HHR Health and Human Rights

DREXEL UNIVERSITY Dornsife School of Public Health

FXB Center for Health & Human Rights at Harvard University

When Scaling Up Isn't Enough: The Impacts of Peru's Mental Health Care Reform on Adolescents

CAMILA GIANELLA MALCA

Abstract

In the last 15 years, coalitions of individuals and institutions worldwide have been calling for global policies to close the treatment gap for people living with mental disorders. This paper seeks to contribute to the literature on the effects of the diffusion of these global mental health polices by exploring their implementation and impact in Peru. Aligned with the Movement for Global Mental Health, Peru has carried out a mental health reform aimed at scaling up mental health care in public facilities. Using the human rights-based framework of availability, accessibility, acceptability, and quality, this paper examines the reform's effects on a population prioritized by global and Peruvian policies: adolescents. The analysis, based on qualitative research, illustrates how the reform's overemphasis on scaling up access to pharmaceutical treatment neglects critical issues such as health system capacity, the availability of trained human resources, the need for intercultural approaches tailored to adolescents, and information systems that adequately monitor policy impact. The analysis also highlights how a reform that promotes pharmacological treatment creates risks of abuse by private actors involved in the marketing of psychiatric medications.

Camila Gianella Malca is an associate professor the Department of Social Sciences, Pontificia Universidad Católica del Perú, Lima, Peru.

Please address correspondence to the author. Email: gianella.c@pucp.edu.pe.

Competing interests: None declared.

Introduction

In the last 15 years, coalitions of individuals and institutions around the globe have been calling for policy reforms to close the treatment gap for people living with mental disorders. Specifically, they have been asking for mental health policies that adhere to two fundamental principles: evidence on effective treatments and the fulfillment of the human rights of people with mental disorders.[1] Although countries' adoption of such reforms are presented as positive changes aimed at improving the mental health of the population, these reforms have not been immune to criticism. Some authors have raised concerns regarding the biomedical approach adopted in policy recommendations to scale up mental health care, which could contribute to the reproduction of power asymmetries and victimization of people living with mental disorders, as well as the biomedical bias of the evidence used to inform policy development and practice.[2] Concerns have also been raised regarding forms of institutional corruption in which private actors exert an outsized influence over the design of public health policies and profit from public funds as a result of their implementation.[3]

The promotion of private interests against the public good is a risk in the design and implementation of any public policy, including global policies. Global public policies are not designed in a vacuum. They are shaped and promoted by experts from global epistemic communities, which have their own limitations, preferences, assumptions, and motivations, including profit ones.[4] Additionally, global policies are implemented in the context of varying institutional capacities to deliver the recommended services, as well as to control the potential abuse of power by private actors.

This paper aims to contribute to the debate on the adoption of global mental health policies to scale up mental health care by analyzing how Peru's recent mental health reform has impacted the treatment and experiences of adolescents in five regions of Peru. Mental health in this group (14- to 19-year-olds) has been recognized as a public health priority by the World Health Organization, which has urged governments to create adolescent-responsive health systems.[5] This urgency is reflected in the situation faced by adolescents in Peru. For example, the suicide rate among adolescents aged 12–17 is higher than among the general population (3.6 per 100,000 inhabitants and 2.2 per 100,000 inhabitants, respectively). Suicide is one of the leading causes of maternal mortality among adolescents in Peru.[6] Girls and adolescents are exposed to disproportionate rates of obstetric violence at health facilities.[7] During the COVID-19 pandemic, 1 out of 100 children and adolescents lost one parent or principal caregiver, increasing their risks of suffering sexual violence, failing or dropping out of school, and experiencing psychosocial problems.[8] Further, an estimated 62% of children and adolescents aged 5–17 in Peru experience multidimensional poverty, including 96% in rural areas and 50% in urban areas.[9] In this context, where there is a need for a health system that ensures adolescents' well-being, it is essential to analyze which institutional elements contribute to or limit the state's public policy efforts to address adolescent health, including mental health.

The analysis presented here is based on a qualitative study that triangulated three sources of information: (1) official reports and regulations issued by national authorities on mental health and adolescent pregnancy between 2013 and 2024; (2) reports and articles produced by nonstate actors, including nongovernmental organizations, multilateral actors, and academia, during the same period; and (3) 27 semi-structured interviews with health workers involved in mental health programs and with adolescent groups from five regions selected for their high rates of adolescent pregnancy relative to the national average (Amazonas, 21.1%; Ayacucho, 9.5%; Madre de Dios, 9.6%; Piura, 12%; and Ucayali, 21.1%; compared to the national rate of 8.2%). Additionally, the regions of Amazonas, Madre de Dios, and Ucayali rank among the country's top five regions with the greatest gaps in mental health care. Further, all selected regions are recognized as priority areas for exploring the intersection between mental health and adolescent pregnancy, as agreed by the Ministry of Health and civil society organizations (la Mesa de Concert-

ación para la Lucha Contra la Pobreza).[10] The study protocol was approved by the Institutional Ethics Committee of the Pontificia Universidad Católica del Perú in Lima (approval number 573-33-20).

In presenting the empirical evidence, this paper draws on the human rights framework of availability, accessibility, acceptability, and quality (AAAQ) to analyze the outcomes of the mental health reform implemented in Peru since 2012. The AAAQ framework—developed by the United Nations Committee on Economic, Social and Cultural Rights and widely adopted by national governments and international organizations (including the World Health Organization)—provides a useful lens for organizing empirical data in line with well-established normative criteria.[11] Applying the AAAQ framework holistically, the paper aims to (1) assess the extent to which Peru's mental health reform has been implemented in accordance with human rights principles, and (2) analyze whether the diffusion of global mental health policies in the Peruvian context has allowed private actors to profit at the expense of the public interest through "institutional corruption." Peru provides an instructive case study on the limits and possibilities of public policy diffusion, given its history of adopting neoliberal reforms and its weak institutional capacity to prevent abusive practices by private actors, including substandard care, corruption, price fixing for medicines, and anti-competitive practices.[12]

It is important to note that Peru's national mental health policies are based on data from "burden of disease" reports.[13] This approach situates the mental health crisis within a biomedical model, focusing policy attention toward screening and treating individual conditions while neglecting to address social determinants of mental health.[14] Although this paper recognizes the importance of social determinants in shaping adolescent mental health, it examines the impacts of the mental health law on its own terms with respect to the health system.

The remainder of the paper is organized into four sections. The first provides background on Peru's health system and the recent mental health reform. The second section applies the AAAQ framework to examine the outcomes of the reform, focusing on how policy documents address adolescents (if at all) and on the indicators used to assess the policy impact on this group. The third section deepens the AAAQ analysis, focusing on adolescents' experiences with mental health services and drawing on qualitative findings from the study. Finally, the conclusion posits that while the mental health reform has positive aspects, without a more holistic AAAQ approach that takes into account Peru's sociocultural context and the institutional capacity within the health system, it opens the door for institutional corruption and fails to uphold adolescents' rights to mental health.

Background on Peru's health system and mental health reform

The Peruvian health system is highly fragmented and segmented, which constrains the state's capacity to deliver quality health care to all.[15] This fragmentation is reflected in both financing and service delivery.[16] Funding for the health system is complex, deriving from multiple sources (general taxation, results-based budgeting, and direct contributions) and allocated to different units (regional governments, the Ministry of Health, health facilities, and public insurers). Service provision is linked to different insurance schemes, with the government-funded Comprehensive Health Insurance (SIS) being the leading insurer in the country and the main buyer of medical supplies and health services from the private sector.[17] SIS is funded primarily through general taxation and targets those living in poverty, providing free health care for a set of prioritized health conditions. Within this structure, mental health has traditionally been neglected. Despite the high prevalence of mental health disorders, these conditions have often gone undiagnosed and undertreated at health facilities.[18] Furthermore, mental health policies have historically not been a priority. In 2011, the Ministry of Health allocated only 0.27% of its budget to mental health, 98% of which was directed to psychiatric hospitals.[19] This share increased to 1.4% in 2015 and 2.6% in 2023.[20]

Seeking to address the unmet need for mental health services, Peru enacted Law 30947 in 2019—commonly referred to as the Mental Health Law—establishing a "comprehensive legal framework to ensure the right to health and well-being through access to promotion, prevention, treatment, and rehabilitation services for mental health."[21] The law explicitly recognizes and defines the right to mental health (articles 7, 8, and 9); acknowledges the social determinants of mental health (article 5); and underscores the need for a multisectoral approach to guarantee the enjoyment of mental health, including the integration of mental health services into the general health care system and the promotion of community-based care (articles 2 and 19). Law 30947 explicitly states that the approach adopted for mental health care is based on human rights and on community and intercultural approaches (article 1).[22]

Law 30947 marks a milestone in the ongoing process of mental health reform in Peru, which began in 2012, and it incorporates two key features: (1) a focus on expanding access to mental health care within public health facilities and (2) the adoption of human rights language. In this respect, the Peruvian mental health reform aligns with the Caracas Declaration on mental health and human rights, as well as the aims of the Movement for Global Mental Health.[23] Its main goal is to scale up coverage of mental health services and treatments through primary care.

Budgetary efforts have accompanied the mental health reform. In 2012, SIS approved financial coverage for psychiatric consultations, treatment (including medication), and rehabilitation procedures such as individual, group, and family therapy.[24] Additionally, in 2015, the Results-Based Budget Programme 0131, titled "Control and Prevention of Mental Health," was established, providing financial resources to strengthen mental health services nationwide. Results-based budget programs (known as PpR programs), introduced in 2007 as part of the fiscal reform led by the Ministry of Economy and Finance, are a performance-based budgeting tool intended to improve the health system's capacity to respond to health problems.[25] This tool ensures continued program funding as long as specific goals and indicators are met. By 2024, the 12 health-related PpR programs represented 40% of the total health budget.[26]

In addition to financial measures, Peru has developed regulations adopting a human rights approach to mental health. For example, in 2015, Regulation 29889 established that mental health care provided at public health facilities must adhere to the principles of respect for human rights and the dignity of individuals, incorporate intercultural and community-based approaches, and aim to eradicate discrimination and stigmatization of people with mental health problems. The regulation also guarantees the right to access mental health care.[27]

To date, most of the research conducted on Peru's mental health reform has focused on its impact on coverage indicators, including the expansion of mental health services and the number of people receiving pharmacological treatment.[28] Less attention has been given to assessing the extent to which the reform guarantees the enjoyment of the right to mental health, especially for marginalized populations such as adolescents.

Impacts of the mental health reform on policies and adolescent health

The AAAQ framework

The AAAQ framework offers a useful lens for examining the Peruvian mental health reform.[29] The first pillar of this framework, *availability*, requires that health care facilities, goods, and services be continuously available. Availability requires a sufficient number of functioning health facilities equipped to receive adolescents with mental health issues; sufficient numbers of trained medical professionals available to diagnose and treat mental health conditions; and a sufficient supply of appropriate commodities, including pharmaceuticals. This includes the capacity of institutions to provide adequate follow-up to screened patients.

The second pillar, *accessibility*, includes four components as defined under international law: physical accessibility, economic accessibility,

information accessibility, and accessibility on a nondiscriminatory basis. All of these factors are relevant to mental health care for adolescents.

1. Diagnosis and care should be universally accessible within a safe or reasonable physical distance, including for people in rural areas.
2. Economic accessibility is critical given that chronic diseases can generate catastrophic expenses for families.
3. Information accessibility is critical because it ensures that individuals have the opportunity to explore treatment options and understand the potential long-term side effects of pharmaceutical interventions.
4. With respect to nondiscrimination, mental health services must be available on an equal basis with physical health services and made accessible to adolescents as well as adults.

Acceptability requires culturally appropriate and medically acceptable care, which calls for respecting the dignity of patients. In particular, this includes respecting the right to confidentiality—meaning that those seeking treatment for mental health issues feel that information regarding their health status, information related to pregnancy, and any other sensitive information will be kept private.

Finally, *quality of care* calls for skilled personnel who are well-equipped to treat adolescents with mental health issues, together with appropriate medications and other health goods that are safe and effective.

These four elements of the AAAQ framework should be understood as interrelated; for example, barriers to geographic and economic accessibility of care in the medical system may be linked to inappropriate standards of quality and acceptability of care, such as the prescription of pharmaceuticals with little follow-up.

Applying AAAQ to the mental health reform

The Mental Health Law proposed adopting and scaling up a community-based mental health care model. This model represents a distinct approach to organizing mental health services, whereby health is acknowledged as a social good shaped by relationships within the family and community, rather than merely a biomedical issue.[30] It also seeks to guarantee respect for the dignity of people with mental health conditions or disabilities by establishing a legal regime of comprehensive protection and care that supports continuity of care, psychosocial rehabilitation, and social reintegration.

The community mental health care model was crystallized through the creation of public community mental health centers (CMHCs). By early 2025, the Ministry of Health reported 255 CMHCs nationwide. In terms of availability, one major constraint is the limited number of facilities. Under a territorial approach, each CMHC is expected to serve 100,000 people.[31] However, this approach has not closed the gap in mental health care. It is estimated that seven out of ten people with mental health problems still do not receive the services they need.[32] This could be due to various factors, including geographical barriers (since most CMHCs are located in urban areas) and limitations related to facility capacity (such as opening hours and number of personnel).

Furthermore, the mere existence of a health facility does not guarantee that it has the material and human resources necessary to serve the population under its coverage, which is required to meet the standard of "availability." Currently, the minister of health is proposing one CMHC for every 50,000 people.[33] Although the reform has led to an increase in human resources, such as psychologists working at public health facilities, it remains unclear whether there are enough professionals to meet the required profiles in each CMHC; this is due to shortages of mental health professionals, high turnover, and dissatisfaction with working conditions.[34] According to the regulations, each CMHC requires a psychiatrist, preferably with training in child psychiatry, as well as a psychiatrist or general practitioner with training in community or family medicine, and a psychiatrist with expertise in addiction.[35] The Ministry of Health acknowledges a shortage of these professionals. Each CMHC should also have at least eight psychologists, with

expertise in children and adolescents, addiction, and psychotherapy. However, the ministry reports a shortage of 350 psychologists across CMHCs, and many of those working in these facilities do not have training in psychotherapy (i.e., they do not meet the profile). Furthermore, some primary care health facilities lack psychologists, which means that the referral system from non-specialized health facilities to CMHCs cannot be guaranteed.

In the case of adolescents, there are few mental health specialists in Peru who are trained to work with adolescents. As of 2025, the Ministry of Health reports only nine psychiatrists specialized in child and adolescent care nationwide—one based in a CMHC in the region of Tacna and the other eight based in hospitals in Lima.

This lack of specialists trained to work with adolescents raises questions regarding the availability, accessibility, and quality of care for this population. In terms of policies, most policy documents do not include specific interventions targeting this group, and they often group adolescents together with children and other adults. The overemphasis on general coverage ignores the need for targeted interventions for marginalized populations and the barriers that specific groups, such as adolescents, face in accessing care.[36]

In terms of the acceptability of care, as documented in other health policies, and despite the existence of an intercultural health policy (Supreme Decree 016-2016-SA), mental health services lack an intercultural approach.[37] The services offered are the same nationwide, and there is no analysis of the cultural relevance of the interventions and service packages offered.

Another critical issue is accessibility. Although CMHCs are described as a tool to bring mental health services closer to the community, their services are specialized. Individuals with moderate or severe conditions are expected to arrive after being referred from a primary health care facility.[38] Yet reports from the Ministry of Health show that people are not routinely screened for mental health problems in primary health facilities, which casts doubt on the viability of the model for early detection and referral.[39] For example, data on follow-up care after suicide attempts show the weakness of the health system in referring and following up on cases: in 2023, 87.32% of the reported cases did not receive follow-up within the recommended three-month period.[40]

Furthermore, despite adolescents being a prioritized group, significant gaps exist in the data collected by the Ministry of Health, which hinders the government's ability to assess the impact of mental health interventions on adolescents, the adequacy of these interventions, and the quality of care provided.

The emphasis on the economic burden of mental health conditions in Peru has produced some unintended effects. One such effect is the lack of data on prioritized and vulnerable groups, such as adolescents. National reports on the economic burden of disease do not provide data specific to adolescents' mental health, instead grouping information into the age ranges 5–14 and 15–49.[41] Adolescents aged 14 years and above are part of the economically active population in Peru. The statistics on the economic burden of disease focus on reporting the impact of mental health and other health conditions on the population's capacity to "produce." As a consequence, they fail to provide detailed information on the impact of the disease across population groups, such as adolescents aged 15–19.[42]

Beyond the narrow approach of the burden-of-disease reports, another critical weakness of the Peruvian health system is the fragmentation of databases and the absence of information systems to monitor the outcomes of health policies.[43] Peru's mental health reform has not addressed this problem. For example, different databases use different age ranges to define adolescents. Some official statistics (such as those on suicide rates) define adolescents as those individuals aged 12–17, while others (such as those on adolescent pregnancy) classify adolescents as those individuals aged 15–19.

Similarly, key goals of Budgetary Program 0131 (for example, screening for family violence and mental and behavioral disorders) group data into minors (up to 17 years of age) and adults (18 years

of age and older).[44] Reports from the government body responsible for youth, the National Youth Secretariat, include aggregate data on young people aged 15–29.[45]

This lack of disaggregated data, which is a critical component of information accessibility, makes it impossible to follow the number of adolescents who are under psychiatric care treatment, the length of time they are under this type of treatment, and their adherence to such treatment.

The accessibility of information is important not only for patients on an individual basis but also for the transparency and integrity of the mental health system as a whole. Between 2017 and 2021, the Ministry of Health conducted nine corporate purchases, resulting in 5,930 contracts to provide the country with psychotropic medications, valued at US$12.7 million. Although 61 companies held sanitary registrations to market these products, only 14 companies won these contracts. In addition, 3,831 contracts (64% of the total), valued at US$9.1 million, were awarded without competitive bidding.[46] These purchases, which benefited a small group of companies, were made through a reverse auction mechanism designed, in principle, to allow the state to secure the lowest price; however, there is no evidence that lower prices were obtained. In some cases, a single company submitted the only bid for a product at a price that was three or four times higher than the government's forecast.[47] This dynamic of institutional corruption reveals the inability of the state to control private actors when it comes to the purchase of critical supplies in a highly concentrated market, such as the market for psychotropic drugs. Notably, the country's mental health reform, which promotes universal access to psychotropic medications, has not been accompanied by policy recommendations to prevent concentration in the drug market or to prevent private suppliers from abusing drug prices.

Despite the rise in public purchases of psychotropic medications, the supply system is irregular, and it is common for CMHCs to face drug shortages, creating barriers to treatment.[48] This is a serious problem because people taking psychotropic medication cannot risk interrupting their treatment, often leaving them with no choice but to purchase the drugs from private retailers. Peru has comparatively high out-of-pocket health expenditures relative to other countries in the region with similar income levels, and such expenditures have continued to rise, with medicines representing a significant share.[49] Among these, psychotropic medications are a primary source of out-of-pocket expenditures at private retailers.[50]

The lack of regulations allows private pharmacies to prioritize the sale of imported medications over those produced nationally, and of branded generics over generic ones, thereby increasing the cost of the purchased drugs.[51] This is not insignificant: in Peru, it is estimated that paying for a one-month course of treatment with brand-name innovative psychiatric drugs represents approximately 11.85 working days, compared to 11.4 working days for brand-name generics and 5.53 working days for generics with the International Common Denomination.[52]

This section's analysis highlights the challenges of implementing an ambitious mental health reform in a setting characterized by weak institutional capacity. There are not enough health workers to deliver the model adopted by the reform, which undercuts availability, accessibility, and quality of care. Further, deregulation and a lack of transparent data have enabled abuse by private actors, particularly in drug procurement. These structural conditions expose people to the risks of over-medicalization, negative impacts on their health due to a lack of treatment, and out-of-pocket expenses. They also foster institutional corruption by contributing to the abuse of power by private actors, such as the pharmaceutical industry and private pharmacies.

More broadly, the scaling-up approach embedded in the law reform follows a neoliberal understanding of health, which reduces policy indicators to a report of the number of services provided. Under this approach, health is framed as a private good, and the focus of the public health system is on offering cost-effective basic packages in which psychotropic drugs are a first-line therapy.[53] This results in an emphasis on the product provided and the coverage reached, instead of on the impact

on people, which makes it difficult to evaluate the quality of the services. The overemphasis on general coverage ignores the need for targeted interventions and neglects the barriers that specific groups, such as adolescents, face in accessing care.[54] This lack of quality and outcome indicators is not exclusive to mental health interventions—on the whole, Peruvian health information is not standardized, and the poor integration of personal health data across health care settings makes it challenging to measure activities, care quality, and outcomes.

Listening to adolescents: Experiences with the services

The semi-structured interviews conducted for this study offer an additional layer of insight into adolescents' experiences with mental health services. Interviewees noted that the limited availability of health facilities and health professionals creates a barrier to accessing mental health care, and emphasized that long wait times are closely tied to the poor quality of public health services. The experiences recounted by adolescents also show a lack of trained health personnel to guarantee adolescents' right to autonomy, which creates barriers to accessing to sexual and reproductive care and mental health care. In the case of mental health services, a critical concern among respondents was adolescents' lack of trust in health care workers to maintain confidentiality, a key component of quality care. Interviewees reported that adolescents perceive public health services as insecure spaces, which forces them to seek care in private clinics and pharmacies, in turn leading to greater out-of-pocket expenses. As recounted by one adolescent:

> *We may have advised her to go to a psychologist, but she was afraid that the psychologist, upon finding out, might tell her parents, and the problem would become bigger.* (group interview with adolescents, City 5, May 27, 2025)

This distrust is further reinforced by adolescents' lack of autonomy in accessing health services. Although national regulations allow minors to access health services, health workers often interpret this as applying only to sexual and reproductive health services.[55] Thus, mental health facilities frequently require adolescents to attend consultations with an adult, which can place them at risk of violence and limits the possibility of having a safe space where they can be heard. One interviewee explained:

> *When making an appointment for a consultation at the mental health center, minors must be accompanied by their guardian. Still, at the time of the talk where the psychologist talks with you, I think you should be alone because some teenagers are afraid to talk about things they do not want their parents to know and that is why they should go alone so as not to feel any discomfort and be able to say everything.* (group interview with adolescents, City 3, April 15, 2025)

Health workers recognize major weaknesses in health services that obstruct adolescents' access to mental health care. Among the main factors affecting service availability are the physical limitations of health facilities, the lack of human resources, and the fear of mistreatment. Interviewees described problems with the infrastructure (lack of space), as well as a lack of resources to adapt CMHCs to adolescents' needs and to ensure quality care. For example, they pointed to health workers who are not trained to work with adolescents, operating hours that do not align with adolescents' schedules, excessive workloads among personnel, and long wait times. One health worker explained:

> *Now, another issue could be access, accessibility, or a slight difficulty in obtaining consultations. Sometimes, there is a bit of desertion because I am the only child and adolescent psychologist here. There are only four of us psychologists so that the agenda can be very full at times, and they have to wait 15 days, sometimes a little more, for attention. This can sometimes be a barrier. (interview 13, health worker, City 4, May 21, 2025)*

The lack of human resources poses a serious barrier to guaranteeing adolescents' access to quality and adequate mental health care. Moreover, indicators are overly focused on the number of visits provided, which obscures problems in the ability to access continuous treatment. This can ultimately lead

adolescents who need care to abandon treatment, as demonstrated by the quote above.

As suggested earlier, a critical factor—one not often mentioned as a barrier to accessibility—is the practice of requiring the presence of an adult during consultations. For health workers, this is a nonnegotiable point, though their justifications vary, suggesting that the rule is enforced more out of habit than careful reasoning. There is little reflection on its impact on care. In the interviews, health workers justified this practice on administrative grounds (for example, an adult must sign the care sheet, such as the *formato único de atención*), but also, as the following quote shows, based on a conception of mental health that holds parents responsible for the mental health problems their children may be experiencing. Parents are seen as needing to be sensitized, and this is typically expected to occur during the same consultation:

> ***Interviewer***: *And is it necessary for an adolescent or an adolescent seeking health, mental health care, to be accompanied by an adult, his or her mother, or someone, or not?*
>
> ***Health worker***: *For me, yes … But now I think a rule has come out that the adolescent can come alone, but, for me, yes, because there are kids who don't even know what is going on with their mental health or with their life, so, and a little bit also to sensitize the mother. Why? Because the mother is: "Well, you have to do something at home," they start bombarding the adolescent, "You have to do something, well, you have to do something. You are going to have children, you have to do something." The adolescent feels bad. So it is a little sensitizing. Something will help, something will help, that at least the mother will think that she should not act like that with her daughter, that suddenly she has to be a little more understanding, right? So and so on. I think, I think it is like that.* (interview 2, health worker, City 2, April 11, 2025)

The practice of requiring parents to be present during consultations is deeply ingrained, even though it puts victims of sexual violence—a population that should be prioritized and protected by the health system—at risk. Although health personnel recognize these risks, they do not question the practice and continue to apply it. In addition, the absence of quality indicators and spaces for discussion on how to adapt services to this population's needs allows these practices to continue. One health worker illustrated the challenges created by this situation:

> *For example, one of the barriers, in the case of violence, is that, for example, when a child, and this is still happening, when a child denounces his parents for physical or psychological abuse, the parents are the ones who have the obligation to take the child, regardless of whether your child has denounced you, so the parents do not take them. They take you, already, because there is a court order from the Prosecutor's Office and from there. So it is not so much that the children do not want to come, but that the parents tell them: "Oh, you are going to go there? Surely it is because you want them to take me to jail." Or there are mothers who denounce their partners for abuse and the children were involved, but then the mother resumes her relationship with the partner, so, therefore, the mother abandons the treatment [for the children] so that the case is filed.* (interview 12, health worker, City 4, May 21, 2025)

In general, the interviews reveal a lack of critical evaluation of the mental health program's adaptability for Indigenous and rural communities, as well as for adolescents in general. As described earlier, the distribution of CMHCs is based on a territorial approach.[56] However, geographic accessibility barriers continue to compromise the ability to ensure quality treatment. This situation is especially evident in rural and remote areas, where health personnel often cannot travel regularly due to limited budgets. In these cases, although health workers and health authorities acknowledge that geographical and economic barriers exist for workers and service users, there is little questioning of whether the current model of care is truly the most suitable for rural populations.

This study found no reflection among the health workers interviewed on the need for an intercultural approach. "Culture" is reduced to a set of beliefs and framed as a barrier for the population, without consideration of other possible approaches to mental health beyond the biomedical model.

This restrictive view of culture was aptly illustrated by one health worker:

> *The issue of accessibility is that there are adolescents who come from very remote areas, making it difficult for them to attend the center. Another reason is that each district has its own beliefs, which sometimes do not believe in psychology, making it still taboo for them, isn't it? They believe in the shaman, in some districts here in Chachapoyas. (interview 7, health worker, City 5, May 27, 2025)*

In summary, the interviews show that the focus on coverage and the absence of quality indicators have enabled the delivery of mental health services that do not adhere to a holistic understanding of human rights principles (namely, the AAAQ framework) in practice. Interviewees identified challenges in the availability, accessibility, acceptability, and quality of mental health services. Coverage indicators used in the abstract are not sensitive to these problems, nor to situations where—due to the organization of services and requirements for adult accompaniment or authorization—the health of adolescents may be put at risk. These factors take on heightened relevance in the case of adolescents living in rural and remote areas, Indigenous adolescents, and adolescents who are victims of sexual abuse.

Conclusion

By zooming in on adolescents' access to mental health care, this paper has sought to illustrate how global mental health policies focused on scaling up mental health coverage are implemented in a context such as Peru. As a country with an underfunded and fragmented health system, Peru presents a context in which for-profit private actors, such as pharmaceutical and medical supply providers, have undermined the public interest by taking advantage of public resources. This case study shows that global mental health policies adopted uncritically by countries with weak institutional capacity can foster institutional corruption that benefits private interests while undermining the human rights of vulnerable populations, such as adolescents.

The analysis using the AAAQ framework demonstrates that the efforts undertaken by the Peruvian government, in collaboration with health professionals, to enhance mental health services in recent years have had some positive effects: increased financial and human resources for public mental health services, as well as the creation of specialized centers at the primary health care level. However, these advancements have not been sufficient in terms of providing the mental health care required by vulnerable groups such as adolescents. This is due to several institutional factors, including the persistent shortage (despite some progress) of material and trained human resources, inadequate health information systems, and administrative barriers generated by health workers that prevent adolescents from accessing health care. Furthermore, the lack of resources inhibits the effective implementation of the proposed model: the shortage of health professionals, supplies, and medications puts the health of people with mental illnesses at risk.

Further, the focus on quantitative coverage indicators ignores the importance of qualitative indicators. Although adolescents are a target population for screening and treatment, they face barriers to accessing health facilities on their own, which can sometimes put them at risk of (further) violence. There is also no information system to assess the impact of services on people's health outcomes.

The analysis also shows that although the mental health model adopted in Peru relies heavily on the provision of drugs that must be administered continuously—and despite knowledge of cases of anti-competitive behavior, such as the price fixing of medications—the country's mental health reform has not included efforts to strengthen the state's capacity to purchase medicines or to ensure that it is not dependent on a handful of suppliers. The data reveal abusive behavior by psychiatric drug suppliers and the failure of policies that attempt to lower drug purchase prices.

The Peruvian case highlights the limitations of a mental health reform that, despite embracing human rights principles in theory, adopts a global scaling-up approach grounded predominantly

in a biomedical model. This approach prioritizes individual treatments and overlooks the social, economic, and cultural context, contradicting the World Health Organization's recommendation that mental health policy "address a wide range of topics, with a central focus on establishing a comprehensive network of services both within and beyond the health sector."[57] The World Health Organization has also stressed the need to recognize that biomedical approaches, such as the one adopted by Peru in its mental health reform, place too much focus on diagnosis, medication, and symptom reduction while overlooking the social and structural determinants of mental health and individuals' rights to inclusion and social protection.

Funding

The research project "Identifying Policy Implementation Gaps to Address the Intersecting Burdens of Mental Health Problems and Adolescent Pregnancy in Peru", was funded by IDRC (Project ID 110534, Global Health Program).

Acknowledgments

I am most grateful to Alicia Ely Yamin for her insights and suggestions which helped strengthen this paper.

References

1. V. Patel, P. Y. Collins, J. Copeland, et al., "The Movement for Global Mental Health," *British Journal of Psychiatry* 198 (2011).

2. L. Cosgrove, C. Mills, J. Amsterdam, et al., "Global Mental Health," *Lancet* 394 (2019); Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. A/HRC/35/21 (2017), para. 25.

3. L. Cosgrove, S. Krimsky, M. Vijayaraghavan, and L. Schneider, "Financial Ties Between DSM-IV Panel Members and the Pharmaceutical Industry," *Psychotherapy and Psychosomatics* 75 (2006); L. Cosgrove, E. H. Patterson, and H. J. Bursztajn, "Industry Influence on Mental Health Research: Depression as a Case Example," *Frontiers in Medicine* 10 (2023).

4. M. Hadjiisky, L. A. Pal, and C. Walker, "Introduction: Traversing the Terrain of Policy Transfer: Theory, Methods and Overview," in M. Hadjiisky, L. A. Pal, C. Walker (eds), *Public Policy Transfer: Micro-Dynamics and Macro-Effects* (Edward Elgar, 2017).

5. World Health Organization, *World Mental Health Report: Transforming Mental Health for All* (2022); World Health Organization, "Adolescent and Young Adult Health" (November 26, 2024), https://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions.

6. Mesa de Concertación Para La Lucha Contra la Pobreza, *Perú: Prevenir el embarazo en niñas y adolescentes y reducir las muertes maternas, año 2022* (2022).

7. C. Gianella Malca, "Despite Legal Exceptions, Access to Abortion Denied in Peru," Petrie-Flom Center (October 23, 2023), https://blog.petrieflom.law.harvard.edu/2023/10/23/despite-legal-exceptions-access-to-abortion-denied-in-peru/.

8. Ministerio de Salud, Resolución Ministerial No. 686-2024-MINSA "Plan Nacional de Fortalecimiento de Servicios de Salud Mental Comunitaria 2024–2028" (2024).

9. Ministerio de Desarrollo e Inclusión Social and UNICEF, *Pobreza multidimensional en el Perú: Una propuesta de medición para toda la población y para la niñez y la adolescencia* (2023).

10. Ministerio de Salud, Resolución Ministerial No. 686-2024-MINSA (see note 8).

11. Committee on Economic Social and Cultural Rights, General Comment No. 14, UN Doc. E/C.12/2000/4 (2000).

12. F. Durand and E. Salcedo, "Intereses, gremios y situaciones de captura del Estado," in E. Beteta, O. Elorreaga, F. Durand, et al. (eds), *Las patologías del sistema de salud peruano* (Fondo Editorial PUCP, 2020); World Bank, *Competition: The Missing Ingredient for Growth?* (2024); R. Zapata, "Compañías que dominan el negocio del oxígeno deberán pagar S/24 millones por repartirse el mercado," *Ojo Público* (June 16, 2020), https://ojo-publico.com/1904/justicia-confirma-fallo-empresas-que-dominan-negocio-del-oxigeno.

13. See, for example, Ministerio de Salud, *Contenidos mínimos del programa presupuestal* (2021), anexo 9.

14. Human Rights Council (see note 2).

15. O. Lazo-Gonzales, J. Alcalde-Rabanal, and O. Espinosa-Henao, *El sistema de salud en Perú: Situación y desafíos* (Colegio Médico del Perú, 2016); L. B. D. Göttems and M. L. R. Mollo, "Neoliberalism in Latin America: Effects on Health System Reforms," *Revista de Saúde Pública* 54 (2020).

16. Organisation for Economic Co-operation and Development, *OECD Reviews of Health Systems: Peru 2025* (2025).

17. Durand and Salcedo (see note 12).

18. M. Toyama, H. Castillo, J. T. Galea, et al., "Peruvian Mental Health Reform: A Framework for Scaling-up Mental Health Services," *International Journal of Health Policy and Management* 6 (2017).

19. Ibid.

20. Organisation for Economic Co-operation and Devel-

opment (see note 16).

21. Ibid.

22. Ley No. 30947, Ley de Salud Mental (2019).

23. Pan-American Health Organization and World Health Organization, The Caracas Declaration (1990); Patel et al. (see note 1).

24. Ley No. 29889, Ley que modifica el artículo 11 de la Ley 26842, Ley General de Salud, y garantiza los derechos de las personas con problemas de salud mental (2012); H. Castillo-Martell and Y. Cutipé-Cárdenas, "Implementación, resultados iniciales y sostenibilidad de la reforma de servicios de salud mental en el Perú, 2013–2018," *Revista Peruana de Medicina Experimental y Salud Pública* 36 (2019).

25. E. Dale, L. Prieto, J. Seinfeld, et al., *Presupuesto por resultados de salud: Características, logros y retos clave en el Perú* (World Health Organization, 2020).

26. Organisation for Economic Co-operation and Development (see note 16).

27. Pan American Health Organization, *Avances y desafíos de la reforma de salud mental en el Perú en el último decenio* (2023).

28. J. J. Miranda, F. Diez-Canseco, R. Araya, et al., "Transitioning Mental Health into Primary Care," *Lancet Psychiatry* 4/2 (2017); H. Castillo-Martell and Y. Cutipé-Cárdenas, "Implementación, resultados iniciales y sostenibilidad de la reforma de servicios de salud mental en el Perú, 2013–2018," *Revista Peruana de Medicina Experimental y Salud Pública* 36/2 (2019).

29. Committee on Economic Social and Cultural Rights (see note 11).

30. Ministerio de Salud, *Lineamientos de política sectorial en salud mental: Perú 2018* (2018).

31. Ministerio de Salud, *Norma técnica de salud: Centros de salud mental comunitarios* (2017).

32. Ministerio de Salud, Resolución Ministerial No. 686-2024-MINSA (see note 8).

33. Ibid.

34. Organisation for Economic Co-operation and Development (see note 16); M. Toyama, A. L. Vilela-Estrada, L. Hidalgo-Padilla, et al., "Mental Health Policies for Adolescents and Young Adults in Peru: A Policy Analysis" (2024), https://ssrn.com/abstract=4917379.

35. Ministerio de Salud (2017, see note 31).

36. Toyama et al. (2024, see note 34).

37. C. Gianella, M. A. Pesantes, C. Ugarte-Gil, et al., "Vulnerable Populations and the Right to Health: Lessons from the Peruvian Amazon Around Tuberculosis Control," *International Journal for Equity in Health* 18 (2019); M. A. Pesantes and C. Gianella Malca, "¿Y la salud intercultural?: Lecciones desde la pandemia que no debemos olvidar," *Mundo Amazónico* 11 (2020).

38. Ministerio de Salud, Resolución Ministerial No. 686-2024-MINSA (see note 8).

39. Ibid.

40. Centro Nacional de Epidemiología Prevención y Control de Enfermedades, *Boletín epidemiológico 44 – 2023* (Ministerio de Salud, 2023).

41. Centro Nacional de Epidemiología Prevención y Control de Enfermedades, *Carga de enfermedad en el Perú: Estimación de los años de vida saludables perdidos, 2019* (2023).

42. Ministerio de Salud, Resolución Ministerial No. 686-2024-MINSA (see note 8).

43. Organisation for Economic Co-operation and Development (see note 16).

44. Ministerio de Salud, *Programa Presupuestal 0131: Control y prevención en salud mental; Reporte de seguimiento al mes de agosto 2024* (2024).

45. Secretaría Nacional de la Juventud, *Juventudes Perú: Reporte de datos e indicadores sobre población joven 2017–2022* (2024).

46. E. Salazar, I. Velasco, I. Morales, et al., "Concentración y contratos sin competencia en compras para la salud mental en América Latina," *Ojo Público* (June 22, 2022), https://ojo-publico.com/3550/los-negocios-detras-la-salud-mental-america-latina.

47. Ibid.

48. A. Tovar and L. Romero, "7 de cada 10 centros de salud mental comunitaria se quedaron sin medicinas en el último año," *Saludconlupa* (May 24, 2023), https://saludconlupa.com/salud-mental/7-de-cada-10-centros-de-salud-mental-se-han-quedado-sin-medicinas-por-que-el-estado-no-esta-comprandolas-a-tiempo/.

49. COMEX, "Salud: El gasto de bolsillo aumento en todos los departamentos entre 2019 y 2023" (September 20, 2024), https://www.comexperu.org.pe/articulo/salud-el-gasto-de-bolsillo-aumento-en-todos-los-departamentos-entre-2019-y-2023; Organisation for Economic Co-operation and Development (see note 16).

50. Dirección General de Medicamentos, Insumos y Drogas, *Informe del gasto de bolsillo en productos farmacéuticos en farmacias y boticas privadas del sector retail* (Ministerio de Salud, 2024).

51. J. Llamoza Jacinto, R. Solís Cóndor, and S. E. Zevallos Bustamante, *Estado situacional de la depresión en el Perú: Cómo se comporta la depresión en el país, a cuántos afecta y con qué contamos para combatirla* (Gobierna Consultores, 2022).

52. Ibid.

53. E. S. Rotarou and D. Sakellariou, "Neoliberal Reforms in Health Systems and the Construction of Long-Lasting Inequalities in Health Care: A Case Study from Chile," *Health Policy* 121 (2017).

54. Toyama et al. (2024, see note 34).

55. Dirección General de Intervenciones Estratégicas en Salud Pública, *Norma técnica de salud para la atención*

integral de salud de adolescentes (2019).

56. Ministerio de Salud, Resolución Ministerial No. 686-2024-MINSA (see note 8).

57. Human Rights Council (see note 2); World Health Organization, *Guidance on Mental Health Policy and Strategic Action Plans: Module 2: Key Reform Areas, Directives, Strategies, and Actions for Mental Health Policy and Strategic Action Plans* (2025).