanding systems and consortia of clinics and insurance plans and, on the other, numerous small-scale independent specialty services with very little government oversight.[11] There is also a significant presence of traditional health systems and practices, even in the most modern urban centers, which adapt to and compete marginally with the dominant western health care system.

Lima and Carabayllo

Peru's capital, Lima, is a city characterized by diversity and inequality, a mega-metropolis created by successive waves of migration from rural to urban areas that began in the 1940s. The city's 2016 population was 9,111,000. Metropolitan Lima comprises 43 very diverse districts, one of which is Carabayllo, a relatively young district that is the largest in the department in terms of surface area. It is located in the northern part of the city and in 2015 had a population of 301,978.[12]

Up to the 1960s, Carabayllo was an area of haciendas, but it underwent rapid urbanization as a result of waves of migration from rural regions and from other slum areas of Lima. The result was a culturally heterogeneous society, with many economic constraints and few public services. Sixty percent of the population is under 30 years of age, and 75 percent of women are engaged in domestic activities. Carabayllo, like other districts of Metropolitan Lima, has grassroots solidarity organizations, such as neighborhood associations, soup kitchens, mothers' clubs, and numerous community-based committees. Despite its poverty, Carabayllo has been the scene of impressive examples of health care delivery innovation, notably in the field of tuberculosis (TB) treatment.[13] These have featured successful intersectoral collaboration among national health authorities, local government, non-governmental organizations (NGOs), and communities.

Peru's Mental Health Challenge

As noted, neuropsychiatric diseases are the leading cause of disease burden in Peru. These conditions account for an estimated 16 percent of total healthy years of life lost in the Peruvian population, owing to the long duration of illness and disability, as well as the possibility of premature death.[14] Mental disorders are already known to represent the country's largest share of economic burden from common chronic diseases. Moreover, the true cost of these disorders probably exceeds current estimates, since individuals with mental disorders are also more likely to develop comorbid chronic pathologies.[15]

> ***"MNS disorders in Peru are highest among the economically poor and the victims of political violence."***

Patterns of inequity. Rates of MNS disorders in Peru are highest among the economically poor and the victims of political violence. The annual prevalence of mental disorders is almost twice as high among those who cannot meet their basic needs as among those who can. Ayacucho, the region hardest hit by the country's internal armed conflict between 1980 and 1990, has the highest prevalence of mental disorders (50.6 percent of the population) of all the regions of Peru.[16]

A centralized, hospital-based system. Despite scattered successful community-based programs, mental health care in Peru in the past 30 years has continued to be concentrated in specialized hospitals and psychiatric services of national hospitals (Box 1.2).[17] [18] Modules for the treatment of addiction and child abuse cases were implemented in fewer than 5 percent of health centers, and the WHO Mental Health Atlas reported that, in 2011, Peru's Ministry of Health allocated only 0.27 percent of its total budget to mental health, with 98 percent of that allocation going directly to psychiatric hospitals.[19]

Human resources and sectoral culture. The country has approximately 700 psychiatrists, of whom more than 80 percent are in the city of Lima and more than half work exclusively in private practice. Of the psychiatrists who work for the Ministry of Health, only 20 percent practice in general hospitals. The number of psychologists currently practicing in Peru is estimated at 1,500.[20] In both the public and private sectors, the approach to mental health care is predominantly biomedical and provided through the modality of on-demand care in private psychiatry and psychology clinics, each with its own rules, modes of financing, and technologies. Hospitals and clinics often function as clusters of private practices providing individual care, with minimal community-based interventions.

Care gaps. This situation has given rise to large and persistent mental health care gaps in the country. Based on the projected annual national prevalence of mental disorders, it was estimated in 2012 that approximately 3,840,065 people over the age of 18 were in need of mental health care in Peru. However, only 392,693 persons in that age group received care in 2012, representing just 12.8 percent of the total population estimated to need mental health services. In other words, the care gap was more than 85 percent.[21]

Turning point: the 2012 Mental Health Law. Echoing global and regional mental health movements and the World Health Organization's call to action on mental health, Peru's Law 29889, enacted in 2012, amended Article 11 of the country's General Health Law and proposed a reform of mental health services. Promoted by academic groups and community mental health activists, the 2012 law established community-based care as the mental health care model for the Peruvian health system.

Box 1.2.
Mental health care in Peru: historical background

Early history. Historically, mental health care in Peru has had a marginal status. Until 30 years ago, care strategies focused on severe cases with high levels of mental disability, usually as a result of social and clinical neglect. Care was provided mainly in two specialized hospitals located in the city of Lima, in regional inpatient facilities (sometimes referred to as "rehabilitation centers" or "psychiatric farms"), in the psychiatric departments of national and regional hospitals, and in specialized private clinics, where extended confinement was the mainstay of care.[22]

Legacy of the Caracas Declaration. Changes began with the advent of the international community-based mental health care movement. This movement achieved one of its clearest programmatic expressions in Latin America, with the 1990 Caracas Declaration.[23] In line with this agenda, Peru has recently seen multiple efforts to modernize and expand mental health care through primary health care approaches. An important early milestone was the creation of the San Juan Bosco Community Mental Health Center, originally launched in 1980, and which later became Peru's National Mental Health Institute (INSM). This institution combined community-based mental health services in primary health care facilities, schools, and community organizations with the incorporation and developments of biological psychiatry. Regional partnerships created in the wake of the Caracas Declaration, such as the PAHO/WHO-led Initiative for the Restructuring of Psychiatric Services, helped further propel these efforts.[24]

Box 1.2. Continued

Internal conflict and mental health needs. At the start of the present century, a key catalyst for national mental health reform was awareness of the individual and collective sequelae caused by Peru's two decades of internal armed conflict (1980-2000). These effects were brought to light by the country's Truth and Reconciliation Commission. Between 2001 and 2003, the Commission collected testimony from 1,985 people and organized 21 hearings with victims of violence, which were attended by more than 9,500 people.[25] This resulted in the launch of a Comprehensive Reparations Plan, which stipulated that mobile or fixed health facilities be made available in the most seriously affected areas.

Innovative approaches in vulnerable communities. In the following years, mental health policy proposals were put forward by universities and civil society, and pilot studies and interventions were carried out. For the most part, concrete interventions during this period focused on the most affected areas and targeted direct victims of political violence or specific vulnerable populations. One of the pilot interventions that demonstrated the significant impact that mental health interventions could have on people's lives was conducted in Carabayllo between 1996 and 2006, in the context of a community-based mental health program for people with multidrug-resistant tuberculosis (MDR-TB). Beginning in 2010, the INSM carried out a successful research and action experience in the Apurímac region, one of Peru's poorest. The project captured policy makers' attention and supported an emerging awareness that mental health action could bring remarkable benefits for disadvantaged communities.[26]

Research Methods

This report synthesizes the findings of five specially commissioned background studies. The rationale for these studies' topics and approaches, along with details on the specific methods used in each, are set out in the report's technical appendix (Appendix A). The appendix also discusses the report's limitations.

Data types and sources. Background studies used both primary and secondary data sources. Qualitative and quantitative methods were applied, including the following specific techniques:

- **A review of peer-reviewed and gray literature, including published and unpublished government documents on policies, plans, and programs, from Peru's Ministry of Health, the National Mental Health Institute, the municipality of Carabayllo, and the Comprehensive Health Insurance system (SIS)**

- **Review and analysis of published statistical data on MNS epidemiology and of mental health care financing data from the Ministry of Economy and Finance, the Ministry of Health, and individual health facilities**

- **Qualitative reports on the experiences of individuals and technical teams involved in the 2013–2016 reforms**

- **Semi-structured interviews, opinion polls, and focus groups with key informants, including local and national policy makers and administrators, as well as health care workers participating in frontline mental health service delivery.**

Why Carabayllo? The District of Carabayllo was chosen as a focus for several reasons. It was one of the first localities where community-based mental health reform initiatives were implemented during the study period and arguably one where reforms progressed farthest. In Carabayllo, multiple modalities of community-based mental health care were deployed conjointly, providing an opportunity both to document the delivery of individual reform components and to consider their interactions. Collaboration among national health officials, territorial health authorities, local government leaders, and non-governmental organizations (NGOs) was also unusually well developed and documented in Carabayllo, offering a chance to assess the potential of such partnerships to support future reforms.

A credible test. While Carabayllo has benefited from strong local political leadership and a rich civil society fabric, the area's socioeconomic and demographic profile means that it is not a privileged community where reforms might be suspected of "coming easy." On the contrary, researchers could approach the Carabayllo investigation as both a case study and a "proof of concept" exercise, in the sense that, if reform measures are found to succeed in this historically marginalized and economically challenged district, there is reason to believe they may be viable in other parts of the country.

Roadmap of this Report

The remainder of this report is structured as follows. **Chapter 2** examines the specific community-based mental health reform modalities that were implemented in Carabayllo from 2013–2016. It draws on program records and qualitative research with implementers to evaluate the degree of success achieved by the different modalities, which was variable. The chapter proposes hypotheses on factors influencing success or relative stagnation in the district-level delivery of reforms.

Chapter 3 acknowledges that community-based mental health agendas must engage the large psychiatric hospitals that have historically dominated Peru's mental health system and still absorb most of its resources. The chapter shows that, as community-based reforms rolled out in places like Carabayllo, financing and service-delivery changes largely attuned to community approaches were also underway in Peru's flagship psychiatric hospitals. If nurtured, such initiatives may lay foundations for a collaborative, rather than competitive, relationship between the hospitals and the institutions driving community-based reforms.

Chapter 4 steps back from the clinical frontlines to consider Peru's 2013–2016 mental health reform as a political process. The chapter is primarily based on a battery of interviews with political stakeholders in two spheres: (1) high-ranking decision makers in the Ministry of Health during the study period (including two former Ministers), and (2) local political and health officials in Carabayllo. Drawing on the accounts of actors directly engaged in the reform, the chapter seeks to identify key factors that enabled or obstructed political uptake and implementation of the change agenda. Reinforcing the enablers while containing the threats will be crucial to further advance reforms.

Chapter 5 looks to the future. It weighs the prospects of accelerating Peru's community-based mental health reform at the national level, by scaling up successful strategies road-tested in Carabayllo, while learning from and correcting implementation failures. The chapter maps political and contextual forces likely to influence the consolidation and expansion of recent reform gains in the years ahead, including trends affecting Peru's health system as a whole.

The report's **Conclusions** and **Recommendations** outline specific actions to take Peru's mental health reform forward. A portion of this learning may apply in other countries planning or already implementing their own community-based reforms.

In health reform, ambitious designs are common, robust results less so. The test of mental health action lies in the delivery of services in grassroots communities, especially poor ones. We turn to that subject now.

02

DELIVERING COMMUNITY-BASED MENTAL HEALTH REFORMS IN CARABAYLLO:

WHAT WAS ACHIEVED?

Background

Peru's mental health reform seeks to move from a traditional care paradigm centered on large, specialized hospitals to a model based on the disseminated delivery of mental health services in communities. Community-based mental health care has long been well described in theory.[27] The recurring challenge is to make it work in practice. That is why this report focuses primarily on grassroots implementation of reform components in a local setting.

From 2013–2016, four of the most critical modalities of community-based mental health care were rolled out in the North Lima district of Carabayllo:

- **Launch and operation of a community mental health center (CSMC)**
- **Strengthening mental health care capacities in primary health care facilities**
- **Effort to implement a mental health and addiction hospital service in a general hospital**
- **Launch and operation of a mental health halfway house.**

Carabayllo was the only locality in Peru where all four of these approaches were implemented simultaneously during the period.[28] Some of the initiatives generated notable successes, while progress on others was very limited. The effort to deliver these four treatment modalities at once in a community historically marked by poverty and exclusion was a challenging reform road test. The results provide critical information on strengths and potential vulnerabilities of community-focused mental health reform in Peru.

In this section, we assess what was accomplished in rolling out these approaches in Carabayllo and explore factors that appear to have contributed to success or relative stagnation. We cannot offer definitive explanations of why some efforts worked while others failed to gain traction. However, we present hypotheses that appear plausible based on the evidence available.

1. The Community Mental Health Center

The keystone of Peru's community-based mental care reform model is the community mental health center (CSMC). CSMCs are the reform's primary vehicle for decentralizing mental health action to local settings. Staffed by inter-disciplinary teams including psychiatrists, psychologists, occupational therapists, and social workers, CSMCs treat patients with mental disorders who are referred to them by local primary-care centers or community networks. CSMCs of various designs have been part of several recent mental health reforms in Latin America.[29 30] 22 CSMCs were launched across Peru in 2015.

The Carabayllo District Municipal CSMC was the first established in Lima. It was a joint project of the Carabayllo municipal government, the National Mental Health Institute (INSM), the National Directorate of Mental Health, and the local Territorial Health Authority (Túpac Amaru Network). Carabayllo's municipal Women's Bureau originated the idea of creating a CSMC in the community. Subsequently, local authorities were proactive in making the CSMC a reality. The Municipality provided some of its own office space to provisionally house the center, and donated land for the eventual construction of a permanent CSMC facility.

Obstacles and solutions in the early implementation of the Carabayllo CSMC are summarized in Table 2.1.

TABLE 2.1. CHALLENGES FACED AND SOLUTIONS FOUND IN IMPLEMENTING CARABAYLLO'S COMMUNITY MENTAL HEALTH CENTER (CSMC)

CHALLENGE	SOLUTION
Studies reveal elevated prevalence of mental disorders in Carabayllo and highlight associations with family and sexual violence	Women's Bureau of the Carabayllo Municipality approaches National Institute of Mental Health (INSM) to request collaborative development of community-based mental health strategy tailored to local needs
Mental disorders are poorly understood and heavily stigmatized in the community. Need to build grassroots buy-in for mental health action	Grassroots consultations were held with neighborhood councils to explore local mental health needs, community attitudes, rationale for action, and technical basis of the INSM plan
Resources and institutional responsibilities for mental health are fragmented. Need to coordinate action across government branches and non-governmental organizations	Core partnership is established among Carabayllo municipal government, INSM, National Directorate of Mental Health, and Territorial Health Authority (Túpac Amaru Network); community groups and NGOs are also engaged
Limited resources to pay for physical space to house CSMC	Municipality of Carabayllo donates office space to establish facility
Management of mental disorders in local primary health care facilities is weak	CSMC provides in-service mental-health clinical and management support to professionals in local primary health care centers, reinforcing first-level mental health management and strengthening the referral system
Need for rigorous follow-up of mental health and addiction patients at high risk of relapse or abandoning treatment	Continuous Care Program (PCC) has achieved strong results. Nurses and social workers address patient needs through tailored comprehensive care and home visits. Group activity treatments also show promise

The CSMC Care Model

The CSMC's goal is to meet a broad spectrum of medical and social needs using a patient-centered, multi-disciplinary model of care. The approach sidesteps traditional medical hierarchies and seeks to break down silos between specialties, as well as between medicine and psychosocial work. Thus, according to one CSMC physician, "The hierarchy of the doctor is not paramount here." Instead, for each patient, it is that person's designated case agent, usually a nurse, who "calls the shots" and oversees the care process.[31]

The case agent model was designed to ensure sustained personal attention to each patient and improve the quality and continuity of mental health care. Case agents work individually with clients and coordinate the internal flow of services to meet specific needs. For each client, the case agent manages home visits and therapy sessions, liaising with a local general health center to simultaneously address physical comorbidities. Case agents assume overall responsibility to ensure that patients receive the care they need and that their rights and dignity are respected.

Does the Model Work?

The Carabayllo CSMC delivered impressive results in several areas from its launch through the end of 2016. Interviews with CSMC personnel and other stakeholders point to likely success factors, but also indicate risks that the center must manage in the long term.

High volume of interventions. The CSMC delivered more than 20,000 mental health interventions in its first year of existence. In calendar year 2016, its staff conducted more than 30,000 outpatient mental health consultations. The volume of services confirmed high community demand and showed impressive response capacity in the CSMC. By the end of the study period, four key services had been brought online: the Children and Adolescents Service, the Adults and Senior Adults Service, the Addictions Service, and the Participation and Community Mobilization Service.

Success in supporting high-risk patients. Systematic data on CSMC patients' clinical outcomes is not available. Available data also do not allow us to measure the care provided against standard quality criteria. However, qualitative research including in-depth interviews with frontline care providers and other stakeholders provides a broad picture of the quality of CSMC care as assessed by implementers.

Among programs deployed at the CSMC, the Continuous Care Program (PCC) is viewed by stakeholders as among the most effective. This program ensures follow-up with clients with serious mental illnesses at risk of relapse or abandoning treatment. It also serves adult clients experiencing symptoms of withdrawal from drugs or alcohol, as well as clients who have experienced a first psychotic episode or who have serious family problems. The program is carried out by a team including a nurse and a social worker, and includes home visits with comprehensive care.

Promising results with group therapies and peer support. According to implementers, group-activity therapies have generally been the most widely accepted by CSMC clients and have garnered the widest participation. The creation of mutual support groups for clients and families has also shown early success. A number of structures for peer support and community engagement have been launched. A psychosocial integration club for people with mental disabilities meets on a weekly basis. An association of clients and families is being rolled out, though it was still at an early stage at the end of 2016.

Growing partnership with general health centers, but more must be done. The Carabayllo CSMC has begun to play a valuable role in linking local primary health care centers with specialized services and helping ensure continuity of care for patients. Stakeholders note, however, that the CSMC-primary care partnership has several vulnerabilities. In particular, its success depends on primary-care doctors' competency to detect, evaluate, and diagnose MNS conditions in their patients and make appropriate decisions about referrals.[32] Training and in-service technical support by CSMC professionals to general health care professionals have begun to address these needs. This topic is discussed in the next section. Currently, however, hands-on psychosocial clinical support to primary-care centers has not been fully rolled out. In-service training for doctors is, in many cases, provided ad hoc through the referral and counter-referral of patients.

Concerns among CSMC staff. Informants report that recent organizational changes at the Ministry of Health led to the loss of some statistical information on interventions conducted at the CSMC. CSMC personnel also complain that stigmatizing attitudes about mental disorders have been encountered among some primary-care professionals, government officials, and mental health clients themselves. Public education campaigns to change social attitudes about mental health are needed. CSMC personnel identify the precarious nature of the center's physical structure as a major concern.

Suffering from Success?

Many of the most serious challenges reported by CSMC implementers have to do with excessive workloads imposed on clinical staff, due to the center's very high patient volumes. In other words, the CSMC may be a victim of its own success.

Drawing patients from distant communities. Carabayllo's CSMC was initially intended to provide service to approximately 100,000 inhabitants, but in practice receives referrals from a population more than three times greater. By some estimates, the provision of quality specialized mental health care requires a minimum of five psychiatrists per 100,000 inhabitants.[33] The number of psychiatrists at the CSMC equates to 0.24 per 100,000 inhabitants.[34 35] In the face of high client demand, CSMC staff report that insufficient resources are available for effectively carrying out their functions.

Threat to the care model. Heavy patient loads threaten the quality of care, as well as provider wellbeing and motivation. One tangible effect at the CSMC has been the modification of a key feature of the center's original care model: the comprehensive assessment of each incoming patient by a full multi-disciplinary team. Engagement of the full clinical team in patient intake is one of the therapeutic practices most valued by CSMC professionals. However, the initial patient assessment is now often carried out only by a nurse and a psychologist or social worker, due to time pressures and the expense of having a psychiatrist present for each intake evaluation.[36] For informants, this specific change in the care model was symbolic of the larger threat to care quality and patient and provider satisfaction posed by heavy patient loads.

2. Strengthening Mental Health Care in Primary Care

In line with the goal of bringing mental health services out of centralized institutions and into communities, WHO norms stress the importance of mental health care delivery through primary health care. "Services at the primary health care level are generally the most accessible, affordable, and acceptable for communities. Where mental health is integrated as part of these services, access is improved, mental disorders are more likely to be identified and treated, and comorbid physical and mental health problems [can be] managed in a seamless way."[37] In Latin America and the Caribbean, efforts to integrate mental health into primary care with a health promotion and prevention focus have characterized recent mental health reforms in countries including Brazil, Chile, Cuba, and Panama.[38]

What was the Strategy?

In Carabayllo, reforms aimed to reinforce mental health care delivery capacities in local first-level general health centers. Plans were developed collaboratively by mental health authorities and the leaders of local primary care networks. The strategy involved two main components: (1) theoretical and practical mental health training for general health care providers (through courses and internships); and (2) in-service clinical and management support to primary care teams from specialized mental health professionals.

In a community-based care model, the clinical management of mild-to-moderate mental disorders should take place largely in the primary care setting. In Peru, as elsewhere, this is currently far from the case. Primary-care professionals often feel they do not have the knowledge required to diagnose, evaluate, and treat common mental health problems, which also remain heavily stigmatized. Mental health care training to build the skills and confidence of primary care practitioners was a key part of the mental health reform agenda adopted in Carabayllo (Box 2.1). In addition to trainings, ongoing mental health clinical and management support was provided to primary care workers through in-service technical assistance (Box 2.2).

Box 2.1.
Mental health training for Carabayllo's primary-care professionals

In Carabayllo, strengthening mental health care capacities among local primary-care providers was recognized as crucial to create a decentralized local mental health system. Accordingly, reform plans prioritized mental health training for general health professionals.

The World Health Organization (WHO) MhGap Interventions Guide on MNS disorders for non-specialist health settings served as the main technical reference for the design of the training curriculum.[39] The curriculum aimed to anchor basic competencies that all first-level general health professionals need, including:

- Identification of mental health risk factors;
- Detection and screening for MNS conditions;
- Examination, evaluation, and diagnosis;
- Criteria for referral to a higher level of care;
- Pharmacological treatment; and
- Psychosocial interventions.

Box 2.1. Continued

Thematic content of the course included: general principles of mental health care; depression and suicide; psychosis; disorders related to alcohol use; and behavioral disorders in children.

The recipient population for training comprised 62 professionals, including 22 doctors, 27 nurses, 20 obstetricians, two psychologists, and two social workers. Together, participants represented 61.6 percent of the local health micro network professional staff. Training lasted 12 weeks. Participants were expected to attend the course once per week and take part in a concluding intensive workshop.

Professionals receiving the mental health training generally evaluated it favorably. One participant, a primary care nurse, reported: "Formerly, there was not much interest on the government's part to tackle this issue [mental health], not only at a specialized level but also in first-level care (...) This time, there was considerable openness, and opportunities to participate were easily available."[40] A 2016 review of the training by the INSM found that, "The majority of participants felt that the content provided in the training program was very relevant and suitable for the cases seen in Lima's health networks. The methodology was appropriate, and the clinical content proposed was suitable. The instructors' expertise motivated participants to implement the material acquired."

Box 2.2.
Hands-on help: supporting frontline mental health care through in-service technical collaboration

Reform planners knew that, in addition to classroom training, local general health providers would benefit from in-service mentoring and support in managing patients with MNS disorders in the clinic. In Carabayllo, weekly support visits by mental health professionals targeted multi-disciplinary teams at first-level general health care facilities. Two such facilities were initially prioritized.

Support visits typically lasted two to three hours. Psychiatrists accompanied non-specialist doctors in their patient care activities; psychiatric nurses accompanied general nurses; psychologists supported other psychologists; and psychologists or nurse specialists accompanied obstetricians. These activities were complemented by inter-disciplinary meetings to discuss case studies and prepare tailored patient care plans with a community approach.

Qualitative data from mental health professionals providing support indicate generally positive results, with many primary-care providers showing the capacity to apply new mental health skills in their clinical work. In some cases, technical mentors reported that primary-care providers' clinical routines already involved meaningful community-based mental health action, not always recognized as such. One mentor found that obstetricians working with adolescent clients in primary care were "already providing mental health screening and counseling" to these young women on a regular basis. These interventions needed to be recognized, systematized, and documented in patients' records.[41]

What Were the Results?

By 2016, the effort to strengthen mental health care in select primary care sites had generated some notable successes. However, important challenges remained only partially resolved.

Training and in-service support rolled out. A training curriculum was designed, and trainings and in-service technical support were delivered to primary care teams (Boxes 2.1 and 2.2). In-depth interviews found that both training and technical support were generally evaluated positively. Support visits were initially conducted by INSM teams, then gradually taken over by the staff of the Carabayllo CSMC in 2016. Visits were weekly at first, but were cut to just one per month for budget reasons. Primary-care personnel and support teams both criticized this cutback.

Stronger competencies reflected in the quality of referrals. Available data do not permit an evaluation of impacts on patient outcomes or standard quality markers. In interviews, CSMC clinical personnel report a substantial improvement in the quality of information provided in mental health patient referrals from the targeted primary care centers to the CSMC. These changes were progressive and coincided chronologically with the roll-out of training and in-service technical support to the health centers. Referrals now generally attest to the conduct of mental examinations and diagnosis, which had not previously been the case. Informants concluded that a majority of local first-level health professionals have gained stronger mental health competencies and have become involved to some degree in the screening, evaluation, and management of mental health problems among patients.

Hands-on provision of mental health treatment in primary care must expand. The provision of hands-on mental health care in first-level general health care facilities remained limited at the end of the study period. Notably, primary-care personnel were still hesitant to prescribe psychotropic medications. Their professional knowledge of mental health had increased, but they still often opted to refer even relatively uncomplicated cases immediately to the CSMC. Reportedly, only a few primary-care doctors routinely prescribe or conduct psychosocial procedures before referring a patient to CSMC specialists.

Reliable supply and appropriate use of psycho-pharmaceuticals remain a challenge. The availability of psychotropic medications in local general health facilities remained problematic through much of the study period. Confusion also surrounded the prescribing and management of psycho-pharmaceuticals at different levels of care. For depression and anxiety disorders, a prescription at the first level of care was recommended, while for cases of psychosis and alcohol abuse or dependency, second-level care was suggested as most appropriate. In practice, owing to the absence of psychiatrists and to many doctors' lack of adequate training, there was often no one to authorize the dispensing of psycho-pharmaceuticals at the first level of care.

In summary, detection and diagnosis of MNS issues in representative local primary care facilities appear to have improved, and an effective referral mechanism now links these facilities to the CSMC. However, progress was limited towards the goal of transferring the actual ongoing management of uncomplicated mental health cases to first-level general health facilites.

3. Creating a Mental Health Hospitalization Unit Within a General Hospital

In addition to first-level facilities like CSMCs, a fully operational community-based mental health care network includes an important role for local general hospitals. As part of decentralizing mental health services, WHO norms recommend building mental health capacities in district hospitals. "District general hospitals provide an accessible and acceptable location for 24-hour medical care and supervision of people with acute worsening of mental disorders, in the same way that these facilities manage acute exacerbations of physical health disorders."[42]

Peru's reform model foresees the inclusion of a mental health hospitalization unit in general hospitals in each jurisdiction to address acute and sub-acute mental disorders. Key functions of these units would include:

- **Stabilizing patients with symptoms of clinical decompensation not manageable in the community setting;**
- **Stabilizing cases of intoxication from psychoactive substances;**
- **Serving patients who require diagnostic or therapeutic hospital care, including:**
  - **Patients presenting an imminent suicide risk**
  - **Patients with psychiatric symptoms who are homeless or without support systems**
  - **Women in violent and life-threatening situations.**

In the Carabayllo area, an effort was made to launch a mental health hospitalization and addictions unit within the local general hospital of reference, the Sergio Bernales Hospital.

An Uphill Struggle, with Minimal Gains

This effort was by most accounts the least successful mental health delivery innovation enacted in Carabayllo during the study period.

Budgetary allocations were effectively transferred for the implementation of the mental health hospitalization and addictions unit in 2015. However, in the context of a general financial crisis affecting Peru's hospitals at the time, decision makers within the institution redirected the funding to other priorities. For example, an interdisciplinary team of nurses and technical personnel was hired for the planned mental health unit, but hospital management reassigned them to other areas of emergency or medical services. Similarly, the basic furnishings for four mental health beds were acquired, but in practice this equipment was used for other purposes.

The hospital originally had only one psychiatrist, in the medical department, along with six psychologists. With the new budgetary injection, an additional psychiatrist was hired, which led to a temporary increase in the delivery of outpatient mental health interventions. However, the mental health and addictions unit was never brought on stream. According to one informant: "The psychiatrists increased the provision of care, and the Carabayllo community mental health center would refer emergency [psychiatric] cases, but the hospital's response was limited, and eventually the provision of care ceased completely."[43]

Why did this Initiative Break Down?

A countrywide pattern. The difficulty of launching the hospitalization unit at the Sergio Bernales Hospital was mirrored in other settings in Peru where similar attempts were made during the period. The causes of these failures are multiple. Qualitative research with care providers and other stakeholders suggests several factors that appear to have been important in the Carabayllo case.

Material constraints and attitudinal resistance. The hospital's overall budget shortfalls almost certainly played a role in prompting management to reassign resources originally earmarked for mental health. But these decisions were also shaped by a generalized posture of resistance among many hospital managers and clinical staff to expanding mental health care within the institution. According to stakeholders, this stance reflected staff's unfamiliarity with the aims and methods of mental health reform; the stigma associated with MNS problems; and the heavy workloads already affecting general hospitals. Informants cited a shortage of human and strategic resources and infrastructure for quality patient care in general.

Community mental health principles are not understood. Qualitative research suggests that many health professionals still believe psychiatric emergencies and hospitalization should be resolved in psychiatric hospitals. The community mental health model remains poorly assimilated. Addressing these gaps is especially urgent, given the high potential of mental health services in general hospitals to contribute to priority public health agendas such as suicide prevention and combating epidemics of substance use.[44] Our observation of a need to prioritize financing and staff education in this area is consistent with the recommendations of previous studies.[45] [46] [47]

Implications for future reforms. The virtually complete failure of this effort to build mental health hospitalization capacities in a general hospital suggests that this may be one of the reform agenda's most vulnerable components, requiring special focus as national scale-up efforts proceed.

4. A Women's Mental Health Halfway House

In 2015, the INSM, the Municipal District of Carabayllo, and the Peru branch of the international medical organization ENIEX *Socios en Salud* (Partners In Health) reached an agreement to jointly implement a halfway house for women suffering from severe chronic mental illness, the first of its kind in Lima. The mental health halfway house is a medical support facility that provides alternative temporary residential services to persons with serious mental disorders who have been discharged from hospital, require minimum care, and have weak family support systems.

Under the public-private partnership arrangement reached by the three parties, ENIEX *Socios En Salud* assumed all implementation (furnishings and equipment) and operational costs of the halfway house during the first year, including costing and financing for the hiring of caregivers, general expenditures, and administrative expenses. As of the second year, the INSM and the Municipal District of Carabayllo share operating costs. ENIEX *Socios En Salud* continues to participate in the facility's administration.

Key barriers and solutions in the implementation of the halfway house are summarized in Table 2.2.

TABLE 2.2. CHALLENGES FACED AND SOLUTIONS FOUND IN IMPLEMENTING THE CARABAYLLO WOMEN'S MENTAL HEALTH HALFWAY HOUSE

CHALLENGE	SOLUTION
Many long-stay patients in the INSM are socially abandoned women. Transitioning these patients out of long-term specialized hospital care is problematic. Their families will not accept them, and they are unprepared to live independently.	The halfway house model has been shown effective in supporting mental health patients with severe disease and weak social and family networks. The halfway house provides patients with residential arrangements that enable them to progressively rebuild their autonomy and transition gradually from extended hospitalization back to life in the community.
Halfway house implementation requires resources and capacities that may not all be available in any single organization.	INSM, Municipal District of Carabayllo, and ENIEX *Socios En Salud* (Partners In Health) form a public-private alliance to pool capacities and jointly implement the halfway house.
The public sector cannot fully fund the halfway house, particularly given that the model is unproven in this community. Initial implementation may pose unexpected challenges and unforeseen costs.	ENIEX *Socios En Salud* agrees to fund implementation (furnishings and equipment) and operational costs for the first year, including caregiver salaries, food, general expenditures, and administrative costs. As of the second year of operation, the INSM and Municipal District of Carabayllo jointly take over operating costs, while *Socios En Salud* continues to participate in project administration.
Residents tend to have multiple physical comorbidities that are difficult to manage.	Coordination is established with a local general health clinic (La Flor Health Institution) and with the Carabayllo CSMC to ensure comprehensive mental and general health care for halfway house residents, including regular preventive check-ups.
Even if their clinical situation improves, patients may not have needed social and vocational skills to advance toward greater autonomy, including greater financial self-sufficiency.	Psychosocial and vocational rehabilitation programs are provided to ease residents' return to social life, educational opportunities, and economic activity. Residents are encouraged to attend municipal vocational workshops run by Carabayllo community organizations.

Model of Care

The halfway house uses a model of residential care that respects residents' human rights and places minimal restrictions on their personal freedoms, thus activating their reintegration into the community. At the same time, while they enjoy considerable autonomy, residents are carefully monitored and mentored by staff present in the facility 24/7.

Halfway house residents enjoy healthy accommodations, a balanced diet, comprehensive medical care, support with daily activities as needed, and personalized psychosocial and vocational rehabilitation, with the goal of recovering their maximum level of self-sufficiency. Self-sufficiency is taken to mean the capacity to carry out daily functions, become more proactive in self-care, and hone the skills and interests needed to rejoin the community.

As part of their progressive social reintegration, residents participate in vocational workshops; renew contacts with community organizations such as churches; and enjoy leisure activities in their neighborhood. Halfway house care staff provide guidance and facilitate these contacts, which may initially be difficult for residents emerging from long-term hospitalization and relative social isolation.

Results

High levels of patient and provider satisfaction. In-depth stakeholder interviews with caregivers and health professionals yield qualitative data on the performance of the halfway house in meeting client needs and enabling overall psychosocial wellbeing. Residents display a high level of satisfaction. One caregiver said simply, "They are happy now. They compare it to how things were before, in the psychiatric hospital. It was like a prison.... Now they can go out, walk in the park, do their shopping...They're happy to be here."[48] Care team members also express high personal satisfaction with the halfway house and their own roles. The model gives them the opportunity to serve patients in a highly personalized way and see the difference their efforts make. "When you put in the effort, the love, when you do the work, the most rewarding thing is to see them getting better every day.... I don't think it's only due to the medication. That's part of the treatment, which is extremely important. But it's also the confidence, the affection that we show to every resident." [49]

Evidence of social reintegration. The halfway house's reintegration program enabled two residents (out of a total of eight) to resume interrupted education and two others to earn an income in 2016. Interviews with halfway house caregivers and professional staff brought additional qualitative evidence of residents' participation in social groups and community activities and of the psychosocial benefits that result. One caregiver stated that residents have reclaimed their place as "normal people." "[Residents] are studying, they have learned pyrography, they go to the psychosocial club, they are receiving therapy. Now they have their own businesses, and can pay for some of their own needs with the earnings from their sales."[50] Another informant added: "This is social rehabilitation: to be able to work, to study... For example, I saw a resident selling her homemade candies in the neighborhood ... If no one told me she suffered from schizophrenia, I could never guess.... We are going to see that the social return is — by far— better than in the traditional hospital system."[51]

Plans to replicate the model. When public authorities assumed management of the Carabayllo women's halfway house after its successful pilot phase, officials expressed the hope that the model could be replicated throughout Peru, eventually creating some 200 facilities nationwide. Meanwhile, *Socios En Salud* has proposed the possibility of a new public-private partnership. The goal is to launch a halfway house in Carabayllo specifically for men living with chronic mental illness, based on the positive experience with the women's facility.[52]

Success Factors

Qualitative research with halfway-house staff and other stakeholders identified a number of factors that frontline actors see as contributing to the model's success:

+ **Public-private partnership.** Informants cite effective partnership among public-sector health authorities, local government, and the private medical charity as crucial. The participating organizations complemented each other, and the arrangement allowed each to contribute distinctive strengths.

+ **Local government leadership.** The proactive engagement of local government leaders at all stages of the process was perceived by many stakeholders as especially important in gaining credibility for the project, resolving practical problems, and ensuring that good intentions translated into results.

+ **"Test drive" before buying.** Under the partnership agreement, the private charity assumed all financial risks during the facility's pilot year. Public authorities received a clear practical demonstration that the halfway house model was technically and financially viable in the Carabayllo context, before investing public funds.

+ **Intensive personalized care model.** The Carabayllo halfway house is a deliberately small, close-knit community in which each resident receives continuous personal attention and psychosocial support tailored to her specific needs. While such a model might be seen as a "boutique" approach, it actually costs far less per patient/day than standard mental health hospitalization (see next section) and shows promise for national scale up.

Can Community-Based Mental Health Care Save Money?

Community-based mental health care modalities like CMHCs and halfway houses offer alternatives to treatment in psychiatric hospitals, which have historically been the focus of Peru's mental health system. We have seen that, in Carabayllo, community-based models show early evidence of improving the accessibility and quality of care, providing a viable means to begin closing Peru's mental health treatment gap. On grounds of clinical effectiveness, as well as social inclusion and citizens' rights, Peru's health leaders may have strong reasons to accelerate the scale up of these community-based modalities nationwide.

But a key question must be faced: how much will it cost? Would scaling up community-based mental health care in Peru be prohibitively expensive, or on the contrary might it actually save the government money?

Research carried out for this report offers, not a complete answer, but important data for an evidence-based discussion of issues and options. Here, we briefly summarize the main findings of a health care costing study which is presented in its entirety as Appendix C of this report. The study's purpose was to estimate and compare the unit costs for routine mental health care services in Lima's specialized mental health hospitals and in the CSMC and halfway house in Carabayllo. The appendix includes extensive discussion of the background, data sources, methods, and analytic steps that led researchers to their findings.

Hospital vs. Community-Based Mental Health Care: Comparing Unit Costs

The prorated institutional expenditure method[53 54 55] was used to calculate costs of outpatient and inpatient treatment in specialized mental health hospitals vs. Carabayllo's community-based mental health care facilities.

To calculate the unit cost of outpatient treatment at the three mental health hospitals in 2016, the total expenditure on outpatient treatment at each institution in that year was divided by the number of outpatient consultations reported. The average unit cost per outpatient consultation across all three specialized hospitals was US$ 58.96. The unit cost for a standard outpatient consultation at the Carabayllo CSMC was US$ 11.58.

A hospital's bed-day cost is calculated by dividing the facility's total hospitalization expenses by the number of hospital bed-days reported in the year. The average bed-day cost in the three specialized mental health hospitals in Lima in 2016 was US$ 90.86. The per capita daily cost of residential treatment at Carabayllo's halfway house was found to be US$28.48.[56]

The Bottom Line

Table 2.3 compares the unit cost ratio for outpatient consultations in specialized hospitals and CSMCs. Unit costs at the specialized hospitals range from 2.28 to 8.43 times the corresponding cost at the CSMC.

TABLE 2.3.- UNIT COST RATIO FOR OUTPATIENT CONSULTATIONS IN SPECIALIZED HOSPITALS AND CSMCS, 2016

OUTPATIENT TREATMENT	SPECIALIZED HOSPITALS/CSMC, US$			
	INSM	HVLH	HHV	TOTAL
Unit cost - Hospital	75.68	97.54	26.45	58.96
Unit cost - CSMC	11.58	11.58	11.58	11.58
Outpatient treatment cost ratio Hospital/CSMC	6.54	8.43	2.28	5.09

CSMC: community mental health center; INSM: National Mental Health Institute; HVLH: Víctor Larco Herrera National Hospital; HHV: Hermilio Valdizan Hospital.

Table 2.4 shows the ratio of costs per inpatient day in the specialized hospitals to the per capita daily cost of residential treatment at Carabayllo's halfway house. Costs per inpatient day at the hospitals range from 2.84 to 4.15 times the daily per capita cost of halfway-house treatment.

TABLE 2.4.- UNIT COST RATIO PER INPATIENT DAY IN A SPECIALIZED HOSPITAL VS. PER CAPITA DAILY COST IN A HALFWAY HOUSE, 2016

HOSPITALIZATION	SPECIALIZED HOSPITALS/HALFWAY HOUSE, US$			
	INSM	HVLH	HHV	TOTAL
Unit cost of hospitalization	91.02	101.21	69.18	90.86
Daily per capita cost - Halfway house (HH)	24.38	24.38	24.38	24.38
Hospitalization cost ratio – Hospital/HH	3.73	4.15	2.84	3.73

HH: mental health halfway house; INSM: National Mental Health Institute; HVLH: Víctor Larco Herrera National Hospital; HHV: Hermilio Valdizan Hospital.

Community-Based Mental Health Care on a Large Scale: How Much Could be Saved?

We can use the results from the preceding analysis to produce a hypothetical estimate of the savings that might be obtained by taking advantage of the cost differentials between hospital-based and community-based mental health treatment. This estimate shows that if 90 percent of all outpatient treatments in Lima's three psychiatric hospitals were shifted to CSMCs, Peru's health system would save US $7,669,519 annually. This sum would cover the cost of operating 21 community mental health centers (Table 2.5). Similarly, if 50 percent of all long-stay hospitalizations took place in halfway houses, the system would save US $7,845,079 annually and could cover the operating costs of 92 halfway houses.

TABLE 2.5.- HYPOTHETICAL HEALTH SYSTEM SAVINGS WITH SHIFT OF OUTPATIENT MENTAL HEALTH INTERVENTIONS FROM HOSPITALS TO CSMCS

OUTPATIENT TREATMENT EXPENSE - HOSPITAL/CSMC	SPECIALIZED HOSPITALS, US$			
	INSM	HVLH	HHV	TOTAL
Outpatient treatment expense – Hospital	75.68	97.54	26.45	58.96
Outpatient treatment expense – CSMC	11.58	11.58	11.58	11.58
Total hospital outpatient treatments	57,922	42,146	79,796	179,864
90 % of outpatient treatments in CSMC	52,130	37,931	71,816	161,878
Adjusted institutional expenditure for outpatient treatments in hospital	3,944,960	3,699,720	1,899,381	9,544,061
Outpatient treatment expense – CSMC cost	603,663	439,246	831,634	1,874,543
Institutional savings resulting from change of modality	3,341,297	3,260,474	1,067,748	7,669,519
Annual CSMC cost	351,175	351,175	351,175	351,175
Number of CSMCs that could be financed	10	09	03	21

Could this Really Happen?

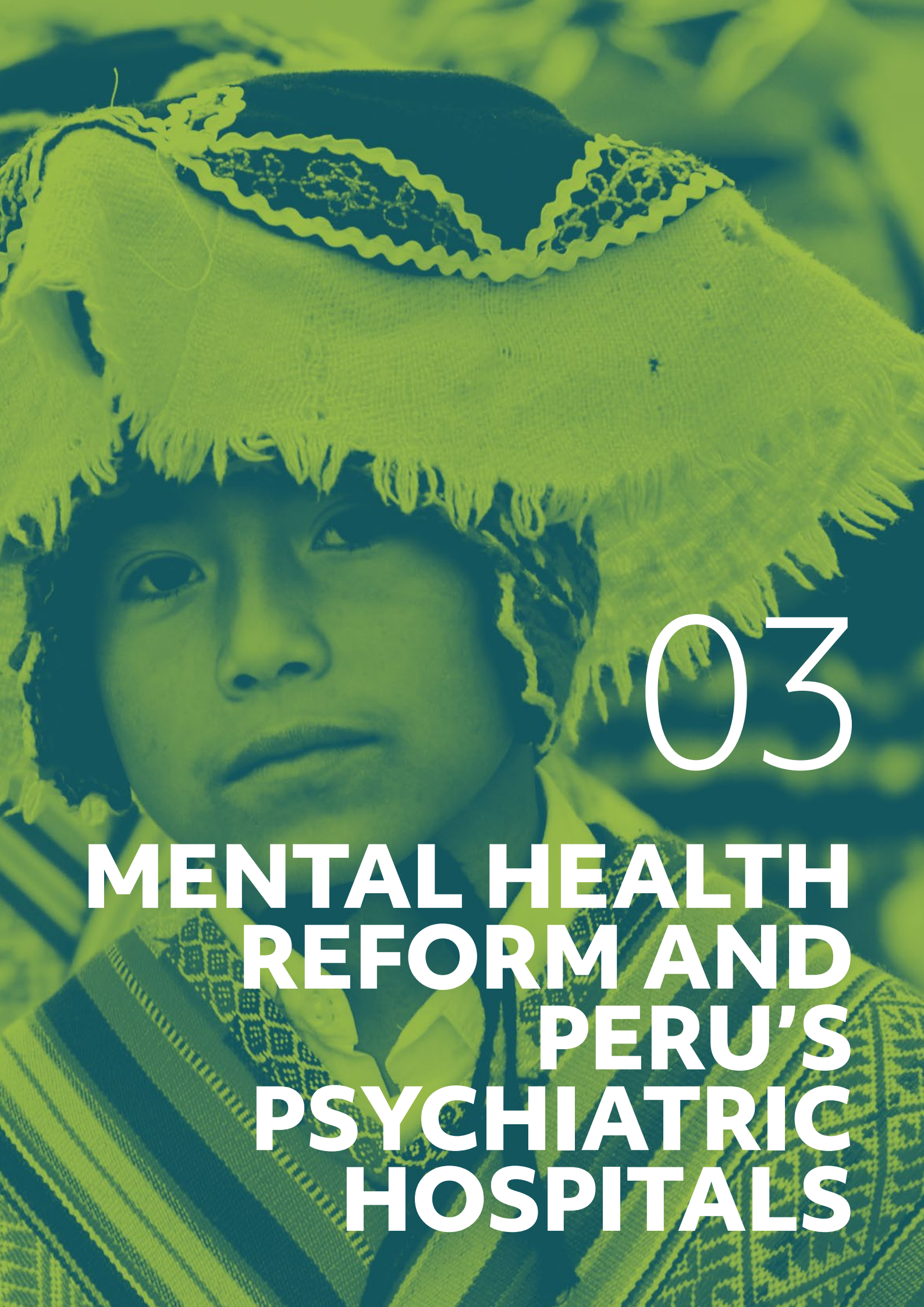
Such substantial shifts in established patterns of care delivery are obviously not likely to occur in the short term. In weighing such changes, quality of care and other variables must be considered, not just treatment costs. The implications for patients of any such change would have to be carefully weighed and clinical impacts rigorously monitored during implementation. However, this exercise suggests the magnitude of gains the health system might reasonably hope to obtain in the future by capitalizing on the large cost differentials this study has found.

Conclusions

Implementation of key community-based mental health care modalities in Carabayllo in 2013–2016 provides an important proof of concept for nationwide community-based mental health reform in Peru. Two key types of local mental health facilities established in Carabayllo, the community mental health center (CSMC) and the mental health halfway house, achieved strong early results and showed promise to succeed as workhorse facilities for a nationwide scale up of community-based mental health care. Potentially overwhelming patient loads at the CSMC point to the need to ensure that these facilities are adequately resourced. Multiplying the number of CSMCs and defining a clear territorial area of responsibility for each would help manage the issue of disproportionate patient loads on some facilities.

Carabayllo's experience also highlights important obstacles that will have to be confronted as new mental health mechanisms are scaled up. The effort to create a mental health hospitalization service in a local general hospital failed, despite the availability of some resources. Given their potential importance for the decentralization of mental health care, local general hospitals may require special focus and innovative strategies as reforms advance.

A cross-cutting issue revealed by this study concerns the collection and quality of data to evaluate mental health care reform efforts, particularly in terms of patient outcomes, the ultimate criterion of success. Currently, no integrated system-wide plan for the monitoring and evaluation of Peru's mental health care reform and scale-up is in place. There is an urgent need for work in this area while implementation is still in its early stages. Global partners, NGOs, and academic institutions have the capacity to contribute in this critical respect.[57]



03

MENTAL HEALTH REFORM AND PERU'S PSYCHIATRIC HOSPITALS

Background

A community-based mental health reform cannot leave specialized psychiatric hospitals out of the equation. In Peru, as in most countries, such hospitals remain the dominant components of the mental health care system today. As recently as 2011, 98 percent of the mental health budget of Peru's Ministry of Health went to fund the nation's psychiatric hospitals.[58] If Peru's mental health care system as a whole is going to progress, then these hospitals must evolve: in terms of financing, management, care delivery, and how the institutions interface with other health system actors.

Peru's three flagship national mental health hospitals are the Víctor Larco Herrera National Hospital (HVLH), the Hermilio Valdizan Hospital (HHV), and the Honorio Delgado-Hideyo Noguchi National Mental Health Institute (HD-HN INSM), all located in Metropolitan Lima. As community-based mental health care modalities were rolled out in Carabayllo in 2013–2016, several reforms to hospital-based mental health services were being pioneered in these flagship institutions.

This chapter examines three of the most important innovations introduced in specialized hospitals during the period. The measures concerned: (1) the financing of mental health services for low-income citizens through Peru's Comprehensive Health Insurance system; (2) a new hospital-based service delivery model informed by community mental health principles; and (3) an innovative provider-led networking effort to strengthen collaboration among institutions delivering mental health services in Lima, including specialized hospitals and community-level facilities.

These and related innovations undertaken in Peru's psychiatric hospitals during this period were not part of a comprehensive reform plan for the institutions. Rather, these efforts can be understood as independent ad hoc experiments carried out by constituencies at different levels of the mental health care system to solve specific problems. As such, the measures we discuss do not add up to a complete change program for Peru's mental health hospitals. But they bring challenges and opportunities for these institutions into focus and open paths for continued innovation as mental health reforms advance.

Comprehensive Health Insurance for Mental Health: Making Care Affordable for the Poor

Launched in 2002, Peru's Comprehensive Health Insurance (SIS) is a public health insurance system for people with limited economic resources and no other type of insurance. Following pilot projects involving partial, gradual coverage, the SIS became a universal insurance system. For a decade following the creation of the SIS, however, Lima's three large mental health hospitals did not join the system. Barriers were partly administrative and partly due to reported fears among the hospitals' patient population that people would lose access to mental health services if they registered as SIS beneficiaries.

Until 2012, all patients, even the poorest, continued to pay for care at the three flagship mental health hospitals using their own funds or insurance. The hospitals' institutional fee schedules encompassed mental health services and medications, which had to be paid out of pocket. This situation placed major obstacles in the way of low-income people seeking care for serious mental disorders, contributing to socioeconomic inequities in mental illness vulnerability, prevalence, and outcomes in Peru.[59]

Turning Point

The turning point came in 2012-2013, when the three mental health hospitals successively signed agreements with the SIS administration, opening the way for their integration into this financing system. The key change was not just the hospitals' agreement to accept SIS payments, but also a new administrative classification of mental health actions within the SIS itself, which boosted the fees paid to mental health care providers (see Box 3.1). In late 2016, CSMCs were also integrated into the SIS.

Box 3.1.
A breakthrough in mental health financing for low-income Peruvians

Including mental health services among the benefits available to low-income people under Peru's Comprehensive Health Insurance (SIS) was a crucial step towards greater equity in mental health. But simply including psychiatric care as a category of covered services was not enough, if mental health actions were not reimbursed at a level considered viable by provider institutions and clinicians.

Prior to 2013, the SIS categorized all mental health clinical work under the heading of "consultations" and reimbursed all such actions at low rates. A breakthrough came with the formal recognition that psychiatry and mental health involved not only diagnostic consultations but also curative actions, i.e., that a "psychiatric consultation" was also simultaneously a "therapeutic intervention." This change in definitions transformed the relationship between the SIS and Lima's flagship mental health hospitals, opening the way for low-income Peruvians to be able to use SIS benefits to access care in these specialized facilities.

In March 2013, a landmark agreement was signed between the SIS and the National Mental Health Institute (INSM). It changed the financing paradigm for most services typically provided in a mental health clinic, including common individual, group, family, and multifamily psychotherapies. The agreement acknowledged that mental health interventions primarily involve human resources, with a minimal equipment and material component. In line with this principle, a new costing structure for mental health procedures was introduced, incorporating a 50 percent share for human resources costs. As a result, the fees paid by the SIS to mental health service providers increased more than fivefold.

This change has enabled a transformative revaluation of psychiatric and psychotherapeutic work and is expected to produce a gradual but steady net increase in financing for mental health in Peru. Moreover, given that the delivery of SIS funds takes place prior to the provision of services, clinical staff can be hired to anticipate demand. The higher SIS rates have made it possible for provider facilities to boost their staffing levels and thus move to a virtuous circle of expanding supply and demand for mental health interventions.

Originally operative only at the INSM, the new financing model was extended to Lima's other specialized mental health hospitals in 2014, and by late 2016 was adapted to include community mental health centers (CSMCs).

The new financing approach was a boon for mental health facilities, providers, and patients. But it also posed new challenges that forced institutions and health professionals to adapt. For the most part, they did so successfully, demonstrating flexibility and capacity to innovate (see Box 3.2). As a result, large numbers of low-income people with mental disorders who had previously been excluded from the system gained access to needed care. Table 3.1 documents some of the quantitative milestones in service provision achieved at the INSM following implementation of the SIS.

TABLE 3.1. INSM PERFORMANCE GAINS ATTRIBUTABLE TO SIS IMPLEMENTATION

INDICATOR	SITUATION PRIOR TO THE PILOTING OF SIS FINANCING	RESULTS AFTER THE INCORPORATION OF SIS
Number of persons treated as outpatients	In 2012, 3,828 persons were treated as outpatients	In 2016, 17,619 persons were treated
Number of outpatient consultations	In 2012 16,963 outpatient consultations were recorded	In 2016, 57,922 outpatient consultations were recorded
Number of FUAs* issued	In 2012, no FUAs* were recorded. In 2013, 803 FUAs* were recorded	In 2016, 91,736 FUAs* were recorded
Number of prescriptions issued	In 2012, 62,205 prescriptions were issued	In 2016, 101,516 prescriptions were issued
Sale of medicines	In 2012, the value of medicines sold was US$280,928	In 2016, the value of medicines sold was US$539,612 (a 92 percent increase over 2012 sales)
Improved distribution of medicines to SIS beneficiaries	In 2012, the value of medicines distributed to SIS beneficiaries was US$ 0	In 2016, the value of medicines distributed to SIS beneficiaries was US$1,052,692
Increase in directly collected resources	In 2012, net resources collected, not including medicines, totaled US$254,026	In 2016, despite the SIS, net collections totaled US$ 305,149
Increase in SIS funds paid	There were no SIS payments in 2012	In 2016, the SIS paid US$2,287,176, according to official records

Note: (*) FUA: *Formato Único de Atención*, standardized electronic record of a clinical intervention

Box 3.2.
Mental health equity as a management challenge: adapting hospital information systems to a fairer insurance model

In countries working to expand mental health care for the poor, some of the barriers to be overcome are obvious: for example, public-sector resource constraints and the social stigma attached to mental disorders. But other challenges may be unexpected. In Peru, the change in treatment systems based on the SIS insurance model for low-income patients posed serious management and administrative problems for hospitals providing mental health care. The new insurance mechanism exposed weaknesses in the institutions' information systems and pressured them to modernize.

Peru's large mental health hospitals had previously been accustomed to a makeshift patient registration system used solely for statistical purposes. With the new SIS regime, incorrect entries in the records suddenly had financial consequences for provider institutions. Pressure for better performance spurred collaborative efforts within and between provider institutions to improve management. As part of the process, hospitals committed to automate treatment documentation for patients insured under the SIS, which implied automation of clinical registration systems.

Many clinicians at the hospitals initially resisted the changes, claiming that documenting cases in this way would increase their administrative burden. However, the hospitals provided continuous, mostly on-the-job training for clinicians as the new record-keeping system was rolled out; made IT teams available in each consulting office; and continuously reviewed the flows of documentation to clarify responsibilities and resolve problems. Sustained effort successfully institutionalized the new practices. The INSM won second prize in Peru's 2014 National Health Quality Competition for its creation of an innovative IT support system to help its service providers and managers implement the new approach.[60]

In the end, the pro-equity insurance reform also worked as an incentive to help the hospitals modernize their information systems and medical record keeping. Over time, these changes are likely to substantially boost efficiency and improve the quality and continuity of care provided to patients.

Reducing Medication Costs for Low-Income Patients

One of the most important equity gains attributable to SIS implementation concerned the affordability of psychiatric medications for low-income patients seeking care in mental health hospitals.

In 2013–2016, Lima's three psychiatric hospitals collectively received a total of US$ 9,699,293 in SIS funds (Table 3.2). From the hospitals' SIS-source revenues, US$ 5,313,799, or 55 percent of the total, went to pay for medications (Table 3.3). The proportion of the institutions' spending on medications that was covered by SIS funding grew substantially over the period. SIS-source expenditure as a proportion of total expenditure on medicines at the three hospitals rose more than ten-fold, from an average of 6 percent in 2013 to 68 percent in 2016.

TABLE 3.2- TOTAL FUNDING FROM SIS TRANSFERS AND GRANTS IN LIMA'S THREE MENTAL HEALTH HOSPITALS, 2013–2016

YEAR	TOTAL SIS-SOURCE REVENUES BY HOSPTIAL, US$			
	INSM	HVLH	HHV	TOTAL
2012	0	7,434	0	7,434
2013	184,170	70,078	233,207	487,455
2014	265,739	430,885	816,391	1,513,015
2015	1,415,074	1,533,012	1,016,238	3,964,325
2016	928,025	1,254,496	1,544,543	3,727,064
Total US$	**2,793,009**	**3,295,905**	**3,610,380**	**9,699,293**

INSM: National Mental Health Institute; HVLH: Víctor Larco Herrera National Hospital; HHV: Hermilio Valdizan Hospital.

TABLE 3.3. - EXPENDITURE ON MEDICINES BY MENTAL HEALTH HOSPITALS USING DIRECTLY COLLECTED RESOURCES (DCR) AND SIS GRANTS AND TRANSFERS, LIMA, 2012 - 2016

YEAR	EXPENDITURE ON MEDICINES BY HOSPITALS USING DIRECTLY COLLECTED RESOURCES (DCR) AND SIS GRANTS AND TRANSFERS, US$					
	INSM		HVLH		HHV	
	DCR	SIS	DCR	SIS	DCR	SIS
2012	214,494	0	304,267	0	474,269	0
2013	261,962	0	446,356	9,510	599,825	79,484
2014	515,489	85,767	388,259	191,756	532,194	312,823
2015	289,888	998,492	475,851	932,540	739,197	553,174
2016	377,107	589,927	204,712	576,436	407,827	983,889
Total US$	1,658,939	1,674,187	1,819,445	1,710,242	2,753,311	1,929,370

The rise in SIS resources to cover drug costs dramatically reduced low-income patients' out-of-pocket expenditures on psychiatric medications. In 2013, before SIS, 94 percent of spending on drugs at the three flagship hospitals had been out-of-pocket. In 2016, SIS funding had cut the out-of-pocket share of drug costs at these facilities to 32 percent, with the largest gains for poor and extremely poor patients.

SIS Insurance: Changing the Game in Mental Health Equity

The introduction of the new SIS financing mechanism for mental health care has contributed to the launch of a quiet revolution in access to MNS services for low-income Peruvians. The financing reform is a crucial step towards closing the country's equity gaps in mental health care.

In Peru, as in most countries, poor and marginalized people suffer disproportionate MNS disease burdens, relative to more socioeconomically advantaged groups. Yet, even as they have faced higher prevalence of mental disorders, poor Peruvians have historically enjoyed low effective access to mental health services, with financial barriers as a main contributing factor. The incorporation of the SIS insurance mechanism by Peru's mental health hospitals and more recently CSMCs has begun to transform this situation, though much remains to be achieved.

Implementation of the SIS and its practically unlimited coverage of psychiatric and psychotherapeutic care in the specialized hospitals in Metropolitan Lima has resulted in empowerment of low-income SIS beneficiaries, including the realization of their right to free mental health services and an adequate supply of psycho-pharmaceuticals, while significantly reducing out-of-pocket expenses. At the same time, the new SIS model of mental health care financing compensates provider institutions and clinicians more fairly: a win-win approach that benefits all stakeholders.

Bringing Community Care Strategies into the Hospital: The "Short-Term Intervention Module"

As the SIS financing mechanism for low-income patients was implemented in Lima's mental health hospitals, demand for outpatient care rose in these facilities: exactly the result community advocates and health leaders were aiming for. The new financing model made mental health care more affordable for the poor. As a result, people previously unable to afford treatment for MNS conditions came forward to demand it.

The INSM, for instance, substantially increased both its total number of outpatient consultations and its patient coverage after joining the SIS. The number of patients receiving outpatient care at the INSM rose from 3,838 in 2012 to 17,619 in 2016.[61] Similar changes in outpatient production curves were seen across all three flagship hospitals.

Higher Demand Spurs Supply-Side Innovations

A new social dynamic was being created with the potential to narrow treatment gaps. Low-income clients felt they had a right to be treated once they had insurance, and this right was affirmed by bodies such as Peru's Health Superintendency, the SIS supervisory authorities, the Ministry of Health, patients' organizations, and external actors like the Office of the Ombudsman.

Growing patient demand in turn generated pressure on provider institutions to increase the supply of mental health services and improve their quality. Pressure rose, especially for the creation of innovative urgent care mechanisms. In several hospitals, including the INSM, urgent care offices were opened to respond.

The Short-Term Intervention Module: Redistributing Tasks and Boosting Efficiency

In this context, the INSM pioneered an innovative treatment delivery approach called the Short-Term Intervention Module (*Módulo de Intervención Breve*, or MIB). The mechanism was based on a triage system that identified clients who needed psychiatric or psychological attention, but didn't necessarily have to be seen individually by a psychiatrist (a scarce system resource). Seeing a psychiatrist had previously been a required step for all patients in specialized hospitals.

Under the new approach, preference was given to group and workshop treatments. These interventions are efficient, and a growing body of evidence suggests that they are also more effective for many mental health problems. Financed primarily with SIS resources, the MIB may ultimately be able to resolve up to 80 percent of psychiatric cases of moderate complexity: those that require approximately eight weeks of therapy.

Essentially, the MIB replicates a community mental health center treatment model inside the hospital. The module incorporates a culture of service and a community mental health philosophy similar to those in CSMCs, while integrating additional management innovations, notably performance-based management. As they are further tested and refined, innovations like the MIB may help answer recent calls for better evidence on mental health care delivery solutions in contexts where psychiatrists are undersupplied.[62]

Innovation in Service Coordination: Lima's Mental Health Network

Historically, problems of fragmentation, inadequate communication, and competitiveness among actors within the system have hampered a unified approach to mental health in Peru. New community-based mental health care modalities are strengthening the overall mental health system but also increasing its diversity and complexity, making coordination both more crucial and more difficult.

By Providers, for Providers

In this context, there was a clear need to strengthen management and operational coordination among entities providing mental health services. This led to the establishment of the Comprehensive Mental Health Network of Metropolitan Lima. Formally launched in early 2016, the network's roots reached back to longer-

standing initiatives among mental health service-provider organizations that had come together over a period of years to jointly tackle basic problems like access to financing, staff training, drug supply, and improvement of referral and counter-referral systems.

As of 2016, the network encompassed a wide range of specialized mental health institutions and others providing mental health services, including Lima's three flagship mental health hospitals, the mental health and/or psychology or psychiatry departments of level II and III hospitals, and the community mental health centers. In total, the network had the potential to engage some 383 health facilities, influencing care delivery and coordination across all these settings. Originally self-organized, the network was ultimately placed under the convening authority of Peru's Health Services Management Institute (IGSS).

The Mental Health Network's distinctive qualities derived from its character as an organization created by providers, for providers, in response to common needs. The forum sought to foster collaboration, generate shared solutions to cross-cutting problems, and ultimately provide better service to patients. Up to 100 people came together at monthly meetings that became forums for dialog, joint problem solving, and a reduction in finger pointing. Participants pooled their knowledge on the magnitude of challenges and internalized the need to work together. Sixteen thematic round tables were created on topics such as the SIS, psychosocial interventions, human resource development, research, protection of patients' rights, and the implementation of community-based treatment approaches. These working groups prioritized issues and proposed key actions for the larger Network.

One participant, a hospital director, described the Mental Health Network in glowing terms that were echoed by other informants:

> ***"Actors who had seen themselves as competitors now see themselves as allies, and the 'shuffling' of patients has been replaced by a collaborative approach. [We came together around] the idea that all providers are responsible for what happens in mental health throughout the territory..."***

Promise Denied: Deactivation of the Network, but Some Lasting Benefits

Just as its momentum and influence were growing, the Mental Health Network fell victim to political changes. Under a newly elected government, the Health Services Management Institute, which had overseen the Network, was deactivated. Simultaneously, new leadership at the INSM deprioritized the Institute's support for mental health work within Metropolitan Lima. As the INSM pulled back, Lima's Mental Health Network gradually shut down.

Some of the Network's contributions have survived. In some areas of the capital, for example, mental health actors have maintained the service coordination mechanisms that the Network helped create. This reflects the continued need to manage and support territorial mental health service networks and the relevance of coordination at this level. The loss of the Comprehensive Mental Health Network is a missed opportunity to support pragmatic collaborative mechanisms created by service implementers. Notably, the Network had shown promise to help strengthen coordination between hospital-based mental health services and the community-based structures promoted under current reforms.

The Future of Specialized Hospitals as Reforms Advance

We have seen several ways Peru's flagship mental health hospitals have begun to modify their institutional structures and practices in keeping with the community-based mental health care agenda. However, in Peru as in other countries currently weighing ambitious mental health reforms, the role of specialized hospitals in the future of MNS services remains contested.

Community mental health advocates emphasize the deinstitutionalization of psychiatric care. This is often taken to mean the closure of psychiatric hospitals, pure and simple. In Peru, will authorities ultimately seek to shut down specialized hospitals, including the INSM? This charged issue demands attention, as health leaders and stakeholders debate priorities for the evolution of Peru's mental health system.

Some have argued that, for mental health reform to succeed, psychiatric hospitals must close down and rapidly transfer their resources to new community-based structures, such as CSMCs and halfway houses.[63 64] The costing analysis reported above, in Chapter 2, could be seen as supporting such a claim. Our study found that the cost of mental health care using community-based modalities tends to be substantially lower than care in specialized hospitals. For example, a standard outpatient mental health consultation at Carabayllo's CSMC costs the government on average just one-fifth as much as a comparable consultation in a specialized hospital.

Large mental health hospitals may have to change, perhaps radically. But are they destined to disappear? From a pragmatic perspective, we may recall that these hospitals have played an important historical role in Peruvian health care, and that their influence remains considerable. Each such institution has a specific image in Peruvian society. Each, at some point, has represented a technological and organizational innovation and, in its evolution, has negotiated complex developments in the health sector and society at large. Each has learned and adapted to its reality, though to date not in all the ways that will be required by a robust community mental health reform.

Our discussion in this chapter suggests that, under appropriate political and sectoral conditions, the flagship mental health hospitals can accelerate their own transformation and contribute positively to reforms. In recent years, even the most tradition-bound among these hospitals have modernized their care systems. They have experimented successfully with delivery models, such as the MIB, that incorporate community-based mental health values and treatment approaches into the tertiary care setting.

Arguably, meanwhile, a new culture of collaboration has begun to take root within and among the mental health hospitals. All three flagship institutions participated in joint planning, knowledge sharing, and capacity building through Lima's metropolitan mental health services network, for example. All have invested in activities aimed at strengthening first-level care. All have collaborated increasingly with regional authorities. Rather than isolated institutional fortresses, they have shown growing capacity to work as partners in collective processes.

Today, we can picture hospitals' evolving roles from a network perspective: thinking beyond specific facilities toward an ensemble of health care resources that collaboratively address all the mental health needs of a territory. Community-based facilities, but also general hospitals and specialized hospitals will contribute. Increasingly critical will be the collaborative spaces and mechanisms that will enable different types of structures to work together seamlessly.

Conclusions

Community-based and hospital-based mental health care delivery can evolve and advance together. In 2013–2016, as community-based strategies were rolled out in places like Carabayllo, financing, management, service delivery, and partnership innovations were being introduced in Lima's specialized mental health hospitals. The integration of Comprehensive Insurance (SIS) coverage for mental health services made mental health care in specialized hospitals and community-based facilities affordable for low-income Peruvians. As the SIS reform sparked higher demand for care at the flagship hospitals, the innovative MIB care delivery model showed that community mental health philosophies and practices could be operationalized in a psychiatric hospital setting. To multiply such innovations, coordinate action across facilities, and better serve patients, leaders of the specialized hospitals and other mental health stakeholders launched the Comprehensive Mental Health Network of Metropolitan Lima. This participatory structure facilitated collaboration among mental health system partners until its dissolution following a change of political administrations in 2016.

The SIS, MIB, and Lima Mental Health Network project are far from constituting an exhaustive reframing of the role of psychiatric hospitals in Peru's national mental health care system. Such a critical reappraisal and deep institutional restructuring will inevitably be required, as community-based mental health reforms progress. But while the innovations discussed in this chapter have not obviated the need for deeper change, they provide examples of success and valuable entry points to orient and inform future work. They have confirmed that Peru's flagship psychiatric hospitals are learning institutions: able to experiment, invent new delivery strategies, build new partnerships, and adapt to new demands.

In different ways, SIS financing for mental health and the premature deactivation of Lima's Mental Health Network both illustrate the extent to which mental health action is shaped by political forces. Along with its considerable technical challenges, mental health reform is a deeply political process. Understanding and managing the politics of reform in local, national, and global terms will be crucial to consolidate what has been achieved in Peru and take gains to the next level in the years ahead. The political side of mental health reform is the focus of the next chapter.

04 MENTAL HEALTH REFORM AS A POLITICAL PROCESS

Background

It is hard to be violently opposed to community-based mental health reform. Its characteristic strategies unite compassion, efficiency, and common sense. Few experts today dispute its basic philosophy or question the scientific evidence of its beneficial effects. If resources were unlimited, almost all countries would soon carry out community-based mental health care reforms. Yet, in the real world of scarce resources and urgent competing demands, these reforms struggle for support.

The difficulty with community-based mental health reform is not about technical feasibility or clinical efficacy. It is political. It is the classic challenge of moving from evidence of a problem to the investment of public resources in fixing it—which necessarily means withholding those resources from other uses that to some will appear at least equally critical.

If the difficulties of mental health reform are mainly political, so too are the solutions. The difference between jurisdictions in which reforms advance and those where they stagnate is not that the burdens of mental illness in the former are heavier, pushing authorities to act. Nor is it that the countries that take action are wealthier than those that do not, so they simply have more resources to spread around. The difference is that political conditions have converged in the former contexts to enable transformative action on mental health, while in the latter cases, the politically catalytic factors have not been aligned.

For this reason, one of the most important aspects of understanding mental health reform efforts in a given context is exploring how those efforts have been managed politically. The case of Peru's 2013–2016 reforms is especially instructive, because the agenda made impressive gains in some areas, yet fell short in others. As a result, Peru's experience may simultaneously provide insights on enabling political factors that help drive reforms and on forces that constrain them.

This chapter looks at the politics of Peru's 2013–2016 mental health reform. It presents the results of a qualitative, cross-sectional study based on semi-structured interviews with political stakeholders who participated directly in the reform process. Informants included both top-ranking policy makers in the Ministry of Health during the period and local Carabayllo officials involved in municipal-level planning and implementation. Together, these constituencies shed light on political decision-making processes from multiple angles, describing factors that favored or impeded politicians' embrace of mental health reforms and their subsequent delivery on the ground.

The findings are presented below in two main sections. The first examines factors that informants identified as positive enablers contributing to political momentum for reforms. The second discusses conditions that limited or constrained mental health policy initiatives. Table 4.1 summarizes key findings to be unpacked in the remainder of the chapter.

TABLE 4.1. MAKING MENTAL HEALTH REFORM WORK AS A POLICY ISSUE, 2013–2016: ENABLERS AND CONSTRAINTS

ENABLING FACTORS	
Technical quality of proposals and political "marketing"	Reform proposals were backed by a high-quality technical analysis
	Proponents were able to present community mental health reform "not as a problem, but as a solution"
	Proposals were feasible in resource terms
	Proponents showed that action on mental health care would help address other social issues of concern to policy makers (e.g., economic productivity, violence against women)
Supportive structural factors	Expansion of Comprehensive Health Insurance (SIS) to cover mental health care interventions
	Technical team launched constructive early engagement with the Ministry of Economy
	Oversight by Public Defender's Office enhanced credibility
Policy arena and stakeholder interactions	Local media were harnessed to build public awareness and support
	Municipality of Carabayllo strongly engaged
	Local implementation partnership perceived as a "win" for all actors (e.g., Municipality, local health care network, INSM, NGO partners, and patients)
LIMITING FACTORS	
Understanding of community-based mental health approach failed to penetrate influential segments of the government	
SIS weakened by economic downturn and 2016 budget cuts	
Reforms emanated from Ministry of Health "middle management" technical experts and not from senior leadership, potentially limiting political support	
Proposals formed a compelling set of innovations, but were advanced without the backing of an over-arching, comprehensive national mental health reform plan	
Local implementation capacities require additional strengthening	
Proponents missed opportunities to more fully engage civil society	
Persistent stigma around mental illness weakened demand mobilization	

Source: authors' analysis of stakeholder interview data

Factors that Enabled Political Momentum for Reform

In describing how mental health reform proponents generated political momentum for their cause, many interviewed stakeholders emphasized five factors: (1) the strength of the technical analysis underlying reform policy proposals; (2) reform proponents' effective political marketing of their ideas, emphasizing credible solutions, not the magnitude of problems; (3) mental health reforms' potential to catalyze progress on additional social issues; (4) mutually beneficial partnerships linking multiple stakeholders, particularly at the district level; and (5) reformers' success in maintaining political visibility for their issues over time.

Solid Foundations: Anchoring Proposals in a Strong Technical Analysis

In the early phases of the process, a group of technical professionals from the National Mental Health Institute (INSM) and the National Mental Health Directorate shaped the emerging reform proposal and drove it politically. The group was led by the then directors of the two institutions, who shared a long-standing commitment to community mental health. The group has been referred to as the Community Mental Health Technical Team (ETSMC).

Asked what gave mental health reform proposals initial credibility, many interviewed stakeholders cited the strength of the technical team and its evidence-driven analysis of issues and solutions. With some interlocutors, the ETSMC's technical analysis gained additional traction when reformers showed how the community-based mental health strategies proposed were informed by models already implemented and validated internationally.[65] Both ministerial officials and local decision makers in Carabayllo cited the strong technical analysis and evidence of global precedents as important motivators.[66]

A Winning Strategy: Focus on Solutions, Not Problems

Solid technical analysis alone is rarely enough to spur policy change. The positive content derived from global and regional experiences had to be packaged politically so as to capture decision makers' imagination. Here, a decisive strength of the ETSMC proposal was that it offered solutions, rather than simply pointing out problems. Where many scientifically sound and well-intentioned public health proposals devote much time to painstakingly describing what has gone wrong, community mental health reform proponents immediately focused on answers and action steps, framing their proposal in positive, practical, "can-do" terms.

This proved crucial. In interviews, senior Ministry of Health officials repeatedly underscored how many critical problems are competing for their attention at any given time. As such, debating the degree of importance of various problems is not the way to secure political backing. What makes the difference is when a decision maker recognizes that a team requesting support has a strong solution ready to apply.[67]

A former Minister of Health summarized the situation by stating that high-level decision makers do not see competing problems, only competing solutions. "If someone has five minutes with the President and he's only going to talk about problems, then nothing will happen.... [He needs] a viable solution, a solution that motivates." When listening to a technical team's pitch, the question the Minister always asks is: "How can I take this analysis and transform it into something that can be brought to [Cabinet level] to compete for resources?"[68]

Proposed solutions can and should have an ambitious and potentially even visionary quality. However, they must also be realistic, especially in terms of the financing needed to launch the process and obtain initial results. Even the most inspiring proposals must reckon with the scarcity of resources. In this respect, as well, ETSMC's proposals offered solutions that ministerial officials recognized as viable. The former Minister summed the matter up wryly: "If [they] had told me that we needed to hire 5,000 psychiatrists, that would have been the end of the conversation." But the ETSMC's rigorously costed reform proposals were feasible in terms of the required investments.[69]

Leveraging Mental Health Reform to Tackle Other Social Problems

Decision makers' valuation of the proposed mental health reform was also closely related to its potential to "kill several birds with one stone": contributing to progress on multiple social issues of importance to policy makers and their constituents. For example, community-based mental health measures showed promise to help reduce violence against women and boost economic productivity among low-income and marginalized communities. Such linkages expanded the perceived capacity of mental health initiatives to deliver positive change that could appeal to voters, and thus gave mental health increased traction as a policy issue.

According to interviewees from the Carabayllo municipal government, for example, local political leaders and citizens responded to the argument that better access to mental health care would strengthen social and economic wellbeing for individuals, families, and communities. The themes of "restoring people's productivity" and nurturing "happiness in the lives of young people" through mental health services resonated.[70]

Building Win-Win Partnerships

Building political momentum for reform involved fostering a network of partnerships that spanned multiple sectors and governance levels. Reform leaders strove to shape these linkages to yield rewards for all stakeholders: a "win-win" dynamic. The work unfolded in two main dimensions: locally, as innovative practices were implemented on the ground in communities like Carabayllo, and nationally, where the technical aspects of interventions, political alliance building, and preparations for the national scale up of innovations were addressed. The ETSMC was the pivotal actor coordinating the work across these levels.

Locally, the leadership assumed by the Carabayllo government was key. Informants noted that Peru's municipalities enjoy substantial autonomy to tailor their own social development agendas. In the case of Carabayllo, the philosophy guiding proposed community-based mental health reforms resonated with the Municipality's existing social development vision. This created a natural "fit" and made Carabayllo a prime laboratory to develop and test reforms (see Box 4.1).

Reform advocates and local leaders in Carabayllo used creative strategies to raise public awareness of mental health challenges and the availability of new, community-based services. For example, popular local media became vehicles for mental health education. Carabayllo's Mayor recalled: "We even went on the radio. The show was on Saturdays, from 11 to 12.... We discussed topics like domestic conflict and problems with kids. They opened the telephone lines, and people called in, asked questions. We would answer. Then people would come to the Mental Health Center."

Ultimately, most informants believed, the greatest benefits of the reform agenda were felt at the local level. These local gains were reflected in the strong uptake of mental health services by communities. Grassroots benefits also included enhanced political visibility for local leaders who helped drive the reform. In the end, both local and national stakeholders felt they came out as winners. In the words of the director of the local primary care network (Túpac Amaru Health Network), a collaborative dynamic emerged in which "nobody felt belittled or disempowered by the actions of anyone else." On the contrary: "Everybody won – the Network won, Hideyo [the HD-HN INSM] won – so did the Municipality."[71]

Box 4.1.
"We are helping people lead better lives": Mental health and social development in Carabayllo

Community mental health offers a powerful lever to accelerate local social and economic development. Carabayllo's political leaders embraced community-based mental health reform as an opportunity to bring new services to the district; boost local quality of life and social capital; advance equity; and ultimately increase economic productivity among Carabayllo's citizens.

Carabayllo's Mayor exercised personal leadership in promoting the community mental health agenda. In an interview, he described his concern as part of a broader philosophy of addressing citizens' welfare in a comprehensive way. "We as a Municipality have become more and more involved in helping our residents," he explained. "When a Carabayllo resident has any kind of problem, the first door he knocks on is the Municipality's." The Mayor and other local leaders believed this principle should extend to mental health, an area where they were aware of significant unmet needs.[72] "[Our citizens] were going to other places [for mental health services], but they were not being taken care of. They were feeling abandoned, defenseless," the Mayor said. Instead of continuing to see people leave the district to seek mental health care that often failed to satisfy them, local leaders joined with the National Mental Health Institute and other partners to offer the services right in Carabayllo. The agenda promised tangible benefits for Carabayllo's citizens and offered leaders political wins.

Today, the Mayor is proud of what has been achieved. "We are helping people to have better health, lead better lives, be happy." He believes even greater benefits will accrue over time. As people's mental health improves, they are able to be more productive and creative. They are less likely to self-medicate with alcohol or other substances. Family dynamics improve, and work and school performance may rise. "We're going to see much happier people in Carabayllo," the Mayor says. "People who have dreams, who want to produce, to compete, to work and make a contribution."

As of late 2016, national political shifts had temporarily slowed momentum for the countrywide scale up of the community mental health reforms that had brought benefits to Carabayllo. The Mayor remained optimistic, however: "We have made political stakeholders aware of a very important issue [community mental health].... This will continue to influence policy."

Maintaining Visibility and Political Buy-In Over Time

An additional point highlighted by stakeholders was the ETSMC's success in ensuring the continued political visibility of mental health reform for decision makers, for example by providing regular updates on reform achievements and staging public political events linked to the reform in which decision makers were invited to participate. Such political "maintenance work" is crucial. If the group driving a policy process is not proactive in ensuring visibility, a former Minister of Health emphasized, their issue will rapidly drop off the top leaders' radar.[73]

Some stakeholders described the ETSMC's diligence in performing its political visibility work as a change from traditional patterns within the INSM. The core team's steady activity created a sense of momentum and prompted stakeholders to deepen their own commitments to the reform effort. An advisor to the Minister of Health recalled: "I felt that with [the mental health team], every day something new happened. They went to talk to the Ministry of Economy, or they signed an agreement that with MANANTIAL [Foundation]. There was the community mental health center, then there was something new with the Loreto regional government. It was a change in the way of working at the INSM. All as if to keep reminding us: 'Don't forget about this!'"

To maintain broad political and social visibility for mental health issues, a key strategy is engaging the media. Studies have found that coverage of mental health topics in Peru's popular media increased substantially during the period 2013–2016, as reform efforts unfolded. Media have the power to inform the public about mental health and influence policy makers (Box 4.2).

Box 4.2.
The role of the media in mental health reform

Background studies for this report examined: (1) recent quantitative trends in popular media coverage of mental health in Peru; and (2) journalists' perceptions of how the media may inform the public, influence mental health policy debates, and contribute to ongoing reforms.

A higher media profile for mental health. The study documented increased coverage of mental health topics in Peruvian media from 2013–2016, as reforms gathered momentum. Mental health stories doubled as a proportion of total media health coverage: from 3 percent in 2013 to 6 percent in 2016. Increases for television and digital media were even more substantial (Table 4.2). Violence in its multiple forms was the predominant theme of media mental health coverage. A total of 22.9 percent of stories evoked this theme in 2013, and the figure remained at 21.4 percent in 2016. Analysts found that the main perceived attitude towards people with mental health problems in Peruvian media coverage in 2013 was one of *justifying* (18.0 percent), followed by *associating with a stigmatized condition* (17.6 percent), *victimizing* (15.9 percent), and *blaming* (9.2 percent). 29.9 percent of stories in 2013 were assessed as having a neutral attitude towards people with mental health problems. In 2016, the proportion of neutral coverage increased to 41.9 percent; however, the attitude of *victimizing* also increased to 29.9 percent.

Media's power to educate the public and influence lawmakers. Most interviewed journalists stated that the topic of mental health is important to them and expressed concern to inform the public on the issue. They felt that some recent reporting has helped make the public more aware of mental health, for example helping people assess if a loved one may be confronting mental health problems. Still, informants acknowledged that most mental health news in Peru focuses on sensational events, seeking ratings. In media coverage, mental health often remains entwined with violence. Approaches to covering mental health should be fundamentally rethought to ensure a more balanced and objective portrayal.

Many interviewed journalists believe that media coverage of issues like mental health can substantially influence policy debates. However, lawmakers often try to ignore reporting that challenges current policies. They dismiss critical stories as anecdotal. Most journalists feel that the government is currently failing to sufficiently emphasize constructive mental health approaches, such as prevention and early detection.

How advocates and the government should engage the media to support reforms. Informants argued that the government should create strategic alliances with communications media and opinion leaders to expand dissemination of mental health knowledge, taking advantage of journalists' distinctive skills. One informant rapidly sketched out a strategy: "Identify the key communications media at the national level and design a work plan for each one. Identify opinion leaders and allies at the national level. Provide a permanent space for opinions and/or programming [on mental health] in the communications media: print, radio, television. Get the support of the social networks." A specific content recommendation was that mental health specialists from medical and scientific fields should enjoy greater media visibility, regularly addressing constructive mental health topics such as preventive measures and explaining community-based care models.

TABLE 4.2. MEDIA MENTAL HEALTH COVERAGE AS A PROPORTION OF TOTAL HEALTH COVERAGE, PERU, 1ST HALF 2013 – 1ST HALF 2016

MEDIA	1ST HALF 2013			1ST HALF 2016		
	Nº. NEWS ITEMS/ REPORTS GENERAL HEALTH	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%	Nº. NEWS ITEMS / REPORTS GENERAL HEALTH	Nº. NEWS ITEMS / REPORTS GENERAL HEALTH	%
1. Television	2,107	37	2%	1,469	87	6%
2. Radio	971	32	3%	942	61	6%
3. Print	8,816	249	3%	5,996	224	4%
4. Digital	1,609	38	2%	1,796	240	13%
Total	**13,503**	**356**	**3%**	**10,203**	**612**	**6%**

Factors that Weakened Mental Health as a Policy Issue

We now summarize informants' observations on factors that constrained political momentum for mental health reform from 2013–2016. These fall under three broad headings: (1) technical barriers; (2) attitudinal and pedagogical factors; and (3) political concerns.

Technical Barriers

The limits of conventional measurement techniques. Some informants argued that the traditional approach to measuring disease burdens and health outcomes impedes recognition of the full importance of mental health as a social challenge and a policy task. Conventional epidemiology looks at the reported incidence of disease or at mortality as prime indicators of population health and of the benefits of public health policies. This approach tends to mask the importance of mental health, where mortality is low and morbidity is socially concealed, since the demand for services is not out in the open. As a result, interviewees claimed, many policy makers continue to underestimate the magnitude of mental health burdens and their social and economic consequences.

Weak mental health management capacities at the local level. Among key practical constraints to the expansion of reforms, informants highlighted the lack of know-how in municipalities for the design and implementation of mental health plans and budgets. External technical experts are needed to help build up local governments' capacity to administer community mental health. During the 2013–2016 period, the lack of such support hampered the dissemination of successful community-based mental health initiatives from Carabayllo to the wider North Lima Association of Municipalities. While neighboring municipalities admired what Carabayllo had achieved and recognized similar needs in their own communities, local governments lacked the competencies to replicate the approach. Key local political actors, including the Mayor of Carabayllo, argued that, to avoid losing momentum for reforms, partners able to provide the necessary technical guidance need to be rapidly engaged to help local institutions overcome planning and management deficits. Based on his own experience, the Mayor of Carabayllo stated that, to launch and sustain community-based mental health efforts, most if not all local governments will "need specialized external support on the subject for some time."[74]

Re-visioning first-level care. Some informants proposed that the technical barriers to implementation of community-based mental health care in Peru can best be overcome by reconfiguring the country's primary health care model. First-level care in Peru currently focuses heavily on prevention. While disease prevention is critical, the care model should also embrace more solution-oriented measures that can provide alternatives to a hospital-based health system in deep crisis. Community-based mental health care could benefit from this broader transformation of first-level care and may also help catalyze it.

The need for multi-sectoral strategies. Extending the argument about mental health and primary care, some informants urged that decision makers committed to community-based mental health look beyond the health sector as a whole to promote multi-sectoral action on the social and environmental determinants of citizens' mental wellbeing: for example, city planning. Such an approach could bring about a city that is less dispersed and more compact. This would promote healthier lifestyles, nurture social connectedness, and shorten the distances citizens need to travel to access essential public services, including mental health services.

Attitudinal Barriers and Knowledge Gaps

Persistent stigma. A constraint recurrently evoked by stakeholders is the prevalence of stigma around mental illness, including among government and civil society actors. Because of this, people affected by mental health problems continue to suffer social exclusion, while some constituencies regard efforts to reintegrate mental health patients into communities with mistrust. For example, some local people worry that the presence of mental health facilities in communities may worsen insecurity. The fact that the location of Carabayllo's mental health halfway house is not disclosed to the public is illustrative. Authorities fear that populations will resist, if they learn that a housing facility for persons with mental illness is located close by in their neighborhood.

People with mental disorders and their families internalize stigmatizing attitudes toward their own conditions, making patients reluctant to demand the mental health services they need. As a result, the more robust supply of services provided by the reform was not immediately accompanied by the full expression of social demand that could have been achieved in the absence of stigma.

For the former director of the Túpac Amaru Health Network, tackling stigma around mental disorders must involve systematic pedagogy directed towards political officials, especially at the local level. "I think that it is all about being able to provide training to mayors as soon as they start their four-year term of office.

The mental health directorate or the Ministry itself or the institutes should find ways to train them, to show the merits of community mental health.... This should be done not only in Lima but also in regional, provincial, and district governments."[75]

Ignorance of the community-based mental health care approach. Along with stigma, interviewees cited a pervasive lack of understanding of community-based mental health strategies among many political leaders. While the ETSMC worked hard to educate policy makers and to some extent the wider public about the reform agenda, informants found that these efforts were not sufficient. A former Minister of Health commented: "The subject of mental health has still not been recognized in Peru. I mean, it has not taken root. There is a lot of work to be done going forward. What is mental health all about? What can be done about it from a public health perspective? Why is it important to allocate resources to this area, and what type of solutions are we talking about?" Many informants concurred that intensified pedagogy for decision makers must accompany future efforts to propagate reforms.

The Political Dimension

Hierarchies and power dynamics. Among properly political factors that constrained the success of mental health reform efforts, informants pointed to power dynamics associated with reform champions' location in the government hierarchy. In particular, some saw a connection between key reformers' moderate political rank and what may be described as an ad hoc quality in the community mental health innovations implemented during 2013–2016.

Noting that reform advocates failed to shape disparate modalities such as CSMCs and halfway houses into a comprehensive, fully integrated national mental health reform strategy, some informants argued that this failure may be explained by the fact that reform thinking emanated primarily from Ministry of Health middle management (the ETSMC), not from the Ministry's top leaders. Middle-management reform proponents and their allies in local government lacked the authority to establish a comprehensive reform agenda encompassing a full range of community-based mental health care tools. Instead, they had to work selectively and opportunistically, implementing what they could, where and when opportunities emerged.

Interviewees noted the trade-offs associated with "bottom-up" change processes of this type. On the one hand, such approaches can secure strong participation and buy-in at the grassroots, as community-based mental health reforms did in communities like Carabayllo. On the other hand, however, these grassroots strategies may yield a lower level of political visibility outside the local and regional contexts, slowing the crystallization of a definitive national reform agenda.

The weakening of the Comprehensive Health Insurance system. Another key political constraint cited by informants was the weakening of the Comprehensive Health Insurance (SIS) mechanism for mental health care, following budget cutbacks and financing policy changes adopted by the new government in 2016. New policy priorities introduced at this time meant that certain mental health initiatives were no longer considered viable, as they were no longer aligned with wider governmental priorities.

A former head of the Health Services Management Institute (IGSS), interviewed in late 2016, recalled that, between 2013 and 2015, the SIS budget had tripled, but that, as of 2016, it had undergone severe cuts. From a high of 1.75 billion in 2015, he reported, SIS funding had been reduced to 1.4 billion. These stark cuts, he argued, "explain the state that the hospitals are in. There are no inputs, not even for priority items.... What is happening is a regressive policy from a financing standpoint."[76]

Missed opportunities to mobilize partners. The limited engagement of civil society in the reform process appeared to some informants as a major strategic weakness. Interviewees noted a marked absence of organizations of people directly affected by mental disorders and of academic institutions in reform planning and implementation. Such groups could and should have been more strongly engaged. Partnerships with these constituencies would have served the interests of the reform in multiple ways and might notably have shielded it against the effects of government and administrative changes. The weakness of civil society alliances raises concerns for the continuity of mental health innovations and their sustainability over time. Informants argued that building or reestablishing civil society and multi-sectoral partnerships should be a priority as reforms advance.

Conclusion

This chapter has explored community-based mental health care reform as a political problem. Our starting point was the understanding that epidemiological, clinical, and ethical arguments for this model of mental health action are strong, but that such arguments are rarely if ever sufficient in themselves to make reforms happen. Like other public health and social goals, community-based mental health must compete for political support with numerous alternative options for the investment of public resources. In Peru as elsewhere, the proposals that "win" are not necessarily the most compelling in scientific terms, but rather those whose champions are able to align strong interests behind them at critical moments of political choice.

To those who want to understand why community-based mental health reform efforts succeed or fail, the political management of these efforts is of the greatest concern. That is what this chapter has tried to bring to light in the Peruvian case. The outcomes of the reform process in Peru to date are mixed, which is part of

what makes the case instructive. The Peruvian reform movement scored notable successes during the period 2013–2016, but has also suffered setbacks. The lessons it bears may be all the more rich.

We have sought to extract some of those lessons by eliciting the views of political actors directly involved in the elaboration and implementation of reforms, either within national policy structures (principally the Ministry of Health) or on the local government level in the municipality of Carabayllo. On the one hand, informants identified strategies and factors that helped reform proponents market their agenda and gain unexpected political traction. On the other hand, informants also analyzed countervailing factors they saw as having impeded the political uptake and propagation of reform proposals.

On a number of themes, the views of substantial numbers of interviewed stakeholders converged. Factors widely cited as key political enablers for the reform movement included: (1) a technically robust set of proposed actions aligned with global norms and championed by respected national experts; (2) a window of political opportunity created by structural and contextual shifts, especially changes in Peru's Comprehensive Health Insurance scheme that increased financing flows to mental health provider institutions; (3) reform proponents' skill in marketing their ideas politically, notably through a positive framing in terms of ready solutions, not the magnitude of problems, and the argument that mental health action would help address multiple social concerns; and (4) the creation of a network of collaborative, mutually beneficial implementation partnerships spanning national and local levels, within which many stakeholders simultaneously perceived themselves as winners.

On the negative side, constraints on political uptake identified by informants included persistent misperceptions of the community mental health agenda among some influential stakeholders in health and other sectors, together with the stigma attached to mental disorders, which weakened political support and constrained the demand for services at community level. Reforms also suffered from measurement deficits. These included the tendency of conventional epidemiological metrics, such as mortality statistics, to mask the impact of mental health burdens. Reform advocates' arguments for the effectiveness of new community-based mental health strategies are weakened by the current failure to systematically measure the impact of innovations on patient outcomes.

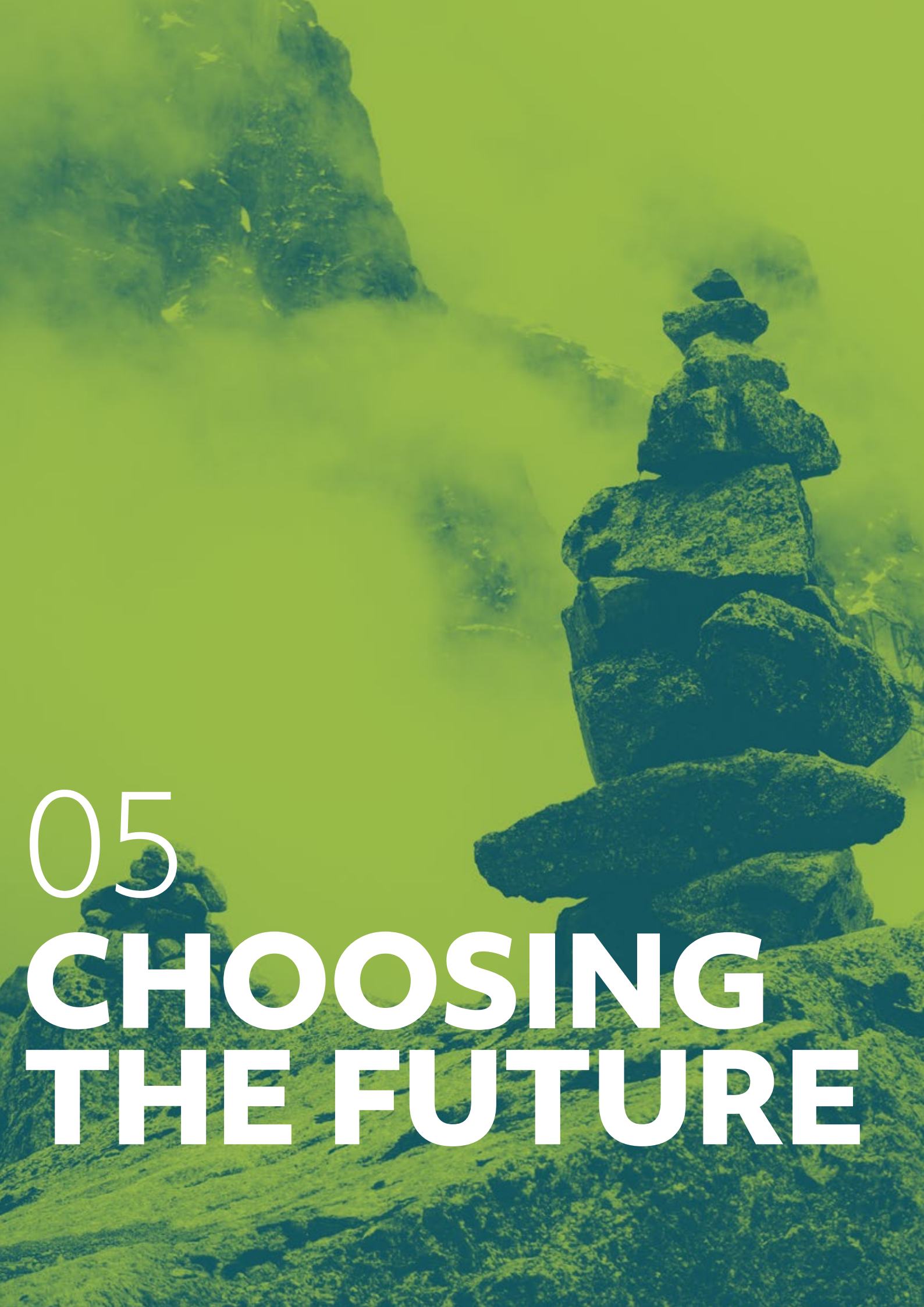
Some informants pointed to inadequate mobilization of civil society allies and multi-sectoral partners as another key weakness of recent reforms. Patients' organizations and academic institutions, for example, were noticeably absent from the table. The ETSMC appeared unaware of this gap. Reform leaders neglected to develop a multisectoral strategic plan for mental health. For some

informants, such a plan would have given greater programmatic cohesiveness to the community mental health actions implemented during the period and enhanced their visibility. A more deliberate, inclusive mobilization of civil society partners might have strengthened the sustainability of reform actions in the face of government and administrative changes.

Factors well beyond the political reach of the health sector impinged on the delivery of reforms. Despite encouraging results with the implementation of community-based modalities including CSMCs and halfway houses in settings like Carabayllo, the planned spread of these models to other areas of Peru was in suspension at the end of 2016. Large-scale political and financing shifts determined this situation, notably the weakening of the Comprehensive Health Insurance (SIS) system. This resulted from economic policy changes imposed in response to the growth slowdown affecting Peru at the time. As a consequence, the intended regional and national scale-up of community-based mental health innovations failed to materialize during the timeframe of this study.

From 2013–2016, political factors enabling and obstructing Peru's mental health reforms entwined in a complex and shifting interplay. Results at the end of the period were mixed. Some components of the reform agenda had registered remarkable advances. In other areas, work stagnated. Impressive local successes had been achieved, but the anticipated national expansion of community-based mental health care services was provisionally on hold.

Where is Peru's mental health reform movement headed next? What threats and opportunities will it face? How can proponents consolidate recent achievements and generate momentum for further gains? The next chapter considers these questions.



05 CHOOSING THE FUTURE

Today, Peru's mental health care system stands with one foot in the past and the other in the future. Reform efforts in settings like Carabayllo have shown that community-based strategies can improve the coverage, acceptability, efficiency, and equity of mental health services. As these models expand, they promise transformative health gains for individuals and substantial social and economic benefits for communities.

While recent progress has been impressive, however, several important components of the 2013–2016 mental health reform effort failed to gain traction, and the geographical scale-up even of successful modalities has been slower than anticipated. At the end of our study period, the planned countrywide dissemination of community-based mental health care innovations showed diminished momentum. The willingness of the government to maintain and ramp up support for mental health reforms was unclear.

For Peru's leaders, the choice between past and future in mental health care remains open. This chapter summarizes what was achieved from 2013–2016 and considers factors that will influence whether and how fast Peru's mental health system moves forward.

Milestones and Persistent Challenges

Peru achieved substantial advances in community-based mental health service delivery from 2013–2016. Four "master keys" of this progress were: the implementation of 22 CSMCs in a single year; the incorporation of specialized mental health care into the Comprehensive Health Insurance system with new rates; intensified collaboration among providers; and the effective involvement of local governments in the provision of mental health services.

Grassroots gains: CSMCs and halfway houses. During 2015 alone, 22 CSMCs became operational across Peru, a remarkable achievement. Our study in Carabayllo found that the implementation of the district's CSMC and halfway house proceeded rapidly, driven by goal-focused partnerships among national and territorial health institutions, local government, and NGOs. Carabayllo's CSMC transformed mental health care access in the community, delivering more than 20,000 outpatient mental health interventions during its first year of operation. The municipality's halfway house rapidly reached full patient capacity. By the close of the study period, it had operated successfully for more than two years, transitioned smoothly from NGO financing to government funding and management, and registered impressive results on qualitative measures of patients' recovery, wellbeing, and social reintegration.

Receptivity and resistance. On the negative side, while progress was made on the incorporation of mental health care into community-based primary care, gains on this front were slow in Carabayllo. Efforts to launch a mental health and substance use hospitalization unit in a local general hospital met resistance from hospital administrators and clinical personnel and made almost no progress.

This pattern of simultaneous receptivity and resistance with respect to community-based mental health modalities was observed not only in Carabayllo but in other areas of Peru where reforms were introduced. Thus, all of the CSMCs planned for launch across the country in 2015-2016 were brought into at least partial operation. In contrast, of the eight proposals for the establishment of psychiatric hospitalization in general hospitals, only one project was partially completed.

Changes in psychiatric hospitals. Peru's community-based mental health care reforms have been accompanied by a series of policy and practice changes in psychiatric hospitals and the specialized mental health care system, particularly in Metropolitan Lima. A tipping point for the mental health care system occurred in 2013, with the incorporation of public Comprehensive Health Insurance (SIS) as a payment mechanism for low-income patients in Lima's three flagship psychiatric hospitals. The comprehensive insurance model now pays for mental health services and guarantees patients the right to timely, quality care. As the availability of SIS financing boosted demand for outpatient services, the psychiatric hospitals responded by introducing more efficient care-delivery models that essentially replicate the treatment strategies of a community mental health center inside the hospital. Such care models emphasize group therapies and peer support, minimizing reliance on psychiatrists. Early results appeared promising, particularly in terms of coverage gains.

Intensified collaboration to improve services. Another achievement during this period was the creation of a self-organized collaborative network linking providers of specialized mental health care services across Metropolitan Lima. Previously, each psychiatric hospital had managed its affairs independently, generally in competition with the others. In 2013, the three flagship psychiatric institutions joined other hospitals and health-center networks in a citywide alliance to strengthen mental health services. According to participants, the network boosted the quality and continuity of care in greater Lima's mental health system until the initiative's premature termination.

Local government's catalytic role. The participation of community stakeholders and local governments will be critical to expand successful community-based mental health care models. A key enabling factor in settings like Carabayllo has been local government leaders' interest, commitment, and capacity to facilitate territorial coordination between institutional and community-based mental health care modalities.

The wave of the future: organizing services by territory. Success for a community-based service delivery model depends on the balanced development of all its functional components (e.g., CSMCs, halfway houses, basic mental health care in primary-care facilities, general hospitals, specialized hospitals.). Striking this balance requires conceptualizing and measuring progress geographically (for a whole territorial network) rather than by considering individual system components in isolation (e.g., looking just at the performance of individual facilities). Although it can reduce care gaps, strengthening individual facilities or system functions without territorial coordination will not result in substantive changes toward a community-based model.

Emergence of a new paradigm. In sum, a new paradigm for the delivery of mental health care is emerging in Peru today, bringing change to all system components and redefining their relationships. Specialized hospitals are transferring their leading role to the CSMCs in an interactive and collaborative way. Psychiatric hospitals and other traditional structures have shown that they can adapt to changes and work collaboratively with community-based providers. Primary-care facilities have also shown that they have the capacity to deliver frontline mental health care and that embracing this challenge could prove beneficial for them. Research has found that, when primary health care facilities begin providing mental health care, their overall performance tends to improve and they accrue positive feedback.[77]

Reform, Peruvian style? Today, Peru's ambitious mental health reform is in a formative stage, where critical direction is being imparted. Decisions now will shape the future of the country's mental health care system and have far-reaching implications for the wellbeing of future generations of Peruvians.

Peru's planned mental health transformation shares sources of inspiration with recent reforms in a number of other Latin American countries. The architects of the Peruvian process have learned extensively from regional and global examples.[78] However, some protagonists argue that the Peruvian reform has distinctive features, as well, native to the country's general culture, the structure of the health system, health policy processes, and the cultural configuration of Peruvian psychiatry. Some possible distinctive features of the Peruvian process could be the active participation of specialized hospitals, specific territorial coordination, and the universal insurance approach as a means of ensuring universal access.[79] Peru's reform process also reflects the specificities of the country's recent history and the evolution of an expanding alliance of national mental health partners over some three decades (Box 5.1).

Box 5.1.
Progressive mental health action in Peru: remembering history

A public mental health alliance had been in the making in Peru for some 30 years, supported by partner institutions including the INSM, the National Mental Health Directorate, the Cayetano Heredia Peruvian University (UPCH), the local headquarters of PAHO, the specialized hospitals, and some NGOs, among others. Early leaders of the movement included Dr. Renato Castro de la Mata, a professor at UPCH and co-founder of the INSM, who in the 1980s already argued that, "Community mental health is the most direct, most effective, and cheapest way" to deliver mental health care to the population. In that era, the concept of community mental health centers as vectors of specialized care in grassroots settings was already emerging. Thus, before taking its current form, the INSM was known as the "San Juan Bosco Community Mental Health Center."

In the 1990s, UPCH and the INSM teamed with McGill University to launch a mental health partnership, whose fruits included the creation of a master's degree program in citizens' mental health. Over the years, this program has contributed to creating a critical mass of professionals in mental health science committed to ambitious reforms.

Through the decades, groundbreaking mental health care delivery and epidemiological research experiences have unfolded in settings across Peru and have informed the community-based mental health agenda. Examples include 30 years of community interventions in the northern cone area of Lima; a decade of epidemiological research in almost all regions of the country; intervention programs in the Ayacucho region related to the mental health impacts of armed conflict; and a program to strengthen mental health care in primary health care in the country's poorest regions and roughest terrain (Apurímac). The Apurímac project continued for four years, with the active participation of more than 30 professionals. The core group of mental health leaders formed through these initiatives went on to produce a series of policy documents that resulted in the enactment of Peru's 2012 Mental Health Law, the legislation that set the stage for today's reforms.

Sustaining Momentum

From 2013–2016, favorable contextual and structural conditions helped accelerate Peru's mental health reform process. Changes to mental health service delivery models were correlated with the implementation of new financing mechanisms and a broadly favorable political climate. Supportive external conditions and collaborative relations among stakeholders nurtured a virtuous cycle, in which the results of some innovations served as inputs for others, with the whole greater than the sum of its parts. A culture of trust among partners, a shared vision, and a leadership approach that was at once technical and policy-oriented brought mental health reform towards a take-off point, where its momentum will become self-sustaining and not easily reversed.[80]

The favorable conditions that facilitated the reform movement during its initial phases will not necessarily continue to operate, however. Careful strategy and contingency planning will be required going forward. Here, we focus on four key challenges reform leaders must negotiate: (1) ensuring sufficient financing to keep reforms on track; (2) coordinating mental health action across provider institutions and territories; (3) adapting mental health reforms to potential broader structural changes in the nation's health system; and (4) navigating a political landscape marked by Peru's frequent change of government officials.

How will Ongoing Reforms be Financed?

Financing is the critical sticking point for most bold public health proposals in most contexts. For Peru's mental health reform agenda, resource constraints are also clearly a serious concern. Yet the outlook is more positive than might be assumed. One reason for this is the results-based budgeting mechanism established in 2014 to support the roll-out of innovative community-based mental health care modalities in Peru (Box 5.2 and Appendix B).

Box 5.2.
Results-based budgeting for mental health: targeted funding to speed community-based reforms

As part of its effort to modernize governance, Peru is moving toward a performance-based public-sector budgeting approach (*Presupuesto por Resultado*, PpR). This involves reorienting government budgets toward the achievement of measurable results, with targets often framed in terms of numbers of people served. In the health sector, this approach has been deployed progressively over the past decade, with early successes obtained in areas like nutrition and maternal health.

Until 2014, public-sector mental health activities in Peru were funded by the government budget for control of non-communicable diseases. Mental health competed with activities such as fighting cancer and the full range of degenerative chronic diseases. In 2014, however, the Ministry of Economy and Finance approved the establishment of a specific new results-based mental health budget program: PpR 131, entitled "Control and Prevention in Mental Health." Established as a ten-year program, PpR 131 provides funding for the roll-out of key community-based mental health care modalities. This has included the creation of CSMCs and efforts to shift mental health hospitalization capacities from central psychiatric institutions to local general hospitals.

Rules governing the disbursement of PpR 131 funds ensure that financing flows to priority mental health reform actions. For example, PpR 131 was allocated PEN 78 million (~US$20 million) in fiscal year 2015. Funding was to be used exclusively for mental health care reform activities, which encompass screening and diagnosis; treatment; community mental health actions (e.g., training and deploying community health workers with basic mental health skills); and support and supervision (Table 5.1).

The results-based budget is attached to pre-defined indicators which are measurable at the primary care level. At the end of the month, any unspent PpR 131 funds revert back to the Ministry of Economy and Finance, automatically triggering a reassessment of the amount assigned and a possible reduction in the budget allocated for the following month. In this way, managers and frontline providers are strongly incentivized to achieve the proposed goals related to mental health services. Meanwhile, the regulations associated with Peru's 2012 Mental Health Law (Law 29889) require health institutions to allocate at least 10 percent of their budget for staff training and capacity building in mental health care.

The new funding mechanism provides a powerful lever to shift services and resources from psychiatric hospitals to community mental health facilities, and to integrate mental health care services into primary care. By setting objective performance targets and establishing what is intended to be a stable, reliable funding stream for a decade ahead, PpR 131 holds the potential to anchor and protect Peru's mental health reform process through economic vicissitudes and political priority shifts.

TABLE 5.1. FUNDING COMMITTED, GEOGRAPHICAL SCOPE, ACTIVITIES AND INDICATORS FOR MENTAL HEALTH. FISCAL YEAR 2015 AS PER PPR 131[a]

	SUPPORT AND SUPERVISION	SCREENING AND DIAGNOSIS	TREATMENT	COMMUNITY ACTIONS
BUDGET ($US)	2,149,977	6,369,266	10,018,373	184,455
PURPOSE	Monitoring and evaluation of the implementation of the mental health program	Early detection of mental disorders	Opportune treatment for identified cases	Mental health promotion
WHERE	National, regional, and local			
HEALTH CARE LEVEL	Primary, secondary, and tertiary	Primary	Primary, secondary, and tertiary	Primary and secondary
WHAT	• Monitoring, supervision, evaluation and control of the mental health program • Creation of intervention guides for health workers • Epidemiological surveillance	Screening of: • Mental disorders (depression, anxiety, psychotic disorders, alcoholism) • Poor social skills in children and teenagers	Treatment for: • Depression and anxiety • Psychotic disorders • Alcoholism	• Community health workers and neighborhood councils trained to promote and improve mental health in their communities • Educational sessions for families • Community interventions for victims of political violence

Source: Toyama et al. 2017.
[a] Information derived from Ministry of Economy and Finance's online transparency portal.

Financing mental health equity: the SIS. Another crucial source of finance for mental health action is the Comprehensive Health Insurance (SIS) financing mechanism. As we have seen, SIS has covered mental health treatment and medication costs for low-income Peruvians since 2013. About 30 percent of the cost of specialized mental health benefits and virtually 100 percent of the cost of halfway houses could be financed with the SIS mechanism at current levels. Moreover, if the SIS budget had continued to grow in more recent years at the same rate as in 2015, by 2022 it would probably have been possible for SIS to cover at least 80 percent of the demand for mental health care in the country. Today, however, the model of public health insurance embodied by the SIS is a focus of critical reexamination and political debate in Peru (Box 5.3).

Box 5.3.
Mental health insurance coverage for low-income Peruvians: what future for the SIS?

A basic political goal of mental health reform is to maintain mental health as a priority within a viable, equitable model for the development of health services in general.

A Universal Health Insurance (AUS) framework is a means of providing universal access to the full range of health services that people need. Peru's adoption of this model in 2002 has facilitated the country's subsequent mental health reforms. The modalities of Peru's AUS have provided incentives for the modernization of the mental health care system, boosted mental health financing, enabled the revaluation of psychiatric and psychotherapeutic work, and empowered mental health patients.

Currently, however, fundamental aspects of Peru's health system are being questioned. Clarity has not emerged on the health care delivery, management, and financing models that will ultimately be adopted. With system structures in flux, several components of the AUS have been substantially impacted, including the Comprehensive Health Insurance (SIS) system for low-income and unemployed Peruvians. SIS resources have been cut back, relative to previous years, just at a time when a funding increase for this pro-equity financing modality was expected and needed. The slowdown started in 2015, but the current drop in SIS funding (as of August 2017) is greater and has been accompanied by an administrative and reputational crisis.

The immediate effect of the weakening of SIS is the loss of enforceable rights to care among low-income citizens. This relegates low-income patients to the status of passive recipients of assistance, who cannot press service demands based on legal guarantees, but must content themselves with whatever the system provides. Administrative dysfunctions have worsened the situation. Through much of 2017, for example, the differential rates for sensitive SIS-sponsored services—including mental health services—had not been officially set, creating a situation in which psychiatric or psychotherapeutic interventions were often priced at lower rates than injections. After months of confusion, this situation was rectified, largely due to pressure from unions. However, amidst the financial and administrative turmoil, SIS's expansion into community mental health centers and general-hospital mental health services had practically stopped.

How will Mental Health Action be Coordinated?

Along with financing, the coordination of mental health action remains key for the success of reforms. As we have discussed, promising new models of provider-led coordination began to emerge among leading Peruvian mental health institutions during 2013–2016. However, recent policy changes have dismantled some of these mechanisms.

A promising experiment, interrupted. An important example is the 2016 deactivation of the Health Services Management Institute (HSMI). This entity was administratively independent of the Ministry of Health and had emerged as a mechanism to link health services across the city of Lima. Previously, mental health services in Peru's sprawling capital formed an archipelago of isolated health care islands, each with its own internal rules, practices, and funding streams, each struggling to survive and maximize its resources. Individual facilities (for example, the large mental health hospitals) tended to treat peer institutions and other system actors as rivals, engaging in competitive behavior that undermined the effectiveness and efficiency of the overall system. Beginning in 2014, the HSMI and the Mental Health Services Network that it oversaw began to change this culture and foster new patterns of cooperation.

Coordination challenges, still pending. With the change in government, this experiment was abruptly stamped as a failure and cut short. After being allowed to operate for less than two years, the Health Services Management Institute had clearly not succeeded in solving the health care sector's numerous coordination and efficiency problems. However, many providers felt that the Institute was becoming a promising incubator for solutions, particularly in mental health.

At present, Lima's health services once again depend administratively on the Ministry of Health, while regional health systems are under the control of the respective regional authorities, with the overall picture profoundly fragmented. For mental health actors, the challenge of coordinating and integrating reforms across institutions, stakeholders, and territories remains to be resolved.

How May Health System Structures Change?

The weakening of the SIS and the politically-prompted elimination of the Health Services Management Institute both raise deeper questions about structural changes to Peru's health system as a whole. Arguably, the SIS and the Health Services Management Institute had been among the system's stronger components. Thus, for some observers, the deliberate weakening of these structures could signal

the intent to introduce deeper changes in Peru's health care model. However, if the old ways are being questioned, a coherent new health system model has not yet emerged. Rather, the system may currently be seen as experiencing an "identity crisis," in which models of care delivery, governance, and financing are in flux, and definitive decisions have not been reached. How this process of system self-redefinition plays out will have implications for the country's mental health reform agenda.

Elusive consensus. Realistically, there are limited options for deep restructuring and a new health system model in Peru. The creation of a single, unified health system would involve the coordination of public and social security funds, which would require consensus and commitment from both the executive branch of government and the legislature. This presents a major challenge in the short term in light of the current configuration of these branches, all the more so given that consensus has been elusive even under more favorable political conditions.

Grappling with fragmentation. Now, as in the past, fragmentation remains a salient trait of the country's health system. For example, the social security health system, EsSalud, is attached to another ministry, and even the strong political leadership of some health ministers is barely felt in this vast subsector. One sign of this is EsSalud's limited involvement in controlling epidemics. With respect to mental health, EsSalud demonstrated its intention to promote a reform process that was also based on the community model. In light of this political reality, the AUS approach may be resumed and, as happens with many opportunities in Peru, it may reappear in an enhanced form. Since crises are also opportunities, there is also the possibility, albeit slight, of the emergence of a single countrywide health system.

A burgeoning private sector. What seems clear is that, with the weakening of public-sector health services, the private health care sector has opportunities for expansion. This has already been evident in recent years. While the public sector has considerable difficulty building and operating new hospitals or health facilities, the private sector is steadily expanding its infrastructure. For example, in Trujillo, while the two public hospitals have been declared to be in crisis and new hospital projects have not been completed, five medium and large private clinics have emerged and already exceed the supply capacity of public providers. The private sector is integrating vertically, in the sense that insurers and service providers are being assimilated, allowing them better capitalization.

Health workforce dynamics. One of the challenges impeding the operationalization and development of new hospitals and public services is the shortage of specialized human resources. Nationwide, a deficit of more than eleven thousand specialists is estimated. The public-sector crisis and the sector's difficulty in attracting and retaining specialized health workers facilitates the migration of scarce spe-

cialized human resources to the private sector. In Peru, training of specialists is still limited in the private sector, and there is a need for trained specialists in the public sector. In addition, the participation of physicians and professionals in the economic revenue of the sector has been reduced. As a consequence, the low competitiveness of the public sector in terms of human resources has lowered the "price" of medical interventions in relation to other factors of production, reducing profits and further weakening the sector.

Additional space for private-sector growth. It is possible that the current public health policy crisis may have the effect–intended or not–of facilitating the expansion of private health care in Peru. This is even more likely if we consider that private participation in the country's health care is still low in comparison to neighboring countries such as Brazil, Chile, and Colombia. In Peru, private participation is less than 10 percent, while in these other countries, it exceeds 30 percent. It is also worth mentioning that Peru has a broad informal health services sector that is typically centered around public hospitals and tends to expand in tandem with the crises they experience.

The private sector: a new frontier for mental health reform? Mental health reform can succeed under a variety of health system models. However, leaders must clarify the model they intend to promote, in order to establish strategic and programmatic coherence, which is crucial for reforms. It is important to note that Peru's private mental health system is still excluded from insurance. The majority of insurance companies do not include mental health services in their benefits packages. Similarly, in the private sector, mental health care is essentially provided in the private clinics of psychiatrists and psychologists, with a more individualistic perspective (individual supplier/individual consumer) far removed from a social, community-based model. Mental health reform is also needed in the private sector.

Mental Health Reform and the Challenge of Public Health System Reform

Without an encompassing political and systemic strategy, Peru's public health sector risks finding itself locked in sterile internal strife and losing the commitment to public service. This could cause grave harm to citizens, especially those most disadvantaged and vulnerable to discrimination and neglect. This includes people affected by mental, neurological, and substance use disorders.

To reduce suffering, improve social wellbeing, raise economic productivity, and advance social integration among individuals and communities affected by MNS disorders, scaling up of mental health services reforms as part of integrated health system reforms will contribute to healing social fractures and restoring trust in governance that works for the common good.

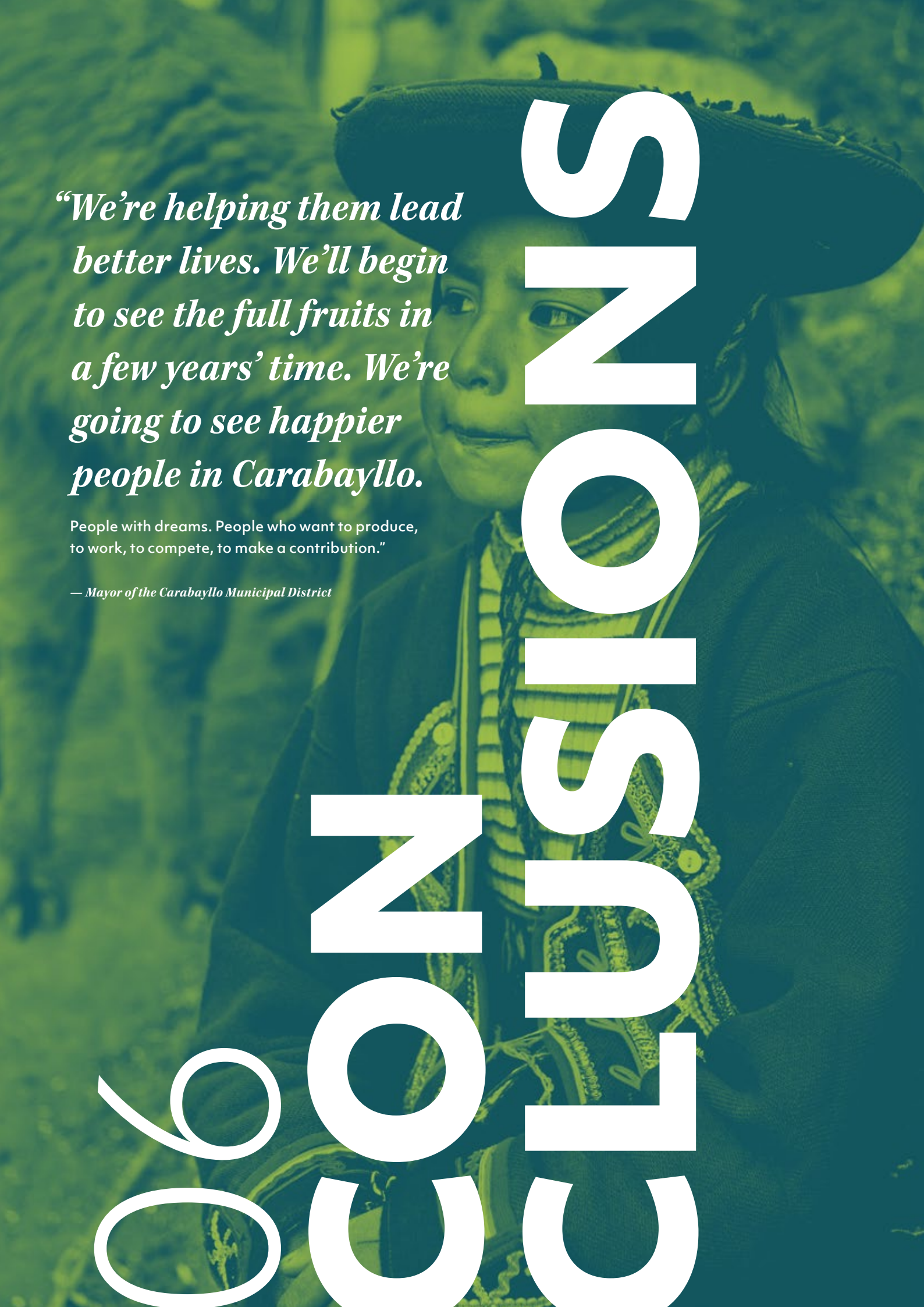
Conclusion: Mental Health Reform and Development

Worldwide, people suffering from mental, neurological, and substance use disorders are stepping from the shadows, challenging stigma, and demanding both respect and effective care.[81] As countries take action to close MNS treatment gaps, they are tackling several of the most devastating causes of human suffering and lost years of healthy life among their people. This is emphatically the case in Peru, where neuropsychiatric disorders are the country's leading cause of disease burden.[82]

Countries reforming their mental health care systems are not doing so out of charity. They are following their economic interests. They are safeguarding and enhancing their most critical development resource: their people's capacity to think, act, communicate, and build healthy relationships. Mental wellbeing is a requirement for happiness: a social goal that today is widely measured and on which countries are increasingly judged—not least by their own people.[83] Mind power is also money power. In the age of the knowledge economy, no country can let preventable and treatable illness erode this asset. The economic impact of mental health on individuals and society remains a major challenge for development, to which countries are beginning to seek and find creative solutions.[84] [85]

Mental health is emerging as a unique opportunity for mediation between society and the individual, between the social and the biological, between health and development, between the past and the future. The tensions and potentialities of a society are expressed in the emotions, the feelings, the desires, and the attitudes of its people. There is increasing evidence of the social and transgenerational character of the mental health/disease process. At the same time, mental health care demonstrates the ability to effectively intervene and change these conditions, from distress to calm, from violence to tolerance, from depression to hope, from suspicion to confidence.

Mental health care works. And, as it does so, it raises individual wellbeing and economic productivity and multiplies human capital for development. A growing number of societies are opting for the virtuous circle of mental health and development. In 2013–2016, Peru took bold strides along this path, advancing at an impressive pace and documenting successes and occasional missteps that can inform future action. Today, the country is poised to continue the journey.



06 CONCLUSIONS

"We're helping them lead better lives. We'll begin to see the full fruits in a few years' time. We're going to see happier people in Carabayllo.

People with dreams. People who want to produce, to work, to compete, to make a contribution."

— Mayor of the Carabayllo Municipal District

An unprecedented opportunity exists today to transform Peru's mental health system for the good of all its citizens.

From 2013 to 2016, innovative mental health care delivery modalities were implemented in several settings around the country, including the North Lima district of Carabayllo. Some of these efforts created novel grassroots delivery partnerships and yielded remarkable gains in mental health service coverage. Some produced qualitative evidence of substantial improvements in mental health patients' well-being and social re-integration. Other projects fell short of their goals but yielded multiple lessons to improve future work.

Reform protagonists aspired to take successful innovations to national scale. At the end of this report's study period, however, economic conditions were changing, growth had dipped, and political forces were shifting in Peru. The future of the mental health reform process was uncertain.

What lessons can Peru's recent mental health experiences teach, and what should be done to fulfill their promise? In closing this study, we distill key findings, then formulate recommendations for the health leaders and partners who will shape Peru's mental health agenda going forward.

The specific conclusions of this study are the following:

COMMUNITY-BASED MENTAL HEALTH CARE IN PERU: THE BOTTOM LINE

+ **Primary health care in Peru is able to incorporate mental health care. This requires providing primary care workers with training and in-service technical support; making management responsive to conditions in local facilities; and ensuring the continuous availability of psychotropic drugs in primary care services.**[86]

+ **Peru's model for providing specialized mental health services is shifting from psychiatric hospitals to community mental health centers (CSMCs), which already show some evidence of higher levels of productivity, effectiveness, social acceptability, and capacity for innovation to improve care processes.**

+ **Expanded CSMC implementation is feasible under Peru's current national and sectoral conditions. CSMCs have quickly (in less than two years) achieved a cost-benefit advantage compared to the traditional model of care in specialized hospitals.**

+ In cost-benefit terms, mental health halfway houses are a better alternative for the care of socially isolated people with mental disabilities than keeping these patients in hospitals. Limited qualitative evidence suggests appreciable health and social-integration gains for patients in halfway houses. A network of halfway houses sufficient to serve the current hospitalized population is technically feasible and financially sustainable.

SYSTEMIC ISSUES AND THE ROLE OF HOSPITALS

+ The creation of short-term mental health hospitalization units in local general hospitals largely failed during 2013–2016. International norms recognize local general hospitals as a key component of a community-based mental health system.[87] Shaping fresh strategies to resolve this bottleneck is an urgent task.

+ The model of Universal Health Insurance associated with Peru's national health reform favored the effective transfer of financial resources for mental health care, significantly reduced out-of-pocket expenses, stimulated the production of mental health care, and revalorized psychosocial work, empowering clients and promoting the exercise of their rights.

+ Peru's flagship mental health hospitals have shown a capacity to evolve with the shift to community-based care and to contribute to reform success. Some hospitals have incorporated nurse-led outpatient care modules that essentially reproduce a community-based care approach.

+ An efficient, collaborative transfer of competencies from specialized hospitals to CSMCs is possible but will not be automatic. Sustained oversight and facilitation will be required, particularly as substantial human and financial resources begin to be redirected.

+ Linking health services through provider-led collaborative networks has high potential to promote a community mental health model but faces resistance from a bureaucratic culture and a tradition of fragmentation and internal competition in the health system.

REFORM POLITICS

+ From 2013–2016, mental health reform efforts were largely driven by technical experts in the middle-management levels of the Ministry of Health. This enhanced reform proposals' technical strength, but may have limited top-level political support, relative to other agendas that originated in higher echelons.

+ The popular media are capable of redirecting their approaches to mental health issues and can positively influence decision makers, mental health implementers, and the public. The media are becoming allies for community-based mental health reform in Peru. The full potential of this convergence has not yet been reaped.

+ According to frontline implementers, stigma around mental disorders, including among health professionals and patients, remains a major barrier to reforms. Health authorities have attempted to address this problem, but with scant success.

+ Reforms to date show little participation by civil society. The absence of groups representing people directly affected by mental disorders is notable. Partnership with academic institutions has also lagged. This raises concerns for the reform's long-term sustainability, particularly during changes of government.

+ Proactive participation by local political leaders helped spark reform successes in Carabayllo. Grassroots partnerships linking local political leaders and health networks to national reform actors may be catalytic for scale-up.

WHAT CAN BE ACHIEVED

+ **Mental health reform can contribute to public health agendas that are important to citizens, including suicide prevention and the control of alcohol and substance abuse.[88] [89] Gains in these areas can be promoted by making mental health services more accessible at community level. Positive effects on community quality of life may emerge relatively rapidly.**

+ **MNS disorders inflict heavy losses on national economies, including Peru's. Community-based mental health models can go far in reducing these burdens. Access to affordable, quality mental health care improves wellbeing and boosts productivity for individuals, households, and communities. Mental health action promotes social cohesion, builds human capital, and fuels virtuous circles of social and economic development.**

07 RECOMMENDATIONS

A countrywide community-based mental health care model can succeed in Peru and would bring substantial health, social, and economic benefits to the nation. Making this happen will not be simple. It will require changes in mental health policy, service provision, and financing, along with multi-sectoral action and deeper cultural shifts over time.

Reform efforts during 2013–2016 have opened pathways and provided examples for many of the needed actions.

This study supports the specific recommendations below. These do not constitute an exhaustive reform agenda in themselves. Rather, they identify a selected set of actions that would advance reform efforts in key areas and that are supported by the evidence and analyses presented in this report.

SETTING STRATEGY AND REVISING POLICY

+ **A multi-sectoral, multi-year national mental health plan should be designed and implemented, with clear responsibilities and financing mechanisms.**

+ **National, regional, and local governments should rapidly invest in launching community mental health centers and halfway houses throughout the country. The first wave should cover at least one-fourth to one-third of Peru's estimated mental health care need. Specialized mental health hospitals should decentralize their services to these community-based facilities. Financial and human resources should be transferred from specialized hospitals to community facilities along with patients.**

+ **A revised strategy to incorporate mental health hospitalization units in local general hospitals should be developed, with the participation of relevant stakeholders, including those who vigorously resisted the effort in 2013–2016 (e.g., hospital administrators). A new strategy should draw lessons from the previous failure and from international experiences.**

MAKING MENTAL HEALTH FINANCING FAIRER

+ Public and private insurance plans should incorporate mental health benefits that will eliminate out-of-pocket expenses for beneficiaries.

OPTIMIZING COMMUNITY-BASED SERVICES

+ Health authorities and facility managers should ensure that appropriate tools and conditions for mental health care are provided in all first- and second-level health facilities. This includes a reliable supply of psycho-pharmaceuticals.

+ The main risks facing the community mental health center (CSMC) model, such as quality threats due to high patient loads, are basically reflections of CSMCs' success. In Carabayllo, the more than 30,000 interventions delivered at the CSMC during 2016 attest to strong community uptake. Reform coordinators should seek solutions to increase delivery capacity in Carabayllo. They should also plan and budget for large patient flows at future CSMCs.

+ All CSMCs should have a clear territorial delimitation. They should have the mandate and resources to support the first-level general health facilities in their designated area that serve as gateways to the health system.

+ Community health promoters and peer service providers should have a leading role in promoting mental health; detecting mental health problems; early intervention; and the continuity of care. Community and peer health workers involved in mental health action should be adequately rewarded for their work.

CHANGING SECTORAL AND INSTITUTIONAL CULTURES

+ Both standalone mental health facilities such as CSMCs and the mental health units of larger institutions should be integrated in collaborative networks, share resources, have compatible standards, and work together to comprehensively address the mental health of populations.

+ **The universities and systems that train undergraduate and postgraduate students for the health professions should apply the community mental health approach as a theoretical and practical framework. This will support a progressive shift of mindset within the health professions, changing the culture of mental health care and improving outcomes.**

TACKLING STIGMA

+ **A national campaign to destigmatize mental health should be undertaken in partnership with the media. At grassroots level, public education programs and social integration groups organized by CSMCs for patients, families, and community members are promising vehicles to fight stigma.**

BUILDING AN INCLUSIVE MOVEMENT

+ **Communities, local governments, civil society organizations, and businesses should be actively involved in health promotion, disease prevention, and care for people affected by mental disorders. Long-term reform plans should include strategies to engage these partners. Experiences in Carabayllo suggest that the contributions of local government leaders may be especially valuable.**

+ **Patients' organizations and a broad range of civil society groups that promote mental health rights, health equity, social and economic inclusion, and poverty reduction should participate in building a movement for community mental health reform. Reform leaders should foster civil society participation and community voice. The reform movement should also engage academic institutions, which can contribute to research, planning, implementation, and dissemination.**

MEASURING RESULTS

+ **Scale-up of community-based mental health modalities should include an integrated, system-wide plan for monitoring and evaluation, ideally incorporating patient outcomes. Policy makers should engage the expertise of academic institutions and international partners.**[90]

STAYING THE COURSE

+ Consistent political engagement by the Ministry of Health is a prerequisite for completing reforms. Advocates should not downplay the challenges ahead or the political and fiscal efforts required. To ensure lasting success, the Ministry of Health will have to maintain mental health as a priority with a well-structured plan for a minimum of 15 years. The investment of time and resources will be considerable. The rewards will be far more so. Peru's recent establishment of a ten-year performance-based budgeting framework for mental health care and prevention sends an encouraging signal.

A Time to Lead

Mental disorders are not exotic conditions that affect only a handful of citizens, and that can be dealt with by isolating the afflicted from the rest of society. Every year, one in five Peruvians is affected by an MNS disorder. Today, however, only a tiny minority access care. The price of this failure is paid by affected individuals and their families, but also by Peruvian society as a whole. Pervasive untreated mental illness fuels violence, suicide, substance abuse, and instability that weaken social bonds, spur discontent, and undermine citizens' confidence in institutions.[91 92 93] Through a multitude of channels, the burden of mental illness weighs on individual productivity and the national economy, slowing development.

Nor are Peru's mental health statistics in any way exceptional. On the contrary, they are typical of what most countries face. This is one reason Peru's reform efforts are so important. Mental health treatment gaps are a global scourge, against which Peru may now be positioned to take leadership. It will do so, if authorities carry forward the efforts described in this report: correcting failures, filling knowledge gaps, supporting continued innovation, and rapidly expanding successful approaches so that more citizens can benefit. As Peru takes its community-based mental health reforms to scale, it will inspire other countries and contribute to the global movement for mental health.

The power that will transform mental health care, in Peru as elsewhere, is the power of ordinary people doing apparently unexceptional things. Patients, health workers, families, and neighbors. Working, loving, suffering, surviving. Quietly reclaiming their right to be "people with a dream," in the words of the Mayor of Carabayllo. Building healthier minds and better lives, together.

For certain tasks, the power of the ordinary is irresistible. To unleash that power is the privilege of leaders who can discern transformational opportunity in places and times where others fail to notice them. Peru's low-income communities are such places. Now is such a time.

APPENDICES

Appendix A. Methodological Considerations

The object of analysis of this study is the set of political, financial, administrative, and benefits initiatives that occurred in Peru in the period 2013–2016 and that caused changes in the mental health service system or created the conditions for such changes. The analysis is limited to the administrative area of the Ministry of Health and excludes other health sub-sectors such as the private sector, the social security sector, and the armed and police forces.

The observation units of this study include both national interventions such as Comprehensive Health Insurance, as well as other metropolitan interventions developed in the city of Lima. For the analysis of local implementation, the delivery system of health services in a specific territory was used, choosing as the "case" the District of Carabayllo, in northern Lima. This choice was based primarily on the fact that all of the most salient structures and processes of Peru's mental health reform were implemented concurrently in Carabayllo during the relevant period. Thus, one of the country's 22 community mental health centers was launched; one of the seven halfway houses was created; a first-level strengthening plan was implemented for the care of mental health problems in local primary health care centers; and one of the eight projects for the implementation of hospitalization units for people with mental disorders and addictions in a general hospital was undertaken.

The main questions posed by the study were: whether these initiatives constitute a true community-based mental health reform; whether they are sustainable; and whether their scaling up at the national level is viable. To answer these questions, five component studies were organized:

Component 1: Systematization of experiences in the implementation of changes in mental health service provision in the district of Carabayllo, 2013–2016.

Component 2: Systematization of experiences in the implementation of changes in the management of specialized mental health care in Lima, 2013–2016.

Component 3: Estimation and comparison of the costs of care in Carabayllo's community mental health center (CSMC) and mental health halfway house, as alternatives to the traditional model of care centered in the psychiatric hospital.

Component 4: Analysis of the political role of local authorities and officials (Carabayllo) and the health sector in the implementation of changes in mental health care during the period 2013–2016.

Component 5: Analysis of the approach to mental health by the media of metropolitan and national circulation, 2013–2016.

The methodological design used in each of the study components is described below.

COMPONENTS 1 AND 2: SYSTEMATIZATION OF THE IMPLEMENTATION OF SERVICES FOR THE TERRITORIAL COMMUNITY MENTAL HEALTH CARE NETWORK IN CARABAYLLO AND SYSTEMATIZATION OF THE IMPLEMENTATION OF CHANGES IN THE MANAGEMENT OF SPECIALIZED MENTAL HEALTH CARE IN LIMA.

The methodology corresponds to a type of retrospective systematization, which seeks to investigate, identify, and further disseminate good practices of community mental health implemented in the period 2013–2016. It is based on an approach to development that understands systematization as a "critical interpretation of one or several experiences that, through their ordering and reconstruction, discover or explain the logic of the lived process, the factors that have intervened in this process, how they have interrelated, and why they have interconnected in that specific way."[94]

The aim is to move from the implicit knowledge that emerges in the practice of implementing community mental health services to a more rigorous, delimited, precise, and verifiable knowledge that is formalized in a communicable discourse. Thus, the approach is expected to promote a virtuous circle of practice - critical reflection - practice, where from the precise knowledge of the initial experience new experiences can be better oriented.[95]

Primary and secondary data sources were used. Among the latter, analyses were made of documents concerning the current regulations, intervention programs and plans, operational and management reports, service databases, and implementation logbooks of the technical team.

For the collection of primary data, in-depth interviews and systematization workshops were carried out with key stakeholders involved in implementing the 2013–2016 reform. We included those who accepted participation in the study and who were active as managers, trainer/facilitators, or service providers in primary-care establishments, the community mental health center, or the reference hospital during the study period. Interview guides, systematization report guides, and systematization workshop guides were used.

We sought to reconstruct the events in phases or stages of the mental health care reform implementation processes, with the actors involved. The implementation stages considered were: Stage 1: exploration for the implementation of the mental health service or initiative; Stage 2: preparation for implementation; Stage 3: early implementation; Stage 4: complete implementation; and Stage 5: sustainability.

Informants' perceptions about the effects of these processes and the factors that influenced their implementation were explored. We elicited participants' perceptions on: a) the availability of human resources for the mental health care reform, b) technical quality of individual, collective, and management

interventions implemented as mental health care reforms, c) respect for the rights of patients, d) satisfaction of intermediate beneficiaries (that is, professionals providing the services), e) the perception of cost-effectiveness for the system, and f) the perception of a community approach in mental health actions connected with the reform.

The factors that influenced implementation were defined as those contextual elements of the political, social, economic, and cultural order that facilitated or limited the process of reform implementation in Carabayllo. Researchers considered: a) technical factors: quality of the technical design of the proposal, previous implementation strategies, technical capacity of implementers; b) political factors: political backing of those responsible, decisions by the authorities, correlations of power; c) economic factors: sufficiency or otherwise of economic resources; d) efficiency or agility of the service system: in particular, the complexity of planning and administrative processes; and e) social factors: community pressure and responses among beneficiaries.

Fifteen interviews were carried out with key informants from the care teams. Informants included: six professionals from two health centers in the first level of care, three staff members of the CSMC, four professionals from the reference hospital, and two caretakers at the halfway house. Reports were also obtained on the implementation experiences of six technical facilitators and/or trainers who participated in the implementation of reforms, as well as on the experiences of directors from the ministerial level who were involved in policy making.

Interviews with key informants were carried out by the research team. The content analysis was carried out using the Atlas Ti Program.

These studies describe the implementation of the mental health care reform within a single district of Metropolitan Lima. Thus, while the results illustrate the process and generate learning, they may not necessarily be extrapolated to other contexts. An additional limitation is that it does not explore the participation and the views of the beneficiaries.

COMPONENT 3: ESTIMATION AND COMPARISON OF THE COSTS OF CARE IN A COMMUNITY MENTAL HEALTH CENTER AND A HALFWAY HOUSE, AS ALTERNATIVES TO THE TRADITIONAL MODEL OF SPECIALIZED HOSPITAL-CENTERED CARE.

This component involved comparing the costs of (1) delivering selected mental health services at the community mental health center and halfway house in Carabayllo versus (2) providing similar services in Lima's specialized mental health hospitals: the Honorio Delgado - Hideyo Noguchi National Institute of Mental Health (INSM), Victor Larco Herrera National Hospital (HNVLH), and Hermilio Valdizán National Hospital (HHV).

The study consisted of estimating the total costs (in terms of opportunity costs) of ambulatory care services and inpatient services for clients in the CSMC and the halfway house and comparing them with the costs of similar services in a specialized hospital. In practical terms, this economic evaluation would be defined as the comparative analysis of costs and economic consequences, between a new program and a traditional comparator. Its main result is expressed as the incremental cost ratio, which is described with the following algorithm:

$\Delta C / \Delta E = C1 - C2$

Where: C2 represents the costs of the most effective program (new program) and C1 represent the costs of the comparator (traditional program).

COMPONENT 4: ANALYSIS OF THE POLITICAL ROLE OF LOCAL CARABAYLLO AUTHORITIES AND OFFICIALS AND THE HEALTH SECTOR IN IMPLEMENTING MENTAL HEALTH CARE CHANGES DURING THE PERIOD 2013–2016.

This is a qualitative descriptive study based on the analysis of interviews with decision makers. It sought to complement the systematizations by exploring the contribution of political actors who played an important role in the implementation of changes or innovations in mental health care during the reference period. This component again has complementary reference to local and national levels. Therefore, the scope of management of the interviewees covers the health services networks in the northern area of Metropolitan Lima and the national health sector.

The informants in the study included ten authorities and senior officials from the health sector and the local government of Carabayllo who were active in the period 2013–2016 and who voluntarily participated in the study. At the local level, the Mayor (the highest local authority), the municipal manager of social affairs of the district, and the then Director of the Health Network of the area of study were interviewed. At the national level, three former Health Ministers, a former Deputy Minister of Health, two former IGSS officials and the then Institutional Head of Comprehensive Health Insurance were interviewed.

The interviews were recorded, transcribed, and processed with the use of Atlas Ti software. The analysis was made at content and discourse levels, understanding the former to analyze what is manifested and the latter to analyze the absences and the conditions of the production of what is said. Although an interview guide was used that noted the issues to be addressed, the guide was quite flexible, and the discursive paths adopted depended on the experience of each official.

The main categories of study are: (1) the political relevance of the reforms for the government and management agenda of authorities and officials; (2) the conditioning factors (both facilitators and constraints) that influenced the constitution of mental health reforms as a politically relevant issue for stakeholders; and (3) relationships of collaboration and influence among levels of government.

COMPONENT 5: ANALYSIS OF THE APPROACH TO MENTAL HEALTH IN METROPOLITAN AND NATIONAL MEDIA, 2013–2016.

This component implemented two methodological strategies, one quantitative, based on secondary sources, and another qualitative, based on interviews.

The first consisted of the analysis of a database of health news registered and disseminated by radio, television, print media, and digital media during the 2013–2016 period. Data were collected by the Ministry of Health. The health news synthesis databases were reviewed and analyzed, and two news samples were constructed with two temporal parameters, corresponding to the first semester 2013 and the first semester of 2016. This selection tried to identify the changes that occurred during the period of analysis of the overall study. In these two samples, contents were analyzed and categorized in order to identify the frequency of mental health news items and their focus. The following inclusion criteria were applied. Researchers included database entries on news stories that: made reference to the medium in which they were published, had publication dates in the proposed range, and directly alluded to the health issue.

The qualitative strategy consisted of interviewing influential journalists working in the media in the city of Lima and communicators who were involved in the topics of mental health reforms during the study period. The inclusion criteria were to have issued or produced at least five mental health communication products during that period. Semi-structured interviews were conducted with 33 people. Interviews were recorded in writing by the interviewer or the interviewee as a report of their experience, the results were coded, and their contents analyzed.

Ethical Considerations

The informant population consisted of adults, over 18 years of age, professionals in health or public management. None at the time of study had a hierarchical link with the researchers. Prospective informants were consulted about their interest and desire to participate. They provided Informed Consent and, in writing, their consent to the use of the information in this study. In no case did persons solicited refuse to participate in the study. On the contrary, many of those interviewed gave their time with great generosity, despite overloaded agendas.

The information that has been collected in this research is mainly related to management experiences or professional performance, generally of a public nature. Personal or sensitive information, not relevant to the study, has been systematically omitted. Confidentiality has been maintained throughout the entire process. The report of experiences has been anonymous both in its electronic version and on paper. For the former, Google surveys were used to encrypt the information. In the transcription of the data, names were omitted, replaced by generic titles of office or profession, except in the case of high-level officials who were previously consulted about the publication of their testimonies.

Another important ethical consideration has been the protection of the honor and prestige of third parties, individuals, and institutions. Participants were reminded to avoid insulting or slanderous expressions. It has not been necessary to omit anything in the transcripts and reports.

Limitations of the Study

We consider that the most important limitations of this study are related to the circumscription of the observations to a single territorial area, the district of Carabayllo. Thus, the project exhibits the limitations inherent in any case study.

The approach in the study components is predominantly qualitative, so the potential extrapolation of findings to other contexts is limited.

The study does not explore participation or the perceptions of patients, families, and the community, which restricts the incorporation of their vision in the evaluation of the processes analyzed in this report.

Appendix B. Budget Program PP 131, "Mental Health Prevention and Control": Its Importance for the Reform and Recommendations to Further Strengthen its Impact

TECHNICAL BACKGROUND ON PP 131

In 2015, Peru's Ministry of Economy and Finance approved the establishment of a new budget program: PP 131 - Mental Health Prevention and Control.

A brief overview of budget management is needed to accurately explain the importance of PP 131. The main sources of financing of the budget in Peru are ordinary resources (resources collected by the Public Treasury or via taxes), directly collected resources (those collected on a subsidized basis), and grants and transfers (funds from the Comprehensive Health Insurance).

As part of its effort to modernize government, Peru is moving toward a performance-based budgeting approach. This involves reorienting the budget toward the achievement of results, particularly in terms of numbers served. The approach is progressive and involves a new distribution by budget category, as has been the case for about 10 years for PP 001, Articulated Nutritional Program, and PP 0002, Perinatal Maternal Health, which were among the first.

Because changes are gradual, two categories currently subsist: "Central Actions" for own expenditures of the institutional administration, which include handling charges, planning department costs, and the costs of administration itself; and a budget category called "Budget Allocations that do not Result in Products (APNOP)" for a whole range of activities that cannot be included in a particular budget program.

However, as the entire budget management approach is aligned with the financial planning and management processes (purchase of goods and services), planning for the fiscal year takes place 10 months before the start of the year, i.e., between March and April of the previous year. The draft budget is then submitted to Congress for discussion in June, with the period through to December allowed for its approval. Approval means that the resources are available at the start of the year in the so-called Initial Institutional Budget (*Presupuesto Institucional de Apertura*—PIA).

Supplementary appropriations are intended for unexpected expenditures in the fiscal year, although sometimes they are used to commit expenditures, such as the hiring of personnel under Administrative Services Contracts (CAS) or Third-Party

Services for health care activities. This makes the supplementary appropriations difficult to suspend in the following fiscal year if care was not taken to incorporate the expenditures in the PIA.

Expenditure has special characteristics in the Budget Program, since it has a structure divided into products, activities, physical targets, and budget targets and in theory should be executed as programmed. Any change should be exceptional, requiring the authorization of a referring entity as an auditable expenditure. That is to say, the Budget Program is executed as programmed.

Until 2014, mental health activities were included in PP 018, Control of Non-Communicable Diseases, and competed with activities such as fighting cancer and other degenerative chronic diseases. Specialized hospitals used this program to develop activities such as mental health screening, an activity that is widespread at the national level. Handling mental health via PP 018 did not make sense.

What does PP 131 mean for the reform?

With the approval of PP 131, the Ministry of Health (MINSA) obtained a supplementary appropriation and was able to create 22 community mental health centers in various regions of the country and Lima. In the Carabayllo CSMC, for example, the budget was used to hire personnel under a CAS or third-party services approach and to purchase furniture and equipment.

One of the first problems faced by PP 131 in 2016 was not having the budget to continue the services created in 2015, including the CSMCs, which meant having to obtain a new supplementary appropriation. This was partially achieved in the second half of the year.

The characteristics of budget management for the first-level services mean that it is almost impossible to identify the expenditures of a CSMC owing to its dependency on an Implementing Unit that covers a large number of facilities. This meant that for 2016 the human resources expenditures of the CSMCs constituted institutional expenses, as part of the decisions made by their managers.

To return to the question of what the PP 131 means for the mental health reform, in general it has been very useful. However, the work has not yet been concluded. A number of recommendations for further refinement can be made:

- The MEF allocates budgetary funds primarily to Budget Programs (*Programas Presupuestales*—PP); as such PP 131 constitutes a management channel for the budgeting of modalities that have been created or will be created in the future.

- The PP 131 should be aligned with the budgeting and planning process, i.e., an Annual Operating Plan should be prepared in the first three months of the previous year.

- A network of coordinators whose profile will cover not only the technical aspects of the services, but also management (budgetary and financial planning and programming) should be established.

- Supervision is vital during the execution of the physical targets and the budget; the budget must be executed as programmed; any variations must be adequately substantiated.

- Without exception, all hospitals must open a PP 131, particularly those that provide specific mental health services, and must gradually program and execute activities within this framework as part of the transition toward performance-based budgeting.

- The structure of PP 131 should be reviewed so that it becomes a management instrument that facilitates the mental health reform.

TABLE 1. PP131 RESOURCES IN 2015-2016

	TOTAL	ORDINARY RESOURCES	DIRECTLY COLLECTED RESOURCES	GRANTS AND TRANSFERS
2015	84,067,881	74,468,803	335,849	9,263,228
2016	109,674,620	98,002,755	178,899	11,492,966

Source: Integrated Financial Administration System (SIAF)

Appendix C. Estimating Unit Costs for Selected Services at the Carabayllo Community Mental Health Center and Halfway House as Alternatives to Traditional Hospital-Based Care: Complete Study

This appendix presents the complete study whose main findings are summarized above in Chapter 2. This complete version of the study notably includes all intermediate calculations and analytic steps used to arrive at the final results.

The aim of the study is to estimate the unit costs of mental health care services at the Carabayllo halfway house and community mental health center, as alternatives to the traditional model of hospital-based treatment. The analysis is based on secondary data obtained from Lima's specialized mental health hospitals, including the Honorio Delgado-Hideyo Noguchi National Mental Health Institute (INSM), the Victor Larco Herrera National Hospital (HVLH) and the Hermilio Valdizan Hospital (HHV), as well as documentation from the community mental health center (CSMC) of the District of Carabayllo and the halfway house of the District of Carabayllo. The unit costs of outpatient treatment and a hospital bed-day were established for the three hospitals using the cost structure method and the institutional expenditure method, also called the top-down costing method, based on all sources of financing. The cost of outpatient treatment at the CSMC and the per capita per day cost in the halfway house were calculated. The data sources included reports from the Integrated Financial Administration System (SIAF), statistical reports from each hospital, proposals and reports from the halfway house, and a self-assessment of its operation.

Background

The reforms undertaken in various countries around the world have aimed to improve the health of their inhabitants through the introduction of health policies and systems that have in general tried to (a) limit cost increases; (b) improve efficiency; and (c) increase equity.

However, it is worth noting that in the various countries that have attempted to apply these reforms, there is some reluctance to define and prioritize health policy objectives using existing health economics and assessment methods.

One of the strategies for implementing Peru's mental health reform after 2012 was to strengthen local health networks by introducing community mental health centers (CSMCs). The CSMCs are frontline health care facilities with a specialized interdisciplinary team of professionals including psychiatrists, psychologists,

and occupational therapists. They provide care to patients with mental health problems referred by primary health care facilities. Additional community mental health care modalities deployed in Peru include halfway houses (HP), which are residences or homes for individuals with chronic mental health problems who do not have family support but do enjoy a certain level of autonomy.

These modalities are presented as alternatives to outpatient treatment and lengthy hospitalizations in specialized hospitals, which in Peru continue to be the focus of the mental health treatment system.

Knowing the costs and benefits of the services provided in a CSMC and an HP, in comparison with similar services in a mental health hospital, will be useful for improving the management of these institutions. Such evidence may also inform government policies and programs in the area of mental health and contribute to improvements in the country's mental health system.

This study does not propose a complete cost-benefit analysis of new versus traditional mental health care modalities. However, it aims to contribute to the future elaboration of such an analysis. The present study focuses specifically on the cost component of the cost-benefit picture. It generates and compares unit cost estimates for key basic mental health services, when these are provided in community-based settings and when they are delivered in specialized mental health hospitals.

VALUE OF OUTPATIENT TREATMENT IN A CSMC AND SPECIALIZED HOSPITAL USING THE COST STRUCTURE METHOD

The cost structure method uses the "methodology for estimating standard costs in health institutions"[98] and the "methodology for estimating standard costs of medical procedures."[99]

For this study, remuneration was updated with reference to the INSM 2016 Analytical Personnel Budget (PAP), taking the remuneration for the basic level occupational group.[100] Outpatient treatment by a specialist doctor in the CSMC outpatient office and in a Level III Hospital is considered. The estimated time of 30 minutes for outpatient treatment is used as the standard provided to a continuing patient. For the purposes of this study, the time required for a new patient is assumed to be 60 minutes. The value of the human resource is calculated using the per minute value for each occupational group. To calculate the cost of basic and additional equipment, the per minute value of the average useful life of each piece of equipment is calculated.

Overhead and administrative expenses are prorated using the human resource cost of the process as a reference. For infrastructure costs, the cost per square meter is calculated on the basis of the category level and average useful life of a concrete and brick building.

The cost of a psychiatric consultation is estimated to be US$13.83 in a CSMC and US$15.13 in a Level III Hospital.

COSTING OF OUTPATIENT TREATMENT USING THE PRORATED INSTITUTIONAL EXPENDITURE METHOD

The institutional expenditure method considers the real expenses of the institution regardless of output in a fiscal year, totaling all direct and indirect costs incurred by the institution in producing the service in question.

The budget specifically linked to the outpatient consulting office or hospitalization, as appropriate, is extracted. This annual expenditure is divided by the number of services provided by the institution during the period under study.

The source of the data is the official software program used by the Peruvian government - the Integrated Financial Administration System (SIAF), the reports of which can be accessed using the user-friendly interface on the Ministry of Economy and Finance website. It should be noted that Peru uses this software program for the preparation, programming, execution and assessment of revenue and expenditures from all sources of financing from generic to specific levels of expenditure, by budget program, product and activity executed by all government entities throughout the country.

Specifically, it is disaggregated into revenue and expenditures by budget target. For purposes of calculating outpatient treatments and hospitalization, the specific target of this activity is considered to be direct expenses. As not only direct expenses are considered in all health activities, the software was used to calculate indirect expenses, such as administrative expenses and overhead. Administrative expenses are covered in the SIAF Central Action Budget Program, and overhead, including equipment and infrastructure maintenance, is covered in the specific targets of the Budget Allocations that do not Result in Products (APNOP). The SIAF does not consider depreciation expenses for infrastructure and equipment, so an additional calculation is made for these costs based on the projected market value of infrastructure with a useful life of 30 years and equipment with a useful life of between 5 and 10 years.

It should be noted that outpatient treatment covers outpatient appointments with doctors and that individual and group procedures are shown as outpatient activities.

Expenses are expressed in soles, which is the official currency of Peru, and for the purposes of this study they are converted into US dollars at a rate of S/3.3 per US dollar.

The process followed for estimating institutional expenditures is as follows.

Costing of Outpatient Treatment in Specialized Hospitals

STEP 1. CALCULATION OF TOTAL COSTS AND COSTS BY TYPE OF EXPENDITURE IN SPECIALIZED HOSPITALS

The total expenses of the institution in a fiscal year, broken down by type of expenditure, were calculated as the baseline.

For 2016, the MEF user-friendly SIAF interface shows that the three hospitals specializing in mental health in Lima spent US$42,487,395 from all sources of financing, with the HVLH having the highest expenditure at US$17,762,100.

On average, 55 percent is expenditure on the permanent staff payroll, not including staff hired under CASs. Only 0.5 percent of the total budget is spent on nonfinancial assets.

On a disaggregated basis, the INSM and HVLH spent 58 percent of their total budget in 2016 on the staff payroll and the HHV spent 48 percent. The HHV spent 48 percent of the budget on goods and services, compared to 37 percent for the INSM and 29 percent for the HVLH.

TABLE 1. TOTAL EXPENDITURES AND EXPENDITURES BY CATEGORY FROM ALL SOURCES OF FINANCING, MENTAL HEALTH HOSPITALS, LIMA, 2016

CATEGORY	SPECIALIZED HOSPITALS				
	INSM	HVLH	HHV	TOTAL	PERCENT
Wages and pay-roll taxes	22,216,877	34,335,751	20,800,673	77,353,301	55.17%
Pensions and other social benefits	1,094,479	4,688,301	2,790,218	8,572,998	6.11%
Goods and services	14,021,321	16,965,535	19,473,711	50,460,567	35.99%
Other expenses	416,453	2,265,001	421,522	3,102,976	2.21%
Purchase of non-financial assets	249,252	360,342	108,966	718,560	0.51%
Total in new soles	**37,998,382**	**58,614,930**	**43,595,090**	**140,208,402**	**100.00%**
Total in US$ (S/3.3 x US$)	**11,514,661**	**17,762,100**	**13,201,633**	**42,487,395**	

Source: SIAF – MEF

STEP 2. CALCULATION OF DIRECT EXPENSES RELATED TO OUTPATIENT TREATMENT

To calculate the direct expenses related to outpatient treatment in the three specialized hospitals using the institutional expenditure methodology, all expenditures of all budget programs that specifically contain this item are totaled. Outpatient treatment is identified in the APNOP and Budget Program 131 Mental Health Prevention and Control.

The direct expenses for the three hospitals totaled US$4,856,898 in 2016.

TABLE 2. DIRECT OUTPATIENT TREATMENT EXPENSES IN SPECIALIZED MENTAL HEALTH HOSPITALS, LIMA, 2016

DESCRIPTION	SPECIALIZED HOSPITALS, US$			
	INSM	HVLH	HHV	TOTAL
Outpatient Treatment Expenses	2,362,295	1,474,401	1,020,202	4,856,898

STEP 3. ESTIMATION OF INDIRECT EXPENSES: ADMINISTRATIVE EXPENSES AND OVERHEAD

To determine indirect expenses, administrative expenses and overhead are calculated.

For administrative expenses, all expenses of the Central Actions Budget Program for each specialized hospital are consolidated, as this program covers all expenses relating to administrative personnel and expenditures by said personnel.

Overhead is consolidated in the budget targets relating to expenses not attributable to health care, such as maintenance of infrastructure, maintenance of equipment, purchase of clothing, and basic services.

In 2016, the three hospitals spent US$18,357,078 on administrative expenses and overhead.

TABLE 3. ADMINISTRATIVE EXPENSES AND GENERAL SERVICES IN SPECIALIZED MENTAL HEALTH HOSPITALS, LIMA, 2016

DESCRIPTION	SPECIALIZED HOSPITALS, US$			
	INSM	HVLH	HHV	TOTAL
Administrative expenses	2,093,819	3,395,612	2,631,207	8,120,638
General services	2,194,006	4,883,439	3,158,995	10,236,440
Admin. Exp. + Overhead	**4,287,825**	**8,279,051**	**5,790,202**	**18,357,078**

Source: SIAF

STEP 4. ESTIMATION OF THE WEIGHTING FACTOR FOR THE PRORATING OF INDIRECT EXPENSES

The next step is to calculate the weighting factor for administrative expenses and overhead attributable to outpatient treatment. For this purpose, the cost of outpatient treatment, hospitalization and other activities covered by the headings training, research, epidemiology, including management of the provision of services, is calculated.

The percentage of the budget allocated to each of these functions will be taken as the factor for prorating indirect expenses: administrative expenses and overhead.

TABLE 4. DIRECT OUTPATIENT TREATMENT AND HOSPITALIZATION EXPENSES AND OTHER NON-ADMINISTRATIVE EXPENSES OF THE SPECIALIZED MENTAL HEALTH HOSPITALS, LIMA, 2016

DESCRIPTION	SPECIALIZED HOSPITALS, US$							
	INSM		HVLH		HHV		TOTAL	
	EXPENSE	%	EXPENSE	%	EXPENSE	%	EXPENSE	%
Outpatient Treatment	2,362,295	38.52%	1,474,401	16.94%	1,020,202	16.92%	4,856,898	23.28%
Hospitalization	1,457,660	23.77%	5,432,809	62.43%	2,149,031	35.65%	9,039,500	43.33%
Public health	2,313,361	37.72%	1,794,593	20.62%	2,858,818	47.43%	6,996,772	33.39%
Total	6,133,316	100%	8,701,803	100%	6,028,050	100%	20,863,169	100%

Source: SIAF

STEP 5. TOTALING OF OVERALL DIRECT AND PRORATED INDIRECT EXPENSES OF OUTPATIENT TREATMENT

The proportional expenditure on administrative expenses and overhead for each hospital on outpatient treatment, as appropriate, is totaled.

Another item to be considered is the depreciation of infrastructure and equipment. The three hospitals have their own land, but it should be noted that in the case of the HVLH it is a grant conditional on exclusive use for this purpose and, according to the market study, it is located in one of the districts with the highest value per m2 for constructed and unconstructed land.

The value of the unconstructed land attributable to outpatient treatment services, i.e., the parking lot, gardens and other outdoor spaces that have a market value, is calculated.

The annual cost, based on the market price, of the depreciation of infrastructure for a useful life of 30 years that is attributable to outpatient treatment is US$346,018 for the INSM, US$1,219,412 for the HVLH and US$99,767 for the HHV.

The annual depreciation expense for equipment for medical offices is US$618.07.

The total cost (direct and indirect) of outpatient treatment services at the three specialized hospitals is US$10,604,512, with INSM having a cost of US$4,383,289, the HVLH, US$4,110,800, and the HHV, US$2,110,424.

The cost of an outpatient appointment is highest for the HVLH (US$97.54) and lowest for the HHV (US$26.45).

TABLE 5. TOTAL EXPENDITURE ON OUTPATIENT TREATMENT BY SPECIALIZED MENTAL HEALTH HOSPITALS, USING THE INSTITUTIONAL EXPENDITURE METHOD, LIMA, 2016

EXPENSES ATTRIBUTABLE TO OUTPATIENT TREATMENT	SPECIALIZED HOSPITALS, US$			
	INSM	HVLH	HHV	TOTAL
Direct treatment expenses	2,362,295	1,474,401	1,020,202	4,856,898
Admin. Expense + overhead	1,651,489	1,402,771	979,948	4,034,209
Annual depreciation cost for infrastructure	346,018	1,219,412	99,767	1,665,197
Annual depreciation cost for equipment				
• Depreciation cost for Consulting	618.07	618.07	618.07	
• Consulting total	38	23	17	78
• Equipment depreciation total	23,487	14,216	10,507	48,209
Total cost of outpatient treatment	**4,383,289**	**4,110,800**	**2,110,424**	**10,604,512**

STEP 7. ESTIMATE OF THE UNIT COST OF OUTPATIENT TREATMENT

To calculate the unit cost, the total expenditure on outpatient treatment is divided by the number of outpatient consultations.

TABLE 6. UNIT COST OF OUTPATIENT TREATMENT AT SPECIALIZED MENTAL HEALTH HOSPITALS USING THE INSTITUTIONAL EXPENDITURE METHOD, LIMA, 2016

EXPENSES ATTRIBUTABLE TO OUTPATIENT TREATMENT	SPECIALIZED HOSPITALS, US$			
	INSM	HVLH	HHV	TOTAL
Total cost of outpatient treatment	4,383,289	4,110,800	2,110,424	10,604,512
Annual consultations	57,922	42,146	79,796	179,864
Unit cost of outpatient treatment	75.68	97.54	26.45	58.96

COSTING OF OUTPATIENT TREATMENT IN THE CSMCS

According to reports from the managers of the Carabayllo CSMC, there were 30,335 outpatient consultations in 2016, with the highest demand being for children, followed by adolescents and young people. By gender, there were 16,296 consultations by male patients compared to 14,039 by female patients.

It is not possible to determine the costs attributable to specialized outpatient treatment using the SIAF application for the Carabayllo CSMC. Expenditures by the CSMC fall under the Túpac Amaru Network administrative unit as the Implementing Unit that administers the resources and budgets of the Independencia, Santa Luzmila, Collique and Carabayllo Micronetworks, with the latter being the entity to which the Carabayllo CSMC reports. The expenditures of the Carabayllo CSMC are administered by the Implementing Unit, which consolidates the human resource expenses, variable expenses and other assets. These are not necessarily broken down, instead showing the products, activities and resources for the entire network of health institutions.

Considering that outpatient consultations are in fact the main service provided by the CSMC, the total number of persons under CASs was used to calculate the cost for the purposes of this study.

The value of equipment depreciation is calculated as shown. Each medical office has an annual equipment depreciation cost of US$618. As there are three offices, this provides an annual total expense of US$ 1,854.

The CSMC spends approximately US$19,333 for overhead and office supplies,[101] as established by the INSM's Executive Directorate of Research, Training and Specialized Care for Collective Health (DEIDAE Salud Colectiva). The expenses include cleaning services and security. An annual rent of US$18,182 is used. Human resources account for 76 percent of expenses. The unit cost of outpatient consultations for the CSMC using the institutional expenditure method is US$11.58.

TABLE 7. UNIT COST OF OUTPATIENT CONSULTATIONS BY A CSMC USING THE INSTITUTIONAL EXPENDITURE METHOD, LIMA, 2016

BREAKDOWN	US$	PERCENTAGE
Annual personnel expense	266,000	76%
Equipment depreciation expense	1,854	1%
Rental of premises (S./5,000 x month)	18,182	5%
Overhead and supplies	19,333	6%
Subtotal	305,369	
Administrative expenses (10 percent)	30,537	9%
Contingencies (5 percent)	15,268	4%
Annual total	351,175	100%
Annual psychiatric outpatient consultations	30,335	
Unit cost per outpatient consultation	11.58	

Person-Day Cost of Hospitalization Using the Prorated Institutional Expenditure Method

PERSON-DAY COST OF HOSPITALIZATION IN A SPECIALIZED HOSPITAL

To calculate the cost of hospitalization, we will use the same methodology as for the calculation of the cost of outpatient treatment. **Steps 1 to 3** will be carried out together with the same tables being used. The direct costs and the prorating factor for indirect costs of hospitalization are established in **Step 4**.

TABLE 8. DIRECT EXPENSES OF HOSPITALIZATION IN SPECIALIZED MENTAL HEALTH HOSPITALS, LIMA, 2016

DESCRIPTION	SPECIALIZED HOSPITALS							
	INSM		HVLH		HHV		TOTAL	
	EXPENSE	FACTOR	EXPENSE	FACTOR	EXPENSE	FACTOR	EXPENSE	FACTOR
Hospitalization	1,457,660	23.77%	5,432,809	62.43%	2,149,031	35.65%	9,039,500	43.33%

STEP 5. CALCULATION OF TOTAL INSTITUTIONAL EXPENDITURE ON HOSPITALIZATION

The cost attributable to the hospitalization service is subtracted from indirect expenditures on administration and general services for each specialized hospital. For this purpose, the appropriate prorating factor is used. The cost of the depreciation of infrastructure and equipment, as appropriate, is included for each hospital. The indirect expenses (administrative, overhead, infrastructure and equipment depreciation) are added to the direct expenses for the hospitalization service.

The three specialized mental health hospitals in Lima spend US$21,443,776 annually on hospitalization services.

TABLE 9. TOTAL EXPENSES ATTRIBUTABLE TO HOSPITALIZATION IN SPECIALIZED MENTAL HEALTH HOSPITALS, IN US$, USING THE EXPENDITURE METHOD, LIMA, 2016

DESCRIPTION	SPECIALIZED HOSPITALS, US$			
	INSM	HVLH	HHV	TOTAL
Total Admin. Expense + Overhead	4,287,825	8,279,051	5,790,202	18,357,078
% of Admin. exp. + overhead – Hospitalization	23.77%	62.43%	35.65%	
Adm. exp. + overhead – Hospitalization	1,019,056	5,168,872	2,064,236	8,252,164
Infrastructure and equipment expenses – Hospitalization	290,857	3,466,209	395,036	4,152,102
Direct expense – Hospitalization services	1,457,660	5,432,809	2,149,031	9,039,500
Total annual expense – Hospitalization	**2,767,573**	**14,067,890**	**4,608,303**	**21,443,766**

STEP 6. CALCULATION OF THE BED-DAY COST

This cost is calculated by dividing the total hospitalization expenses by the actual hospital bed-days in the year.

The average bed-day cost in the three specialized mental health hospitals in Lima is US$90.86, with the HNVLH having the highest cost at US$101.21 and the HHV the lowest at US$69.18.

The bed-day cost in specialized hospitals in US$ using the expenditure method:

TABLE 10. BED-DAY COST IN SPECIALIZED MENTAL HEALTH HOSPITALS, IN US$, USING THE EXPENDITURE METHOD, LIMA, 2016

DESCRIPTION	SPECIALIZED HOSPITALS, US$			
	INSM	HVLH	HHV	TOTAL
Total cost of hospitalization	2,767,573	14,067,890	4,608,303	21,443,766
Total hospitalization bed-days	30,406	138,997	66,609	236,012
Bed-day cost	**91.02**	**101.21**	**69.18**	**90.86**

PER-DAY COST OF CARE IN A HALFWAY HOUSE

To calculate the per-day cost of care in a halfway house, two alternatives were considered.

The halfway house of the District of Carabayllo, the first in Metropolitan Lima, resulted from a tripartite public-private cooperation agreement between the INSM, the District Municipality of Carabayllo and ENIEX Socios en Salud (SES). It was established during the first half of 2015, and operations began in July of that year, with six persons housed in a rented house with a capacity for eight, in addition to the caregivers. After one year of operation financed exclusively by ENIEX Socios en Salud, the MDC and INSM began participating in the financing. The former covered the cost of paying three caregivers and the rent for the building previously covered by SES, and the INSM covered the cost of three other caregivers and other expenses such as food, maintenance, etc. The cost of administration is covered by the SES, with which INSM signed a contract under which the SES assumes the management costs.

The annual cost of this arrangement is US$55,250, with INSM covering US$30,843 and the MDC covering US$24,407.

A summary of the cost of this arrangement is provided in the following table.

TABLE 11. OPERATING COST IN US$ OF THE CARABAYLLO HALFWAY HOUSE FOR WOMEN, WITH PUBLIC-PRIVATE COOPERATIVE FINANCING, LIMA, 2016

DESCRIPTION	MONTHLY EXPENSE UNDER THE PUBLIC-PRIVATE AGREEMENT, US$					
	MONTHLY EXPENSE			ANNUAL EXPENSE		
	MDC	INSM	MONTHLY SUBTOTAL	MDC	INSM	ANNUAL TOTAL
Human resources: 6 persons*						
• Wages + benefits for caregivers	966	966	1,932	11,593	11,593	23,185
• House maintenance expense	758	955	1,712	9,091	11,455	20,545
• Activities expense	0	258	258	0	3,091	3,091
• Management expense	0	0	0	0	0	0
Subtotal	1,724	2,178	3,902	20,684	26,138	46,822
Adm. costs 10%			0			0
Total	1,724	2,178	3,902	20,684	26,138	46,822
IGV (general sales tax) 18%	310	392	702	3,723	4,705	8,428
Total US$	**2,034**	**2,570**	**4,604**	**24,407**	**30,843**	**55,250**

In the other alternative, the rental of a fully equipped and furnished building for eight residents and one caregiver is considered.

The market-based cost of the furnished house option is US$6,834 monthly, for an annual cost of US$82,010.

TABLE 12. COST IN US$ OF A HALFWAY HOUSE AT MARKET PRICE INVOLVING A FURNISHED AND UNFURNISHED HOUSE IN LIMA, 2016

DESCRIPTION	MARKET COST – FURNISHED HOME US$	
	MONTHLY COST	ANNUAL EXPENSE
Human resources: 6 persons*		
• Wages + benefits for caregivers	2,318	27,818
• House maintenance expense	2,470	29,636
• Activities expense	258	3,091
• Management expense	220	2,636
Subtotal	5,265	63,182
Adm. costs 10%	527	6,318
Total	5,792	69,500
IGV 18%	1,043	12,510
Total US$	6,834	82,010

CALCULATION OF PER CAPITA MONTHLY COST OF AN HP

The per capita daily cost under the agreement is US$19.18. For the furnished house, it is US$28.48.

TABLE 13. PER CAPITA DAILY COST IN A HALFWAY HOUSE BY TYPE OF CONTRACT, LIMA, 2016

DESCRIPTION	MARKET COST – FURNISHED HOME US$
Total monthly expense	6,834
Per capita monthly cost	854
Daily per capita cost, US$	28.48

COMPARATIVE ANALYSIS OF COSTS OF NEW AND TRADITIONAL TREATMENT MODALITIES

TABLE 14. UNIT COST RATIO USING THE INSTITUTIONAL EXPENDITURE METHOD FOR OUTPATIENT CONSULTATIONS IN SPECIALIZED HOSPITALS AND CSMCS, LIMA, 2016

OUTPATIENT TREATMENT	SPECIALIZED HOSPITALS/CSMC, US$			
	INSM	HVLH	HHV	TOTAL
Unit cost – Institutional expenditure method – Hospital	75.68	97.54	26.45	58.96
Unit cost – Expenditure method – CSMC	11.58	11.58	11.58	11.58
Outpatient treatment cost ratio – Expenditure method – Hospital/ CSMC	6.54	8.43	2.28	5.09

TABLE 15. UNIT COST RATIO (INSTITUTIONAL EXPENDITURE METHOD) PER INPATIENT DAY IN A SPECIALIZED HOSPITAL AND PER CAPITA DAILY COST IN A HALFWAY HOUSE, LIMA, 2016

HOSPITALIZATION	SPECIALIZED HOSPITALS/HP, US$			
	INSM	HVLH	HHV	TOTAL
Unit cost of hospitalization – Institutional exp. method – Hospitalization	91.02	101.21	69.18	90.86
Daily per capita cost – Halfway house (HP)	24.38	24.38	24.38	24.38
Hospitalization cost ratio (Exp. Method) – Hospital/HP	3.73	4.15	2.84	3.73

HYPOTHETICAL ESTIMATES OF THE COSTS OF NEW MODALITIES BASED ON THE INSTITUTIONAL EXPENDITURES OF SPECIALIZED HOSPITALS

A merely hypothetical estimate shows that if 90 percent of all outpatient treatments in the three specialized hospitals in Lima were eliminated, the system would save US$7,669,519, which would cover the cost of operating 21 community mental health centers. As well, if 50 percent of all hospitalizations (lengthy stay estimate) took place in halfway houses, the system would save US$7,845,079 and could cover the operating costs of 92 halfway houses.

TABLE 16. SAVINGS OF INSTITUTIONAL OUTPATIENT TREATMENT EXPENDITURES RESULTING FROM A CHANGE OF TREATMENT MODALITY, LIMA, 2016

OUTPATIENT TREATMENT EXPENSE - HOSPITAL/CSMC	SPECIALIZED HOSPITALS, US$			
	INSM	HVLH	HHV	TOTAL
Outpatient treatment expense – Hospital	75.68	97.54	26.45	58.96
Outpatient treatment expense – CSMC	11.58	11.58	11.58	11.58
Total hospital outpatient treatments	57,922	42,146	79,796	179,864
90 % of outpatient treatments in CSMC	52,130	37,931	71,816	161,878
Adjusted institutional expenditure for outpatient treatments in hospital	3,944,960	3,699,720	1,899,381	9,544,061
Outpatient treatment expense – CSMC cost	603,663	439,246	831,634	1,874,543
Institutional savings resulting from change of modality	3,341,297	3,260,474	1,067,748	7,669,519
Annual CSMC cost	351,175	351,175	351,175	351,175
Number of CSMCs that could be financed	10	09	03	21

TABLE 17. SAVINGS ON INSTITUTIONAL HOSPITALIZATION EXPENDITURES RESULTING FROM CHANGE OF TREATMENT MODALITY, LIMA, 2016

HOSPITALIZATION EXPENSE	SPECIALIZED HOSPITALS/HP, US$			
	INSM	HVLH	HHV	TOTAL
Bed-day cost institutional expenditure – Hospital	91.02	101.21	69.18	90.86
Bed-day cost – Halfway house	24.38	24.38	24.38	24.38
Total bed-days hospitalization	30,406	138,997	66,609	236,012
Total bed-days hospitalization at 50% for HP	15,203	69,499	33,304	118,006
Total cost hospitalization x institutional expenditure	1,383,786	7,033,945	2,304,152	10,721,883
Total cost hospitalization x HP expense	370,626	1,694,267	811,911	2,876,804
Institutional savings resulting from change of modality	1,013,160	5,339,678	1,492,241	7,845,079
Annual cost Halfway House	82,010	82,010	82,010	82,010
Total Halfway Houses	12	65	18	96

SUMMARY

The unit cost of outpatient consultations using the expenditure methodology, for all sources of financing, is US$58.96, with the HVLH being the most expensive at US$97.54, the INSM costing US$75.68, and the HHV being the least expensive at US$26.45. This is explained by the fact that the HHV carries out 79,796 specialized consultations annually, compared to just 42,146 for the HVLH. With greater resources, a greater output could be expected, but the evidence shows the opposite, with greater resources providing less availability of outpatient treatment services.

To calculate the cost of outpatient treatment at the Carabayllo CSMC, the cost of human resources was used, i.e., 31 workers including professionals and technical officers with average remuneration, for a total cost in 2016 of US$266,000, as well as 3 psychiatrists and 1 family physician, producing 30,335 specialized outpatient treatments in the year.

The 30,335 outpatient treatments by the Carabayllo CSMC cost approximately US$351,175 annually, for a unit cost of US$11.58 per consultation. The specialized hospitals provide 179,864 annual outpatient consultations for a total cost of

US$10,604,512 and a unit cost per outpatient treatment of US$58.96. This means that the unit cost of outpatient consultations in specialized mental health hospitals in Lima is 5.09 times higher than the cost of the same services provided in the CSMC.

The three specialized mental health hospitals in Lima had 848 beds in 2016, with an occupation rate of 76 percent, for 236,527 occupied bed-days.

The distribution of the beds among the three specialized hospitals was as follows: 62 percent in the HVLH (526 beds), followed by the HHV with 27 percent (231 beds) and finally the INSM with just 11 percent (91 beds).

The HVLH distributes its beds by services, with the recovery and family and social reintegration service having 375 beds, i.e., 71.35 percent of the total beds that could potentially be located in halfway houses.

The bed-day cost of hospitalization using the average expenditure method for the three specialized mental health hospitals in Lima in 2016 is US$90.86, with the HVLH having the highest bed-day cost of US$101.21, followed by the INSM at US$91.02 and finally the HHV with a cost of US$69.18.

The District of Carabayllo Halfway House was established under a Public-Private Agreement between the District Municipality of Carabayllo (MDC) and the National Mental Health Institute, and subsequently came under a Tripartite Agreement that brought in ENIEX Socios En Salud Sucursal Perú (SES). Initially, during the first year, SES established and administered the home with its own resources. Since the second year, the MDC and INSM have been assuming the variable costs and SES the administrative expenses.

This study proposes two costing methods, the first involving a public-private agreement (INSM - MDC - SES), which does not consider administrative expenses, which are contributed by the private partner. Under this arrangement, the annual cost is US$55,250. The cost of the market arrangement involving the rental of a furnished house is US$82,010 annually.

The daily per capita cost, which is analogous to a bed-day cost, is US$19.18 under the public-private agreement and US$28.48 in the furnished house rental arrangement.

If we consider the cost of the market arrangement involving an unfurnished house, the per capita daily cost is US$28.48, which is 3.1 times lower than the average bed-day cost in a specialized hospital (US$ 90.86).

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Appendix D. Participation of the Communications Media in Peru's Mental Health Care Reform, 2013–2016

This study aims to characterize the role of Lima's communications media in the mental health care reform process. Health news databases for the period 2013–2016 were reviewed and analyzed to identify: (1) the frequency with which mental health topics were covered; (2) how these topics were treated; and (3) how the measured variables changed over the study period. Additionally, influential journalists and communicators were asked to report on their experiences and to describe their motivations and perspectives in covering mental health. Linking quantitative and qualitative findings, this study seeks to contribute to deeper understanding of the media's potential role in influencing attitudes, practices, and policies around mental health.

Background: the Peruvian media landscape and mental health

The communications media are channels of communication to inform and engage the public on a mass scale. They have a significant capacity to influence the culture, conduct, and decisions of individuals, groups, organizations, social leaders, and even the highest government authorities. Public health and mental health are not exempt from this influence. The media affect the way in which we conceptualize health, our attitudes toward diseases and sick people, beliefs about causes and treatments, etc. The fact that the communications media tackle mental health topics and how they do so is important in the promotion of healthy behaviors and in the responses deployed by organizations, government, and society as a whole.

The communications media are part of a complex system of social stakeholders. Their mission is to communicate, but they are also profit-making businesses. Information is a product that is consumed by an audience. Media customers include sponsors that are also seeking to sell their products, whether they be material or symbolic, for individual or collective consumption.

In Metropolitan Lima, mental health news is typically disseminated with a focus on law enforcement and in a sensationalist manner, focusing on the individuals directly involved. Stories frequently address, for example, cases of femicide, suicide, or parricide, along with child custody battles, children addicted to video games, parents who abandon their children, and homelessness, to name a few. At other moments, however, the media present mental health news with a more explanatory and preventive focus, though such approaches tend to be less common. Media coverage frequently reinforces the stigma associated with mental health, viewing mental illness as madness, and presenting an image of the mental health patient as violent or weak.

The experience of the National Mental Health Institute (INSM) in its communications work with the media from 2013–2016 shows that an opportunity was perceived to provide preventive informational support in the coverage of mental health-related news. To this end, the INSM strategically used publicity tools and strengthened its relationships with the media to promote a shift toward news with a more preventive focus, taking advantage of media demand for more information on mental health during this period. INSM communicators observed that the media and opinion leaders (including journalists) also began to influence government policies on mental health, generating opinion trends that increased interest in news items or series on mental health in the most influential media, including Radio Comas and Lima Norte. Such trends also spurred interest in initiatives to create programs specifically about mental health, like the online radio program "SanaMente," transmitted on Andina Radio Online, the digital platform of the Agencia Andina Perú.

Understanding the interest of the communications media in mental health issues, how they cover such issues, and how they succeeded in nurturing a more positive public interest in the topic may help decision makers and advocates of the mental health reform establish alliances and/or act strategically with influential stakeholders, as mental health reform efforts continue.

Study Methods

The study analyzed health news disseminated via Lima's communications media (radio, television, print, and digital media) during the period 2013–2016, as reported in Health News Summary. News with mental health content was identified, classified using descriptive variables or criteria, and tabulated on the basis of these criteria to establish percentages of the types of news coverage on offer (Box 1). A temporal distribution was also prepared showing the intent perceived in the news, the main entity or sector involved, and the perceived journalistic attitude vis-à-vis persons with mental health problems.

In addition, journalists' experiences were categorized and perceptions analyzed. Influential journalists working in the communications media in Lima and communicators involved in mental health reform topics during the study period were selected as the analysis unit. The inclusion criteria were having issued or produced at least five communications products on mental health during the period.

Box 1
Operational definitions of variables

A: ANALYSIS OF MENTAL HEALTH NEWS

- Variable 1. Media coverage relating to mental health: percentage in comparison with reports on health in general in television, radio, print, and digital media.
- Variable 2. Main mental health topic covered in the news: suicide, violence (violent death – femicide, parricide, urban social violence, gender violence, physical/sexual violence against children, bullying in school); addictions, emotional problems and depression (emotional problems, depression, sleep disorders); severe mental health disorders and symptoms (psychosis and strange behaviors; mental disability, schizophrenia, mental health and development, antisocial behaviors), public policies on mental health (mental health care services, mental health policies, mental health issues in Peru); other.
- Variable 3. Main sector or entity involved in the news.
- Variable 4. Main intentional focus perceived in the news: alert/warn, alarm, explain/understand, prevent/educate, strategic policy, other.
- Variable 5. Main attitude perceived vis-à-vis the individual with the mental health problem.

B: CATEGORIZATION OF JOURNALISTS' EXPERIENCE

- Variable 1. Personal and professional motivation for covering the mental health topic.
- Variable 2. Valuation of mental health as a news product.
- Variable 3. Perception of interest in positive coverage of mental health on the part of the public.
- Variable 4. Perception of the influence of mental health news on policymakers.
- Variable 5. Perception of the influence of news on the implementation of mental health reforms.

Trends in the News Coverage of Mental Health

The analysis looked at health news compiled in Daily News Summary in the first half of 2013 and the first half of 2016, respectively. Results showed that, in 2013, 3 percent of all health news items related to mental health topics, while in 2016 this figure had risen to 6 percent. By type of media, news items on mental health in the *print media* totaled 3 percent of all health news coverage in 2013, increasing to 4 percent in 2016. For *television*, the figures were 2 percent in 2013, rising to 6 percent in 2016. *Digital media* mental health news as a proportion of all health coverage increased from 3 percent in 2013 to 13 percent in 2016 (Table 1).

TABLE 1. MEDIA COVERAGE OF MENTAL HEALTH, COMPARED WITH COVERAGE OF HEALTH IN GENERAL, 1ST HALF 2013 – 1ST HALF 2016

MEDIA	1ST HALF 2013			1ST HALF 2016		
	Nº. NEWS ITEMS/ REPORTS GENERAL HEALTH	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%	Nº. NEWS ITEMS / REPORTS GENERAL HEALTH	Nº. NEWS ITEMS / REPORTS MENTAL HEALTH	%
1. Television	2,107	37	2%	1,469	87	6%
2. Radio	971	32	3%	942	61	6%
3. Print	8,816	249	3%	5,996	224	4%
4. Digital	1,609	38	2%	1,796	240	13%
Total	**13,503**	**356**	**3%**	**10,203**	**612**	**6%**

Table 2 shows that out of 100 percent of mental health news items/reports in 2013, 66.7 percent were found in the *print media*, followed by *television* at 15 percent, *digital media* at 10.1 percent and, finally, *radio* at 8.2 percent. In 2016, print coverage accounted for 49.3 percent of total media mental health coverage, followed by television at 20.3 percent, digital media at 16.7 percent, and radio at 13.7 percent.

Comparing the two periods, we see that print media continue to provide the largest share of mental health coverage, despite a drop of 17.4 percentage points between 2013 and 2016 in the portion of total mental health coverage that appeared in print. For radio, television, and digital media, in contrast, their respective shares of total mental health coverage rose by more than 5 percentage points each during the period 2013–2016. Studies show that these non-print media reach a larger audience than do print outlets.

TABLE 2. WHO COVERS MENTAL HEALTH? PERCENTAGE OF TOTAL MENTAL HEALTH MEDIA COVERAGE APPEARING IN DIFFERENT MEDIA PLATFORMS, 1ST HALF 2013 – 1ST HALF 2016

MEDIA	2013		2016		TOTAL	
	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%
1. Television	46	15.0%	74	20.3%	120	17.9%
2. Radio	25	8.2%	50	13.7%	75	11.2%
3. Print	204	66.7%	180	49.3%	384	57.2%
4. Digital	31	10.1%	61	16.7%	92	13.7%
Total	306	100.0%	365	100.0%	671	100.0%

Main Mental Health Topics Covered in the News

For this variable, the news disseminated by the radio, television, print, and digital communications media reported in Daily Health News Summary during the first half of 2013 and 2016, respectively, were analyzed. The findings (Table 3) show that *violence* was the most-covered topic, accounting for 22.9 percent of total media mental health coverage in 2013 and 21.4 percent in 2016. In this category, *gender violence* was the subtopic most covered in 2013 at 7.8 percent, followed by *physical/sexual violence against children* at 5.2 percent, *school bullying* at 4.9 percent, *violent death (femicide, parricide)* at 2.9 percent, and *urban social violence* at 2.0 percent. Comparatively, in 2016, the predominant subtopics in this category were *violent death* at 6.3 percent, followed by *gender violence* at 4.7 percent, *urban social violence* at 4.1 percent, *physical/sexual violence against children* at 3.8 percent and, finally, *school bullying* at 2.5 percent.

The study also shows that another topic widely covered was that of *mental disorders and symptoms* at 19.9 percent in 2013, dropping to 8.8 percent in 2016. In this category in 2013, *mental disability* was the most-covered subtopic at 10.5 percent, followed by *schizophrenia* at 8.5 percent, while in 2016 *mental disability* was covered at a rate of 4.7 percent, followed by *strange behaviors* at 3 percent. *Schizophrenia* declined to 0.8 percent.

The topic of *addictions* accounted for a substantial portion of media mental health reporting, representing 12.4 percent of stories in 2013 and rising to 22.2 percent in 2016. In this category, news treatment of smoking as an addiction was most prominent.

In 2013, the topic of *emotional problems and depression* received 16.0 percent of media mental health coverage, with *emotional problems* at 7.2 percent, *depression* at 6.2 percent and *sleep disorders* at 2.6 percent. 2016 saw a slight drop for this overall category (to 14.0 percent), with the predominant topics in the category again being *emotional problems* at 8.5 percent, followed by *depression* at 3.8 percent and *sleep disorders* at 1.2 percent.

Another common subject was *public mental health policies*, with 8.8 percent coverage in 2013 and 12.6 percent in 2016. Under this heading, coverage of *mental health care services* stood at 6.2 percent in 2013, but declined to 1.4 percent in 2016. In contrast, the subtopic of *mental health in Peru* rose from 1.3 percent of all mental health stories in 2013 to 8.8 percent three years later.

The topic of *suicide* represented 5 percent of the news coverage of mental health in 2013, rising to 7.4 percent in 2016.

TABLE 3. MAIN MENTAL HEALTH TOPICS COVERED IN THE NEWS, 1ST HALF 2013 – 1ST HALF 2016

CATEGORY	SUBCATEGORY	2013		2016		TOTAL	
		Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%
Suicide	1 Suicide	14	5%	27	7.4%	41	6.1%
Violence	2 Violent Death (femicide, parricide)	9	2.9%	23	6.3%	32	4.8%
	3 Urban social violence	6	2.0%	15	4.1%	21	3.1%
	4 Gender violence	24	7.8%	17	4.7%	41	6.1%
	5 Physical/sexual violence against children	16	5.2%	14	3.8%	30	4.5%
	6 School bullying	15	4.9%	9	2.5%	24	3.6%
	Subtotal	**70**	**22.9%**	**78**	**21.4%**	**148**	**22.1%**
Addictions	7 Addictions	38	12.4%	81	22.2%	119	17.7%
Emotional problems and depression	8 Emotional problems	22	7.2%	31	8.5%	53	7.9%
	12 Depression	19	6.2%	14	3.8%	33	4.9%
	15 Sleep Disorders	8	2.6%	6	1.6%	14	2.1%
	Subtotal	**49**	**16.0%**	**51**	**14.0%**	**100**	**14.9%**
Severe mental symptoms and disorders	9 Psychosis and strange behaviors	2	0.7%	11	3.0%	13	1.9%
	10 Mental disability	32	10.5%	17	4.7%	49	7.3%
	11 Schizophrenia	26	8.5%	3	0.8%	29	4.3%
	14 Antisocial behaviors	1	0.3%	1	0.3%	2	0.3%
	Subtotal	**61**	**19.9%**	**32**	**8.8%**	**93**	**13.9%**
Public mental health policies	13 Mental health and development	2	0.7%	1	0.3%	3	0.4%
	16 Mental health care services	19	6.2%	5	1.4%	24	3.6%
	17 Mental health policies	2	0.7%	8	2.2%	10	1.5%
	18 Issue of mental health in Peru	4	1.3%	32	8.8%	36	5.4%
	Subtotal	**27**	**8.8%**	**46**	**12.6%**	**73**	**10.9%**
	21 Other	46	15.0%	50	13.7%	97	14.5%
	22 None	1	0.3%	0	0.0%	1	0.15%
	Total	**306**	**100%**	**365**	**100%**	**671**	**100.0%**

Main Sectors and Institutions Involved in Mental-Health News

The *general health services of the Ministry of Health* (e.g., hospitals) were the institution most prominently covered in 2013 mental health news, appearing in 15.4 percent of stories (Table 4). The second most widely covered entity was the *Ministry of Health headquarters* at 15 percent, followed by *diverse organizations* at 10.8 percent, *specialized mental health services of the Ministry of Health* at 8.8 percent, the *National Mental Health Institute* at 7.8 percent, *Government – Congress of the Republic* also accounting for 7.8 percent, and *public safety institutions/Minister* at 7.5 percent. In 2016, the corresponding figures showed *diverse health organizations* appearing in 27.7 percent of stories, followed by the *National Mental Health Institute* at 18.9 percent, *health services of the Ministry of Health (hospitals)* at 15.3 percent, *Ministry of Health headquarters* at 8.8 percent, *public safety institutions/Minister* at 8.2 percent, *specialized mental health services of the Ministry of Health* at 2.7 percent, *and Government – Congress of the Republic* at 2.2 percent.

TABLE 4. MAIN SECTOR OR ENTITY COVERED IN MENTAL HEALTH NEWS, 1ST HALF 2013 – 1ST HALF 2016

MAIN SECTOR OR ENTITY	2013		2016		TOTAL	
	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%
1 General health services (hospitals) – Ministry of Health	47	15.4%	56	15.3%	103	15.4%
2 Specialized mental health services – Ministry of Health	27	8.8%	10	2.7%	37	5.5%
3 National Mental Health Institute – Ministry of Health	24	7.8%	69	18.9%	93	13.9%
Subtotal Providers		**32**		**36.9**		
4 HQ – Ministry of Health	46	15.0%	32	8.8%	78	11.6%
5 Diverse (nonpublic) health organizations	33	10.8%	101	27.7%	132	19.7%
6 Government – Congress of the Republic	24	7.8%	8	2.2%	32	4.8%
7 Public safety institutions/ Minister	23	7.5%	30	8.2%	53	7.9%
8 Education Sector	6	2.0%	5	1.4%	11	1.6%
9 Ministry of Women	2	0.7%	0	0.0%	2	0.3%
10 Political groups	2	0.7%	9	2.5%	11	1.6%
21 Other	72	23.5%	45	12.3%	119	17.7%
Total	**306**	**100%**	**365**	**100%**	**671**	**100%**

Main Intentional Focus Identified in Mental Health News

The content of mental health news disseminated via radio, television, print, and digital media and reported in Health News Summary was analyzed for the same 2013–2016 study period.

As shown in Table 5, in 2013, the main intentional focus perceived in the news was to *alert/warn* at 43.8 percent, followed by *explain/educate* at 42.5 percent, trailed by strategic policy at 10.8 percent. In 2016, the main perceived intentional focus was to explain/educate (45.5 percent of stories), followed by *alert/warn* at 42.7 percent and, finally, *strategic policy* at 10.4 percent.

TABLE 5. MAIN INTENTIONAL FOCUS PERCEIVED IN MENTAL HEALTH NEWS, 1ST HALF 2013 – 1ST HALF 2016

INTENTIONAL FOCUS	2013		2016		TOTAL	
	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%
1 Alert / Warn	134	43.8%	156	42.7%	289	43.1%
3 Explain / educate	130	42.5%	166	45.5%	296	44.1%
5 Strategic policy	33	10.8%	38	10.4%	71	10.6%
21 Other	9	2.9%	5	1.4%	15	2.2%
Total	**306**	**100.0%**	**365**	**100.0%**	**671**	**100.0%**

Main Perceived Attitude Towards People with Mental Health Problems

To assess journalistic attitudes towards people portrayed as exhibiting mental health problems, researchers once again analyzed the content of mental health news disseminated via radio, television, print, and digital communications media and reported in Health News Summary during the first half of 2013 and the first half of 2016.

As shown in Table 6, prevalent perceived attitudes vis-à-vis people with a mental health problem in 2013 included that of *justifying* at 18.0 percent, *associating with a stigmatized condition* at 17.6 percent, *victimizing* at 15.9 percent, and *blaming* at 9.2 percent. A substantial proportion (29.9 percent) was reported as none (i.e., the evaluators assessed the journalistic treatment as neutral). In 2016, a large percentage (41.9 percent) again reflected a neutral attitude, scored as *none*, and 10.8 percent were classified as *other*. Otherwise, in 2016, the main attitude perceived was one of *victimizing* at 29.9 percent, followed by *associating with a stigmatized condition* at 11.2 percent.

TABLE 6. MAIN PERCEIVED ATTITUDE VIS-À-VIS PEOPLE WITH MENTAL HEALTH PROBLEMS, 1ST HALF 2013 – 1ST HALF 2016

PERCEIVED ATTITUDE	2013		2016		TOTAL	
	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%	Nº. NEWS ITEMS/ REPORTS MENTAL HEALTH	%
1 Victimizing	47	15.4%	109	29.9%	156	23.2%
2 Blaming	28	9.2%	39	10.7%	67	10.0%
3 Justifying	55	18.0%	20	5.5%	75	11.2%
4 Associated with a stigmatized condition	54	17.6%	41	11.2%	95	14.2%
21 Other	33	10.8%	3	0.8%	36	5.4%
22 None	89	29.1%	153	41.9%	242	36.1%
Total	306	100.0%	365	100.0%	671	100.0%

Journalists' Perceptions of Mental Health Coverage

Reports were considered concerning the experience of influential journalists and communicators in the television, radio, print, and digital media in Peru who were prominent in the dissemination of topics relating to the 2013–2016 mental health reforms. The sample included 33 people.

Journalists' Personal Attitudes and Experiences

Many of the journalists noted in their comments that the topic of mental health was important for them, and that they recognized it as newsworthy. They identified family violence, suicide, rape, femicide, and individuals with addiction problems as mental health issues covered in the communications media. Informants expressed their concern to alert and inform the public on these topics. However, all informants indicated that there is generally little interest in mental health issues in Peru's media. When current events did permit, the journalists seized the opportunity to transmit mental health messages for the general public.

> ***"(...) It is my duty to be informed. The violence that we experience every day is the result of the lack of importance given to mental health."***
>
> (Experience Report. 021 – Presenter of the Estación 103 Program – Radio Nacional del Perú).

> ***"A suicide may be news for other media, but for me it is an opportunity to provide education, to explain that behind the suicide lies depression (...)."***

(Experience Report. 030 – Editor, Local Section, Agencia Andina de Noticias).

Most informants said that a perceived need for societal change had spurred them to try and place mental health higher on the media agenda and ultimately to help reorient public policies. Some also noted that personal and/or family situations had made them more concerned about the topic.

> ***"My sister suffers from schizophrenia. Also, I listened to various psychiatrists and psychologists who are opinion leaders who made me see how important it is to talk about mental health in the communications media."***

(Experience Report. D030 –Editor, Local Section – Agencia Andina de Noticias).

> ***"Based on my personal experience, helping persons recognize that they may have a mental health problem and preventing such problems has been (and is) an important motivation in covering the topic in Andina."***

(Experience Report. 029 – Writer, Local Section – Agencia Andina de Noticias).

Most respondents indicated that they believed their mental health reporting had helped them increase public awareness, while also making them personally better informed and, in some cases, helping them realize in time if a family member or friend was in a situation that could affect their mental health.

Beyond Sensationalism

Most journalists concur that media mental health news generally focuses on crime and current events in an effort to boost ratings. Informants are not comfortable with this situation. Many argue that they should not be covering topics of this type only when a tragedy occurs. Instead, they could be regularly transmitting what is important, i.e., information on mental health care and prevention strategies.

> ***"The communications media are constantly chasing ratings and looking to increase sales. We know that sensationalism always sells, but I believe (...) that more creative efforts should be made to position the topic."***

(Experience Report. 022 – Section Manager, País- Diario Oficial El Peruano, Agencia de Noticias Andina).

> ***"We discuss mental health only when there is a crime, a scandalous murder, and after that we return to banal, meaningless topics."***

(Experience Report. 023 – Senior Editor, Current Events Section – Diario Trome).

Informants do note that some media and journalists consistently seek to inform and to highlight prevention messages.

> *"There are various myths surrounding mental health. We try to provide information on prevention, on what the illnesses involve, etc."*

(Experience Report. 031 – Graphic Artist / Audiovisual Graphic Journalism – RPP).

> *"In the media that I work for, interest in and openness to these topics has been gradually increasing. More awareness raising is needed to not lose the ground that has been won. Today the items are still random, but I believe that it is fundamental to have regular items that create a habit of reading about these topics and awareness of their importance."*

(Experience Report. 022 – Section Manager, País – Diario Oficial El Peruano, Agencia de Noticias Andina).

Mental Health News and Public Policy

Most interviewed journalists agree that the public is interested in the topic of mental health, but mainly when people feel directly affected. Informants also note that there is still too little information available, which results in insufficient knowledge of mental health issues. Support for better public policies also remains inadequate.

> *"People do not take preventive measures. They access services only when they have a problem. There is no interest in creating [better] public policies. If there were, various ministries would be working together on this topic (...)."*

(Experience Report. 030 – Editor, Local Section– Agencia Andina de Noticias).

> *"There is a good response to coverage of mental health topics, but we need to go into greater depth, to ensure that there is a culture of interest in political circles."*

(Experience Report. 031. Graphic Artist / Audiovisual Graphic Journalism – RPP).

Informants believe that, in many cases, the authorities do not adequately take into account what the media present, or else they see reported mental health cases as isolated, not requiring a systematic policy response.

> *"The authorities do not hear what the media publish, or they see it as isolated cases."*

(Experience Report. 027 – Section Editor: Society – Diario La República).

> *"I believe that my contribution, like that of my [journalist] colleagues, is ignored by the Government..."*

(Experience Report. 023 – Senior Editor, Current Events Section – Diario Trome).

> ***"On policies, first of all, useful information should be increased so that the public knows that mental health is being discussed, so that society will demand adequate public policies from the authorities."***

(Experience Report. 031 – Graphic Artist / Audiovisual Graphic Journalism – RPP).

Media Coverage and Public Awareness: Opportunities to Increase Impact

Respondents note that, in comparison with the past, information on mental health has increased significantly, but that much more can be achieved. Some argue that mental health specialists should be given more media visibility, and that they should talk about mental health above all in terms of preventive measures. There should be constant coverage of the topic from this perspective.

> ***"Clearly, much progress has been made in the dissemination of these topics, particularly the tremendous work carried out by the Noguchi National Mental Health Institute and its Communications Department, which seeks to place topics, always from a preventive perspective, with an intent to clarify and educate."***

(Experience Report. 022 – Section Manager, País- Diario Oficial El Peruano, Agencia de Noticias Andina).

> ***"Compared to the past, the output of information has increased significantly, but it has not had the impact that such an effort should have had. Mental health is still a reality that people do not want to see, show, or address."***

(Experience Report. 029 – Writer, Local Section – Agencia Andina de Noticias).

One of the strategies that many journalists mention for achieving greater coverage of mental health is that the Government should give priority to mental health in its work plan, creating strategic alliances with the communications media, opinion leaders, and other stakeholders. This would make it easier to expand the information available to the public through programs and opinion pieces in both traditional and digital media, taking advantage of the large proportion of the population that now uses social networks to communicate. The public should also receive assistance and guidance through Ministry of Health (MINSA) campaigns.

Topics that encourage the public to seek more information on mental health should be given priority coverage, encouraging healthy lifestyles and habits. Also, information should be provided to young people early on: for example, through mental health workshops in schools, helping preempt prejudice and fear around mental health problems and therapies. Young people especially should not be afraid to ask for help if it is needed, as detecting a mental disorder in time can often prevent it from becoming a tragedy.

> ***"The public medical institutions should create communications processes that enable them to interact directly with the communications media, telling positive stories, creating preventive campaigns with Minedu, Minjus, MINP, starting with schools, and with the participation of the Office of the President of the Republic."***

(Experience Report. 018 – Content Producer – Capital Radio/TV – Grupo RPP).

> ***"It is very important that the Communications Department of the Ministry of Health try to generate many opportunities for communication with the public. They should seek friendly media and make some journalists, who I am sure would be interested in these topics, their spokespersons."***

(Experience Report. 022 – Section Manager, País- Diario Oficial El Peruano, Agencia de Noticias Andina).

> ***"Identify the communications media at the national level, and design a work plan for each. Identify opinion leaders/allies at the national level. Provide a permanent space for opinions and/or programs in the communications media: print, radio, television. Have the support of the social networks."***

(Experience Report. 029 – Editor, Local Section – Agencia Andina de Noticias).

Capitalizing on Journalists' Role as Opinion Leaders

Informants note that different media tend to present mental health topics differently. They may require different approaches and incentives to improve. Journalists surveyed emphasized recent progress in some print and radio communications media, but stated that, on television, cases of violence are often more visible, neglecting the preventive and educational focus. Informants argue that communications on mental health should not be dictated by current events, but should focus above all on the sustained dissemination of information on healthy behaviors and quality of life.

To the extent that individuals believe that they do not need to be afraid of analyzing and caring for their mental health, they will be working to achieve better mental health for the entire population.

> ***"Every day we see this need and hunger for the morbid in society. It is something that we also feed into, what we are asked for, what people tune in to every day. I am in a news service where, if I give a piece of serious news, the ratings fall, so in the end I provide showbiz news, and the ratings rise. We are trying ... It is a chicken and egg thing, one topic out of two. As for the journalists, the only thing that I can say to them is to broadcast the news, whatever type it may be, knowing that it involves human beings. (...) We are complicating the topic of mental health. We must look at the essence with personal, fundamental values, and never lose sight of the fact that, if journalists lose their sensitivity, they also lose their humanity."***

(Mónica Delta, Peruvian journalist and opinion leader).

> *"When does the topic of mental health come onto the journalism agenda? When someone commits suicide, we immediately think that it is because their lover has abandoned them, they have failed in business or something. When a person kills someone else, we think that the murderer is crazy. The various mental health topics seem subordinated to other topics relating to violence. In the communications media, there is a close relationship between mental health and violence. This is the first mistake that we make as journalists."*

(José María Salcedo, Peruvian journalist and opinion leader).

> *"Journalism can help to place pressure on the authorities so that they allocate more public resources to mental health. I feel that today the topic of mental health can be covered when there is money, but when there is no money there are few options. There are hospitals, such as Noguchi, clearly, that do this, but they need much more funding. I believe that there is a very large deficit in the capacity to treat all those with mental health problems in our country. A larger budget is needed, with more funds in the health sector budget going to mental health."*

(Augusto Álvarez Rodrich, Peruvian journalist and opinion leader).

CONCLUSION: BALANCING MEDIA BUSINESS INTERESTS AND PUBLIC MENTAL HEALTH GOALS—CHALLENGING BUT FEASIBLE

Many journalists and opinion leaders have suggested that it is possible to find a balance between the business interests of the communications media and public mental health and that there can be motivation to promote mental health coverage in a healthy way.

The findings from our study of a group of journalists reinforce this perspective. We conclude the chapter by recalling key results obtained in relation to each variable explored with the journalists in the qualitative portion of the study.

Personal and professional motivation to promote the topic of mental health. Most participating journalists state that the topic of mental health is important to them. They express concern for alerting the public. Nevertheless, they also indicate that there is little spontaneous interest in this topic in the media in general. When possible, they seize current events as an opportunity to capture audience attention and promote awareness of mental health.

Valuation of mental health as a news product. Most journalists surveyed see mental health as a problem that is newsworthy and current and thus calls for their attention. They emphasize that some media reporting has helped make the public much more aware of mental health, potentially enabling people to detect in time if a family member or person close to them is confronting mental health problems. Still, informants acknowledge that most mental health news covered by the media focuses on crimes and current events, seeking ratings. The coverage of mental health should be reformulated. Journalists should not be covering topics of this type only when a tragedy occurs.

Today, a close relationship still persists in the media between mental health and violence. There is often a distortion of the journalist's vocation in the coverage of mental health. The reporters producing mental health-related stories too frequently rely on stereotypes and do little research. The reporters' supervisors and editors are also typically poorly informed on mental health topics. Often, the journalist covering mental health then covers crimes, reinforcing the misleading association between crime and mental health.

Perception of interest in positive coverage of mental health on the part of the public. Most respondents agree that the public is interested in mental health, but mainly when people feel directly affected. Available objective information remains scant, which results in limited knowledge. The media still provide information primarily in connection with current events.

Perception of the influence of mental health news on policymakers. Respondents argue that the contribution of journalism to mental health has a substantial influence on policymakers. However, despite the motivation on the part of communications professionals, they feel that the Government is still failing to sufficiently emphasize topics of mental health, such as prevention and early detection. The Government should create strategic alliances with the communications media and opinion leaders to expand dissemination of mental health knowledge, taking advantage of journalists' distinctive skills.

Perception of the influence of the news on the implementation of mental health reforms. Informants believe there have been substantial advances in the dissemination of mental health topics in the media. However, much more can be done to raise social and political impact. To help, mental health specialists should enjoy greater media visibility, regularly addressing constructive mental health topics such as preventive measures.

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