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**Reducing excess mortality of people with
mental disorders: A policy-document
analysis of the Peruvian Mental Health
Reform**

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1. Executive summary

Aim: People with mental disorders (PMD) die up to 30 years earlier than the general population. This policy report explored the extent in which excess mortality of PMD was recognised as a relevant issue in the Peruvian Mental Health Reform (MHR) agenda, by analysing the role of actors, ideas, political contexts, and issue characteristics proposed by the Shiffman and Smith's (2007) framework.

Findings: A total of 25 documents were analysed, including government policies, research articles and civil society's reports. Main *actors* were policymakers and researchers, who portrayed the *idea* that excess mortality was an important problem to address; and 2014-2018 appeared as a favourable *Political context*, when most documents stating the issue were published. Nonetheless, *excess mortality's characteristics* were not entirely considered, since documents mainly declared its relevance and the need to reduce it; but did not explicitly mention strategies to do so.

Recommendations:

- Expand the agenda setting of excess mortality, by involving professional associations and users-led organisations; framing it in a way that resonates with political leaders; and explicitly present interventions to reduce it.
- Define which effective interventions to reduce excess mortality will be implemented, by updating legislation to incorporate the goal of reducing excess mortality and tailoring effective interventions to the local context.
- Strengthen the role of research to set excess mortality into MHR agendas, through conducting local research to inform policy guidelines; building research-capacities in policy communities; enhancing partnerships among policymakers and researchers; and positioning excess mortality into global funders' priorities.

Conclusions: The study found that excess mortality has been gaining position into the Peruvian MHR agenda; in which some determinants proposed by Shiffman and Smith's (2007) helped its positioning, and some others would still be needed to expand the agenda setting.

Limitations: The main limitations were the grounding on openly-access documents and focus on predetermined codes.

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3. Abbreviations

CBMC	Community-based model of care
DALYs	Disability-Adjusted Life Years
DMH	Direction of Mental Health
GBD	Global Burden of Disease
LMIC	Low- and middle-income countries
MHR	Mental Health Reform
MOH	Ministry of Health
NCDs	Non-communicable diseases
PAHO	Pan American Health Organisation
PMD	People with mental disorders
SDGs	Sustainable Development Goals
SIS	Seguro Integral de Salud (<i>Comprehensive Health Insurance</i>)
SMD	Severe mental disorders
WHO	World Health Organisation

4. Introduction

Globally, mental disorders are highly prevalent, represent the fifth leading cause of years lived with disability and 7.4% of the global burden of disease (GBD) (Whiteford et al., 2013). This burden is even higher in low- and middle-income countries (LMIC), where mental disorders account for 11% of the total burden of disease (Patel, 2007).

One relevant problem that people with mental disorders (PMD) face is their 40%-60% higher risk of premature death (World Health Organisation, 2013), dying up to 30 years earlier than the general population (Walker et al., 2015, Vigo et al., 2016). Contrary to common belief, suicide is not the main reason for these extra deaths, but common physical conditions, as cardiovascular diseases, cancer or respiratory illnesses (World Health Organisation, 2015a). Some authors argue that considering the incidence of these conditions in PMD is not higher than in the general population, excess mortality could be related to broader conditions, as appropriate physical treatment (Kisely, 2010).

This shows a major health inequality for PMD, who are in a condition of vulnerability for premature death. Indeed, excess mortality has been claimed as a *scandal* (Thornicroft, 2011) and “human rights disgrace” (Thornicroft, 2013), calling for the implementation of evidence-based interventions to reduce the mortality gap (Thornicroft, 2013). In 2015, the World Health Organisation (WHO) held a meeting to discuss this excess mortality, and developed a multilevel intervention framework to reduce it, including a set of recommendations and priorities for clinical practice, policies, and research (World Health Organisation, 2015a).

Over the last decades, several countries have implemented mental health reforms (MHR), shifting from psychiatric institutions to a community-based model of care (CBMC), promoting rehabilitation and recovery, as well as community mental health networks (Aviram et al., 2012, Giannakopoulos and Anagnostopoulos, 2016, Hickie et al., 2005, Pec, 2019, Vázquez-Barquero et al., 2001, Minoletti et al., 2012). This care model could imply the implementation of interventions aiming to reduce excess mortality (i.e. recovery-oriented treatment, lifestyle behaviour interventions); however, previous research specifically assessing the excess mortality as a priority within MHR agendas was not found.

This study seeks to close this research gap by analysing to what extent does excess mortality is positioned into MHR’s agendas. The Shiffman and Smith’s (2007) framework has been used for this purpose, exploring different initiatives into global health agendas, as maternal mortality (Shiffman and Smith, 2007), non-communicable diseases (NCDs) (Heller et al., 2019), or neglected tropical diseases (Aya Pastrana et al., 2020); as well as specific issues in national

agendas, such as oral health in Italy (Benedetti et al., 2015) and India (Janakiram et al., 2018), or violence against women in Sri Lanka (Colombini et al., 2018). This project takes the MHR of Peru as a case study due to its ongoing efforts to improve its mental healthcare provision, and its internationally recognised progress in this regard (Ministerio de Salud, 2019a). Results will provide policy-level recommendations and lessons learned for other countries.

Excess mortality of people with mental disorders

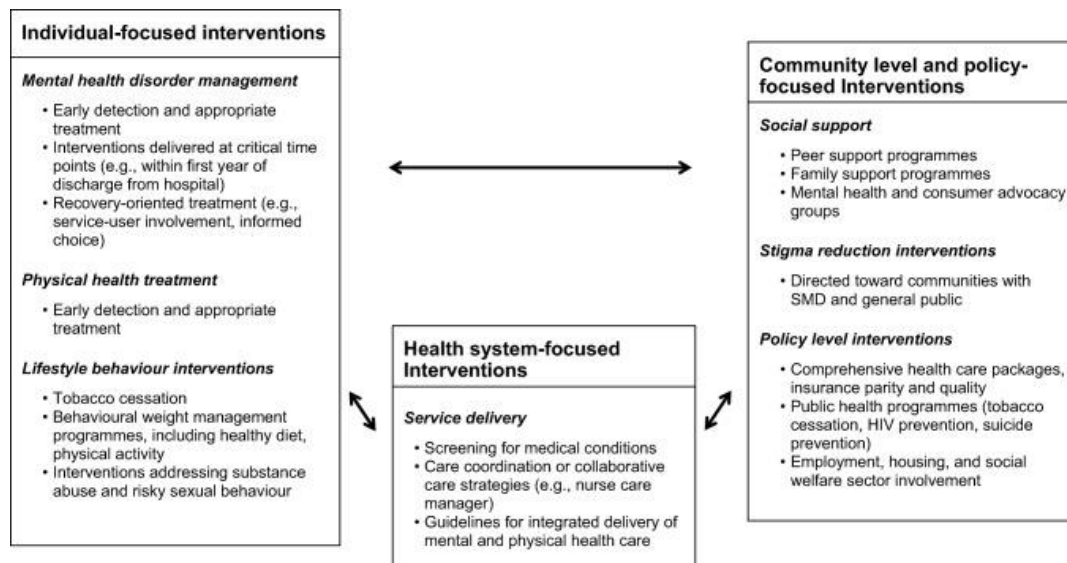
Around the world, an estimated 970 million people live with a mental disorder (James et al., 2018), and it is well acknowledged that these disorders represent a high disability burden (Whiteford et al., 2013). PMD not only experience a high morbidity but also an excess mortality compared to the general population, with higher mortality risks (Chesney et al., 2014) and dying on average 10 years earlier (Walker et al., 2015).

This excess mortality has been more studied among people with severe mental disorders (SMD) such as schizophrenia, bipolar mood disorder, and moderate-severe depression (Das-Munshi et al., 2017, Fekadu et al., 2015, Saha et al., 2007, World Health Organisation, 2015a) but similar patterns are found across all mental disorders (Walker et al., 2015, Chesney et al., 2014). The mortality rate of PMD is 2.22 times higher than in the general population or people with no mental disorders; and they experience a reduced life expectancy, ranging among 1.4-32 years (median=10 years) (Walker et al., 2015).

Excess mortality is mainly due to preventable physical diseases, mainly cardiovascular (2-3 times higher), respiratory (2-5 times higher), diabetes (2-4-fold risk), among others (World Health Organisation, 2015a). A body of evidence shows that factors for this excess mortality include the higher prevalence of risk factors for NCDs, psychotropic medications' iatrogenic effects, higher prevalence of suicide, accidental and violent deaths, and poor access to and quality of care for physical diseases (Thornicroft, 2011, De Hert et al., 2011b, Liu et al., 2017).

In 2015, the WHO held a meeting with global mental health experts to discuss the excess mortality of people with SMD (World Health Organisation, 2015a). These experts designed a Multilevel model of risk for excess mortality, a Multilevel intervention framework to reduce excess mortality, and guidelines for policy and research agendas. This was later published as a research article, in 2017 (Liu et al., 2017). Figure 1 shows the multilevel intervention framework, which includes a series of interventions at the individual level, health-system level, and community and policy level:

Figure 1. WHO multilevel intervention framework to reduce excess mortality in persons with SMD.



Legend: The WHO framework outlines interventions at individual, health system, community, and policy level to reduce excess mortality in people with severe mental disorders. **Source:** (Liu et al., 2017).

Excess mortality into Mental Health Reform agendas

Despite the large body of evidence (Almeida et al., 2014, Baxter et al., 2016, Charlson et al., 2015, Chesney et al., 2014, Das-Munshi et al., 2017, Fekadu et al., 2015, Kisely, 2010, Lawrence et al., 2013, Wahlbeck et al., 2011, Walker et al., 2015) and recommendations from the WHO (Liu et al., 2017, World Health Organisation, 2015a), excess mortality has remained largely overlooked and untreated (Saxena, 2018, Thornicroft, 2011). Even in Scandinavian countries, which have a strong healthcare system, excess mortality has been scantily reduced in the last two decades (Wahlbeck et al., 2011).

Forty years ago, in order to reduce institutionalization of PMD and improve their mental healthcare systems, several countries around the world, as Australia, Italy, Greece, Israel or China, implemented MHR (Amaddeo and Barbui, 2018, Hickie et al., 2005, Liu et al., 2011, Pec, 2019, Stefansson and Hansson, 2001, Aviram et al., 2012, Vázquez-Barquero et al., 2001, Giannakopoulos and Anagnostopoulos, 2016). Latin American countries joined 10 years later (Minoletti et al., 2012). Still, only few MHR globally have issued policies or guidelines directed to the reduction of excess mortality. For instance, addressing the high comorbidity of physical illnesses in PMD is the main recommendation to reduce excess mortality (De Hert et al., 2011a, World Health Organisation, 2015a); yet, the United Kingdom (NHS England, 2018) and Australia (Henderson and Fuller, 2011) are among the few countries with guidelines on the physical healthcare for PMD.

After a rapid review of similar guidelines in LMIC with MHR, I did not find initiatives in this regard. This is an important concern, since the mortality gap in LMIC is believed to be even higher than in high-income countries (Barber and Thornicroft, 2018). Indeed, evidence suggest that PMD are dying prematurely due to physical diseases (Liu et al., 2017, Fekadu et al., 2015), but healthcare systems in LMIC are still not well prepared to properly respond (Checkley et al., 2014).

The Peruvian Mental Health Reform

Around the world, several MHR have moved to a community-based model of care (CBMC) in order to reduce the high prevalence, GBD and huge treatment gap¹ of mental disorders (Whiteford et al., 2013, World Health Organisation, 2010, World Health Organisation, 2015b). This model has been proposed as an effective and efficient approach to tackle these problems (World Health Organisation, 2013). It incorporates the integration of mental health into primary care, involvement of users, families and communities in the promotion, prevention and treatment of mental health problems, and shifting to an interdisciplinary recovery-oriented care model (World Health Organisation, 2013, World Health Organisation, 2019, World Health Organisation, 2010).

Even though MHR with a CBMC are implementing interventions that could have an impact in reducing the excess mortality of PMD, no specific research exploring the agenda setting of excess mortality into MHR were found. This study aims to bridge this knowledge gap by taking the Peruvian MHR as a case to analyse to what extent does excess mortality is positioned into MHRs agendas. Peru has been selected because of its meaningful progress during the last years in implementing its MHR (Ministerio de Salud, 2019a).

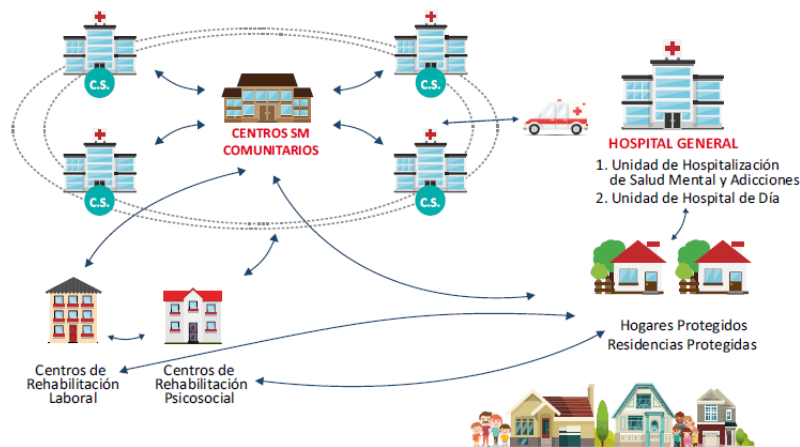
Peruvian mental health initiatives begun 40 years ago, in which in alignment to WHO recommendations, implemented a series of CBMC interventions, but only at small scale, in institutions, districts, and regions (Castillo-Martell and Cutipé-Cárdenas, 2019). Since early 2000, the Ministry of Health (MOH) started to design and implement guidelines, plans and strategies at a national scale (Ministerio de Salud, 2018a, Toyama et al., 2017). This laid the ground for the approval of Law 29889, entitled “[...] General Health Law guaranteeing the rights of people with mental health problems” (Ministerio de Salud, 2012), which represented a landmark to the mental healthcare in Peru and the beginning of its MHR (Toyama et al., 2017, Ministerio de Salud, 2018a, Dirección de Salud Mental, 2016).

¹ Treatment gap is the difference between those who needing mental health care do not receive it. KOHN, R., SAXENA, S., LEVAV, I. & SARACENO, B. 2004. The treatment gap in mental health care. *Bull World Health Organ*, 82, 858-66.

This Law guaranteed the provision of mental health services under a CBMC across the country, with interventions of promotion, prevention, recovery and rehabilitation (Toyama et al., 2017) for PMD and people with psychosocial problems (Dirección de Salud Mental, 2016). This MHR proposed universal health coverage and health insurance for the poorest populations (Consejo Nacional de Salud, 2013); inclusion of mental health into the Universal Insurance Plan (Instituto Nacional de Salud Mental, 2014); and the approval of a 10-year budget (Ministerio de Economía y Finanzas, 2014) that has been gradually increasing (~\$20 million in 2015 (Castillo-Martell and Cutipé-Cárdenas, 2019), ~\$100 million in 2020 (Ministerio de Economía y Finanzas, 2019)).

In 2015, the National Congress approved the Regulation of Law 29889 (Ministerio de Salud, 2015); which proposed the creation of new community-based infrastructures into existing health networks at the primary and secondary care levels (Ministerio de Salud, 2015). Figure 2 presents the MHR network and the referral pathways across facilities.

Figure 2: Network of community-based mental health services.



Legend: Community-based network for mental health services created by the MHR. Community mental health centres are at the primary care level and coordiante with all other facilities at primary and secondary care. The network includes services for psychosocial and labour rehabilitation, and housing for people with severe mental disorders. Source: (Dirección de Salud Mental, 2016).

Since then, the Peruvian government has been implementing this network across the country, in collaboration with national and regional mental health authorities (Toyama et al., 2017). By August 2020, Peru had 155 CMHC (Ministerio de Salud, 2020f) and 11 protected homes (Ministerio de Salud, 2020e) in different regions.

Important documents published during the MHR include the “Strengthening National Plan of Community Mental Health Services 2018-2021” (Ministerio de Salud, 2018c) and the “Sectoral Policy Guidelines on Mental Health” (Ministerio de Salud, 2018a). The former outlines the Peruvian mental health situation, as well as objectives and activities to overcome them and

respond to the legal framework of the MHR. The latter pursues the universalisation of mental health care by interventions in promotion, protection, prevention, treatment, recovery, psychosocial rehabilitation and social reinsertion in mental health.

In 2019, the Mental Health Law was approved (Law 30947) (Ministerio de Salud, 2019b), which seeks to protect the health and wellbeing of people, their families and communities; guarantee the dignity of PMD or disabilities through a CBMC; promote an intersectoral and multisectoral work for mental health services; strengthen the capacities of healthcare providers; and assure the access to health services and medications to those who need them. The priorities of this Law are to assure the mental health care for vulnerable populations, the implementation of community mental health services, and the implementation of the CBMC as a core strategy for the mental health policy framework. The Law's Regulation was launched in early 2020 (Ministerio de Salud, 2020a).

In March 2020, the COVID-19 pandemic reached Peru (Presidencia de la República del Perú, 2020). In this context, the Direction of Mental Health (DMH) launched a "National Plan for Mental Health in the context of COVID-19", to reduce the impact of the pandemic in the population's mental health (Ministerio de Salud, 2020g). Two mental health guidelines were also published: one regarding mental healthcare for the general population and for PMD (Ministerio de Salud, 2020c); and another for health providers (Ministerio de Salud, 2020d).

The Peruvian MHR has been considered as a role model for other South American countries by the World Bank and the Pan American Health Organisation (PAHO) (Ministerio de Salud, 2019a). Some reports and research articles have been published reporting the progress of its implementation, showing promising results as well as challenges and barriers to be addressed (Castillo-Martell and Cutipé-Cárdenas, 2019, World Bank, 2018). However, none of these documents have stated the reduction of excess mortality as a priority or final goal, and the Peruvian government official website does not comprise specific policies nor guidelines addressing the excess mortality of PMD.

Indeed, the recently launched Mental Health Law does not mention excess mortality. As the core document of the Peruvian MHR, the absence of excess mortality might imply that it has not been positioned as a priority on the MHR agenda. Nonetheless, reaching to this conclusion will need appropriate methods to analyse if and why excess mortality has not gained political priority in the Peruvian MHR agenda.

The Framework for determinants of political priority for global initiatives of Shiffman and Smith (2007)

The Shiffman and Smith's (2007) framework has been widely used across the world to understand why certain issues gain political priority in health agendas, and why some others do not. This framework has been used in global initiatives as oral health (Benzian et al., 2011), NCDs (Heller et al., 2019), or mental health (Tomlinson and Lund, 2012); as well as for analysis at a country-level, as experiences in Kenya (Onono et al., 2019), Sri Lanka (Colombini et al., 2018), India (Janakiram et al., 2018), Italia (Benedetti et al., 2015), and Mexico (Becker and Díaz Olavarrieta, 2013).

Shiffman and Smith (2007) define political priority as the degree in which “political leaders actively give attention to an issue, and back up that attention with the provision of financial, technical, and human resources that are commensurate with the severity of the issue” (p. 1370). This framework is mainly concerned with the role of power to bring collective action into policy. It is comprised of four categories: actors, ideas, political contexts, and issue characteristics. Each category is subdivided into specific factors or determinants, allowing to understand why certain initiatives receive political support while others do not (ibid).

Actors represent the power of the individuals and organisations concerned with the initiative. Issues vary depending on who are the actors, the quality of their connections, and their ability to confront those against. One determinant is the *Policy community cohesion*. Policy community are those who influence the positioning of the issue on the policy agenda. If cohesive in basic features of the issue, as how it should be solved, they will be more likely to gain political support. The second determinant, *Leadership*, is the presence of specific individuals, recognised as champions, who can bring together the policy community and who help direct the initiative. The third determinant is *Guiding institutions*. Having institutions who can lead the initiative is essential. Even though they may start as informal groups; they must be later institutionalized. It is also important to avoid competition among institutions since this could limit their alliance. Finally, the fourth determinant is *Civil society mobilization*. If civil organisations pursuing the same issue are involved, it would be easier for the initiative to acquire political support (Shiffman and Smith, 2007).

Ideas refers to the different ways in which people interpret the world. A central point is to analyse how the issue is understood and publicly portrayed, because it can resonate more on certain actors and less in others. Shiffman and Smith (2007) set the example of HIV/AIDS, which has been framed in terms of a public-health priority, development issue, humanitarian crisis, and a threat to security, having different impacts depending on their audience. This

element is divided in Internal frame and External frame. The *Internal frame* is how the policy community understands and portrays the issue. Unified policy communities are the result of shared definitions, causes and solutions of the problem. The *External frame* is how the external audiences understand and portray the issue, which can lead them to act. Political leaders who control resources are of special importance in this regard.

Political contexts are the actors' environments. Even if actors have little control over these contexts, they need to be considered when setting the agenda. Two determinants are essential. *Policy windows*, which are timepoints in which conditions align favourably and generate momentum for an initiative, giving actors strong opportunities to reach political leaders. These policy windows often occur after major disasters, discoveries, or forums. The second determinant, *Global governance structure*, is the shared set of norms and institutions that enforce them. Their capacity to coordinate and work well are essential to provide a platform for the initiative.

Finally, *Issue characteristics* refer to the fact that some initiatives are easier to promote due to their own characteristics. The determinant *Credible indicators* refer to the presence of clear measures that allow policymakers to assess the severity of the problem and monitor its progress. *Severity* is related to the objective harm associated with the problem, as number of deaths, which can attract more resources since policymakers will perceive them as more serious. Finally, initiatives that count with *Effective interventions*, that are clearly explained, affordable, evidence-based, and feasible to implement, will receive more resources due to their potential easiness to implement and solve the problem.

Shiffman and Smith (2007) explain that no single factor is necessary nor sufficient to assure political support. There are some initiatives that have reached the policy agenda without fulfilling many of these factors; and others that have not gained political attention despite having many of them. Nonetheless, authors state that counting with these factors will raise the probabilities of an initiative to be prioritized.

5. Aims and objectives

Aim

To explore to what extent the Peruvian Mental Health Reform acknowledged the reduction of excess mortality of people with mental disorders as a relevant issue, and to analyse the role of different factors in influencing the extent to which this issue reached the political agenda. The dissertation will provide policy-level recommendations and lessons learned for other countries.

Objectives

Analyse existing policy documents to:

1. Identify the role of actors, ideas, political contexts, and issue characteristics that aim to reduce the excess mortality of PMD in the Peruvian context, based on the Shiffman and Smith's (2007) framework.
2. Identify, describe and analyse the interventions contained in Peruvian policies, reports and research that address the excess mortality of PMD, following the WHO (2015) framework.

6. Methods

Study design

This project is a policy document analysis, which follows a systematic procedure to review and assess documents to generate knowledge (Bowen, 2009) and explore to what extent they are aligned to a defined framework (Cheung et al., 2010). It is based on an analysis of documents published during the implementation of the Peruvian MHR.

Search strategy

A literature search was conducted to identify published evidence and grey literature. The timeframe was from June 2012 to June 2020, to include the beginning of the Peruvian MHR (Toyama et al., 2017). Documents were selected from the official websites of the Peruvian government (<https://www.gob.pe/>), international associations working in the country (i.e. PAHO, World Bank, Fundación Manantial), national professional associations (psychiatrists, psychologists, physicians and nurses), Peruvian National Institute of Health, National Institute of Mental Health, non-government organisations working in mental health, and mental health users' associations. LILACS, Scielo, Medline, Embase, Global Health, PsycInfo, Web of Science, and Google were also used to identify relevant documents. Websites for users' associations were identified by Google search tools, finding only social media pages and not official websites.

The search strategy was tailored to each platform, using different terms depending on the websites (See Table 1). For instance, the Peruvian government website had specific filters for type of publication, thereby it was only needed to use the term "mental". In contrast, Fundación Manantial is an organisation working on mental health, so this term was not included in the search strategy. In most platforms, when including the words "policy" and "reform", the number of documents retrieved was highly reduced or did not add any relevant document, which is why they were not included in most search strategies.

Table 1. Search strategy per platforms used.

Platform	Search strategy
Official website of the Peruvian government	"Mental", with filters of "Legal norms", "Reports and publications", and "Campaigns".
International associations working in the country	
PAHO	Mental AND Peru -blog; Reform AND Peru -blog
World Bank	Mental AND Peru
Partners in Health	Mental AND Peru
Fundación Manantial	Peru; Reform; Policy
Professional associations	
Psychiatrists, psychologists, physicians, and nurses	Mental
Peruvian National Institutes	
Peruvian National Institute of Health	Mental AND Peru site:ins.gob.pe
Peruvian National Institute of Mental Health	Mental AND Peru site:insm.gob.pe
Non-government organisations working in mental health	
SODIS, APRODEH	Mental AND Peru
Mental health users' associations	Mental AND Peru
Scientific databases	
Virtual Health Library (Medline, LILACS, Scielo)	tw:((tw:(mental)) AND (tw:(peru))) AND (year_cluster:[2012 TO 2020]) 1: exp mental health/ or (community adj3 mental health).mp 2: south america/ or peru/ 3: (exp health/ adj3 policy/) or poli?/ or reform/ 4: 1 or 3 5: 2 and 4 6: remove duplicates from 5
Ovid (Medline, Embase, Global Health, PsycInfo, Web of Science)	
Google Advanced Search:	allintitle: Peru mental
<u>Legend:</u> Search strategy used according to each platform's characteristics.	

Inclusion and exclusion criteria

Inclusion criteria:

- Documents describing interventions implemented or to be implemented nationwide for PMD OR Documents describing and/or analysing the Peruvian MHR. AND:
 - Documents currently in force and published during June 2012 to June 2020.
 - Documents addressing PMD.
 - Documents openly accessible.
 - Documents in Spanish and/or English.

Exclusion criteria:

- Press releases or institutional communications that report an event but do not contain or redirect to any document fulfilling inclusion criteria.
- Documents related to settings different than Peru.
- Documents reporting or recommending interventions implemented or to be implemented in small scale (i.e. organisations, districts, cities).
- Documents that do not mention PMD or actively exclude them.

Data extraction methods

Information from documents were extracted using a matrix based on the Shiffman and Smith's (2007) framework as well as the WHO multilevel intervention framework to reduce excess mortality (World Health Organisation, 2015a) (See Appendix 1). This matrix included the following headings:

- **Information to identify the document:** Document ID, title, institution/author, date of publication, date of access, type of document, and link.
- **Contents related to the WHO framework:** Individual-focused interventions (Mental disorder management, Physical health treatment, Interventions addressing lifestyle behaviours), Health system-focused interventions (Service delivery), and Community-level and policy-focused interventions (Social support, Stigma reduction interventions, Policy level interventions).
- **Contents related to the Shiffman and Smith's framework:** Categories used in the original framework were reframed to ease the coding process. For example, "Internal frame" was divided in three sub-categories to code how the analysed document defined excess mortality, its causes and solutions. Reframed categories are presented in Appendix 1, which include: Actors (Policy community cohesion, leadership, guiding institutions, civil society mobilisation), Ideas (Internal frame, External frame), Political contexts (Policy windows, Global governance structure), and Issue characteristics (Credible indicators, Severity, Effective interventions).

Data analysis

All selected documents were analysed through directed content analysis, which uses existing theory or research to guide the coding process (Hsieh and Shannon, 2005). Two frameworks were used: the Shiffman and Smith's (2007) framework on determinants of political priority for global health initiatives and the WHO multilevel intervention framework (Liu et al., 2017, World Health Organisation, 2015a). To analyse, four stages were followed: decontextualization, recontextualization, categorization, and compilation (Bengtsson, 2016).

For decontextualization, the researcher familiarized with the data, reading all the collected documents to have a general idea about its contents. Then, a deductive coding process was followed (Bengtsson, 2016). To do so, an a priori coding list based on the Shiffman and Smith's framework and the WHO multilevel intervention framework was created, which had the codes' names and definitions in a matrix. Based on this coding list, data was analysed to identify

meaning units (quotes) and allocate them in the relevant code. This process was made using matrixes in Excel. When new relevant codes emerged, they were added to the coding list.

Later, data was recontextualized. This means that after finishing all the coding process, all the text was read again and checked if all the contents related to the frameworks were covered. The third stage is categorization, which involved reducing the number of codes through collapsing those which are related into broader categories. Since there is not a fixed number of categories that should be developed, the process of categorization finished when the final set of categories provided a reasonable explanation of the study aim.

Finally, for the compilation stage, a deeper understanding of the data was reached through both manifest and latent levels of analysis. Codes under the WHO framework were analysed in a manifest level, this is, the researcher used the documents' words, referring back to the original text in a more descriptive manner. Codes under the Shiffman and Smith's (2007) framework were analysed in a manifest and latent level; which means that, in addition to the manifest level previously described, the researcher immersed in the data and explored the "hidden meanings" in the text (Bengtsson, 2016).

Quality assessment criteria

The Consensus standards for the reporting of organisational case studies (Rodgers et al., 2016) and the PRISMA checklist (Moher et al., 2009) were followed.

Ethics

No ethical approval was needed since no human data is collected and all documents included are publicly accessed. All documents were downloaded and stored in an online folder only accessible for the researcher and project supervisors in Dropbox and Drive. Since documents were from the public domain and their contents did not involve any individual personal data, no deidentification was needed. At the end of the project, the folder will be erased.

7. Results

The initial search yielded 2,133 publications; out of which 66 were selected for full-text assessment. Of these, 25 met all inclusion criteria. Table 2 presents the documents analysed.

Table 2. General information of analysed documents.

Documents	Year of publication	Type of document
1. Ley N°30947, Ley de Salud Mental (<i>Mental Health Law</i>)	2019	Government document
2. Reglamento de la Ley N°30947 (<i>Regulation of Law N°30947</i>)	2020	Government document
3. Plan Nacional de Fortalecimiento de Servicios de Salud Mental Comunitaria 2017-2021 (<i>National Plan to Strengthen Community Mental Health Services 2017–2021</i>)	2018	Government document
4. Lineamientos de Política Sectorial en Saldu Mental (<i>Sectoral Policy Guidelines on Mental Health</i>)	2018	Government document
5. Definiciones operacionales y criterios de programación y de medición de avances del programa presupuestal 0131: Control y prevención en salud mental (<i>Operational definitions and criteria for programming and measuring progress of the budget program 0131: Control and prevention in mental health</i>)	2020	Government document
6. Norma Técnica de Salud: Centros de Salud Mental Comunitarios (<i>Technical Health Guideline. Community Mental Health Centres</i>)	2017	Government document
7. Norma Técnica de Salud: Hogares Protegidos (<i>Technical Health Guideline. Protected Homes</i>)	2018	Government document
8. Guía técnica para el cuidado de la salud mental de la población afectada, familias y comunidad, en el contexto de COVID-19 (<i>Technical Guideline for the mental health care of the affected population, families, and the community, in the context of COVID-19</i>)	2020	Government document
9. Plan de Salud Mental en el contexto de COVID-19 – Perú, 2020-2021 (<i>Mental Health Plan in the context of COVID-19 – Peru, 2020-2021</i>).	2020	Government document
10. Salud mental comunitaria. Nuevo modelo de atención (<i>Community mental health. New model of care</i>)	2016	Government document
11. Vigilancia de problemas de SM en establecimientos centinela y encuesta poblacional (<i>Surveillance of mental health problems in sentinel centres and population survey</i>)	2016	Government document
12. Implementation, initial results, and sustainability of the Mental Health Services Reform in Peru, 2013-2018	2019	Research article
13. La Reforma de Salud Mental en Perú. Un quinquenio de innovaciones sostenibles. (<i>The Mental Health Reform in Peru. A five-year period of sustainable innovations</i>)	2018	Research article
14. Peruvian Mental Health Reform. A framework for scaling-up mental health services	2017	Research article
15. Transitioning mental health into primary care	2017	Research article
16. Addressing severe mental illness rehabilitation in Colombia, Costa Rica, and Peru	2020	Research article
17. Perceptions of community involvement in the Peruvian Mental Health Reform process among clinicians and policymakers. A qualitative study	2019	Research article
18. Integration of mental health and chronic non-communicable diseases in Peru. Challenges and opportunities for primary care settings.	2014	Research article
19. Salud Mental y Salud Pública en Perú. Es tiempo de actuar (<i>Mental Health and Public Health in Peru. It is time to act</i>)	2015	Research article
20. Mental health law in Peru. Work in progress	2014	Research article
21. Healing minds, changing lives. A movement for community-based mental health care in Peru. Delivery innovations in a low-income community, 2013-2016.	2018	Academic report
22. Supervisión de la implementación de la política pública de atención comunitaria y el camino a la desinstitucionalización. (<i>Supervision of the implementation of the public policy of community care and the path to deinstitutionalization</i>)	2018	Civil society report
23. Recomendaciones al Plan Nacional de Salud Mental (<i>Recommendations for a National Mental Health Plan</i>)	2017	Civil society press release
24. Observaciones de APP al Proyecto de Reglamento de la Ley de Salud Mental (<i>Observations of the Peruvian Psychiatrist Association to the Mental Health Law's Regulation Draft</i>)	2019	Civil society press release
25. Proyecto de Modificatoria de la Ley de Salud Mental (<i>Draft Amendment of the Mental Health Law, from the Peruvian Psychologist Association</i>)	2020	Civil society press release

Legend: List of analysed documents, indicating its title (translated if originally in Spanish), year of publication and type of document.

The determinants of political priority for excess mortality in people with mental disorders within the Peruvian Mental Health Reform.

Actors

The analysed documents did not mention specific actors setting the issue of excess mortality into the MHR agenda; but they did allow to identify two groups of actors involved in the Peruvian MHR who mentioned the topic of excess mortality in their publications. One of these was the DMH, which mentioned the excess mortality of PMD in three documents published in 2016-2018 (Ministerio de Salud, 2018a, Ministerio de Salud, 2018c, Dirección de Salud Mental, 2016). One of these documents was the Sectoral Policy Guidelines on Mental Health (Ministerio de Salud, 2018a), which highlights the need of actions to address, among other priorities, the premature death of PMD:

“In the country, forceful actions are required to promote mental health, protect it, reduce the risks of damaging it, and address the suffering that affects millions of Peruvians who are exposed to stigma and social isolation, to the difficulties in enjoying life, lack of access to specialized health services, worsening of physical illnesses, increased poverty, disability and premature death.” (Document 4).

The second group of actors were researchers. In a 2017 paper aimed to review the progress of the MHR (Toyama et al., 2017), –co-authored with some policymakers from the DMH– authors cited the reduction of PMD mortality as one of the WHO’s priorities:

“The World Health Organization (WHO) calls to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders.” (Document 14).

Despite the DMH appearing as the main actor leading the issue of excess mortality, its latest documents, including the current Mental Health Law (Ministerio de Salud, 2019b) and its Regulation (Ministerio de Salud, 2020a), did not mention this issue. Additionally, the alignment among policymakers and researchers regarding excess mortality suggest certain level of cohesion in the policy community, though the absence of other actors, as professional associations and users’ organisations was notorious.

Ideas

Among the documents mentioning the issue of excess mortality, the wording of “excess mortality” was not found. Instead, the expression used was “premature mortality”, but this category showed different meanings: 1) Premature mortality of PMD, 2) Premature mortality of the general population, and 3) Premature mortality as a component of the Disability-Adjusted Life Years (DALYs).

The idea of “premature mortality” of PMD.

Two documents cited the premature mortality of PMD in similar terms as excess mortality: the higher probability of PMD of dying earlier than the general population. When mentioned, these documents portrayed the issue very succinct, just as a sentence or paragraph to justify the relevance of the mental health agenda. The National Plan to Strengthen Community Mental Health Services (Ministerio de Salud, 2018c), published in 2018, phrased this idea as follows:

“Additionally, people with mental disorders have very high rates of disability and have a 40% to 60% greater probability of premature death than the general population, due to physical health problems, which are often not treated, and suicide.” (Document 3).

In terms of causes and solutions, excess mortality was presented as the result of comorbid physical diseases and suicide. A research article (Diez-Canseco et al., 2014) reported that people with depression experienced a higher risk of mortality due to NCDs:

“Thus, it is not surprising that depression in patients with diabetes or cardiovascular disease carries an increased risk of morbidity and mortality (12,14). For example, the risk of mortality is two to three times higher for patients with type 2 diabetes (2), and twice as high for those with cardiovascular disease who suffer from depression (18)” (Document 18).

The idea of “premature mortality” of the general population.

A second use of “premature mortality” was related to the general population’s mortality. Some documents mentioned the importance of reducing premature mortality due to NCDs, but as an objective for the general population and not for PMD in specific. Here, mental health was used as a mean to reduce mortality, by prevention, promotion, and treatment.

This is an interesting finding, because it implies that the MHR acknowledges that premature mortality can be reduced by preventing and treating mental disorders. As such, improving mental health, either by reducing excess mortality among people with mental disorders or

preventing mental disorders altogether, can reduce premature mortality in the entire population. The following quote exemplifies that excess mortality associated with mental disorders is a priority for the Peruvian MHR:

“[Sustainable Development Goal] SDG N°3, planned to guarantee a healthy life and promote well-being for all at all ages, has set goal 3.4 for the year 2030, to reduce premature mortality from non-communicable diseases by one third, through prevention, treating and promoting mental health and well-being.” (Document 4).

The idea of “premature mortality” as a DALYs component.

Finally, premature mortality was sometimes mentioned in the context of DALYs. This is a measure used to express the burden of specific diseases, based on the years of life lost due to disability or premature mortality (Institute for Health Metrics and Evaluation, 2018). For too long, mental disorders were not prioritized in global and national agendas because of their low mortality burden; but once their impact in terms of disability was highlighted, they started to gain attention (Vigo et al., 2016, Whiteford et al., 2013). Therefore, in the mental health arena, DALYs are mostly used to portray disability rather than mortality, which may explain why the framing of mortality, in general, is not extensively used in the MHR documents.

Despite these documents used “premature mortality”, this was not related to excess mortality of PMD, but only to present an empirical fact, supported by previous research, as shown in the following quote:

“The number of DALYs lost due to disability (894 376) is greater than those lost due to premature mortality.” (Document 4).

Worth noting, DALYs compare the overall health and life expectancy of different populations (Whiteford et al., 2016), and not the higher mortality that PMD face in comparison to the general population. Therefore, this framing is beyond the scope of this study.

Policy contexts

The political contexts, understood as the environments in which actors interact, were difficult to capture from the documents analysed. However, based on years of publication, there seems to have been a policy window around 2014 and 2018. Government and research documents published in this period did clear claims regarding excess mortality of PMD, mainly as stating the fact of their premature death or calling for actions to reduce it (Diez-Canseco et al., 2014, Ministerio de Salud, 2018a, Ministerio de Salud, 2018c, Toyama et al., 2017, Dirección de Salud Mental, 2016).

“[Document] Purpose: Improve the health status of the Peruvian population, instituting comprehensive mental healthcare with protection of rights, and guaranteeing an offer of sufficient and articulated community services in health networks, for mental health promotion, as well as reduction of risks, damages, disability and premature mortality due to mental health problems.” (Document 4).

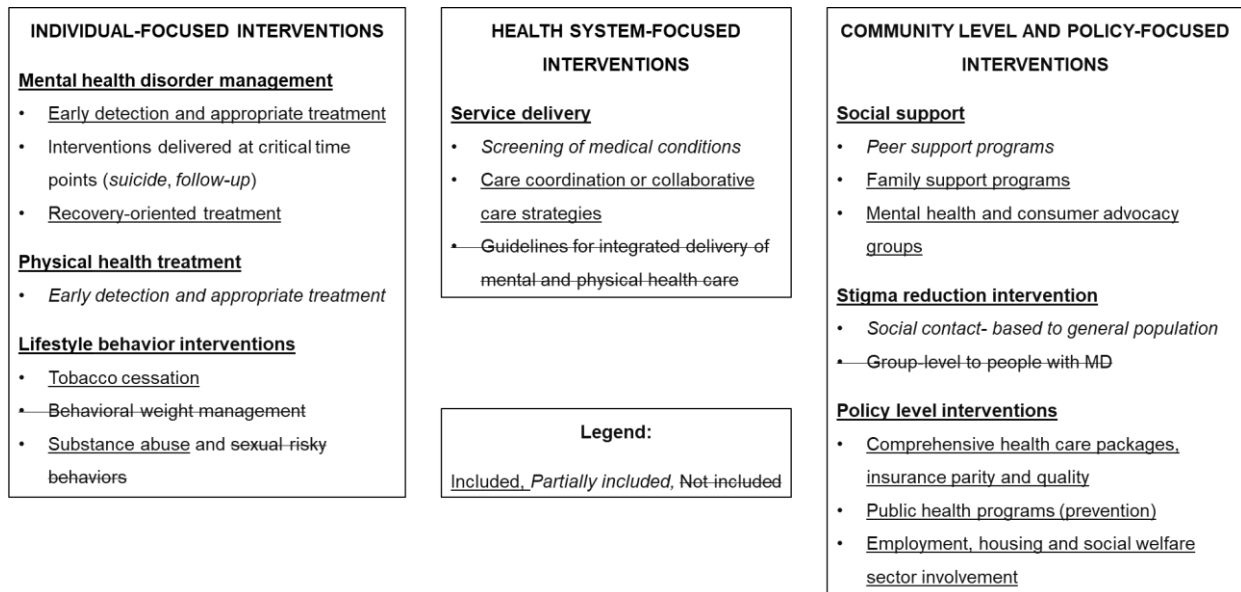
This phrasing was no longer found in the Law or the ones published in the context of COVID-19, during 2019-2020 (Ministerio de Salud, 2019b, Ministerio de Salud, 2020a, Ministerio de Salud, 2020g, Ministerio de Salud, 2020c); yet, as will be presented below, these documents described interventions that can reduce excess mortality. Since documents from 2014-2018 are still in force, it may explain the absence of this issue in recent publications.

In terms of governance structure, both actors raising the issue of excess mortality –DMH and researchers– portrayed a common set of norms, stating the severity of excess mortality and the need of mitigating strategies. Moreover, evidence of previous collaboration in a research publication, co-authored by these actors (Toyama et al., 2017), may suggest a platform for excess mortality in the MHR agenda.

Issue characteristics

Excess mortality was outlined as a serious problem, but lacked of credible indicators to measure its reduction. Regarding effective interventions to address it, the WHO framework allowed to identify a series of interventions promoted by the MHR. Figure 3 present the WHO framework (Liu et al., 2017), highlighting which interventions were described in the documents analysed. Following, they will be detailed.

Figure 3. Interventions to reduce excess mortality described (or not) in MHR documents, following the WHO framework.



Legend: Following the WHO framework (2015), underlined interventions were described in the MHR documents; those in italic were partially described; and those crossed out, were not present.

In terms of individual-focused interventions, the MHR is already working on the early detection and evidence-based treatment of mental disorders, with a recovery-oriented model of care. The Law’s Regulation stated all mental health interventions must be based on evidence or scientific theories:

“The MOH prepares normative documents intended to guide mental health interventions, based on the scientific evidence available in the different fields of science, contexts and resources.” (Document 2).

For example, a government document that operationalizes mental health interventions (Ministerio de Salud, 2020b), indicates evidence-based treatment for depression, as cognitive-behavioural therapy or interpersonal therapy. Likewise, many documents mentioned rehabilitation and recovery interventions as part of the CBMC.

“In community mental health, comprehensive care is not limited to services based on symptoms or diagnoses of mental disorders, deficits and disabilities (illness perspective), but also emphasizes people’s strengths, capacities and aspirations (recovery perspective).” (Document 4).

Few documents mentioned suicide prevention strategies. The law mentioned suicide as one risk factor to be assessed in the community; whereas two other core government documents only acknowledged its higher prevalence in specific Peruvian regions. Documents produced on the COVID-19 context, however, did mention more specific actions to identify, treat and refer these cases (Ministerio de Salud, 2020c):

“Explore in each intervention if there is imminent suicide risk and inquire about the presence of risk factors such as (...); as well as the presence of protective factors such as (...). If there is an imminent suicidal risk, it is necessary to refer for care as emergency to the nearest hospital. Ensure continuity of care depending on each case.” (Document 8).

Regarding recommended follow-up during the first year of discharge from psychiatric hospitalization to reduce suicide risk (Nordentoft et al., 2011), Peruvian guidelines have partial measures. The Law mentions that after hospital discharge, continuity of care should be assured (Ministerio de Salud, 2019b), but it did not specify any timeframe nor procedures on how to conduct it. *“At the time of medical discharge, the continuity of care required by each case must be ensured.”* (Document 1).

A research paper co-authored with DMH policymakers indicates that users should be referred to CMHC and participate in the continuity of care program, again with no timeframe nor procedures (Toyama et al., 2017). One government document used for surveillance indicates that cases identified as first episode of psychosis in consultation or hospitalization will be followed-up at six months (Ministerio de Salud, 2016). Despite having some indications, none of these documents met the entire recommendation of follow-up during –and not only after– 12 months of discharge for any person who was hospitalized.

In terms of physical health treatment, the Law’s Regulation mentioned that a physician should treat PMD who are suspected to have comorbid physical diseases (Ministerio de Salud, 2020a). Screening of physical conditions was mentioned in the CMHC Guidelines (Ministerio de Salud, 2017), which are supposed to conduct laboratory tests for physical conditions. Guidelines for protected homes (Ministerio de Salud, 2018b) would connect their users with the corresponding primary care centres for preventative check-ups.

“It [protected home] ensures the attendance of the user and coordinates with the local health centres, for the comprehensive healthcare of the users, including periodic preventive check-ups and other evaluations if necessary.” (Document 7).

For lifestyle behaviour interventions, documents released in the context of COVID-19 (Ministerio de Salud, 2020g, Ministerio de Salud, 2020c) reported guidelines for people with substance abuse and tobacco consumption, including detection, diagnose, treatment and recovery for these conditions in the context of pandemic and lockdowns.

“(...) people with problems of consumption and abuse of alcohol, tobacco and other psychoactive substances, could present conditions related to abstinence and other related problems; these people will need medical support and greater psychosocial intervention measures, requiring, if applicable, access to timely specialized care or, if they are in home isolation, access to telemedicine by CMHC or primary care providers.” (Document 8).

However, guidelines directed towards behavioural weight management and sexual risky behaviours were usually for the general population only and not for PMD (Ministerio de Salud, 2020a, Ministerio de Salud, 2018a).

For health system-focused interventions, care coordination and collaborative care strategies are the main strategy of the CMHC’s continuity of care program, which is an intensive case management program for the rehabilitation and recovery of people with SMD (Miranda et al., 2017). Guidelines for integrated delivery of mental and physical health, on the contrary, were not found. Some government documents and research papers stated the comorbidity of physical and mental health conditions (Ministerio de Salud, 2018c, Ministerio de Salud, 2018a, Toyama et al., 2017, Diez-Canseco et al., 2014), but did not mention any guideline or potential management.

“Generally, these mental health problems influence and are influenced by others, also priority ones, such as those related to child and maternal health, sexual and reproductive health, cancer, cardiovascular and metabolic diseases, even infectious diseases such as tuberculosis and HIV/AIDS, among others.” (Document 3).

Lastly, for community level and policy-focused interventions, most policy-level interventions were found, mainly in terms of healthcare packages, insurances, public health programs, and employment and housing for the general population, which PMD could benefit from. Importantly, the Law mandates private health insurances to cover mental health and the government to include PMD living in extreme poverty to be included in the national health insurance (SIS):

“Private companies that offer health insurance are forced to provide coverage for diagnosis, treatment and rehabilitation in mental health (...) with the necessary frequency, quantity and duration. (...) People with mental disabilities living in poverty or extreme poverty, who do not have insurance, should be included in the SIS, according to a progressive care plan or benefits” (Document 1).

Worth noting, according to the Law’s Regulation and technical guidelines, protected homes and residences, as well as psychosocial and employment rehabilitation centres, aimed to promote employment, housing and social welfare for people with SMD (Ministerio de Salud, 2018b, Ministerio de Salud, 2015).

The Law’s Regulation, technical guidelines and COVID-19-related documents stated that social support programs directed to family members were an important component of the CBMC (Ministerio de Salud, 2020a, Ministerio de Salud, 2017, Ministerio de Salud, 2018b, Ministerio de Salud, 2020g, Ministerio de Salud, 2020c), and strongly encouraged the creation of consumer advocacy groups (Ministerio de Salud, 2018a, Ministerio de Salud, 2017, Ministerio de Salud, 2020c). *“Functions of the rehabilitation unit: Promote the creation of self-managed user groups” (Document 6).*

A research paper explained that peer support programs were normally self-help or support groups (Arriola-Vigo et al., 2019) for people who share a same mental disorder or psychosocial problem. This article and the CMHC guidelines mentioned examples as psychosocial clubs for people with SMD, or mutual support groups for people with depression, substance abuse or violence (Ministerio de Salud, 2017). Nonetheless, these groups were related to their mental health only and not for their physical health.

“A few participants reported that peer support groups were inconsistently implemented and they aim to provide patients with a safe environment to share their experiences about mental illness, normalize their symptoms, and learn coping skills from their peers. This model is an example of a recovery oriented intervention that is not only directed for people with substance use disorders, but also people with mood or psychotic disorders.” (Document 17).

Finally, stigma was portrayed as a major problem to overcome, and some stigma reduction interventions were mentioned by the Law’s Regulation, technical guidelines and research papers. These included social media campaigns (Ministerio de Salud, 2020a, Ministerio de Salud, 2018a, Ministerio de Salud, 2017, World Bank, 2018); training of authorities, teachers, administrative staff, and students on schools, with emphasis of detecting and treating students

with no stigma (Ministerio de Salud, 2020a); exchange and critical reflection spaces with different key stakeholders, including users (Ministerio de Salud, 2018a); and individual placement and support programs (Cubillos et al., 2020). The CMHC guidelines had a specific activity related to talking stigma, named *social mobilization*:

“Social mobilization: Destigmatization activity and promotion of campaigns for the insertion of users who suffer from mental health disorders in the community, motivate socialization actions and active participation (in markets, social-based organisations sports tournaments, fairs, festivities, mass concentrations, marathon and parades).”
(Document 6).

On the contrary, group-level interventions to PMD were only stated as a recommendation from an academic report to promote social integration groups organised by CMHC (World Bank, 2018). *At grassroots level, public education programs and social integration groups organised by CMHCs for patients, families, and community members are promising vehicles to fight stigma.* (Document 21).

8. Discussion

This study aimed to explore to what extent the MHR prioritized the reduction of excess mortality of PMD in its agenda, by using the Shiffman and Smith's (2007) framework of determinants of political priority. Our findings suggest that excess mortality appears as a relevant problem to be addressed; where the connections between PMD and their premature mortality came out in some of the documents. However, explicit strategies on how to reduce excess mortality or what are the initiatives currently taken by the MHR were missing.

Actors portraying the issue of excess mortality were the DMH and a group of researchers, who stated the fact of PMD dying prematurely and the need to act upon this. Despite these actors' collaboration, as evidenced by joined publications in scientific journals (Miranda et al., 2017, Toyama et al., 2017), further involvement and leadership from other sectors, such as professional associations and users-led organisations, would be required to build a cohesive policy community and positioning excess mortality into the MHR agenda. As the Australian MHR experience suggests, "genuine leadership" from different political actors is needed to assure progress (Hickie et al., 2005). Yet, the involvement of diverse stakeholders will require careful consideration of the stigma found among Peruvian government and civil society (World Bank, 2018), since this usually undermines initiatives' success (Kisely, 2010).

Importantly, the DMH produced most of the government documents analysed; thereby, their current leadership in positioning excess mortality into the MHR agenda could be used as a platform to expand its prioritization on future MHR initiatives. For example, the National Plan to Strengthen Community Mental Health Services (Ministerio de Salud, 2018c) will formally expire in 2021; opening an opportunity for the next one to better address the issue of excess mortality. This could be done by portraying not only its occurrence, but also which strategies would take the MHR to reduce it. Still, insights from the Spanish MHR, stating the need to assure commitment and political support beyond the government (Vázquez-Barquero et al., 2001), should be stressed.

Ideas behind excess mortality were mainly based on empirical facts, reporting that PMD die prematurely, and claiming the importance to tackle this. Even though this idea was present in various documents, the main idea behind the MHR was closing the large treatment gap. This approach has been part of several MHR (i.e. China (Liu et al., 2011), Spain (Vázquez-Barquero et al., 2001), Latin America (Minoletti et al., 2012)); however, it might lead MHR to direct their efforts on this direction, disregarding possible solutions to other relevant areas, as excess mortality. Nonetheless, reducing excess mortality has been considered as one of the

main components for mental health policies (Jenkins, 2003), which emphasizes the need to incorporate it into MHR agendas.

Regarding *political contexts*, years 2014-2018 appear as a period in which excess mortality gained a space in the policy agenda. This could be related to the accumulation of evidence on excess mortality of PMD, united to a global momentum brought by the WHO meeting on excess mortality on November 2015 (World Health Organisation, 2015a). Even though past policy windows were not properly identified, potential opportunities in the future could benefit the agenda setting of excess mortality. For example, the Law establishes the creation of a National Mental Health Coalition, composed of ministries and health institutions, which can receive technical advice from civil society, private sector and researches for multisectoral strategies (Ministerio de Salud, 2019b). Rising awareness of excess mortality to this platform could ease its political priority. Likewise, the MOH encourages the active participation of users, health providers, local leaders, non-government organisations, and academics in developing, among other things, legal frameworks and legislation (Ministerio de Salud, 2018a), which may represent a potential political window.

Finally, regarding *issue characteristics*, the WHO framework (Liu et al., 2017) allowed to identify that many of the MHR strategies can reduce excess mortality; but this reduction was not mentioned as an expected outcome. This absence may imply a gap between the relevance of the problem –present in the analysed documents– and the acknowledgement of which interventions can solve it. A clearer connection of the problem to effective interventions can led to a better positioning of excess mortality in the MHR agenda, for which the WHO framework could be useful.

Lessons learned for other countries

Active collaboration among different stakeholders, as those coming from the government, academia and user organisations, is still emerging in the Peruvian MHR (World Bank, 2018). Countries might learn from this and aim to increase their exchange and close partnership with other sectors. This could be especially relevant for the issue of excess mortality, since it demands the involvement of other health strategies –i.e. NCDs, eliminate violence– as well as government sectors –i.e. housing, employment, and welfare initiatives (Liu et al., 2017).

It would also be important to understand how ideas should be framed to gain political position. A way to do so could be the argument of reducing excess mortality to reach the SDGs. Since 2015, global mental health leaders advocated for the introduction of mental health in the SDGs, and achieved its explicit introduction in Goal 3 and particular mention of people with

disabilities in Goals 4, 8, 10 and 11 (Scorza et al., 2018). Actors may use this framing to set excess mortality into their national mental health agendas. Likewise, policy communities could use the existing framework of the WHO on effective interventions to reduce excess mortality (World Health Organisation, 2015a) to present credible indicators and deliver feasible interventions in their countries.

Additionally, it is deemed relevant to enhance the role of research into policy agenda settings. It would be important to expand the production of local research on the excess mortality of PMD; especially in South America, which lacks research on this topic, as shown in a systematic review that estimated years of potential life lost and life expectancy in people with schizophrenia and did not find publications in the Region (Hjorthøj et al., 2017). Research should explore context-specific causes and interventions to advise policy guidelines, including the role of comorbidities in excess mortality and healthcare system's response (Saxena, 2018). Meanwhile, the uptake of international research by local policy communities (World Health Organisation, 2013) could be used by policy actors to introduce excess mortality into MHR agendas.

Capacity building, knowledge translation and further cooperation among policymakers and academics should also be promoted, as previously recommended (World Bank, 2018). The National Institute for Health and Care Excellence (NICE) in the United Kingdom is a good example on how research can inform policies by providing evidence-based guidance and measures for public health and social care services (National Institute for Health and Care Excellence, 2020).

Countries could also highlight the issue of excess mortality to international donor communities to conduct research and effective interventions. As found in a Sri Lankan study about violence against women, international donor communities are relevant in influencing and shaping local ideas and policy agenda settings (Colombini et al., 2018). In the case of mental health, Grand Challenges Canada, the UK Department for International Development, and the US National Institute of Mental Health have been funding initiatives to overcome mental health disparities (Tomlinson and Lund, 2012), with the latter funding projects to prevent and treat physical conditions in people with SMD (US National Institute of Mental Health, 2015). Countries could build over these opportunities to position the topic of excess mortality as a funding priority.

Finally, countries might consider the usual barriers faced by low-resource nations when introducing new policies and scaling-up interventions, such as the ones found in LMIC settings (Saraceno et al., 2007) and when integrating mental health into primary care (Wakida et al., 2018, Diez-Canseco et al., 2018, Caverro et al., 2018). These include the disconnection of

services within a decentralized system, overburden of providers from all levels and facilities, non-specialized mental health providers' lack of training and resistance to treat PMD, providers' lack of time to train and supervise others, and time constraints. Yet challenging, addressing these barriers might result in important improvements towards the health and life expectancy of PMD.

Strengths and limitations

The first strength of this study was its theory-driven approach, based on the Shiffman and Smith's (2007) framework. This allowed to analyse how excess mortality has gained position into the MHR agenda, as well as identifying current progress, gaps and the way forward. Second, its use of the WHO framework (World Health Organisation, 2015a) eased the identification and proposal of appropriate evidence-based interventions to address this issue, pointing out which ones will need to be enhanced or incorporated into the MHR. This provides a starting point for policymakers to evaluate their current performance and sign-post future initiatives. Third, the study included a wide range of documents from different sources, databases and sectors, which enabled a broad assessment of excess mortality into the MHR. Lastly, it addressed the highly relevant, and yet hidden and neglected topic of excess mortality and its incorporation into MHR agendas.

Conversely, the main limitations of this study are its grounding on openly-access documents and focus on predetermined codes that could left behind relevant topics. However, this is unlikely due to the use of a validated and comprehensive framework, which have proven to be useful (Aya Pastrana et al., 2020, Heller et al., 2019, Tomlinson and Lund, 2012). Input from identified actors through surveys or interviews would broaden the scope of this study, allowing to better understand excess mortality positioning in the MHR. Yet, the use of a range of documents (policies, reports and research) from both scientific and grey literature, in addition to theory-driven and evidence-based frameworks, enabled a solid basis to explore this problem and suggest pertinent recommendations.

9. Conclusions

This study analysed a range of documents (policies, reports and research) through the lens of the theoretical Shiffman and Smith's (2007) framework, to gain understanding on the recognition of excess mortality of PMD as a political priority within the Peruvian MHR. Findings suggest that excess mortality was prioritized into the MHR agenda by having key actors stating its relevance, but effective interventions on how to reduce it were not properly outlined.

Main *Actors* portraying the issue of excess mortality were policymakers and researchers, who previously worked in collaboration; but a cohesive policy community would still need users-led organisations and professional associations. In *Ideas*, excess mortality was framed as a relevant problem, but with no strategies to address it. Most MHR's initiatives seem in alignment to the idea of closing the treatment gap, which might be leaving behind other relevant issues, as excess mortality. The period of 2014-2018 appeared as a favourable *Political context* for the positioning of excess mortality, with core documents portraying the issue. The creation of the National Mental Health Coalition proposed in the Mental Health Law is a potential policy window for excess mortality. Regarding *Issue characteristics*, the WHO framework allowed to identify some interventions to reduce excess mortality already included in the MHR documents, but this reduction was not mention as their aim. Thereby, excess mortality is part of the MHR, but some of the Shiffman and Smith's (2007) determinants would still need to be considered to expand its agenda setting.

Other countries could learn from the Peruvian experience on how to incorporate excess mortality in their national agendas by specific actions, like promoting collaboration among different sectors to effectively address excess mortality; framing the issue to resonate in national audiences; generating rigorous research responsive to local needs and able to inform their policies; positioning excess mortality into international donor communities' agendas as a funding priority; and acknowledging usual barriers faced by LMIC when introducing new policies and scaling-up interventions.

10. Recommendations

Expand the positioning of excess mortality into the Peruvian MHR agenda. Excess mortality has been acknowledged by policymakers and researchers as a relevant problem to be addressed; but in order to gain further political priority, it still needs to:

- Build a cohesive policy community involving professional associations and users-led organisations,
- Frame excess mortality in a way that resonates with political leaders (i.e. reducing excess mortality to reach the SDGs),
- Explicitly propose effective interventions to reduce it.

Define which interventions to reduce excess mortality will be implemented. By using the WHO framework (World Health Organisation, 2015a), my results evidenced that some of these interventions were part of the Peruvian MHR, but they were not targeting the reduction of excess mortality. Therefore, the MHR could:

- Update its legislation to incorporate the goal of reducing excess mortality,
- Tailor the remaining interventions proposed by the WHO to its context.

Strengthen the role of research to set excess mortality into MHR agendas. Research can ease the process of agenda setting by providing relevant information on context-specific characteristics to the policy community. To enhance this, the following could be done:

- Develop local research to inform policy guidelines (i.e. context-specific causes, healthcare system's response),
- Build research-capacities in policy communities to conduct, interpret and effectively use research,
- Enhance partnerships among policymakers and researchers,
- Position excess mortality into global funders' priorities.

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WORLD HEALTH ORGANISATION 2019. Sustainable Development Goals (SDG). WHO.

Appendix 1

Codebook

General Information		
#		
Title		Title of the document as appears in the original source
Institution/Author		Institution that published the document and/or author(s) who wrote it
Date published		Date in which the document was published in the original source (website). Format: 21 Jul 2020 or 2020
Date accessed		Date in which the document was retrieved by the researcher. Format 21 Jul 2020
Type of document		Government document, Institutional communicate, Scientific paper, Report, Clinical guidelines, Conference presentation
Link		Link to the original source
WHO Framework		
1	Individual-focused interventions	Strategies delivered to the individuals with SMD to target their mental health condition, physical health, and lifestyle behaviours
1.1.	Mental health disorder management	Interventions addressing one or more of the following:
1.1.1.	MH Interventions	Evidence-based mental health interventions, based on the MhGAP
1.1.2.	Medications	Medications: Appropriate administration of medications (continuous medication treatment, proper dosing ranges and current and long-term use compared with no medication), and adherence to medication guidelines
1.1.3.	Recovery-oriented programmes	Recovery-oriented programmes, with a focus on psychoeducation and increased awareness of symptoms, coping with stress and problem-solving skills, as well as strategies supporting people with SMD and their families around treatment engagement
1.1.4.	Suicide prevention	Suicide prevention interventions for those with SMD, especially early in the course of illness.
1.1.5.	Follow-up after psychiatric hospitalization	Follow-up within one year after discharge from psychiatric hospitalization
1.1.6.	Interpersonal violence	Interventions for interpersonal violence (persons with SMD are commonly victims of interpersonal violence)
1.2.	Physical health treatment	Interventions addressing one or more of the following:
1.2.1.	Tailored medical treatment	Tailored medical treatment for hypertension, diabetes mellitus and dyslipidaemia. I.e. Self-management components (e.g., for diabetes) may require tailoring which accounts for cognitive, functional, or motivational deficits.
1.2.2.	Screening	Screening for obesity, hyperlipidaemia and hypertension
1.3.	Interventions addressing lifestyle behaviours	Interventions addressing one or more of the following:

1.3.1.	Tobacco cessation	Tobacco cessation interventions, especially at the earliest possible phases of treatment: Combination treatment with counselling and bupropion with or without nicotine replacement therapy or varenicline
1.3.2.	Weight loss	Tailored behavioural weight loss programmes: Improving diet and increasing exercise with adaptations for cognitive needs of those with SMD, such as tailoring content and delivery to address memory and executive function deficits, and emphasizing environmental supports
1.3.3.	Substance abuse	Substance abuse and risky sexual behaviour: Limited evidence
1.3.4.	Risky sexual behaviour	Substance abuse and risky sexual behaviour: Limited evidence
2	Health system-focused interventions	Interventions and programmes within health systems targeting health care providers and service delivery components.
2.1.	Strengthening health systems' six building blocks	Strengthening of the six building blocks of the health systems – service delivery; health workforce; information; medical products, vaccines, and technologies; financing; and leadership and governance (stewardship) – would improve outcomes for persons with SMD
2.2.	Care coordination, collaborative care, or integrated care	These programmes include support to better equip health systems, usually through the provision of additional supportive members who can serve as a liaison between mental health and physical health care systems or through linking of delivery of physical and mental health services
2.3.	Nurses in MH	Nurse practitioners in mental health have a role as both coordinators and providers, including for: comprehensive physical health evaluation; management and referral; education and support to consumers; enhancing continuity of care for patients; facilitating communication, appropriate access and utilization of hospital services for persons with SMD; collaboration between mental health professionals and primary care, including dietitians and other lifestyle consultants; provision of health promotion; assisting the patient in making appointments or involving the case manager in ensuring the patient is able to attend appointments.
2.4.	Physical comorbidity	Providers' assessment and treatment of physical health conditions, and routine monitoring of the physical health side effects of medication, offering behavioural counselling and linking to other guidelines (e.g., obesity or diabetes) when appropriate. Mental health care providers routinely monitor weight and cardiovascular and metabolic indicators of morbidity in people with SMD and offer interventions for obesity, lipid modification or preventing type 2 diabetes, as appropriate.
2.5.	Guidelines of care for SMD in organisations	Health care leaders implementing national and international guidelines for care of persons with SMD in their organisation and aligning financing policy and information systems for the missions of improving and monitoring quality of care.
3	Interventions focused on socio-environmental determinants	The broadest level of the framework incorporates socio-environmental factors and the social determinants of health. This part of the model acknowledges the range of potential interventions originating from the community to address contributors to premature mortality.
3.1.	Social Support	
3.1.1.	Peer support programmes	Are potential resources that can implement or assist with health interventions, whether focused on health behaviours, chronic disease self-management, or recovery-based programmes. Especially for chronic disease self-management

3.1.2	Family support programmes	Are potential resources that can implement or assist with health interventions, whether focused on health behaviours, chronic disease self-management, or recovery-based programmes
3.1.3.	Mental health consumer groups	Are potential resources that can implement or assist with health interventions, whether focused on health behaviours, chronic disease self-management, or recovery-based programmes
3.2.	Stigma reduction interventions	
3.2.1.	No SMD: Social contact-based interventions	For people with no SMD, social contact-based interventions seem to be the most effective. Studies should examine behavioural and not only attitudinal change as a result of interventions to decrease stigma and discrimination
3.2.2.	SMD: Group-level interventions	For those with mental disorders, group-level interventions appear helpful. Studies should examine behavioural and not only attitudinal change as a result of interventions to decrease stigma and discrimination
3.3.	Policy level interventions	On a wider scale, policies that have a beneficial effect on all individuals may also be beneficial for those with SMD, or policies may need to be shaped specifically to influence health for persons with SMD. Importantly, the factors in this part of the model link across to both health system and individual-focused interventions.
3.3.1.	Integration into society: Parity, employment, and housing	Public health policies providing mental health parity could greatly improve lives of those with SMD. Employment programs and policies to provide stable housing may impact the ability of persons with SMD to fully integrate into society, which should lead to improved physical health.
3.3.2.	Individual-level interventions in policies	Policy-level interventions that affect screening or management of suicide, HIV or tobacco smoking are especially relevant to those with SMD and may have even greater effects on the health and well-being of this high-risk population. Knowing how policy-level interventions need modifications to best improve and lengthen the lives of persons with SMD will be important for future impact. For example, protection legislation may be in force, but individuals may not seek this protection due to not wanting to be identified as having a mental disorder.
Shiffman and Smith's Framework		
1	Actor power	The strength of the individuals and organisations concerned with the issue
1.1.	Who is the actor?	Policy community cohesion: The degree of coalescence among the network of individuals and organisations that are centrally involved with the issue at the global level
1.2.	Is this actor a champion?	Leadership: The presence of individuals capable of uniting the policy community and acknowledged as particularly strong champions for the cause
1.3.	If institution, does it lead the initiative?	Guiding institutions: The effectiveness of organisations or coordinating mechanisms with a mandate to lead the initiative
1.4.	If civil society, has mobilised authorities to address the issue?	Civil society mobilisation: The extent to which grassroots organisations have mobilised to press international and national political authorities to address the issue at the global level
2	Ideas	The ways in which those involved with the issue understand and portray it

2.1.	Internal frame	Internal frame: The degree to which the policy community agrees on the definition of, causes of, and solutions to the problem
2.1.1.	How is the problem defined	
2.1.2.	What are the causes of the problem	
2.1.3.	What are the solutions to the problem	
2.2.	External frame	External frame: Public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources
2.2.1.	If not government, how is the issue portrayed	
2.2.2.	If not government, their portrayals of the issue resonate with political leaders?	
3	Political contexts	The environments in which actors operate
3.1.	Policy windows: How was the context when the document was published	Policy windows: Political moments when global conditions align favourably for an issue, presenting opportunities for advocates to influence decisionmakers
3.2.	Is there a government platform for this document?	Global governance structure: The degree to which norms and institutions operating in a sector provide a platform for effective collective action
4	Issue characteristics	Features of the problem
4.1.	Credible indicators	Credible indicators: Clear measures that show the severity of the problem and that can be used to monitor progress
4.1.1.	Are there clear measures to show the severity of the problem?	
4.1.2.	Can these measures be used to monitor progress	
4.2.	How severe is this problem? Relative to other measures, as mortality	Severity: The size of the burden relative to other problems, as indicated by objective measures such as mortality levels
4.3.	Are solutions proposed clearly explained, evidence-based, feasible, and affordable?	Effective interventions: The extent to which proposed means of addressing the problem are clearly explained, cost effective, backed by scientific evidence, simple to implement, and inexpensive