Mental Health Strategy of the National Health System

2022 - 2026

2022

MINISTRY OF HEALTH

versión v. 2021 11 25

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The Institutional Committee of the Mental Health Strategy has approved this document.

The National Health System´s Interterritorial Council approved this document on 2 December 2021.

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versión v. 2021 11 25

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The final editor of this document is the Ministry of Health. The proposals reflect the contributions of many professionals, particularly those made by the advisory committee. The final text does not necessarily reflect the views of all those involved in the complex drafting process.

versión v. 2021 11 25

INDEX

PRESENTATION

The Ministry of Health drives and promotes the Mental Health Strategy of the National Health System (NHS). The Mental Health Strategy was initiated in 2006, with the collaboration of the autonomous communities of Spain. It was developed by integrating the contributions of people with mental health problems, their families, and healthcare professionals. The strategy combines the promotion of mental health, the prevention of mental health problems, the diagnosis and treatment of people with mental health issues, intra- and inter-institutional coordination, as well as adopting measures to promote the social integration of people with mental health problems and the fight against stigma.

The Mental Health Strategy was a reference document that allowed plans or programmes for promoting mental health, prevention programmes and diagnostic tools, and appropriate therapeutic and rehabilitative services to be coordinated throughout the country. This coordination facilitated comprehensive and continuous care for people with mental health problems. One of the objectives of the Mental Health Strategy was to promote research in mental health and create tools to evaluate the progress of knowledge in this field and monitor and develop the strategy itself.

Based on the agreement of the Interterritorial Council of the NHS held on 21 June 2017 regarding the reorientation of the Mental Health Strategy, this update will cover the period from 2022 to 2026. The aim is to have a document which provides an overview of what has been done previously in this area, facilitating reflection and consensual decision-making on mental health in the NHS during this new period.

This update of the Mental Health Strategy results from an in-depth dialogue on mental health between all those who provided input during the strategy development process. A process that has highlighted fundamental values of our NHS, especially when it comes to mental health: the collaboration and institutional co-responsibility of the autonomous communities; the involvement of professionals and their organisations; the participation of scientific societies; and especially the leading role played by people with mental health problems and their families, who have made innovative contributions resulting in progress that has led to their empowerment.

The update presented here incorporates new strategic guidelines, includes the current recommendations on mental health, proposes objectives, and the development of an evaluation system agreed upon with the autonomous communities, which will make it possible to measure the scope of this new strategy.

Finally, this document includes an analysis of the impact of COVID-19 on mental health, given that the pandemic has highlighted the need to improve our care capacities in this area, focusing on the most vulnerable groups.

With the publication of this participatory strategy, we are establishing the framework of actions aimed at improving the mental health of the population from 2022 to 2026, including the response to temporary situations such as the Mental Health and COVID-19 Action Plan for the period of 2022 to 2024, created under the guidelines of this document.

My thanks go to all of those who have participated in preparing this document, which will undoubtedly contribute to making it possible for the NHS to improve the mental health of its citizens in the future.

Carolina Darias
Minister of Health

I. INTRODUCTION

Improving the quality of care has always been inherent to the NHS principles, as seen in the General Health Act (1). This Act provided a reference system for quality in healthcare services, which has been subject to regulatory development in the different autonomous communities.

In this context and under the auspices of the 2003 Cohesion and Quality Act, in 2006, the Ministry of Health began to develop, in collaboration with the regional administrations, the NHS Mental Health Strategy based on international recommendations and those of Spanish experts (2). This strategy, included in the 2010 Quality Plan (3), was a tool and reference framework for establishing programmes and actions developed in Spain in the mental health field. The 2010 Quality Plan contributed to financing specific projects on relevant mental health issues, such as the conference *"Mental Health and Well-being of Older People – Making it Happen"* (4), which took place within the framework of the European Presidency. This financing of projects enabled active participation in the development of international commitments such as the WHO Helsinki Conference (5), the European Pact for Mental Health of the WHO-Europe and the EU Commission (6), the OECD indicators (*Health Care Quality Indicators - Mental Health Care OECD*), and Human Rights (Council of Europe). The financing also helped elaborate a general good practice guide on ethical and legal aspects of any intervention against the patient's wishes. For the evaluation of the 2006 National Health System Mental Health Strategy, a monitoring and evaluation committee was set up, it was made up of representatives from different units of the Ministry of Health, the autonomous communities (ACs), the National Institute of Health Management (Instituto Nacional de (Gestión Sanitaria [INGESA]), the General Director of Penitentiary Institutions, the scientific societies within the scope of the strategy, and patient and family associations [Spanish Confederation of Associations of Families and Persons with Mental Illness (FEAFES) and the Bipolar World Foundation]. The evaluation methodology was agreed upon, and a model was designed to collect the information. The evaluation report was drawn up and published (7).

The Interterritorial Council of the NHS (ICNHS) drafted and approved a second version of the strategy in 2009 (Mental Health Strategy of the National Health System 2009- 2013) (8).

Based on the evaluation of that second version, a new update was submitted to the ICNHS in 2016, but it was not approved (9).

Following the agreement of the ICNHS on 21 June 2017 regarding the reorientation of the Mental Health Strategy (10) and the approval in 2017 of the Proposition No of Law on the Updating of the National Mental Health Strategy of the National Health System (11), this new update is planned for 2021- 2026, with a new approach based mainly on citizenship rights, social inclusion, combating stigma, mental health promotion and prevention of mental health problems, and prevention of suicidal behaviour and recovery of the individual. The COVID-19 pandemic is taking place during the updating of the Mental Health Strategy, which has led to the addition of a chapter dedicated to the importance of paying particular attention to the population´s mental health during and after a pandemic on this scale.

This strategy is guided by respect for and promoting the human rights of persons with mental health problems. Therefore, the strategy invokes the general principles in the International Convention on the Rights of Persons with Disabilities, such as respect for inherent dignity,

individual autonomy and independence, and full and effective participation and inclusion in society.

It also reaffirms the right of everyone to enjoy the highest attainable standard of physical and mental health and emphasises that mental health is an essential part of that right.

Ultimately, it seeks to protect, promote and respect all human rights in the overall response to mental health issues.

Mental health has been identified as a key priority in the WHO European Region through the work on mental health *European Programme of Work, 2020-2025 "United Action for Better Health"*, which set out the health priorities for the coming years. To address these priorities, WHO/Europe has identified four flagship initiatives. One of these is the launch of a Mental Health Coalition in 2021, which will bring together the countries of the European Region, as well as service users and providers (12).

The WHO anticipates that the Mental Health Coalition will help change the way societies in the European Region view mental health and help countries improve how their health services work with individuals and communities to improve their mental health.

II. TECHNICAL NOTE

This document consists of ten distinct parts:

1. Introduction, with a brief overview of the previous versions of the NHS Mental Health Strategy, evaluations, and attempts to update it.

2. Technical note.

3. General aspects, addressing the rationale for the Mental Health Strategy, purpose, target population, and situation analysis.

4. Strategy guidelines, developing the basic principles of the strategy:

   Strategy 1: Autonomy and rights. Person-centred care.

   Strategy 2: Promoting mental health in the population and preventing mental health problems.

   Strategy 3: Prevention, early detection, and attention to suicidal behaviour.

   Strategy 4: Providing mental healthcare based on recovery in the community.

   Strategy 5: Mental health in childhood and adolescence.

   Strategy 6: Family care and intervention.

   Strategy 7: Coordination.

   Strategy 8: Citizen participation.

   Strategy 9: Training.

   Strategy 10: Research, innovation, and knowledge.

5. Mental health during a pandemic.

6. Evaluation.

7. Mental Health Policy Annex.

8. Abbreviations and acronyms.

9. Index of figures and tables.

10. Bibliography.

III. GENERAL ASPECTS

a. Justification

Attention to the mental health of individuals and their communities is essential for developing the quality of life and allowing citizens to exercise their rights and duties fully. As established in the Helsinki Declaration of the 2005 WHO Ministerial Conference on Mental Health, "there is no health without mental health" (13).

Mental health care is an issue which still needs to be sufficiently addressed. The various rights (civil, political, economic, social, and cultural) and the development of a dignified life for all will only be possible with the collaboration between the different groups, organisations, and institutions that make up a community.

Misinformation and lack of awareness about mental health often cause society to discriminate against, reject or stigmatise people with mental health problems. However, it can be said that everyone will be affected by some mental health problem during their lifetime, either personally or through the people around them (i).

Over and above the symptoms of their health problem, stigma and discrimination are often the main barriers in the general population´s attitudes, hindering the recovery and social inclusion of people with mental health problems. Stigma and discrimination discourage people from recognising their health problems and starting their recovery process. The persistence of myths, prejudices, and stereotypes contributes to the consolidation of stigma and normalises discriminatory behaviour.

The diversity surrounding each person should be considered to avoid severe rights violations. Due to the action and effect of stigma, mental health problems become a label which annuls the individual, preventing them from being considered as a whole and their specific needs from being adequately addressed. Having or presuming to have a mental health problem continues to constitute a commonly assumed justification for depriving the person of their rights.

In this context, and in response to the sensitivity and empathy that mental health problems arouse among the public, professionals, social and health service managers, and associations of people with mental health problems and their friends and families, the Ministry of Health established comprehensive mental health care as one of its main objectives.

For this reason, the Ministry of Health has developed and implemented the National Health System's Mental Health Strategy over the last decade, working with people with mental health problems, their friends and families, professionals, organisations, and social and health service stakeholders.

Experts in the field of mental health, representatives of people with mental health problems, and family members were involved in preparing the update of the strategy that is now presented. These people constituted the advisory committee (see the index of contributors).

(i) "*e*). Disability is an evolving concept resulting from the interaction between persons with impairments and attitudinal and environmental barriers that prevent their full and effective participation in society on an equal basis with others. United Nations. Preambular paragraph (e) of the Convention on the Rights of Persons with Disabilities and Optional Protocol. 2006 (15).

They contributed to this document based on previous versions and evaluations, the new developments in the scientific and organisational fields, and the considerations of the Interterritorial Council of the National Health System to the proposal presented previously (the complete sequence is detailed in the Introduction).

This strategy aims to provide a valuable tool for the improvement of the mental health of the population, to attend to and accompany people with mental health problems in a comprehensive manner from a demanding human rights perspective, to support their families and to promote a model of comprehensive and community-based care that favours recovery and social inclusion.

b. The purpose of the strategy: mission, vision, values, overall goal, and principles

Mission

To establish objectives and recommendations to improve the population´s mental health. To have early detection and effective care for people with mental health problems from the moment they appear, regardless of their age or level of development. Respect their rights and decisions, support the families of people with mental health issues, and promote a comprehensive community care model favouring recovery and social inclusion.

Vision

This strategy aims to be a reference source for improving mental health in the National Health System based on equity, the system´s sustainability, and human rights, always considering the best available evidence, the recommendations made, and the feasibility of its implementation.

Values

This strategy promotes mental health and recognises the human rights of people with mental health problems. It seeks equity, sustainability, and quality care for people with mental health problems based on the recovery model and their environment, incorporating public participation. The strategy has been created with a gender perspective and a view to eliminating social inequalities in health.

Overall goal

"Improving the mental health of the population at all levels and in all areas of care of the National Health System".

Principles

This strategy is based on the belief that any action or model must respect the human rights of people with mental health problems and must, inevitably, provide an adequate response to their support or care needs at any time in their lives.

The strategy approaches mental health problems by integrating biological aspects and psychological and social factors. Therefore, it is essential to contemplate the interaction of these factors and understand them from the perspective of integrating vulnerability factors

(characterised as psychobiological) with risk factors (defined as psychosocial) and protective factors. It is also essential to enhance resilience, considering it as a constitutional basis and the interaction with the psychosocial environment in which it is produced, as theorised by Rutter (14).

The strategy seeks to promote the diagnostic and therapeutic approach to mental health problems using tools and interventions that have demonstrated scientific evidence.

The principles underpinning the update of the strategy are as follows:

- **A person with mental health problems is a subject of law.** The UN Convention on the Rights of Persons with Disabilities (80) entered into force in our legal system on 3 May 2008, ensuring that mental health problems are addressed as a human rights issue and from a predominantly biopsychosocial model perspective (15). There is a growing conviction that the human right of people with mental health problems should be protected and respected. To this end, it is essential to guarantee compliance with the convention and the rest of the legislation in force on disability and to offer care based on the fulfilment of rights, guaranteeing fairness and equality in access to the necessary resources and care. Law 41/2002 of 14 November 2002, the fundamental law regulating patient autonomy and the rights and obligations regarding clinical information and documentation and the legislation in force in the different autonomous communities, recognises the right of the patient, as well as his or her legal representative if necessary, to be informed (16).

- **Gender focus.** The gender focus considers women´s and men´s different needs throughout planning and delivering mental health services. It considers a holistic psychosocial approach where gender is a fundamental pillar, recognising that psychosocial factors disadvantage women and girls and undermine their mental health. It implies a willingness to participate in achieving absolute equality between men and women.

- **People with mental health issues and their family's participation.** Within the community model of mental health care, the rights of persons with mental health problems and their families should always be considered in the recovery process. Participation is their fundamental right, and therefore they must be allowed to participate on equal terms with professionals, ensuring that the decisions taken during the intervention are consensual and have a clear impact at all levels: planning, development and evaluation.

- **Dialogue and active listening** are fundamental elements on which the therapeutic relationship and intervention in mental health should be based. The mental health care network requires professionals who are well-prepared technically and prepared to establish therapeutic alliances and empathic and supportive relationships with people with mental health problems and their families. All this will lead to a shared and agreed decision-making process between professionals and users.

- **Personal recovery** is a unique and individual process linked to the personal development of each individual. This process involves a substantial modification of attitudes, values, feelings, objectives, and roles of the person with mental health problems in the

construction of a life project that does not revolve around the diagnosis and symptoms of the person's mental health problem. Personal recovery is linked to discovering or rediscovering a personal identity separate from the disease or disability. A person can recover his or her life (social recovery) without necessarily recovering from his or her health problem (clinical recovery).

- **Personalised and safe care.** Generic and individualised treatment. All people with mental health problems are different. Therefore, the therapeutic relationship and treatment plans must be individualised. These should be adjusted from the outset and periodically to the person´s needs. It is essential to improve the therapeutic environments to offer people with this health problem the chance to continuously offer their opinions on the evolution of the care they receive and their satisfaction.

- **Continuity of assistance and care.** Continuity of care derives from the need of people with mental health problems for ongoing attention, care, treatment, and social support. The extent to which this objective can be achieved reflects, in part, the ability of the various services in a local area to coordinate and work together harmoniously. Continuity of care is the ability of the care network to provide care and support throughout the person's life (longitudinal continuity) and, in a coherent way, between its component services (transversal continuity). This continuity of care should have a community mental health care approach, whereby the specialised mental health services work in close coordination with the community network, such as social services. A guarantee of continuity of care and assistance from the mental health teams should include the direct involvement of people with mental health issues in their processes.

- **People** are **part of a society with rights and obligations** that voluntary or involuntary events can undermine. Natural disasters, human impact on the environment, economic crises, wars, and pandemics, for example, the recent COVID-19 pandemic, generate post-traumatic stress that exposes vulnerable groups needing social protection, such as those with mental health problems. This issue needs to be addressed.

c. Target population

This strategy is aimed at the entire population, and especially at all people with mental health problems who receive healthcare in the NHS, its professionals (clinical and management), organisations and healthcare providers in the NHS, the families of people with mental health problems, and all academic and social entities and agents involved in improving mental health in Spain.

d. Analysis of the situation

Background

For the World Health Organisation (WHO), mental health is defined as a state of well-being in which a person is aware of his or her capabilities, can cope with the everyday stresses of life, can work productively and fruitfully, and can contribute to his or her community. Therefore, it does not only correspond to the absence of mental health problems but is closely related to the promotion of well-being, the prevention of mental health problems, and the comprehensive treatment and recovery of individuals.

Various international organisations, including the WHO, and observations of healthcare professionals directly involved in care warn that the increase in mental health problems is closely linked to lifestyle, living conditions, and social determinants, which, added to biological determinants, constitute the biopsychosocial model. Therefore, it is necessary to understand mental health as an additional aspect of well-being. The design of this strategy includes the biopsychosocial conception formulated by Engel, which enables an updated approach with future perspectives in its development (17).

Determinants of mental health and mental disorders include not only individual characteristics such as neurobiological factors, the interaction between the individual's genetics and the environment (epigenetics), the ability to manage thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political, and environmental factors. These factors include national policies, social protection, living standards, working conditions, and social support in the community. Population health determinants can be conceptualised as rainbow-like layers, with individual factors at the centre and the surrounding layers being made up of factors related to lifestyle, social and community networks, living and working conditions, and socio-economic, cultural, and environmental conditions. In order to set priorities and propose appropriate interventions and strategies, the effect of the different risk factors on the total burden of disease must be assessed (18).

In collaboration with the European Commission, the Organisation for Economic Co-operation and Development (OECD) develops a series of Health at a Glance reports, assessing progress towards effective, accessible, and resilient health systems across the EU. The report published in 2018 (61) estimated that the total cost of mental health problems represents 4% of GDP in EU countries: €190 billion (1.3% of GDP) reflects direct spending on healthcare, €170 billion (1.2% of GDP) is spent on social security programmes. Approximately €240 billion (1.6% of GDP) represents indirect costs to the labour market due to reduced employment and lower productivity. The estimated data for Spain collected in the report were: a total cost of €45,058 million in mental health problems (4.2% of GDP), divided into direct healthcare costs of €14,415 million, direct social security programme costs of €12,318 million, and indirect costs related to reduced labour productivity of €18,325 million (61).

To maintain the rights of the person with mental health problems, they must be central to their care and have a leading role in the recovery process. It is essential to avoid perceptions that the person with mental health problems merely suffers, emphasising their strengths, capacities, and resources at all times, giving them a central role, and assuming person-centred care.

This strategy is based on a recovery model whereby the person is placed as the protagonist of his or her process and on a community care model. Recovery is a unique and individual process linked to personal growth and sometimes includes a change in a person's attitudes, values, feelings, goals, skills, and roles. It is a process that aims for the subject to return to being fully functional in all areas of his or her life (family, social, economic, work, academic, etc.) and that undoubtedly goes beyond the simple reduction of symptoms.

This model requires a change in the relationship between people with mental health problems and professionals in the health and social spheres. A shift is needed towards a position of collaboration and joint construction of treatment plans, presenting from the professional sphere the current therapeutic options and supporting the person with mental health problems in choosing the most appropriate recovery path according to their interests and possibilities.

The recovery model will also consider the gender perspective in all actions to ensure the suitability of mental health programmes and services, considering the different needs of women and men, as recommended by the European Parliament in its Resolution of 14 February 2017 (19).

In 2018, the evaluation of the community model of care for mental disorders in Spain (20), proposed in the NHS Mental Health Strategy approved in the ICNHS in 2009, was published. (8) The most important conclusions of this study were that the most critical shortcomings in the implementation of the community model in 2014 were related to the absence of a public health perspective, poor management and accountability, and the slowdown in the development of community-oriented teams, services, and networks of services.

The model changed little overall between 2008 and 2014. However, some key practices, such as the universality and gratuity of the system, sectorised care, the shortening of waiting times, subsidising the associations of users and relatives, and the application of Law 39/2006, of 14 December on the Promotion of Personal Autonomy and Care for Dependent Persons, were substantially reduced in many communities, during the worst years of the economic crisis.

Other practices, such as computerised medical records, individualised care plans, and assertive community treatment, increased in some communities despite the recession.

The WHO Regional Office for Europe Statement "Empowering the mental health user" (21) proposes the following actions concerning the education and training of professionals, users, carers and the community (quoted verbatim):

- “Those who design and deliver mental health professionals’ training should do so in systematic partnership with users and carers”.
- “Seek trainers with a range of perspectives; for instance, include trainers on the issues relevant to users from ethnic or linguistic minorities, and on those relating specifically to girls and women with mental health problems”.
- “Include the stigma of mental illness as a topic in the curricula of primary care and mental health professionals”.
- “Offer training for relevant community actors such as police officers and employers”.

- "Ensure parity between users and non-users: if a professional consultant or trainer is offered a fee, so must a user or carer consultant or trainer".

- "Offer training for users and carers in skills for committee work and leadership development".

- "Develop user routes and pathways into roles and opportunities in the caring professions at qualifying and post-qualifying levels".

The approval of **the General Health Act** of 1986 (1) was one of the major milestones in mental health care in Spain, as it put the care of people with mental disorders and those with other health problems on the same level. This Act incorporated the general content and recommendations for psychiatric reform and mental health care outlined in the 1985 Plan for the Reform of Psychiatric and Mental Health Care (22). The implementation of these recommendations was uneven, particularly concerning the development of specific terms such as community services, integration, rehabilitation, consultation, psychotherapy, community work, prevention, evaluation, and quality.

Despite the critical evolution that has taken place in the model of care for people with mental health problems in recent years, it is urgent and essential to introduce a series of principles that allow us to evolve towards a model that offers the possibility of advancing in social inclusion, as well as the capacity to enjoy a full social role in the community and the necessary resources for effective coordination between the NHS and social and community agents.

In order to achieve this situation, it is necessary to:

a. Strengthen the autonomy of people with mental health problems, developing their capacities, resources, health assets, and skills.
b. Increase the possibility of making decisions in different spheres directly affecting their personal development.
c. Respect their times, needs, and values; in other words, respect their diversity.

Mental health epidemiology

Risk of poor mental health in the population

The Spanish National Health Survey (SNHS) assesses the risk of poor mental health (23).

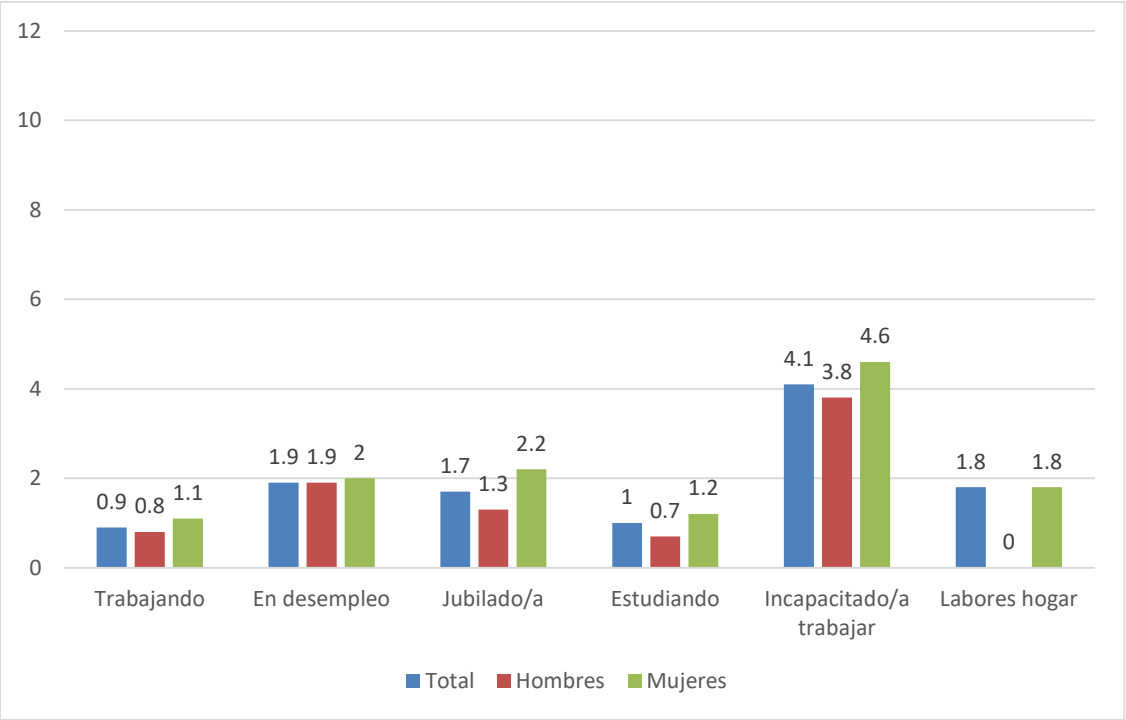
The Goldberg GHQ-12 general health questionnaire makes it possible to detect the prevalence of probable psychiatric morbidity or psychological problems in the population aged 15 years and over. It is a self-administered questionnaire that explores the person's assessment of their general state of well-being by examining subjective symptoms of psychological distress, somatic manifestations frequently associated with anxiety, depression, relationship difficulties, and difficulties in fulfilling social, family, and professional roles. It is a screening instrument unsuitable for clinically diagnosing or assessing chronic disorders. The values range from 0 to 12, with 0 points indicating the best and 12 points indicating the worst levels of mental health (24).

According to the data provided by the 2017 SNHS, the average value in the population aged 15 and over was 1.4 (SD 2.6). In men, the score was lower (1.1; SD 2.3), suggesting a better perception of mental health than in women (1.6; SD 2.8) [ii].

With economic activity (Figure 1), paid work was one of the main determinants of a person's general health status and mental health. Unemployed people (1.9; SD 3.0) scored differently from those who were working (0.9; SD 1.9), although the highest values were observed in the population unable to work (4.1; SD 4.3) (25).

[ii] The values of the mental health variable in the adult population range from 0 to 12 points, with 0 points indicating the best and 12 points indicating the worst levels of mental health (24).

Figure 1. Risk of poor mental health in the population aged 15 and over according to sex and economic activity. Spain 2017 [iii]



Source: The Spanish National Health Survey (SNHS), Spain 2017. Case study #1 – MENTAL HEALTH (25).

The SNHS also assesses the risk of poor mental health in children. (23) The risk of poor mental health in children aged 4-14 is measured with the *Strengths and Difficulties Questionnaire* (SDQ) (iv, v) It encompasses five measurements: emotional symptoms, behavioural problems, hyperactivity, peer problems, and positive socialisation or prosocial behaviour. (vi, vii) (26). Of the four negative measurements studied, boys scored higher (worse mental health) than girls in three of them (behavioural problems, hyperactivity, and peer problems), and girls scored higher in emotional symptoms (Figure 2). Prosocial behaviour (positive measurement) shows higher values for girls (9.2) than for boys (8.9).

[iii] Mental health in the adult population according to sex and economic activity. The mean score obtained in the GHQ-12 was calculated using a scale of 0-12 (the higher the score, the worse the mental health). The population was aged 15 and over. Spain 2017

[iv] SDQ. *Information for researchers and professionals about the Strengths and Difficulties Questionnaires* 2014. www.sdqinfo.com

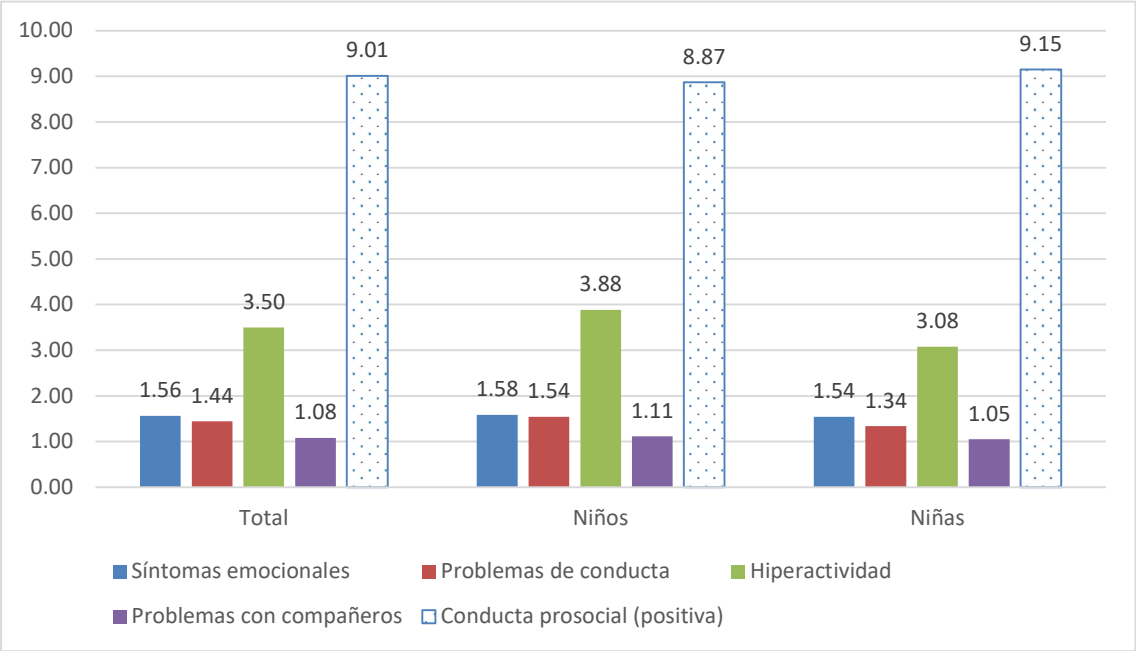
[v] The Convention on the Rights of the Child states "A child means every human being below the age of eighteen years" (151).

[vi] The SDQ is a brief questionnaire designed in 1997 by Goodman to identify mental health problems in children aged 4-16. It effectively screens for behavioural, emotional, and hyperactivity disorders. It consists of 25 items grouped into five dimensions.

[vii] The values of each category of the variable "mental health in children" range from 0 to 10 points, from best to worst mental health for "emotional symptoms", "behavioural problems", "hyperactivity", and "peer problems" and from worst to best for the scale "prosocial behaviour". The higher the score, the worse the mental health, except for the prosocial measurement, which scores in the opposite direction (the higher the score, the better the mental health). The sum of the first four measurements (except prosocial) generates the Total Difficulties Score (TDS) of the SDQ questionnaire, which has a range of values between 0 and 40. The higher the TDS score, the worse the mental health.

Data from the 2017 survey showed that of the children studied, 3.5% were hyperactive, 1.6% showed emotional symptoms, and 1.4% had behavioural problems (31).

Figure 2. Risk of poor mental health in children aged 4-14. Spain 2017[viii]



Source: The Spanish National Health Survey (SNHS), Spain 2017. Case study #1 – MENTAL HEALTH (25).

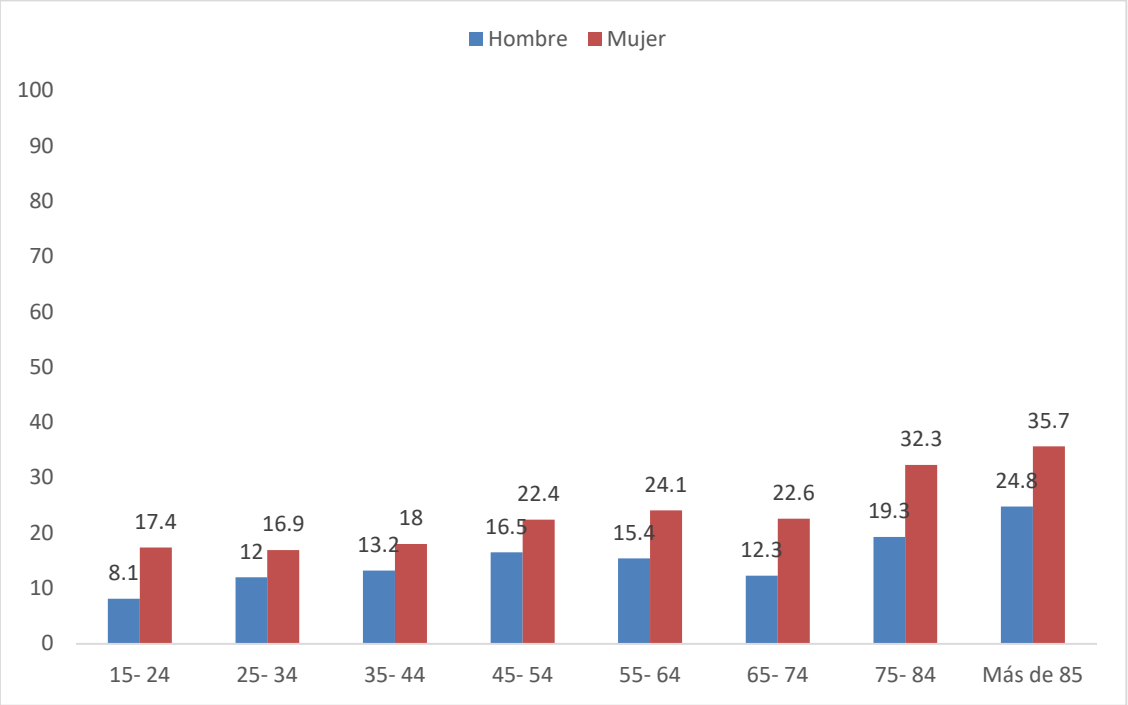
The population most at risk of poor mental health

The 2017 SNHS showed that 18% of the population aged 15 or over (13.9% of men and 21.9% of women) were at risk of mental disorders when regarding the cut-off point established (GHQ-12 ≥ 3) (ix). The risk increased with age, showing a more marked increase in the older age groups: 12.6% of those aged 15–24 compared with 31.9% in the over 85 age group (Figure 3).

[viii] The mean score (scale 0-10) is obtained in five measurements of the SDQ. The values of each category of the variable "mental health in children" range from 0 to 10 points, from best to worst mental health for "emotional symptoms", "behavioural problems", "hyperactivity", and "peer problems" and from worst to best for the scale "prosocial behaviour". The population was aged 4-14. Spain 2017. SNHS

[ix] The cut-off point for identifying possible psychiatric cases is 3. An individual scoring 3 or more is a possible psychiatric case or is at risk for a mental disorder (the term poor mental health is used for this score), bearing in mind that this is a screening and not a diagnostic instrument. Different studies show that there are cultural factors that determine differences in the responses and, consequently, in the point where the cut-off should be placed. It is advisable to assess the evolution of the series rather than the data obtained.

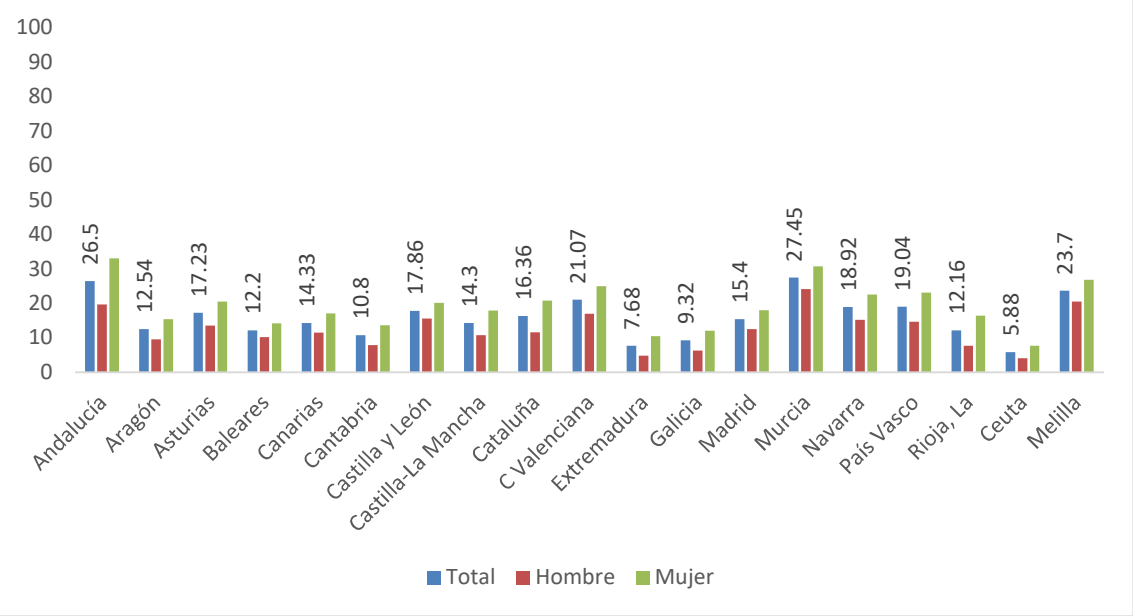
Figure 3. Percentage of the population at risk of poor mental health (GHQ-12 ≥ 3) aged 15 and over according to sex and age (%). Spain 2017



Source: The Spanish National Health Survey (SNHS), Spain 2017. Case study #1 – MENTAL HEALTH (25).

In the analysis by the autonomous communities, in terms of the estimated adult population at risk of poor mental health, Murcia and Andalusia occupied the top positions, above 25%, and Galicia, Extremadura, and Ceuta had the lowest percentages (Figure 4). This distribution by the autonomous communities is not consistent with reported morbidity. Asturias and Galicia, where more than 20% of the women reported "some mental illness" (chronic anxiety, depression, and/or others), have values below average on the GHQ-12. In contrast, Andalusia, the Valencian Community, and Murcia stand out for obtaining the highest scores on the GHQ-12, occupying intermediate places in reported morbidity. The GHQ-12 is not directly related to the consumption of antidepressants and tranquillizers.

Figure 4. Percentage of the population at risk of poor mental health (GHQ-12 ≥ 3) aged 15 and over according to sex and autonomous community (%). Spain 2017



Source: The Spanish National Health Survey (SNHS), Spain 2017. Case study #1 – MENTAL HEALTH (25).

✓ Child population at risk of poor mental health (x)

According to the cut-off point established for the SDQ (14 or more points) (xi), in 2017, 13.2% of the population aged 4-14 were at risk of poor mental health. The percentage was higher in boys (15.6%) than in girls (10.5%).

Children aged 4-9 showed higher percentages (14.2%) than those aged 10-14 (11.9%), both in boys and girls (Table 1).

When looking at the autonomous communities, Andalusia, Castile and Leon, and Catalonia presented the highest percentages, with above 15% of children being at risk of poor mental health.

[x] The Convention on the Rights of the Child states "A child means every human being below the age of eighteen years" (151).

[xi] The original authors of the SDQ developed cut-off points whereby it is possible to categorise mental health. This section describes the variable "at risk of poor mental health", defined as scores ≥ 14 on the TDS scale.

Table 1. Population aged 4-14 are at risk of poor mental health (SDQ ≥ 14) according to sex and various characteristics (%). Spain, SNHS 2017

	SDQ ≥14		
	Total	Boys	Girls
Number of respondents	4723	2449	2274
	%	%	%
Total (4-14 years old)	13.16	15.63	10.53
Age group			
From 4 to 9	14.20	16.62	11.57
From 10 to 14	11.91	14.41	9.32
Social class			
I	8.54	10.50	6.66
II	9.20	9.39	8.99
III	10.43	11.35	9.42
IV	12.61	14.86	10.34
V	15.69	21.29	10.18
VI	20.96	20.38	21.62
No record	10.45	13.80	5.14
Autonomous Community			
Andalusia	17.60	19.06	16.12
Aragon	13.11	17.35	8.36
Asturias	12.89	17.52	7.53
Baleares	10.63	7.20	14.45
Canary Islands	5.74	9.01	2.44
Cantabria	6.94	3.47	10.40
Castile and Leon	16.21	20.25	11.85
Castilla-La Mancha	14.53	16.63	12.27
Catalonia	15.56	20.09	10.73
Valencian Community	10.62	14.37	6.54
Extremadura	6.89	12.69	0.79
Galicia	8.29	12.29	4.16
Madrid	11.64	13.34	9.82
Murcia	8.79	8.20	9.46
Navarra	14.14	13.26	15.05
Basque Country	14.28	14.47	14.07
La Rioja	8.38	6.83	10.25

*Ceuta and Melilla are not presented due to insufficient numbers.
Source: The Spanish National Health Survey (SNHS), Spain 2017. Case study #1 – MENTAL HEALTH (25).

Table 2. Evolution of the population aged 4-14 at risk of poor mental health (SDQ ≥ 14) according to sex and various characteristics (%). Spain, SNHS 2006, 2011, and 2017

	% SDQ ≥14		
	2006	2011	2017
Total	22.50	17.09	13.16
Boys	23.66	18.18	15.63
Girls	21.3	15.92	10.53

Source: The Spanish National Health Survey (SNHS), Spain 2017. Case study #1 – MENTAL HEALTH (25).

Mental health problems in the general population

Since the introduction of specific diagnostic criteria for mental health problems in the 1970s, there has been a rapid expansion in the number of large-scale mental health surveys that provide population-based estimates of the combined prevalence of common mental health problems.

The systematic review conducted between 1980-2013 by Steel Z et al. on the global prevalence of mental health problems in 63 countries worldwide identified that 29.2% (25.9 to 32.6%) of respondents had experienced a mental disorder at some point during their lives. A consistent gender effect in the prevalence of common mental disorders was evident: women had higher rates of mood (7.3% vs 4%) and anxiety (8.7% vs 4.3%) disorders during the past 12 months, and men had higher rates of substance use disorders (2% vs 7.5%), with a similar pattern for lifetime prevalence (some mental disorder at some point in their lives). This systematic review confirmed that common mental disorders are highly prevalent globally and affect people in all regions of the world (27).

In the study "The global burden of mental disorders: an update from the WHO World Mental Health (WMH) surveys", Kessler et al. (2009) concluded that the lifetime prevalence of mental disorders was 18.1% to 36.1% and the annual prevalence was 9.8% to 19.1%. Of these, 4% to 6.8% are severe mental disorders in half of the countries, and many begin in childhood and adolescence (28).

The WHO Health Survey conducted in 11 countries in the Americas, Europe, and Asia reveals that despite differences between countries, the prevalence rates of bipolar disorders were very similar, as were their severity and comorbidity. The lifetime prevalence of bipolar spectrum disorders was 0.6% for bipolar disorder type I, and 0.4% for bipolar disorder type II, and the yearly prevalence was lower at 0.4% and 0.3%, respectively. Depressive episodes revealed a higher severity and frequency than manic episodes (74% with depression and 50% with mania) (29).

According to a European study on the prevalence of mental disorders in Europe, almost 165 million people each year have a mental disorder, such as depression, anxiety, insomnia, or

dementia (30). The study described mental disorders as "the biggest challenge facing Europe in the 21st century".

In Europe (30), 38.2% of the population is estimated to have a mental disorder yearly. The most frequent disorders are anxiety (14%), insomnia (7%), major depression (6.9%), somatoform disorders (6.3%), and alcohol and drug dependence (>4%). Brain and mental disorders contribute 26.6% to all causes of disability, which is higher than in other regions worldwide. The most disabling individual conditions were depression, dementia, and alcohol use disorders.

In Spain, the SNHS and the European Health Survey in Spain (EHS) provide regular information on the mental health status of the population. They alternate every 5 years, allowing for a follow-up of the issues they share every 2.5 years. The risk assessment of poor mental health and the prevalence of mental disorders in the population aged 0-14 is only available in the NHS, so data are available every 5 years (xii). These are questionnaires designed to provide information on the assessment of general health status, to identify the main health problems of citizens, to know the degree of access to and the use of health services, and to specify the determinants of health (31, 32).

When drafting the strategy, the latest EHS was from 2020 (32).

The primary mental health outcomes it reflected in 2020 are: (xiii)

- Anxiety and depression are among the most frequent mental health problems.
- 5.84% of the population aged 15 and over (3.5% of men and 8.06% of women) reported being diagnosed with chronic anxiety.
- A diagnosis of depression is reported by 5.28% of the population. Like anxiety, the frequency of depression in the adult population is more than twice as high in women 7.22% as in men 3.23%
- The prevalence of depression is three times more frequent among those unemployed (7.62%) than those working (2.47%) and reaches 23.71% among those who cannot work. Something similar occurs in the case of chronic anxiety, with 8.52%, 4.4% and 24.44%, respectively.
- 10.86% of the population aged 15 and over report having used medication such as tranquillisers, relaxants or sleeping pills in the last 2 weeks (14.19% of women and 7.35% of men) and 4.52% antidepressants or stimulants (6.33% of women and 2.6% of men).
- 4.77% of the population aged 15 and over reported having seen a psychologist, psychotherapist or psychiatrist in the last 12 months, 5.49% of women and 4% of men.

Depressive disorders cause many work days to be lost annually due to illness (33, 34, 35).

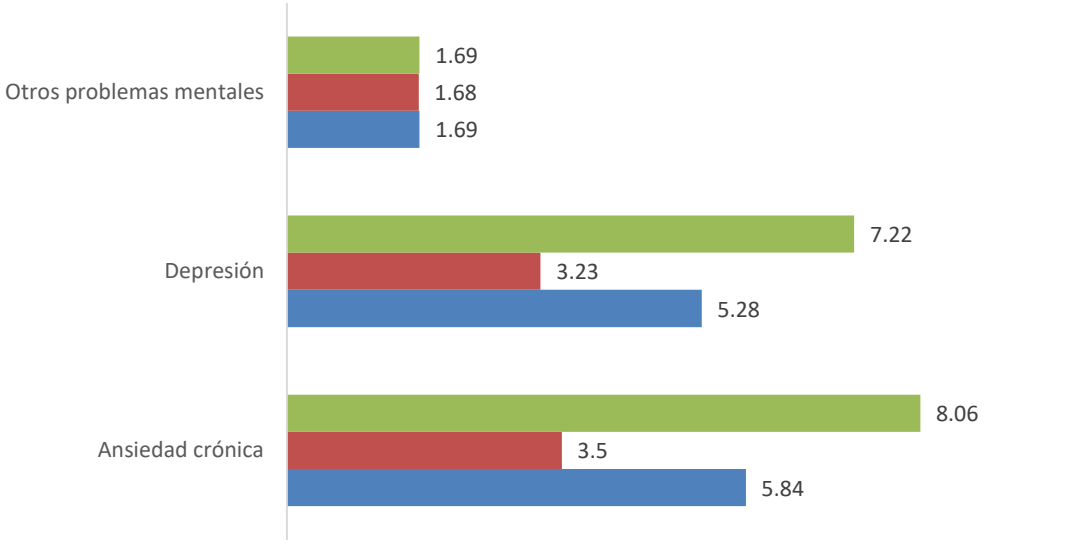
Figure 5 shows the prevalence data for depression and chronic anxiety in the population aged 15 and over. This data refers to the self-reported frequency of disorders diagnosed by a doctor during the last 12 months, according to the NHS and the EHS in Spain. Depressive symptoms are more common than depression in the strict sense. Confusing bereavement, the adolescent

[xii] Although the Convention on the Rights of the Child states "A child means every human being below the age of eighteen years", the results of the SNHS available to date are divided into two main groups: 0-14 years and 15 years and above.

[xiii] Self-reported prevalence of physician-diagnosed disorders in the non-institutionalised population aged 15 and above in the last 12 months.

"slump", or states of sadness with a depressive disorder, and even states of tiredness or depression can be confused with depressive symptoms. These confusions may be one of the reasons for the increase in the diagnosis of these disorders.

Figure 5. Prevalence of depression, chronic anxiety, and other mental health problems in the population aged 15 and above according to sex (%). Spain 2020 (xiv)



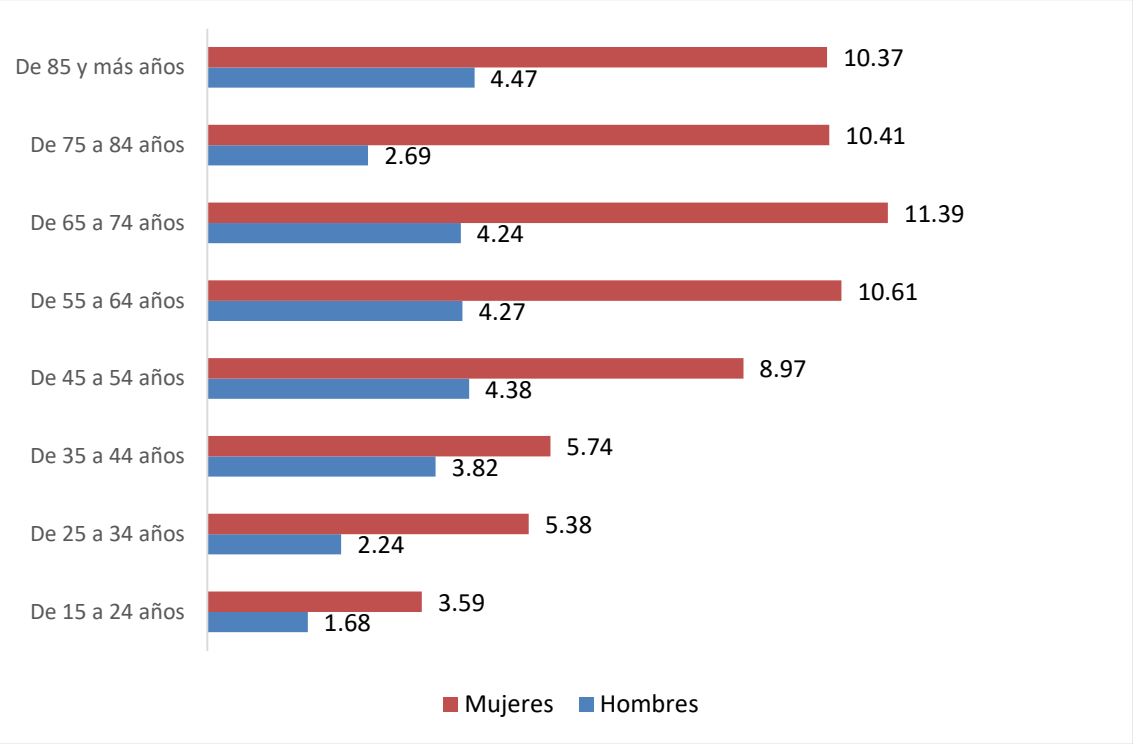
	Ansiedad crónica	Depresión	Otros problemas mentales
Mujeres	8.06	7.22	1.69
Hombres	3.5	3.23	1.68
Total	5.84	5.28	1.69

Source: European Health Survey in Spain (EHS) 2020 (32).

When analysed by age, the gender differences in the frequency of chronic anxiety and depression become twice as frequent between the ages of 45 and 55.

[xiv] Self-reported prevalence of physician-diagnosed disorders in the non-institutionalised population aged 15 and above in the last 12 months.

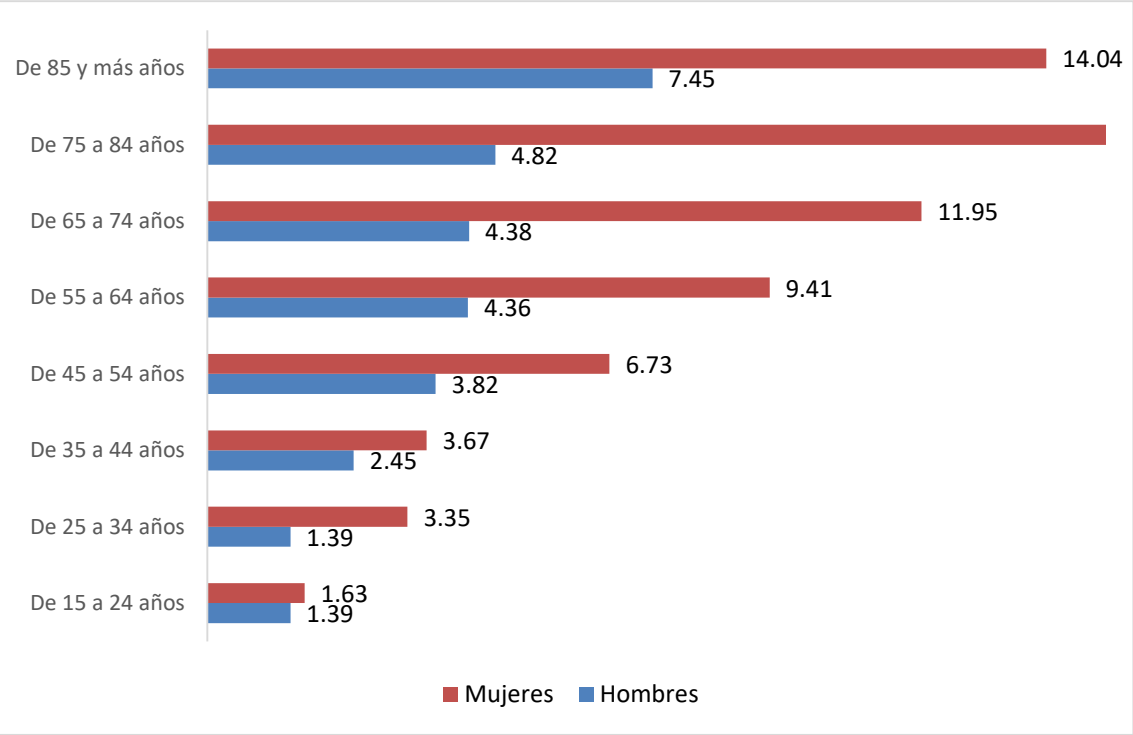
Figure 6. Prevalence of chronic anxiety in the population aged 15 and above according to sex and age (%). Spain 2020 (xv)



Source: European Health Survey in Spain (EHS) 2020 (32).

[xv] Self-reported prevalence of physician-diagnosed disorders in the non-institutionalised population aged 15 and above in the last 12 months.

Figure 7. Prevalence of depression in the population aged 15 and over according to sex and age (%). Spain 2020 (xv)



Source: European Health Survey in Spain (EHS) 2020 (32).

The National Health Survey does not include mental health problems such as bipolar disorder, schizophrenia, obsessive-compulsive disorder, borderline personality disorder, eating disorders, etc.

As for the **prevalence of mental health problems in children,** the EHS does not study this population, so the latest data available are those of the SNHS of 2017. The SNHS explores the presence of specific problems in the population explicitly during the last 12 months and diagnosed by a doctor. In the population aged 0 to 14, these are behavioural and mood disorders; in those aged 3 to 14, autism spectrum disorders are added (xvi).

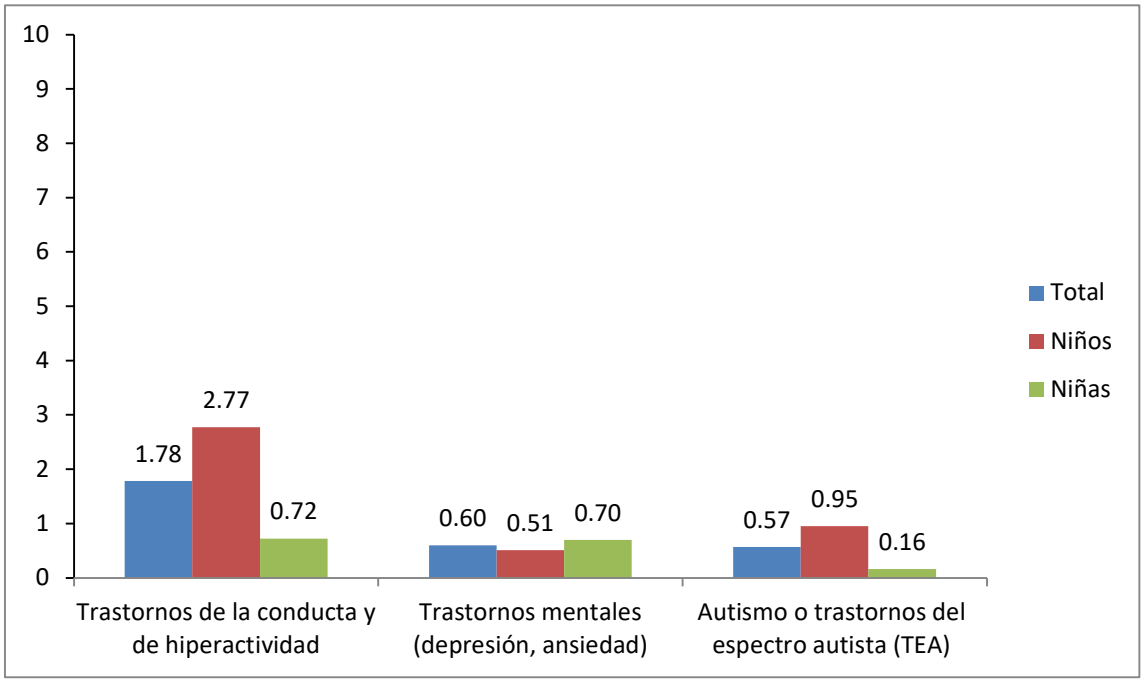
In 2017 1.78% of minors had been diagnosed with behavioural and hyperactivity disorders (xvii), 0.6% with mental disorders (depression, anxiety), and 0.6% with autism or autistic spectrum disorders (3-14 years). Information on the latter was collected for the first time in 2017.

The mental health problems explored were more frequent in males than females, especially in the behavioural and autistic spectrum disorders.

[xvi] Although the Convention on the Rights of the Child states "A child means every human being below the age of eighteen years", the results of the SNHS available to date are divided into two main groups: 0-14 years and 15 years and above.

[xvii] Although hyperactivity disorders have been separated from behavioural disorders (classified under neurodevelopmental disorders) since the DSM-5 version of the guidelines, the 2017 SNHS still showed the prevalence of both disorders, which should not be interpreted as hyperactivity disorders being considered behavioural disorders in this document.

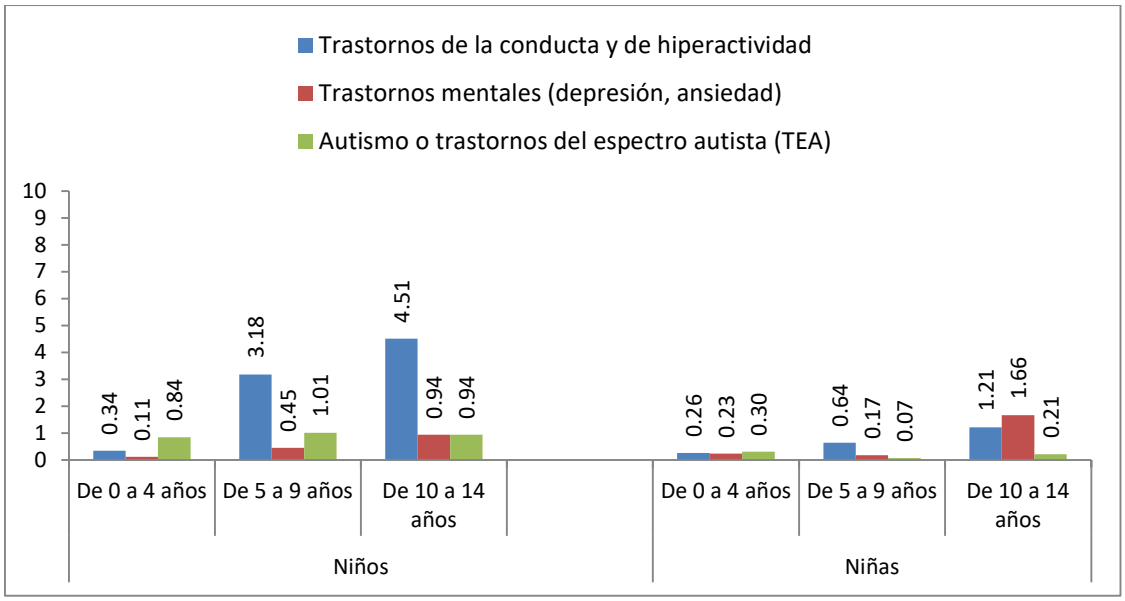
Figure 8. Prevalence of mental health problems in the population aged 0-14 according to sex (%). Spain 2017



* Occurring within the last 12 months and diagnosed by a physician
Source: The Spanish National Health Survey (SNHS), Spain 2017. Case study #1 – MENTAL HEALTH (25).

All disorders showed an upward gradient with age, especially behavioural disorders in children, the most frequently reported group of problems.

Figure 9. Prevalence of different mental health problems in the child population aged 0-14 according to sex and age (%). Spain 2017



*Occurring within the last 12 months and diagnosed by a physician
Source: The Spanish National Health Survey (SNHS), Spain 2017. Case study #1 – MENTAL HEALTH (25).

The health problems studied in children remained at similar levels to previous years (Table 3).

Table 3. Evolution of the reported prevalence of mental health disorders in the child population aged 0-14. Spain, SNHS 2006- 2011- 2017

Health problem/ year	2006	2011	2017
Behavioural and hyperactivity disorders xvii	1.95%	2.2%	1.78%
Mental disorders (depression, anxiety)	0.82	1.0	0.60

*Occurring within the last 12 months and diagnosed by a physician
Source: The Spanish National Health Survey (SNHS), Spain 2017. Case study #1 – MENTAL HEALTH (25).

Registry of mental health problems in primary care

In Spain, the Primary Care Clinical Database (PCCD) collects clinical information from a large sample (4.8 million in 2017) of medical records of individuals assigned to primary care in the NHS. For each individual in the sample, information is collected annually on their active health problems, referrals to the second level, procedures (imaging, laboratory, and other diagnostic and therapeutic procedures), the value of a selection of parameters, medicines that have been prescribed and dispensed, and contacts with primary care.

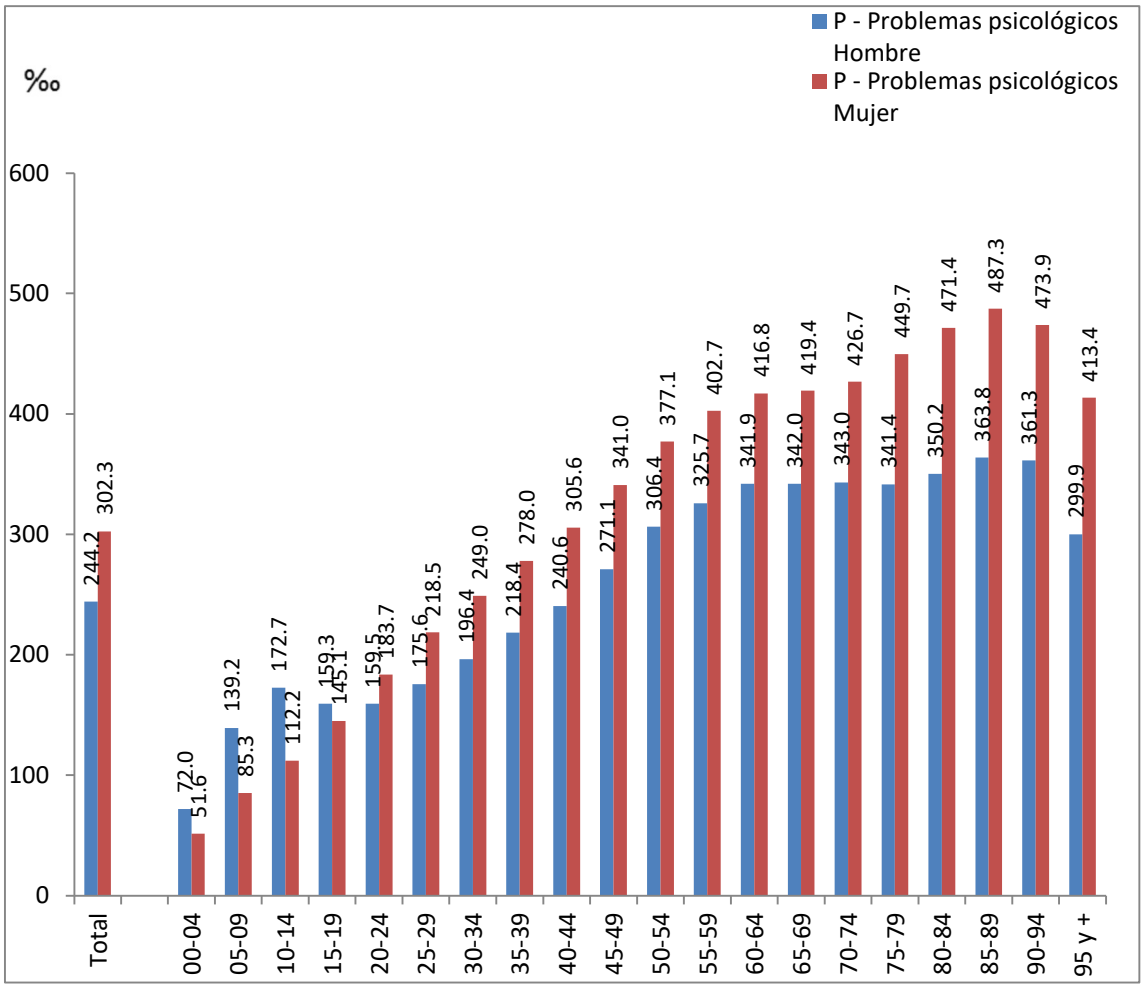
Concerning the data recorded in PCCD, the most prominent results related to the prevalence of mental health problems in 2017 were: (36, 37)

- The overall prevalence of mental health problems in primary care in 2017 was 27.4%.
- The most frequently recorded mental health problem in primary care clinical records is an anxiety disorder, which affects 6.7% of the population with a health card.
- Depressive disorders affect 4.1% of the population and increase with age.
- Psychosis, as a whole, affects 1.2%.
- The most frequent symptom is a sleep disorder, which affects 5.4%.
- A female predominance is observed in adults, mainly in the case of anorexia nervosa (7 times more common in females than males) and depressive disorders (3 times more common in females than males).
- The existence of a social gradient (health problems are more prevalent in lower-level income groups) is frequent, especially in psychoses (schizophrenia is 12 times more common in the lowest-level income groups compared to the highest), personality disorders (11 times more) and somatisation disorders (7 times more).
- In 2007, 34.3% of women and 17.8% of men aged 40 and over were administered at least one bottle of antidepressant, anxiolytic or hypnotic/sedative at the pharmacy. Quantitatively, a total of 203.6 DHDs (defined daily doses per thousand persons per day) were dispensed, with antidepressants (98.8 DHDs), anxiolytics (64.5 DHDs) and hypnotics and sedatives (40.2 DHDs) being the most commonly used.

When analysing these data in more depth, it can be seen that the overall prevalence of mental health problems recorded in primary care in 2017 is 27.4% (percentage of people assigned to primary care who present some of the psychological or mental health problems listed in the

International Classification of Primary Care - ICPC2 under the heading P-Psychological problems). The frequency is higher in women (30.2%) than in men (24.4%), although it varies with age (Figure 10).

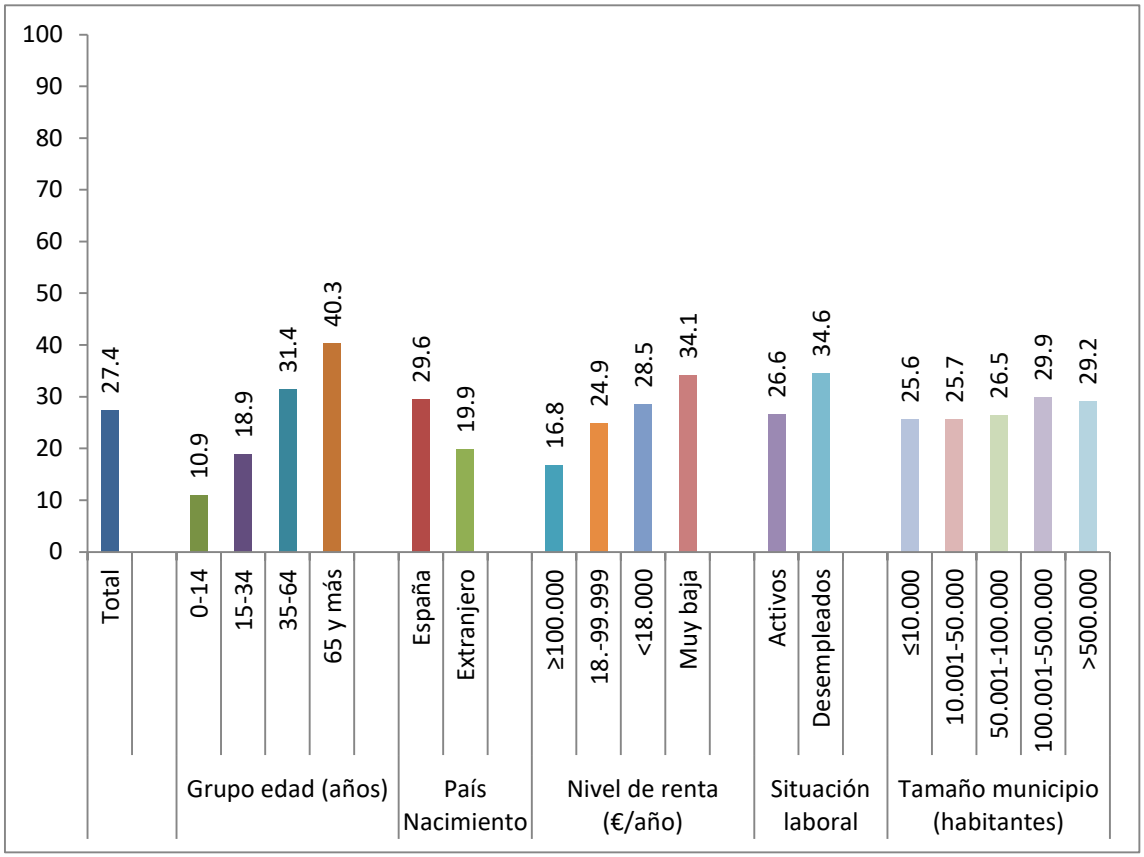
Figure 10. Prevalence of mental health problems according to sex and age. 2017



Source: Primary Care Clinical Database, 2017 (36)

When analysing the people with at least one psychological problem registered in the PCCD in 2017 (section P of ICPC2) by country of birth, income level, employment status, and the size of the district per inhabitant, the results observed are: there is a social gradient in both sexes, with higher reporting and registration of psychological problems in the lowest income brackets and unemployed (active 26.6% vs unemployed 34.6%). Regarding country of birth, the frequency is higher among people born in Spain than those born abroad (29.6% vs 19.9%). When analysing the data concerning the district´s size, psychological problems are more frequent in districts with more than 100,000 inhabitants (see Figure 11).

Figure 11. Prevalence of mental health problems by age, country of birth, income level, employment status, and district size. 2017



Source: Primary Care Clinical Database, 2017 (36).

Consumption of psychotropic drugs

Another interesting figure is the consumption of psychotropic drugs, estimated based on the number of packs dispensed in pharmacies at the expense of the NHS. Following the recommendations of the World Health Organisation (WHO) on drug use studies, drug consumption is expressed in defined daily doses (DDD) per 1,000 inhabitants per day (DHD). In 2017, according to information recorded in the PCCD, for every 1,000 persons assigned/day, the most dispensed group of psychotropic drugs was antidepressants (N06A) with 62.18 DHD (89.36 DHD in women and 33.61 DHD in men), followed by anxiolytics (N05B) with 40.7 DHD (52.54 DHD in women and 27.17 DHD in men), and by hypnotics and sedatives (N05C) 24.06 DHD (31.86 DHD in women and 15.85 DHD in men). The consumption of the antipsychotic group (N05A) was 7.97 DHD (6.73 DHD in women and 9.28 DHD in men) (38).

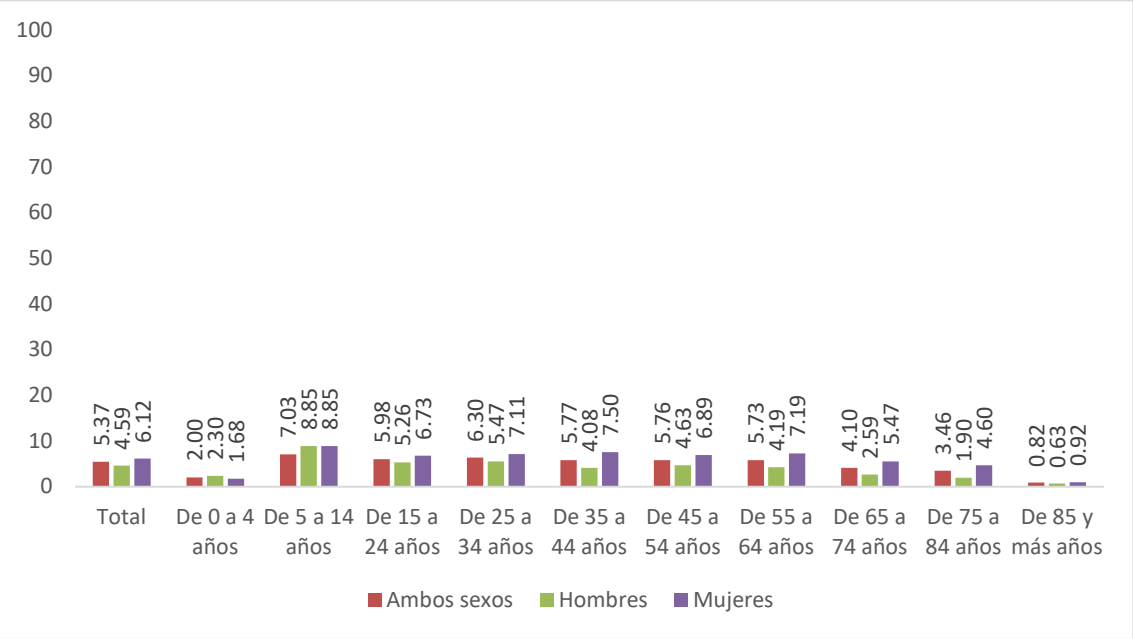
The SNHS and the EHS provide another approach. These surveys ask whether the person has taken medication in the last 2 weeks and which ones they have taken (concerning mental health, they ask whether they have taken medication categorised in the survey into two types: "tranquillisers, relaxants, sleeping pills" or "antidepressants, stimulants") and which of these were prescribed to them. Some of the data observed in the 2017 SNHS were: 5.6% of the population aged 15 and over reported having used antidepressants or stimulants in the last 2 weeks, while 12.5% reported having used tranquillisers, relaxants or sleeping pills. The vast majority reported having taken them with a doctor's prescription:

99.6% in the case of "antidepressants, stimulants" and 97% in the case of "tranquilisers, relaxants, sleeping pills" (there is slightly more self-medication in men, 4% than in women, 2.5%) (25).

Consultation with a psychologist, psychotherapist, or psychiatrist

The SNHS, and the EHS, also provide information on the percentage of the population who have consulted a psychologist, psychotherapist, or psychiatrist (public or private) in the last 12 months. The EHS collects data from age 15, and the SNHS collects data from birth.

Figure 12. Visits to a psychologist, psychotherapist, or psychiatrist in the last year, according to sex and age (%). Spain 2017



Source: The Spanish National Health Survey (SNHS), Spain 2017.

Another area where mental health care requires special attention is prisons. The data collected in the General Report, 2017 of the General Secretary of Penitentiary Institutions indicate that 4% of the prison population has a severe mental disorder, which highlights the importance of coordination between the prison administration which depends on the central government, and the health administration which depends on the autonomous communities (39).

Mental health resources

Health expenditure

The data on total expenditure on specialised mental health care in Spain for the NHS, corresponding to 2017, making an estimate based on different sources (Specialised Care Centres Statistics and SCR-CMBD), is close to 4% of the total expenditure on specialised care. Table 4 shows the calculated data broken down by the type of hospital. To these data, we would have to add, on the one hand, expenditure on pharmacy and, on the other, the estimate of expenditure derived from care for mental health problems at the primary care level (the percentage of expenditure at this level of care that is devoted to such care).

Table 4. Expenditure on mental health care in NHS hospitals, Spain. 2017

	Expenditure on mental health care in hospitals	Total expenditure on specialised care in hospitals	% of total
Acute hospitals*	945.452.666	38.806.337.865	2.44%
Medium and long-stay hospitals **	14.195.519	742.650.465	1.91%
Mental health and drug addiction treatment hospitals	521.133.334	521.133.334	100%
Total	**1.480.781.519**	**40.070.121.664**	**3.70%**

* Calculated based on the cost per hospital process in the NHS (RAE-CMBD) for hospitalisation and by UPA cost for outpatient activity and day hospital.

** Calculated using the estimated UPA cost for stays, day hospital and psychiatric consultations plus the estimated percentage of emergencies (proportional to other modalities).

Source: Ministry of Health. Specialised Care Information System (SCIS)/Specialised Care Activity Register. SCR-CMBD (43).

Hospital resources

The Specialised Care Health Centres Statistics regarding hospital centres, speciality centres dependent on them and outpatient specialised care centres cover the entire scope of hospital activity on a national level, including information on all hospital centres, both public and private, as well as centres without hospitalisation that offer specialised activity, outpatient surgery and diagnostic imaging (40).

In these Statistics, hospitals are classified by care purpose according to annexe II of Royal Decree 1277/2003, of 10 October, which establishes the general bases on the authorisation of health centres, services and establishments, in C.1. Hospitals: C.1.1. General Hospitals, C.1.2. Specialised Hospitals, C.1.3. Medium and Long-Stay Hospitals, C.1.4. Mental Health and Drug Addiction Treatment Hospitals.

Table 5. Hospitals and peripheral speciality centres (PSC) according to the purpose of care. 2018

	General hospitals		Specialised hospitals		Medium and long-stay hospitals		Mental health and drug addiction treatment hospitals		Total	
	Hospital	PSC	Hospital	PSC	Hospital	PSC	Hospital	PSC	Hospital	PSC
Public-NHS	291	330	30	4	103	6	44	23	468	363
Private	206	18	43	0	20	0	45	0	314	18
Total	497	348	73	4	123	6	89	23	782	381

Source: Ministry of Health. Specialised Care Information System (SCIS). Statistics on specialised care health centres, hospitals and outpatient centres (41).

The Specialised Care Health Centres, Hospitals and Outpatient Centres Statistics also offers information on the Functional Units that the centre has authorised following the classification established in Royal Decree 1277/2003, of 10 October, which establishes the general bases for the authorisation of health centres, services, and establishments (40). In 2018, the centres that offered psychiatry and clinical psychology care were the following:

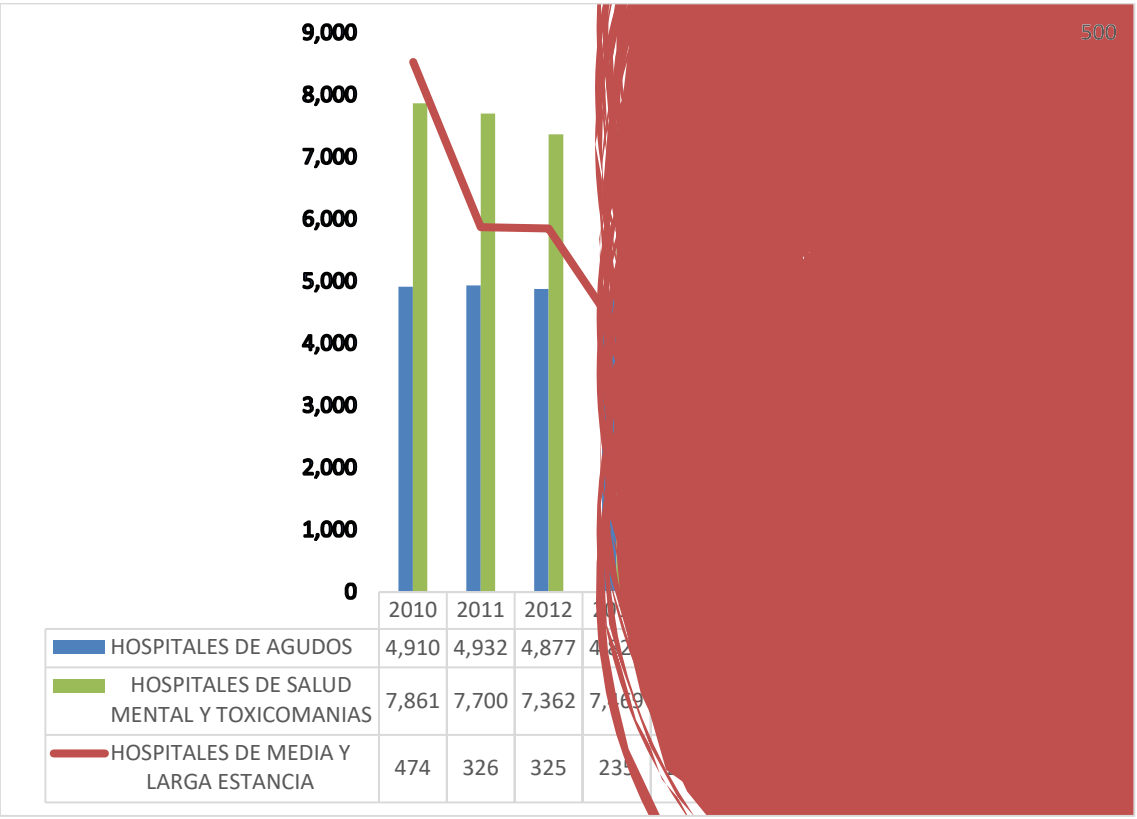
Table 6. Supply of care by dependency in specialised care health centres, hospitals, and outpatient centres. 2018

Care offer	Public		Private		Total number of centres	
	Total number of centres	% of the total number of centres	Total number of centres	% of the total number of centres	Total number of centres	% of the total number of centres
Psychiatry	284	61%	222	71%	506	65%
Clinical psychology	290	62%	164	52%	454	58%
Occupational therapy	280	60%	70	22%	350	45%

Source: Ministry of Health. Specialised Care Information System (SCIS). Statistics on specialised care health centres, hospitals and outpatient centres (42).

Between 2010 to 2019, the total number of psychiatric beds in NHS hospitals (counting both acute, medium, and long-stay units) in acute hospitals has remained constant at around 5,000 beds. In medium and long-stay hospitals, it has fallen, especially in the first years of the series, from 474 to 247 beds, and in the case of mental health and drug addiction hospitals, it has fallen from 7,861 to 6,976 beds.

Figure 13. Total number of psychiatry beds used for care in NHS hospitals from 2010- 2019 (xviii)

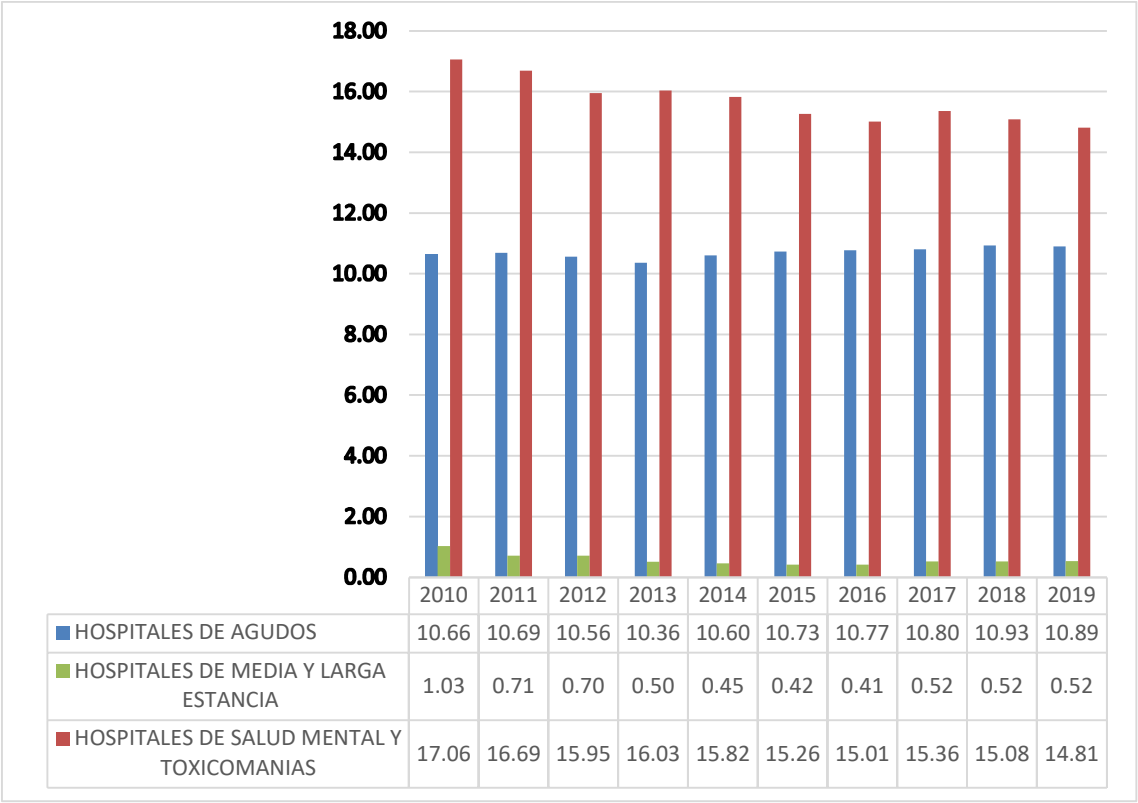


Source: Ministry of Health. Specialised Care Information System (SCIS). Statistics on specialised care health centres, hospitals and outpatient centres (43).

Concerning the rate of psychiatry beds per 100,000 inhabitants in acute, mental health, drug addiction, and medium and long-stay hospitals of the NHS, it has increased slightly in acute hospitals from 10.66 in 2010 to 10.89 in 2019. In medium and long-stay hospitals, it has gone from 1.03 in 2010 to 0.52 in 2019. In mental health and drug addiction hospitals, it has gone from 17.06 in 2010 to 14.81 in 2019.

(xviii) In these Statistics, hospitals are classified by care purpose according to annexe II of Royal Decree 1277/2003, of 10 October, which establishes the general bases on the authorisation of health centres, services and establishments, in C.1. Hospitals (inpatient centres): C.1.1. General Hospitals, C.1.2. Specialised Hospitals (these two grouped as "Acute Hospitals"), C.1.3. Medium and Long-Stay Hospitals, and C.1.4. Mental Health and Drug Addiction Treatment Hospitals.
The definition that the Royal Decree includes in Annexe II for C.1.4 is the following (transcribed verbatim): "Hospitals for mental health and drug addiction treatment: hospitals intended to provide diagnosis, treatment and monitoring of their illness to patients who need to be admitted and who have a mental illnesses or disorders derived from drug addiction".

Figure 14. Rate of psychiatry beds by hospital type per 100,000 inhabitants in acute, medium and long-stay, and mental health and drug addiction NHS hospitals from 2010- 2019 (xviii)

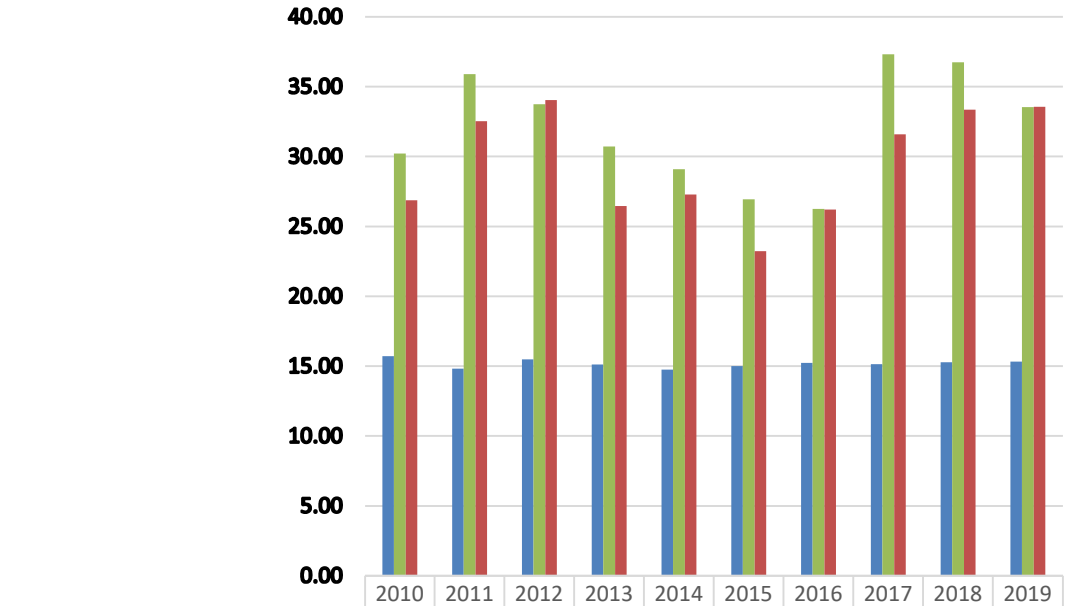


	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
HOSPITALES DE AGUDOS	10.66	10.69	10.56	10.36	10.60	10.73	10.77	10.80	10.93	10.89
HOSPITALES DE MEDIA Y LARGA ESTANCIA	1.03	0.71	0.70	0.50	0.45	0.42	0.41	0.52	0.52	0.52
HOSPITALES DE SALUD MENTAL Y TOXICOMANIAS	17.06	16.69	15.95	16.03	15.82	15.26	15.01	15.36	15.08	14.81

Source: Ministry of Health. Specialised Care Information System (SCIS). Statistics on specialised care health centres, hospitals and outpatient centres (43).

The evolution of the average length of stay in psychiatry for admissions to acute units from 2010 to 2017 can be seen in Figure 15.

Figure 15. The average length of stay in days in acute units according to the type of hospital (acute hospitals, medium and long-stay hospitals, and mental health and drug addiction hospitals) of the NHS from 2010- 2019 (xviii)



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
HOSPITALES DE AGUDOS	15.70	14.82	15.48	15.11	14.76	15.00	15.24	15.15	15.27	15.32
HOSPITALES DE SALUD MENTAL Y TOXICOMANIAS	30.21	35.89	33.73	30.71	29.09	26.93	26.26	37.31	36.73	33.54
HOSPITALES DE MEDIA Y LARGA ESTANCIA	26.86	32.53	34.03	26.45	27.28	23.23	26.21	31.58	33.34	33.56

Source: Ministry of Health. Specialised Care Information System (SCIS). Statistics on specialised care health centres, hospitals and outpatient centres (43).

In this section on resources, the work carried out in mental health from Primary Care Centres should be acknowledged. Although it is not easy to obtain national data quantifying the specific dedication of its professionals to this task, the work carried out by family doctors, paediatricians, and nurses in these facilities is vital to the mental health care provided in the NHS.

Professionals

In 2018 3,999 psychiatrists were working in the NHS public health centres, and there were 898 resident interns in training (40).

The ratio of psychiatrists per 100,000 inhabitants in Spain increased from 8.1 in 2015 to 8.6 in 2018. [Source: Ministry of Health. Specialised Care Information System (SCIS). Statistics on specialised care health centres, hospitals and outpatient centres (43)].

In the autonomous communities, the Basque Country, Catalonia, Asturias, and Madrid show the highest proportions (see Table 7 below).

Table 7. The proportion of psychiatrists linked to NHS public centres per 100,000 inhabitants broken down by autonomous community from 2015- 2018

	2015	2016	2017	2018
ANDALUCÍA	7,275	7,341	5,629	6,127
ARAGÓN	8,620	8,808	8,740	8,738
ASTURIAS	10,436	10,414	10,777	11,519
ILLES BALEARS	8,856	8,573	8,723	9,519
CANARIAS	7,524	6,722	6,981	6,945
CANTABRIA	6,509	6,536	7,402	7,401
CASTILLA Y LEÓN	8,678	8,388	9,862	9,416
CASTILLA-LA MANCHA	8,468	8,518	7,771	7,977
CATALUÑA	9,934	10,127	11,731	12,027
COMUNIDAD VALENCIANA	5,106	4,890	5,010	5,557
EXTREMADURA	6,066	5,272	5,404	5,528
GALICIA	6,822	6,855	7,028	7,409
MADRID	9,139	9,168	9,700	10,307
REGIÓN DE MURCIA	5,187	5,176	4,886	4,868
C. FORAL DE NAVARRA	4,716	4,857	4,680	7,119
PAÍS VASCO	12,567	12,563	13,379	13,670
LA RIOJA	5,758	6,077	7,043	7,035
CEUTA	1,183	3,540	3,530	5,888
MELILLA	3,536	5,900	5,896	4,724
Total España	**8,065**	**8,034**	**8,194**	**8,574**

Source: Ministry of Health. Specialised Care Information System (SCIS). Statistics on specialised care health centres, hospitals and outpatient centres (43).

As for specialists in **clinical psychology** and **nursing** professionals with the title of **mental health specialist** working in NHS mental health units, there was no updated or complete information available when writing this strategy. The incomplete information regarding the number of staff employed in NHS public health centres in all autonomous communities and the type of centre they are employed in affects the ability to present a reliable figure of the ratio of professionals in these specialities at the national level. The most up-to-date information relating to professionals nationally is that of those with qualifications in the specialities listed above, which does not mean that all of them are working on healthcare tasks, nor that those who do are doing so in public NHS centres.

In a situation of a recognised lack of sufficient resources in these specialities, the data mentioned in June 2021 are as follows:

Table 8. Specialist titles in Clinical Psychology and Mental Health Nursing in Spain in 2021

Speciality	Specialist titles	Specialist titles <65 years old
Clinical psychology	8.041	6.010
Mental Health Nursing	7.159	5.994

Source: Ministry of Universities and Ministry of Health. Data as of June 2021.

The Ministry of Health is working on improving the information systems so that, with the help of the autonomous communities and health centres, it will have information on how many of these graduates are practising in mental health and in what type of centre within the State Register of Health Professionals (SRHP). It is hoped that in the evaluation process of the strategy, it will be possible to analyse this information with the data on personnel linked to the different public centres of the NHS that provide mental health care at a national level from the SRHP portal.

In 2018, 1,845 social workers were linked to public health centres of the NHS (in public centres, with a substitute agreement and Public Utilisation Network, PUN) (40).

The promotion of the SRHP and the work being carried out by the NHS Human Resources Commission as well as the 2021 update of the Supply-Need Study of Medical Specialists 2021-2035 to plan the needs of healthcare professionals (both included as objectives in this strategy) are expected to facilitate the training and availability of a sufficient number of mental health professionals to meet the needs of the population.

Child and adolescent mental health

For several reasons, the early stages of human development are an area of interest which is prioritised for mental health. On the one hand, during this period, the individual´s biological, psychological, and social maturation takes place, which will have a crucial influence on health and illness in adult life. On the other hand, many mental health problems, especially the most serious ones, actually begin in childhood and adolescence, so early care can have a powerful influence on a person's immediate and future well-being. At this stage, recovery-oriented care based on biopsychosocial intervention, with full respect for the individual´s rights and autonomy, is a priority. In order to achieve this objective, it is essential to have professionals with specific training in this field who can provide quality intervention.

Addressing mental health problems early in childhood and adolescence is essential since 70% of mental disorders generally begin in the infant-juvenile stage (44).

Recently, international studies have been conducted, such as a study on the prevalence and distribution of mental health problems in first-year university students in eight countries (45). Six common disorders from the DSM-IV classification were studied: major depression, mania/hypomania, generalised anxiety disorder, panic disorder, alcohol use disorder, and substance use disorder. The result was that 35% of students tested positive for at least one of the common disorders assessed in the lifetime prevalence analysis, and 31% tested positive for at least one disorder in the 12-month prevalence analysis. These syndromes generally had onset in early adolescence and persisted into the survey year.

New times and lifestyles have influenced the emergence of new and emerging mental health problems, highlighting issues related to the abusive use of screen-based tools and one of their consequences in the form of bullying and cyberbullying behaviours in childhood and adolescence (46).

Non-substance addictive behaviours (cyber addiction and cyberbullying) have not been included as disorders in the American DSM-5 classification, and in the WHO ICD-11 classification proposal (at the time of writing, ICD-11 has not yet been adopted in Spain), they are included as "addiction to video games" (and to the Internet: gambling disorder and gaming disorder) (47). The scientific community accepts them under behavioural addictions (disorders like pathological gambling addiction, information and communication technology (ICT) addiction, and indiscriminate use of screen-based tools). ICT use is different from abuse and dependence behaviours. ICTs are potentially addictive because of two characteristics: their use produces immediate gratification and an escape from the world around them. Their habitual use produces tolerance (need for a more extended period of use to produce the same response), abstinence (production of high-intensity anxiety in their absence), loss of control, concealment of their use, abandonment of other habitual activities with behavioural change, and "craving" (longing for their use). All of these characteristics are present in a particular way in each person, according to their personality structure, presenting physical, emotional, and social consequences that produce symptoms in the subject. Sometimes the use of these instruments (video games and hyper-use of social networks) is so severe that it leads to a self-confinement of the subject to only relate by and through these computer media, a disorder known as "Hikikomori", as it was initially described in Japan. There is also a dysfunctional use of ICTs: harassing/being harassed

through ICTs, with defamatory content to harass a peer or group of peers, through personal attacks. Some authors consider these behaviours a real public health problem in their multiple forms of presentation (cyberbullying, cyberstalking, sexual abuse or grooming, baiting or luring, using recordings to ridicule a person, or adding insulting messages to forums) (48). The greatest repercussions and prevalence of these situations occur in childhood and adolescence, with all their real impact on mental development in the short, medium and long-term, with the possibility of symptoms included in post-traumatic stress syndrome (46).

Cyberbullying includes sending offensive messages or comments online, spreading rumours, excluding victims from online groups and other forms of harassment (OECD, 2017) (49). Like bullying, exposure to cyberbullying has been linked to a wide range of adverse outcomes, including stress and suicidal thoughts (Kowalski et al., 2014) (50), depression and anxiety (Fahy et al., 2016) (51).

The Health Behaviour in School-aged Children (HBSC) survey in 42 countries asked children about their experiences of online bullying. It found that, on average, 11% of 11, 13, and 15-year-olds reported having experienced cyberbullying through messaging at least once. Just over 3% of children reported being cyberbullied by messages at least 2-3 times a month. In all countries, a relationship was found with the rate of bullying (52).

School is the ideal environment for school-aged children to develop preventive interventions to promote mental well-being. These school-based interventions can improve mental health, develop mental health assets, respect diversity and improve social and educational outcomes. Long-term benefits include improved academic performance, resilience, and cognitive skills (Weare & Nind, 2011; Durlak et al., 2011) (53,54). Investing in the mental health of school-aged children can reduce the risk of dropping out or having difficulty transitioning from school to work (OCDE, 2015) (55).

Interventions in schools can include targeted actions to prevent bullying and cyberbullying. These activities to prevent bullying in the classroom help to improve the classroom environment, reduce bullying and improve academic grades (Clarke, Bunting y Barry, 2014) (56).

Behavioural disorders in adolescence (child-to-parent and social violence) constitute one of the emerging problems in mental health.

These problems refer to instances in which adolescents evidence a pattern of antisocial behaviour, which poses a significant difficulty almost daily for their functioning at home or school, or when the behaviour is referred to as unmanageable in a significant way by the persons of reference.

Addressing adolescent behavioural disorders includes elucidating the variables that predispose, trigger, and maintain the aggressive reaction in each case. It should not be forgotten that these adolescents often show a relevant deficit in problem-solving, perceptions, self-esteem, and self-attributions. Adolescents who display these behaviours show a low tolerance to frustration and a high level of demand, accompanied by addictive behaviours to information and communication technologies (ICT), exacerbating confrontations.

Children with behavioural disturbances often interpret the intentions of others' actions as hostile and have poor social relationships with peers, teachers and parental figures. Peer violence and bullying show that 40% of children their peers reject, display aggressive behaviour and are at high risk of developing antisocial behaviour in adolescence.

Among families who start treatment, 40-60% end treatment prematurely, and those individuals who leave treatment early have more severe pathologies than those who continue treatment. The presence of protective factors should also be identified, such as having an adequate level of self-esteem, family support oriented towards supervision, maintaining continuity in the therapeutic intervention if it was initiated, early diagnosis leading to early treatment, good accessibility to mental health care services in childhood and adolescence, adequate social support with peers and in the social context and, finally, adequate school support.

In order to tackle mental health problems in childhood and adolescence, a strategic line has been included in the strategy in which specific objectives and recommendations are developed. Given its specificities, it will likely require the creation of an ad hoc interdisciplinary working group to facilitate its implementation.

The evolution of mental health problems. Rehabilitation and social reintegration: Recovery-based intervention

The available scientific evidence shows a certain tendency towards the chronic evolution of many mental health problems. In addition, there is evidence of the emergence of new chronicity as an expression of attending a mental health service as a user and not being discharged. These two types of chronic evolution coexist in care services, one of them evolutionary and process-dependent and the second, almost iatrogenic, dependent on a therapeutic interaction that is not resolved.

The process-dependent chronic evolution requires active rehabilitation and social reintegration programmes to avoid cognitive and social deterioration while enhancing the person´s autonomy and reducing dependence on the family and the community.

Emerging chronic evolutions include aspects closely related to the meaning and evolution of therapeutic action and the "sick role".

All therapeutic action must intend to remove the sick role, facilitating the person's autonomy. Sometimes, the subject constantly seeks care and advice, either for reasons of personality or because the care services increase the actions that encourage this dependence on the centre. This type of development takes up time and costs money.

Rehabilitation and social reintegration: Intervention based on recovery

Psychosocial rehabilitation is the interdisciplinary practice that promotes and maintains the autonomy of people with potentially disabling mental health problems and their community integration. The goal of psychosocial rehabilitation is personal recovery (57).

From this perspective**, recovery, as a goal, has the final objective of enabling the person to develop their life in equality and dignity, which includes work, training, and emotional, sexual, and social development**. The paradigm of recovery implies a process of change in the person who has the difficulty or disorder and commits them to greater involvement and protagonism in their process; in those who accompany them in their daily lives and build together the ways of living; in the professionals or technicians who have to go from possessing the knowledge to accompanying them in the process; and in society, which has to offer the framework for their autonomy, freedom, and the development of the right to live in situations of equality.

Suicidal behaviour as a public health issue

In Europe, in 2015, the deaths of more than 56,000 people were attributed to suicide, with a predominance of men (43,000 men and 13,000 women) (58). In Europe, the number of suicides steadily increases with age among men and women, reaching a peak between the ages of 45 and 64. By country, the suicide rate among all ages is the highest in Lithuania, with rates (age-standardised) in 2015 of 30 deaths per 100,000 inhabitants. Slovenia, Latvia, and Hungary also have high rates of around 20 deaths per 100,000, almost twice as high as the EU average (11 per 100,000 population) (59). The lowest rates are in the southern European countries (Greece, Cyprus, Italy, Malta, and Spain). Some caution is required when interpreting suicide rates, as they may reflect, at least in part, methodological differences in recording methods. On average, across all EU countries, suicide rates among men were 3.7 times higher than among women (a difference that may be partly affected by a higher percentage of suicide attempts that succeed in the case of men). The hospital discharge rate for suicide attempts was 52% higher among women in 2015 (*Observatoire National du Suicide*, 2018) (60). This gender gap was most prominent in the four countries with the highest suicide rate but also in Estonia, Poland, and Romania. Suicide is one of the leading causes of death among adolescents and young adults. In 2015, 3,400 young people aged 15-24 died by suicide in EU countries, making it the leading cause of death in this age group after road traffic injuries (59). Young people are likelier to attempt suicide if they have a family history of alcohol and drugs.

According to recent estimates, more than one in six people in the EU had a mental health problem in 2016, equivalent to about 84 million people (61). A cross-national analysis based on the WHO World Mental Health Surveys found that a wide range of mental disorders increased the likelihood of experiencing suicidal thoughts, and fewer disorders increased the likelihood of acting on such thoughts (Nock et al., 2009) (62). Many factors may explain why some people attempt or die by suicide, including major life events (such as the death of a loved one, divorce, or job loss), social or socioeconomic isolation, or cultural context. However, **many people who have survived a suicide attempt or died by suicide have a mental health disorder** (Hoven, Mandell & Bertolote, 2010; Cavanagh et al., 2003; OMS, 2014) (63, 64, 65).

In Spain, suicide is also a serious public health problem:

- According to data from the National Institute of Statistics, in 2020, the suicide rate by age and sex was 8.3/per 100,000 inhabitants/year (66).
    - Suicide in 2020 remained the **leading external cause of mortality**, with 3,941 deaths, of which 2,930 were male and 1,011 female.

- A turning point occurred in adolescence, from 14 suicides in the under-15 age group to 300 suicides in the 15-29 age group.

Adolescence is a time of risk. As for the trend, National Statistics Institute (NSI) data for the last 4 years available, 2017 to 2020, show that in the under-15 age group, there were 13, 7, 7, and 14 deaths by suicide and in the 15-29 age group there were 273, 268, 309, and 300 suicides, respectively.

The World Health Organisation (WHO) already warned in 2000 that an individual suicide intimately affects at least six other people. This fact means that more than 18,000 people in Spain each year could experience the tragic and traumatic consequences of the suicide of a loved one.

For all these reasons, this Mental Health Strategy includes **an exclusive strategic guideline dedicated to preventing suicidal behaviour** in which the autonomous communities set out objectives and actions to be carried out.

Mental health and gender

The inclusion of the gender perspective in the strategic health planning process is a mandate stipulated in current legislation. Organic Law 3/2007, of 22 March, for the effective equality of women and men, in its article 27, stipulates the integration of the principle of equality in health policy, to which are added the references in this respect in the modifications of Law 14/1986, of 25 April, General Health Law, Law 16/2003, of 28 May, on Cohesion and Quality of the National Health System and the Quality plan of the National Health System, among others. The gender perspective has also been included in the World Health Organisation since 2001 and specifically in the European agreements for mental health, where it is necessary to include gender transversally in all health planning processes and the lines of work.

Gender as a social determinant of health does not act alone but interacts with other social determinants. Highlighting the influence of gender on health, particularly mental health, highlights that other social factors can deepen or contrast the effect of gender on health (67).

The main aspects identified concerning mental health and gender that need to be taken into account in planning and organisation are:

- The most prevalent mental disorders present differently by gender and according to different stages in the life cycle. Women are relatively protected from some of the more severe neurodevelopmental disorders, which manifest themselves in childhood and pre-adolescence (68). However, this pattern changes from adolescence, and women develop more psychiatric problems than men (69). All community studies show a higher frequency of psychiatric disorders among women.
- Women have higher rates of depression, anxiety, stress, somatisation, and eating disorders, while men have higher rates of substance use, suicide, and antisocial disorders.
- Mental health and well-being determinants vary between men and women and by life cycle. The higher risk of poor mental health among women may be due to psychosocial risk factors associated with socio-economic and gender determinants, such as work and care overload and the wage gap, which condition women's greater exposure to poverty

and overwork, socio-economic discrimination, and gender-based violence. However, despite the greater psychiatric morbidity in women compared to men, it has not been demonstrated that women are more vulnerable due to their biological and physiological make-up, hence the importance of considering the gender perspective with the other social determinants of inequality in mental health.

- There are no significant gender differences in the case of severe mental disorders. However, among these, more men than women access mental health services.
- The WHO identified violence against women as the leading cause of health problems in 2011. Studies have shown that women who experience or have experienced gender-based violence have greater physical and mental health problems. Despite the limited data, it can be noted that women diagnosed with severe mental disorders are more vulnerable or more likely to experience gender-based violence than women without a severe mental disorder diagnosis (70).
- Women with severe mental disorders or addictions are in a situation of particular vulnerability. This double discrimination marks their lives. Compared to men, women with these disorders are at greater risk of living in poverty and isolation, receiving lower wages, and being less represented in the labour market (71).
- Among all the psychosocial factors associated with gender, violence in its different forms (gender-based violence from partners or ex-partners, sexual violence, human trafficking with or without the purpose of sexual exploitation, forced marriages, and harassment at work) (72) directly affects the mental health and well-being of the women who experience it. Violence is often at the origin of the mental disorder, and having a mental disorder or addiction, particularly severe, increases the risk of experiencing violence and abuse, causing the pre-existing mental disorder to worsen.
- Women with severe mental disorders often care for their offspring, and their responsibilities may make accessing health services difficult. The mother-child bond may be affected when the mother has a severe mental disorder or addiction. She will require support while not limiting personal rights, prioritising her right to have a family, and, if required taking the necessary measures to avoid the withdrawal of guardianship.

In children under 14, mental health problems are more prevalent in boys. Between 15 and 19, it is equal in both genders; from 19 onwards, women have a higher prevalence than men (73).

Due to the above points, within the framework of this strategy, it is considered especially relevant to take into account the following general issues in its implementation:

- Include modules with content relating to the gender perspective in health and especially concerning the impact on health when women have experienced gender-based violence (prevention and early detection) in the training of professionals in mental health teams and primary care.
- To collect data and obtain indicators disaggregated by sex, which are comparable, exhaustive, reliable, and regularly updated to enable resources and services to be adjusted to the different needs of women and men.
- Include actions aimed at severe mental disorders or addictions in women. These actions should consider both the early detection and care of the different expressions of gender-based violence they may have experienced or be experiencing and resources adapted to their socio-family and parenting needs.

- Good practices should be implemented while developing applicable strategic guidelines and objectives.

Mental health and work

Work is beneficial for mental health. However, the negative demands of work and its conditions can pose a risk to the health of working people, which is an issue of concern to employers, workers, and governments worldwide (74, 75).

Work is one of the main determinants of people's physical and mental health. When work has undergone continuous and substantial organisational change, this can lead to mental health problems. Some key aspects include teleworking, the use of information and communication technologies, the increase in the volume and speed of information, and the growing use of outsourcing and subcontracting. When added up, these changes introduce increasing demands on the worker´s flexibility in terms of the required number and type of skills, which is often accompanied by tensions over the distribution of working time in schedules that do not allow for a good work-life balance.

Experts and workers consider psychosocial risks associated with inadequate work organisation a major health and safety problem. Successive European Surveys of Working Conditions (76), National Surveys of Working Conditions (77), and the ESENER survey (78) carried out by the European Agency for Safety and Health at Work show that:

- Stress at work can affect anyone at any level. It can occur in any sector and size of the organisation. It affects the health and safety of individuals and the health of organisations and national economies. It is Europe´s second most common health problem, affecting 22% of workers.
- Stress can jeopardise workplace safety and contribute to other occupational health problems, such as musculoskeletal and cardiovascular disorders.
- It also has a significant impact on organisational performance. Studies in Europe and other developed countries have found that 50-60% of all work days lost are due to stress.
- After musculoskeletal diseases, mental health problems are the second leading cause of temporary and permanent sick leave.
- The incidence of harassment at work is estimated at a European level of 2.7% and a Spanish level of between 1.4 and 2.9%.
- The annual economic cost of work-related stress in Europe has been estimated at 20 billion euros.
- In 2007, the total production costs of absenteeism due to mental health problems were 136 billion euros.

Despite the abovementioned problems, work is generally good for mental and physical health. Research has repeatedly shown that quality work can promote and protect health. There is a growing recognition that the mental well-being of workers has positive effects on organisational performance, as well as on the health, professional fulfilment, and quality of life of the worker.

It is also necessary to consider the existence of legal regulations in Spain, such as Law 31/1995, of 8 November, on the Prevention of Occupational Risks. This law establishes the policy on the prevention of occupational risks as a set of actions of the public authorities aimed at promoting the improvement of working conditions to raise the level of protection of the health and safety of workers. The law is based on the principles of efficiency, coordination, and participation,

organising the actions of the various public administrations with powers in preventive matters, and the necessary participation of employers and workers in these actions, through their representative organisations. The workplace is configured in it as an ideal space for promoting the good mental health of workers and preventing mental health problems derived from work.

Due to the above information, within the framework of this strategy, it is considered of particular relevance to actively contribute to improving working environments with interventions that have a threefold focus:

- To protect mental health by reducing work-related risk factors.
- To promote mental health by developing the positive aspects of work and the qualities and capabilities of workers.
- To address mental health problems, regardless of their cause.

Mental health interventions in companies should be part of an integrated health and safety strategy covering prevention, early detection, support and reintegration, or readjustment. Prevention services and occupational health professionals can help organisations design and develop these interventions to protect and promote mental health. The key to success is to involve stakeholders and staff at all levels when implementing protection, promoting and supporting interventions, and evaluating their effectiveness.

SWOT analysis

A SWOT analysis (Strengths, Weaknesses, Opportunities, Threats, and Opportunities) of the mental health care situation has been carried out to provide a schematic analysis.

	STRENGTHS	WEAKNESSES
INTERNAL ANALYSIS	Important basis for strategic planning in mental health and related regulations at international, European, national, and regional levels.	Lack of continuity in previous versions of the NHS Mental Health Strategy without fully achieving its objectives.
	Background of previous NHS strategies and strategic plans in the different regional health services.	Limitations of the NHS strategies regarding their capacity to promote certain changes. Heterogeneous and irregular development of regional strategic plans.
	Normalisation and integration of mental health in the health system from Law 14/1986, of 25 April, General Health.	Heterogeneous and irregular development of the mental health care network and services in the different autonomous communities, with a potential risk to the accessibility and equity of the system.
	A network of mental health care devices and services aimed at meeting the population´s needs in the different stages of life in coordination with primary care and other sectors, social, educational, judicial services, etc.	“Hospital-centric" model: excessive weight of hospital resources instead of community development. Progressive abandonment of the community design of health care services.
	High professional qualification of mental health service professionals. Specific specialised training in mental health (MIR/PIR/EIR).	Improved training of mental health professionals. New areas of knowledge.
	Advances in the mental health care model, oriented towards person (and family) centred care, human rights, health promotion, and recovery in the community. The experience accumulated in processes of psychiatric reform towards mental health care.	Resistance to change. There is still too much weight sometimes given to "classical" conceptions of mental health.
	There is a growing recognition of the importance of the social determinants of health in consideration of mental health and their weight in shaping proposals for care strategies.	

	STRENGTHS	WEAKNESSES
	Consolidation of interdisciplinary mental health teams that begin to include users with first-person experiences. Greater horizontality in relationships.	Fragmentation of mental health care: NHS - Social Services - Addiction Care Network - Prison mental health. Absence of complete interdisciplinary teams: psychiatrists, clinical psychologists, nurses, and social workers.
	Willingness on the part of professionals and other social agents for continuous improvement and total quality management: motivation for change. Integration and participation of users and relatives in mental health policies.	Insufficient human resources to provide care based on the health care model, promoting the humanisation of care and patient safety. Overcrowding of services, delays in care, deterioration of quality, and practices that do not guarantee human rights. Difficulties in implementing evidence-based psychological treatments (due to lack of professionals, overload of care, etc.).
	Support from the highest executive level and incorporation into the political agenda. The Mental Health Strategy has been set as a priority by the government. Numerous initiatives and parliamentary attention from the different groups.	Lack of sensitivity to mental health on the part of health managers. Investment in mental health care could be improved. Asymmetry between mental health professionals' perceptions and the investment public administrations applied. Insufficient allocation of new resources with a new perspective. Little influence of mental health services and professionals on health policies to achieve budgetary improvements.
	Existence of evidence-based Clinical Practice Guidelines on various prevalent health problems. Examples of good clinical practice and process management.	A deficit in consideration of the child and adolescent populations´ mental health and the investment in specific resources. Scarce results of clinical research→ Need to strengthen Evidence-Based Practice. Lack of objective and valid information regarding the resources, care and needs of mental health care of the population, health care facilities, and professionals.
	An abundance of associations and scientific societies for mental health. The climate of cooperation between them.	Internal discrepancies in the people involved in mental health (professionals/users/families) due to different orientations and interests.

EXTERNAL ANALYSIS	OPPORTUNITIES	THREATS
	Social support, citizen participation, and mutual help groups.	Socio-demographic and socio-economic crisis and other psychosocial problems: poverty, unemployment, difficulties in reconciling work and family life, addictions, and stress due to overload.
	Demands from social and community institutions to increase mental health resources.	Privatisation of mental health care. Low prioritisation of mental health research.
	Support from associations of relatives of the people affected by mental health problems.	Lack of visibility of mental health problems in society, lack of knowledge about mental health and social stigma.
	Increasing public awareness concerning protecting the human rights of people affected by mental health problems. Strengthening the human rights approach in mental health care.	Possibility of disagreements between administrations regarding the prioritisation and approach to mental health. Possibility of rigid and conflicting positions of some professional associations and the group of people affected by mental health problems, particularly concerning decisions that may affect the rights and autonomy of the latter, the role of the patient and the implications of diagnoses.
	To gain support from other professionals in the general health system and other sectors.	Mistrust of professionals from other institutions towards the coverage of mental health problems.
	To increase the detection of mental health problems at the primary care level.	Risk of "psychiatrisation" of everyday problems with an uncontrolled increase in the demand for mental health care services.
	Perception in other institutions of under-investment and under-resourcing in mental health.	Lack of sensitivity of health managers to mental health.
	Improved efficacy of treatments. Diversity of therapeutic modalities.	Weight and influence of the pharmaceutical industry, particularly in professional training.
	The COVID-19 pandemic has highlighted the importance of mental health problems in the population, bringing mental health into the social dialogue and increasing the demand (expressed need) from different sectors and the population in general. Incorporation of mental health within the European funds of the recovery, transformation and resilience plan.	The consequences of the COVID-19 pandemic on the population and health professionals → Increase in the magnitude and severity of mental health problems.

	Health professionals perceive the need for mental health support for their professional practice.	The exhaustion of the informal caregivers.

IV. STRATEGY GUIDELINES

Strategy 1. Autonomy and rights. Person-centred care

Everyone has the right to live with dignity and to be treated with consideration regardless of their health situation. Regardless of the percentage of people who currently have mental health problems, it is clear that everyone can have mental health problems throughout their lives, just like any other health problem. Unfortunately, people with mental health problems suffer from a set of discriminations based on erroneous beliefs produced throughout history.

The stigma associated with such erroneous and unsustainable beliefs adds to the suffering and diminishes rights. A stigma is a form of social, cultural, and structural violence. It is often accompanied by rejection of the person and sometimes those close to them, based on stereotypes without demonstrating possible truth. This situation leads to numerous experiences of rejection and discrimination and the person suffering various types of violence.

The commitment to fight against various discriminatory and stigmatising attitudes and practices has led to the creation of the international "*Global Anti-Stigma Alliance,* comprised of various anti-stigma strategies. Some of the initiatives developed at the Spanish regional level have joined this alliance, such as "*Openly*" (Catalonia), "1 in 4" (The Andalusian board) and others from the associative network.

Fighting for the recognition and exercise of rights and the recovery of those arbitrarily lost is the main objective of any care policy for people with mental health problems.

When analysing the stigma associated with mental health problems and the stigma associated with gender as categories of discrimination with points of convergence, it is clear that women with mental health problems encounter additional obstacles in achieving equal opportunities.

Women and girls with mental health problems require specific policies that analyse and seek solutions to the impact of gender on mental health policies in order for them to be fully integrated. The **Committee on Women's Rights and Gender Equality of the European Parliament** has expressed its opinion in this regard following the publication in 2005 of the Green Paper on mental health drawn up by the European Union, pointing out that the gender dimension had not been sufficiently considered (79).

In 2008, Spain signed and ratified the **International Convention on the Rights of Persons with Disabilities**, signed in New York at the United Nations on 13 December 2006 (80) and its optional protocol (81) to implement the obligations of the Convention, which has been part of the Spanish legal system since then (articles 96 and 10.2 of the Spanish Constitution) (82). This Convention provides for non-discrimination and positive action to ensure that persons with disabilities can enjoy their rights on an equal footing. It commits the States that sign it to develop non-discrimination policies and positive action measures and adapt their legal system to defend the rights of persons with disabilities.

In June 2021, Law 8/2021 of 2 June was passed, reforming civil and procedural legislation to support persons with disabilities in exercising their legal capacity, which came into force in September of the same year, 3 months after its approval. Law 8/2021, of 2 June, is a milestone

in the work of adapting our legal system to the New York Convention, as well as in the updating of our domestic law (83).

As stated in the International Convention on the Rights of Persons with Disabilities, the approach to mental health problems from a social and rights-based perspective is a fundamental and mandatory issue.

We find ourselves, therefore, in a biopsychosocial and rights-based model that determines that mental health problems do not have a merely biological causality but are produced in specific psychosocial contexts that also play an essential role in triggering or aggravating the different mental health problems. Mental health directly connects with the environment we relate to daily and not only with individual characteristics.

In this way and following the **2nd Manifesto on the Rights of Women and Girls with Disabilities of the European Union** disseminated in 2011: "According to the World Health Organisation, gender fundamentally affects mental health and mental illness, as it determines the differential power and control that men and women have over the socioeconomic determinants of their lives, their social position and status, the way they are treated within society, and their susceptibility and exposure to specific mental health risks". For all these reasons, **in all the objectives or recommendations of this NHS Mental Health Strategy, "gender" should be taken into account in all the policies or actions that are developed, being integrated throughout the entire strategy, which is why it is not reiterated in each of the strategic lines** (84).

It is also necessary to promote access to quality mental health care for everyone, including the most vulnerable groups such as migrants, people with disabilities, LGTBIQ+ people, older people, people living in poverty, people living on the streets, people in situations of social exclusion, victims of crime and inappropriate treatment, children and adolescents, and people in penitentiary institutions, among others (85).

1.1 General objective. To guarantee the exercise of autonomy and independent living rights.

Specific objectives:

1.1.1. To urge the development of a model of care following the regulations and recommendations of international bodies on the rights of people with disabilities.

1.1.2. To inform and train people with mental health problems, their closest environment, and professionals on the active exercise of rights and how to exercise them.

1.1.3. To guarantee the person with mental health problems, or the person designated by him/her, active participation in everything concerning him/herself from the very first moment he/she comes into contact with the care services.

1.1.4. To establish, with the person receiving care, a plan for advance decisions during their care and recovery process.

1.1.5. To establish procedures to facilitate the planning of decisions in situations or when ethical dilemmas may arise, especially in crises, which are binding (prior instructions).

1.1.6. To implement the figure of the facilitator for equal access to justice.

1.1.7. To base the practice of care on the person´s will and try to avoid involuntary treatment except in cases where a judge imposes a measure or a judicial authorisation is requested due to vital risk for the person with a mental health problem. In these situations, an attempt will be made to strengthen the therapeutic alliance with the person with mental health problems.

1.1.8. To promote the employability of people with mental health problems in the appropriate individual conditions with the appropriate social support as the maximum expression of autonomy.

1.1.9. To facilitate autonomy and independent living by guaranteeing access to decent housing and access to work for people with mental health problems.

1.1.10. To promote preventive public health policies, considering the impact of the social context on the mental health of the general population.

1.1.11. To design public health policies considering the gender perspective and its different impact on the mental health of men and women, people with disabilities, children, adolescents, and older people.

1.1.12. To establish channels of participation between the different departments of the General State Administration and organisations in the associative sphere to design the different public policies on mental health.

1.1.13. To protect the sexual and reproductive rights of people with mental health problems by creating specific information and support programmes on motherhood/fatherhood and improving access to services.

1.2 General objective. Eradicate discrimination and promote social inclusion with a gender perspective

Specific objectives:

1.2.1. To achieve equal rights for everyone regardless of their difficulties and to eradicate the personal and social stigma and discrimination associated with mental health problems.

1.2.2. To enable people with mental health problems and related associative movements to take action against gender discrimination, promoting parity between men and women

1.2.3. To carry out and evaluate a comprehensive plan of intervention against stigma, stereotypes, prejudice, and discrimination that addresses the following areas: employment, the media, social services, the cultural sphere, health services, law enforcement, education, the executive, the legislative and judicial system, the family, and prisons.

1.2.4. To promote attitudes in professional teams towards incorporating inclusive language, avoiding sexist use of language, and stigmatising terminology.

1.2.5. To promote the production of evidence and the best available scientific knowledge on gender inequalities in mental health, including disseminating and communicating such evidence to organisations related to people with mental health problems and their families.

1.2.6. To promote the training of health service professionals in the gender perspective in health, especially concerning mental health teams and primary care.

1.2.7. To promote special attention to training professionals in primary care and mental health centres on the impact of gender-based violence on the mental health of women and their children as victims of violence due to the particular impact on the rest of their adult lives.

1.2.8. To promote the dissemination and knowledge among mental health professional teams of the protocols for treating gender violence in women with severe mental disorders.

1.2.9. To review and act on regulatory barriers that limit the rights of people with mental health problems.

1.2.10. To facilitate in care services the existence of specific rules in their protocols, monitoring, and control procedures to promote integration, avoiding stigma, stereotypes, prejudices, and discrimination of people with mental health problems and their closest environment.

1.3 General objective. Minimise involuntary interventions on people with mental health problems while ensuring respect for the individual´s dignity.

Specific objectives:

1.3.1. To design actions that reduce involuntary interventions to the minimum and only indispensable, tending towards their progressive elimination. This reduction and progressive elimination will involve the participation of stakeholders, including rights-holders.

1.3.2. To promote adequate care services, with sufficient material and personnel resources, to guarantee comprehensive care for people with mental health problems.

1.3.3. To train professional teams in crisis intervention skills to anticipate crises and establish quality bonds of security and trust based on a therapeutic relationship that has positive effects on the person.

1.3.4. To promote the implementation of specific intervention procedures (risk assessment, verbal restraint, stimulus regulation, and de-escalation techniques) that make using mechanical or pharmacological restraint unnecessary.

1.3.5. To facilitate the participation in crises of those close to people with mental health problems so that they can act as facilitators to reduce stress and suffering.

1.3.6. Autonomous communities should define a procedure for emergency or urgent situations, fully guaranteeing the dignity, safety, and care of people with mental health problems whilst respecting the advance directives document (also known as advance directives in some autonomous communities).

1.3.7. To develop mechanisms for precisely monitoring guarantees of good treatment and detecting non-compliance and measures to resolve them.

Recommendations

I. To progressively reduce interventions against the will of the person with a mental disorder to the minimum, as well as any other restrictive measure, and create the conditions that make them unnecessary.

II. To implement an action protocol and a register of the use of restraints and other coercive practices in all services and monitor their evolution. Continuously evaluate the impact of these practices on all those involved (people with mental health problems, family members, and professionals) to reduce them.

III. To facilitate the exchange of good national and international practices that avoid restraints.

IV. To study complaints and claims in health care, analyse and identify the critical areas for improvement, and pay particular attention to those that have to do with respect for the rights of people with mental health problems.

V. To train people with mental health problems on public exposure and dealing with the media to become advocates and activists against stigma.

VI. To take all appropriate legislative, administrative and other measures to prevent discriminatory acts or practices.

VII. To raise awareness and sensitise society through campaigns or specific actions to increase awareness and promote respect for the rights and dignity of persons with mental health problems.

VIII. To include effective participation of people with mental health problems in the mental health teams that evaluate each developed action.

IX. To promote mutual support among peers, valuing their crisis resolution strategies.

X. To promote legal compliance recognising that from the age of 12, children and adolescents must be heard (Organic Law 1/1996, of 15 January, on the Legal Protection of Minors and Organic Law 8/2021, of 4 June, on the comprehensive protection of children and adolescents against violence) (86, 115).

XI. To adequately and sufficiently equip mental health services, including services in which emergencies or crises are treated, in order to be able to offer correct care without the need for mechanical or pharmacological containment measures and without exercising coercion. To promote therapeutic environments that increasingly enable full access to rights on an equal footing with the rest of the system´s users.

XII. To establish procedures to ensure adequate information about therapeutic proposals and how their process will be approached, offering alternatives so that, in the event of refusal, this does not entail the loss of continuity of care (known as prior instructions (xix) or also known as advance directives in some autonomous communities).

(xix) Law 41/2002, of 14 November, is a basic law regulating patient autonomy and the rights and obligations regarding clinical information and documentation. Article 11. Advance directives.
1. Using the advance directives document, a person of legal age, capable and free, declares his or her will in advance, with the aim of this being fulfilled at the time when he or she reaches situations in circumstances in which he or she is not capable of expressing them personally, regarding the care and treatment of his or her health or, once death has occurred, regarding the destination of his or her body or the organs of the same. The grantor of the document may also appoint a representative to act as his or her interlocutor with the doctor or health care team to ensure that they comply with the advance directives.
2. Each health service shall regulate the appropriate procedure to ensure compliance with the advance directives of each person, which shall always be in writing.

Strategy 2. Promoting mental health in the population and preventing mental health problems

In its Mental Health Action Plan (2013-2020), the World Health Organisation (WHO) states that good mental health is an integral component of the health and well-being of the population and contributes to the functioning of individuals, families, communities, and the social and economic prosperity of society. This statement is in line with what has already been expressed previously in this strategy, that mental health, as with other aspects of health, can be affected by a range of socio-economic factors that need to be addressed through comprehensive promotion, prevention, treatment, and recovery strategies. The determinants of mental health and mental health problems include individual characteristics and social, cultural, occupational, economic, political, and environmental factors such as state policies, social protection, the standard of living, working conditions, or social support in the community. Exposure to adversity early is a well-established preventable risk factor for mental health problems (87).

Depending on the context, some individuals and social groups may be at significantly increased risk of mental health problems. These vulnerable groups include families living in poverty, social exclusion, people experiencing homelessness, people in correctional institutions, people with chronic health problems, children exposed to abuse or neglect, adolescents exposed to substance abuse for the first time, and minority and subordinate groups (women, LGTBIQ+ groups), older people, people subject to discrimination and human rights violations, and migrants (WHO, 2013) (5).

An environment of respect for and protection of basic civil, political, socio-economic, and cultural rights is fundamental to promoting mental health. Without the security and freedom these rights provide, it is very difficult to maintain good mental health (WHO, 2004) (88).

Moreover, as the UN Special Rapporteur describes in his report (89), on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2017), despite clear evidence that there can be no health without mental health, nowhere in the world does mental health enjoy equal status with physical health with regards national policies and budgets. Globally, it is estimated that less than 7% of health budgets are allocated to mental health. Most of the investment goes to institutional long-term care and mental health care hospitals, resulting in almost no policies for comprehensive mental health promotion. Therefore, to ensure that all mental health promotion´s underlying and social determinants are addressed, the Special Rapporteur recommends prioritising mental health promotion and prevention in public policy and increasing investments in all relevant areas.

In operational terms, health promotion addresses the whole population; it aims at enabling people to manage their health and illness by becoming less dependent on care services and achieving greater autonomy; it is achieved by changing, according to health determinants, the socio-community context of life, through individual and community participation and political commitment; this process, therefore, includes individual, group, and community change. Mental health promotion must occur from the earliest stages of life, beyond birth and bonding during family planning and between generations to the end of life. Aspects of early life promotion are developed explicitly within the strategy in the strategic line dedicated to mental health in childhood and adolescence.

Prevention of healthcare-associated harm. Quaternary prevention

This level of prevention is new in mental health, although it applies to the health system as a whole. Quaternary prevention is defined as an intervention that avoids or attenuates the consequences of unnecessary or excessive health system activity. (90) It aims to avoid overdiagnosis and overtreatment to prevent healthcare-associated harm.

Evidence-based practices should guide healthcare interventions to avoid preventable harm and to ensure patient safety throughout the healthcare process. These evidence-based practices should also guide the ongoing assessment of treatment burden, particularly in polymedicated patients with chronic conditions, among which mental health problems are often also present, and de-prescribing as appropriate, as part of the process of good prescribing, and with the aim of optimising care and safety and improving people's quality of life.

These practices require the active involvement of the person with a mental health problem, weighing up the risks and benefits as contrasted by evidence-based medicine. The person must be involved in treatments, especially in medication use, remembering that therapeutic alliance is the most important factor associated with a good clinical prognosis and considering that the indication for non-treatment is just another intervention in the care repertoire. Within the individualised care plan, non-pharmacological treatment includes programmes and activities supported by scientific evidence, such as, for example, improving independent living skills (motor skills, processing skills, and personal interaction skills) and promoting meaningful activities that enhance, strengthen, and improve the habits, routines and roles of users.

2.1 General objective. To promote the mental health of the community and specific groups.

Specific objectives:

2.1.1 To have a comprehensive plan (independent or included in a general plan) for promoting mental health and preventing mental disorders within the framework of the strategy for Health Promotion and Prevention in the NHS. Priority should be given to promoting psychosocial development from primary care services during the first 5 years of life.

2.1.2 To promote and disseminate new models of egalitarian and healthy relationships between women and men, governed by respect for individual preferences, opinions, beliefs, and abilities and incorporating the gender perspective into all actions in the mental health field.

2.1.3 To encourage all plans, programmes, projects, and regulations subject to environmental impact studies and assessments and to assess their impact on health (both physical and mental), thus promoting people's mental health.

2.1.4 To promote measures specifically aimed at raising awareness, advising and informing those responsible for institutions in different areas (education, environment, employment, justice, and health, etc.) of the relationship between their actions and mental health. To highlight the central role of mental health as a generator of well-being and productivity and the adverse socio-economic consequences of ignoring it.

2.1.5 To promote mechanisms for the early identification of ill-treatment of vulnerable groups, especially children, adolescents, and older people, promoting community networking.

2.1.6 To carry out specific awareness-raising actions aimed at the media, incorporating them as active agents with the power to transform public opinion.

Recommendations

I. In interventions aimed at institutional representatives, point out the central role of mental health as a generator of well-being and productivity, and the importance of the interaction of habitat (urban ecology), education (human capital), the possibilities of citizen participation (social capital), the protection of the most vulnerable population for access to resources that dignify their lives and ensure greater well-being, egalitarian gender relations and the psychosocial determinants of gender with the mental health of the population, as well as the adverse socio-economic consequences of ignoring them.

II. To raise awareness and train professionals from different health and non-health disciplines working in mental health teams to identify better abuse and sexual violence against vulnerable people, especially children, adolescents, and older people.

III. To promote interventions aimed at the media to involve them in promoting mental health from the national and autonomous community-level health administrations.

IV. To promote healthy lifestyle habits (such as physical activity, healthy eating, maintaining proper hygiene, an optimal sleep pattern and quality, healthy sexuality, avoiding toxic habits and preventing substance use disorders and addictions, maintaining good personal and social relationships, conflict resolution techniques, managing stressful situations, and knowing how to cope with life changes, etc.).

V. To promote the location of health assets by people with mental health problems.

VI. To contemplate the need for evaluations of every one of the actions to be developed, with the real and effective participation of people with mental health problems in the process.

2.2 General objective. To prevent mental health problems, substance use disorders, and addictions in the community.

Specific objectives:

2.2.1 To develop and evaluate community interventions in areas at high risk of social exclusion, discrimination, poverty, and marginalisation to act on the social determinants, including gender determinants of mental health problems and substance use disorders and addictions.

2.2.2 To develop and evaluate interventions within the framework of the National Strategy on Addictions 2017-2024 (91) and the action plans that develop it (and, where appropriate, with the plans developed in the different autonomous communities) to reduce substance and non-substance addictions.

2.2.3 To consider behavioural addictions, or non-substance addictions, such as those arising from a problem or pathological gambling behaviour. To promote measures for their early detection and direct intervention in the gambling capacity of this type of participant, and also in young people (under the age of 18), specifically in cyberaddiction and its consequences.

2.2.4 To promote the development of what has been termed 'social capital', supporting activities which increase citizen participation, encouraging mutual support groups, first-person movements, and all kinds of community initiatives to prevent loneliness, improve the management of stressful life situations, and promote resilience.

2.2.5. To establish and evaluate collaborative interventions between social services, primary care, and mental health to prevent mental health problems, with particular emphasis on the most vulnerable population (social exclusion, gender violence, history of mental health problems in the family, carers, people with chronic health problems, and disability, etc.).

2.2.6. To promote actions to support prevention and occupational health services to prevent work-related stress, harassment, and mental disorders associated with work.

2.2.7. To include specific prevention and awareness-raising programmes in schools, incorporating them into educational programmes, always with a cross-cutting perspective, and using materials, resources, and first-hand experience.

2.2.8. To initiate campaigns to promote health and prevent mental health problems among people in prisons, prison psychiatric hospitals, and other vulnerable groups.

Recommendations

I. To carry out community interventions to improve social dynamics in geographical areas with high social risk and/or morbidity in mental health to reduce the determinants and/or consequences of various forms of violence in public, institutional, and private spheres.

II. To carry out these actions, the participation and intersectoral cooperation between the areas of justice, security, legislation, housing, infrastructure, work, education, women's institutes, and others at a municipal and autonomous community level is essential.

III. All these actions should follow the guidelines set out in the framework of the United Nations International Convention on the Rights of Persons with Disabilities, ratified by Spain in 2008 (82).

IV. To contemplate the need for evaluations of every one of the actions to be developed, with the real and effective participation of people with mental health problems in the process.

V. To implement promotion and prevention programmes based on the best available evidence for achieving the proposed objectives and on the needs detected.

VI. To promote awareness-raising training actions that stimulate interventions to prevent harm associated with healthcare for people with mental health problems.

Strategy 3. Prevention, early detection, and care of suicidal behaviour

Not all suicidal behaviour is an expression of a mental disorder. However, it is known that people with mental disorders commit suicide in a much higher proportion than the general population. The proportion of completed suicide associated with a mental disorder is around 80-90% (there are mental health problems that favour the development of suicidal tendencies). The common factor in suicides seems to be the existence of great emotional distress (92, 93).

Suicidal behaviour constitutes one of the most critical public health problems in Europe and worldwide. Death by suicide involves a personal drama with extreme suffering that severely impacts the deceased's environment.

Suicide is one of the major challenges facing health and social systems worldwide, and it is one of the most severe public health problems today. In 2019, the number of deaths by suicide was double those caused by traffic accidents and more than 50 times more than those caused by male violence, without minimising the latter´s importance (66, 94). Adolescence is a period of risk that needs to be considered in a particular and specific way when programming community and health prevention interventions (95).

Addressing the issue requires collaboration between health authorities and other institutions and sectors.

The WHO devotes special attention to it with a website dedicated to suicide prevention and a specific strategy (https://www.who.int/health-topics/suicide#tab=tab_3). Likewise, the European Commission, as part of its *EU Compass for Mental Health and Wellbeing* project, has devoted one of its annual studies to the study of the actions of the member states in dealing with suicide (96).

3.1 General objective. Early detection and prevention of suicidal behaviour.

Specific objectives:

3.1.1. To improve the information given to the general population through awareness-raising, sensitisation and actions promoted by public institutions, the media, and social entities dedicated to the cause.

3.1.2 Early detection and prevention of suicide risk.

- To improve access to mental health services and care for people with suicidal behaviour.
- To improve the detection of people at risk of suicidal behaviour by professionals working in health services (emergency teams, primary care, mental health, and other specialities).
- To provide professionals with tools that enable the identification of possible suicidal thoughts and the assessment of the risk factors associated with them (especially in situations of emotional crisis, in people with mental health problems and chronic illnesses, as well as in social situations that involve helplessness or increased vulnerability). To increase personal and professional sensitivity to understand people engaging in this behaviour.

- To establish criteria for the detection of possible suicidal behaviour or high-risk factors that could lead to the reappearance of suicidal ideas and establish criteria for intervention and help in the event of the detection of suicidal risk.

- To promote continuous training to detect risk, appropriate diagnosis, and approach towards suicidal behaviour.

- To promote knowledge about the profile of methods used and places of risk, and limit access to potentially lethal places and means, when it is impossible to establish dissuasive measures.

- To promote the recording and clinical follow-up of suicide attempts that contributes to improving epidemiological surveillance (e.g. concerning the suicide risk code).

- To develop accurate records of completed suicides with the necessary socio-demographic variables to identify and act upon vulnerable groups and record and monitor risk factors leading to suicide.

- To implement the suicide risk code in clinical records with maximum guarantees of respect for confidentiality and the individual´s rights.

- To intervene in vulnerable groups according to their specific needs, such as older people (with particular attention to those who are in a situation of unwanted loneliness), children and young people, cases of violence, sexual violence, people with disabilities, chronic illnesses, dependency, residents in prisons, people in situations of social exclusion, homeless people, and people discriminated against because of their sexual orientation or gender identity, among others.

3.2 General objective. To improve care for people at risk of suicide.

Special objectives:

3.2.1 To promote the development of integrated care processes for caring for people at risk of suicide.

- To guarantee that the report on discharge from the emergency department reaches the primary care doctor (with due guarantees of confidentiality and exercise of autonomy) to ensure the continuity of the necessary care and the Mental Health Centre (MHC).

- To offer families and people close to them information, resources, and tools to enable them to act in the event of a new episode.

- To promptly attend to caregivers, family members, and relatives of people who have died by suicide by establishing an appointment procedure and immediate assessment in primary care and mental health services to explore the initial response to the loss and the eventual need for help.

3.2.2 To support and encourage mutual support between survivors of suicide attempts and people with suicidal ideation.

3.2.3 To support and encourage mutual help between family members in the community for people bereaved by suicide.

3.2.4 To establish counselling and support for professionals who have experienced suicide in their work.

3.2.5 To facilitate and promote direct access for adolescents with mental health problems to develop specific programmes for those who manifest suicidal ideation.

3.2.6 To develop an efficient, coordinated, and integrated telephone helpline network to improve the approach to people at risk of suicide.

Recommendations

I. To encourage cooperation with other sectors in the framework of the 2030 Agenda to achieve these goals.

II. To promote an adequate continuum of care for people who have attempted suicide.

III. To promote the education and training of primary care, medical, nursing, and social work professionals in identifying risk groups and interviewing techniques for detecting and managing suicidal risk.

IV. To develop age-appropriate care for the population to address their specific needs with trained professionals.

V. To facilitate quality information work that avoids scaremongering, stigma, prejudice, and stereotypes of suicidal behaviour:
- To combat myths in order to eliminate misconceptions about suicide.
- To have first-person testimonies from people who have been through this situation to raise awareness of this problem more effectively.
- To refer to suicidal behaviour as a health problem, offering all the information and mechanisms to prevent suicide (information or care services of each autonomous community and social entity).
- To raise awareness among media professionals about the treatment of news related to suicide, following international recommendations.

VI. To develop lines of work aimed at suicide prevention between the Ministry of Health and other institutions, organisations, and sectors to promote a network of intersectoral collaboration in this area that reaches multiple fields.

VII. To develop and implement prevention protocols in schools, universities, the administration, workplaces, social and health centres, and care centres for older people.

Strategy 4. Providing mental healthcare based on recovery in the community

Care for people with mental health problems involves developing services adapted to each person´s diverse and unique needs. This fact requires considering the characteristics, origins, intensity of the psychological suffering, the context and the various factors that influence health, and its difficulty. Mental health care must be considered a set of actions and proposals ranging from prevention to recovery. The various international directives, including most notably the UN Convention on the Rights of Persons with Disabilities (15), emphasise the need for care centred on the person and his or her rights. A comprehensive assessment of the situations and needs of people with mental health problems and their environment should be promoted within social and health care.

Care for people with mental health problems should be structured and based on some basic principles:

- Favouring the development of the capacities and potentialities that the person has.
- Considering the person with mental health problems as an essential part of their recovery process, placing them at the centre of care.
- Relationships between professionals and people cared for should be based on mutual recognition and the idea of accompaniment and cooperation.
- Promoting dialogue and active listening as fundamental elements on which mental health intervention should be based.
- Individualised treatment and treatment should be adapted to the needs presented by the person at any given moment, placing value on their preferences in the context of clear and truthful information.
- Rights-based care guarantees equity and equality in access to resources and necessary care.
- Holistic assessment of the problems affecting the person from an objective and subjective point of view. This assessment shall consider the person´s social, psychological, and biological aspects and experiences.
- Care should ensure people have a dignified life, including work, educational, affective, sexual and social experience.
- Treatment should be carried out whenever possible in the person's usual environment.
- Treatment should consist of psychological, biological, social, and occupational/functional interventions that respond to ethical principles and have shown evidence of efficacy and safety. When these are unavailable, scientific institutions or social groups' recommendations shall be considered.
- Ensure the autonomy of the individual by avoiding iatrogenic interventions.

- In the context of an informed dialogue, the person's choices and strategies should play a relevant role in organising the treatment plan.
- A joint approach between social and psychosocial rehabilitation services and the continuity of rehabilitation in the person's natural environment.
- Socio-health coordination between the health and social spheres, thus improving the quality of life of individuals, the quality of care and the optimisation of resources.

Community mental health

The care model must be oriented towards the best care for people and their families, placing them at the centre of the process (person-centred care). The interdisciplinary teams and the various services from the different levels of care must be articulated around their mental health needs; for example, from the procedure of "case analysis". The case analysis provides a way of assessing the co-responsibility of the different administrations of the territory in each specific case.

The guide published by WHO in 2021 on community mental health services "promoting person-centred and rights-based approaches" presents good practices in mental health services around the world to help countries develop and reform community services and responses from a human rights perspective, promoting fundamental rights such as equality, non-discrimination, legal capacity, informed consent, and community inclusion (97).

Bearing in mind the maxim that there is no health without mental health, an idea already reflected in the Helsinki Declaration of the 2005 WHO Ministerial Conference on Mental Health and implicit in the definition of health in the WHO constitution in 1946, mental health should be considered transversally in all contexts of life (13, 98). Within the NHS, primary health care in close coordination with specialised mental health care and social services takes on a particular relevance.

The work of primary health care teams is essential to promote mental health, to attend to psychosocial processes in daily life that influence people's health, to reduce stigma, and to detect and intervene early in the appearance of risk factors or symptoms associated with mental health problems. Individual consultation, group interventions and the promotion of mutual help are essential tools for care and attention with the community, without ignoring the opportunities for intervention in coordination with other sectors (for example, in the educational system, schools, and academic centres) and community participation, associations, and mutual help groups.

In the face of more complex health processes, **inter-consultation** and **liaison** with specialised mental health care are considered highly effective instruments since it makes it possible to improve diagnostic skills and the incorporation of therapies in the framework of primary health care, as well as referral to specialised services, reducing "lost" cases and making it possible to attend mental health services in a less stigmatised way (99).

Inter-consultation and liaison also enable care coordination and counselling between professionals from different disciplines, positively affecting the quality of care and health outcomes.

Once a referral has been made to the mental health services of specialised health care, the mental health centre represents the backbone of the system, from which personalised care will be offered as necessary for the person and their family, ensuring that people face their life processes in their environment, with as little fragmentation of their lives as possible, resorting to traditional hospitalisation only when strictly necessary. To this end, programmes and services accompanying people and families in their recovery process will be reinforced, highlighting case management models, home hospitalisation, partial hospitalisation, and other intermediate and rehabilitation resources.

Care for people in acute episodes

Since the approval of the General Health Act and the development of the Psychiatric and Mental Health Reform document by the autonomous communities, the admission of patients with acute episodes has been carried out in general hospitals, which have a specific psychiatric area and psychiatric admissions.

Psychiatric hospitalisation should be considered as another therapeutic moment, not an end in itself. It impacts the longitudinal evolution of many psychopathological conditions and can improve their prognosis and evolution. Integrating a community and outpatient mental health professional in the therapeutic activity is essential to establish this continuity consistently.

It is essential to reduce the time of psychiatric hospitalisation to what is strictly necessary in order to maintain the patient in their context with the referents of the community mental health centre (essential axis of mental health care), primary care, and social services (coordination), to contribute to progress in home hospitalisation, day hospital, telematic consultations, and health education for patients and families within the framework of admission, etc., as alternative formulas to the hospital-centred model.

In caring for people in acute episodes, other alternatives to hospitalisation, such as home care, crisis care, and partial hospitalisation, should also be promoted (100).

Another point to be taken into account is that of involuntary admissions. While it is true that efforts are being made to ensure that admission is voluntary, it is no less accurate that the number of involuntary admissions is still significant, sometimes involving mechanical restraints, which is highly controversial from the perspective of ethics and respect for the patient (101).

Being admitted should not mean being disconnected or inactive. It is important to carry out activities that make it possible to connect with the person admitted. Group activities can be introduced gradually, and individualised activities are very relevant. Family visits and possible outings should be scheduled progressively. This period should also be used to work with the family and close relatives for information, support, and guidance in the preparation phase for discharge.

Intermediate facilities

The most representative of all is the mental health day hospital, nowadays also known as "partial hospitalisation", an instrument of secondary prevention (102). The mental health day hospital aims to intervene actively to avoid the tendency towards chronic evolution, which implies acting in the face of a new pool of complex, slow-evolving, complicated, or unstable cases.

The stay in the mental health day hospital favours some specific interventions: in cases in which there has been a crisis with a rupture of affective and social bonds. The aim is to increase the quality of life and satisfaction, reducing the suffering of patients with severe and unstable mental health problems.

In terms of clinical indications, the mental health problems which indicate a need for the mental health day hospital are those belonging to the most unstable groups, such as psychotic disorders (especially in adolescents and young adults), mood disorders, personality disorders, eating disorders and, to a lesser extent, some behavioural disorders (except dissocial disorder). The exclusion criteria are organic mental disorders, mental and behavioural disorders due to certain addictive behaviours, and moderate to severe mental disability (102).

Other intermediate devices are "mini-residences" aimed at patients with cohabitation difficulties or who lack a family to care for them. These mini-residences include supervised flats, a method of family reintegration that requires supervision by mental health professionals, and therapeutic communities, which incorporate work activity as a form of social rehabilitation, home hospitalisation, or crisis units.

4.1 General objective. To contribute to recovering, maintaining, and improving the autonomy and quality of life of people with mental health problems.

Specific objectives:

4.1.1. To focus on the person and their needs and carry out Individualised Care Plans (ICP) within the framework of a therapeutic alliance, with the person's active participation.

4.1.2. To assess the person's difficulties, strengths, health assets, and/or skills from a biopsychosocial and interdisciplinary perspective by the interdisciplinary team.

4.1.3. To ensure the participation of people with mental health problems and their organisations in designing, implementing, delivering, and evaluating mental health policies, systems, and services.

4.1.4. To prioritise support for people in their community by facilitating the maintenance of links with it, for which purpose the adequate provision of services should be planned: assertive community treatment teams and interdisciplinary home care teams (psychiatry, clinical psychology, nursing, and social work).

4.1.5. To underpin treatment with good treatment, ethical principles and the complementarity of social, psychological and biological interventions.

4.1.6. To promote individual, family, and group psychotherapeutic interventions that are known to be effective and which will be carried out by appropriately trained professionals.

4.1.7. To actively promote alternatives to involuntary interventions for people with mental health problems, applying in all cases the principle of least possible restriction, guaranteeing the respect and dignity of the individual. Involuntary interventions shall be limited to the specific situations established by Spanish legislation and the International Convention on the Rights of Persons with Disabilities (Art 14).

4.1.8. To facilitate accessibility to the social and health resources network using specific actions to improve and adapt them.

4.2 General objective. To have services and resources aligned with the basic principles of care based on the recovery model for people in the community setting.

Specific objectives:

4.2.1. To strengthen assertive community treatment teams is a fundamental objective, bearing in mind that intervention must be interdisciplinary (psychiatry, clinical psychology, nursing, occupational therapy, and social work) and highlighting the role of "case manager" in order to ensure adequate coverage by the community institutions involved in each case.

4.2.2. To prioritise, as opposed to institutionalisation, the development of mental health care resources and services (crisis houses, residential programmes with different levels of support, home support programmes, parenting support units, and personal assistance, etc.) when symptoms are present, or needs make this advisable.

4.2.3. To develop programmes and resources to facilitate social and occupational integration, independent living and exercising the person's rights.

4.2.4. To reduce the use of medium and long-stay units in psychiatric hospitals, replacing them with alternative programmes and services that facilitate social integration, integration into the labour market, access to housing, and ensuring the exercise of the person's rights.

4.2.5. To adapt professional resources in primary care and mental health to what is necessary for a context of equity from the perspective of respect, capacity, and autonomy of the person and promoting actions based on professional consensus.

4.2.6. To promote the State Register of Professionals and the work of planning the needs of healthcare professionals through the NHS Human Resources Commission.

4.2.7. To update the Supply-Needs Study of Medical Specialists 2021- 2035 to facilitate the training and availability of a sufficient number of these mental health professionals to meet the population's needs (103).

4.2.8. To develop or update Clinical Practice Guidelines for the early detection and management of the most common mental health problems with the most significant impact

4.2.9. To promote the figure of the personal assistant recognised by Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for Dependent Persons.

4.3 General objective. Promote and develop innovative lines of intervention related to factors that generate mental health problems: sexual violence, addictions, harassment in its different forms, or the misuse of new technologies.

4.3.1. To raise awareness among professionals and teams of the emergence of new fragilities linked to social issues (job insecurity, new situations of poverty, difficulty of access to

housing, overcrowding, migratory processes, increase in the number of people living alone, ageing population, minors with insufficient protection, and difficulties in reconciling parenting, etc.) which can have a determining effect on the onset of mental suffering and mental health problems (e.g. personality disorders, dual pathology, or first psychotic episodes, etc.).

4.3.2. To define and implement resources, programmes and measures for developing new mental health intervention lines.

4.3.3. To include in the understanding and approach to behavioural disorders in adolescence the identification of conflictive or dysfunctional behaviour and work with positive parental aspects to favour the development of personal resilience and recover their narcissism as parental figures.

Recommendations

I. To provide primary care with resources and instruments for the initial approach to mental health care (e.g., actions concerning objective A.3 of the 2019 Strategic Framework for Primary and Community Care dedicated to "boosting the strengthening of primary health care through the development of National Health System strategies") (104).

II. To strengthen and develop mental health in primary care. The 2019 Strategic Framework for Primary and Community Care highlights the need to update the portfolio of primary care services of the NHS (objective A.4) to cover the needs and problems of the population under a multidisciplinary approach, to organise the available resources and to enhance coordination between levels of care. The framework emphasises, among other things, "strengthening the figure of the clinical psychologist within the health system and protocolising referral circuits" (action A.4.4).

III. To provide mental health services with the human and financial resources and physical spaces necessary to adequately develop the lines of intervention set out in strategy 4.

IV. To promote knowledge to understand recovery as a unique and individual process linked to the personal growth of each person with mental health problems, encouraging their leading role in modifying attitudes, values and feelings.

V. To incorporate the gender perspective in mental health care.

VI. To draw up joint intervention plans that include planning decisions so that people with mental health problems can express their needs and preferences concerning the care they may receive.

VII. To establish appropriate procedures so that the advance directives document (also known as advance directives in some autonomous communities) is applied as a tool for respecting decision-making.

VIII. To promote the participation of people with their own experience in mental health in the ongoing training of teams and the eventual support in constructing therapeutic intervention plans, complementing the persons being cared for fundamental perspective.

IX. To encourage the development of models of intervention based on voluntariness and collaboration between people with mental health problems and health professionals.

X. To encourage peer support in the recovery process by promoting shared learning through peer-run support networks, recovery institutes, community centres, and peer-run supported accommodation according to the level of need.

XI. To develop socio-health programmes, such as multi-level cooperatives for people with mental disorders, with appropriate direct psychosocial supervision, sheltered flats, sheltered farms, mini-residences, and therapeutic communities, from lower to higher levels of dependency and supervision.

XII. To develop the evaluation of actions that include the active participation of people with mental health problems.

XIII. To promote the development and adequate provision of units specialised in the early detection and treatment of mental health problems in childhood and adolescence.

XIV. To train parental figures to establish, in a consistent and conveniently defined manner, both the positive and negative consequences of accepting frustration, the norm, and how to transmit it.

XV. Care services should offer interdisciplinary approaches that allow working with the adolescent, the family, the school, and the community environment. This approach is the one that has shown the most positive results.

XVI. Being in the hospital should not mean being disconnected or inactive. It is essential to carry out activities that make it possible to connect with the patient. Group activities can be introduced gradually, and individualised activities are very relevant. Family visits and possible outings should be scheduled progressively. This period should also be used to work with the family and close relatives for information, support, and guidance in the preparation phase for discharge.

XVII. To implement and improve the quality of prescription psychotropic drugs by designing and implementing programmes for the appropriate use of psychotropic drugs in different care settings.

XVIII. To avoid stigmatisation in any care practice due to suffering from a mental disorder.

Strategy 5. Mental health in childhood and adolescence

The conditions and experiences of life in the early years are especially transcendental concerning growth and biopsychosocial development in different areas (cognition, language, habits, social skills, and emotional development etc.), substantially influencing the health and quality of life of people in the rest of the stages of the life cycle.

Mental health care in childhood and adolescence is a priority for all social agents. An approach aimed at strengthening health assets and protective factors in mental health, beyond the early identification of risk factors, must be considered to improve mental health in childhood and adolescence in all its dimensions.

Developmental research has highlighted the importance of the family context, where the circumstances and relationships that shape its members' development occur. Parents or caregivers influence their children through affect, behaviour, and cognition. Thus, while some children develop secure attachments, others develop insecure attachments (anxious, avoidant, or disorganised) with different consequences for human development. Participatory programmes promoting and strengthening parenting skills from a positive approach contribute to developing secure attachments (105).

It is essential that the school setting contributes to creating a sense of belonging that makes children feel connected and welcome, strengthening identity and self-esteem, developing resilience and coping skills, and promoting positive behaviours such as respect, responsibility, and kindness towards friends and loved ones can increase mental well-being. Helping others and getting involved reinforces community participation (106).

The information helps to understand the stigma around mental health and enables adults and students to recognise when to seek help and naturalise it. School health professionals can provide helpful information to help children and adolescents develop coping skills and identify early signs and symptoms that point to broader psychosocial and mental health problems, which may include problems with emotional regulation, development, mood disturbances such as depression, prodromal to other mental health problems, and suicide risk. These may include a change in habits, isolation, decreased social and academic functioning, erratic or changing behaviour, and increased physical complaints (106).

Educational psychology professionals, educational counselling teams, school and family, and community care nurses and social workers can provide students with a range of mental health services ranging from behavioural support and promotion of universal mental well-being to parent and staff training, identification and assessment, individual and group counselling, crisis intervention, and referral to community services (106).

Simultaneously, from primary health care, it is necessary to reinforce the promotion of mental health and the prevention of psychosocial and mental health problems in the medium and long term in the early stages of life. Comprehensive (biopsychosocial) interventions and care aimed at family planning, monitoring of pregnancy, birth and puerperium, support for the transition to parenthood, monitoring of children's growth and development through the Healthy Child Care Programme, and reinforcement of care for adolescents are recommended. Early care,

stimulation, and referral to mental health services for diagnosis, treatment and early intervention are particularly relevant at this stage.

There is increasing scientific evidence on the screening of significant depression in the child and adolescent population, its prevalence and under-diagnosis in adolescence, and its importance as a disabling disorder associated with the risk of suicide and severe long-term morbidity, which suggests the incorporation of screening procedures that allow its identification in adolescents attending a primary care service and the implementation of intervention strategies for milder cases, using simple and validated screening tools such as the PHQ-2 (107).

Emerging mental health problems that have an apparent prevalence of onset throughout the developmental stages of childhood and adolescence are non-substance addictive behaviours (cyberaddiction and cyberbullying), behavioural disorders in adolescence (parental abuse by children and social violence), and the prodromes of psychosis and first psychotic episodes, as described above in the situation analysis chapter.

Measures to promote adherence and a functional and meaningful approach should be put in place, as it is estimated that 40-60% of families end treatment early, and it is known that these people often have more severe pathologies than those who end treatment.

Mental health problems can negatively affect the lives of the people who experience them and those with whom they live. Often this negative impact is not caused by the symptoms but by the view of the social context. Mental health remains taboo for a large part of the population at this point, despite everyone being at risk of being diagnosed during their lifetime. The most effective anti-stigma strategies experiences involve people with and without mental health problems in shared, meaningful projects with common goals and equity (108).

Addressing mental disorders early in childhood and adolescence is essential, as a significant percentage begins in childhood and adolescence (109).

Multidisciplinary teams will carry out mental health care in mental health care facilities through health professionals with specific qualifications in childhood and adolescence. In this sense, on 3 August 2021, Royal Decree 689/2021, of 3 August, was approved, establishing the title of a medical specialist in Child and Adolescent Psychiatry and updating various aspects of the title of a medical specialist in Psychiatry (110). The network of mental health care facilities must be strengthened following present and emerging mental health needs and the principles of care of the NHS. Continuity of care programmes for the care of children and adolescents with mental health problems that tend towards chronicity and potentially to a variable degree of disability are especially recommended for the technique known as "case management" and the coordination of the individualised therapeutic plan.

Early intervention and first psychotic episodes

The diagnosis of psychosis and, in particular, schizophrenia is based on the presence of delirium and other psychotic symptoms. Relying on this criterion, which is included in the categories of the diagnostic systems of mental disorders, causes a late diagnosis by diagnosing an old psychosis, even if it has been present for a short time. The importance of these prodromes led Mc Gorry, William Carpenter and other researchers to propose the category of "attenuated psychosis syndrome" for the DSM-5, a proposal that was not accepted (111, 112). It is of interest

to be able to work on levels 2-3 of the development of the psychotic disorder and to promote community therapeutic interventions at level 1 of Yung's pyramid (2006) (113, 114). Working with these cases is fundamental because, as Mc Gorry and Carpenter state, it is possible to "stop" the evolution of psychosis.

Prevention in childhood: abuse, sexual violence, bullying and school failure

Of particular importance is the case of child abuse and sexual violence, where there is a tendency to reduce them only to the physical sphere, giving less importance to psychological-emotional abuse. However, psychological and emotional child maltreatment is the one that leaves the most after-effects and has the highest subsequent costs in terms of care, mainly mental health care. Specific examination forms are necessary, adapted to the stage of child development and with a precise interview technique. This form of examination is essential in cases of sexual violence without biological evidence (e.g. inappropriate touching and other types).

School bullying and its variant cyberbullying are fundamental due to its medium and long-term psychological consequences and increasing prevalence. It is often linked to increased cyber addiction behaviours in these stages.

Nor is the LGBTI population in the school context and the specific ways of dealing with it forgotten, above all in those cases of transgender children (48).

The relationship between mental disorders and school failure and between school failure and mental disorders, two situations of particular significance, require a special preventive approach.

All of the above is of fundamental importance for preventing healthcare-associated harm in childhood and adolescence, promoting what is known as quaternary prevention.

During the final phase of drafting this strategy, Organic Law 8/2021, of 4 June, on the comprehensive protection of children and adolescents against violence, was approved. It is worth highlighting regarding this section, the provisions of Article 38. Actions in the health sphere, which establishes, among other issues, that health administrations will promote and encourage actions for the promotion of good treatment of children and adolescents, as well as for the prevention and early detection of violence against children and adolescents and their risk factors, promoting the development of protocols to facilitate this. It is also worth highlighting that the provisions of Article 39 establish the creation of a Commission against violence against children and adolescents (115).

5.1: General objective. Promotion of mental health in childhood and adolescence. Prevention and early detection of mental health problems at this age.

Specific objectives:

5.1.1. To promote protective factors such as resilience, self-esteem, social competencies, decision-making, and conflict resolution skills in the educational environment. To ensure a positive and safe school environment, develop prosocial helping behaviours, and promote physical health (106).

5.1.2. To plan preventive and mental health promotion actions in coordination with other health and non-health resources.

5.1.3. To develop programmes and protocols in the educational, health, and community spheres for promoting positive parenting, including families in social, developmental, and psycho-affective risk situations.

5.1.4. To establish training and awareness-raising programmes for the educational community on the symptoms of and help with mental health problems and to combat stigmatisation(106).

5.1.5. To ensure accessibility to mental health support in the educational setting by establishing partnerships with support networks and community resources (106).

5.1.6. To incorporate screening procedures to identify better the major depressive disorders in adolescents attending primary health care. To integrate this tool within the healthcare process, ensuring access to early treatment and appropriate follow-up (107).

5.1.7. To design specific actions to raise awareness and prevent ICT abuse in childhood and adolescence and non-substance addictive behaviour (cyberaddiction and cyberbullying).

5.1.8. To include specific prevention programmes in dysfunctional family environments to identify abuse, violence, and mistreatment or vulnerability, both in terms of child and gender-based violence, given its particular impact on the mental health of those who suffer it.

5.1.9. To strengthen training in discrimination and monitoring of mental health problems in educational guidance teams, school psychologists, school nurses, and social workers, establishing relations and synergies with mental health services, offering the educational community behavioural support and promotion of mental well-being, identification and assessment of early interventions, individual and group counselling, and referral to community services (106).

5.2: General objective. Care for children and adolescents with mental health problems.

Specific objectives:

5.2.1. To provide early attention to mental health problems in childhood and adolescence. This early attention is especially relevant following symptoms indicating the onset of severe mental disorders.

5.2.2. To develop early attention to emerging mental health problems in the developmental stage of childhood and adolescence.

5.2.3. To develop plans for early identification of the prodrome of psychotic disorders and to intervene early and effectively in the first psychotic episodes in adolescence.

5.2.4. To develop programmes to promote adherence to treatment and meaningful treatment and to prevent early abandonment of treatment for mental health problems in childhood and adolescence.

5.2.5. To plan and develop ongoing training programmes for family doctors, primary care paediatricians, and primary and community care nurses to assess children and adolescents at risk of depression and other mental health problems and to record the risk profile in their medical records (107).

5.2.6. To promote continuing and postgraduate training programmes for mental health professionals in disorders specific to childhood and adolescence.

5.2.7. To address behavioural disorders early, with special emphasis on parental abuse by children.

5.2.8. To address mental health problems arising from ICT use, abuse and addictive behaviour, including bullying and cyberbullying.

5.2.9. To improve child and adolescent care resources and services and provide sufficient resources for paediatric primary care and child mental health services.

5.2.10. To strengthen continuity of care and case management programmes for children and adolescents with illnesses or disorders that tend to become chronic, disabled, and dependent.

5.2.11. To incorporate the assessment of parental competencies and the screening of mental health problems, including emotional, social psychological, and/or occupational well-being, into child health programmes in primary care (105).

5.2.12. To promote good treatment of children and adolescents, respect for children's fundamental rights and humanisation in care.

5.3: General objective. To fight against discrimination and social stigmatisation of children and adolescents with mental health problems.

Specific objectives:

5.3.1. To promote awareness campaigns among key groups: social, educational, health professionals, family members, police officers, teachers, journalists, university students, and high school students (108).

5.3.2. To implement shared projects between children and adolescents with and without mental health problems, with shared objectives and equal status (108).

5.3.3. To develop community programmes with the participation of institutions and associations that contribute to the fight against social stigma (108).

Recommendations

I. To adequately train family and community medicine professionals, paediatricians, and primary care nurses to assess children and adolescents at risk of depression and other mental health problems, recording the risk profile in their clinical history (107).

II. To improve knowledge of depression and other mental health problems, and their consequences, among young people and their families and reduce the associated stigma (107).

III. To routinely include questions about depressive symptoms and mental state in every mental health assessment of a child or adolescent in primary care (107).

IV. To bring health spending on mental health in those autonomous communities where spending is lower, closer to the Spanish average.

V. To provide mental health services with the human and financial resources and physical spaces necessary to develop a comprehensive treatment of mental health problems adequately. This situation can be achieved by evaluating the psychological, pharmacological, and psychosocial interventions necessary to improve well-being and functional capacity, paying attention to family factors and the social context that may interfere with evolution (107).

VI. To ensure continuity of care when, for reasons of age, it is necessary to switch between child and adult care services (107).

VII. To implement and/or develop specific mental health units for childhood and adolescence in community mental health care facilities, with professionals who have the specific training necessary to perform these services and in such a way that early detection and treatment of mental health problems in childhood and adolescence can be carried out.

VIII. To promote the development and adequate provision of specialised units.

IX. To include specific attention to mental health problems in childhood and adolescence in the annual objectives of the mental health services.

X. To work in an early and integrated manner to address behavioural problems in childhood and adolescence, placing particular interest and intensity on parental abuse by children.

Strategy 6. Family care and intervention

In the community model of mental health care, care and intervention with families is a critical element of the therapeutic design that must be addressed from a social and rights-based perspective, as expressed in the preamble of the Convention on the Rights of Persons with Disabilities (82). Their real and effective participation in the decisions taken to develop any type of care must be guaranteed and have a clear impact on planning, development and evaluation at all levels of care.

Family intervention activities contemplate the family and its environment as an active element in the psychosocial recovery of the person with mental health problems. It is contemplated not only the transmission of knowledge but also involves educational guidance by people specialising in this subject and the possibility of sharing personal experiences, which implies an opening of social networks, sharing similar situations and avoiding social isolation. It is about reinforcing the idea of the health of the family. The family is not only a care provider but also a potential user. The family system is an environment where mental health problems are protected or encouraged, care is provided, and self-care is learned.

For this, family members or close relatives need information, counselling, training, care, and self-care on issues related to mental health problems, such as different treatments, specific strategies (type of communication, approach, coping, and problem-solving), and existing resources.

Family intervention training programmes are fundamental in a community mental health care model and have the objectives of covering the training needs relating to the mental health problem and psychosocial recovery, providing the person with tools for the development and improvement of basic social skills, and promoting a healthy family climate and the resolution of possible conflicts in the family system.

6.1: General objective. Attention and relationship with families.

Specific objectives:

6.1.1 To promote models of care and support for families to establish an effective alliance between professionals and people with mental health problems based on autonomy and empowerment.

6.1.2 To facilitate the implementation of psychosocial support itineraries for the families of people with mental health problems.

6.1.3 To encourage leisure activities among family members.

6.1.4 To encourage associations of family members and people with mental health problems.

6.1.5 To encourage the creation of mutual support groups between family members.

6.1.6 To raise awareness and inform families about the impact of the overload related to caring for their family members on their physical and mental health.

6.1.7 To encourage joint family responsibility in providing care and domestic tasks.

6.2: General objective. Strengthening the network of public resources specialised in caring for families of people with mental health problems (xx).

Specific objectives:

6.2.1 To design or reformulate actions, services, and benefits for the care of families of people with mental health problems in the public sphere.

6.2.2 To promote policies for the prevention of situations of dependency.

6.2.3 To promote actions to guarantee a network of resources to promote autonomy and care for dependency.

6.2.4 To guarantee access for families to home care teams that provide monitoring, assessment, and personalised support.

6.2.5 To implement training programmes for professionals who accompany and provide services to families.

Recommendations

I. To ensure that a comprehensive assessment of the situations and needs of families is carried out during social and health care, with particular emphasis on the primary carers.

II. To facilitate the development of Family Intervention and Support Programmes.

III. To strengthen interdisciplinary assertive community treatment teams (psychiatry, clinical psychology, nursing, occupational therapy, and social work).

IV. To orientate training towards eradicating paternalistic or compassionate attitudes and promote the autonomy of people with mental health problems, healthy lifestyle habits, and coping with stressful situations and family conflict.

V. To promote training actions for those who provide informal care for people with mental health problems, primarily aimed at two fundamental levels: identifying the prodromal signs of possible relapses and managing conflictive situations.

VI. To encourage the evaluation of the actions to be developed with the active participation of people with mental health problems and their families to avoid harm associated with health care.

VII. To encourage the development of care programmes or care at home.

VIII. To draw up and disseminate training guides or manuals for family members on the various mental health problems and their treatment; these guides shall respond to families' information and training needs and point out the professional resources for support in crises and sustained stress.

(xx) Article 28 of the UN Convention on the Rights of Persons with Disabilities on Adequate Standard of Living and Social Protection states: "2. c) To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability-related expenses, including training, counselling, financial assistance, and appropriate respite care services;" (82).

IX. To propose training actions involving family members and people close to them, people with experience in mental health and health and social care professionals.

X. To develop training content to guide and identify mental health problems, focus on possible alternatives and proposals that favour quality of life, and propose strategies for dealing with different situations.

Strategy 7. Coordination

Coordination is how the different levels of care in mental health and any other field of activity are coordinated. It aims to guarantee the necessary continuity of care, especially in complex situations or the complementarity - and its temporal articulation - in interventions with professionals from different service networks (social services, justice, education, and work, etc.). As a result, people with mental health problems may have other needs whose coverage requires the contribution of other organisational areas outside the health field. It is, therefore, essential to achieve levels of cooperation between professionals, institutions, and sectors that facilitate the creation of a network that sustains care and guarantees people's right to coherent and properly articulated care. Within the field of care, it is also essential to coordinate with other specialities that treat pathologies with a significant impact on the mental health of the patients who suffer from them.

This type of work is based on a multidisciplinary approach that converges to fulfil five fundamental tasks: establishing a multi-sectoral therapeutic prescription; developing interconsultation, developing clinical guidelines, and/or joint protocols that are agreed and operational; developing and using family psychoeducation techniques; developing the "case management" procedure for more severe cases or cases with risk factors of various kinds; and obtaining legal and institutional coverage for severe cases and/or cases with significant behavioural problems (116).

7.1. General objective. To develop inter-institutional and inter-sectoral coordination.

Specific objectives :

7.1.1 To boost interdisciplinary, inter-institutional and intersectoral coordination to meet the various needs and guarantee continuity of care.

7.1.2 To progressively promote close and coordinated collaboration in interventions between all areas involved in mental health (social services, justice, state security forces and corps, education, culture, employment, health, and media, etc.).

7.1.3 To encourage the creation of conceptual, operational, and ethical frameworks between all the services and professionals in the fields involved in direct work with people with mental health problems.

7.1.4 To promote the creation of communication channels between institutions, sectors, and professionals to facilitate effective and unified coordination.

7.1.5 To facilitate the development of a network of intersectoral mechanisms with diverse and complementary functions, which intervene in a coordinated and collaborative manner to provide care for people with mental health problems.

7.1.6 To promote the inclusion of networking actions in regional mental health plans.

7.1.7 To encourage socio-health coordination.

7.2. General objective. To develop coordination in the mental health system and associative networks in mental health.

Specific objectives:

7.2.1 To implement cross-cutting and specific programmes with other bodies, organisations, and associative networks: children, youth, gender, older people, homeless people, migrants, etc.

7.2.2 To incorporate coordination between public resources and those of associative networks in mental health programmes, promoting associations of people with mental health problems and facilitating information from primary care services.

7.2.3 To promote the presence of associations of people with their own experience of mental health, family members, and people close to them in decision-making in the coordination processes between the different areas involved.

7.2.4 To establish and evaluate collaborative interventions between the child and youth mental health systems and those of adults, establishing protocols for transition programmes from one to the other.

7.3. General objective. To develop cooperation within the interdisciplinary mental health team.

Specific objectives:

7.3.1 To promote and generate conditions, elements, and means that facilitate interdisciplinary work in the team´s functioning.

7.3.2 To design, implement, and evaluate models of interdisciplinary coordination to ensure continuity of care and the necessary care when different needs converge in care. In these cases, mental health nursing, clinical psychology, social work, and occupational therapy professionals play an essential role.

7.3.3 To focus intervention on the needs of the person, guaranteeing the participation of people with their own experience of mental health and their families in decision-making processes so that the results are meaningful.

Recommendations

I. To move towards a model of care based on complementary and coordinated interventions between professionals, services, and sectors that coherently provide care, optimising the available resources.

II. To stimulate a culture of team participation, deliberation, consensus, diversity, and horizontal relationships.

III. To develop preventive actions and promote mental health in coordination with other health and non-health resources.

IV. To evaluate every one of the actions to be developed, with the real, significant, functional, and effective participation of people with mental health problems.

V. To ensure that the rights of people with mental health problems are respected in all interventions, promoting the availability of counselling and support services.

VI. To tend towards integration between mental health and addiction care networks in those autonomous communities where they are not yet integrated, thus responding to goal 3, "Health and Well-being" of the Sustainable Development Goals, which in its target 3.5 establishes "strengthening the prevention and treatment of addictive substance abuse, including drug abuse and harmful use of alcohol" (117).

VII. To develop joint programmes between social and mental health services, establishing programmes that guarantee continuity of care.

Strategy 8. Citizen participation

Citizen participation in everything that affects the individual and the community is one of the pillars of democratic life. It is exercised through a set of mechanisms with different levels of formalisation of greater or lesser extent and complexity depending on the issue in question.

In the field of health, participation should be understood as the process by which all those involved in any situation collaborate in the decision-making process that affects them, whether in terms of lifestyles, the prevention and promotion of mental health, in terms of the choice of treatments, or for the redistribution of resource (118). Such collaboration is essential to develop a practice that respects the autonomy and all other rights of the individual and promotes community development. Community participation brings advantages in perceived social support and establishing social networks, which are essential for promoting health and recovery. It is interesting to note here the role of self-help groups and associations.

8.1 General objective. Promote collective participation through organised civil society groups.

Specific objectives:

8.1.1. To facilitate the participation of social and representative agents in mental health strategies and plans.

8.1.2. To establish in each autonomous community mechanisms for the participation of associative movements, scientific societies, and professionals related to mental health in the design, planning, and evaluation of services.

8.1.3. To establish mechanisms in each mental health service to stimulate interdisciplinary participation from a horizontal perspective.

8.1.4. To integrate the gender perspective in developing mental health plans and strategies, favouring the development of resources and support networks for women with mental health problems.

8.1.5. To promote mechanisms that facilitate people with mental health problems and their families to exercise their right to participation.

8.2. General objective. To incorporate people with their own experience of mental health problems as active health agents.

Specific objectives:

8.2.1. To establish mechanisms for effective participation in service design, planning, and evaluation.

8.2.2. To implement measures for effective participation in care services for decision-making.

8.2.3. To implement the "peer support" model to guarantee the rights of people with mental health problems.

8.2.4. To incorporate people with their own experience of mental health in training and awareness-raising programmes for professionals.

8.3. General objective. To promote good practice in participation.

Specific objectives:

8.3.1. To promote mutual help groups in their different roles (professionals, family members, relatives, and people with mental disorders) from the care services.

8.3.2. To provide spaces and tools for exchanging good practices at national and international levels.

Recommendations

I. In the interest of full transparency regarding conflicts of interest, the autonomous communities shall regulate the participation in the advisory and consultative bodies which assess the mental health of those in associations of mental health professionals.

II. The autonomous communities shall have a participatory structure in each health department, including people with mental health problems in the working groups and commissions.

III. The autonomous communities shall facilitate the development of advanced decision planning for situations that require it.

IV. To include people with their own experience of mental health problems in assessment programmes.

Strategy 9. Training

The advancement of knowledge in Health Sciences and the breadth of related fields require continuous training of professionals.

It is necessary to increase the knowledge of mental health and primary care professionals on the evidence of the different therapies in mental health through educational initiatives by the health authorities. Training related to mental health issues must be carried out in such a way as to ensure that there is no conflict of interest, especially concerning the use of medication.

Expanding the proposals and development of psychotherapeutic activities in mental health facilities is important. To this end, it is essential that the needs of each territory are assessed and that training initiatives aimed at professionals and focused on those psychotherapeutic techniques that are suitable in each context and based on scientific evidence and existing programmes in other countries in our environment (e.g. Germany, Austria, Italy, and the Nordic countries) are implemented.

Both the child and adolescent population and older people constitute a key group with mental health problems that require care by professionals with adequate training in this field.

It is necessary to promote and encourage the continuous training of mental health professionals based on new scientific evidence and existing experiences in other countries in our environment. It is necessary to detect and cover training needs and to strengthen the interdisciplinary and transversal approach, incorporating the experience and knowledge of people with mental health problems and their organisations.

Undergraduate

It is necessary to adapt over time the content and syllabuses of university psychiatry studies in medicine, psychology, nursing, social work, occupational therapy, and all those qualifications linked to mental health care, in line with the ideas and recommendations set out in this strategy, also facilitating the link with care services.

Specialised health training

Postgraduate training via the MIR (medical degree specialising in psychiatry), PIR (psychologist degree specialising in clinical psychology) and EIR (nursing degree specialising in mental health) is one of the most prestigious programmes in our NHS at an international level. The accreditation of the teaching units must respond to the professionals' real and updated training needs. Each commission of the related speciality establishes the programme. All of them include the acquisition of competencies for the management of people with chronic symptomatology and severe mental health problems, for the care and diagnosis process, therapeutic and care orientation, introduction to interconsultation with other services, and care for addictive disorders due to substance use (alcohol and other substances of abuse). The subjects of health promotion and prevention of health problems at all stages of life are essential. The training programme is carried out in facilities such as hospitalisation units for people with severe mental disorders in general hospitals, mental health centres, intermediate facilities, care facilities for people with substance use disorders, and psychosocial rehabilitation facilities. It includes an on-

call duty for emergency care. These programmes must be periodically updated and adapted to social changes and emerging needs.

In the different specialities in the field of mental health, far from being monolithic, areas of knowledge have been appearing with their field of development and scientific contributions that need to be addressed in training, including care and attention in childhood and adolescence, psychotherapy, neuropsychology, clinical health psychology, substance abuse, and psychogeriatrics, among others.

The professionals who make up the mental health teams develop specialised competencies in mental health care, so it is a priority to reinforce professional qualifications in this field and the categorisation of jobs.

During the preparation of this strategy, Royal Decree 689/2021 of 3 August was approved, establishing the title of a doctor specialising in Child and Adolescent Psychiatry and updating various aspects of the title of a doctor specialising in Psychiatry. Specialised training within the framework of the professions involved in mental health must evolve to respond to society's needs and the idiosyncrasies and evolution of each profession. The opportunity to create new specialities in the mental health field will be analysed once the Royal Decree has been approved (in process at the time of drafting this strategy), which determines the procedure and criteria for the creation of a new speciality in Health Sciences.

Continuing education

Continuous training is an active and permanent teaching-learning process aimed at updating and improving knowledge, skills, attitudes, and competencies, which is of great importance for professionals in mental health teams in the face of scientific and technological evolution and the demands and new needs, both social and of the health system itself (119).

It is necessary to promote and encourage continuous training free of conflicts of interest for mental health professionals based on new scientific evidence and internationally recognised practices and experiences existing in other countries in our environment, including those that contribute to reducing the use of coercion in mental health. Training needs should be detected and covered in each autonomous community. The interdisciplinary and cross-cutting approach should be promoted, incorporating the experience and knowledge of people with mental health problems and their organisations.

9.1 General objective. Promote mental health training from public administrations.

Specific objectives:

9.1.1. To update the training programmes for mental health specialities and the accreditation requirements for Multiprofessional Mental Health Teaching Units.

9.1.2. To strengthen the continuous training of mental health specialists and update competencies on mental health problems of other specialists, especially in primary care.

9.1.3. To develop training actions in mental health with and for primary care professionals, mental health professionals, and others involved in caring for people with mental health problems.

9.1.4. To develop specific training actions in child and adolescent mental health and later life stages among professionals working in this field.

9.1.5. To promote training outside the professional health field, especially in other areas involved, such as social services, education, justice, labour, penitentiary institutions, and the media.

9.1.6. To promote cross-cutting training from a social perspective that guarantees the human rights of people with mental health problems, training in values emphasising gender equality, the benefits of physical activity, and self-care.

9.1.7. To promote training actions on the impact of the social context on the population's mental health, stressing the importance of preventive actions and their effects on increasing equality and quality of life in the community.

9.1.8. To promote training actions that facilitate the integration of various types of interventions based on the available scientific evidence within the framework of interdisciplinary care.

9.1.9. To facilitate continuous training sensitive to gender and the diversity of cultures and experiences of mental health project evaluators at the national and autonomous community levels.

9.2. General objective. To open avenues for citizen participation in the design of public policies on mental health training.

Specific objectives:

9.2.1. To establish channels for collaboration and participation between public administrations and organisations designing and implementing the different training actions in the associative field.

9.2.2. To promote training actions carried out by people with their own experience in mental health.

9.2.3. To guarantee training in citizen participation for professionals related to mental health.

9.3. General objective. To establish training plans concerning the care of people at risk of suicide for the different sectors involved.

Specific objectives:

9.3.1. To educate and train health professionals in managing suicidal behaviour, especially those who care for people at risk of suicide.

9.3.2. To train and qualify professionals such as teachers, educators, firefighters, police forces, members of civil protection, professionals caring for the most vulnerable people, and social services professionals to improve the detection of people at risk of suicide by their referral to available services.

Recommendations

I. To promote training based on a model centred on the person and the promotion of their autonomy and rights.

II. To promote the specific training of the professionals in the mental health field, according to the established areas of knowledge and with the qualifications to be determined.

III. To promote training actions for people who provide informal care for people with mental health problems.

Strategy 10. Research, innovation, and knowledge

Research must be a central element in the work of the health system. Reflection on the work carried out, its evaluation and the search for solutions to health problems are an inescapable responsibility of the health system and its professionals.

Until now, research has primarily depended on the individual initiative of professionals and teams. Unlike care and the training of new professionals, research is not part of the tasks assigned to each professional, and therefore it is up to them to decide whether and to what extent to include it in their remit. Therefore, research is a fragile activity that the health authority must actively promote and protect.

Clinical research focusing on the needs of people with mental health problems and taking into account the social and economic context in which they live their lives, as well as the evaluation of the efficacy and safety of the different treatments, should be a priority in the public health system.

On many occasions, the methodology to be selected is called action research, a subtle and challenging design methodology, as it combines direct clinical intervention with the methodological rigour of data collection for research. Similarly, research is often conducted using qualitative methodology, which implies difficulty in collecting data and treating the results obtained (120). Research in mental health is a complex process encompassing, among others: basic research, genetic-environmental interactions, economic evaluation of services or care programmes, and research with a more clinical orientation. Promoting research at all levels, including health promotion, pathophysiology, prevention, epidemiology, and effectiveness of interventions or health outcomes, is necessary. The prodromal phase of psychosis is another line of research interest in the clinical field, consistent with establishing early intervention.

Since 2006, Spain has had the Biomedical Research Networking Centre (CIBER, www.ciberisciii.es), a public state consortium, one of whose areas is mental health (CIBERSAM). CIBER and CIBERSAM were created to generate a critical mass of researchers by promoting translational, basic, clinical, epidemiological and health services research. The research groups and programmes are available on its website: https://www.ciberisciii.es/areas-tematicas/cibersam

Without losing sight of the complementarity of the lines of research and the need to promote the creation of multidisciplinary competitive research groups, including specialists from other areas of knowledge, it seems reasonable to prioritise those lines of research with a high translational component with a more significant impact on the quality of life of people with mental health problems and the improvement of the care offered to them. Similarly, multicentre research and research with international collaborations should be promoted so it is possible to include professionals in training. Likewise, the task of disseminating the research carried out should be included, informing the services and the health system of the studies carried out, as well as the results obtained or, where appropriate, the patents obtained (e.g. the creation and validation of a general or specific assessment scale).

The **drive towards digital health**, expected in the coming years, should be targeted and represents an opportunity for better patient care.

The incorporation of disruptive digital technologies into the NHS must adapt the progress of the healthcare system to the demands of today's society through innovation policies oriented towards 5P medicine (population, preventive, predictive, personalised, and participatory) and translate into new and better services in line with the needs of the population, more adapted to each person, with more autonomy and decision-making capacity for patients and compatible with the sustainability of the system. This innovation, as is the norm in the health field, must also demonstrate evidence of its benefits and the proportionality and efficiency of the healthcare effort.

The WHO states that "information, evidence and research are essential for sound mental health policy-making, planning, and evaluation. Developing new knowledge through research enables any policy or action to be based on evidence and best practice. The existence of relevant and up-to-date data or monitoring arrangements makes it possible to monitor actions and identify services where there is room for improvement. (WHO. Mental Health Action Plan 2013-2020) (87).

10.1. General objective. To promote research in all areas related to mental health.

Specific objectives:

10.1.1. To promote the inclusion of aspects of the Mental Health Strategy in state and regional scientific research and innovation programmes.

10.1.2. To encourage the creation of multidisciplinary working groups in networks to promote research and improve knowledge in the different areas of mental health.

10.1.3. To promote the participation of these groups in ethics and research committees in mental health.

10.1.4. To improve the information systems that enable common and comparable quantitative and qualitative indicators in all the autonomous communities that provide quality information for developing reports, research and decision-making.

10.1.5. To disseminate the research results, promoting the generation of shared knowledge.

10.1.6. To encourage and provide incentives for the participation of health professionals with a more clinical profile in quality health research activities.

10.1.7. To promote research into suicidal behaviour.

10.2. General objective. Establish interdisciplinary lines of research in mental health.

Specific objectives:

10.2.1. To promote close and coordinated collaboration between researchers in all related fields: health (primary care and other specialities - including basic and pre-clinical researchers), social services, justice, education, culture, employment, and the media, etc., through the creation and formation of interdisciplinary teams for the development of research, in which the participation of people with their own experience should be envisaged.

10.2.2. To encourage translational research so that all research projects in mental health, in any of its areas, incorporate aspects for direct implementation in clinical care.

10.3. General objective. To incorporate the gender perspective in all lines of research.

Specific objectives:

10.3.1 To have segmented information available that includes the gender perspective according to different variables: differential morbidity by sex, gender inequalities, and gender psychosocial determinants, from the point of view of vulnerability and protection.

10.3.2 To promote the development of innovative lines of research into the relationship between women and mental health in different areas.

10.3.3 To implement actions specifically to eradicate gender bias in mental health research.

10.4. General objective. To develop research into the socio-familial factors of people with mental health problems.

Specific objectives:

10.4.1. To promote research on new models of families, forms of care, and mental health.

10.4.2 To develop studies on the effects of poverty according to the Sustainable Development Goals (SDGs), considering the new situations of homelessness and their relationship with mental health (117).

10.4.3 To conduct studies to assess the impact on the population's mental health following major life traumas (pandemics (e.g. the COVID-19 pandemic), environmental disasters, migration, wars, etc.).

10.4.4 To promote research and analysis of the impact on the mental health of primary carers of people with mental disorders and the provision of care and support.

10.4.5 To promote research and analysis of families with difficulties in functioning and structure (situations of abuse, ill-treatment, or risk thereof within the various family systems) and their impact on mental health.

10.4.6 To promote lines of research into the presence of mental disorders in childhood and adolescence, their clinical presentation, the different treatments developed, and their longitudinal evolution.

10.5 General objective. To promote information technologies in mental health care concerning the future Digital Health Strategy of the National Health System.

Specific objectives:

10.5.1 To develop **digital public services** that consider mental health care needs. For example, the development of a **telematic care model** that helps to **improve access** to services, particularly for the most vulnerable groups, the rural population, and those with limited mobility and guarantees equity, continuity, and security of care without compromising the quality of care. This care model should be based on existing good practice and the

applicable regulations (guaranteeing, among other things, consent, privacy, and confidentiality in the relationship between health professionals and patients, providing it with the necessary legal certainty and always within the framework of the ethics of the health professions).

10.5.2 To promote the **interoperability of mental health information** with measures such as the adoption of standards and good practices for the operation of the digital health record, the integration of each person's essential clinical data throughout the NHS, reinforcing the single identity system throughout the NHS, and access from all healthcare centres. To promote and support the digital identification resources necessary for professionals and patients to access the different digital services of the NHS and achieve full integration in European interoperability projects of the summarised clinical record and the e-record.

10.5.3 To expand, integrate and improve the **health information system,** which would involve reinforcing the adoption of models, standards, procedures, and good practices by all NHS actors to facilitate the exchange of data and information. To increase the aggregation and consolidation of information at the national level and reinforce international exchange and collaboration. To incorporate new data sources, integrate them, and incorporate new tools for the analysis and presentation of information by improving the NHS information portal and developing mechanisms to facilitate access, consultation, and reuse of information. To improve the health information system for a better evaluation of the activity, quality, effectiveness, and efficiency of the NHS, as well as the monitoring of health risks and threats.

Recommendations

I. To include the promotion and encouragement of research in regional mental health plans.

II. To promote networking in mental health information and research systems to promote research in all areas related to mental health.

III. To promote coordination in research and innovation matters with other national and international bodies.

IV. To develop research studies on stigma in the media and social networks.

V. To develop research into new lines of intervention related to possible social elements that generate mental health problems (e.g. new addictions, bullying and cyberbullying, image worship, pandemics, environmental disasters, migrations, wars, etc.).

VI. To include in research two fundamental dimensions: the gender dimension and the age dimension for children and adolescents and older people.

VII. To promote initiatives to improve existing information on mental health data for health management and epidemiological analysis.

V. MENTAL HEALTH DURING A PANDEMIC

On 30 January 2020, the Director-General of the WHO, Tedros Adhanom, declared for the sixth time since the adoption of the International Health Regulations in 2005 the outbreak of the new coronavirus-2019 that began in the People's Republic of China as a Public Health Emergency of International Concern (121). One month and a half later, and given the alarming levels of the spread of the disease and the seriousness of its cases, the WHO determined, in its assessment of 11 March, that COVID-19 had the characteristics to be considered an international pandemic, which led the Spanish government to adopt a series of immediately applicable measures, including the declaration of a state of alarm, house confinement, and the cessation of all non-essential activities throughout the national territory. This situation was finally extended until 21 June.

Even today, it is still difficult to determine the impact that this pandemic has had and continues to have on the health and well-being of the Spanish population. The impact on the NHS has been evident. It has faced one of the most complex and overwhelming health crises in recent history and with a global scope.

In Spain, at the economic level, the effects of confinement and the measures to contain commercial activity were reflected, according to an analysis carried out by the Bank of Spain, in a fall in GDP of 11% during the year 2020 (122). The employed population fell in the second quarter of 2020 by 1,074,000 people, which must be added to the people affected by a Temporary Layoff Plan (furlough) or directly in a situation of suspension of employment, with the smallest companies being the most affected. The economic consequences will take a very long time to recover (123).

When measuring the impact on the population's mental health, many studies point to the significant impact of the pandemic on the population's mental health.

Various national and international studies have shown increased anxiety and depressive disorders and, on occasion, symptoms compatible with post-traumatic stress disorder. An increase in self-injurious behaviour has been reported. Similarly, there has been an increase in somatisation disorders and the decompensation of pre-existing clinical conditions, such as eating disorders, psychotic conditions, and addictive behaviours (especially non-substance addictions, such as screen devices or online gambling).

Perhaps two of the most representative studies in our country are the CIS surveys on " the mental health of Spaniards during the COVID-19 Pandemic" and the European Health Survey in Spain, EHS, 2020 (124, 125).

For the CIS survey, over 3,000 telephone interviews were conducted between 19 and 25 February among the Spanish population aged 18 and over in 50 provinces. The study found that fears related to the coronavirus were widespread in the population. The most prevalent were those related to contagion (72.3%) and death (68.6%) of a family member or loved one, to infecting a loved one (65.8%), and to the spread of the virus (75.3%). In contrast, fears of death (23.4%) and of becoming infected (44%) were significantly less frequent. Other fears and worries that occurred in high percentages were the fear of not being able to see family or friends (65%) and of a family member losing their job (61.5%). It was striking that the over-65s were the least

fearful of dying, despite being the age group with the highest mortality from the coronavirus. One in three Spaniards (35% of the population interviewed) indicated they were very worried about the pandemic. The most worried people were the oldest (55+), with 40.1% of those affected being very worried, in contrast to 20.7% and 25.2% in the 18-24 and 25-30 age groups, respectively.

This relative lack of concern among young people contrasts with their poorer management of emotional and psychosomatic responses. It also contrasts with the high percentage of 18-24-year-olds afraid of infecting their loved ones (77.9%), the pandemic becoming part of our lives (61.3%), and society never being as before. Many Spaniards reported suffering from somatic symptoms, especially tiredness and lack of energy (51.9%), sleep problems (41.9%), headaches (38.7%), back pain (37.9%) and joint pain (33.1%).

In childhood and adolescence, the intensity of mental impairment was described as mild to moderate unless there was a previous mental health problem which was then aggravated. Some disturbances manifest themselves persistently, lasting more than 3 months. The prevalence of the disorders reported in this age range reached 30-35%, whereas prior to the onset of the pandemic, studies referred to 10-15%. The prevalent form of presentation in these stages of childhood and adolescence were the symptoms of the anxious series, with a predominance of the feeling of fear of contagion and death, especially in young adults. Behavioural symptoms, irritability, nervousness, restlessness, opposition to things or people, disobedience, increased aggressive responses, and inhibition behaviours, such as withdrawal or hyper-reactivity, were almost equally distributed in both forms of presentation, with those of inhibition and withdrawal being of greater clinical importance.

The 2020 European Health Survey in Spain (EHS) had a section of additional indicators referring to the COVID-19 pandemic, which was particularly interesting. Given that the information collection period of this survey covered the period from July 2019 to July 2020, it has been possible to add some indicators that allow us to know their behaviour in two different periods: prior to the pandemic (July 2019-February 2020) and during the pandemic (March 2020-July 2020) (xxi). In the mental health indicators, it was observed that 20.3% of the population aged 15 and over reported having little interest or joy in doing things during the pandemic, compared to 17.0% in previous months. This increase in the lack of interest or joy in doing things affected more women (25.4% compared to 20.4% before the pandemic) than men (14.9% compared to 13.4%). Meanwhile, the percentage of people feeling down increased to 21.0% in the pandemic period from 18.2% in the pre-pandemic period. The increase was greater in women (26.9% compared to 22.5%) than in men (14.8% compared to 13.6%).

The decrease in lack of interest or joy in doing things and the increase in people feeling down affected all age groups.

In the first months of the pandemic, sleeping problems also increased. 21.2% of people aged 15 years and older had them, compared to 19.2% before the pandemic.

The previous surveys have the value of being carried out among the general population, with large sample size and a consolidated methodology. However, even though in a pandemic, the

[xxi] In order to make comparisons between the two periods, the published indicators refer to the 2 to 4 weeks before the interview or to the current time at which the information is provided.

entire population should be considered vulnerable to a greater or lesser extent, there is evidence of the existence of groups in which the impact of the pandemic on mental health has been particularly significant, which may have implications for the management of mental health care in this and future pandemics. These groups include:

- People with pre-existing mental health problems: A study in the UK during the first 6 weeks of confinement found that people with pre-existing disorders showed significant differences, compared to those without, in the frequency of self-reported symptoms of depression and anxiety (126). In Spain, during the peak of the pandemic, approximately 6% of people with a severe mental disorder required admission to an acute unit, with the most prevalent problems being negative symptoms in the form of slowness or inactivity (47.5%), anxiety (54%), and sleep structuring problems (41%) (127, 128, 129, 130). Twenty per cent of people with severe mental disorders included in this study would have required increased medication to cope with emotional problems and decompensations (127).
- Healthcare workers (131): The meta-analysis by Li Y et al. analysed 65 studies on the prevalence of depression, anxiety, and post-traumatic stress disorder among health professionals, totalling 97,333 health professionals from 21 countries. The combined prevalence of moderate depression was 21.7% (95% CI, 18.3%-25.2%), anxiety 22.1% (95% CI, 18.2%-26.3%) and post-traumatic stress disorder 21.5% (95% CI, 10.5%-34.9%) (132). In our country, a survey carried out by the Spanish Medical Association (133) showed an increase in sleep-related problems (from 9.4% before the pandemic to 33%), the presence of burnout (the prevalence of which had doubled), and the use of tranquillisers or hypnotics (from 18.6% before the pandemic to 29.4%).
- COVID patients: These patients are twice as likely to have imbalances in their mental health as other people with other pathologies. Approximately 20% of survivors have been confronted for the first time with a diagnosis of anxiety, depression, or insomnia (134).
- Family members: Families of the victims, who have faced a grieving process in conditions that have made it particularly difficult, and also families of the patients who have faced situations of uncertainty, fear or guilt.
- Those with fewer resources: It has become apparent in the surveys above that people with fewer resources have suffered a more significant impact and may find it more challenging to access the alternative forms of assistance developed during confinement, such as teleconsultation.
- Women: The surveys above and other studies have shown a more significant impact of the pandemic on women's mental health, aggravated by the unequal distribution of household tasks and family burdens and the difficulties of reconciling work and family life in the context of teleworking.
- Children and adolescents: The pandemic on mental health has been particularly significant in these groups, as shown in the survey carried out by the CIS in Spain, with the above data.

All of the above highlights the importance of paying particular attention to the population's mental health during a pandemic. The magnitude and breadth of the impact and the speed with

which events unfold, like a tsunami, make implementing effective measures in the first moments difficult if they are not prepared beforehand.

In this regard, several recommendations can be drawn from the experience to date during the months of the ongoing COVID-19 pandemic:

Lessons learnt for improving mental health care during and after a pandemic

1. To pay special attention to the mental health of the population. The expected increase in the prevalence of mental health problems during a pandemic requires an appropriate response, which may need to be extended beyond the pandemic.
2. To design a scorecard based on key indicators of demand and resources that allows decision-making and the development of measures in an agile and precise way, responding to needs in real-time and monitoring them over time.
3. To conduct analyses and studies to assess the impact on the most vulnerable social groups during the COVID-19 pandemic, identify the factors that increase this impact and develop interventions to reduce them in similar future situations.
4. To determine the type of assistance needed from mental health services for all ages and stages of development.
5. To develop operational intervention tools that are useful in these circumstances (e.g. group therapies, family approaches, and teleconsultation).
6. To reinforce mental health care professionals for intervention in different settings: hospitals, through inter-consultation, in primary care, and through referral to mental health centres.
7. To facilitate the work of inter-consultation and liaison at different levels of the health care system to provide comprehensive care to the population and help to contain the health professionals, with priority being given to the development of actions with primary health care.
8. To promote interventions that prevent and address the effects of pandemic fatigue on the population and health professionals.
9. To facilitate the involvement of other levels of care in the established educational and community activities, particularly for the prevention and early management of so-called pandemic fatigue.
10. To prioritise attention to health professionals. From an occupational health perspective, coordination between professionals from mental health services, occupational risk prevention services, and a psychosocial preventive programme must be adequate. Good psychosocial intervention practices in healthcare centres should be designed to monitor and protect the mental health of frontline healthcare workers (ICU, emergency, COVID hospitalisation wards, and primary care).
11. To strengthen care for adolescents with more complex mental health problems.

VI. EVALUATION

Evaluation methodology

Following the model of previous evaluations of the NHS Mental Health Strategy (7), the following evaluation methodology is proposed to be reviewed and confirmed by the Strategy Monitoring and Evaluation Committee established to coordinate the evaluation:

The evaluation of the Mental Health Strategy of the NHS has a dual aspect: the impact evaluation, which seeks to know to what extent the objectives of the strategy have been achieved, and the evaluation of the execution of the strategy, which seeks to know to what extent the recommendations set out in the strategy or the projects established to achieve its objectives have been implemented (either by the autonomous communities or by the central administration).

The impact assessment to find out quantitatively to what extent the objectives of the strategy have or have not been achieved, starting with its main objective of "Improving the mental health of the population at all levels and areas of care of the National Health System") and continuing with the different objectives developed in the strategy. To this end, a series of indicators will be defined based on the available data and sources of information, selecting those related to the objective to be measured (see below for a proposal of quantitative indicators).

The evaluation of execution, to qualitatively assess the extent to which the objectives and recommendations set out in the strategy have been implemented (either by the autonomous communities or by the central administration, as appropriate), which will be carried out using an "ad hoc" qualitative evaluation questionnaire designed to be completed by the autonomous communities in order to ascertain the extent to which the objectives and recommendations established in the strategy are being achieved.

Once the strategy has been approved by the Interterritorial Council of the National Health System, work will begin on setting up the Monitoring and Evaluation Committee.

This committee will draw up the qualitative evaluation questionnaire, among other tasks.

Concerning the definition of quantitative indicators for impact assessment by the committee, the following aspects, among others, may be taken into account: health status, morbidity, indicators of access to services, indicators of expenditure on mental health and health resources, and activities and indicators on suicide. As a guideline, some of the quantitative indicators on which to elaborate this part of the evaluation are shown below in the section on proposed quantitative indicators.

Proposed indicators

- **Demographic, socio-economic, and health data**

Given the importance of socio-economic factors as determinants in the mental health of the population, it is necessary to contextualise the evaluations of mental health indicators with some of the primary socio-economic and health data at the time of the evaluation, such as, for example, the following provided by the National Statistics Institute (NSI):

- ✓ Total population of residents in Spain (NSI)
- ✓ Population by age, five-year groups (NSI)
- ✓ Life expectancy at birth according to sex (NSI)
- ✓ The mortality rate at birth per thousand (NSI)
- ✓ Number of deaths/year, total (NSI)
- ✓ Unemployment rate (NSI)
- ✓ The population at risk of relative poverty (NSI)

A. Mental health status

A1. Risk of mental ill-health in the population aged 15 and over

A2. Percentage of the population at risk of mental ill-health in those aged 15 and over

A3. Risk of poor mental health in the population aged 4-14

A4. Percentage of the population at risk of poor mental health in those aged 4-14

A5. Percentage of people with a disability certificate due to mental health problems

B. Morbidity

B.1 Prevalence of depression in the population aged 15 and over

B.2 Prevalence of chronic anxiety in the population aged 15 and over

B.3 Prevalence of other mental disorders in the population aged 15 and over

B.4 Prevalence of conduct disorders in the population aged 4 to 14

B.5 Prevalence of hyperactivity disorders in the population aged 4 to 14

B.6 Prevalence of mental disorders (depression, anxiety) in the population aged 4 to 14

B.7 Prevalence of autism or autism spectrum disorders (ASD) in the population aged 3 to 14

B.8 Overall prevalence of mental health problems recorded in primary care

B.9 Packages of dispensed medicines from the antidepressant group (N06A)

B.10 Packs of dispensed medicines from the anxiolytic group (N05B)

B.11 Packages of dispensed medicinal products from the hypnotics and sedatives group (N05C)

B.12 Packs of dispensed medicines from the antipsychotic group (N05A)

B.13 Percentage of the population having visited a psychologist, psychotherapist, or psychiatrist

C. Expenditure on mental health

C.1 Total annual expenditure on mental health in hospitals in the NHS

C.2 Percentage of hospital expenditure on mental health as a percentage of total hospital expenditure on mental health in the NHS

D. Health Resources

D.1 Total number of psychiatry beds in NHS hospitals

D.2 Ratio of psychiatric beds in NHS hospitals per 100,000 inhabitants

D.3 Average length of stay in psychiatry of hospital admissions in acute care units

D.4 Number of mental health centres

D.5 Number of psychiatrists linked to NHS public health centres

D.6 Ratio of psychiatrists linked to public health centres of the NHS per 100,000 inhabitants

D.7 Number of psychologists with a speciality in clinical psychology

D.8 Number of nurses with the title of mental health specialist

D.9 Number of social workers in public health centres of the NHS

E. Indicators concerning suicidal behaviour

E.1 Number of suicides

E.2 Suicide rate/ 100,000 inhabitants/year

E3. Rate of hospital discharge due to self-harm/ 100,000 inhabitants/ year

Description of the proposed indicators

A. Mental health status

A1. Risk of poor mental health in the population aged 15 and over

Formula/Definition: Mean score on the Goldberg Health Questionnaire GHQ-12.

Disaggregation: total, sex, economic activity.

Source: National Health Survey (SNHS)

Frequency: Every 5 years.

Comments: The following year for the survey is 2023. Publication delay 1 year.

A2. Percentage of the population at risk of poor mental health in the population aged 15 and over

Formula/definition: Goldberg Health Questionnaire GHQ-12 stratifying according to the established cut-off point for estimating the population aged 15 and over at risk of mental disorder (GHQ-12 ≥ 3). The cut-off point for identifying possible psychiatric cases is 3.

Disaggregation: sex, age group, autonomous community.

Source: National Health Survey (SNHS)

Frequency: Every 5 years.

Comments: The following year for the survey is 2023. Publication delay 1 year.

A3. Risk of poor mental health in the population aged 4-14

Formula/Definition: Mean score obtained in the *Strengths and Difficulties Questionnaire* (SDQ).

Disaggregation: total, sex.

Source: National Health Survey (SNHS)

Frequency: Every 5 years.

Comments: The following year for the survey is 2023. Publication delay 1 year.

A4. Percentage of the population aged 4-14 at risk of poor mental health

Formula/definition: *Strengths and Difficulties Questionnaire* (SDQ) stratifying according to the cut-off point established to estimate the population at risk of suffering from a mental disorder (SDQ 14 or more points).

Disaggregation: sex, age group, autonomous community.

Source: National Health Survey (SNHS)

Frequency: Every 5 years.

Comments: The following year for the survey is 2023. Publication delay 1 year.

A5. Percentage of persons with a disability certificate due to mental health problems

Formula/definition: Persons with disability certificate by impairment group according to the degree of disability and sex. Units: thousands of persons and percentages.

Disaggregation: sex, age group.

Source: Disability: State Database on Persons with Disabilities. Available on the website of the National Statistics Institute (NSI).

https://www.ine.es/jaxi/Tabla.htm?tpx=29862&L=0

Frequency: Annual.

Comments: Publication delay approximately 2 years.

B. Morbidity

B.1 Prevalence of depression in the population aged 15 and over

Formula/definition: Self-reported prevalence in the non-institutionalised population aged 15 and over of disorders diagnosed by a doctor in the last 12 months.

Disaggregation: sex, age group, autonomous community.

Source: National Health Survey (SNHS) y European Health Survey (EHS)

Frequency: Every 2.5 years (the SNHS and the EHS have a frequency of every 5 years, alternating).

Comments: The following year for the survey is 2023. Publication delay 1 year.

B.2 Prevalence of chronic anxiety in the population aged 15 and over

Formula/Definition: Formula/definition: Self-reported prevalence in the non-institutionalised population aged 15 and over of disorders diagnosed by a doctor in the last 12 months.

Disaggregation: sex, age group, autonomous community.

Source: National Health Survey (SNHS) y European Health Survey (EHS)

Frequency: Every 2.5 years (the SNHS and the EHS have a frequency of every 5 years, alternating).

Comments: The following year for the survey is 2023. Publication delay 1 year.

B.3 Prevalence of other mental disorders in the population aged 15 and over

Formula/Definition: Formula/definition: Self-reported prevalence in the non-institutionalised population aged 15 and over of disorders diagnosed by a doctor in the last 12 months.

Disaggregation: sex, age group, autonomous community.

Source: National Health Survey (SNHS) y European Health Survey (EHS)

Frequency: Every 2.5 years (the SNHS and the EHS have a frequency of every 5 years, alternating).

Comments: The following year for the survey is 2023. Publication delay 1 year.

B.4 Prevalence of conduct disorders in the child population aged 4-14

Formula/ definition: Self-reported prevalence in the population aged 4-14 of disorders diagnosed by a doctor in the last 12 months.

Disaggregation: sex, age group, autonomous community.

Source: National Health Survey (SNHS)

Frequency: Every 5 years.

Comments: The following year for the survey is 2023. Publication delay 1 year.

B.5 Prevalence of hyperactivity disorders in the child population aged 4-14

Formula/Definition: Self-reported prevalence in the population aged 4-14 years of disorders diagnosed by a doctor in the last 12 months.

Disaggregation: sex, age group, autonomous community.

Source: National Health Survey (SNHS)

Frequency: Every 5 years.

Comments: The following year for the survey is 2023. Publication delay 1 year.

B.6 Prevalence of mental disorders (depression, anxiety) in the child population aged 4-14

Formula/Definition: Self-reported prevalence in the population aged 4-14 of disorders diagnosed by a doctor in the last 12 months.

Disaggregation: sex, age group, autonomous region.

Source: National Health Survey (SNHS)

Frequency: Every 5 years.

Comments: The following year for the survey is 2023. Publication delay 1 year.

B.7 Prevalence of autism or autistic spectrum disorders (ASD) in children aged 3-14

Formula/definition: Self-reported prevalence in the population aged 3 to 14 of disorders diagnosed by a doctor in the last 12 months.

Disaggregation: sex, age group, autonomous region.

Source: National Health Survey (SNHS)

Frequency: Every 5 years.

Comments: The following year for the survey is 2023. Publication delay 1 year.

B.8 Overall prevalence of mental health problems recorded in primary care

Formula/definition: percentage of persons (aged 0 and over) assigned to primary care who present some psychological or mental health problems included in the International Classification of Primary Care- ICPC2 under the heading P-Psychological problems.

Disaggregation: sex, age group, autonomous community, country of birth, income level, employment status, and the district size.

Source: BDACP

Frequency: Annual.

Comments: Publication delay 2 years.

B.9 Packages of dispensed antidepressants (N06A)

Formula/definition: number of packages dispensed in pharmacies at the expense of the NHS expressed in defined daily doses (DDD) per 1,000 inhabitants per day (DHD) (dosis por habitants y dia). Official population figures are obtained from the NSI (municipal census data).

$$DHD = \frac{UV \times FF \times C \times 1000}{DDD \times N^{\circ} \text{ de habitantes} \times 365 \text{ días}}$$

UV: units of packages sold (unidades de envases vendidas)

FF: number of dosage forms per pack (número de formas farmacéuticas por envase)

C: quantity of active ingredient in each dosage form (cantidad de principio activo en cada forma farmacéutica)

Disaggregation: sex, age group, autonomous community, country of birth, income level, employment status, and the size of the district.

Source: BDACP

Frequency: Annual.

Comments: Publication delay 2 years.

B.10 Packages of dispensed medicines of the anxiolytic group (N05B)

Formula/definition: number of packages dispensed in pharmacies at the expense of the NHS expressed in defined daily doses (DDD) per 1,000 inhabitants per day (DHD) (dosis por habitants y dia)-see formula above-.

Disaggregation: sex, age group, autonomous community, country of birth, income level, employment status, and the size of the district.

Source: BDACP

Frequency: Annual

Comments: Publication delay 2 years

B.11 Packages of dispensed pharmaceuticals of the hypnotics and sedatives group (N05C)

Formula/definition: number of packages dispensed in pharmacies at the expense of the NHS expressed in defined daily doses (DDD) per 1,000 inhabitants per day (DHD) -see formula above-.

Disaggregation: gender, age group, autonomous community, country of birth, income level, employment status, and the size of the district.

Source: BDACP

Frequency: Annual.

Comments: Publication delay 2 years.

B.12 Packages of antipsychotic drugs dispensed (N05A)

Formula/definition: number of packages dispensed in pharmacies at the expense of the NHS expressed in defined daily doses (DDD) per 1,000 inhabitants per day (DHD) (dosis por habitants y dia)-see formula above-.

Disaggregation: sex, age group, autonomous community, country of birth, income level, employment status, and the size of the district.

Source: BDACP

Frequency: Annual.

Comments: Publication delay 2 years

B.13 Percentage of the population having visited a psychologist, psychotherapist or psychiatrist

Formula/Definition: Percentage of the population reporting having visited a psychologist, psychotherapist or psychiatrist (public or private) in the last 12 months.

Disaggregation: sex, age group, autonomous community.

Source: National Health Survey (SNHS) y European Health Survey (EHS)

Frequency: Every 2.5 years (the SNHS and the EHS have a frequency of every 5 years, alternating).

Comments: The following year for the survey is 2023. Publication delay 1 year. The EHS collects data from 15 years of age, while the SNHS collects data from 0 years of age.

C. Expenditure on mental health

C.1 Total annual expenditure on mental health in hospitals in the NHS

Formula/ definition: sum of expenditure on care in acute*, medium and long-stay** and mental health and drug addiction hospitals. *Calculated based on the cost per hospital process in the NHS (RAE-CMBD) for hospitalisation and using UPA cost for outpatient and day hospital activity. **Calculated using the estimated UPA cost for stays, day hospital and psychiatric consultations plus the estimated percentage of emergencies (proportional to the rest of the modalities).

Disaggregation: type of hospital.

Source: Specialised Care Information System (SCIS)/ Specialised Care Activity Register. RAE-CMBD (43)

Frequency: Annual.

Comments: Publication delay approx. 2 years.

C.2 Percentage of hospital expenditure on mental health out of total hospital expenditure in the NHS

Formula/definition: sum of expenditure on acute*, medium, and long-stay** and mental health and drug addiction hospitals. *Calculated based on the cost per hospital process in the NHS (RAE-CMBD) for hospitalisation and using UPA cost for outpatient and day hospital activity. **Calculated using the estimated UPA cost for stays, day hospital, and psychiatric consultations plus the estimated percentage of emergencies (proportional to the rest of the modalities).

Disaggregation: type of hospital.

Source: Specialised Care Information System (SCIS)/ Specialised Care Activity Register. RAE-CMBD (43)

Frequency: Annual.

Comments: Publication delay approx. 2 years.

D. Health Resources

D.1 Total number of psychiatry beds in NHS hospitals

Formula/definition: total number of psychiatric beds in NHS hospitals (counting both acute and medium and long-stay units) in acute hospitals, medium and long-stay hospitals and mental health and drug addiction hospitals. The classification by purpose of the centres C1 Hospitals (inpatient centres) used is that included in annexe II of RD 1277/2003, of 10 October, which establishes the general bases on the authorisation of health centres, services, and establishments: C.1.1. General Hospitals, C.1.2. Specialised Hospitals (these two grouped as "Acute Hospitals"), C.1.3. Medium and Long Stay Hospitals, and C.1.4. Mental Health and Drug Addiction Treatment Hospitals.

Disaggregation: type of hospital

Source: Specialised Care Health Centres Statistics. Hospitals and Non-Inpatient Centres:
https://www.mscbs.gob.es/estadEstudios/estadisticas/estHospiInternado/inforAnual/homeESCRI.htm

Frequency: Annual.

Comments: Publication delay approx. 2 years.

D.2 Rate of psychiatry beds in NHS hospitals per 100,000 inhabitants

Formula/definition: total number of psychiatric beds in NHS hospitals (counting both acute and medium and long-stay units) in acute hospitals, medium and long-stay hospitals, and mental health and drug addiction hospitals. The classification by purpose of the centres C1 Hospitals (inpatient centres) used is that included in annexe II of RD 1277/2003, of 10 October, which establishes the general bases on the authorisation of health centres, services, and establishments: C.1.1. General Hospitals, C.1.2. Specialised Hospitals (these two grouped as "Acute Hospitals"), C.1.3. Medium and Long Stay Hospitals, and C.1.4. Mental Health and Drug Addiction Treatment Hospitals. Denominator: official population figures from the NSI (municipal census data).

Disaggregation: type of hospital.

Source: Statistics on Specialised Care Health Centres. Hospitals and Non-Inpatient Centres:
https://www.mscbs.gob.es/estadEstudios/estadisticas/estHospiInternado/inforAnual/homeESCRI.htm

Frequency: Annual.

Comments: Publication delay approx. 2 years.

D.3 Average length of stay in psychiatry of hospital admissions in acute units

Formula/ definition: Average length of stay in days in acute units by the type of hospital (acute hospitals, medium and long stay hospitals, and mental health and drug addiction hospitals) of the NHS.

Disaggregation: type of hospital.

Source: Specialised Care Health Centres Statistics. Hospitals and Non-Inpatient Centres:
https://www.mscbs.gob.es/estadEstudios/estadisticas/estHospiInternado/inforAnual/homeESCRI.htm

Frequency: Annual.

Comments: Publication delay approx. 2 years.

D.4 Number of mental health centres

Formula/definition: Mental health centres as defined by Royal Decree 1277/2003, of 10 October, which establishes the general bases on the authorisation of health centres, services and establishments as those health centres in which outpatient diagnosis and treatment of mental illnesses are carried out (code C.2.5.11).

Disaggregation: autonomous community

Source: General Register of Healthcare Centres, Establishments and Services–REGCESS (Registro General de Centros, Establecimientos y Servicios Sanitarios) http://regcess.mscbs.es/regcessWeb/inicioBuscarCentrosAction.do

Frequency: Continuous.

Comments: Data is continuously uploaded to the register by the autonomous communities.

D.5 Number of psychiatrists in public health centres of the NHS

Formula/definition: personnel linked to the speciality of psychiatry in public health centres of the NHS (40).

Disaggregation: autonomous community.

Source: Statistics on Specialised Care Health Centres, Hospitals, and Outpatient Centres: https://www.mscbs.gob.es/estadEstudios/estadisticas/estHospiInternado/inforAnual/homeESCRI.htm

Frequency: Annual.

Comments: Publication delay approx. 2 years.

D.6 Ratio of psychiatrists linked to public health centres of the NHS per 100,000 inhabitants

Formula/Definition: Numerator: personnel linked to the speciality of psychiatry in public health centres of the NHS. Denominator: official population figures from the NSI (municipal census data).

Disaggregation: autonomous community.

Source: Statistics on Specialised Care Health Centres, Hospitals, and Outpatient Centres: https://www.mscbs.gob.es/estadEstudios/estadisticas/estHospiInternado/inforAnual/homeESCRI.htm

Frequency: Annual.

Comments: Publication delay approx. 2 years.

D.7 Number of psychologists with a speciality in clinical psychology

Formula/Definition: Cumulative number (absolute value) of psychologists specialising in clinical psychology.

Source: Consultation with the Ministry of Universities and Ministry of Health or State Register of Health Professionals (SRHP)

Frequency: Annual.

Comments: The indicator could be improved pending that the State Register of Health Professionals (SRHP) completes the information on autonomous regions and staff linkage to the different centres.

D.8 Number of nurses with a specialist mental health qualification

Formula/Definition: Cumulative number (absolute value) of professionals with a mental health nursing speciality qualification.

Source: Consultation with the Ministry of Universities and Ministry of Health or State Register of Health Professionals (SRHP)

Frequency: Annual.

Comments: The indicator could be improved pending that the State Register of Health Professionals (SRHP) completes the information on autonomous regions and staff linkage to the different centres.

D.9 Number of social workers in public health centres of the NHS

Formula/definition: social workers linked to public health centres of the NHS (in public centres, with a substitute agreement and Public Utilisation Network, PUN).

Disaggregation: autonomous community.

Source: Statistics on Specialised Care Health Centres, Hospitals, and Outpatient Centres: https://www.mscbs.gob.es/estadEstudios/estadisticas/estHospiInternado/inforAnual/homeESCRI.htm

Frequency: Annual.

Comments: Publication delay approx. 2 years.

E. Indicators concerning suicidal behaviour

E1. Number of suicides

Formula/ definition: number of suicide deaths.

Disaggregation: age group, sex.

Source: Suicide deaths statistics: Statistics on deaths by suicide. Available on the website of the National Statistics Institute (NSI) https://www.ine.es/up/eaP6xsvsi1

Frequency: Annual.

Comments: Publication delay approx. 2 years.

E2. Suicide rate/ 100,000 inhabitants/year

Formula/ definition: numerator: number of deaths by suicide; denominator: official population figures of the NSI (municipal census data).

Disaggregation: age group, sex.

Source: Suicide deaths statistics: Statistics on deaths by suicide. Available on the website of the National Statistics Institute (NSI) https://www.ine.es/up/y9dBdiRq

Frequency: Annual.

Comments: Publication delay approx. 2 years.

E3. Hospital discharge rate due to self-harm/ 100,000 inhabitants/year

Formula/ definition: numerator: number of hospitalisations discharged (number of contacts); denominator: official population figures of the NSI (municipal census data).

Disaggregation: age group, sex.

Source: Specialised Care Information System (SCIS)/ Specialised Care Activity Register. RAE-CMBD.

Frequency: Annual.

Comments: Publication delay approx. 2 years.

Main sources of information

The administrative databases provided by the Ministry of Health will be used to collect information, among others, such as those used in carrying out the situation analysis of this strategy, included in the section on mental health epidemiology, including:

- Hospital Activity Register of the Minimum Basic Data Set of Hospital Discharges, RAE-CMBD, of the Specialised Care Information System (SCIS). Available on the website of the Ministry of Health: https://www.mscbs.gob.es/estadEstudios/estadisticas/cmbdhome.htm
- Health Centres Statistics: Hospitals and Outpatient Centres, from the Specialised Care Information System (SCIS). Available on the website of the Ministry of Health: https://www.mscbs.gob.es/estadEstudios/estadisticas/estHospiInternado/inforAnual/homeESCRI.htm
- Primary Care Clinical Database, PCCD, of the Primary Care Information System (PCIS). Available on the website of the Ministry of Health: https://pestadistico.inteligenciadegestion.mscbs.es/publicoSNS/N/ense/serie-historica/i/salud-mental
- The Spanish National Health Survey (SNHS) and the European Health Survey (EHS). Available on the website of the National Statistics Institute (NSI) and the website of the Ministry of Health: https://pestadistico.inteligenciadegestion.mscbs.es/publicoSNS/S/ensel, https://www.mscbs.gob.es/estadEstudios/estadisticas/EncuestaEuropea/home.htm
- General Register of Health Centres, Establishments and Services. Registro General de Centros, Establecimientos y Servicios Sanitarios (REGCESS)
- Statistics on registered health professionals by sex (NSI)
- Death statistics by cause of death per year. Available on the website of the National Statistics Institute (NSI)

- Other sources that can be identified in the autonomous communities are the Institute for the Elderly and Social Services (IESS) and the National Social Security Institute (NSSI).

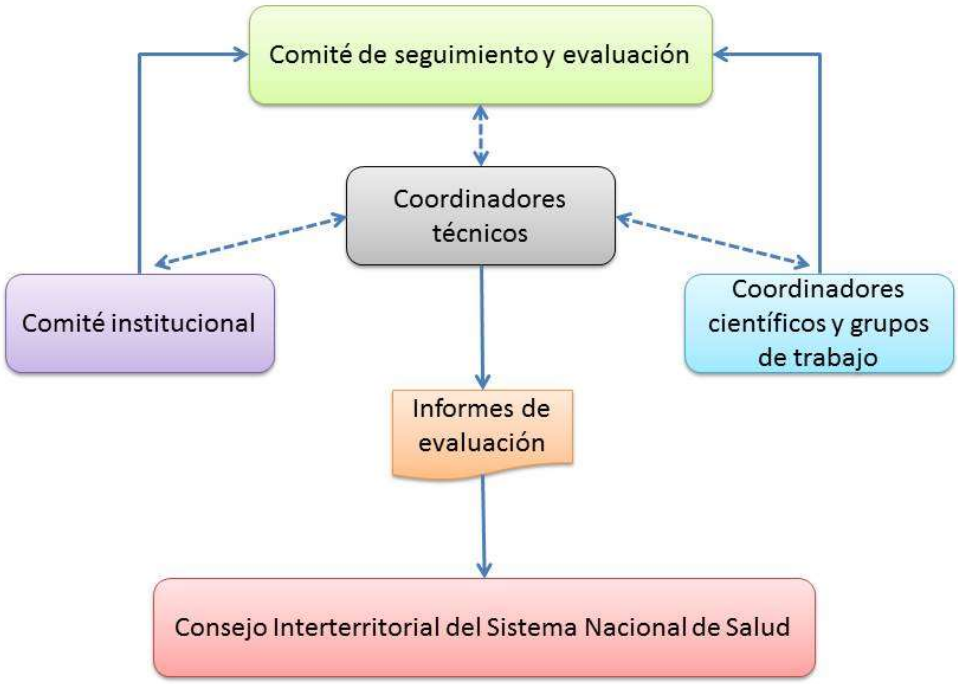
Stages of the monitoring and evaluation process

The following stages are proposed in the evaluation proposal:

1. Constitution of the Monitoring and Evaluation Committee.
2. Elaboration and approval of the qualitative evaluation questionnaire.
3. Definition of the quantitative evaluation indicators based on the available databases.
4. Gathering information for the first partial monitoring and evaluation report.
5. Elaboration of the first partial monitoring and evaluation report.
6. Presentation of the report to the Interterritorial Council of the National Health System.
7. Gathering information for the final evaluation report.
8. Preparation of the first final evaluation report.
9. Presentation of the final evaluation report of the strategy to the Interterritorial Council of the National Health System.

The proposed organisational structure of the monitoring and evaluation process of the Mental Health Strategy

Figure 16. The proposed organisational structure for the monitoring and evaluation process of the Mental Health Strategy



Schedule for the monitoring and evaluation process of the Mental Health Strategy

From the planning point of view, the timetable foreseen for its monitoring and evaluation envisages measuring the results from the third year of the strategy's approval (qualitative questionnaire and data collection of quantitative indicators) so that, on the one hand, there is time for the autonomous communities to develop the objectives included in the strategy and, on the other hand, the evaluation report can be presented during its final year.

2021 Q4: Approval of the Mental Health Strategy of the NHS 2022- 2026.

2022 Q1: Constitution of the Monitoring and Evaluation Committee.

2022 Q1-Q2: Review and approval of the methodology of the evaluation report by the Monitoring and Evaluation Committee.

2022 Q2- Q3: Elaboration of the qualitative evaluation questionnaire.

2022 Q4: Approval of the qualitative evaluation questionnaire by the Monitoring and Evaluation Committee.

2023 Q1- Q3: Definition of the quantitative evaluation indicators and sources of information.

2023 Q4: Approval of the table of evaluation indicators by the Monitoring and Evaluation Committee.

2025 Q1- Q2: Data collection: questionnaire and indicators.

2025 Q3- Q4: Elaboration of the evaluation report.

2026 Q1: Approval of the strategy evaluation report by the Monitoring and Evaluation Committee.

2026 Q2- Q3: Submission of the Mental Health Strategy evaluation report to the Interterritorial Council of the National Health System.

VII. ANNEX REGULATORY FRAMEWORK

i. **Spain**

The Spanish regulatory framework used to protect and guarantee the exercise of the rights of people with mental health problems has been developed in our country through various regulations:

- Spanish Constitution (135).

Article 43 of the 1978 Constitution recognises the right to health protection, and Article 49 regulates care for people with disabilities.

- Law 14/1986 of 25 April 1986 on General Health (1).

Article 18, point 8, mentions promoting and improving mental health, and Article 20 of Chapter III is entirely dedicated to mental health.

- Law 41/2002, of 14 November, is a basic law regulating patient autonomy, rights, and obligations regarding clinical information and documentation (16).

- Law 16/2003, of 28 May, is a law concerning the cohesion and quality of the National Health System (136).

Article 64. "Comprehensive health plans" has been instrumental in the joint drafting of comprehensive health plans by the Ministry of Health and the competent bodies of the autonomous communities, guiding their approach and scope.

- Law 44/2003, of 21 November, is a law on the organisation of health professions (137).

- Royal Decree 1030/2006, of 15 September, outlines a portfolio of common services of the National Health System and the procedure for updating it (138).

- Law 39/2006 of 14 December 2006 concerns the Promotion of Personal Autonomy and Care for Dependent Persons (139).

- Law 26/2011, of 1 August, is a law on adapting regulations to the International Convention on the Rights of Persons with Disabilities (140).

From this point onwards, equal opportunities are understood to mean the absence of any direct or indirect discrimination on the grounds of or based on disability, including any distinction, exclusion, or restriction which has the purpose or effect of impairing or nullifying the recognition, enjoyment, or exercise on an equal basis by persons with disabilities of all human rights and fundamental freedoms in the political, economic, social, cultural, civil, or any other field. Equal opportunities are also understood as the adoption of positive action measures aimed at avoiding or compensating for the disadvantages of a person with disabilities in order to participate fully in political, economic, cultural, and social life.

- Royal Decree 1276/2011, of 16 September, concerns adapting regulations to the International Convention on the Rights of Persons with Disabilities (141).

The general principles are respect for the inherent dignity of the person, individual autonomy (including the freedom to make one's own decisions), independence of every human being, non-discrimination, full and effective participation and inclusion in society, equal opportunities, respect for difference, and acceptance of persons with disabilities as a manifestation of diversity and the human condition.

- Law 33/2011, of 4 October, is a general law on Public Health (142).

- Royal Legislative Decree 1/2013, of 29 November, concerns approving the consolidated text of the General Law of the Rights of Persons with Disabilities and their Social Inclusion (143).

The right to equal opportunities and treatment is guaranteed, on equal terms with other citizens, by promoting personal autonomy, universal accessibility, access to employment, and inclusion in the community and life.

- Law 8/2021, of 2 June, concerns reforming civil and procedural legislation to support persons with disabilities in exercising their legal capacity (83).

This law concerns reforming civil and procedural legislation to support persons with disabilities in exercising their legal capacity. The law was passed in June 2021 and entered into force in September of the same year, 3 months after its adoption. Law 8/2021, of 2 June, is a milestone in the work of adapting our legal system to the New York Convention, as well as in the updating of our domestic law.

Mention should be made here of the Spanish Strategy on Disability 2014-2020, approved by the Council of Ministers on 14 October 2011, established as the long-term reference and guideline for Spanish public policies on disability (144).

The Strategy for Dealing with Chronicity in the National Health System, approved by the Interterritorial Council of the National Health System on 27 June 2012, also includes aspects related to disability and equity in health and equal treatment of all people due to any illness or health problem, developmental disorder, disability, or dependence (145).

The following is a list of the instruments of ratification to which the Spanish State has given its consent at the international level to what has been agreed upon in different treaties:

- Instrument of Ratification of the Convention for the Protection of Human Rights and Fundamental Freedoms, occurring in Rome on 4 November 1950 and amended by additional protocol numbers 3 and 5 on 6 May 1963 and 20 January 1966, respectively (146).

- Instrument of Ratification of the International Covenant on Civil and Political Rights, occurring in New York on 19 December 1966 (147).

- Instrument of Ratification of the International Covenant on Economic, Social, and Cultural Rights, occurring in New York on 19 December 1966 (148).

- Instrument of Ratification of the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatments or Punishments, occurring in New York on 10 December 1984 (149).

- Instrument of Ratification of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment occurring in Strasbourg on 26 November 1987 (150).

- Instrument of Ratification of the Convention on the Rights of the Child, adopted by the General Assembly of the United Nations on 20 November 1989 (151).

- Instrument of Ratification of the Convention for the Protection of Human Rights and Dignity of the Human Being concerning the Application of Biology and Medicine, occurring at Oviedo on 4 April 1997 (Oviedo) (152).

ii. International

At the European level, the systematic protection of the rights of people with psychosocial disabilities took place well into the 20th century, especially at the hands of the Council of Europe, because, although there are other bodies in this geographical area with some work on the subject, it is the Council of Europe that carries out the most extensive and intense work in this field.

Europe

In Europe, the normative framework of reference and the system of guarantees is very broad regarding human rights in general and the protection of these rights in the particular mental health field (153).

- Council of the European Union. Council Resolution of 18 November 1999 on promoting mental health (154).

- Council of the European Union. Council Conclusions of 2 June 2003 on combating stigma and discrimination concerning mental health problems (155).

- Council of the European Union. Resolution of the Council of the European Union of 15 July 2003 on promoting the employment and social inclusion of people with disabilities (156).

In the form of recommendations, several have been adopted in the field of mental health and the protection of people with mental health problems, the most important concerning the approach of this update of the Mental Health Strategy being the following:

- Council of Europe. Recommendation CM/Rec (2004)10 of the Committee of Ministers to member states on the protection of the rights of men and women and the dignity of persons with mental disorders (157)

Recommendation CM/Rec (2004)10 is undoubtedly the main reference in protecting the rights of people with mental health problems at the European level. It enshrines the principles of non-discrimination (art. 3), preservation of the exercise of the civil and political rights of the person with a mental health condition (art. 4), and minimum restriction (art. 8), among other articles.

- Council of Europe. Recommendation CM/Rec (2009)3, on monitoring the protection of the human rights and dignity of persons with mental disorders (158).

Recommendation CM/Rec (2009)3 establishes the need to ensure the non-discrimination of people with mental health problems. However, it admits adopting positive action measures so that people with mental disorders can participate in social life. It invites member states to adopt legal measures to prevent discrimination and to enable social and occupational inclusion. It calls for developing campaigns against stigmatisation and training professionals (especially police and teachers) (Principle 1). In terms of civil and political rights, it postulates the broadest possible guarantee of their exercise with the establishment of control and defence mechanisms and the promotion of the participation of these persons (including access to the civil service if possible), as well as the most scrupulous respect for data confidentiality and privacy (Principle 2).

The recommendation (2009)3 also states that in order to create and implement the National Mental Health Strategy in the member states, the following aspects should be taken into account: promoting understanding and knowledge of mental disorders; making accessible and quality services available, based on the needs of individuals; working to reduce stigma and discrimination against people with mental disorders; and ensuring optimal protection of the human rights and dignity of people with mental disorders.

Furthermore, it provides a checklist as a fundamental principle of the creation and monitoring tools, which help to determine the degree of compliance with Recommendation CM/Rec (2004)10, in order to protect the dignity and human rights of people with mental disorders and to ensure that they receive appropriate assistance.

- European Parliament resolution of 14 February 2017 on promoting gender equality in the field of mental health and clinical research [2016/2096(INI)] (159).

This resolution, among other things, calls on the commission and member states to follow up the EU orientation for action on mental health and well-being with an ambitious new strategy on mental health, promoting a holistic psychosocial whole-of-society approach, including a key gender pillar and ensuring policy coherence on mental health.

- Parliamentary Assembly of the Council of Europe. Resolution 2291 (2019). Ending coercion in mental health: the need for a human rights-based approach (160).

- Parliamentary Assembly of the Council of Europe. Recommendation 2158 (2019). Ending coercion in mental health: the need for a human rights-based approach (161).

European Commission

- Green Paper. Improving the population's mental health: Towards a strategy on mental health for the European Union. Commission of the European Communities, 2005 (79).

- In 2016, all member states endorsed the implementation of the Mental Health Pact for Europe through a Joint Action (*Joint Action "Mental Health and Well Being"*) (162).

In this framework agreement on mental health and well-being, Spain actively participated, especially in one of its areas: transition to community-based treatment.

- In the framework of the third EU-Compass Annual Forum, held in February 2018, the European Commission presented the report on community-based mental health services: “Providing community based mental health services: position paper”. (163)

The report specifies that "the last fifty years have seen one of the most important international social movements of all time: the closure of large institutions and the development of community-based services for people with mental health problems. One of the main drivers has been the shift in society's attitude towards people with mental disorders, away from exclusion and marginalisation towards inclusion and participation".

Following the analysis of the situation through this report, a team of experts made, among others, the following recommendations to member states and stakeholders:

- Develop advocacy strategies to generate political commitment based on evidence that can demonstrate to health policymakers why they should commit to action.
- Promote debate and build consensus on incorporating the principles of the Convention on the Human Rights of Persons with Disabilities into mental health legislation.
- Develop/update mental health policy to move from institutional care to integrated and well-coordinated community-based mental health care, including inpatient treatment in general hospitals.
- Promote the use of the opportunities provided by the EU 2020 Strategy on research and development to improve the monitoring and evaluation of policies addressing the social exclusion of people with mental disorders.
- Integrate mental health into primary care services and expand collaborative care.
- Promote the active involvement of people with lived experience and carers in service delivery, planning, and reorganisation.

- EU High-Level Conference Together for Mental Health and Well-being (12-13 June 2008). European Pact for Mental Health and Well-being held in Brussels (6).

- European Commission Decision of July 2019, “*Horizon 2020 Work Programme 2018-2020, "Health, demographic change and well- being*", whose priorities include addressing mental health (164).

United Nations (UN)

Since its commencement, the United Nations has sought to ensure member states' human rights and internationally agreed development goals through the powers vested in its charter.

- The International Convention on the Rights of Persons with Disabilities and its Optional Protocol were adopted on 13 December 2006 by the United Nations (UN) General Assembly (82).

Both international treaties set out the rights of persons with disabilities and the obligations of states parties to promote, protect, and fulfil these rights.

This convention is the consecration of the change of model in the approach to disability policies. It moves from a welfare-based approach to disability to a human rights-based approach. Disabled people are now fully considered rights-holders not mere objects of treatment and social protection.

Therefore, the general principles established are respect for the inherent dignity of the person, individual autonomy (including the freedom to make one's own decisions), the independence of each human being, non-discrimination, total and effective participation and inclusion in society, equal opportunities, respect for difference, and acceptance of persons with disabilities as a manifestation of diversity and the human condition.

Spain ratified the convention and its optional protocol on 21 April 2008 (165), and it entered into force on 3 May of the same year. From that moment on, and by the provisions of the first paragraph of Article 96 of the Spanish Constitution of 1978, it has formed part of the domestic legal system, with the necessary adaptation and modification of various regulations to give effect to the rights enshrined in the convention.

The Council of Ministers Agreement of 30 March 2010 approved the report on the measures necessary to adapt Spanish legislation to the UN Convention on the Rights of Persons with Disabilities and instructed various ministerial departments within the scope of their competencies to promote the reforms committed to in the agreement.

- Concluding Observations of the Committee on the Rights of Persons with Disabilities in 2011 (166).

This document is a consideration of the reports submitted by states parties under Article 35 of the International Convention on the Rights of Persons with Disabilities, which occurred between 19 and 23 September 2011. It includes assessments of the convention's implementation in the Spanish state, with recommendations for better compliance. It encourages the state to provide funding to enable persons with disabilities to choose where to live, to access community services such as personal assistance, and to include a gender perspective in its public policies.

- General Comment of the Committee on the Rights of Persons with Disabilities 2014 on article 12 of the Convention: equal recognition before the law (167).

States are encouraged to consider and develop best practices that respect the right to equal recognition of the legal capacity of persons with disabilities and support in exercising legal capacity or allocating resources for this purpose.

- Resolution 32/18 on mental health, adopted by the UN Human Rights Council in 2016 (168).

This resolution reaffirms the obligation of states to promote and protect all human rights and fundamental freedoms and to ensure that policies and services related to mental health comply with international human rights standards. It recognises the need for them to take active steps to fully integrate a human rights perspective into mental health and community services, in particular, to eliminate all forms of violence and discrimination in this context and to promote the right of everyone to full inclusion and effective participation in society.

- Human Rights Council resolution on mental health and human rights of 2017 (169).

States are encouraged to promote the effective, full and meaningful participation of persons with mental health conditions or psychosocial disabilities. The resolution stresses the importance of investing more in promoting mental health through a multisectoral approach

based on respect for human rights that addresses the underlying social, economic, and environmental determinants of mental health.

- UN Committee on the Rights of the Child. Concluding observations on Spain's combined fifth and sixth periodic reports, 5 March 2018 (170).

The Committee's recommendations include formulating a national policy on children's mental health and ensuring the availability of qualified personnel throughout the state.

- Concluding observations of the Committee on the Rights of Persons with Disabilities 2019 on Spain's combined second and third periodic reports (171).

Different Special Rapporteurs have submitted reports to the Human Rights Council and set out observations related to persons with mental health problems:

- Report of the Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment, February 2013. It recommends preserving free and informed consent on an equal basis for all and without exception, through the legal framework and judicial and administrative mechanisms, for example, with policies and practices to protect against ill-treatment. Legal provisions that contravene the above should be reviewed, such as those that allow for mandatory seclusion or treatment in mental health settings, including through guardianships and other methods of surrogate decision-making. Policies and protocols should be adopted that respect autonomy, self-determination, and human dignity (172).

- Report of the Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health, April 2015. The report highlights that in some regions, resources for care are used to maintain psychiatric hospitals; it calls for investment in the mental health of children and young people and expresses concern about the high number of suicides, among other issues (173).

- Report of the Special Rapporteur on the rights of persons with disabilities, March 2017, recommends that states abandon welfarist and medical approaches and rethink their policy and practice of care from a human rights perspective (174).

- Report of the Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health, June 2017. It provides an overview of the mental health situation and identifies some barriers, such as the dominance of the biomedical model and power imbalances in the clinical setting. It recommends a change of model, including the need to resource mental health, the psychosocial model, peer support and eradicating all forced psychiatric treatment and isolation, among other recommendations (175).

- Report of the Special Rapporteur on the rights of persons with disabilities 2019 presents a thematic study on disability-specific forms of deprivation of liberty, considering the standards set out in the Convention on the Rights of Persons with Disabilities (176).

World Health Organization (WHO). Regional Office for Europe

Health is a universal right recognised in the World Health Organization´s (WHO) Constitution, which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.

In 2010, in collaboration with the European Commission's Directorate-General for Health and Consumer Protection, the WHO issued the statement "Empowering the user in mental health" (21). This statement defines measures to be taken to empower people with mental health problems and their carers. In addition to the individual level, these measures also refer to the social and structural level, the provision and development of services, education, and training professional teams.

The Spanish Ministry of Health participated in elaborating the World Health Organisation's comprehensive Mental Health Action Plan 2013-2020, approved at the 66th Assembly in May 2013 (87).

In Europe, the WHO Regional Committee approved the European Mental Health Action Plan 2013-2020 (177) at its 63rd Assembly in September 2013. This document highlights mental disorders as one of the major challenges for public health care in the European Region of the World Health Organisation. The WHO European region faces numerous challenges affecting the population's mental well-being and providing care for people with mental health problems. Systematic and coherent actions are needed to address these challenges. The European Mental Health Action Plan focuses on seven interrelated objectives and proposes effective and integrated actions to strengthen mental health and well-being in the European region. Mental health research is essential for the sustainability of health and social policies in the European region.

The seven objectives set out in the European Mental Health Action Plan 2013- 2020 are as follows:

1. All people have an equal opportunity to achieve mental well-being throughout their lives, particularly those most vulnerable or at risk.
2. People with mental health problems are citizens whose human rights are fully valued, respected, and promoted.
3. Mental health services are accessible, competent, affordable, and available in the community as needed.
4. Individuals have the right to respectful, safe, and effective treatment.
5. Health systems provide good physical and mental health for all people.
6. Mental health systems work together, well-coordinated with other sectors.
7. Sound information and knowledge guide mental health leadership and delivery.

In 2019, the 72nd World Health Assembly confirmed the goals of the WHO's comprehensive plan of action on mental health (2013-2020). It extended its implementation period to 2030, ensuring alignment with the 2030 Agenda for Sustainable Development (178).

VIII. ABBREVIATIONS AND ACRONYMS

AEMPS	Spanish Agency for Medicines and Health Products Agencia Española de Medicamentos y Productos Sanitarios
ACs	Autonomous Communities
ICD	International Classification of Diseases
ICNHS	Interterritorial Council of the National Health System
CMBD	Minimum Basic Data Set at hospital discharge Conjunto Mínimo Básico de Datos al alta hospitalaria
MHC	Mental Health Centre
EIR	Nurse Resident Intern. A specialist mental health nurse. Enfermera/o Interno Residente
SNHS	Spanish National Health Survey
MHS	Mental Health Strategy
FEAFES	Confederación Española de Agrupaciones de Familiares y Personas con Enfermedad Mental
GPC	Clinical Practice Guideline Guía de práctica clínica
IESS	Institute for the Elderly and Social Services
NSI	National Statistics Institute
INGESA	National Institute of Health Management Instituto Nacional de Gestión Sanitaria
ISCIII	Carlos III Health Institute Instituto de Salud Carlos III
MIR	Resident Medical Intern. A medical specialist in psychiatry Médica/o Interno Residente
WHO	World Health Organisation
ICP	Individualised Care Plans
PIR	Psychologist Resident Intern. A psychologist specialising in clinical psychology Psicóloga/o Interno Residente
NHS	National Health System
EU	European Union

IX. INDEX OF FIGURES AND TABLES

- **Index of figures**

- **Index of tables**

X. BIBLIOGRAPHY

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