Mental Health Strategy of the Spanish National Health System

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GOBIERNO DE ESPAÑA

MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

Plan de **Calidad** para el Sistema Nacional de Salud

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Index

Presentation

Improving the care provided in the mental health field in Spain is one of the strategy objectives of the Ministry of Health, Social Policy and Equality. Thus, the project of preparing the Mental Health Strategy for the entire National Health System as a whole was undertaken toward the end of 2004.

For this purpose, the professional associations and civil association directly interested in Mental Health and the Autonomous Communities were called upon by the National Health System Quality Agency to take part for this purpose. The result of the concerted endeavor of all thereof was the Mental Health Strategy of the Spanish National Health System, of which approval was rendered by a unanimous vote in favor thereof by the National Health System Inter-territorial Council on December 11, 2006, it being set forth that an initial evaluation be conducted two years immediately subsequent to the approval thereof.

The evaluation thereof now having been conducted, the New Strategy for the 2009-2013 period is presented herein. This document includes a summarized version of the results of the evaluation, which, in conjunction with the information on technical and scientific findings published over the past few years, have made it possible to revise the initial proposal of this Strategy, to amend or eliminate some objectives and to add yet others.

This Strategy, as a dynamic process of an undefined time frame has become a reference point of authority and scientific prestige in both national and international discussion forums concerning mental health-related matters. The work done must also be valued due to the consolidation of a team, the Monitoring and Evaluation Committee, which has shown itself to be coherent and motivated for supervising and fostering the development of this Strategy, making this Committee into a working team capable of spearheading the modernization of the mental health system in our country.

I would like to express my sincerest appreciation to all those who have contributed to making this Strategy a reality, for all their efforts and valuable contribution to the continuing improvement of the care with which our citizens are provided in the field of mental health.

Leire Pajín Iraola
Minister of Health, Social Policy and Equality

Introduction

The Mental Health Strategy was approved by the National Health System Inter-territorial Council(CISNS) in December 2006. The Monitoring and Evaluation Committee (CSE) has worked on the implementation and improvement thereof. This Committee brings together the Institutional Committee (IC) and the Technical Committee (TC) which were those who took part in preparing the Strategy in 2006.

The scientific coordinator for this strategy is Dr Manuel Gómez Beneyto.

The functions of these Committees are as follows:

- **Institutional Committee:** Assess the fittingness and feasibility of the objectives put forth in the Strategy. This Committee is comprised of representatives from all of the Autonomous Communities and INGESA (Ceuta and Melilla), the Directorate General of Prison Institutions and, on the part of the Ministry of Health and Social Policy, the Quality Agency, Directorate General of Cohesion, Institute for the Elderly and Social Services (IMSERSO) and the Central Government Delegation for the National Plan on Drugs.
- **Technical Committee:** In charge of preparing the draft objectives and the resulting recommendations for taking action to achieve the same whilst also having made improvements and/or changes based on the most recent scientific evidence. This Committee is comprised of representatives from scientific societies, patients' and family members' associations and independent experts appointed by the Ministry of Health and Social Policy.

The National Health System Quality Agency has been in charge of furnishing, through the Health Planning and Quality Office with the collaboration of the Health Information Institute, the necessary technical, logistic and administrative support in order for the duties of the Monitoring and Evaluation Committee to be performed and carried out properly.

Evaluation Report

The Monitoring and Evaluation Committee prepared a questionnaire for the purpose of collecting the data to make it possible to evaluate the degree, to which the objectives for which there was no quantitative indicator are being met on the part of the Autonomous Communities.

The information necessary for evaluating the Strategy objectives was furnished mainly by the Autonomous Communities and by the Ministry of Health and Social Policy.

Based on the information provided by the Autonomous Communities, work was then begun on preparing the evaluation report, which, in conjunction with the data collected by all of the other sources of information, was presented and debated by the CSE members in March 2009. Changes, deletions or incorporations of new objectives and recommendations were suggested in addition to two Annexes (ANNEXES I and II) having been added, specifying the quality criteria both in Promotion and Prevention and in Psychotherapy. The CISNS approved the Strategy Evaluation Report in October 2009. It must be recognized that the short length of time to which the data collected refer for the evaluation of the 10 general objectives and the 45 specific objectives make it impossible for information differing greatly from that presented in the initial strategy from being presented on the evolution of the mental health of the population, this information however will serve as a basis of comparison for the following evaluations of this Strategy.

Updating of the 2009-2013 Mental Health Strategy

This document includes:

1. **New scientific evidence which has become available since the approval of the Strategy:** epidemiological, scientific and technical studies related to the mental health of Spain's population published within the 2007-2009 time period. This knowledge resulting from models and examples which have been put into practice has been included in this revision, even though they were not to have been published, provided that they were pertinent for the revision of any of the objectives of the Strategy and that they had been in use long enough to prove their usefulness.

2. **Analysis of the results of the evaluation:** A brief extract is included in the situation analysis of each line of strategy concerning the results of the evaluation so as to thus show the overall status of the implementation of the objectives. The evaluation summary was published in both Castilian Spanish and English:
   http://www.msc.es/organizacion/sns/planCalidadSNS/pdf/excelencia/Resumen_Evaluacion.pdf
   http://www.msc.es/organizacion/sns/planCalidadSNS/pdf/excelencia/Resumen_Evaluacion_eng.pdf

3. **Examples of good practices:** Examples have been compiled of good practices developed within the Spanish context which have shown

themselves to be efficacious and effective, these good practices being available at:
http://www.mspsi.es/organizacion/sns/planCalidadSNS/pdf/Buenas_practicas_2009_2013.pdf.

4. **Redefining and suggesting new objectives and recommendations:** Regarding which a consensus was reached by the CSE in March 2009 and approval of which was rendered by the plenary meeting of the CISNS in October 2009.

5. **Indicators:** The indicators currently approved and pending review by the CSE evaluating group have been included.

1. Situation analysis

1.1. Principles and values

Included hereunder are the main principles and values of the community model of mental health care set out in the first edition of this strategy and on which the Strategy is based, supported by the General Health Law (1986) and by the Ministerial Commission for Psychiatric Reform (1985)[1-9].

Autonomy

Ability of the service to respect and promote the independence and self-sufficiency of individuals.

Continuity

Ability of the care-providing network to provide treatment, rehabilitation, care and support on an uninterrupted basis on a lifelong basis (longitudinal continuity) and coherently, among the services of which they are comprised (transversal continuity).

Accessibility
Ability of a service to provide care to the patients and the family members thereof when and where they need it.

Comprehensiveness

Implementation of all the basic facilities of a service in each health district. Recognition and realization of the right to receive care within the full range of needs caused by the mental disorder in question.

Equity

Distribution of the health and social resources of adequate quality and proportional in quantity to the needs of the population in accordance with explicit, rational criteria.

Personal recovery

Includes the recovery of health in the strict sense and of the consciousness of citizenship despite the disability caused by the disorder in question.

Accountability

Recognition on the part of the health institutions of their responsibility to patients, family members and the community.

Quality

Characteristic of the services which is aimed at continuously heightening the probability of achieving the desired outcomes by using tested procedures.

1.2.   Epidemiology

The section includes the new epidemiological information which has come out since the Strategy was published in 2006 and is rounded out with the results of the evaluations commented upon in the situation analysis of the lines of strategy.

Prevalence

In Spain, a number of studies have been conducted for the purpose of evaluating the prevalence of mental disorders, one of the most outstanding of which is Spain's participation in the ESEMeD (European Study on the Epidemiology of Mental Disorders), a study of a diagnostic nature in which it is estimated that 19.5% of the people in Spain have had some mental disorder at some time in their lives (prevalence-life), 15.7% of the males and 22.9% of the females. In relation to the prevalence within the 12 months immediately prior to the study having been conducted (prevalence-year), a total of 8.4% of the population showed some mental disorder, 5.2% in males and 11.4% in females[10].
  The prevalence of poor mental health in Spain resulting from the analysis of the National Health Survey for 2006 was of 21.5% among those surveyed, being higher among the females (27%) than among the males (15.7%), increasing with age, mainly among the individuals above 65 years of age, both in male (20.5%) and in females (36,0%)[11]. This study

finds significant differences among Autonomous Communities with regard to the prevalence of poor mental health, which could be related to characteristics such as the socioeconomic level, the educational level, the immigration and unemployment rates and also to the unequal degree to which the psychiatric reform has been further expanded upon in the different Autonomous Communities. No significant differences have been found in the prevalence of poor mental health depending on whether living in urban or rural areas[11]. One must bear in mind in this regard that the population is expected to be aging over the upcoming years, the highest population increase would be taking place in those over 64 years of age, with a growth of 1.29 million individuals (16.9%) within the next ten years (2009-2019)[12]. In reference to this age range, it is estimated that the prevalence of illness will reach 10-12% of the cases, being even greater among the patients institutionalized in residence facilities and those hospitalized[13].

The prevalence of poor mental health is greater among females of more highly disadvantaged social classes and among males and females who have lower educational levels. A total of 32% of the females who have an elementary school education have poor mental health. With regard to marital status, widowed, legally separated and divorced persons are found to have worse mental health. The fact of being a female and an immigrant from developing countries is related to a higher prevalence of poor mental health (29.5%). However, the immigrants from developed countries or from the European Union have better mental health that those persons native to Spain.

In relation to the working conditions, those individuals who are on leave from work are found to show a higher prevalence of poor mental health, following by those individuals who are unemployed (37.6% among the retired females or pensioners). It has been suggested that, in a situation of a long-term economic depression, it is probable to find higher rates of alcoholism and drug addiction, depression, suicide and other mental health problems, both in industrialized countries as well as in the less developed countries the social class likewise has a major influence on the risk of having mental disorders[14]. The unemployment rate in Spain showed a growing trend as of the first quarter of 2007 up to the first quarter of 2010, totaling 20.05% of the working-age population.

A high prevalence of poor mental health is also noted among those individuals who are limited with regard to performing their everyday activities. In addition thereto, the causes of these limitations are due to mental health and/or physical problems, which heightens the negative impact in terms of disability of the mental health problems in the day-to-day lives of these individuals[15,16]. It is important to take into account the high degree of

comorbidity between physical health problems and mental disorders, which orients the need of carrying out interventions targeting both the physical and mental health of individuals[17].

Lastly, worth of special mention is the fact that there are no significant differences in the prevalence of poor mental health among those individuals who live in urban areas and those who live in rural areas. These results differ from prior studies in which a greater prevalence of poor mental health was found in urban areas[18].

Estimate of overall burden and costs associated with the treatment of mental disorders

Within these last two years, numerous studies have been published on healthcare spending generates by the care provided for mental disorders. Approximately 14% of the overall burden of illnesses worldwide may be attributed to neuropsychiatric disorders, most of which are due to illnesses of a chronic nature, such as, for example, depression[15]. Among non-fatal illnesses, depression is the greatest cause of years lived with a disability[16].

In the twelve-month European prospective study in which Granada took part, an analysis is made of the direct costs generated by way of the care provided for individuals diagnosed with schizophrenia. The costs of medication were relatively uniform from one country to another, but the costs of non-pharmacological care showed quite remarkable differences, ranging from 2,958€ in Granada up to 36,978€ Switzerland. The costs were associated more with the locations than with the characteristics of the disorder in question[20].

A population-based prospective study conducted in Catalonia on 4,572 individuals diagnosed with depression for the purpose of comparing the expenses generated by the patients who went into remission as compared to those who failed to do so, revealed that the health care costs totaled 1,874€, of which 1,100€ was for primary care and 774€ for specialized care, the loss of productivity having been calculated at 3,890€ and the total health care and non-health care costs having amounted to 5,764€[21].

1.3.   Regulatory framework

As of the publication of the Strategy, some regulatory changes have taken place within the European, national and AC realms. These changes mainly have a bearing on the issues of addictions, dependence and non-discrim-

inatory access to jobs on the part of persons who have mental health problems. Special mention must be made of the importance of Law 39/2006 of December 14th on the *"Promotion of Personal Autonomy and Care for Persons in a Situation of Dependence"*, which was enacted with the aim of serving as the fourth pillar of the Welfare State and which provides a response to some of the objectives set forth under the Strategy. The CA have also drafted regulations concerning aspects of governing mental health services, true equality, prevention of gender violence, rights and obligations of those making use of mental health services, subsidies, etc. The compiled substance of the regulations published since 2006 regarding mental health can be accessed at:

http://www.mspsi.es/organizacion/sns/planCalidadSNS/pdf/Normativa.pdf

1.4. International framework

The Ministry of Health and Social Policy maintains a close cooperating relationship with international organizations which deal with mental health in programs and projects related to the objectives of this Strategy.

The World Health Organization (WHO)

The Helsinki Declaration[22] and the Plan for Action, agreed by all of the Ministers of Health of the European Region of the WHO in 2005 involves a project of systematically evaluating the implementation thereof in the signing countries. The WHO is spearheading this monitoring process and therefore set up a panel of experts, in which MSPS is taking active part, for the purpose of developing a tool, by way of a set of strategic indicators, which will afford the possibility of following the progress of this Plan.

The WHO proposed the preparation of a self-evaluation tool which could be used by each one of the countries, thus making it possible for a domestic record to be kept. This thus eliminates the differences in language, concepts and methods which hinder comparisons being drawn, just as was revealed in the WHO report on "European Policies and Practices in Mental Health"[23]. The European Foundation for Quality Management (EFQM) was selected as the model for developing this tool, due to the ability thereof of identifying areas for improvement, flexibility and adaptability to the specific conditions of each country. The working group is adapting this model to the mental health services from the standpoint of the Helsinki Plan for Action and is expected to fully complete its work in 2010.

The Council of Europe

The Council of Europe (COE) has as its mission the defense of human rights, pluralist democracy and the rule of law, as well as that of promoting awareness and encouraging the development of Europe's cultural identity among all of the citizens of this continent.

Three agreements signed by Spain are of particular interest for mental health:

- European Convention on Human Rights 1950[24].
- European Convention for the Prevention of Torture[25], by virtue of which the European Committee for the Prevention of Torture (CPT) was formed and conducts random inspections regarding the treatment given to individuals in a situation of deprivation of their freedom, which includes individuals confined for mental health-related reasons, and recommending measures which must be adopted with a view to bolstering their protection.
- Convention on Human Rights and Biomedicine (Oviedo Convention)[26].

Rights of persons who have mental health disorders.
A reference tool

The Council of Europe Committee of Ministers rendered approval in 2004 of Recommendation 2004 REC (2004)[27] regarding the safeguarding of the dignity and human rights of the persons who have mental disorders.

By order of the European Health Committee, a Panel of Mental Health Experts was formed in October 2006 with the mission of creating an instrument which would be supplementary to the documents generated by the WHO (Helsinki documents) and the European Commission (Green Paper, subsequently European Pact) and must have as the object thereof that of keeping watch over the rights of those persons who have mental health disorders. MSPS undertook the COE's the endeavor commended thereto of compiling and checking the coherence of all of the recommendations and provisions given out by different COE bodies and by other international agencies[28]. This tool checks to ensure the degree to which compliance is rendered with Regulation REC (2004)[27] and was adopted, by consensus of the ministerial representatives, in May 2009 (this instrument has been translated into Castilian Spanish[29]). In 2009, the Council of Europe conducted a survey for the purpose of evaluating the repercussion of this instrument, the findings of which have not yet been published.

Organization for Economic Co-operation and Development (OECD)

The HCQI Project

The HCQI (Health Care Quality Indicators) Project is a project for developing quality indicators in health care. In 2007, the Health Committee of the Directorate for Employment, Labor and Social Security of the OECD published the report "Health at a Glance 2007" (Health Panorama 2007 OECD Report) with indicators on structure, costs, childhood mortality, avoidable death and quality. For preparing the 2009 report, the decision was made to develop new indicators regarding aspects not included in the previous report, such as mental health, security, promotion, prevention, primary care and patient experience. For this purpose, the Panel of Mental Health Experts was formed, being comprised of several countries (Australia, Canada, Czech Republic, Denmark, Finland, France, Germany, Holland, Hungary, Iceland, Italy, New Zealand, Norway, Poland, Portugal, Slovakia, South Korea, Spain, Sweden, Turkey, the United Kingdom and the United States). After having prepared an ample repository of indicators, having conducted a survey of the member states, assessing the difficulties involved in obtaining mental health indicators due to the non-existence thereof or to variability of the sources of data, and carrying out a pilot test, the number of indicators which would afford the possibility of drawing comparisons have been limited to two in number:

1) Unplanned readmission rate (within the 30 days immediately following release) in patients diagnosed with a schizophrenic disorder

2) Unplanned readmission rate (within the 30 days immediately following release) in patients with bipolar disorder

The data collected in the pilot experience was found to be debatable. The highest readmission rate was that of the Scandinavian countries, Spain having been the country with a lower readmission rate (on completing the "Health at a Glance 2009" study, the United Kingdom and Slovakia, not included in the pilot study, turned out to have even lower rates). In this group, different explanations were evaluated: that the countries with lower rates did not take in all of the readmissions, that on there being no one single identifier, they collected the data attributing it to different patients, that the countries with a large number of readmissions were artificially dividing the admissions for reasons of spending, etc.

Health at a Glance 2009: An interpretation from Spain[30,31]

The final text has two aspects which are particularly relevant for mental health in general and for mental health care in Spain in particular. One is

the fact of using quality indicators in the care provided in mental health. The other has to do with human resources in which an analysis is made of the ratio of the number of psychiatrists per 100,000 inhabitants in 27 countries, the average for the OECD being 15 psychiatrists, Spain being ranked 24th with 8 psychiatrists / 100,000 inhabitants. As is indicated at a further point in the results of the evaluation, these ratios must be analyzed taking into account other factors, and the OECD proper makes special mention of Spain's vast primary care network.

European Commission: The European Pact for Mental Health and Well-Being

As a result of the Helsinki Declaration and Plan for Action[22], the European Commission was of the opinion that the European Union Member States ought to undertake joint lines of work and action which would afford the possibility of developing the Helsinki contents and of synchronizing actions and strategies. All of this was set out in the "Green Paper on Mental Health in Europe" project. Improving the mental health of the population – Towards a strategy for mental health in the European Union"[32].

The European Pact for Mental Health and Well-Being was the proposal for continuing the Green Paper. It was on the basis of the document for the preparation thereof that the Pact was drafted which the European Commissioner for Health, in conjunction with the European Commissioner for Employment, Social Affairs and Equal Opportunities launched as an intersectorial declaration regarding the mental health actions in Europe at the High-Level Conference "Together for Mental Health and Well-Being".

This Pact has to do with five top-priority areas based on five consensus documents, which are:
- Mental health among young people and in education
- Prevention of suicide and depression
- Mental health in the working environment
- Mental health of the elderly
- Combating stigma and social exclusion

The objectives of this Pact are to support and inform the Member States and other interested stakeholders and to promote the best practices, to foster actions being carried out to deal with the main challenges involving mental health and to lessen social inequalities.

On January 18, 2009, the European Parliament passed resolution 2008/2009 (Report A6-0034/2009) in which the postulates and proposals of the Pact were undertaken, as well as a number of calls to carry out actions regarding mental health at both the national as well as the European level

(http://www.ec-mental-health-process.net/implemen0tation.html#01). This Pact is currently in the stage of being implemented, one of the aspects of most outstanding important of which is that of the holding of five theme-based conferences on each one of the top-priority areas:

1. Promotion of Mental Health and Well-Being of Children and Young People. September 29-30, 2009, Stockholm, during the Swedish Presidency of the EU[33-35].

2. Prevention of Suicide and Depression. December 10-11, 2009, in Budapest, organized by the Hungarian Ministry of Health[36, 37].

3. The Mental Health of the Elderly, Madrid, June 28-29, during Spain's Presidency of the EU.

4. Combating Stigma and Improving Social Inclusion, Lisbon, November 15-16, 2010, organized by Portugal's Ministry of Health.

5. Mental Health at the Workplace, Berlin, March 2011, organized by Germany's Ministry of Labor and Social Affairs and Ministry of Health.

EU-Compass[38]

To facilitate and encourage the sharing and assimilation of good practices in all of the Member States, the Commission has designed the "EU-Compass", an online resource which is aimed at being an open, dynamic working tool which will provide an array of documents, declarations, good practices and policies for improving and promoting mental health and well-being.

2. Strategy line execution

Strategy line or line of strategy 1. Promotion of the mental health of the population, prevention of mental illness and eradication of the stigma associated with persons who have mental disorders

Situation analysis of mental health promotion

Positive Mental Health in Spain's population

The positive dimension of mental health refers to the concept of well-being and to the abilities of adapting to adversity, encompassing self-esteem, self-control, optimism and the sense of coherence. Mental health is the basis for the well-being and emotional functioning of an individual and a community, being much more than the absence of illness, given that it has a value in itself (WHO, 2001). The degree of mental health is related to the ability to deal with and overcome the adversities in life without losing one's mental balance. This ability depends on personal factors and on the sociocultural and economic context.

For evaluating the mental health of the population within the context of the Strategy, two variables were selected from Spain's National Health Survey for 2006 (ENSE 2006) which are highly correlated with the ability to cope with stress and therefore with one's positive mental health, "the perceived social support" (which is measured by means of the Duke-UNC questionnaire) and "the family function" (which is measured with APGAR). Both of these tools have been adapted and validated in Spain's population[39, 40].

Fig. 1. Percentage of individuals who consider themselves to have a low degree of social support
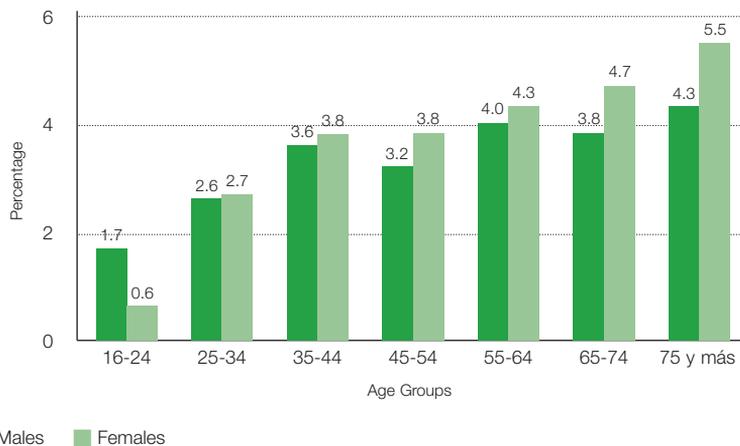
Source. 2006 National Health Survey. Ministry of Health and Social Policy

The term "social and family support" is understood as being the result of the interaction among individuals in terms of the degree of help perceived in the emotional, informative, functional and material aspects. Generally speaking, the perception of a low degree of social support advances with age.

The older the age, the greater the differential between males and females, the females being those who, in all of the groups, with the exception of the young people within the 16-24 age range – perceive a lesser degree of social support. So state 4.3% of the males and 5.5% of the females aged 75 and older, these being the highest figures.

As far as family functioning is concerned, the APGAR questionnaire measures the components of family functionality with regard adaptability, cooperation, development, affectivity and problem-solving ability. The results show quite positive scores, a total of 93.4% of Spain's population stating having what they consider to be a normally-functioning family, there being very little difference between males and females or from one Autonomous Community to another.

Health promotion programs

Practically all of the AC have incorporated promotion programs into their mental health plans. More than thirty-four thousand interventions have been carried out in elderly persons, adolescents and ethnic minorities, some of which have been direct and others through the media. Only a very few of these programs and interventions have been evaluated, although it is true that a two-year peri-

od is a relatively short length of time for evaluating the results of this type of actions. The situation in Spain is comparable to that of other European countries. Mental health promotion has still not as yet become widespread throughout the country[41], perhaps due to effective intervention techniques based on scientific evidence having only recently been published. Nevertheless, special mention must be made of the number of interventions reported and the wide degree of variability from one Autonomous Community to another.

Recently, interest is being focused on "literacy campaigns" in mental health, there now being different evidence of the effectiveness thereof[42]. "Literacy" is considered as psychoeducational and informative campaigns for the general population concerning mental illness, prevention, resources, etc. The media are privileged tools for this type of interventions.

Little over half of the ACs have included interventions in their mental health plan specifically aimed at counseling and informing those in charge of institutions as to the relationship which exists between the measures of an institutional nature and mental health. It is not surprising to find that very few interventions are evaluated due to how new the objective is and the difficulty involved in the implementation thereof. This is a matter of heightening the awareness of politicians and high-ranking civil servants regarding the need of taking into account the implications on the mental health of the population which all types of policies may have, including those which do not have any apparently health-related objective. A survey taken in countries within the WHO European Region revealed that, as a result of this type of interventions, a total of 41% of the countries included mental health in the systems for evaluating the impact public policies have on health[43].

The vast majority of the ACs state having included community interventions in their plan in "areas at a high risk of social exclusion or marginalization," having totaled as many as 400 interventions initiated, a total of 54% of which were evaluated. There are effective programs in place for reducing violence and substance abuse in high-risk communities[44]. These programs are complex, requiring the collaboration of the local authorities to be carried out, and their success entailing getting part of the community residents actively involved in carry out the programs.

Mental Health and Environment

The interest in the effects of human action on the environment and the repercussion thereof on health is long-standing, but it only recently having been possible to furnish reliable data and set out solid hypotheses which may serve as a rational basis for justifying public health interventions in this field. The interest of the researchers has revolved mainly around identifying the environmental factors subject to being modified by means of standards or measures in the field of public health.

The existence of adequate infrastructures, the distribution of services, the extension and location of "spaces for getting away", the noise and urban pollution level, the population density and many other factors stemming from the growth of cities may have a negative or positive effect on the well-being of the population, on health in general and on mental health in particular[45-47]. Added to these physical environmental effects are certain lifestyles and ways of social relations which are conditioned, in part, by the way in which cities are physically structured per se[48]. Of special interest is the influence which some of these factors have on raising children and on the school-age learning proces[49].

The operativity of the concepts involved in explaining the relationship between the surrounding environment and health is a topic of recent interest. All procedures, methods and tools as a whole for evaluating a certain policy, program or project in relation to the potential effect thereof on health is known as an HIA – Health Impact Assessment)[50]. The European Observatory on Health Systems and Policies has recently published an evaluation of the effectiveness of the HIA[51].

We currently avail of a tool, although in the experimental stage, for evaluating the impact which policies, programs, services or projects of any type might have on the mental well-being of the population[52]. This is a protocol which the interested parties such as non-governmental organizations for the defense of the environment, construction firms and developers, those potentially affected and the government administration proper may apply to the documentation of the project or program during the application stage prior to the approval thereof for the purpose of aiding toward making the decision on an objective, rational basis. One paradigmatic example is that of the application of this tool for evaluating all of the activities as a whole organized by the municipal government of Liverpool for the purpose of this city being declared the 2008 Cultural Capital of Europe[53].

Objectives

General Objective 1: **Promote the mental health of the general population and of specific groups**

Specific objectives

1.1. Set out, carry out and evaluate a set of intervention for promoting mental health in each one of the age groups or stages of life: childhood, adolescence, adult age and the elderly, distinguishing differential needs of males and females in each stage.

1.2. Set out, carry out and evaluate a set of interventions aimed at counseling and informing those responsible for the institutions of the Central Government, AC and Municipal Administrations regarding the relationship which exists between the measures of an institutional nature which are taken and mental health.

1.3. Develop, between MSPS and ACs, a set of interventions aimed at promoting mental health by way of the mass media.

1.4. The CAs will develop promotion and prevention interventions according to the minimum quality criteria set out in the quality criteria table in Annex I.

1.5. Make an evaluation of the impact on health, preserving and promoting the mental well-being of the population in the processing of standards, the drafting of plans and the evaluation of projects subject to the environmental impact assessment.

1.6. Generate a critical health-related social current which will promote and disseminate new models of healthy relations of equality between females and males, with effective communications strategies and sufficient economic support for accomplishing this objective.

1.7. Heighten the awareness of the healthcare and mental health professionals, leading sectors of the community and the mass media regarding the need of incorporating the gender perspective into all their actions and to furnish them with training as to how to carry this out as a means of making the change of gender models determining mental health possible in the target populations and the community as a whole.

Recommendations:

1. The mental health promotion interventions are to target specific population groups and are to comprise part of the strategies for taking action in primary care, specialized care and public health. These measures are to be integrated into a specific plan or are to be integrated into the health plans and in the mental health plans of the ACs.
2. Interventions of proven effectiveness aimed at improving resilience are recommended, including those such as coping with stress, seeking social support, learning problem-solving techniques, raising self-esteem and developing social skills.
3. The interventions targeting institutional representatives are to highlight the central role of mental health as a force generating well-being and productivity and the importance of the interaction with the habitat (urban ecology), education (human capital), the possibilities of citizen participation (social capital), equality in gender relations and the determining psychosocial gender factors with

the mental health of the population, as well as the negative socioeconomic consequences stemming from ignoring the same.

4. The Ministry of Health and Social Policy and the AC are to develop interventions targeting the mass media for the purpose of getting them involved in promoting mental health.

Situation analysis of the prevention of mental illness, suicide and addictions

Percentage of persons at risk of poor mental health

The mental health of the **adult population** (age 16 or older) has been evaluated in the 2006 National Health Survey with the *12-item General Health Questionnaire* (GHQ-12), setting the cutoff point at 4/12. This questionnaire makes it possible to do a population screening, detecting the prevalence of probable cases of psychiatric morbidity or of psychological distress, exploring the condition of the person surveyed within the last month as compared to their normal condition. This is not appropriate for making clinical diagnoses or for assessing chronic disorders. The results show females as being at greater risk of poor mental health (19.9%) than males (11%), this item of data being similar for all of the ACs.

The mental health of the **childhood population** was evaluated in the 2006 National Health Survey with the Strengths and Difficulties Questionnaire (SDQ). This instrument detects probable cases of mental and behavioral disorders in the population within the 4-15 age range. A total of 11.96% of the childhood population shows indexes considered as being at risk of poor mental health (12.9% in male children and 10.9% in females children).

Both of these instruments (GHQ-12 and SDQ) have been adapted and validated in Spain's population[54-56]. The prevalence and the spread by gender and age respond to what was expected, using other studies as a reference, the interpretation of this indicators in the adult or childhood population must however be precautious due to the fact that the National Health Survey made use thereof for the first time in 2006.

Prevalence of self-reported mental problems

It is estimated based on the information collected in the 2006 National Health Survey and in response to the question: "are you currently experiencing or have you experienced depression, anxiety or other mental disorders and, if so, have you experienced any thereof within the last 12 months and have told your physician that you are/were experiencing the same". In the population age 16 and older, the prevalence of self-reported mental problems totaled 11.5%, being more than double in females (16.3%) than in

males (6.6%). This result agrees with the trend found to exist by way of the GHQ-12.

Suicide prevention

In regard to the **self-inflicted injuries** identified as hospital admissions in the Minimum Basic Data Set (CMBD) at release, the hospital release registry in Spain, in which there is a record of the existence of a self-inflicted injury encoded with the ICD 9-MC classification (Codes E950-E959), excluding the cases of death, the incidence in 2007 was 11% (10% in males and 12% in females).

The **attempted suicides** recorded at the hospitals show a high degree of variability from one AC to another and an extremely low total (11 releases per 100,000 inhabitants), which leads one to consider the existence of different criteria when recording and encoding them, it being possible for cases of under-recording on the clinical records and/or under-encoding thereof to exist. In studies conducted on the general population in Spain, a prevalence of ideas and plans of suicide of 4.4% and of 1.5% for attempted suicides has been found, the latter of these two items of data being more frequent in young females who possess a low educational level[57].

Fig. 2. Evolution of the suicide death rate adjusted by age, per 100,000 inhabitants.

Source: Exitus by cause of death. National Institute of Statistics and Ministry of Health and Social Policy.
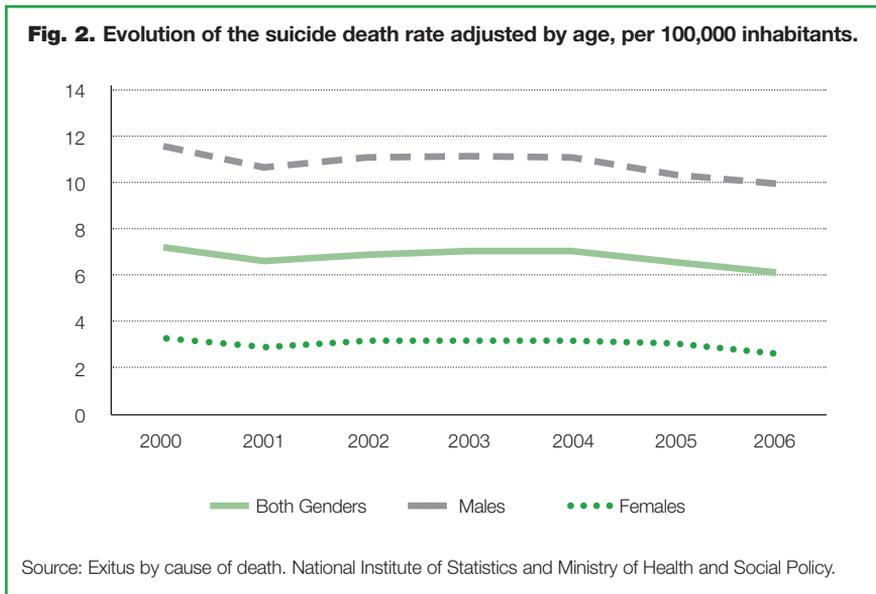
In Spain, the **suicide death rate** adjusted by age (using the European population as a standard) was 6.23 deaths per 100,000 inhabitants in 2006, being higher among males (10.04) than among females (2.76). Within the 2000-2006 period, the rate declined slightly for both males and females,

from 7.2 cases in 2000 to 6.2 cases in 2006. Gabilondo[57] has studied the **prevalence of the risk factors of the idea of suicide, the plans for suicide and the attempted suicides** by means of the Composite International Diagnostic Interview Version 3.0 (CIDI 3.0). For this purpose, he conducted a personal household survey on a sample of 5,437 individuals representative of the non-institutionalized population over 18 years of age. The prevalence of ideas and plans of suicide was 4.4% and of attempted suicides, 1.5%. The presence of ideas and plans was related independents and statistically significantly with the gender (high risk among females), age (high risk in the younger age groups), education (higher risk in lower educational level) and the presence of 2 or more psychiatric disorders. The present of attempted suicides showed a similar pattern, but the greatest association of the risk in females did not total high enough to be statistically significant.

In relation to specific actions taken by the AC for lowering the depression and suicide rates in risk groups, special mention may be made of the fact that twelve Autonomous Communities have included measures of this type in their mental health plans, a total of 11 measures having been carried out, seven of which were evaluated. The low incidence rates and the stability in the trend over the past few years may explain the differing degree of extension and quality of these programs, which range from the campaign for heightening the awareness of the general population to the complex implementation of the European Alliance Against Depression Project[58]. Depressive symptoms, particularly among the elderly, however position Spain in first place in the European ranking[59], the prevalence of depression totaling 3.9% of the general population, being double in females (5.62%) than in males (2.15%). The number of programs for preventing depression in the AC does not tally with the high prevalence thereof.

Prevention of addictions

Three surveys have been referenced:
- Household Survey on Drug Abuse (EDADES 2001-2007) regarding the adult population.
- National Survey on Drug Use in Secondary Schools (ESTUDES 2008) for the age 14-18 population both focused on illegal substances.
- National Health Survey (ENSE 2006) for the data regarding drinking alcohol.

Fig. 3. Prevalence of drug use within the last 12 months in Spain's population with the 15-64 age range, by type of substance. 2001-2007

Percentage / Year

Cannabis — Cocaine — Hallucinogens — Amphetamins — Ecstasy — Heroin
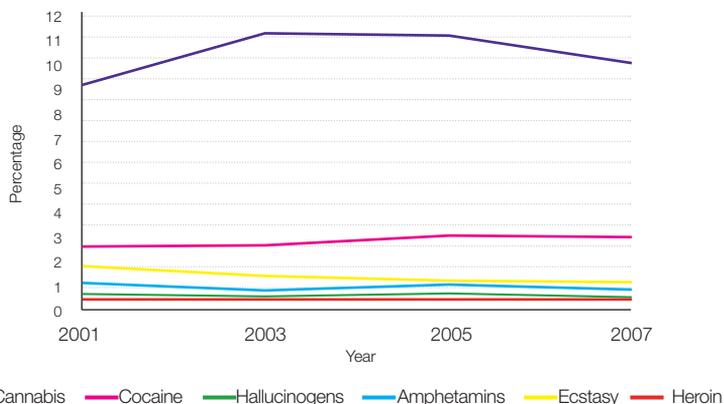
Source: MSPS. Central Government Delegation for the National Plan on Drugs. Household Survey on Drug Abuse in Spain (AGES) 2001-2007

The psychoactive substance used most in Spain in the adult population is cannabis, with a prevalence of 10.1% in 2007, far higher than that of cocaine, ecstasy, amphetamines, hallucinogens or heroin. The prevalence in males is twice as high as among females. As a whole, a slight decline is noted in the prevalence of use in males and females, with the exception of cocaine among females.

Fig. 4. Evolution of the prevalence of psychoactive substance use within the last 12 months among the Secondary School students within the 14-18 age range (percentages) Spain 2002-2008

Percentage / Year

Cannabis — Cocaine — Hallucinogens — Amphetamins — Ecstasy — Heroin
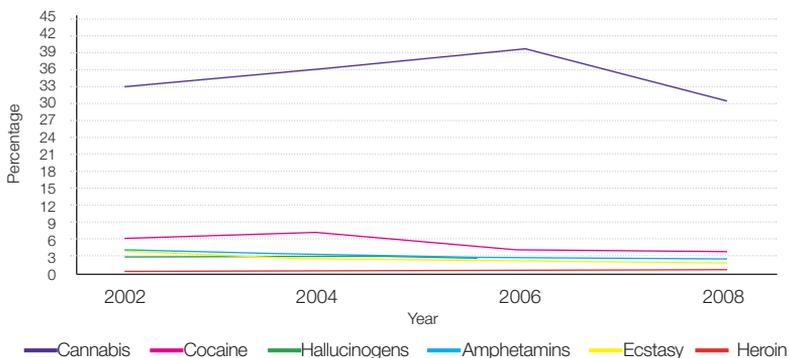
Source: MSPS. Central Government Delegation for the National Plan on Drugs. National Survey on Drug Use in Secondary Schools (ESTUDES) 2002-2008

The use of cannabis in Spain poses a major problem, especially in the school-age population, being the substance used the most in Spain's adolescent school-age population, with a prevalence of 30.5% (33.5% in males and 27.5% in females). Worth of special note, as positive data, that the use of all the psychoactive substances, with the exception of heroin, has undergone a moderate decline within the 2002-2008 period. Being aware of the degree of seriousness of this problem, nearly all of the Autonomous Communities are including interventions in their mental health plans for reducing the use and abuse of addictive substances, most of which have been evaluated.

As regards drinking alcohol, at-risk drinkers being considered to be those individuals who normally drinking the equivalent of more than 40 g/day in males and 20 g/day in females, in a population age 16 and older, the prevalence in Spain's adult population being 4.7% (6.8% in males and 2.7% in females). The highest prevalence in males is found in all the age groups (totaling up to 10.4% in males within the 45-54 age range) although the difference is less marked among the young males.

Fig. 5. Alcohol drinking with a risk to health, by age group and gender.

Source: 2006 National Health Survey. Ministry of Health and Social Policy
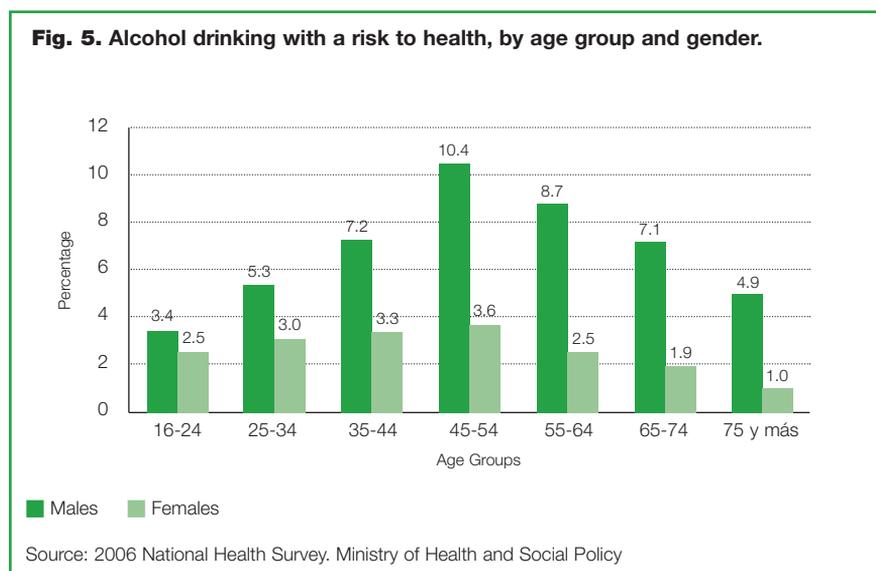
Other preventive interventions

The ACs have few programs which include activities for supporting sectors outside of mental health, such as:

- Primary Care for providing care for caregivers of persons with chronic illnesses

- Occupational health prevention services and committees for preventing occupational stress and the work-related mental disorders.

This is probably due to the fact that they have nothing to do with the everyday scope within which the mental health services take action and due to the difficulties involved in relating to other sectors. A similar situation applies with regard to the interventions aimed at preventing occupational burnout. However, work-related stress in general and burnout in particular and the burden born by unofficial caregivers are a problem of a prevalence which is cause for concern in our environment given the major health-related, social and economic repercussions thereof[60]. It is necessary to facilitate and promote psychoeducational programs being carried out for family members and caregivers of chronically-ill dependent persons, quite particularly for those who have a severe mental disorder, given that there are interventions for this group of caregivers which have shown themselves to be effective in many controlled clinical trials[61].

Other mental health-related experiences

This Strategy has been carried out in parallel to other strategies and plans of a national scope which have been promoted by other Ministries and which put forth objectives and actions sharing the common aim of social integration:

- The National Plan for Action for Social Inclusion of the Kingdom of Spain 2008-2010[62] includes the guarantee of equity in the care of persons in a situation of dependence and the fostering of access to employment as a means of combating poverty and exclusions, in conjunction with those related to the income, education and immigration policy; adding further bolstering of the measures for accessing resources and right in attention of the most vulnerable population, including disabled persons, the elderly, inmates and homeless persons. In this regard, this plan declares its support of the implementation of the Mental Health Strategy.
- With a gender perspective, the 2007 Plan for Action for Females with Disabilities[63] focuses specific attention on the health of females throughout the full life cycle.
- The Global Strategy for Action for the Employment of Persons with Disabilities 2008-2012[64] has a twofold objective: to raise the employment rate and heighten the quality of the employment for which persons with disabilities are hired.
- The inmate population avails of a Global Strategy for Action in Mental Health 2007[65]. This Strategy makes a quantitative and qualitative analysis of this problem and designs government-

approved methods and procedures for identifying, evaluating, rehabilitating and reinserting the inmate population who have mental illness.

- The 2006-2009 National Childhood and Adolescence Strategy Plan[66] places emphasis specifically on "special care for deficiencies and mental health in childhood and adolescence". This entails going beyond health-related objectives, which have already been achieved, revolving around childhood and perinatal mortality, moving on to other ways of becoming ill.

Objectives

General Objective 2: **Prevent mental illness, suicide and addictions in the general population**

2.1. Carry out and evaluate a set or plan of "community interventions" in areas at high risk of social exclusion or marginalization for the purpose of taking action on the determining factors, including the gender-related determining factors of mental disorders and addictions.

2.2. Carry out and evaluate a set or plan of interventions, within that which is set out under the National Plan on Drugs and, wherever applicable, in the Autonomous Community plan, for the purpose of reducing the use and abuse of addictive substances throughout the entire Community.

2.3. Carry out and evaluate specific actions for lowering the rates of depression and suicide in groups at risk.

2.4. Develop interventions in primary care aimed at offering support to the families, aimed at sharing and balancing out the burden of the females who take care of and provide for persons who have chronic disabling illnesses so as to prevent the mental health problems which might stem from carrying out this role.

2.5. Carry out and evaluate a set of actions for supporting the Autonomous Communities occupational health committees and prevention services aimed at preventing work-related stress and work-related mental disorders.

2.6. Carry out and evaluate interventions targeting the professionals so as to prevent occupational burnout.

2.7. Include in the plans for preventing depression and substance use actions aimed at improving the gender-related social conditions determining differential gender-related vulnerability of females and of males.

2.8. Stimulate the creation of group resources for the prevention of common mental disorders and re-socialization specifically for females in primary care and/or social or community services.

2.9. Foster the creation of resources for the care of mental patients and the actual enforcement of the Dependence Law for redistributing the burden of the provision of care and fostering a social climate valuing and taking the blame away from turning over the care of dependent persons to institutions and other resources than those of the family.

Recommendations:

1. Suggested priority areas of intervention in specific groups: the prevention of violence, of eating behavior disorders, of substance abuse, of social isolation and dependence and the prevention of gender-related discrimination and violence.
2. Carry out preventive interventions targeting groups at risk in early childhood and adolescence (children of parents who have a mental disorder or addiction, children who are victims of abuse or abandonment and others…), according to the definition thereof in prior epidemiological studies.
3. Carry out preventive interventions, preferably specific workshops for training in skills for the prevention of depression and suicide, in each one of the following environments: 1) schools 2) prison institutions 3) senior citizen living facilities.
4. Carry out community interventions aimed at improving the social dynamic in geographic areas at high social risk and/or psychiatric morbidity which are to be for the purpose of reducing the determining factors and/or the consequences of violent behavior in the public areas (vandalism), at school (bullying) and in the home (gender violence and/or child abuse or abuse of the elderly). It is indispensable for carrying out these actions that other departments such as housing, infrastructures, employment, education, women's institutes or others at the municipal or Autonomous Community level become involved.
5. The Ministry of Health and Social Policy and the ACs, through their representatives serving on the executive/participation bodies (stemming from the Law governing occupational risk prevention) related to occupational safety and health within their respective territorial bounds are to promote the inclusion of actions for the prevention of "psychosocial risks" (work-related stress) and of the work-related mental disorders in the occupational health plans and are to set out lines of support for the prevention services which carry out these actions.

6. Carry out and evaluate interventions aimed at informing and educating concerning the risks involved for health in general and for mental health in particular in the use of addictive substances on the part of adolescents.
7. Carry out and evaluate interventions for preventing the mental health problems of the caregivers and family members of chronically-ill dependent persons and of mentally-ill persons.
8. Facilitate and promote psychoeducational programs being carried out for family members and caregivers of chronically-ill dependent persons and of mentally-ill persons which will foster the suitable handling of the situations which arise as a result of providing care for these patients.

Situation analysis of the eradication of the stigma and discrimination associated with persons who have mental disorders

In Spain, according to the Disability, Personal Autonomy and Situations of Dependence Survey (EDAD, 2008), the disability attributed to cases of dementia, mental disorders and mental deficiency has a bearing on 719,000 individuals older than 6 years of age, 19% of the total number of persons who have disabilities, for a rate of 17 cases for every one thousand inhabitants, the percentage being higher in females than in males, with very minor variations from one AC to another. The prevalence of disability caused by dementia is greater in the females, the differences between males and females however not being significant for all of the other causes of disability. The disability rate which can be attributed specifically to mental and behavioral disorders is 6.4% (6.6% in males and 6.1% in females).

The majority of ACs have included in their mental health plans and have carried out interventions for the purpose of fostering the integration and reducing the stigmatization of those persons who have mental disorders. The interventions carried out are campaigns for heightening awareness, revision of the standards, drafting of protocols for the centers providing care, etc. In this regard, as previously mentioned, the MSPS has taken upon itself, in collaboration with the Council of Europe, to prepare the "Fundamental Freedoms, Basic Rights and Providing Care for Mental Patients" report.

One of the most specific and useful objectives of this Strategy for combating the stigma and discrimination associated with persons who

have severe mental disorders is that of suggesting that those persons in acute stages be admitted to psychiatric units integrated into general hospitals suitably adapted to their needs. This aspect will be dealt with in greater detail at a further point herein under Line of Strategy 2, General Objective 4.

Documents and programs of interest related to the promotion, prevention of mental disease and reducing stigma

- The British National Institute of Clinical Excellence (NICE) has guides of recommendations for promoting mental health in young children, adolescents and the elderly[67, 68].
- One of the outstanding programs aimed at improving mental health in childhood which have proven themselves to be effective is PATHS (Promotion of Alternative Thinking Strategies)[69, 70], aimed at improving emotional literacy, self-esteem, skills for self-control and solving problems in interpersonal relations whilst improving learning and reducing academic failure.
- The SEAL (Social and Emotional Aspects of Learning)[71] program is aimed at promoting the mental health of primary and secondary school students by means of developing a school climate fostering the acquisition and consolidation of skills for knowing oneself, managing emotions, empathy, motivation and establishing social relations.
- *"The Spanish Neuropsychiatry Association consensus on promoting mental health, preventing mental disorders and reducing stigma"* published in 2008 provides factual information on the promotion of mental health, prevention of mental disorders and reduction of stigma[41], divided into 4 parts: 1. Revision of definitions and concepts. 2) Description of the position of some international organizations on this issue. 3) Update and thorough review the available scientific evidence and some international, European and Spanish experiences. 4) Some general and specific recommendation concerning carrying out actions and interventions for promoting mental health, preventing mental disorders and reducing the associated stigma.
- As regards the promotion of mental health in the elderly, the consensus document prepared within the framework of the European Pact for Mental Health and Well-Being[72] is available.
- Recommendations are provided in Annex I concerning the quality criteria for the preparation of programs for the promotion of mental health and the prevention of mental disorders.

Objectives

General Objective 3: **Eradicate the stigma and discrimination associated with persons who have mental disorders.**

Specific objectives

3.1. The Ministry of Health and Social Policy and the ACs are to include interventions in their plans and programs which will foster integration and reduce stigmatization, including the work-related stigma which persons who have a mental disorder experience.

3.2. The Ministry of Health and Social Policy and the ACs are to promote initiatives for reviewing and taking action on the regulatory barriers which may have a bearing on persons who have mental disorders fully exercising their citizenship.

3.3. The centers providing care are to avail of specific rules in their protocols and procedures aimed at fostering integration and avoiding stigmatizing and discriminating against the persons who have mental disorders.

3.4. The persons with mental disorders are to be admitted in psychiatric units integrated into general hospitals, suitably adapted to the needs of these patients. The ACs are to progressively adapt the infrastructures necessary to suitably accomplish this objective.

3.5. The Ministry of Health and Social Policy will promote initiatives for coordinating with the WHO, the European Union and other international organizations within the realm of fostering integration and combating stigma and discrimination.

Recommendations

1. Implement mechanisms which will afford the possibility of identifying the barriers in the legislation in force and in the new bills presented which will prevent the persons with mental disorders from exercising their citizenship.
2. The interventions aimed at fostering integration and reducing the stigma of the persons who have mental illnesses are to preferably target healthcare professionals, media professionals, education professionals and students, businessmen and social agents, associations of persons who have mental disorders and their family members.
3. Within the realm of the ACs, the internal rules and procedures are to be adapted to foster the integration and reduce the stigma and the discrimination of the persons with mental disorders and their families. This is to be carried out mainly in the internal regimen of

regulations of the health care-related facilities. These adaptations of regulations in the ACs must incorporate the transversal gender focus and adapt the texts thereof to non-sexist language.

4. The psychiatric units are to progressively adapt their spaces, equipment, furnishings, staffing and internal organization suitably to the particular needs of both the male and female patients who have mental disorders: needs of leisure time, relating to others, occupying their time and taking part, with regard to their privacy, their dignity and their freedom of movement.

5. For the purpose of avoiding unnecessary hospital stays and assuring continuity of care and an appropriate alternative placement to the home and hospitalization, it is recommended to avail of a number of residential alternatives fostering peaceful living with others and the integration of the persons who have a severe mental disorder who so required.

6. Through the cohesion funds, promotion and prevention lines or projects are to be promoted aimed at eradicating stigma and fostering insertion into society and working life without any gender discrimination.

EXAMPLES OF GOOD PRACTICES, at: http://www.mspsi.es/organizacion/sns/planCalidadSNS/pdf/Buenas_practicas_2009_2013.pdf

Strategy line 2. Providing care for mental disorders

Situation analysis

Attended morbidity

No data is available at this time regarding the morbidity for which care has been provided at mental health centers, evaluating depressions, bipolar disorders, schizophrenic disorders and eating disorders for which care has been provided on an outpatient basis. Nine ACs furnished complete information regarding this indicator, the high degree of variability between one and another thereof leading one to think it necessary to develop a general, record-keeping system which can be homologated among all the ACs for the purpose of drawing comparisons for epidemiological purposes.

Concerning the ESEMeD study of a diagnostic nature, some articles have been published recently which come to the conclusion that the prevalence of major depressive episode diagnosed by the CIDI 3.0 was of

4.0% in Spain. Major depression was associated with gender (5.7% in females and 2.2% in males), age (greater prevalence within the 50-64 age group), marital status (greater prevalence in people who are separated, widowed or divorced), economic activity (greater prevalence in activities different than being gainfully employed: housewives and students or retired individuals)[59].

According to the data from the Survey of Health, Ageing and Retirement in Europe", Ploubidis[73] studied depression (using a scale of 12 depressive symptoms) and well-being (using a scale of satisfaction with one's life, positive outlook and happiness) in nine (9) of the European Union Member States. This study included a sample of the Spanish State comprised of 595 males and 845 females over 49 years of age. After adjusting by demographic factors, a considerable degree of variability was found to exist from one country to another. The highest depression-related score was recorded in Spain, followed by France, Italy and Greece, the lowest scores being in Austria, Germany; Sweden, Denmark and Holland. The highest scores regarding well-being were found in Denmark, Holland, Sweden and Austria, the lowest being in Italy, Greece, France, Germany and Spain. In scoring depressive symptom, there were no statistically significant differences between males and females in Denmark, Holland, Austria and Sweden, whilst in all of the other States, the females scored higher. In Austria, France and Greece, the males showed higher well-being scores than the females, the opposite of the case of Sweden and Denmark. Generally speaking, the people who live in Spain, Italy and Greece showed the worst results in mental health.

Psychiatric comorbidity

As in other countries, the mental disorders among Spain's overall population, especially mood disorders, usually occur entailing comorbidity, this term being understood as meaning the presence of one or more disorders or illnesses and are associated with a greater degree of disability.

Using the CIDI 3.0, Autonell[74] found that 28.6% of the mental disorders showed some type of comorbidity. The disorders entailing percentages of comorbidity ≥50% are: alcohol dependence (100%), generalized anxiety disorder (81.5%), dysthymia (73.0%), angst disorder (70.6%), agoraphobia (59.7%), post-traumatic stress disorder (59.5%), major depressive disorder (56.4%) and social phobia (52.7%). The comorbidity between emotional disorders and anxiety disorders was greater, independently and statistically significantly, in females, in the 18-24 age range, in being married or living with someone and in another occupational activity other than being gainfully employed (student, housewife or retired).

The use of services

The use of services is associated with the degree of severity, the type of diagnosis and socio-demographic factors, but also with the opinion one regarding these services. In 2009, the attitude toward the health services in Spain was a positive attitude of trust. Specifically, unlike other European countries where the percentage is much lower, around 90% of those surveyed in Spain answered favorable to seeking professional help, over half expressing confidence in the effectiveness of this measure[75].

However, a substantial percentage of individuals who have mental disorders do not consult the health care services and if they do so, they do not undergo treatment. Solely 57% of the persons who suffer from depression, 30% of those who suffer from anxiety and 71% of those who suffer from both of these disorders consulted these services, and 31% thereof did not undergo treatment. A total of 4% of the individuals who did consult these services were not suffering from a mental disorder. The females used the health care services twice as much as the males, as well as the persons who had been married in the past and those who had never been married. The treatment provided most often was pharmacological, alone or in combination with some psychological intervention. The health care professional consulted most for all of the mental disorders was the psychiatrist, alone or in conjunction with the family practitioner, except if the anxiety was present, in which case the general practitioner was consulted most often[76].

Along this same line, special mention must be made of a research study conducted at 77 Primary Care centers in Catalonia for the purpose of determining the validity of the diagnosis of depression and the suitability of the treatment. It was found that the GPs correctly identified 39%-55% of the cases taking as a reference the independent diagnosis made with the **Structured Clinical Interview for DSM-IV** (SCID) and correctly treated 40%-55% by taking as a comparative reference the recommendations included in the Clinical Practice Guides[77].

Apart from the above, the persons most in need of treatment are those who consult these services less. Girón[78] found a statistically significant association between the use of mental health services and being a female, suffering from a chronic mental health problem, losing days of everyday living activity, marital status (less use in among married people), educational level (the higher the level, the greater the degree of use), economic activity (less use in unskilled workers), disability (greater use among the disabled) and the somatic health condition (less use in those who have somatic problems which evolve over a long period of time). In this regard, in relation to the use of services by the persons who have a severe mental disorder, a study

based on the Granada-South case registry suggests that the time lapse between outpatient contacts of persons diagnosed with schizophrenia does not depend solely on clinical factors but also on the age (being young) and residing in the rural environment, both of these variable contributing to spacing the contacts[79].

According to the results of the ESEMeD-Spain study, the use of **psychotropic drugs** among Spain's overall population is frequent, however many individuals who have mental disorders do not use them. Approximately 16% of Spain's population has used some psychoactive drug, those used the most being benzodiazepines and derivatives (11.4%) and, secondly, antidepressants (4.7%). The females use twice as many as the males, and the probability of use increases with age, decreasing as the educational level rises. A scant relationship was found between the type of mental disorder the person has and the psychotropic drug used. This item of data is especially relevant in the group of individuals who have some mood disorder who were given anxiolytics nearly twice as often as antidepressants[80]. According to the data furnished by the Directorate General of Pharmacy and Medicinal Products on the sue of medicines, the increase in the dose/inhabitant/day within the 2006-2008 study period was 11.8% in antidepressants, 9.2% in antipsychotics and 6.8% in anxiolytics. In these three groups of drugs, the increases have been more marked among pensioners, especially in antidepressants (14%). In the current Information Systems, there is not information broken down by gender or by care-providing areas. The majority of the ACs have developed plans for heightening the quality, effectiveness, safety but also for reducing the variability of pharmacological treatments, all of which are in keeping with the criteria of rational use of medicines.

Admissions to General Hospitals

One of the objectives of the Psychiatric Reform was and is for the patients who have mental disorders to be admitted to general hospitals. In this regard, it is noted how the bed ratio in monographic hospitals has evolved over the last few decades toward a progressive, continued decline.

Source: Statistics of Health Care Establishments with Confinement Regimen (EESCRI). Ministry of Health and Social Policy.

In 2006, 36.6 beds per one thousand inhabitants were censuses, this being a figure which is lower than that detailed in other countries within the European Region of the WHO, where the average amounts to 50.2[81]. In the case of our country, one must bear in mind that 65% of the beds in monographic hospitals do not come under the authority of the National Health System.

Fig. 7. Evolution of the ratio of psychiatric beds for acute patients in general hospitals in the National Health System per 100,000 inhabitants.
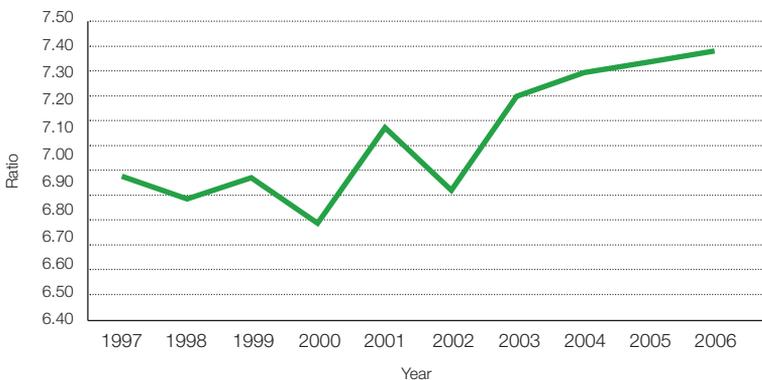
Source: Statistics of Health Care Establishments with Confinement Regimen (EESCRI). Ministry of Health and Social Policy.

The ratio of psychiatric beds in general hospitals for admitting patients in acute condition was, at the closing of 2006, 7.38 /100,000 inhabitants, ranging from 4.6 to 13.5 in the ACs. (EESCRI). In the European Region of the WHO, this rate is 14.8%, with a major degree of variability from one country to another. One must also bear in mind that the European figure does not make any distinction between beds for acute patients and beds for sub-acute patients. The percentage of acute beds which are located in general hospital compared to the total number of acute beds (in general and monographic hospitals) may also provide an approximate idea as to the degree to which the objective of the reform has been accomplished. Although this indicator shows difference from one AC to another, ranging from 30% up to 100%, it is not possible to suggest an ideal rate which would be applicable to all, given that the needs depend on the development of other community resources and on other factors of a cultural and social order social[82].

A readmission is considered as being that which is for one same person on an unscheduled basis within a time period of less than 30 days following their release for the same reason. The data taken from the MBDS show a percentage of readmissions of 10.7% in females and 10.3% in males.

Child and adolescent care

Two recent health policy documents place the mental health of children and adolescents in the forefront:

- The consensus document which was drafted within the framework of the aforementioned European Pact for Mental Health and Well-Being titled "The Mental Health and Education of Young People"
- The "Report on the Situation of Mental Health and Care Provided for Mental Disorders in Children and Adolescents in Spain", pinpointing the problems which are being posed at this point in time and the possible solutions. At the same time, this report sets out possible lines of application of the philosophy of the Mental Health Strategy to this population group.

In a population-based study revolving around childhood mental disorders, Cardo calculated the prevalence of attention deficit disorder with or without hyperactivity in a simple of 1,509 non-repeating school children within the 6-11 age range at public schools and publically-funded schools on the Island of Majorca based on the application of the Attention-Deficit/Hyperactivity Disorder Rating Scales IV for parents and teachers. The prevalence of cases was not defined clinically but rather based on the score obtained on the parents and teachers scales. The diagnosis thus defined, the total prevalence was 1.7%-3.5% in male children and 2.8%-5.8% in female children. The problems of this study are: there being no validation of the scales in the environment in which the study was conducted

or of the scoring or of the diagnostic criteria, as well as the use of a sample which was not population-based in the strict sense of the term and which was incomplete as regards schoolchildren and schools[83].

Practically all of the ACs state including measures in their health plans for suitably adapting the services to the needs of children and adolescents as regards mental health, and nearly all reporting having carried out interventions in this area, such as: promoting physical activity, balanced diet, quitting smoking, promotion of healthy lifestyles and programs on educating for health.

Care provided for the physical health of the persons who have mental disorders

Lobo-Escolar has studied the comorbidity between somatic and psychiatric problems in a representative sample of the general, non-institutionalized population over 54 years of age in Zaragoza using the Geriatric Mental State (GMS-AGECAT). He found no psychiatric or somatic morbidity in 9.4%, solely somatic morbidity in 36.6%, solely psychiatric morbidity in 9.5% and psychiatric-somatic comorbidity in 44.5%. The comorbidity was positively associated with being females and with the age. After checking demographic variables, he found a significant correlation between psychiatric morbidity and strokes and thyroid disease[84].

Lobo studied the comorbidity between somatic and psychiatric disorders in a representative sample of 1,559 patients in Primary Care. A total of 28% of the comorbid cases had depressive disorders, 51% having anxiety disorders. The probability of being a psychiatric case increased twofold with each medical diagnosis made by the family medicine specialist[85].

In another research study conducted in Catalonia with 3,805 patients in Primary Care, chronic somatic comorbidity was found to have less of an influence on the deterioration of the quality of life than a mental disorder, mainly due to the presence of chronic pain, and that 75% of the patients who had mental disorders had chronic pain[86].

Recently, it has been revealed that the prevalence of some somatic disorders (type 2 diabetes) and the mortality rate, especially due to cardiovascular disorders, is significantly greater in persons who have severe mental disorders than in the general population. Such disorders deteriorate the quality of life given that they experience difficulties for accessing the health services, and when they are provided with treatment, it is usually inadequate or insufficient[87, 88]. Hence, it is justified to consider the providing of care for the physical health of the persons with severe mental disorders as being a priority matter. The research of somatic comorbidity in psychiatric patients is an opportunity for understanding the biological connections among illnesses[89]. The importance and the degree of seriousness of the combined occurrence of two

or more psychiatric disorders is not less in the case of psychiatric disorders and substance abuse. The U.K. Center of Excellence for Concurring Mental Disorders and Substance Abuse has launched a series of eight review articles covering clinical and psychopathological, treatment, organization of services, training and research aspects for the purpose of informing the professionals and managers of the most relevant results of the research in this field[90].

Specific interventions

One of the major objectives of the Mental Health Strategy is to increase the degree to which effective intervention techniques are used: psychotherapy, psychoeducation family interventions and rehabilitation. Along general lines, most of the ACs can be said to be working on increasing the percentage of patients who have mental disorders for whom these intervention techniques are provided.

Although there are not surveys published in our country on the frequency with which the aforementioned techniques are practiced, the idea is quite widespread that the use thereof has now become generalized. However, solely some of these techniques have shown themselves to be effective in experimental studies. The use of psychotherapy, psychoeducational and rehabilitation technique "based on evidence" should be more intensive. It would not be a desirable practice to exclude from the catalogs of services provided those techniques who are not backed by experiment, given that most have none because they have not been put to a test, it being unavoidable to include and offer all those which do have such backing. It would be necessary to make a major effort in training mental health personnel to increase the number of technique available.

Clinical practice guides

The preparation, dissemination and implementation of clinical practice guides is one element which decisively contributes to improving the quality of the care provided and to said care being based on the best available evidence.

From the time at which the Strategy was approved up to the end of 2008, through the agreement with "GuíaSalud" (HealthGuide), the MSPS has funded a total of six clinical practice guides (CPGs) related to mental health. These six guides have been evaluated in keeping with National Health System quality criteria ("GuíaSalud" HealthGuide project), three of which were included in the Health Guide catalogue: CPG to eating disorders, CPG to handling major depression in adults, CPG to handling patients with anxiety disorders in primary care. The following CPGs are currently in the stage of being prepared and developed: schizophrenia, depression in adolescents, autism, attention deficit disorders and hyperactivity, severe mental disorders and bipolar disorder. All thereof are available at: http://www.guiasalud.es/egpc/index.html

Organization of the mental health services

Most of the ACs have included programs in their mental health plans for preventing the abandonments of the "assertive community treatment" type, guidelines for providing care in psychiatric emergencies and crisis situations. Nearly 100 clinical protocols for the care-providing processes which are most prevalent and/or entail the greatest complexity in providing care have now been implemented.

The MSPS has a directory of mental health facilities currently operating under the regional health services and a document describing the organization of the mental health care provided through these services, said directory having been prepared by the Health Information Institute. (http://www.msc.es/organizacion/sns/planCalidadSNS/saludMental.htm)

Human Resources

The ratio of psychiatrists assigned to a hospital in Spain (EESCRI 2006) is of 7.5 per 100,000 inhabitants (5.8 operating under the National Health System and 1.7 not operating under the National Health System). Within the last ten years, this ration has risen by 33%. At this point in time, the professionals who are rendering their services at community centers not connected to a hospital are not counted, thus reducing the total number available. This situation may be remedies by way of the implementation of the new EESCRI, which makes provision for these situations. From the evolution-related standpoint, a trend is noted toward a rise in the total ratio of psychiatrists in Spain within the last ten years, having risen from 5.63 psychiatrists per 100,000 inhabitants in 1997 to 7.49 in 2006.

Fig. 8. Ratio of psychiatrists in Spain per 100,000 inhabitants

Source: EESCRI. Ministry of Health and Social Policy, 2009
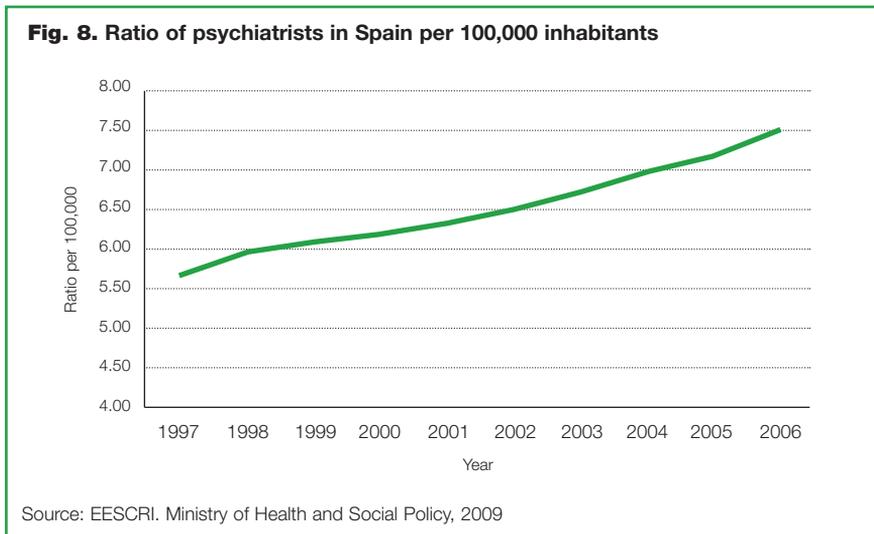
Latest trends in the field of providing care for mental disorders

Management by processes

The difference between conventional management and management by processes (see the ISO 9000:2000 in the Glossary) may be summarized by saying that management by processes takes into account what adds value or contributes customer to satisfaction (being cured, remission, recovery of the person who has a mental disorder) and, for this purpose, incorporating scientific evidence, grouping together the different professionals and levels (psychiatry, family medicine, nursing, hospital, health care center, primary care, etc.) and adding in the clinical protocols or procedures and also the management, administrative, logistics and other procedures or protocols for carrying out the process effectively. This incorporates the concept of the person responsible for the process in all stages and at all levels, who necessarily keeps an evaluation and improvement system.

Special mention must be made of a document published by the Psychiatric Section of the European Union of Medical Specialists with regard to the quality control-related aspect of the providing of care for mental disorders[91].

Employment with support

Perhaps the most critical aspect in the recovery of severe mental disorders lies in the difficulty of finding and keeping a job. Most of the procedures employed to date for overcoming this difficulty are based on the idea that the illness generates a deterioration which is the cause of this difficulty and that it is therefore necessary to reduce the same by means of rehabilitation (training in skills, vocational rehabilitation, protected employment, etc.) prior to attempting reinsertion into the working world. However, the idea is becoming progressively taking a stronger hold that, in a large percentage of cases, the most effective approach is to help the patient to find a job and go back to their usual work once the acute episode has been overcome and to provide this person with support for keeping that job without any prior preparatory process necessarily being involved. All of the procedures which are based on this idea go by the general name of "employment with support", one of the most outstanding of which, as a result of its proven effectiveness, being the model known as "Individual Placement and Support (IPS)[92]. Along general lines, this intervention entails helping the person find a job and adjusting to their preferences and needs once the acute episode has been overcome and then setting up the support so as to be able to help the person in question to keep their job. This intervention, which must be carried out by a person specially trained in this technique and who is integrated into or coordinated with the mental health team that is providing care for the patient in question, which entails supporting both the patient as

well as the person employing that patient. In the latest randomized, multi-center European trial published, it was shown that the patients treated using this technique (insertion-support) not only found employment by a higher percentage than those treated with vocational rehabilitation, but that they also abandoned treatment less and were readmitted less to hospital[93]. Therefore, insertion into working life comprises part of an individual's rehabilitation process, and keeping their job comprises one of the main challenges of the treatment.

Personalized Care Plan (PCP)

The PCP has been put to a review, the PCP for a common mental disorder having been eliminated, being applied solely to clinically-complex, severe mental disorders in patients who are or may foreseeably reach the point of being in a high-risk situation; which entail a major degree of suffering, instability, isolation or abandonment; which involve comorbidity as a result of substance abuse or mental disability, which require multi-sectorial care to be provided. The evaluation of the needs and the preparation of the plan for action include all those aspects of the individual in question which afford the possibility of endowing them with the greatest ethical content and of guiding them to personal recovery. This recognizes the central role of the persons providing care in the recovery and therefore their needs must also be recognized and supported by the PCP.

Specialized Community Teams

The British National Health Service broadened the authorities and professional responsibility of the nursing staff such that most of the specialized teams are managed and comprised almost exclusively of mental health nursing personnel, the psychiatrists playing the role of consulting experts on these teams. A great deal of attention has recently been focused on the psychosis-related intervention teams[94-99]. Although their effectiveness for reducing readmissions and the length of hospital stays and thus of reducing health care spending is not doubted, as well as for improving the accessibility, the care continuity and the satisfaction of the users and family members on a short-term basis, however some of the clinical advantages cannot be maintained on a long-term basis[99].

Program for facilitating access to psychological treatments

Based on NICE recommendations concerning the efficacy of the cognitive psychotherapy services in the treatment of common mental disorders[100] and on a report from the London School of Economics[101], in which the argument is put forth that the spending on psychotherapy can be offset by way of the savings on reducing time off for sick leave[102], psychological treatments centers were created throughout the entire country to which users

readily gain access from Primary Care. Those patients who have more severe disorders are treated by clinical psychologists using behavioral cognitive psychotherapy, the less sever by other professionals possessing lower degrees by means of counseling and brief therapy, and the most minor disorders with psychoeducation, computer-aided therapy and self-help guide. All of these psychotherapists undergo specific training at their respective levels. In all cases, specialized support is also provided so as to not miss work or to go back to work earlier if the patient is on leave.

Objectives

General Objective 4: **Improve the quality, equity and continuity of the care provided for mental health problems**

Specific objectives

4.1. The services which are included in the National Health System list of services provided both within the scope of Primary Care as well as in that of specialized care be developed and implemented effectively by the ACs within the framework of their authorities.

4.2. The ACs are to set out procedures for support from the specialized care provided in mental health to the care provided at the primary care level for the detection and early treatment of mental disorders.

4.3. The ACs are to set out guidelines for providing care for psychiatric emergencies and crisis situations, including home care, in collaboration with the different sectors involved, especially primary care.

4.4. Increase the percentage of patients who have mental disorders who are provided with psychotherapy according to the best practices available and monitoring minimum quality criteria included in the quality criteria table in Annex II.

4.5. Increase the percentage of patients who have severe mental disorders who are included in a rehabilitation program.

4.6. Increase the percentage of families of patients who have severe mental disorders who are provided with a specific family intervention program for the purpose of improving their ability to cope with the crises and prevent relapses.

4.7. Develop specific intervention protocols for the patients who have mental disorders, aimed at improving the care provided thereto for their overall health, placing special attention on the most prevalent "physical" illnesses.

4.8. In their mental health plans, the ACs are to make provision for the necessary specific aspects for the specialized care of those persons who have a mental disability or mental disorder.

4.9. The ACs are to avail of and are to suitably adapt specific units and/or programs for meeting the needs of small boys and girls as well as adolescents with regard to mental health.

4.10. The Ministry of Health and Social Policy is to develop, in conjunction with the ACs, a model for collaborating with the Justice Administration bodies and Prison Institutions for the purpose of improving the care of those persons who have mental disorders who come under the Penal Code and the Juvenile Law, assuring the continuity and equivalence of care to the rest of the population.

4.11. Establish, in each one of the territorial health care structures, the access to all of the treatment facilities or programs, including home care and rehabilitation, sufficing to meet the needs of their population, assuring the continuity of the providing of care through an integrated network of services in which the general hospitals are included and are coordinated with primary care.

4.12. Establish a personalized care plan for the persons who have mental disorders who are undergoing treatment.

4.13. Avail of the mental health teams with a community scope, in regard to long-terms severe mental disorders, of an organizational system for preventing abandonments, facilitating adherence and which includes home care, as well as the multi-sectorial coordination and management of the process of providing their care.

4.14. Define and implement, within the scope of each Autonomous Community, the clinical protocols of the most prevalent and/or most highly complex care-providing processes in the different stages of life. Both the gender perspective as well as the specific problems of certain risk groups are to be taken into account.

4.15. Prepare, adapt or adopt and subsequently implement, within the scope of the ACs, the use of integrated clinical practice guides in keeping with the quality criteria and the priorities set out by the National Health System.

4.16. The ACs are to avail of strategies for heightening the quality, effectiveness, safety and reducing the variability of the pharmacological treatments by following the criteria for the rational use of medicine.

4.17. The Autonomous Communities are to suitably adapt their services to the specific needs of the elderly.

4.18. The Autonomous Communities are to set actions into motion for the identification and early intervention regarding persons who are experiencing psychosis.

4.19. The Autonomous Communities are to take measures to guarantee the exercise of the right to health care on the part of the immigrant population, to facilitate full access to the services offered through the National Health System and to guarantee a use thereof which is compatible with the cultural and religious characteristics of each individual.

4.20. The Autonomous Communities are to coordinate with Prison Institutions the most appropriate resources in each care for providing timely care for the persons who have a mental disorder who are sentenced by a judge to be imprisoned.

4.21. Incorporate the analysis of the social and gender-related inequality in the detection, evaluation and treatment of mental disorders.

4.22. Detect, evaluate and eradicate the social and gender-related inequalities in accessing and being provided with care and the gender biases in the care provided in the mental health services.

4.23. The ACs are to suitably adapt the specific services and programs to meet the specific needs of females who have reached the age of mature adulthood by further bolstering the primary care services and the biopsychosocial approach sensitive to gender-related determining psychosocial factors.

4.24. The ACs are to offer, with an assertive model, interventions of an integral nature capable of facilitating the necessary care to those persons who, as a result of the disorder they are experiencing, are having difficulties exercising their right to the most appropriate treatment by facilitating adherence thereto and the continuity of care.

4.25. Suitably adapt the services with specific programs for bipolar disorder and, if these services are not available, generate them.

4.26. Define and implement clinical protocols for the most prevalent care-providing processes in bipolar disorder and/or any more highly complex disorder as regards the clinical and care-providing aspects thereof.

Recommendations

1. The National Health System Services Portfolio is a general document which defines the functions of primary care and specialized care with regard to providing mental health care. It is recommended that the ACs further expand thereupon specifically within the framework of their authorities.

2. All of the male and female patients diagnosed as having a severe mental disorder must have the possibility of being included early in a rehabilitation program.

3. It is recommended to improve access to all of the treatment and rehabilitating programs and facilities for both the adult as well as the childhood-adolescent population, within the territorial health care structures (see Glossary). These facilities are to take into account the social and family-related differences between females and males.

4. Two types of personal care plans are recommended: the Integrated Care Plan for Patients who have a Severe Mental Disorder (see Glossary) and the Treatment Agreement for patients who have a Common Mental Disorder (see Glossary). Ways of organizing are recommended which are aimed at improving the continuity of the care provided for persons who have a severe mental disorder, reducing the number of hospitalizations and improving their social functioning and quality of life. Two reference models are recommended: the "Assertive Community Treatment" and the "Care Continuity Programs".

5. It is recommended that the following care-providing processes be protocolized: common adult mental disorders, severe adult mental disorders (taking into account the gender-related aspect, given that a greater number of females experience mental disorders and a greater number of males commit suicide), severe mental disorders in the elderly, several personality disorders, common childhood and adolescent mental disorders, severe childhood-adolescent mental disorders and generalized development disorders.

6. Each Autonomous Community is to implement clinical practice guides for the most severe and prevalent disorders[*]. The clinical practice guides or other tools based on evidence which have incorporated the gender perspective are recommended.

7. Continually provide scientific information on usefulness, effectiveness and cost-effectiveness of the medicines to health care professionals and patients.

8. It is recommended to incorporate elements of analysis and monitoring for the purpose of assuring that the variability in prescribing according to gender is in check.

[*] Schizophrenic disorder and other related psychoses, Severe personality disorders, Eating disorders, Bipolar disorder, Depression spectrum disorders, Anxiety disorders, Adaptive disorders, Somatomorphic disorders, Substance abuse-related disorders, Dementias and severe cognitive disorders, Generalized development disorders, Disturbing childhood disorders, Sever emotional disorders in early infancy, Crisis intervention.

9. The Autonomous Communities are to assess and implement and evaluate, wherever applicable, the management by processes or clinical channels experiences.

10. Measures are to be taken to improve the transcultural competence of the institutions and professionals in charge of providing mental health care.

11. The Mental Health unit/center or service is responsible for the treatment process of the persons who have a mental illness. They must be comprised of multidisciplinary teams staffed with a sufficient number of personnel in psychiatry, clinical psychology, nursing, social work, assistants, home support assistants and all those others (vocational therapy, social educator or similar) which are recommended by the best practices available. These teams are to provide integral care by taking into account the bio-psychosocial nature of health, the diversity of individuals and the specific requirements of the patients and of the environment in which they are living so as to guarantee the least restrictive treatments as possible with the active involvement of the person who has the mental illness in the decisions and facilitating the collaboration of the caregivers, if any, of the person in question.

Involuntary restraint

Most of the ACs have prepared Safety Guides for picking up, transferring and restraining patients. Protocols have been set out regarding how to proceed in cases of abandonment, mechanical and pharmacological restraint in hospitals so as to keep them from hurting themselves or others.

The MSPS placed the University of Granada in charge of preparing the document on "Criteria for the use of coercive measures during psychiatric hospitalization and transfer to the hospital". This report is to serve as a reference point for quality and harmonization of the practices in this realm.

Objectives

General Objective 5: **Implement involuntary restraint procedures which will guarantee the use of good practices and the respect for the rights and dignity of both the female and male patients.**

Specific objectives

5.1. Prepare a general guide related to good practices concerning ethical and legal aspects of the care-providing process in any modality of intervention against a patient's will.

5.2. A protocol be set out or updated by the AC for transfer and involuntary hospitalization.

5.3. Regulate, by means of protocols, the procedures for physical restraint, involuntary treatment of hospitalized patients and any restrictive measure within that for which provision is made under the current body of law in force.

Recommendations

1. The protocol is to be prepared with the collaboration of all of the stakeholders potentially involved in the involuntary hospitalization procedures: mental health professionals and Law professionals, police, health transport and associations of family members and patients.
2. In addition to the aforementioned protocol, an operative "involuntary hospitalization channel" version is to be prepared to be individually applicable, in which each one of the steps, the times, the names and the signatures of the stakeholders involved are to be recorded.
3. Similarly, protocols and channels are to be prepared for applying physical restraints and involuntary treatment to patients who so require during hospitalization.
4. The protocols are to be in keeping with the laws and regulations in effect and are to take in the principle of the minimal restraint necessary, the respect for and dignity of the persons who have mental disorders, preventing stigmatizing and placing special emphasis on the expeditiousness and timely response of the procedure.
5. Develop an informed consent form for the family members in view of care-providing situation which entail adopting restraint measures in accordance with Articles 8 and 9 of the Patient Autonomy Law.

EXAMPLES OF GOOD PRACTICES are available at:
http://www.mspsi.es/organizacion/sns/planCalidadSNS/pdf/Buenas_practi-cas_2009_2013.pdf

Strategy line 3. Intra-institutional and inter-institutional coordination

Situation analysis

Cooperation and joint responsibility of all of the departments and agencies involved in improving mental health

Mental disorders, especially severe mental disorders, entail many social, work-related, legal, educational and other types of consequences which

must be considered as being aspects intrinsic to the illness in question and therefore given attention on the part of the mental health services in collaboration with the sectors involved. Coordinating all the measures is aimed at providing integrated services by maximizing the efficiency and guaranteeing the continuity of care over the course of time. The mechanisms which facilitate this coordination may be considered transversally from the needs of the health care and social organizations or, longitudinally, from the needs of the patients. This section deals with the mechanisms of transversal coordination. The procedures focused on the needs of the patients and aimed at guaranteeing the continuity of care have been reviewed in Strategy Line 2.

Most of the ACs state having maintained areas of coordination and cooperation with Welfare, Education, Employment, Justice and Public Administration, Prison Institutions, Culture, Ombudsman, Antidrug Agency, Municipal Governments, Guardianship Agencies, as well as with patient and family member associations.

Regarding the "Law for the Promotion of Personal Autonomy and Providing Care for the Persons in a Situation of Dependence" for those persons who are dependent due to a mental illness, most of the ACs have defined the evaluations and characteristics for the application thereof, being necessary to delve deeper into and to continue with this objective.

Participation of the persons who have mental disorders and their family members and professionals in the public health system of their autonomous community.

This Strategy explicitly supports the furthering of family members and patients taking part in associations and their actual active involvement in the planning and evaluation of the mental health services. This is simply a matter of rights. Nevertheless, it must be admitted that, at this point in time, the scientific evidence on the effectiveness of participation for improving the planning and evaluation of the services is insufficient. Indications of effectiveness are available as furnished by qualitative studies[103]. It is particularly important and pressing to promote more research in this area by getting family members and patients actively involved.

A survey conducted recently in Spain among mental health professionals revealed an extremely small degree of actual participation on the part of the family members and patients in the mental health services in addition to a generalized negative attitude on the part of the professional regarding said participation[104]. To deal with this problem, in addition to their actual participation, it is also necessary to actively influence the professionals in graduate training –MIR, PIR and EIR– by getting the patients and family members actively involved in their training.

The Association-Joining Movement

The patients' associations have taken care of three major areas of activity:

- Mutual support and companionship, taking part by way of personal experience in the recovery processes.
- The activities of a more creative type, such as the radio stations or the artistic groups, thus contributing to disseminated a self-dependent, positive message countering stigma.
- Lastly, it has been sought to set out the organization for group representation, thus generating a voice in favor of equality in the different planning forums and, to a lesser degree, in the management, teaching and research fields.

This all has been furthered to differing degrees in the different territories in Spain, and many associations are of a local nature, but there are clearly attempts being made to bring them together. In 2009, the processes for setting up two major patients' associations reached an end:

- The Platform of Mental Health Patient Associations of Andalusia (PAUSAME, plataforma@enprimerapersona.es), bringing together 10 associations which are self-managed by persons who have mental illness from five Andalusian provinces.
- The Pro Mental Health Association of Spain-ASME-Dédalo (comunicacion.asmededalo@gmail.com), which combines associations from the Balearic Islands, Badajoz, Catalonia, Asturias, Andalusia, Madrid and the Canary Islands.

The objectives of defending the rights and interests of the whole, vindicating better health care, developing strategies to combat stigma and discrimination, fostering the forming of associations and social involvement are summed up in the "Dédalo" slogan "Nothing for us without us". These associations are not confined to specific disorders nor do they exclude any disorder, most of these associations being mental health associations in general.

Special mention must be made of FEAFES, the Spanish Confederation which, since 1983, has grouped together federations and associations of persons who have a mental illness and their family members throughout the entire country. This Confederation comprises part of the Strategy Monitoring and Evaluation Committee. The mission thereof is that of improving the quality of life of the persons who have mental illness and their family members, the defense of their rights and the representation of the association movement. This is the only nationwide organization in existence in Spain, and its activities are open to anyone interested in mental health.

The participation of patients who have mental disorders and their family members in health planning and services evaluation activities has been implemented in nearly all of the ACs. Numerous ACs now have some con-

sulting-advisory body (i.e. Mental Health Advisory Board comprised of professionals from the mental health field and different associations of family members and patients, working groups for the planning and evaluation of the services, meetings of the regional offices with the main professional societies and associations, etc.). Similarly, some ACs have set up agreements with patient and family member associations for the purpose of carrying out campaigns for heightening awareness of the society, eradicating disadvantaged situations and developing methods for gauging the satisfaction of those persons who use the rehabilitation centers.

Objectives

General Objective 6: **Promote the cooperation and joint responsibility of all the departments and agencies involved in improving mental health**

Specific objectives

6.1. Implement mechanisms, on the part of the ACs, for the coordination and cooperation at the institutional and inter-institutional level which will guarantee the providing of integral care for people.

6.2. The ACs are to set out a general framework which will determine the involvement and role of the "Law for the Promotion of Personal Autonomy and the Providing of Care of Persons in a Situation of Dependence" among those persons who are in a situation of dependence due to a mental illness.

6.3. Implement on the part of the ACs, within the framework of their authorities, mechanisms which will be effective for coordinating care within each territorial health care structure, among the different health care and social facilities involved in providing care for severe mental disorders.

6.4. Increase the number of persons who have mental disorders who have the benefit of the employment service with support or protected employment.

6.5. Foster equal representation among female and male professionals in the decision-making areas of the mental health network.

6.6. Take the gender perspective into consideration as a powerful quality tool which must be present in all those actions which are started up within the decision-making scopes of the Autonomous Communities and at the national level by way of this Strategy.

6.7. Establish support procedures through specialized mental health care for the facilities providing care for patients who have substance use-related disorders for the detection and early treatment of Dual Disorder.

Recommendations

1. The ACs are to develop and further bolster the aspects set out under the "Law for the Promotion of Personal Autonomy and Providing Care for Persons in a Situation of Dependence".
2. It is recommended, within the authorities of the AC and in keeping with the "Law for the Promotion of Personal Autonomy and Providing Care for Persons in a Situation of Dependence", to set up an Interdepartmental Coordination Commission among the Autonomous Community Departments of Health, Social Services, Labor, Education, Housing, Justice, Economy and Finance, as well as with the Ministry of the Interior and whatever others might be involved, in order to: 1) Integrate the mental health policies 2) provide advisory in the preparation of the Autonomous Community Mental Health Plan.
3. Design, implement and evaluate a model of coordination with Social Services, Education and Justice which will guarantee the continuity of the care provided for the male and female children and adolescents who are in treatment.
4. Design, implement and evaluate a model for coordinating with Primary Care and Social Services which will guarantee the continuity of the care provided for the elderly population within the environment where they live under the protection of that which is set forth under the "Law for the Promotion of Personal Autonomy and Providing Care for Persons in a Situation of Dependence".
5. Create coordinating mechanisms within the scope of the Autonomous Community so as to guarantee integrated care being provided for the problem of drug dependence within mental health.
6. Design, implement and evaluate a model for coordinating with prison institutions and shelter and residential centers.
7. In the event of publically-funded and/or purchased services, criteria are to be established regarding quality, evaluation, coordination and integration with the organizational structure of providing mental health care within the Autonomous Community.

General Objective 7: **Bolster the participation of the persons who have mental disorders and their family members and professionals in the public health system of their Autonomous Community**

Specific objectives

7.1. Develop an information strategy in each Autonomous Community for persons who have mental disorders and their family members concerning

rights and obligations, resources and services they can use and the administrative procedures for filing suggestions and complaints.

7.2. Implement in each Autonomous Community mechanisms and channels for the participation of the persons who have mental disorders and their family members in all aspects of mental health, including the planning and evaluation of the services.

7.3. The ACs establish the mechanisms and channels for the participation of the scientific and professional societies related to mental health in the planning and evaluation of the services.

Recommendations

1. In the consulting and advisory bodies related to mental health, there are to be representatives from the professional mental health associations.

2. On the consulting and advisory bodies related to mental health, there are to be representatives from the associations of patients and family members of persons who have mental disorders.

3. So that the participation of the patients' and family members' association will be effective, it is necessary for their continuity and independence to be bolstered. For this purpose, support is to be provided for the representative associations which can serve as spokespersons in the matters concerning them on the subject of mental health.

4. Support and advisory mechanisms are to be set up for the associations of family members and persons who have mental disorders so that they may effectively perform duties of mutual support, combating stigma and defending their rights.

EXAMPLES OF GOOD PRACTICES are available at:
http://www.mspsi.es/organizacion/sns/planCalidadSNS/pdf/Buenas_practi-
cas_2009_2013.pdf)

Strategy line 4. Health care personnel training

Situation analysis

In the field of specialized mental health care, the training of specialists in Psychiatry, Clinical Psychology and Mental Health Nursing is subject to official approval. This is graduate-level training taken according to Spain's National

Health System Health Science specialization model, which uses the system of residency, guided self-learning and continuing and final evaluation. The current trend is for the specialists in these three professions to be trained jointly in Multi-professional Teaching Units which meeting the common and specific accreditation criteria for training in these three specializations.

On September 1, 2008, the training program for the psychiatry specialization was approved and published (Spanish Official Gazette BOE 224). The most outstanding new aspects were:

- A compulsory, three-year common trunk providing experience by means of rotating through different services (short-stay hospitalization unit, liaison psychiatry, community mental health centers, mental health teams for small children and adolescents, addiction units or programs, psychosocial rehabilitation centers), basic knowledge of the different areas and activities inherent to the specialization by means of seminars and guided reading.
- The fourth year of training provides the residents with the opportunity of completing their training according to their abilities and preferences, allowing them to choose one of the training paths.
  - monographic specialization in child and adolescent psychiatry, psychotherapy, addictions or geriatric psychiatry.
  - combining, according to preference and in agreement with the faculty advisor, the different modules comprising the basic training trunk or rather to train in field which are not specified in the program, provided that the local circumstances so allow.
- The training is completed with a brief period of training in skills common to other specializations (clinical management or bioethics) and a longitudinal component devoted to the training in psychotherapy, research methodology and other subjects of interest.

On June 2, 2009, the Order SAS (1620/2009 was published (Spanish Official Gazette BOE of June 17th) by virtue of which approval was rendered of the new training program of the Clinical Psychology specialization and the same was published. This program has been lengthened to four years and covers:

- General transversal textbook training common with other health science majors (especially with psychiatry and mental health nursing).
- General textbook training in Clinical Psychology.
- A clinical-care training program (community, outpatient care and support for primary care, addictions, rehabilitation, hospitalization and emergencies, clinical psychology of health, interconsultation and liaising, childhood and adolescent clinical psychology).
- Programs for the development of specific training areas to be chosen from among psycho-oncology, neuropsychology, psychogeri-

atrics, palliative care, sexual and reproductive health, eating disorders, free rotation and continuing care.

The professionalization of specialized mental health nursing, an aspect indispensable for carrying out the services, is progressing slowly. Although nurses specialized in mental health have been being trained since 1998, only some of the Autonomous Community health services offer jobs of a specialist category. The new mental health nursing specialization program which has been undertaken by the National Mental Health Nursing Commission will broaden the skills of future specialist and will lengthen the training period to two years.

It is worthwhile to recall that the new information and communications technologies provide a privileged opportunity for training professionals and for the support of clinical practice. Recently, the Andalusian Health Service Mental Health Program created "Psychoevidence", an exemplary website for the management of mental health knowledge. See: http://www.mspsi.es/organizacion/sns/planCalidadSNS/pdf/Buenas_practicas_2009_2013.pdf)

As of the approval of the Mental Health Strategy in the ACs, a considerable training activity has been generated, whether or not included in continuing training plans. Over all, it has been possible to provide training for 13,500 professionals related directly to mental health (primary care, psychiatry, clinical psychology, mental health nursing, social work, occupational therapy and others), but special mention must be made, above all, of the fact that nearly half underwent training within multidisciplinary teams.

Objectives

General Objective 8: **Bolster the training of the health care professionals of both genders for suitably meeting the mental health-related needs of the population**

Specific objectives

8.1. That the ACs avail of a Continuing Training Plan for all of the professionals in primary care, mental health and all those professionals in specialized care who have to do with providing care for persons with mental disorders within the framework of the biopsychosocial care model.

8.2. Incorporate the gender perspective into the different training programs (Undergraduate, Graduate and Continuing Training) of the professional related to mental health throughout the entire country.

Recommendations

1. It is recommended that the Autonomous Communities include the Mental Health Nursing Specialist Diploma as a requirement for these professionals being incorporated into the Mental Health resources and facilities.

2. Broaden this training to the primary care personnel who work in Prison Institutions.

3. The Ministry of Health and Social Policy, through its competent bodies, in conjunction with the ACs, is to review the professional profiles necessary for the future specialists, the criteria for the accreditation of the teaching units and the teaching model in general. All of the foregoing shall be for the purpose of aligning the training of specialists with the needs of the population in keeping with the community model.

4. Revise the current model of the Psychiatry and Clinical Psychology specialization to include the following as preferred areas of training: Childhood and Adolescent Psychiatry and Psychology, Health Psychology, Psychotherapy, Psychogeriatrics, Forensic Psychiatry and Psychology and Addiction Psychology.

5. Unrolling the Continuing Training Plan is to be based on the following principles:

    a. Focusing on problems which must be detected and remedied by the professionals involved, taking into account the morbidity and demand of the population.

    b. Be based on an analysis of the training needs of all of the professionals involved in order to provide care for these disorders.

    c. Promote continuing training by means of joint meetings of the primary care professionals and the mental health teams.

    d. Set priorities concerning participation-based learning activities in small groups, such as workshops, clinical sessions and case supervision sessions, incorporating the "best available practices".

    e. The training programs must take into account measures for reconciling working and family life.

    f. The specific, emerging mental health-related needs of the population of each health district are to be taken into consideration (i.e. cultural diversity, inequalities and determining factors related to gender, gender violence, immigration, etc.

EXAMPLES OF GOOD PRACTICES are available at:
http://www.mspsi.es/organizacion/sns/planCalidadSNS/pdf/Buenas_practicas_2009_2013.pdf)

Strategy line 5. Mental health research

Situation analysis

In 2007, the Carlos III Health Institute Subdirectorate General Cooperative Research Networks and Centers decided to set up the Network for Mental Illnesses-Emotional and Psychotic Disorders (REM-TAP) by way of merging the three networks currently operating in the field of psychiatry and neuroscience (Initial Early-Onset Psychotic Episode Network, Liaising Psychiatry Network and Genetics and Psychiatry Network). The REM-TAP network was comprised of 17 research groups and remained in operation for solely one year. On January 1, 2008, the Networked Mental Health Field Biomedical Research Center (CIBERSAM) was created. The end purpose is to set up a center of research groups open to the scientific, medical and political community and to society, spearheading research in Spain and Europe, which will generate knowledge and provide added value. The CIBERSAM is comprised of 26 clinical and basic research groups, totaling around 300 people pertaining to eight ACs. The research projects are of a multi-disciplinary, multi-institutional nature, in which basic, clinical and population-based research is integrated. Their main objective is to add value to the system by means of pioneering research in the field of psychiatry and related neurosciences. The most important lines of research are: depression, bipolar disorder, schizophrenia and disorders such as childhood and adolescent mental disorders, psychogeriatrics and anxiety disorders. Lastly, there are also projects aimed at creating new tools, validating and perfecting existing tools which will enable us to better evaluate what we want to study in fields including those such as psychopathology, functioning, evaluation of needs, neuropsychology and neuroimaging. According to the report prepared by the CIBERSAM in 2008, a total of 462 articles were published and 203 projects were under way; the total for 2009 being that of 407 articles and 396 projects.

The MSPS has promoted, as a top-priority line, the researching in mental health in the call for applications for aid through the Health Research Fund and Health Technologies Evaluation. A total of 78 mental health-related projects were financed through the Carlos III Health Institute within the 2006-2008 period.

A total of 13 ACs incorporate lines of interdisciplinary research in mental health in their plans, 12 reporting having included the calls for aid for projects as one of the top-priority lines, as a result of which a total of 71 projects have been carried out within the 2007-2008 period. The starting up of measures for bolstering the creation of groups and networks of research

centers accredited in mental health has been included in the mental health plans of 11 ACs.

Objectives

General Objective 9: **Bolster mental health research**

Specific objectives

9.1. The Ministry of Health and Social Policy and the ACs are to promote priority interdisciplinary lines of research in mental health by means of including the calls for research projects.

9.2. The ACs and the Ministry of Health and Social Policy are to set measures into motion to bolster the creation of accredited networks of research centers and groups of excellence in mental health.

9.3. Promote the implementation of gender-aware Research Methodologies (undergraduate, graduate-level and existing research networks).

9.4. Promote lines of research on all of the types of gender analysis in mental health: sex rations, differential morbidity by genders, gender-based inequalities, psychosocial determinants of gender, both of vulnerability as well as safeguarding and the gender biases in the clinical setting.

Recommendations

1. The ACs are to set the priorities, within the scope of their territories, regarding the lines of research in mental health in terms of the needs of their population. The inclusion of the gender perspective in all lines of research is to be fostered.
2. Research-action projects which involve the multi-disciplinary approach and coordination among several health fields of one same Autonomous Community must be promoted and supported.
3. Improve the training of researchers in basic and applied techniques for researching in mental health.
4. Set up a stable working framework for the mental health researchers.
5. The ACs are to place top priority, in the calls for applications, on the topic area regarding mental health and gender to promote the study of the working conditions which may facilitate the onset of mental disorders, especially among females.

EXAMPLES OF GOOD PRACTICES are available at:
http://www.mspsi.es/organizacion/sns/planCalidadSNS/pdf/Buenas_practicas_2009_2013.pdf)

3. Evaluation

The first edition of this Strategy entailed a specific line of strategy concerning Information and Evaluation Systems, a general objective **(Improve the knowledge regarding mental health and the care provided by the National Health System)** and three specific objectives:

1. Gather information on the population's overall degree of mental health.
2. Avail of information at the National Health System level concerning the major causes of morbidity for which care is provided.
3. Avail of integrated information at the National Health System level regarding the specific organization, facilities and resources devoted to providing mental health care.

In the evaluation, it was found that:

1. Validated tools (GHQ-12, SDQ) have been implemented, thus having afforded the possibility of measuring the degree of mental health of the adult population and of the juvenile population on Spain's latest National Health Survey (ENSE, 2006).
2. Information is available on the morbidity for which care is provided in hospitalized patients, although homogenous information on morbidity for which care is provided on an outpatient basis is not as yet available.
3. Information is gathered from the different facilities in operation on the part of the Health Information Institute, which prepares a "Mental Health Facilities Map" that is updated at least yearly.

As a result of all the foregoing, the Evaluation Report suggested and approved:

1. Eliminating this line from the new edition of the Strategy.
2. Creating a Monitoring and Evaluation Committee working group to develop the most appropriate methodology for the purpose of being able to evaluate the objectives and indicators included under the Strategy.
3. New indicators are proposed which measure the human resources of the community model: professionals in the fields of psychiatry, clinical psychology, mental health nursing and social work.
4. That the successive evaluations be conducted every four (4) years.

A report on the methodology of the European Service Mapping Schedule (See Annex III) is currently under way, which may aid toward evaluating the health-related outcomes.

Indicators

This Strategy is evaluated by means of the indicators which are listed in following and with the new indicators or reports which are agreed upon following the contributions and conclusions of the Monitoring and Evaluation Committee working group set up for this purpose.

Lines of strategy	Indicators	Sources
1. Promotion of mental health, prevention of illness and eradication of stigma	Percentage of persons at risk of poor mental health	Spain's National Health Survey
	Stated prevalence of depression, anxiety or other mental disorders	Spain's National Health Survey
	Percentage of persons who state using drugs	Household Survey On Drug Abuse
	Percentage of adolescent students who state using drugs	Survey On Drug Use In Secondary School Students
	Percentage of at-risk alcohol drinkers	Spain's National Health Survey
	Rate of releases for self-inflicted injuries	CMBD
	Suicide death rate	National Institute Of Statistics
	Number of beds for acute psychiatric patients at general hospitals per 100,000 inhabitants	Statistics of Health Care Establishments with Confinement Regimen
	Number of beds in monographic hospitals per 100,000 inhabitants	Statistics of Health Care Establishments with Confinement Regimen
	Social and family support	National Health Survey
	Disability attributed to mental disorder	EDDES
2. Care provided	Clinical practice guides integrated in compliance with the National Health System quality criteria	Healthguide
	Daily dose per capita (DDP) of antidepressants	SI-CF
	Daily dose per capita (DDP) of antipsychotics	SI-CF
	Daily dose per capita (DDP) of narcotic, sedative and anxiolytic substances	SI-CF
	Percentage of readmissions	CMBD
	Morbidity for which care is provided	AC
	Percentage of releases of prison patients in non-prison hospitals	Prison Institutions
3. Intra-institutional and inter-institutional coordination	Mental health facilities map	SIAP-SM
	Ratio of psychiatrists per population	Statistics of Health Care Establishments with Confinement Regimen
4. Training	Qualitative report	AC
5. Research	Number of research projects	Carlos III Health Institute/AC

Annex I. Promotion and prevention quality criteria[1]

I. General aspects and principles of intervention

- The program is coherent with the general objectives of health promotion set out in the regional or local plans and policies.
- The program incorporates a positive, integral approach to health, placing attention on the determining social and environmental aspects thereof.
- The program is based on the best available evidence for achieving the chosen objectives.
- The program stimulates the empowerment of those taking part therein, as well as the impression of belonging and playing a leading role therein.
- The program respects the principles of equity and equality among all individuals.
- The continuity of the project has been studied and assured in the case in which the efficacy and advisability thereof is proven.

[1] This document includes a selection of the quality criteria in promoting mental health reflected in the literature based on the following instruments:

- Bollars C, Kok H, Van de Broucke S. European Quality Instrument for Health Promotion (EQUIHP) User Manual. European Project Getting Evidence into Practice. Netherlands Institute of Health Promotion and Disease Prevention (NIGZ), 2005. Available at: http://ws5.e-vision.nl/systeem3/images/User%20Manual1.pdf

- Lavikainen J, Fryers T, Lehtinen V (Eds). Improving mental health information in Europe. MINDFUL Project. Helsinki, 2006. Available at: http://www.stakes.fi/pdf/mental-health/Mindful_verkkoversio.pdf

- Molleman GR, Peters LWH,. Hommels LM, Ploeg MA. Preffi 2.0. Health Promotion Effect Management Instrument. NIGZ Netherlands Institute for Health Promotion and Disease Prevention, The Netherlands, Woerden, January 2003. Available at: http://www.nigz.nl/index.cfm?act=esite.tonen&pagina=69&a=6&b=54&c=69

- US Department of Health and Human Services. A Practitioner's Guide to Science-Based Prevention: A handbook of Promising, Effective and Model Programmes. 2002 Conference edition. Available at: http://www.nrepp.samhsa.gov/pdfs/Handbook.pdf

II. The program design, implementation and evaluation

- This project includes an analysis of the need for the intervention based on the most relevant epidemiological and sociological information available.
- The analysis incorporates a description of the health problems, the determining factors and distribution thereof, the perception thereof on the part of the community and the context within which the program is to be implemented.

1. Design of the intervention

The main aspects and the methods of the intervention are specifically defined, including:

- Target population: The target population is specified and described clearly, including the main characteristics thereof, such as the age, gender or socioeconomic level, motivational aspects as well as the channels for gaining access thereto. Cultural awareness criteria have been incorporated. Objectives: The objectives of the program are clearly defined. These objectives are realistic, measurable, coherent with the results of the analysis and can be evaluated. They have also been accepted by all of the players involved.
- Intervention techniques: The intervention is based on the techniques of proven efficacy and are well-suited to the planned objectives.
- Duration and intensity of the intervention: They duration and intensity are defined before the fact and are well-suited to the target population and the type of techniques employed.
- Pre-test or pilot trial: This intervention has been tried out in a pilot trial or pre-test for the purpose of ensuring the feasibility and possible efficacy thereof.
- This intervention is multi-component and has a bearing on several risk factors and/or safeguarding factors all at one time.
- The target population has taken part in the planning of the intervention.

2. The program implementation

There are mechanisms for guaranteeing that the program is implemented in according with that which is set out in the protocol:

- Program Implementation Manual: A document is in place incorporating the intervention protocols and other key elements for the

implementation thereof, such as the description of the procedures and activities.

- Continuing Training and Support: The professionals involved avail of continuing training and support for carrying out the activities.
- Monitoring, documentation and feedback: A procedure has been set out for monitoring and documenting the unrolling of the program. Mechanisms are also in place for assuring the feedback to the professionals concerning the evolution or the necessary adjustments therein.
- Strategies have been employed for motivating the professionals in implementing the program so as to improve their observance of and adherence to the program.
- This intervention is aimed at reaching a large percentage of the target population (coverage).

3. Evaluation

- An Evaluation Plan is in place listing the objectives of the evaluation, the researching questions, the method and time schedule, as well as the sharing out of tasks.
- The Evaluation Plan was prepared at the beginning of the project, ideally during the planning of the intervention.
- The evaluation includes an analysis of the process[2], the results[3] plus an economic analysis[4].
- The evaluation methodology is appropriate for the context, is of the utmost degree of quality and scientific rigor possible[5].
- The evaluation incorporates the determining of the short-range, medium-range and long-range effects.

[2] Evaluation of the degree to which the activities have been carried out according to the implementation plan. This may also include the record of the difficulties encountered, the users' opinions of the program and the suggestions for improvement.

[3] Evaluation of the effects caused by the intervention. This must include the study of the validity and reliability of the variables selected, the record of the missing data and abandonments, the potential confounding variables and the suitability of the analysis.

[4] Cost-effectiveness or similar study.

[5] Whenever possible, it is preferable that study methodologies of the experimental type (control group, randomizing…) be selected.

III. The organizational and coordination-related aspects

1. Coordination and leadership

- There is a person in place for coordinating or being ultimately responsible for the project. This person is qualified for carrying of this activity or has the possibility of acquiring the skills in question.
- The tasks and responsibilities are divided clearly among the professionals involved.

2. Planning and documentation

- The working plan, the methods and the organization of the project are well-established and documented clearly and concisely.
- The time schedule is realistic.

3. Necessary resources

- An estimate has been made of the material and human resources necessary, including the professional profiles or skills, and the availability thereof has been assured.
- The economic resources necessary have been clearly identified and specified. A realistic budget is in place, and the sources of funding have been identified.

4. Communication

- A communication plan is in place for facilitating that the target population and the players involved will be furnished with the necessary information on the project and the evolution thereof. This plan must include the communication channels and the points in time for these communications.

5. Dissemination

- Materials are available for the implementation of the program by other professionals, as well as training, support and evaluation resources.

References on mental health prevention and promotion programs

1. Online databases on programs which incorporate a review of the quality / efficacy thereof:

– SAMHSA (Substance Abuse and Mental Health Services Administration) Database. Available at: http://www.nrepp.samhsa.gov.

– IMHPA Database. Available at: http://database.imhpa.net/index.php?id=9.

– CASEL (Collaborative on Academic, Social and Emotional learning) Database. School programs. Available at: http://www.casel.org/database/index.php.

– HEALTHPROELDERLY Database. Programs for the promotion of the mental health of the elderly. Available at: http://www.healthproelderly.com/database.

– Campbell Collaboration Library. Available at: http://www.campbellcollaboration.org.

2. Review reports and documents which include a selection of recommended programs

– Wahlbeck K. & Mäkinen M. (Eds). (2008). Prevention of depression and suicide. Consensus paper. Luxembourg: European Communities. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/consensus_depression_en.pdf.

– Jané-Llopis, E., & Gabilondo, A. (Eds). (2008). Mental Health in Older People. Consensus paper. Luxembourg: European Communities. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/consensus_older_en.pdf.

– Jané-Llopis, E. & Braddick, F. (Eds). (2008) Mental Health in Youth and Education. Consensus paper. Luxembourg: European Communities. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/consensus_youth_en.pdf.

– McDaid (Ed). (2008). Mental Health in Workplace Settings. Consensus paper. Luxembourg: European Communities. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/consensus_workplace_en.pdf.

– Barry, M.M. & Jenkins, R. (2007). Implementing Mental Health Promotion. Oxford: Churchill Livingstone Elsevier.

– Taylor L, Taske N, Swann C, Waller S. Public health interventions to promote positive mental health and prevent mental health disorders among adults Evidence briefing. NHS. NICE Report, January 2007. Available at: http://www.nice.org.uk/nicemedia/pdf/mental%20health%20EB%20FINAL%2018.01.07.pdf.

General review documents on prevention and promotion in mental health:

– World Health Organization. Promoting mental health: concepts, emerging evidence, practice: summary report. Geneva, 2004. Available at: http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf.

– World Health Organization. Prevention of mental disorders: effective interventions and policy options: a summary report. Geneva, 2004. Available at: http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf.

–   Jane-Llopis, E., Barry, M., Hosman, C., and Patel, V., guest editors (2005) The eviden-ce of mental health promotion effectiveness: strategies for action. International Journal of Health Promotion and Education Special Supplement 2.

–   Asociación Española de Neuropsiquiatría. Consenso sobre promoción del trastorno mental y disminución del estigma de la Asociación Española de Neuropsiquiatría 2007. Available at: http://www.aen.es/web/docs/consensoprevencion_08.

Annex II. Psychotherapy quality criteria

1. Definition of psychotherapy

Psychotherapy is a scientific treatment of a psychological nature which, based on psychological or physical manifestations of human distress, promotes the achieving of changes or modifications in the behavior, the physical or psychological health, the integration of the psychological identity and the well-being of the persons or groups such as the couple or the family[1].

2. Measures included in psychotherapy

- Set out the treatment objectives in terms of the prior clinical diagnosis.
- Formalize a treatment contract with the patient, defining the objectives, number of sessions and duration thereof.
- Treatment intervention for the purpose of achieving the treatment objectives.
- Once the treatment intervention has been fully completed, evaluate the outcomes and, in consonance therewith, make the decision as to release or the need of continuing the treatment by setting out further objectives.

3. Psychotherapy objectives

- Contain and accompany the patient in the conflict resolution process.
- Reduce the clinical symptoms and suffering of the patients to the furthest possible extent.

[1] Psychotherapy User's Manual. A document prepared by the Spanish Federation of Psychotherapist Associations (FEAP) executive board members. www.feap.es. - Psychotherapy in Spain's National Health System. Basic Spanish Federation of Psychotherapist Associations document approved on June 9, 2007.. www.feap.es

4. Psychotherapy modalities

Different treatment modalities exist in terms of the orientation and the theoretical framework. Also modalities which may be applied to different age groups with different approaches: individual psychotherapies, couple and family psychotherapy, group psychotherapies, child and adolescent psychotherapies, etc.

5. Minimum criteria for the application of the following psychoterapy modalities

Type of psychotherapy	Minimum number of sessions	Minimum length of each session	How often sessions held
Individual	15	30-45 minutes	Once a week or once every two weeks
Group	25	60-90 minutes	Once a week or once every two weeks
Family	6	75 minutes	Once a month

6. Technique

The technique applied by each psychotherapist will depend upon their training and knowledge, choosing that which is most beneficial for each patient.

7. Conditions necessary for applying the psychotherapy technique

- Well-trained psychotherapists (possessing graduate degree in psychotherapy, supervised clinical practice and personal treatment process).
- Avail of an appropriate space which will provide for the patient's privacy.
- Spacious rooms for holding group psychotherapy sessions.
- Necessary, suitable material (games, furnishings, rooms) for working with children.

8. Psychotherapist accreditation criteria

Officially, through the Ministry of Health and Social Policy, there is not currently any accreditation system.

The Spanish Federation of Psychotherapist Associations has agreed in its Articles of Association what the criteria for the accreditation of psychotherapists must be, as also has the Official College of Psychologists, the Spanish Neuropsychiatry Association having later drafted accreditation criteria.

Reference Sources

– Spanish Federation of Psychotherapist Associations (FEAP). Articles of association and the 2005 rules and standards thereof. www.feap.es

– Psychotherapy User's Manual. A document prepared by the Spanish Federation of Psychotherapist Associations (FEAP) executive board members. Coordinated by Nuria Pi. www.feap.es

– Psychotherapy in Spain's National Health System. Basic Spanish Federation of Psychotherapist Associations document approved on June 9, 2007. Coordinated by Paz Flores Martínez. www.feap.es

Annex III. European service mapping schedule

It is not possible to draw longitudinal or inter-territorial comparisons without an agreed service coding system, given that services which come one same name carry out different activities and vice-versa[105, 106]. The European Service Mapping Schedule (ESMS) was developed by the European EPCAT group in 1997 for the purpose of affording the possibility of drawing comparisons within the European context. Since then, this Schedule has been used in 23 countries both within and outside of Europe[107-114], is the standard mental health service coding system in countries such as Finland[115] and has proven itself to be useful for analyzing care-providing systems from one country or region to another.

Different studies have compared the care-providing systems among different countries (Spain as compared to Italy[116] or Chile[117]) or among different ACs in Spain (Andalusia, Catalonia, Madrid, Navarre[118]).

This system makes it possible to:

1. Encode the mental health social and health care services provided and the basis type of care of a given territory in order to ascertain the availability and accessibility and to be able to draw comparisons among different territories or within one same territory over the course of time.
2. Develop quantitative indicators based on data from the real environment for the analysis of the technical efficiency of small areas (i.e. mental health sectors).
3. Analyze the use of services with transversal and longitudinal comparisons.
4. Prepare catalogs of internationally-standardized services.
5. Draw comparisons between the care-providing systems of different sectors (i.e. social, health care, penal); among different groups of patients (childhood mental health, general mental health, and psychogeriatrics) or among different diagnostic groups (cases of drug dependence, mental health, mental disability, physical disability).
6. Associate units of cost to the basic types of care provided in an area.
7. Incorporation of geographic information systems (GIS) and decision support systems (DSS).

The ESMS/DESDE system is the only system developed internationally for planning and monitoring mental health systems which affords the possibility of drawing inter-territorial comparisons.

Glossary

CARE-PROVIDING PROCESS: All activities of the health care providers (diagnostic strategies, use of supplementary tests and treatment-related decisions) and responses of the patients to these activities which are for the purpose of increasing the degree of health and satisfaction of the population for which this care is provided. *Example: "Process of providing care for an elderly patient who has a fractured hip".*

ACTIVITY: Carrying out the planned task of the professionals in each one of the spaces and with the means involved, in each one of the processes. *Example: "Motherhood Education Activities in Primary Care".*

CLINICAL PRACTICE GUIDE: Essential guidelines for taking action in view of a clinical problem backed by scientific evidence, experts or the consensus of professionals.

CLINICAL PRACTICE PROTOCOL: Thorough, detailed description of the steps and clinical measures which must be taken in view of a certain health problem in accordance with the respective clinical practice guide.

The following are included under the **TREATMENT FACILITIES OR PROGRAMS:** Community Mental Health Unit/Center/Service, General hospital hospitalization unit, Round the clock emergency care, interconsultation and liaising at general hospitals, Day hospitalization for adults, Child-adolescent day hospitalization, Child-adolescent hospitalization in general and/or children's hospital, Community rehabilitation programs (including community monitoring programs and(or assertive or similar community treatment programs, Day rehabilitation, Rehabilitation with residential or hospital support, Long-term care unit, Therapeutic community for adults, Therapeutic community for adolescents, Residential alternatives with varying degrees of support and therapeutic or rehabilitating activity, Home care program, Home (intensive care) hospitalization, Round the clock community care (including community monitoring programs and/or CAT or similar programs), Supported employment programs.

Integrated Plan for Providing Care for Severe Mental Disorders, recorded in writing on the patient's continually-updatable clinical record, including the following four aspects:

1. The evaluation of the needs of treatment, rehabilitation, care and support, as well as the foreseeable of possible risk situations.

2. The scheduling of all the measures necessary for providing a response to these needs and the criteria and time frames for the evaluation of the effect thereof.
3. The agreement between the mental health team, those of other services which were to be involved in the case, the patient and/or caregiver responsible regarding this scheduling.
4. The name of the member of the team who will be responsible for carrying out this plan and the names of the reference persons, in each one of the facilities that they patient may be using.

The Treatment Agreement for Common Mental Disorders is an agreement made between the designated therapist and the patient and set out in writing on the patient's clinical record following the initial evaluation, including the following five aspects:
1. Assigning of responsibility to the possible professionals who are taking part in the care-providing process (at least the primary care professional and the specialist).
2. Setting out the framework (how often the sessions will be held and how long each session will last, the providing of care in crisis situations, intervention of other professionals, etc.).
3. Personalized treatment objectives.
4. Estimated length of the treatment and the review and completion criteria.
5. A record is to be made on the clinical record of the report sent to primary care with the diagnosis and suggested treatment.

Management by processes adhering to ISO 9000:2000: Set of mutually interrelated or interacting activities which convert elements of entries into results.

European Study of the Epidemiology of Mental Disorders (ESEMeD): Study of a transversal design at the initiative of the World Health Organization, In Europe, this study has been conducted in six European countries (Germany, Belgium, France, Holland, Italy and Spain) and has been developed to study the prevalence, burden and care provided for persons who have mental disorders. An evaluation has been made of more than 21,400 people.

A representative sample of 21,425 adults over 18 years of age, representing more than 212 million adults in Europe was made and may therefore be considered to be the largest comparative study on the epidemiology of mental disorders in Europe. The WMH-CIDI home survey was conducted within the January 2001-August 2003 period. Many factors related to

mental disorders were evaluated, such as the risk factors, the relationship they cause with disability or associated quality of life and the use of health and drug services for the treatment thereof. A study was made of the prevalence/year and prevalence/lifetime of the main mood, anxiety and alcohol abuse-related disorders as well as the influence of the socio-demographic factors on the presence thereof and the age of onset of these disorders. The response rate varied from one country to another, Spain having been where the highest response rate was achieved (78.6%) compared to France (45.9%).

Index of abbreviations and acronyms

ATC	Anatomical Therapeutic Chemical Classification
AC	Autonomous Communities
ICD	International Classification of Diseases
MBDS	Minimum Basic Data Set at hospital release
DDD	Daily Defined Dose
DDP	Daily Dose Per Capita
DSM	Diagnostic and Statistical Mental Health Manual (American Psychiatric Association)
ENSE	Spanish National Health Survey
EESCRI	Statistics of Health Care Establishments with Confinement Regimen
RIN	Resident Intern in Nursing
ESEMeD	European Study of the Epidemiology of Mental Disorders
FEAFES	Spanish Confederation of Family Member and Mental Patient Associations
CPG	Clinical Practice Guide
IMSERSO	Spanish Institute for the Elderly and Social Services
INE	Spanish National Institute of Statistics
ISCIII	Carlos III Health Institute
RMI	Resident Medical Intern
MSC	Spanish Ministry of Health and Consumer Affairs
MSPS	Spanish Ministry of Health and Social Policy
WHO	World Health Organization
RIP	Resident Intern in Psychology
NHS	Spanish National Health System
CMD	Common Mental Disorders
SMD	Severe Mental Disorders
EU	European Union

Bibliography

1.   Thornicroft G, Szmuckler G, Editores. Textbook of community psychiatry. Oxford: Oxford University Press; 2001.

2.   Department of Health. National Service Framework for Mental Health. Modern Standards and Service Models. London: Department of Health; 1999.

3.   House of Lords and House of Commons Joint Committee on the draft mental health bill (2005) Draft Mental Health Bill: Session 200405,Vol.1. London: The Stationery Office.

4.   Scottish Executive. Mental Health Act 2003. Edimburgh: Scottish Executive; 2003.

5.   United Nations. Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. New York: United Nations; 1991.

6.   World Health Organization. Mental Health in Europe, Country Reports from the WHO European Network on Mental Health. Copenhagen: World Health Organization; 2001.

7.   World Psychiatric Association. Declaration of Madrid. Geneva: World Psychiatric Association; 1996.

8.   Sowers W. Transforming systems of care: the American Association of Community Psychiatrists Guidelines for Recovery Oriented Services. Community Ment Health J 2005;41(6):757-74.

9.   World Health Organization. Quality improvement for mental health Mental health politics and service guidance package, Copenhagen: World Health Organization; 2003.

10.   Haro JM, Palacín C, Vilagut G, Martínez M, Bernal M, Luque I, et al. Prevalencia de los trastornos mentales y factores asociados: resultados del estudio ESEMeD-España. Medicina Clínica 2006;126(12):445-51.

11.   Rocha KB, Pérez K, Rodríguez-Sanz M, Borrell C, Obiols JE. Prevalencia de problemas de salud mental y su asociación con variables socioeconómicas, de trabajo y salud: resultados de la Encuesta Nacional de Salud de España. Psicothema 2010;22(3):389-395.

12.   INE. Proyección de la Población de España a Corto Plazo, 2009-2019.

13.   Serna de Pedro I de la. Salud mental en el anciano: identificación y cuidados de los principales trastornos. Madrid: Instituto de Salud Pública; 2003. Disponible en http://www.imsersomayores.csic.es/documentos/documentos/serna-saludmental-01.pdf. Acceso el 6 de mayo 2010.

14.   S Levy B, W Sidel V. Crisis económica y salud pública. Medicina Social 2009 Jun 4(2).

15.   Prince M, Patel V, Saxena S, Maj M, Maselko J, R Phillips M, et al. Global mental health 1: No health without mental health. Lancet 2007;370:859-877.

16.   Ustün TB, Ayuso-Mateos JL, Chatterrji S, Mathers C, Murray CJ. Global burden of depressive disorders in the year 2000. British Journal of Psychiatry 2004;184:386-92.

17.   Alonso J, Lepine JP. Overview of key data from the European Study of the epidemiology of mental disorders. Journal of Clinical Psychiatry 2007;68(suppl 2):3-9.

18.   Vázquez-Barquero JL, Muñoz PE Jáuregui V. The influence of the process of urbanization on the prevalence of neurosis. A community survey. Acta Psychiatrica Scandinavica 1982;65(3):161-70.

19. Gispert R, Puig X, Palomera E, Autonell J, Giné JM, Ribas G, et al. Factores individuales y del entorno asociados a la variabilidad geográfica de los trastornos psicológicos entre áreas pequeñas: un análisis multinivel. Revista Española de Salud Pública 2006;80(4):335-347.

20. Salize HJ, McCabe R, Bullenkamp J, Hansson L, Lauber C, Martinez-Leal R, et al. Cost of treatment of schizophrenia in six European countries. Schizophrenia Research 2009;111:70-77.

21. Sicras-Mainar A, Blanca-Tamayo M, Gutiérrez-Nicuesa L, Salvatella-Pasant J, Navarro-Artieda R. Impacto de la morbilidad, uso de recursos y costes en el mantenimiento de la remisión de la depresión mayor en España: estudio longitudinal de ámbito poblacional. Gac San 2009;24(1):13-19.

22. Declaración Europea de Salud Mental del Plan de Acción de Helsinki. Available at: http://www.msc.es/organizacion/sns/planCalidadSNS/pdf/excelencia/salud_mental/opsc_est17.pdf.pdf.

23. Políticas y Prácticas Europeas en Salud Mental. Available at: http://www.euro.who.int/document/e91732.pdf.

24. Convenio Europeo para la Protección de los Derechos Humanos y de las Libertades Fundamentales: revisado de conformidad con los Protocolos nº 11 y 14: completado por el Protocolo adicional y los Protocolos nos 4, 6, 7, 12 y 13. Available at: http://www.echr.coe.int/NR/rdonlyres/1101E77A-C8E1-493F-809D-800CBD20E595/0/SpanishEspagnol.pdf.

25. Convenio Europeo para la Prevención de la Tortura y de las Penas o Tratos Inhumanos o Degradantes. Available at: http://www.cpt.coe.int/lang/esp/esp-convention.pdf.

26. Convention for the protection of Human Rights and dignity of the human being with regard to the application of biology and medicine: Convention on Human Rights and Biomedicine CETS No.: 164. Available at: http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=164&CM=8&DF=6/5/2007&CL=ENG.

27. Recommendation REC(2004)10 of the Committee of Ministers to Member States concerning the protection of the human rights and dignity of persons with mental disorder and its Explanatory Memorandum. Strasbourg: Council of Europe; 2004. Available at: https://wcd.coe.int/ViewDoc.jsp?id=775685&BackColorInternet=B9BDEE&BackColorIntranet=FFCD4F&BackColorLogged=FFC679.

28. Torres González F, Barrios Flores LF. Libertades fundamentales, derechos básicos y atención al enfermo mental (Informe al "Comité de Expertos para el desarrollo de un instrumento de referencia para el Consejo de Europa (CoE)"). Madrid: Ministerio de Sanidad y Política Social; 2007. Available at: http://www.aen.es/web/docs/libertades_fundamentales_enfermo_mental_coe-esp.pdf.

29. Recomendación CM/Rec (2009)3 del Comité de Ministros a los Estados miembro sobre seguimiento de la protección de los derechos humanos y la dignidad de las personas que padecen trastornos mentales: (aprobado por el Comité de Ministros a 20 de mayo de 2009 en la 1507 reunión de Viceministros). Available at: http://www.aen.es/web/docs/Rec_Consejo_Europa_Dchos_Humanos_SM.pdf.

30. OECD. Health at a glance 2007. Paris: OECD; 2007. Available at: http://books.google.es/books?id=VZwGd_y16VAC&dq=Health+at+a+glance+2007&printsec=frontcover&source=bl&ots=Es0DtK4DgW&sig=ykgehsOSmK7I4Wq3bvUm6lcVnrA&hl=es&ei=dalFS__rK5C64Qa_i52LAw&sa=X&oi=book_result&ct=result&resnum=3&ved=0CBkQ6AEwAg#v=onepage&q=&f=false.

31. OECD. Health at a glance 2009. Paris: OECD; 2009. Available at: http://www.oecdlibrary.org/content/book/health_glance-2009-en.

32. Libro Verde. Mejorar la salud mental de la población. Hacia una estrategia de la Unión Europea en materia de salud mental. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mental_gp_es.pdf.

33. Mensajes clave y resultados de la conferencia Estocolmo. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/ev_20090929_en.htm.

34. Blakgrounds documents Estocolmo. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/ev_20090929_bgdocs_en.htm.

35. Informe final Estocolmo. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/ev_20090929_en.htm.

36. Blackgrounds and key message Budapest. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/ev_20091210_bgdocs_en.htm.

37. Final report and conclusions Budapest: http://ec.europa.eu/health/ph_determinants/life_style/mental/ev_20091210_en.htm.

38. Todo lo referido a EU-Compass puede consultarse en la siguiente dirección http://ec.europa.eu/health/ph_determinants/life_style/mental/mental_health_compass_en.htm.

39. Bellón Saameño JA, Delgado Sánchez A, Luna del Castillo JD, Lardelli Claret P. Validez y fiabilidad del cuestionario de apoyo social funcional Duke-UNC-11. Atención primaria 1996;18(4):153-163.

40. Bellón Saameño JA, Delgado Sánchez A, Luna del Castillo JD, Lardelli Claret P. Validez y fiabilidad del cuestionario de función familiar Apgar-familiar. Atención primaria 1996;18(6):289-296.

41. Hernández Monsalve M, Lalucat L. Consenso sobre promoción de la salud mental, prevención del trastorno mental y disminución del estigma. Madrid: Asociación Española de Neuropsiquiatría; 2007.

42. Jorm AF, Barney LJ, Christensen H, Highet NJ, Kelly CM, Kitchener B. Research on mental health literacy: what we know and what we still need to know. Austral New Zeal J Psychiatr 2006:40:3-5.

43. Policies and practices for mental health in Europe WHO. Available at: http://www.euro.who.int/InformationSources/Publications/Catalogue/20081009_1.

44. Communities that Care SAMHSA. Available at: https://preventionplatform.samhsa.gov/Macro/Csap/dss_portal/templates_redesign/start1.cfm?page=http%3A%2F%2Fncadi%2Esamhsa%2Egov%2Ffeatures%2Fctc%2Fresources%2Easpx&topic_id=0&sect_id=1&CFID=3035897&CFTOKEN=29937233&link_name=Communities%20That%20Care%26reg%3B. Consultado el 12 enero 2010.

45. Guite HF, Clark C, Ackrillc CG. The impact of the physical and urban environment on mental well-being. Public Health 2006;120:1117–1126.

46. Kim D. Blues from the Neighborhood? Neighborhood Characteristics and Depression. Epidemiologic Reviews 2008;30:101-117.

47. Verheij RA, Maas J, Groenewegen PP. Urban Rural Health Differences and the Availability of Green Space. European Urban and Regional Studies 2008;15(4):307-316. Available at: http://eur.sagepub.com/cgi/content/abstract/15/4/307.

48. Sugiyama T, Leslie E, Giles-Corti B, Owen N. Associations of neighbourhood greenness with physical and mental health: do walking, social coherence and local social interaction explain the relationships?. J Epidemiol Community Health 2008;62:1-6.

49. Evans GV. Child development and the physical environment. Annu Rev Psychol 2006;57:423-51.

50. Rivadeneyra Sicilia A, Artundo Purroy C. La evaluación del impacto en salud: el estado de la cuestión. Gac Sanit. 2008;22(4):348-53.

51. Wismar M, Blau J, Ernst K, Figueras J, ed. The effectiveness of health impact assessment. Scope and limitations of supporting decision-making in Europe. Copenhagen: WHO Regional Office for Europe; 2007. Available at: http://www.euro.who.int/document/E90794.pdf.

52. Coggins T, Cooke A, Friedli L, Nicholls J, Scott-Samuel A, Stansfield J. Mental Well-being Impact Assessment: A Toolkit. Cheshire: North West, Care Services Improvement Partnership (CSISP). Available at: http://www.northwest.csip.org.uk/silo/files/mwia-toolit.pdf.

53. Hanna J, West H, Young D. Liverpool Capital of Culture Mental Well-being Impact Assessment. Available at: http://www.ukpha.org.uk/media/15thaphf/parallelD/1400%20d6%20west%20carrick1%20thurs.pdf.

54. Muñoz Rodríguez PE. 1993 Estudio de validación predictiva del General Health Questionnaire (GHQ) en población general urbana. Anales del Fondo de Investigación Sanitaria 1993. Madrid: Fondo de Investigación Sanitaria; 1993:221.

55. Rodríguez Hernández PJ. Estudio de la prevalencia de los trastornos mentales infantiles en la Comunidad Autónoma Canaria (tesis doctoral). Tenerife: Universidad de La Laguna; 2006.

56. Rodríguez Hernández PJ. Trastornos psiquiátricos infantiles de etiología neurobiológica y su despistaje en Atención Primaria. BSCP Can Pediatr 2006;30:9-18.

57. Gabilondo A, Alonso J, Pinto-Meza A, Vilagu G, Fernandez A, Serrano-Blanco A, et al. Prevalencia y factores de riesgo de las ideas, planes e intentos de suicidio en la población general. Medicina Clínica 2007;129(13):494-500.

58. European Alliance against depression and suicide SPI. Available at: http://www.spi-org.org/european_alliance.html.

59. Gabilondo A, Rojas-Farreras S, Vilagut G, Haro JM, Fernández A, Pinto-Meza A, et al. Epidemiology of major depressive episode in a southern European country: results from the ESEMeD-Spain project. J Affect Disord 2010 Jan 120(1-3):76-85.

60. Los costes de los cuidados informales en España Presupuesto y gasto público 56/2009. Available at: http://www.ief.es/Publicaciones/revistas/PGP/56_11.pdf. Consultado el 13 de febrero 2010.

61. Pekkala ET, Merinder LB. Psychoeducation for schizophrenia. Cochrane Database of Systematic Reviews 2002;(2) Art. No.: CD002831. DOI: 10.1002/14651858.CD002831. Available at: http://www2.cochrane.org/reviews/en/ab002831.html. Consultado el 13 de febrero 2010.

62. Plan Nacional de Acción para la Inclusión Social del Reino de España 2008-2010. Available at: (http://www.educacion.es/dctm/mepsyd/politica-social/inclusion-social/2009-0-plan-nac-accion-inclusion-social-2008-2010.pdf?documentId=0901e72b8003c6d2.

63. Plan de Acción para las Mujeres con Discapacidad 2007. Available at: http://www.feafes.com/NR/rdonlyres/084F4110-4A1B-4C55-9D26-372C44FFC7E4/22532/Plandeaccin-paramujeresdiscapacidad2007.pdf.

64. Estrategia Global de Acción para el Empleo de Personas con Discapacidad 2008-2012. Available at: http://www.feafes.com/NR/rdonlyres/BBC08CD6-B565-49F5-84FB-A283 34CC8461/20279/Estrategiaglobalaccinempleopersonascondiscapacidad.pdf.

65. Estrategia Global de Actuación en Salud Mental de 2007. Available at: http:// www.feafes.com/NR/rdonlyres/041A5E88-C806-48DC-8691-5FEAAC2BD32A/ 14174/ESTRATEGIAGLOBALDEACTUACI%c3%93NENSALUDMENTAL.pdf.

66. Plan Estratégico Nacional de Infancia y Adolescencia 2006-2009. Available at: http:// www.feafes.com/NR/rdonlyres/25664F1D-A5BE-4D83-846C-51ECBE31E5B4/ 15387/Planestrategiconacionalinfanciaadolescencia.pdf.

67. Promoting children's social and emotional wellbeing in primary education. NICE public health guidance 12. Londres: National Institute for Health and Clinical Excellence (NICE); 2008. Available at: http://www.nice.org.uk/nicemedia/pdf/PH012Guidance.pdf.

68. Interventions in schools to prevent and reduce alcohol use among children and young people. NICE public health guidance 7. Londres: National Institute for Health and Clinical Excellence (NICE); 2007. Available at: http://www.nice.org.uk/nicemedia/ pdf/PH007Guidance.pdf. Acceso el 10 de diciembre 2008.

69. The PATHS Curriculum: PATHS (Providing Alternative THinking Strategies). Available at: http://www.prevention.psu.edu/projects/PATHS.html.

70. Promoting Alternative Thinking Strategies (PATHS), PATHS Preschool. A Review. SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP); 2007. Available at: http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM _ID=127#replications.

71. Social and Emotional Aspects of Learning – a quick guide to these materials; 2007. Available at: http://www.standards.dfes.gov.uk/primary/publications/banda/seal/pns_137805_get _started.pdf.

72. Jané-Llopis E, Gabilondo A, Editores. Mental Health in Older People. Consensus paper. Luxembourg: European Communities; 2008. Available at: http://ec.europa.eu/health/ph_ determinants/life_style/mental/docs/consensus_older_en.pdf.

73. Ploubidis GB, Grundy E. Later-life mental health in Europe: a country-level comparison. J Gerontol B Psychol Sci Soc Sci 2009 Sep 64(5):666-76.

74. Autonell J, Vila F, Pinto-Meza A, Vilagut G, Codony M, Almansa J, et al. Prevalencia-año de la comorbilidad de los trastornos mentales y factores de riesgo sociodemográficos asociados en la población general de España. Resultados del estudio ESEMdD-España. Actas Esp Psiquiatr 2008;35(Suppl.2):4-11.

75. Have M, Graaf R, Ormel J, Vilagut G, Kovess V, Alonso J. Are attitudes towards mental helath-seeking associated with service use? Results from the European Study of Epidemiology of Mental Disorders. Soc Psychiat Epidemiol 2009. DOI 10.1007/s00127-009-0050-4.

76. Codony M, Alonso J, Almansa J, Vilagut G, Domingo A, Pinto-Meza A, et al. Uso de fármacos psicotrópicos en España. Resultados del estudio ESEMeD-España. Actas Esp Psiquiatr 2007;35(Suppl.2):29-36.

77. Fernández A, Pinto-Meza A, Bellón JA, Roura-Poch P, Haro JM, Autonell J, et al. Is major depression adequately diagnosed and treated by generalpractitioners? Results from an epidemiological study. Gen Hops Psychiatr 2010;32(2):201-9.

78. Giron M, Nolasco A, Pereyra-Zamora P, Munarriz M, Salazar J, Tabarés R, et al. Self-reported chronic mental health problems and mental health service use in Spain. Chronic Illness 2009;5:197–208.

79. Moreno B, Arroyo B, Torres-González F, Luna JD, Cervilla J. Social predictors of outpatient mental health contact in schizophrenia patients. Soc Psychiatr Psychiatric Epidemiol 2007;42(6):452-456.

80. Codony M, Alonso J, Almansa J, Vilagut G, Domingo A, Pinto-Meza A, et al. Utilización de los servicios de salud mental en la población general española. Resultados del estudio ESEMeD-España. Actas Esp Psiquiatr 2007;35:21-28.

81. Communities that Care SAMHSA. Available at: https://preventionplatform.samhsa.gov/Macro/Csap/dss_portal/templates_redesign/start1.cfm?page=http%3A%2F%2Fncadi%2Esamhsa%2Egov%2Ffeatures%2Fctc%2Fresources%2Easpx&topic_id=0&sect_id=1&CFID=3035897&CFTOKEN=29937233&link_name=Communities%20That%20Care%26reg%3B. Consultado el 12 de enero 2010.

82. Bravo Ortiz MF, Coord. Hacia una atención comunitaria de Salud Mental de calidad. Madrid: Asociación Española de Neuropsiquiatría; 2001.

83. Cardo E, Servera M, Llobera J. Estimación de la prevalencia del trastorno por déficit de atención e hiperactividad en población normal de la isla de Mallorca. Revista de Neurología 2007;44:10-14.

84. Lobo-Escolar A, Saz P, Marcos G, Quintanilla MA, Campayo A, Lobo A. ZARADEMP Workgroup. Somatic and psychiatric comorbidity in the general elderly population: results from the ZARADEMP Project. J Psychosom Res 2008 Oct 65(4):347-55.

85. Lobo A, Campos R, Marcos G, García-Campayo J, Campayo A, López-Antón AR, et al.Somatic and psychiatric co-morbidity in Primary Care patients in Spain. Eur J Psychiat 2007;21(1):71-78.

86. Pinto-Meza A, Fernández A, Fullana MA, Haro JM, Palao D, Luciano JV, et al. Impact of mental disorders and chronic physical conditions in health-related quality of life among primary care patients: results from an epidemiological study. Qual Life Res 2009;18(8):1011-1018.

87. Fleischhacker WW, Cetkovich-Bakmas M, De Hert M, Hennekens CH, Lambert M, Leucht S, et al. Comorbid somatic illnesses in patients with severe mental disorders: clinical, policy, and research challenges. J Clin Psychiatry 2008;69:514-9.

88. De Hert M, Schreurs V, Vancampfort D, Van Winkel R. Metabolic syndrome in people with schizophrenia. A Review World Psychiatry 2009;8(1):15-22.

89. Tabarés-Seisdedos R, Gómez-Beneyto M, Haro JM, González Pinto A, Vieta E. The importance of negative comorbidity. J Clin Psychiatry 2009;70(8):1191-1192.

90. COCE. Center for Substance Abuse Treatment. [Sede Web] Overview Papers 1 to 8. DHHS Publications Rockville MD: Substance Abuse and Mental Health Services Administration and Center for Mental Health Services; 2007. Available at: http://coce.samhsa.gov/products/overview_papers.aspx. Acceso el 18 de diciembre 2008.

91. Report of the UEMS Section of Psychiatry. Quality Assurance of Standards in Specialist Psychiatric Care. Discussion Draft. Union Européene des Médecins Spécialistes; 2006. Available at: http://www.uemspsychiatry.org/section/reports/GreenPaperResponse.pdf.

92. Bond GR, Drake RE, Becker DR. An Update on Randomized Controlled Trials of Evidence-Based Supported Employment Psychiatric Rehabilitation Journal 2008;31(4):280-290.

93. Burns T, Catty J, Becker T, Drake RE, Fioritti A, Knapp M, et al. The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial. Lancet 2007;370:1146-52.

94. Killackey E, Yung AR. Effectiveness of early intervention in psychosis. Curr Opin Psychiatry 2007;20:121-5.

95. Marshall M, Rathbone J. Early Intervention for psychosis. Cochrane Database of Systematic Reviews 2006;(4) Art. No.: CD004718. DOI: 10.1002/14651858.CD004718.pub2.

96. Lehman AF. Early intervention for psychosis and schizophrenia. J Nerv Ment Dis 2007;195:965-7.

97. Bertelsen M; Jeppesen P, Petersen L, Thorup A, Øhlenschlæger J, et al. Five-Year Follow-up of a Randomized Multicenter Trial of Intensive Early Intervention vs Standard Treatment for Patients With a First Episode of Psychotic Illness. Arch Gen Psychiatry 2008;65:762-71.

98. Kulhara P, Banerjee A, Dutt A. Early intervention in schizophrenia. Indian J Psychiatry 2008;50:128-34.

99. Dodgson G, Crebbin K, Pickering C, Brabban A, Paxton R. Early intervention in psychosis service and psychiatric admissions. Psychiatric Bulletin 2008;32:413-16.

100. Cognitive behavioural therapy for the management of common mental health problems Available at: http://www.nice.org.uk/usingguidance/commissioningguides/cognitivebehaviouraltherapyservice/cbt.jsp.

101. The Depression Report. A New Deal for Depression and Anxiety Disorders London School of Economics. Available at: http://cep.lse.ac.uk/textonly/research/mentalhealth/depression_report_layard.pdf.

102. Department of Health NHS [Sede Web]. Londres: Department of Health; 2008. Improving Access to Psychological Therapies implementation plan: national guidelines for regional delivery Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083150.uk. Acceso el 10 de diciembre 2008.

103. Crawford MJ, Rutter D, Manley C, Weaver T, Bhui, Fulop N, et al. Systematic review of involving patients in planning and development of health care. BMJ 2002;325:12-63. Available at: http://bmj.com/cgi/content/full/325/7375/1263. Consultado el 25 de Septiembre 2008.

104. Gómez Beneyto M. La participación de los usuarios: ¿qué opinan los profesionales?. En: Carmona J, Del Río Noriega F, Coordinadores. Gestión Clinica en salud mental. Madrid: AEN; 2009.

105. Johnson S, Kuhlmann R; EPCAT Group. European Psychiatric Assessment Team. The European Service Mapping Schedule (ESMS): development of an instrument for the description and classification of mental health services. Acta Psychiatr Scand Suppl. 2000;(405):14-23.

106. Salvador-Carulla L, Poole M, Gonzalez-Caballero JL, Romero C, Salinas JA, et al. RIRAG/PSICOST Group; DESDE Consensus Panel. Development and usefulness of an instrument for the standard description and comparison of services for disabilities (DESDE). Acta Psychiatr Scand Suppl. 2006;(432):19-28.

107. Dernovsek MZ, Sprah L. Assessment of mental health services in Slovenia with The European Service Mapping Schedule. Psychiatr Danub 2008 Sep 20(3):439-42.

108. Dernovsek MZ, Sprah L. A preliminary report on the implementation of the European Service and Mapping Schedule (ESMS) in Slovenia to map preventive and promotion activities in mental health. Psychiatr Danub 2008 Jun 20(2):141-7.

109. Rezvyy G, Oiesvold T, Parniakov A, Ponomarev O, Lazurko O, Olstad R. The Barents project in psychiatry: a systematic comparative mental health services study between Northern Norway and Archangelsk County. Soc Psychiatry Psychiatr Epidemiol 2007 Feb 42(2):131-9.

110. Salvador-Carulla L, Tibaldi G, Johnson S, Scala E, Romero C, et al. CSRP group; RIRAG group Patterns of mental health service utilisation in Italy and Spain—an investigation using the European Service Mapping Schedule. Soc Psychiatry Psychiatr Epidemiol 2005 Feb 40(2):149-59.

111. Trypka E, Adamowski T, Kiejna A. [Presentation of the cost-effectiveness technique questionnaire—the possibility of the Polish adaptation] Psychiatr Pol. 2002 Nov-Dec 36(6 Suppl):389-96.

112. Adamowski T, Trypka E. "European Service Mapping Schedule" (ESMS)—instrument used to describe the structure of mental health care. Psychiatr Pol 2002 Nov-Dec 36(6 Suppl):369-76.

113. Becker T, Hülsmann S, Knudsen HC, Martiny K, Amaddeo F, et al. EPSILON Study Group. European Psychiatric Services: Inputs Linked to Outcome Domains and Needs. Provision of services for people with schizophrenia in five European regions. Soc Psychiatry Psychiatr Epidemiol 2002 Oct 37(10):465-74.

114. Böcker FM, Jeschke F, Brieger P. [Psychiatric care in Sachsen-Anhalt: a survey of institutions and services with the "European Services Mapping Schedule" ESMS] Psychiatr Prax. 2001 Nov 28(8):393-401.

115. Pirkola S, Sund R, Sailas E, Wahlbeck K. Community mental-health services and suicide rate in Finland: a nationwide small-area analysis. Lancet 2009 Jan 10;373(9658):147-53.

116. Salvador-Carulla L, Tibaldi G, Johnson S, Scala E, Romero C, Munizza C. CSRP group, RIRAG group. Patterns of mental health service utilisation in Italy and Spain-an investigation using the European Service Mapping Schedule. Soc Psychiatry Psychiatr Epidemiol 2005 Feb 40(2):149-59.

117. Salvador-Carulla L, Saldivia S, Martinez-Leal R, Vicente B, Garcia-Alonso C, Grandon P, et al. Meso-level comparison of mental health service availability and use in Chile and Spain. Psychiatr Serv 2008 Apr 59(4):421-8.

118. Moreno K, Sanchez E, Salvador-Carulla L. Methodological advances in unit cost calculation of psychiatric residential care in Spain. J Ment Health Policy Econ 2008 Jun 11(2):79-88.

HEALTH