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From Recognition to Enforceability: Constitutionalizing the Right to Mental Health in Peru Through Constitutional Court Jurisprudence

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Abstract

This article examines how the right to mental health has been constitutionalized in Peru through the jurisprudence of the Constitutional Court. Using doctrinal constitutional analysis, the article combines the interpretation of international human rights standards, domestic legislation, and the Court's leading cases with a targeted review of recent scholarship on community mental health reform, disability rights, and coercion. It argues that the Peruvian Court has transformed mental health from a predominantly medical or welfare concern into a constitutionally enforceable right by recognizing its connection to dignity, psychological integrity, equality, and the right to health. The article further argues, however, that this constitutionalization remains incomplete: the Court has been stronger in recognition and remedial activation than in fully confronting coercion, legal capacity, and the structural determinants of unequal enjoyment. The Peruvian case therefore illustrates both the promise and the limits of judicially driven rights-based mental health reform. Its broader contribution lies in showing that constitutionalization should be assessed not only by rights recognition, but also by doctrinal elaboration, institutional remedies, and the extent to which courts reshape the underlying legal model of care.

Keywords: mental health law; Peru; Constitutional Court; right to health; CRPD; community mental health; prison health; social rights



Received: 6 April 2026

Revised: 17 June 2026

Accepted: 14 July 2026

Published: 29 July 2026

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1. Introduction

Mental health law is currently undergoing profound re-evaluation across jurisdictions. The shift is not merely technical. It reflects a broader normative transition from asylum-based, segregated, and coercive models toward approaches centered on rights, autonomy, community inclusion, recovery, and participation. This change is reflected in the World Health Organization (WHO) and Office of the United Nations High Commissioner for Human Rights (OHCHR) guidance on mental health, human rights and legislation, which urges states to reform laws so as to reduce coercion, address discrimination, promote deinstitutionalization, and build high-quality community services ([World Health Organization and United Nations. Office of the High Commissioner for Human Rights 2023](#)). The WHO's 2025 guidance on mental health policy and strategic action plans deepens that

orientation by linking mental health reform to governance, service integration, prevention, lived experience, and the social and structural determinants of well-being ([World Health Organization 2025](#)).

Peru offers an especially instructive case within this global landscape. [Jimenez et al. \(2014\)](#) described the pre-reform system as marked by legislative underdevelopment, concentration of psychiatric services, and serious gaps in the protection of autonomy and due process. [Toyama et al. \(2017\)](#) then documented the shift toward community-based reform, budgetary redesign, and service expansion, while the [Organización Panamericana de la Salud \(2023\)](#) confirms that this shift matured into a broader rights-based framework centered on dignity and community mental health. That transformation includes the 2012 reform of Article 11 of the General Health Law ([Congreso de la República del Perú 2012a](#)), the enactment of Mental Health Law No. 30947 ([Congreso de la República del Perú 2019](#)), the issuance of its regulation ([Ministerio de Salud 2020](#)), the strengthening of the disability-rights framework through Law No. 29973 ([Congreso de la República del Perú 2012b](#)), and the recognition of legal capacity on an equal basis through Legislative Decree No. 1384 ([Ministerio de Justicia y Derechos Humanos 2018](#)). Official Minsa sources reported 291 community mental health centers in May 2025 ([Ministerio de Salud 2025b](#)) and 305 by February 2026 ([Ministerio de Salud 2026](#)).

The Constitutional Court of Peru has played a central role in that process. Through a line of cases beginning with Exp. No. 02480-2008-PA/TC and extending to judgments on psychiatric internment, security measures, prison mental health, and abstract review of the Mental Health Law, the Court has developed a doctrinal framework that treats mental health as a justiciable fundamental right grounded in dignity, health, and psychological integrity ([Tribunal Constitucional del Perú 2009, 2010, 2019, 2021a, 2021b, 2024](#)). Yet the case law also reveals a structural tension: the Court's rights-based language has frequently advanced further than the administrative, territorial, and institutional capacity of the system charged with implementing it.

This article asks two connected questions. First, to what extent has the Peruvian Constitutional Court transformed mental health from a sectoral health concern into a constitutionally enforceable fundamental right? Second, what are the doctrinal and practical limits of that transformation when read against international human rights law, domestic legislation, and the strongest contemporary understandings of the right to mental health? The article argues that the Court has achieved a robust first-order constitutionalization of the right to mental health, but only a partial second-order constitutionalization. At the first level, the Court has recognized mental health as part of the constitutional order of fundamental rights, elaborated its doctrinal content through concrete obligations, treated it as enforceable through individual and structural remedies, and influenced the interpretation of subsequent legislation and policy. At the second level, however, constitutionalization remains incomplete because the jurisprudence secures access, continuity of care, and institutional protection more robustly than it secures autonomy, anti-coercion commitments, and a fully CRPD-consistent account of legal capacity and of the person's will and preferences.

The article's contribution is therefore not limited to describing Peruvian reform. It offers a constitutional account of what "constitutionalization" means in the mental health field and uses the Peruvian experience to illuminate a wider comparative problem: whether courts can move mental health from the domain of welfare administration to the domain of enforceable rights without simultaneously resolving the deeper tension between care, autonomy, disability equality, and coercive power. In that sense, Peru matters beyond Peru. Its comparative significance is heightened by Peru's treaty-integrating constitutional order: ratified human rights instruments do not operate merely as external background, but as part of the domestic interpretive framework through which constitutional rights

acquire legal meaning. It provides a case of judicially accelerated rights-based reform in a middle-income state with significant capacity constraints, and therefore serves as a useful laboratory for broader debates on social rights adjudication, community care, and the constitutional governance of mental health.

Methodologically, this is a doctrinal constitutional law article supported by a targeted review of recent interdisciplinary scholarship. The analysis proceeds in four stages. First, it reviews the main academic and institutional literature on mental health reform in Peru and the broader theoretical literature on the right to mental health. Second, it reconstructs the international and domestic normative framework applicable to Peru, paying particular attention to the constitutional reception of international human rights law through Article 55 and the Fourth Final and Transitory Provision of the Constitution. Third, it analyzes the leading Constitutional Court decisions on mental health. The jurisprudential corpus was selected because it covers the main doctrinal sites where the right has been developed: access and continuity of treatment, psychiatric internment and security measures, prison mental health, and abstract review of the Mental Health Law. Fourth, it evaluates the doctrinal, remedial, and systemic significance of that case law in light of social rights theory and CRPD-informed mental health law.

The article proceeds in the following order. Section 2 explains the methodological design. Section 3 presents the findings in five steps: the state of the art, the theoretical framework, the applicable international standards and their constitutional reception in Peru, the domestic legal framework and its internal tensions, and the Constitutional Court's leading cases. Section 4 discusses the broader constitutional and comparative implications of those findings, and Section 5 sets out the conclusions.

2. Methods

This is a doctrinal constitutional law article. It analyzes the right to mental health through the interpretation of constitutional provisions, international human rights instruments applicable in Peru, statutory and regulatory materials, and the jurisprudence of the Peruvian Constitutional Court. The article does not use interviews, surveys, or human-subjects research; its evidentiary base consists of public legal materials and academic literature.

The case corpus was selected because it captures the principal doctrinal sites through which the Constitutional Court has shaped the right to mental health: (1) access and continuity of care; (2) security measures and therapeutic internment; (3) prison mental health; and (4) abstract review of the Mental Health Law. The analysis focuses on the Court's leading cases in each area and on the standards, obligations, and remedies that those decisions articulate.

The article also undertakes a targeted review of recent interdisciplinary scholarship on mental health reform in Peru and on broader debates concerning social rights, legal capacity, coercion, and community-based care. The method is interpretive and evaluative rather than quantitative. Its purpose is to assess whether, and in what sense, the Court has constitutionalized the right to mental health, and to identify the doctrinal limits of that process.

3. Findings

3.1. State of the Art: Mental Health Reform, Rights, and Implementation in Peru

The literature on mental health law and policy in Peru can be organized into three broad phases. A first phase described the system before comprehensive reform as fragmented, under-regulated, and insufficiently protective of autonomy and due process. [Jimenez et al. \(2014\)](#) offered one of the clearest accounts of that earlier stage. They argued

that Peru had important constitutional principles related to persons with mental health problems, but only patchy legislative implementation, especially regarding involuntary admission, appeal procedures, and the protection of decision-making rights. Their article is historically significant because it captures the legal baseline against which the current reform must be assessed. It shows that the rights-based framework now available in Peru was neither original nor inevitable; it emerged against a background of legislative insufficiency and rights vulnerability.

A second phase of the literature focused on the emergence and scaling-up of reform. The landmark article by [Toyama et al. \(2017\)](#) explained the Peruvian reform not only as a legal development but as a systemic rearrangement of the public health architecture. Their analysis emphasized the convergence of policy reform, results-based budgeting, community service expansion, and integration into first-level care, showing that mental health reform in Peru involves fiscal design, service delivery, and institutional coordination as much as statutory change. The Constitutional Court's later case law repeatedly confronts failures of implementation rather than mere absence of rights language.

The literature then moved toward more fine-grained analyses of community implementation. [Arriola-Vigo et al. \(2019\)](#) examined perceptions of community involvement in Peru's reform process and found that community engagement, although central to the model, faced practical barriers in implementation. [Villarreal-Zegarra et al. \(2023\)](#) analyzed the provision of community mental health care before and during the COVID-19 pandemic, showing both the vulnerability and the resilience of the reformed system during crisis. [Paredes-Angeles et al. \(2024\)](#) examined telehealth in community mental health centers and found that the pandemic pushed services toward new forms of continuity but also exposed digital and organizational inequalities. These studies are important because they show that community care cannot be reduced to the opening of facilities; it requires social participation, continuity, adaptation, and organizational capacity.

Another strand of recent literature has asked whether Peru's reform is being evaluated with the right metrics. [Cavero et al. \(2025\)](#) argue that Peru's mental health system still monitors services largely through volumes of care rather than through recovery-oriented outcomes. A rights-based system therefore cannot be judged solely by the number of persons served or centers opened; it must also be assessed by whether care improves psychosocial functioning, autonomy, quality of life, and meaningful recovery.

Peruvian reform has also been historicized and anthropologically reinterpreted. [Villa-Palomino et al. \(2024\)](#) argue that the transition toward community mental health in Peru must be understood as a sociohistorical process shaped by internal armed conflict, economic crisis, neoliberal transformation, activism, and changing notions of care and madness. Their intervention is valuable because it prevents legal analysis from becoming unduly formalist. If community mental health is treated only as legal design, one misses the broader historical and social forces that both enabled and constrained the reform.

Official and intergovernmental assessments broadly support this mixed scholarly picture. [Organización Panamericana de la Salud \(2023\)](#) highlights substantial progress over the last decade in legal development, service expansion, medications, first-level care, and institutional innovation. The Organisation for Economic Co-operation and Development ([OECD 2025](#)) similarly presents mental health reform as a significant achievement within the broader Peruvian health system, while also emphasizing continuing fragmentation, territorial inequality, and quality deficits. Official figures released by the Ministry of Health reinforce that ambiguity: Peru has markedly expanded community mental health services, but the continued effort to build additional centers, strengthen prison services, and improve intersectoral coordination indicates that equal and effective enjoyment remains unfinished ([Ministerio de Salud 2025b, 2026](#)).

From the standpoint of legal scholarship, however, an important gap remains. Much of the Peruvian literature has focused on policy reform, implementation, or service architecture, while comparatively little work has examined in depth how the Constitutional Court has doctrinally transformed mental health into a constitutional category. The existing literature often invokes rights language, but it rarely specifies what kind of constitutional right mental health has become, how international human rights norms enter that analysis, or whether the Court's case law is fully consistent with a strong CRPD-informed account of autonomy and anti-coercion. The analysis below therefore shifts the focus from reform as policy success to reform as a contested process of constitutionalization.

The comparative literature helps sharpen that shift in focus. Nilsson (2024), writing about Sweden, shows that the CRPD has had important discursive force but uneven domestic impact on coercive mental health law. O'Mahony (2024), discussing Ireland, similarly asks whether law reform genuinely aligns with human rights obligations or merely updates preexisting frameworks without transforming their underlying logic. Alexandrov and Schuck (2021) reach a related conclusion in their analysis of the Netherlands: reform may speak the language of rights while still preserving significant forms of coercive intervention. These studies are useful comparators because they show that the key question is not simply whether a jurisdiction has reformed its law, but whether reform meaningfully redistributes power, reduces coercion, and secures autonomy in practice.

Accordingly, the current state of the art supports neither triumphalism nor pessimism. It supports a more precise conclusion: Peru has developed one of the most ambitious community mental health reform agendas in the region, supported by a considerably stronger legal framework than in the past, but the decisive scholarly and constitutional question is no longer whether Peru has mental health law. It is whether that law, and the jurisprudence that interprets it, have succeeded in transforming mental health into a fully enforceable and autonomy-respecting fundamental right.

3.2. Theoretical Framework: Constitutionalization, Social Rights, and the Right to Mental Health

The analytical framework used here has three elements: a definition of constitutionalization, a substantive account of the right to mental health, and a set of criteria for evaluating whether the Court has actually constitutionalized that right.

3.2.1. Constitutionalization as a Two-Level Judicial Process

Constitutionalization means the judicial conversion of a social claim into a constitutional standard capable of constraining public power. At a first level, that process occurs when a court recognizes the claim as part of the constitutional order of rights, elaborates its doctrinal content through principles and obligations, makes it enforceable through remedies, and produces radiating effects on legislation, administration, and public policy. This conception follows Young's distinction between social-rights recognition and institutional enforceability (Young 2008, 2010), Liebenberg's emphasis on participatory and remedial dimensions in social-rights adjudication (Liebenberg 2018), and Pillay's analysis of social-rights litigation as a mechanism for restructuring state obligations (Pillay 2012). Felner's work is relevant in a narrower sense because it shows that constitutionalization must also generate standards of accountability around progressive realization rather than rhetorical acknowledgment alone (Felner 2009).

That first level is necessary, but it is not sufficient in the mental health field. A court may constitutionalize mental health as a service entitlement while leaving intact the paternalistic assumptions that historically structured psychiatry. A second level of constitutionalization therefore concerns whether doctrine reconstructs the bearer of the right as an autonomous legal subject whose will and preferences matter, rather than as an

object of diagnosis, custody, or protection. Second-order constitutionalization is visible where doctrine gives serious weight to equal legal capacity and the person's will and preferences, as emphasized by the [Committee on the Rights of Persons with Disabilities \(2014\)](#); to rights-based legislative design, as argued by [Eaton \(2019\)](#); to supported decision-making, as elaborated by [Craigie et al. \(2019\)](#) and [Jeste et al. \(2018\)](#); and to strict scrutiny of coercive intervention, a concern highlighted by [Glover-Thomas and Chima \(2015\)](#), [Nilsson \(2024\)](#), and [Alexandrov and Schuck \(2021\)](#).

3.2.2. The Right to Mental Health as a Hybrid Fundamental Right

On this framework, the right to mental health is best understood as a hybrid fundamental right. It is not exhausted by a claim to psychiatric treatment, nor can it be reduced to a negative liberty against state interference. Rather, it combines three interlocking dimensions that are co-constitutive and must be held together in constitutional analysis.

The first dimension is service-based and egalitarian. It concerns the availability, accessibility, acceptability, and quality of services, continuity of care, parity between mental and physical health, and protection against discrimination in funding, organization, and access. [Green \(2000\)](#) supplies the basic ethical claim that mental health care can be a matter of right rather than discretionary benevolence. [Liao \(2016\)](#) then situates health care within the fundamental conditions necessary for agency and a minimally decent life. [Bhugra et al. \(2015\)](#) add the parity dimension by showing that mental health must be treated as a question of equal constitutional concern rather than residual welfare administration.

The second dimension is autonomy-based and anti-coercive. It concerns legal capacity, informed consent, supported decision-making, and the requirement that involuntary intervention be treated as legally exceptional and in need of strict justification. The [Committee on the Rights of Persons with Disabilities \(2014\)](#) makes equal legal capacity and respect for the person's will and preferences central to this dimension. [Eaton \(2019\)](#) translates that insight into a rights-based account of mental health legislation. [Craigie et al. \(2019\)](#) and [Jeste et al. \(2018\)](#) explain why supported decision-making is the institutional expression of that shift. [Glover-Thomas and Chima \(2015\)](#), [Nilsson \(2024\)](#), and [Alexandrov and Schuck \(2021\)](#) show, in different legal settings, that coercive regimes remain the decisive fault line in determining whether reform has genuinely moved beyond softened paternalism.

The third dimension is structural and community-based. Mental health cannot be protected adequately through clinical care alone. [Cosgrove and Shaughnessy \(2020\)](#) argue that mental health as a human right cannot be reduced to access to biomedical treatment. [Maker and McSherry \(2024\)](#) connect that claim to the social determinants of mental health and to interdisciplinary human-rights research. [Wilson \(2024, 2025\)](#) extends the point by locating housing, employment, and public mental health within a rights framework oriented toward social conditions as well as services. [Kirkbride et al. \(2024\)](#) provide the wider evidentiary account of how social determinants shape mental disorder and mental well-being. [Gaynor-Brook \(2023\)](#) and [Tomaszewski et al. \(2024\)](#), finally, underscore the epistemic and policy importance of lived experience and participation in defining what a rights-based mental health framework should look like.

A legal order that expands services while leaving coercive authority largely intact has constitutionalized mental health only partially. Conversely, a legal order that protects formal liberty but leaves services unavailable, unequal, or socially disconnected also falls short. A constitutionally adequate account of the right must therefore integrate provision, autonomy, and structural inclusion, rather than trading one dimension off against another.

The framework generates four concrete evaluative questions. First, recognition: does the Constitutional Court treat mental health as part of the constitutional order of fundamental rights? Second, doctrinal elaboration: does it specify duties of continuity, parity,

non-discrimination, community care, and institutional provision? Third, autonomy and anti-coercion: does it interpret mental health through legal capacity, supported decision-making, free and informed consent, and a demanding scrutiny of coercive intervention? Fourth, radiating effects: do its judgments reshape legislation, administrative practice, prison governance, or public policy through individual or structural remedies?

These criteria support the following working hypothesis. The Peruvian Constitutional Court has achieved a robust first-order constitutionalization of the right to mental health, but only a partial second-order constitutionalization. It has moved mental health into the constitutional core, specified significant duties of care and institutional response, and used structural remedies in contexts of extreme vulnerability. Yet it has been more cautious in reconstructing mental health law around will and preferences, supported decision-making in practice, and a deeper anti-coercion logic.

3.3. International Human Rights Standards and Their Constitutional Reception in Peru

The primary universal basis for the right to mental health applicable to Peru is the International Covenant on Economic, Social and Cultural Rights (ICESCR), ratified by Peru in 1978 ([United Nations 1966](#); [United Nations Treaty Collection 1978](#)). Article 12 recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The most authoritative interpretive source remains General Comment No. 14 of the Committee on Economic, Social and Cultural Rights, which explains that health is a fundamental human right indispensable for living with dignity and that the right includes not only medical care but also the underlying determinants of health ([United Nations Committee on Economic, Social and Cultural Rights 2000](#), paras. 1, 4, 11–12). General Comment No. 14 is especially useful for mental health analysis because it clarifies the criteria of availability, accessibility, acceptability, and quality, all of which are directly relevant where a claimant alleges lack of services, poor conditions of care, discrimination, or failure of continuity.

The Convention on the Rights of Persons with Disabilities (CRPD), ratified by Peru in 2008, is even more decisive for contemporary mental health law ([United Nations 2006](#); [United Nations Treaty Collection 2008](#)). Several of its provisions are directly relevant. Article 12 recognizes equal legal capacity and access to support in exercising that capacity; Article 14 provides that the existence of a disability shall in no case justify a deprivation of liberty; Article 17 protects physical and mental integrity; Article 19 guarantees the right to live independently and be included in the community; Article 25 recognizes the right to health without discrimination and emphasizes free and informed consent; and Article 26 addresses habilitation and rehabilitation ([United Nations 2006](#), arts. 12, 14, 17, 19, 25, 26). Read alongside General Comment No. 1 of the Committee on the Rights of Persons with Disabilities, these provisions challenge older legal models that justified confinement, substitute decision-making, and segregation by reference to diagnosis alone ([Committee on the Rights of Persons with Disabilities 2014](#)).

The inter-American system provides a second essential layer. The American Convention on Human Rights protects dignity, liberty, personal integrity, judicial guarantees, and progressive development, all of which are implicated when mental health issues arise in contexts of involuntary hospitalization, custodial control, or denial of care ([Organization of American States 1969](#)). The Additional Protocol of San Salvador expressly recognizes the right to health as the enjoyment of the highest level of physical, mental, and social well-being ([Organization of American States 1988](#)). For children and adolescents, the Convention on the Rights of the Child reinforces the obligation to organize accessible, age-sensitive, and non-discriminatory services ([United Nations 1989](#); [United Nations Treaty Collection 1990](#)).

For a constitutional analysis in Peru, however, the relevant question is not only what the international standards are, but how they are received domestically. Here Article 55 and the Fourth Final and Transitory Provision of the Constitution are central. Article 55 gives treaties ratified by Peru domestic legal force, while the Fourth Final and Transitory Provision requires constitutional rights to be interpreted in conformity with the Universal Declaration of Human Rights and the human rights treaties ratified by Peru ([Constitución Política del Perú 1993](#), art. 55, Fourth Final and Transitory Provision). The Constitutional Court has repeatedly read these clauses as integrating human rights treaties into the material constitutional order. In Exp. No. 01417-2005-AA/TC, the Court explained that the constitutional canon or “block of constitutionality” includes not only the formal constitutional text, but also human rights treaties and statutory provisions that directly develop the essential content of fundamental rights ([Tribunal Constitucional del Perú 2005](#), para. 9). In Exp. No. 04617-2012-PA/TC, the Court further emphasized that domestic judges are required to exercise control of conventionality in light of the American Convention and Inter-American jurisprudence ([Tribunal Constitucional del Perú 2014](#), paras. 5–10). Scholarly discussions of the Peruvian block of constitutionality reach similar conclusions, even if they debate its precise contours ([Meza Hurtado 2012](#)).

In Peru, international standards function as interpretive and normative benchmarks within constitutional adjudication itself. They do not all carry the same legal weight, however. A rigorous account must distinguish among binding treaty law, authoritative treaty-body interpretation, and persuasive soft law. Thus, the ICESCR, the CRPD, the American Convention, the Protocol of San Salvador, and the Convention on the Rights of the Child are binding international instruments. General Comment No. 14 elaborates the normative content of the right to health under Article 12 of the ICESCR ([United Nations Committee on Economic, Social and Cultural Rights 2000](#)), while the CRPD Committee’s General Comment No. 1 performs a similar interpretive function for legal capacity under Article 12 of the CRPD ([Committee on the Rights of Persons with Disabilities 2014](#)). The 2023 WHO–OHCHR guidance is not binding, but it is highly persuasive because it synthesizes contemporary human rights standards for mental health legislation ([World Health Organization and United Nations. Office of the High Commissioner for Human Rights 2023](#)). The 2025 WHO policy guidance is likewise persuasive because it translates those standards into reform priorities for governance, service organization, and implementation ([World Health Organization 2025](#)).

Because mental health law often cites a wide range of international materials without differentiating their constitutional function, the analysis treats the treaty framework as the hard-law baseline, General Comment No. 14 and General Comment No. 1 as authoritative interpretive elaborations of the rights to health, legal capacity, and non-discrimination, and WHO guidance as persuasive evidence of the current reform horizon in mental health legislation. On that combined standard, a constitutionally adequate mental health framework must do more than provide treatment; it must also address discrimination, promote community inclusion, protect legal capacity, and move away from disability-based coercion whenever possible.

Two qualifications are necessary. First, treaty-body documents are not equivalent to treaty text, even when they carry substantial interpretive authority. [Scheinin \(2017\)](#) usefully explains that interpretation in human rights law depends not only on textual rules but also on institutional mandate, quality of reasoning, and the authority of monitoring bodies. Secondly, the CRPD position on liberty and psychosocial disability exists within a wider and not always uniform United Nations interpretive field. [Doyle Guilloud \(2019\)](#) shows that while the CRPD Committee has read Article 14 as requiring the abolition of disability-based detention, other United Nations bodies have continued to accept mental-health

detention in limited circumstances. This complexity does not weaken the relevance of the CRPD for Peru; it clarifies why domestic constitutional courts may advance rights-based reform through partial, contested, and institutionally mediated pathways.

The implication for Peru is clear. International standards do not merely supplement domestic law; they help determine the constitutional meaning of the right to mental health. This makes the Peruvian case especially relevant for international readers: constitutionalization in Peru is not only a domestic judicial process, but a process mediated by the internal constitutional uptake of international human rights commitments. This is particularly significant for the later analysis of the Constitutional Court. The question is not only whether the Court mentions international law, but whether it uses those standards to constitutionalize mental health in a way that is coherent, sufficiently demanding, and responsive to the CRPD-era critique of coercive psychiatry.

3.4. *The Domestic Legal Framework and Its Internal Tensions*

At the constitutional level, the right to mental health in Peru is rooted principally in Articles 7, 9, and 11 of the Constitution. Article 7 recognizes the right to health protection and adds that a person unable to care for themselves because of a physical or mental impairment is entitled to dignity, protection, care, rehabilitation, and security. Article 9 entrusts the State with determining national health policy and ensuring equitable access to health services. Article 11 guarantees access to health benefits through public, private, or mixed entities ([Constitución Política del Perú 1993](#), arts. 7, 9, 11). Read together, these provisions create the constitutional basis for an understanding of mental health that extends beyond treatment to dignity, protection, and institutional organization.

Before the enactment of a dedicated mental health statute, the principal statutory reference was the General Health Law, Law No. 26842. Its Preliminary Title already made mental health a matter of public responsibility by stating, in numeral V, that it is the State's duty to monitor, protect, and address the population's mental health problems ([Ministerio de Salud 1997](#), Preliminary Title, numeral V). The decisive shift came with Law No. 29889 in 2012, which modified Article 11 of the General Health Law and explicitly recognized every person's right to enjoy the highest possible level of mental health without discrimination ([Congreso de la República del Perú 2012a](#), art. 1, modifying Ley No. 26842, art. 11). That reform introduced principles that later became central to Peruvian mental health law: a community-based, interdisciplinary, decentralized, and intersectoral approach; preference for ambulatory care; internment as an exceptional therapeutic resource; and stronger attention to rights in service delivery. Its implementing regulation, Supreme Decree No. 033-2015-SA, translated those principles into administrative terms ([Ministerio de Salud 2015](#)).

The comprehensive turning point came with Law No. 30947, the Mental Health Law, enacted in 2019. That statute defines mental health in relational and dynamic terms in Article 5.9, places vulnerable populations and the community model at the center of policy in Articles 6.1–6.3, and recognizes rights to mental health, universal access, and user protections in Articles 7–9 ([Congreso de la República del Perú 2019](#)). The Regulation approved by Supreme Decree No. 007-2020-SA then gave that statutory framework institutional and operational content, including coordination mechanisms, service organization, and the establishment of the National Mental Health Council ([Ministerio de Salud 2020](#)). Law No. 31627 strengthened the law's preventive and promotional dimensions with particular attention to children, adolescents, and other vulnerable groups ([Congreso de la República del Perú 2022](#)), and Supreme Decree No. 011-2025-SA implemented that reform at the regulatory level ([Ministerio de Salud 2025a](#)).

This domestic framework is normatively significant for at least three reasons. First, it moves mental health out of a narrow hospital-centered model and into a territorial and

community-based service structure. Second, it expressly links mental health to rights language rather than purely clinical management. Third, it aligns mental health legislation with a broader disability-rights turn in Peruvian law. Law No. 29973, the General Law on Persons with Disabilities, supplies the equality and non-discrimination framework for that shift ([Congreso de la República del Perú 2012b](#)). Legislative Decree No. 1384 then translates the turn into legal-capacity doctrine by recognizing equal legal capacity and supports, which in turn reshapes how consent, autonomy, safeguards, and substitute decision-making should be understood in mental health contexts ([Ministerio de Justicia y Derechos Humanos 2018](#)).

Yet the domestic framework also contains unresolved tensions. The first tension is between the law's rights-based rhetoric and the persistence of exceptional coercive mechanisms. Law No. 30947 strongly emphasizes dignity, voluntariness, and community inclusion, but the broader legal order still accommodates emergency exceptions, judicial mandates, and institutional arrangements in which clinical judgment can displace the person's own preferences. A rights-based mental health regime need not deny that crises occur, but it must justify any departure from voluntariness under exceptionally strict standards. The Peruvian framework does not always articulate those standards with sufficient clarity.

The second tension lies in the relationship between mental health law and disability law. On paper, the recognition of legal capacity on an equal basis and the availability of supports suggest a move away from substitute decision-making. In practice, however, the integration between disability-rights norms and mental health service regulation remains incomplete. The statutory and regulatory scheme is more developed on access to services than on the operationalization of support-based decision-making in everyday psychiatric practice. This means that the system has advanced more quickly on community service expansion than on the legal transformation of professional authority and consent structures.

The third tension concerns the difference between formal legal reform and equal enjoyment. Peru's legal architecture is now much more elaborate than it was a decade ago, but the Constitutional Court's own docket demonstrates that the most difficult problems arise where rights claims meet resource scarcity, institutional fragmentation, and custodial environments. In that sense, the domestic framework is both impressive and fragile: impressive because it creates a more modern and rights-sensitive legal order, fragile because that order continues to depend on uneven implementation, limited specialized capacity, and a legal culture still negotiating the transition from tutelary protection to autonomy-centered care.

These unresolved tensions mean that, if the domestic legal framework had already settled the conflict between rights, coercion, capacity, and implementation, the Court's task would be largely one of application. Peru's legislation does not do that. It provides the materials for a rights-based regime while leaving significant ambiguities in its operation. The Constitutional Court's jurisprudence must therefore be read not only as enforcement of a settled framework, but as a site where those unresolved tensions are interpreted, amplified, or sometimes left unresolved.

3.5. The Constitutional Court and the Constitutionalization of the Right to Mental Health

The jurisprudential corpus analyzed here was selected because it captures the main doctrinal sites through which the Peruvian Constitutional Court has shaped the right to mental health: access and continuity of treatment, psychiatric internment and security measures, prison mental health, and abstract review of the Mental Health Law. The key cases are Exp. No. 02480-2008-PA/TC, Exp. No. 03426-2008-PHC/TC, Exp. No. 03782-2019-PHC/TC, Exp. No. 04007-2015-PHC/TC, Exp. No. 02508-2023-PHC/TC, and

Exp. No. 00009-2020-PI/TC. These decisions do not merely illustrate separate factual disputes. Together they form a line of constitutional development through which the Court recognized the right, specified its content, expanded its remedial repertoire, and tested its limits in hard cases.

For analytical clarity, the cases can be grouped into four categories: (1) access and continuity of care; (2) internment and security measures; (3) prison mental health; and (4) abstract review of the statutory framework. The meaning of the right shifts across these contexts. In access cases, the emphasis falls on treatment, medication, and continuity. In security-measure and prison cases, the focus shifts toward liberty, integrity, vulnerability, and structural duties. In abstract review, the issue becomes whether the legislative model itself is constitutionally adequate. Taken together, these contexts show that mental health has been constitutionalized not through a single doctrinal move, but through repeated judicial encounters with different modalities of state omission and control.

Table 1 summarizes the principal cases analyzed and their distinct doctrinal contributions.

Table 1. Core Constitutional Court Cases on Mental Health.

Case	Context	Core Holding	Contribution
02480-2008-PA/TC (2009)	Access and continuity	Recognized mental health as part of the right to health (paras. 10–11); linked it to dignity, integrity, medicines, continuity, and non-retrogression (paras. 14–16).	Recognition plus doctrinal elaboration.
03426-2008-PHC/TC (2010)	Security measure	Held that prison cannot substitute for therapeutic internment and declared an unconstitutional state of affairs (paras. 30–32).	Shift to structural relief.
03782-2019-PHC/TC (2021)	Pending transfer	Reaffirmed duties toward persons under internment measures and exposed persistent implementation failure (paras. 2–3, 9).	Continuity plus systemic diagnosis.
04007-2015-PHC/TC (2019) + follow-up (2025)	Prison mental health	Declared an unconstitutional state of affairs regarding prison mental health and supervised corrective action (2019 judgment; 2025 order, paras. 2–5).	Extension to custodial settings.
02508-2023-PHC/TC (2024)	Custodial harms	Reiterated the prison-mental-health doctrine first clearly articulated in 04007-2015-PHC/TC, including harms associated with loss of autonomy and social bonds.	Environmental reading of the right.
00009-2020-PI/TC (2021)	Abstract review	The majority declared the challenge unfounded and upheld the challenged provisions of Law No. 30947 as constitutionally compatible.	Statutory validation with limits.

The foundational decision is Exp. No. 02480-2008-PA/TC, decided in 2009. In that case, the Court expressly held that the right to mental health is recognized in international human rights law and is an integral part of the right to health ([Tribunal Constitucional del Perú 2009](#), paras. 10, 11). The Court grounded the right in dignity, health, and psychological integrity, and then gave it unusually concrete content. It stated that the right includes access to preventive, curative, and rehabilitative interventions; medicines; examinations; follow-up; and equal and timely access to services ([Tribunal Constitucional del Perú 2009](#), paras. 14, 15). It also identified a broad range of state obligations: to create adequate service conditions, to provide treatments and medicines considered necessary by medical professionals, to avoid unjustified interruption of services, to design policies and programs, and to regulate providers ([Tribunal Constitucional del Perú 2009](#), para. 16). In doctrinal terms, this was the

moment when mental health ceased to be merely implicit in the Constitution and became an expressly enforceable constitutional claim.

The factual setting is central to the ratio. The claimant's case was not a generalized policy demand but a challenge to the interruption and insufficiency of long-term psychiatric care that the available medical record treated as necessary. That setting allowed the Court to frame mental health as continuity over time, rather than as a one-off claim to access a hospital bed. The reasoning remained partly treatment-centered, but its constitutional importance lies in converting treatment continuity, medicines, periodic examinations, follow-up, and medically indicated hospitalization into enforceable obligations ([Tribunal Constitucional del Perú 2009](#), paras. 14–16).

Exp. No. 02480-2008-PA/TC did more than recognize the right; it also elaborated its doctrinal content. The judgment translated general constitutional and international language into a structured catalogue of obligations and thus performed precisely the kind of doctrinal work that social rights theory identifies as central to constitutionalization ([Young 2008, 2010](#)). It also adopted a clearly non-retrogressive position by indicating that it would be unconstitutional for the State to roll back or reduce the level of protection already achieved, whether by restricting access, decreasing resources, or suppressing services for administrative or budgetary reasons ([Tribunal Constitucional del Perú 2009](#), para. 16(a)). In this sense, the case constitutionalized mental health both substantively and temporally: it defined what the right protects and signaled that regression would require serious constitutional justification.

The second major step came with Exp. No. 03426-2008-PHC/TC, Pedro Gonzalo Marroquín Soto. The case concerned a person found not criminally responsible in criminal proceedings and made subject to a judicial security measure of psychiatric internment, but who remained confined in an ordinary prison instead of being transferred to an appropriate therapeutic institution ([Tribunal Constitucional del Perú 2010](#), paras. 30, 31). The factual posture mattered because the claimant was already subject to a judicially ordered therapeutic measure; the constitutional wrong arose when institutional incapacity converted that therapeutic measure into ordinary imprisonment. The Court held that this situation violated his fundamental rights and ordered corrective action. More importantly, it declared an unconstitutional state of affairs because the violation was not accidental or isolated; it reflected a structural lack of psychiatric beds, inadequate coordination, and the absence of an effective treatment and rehabilitation policy for persons with mental illness subject to security measures ([Tribunal Constitucional del Perú 2010](#), paras. 30–32).

Marroquín Soto shows, first, that prison cannot serve as a substitute for mental health treatment merely because the State lacks specialized facilities. This transforms mental health from a question of ordinary health care provision into one of constitutional limits on punitive and custodial power. Second, by declaring an unconstitutional state of affairs, the Court moved beyond individual relief and into the terrain of structural adjudication. A right is not fully constitutionalized if it can be acknowledged in principle but cannot generate institutional consequences when its violation is systemic. Marroquín Soto therefore marks the point at which the Court began to constitutionalize mental health remedially, not merely substantively.

Later cases confirm and deepen that line. In Exp. No. 03782-2019-PHC/TC, Cristian Roy Rivera Vargas, the Court again confronted the detention of a person with psychiatric needs in an ordinary prison while awaiting placement in a specialized institution ([Tribunal Constitucional del Perú 2021b](#), paras. 2, 3). The decision reiterates that persons subject to internment measures are in a position of special vulnerability and that the State must adopt the measures necessary to ensure treatment and rehabilitation under conditions compatible with their rights ([Tribunal Constitucional del Perú 2021b](#), para. 9). The judgment

is important not because it announces an entirely new doctrine, but because it shows continuity. Years after Marroquín Soto, the structural shortage of appropriate placements remained unresolved. The constitutional problem was therefore not limited to an historical moment; it persisted as a recurrent failure of implementation.

The prison mental health line reaches its clearest expression in Exp. No. 04007-2015-PHC/TC, decided in 2019. In its operative part, the Court declared an unconstitutional state of affairs regarding the mental health situation of persons confined in penitentiary establishments and ordered coordinated action by the Ministry of Justice, the National Penitentiary Institute, and the Ministry of Health ([Tribunal Constitucional del Perú 2019](#), operative part). The Court's 2025 supervisory order confirms the continuing institutional significance of that command ([Tribunal Constitucional del Perú 2025](#), para. 3). The judgment expands the constitutional protection of mental health beyond psychiatric or forensic institutions and into the prison system as such. The Court recognized that penitentiary environments can themselves become sites of acute mental-health vulnerability and that the State's obligations extend to diagnosis, treatment, coordination, and service organization within those settings ([Tribunal Constitucional del Perú 2019](#), paras. 72–80).

The subsequent supervisory order in the same case is equally important for understanding the limits of constitutionalization. In its 2024 evaluation order, published in 2025, the Court reviewed institutional measures adopted in response to the judgment, including diagnosis and identification strategies, policy instruments, and service improvements within prisons ([Tribunal Constitucional del Perú 2025](#), paras. 2–5). This follow-up material shows that the Court's structural intervention prompted administrative action. Yet it also reveals how dependent constitutional effectiveness remains on sustained institutional execution. In other words, constitutionalization is visible here not only in the recognition of a right or the declaration of an unconstitutional state of affairs, but also in the Court's willingness to supervise compliance over time. At the same time, the need for continued supervision illustrates that judicial recognition does not automatically secure transformation on the ground.

The more recent Exp. No. 02508-2023-PHC/TC adds an important qualitative insight, but it does so mainly by reiterating an earlier doctrinal point first clearly articulated in Exp. No. 04007-2015-PHC/TC. In Exp. No. 02508-2023-PHC/TC, the Court repeated that prison environments themselves can pose serious risks to mental health because of the loss of privacy, autonomy, social bonds, and temporal and spatial orientation ([Tribunal Constitucional del Perú 2024](#)). In doing so, it relied on the prison-mental-health doctrine already articulated in Exp. No. 04007-2015-PHC/TC ([Tribunal Constitucional del Perú 2019](#), para. 33). The resulting shift moves away from a narrow clinical conception of mental health harm toward an environmental and relational one. Mental health vulnerability is not limited to pre-existing diagnosis or lack of medication; it can also be produced or aggravated by the very structure of confinement, which links mental health to conditions of institutional domination rather than treating it solely as an individualized medical problem.

These prison decisions are also the Court's strongest move beyond a narrowly medical model of mental health. The right is still operationalized through diagnosis, treatment, and service organization, but the source of constitutional harm is not limited to the absence of psychiatrists or medication. It also lies in the institutional environment that aggravates distress or makes treatment ineffective. The Court has therefore begun to recognize mental health as relational and environmental, although mainly in custodial settings rather than through direct claims to housing, employment, income security, or ordinary community accommodation.

The final indispensable case is Exp. No. 00009-2020-PI/TC, the abstract review judgment on the Mental Health Law ([Tribunal Constitucional del Perú 2021a](#)). In that

decision, the majority that formed the judgment rejected the constitutional challenge as unfounded and thus upheld the challenged provisions of Law No. 30947 as constitutionally compatible ([Tribunal Constitucional del Perú 2021a](#), operative part). Separate votes in the same case nonetheless revealed deeper disagreement over compatibility with the CRPD and the scope of professional authority ([Tribunal Constitucional del Perú 2021a](#)). The judgment reiterates that the right to health and, specifically, the right to mental health must be interpreted in light of dignity and international human rights law. It addresses the law's provisions on evaluation, diagnosis, treatment, and access to services and thereby confirms that Peru's legislative reform is constitutionally permissible, while still leaving unresolved deeper tensions concerning autonomy, coercion, and models centered on the person's will and preferences. The decision is therefore better understood as statutory validation under constitutional review than as a final settlement of the CRPD question.

However, the Mental Health Law judgment also reveals the main doctrinal limit of the Court's approach. The Court strongly supports a rights-based and community model, but it does not fully resolve the tension between that model and the strongest CRPD-inspired critique of disability-based coercion. In effect, the judgment constitutionalizes the law as an instrument of access, dignity, and community inclusion more clearly than as an instrument of autonomy and anti-coercion. The Court has clearly brought mental health into the constitutional sphere, but it has not yet fully transformed the constitutional understanding of mental health in a way that displaces inherited paternalistic and medicalized assumptions.

Seen as a whole, the line of cases allows four conclusions. First, the Court has recognized mental health as a fundamental right rather than a secondary social interest. Second, it has given the right concrete content through obligations related to treatment, services, continuity, policy, and non-retrogression. Third, it has accepted that structural failures in mental health provision may require structural remedies, including declarations of unconstitutional states of affairs and follow-up supervision. Fourth, and most importantly, it has extended the right's protection into hard settings such as forensic internment and prisons, where the State's obligations are at their sharpest. The line therefore supports a strong account of constitutionalization while leaving unresolved the further questions of autonomy, coercion, and the limits of the current framework.

4. Discussion

The first major achievement of the Peruvian model is that mental health has been moved from the periphery of constitutional discourse to its core. The Constitutional Court no longer treats mental health as a purely administrative issue or a derivative welfare concern. It treats it as a fundamental right grounded in dignity, health, and psychological integrity, and as one that can generate both individual entitlements and structural duties ([Tribunal Constitucional del Perú 2009, 2010, 2019](#)). This is already a substantial doctrinal transformation, particularly in a field historically marked by stigma, institutional neglect, and the marginalization of mental suffering in public law.

The second major achievement is the articulation between constitutional adjudication and legislative reform. The Court's jurisprudence did not simply react to Law No. 30947 after the fact. Earlier cases such as Exp. No. 02480-2008-PA/TC and Exp. No. 03426-2008-PHC/TC had already created the constitutional vocabulary of mental health as a justiciable right and of institutional failure as constitutionally actionable. In that sense, the Court helped prepare the doctrinal ground on which later statutory reform could be read as constitutionally appropriate. Comparatively, the Peruvian case shows how constitutional jurisprudence can function not only as post hoc review of legislation but also as a normative accelerator of legislative transformation.

The third major achievement lies in remedies. The Court has not confined itself to declaratory recognition. In the cases on security measures and prison mental health, it has been willing to issue structural remedies and to maintain supervisory attention over time ([Tribunal Constitucional del Perú 2010, 2019, 2025](#)). From the perspective of social rights theory, this is highly significant. As other authors ([Young 2010](#); [Liebenberg 2018](#); [Pillay 2012](#)) suggest, social rights become constitutionally consequential not only when courts identify violations but when they structure institutional dialogue and accountability. The Peruvian Court's use of unconstitutional-state-of-affairs reasoning therefore deserves to be treated as part of the constitutionalization of mental health, not merely as an unusual remedial technique.

Nevertheless, this constitutionalization remains partial. The Court has been more forceful in protecting access, continuity, institutional treatment obligations, and structural correction than in confronting the deepest implications of CRPD-era autonomy and anti-coercion theory. That asymmetry is visible in the abstract review of the Mental Health Law, where the Court strongly endorses dignity, community care, and rights language ([Tribunal Constitucional del Perú 2021a](#)) but stops short of reconstructing the statutory scheme around a robust account of the person's will and preferences, supported decision-making, and the narrowest possible resort to coercion. [Nilsson \(2024\)](#) and [Alexandrov and Schuck \(2021\)](#) show that contemporary CRPD-oriented scholarship treats precisely those issues as the decisive test of whether reform has moved beyond softened paternalism.

The difficulty is not only incomplete implementation of a rights-based framework. The Court's own jurisprudence also reveals an unresolved normative duality. On one side stands a constitutional logic of dignity, equality, community inclusion, and service obligation. On the other stands a residual logic in which clinical authority, psychiatric emergency, and custodial control continue to justify significant departures from autonomy. The Court has clearly mitigated the harshest consequences of the older model, but it has not fully displaced it. The right has therefore been constitutionalized more fully as a justiciable social right than as a fully autonomy-centered disability right.

A further limit concerns equality in enjoyment. The Court's cases repeatedly show that rights are most fragile where the claimant is institutionally controlled, geographically marginalized, or dependent on specialized services that remain scarce. This is why prison mental health is so central to the argument. It reveals the constitutional edge of the right. Where the State controls the environment, the body, and the institutional setting, mental health becomes a test case for whether social rights can genuinely constrain state power. The Court's prison cases are therefore not peripheral applications; they are the clearest evidence of both the reach and the fragility of constitutionalization.

The implementation literature reinforces that conclusion. [Cavero et al. \(2025\)](#) show that Peru's mental health system still struggles to evaluate reform through recovery-oriented outcomes rather than through volumes of care alone. [OECD \(2025\)](#) likewise emphasizes that intersectoral integration and territorial equality remain incomplete within the broader health system. [Organización Panamericana de la Salud \(2023\)](#) reaches a similar conclusion from a regional and institutional perspective. The Court's jurisprudence is therefore not a self-sufficient solution. Constitutional adjudication can identify violations, define obligations, and compel institutional response, but it cannot by itself supply psychiatric beds, build community trust, remedy fragmented administration, or transform the broader social determinants of mental health. In that sense, the Peruvian case supports a catalyzing rather than substitutionary understanding of judicial review.

The cases show that the Court has moved beyond a purely medical account of mental health, but only in a limited and uneven way. In the access cases, the right remains anchored in services, medication, follow-up, and professional treatment. In the security-measure and

prison cases, however, the Court expands the right by treating institutional placement and custodial conditions as constitutional harms. This is best described as a post-medical but not yet fully social understanding of the right: mental health is no longer exhausted by clinical intervention, but the Court has not yet constitutionalized housing, employment protections, income support, or ordinary community accommodation as independent components of the right to mental health.

This distinction also clarifies the question of justiciability. The Court has made services, continuity of care, therapeutic placement, and custodial mental-health protection justiciable. It has not yet made the social determinants of mental health directly justiciable as mental-health rights. Those determinants enter the jurisprudence mainly as background conditions that explain vulnerability and justify structural remedies, rather than as freestanding constitutional claims. A future stage of constitutionalization would require connecting the Court's language of community care and dignity to the material conditions that make autonomy practical: adequate housing, social support, protection against exclusion, and opportunities for participation (Maker and McSherry 2024; Wilson 2024, 2025; Kirkbride et al. 2024).

Peru also offers a comparative insight for the broader field of mental health law and policy. Rights-based reform can advance meaningfully even in contexts of limited state capacity, but it also remains internally differentiated. A jurisdiction may successfully constitutionalize mental health as a question of access, dignity, and community care while still leaving unresolved the harder challenge of aligning mental health law with the strongest anti-coercion implications of the CRPD. This is not a uniquely Peruvian problem; it is visible in recent reform debates in Europe and elsewhere. Peru's importance lies in showing that constitutional courts can accelerate transformation, but also that they may stabilize compromise positions between older protective logics and newer autonomy-centered norms.

The Court is best understood as having achieved a robust first-order constitutionalization—recognition, doctrinal elaboration, enforceability, and radiating effects—while leaving unfinished a second-order constitutionalization centered on autonomy, legal capacity in practice, and the systematic reduction in coercion. This distinction both acknowledges the doctrinal significance of the Court's work and identifies the normative frontier that future jurisprudence and legislation still need to cross.

That frontier has practical implications. A more complete constitutionalization of the right to mental health in Peru would require at least four developments: stronger implementation of support-based decision-making; more explicit doctrinal scrutiny of coercive interventions and psychiatric emergencies; sustained structural oversight in custodial contexts; and greater attention to the social determinants of mental well-being as part of constitutional protection rather than merely public health policy. None of these moves requires abandoning the current legal framework. But they do require reading that framework more demandingly than the Court has done so far.

5. Conclusions

The Peruvian experience demonstrates that the right to mental health can be constitutionalized through a dynamic interaction among international human rights law, domestic legislative reform, and constitutional adjudication. International norms supplied the central concepts of dignity, non-discrimination, legal capacity, community inclusion, and freedom from arbitrary or disability-based deprivation of liberty. Domestic law translated many of those standards into a dedicated legal framework centered on rights and community care. The Constitutional Court then transformed that framework into a justiciable constitutional doctrine.

The Court's contribution has been substantial. Through its case law, it has established that the right to mental health is part of the right to health and is grounded in dignity and psychological integrity; that it includes concrete obligations related to treatment, continuity, medicines, services, and policy; that structural institutional failures may constitute unconstitutional states of affairs; and that prison and custodial environments pose acute constitutional risks to mental health. These developments justify speaking of constitutionalization in a strong sense.

At the same time, the constitutionalization achieved by the Court remains incomplete. The jurisprudence protects access, continuity of care, and institutional responsibility more robustly than it protects autonomy, supported decision-making in practice, and a fully CRPD-consistent anti-coercion orientation. Peru therefore illustrates both the emancipatory potential and the normative limits of rights-based mental health reform. The Constitution has become a meaningful site of protection for mental health, but it has not yet become the vehicle of a complete transformation of the power relations embedded in mental health care.

That conclusion matters beyond Peru. It suggests that the constitutionalization of mental health should not be measured only by whether a right is recognized or whether services are expanded. It should also be measured by whether courts define the right in ways that reshape institutional authority, strengthen autonomy, reduce coercion, and connect mental health to broader conditions of social equality. On that more demanding standard, Peru stands as an important but unfinished constitutional project.

Four broader lessons follow for mental health law reform under the CRPD. First, treaty-integrating constitutional systems may allow international disability-rights norms to shape domestic mental-health doctrine more directly than in dualist systems. Second, recognition and enforceability may advance before courts fully reconstruct autonomy, legal capacity, and coercion. Third, structural remedies can catalyze institutional reform, but they cannot substitute for sustained administrative capacity and intersectoral policy. Fourth, community mental-health reform remains constitutionally incomplete unless courts begin to connect services to the social conditions that make inclusion and autonomy real.

Author Contributions: Writing—original draft, A.R.V.-M., R.F.S.H., C.A.C.Q. and I.N.M.d.I.A.P.-B.; Writing—review & editing, A.R.V.-M., R.F.S.H., C.A.C.Q., I.N.M.d.I.A.P.-B., R.A.J.F.A. and C.A.P.B. All authors contributed to the conception, analysis, drafting, and revision of this manuscript. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: No new empirical dataset was generated for this study. All legal materials and public sources analyzed are cited in the manuscript and are publicly accessible through the references.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

CRPD	Convention on the Rights of Persons with Disabilities
ICESCR	International Covenant on Economic, Social and Cultural Rights
Minsa	Ministerio de Salud del Perú
TC	Tribunal Constitucional del Perú
WHO	World Health Organization

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