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Transitioning mental health into primary care

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Health-care systems in low-income and middle-income countries have not adequately responded to the substantial burden linked to mental health, resulting in enormous treatment gaps and major shortcomings in the delivery of mental health care. Peru is no stranger to this issue, and has attempted to implement several measures to improve mental health care over the past 50 years. However, these measures have been hampered by a combination of factors, including their small scope or scale, insufficient political support, and poor organisation and allocation of human resources.[1]

Historically, mental health care in Peru has been relegated to and centralised at the tertiary care level, which meant the availability of treatment was restricted to three psychiatric hospitals in Lima, the capital city of Peru. In 2011, only 0·27% of Peru's health budget was assigned to mental health, 98% of which was assigned to these three institutions.[2] In 2014, of the 700 psychiatrists practising in Peru, 85% were located in Lima, with half of these psychiatrists working in the private sector or in these three large, public hospitals.[3] Additionally, mental disorders such as depression went largely underdiagnosed and undertreated at the primary care level—patients' first point of contact with the health-care system.[4] This situation increased the treatment gap, leaving specific vulnerable populations, such as people living in extreme poverty, in rural areas, or victims of political violence, without access to quality mental health care.[5]

The past 12 years have seen a steady increase in the political will to improve the delivery of mental health care and redirect it towards a community-based approach to address the shortcomings of the tertiary care model. In June, 2012, the Peruvian Congress passed Law 29889, titled "[…] General Law of Health, that guarantees the rights of people with mental health problems".[6] This law, a landmark accomplishment for mental health services, explicitly guarantees their countrywide availability, free and universal access to treatment for mental disorders for every citizen at every level of the health-care system, and social protection for patients with mental disorders without social support—a substantial achievement for the mental health-care system in Peru. This law was the stepping stone

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towards the implementation of a mental health-care reform. Furthermore, the Government of Peru showed strong commitment to this reform by approving a 10-year budget programme to support the implementation and scalability of this normative framework. This budget programme allocated PEN 78 million (about US$20 million) in the fiscal year 2015, to be used exclusively for implementation of the mental health reform via a performance budgeting approach.[7]

The reform, among other aspects, focuses on a shift towards strengthening the role of primary care, in line with key recommendations from the WHO,[8] by introducing screening, diagnosis, and treatment of common mental disorders at primary health-care centres (PHCs). The reform also proposes the creation of community mental health centres (CMHCs)—specialised primary care facilities providing specialised outpatient treatment, where the provision of mental health care is readily available and in close proximity to the community. One of the main services provided by the CMHCs is the continuity of care programme by use of an intensive case management approach aimed at patient recovery and rehabilitation. This management approach improves social functioning, reduces time of hospital stay, and increases retention in care.[9]

All 8137 PHCs in Peru are expected to implement mental health programmes in the coming years, and are currently being trained to incorporate these programmes into their routine services. Likewise, 23 CMHCs were created in six regions of Peru in 2015. By the end of 2017, 40 additional CMHCs will be created, and by 2021 312 CMHC are expected to be implemented and fully functional. This scenario provides fertile ground to learn about the implementation aspects of the mental health programme in Peru. Studying this reform through the lens of implementation science would be immensely beneficial in informing scale-up efforts in other low-income and middle-income contexts. Many theories and frameworks to design dissemination and implementation research are available, and understanding the key drivers that connect the evidence to real world settings is essential. Designs focused on the adoption or uptake of clinical interventions by health-care providers and systems will be essential to help inform these scale-up processes. Organisational readiness[10] and facilitation[11] could also be assessed to ensure the best available evidence is used in the particular contexts where it is needed. This mental health reform is not yet perfect, with major weaknesses at the planning and delivery levels, but addressing these weaknesses could lead to substantial improvements in the delivery of mental health care in Peru.

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