

Summary of the Strategy in Mental Health of the National Health System

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



REDACTION TECHNICAL COMMITTEE

Scientific Coordinator

Manuel Gómez Beneyto

Experts

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(Spanish Society of Doctors of Primary Health Care)

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(Spanish Society of Psychiatry)

Amparo Belloch Fuster
(Spanish Association of Clinical Psychology and Psychopathology)

Antonio Espino Granada
(Independent Expert)

Alberto Fernández Liria
(Spanish Association Neuropsychiatry)

Mariano Hernández Monsalve
(Independent Expert)

Asensio López Santiago
(Spanish Association of Medicine for the Family and Community)

Rosa Ruiz Salto
(Spanish Confederation of Groups of Family and People with Mental Illness)

José María Sánchez Monge
(Spanish Confederation of Groups of Family and People with Mental Illness)

COLLABORATING INSTITUTIONS

General Management of Penitentiary Institutions
Andalusian School of Public Health
Health Institute Carlos III
Spanish Society of Psychiatric Epidemiology
Rey Juan Carlos University

INSTITUCIONAL COMMITTEE OF THE CC.AA.

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Aragón: Ana Riveses Aunes

Asturias (Principality of): José Fernández Díaz

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Rioja (La): Adolfo Cestafe Martínez

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Rosa Blanca Pérez López – Chief of the Office of Health Planning and Quality

Technical and Methodological Support

Isabel del Cura González

Carlos Mingo Rodríguez

Isabel Montero Montero

Isabel Ruiz Pérez

Olga Solas Gaspar

Silvia Vázquez Fernández del Pozo

Administrative and Logistic Support

Isabel Esteban Sánchez

Ilyana Mendoza Castro

Rosa M^a Pinerós González

Translator

Edward Carlos Jorre

Gema Martín De Bustos

Summary elaborated by

Eusebio Rasillo Rodríguez

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Prologue

Around 450 million people in the world is estimated to suffer a mental or behavioural disorder in a given moment of their life.

The World Health Organization (WHO) estimates that a third of the years lived with disability can be attributed to disorders of neuropsychiatry. Globally, 12% of them are due only to depression.

Mental disorders are frequent or common in all countries; they cause enormous suffering, difficulties in the learning capacities of children and interfere significantly in the life of the people which suffer them. Apart from the disability and premature mortality due to suicide which sometimes originate, they also tend to produce the social isolation of those who suffer it.

Mental disorders as a whole constitute the most frequent cause in burden in Europe, before cardiovascular illnesses and cancer. It is estimated that one in four families has at least one person with mental disorders. The impact of mental disorders on the quality of life is superior to chronic illnesses such as arthritis, diabetes or cardiac and respiratory diseases. Unipolar depression ranks as the third cause in illness burden, after the coronary ischaemia and strokes, representing the 6% of the burden caused by all illnesses.

In Spain, excluding the disorders caused by inadequate use of substances, it can be affirmed that today, 9% of the population suffers at least one mental disorder and that more than 15% will suffer it throughout their life. These numbers will probably increment in the future. Mental disorders affect more to women than to men and increase with age.

Mental disorders also increase the morbidity which is derived from suffering other illnesses like cancer, cardiovascular diseases, diabetes or aids. The non treatment or control of mental disorders brings forward a worsening of the fulfilment of the therapeutic regimes and worst prognosis in these pathologies.

The majority of mental disorders are minor or transient and, in the majority of cases, there are therapeutic and effective rehabilitation measures. Moreover, evidence exists that interventions directed in the promotion of mental health and the prevention of mental disorders increment and facilitate the insertion of the individual in the community and decrease the social and economic costs.

For this, and bearing in mind that improving the attention of mental health in Spain is one of the strategic objectives of the Ministry of Health and Consumer Affairs, from the Agency of Quality of the Ministry, in coordination with the Autonomic Communities, the scientific societies and the associations of patients, this “Strategy in Mental Health of the National Health System” has been prepared.

The Strategy is based in the philosophy and contents of the Helsinki Declaration in Mental Health, based by the European Regional Office of the WHO and which was signed by Spain in 2005. The Strategy adopts, therefore, an integrated approach which combines the promotion of mental health, the prevention of mental disorders, the diagnosis and the treatment of patients, the inter and intrainstitutional coordination, as well as to adopt measures which encourage the work and social insertion of the people which suffer these disorders.

The Strategy constitutes a support text for the nationwide coordination of the plans or promotion programmes of mental health, of the prevention programmes and the diagnosis, therapeutic and rehabilitation measures appropriated to make a complete and continuous attention of the people with mental disorders. The Strategy also includes within its objectives to power research in mental health and create tools which allow the evaluation of the progress in the knowledge inside this field, as well as the advancements and setbacks detected in its development.

The Strategy has been made by experts in all disciplines related to mental health, coordinated by Doctor Manuel Gómez-Beneyto, and in it technicians of the Health Councils of the Autonomic Communities and of the Ministry of Health and Consumer Affairs have participated. For its elaboration the proceedings and plans taken forward in Spain as well as the European Union and the WHO have been taken into account, as well as by other organisms such as the European Council and the OCDE, among others.

This Strategy is part of the Quality Plan for the National Health System and represents an agreed effort between the Ministry of Health and Consumer Affairs, the scientific societies, the associations of patients and the Autonomic Communities to achieve a better attention to people with mental disorders, based in clinical excellence and in equal conditions in the whole territory. In this way, it contributes to the cohesion of our health system in benefit to the citizens independently to where they reside.

With this initiative, the health services, the professionals and the patients have available an instrument of enormous utility for the improvement of the citizens health in general and of the people with mental disorders in particular.

For this, I wish to manifest our thanks to all those who have participated in the preparation of this document, because the result of their work will contribute without doubt to improve the quality of the health attention in the National Health System.

José MARTÍNEZ OLMOS
General Secretary of Health

Introduction

In these last two decades, since the Report of the Ministerial Commission for the Psychiatric Reform in 1984 was published, important economic, social, political, technical and scientific changes have taken place. Motivated by the interests in providing a health service adapted to the changing needs of the country, at the end of 2004, the Ministry of Health and Consumer Affairs called together all the professional and citizens associations directly interested in mental health and the Autonomic Communities for them to reflect over if such changes could require the development of a new framework or strategy of action plan to face them. Thanks to the collaboration of all, two groups of work were configured: one, the Scientific Committee, constituted by representatives of professional and citizen's societies (Spanish Society of Physicians for Primary Health Care, Spanish Society of Psychiatry, Spanish Association of Clinical Psychology and Psychopathology, Spanish Association of Neuropsychiatry, Spanish Society of Family and Community Medicine, and Spanish Confederation of Groups of Family Members and People with Mental Illness), as well as three independent experts appointed by the Ministry of Health and Consumer Affairs, and another, the Institutional Committee, made up by the representatives of all Autonomic Communities.

In January 2005, coinciding with the start of the work meetings by the Scientific Committee, an Intergovernmental Conference was being celebrated in Helsinki summoned by the WHO, the European Community and the Ministry of Health of Finland about the necessity of stimulating the interest in mental health in Europe and therefore make the issue a priority in the ministerial agendas. The Conference concluded with a Declaration, subscribed and signed by all the ministers present, including the Spanish, and a Plan of Actions.

The Scientific Committee adopted from the beginning the Helsinki Plan of Actions as a solid base for the development of the Strategy in Mental Health of the National System of Health, for two reasons : because the content of the Plan was technical, scientific and ethically reasonable, and because to adopt it meant a convergence in Europe.

As a third step for the making of the Strategy it was decided to describe and analyse where the situation of mental health and illness was in Spain, not an easy task as the information around this issue was scarce and incomplete. For this reason the Spanish Society of Psychiatric Epidemiology was ordered to make a report with other sources which has served as a base for the corresponding chapter in this document.

At sight of the epidemiologic information and with the technical support of the Ministry and other collaborating entities, the Scientific Committee proposed itself to make context and priority the Helsinki Plan of Actions. Three principles guided the discussion from the beginning : accept only the agreements reached unanimously with the aim of achieving maximum consensus within the reality of the State of the Autonomies, agree specific proposals sensitive to objective evaluation and finally, consider real approaches with proven efficiency on scientific tests or in the experience, always within the framework of a biopsychosocial and community conception of the attention, as the General Legislation in Health points out in its 21st article.

In September 2006, once the draft which embraced the general and specific objectives, the technical recommendations to achieve them, as well as a set of indicators for its evaluation was completed, the Scientific Committee met with the Institutional Committee to discuss and agree on it. The contributions of the representatives of the Autonomic Communities allowed to identify and fill up gaps, widen the objectives and the recommendations and, especially, to provide the document with greater coherence and global sense.

In parallel, motivated by the wish to show the feasibility of the set objectives and with the aim of providing technical information around these, the Ministry of Health and Consumer Affairs requested the Health Councils of the Autonomic Communities effective examples which were working in its limits and which could be set as examples. In this way a series of “good practice examples” were obtained which are provided as a complement to the document of the Strategy. The aim of it is to show the feasibility of the objectives and to provide to those interested in developing such programmes the necessary data to get in touch with the people responsible of this creation.

The limits pointed by the criteria which were adopted for the debate – unanimity, evaluation and reality - together with the respect to the health competences appropriate to the Autonomic Community, have resulted in a set of proposals which is characterized for representing a common strategy feasible to our environment and its under this perspective in which it must be understood and valued. The strength of this proposal is not in its technical or scientific part, which also, but specially in the authority which confers it to reflect a shared unanimous opinion.

The psychiatry and psychology dragged in the past by speculation and ideology are now areas which base their approaches in the experience and scientific method. In general, all the professionals which have participated in the creation of these documents have shown and given signs of flexibility and pragmatism. In no such way the stigmatizing vision, which still today falls upon them, of being a collective dominated by fantasy and unable to agree is true.

Once concluded, the final draft was remitted for its evaluation and suggestions to be contributed by a series of societies, which is listed in the appendix.

Finally, the proposal was approved unanimously in the Interterritorial Council celebrated December 2006.

The use of this document to influence reality is still to be seen. It won't be easy.

Manuel Gómez Beneyto
Coordinator of the Strategy in Mental Health of the SNS

Technical note

This document is composed of two different parts:

1. - General Aspects – where the justification, history and methodology of the Strategy are undertaken (Pages. 9-12)
2. - The objectives of the Strategy in Mental Health of the SNS approved by the Interterritorial Council of the National Health System on 11th December 2006 – where we find the detailed objectives, recommendations and the evaluation system of the Strategy, all of them treated as priority and agreed by the Committee of Technical Redaction and the Institutional Committee of the Autonomic Communities. (Pages. 12-48)

1. Justification

The attention to the mental health in Spain is a strategic aim for the Ministry of Health and Consumer Affairs. Already in its first parliamentary appearance in the Parliament at the Commission of the Health Congress, on May 31st 2004, the Health and Consumer Affairs Minister anticipated that among the Department's priorities, and in collaboration with the Autonomous Communities, was to promote the mental health, adopting a «strategic initiative» to stimulate activities of prevention, early diagnosis, treatment, rehabilitation and social reintegration.

Since the approval of the General Health Law and the Ministerial Commission for the Psychiatric Reform, 20 years since then, many changes in the political, legislative, conceptual and technical order have occurred, which affect the citizens' health and have been undertaken in a different way by the health institutions of the Autonomous Communities generating rich diversity but also inequalities.

Mental disorders are frequent or common in all countries; they cause enormous suffering, difficulties in the learning capacities of children and interfere significantly in the life of the people which suffer it. Apart from the disability and premature mortality due to suicide which sometimes originate, they also tend to produce the social isolation of those who suffer it.

Mental disorders as a whole constitute the most frequent cause in illnesses burden in Europe, after cardiovascular illnesses and cancer¹. It is estimated that one out of four families has at least a member with mental disorder. The impact of mental disorders on the quality of life is superior to chronic illnesses such as arthritis, diabetes or cardiac and respiratory diseases. Unipolar depression ranks as the third cause in illness burden, after the coronary ischaemia and strokes, representing the 6% of the burden caused by all illnesses². There is not enough data to assess the amount of money that illness supposes to Europe, but it is estimated to be in between 3 and 4% of the PNB.

In Spain, excluding the disorders caused by inadequate use of substances, it can be affirmed that today, 9% of the population suffers at least one mental disorder and that more than 15% will suffer it throughout their life. These numbers will probably increment in the future³. Mental disorders affect more to women than to men and increase with age. The distribution of prevalence-life by Autonomous Communities is relatively uniform, ranging between the 15,71% of Andalusia and the 23,68% of Catalonia. With respect to the economic repercussion, the total cost in 1998 was estimated in 3.005 million euros being mental disorders the cost of 10.5% of lost days for temporary incapacity, and around 6.8% of lost years in working life for long-term disability⁴. More than half of the people who need treatment don't receive it, and of those under treatment; a significant percentage does not receive the adequate one. The most severe mental disorders additionally generate an important family burden which usually falls upon the mother or a sister of the patient⁵. Some of the reasons of the most visible growing lack of safety in the streets are associated to the mental illness in the collective's imaginary when in reality these contribute little to the generation of these blots on society⁶, therefore being fundamental to take initiatives to increase the knowledge of the mental illness and help to reduce the stigma and the exclusion associated to the people and family members who suffer these disorders.

1.1. Principles and Values of the Strategy

The principles and values of the strategy lie on those of the community's mental health model backed by the General Health Law (1986) and by the report of the Ministerial Commission for the Psychiatric Reform. The basic principles of the community's model on attention to mental health are basically:⁷⁸⁹¹⁰¹¹¹²¹³¹⁴¹⁵

- *Autonomy*: the capacity of the service to respect and promote the independency and self-sufficiency of the people.
- *Continuity*: the capacity of the network to provide treatment, rehabilitation, care and support continuously with no interruptions throughout its life (longitudinal continuity) and coherently, among the services which compose it (transversal continuity).
- *Accessibility*: the capacity of the service to supply assistance to the patient and his/her family members when and wherever they need it.
- *Comprehensiveness*
- *Equity*: distribution of the health and social resources, adequate to the quality and provided in the quantity to the needs of the population in agreement to explicit and rational criteria.
- *Personal recuperation*: recuperation after a serious mental disorder implies two processes, parallel and complementary which require to be promoted in a specific way.
- *Responsibility*: acknowledgement in the responsibility of health institutions towards patients, family members and the community.
- *Quality*: characteristics of the services which look for increasing continuously the probability of obtaining the results they wish, using procedures based in evidence.

2. History and Methodology of the Elaboration

Bearing in mind that improving the attention of mental health in Spain is one of the strategic objectives of the Ministry of Health and Consumer Affairs at the end of 2004; and twenty years after the Commission's Report for the Psychiatric Reform; it assumes the project of elaborating a mental health strategy for the National Health System.

From the Quality Agency of the Ministry, all the professional and citizens associations directly interested in mental health were called in to reflect to see whether such changes would require the development of a new framework or strategy of action to undertake them.

Thanks to everybody's collaboration, two work groups were configured:

- **Scientific Committee**, coordinated by Dr. Manuel Gómez-Beneyto, professor of Psychiatry of the University of Valencia, and constituted by representatives of professional and citizens societies:
 - Spanish Society of Doctors in Primary Health Care ,
 - Spanish Society of Psychiatry,
 - Spanish Association of Clinical Psychology and Psychopathology,
 - Spanish Association of Neuropsychiatry,
 - Spanish Association of Medicine for the Family and Community,

- Spanish Confederation of Groups of Family and People with Mental Illness, as well as
- Three independent experts designated by the Ministry of Health and Consumer Affairs.
- **Institutional Committee**, formed by the representatives of all the Autonomic Communities whose principle function has been to give value to the pertinence and viability of the proposed objectives; as it is the Communities themselves and their health services those responsible of organizing and providing the services.

The work methodology of the Writing Technical Committee.

- It was continued with the *description of the current situation* and the future trends, the opportunities and the challenges of the National Health System and the CC.AA., with the aim of configuring the scenario of the strategy with a short and mid term execution horizon.
- Three principles guided the discussion from the beginning:
 - accept only agreements reached unanimously.
 - agree concrete proposals susceptible to an objective evaluation.
 - consider realistic settings with supported efficiency by scientific proof or experience.

Once concluded, the final draft was remitted for its evaluation and suggestions to be contributed by a series of societies. Finally, the proposal was approved unanimously in the Interterritorial Council which was celebrated in Madrid, 11th December 2006.

3. Development of the Strategic Lines

Six strategic lines were proposed, which are sustained in a framework of values and principles which have been mentioned in the previous section:

- **Strategic line 1: Promotion of mental health in the population, prevention of mental illness and clearance of the stigma associated to the people with mental disorder.**
- **Strategic line 2: Attention to mental disorders.**
- **Strategic line 3: Interinstitutional and intrainstitutional coordination.**
- **Strategic line 4: Health staff training.**
- **Strategic line 5: Mental health research.**
- **Strategic line 6: Information system on mental health.**

The strategic action lines are displayed in general and specific objectives, with its corresponding technical recommendations and its follow up and evaluation indicators. Additionally, an epigraph of good practices is included which has been developed in the Spanish context where their efficiency and effectiveness has been demonstrated.

Logically, the strategic lines have not the same entity or complexity; therefore, its operational display in general and specific objectives is not homogeneous in reference to its width (number of objectives that integrate it) nor in relation to the diversity of the proposed interventions.

3.1. Promotion of Mental Health in the Population, Prevention of Mental Illness and Clearance of The Associated Stigma over the People with Mental Disorder

JUSTIFICATION:

The results of the assistance experience centred exclusively in the provision of attention services demonstrate that to achieve better levels of positive mental health is not enough to treat the mental illnesses, but also the necessity of policies, strategies and directed intervention, in specific way, to improve it. Therefore, it is necessary to change the emphasis of the traditional point of view, centred in mental disorders, towards a new perspective which takes into consideration the promotion of mental health.

In order to promote mental health actions must be undertaken. At individual level, reinforcing the “resilience” with interventions increasing self-esteem and providing skills to face the stress. At general level, with interventions to increase the social capital, promote healthy rearing conducts, improve safety, and reduce the stress in schools and in work settings.

CURRENT SITUATION IN SPAIN:

It is not easy to obtain information about promotion and prevention activities in Spain. After looking for clinic essays, meta-analysis and practice guides it is revealed a very scarce scientific production, nearly null, in the last five years.

OBJECTIVES AND RECOMMENDATIONS:

General Objective 1: Promote mental health in the general population and in specific groups.

Specific Objectives

- 1.1. Formulate, make and evaluate a set of interventions to promote the mental health in each of the age groups or life stages: childhood, adolescence, adult life and elderly people.
- 1.2. Formulate, make and evaluate a set of interventions oriented to asses and report the institutional responsible of the central, autonomic and local administrations about the existing relation between the actions of institutional character and mental health.
- 1.3. Develop, between the Ministry of Health and the Autonomic Communities, a set of interventions oriented to the promotion of mental health through the mass media.

Recommendations:

1. The interventions in the promotion of mental health will be directed to specific groups of the population and will be part of the strategies of action in the primary, and specialized health care, and public health. These actuaciones will integrate a specific plan or will be integrated in the promotional plans of health or of mental health in the Autonomic Communities.
2. It is recommended interventions of proved effectiveness and oriented to improve the resilience, such as facing the stress, searching social support, learning techniques of problem solving, increasing self-esteem and the development of social skills, among others.

3. In the interventions directed to institutional representatives, the central role of mental health as generator of wellbeing and productivity will be noted, and the importance of the habitat interaction (urban environment) the education (human capital), the possibilities of citizens participation (social capital) and gender with the mental health of the population, as well as the negative socioeconomic consequences derived from ignoring them.
4. The Ministry of Health and Consumer Affairs and the CC.AA. will develop interventions directed to the mass media to implicate them in the promotion of mental health.

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

Specific objectives

- 2.1. Make and evaluate a set or “community interventions” plan in areas of high risk of social exclusion or rejection with the aim of acting over the determinants of the mental disorders and addictions.
- 2.2. Make and evaluate a set or plan of interventions, inside the mentioned in the National Plan of Drugs and, in its case, in the Autonomic Community, with the aim of reducing the use and abuse of addictive substances in the region.
- 2.3. Make and evaluate specific actions to reduce the rates of depression and suicide in risk groups.
- 2.4. Develop interventions in primary health care directed to offer support to the families which care for and attend people with chronic disabled illnesses, to prevent the problems in mental health which could be derived from the performance of their role.
- 2.5. Make and evaluate a set of support actions to the prevention services and the committees of health at work settings in the Autonomic Communities in order to prevent stress at work and the mental disorders associated at work.
- 2.6. Make and evaluate interventions addressed to professionals to prevent the professional burn out.

Recommendations:

1. The proposed priority areas of intervention are: prevention of violence, eating disorders, the consumption of substances, social isolation, and the prevention of the discrimination and gender violence.
2. Make preventive interventions directed to risk groups in the early infancy and adolescence (children of parents with mental disorder or with addictions, children victims of abuse or abandonment and others...) with respect to their definition in previous epidemic studies.
3. Develop preventive interventions, preferable specific workshops and training in skills for the prevention of depression and suicide, in each of these following environments: 1) teaching institutions; 2) prison institutions, and 3) geriatric institutions.
4. Make community interventions oriented to improve the social dynamics in geographical areas with high social risk and/or psychiatric morbidity, which will have the aim of reducing the determinants and/or the consequences of violent

content in the streets (vandalism) at schools (bullying) and in the house (gender violence and/or infant and old persons abuse). It is a must to obtain, for the making of these actions, the participation of other departments such as housing, infrastructures, work, education, women institutions or others, at local and region level.

5. The Ministry of Health and Consumer Affairs and the Autonomic Communities, through its representatives in the bodies of direction/participation relative to the Safety and health at work in their respective region, will promote the inclusion of actions for prevention of “psychosocial risks” (work stress) and mental disorders associated with work in the working health plans.
6. Make and evaluate interventions oriented to inform and educate around the risks which have, for the health in general and for the mental health in particular, the consumption of addictive substances in adolescents.
7. Make and evaluate interventions to prevent the problems in mental health of the caretakers and family members of dependent people with chronic illnesses and of people with mental illnesses.
8. Facilitate and promote the development of psychoeducative programmes for family members and caretakers of people with chronic illnesses subject to dependency, and of people with mental illnesses, which favour the adequate handling of situations generated by the caring of these ill people.

General Objective 3: Clear the stigma and discrimination associated to the people with mental disorders.

Specific objectives

- 3.1. The Ministry of Health and Consumer Affairs and the Autonomic Communities will include in their plans and programmes interventions which promote the integration and reduce the stigmatization of people with mental disorders.
- 3.2. The Ministry of Health and Consumer Affairs and the Autonomic Communities will promote initiatives to revise and act over the normative barriers which could affect the full exercise of citizenship of the people with mental disorders.
- 3.3. The assistance centres will have available specific rules in their protocols and proceedings, directed to promote integration and avoid the stigma and discrimination against people with mental disorders.
- 3.4. The admission of people with mental disorders in acute phase will be made in psychiatric units integrated in the general hospitals, conveniently adapted to the needs of these patients. The Autonomic Communities will adequate progressively the necessary infrastructures for the fulfilment of this objective.
- 3.5. The Ministry of Health and Consumer Affairs will promote coordinated initiatives with the WHO, the European Union and other international institutions in the area of the promotion of integration and fighting against the stigma and the discrimination.

Recommendations:

1. Implementation of mechanisms which permit to identify in the current legislation and in the new legislation proposals, barriers which obstruct the citizen’s exercise of the people with mental disorders.

2. The interventions directed to promote the integration and reduce the stigma of the people with mental illnesses will be directed preferably to health, communication, teaching staff and students, entrepreneurs and social agents, mentally disordered people's associations and their family members .
3. The rules and the internal procedures of the Autonomic Communities will be adapted to promote integration and reduce the stigma and discrimination of people with mental disorders and their families. This will take place, fundamentally, in the internal regulation of the facilities of health care. These adaptations in the Autonomic Communities must include a gender transversal approach and must adequate their texts to a non sexist language.
4. The psychiatric units will adequate progressively their spaces, equipment, furniture, staff and organisation to the particular needs of people with mental disorders: leisure needs, relationship, occupation, participation, respecting their privacy, dignity and freedom of movement.
5. With the objective of avoiding unnecessary hospital stays and assuring the care continuity and an alternative and adequate location to home and the hospitalization, it is highly recommended to have available a series of alternative residences which promote the living together and integration of the people with a serious mental disease which require them.
6. Through cohesion funds, promotion and prevention projects will be aimed to the clearance of the stigma and will favour the social and working insertion without gender discrimination.

Indicators for the evaluation of the general objectives 1, 2 y 3: (see detailed point 4.1)

1. Percentage of people in risk of bad mental health.
2. Declared prevalence of depression, anxiety or other mental disorders.
3. Percentage of people who declare to consume drugs.
4. Percentage of adolescent scholars who declare to consume drugs.
5. Percentage of alcohol risk drinkers.
6. Autolesion rate of discharge.
7. Mortality rate of suicide.
8. Psychiatric beds for acute patients in general hospital per 100.000 inhabitants.
9. Beds in monographic hospitals per 100.000 inhabitants.
10. Social and family support.
11. Disability due to mental disorder.

Qualitative Report (see detailed point 4.2): The contents and the structure of this Report will be agreed by the Ministry of Health and Consumer Affairs and the Autonomic Communities in the Commission for the Follow-up of the Strategy.

3.2. Attention to Mental Disorders

JUSTIFICATION:

The community's attention network was developed initially to attend patients with serious mental disorders but as time went by the demand for attention to common disorders has increased. In the countries with a national health system, most of the problem are attended and resolved at the primary health care level, and only between a tenth and a twentieth part are derived to the mental health services¹⁶. The results of

studies made in other countries suggest that, with an adequate organization and coordination, the treatments in the community are not only socially much more adequate and accessible, but that also, can be quite much cheaper. In Spain, as well as in other countries around ours, the available data indicates that GPs identify 50% of their psychiatric patients at the first visit showing that a small percentage of these need to be sent to the second level.

CURRENT SITUATION IN SPAIN:

The implementation of the community's model in Spain has been heterogeneous in the different Autonomous Communities. The assistance devices (mental health centres or units, hospitalization units in general hospitals, day hospitals, rehabilitation units or centres of day regime and of admission, therapeutic communities, residential facilities, employment alternatives, etc) have been developed in different unequal manners, under different established names. There are also differences in the definition of facilities which are considered healthcare and those considered social, as well as the access and financing of these in the different Autonomous Communities¹⁷.

Although common mental disorders constitute a substantial volume of visits to family doctors, these not always receive the adequate training to diagnose and treat them, and neither they have the time to do it, therefore conditioning many patients to receive only pharmacological treatment when in many cases they could benefit from multidisciplinary approaches with support and brief psychological advise strategies and techniques¹⁸.

At the specialized level, the attention to common mental disorders represent a growing demand which takes away capacity to more serious and disabling mental disorders fundamentally due to insufficient number of specialists and assistance devices.

THE CURRENT SITUATION OF THE ATTENTION TO CHILDREN AND ADOLESCENTS WITH MENTAL DISORDERS:

An important budgetary effort has made possible the development, unequal but significant, of supplementary "psychopedagogic" resources, facilitating in this way the integration of these children in a "normalized" school environment. Some specific programmes of special attention are: eating disorders, pre-addictive and addictive conducts and the serious conduct disorders.

THE CURRENT SITUATION OF THE ATTENTION TO ELDERLY WITH MENTAL DISORDERS:

Currently, the majority of Autonomous Communities have incorporated in their health plans and/or gerontological plans and/or mental health plans assistance objectives with reference to mental disorders of the elderly in general and/or dementia in particular. The development of specific attention systems to these problems shows, however, the common diversity linked to the territorial organization of the State¹⁹²⁰²¹²².

OBJECTIVES AND RECOMMENDATIONS:

General Objective 4: Improve the quality, equity and continuity of the attention to mental health problems.

Specific objectives

4.1. Develop and implement effectively by the Autonomous Communities in their competences framework, the benefits which are included in their services portfolio of the National Health System, both at Primary Care and specialized care.

- 4.2. The Autonomic Communities will establish supporting procedures both at specialized and primary care for the early detection and treatment of mental disorders.
- 4.3. The Autonomic Communities will establish attention guidelines to the psychiatric emergencies and crisis situations, collaborating with the different involved sectors.
- 4.4. Increase the percentage of patients with mental disorders which receive psychotherapy, according with the best available practices.
- 4.5. Increase the percentage of patients with serious mental disorders which are included in a rehabilitation programme.
- 4.6. Increase the percentage of families with serious mentally disorder patients who receive a specific family intervention programme, to improve their capacity to face the crisis and prevent relapses.
- 4.7. Provide and adequate care of general health to the serious mentally disordered patients.
- 4.8. The Autonomic Communities will contemplate, in their mental health plans, the necessary specifications for the specialized care of people with intellectual disability and mental disorder.
- 4.9. The Autonomic Communities will adequate the units with specific programmes to respond to the needs of children and adolescents in the subject of mental health.
- 4.10. The Ministry of Health and Consumer Affairs will develop with the Autonomic Communities a collaboration model with the Justice Bodies and Penitentiary Institutions to improve the attention of mentally disorder people subjected to the Penal Code and the Under Age Law, assuring the continuity and equity care to the rest of the population.
- 4.11. Establish, in each of the health territorial structures, the access to all the sufficient therapeutic and rehabilitation devices or programmes, to face the needs population, assuring the assistance continuity through an integrated network of services, where the general hospitals will be included, and in coordination with primary care.
- 4.12. Establish, for the mentally disorder people in treatment, an individualized attention plan.
- 4.13. The availability, in the mental health teams in the community limits and in relation to serious prolonged mental disorders, an organized system to avoid the abandonment, facilitate the adhesion and which includes the home assistance, as well as the multisectorial management and coordination in its assistance process.
- 4.14. Define and implement in the field of each Autonomic Community the clinical protocols of the most prevalent attention processes and/or of greatest assistance complexity in the different stages of life. The gender perspective as well as the specific problems of certain risk groups will be taken into consideration.
- 4.15. Elaborate, adapt or adopt, and later implement, in the Autonomic Community limits the use of clinical practice integrated guides, in accordance to the priorities and quality criteria established by the National Health System.
- 4.16. The Autonomic Communities will have strategies to increase the quality, effectiveness, safety and reduce the variability of pharmacological treatments, following the rational use criteria of the medicine.

Recommendations:

1. The Health National System's Services Portfolio is a generic document which defines the functions of the primary care and specialized care in the attention of mental health. It is recommended that the Autonomic Communities, in the framework of their competences, develop it in a concrete and specific way.

2. All the serious mentally disorder patients diagnosed must have the chance of being included at early stages in a rehabilitation programme.
3. It is recommended to include the access to all the therapeutic and rehabilitation devices or programmes, both in the adult in the children-adolescent age, in the health territorial structures¹. These devices must take into account the sociofamily differences of men and women.
4. Two types of individual attention plans are proposed: the Integrated Plan of Attention for patients with Serious Mental Disorder², and the Therapeutic Agreement for Common Mental Disorder³ patients.
5. It is recommended organizing structures oriented to improve the assistance continuity to people with serious mental disorder, reduce the number of hospitalization and improve their social and quality of life functioning. Two reference models are proposed: the “Community Assertive Treatment” and the “Programmes of Care Continuity”.
6. It is recommended to protocol the following attention processes: common mental disorder in adults, serious mental disorder in adults, serious mental disorder in advanced age, serious mental disorder of personality, common mental disorder in infants and adolescents, serious mental disorder in infant-juvenile stage and the generalized disorder of the developing stages .
7. Each Autonomic Community will implement guides of clinical practice of the most serious and prevailing mental disorders⁴. It is recommended the clinical practice

¹ With respect to the therapeutic devices or programmes, they are considered, among others: Unit/Centre/Service of Community Mental Health, Unit of hospitalization in general hospital, 24hours a day Emergency Attention, interconsultancy and links in the general hospitals, Day Hospitalization for adults, Infant-Juvenile Hospitalization, Infant-Juvenile Hospitalization in general and/or paediatric hospital, Rehabilitation Community Programmes (including assertive continuous and/or treatment community programmes or similar), Day Regime Rehabilitation, Residential or Rehabilitation supported Hospital, prolonged care Units, Therapeutic Community for Adults, Therapeutic Community for Adolescents, Residential Alternatives with support gradation and therapeutic or rehabilitation activity, Programmes of home attention , Home (intensive attention) Hospitalization, 24 hours Community Attention (including continuous and/or TAC treatment programmes or similar), Employment Programmes with support.

² The Integrated Attention Plan for TMC, reflected in the clinical background of the patient, continuously updated, includes the following aspects :

1. The evaluation of treatment, rehabilitation, care and support needs, as well as the prevision of possible risk situations.
2. The programming of all necessary actuations to give answer to all these needs, and the criteria and time needs for the evaluation of the effect.
3. The agreement between the mental health team and the other services which could be involved in the case, the patient and/or the responsible caretaker with reference to this programme.
4. The name of the team’s member which will be responsible of the execution and of the referring people, in each of the devices which the patient could use.

³ The Therapeutic Agreement for the TMC, is an agreement established between the designated therapist and the patient and is reflected in writing in his/her clinical history after the initial evaluation, which includes the following five aspects:

1. Responsibility assignment to the possible professionals which participate in the attention process (at least one primary doctor and one specialized facultative).
2. Establishment of the framing (frequency and duration of the sessions, attention in crisis situations, interventions of other professionals, etc.).
3. Personalized objectives of the treatment.
4. The prevision of the treatment’s duration and of the revision and termination criteria.
5. It will be recorded in the clinical history the report referred to primary attention with the diagnosis and the proposed treatment.

⁴ Schizophrenic Disorder and other similar psychosis, Serious Personality Disorders, Diet Conduct Disorders, Bipolar Disorder, Disorders of the depressive spectrum, Anxiety Disorders, Adaptive Disorders, somatoform Disorders, Disorders associated to the use of substances, Insanity and Serious Cognitive Disorders, General Disorders of Development, Disorders due to disturbing conducts in the infancy, Serious Emotional Disorders initiated in Infancy, Intervention in crisis.

guides or other tools based in the evidence which have incorporated the general perspective.

8. Provide in a continuous way, scientific information about utility, effectiveness and cost-efficiency of the medication to health professionals and patients.
9. It is recommended the introduction of analysis and monitoring elements to control the variability in the prescription according to sex.

General Objective 5: Implement involuntary contention procedures which guarantee the use of good practices and the respect of rights and dignity of the patients.

Specific objectives

- 5.1. Elaborate a general guide referring to good practices, about ethical and legal aspects of the assistance practice of any mode of intervention, against the patients will.
- 5.2. Define or update by the Autonomic Communities a protocol for transfers and the involuntary hospitalization.
- 5.3. Regulate, by protocol means, the procedures for the physical contention, the involuntary treatment of hospitalized patients and any freedom restrictive measure.

Recommendations:

1. The protocol will be elaborated with the collaboration of all the potentially implicated agents in the procedures of the involuntary hospitalization: mental health and Law professionals, police, sanitary transport and family associations and users.
2. In addition to the protocol, an operative version will be elaborated; “involuntary hospitalization procedure “; of individual application, where each of the steps, time, name and signatures of all implicated agents will be registered.
3. In the same way, protocols and ways of application to patients which require physical contention and involuntary treatment during involuntary hospitalization will be elaborated.
4. The protocols will adjust to the current legislation and will contemplate the principle of minimum necessary restriction, the respect and dignity of people with mental disorders, avoiding the stigmatization and putting special emphasis in the agility and reactivity of the procedure.
5. Develop an informed consent model for family members for assistance situations which imply the adoption of the before restrictive measures, according to the established in the articles 8 and 9 of the Law of the patient’s autonomy.

Indicators for the evaluation of general objectives 4 and 5: (see detailed point 4.1)

1. Integrated clinical practice guides which comply with the quality criteria of the SNS.
2. Daily dose per inhabitant (DDI) of antidepressants.
3. Daily dose per inhabitant (DDI) of antipsychotics.
4. Daily dose per inhabitant (DDI) of hypnotic, relaxing, anxiolytic substances.
5. Percentage of re-entries.
6. Attended morbidity.
7. Percentage of discharge to penitentiary patients in non penitentiary hospitals.

Qualitative Report: (see detailed point 4.2.) The contents and structure of this Report will be agreed between the Ministry of Health and Consumer Affairs and the Autonomic Communities in the Commission for the Follow-up of the Strategy.

3.3. *Instainstitutional and Interisntitutional Cordination*

JUSTIFICATION:

The main objective of the intrasectorial and intersectorial coordination in mental health is to maintain the assistance continuity, increase the consistency of actions and messages, and achieve a system which works efficiently. The integration of the mental health in the general health system, the unification of all services and the territorial sectorization are the basic elements which allow a coordinated functioning. Other important elements to mention are a working network system, the integrated clinical history, the multidisciplinary team, diverse specific organizing methods (including an attention by processes) and the implication of users and family members in the assistance tasks.

CURRENT SITUATION IN SPAIN:

In these last two decades we have seen in Spain an effective integration of mental health in the general health system; although in some areas still persist monographic units of hospitalization. It has also been achieved the unification of municipal networks, of provincial and autonomic deputations, and practically, although not completely, the whole the share of the neuropsychiatric body has disappeared. However, the tendency to externalize services, especially social services, is generating in some autonomies the appearance of private management devices which don't integrate in the public network set or they only integrate partially²³²⁴. With respect to the coordination with social services it doesn't exist or its insufficient. The assistance by multidisciplinary teams is consolidated but its functioning not always responds to the principal of the necessary interaction between its members. The sole computerized clinical history is still not implemented in Spain in a general way.

OBJECTIVES AND RECOMMENDATIONS:

General Objective 6: Promote the cooperation and the shared responsibility of all the departments and agencies involved in the improvement of mental health.

Specific objectives

- 6.1. The Autonomic Communities must implement efficient coordination mechanisms of coordination and cooperation at institutional and interinstitutional level, which guarantee the integrated care of the people.
- 6.2. The Autonomic Communities will establish a general framework which determines the implication and role of "Promotion Law of Personal Autonomy and Attention to People in a Dependency Situation" dependent people due to mental illness.
- 6.3. The Autonomic Communities must implement, in their competences framework, efficient mechanisms of assistance coordination inside the territorial structure of health, between the diverse health and social devices involved in the attention to serious mental disorders.

Recommendations:

1. The Autonomic Communities will develop and promote the contemplated aspects in the "Promotion Law of Personal Autonomy and Attention to People in a Dependency Situation".
2. It is recommended, inside the Autonomic Communities competences and in accordance with the "Promotion Law of Personal Autonomy and Attention to People in a Dependency Situation", to create a Commission of Interdepartmental

- Coordination between the Health Councils, Social Services, Employment, Education, Housing, Justice, Economy and Finance, as well as with the Home Office and others which could be implicated, for : 1) integrate policies in mental health, and 2) advise in the elaboration of the autonomic Mental Health Plan.
3. Design, implement and evaluate a coordination model with the Social Services, Education and Justice which guarantees the continuity of the care to children and adolescents under treatment.
 4. Design, implement and evaluate a coordination model with Primary Attention and Social Services which guarantees the continuity of the care of the population in advanced age in their residential environment, under the protection of the established in the “Promotion Law of Personal Autonomy and Attention to People in a Dependency Situation”.
 5. Create mechanisms of coordination in the limits of the Autonomic Community to guarantee the integrated attention to the problems of drug dependency inside the mental health.
 6. Design, implement and evaluate a coordination model with the penitentiary institutions and shelter and residential centres.
 7. In the case of agreement and/or buy of services, quality and evaluation criteria will be set, as well as coordination and integration criteria with the organized structure of attention to mental health of the Autonomic Community.

General Objective 7: Promote the participation of people which suffer mental disorders and of their family members and professionals in the public health system of the Autonomic Community.

Specific Objectives

- 7.1. Develop in each Autonomic Community, an information strategy directed to the people with mental disorders and their families, concerning the rights and obligations, resources and services they can use, and the administrative procedures to dispatch suggestions and complaints.
- 7.2. Implement in each Autonomic Community mechanisms and ways for the participation of the people with mental disorders and their family members in all the fields of mental health, including the planning and evaluation of services.
- 7.3. Establish by the Autonomic Communities the mechanisms and ways of participation of scientific and professional societies related to mental health in the planning and evaluation of services.

Recommendations:

1. In the consultancy and advice bodies related to mental health, the availability of the representatives of associations of professionals of mental health will be present.
2. In the consultancy and advice bodies related to mental health, the availability of the associations of users and families of people with mental disorder representatives will be present .
3. For an effective participation of users and family members’ associations it is necessary to reinforce its continuity and independence. For that, the representative associations which could act as interlocutors in questions which concern them in mental health matters will be backed up.
4. Support and advice mechanisms to associations of family members and people with mental disorders will be established for them to exercise with efficiency the functions of mutual support, fight against the stigma and defence of their rights.

Indicators for the evaluation of general objective 6 and 7: (see detailed point 4.1)

1. Map of devices of mental health.
2. Psychiatrists ratio per population

Qualitative Report (see detailed point 4.2): The contents and structure of this Report will be agreed between the Ministry of Health and Consumer Affairs and the Autonomic Communities in the Commission of the Follow-Up of the Strategy.

3.4. Training of the Sanitary Staff

JUSTIFICATION:

In the first field of action, the primary health attention, only in the training program of Family and Community Medicine, the training and rotation in Psychiatric units is contemplated. In the specialized care field for mental health, the postgraduate trainings in Psychiatry, Clinical Psychology and Specialized Nursing in Mental Health are regulated, although this last specialization is not demanded as condition to work as a nurse in a mental health centre or in a hospital unit, if however, it would be desirable a progressive implementation of this requirement.

CURRENT SITUATION IN SPAIN:

In Family and Community Medicine training and rotation around Psychiatric units is contemplated. The regulation in the psychiatry specialization, clinical psychology and mental health nursery is positive but can be improved: increase the length of training, promote audits directed to improve the quality, create an information system to facilitate the management and finally promote the continuous training.

OBJECTIVES AND RECOMMENDATIONS:

General Objective 8: Promote the training of the professionals of the sanitary system to adequately attend the needs of the population in the matters of mental health.

Specific objectives

8.1. The availability in Autonomic Communities of a Continuous Training Plan for all the primary care professionals, of mental health and all those professionals in specialized care related to the attention of people with mental disorders, in the framework of the biopsychosocial attention model⁵.

Recommendations:

1. Widen this training to the primary attention staff which works in Penitentiary Institutions.

⁵ The contents of the continuous training in mental health of the professionals of primary attention can be, preferably, the following: Early detection and intervention techniques to the most prevalent mental disorders (anxiety, depressions, adaptive disorders), Approach to the normal and pathologic mourning, Early detection and intervention techniques by somatisation, Early detection and intervention techniques of the psychiatric disorders associated to chronic somatic illnesses, Communication techniques with people who present mental disorders and their family members, Capacitating in support therapies, Rational use of psychopharmacom, Strategies of shared care with specialized attention and social services.

With respect to the content of the training for professionals of specialized care in mental health, the following sections will be considered with priority: Effective and safe psychotherapy techniques for the treatment of common mental disorders, Community intervention techniques, Evaluation techniques and psychological and neuropsychological techniques, Psychosocial rehabilitation techniques, Effective and safe pharmacological treatment techniques, Updating in the neuroscience field and its clinical applications, Rational use of psychopharmacom.

2. The Ministry of Health and Consumer Affairs through its competent bodies together with the Autonomic Communities, will revise the professional profiles necessary for the future specialists, the accreditation criteria of the educational units and the education model in general. All this with the aim of lining up the training of specialists to the needs of the population according to the community model.
3. Revise the current model of Psychiatry and Clinical Psychology specializations to include as areas of preference capacitating: Infant and Adolescent Psychiatry and Psychology, Psychology of Health, Psychotherapy, and Psychogeriatrics, Forensic and Addictions Psychiatry and Psychology.
4. The development of the Continuous Training Plan will be based in the following principles:
 - a. Focus in the problems which must be detected and resolved by the implicated professionals, taking into account the morbidity and the demand of the population.
 - b. Base in an analysis of the training needs of all the professionals implicated to attend such disorders.
 - c. Promote the continuous training through meetings of primary attention professionals together with the mental health teams.
 - d. Give priority to activities of participant learning in small groups, such as workshops, clinical sessions and case supervision sessions, incorporating the “best available practices”.
 - e. The training programmes must take into account work and family conciliation.
 - f. The resulting and specific needs in mental health of the population in each health area will be considered (ex. culture diversity, domestic and gender violence, immigration, etc.)

Indicators for the evaluation of general objective 8:

Qualitative Report: (see detailed point 4.2.) The contents and structure of this Report will be agreed between the Ministry of Health and Consumer Affairs and the Autonomic Communities in the Commission of the Follow-up Strategy.

3.5. Investigation in Mental Health

JUSTIFICATION:

The Strategy contemplates in its priorities the promotion and arranging of the investigation related to the fields of knowledge useful to evaluate the efficiency and generate new evidence for the development of a modern system and permanently updated in promotion, prevention, treatment, rehabilitation and mental health care. Great difficulty exists to transfer the knowledge provided by the basic research, even by the applied research, to the clinic and from the clinic to the basic research. The results of the research aren't recognized and implemented by the health Administrations with the agility which would be desirable. Summarizing, the basic, clinical, evaluative and translational research, with a biopsychosocial view and in priority integrator, constitute the principal field and orientation of the mental health research.

CURRENT SITUATION IN SPAIN:

The majority of the national scientific production is published in international magazines as few specialized publications exist in Spain. Of the total number of research studies made in the last twenty years, mental health is placed in fourth position

in the subjects researched, accounting 8.7% of the produced total. If we consider the published studies according to pathologies, the sum of the studies in primary attention in addictions (alcohol, tobacco and others) and anxiety and depression represent 9.6% and in this case, the research in mental health occupies the first place²⁵. With respect to the institutional sectors in which the research is made, the greatest production in all disciplines, except psychoanalysis, is in universities, nearly half of the total, followed by the health centres. The psychoanalysis dominates in other institutions and scientific societies. Less production is seen in the public research bodies (CSIC, ISCIII) and in the pharmaceutical companies, but these last ones are the ones which present better ratings in number of references per article, number of documents with ratings and international collaboration.

RECOMMENDATIONS AND OBJECTIVES:

General Objective 9: Promote the research in mental health

Specific objectives

9.1. The Ministry of Health and Consumer Affairs and the Autonomic Communities will promote through the inclusion of call ups, research projects, interdisciplinary research lines with priority in mental health.

9.2. The Autonomic Communities and the Ministry of Health and Consumer Affairs will put into action measures which promote the creation of guaranteed networks in research centres and excellence groups in mental health.

Recommendations:

1. The Autonomic Communities will make as priority, in its territorial limits, the lines of research in mental health with respect to the needs of the population. The inclusion of gender perspective in all the research lines will be promoted.
2. Research-action projects must be pushed and supported which implicate the multidisciplinary character and coordination between various health areas of the same Autonomic Community.
3. Improve the training for those researching in basic and applied techniques of research in mental health.
4. Establish a stable working framework for the mental health researchers.
5. The Autonomic Communities will make priority in their calls the subject area in mental health and gender.

Indicators for the evaluation in general objective 9(see detailed point 4.1):

1. Number of research projects.
2. Mental health research network.

Qualitative Report: (see detailed point 4.2). The contents and structure of this Report will be agreed between the Ministry of Health and Consumer Affairs and the Autonomic Communities in the Commission of the Follow-up Strategy.

3.6. Information and Evaluation Systems

JUSTIFICATION:

The development of an indicated system to structure the measuring in the different fields of action is, without doubt, necessary to assure the quality of the information used be it whichever the reach of it²⁶. This will allow us to take periodic measurements both,

of the applied angles or focus as well as the display of the strategy itself, with the aim of having available, objective data which sustain the progress towards good results in relation to their interest groups. One of the greatest lacks after the psychiatric reform has been the lack of reliable information since the beginning in all the territory of the State to make a correct follow-up of the changing process in psychiatry in the National Health System.

CURRENT SITUATION IN SPAIN:

As from the psychiatric reform, in some Autonomic Communities it was posed the need of using tools which could allow the evaluation of the reform objectives, trying to overcome the information systems of purely administrative character. The current existing information about mental health is centred on:

- Estimation about diverse incident and prevalence problems of mental health based in specific studies.
- Mortality caused by some pathologies included in the concept of mental health.
- Assistance resources and activity.
- Annual information about the existing hospital resources in Spain and by CC.AA, and the global activity developed in them, which are recorded in the National Catalogue of Hospitals (CNH) and in the Statistics of Health Establishments with Institutionalizing Regime (ESCRI).
- Specific comparative studies made by initiative of some Autonomic Communities and/or of scientific associations.
- Attended morbidity through hospital admission, obtained through the Minimum Basic Set of Data (CMBD) at hospital discharge.
- Descriptive information about the functional organization of the mental health services at autonomic level.

OBJECTIVES AND RECOMMENDATIONS:

General Objective 10: Improve knowledge of the mental health and the provided attention by the National Health System.

Specific objectives

- 10.1. Obtain information about the general mental health level of the population.
- 10.2. The availability, at National Health System level, of information about the main causes of attendant morbidity.
- 10.3. The availability, at National Health System level, of integrated information about the organization, the specific devices and resources dedicated to the mental health attention.

Recommendations:

1. Introduce in the National Health Survey a new specific module which allows obtaining a general mental health index of the population, through validated systems.
2. To recommend that those Autonomic Communities in which in their health surveys use wider or specific validated question forms for the knowledge of the mental health levels, to put them in common and to distribute the result of their experiences to the whole of the National Health System.
3. The information system of the Autonomic Communities must guarantee the homogeneity and comparability with strong and consistent indicators, and value the

- nomenclature standardization of the mental health services and devices according to the existing models.
4. Agree and implement exploitation systems of clinical information of attended patients in the local health centres by the mental health specialized services compatible to the SNS level.
 5. Promote at the time of developing register and exploitation systems of data at local and/or autonomic level the compatibility of, the technical as well as the technological criteria, in the clinical computerizing processes of the diverse assistance fields (primary attention, specialized community and hospital attention).
 6. It would be recommended to revise the existent variables and identify new ones which include the gender inequalities in mental health.
 7. Including the “National Register of Centres, Services and Health Establishments “(RECESS) the related devices with the attention to mental health, authorized for this purpose by the Autonomic Communities. Elaborate with such information a “directory” and a “map of resources of mental health of the SNS”.
 8. Compile and inform to the whole of the SNS the different organizing and coordination initiatives which the Autonomic Communities put into action for the mental health attention with other institutions, especially with the Social Services.
 9. The Subcommittee of the Systems of Information of the SNS ,as a designated body by the Interterritorial Council of the SNS for the coordination in matters of the System of Health Information, must lead and validate all the necessary information concerning mental health.
 10. The Autonomic Communities, through the mentioned Subcommittee, will agree the ways of compilation and make common the information which has been made priority, as well as the access and the distribution of the information directed to the population, the professionals and health Administrations.
 11. Incorporate in progressive way to the different information systems of each Autonomic Community, the specific information about mental health.

Indicators for the evaluation of general objective 10:

Qualitative Report: (see detailed point 4.2). The contents and structure of this Report will be agreed between the Ministry of Health and Consumer Affairs and the Autonomic Communities in the Commission of the Follow-up Strategy

4. Evaluation Systems

4.1. Indicators

General objectives 1, 2, 3: General Mental Health of the Population

- **Percentage of people in risk of a bad mental health**

Formula:

$ID = a) \times 100 / b)$, where:

- a) Total number of people surveyed which obtain punctuation in specific questionnaires about mental health, which is over the lintel over which is considered that is in risk of bad mental health.
- b) Total number of people surveyed.

Definitions/Clarifications:

In the case of children aged 4 to 15 years, the questionnaire SDQ will be used and in the case of adults the GHQ-12 questionnaire.

Levels of desegregation:

By CCAA, age groups and sex.

Sources of information:

National Health Survey.

Periodicity:

Biennial.

• **Declared prevalence of depression, anxiety or other mental disorders**

Formula:

ID = $a) \times 100 / b)$, where:

- a) Number of people surveyed who declare to have suffered depression, anxiety or other mental disorders.
- b) Number of people surveyed.

Definitions/Clarifications:

Population over 16 years.

Levels of desegregation:

By CCAA, age groups and sex.

Sources of information:

National Health Survey.

Periodicity:

Biennial.

• **Percentage of people who declare to consume drugs**

Formula:

ID = $a) \times 100 / b)$, where:

- a) Total number of people surveyed who declare to consume some kind of psychoactive substance.
- b) Total number of people surveyed.

Definitions/Clarifications:

It is included as psychoactive substances: hallucinogenic, amphetamines, cannabis, cocaine, ecstasy, heroine, hypo relaxing and volatile inhalers.

Levels of desegregation:

By CCAA, age groups and sex.

Sources of information:

Component a): Government Delegation for the National Plan of Drugs.

Spanish Observatory of Drugs-“Domiciliary survey about the drugs abuse in Spain. (EDADES)”.

Component b): Population projections of INE.

Periodicity:

Biennial.

- **Percentage of adolescent scholars who declare to consume drugs**

Formula:

$ID = a) \times 100 / b)$, where:

- a) Total number of people surveyed, aged 14 to 18 years, who declare to consume any kind of psychoactive substances.
- b) Total number of people surveyed in that age.

Definitions/Clarifications:

The surveys are directed to students aged 14 to 18 years who are in secondary education: ESO, O level and A level studies and training Cycles of medium level or equivalent (Professional Training II).

Levels of desegregation:

By substance type, for CCAA, age groups and sex.

Sources of information:

Component a): Government Delegation for the National Plan of Drugs.

“State survey about the use of drugs in Secondary Education” (ESTUDES).

Component b): Population projections of INE.

Periodicity:

Biennial.

- **Percentage of alcohol risk drinkers**

Formula:

$ID = a) \times 100 / b)$, where:

- a) Total number of people surveyed who declare to consume alcohol in risk considered quantities or in excess.
- b) Total number of people surveyed.

Definitions/Clarifications:

The alcohol consumption is quantified with respect to the frequency and consumption quantity, where it is considered a risk drinker a person who consumes the equivalent or more than 40g/day in the case of a man, and 20g/day in the case of a woman. It is referred to people of 16 or over.

Levels of desegregation:

By CCAA, age groups and sex.

Sources of information:

Component a): MSC- Health National Survey.

Component b): Population projections of INE.

Periodicity:

Biennial.

- **Autolesion rate of discharge**

Formula:

$ID = a) \times 100.000 / b)$, where:

- a) Total number of discharges by auto inflicted lesions, in one year.
- b) Population in that year.

Definitions/Clarifications:

It will be included all those discharges where the codes E950/E959 figure of the CIE classification in its 9-MC version, both in the main diagnosis as well as in the secondary one. Decease discharges will be excluded from these codes.

Levels of desegregation:

By CCAA, age groups and sex.

Sources of information:

Component a): Hospital discharge at CMBD.
Component b): Population projections of INE.

Periodicity:

Annual.

- **Mortality rate of suicide**

Formula:

$ID = a) \times 100.000 / b)$, where:

- a) Total number of people who die via suicide in one year.
- b) Population in that year.

Levels of desegregation:

By CCAA, age groups and sex.

Sources of information:

Component a): Statistics of Deceased from INE.
Component b): Population projections of INE.

Periodicity: Annual.

- **Psychiatric beds for acute patients in general hospitals per 100.000 inhabitants**

Formula:

$ID = a) \times 100.000 / b)$, where:

- a) Number of beds in use in the psychiatric assistance area of acute patients, in general hospitals.
- b) Population.

Definitions:

The ones included in the self ESCRI

Sources:

Component a): Statistics of... (ESCRI).

Component b): Population projections of INE.

Desegregation:

By CCAA, by dependency (if wanted...) note: there are beds for long-term psychiatric stays in general hospitals

Periodicity:

Annual.

• **Psychiatric beds in monographic hospitals per 100.000 inhabitants**

Formula:

$ID = a) \times 100.000 / b)$, where:

a) Number of beds in use in the psychiatric monographic hospitals.

b) Population.

Definitions:

The ones included in the self ESCRI

Sources:

Component a): Statistics of... (ESCRI).

Component b): Population projections of INE.

Desegregation:

By CCAA, by dependency, by beds for acute patients and for long-term stays in hospitals

Periodicity:

Annual.

• **Social and family support**

Formula:

$ID = a) \times 100 / b)$, where:

a) Total number of people surveyed who obtained punctuation in the index of perceived personal and affective support, which is over the lintel where its considered that is in risk of a bad mental health.

b) Total number of people surveyed.

Definitions/Clarifications:

(Lintel to be established).

Levels of desegregation:

By CCAA, age groups and sex.

Sources of information:
MSC- Health National Survey.

Periodicity:
Biennial.

- **Disability due to mental disorder**

Formula:

$ID = a) \times 1.000 / b)$, where:

- a) Number of people, who declare to suffer a disability due to mental disorder.
- b) Population.

Definitions:

The criteria of the WHO are followed with respect to the use of the international classifications about disabilities, deficiencies and disabled.

Sources:

Component a): Disabilities, deficiencies and state of health surveys, of INE.

Component b): Population projections of INE.

Desegregation:

By CCAA, age groups, sex, disability grade.

Periodicity:

Aproximatelly, every 10 years.

Observations:

These surveys are made with a sample of approximately 220.000 people. The last ones made, correspond to the years 1986 and 1999.

It is proposed to exclude the age group of under 6 as, if also these children are analyzed in a specific way, the analysis correspond more to other health problems as causes of the disability.

General objectives 4 y 5

- **Integrated clinical practice guides which comply with the quality criteria of the SNS**

Formula:

$ID = a) \times 100 / b)$, where:

- a) Total number of clinical practice guides which comply with the quality criteria established for the whole of the National Health System (Guíasalud project)
- b) Total number of clinical practice guides which have been evaluated.

Levels of desegregation:

None, the whole of the SNS.

Sources of information:

Ministry of Health and Consumer Affairs.

Periodicity:

Annual.

- **Daily dose per inhabitant (DDI) of antidepressants**

Formula:

$ID = a) \times 1.000 / b)$, where:

- a) Total number of daily defined dose (DDD) of antidepressants, dispensed in a year.
- b) Population that year, multiplied by 365 days.

Definitions/Clarifications:

The ATC classification will be used, and in the time being, the population adjusted by actives and pensioners. However, as the information system measures allowed the adjustment by age groups will be made.

Levels of desegregation:

By CCAA. By actives and pensioners. In the future, by age groups and sex.

Sources of information:

System of information of pharmaceutical consumption of the SNS.

Periodicity:

Annual.

- **Daily dose per inhabitant (DDI) of antipsychotics**

Formula:

$ID = a) \times 1.000 / b)$, where:

- a) Total number of daily defined dose (DDD) of antipsychotics, dispensed in a year.
- b) Population that year, multiplied by 365 days.

Definitions/Clarifications:

The ATC classification will be used, and for the time being, the population adjusted by actives and pensioners. However, as the information system measures allow it the adjustment by age groups will be made.

Levels of desegregation:

By CCAA. By actives and pensioners. In the future, by age groups and sex.

Sources of information:

System of information of pharmaceutical consumption of the SNS.

Periodicity:

Annual.

- **Daily dose per inhabitant (DDI) of hypnotic, relaxing and anxiolytic substances**

Formula:

$ID = a) \times 1.000 / b)$, where:

- a) Total number of daily defined dose (DDD) of hypnotic and relaxing, and/or of anxiolytics, dispensed in a year.
- b) Population that year, multiplied by 365 days.

Definitions/Clarifications:

The ATC classification will be used, and in the time being, the population adjusted by actives and pensioners. However, as the information system measures allow it the adjustment by age groups will be made.

Levels of desegregation:

By CCAA. By actives and pensioners. In the future, by age groups and sex.

Sources of information:

System of information of pharmaceutical consumption of the SNS.

Periodicity:

Annual.

- **Percentage of re-entries**

Formula:

$ID = a) \times 100 / b)$, where:

- a) Total number of discharges for a given reason to the same patient in the year.
- b) Total number of discharges for that reason.

Definitions/Clarifications:

Includes all hospitals which have beds dedicated to the psychiatric attention.

Level of desegregation:

By CCAA.

Source of information:

CCAA.

Periodicity:

Annual

Clarifications:

This indicator includes the possible derived bias of admission in different hospital centres until the personal identification code in the SNS is not generalized.

- **Attended morbidity**

Formula:

$ID = a) \times 100 / b)$, where:

- a) Number of persons diagnosed in each of the following pathologies (anorexia, bipolar disorder, schizophrenia, major depression).

- b) Total population.

Definitions/Clarifications:

It is required the previous agreement by the CCAA of the register and codification criteria of cases, attended in local health centres, by the specialized services in mental health.

Levels desegregation:

By selected pathology type, CCAA, age and sex.

Sources of information:

Mental health services of the CCAA.

Periodicity:

Biennial

- **Percentage of discharges of penitentiary patients in non penitentiary hospitals**

Formula:

ID = a) x 100 / b) where:

- a) Number of people institutionalized in Penitentiary Institutions derived and admitted by psychiatric cause, in non monographic penitentiary hospitals, in a given year.
- b) Total number of psychiatric admissions of these prisoners, in that year.

Desegregation:

By CCAA and hospital type.

Source:

Penitentiary Institutions.

General Objectives 6 and 7

- **Map of devices of mental health**

Formula:

In this case, the compliance of the indicator is the existence, itself, of the relation of all the existing devices to give attention, in its diverse modes, to the mental health problems.

Definitions/Clarifications:

A map with the different types of existing devices and with the available information will later be made.

Levels of desegregation:

By CCAA and devices types.

Sources of information:

MSC- Register of centres, establishments and health services.

Periodicity:

Annual from its implementation and consolidation.

- **Psychiatrists ratio per population**

Formula:

$ID = a) \times 100.000 / b)$, where:

a) Total number of psychiatrists, in a given year.

b) Population in that year.

Definitions:

Included are the psychiatrists which give service (dependent to the establishment which is being treated), at 31st of December of each year. Internal and resident doctors will not be accounted, and neither grantees nor voluntary assistants.

Sources:

Component a): Statistics of Health Establishments with Institutionalizing Regime (ESCRI).

Component b): Population projections of INE or, if preferred, total population of Individual Health Card (TSI).

Desegregation:

By CCAA, by public dependency (or private with greatest activity for the SNS: Network of public use or hospitals with substitution agreements) or private dependency of the centre.

Periodicity:

Annual.

General Objective 8

The evaluation of the Objective will be made inside the mentioned Report in the title 5.

General Objective 9

- **Number of research projects**

Formula:

Number of public financed research projects; through the Health Institute Carlos III of the Ministry of Health and Consumer Affairs; through direct autonomy financing, related to mental health.

Desegregation:

SNS.

Periodicity:

Annual.

Sources of information:

Health Institute Carlos III and Autonomic Communities.

- **Research network in mental health**

Existence of it.

4.2. Qualitative Report

Structure:

The report divides the data collection of the objectives according to the strategic lines and the type of information required:

1. Promotion and prevention.
2. Attention.
3. Coordination, Training and Research.

4.2.1. Promotion and Prevention

- A first group of objectives makes reference to the put in action the **interventions** to promote the mental health and prevent the mental disorders. The data requested is if such interventions are included in the mental health plan of the autonomic community, the number of interventions already made, the number of interventions which are ongoing (in process), the number of these which are evaluated and if there is some kind of documentary support of these (publication, manual, guide or others) in an affirmative case, the documentation card (APPENDIX I) will be filled in and the **publication will be attached**. In the case that no documentation exists a brief description of the intervention will be made.

In the same way, if considered that any of the interventions complies with the requirements to be considered as **good practice**, the good practice card will be filled in (APPENDIX II).

- A second group of objectives makes reference to **organizing and/or management** aspects to clear the stigma. The data which is requested is if the objective is included in the health plan and if it has been made, as well as a section to expose the measures which were taken if it was the case.

4.2.2. Attention

- The first group of objectives makes reference to **assistance interventions** which are made to people with mental illness and/or his/her family members. Here too will be evaluated if such objective is included in the health plan, if it is included as a management objective in the different assistance units (hospitals, primary attention centres, mental health centres...), if it has a measuring system, and in the case it is evaluated, the results will be sent indicating the formula and the source of data.
- The second group of objectives makes reference to **organizing and/or management** aspects. The data which is requested is if the objective is included in the health plan and if it has been made, as well as a section to expose the measures which were taken, if it was the case.

4.2.3. Coordination, Training and Research

- All the objectives have a common section where is valued if the objective is included in the health plan and if it has been made, as well as a section to expose the measures which were taken, if it was the case.
- In the specific objectives of Training and Research specific appendixes are added (APPENDIX III and IV) to complement the information.

The objectives concerning the Ministry of Health and Consumer Affairs are not included in the present document as the information source is the ministry itself.

The objectives 3.4, 4.14, 4.15, 10.1, 10.2, 10.3 are not included either as they have specific quantitative indicators for its evaluation. (See 4.1-INDICATORS).

PROMOTION AND PREVENTION

INTERVENTIONS					
SPECIFIC OBJECTIVES	INCLUDED IN THE HEALTH PLAN	FULFILLED NUMBER	NUMBER IN PROCESS	EVALUATED NUMBER	BRIEF DESCR.
1.1. Formulate, make and evaluate a set of interventions to promote the mental health in each of the age groups or life stages: childhood, adolescence, adult life and elderly people.					
1.2. Formulate, make and evaluate a set of interventions oriented to asses and report the institutional responsible of the central, autonomic and local administrations, about the existing relation between the actions of institutional character and mental health.					
1.3. Develop, between the Ministry of Health and Autonomic Communities a set of interventions oriented to the promotion of mental health through the mass media.					
2.1. Make and evaluate a set or “community interventions” plan in areas of high risk of social exclusion or rejection, with the aim of acting over the determinants of the mental disorders and addictions.					
2.2. Make and evaluate a set of intervention plans, inside what is contemplated in the National Plan of Drugs, and in its case in the Autonomic Community, with the objectives of reducing the use and abuse of addictive substances in all the community limits.					
2.3. Make and evaluate specific actions to reduce the rates of depression and suicide in risk groups.					
2.4. Develop interventions in Primary Attention, directed to offer support to the families which care and attend people with chronic disability illnesses, to prevent the mental health problems which could be derived from their role act.					
2.5. Make and evaluate a set of support actions to the prevention services and committees of health at work of the Autonomic Communities in order to prevent stress at work and the mental disorders associated at work.					
2.6. Make and evaluate interventions directed to professionals to prevent the professional burn out.					

***If considered, attach examples of Good Practices (APPENDIX II)**

ORGANIZATION/MANAGEMENT			
SPECIFIC OBJECTIVES	INCLUDED IN THE HEALTH PLAN	FULFILLED	DESCRIPTION OF THE MEASURES
3.1. The CCAA will include in their plans and programmes interventions which promote the integration and reduce the stigmatization of the people with mental disorders.			
3.2. The CCAA will promote initiatives to revise and act over the legislation barriers which could affect the full exercise of citizenship of people with mental disorders.			
3.3. The assistance centres will have available specific rules in their protocols and proceedings, directed to promote integration and avoid the stigma and discrimination against people with mental disorders.			

ATTENTION

ASSISTANCE PROCESSES					
SPECIFIC OBJECTIVES	INCLUDED IN THE HEALTH PLAN	INCLUDED MNGMNT. OBJECTIVE	MEASUREMENT SYSTEM	EVALUATED	RESULT (INCLUDE FORMULA AND SOURCE OF DATA)
4.4. Increase the percentage of patients with mental disorders which receive psychotherapy, according to the best available practices.					
4.5. Increase the percentage of patients with serious mental disorders which are included in a rehabilitation programme.					
4.6. Increase the percentage of families with serious mental disorder patients which receive a specific family intervention programme, to improve their capacity to face the crisis and prevent relapses					
4.12. Establish, for the mentally disordered people in treatment, an individualized attention plan.					

ORGANIZATION /MANAGEMENT			
SPECIFIC OBJECTIVES	INCLUDED IN THE HEALTH PLAN	FULFILLED	DESCRIPTION OF THE MEASURES
4.1. Develop and implement in an effective way, by the CCAA in their competences framework the service details which are included in the services portfolio of the National Health System, both in the Primary Attention field as in the Specialized care.			
4.2. The CCAA will establish support procedures from the specialized care in mental health to the primary attention, for the detection and early treatment of mental disorders.			
4.3. The CCAA will establish attention guidelines in the psychiatric emergencies and crisis situations, collaborating with the different involved sectors.			
4.7. Provide an adequate care of general health to the serious mentally disordered patients.			
4.8. The CCAA will contemplate, in their mental health plans, the necessary specifications for the specialized care of people with intellectual disability and mental disorder.			
4.9. The CCAA will adequate the services with specific programmes to respond to the needs of children in mental health matters.			
4.11. Establish, in each of the health territorial structures, the access to all the sufficient therapeutic and rehabilitation devices or programmes, to face the needs of their population, assuring the assistance continuity through an integrated network of services, where the general hospitals will be included, and in coordination			

with primary attention.			
4.13. The availability, in the mental health teams in the community limits and in relation to serious prolonged mental disorders, an organized system to avoid the abandonments, facilitate the adhesion and which includes the home assistance, as well as the multisectorial management and coordination in its assistance process.			
4.16. The CCAA will have strategies available to increase the quality, effectiveness, safety and reduce the variability of the pharmacological treatments, following the rational use criteria of the medicine.			
5.1. Elaborate a general guide, referring to the good practices, about ethical and legal aspects of the assistance practice of any mode of intervention, against the patient's will.			
5.2. Define or update, by the CCAA, a protocol for transfers and involuntary hospitalization.			
5.3. Regulate, by protocol means, the procedures for the physical contention, the involuntary treatment of hospitalized patients and any freedom restrictive measure.			

COORDINATION, TRAINING AND RESEARCH

ORGANIZATION AND MANAGEMENT			
SPECIFIC OBJECTIVES	INCLUDED IN THE HEALTH PLAN	FULFILLED	DESCRIPTION OF THE MEASURES
6.1. Implement by the Autonomic Communities, efficient coordination mechanisms and cooperation at institutional and interinstitutional level which guarantee the integrated care of the people.			
6.3. Implement by the Autonomic Communities, in their competences framework efficient mechanisms of assistance coordination inside the territorial structure of health, between the different health and social devices involved in the attention of serious mental disorders.			
7.1. Develop in each. Autonomic Community, an information strategy directed to people with mental disorders and their families, concerning the rights and obligations, resources and services they can use, and the administrative procedures to dispatch suggestions and complaints.			
7.2. Implement in each Autonomic Community mechanisms and ways for the participation of people with mental disorders and their family members in all the fields of mental health, including the planning and evaluation of the services.			
7.3. Establish, by the Autonomic Communities, the mechanisms and ways of participation of the scientific and professional societies related to mental health, in the planning and the evaluation of the services.			
8.1. The availability in the Autonomic Communities, of a Continuous Training Plan for all the primary attention professionals, of mental health and those other professionals of specialized care related to the attention of people with mental disorders, in the framework of the biopsychosocial attention model.			See Appendix II
9. The Autonomic Communities will promote through the inclusion of call ups, research projects, interdisciplinary research lines with priority in mental health			See Appendix III
9.2. The Autonomic Communities will put into action measures which promote the creation of guaranteed networks in research centres and excellence groups in mental health.			

APPENDIX I

FORM OF DOCUMENT NOTIFICATION

Here are included those interventions which respond to a structured programme organized and financed by the autonomic community.

In the following table must be reflected the type of intervention*, the title, the objective and the description of the same as well as, its bibliography reference in the case it was published. .

	Type*	Title	Objetive	Description	Published**
1					
2					
3					
4					
5					

- **A:** Texts or chats broadcasted in the radio, press, TV, Internet and/or hand given or by post;
- **B:** Conference cycles or courses, with or without debate directed to attending audiences of over 30 people ;
- **C:** Highly interactive workshops, directed to groups of under 30 people and given by professionals specifically trained for it (ex. school for parents of high risk children, training for scholars in problem solving techniques, training in techniques to face stress for teleoperators);
- **D:** Articulated programmes with interventions of various lessons and with a sole objective (ex. suicide prevention in an area or sector of the population, reduction of the associated stigma to mental illness between family doctors) ;
- **E:** Others (Describe in observations)

** In the case it is published make reference to the publication and type: magazine article, guide, chapter of a book, reporting committee, communications, audiovisual material, etc....

APPENDIX II

NOTIFICATION FORM OF GOOD PRACTICE EXAMPLES

Of all the fulfilled actions it will be selected, in the case there are any, those which present a sufficient quality and rigorous methodology to be considered as **EXAMPLES OF GOOD PRACTICES**.

The interventions will be valued by an independent experts' panel and those accepted will be included in a catalogue which will be made public.

Such interventions will be described one at a time, with the maximum extension of two pages each, in accordance with the following format:

AUTONOMIC COMUNITY

TITLE OF THE EXAMPLE OF GOOD PRACTICES:

- 1. Specific objective of the Strategy of the SNS which is wanted with the intervention**
- 2. Type of intervention or programme:** Workshop, discussion group, chat, flyer, article, instructions or rules, etc.
- 3. Intervention format:** Universal, community, group, individual.
- 4. Target population:** Family members of patients with TMG, people in work leave situation, professionals of mental health, first episodes, patients in repository treatment, etc.
- 5. Number of people which have been a direct object of the intervention**
- 6. Scenario where it has been made:** Place of an association, mental health centre, school, penitentiary institution, hospitalization units, home, etc.
- 7. Intervention or programme objective:** Inform, modify attitudes, train skills of coping, increase social support, improve communication skills, etc.
- 8. Evaluation result:** used design (cohort, near-experimental or experimental), measuring tools used, obtained results and date of last evaluation.
- 9. Health impact which is wanted:** Increase the mental health (resilience, psychological wellbeing), reduce the prevalence or incidence rates of disorders, improve the inclusion, reduce the violent conduct frequency, improve the quality of life, etc.
- 10. Signs of quality:** If it has been published, bibliography references; testimonies, guaranties, satisfaction surveys.

11. Valuation and conclusions

12. Institution and centre responsible of the intervention or programme

13. Person of contact, telephone, address and email:

APENDIX III

CONTINUOUS TRAINING ACTIVITIES

PERIOD EVALUATED:

Indicate the total number of activities (courses, workshops, working days, etc) guaranteed by the National Agency of Accreditation or by the body of the corresponding Autonomic Community, the total sum of credits given by the Agency and the total number of people assisting.

DIRECTED TO	NUMBERS	CREDITS	PEOPLE No.
Psychiatrists			
Primary Attention Doctors			
Psychologists			
Nursing			
Social Workers			
Occupational Therapeutics			
Other professionals			
Multidisciplinary teams			

In the case of non guaranteed Training include the total number of activities, hours and people assisting.

DIRECTED TO	NUMBERS	No. of Hrs.	PEOPLE No.
Psychiatrists			
Primary Attention Doctors			
Psychologists			
Nursing			
Social Workers			
Occupational therapists			
Other professionals			
Multidisciplinary teams			

APPENDIX IV

NOTIFICATION FORM ABOUT RESEARCHER ACTIVITY

For the studies related to any of the objectives of the Strategy, hand in:

- 1. Specific objectives of the Strategy to which the study makes reference**
- 2. Project title**
- 3. Main Researcher**
- 4. Total budget**
- 5. Source of financing (if it is managed by the ISC III denote the code of the expedient)**
- 6. In course/finished/published and reference**

I.- External Revisers

- Spanish Association of Infant-Juvenile Psychiatry.
- Official Association of Psychologies.
- General Council of Qualified Social Workers and Assistants.
- General Management of Penitentiary Institutions.
- Spanish Society of Geriatrics and Gerontology.
- Spanish Society of General Medicine.
- Society for the Advance in Clinical Psychology and Health Century XXI.

II.- Glossary of Abbreviations

ATC	Anatomical Therapeutic Chemical Classification
CC.AA.	Autonomic Communities
CIBER	Centre of Biomedical Research in Network
CIE	Classification of International Illnesses
CIE	International Counsel of Nurses
CMBD	Minimum Basic Set of Data
CNH	National Catalogue of Hospitals
CSIC	Superior Council of Scientific Research
DDD	Daily Define Dose
DDI	Daily Dose per Inhabitant
DIS	Diagnostic Interview Schedule
DSM	Manual of Diagnose of mental disorders (American Psychiatric Association)
ENS	National Health Survey
ESCRI	Statistics of Health Establishments with Institutionalizing Regime
ESEMED	European Study of the Epidemiology of Mental Disorders.
FEAFES	Spanish Confederation of Groups of Family and People with Mental Illness
FAISEM	Andalusian Foundation for the Social Integration of the Mentally Ill Person
GAF	Global Assessment of Functioning
GPC	Guides of Clinical Practice
IMERSO	Institute of the Elderly and Social Services
INE	National Institute of Statistics
ISCIII	Health Institute Carlos III
LGS	General Law of Health
MIR	Internal and Resident Doctors
MSC	Ministry of Health and Consumer Affairs
WHO	World Health Organization
NGO	Non Governmental Organization
OR	Odds Ratio.
PIR	Internal and Resident Psychologist
PNB	Gross Domestic Product
RCP	Accumulative Register of Psychiatric Cases
RECESS	National Register of Centres, Services and Health Establishments
RETICS	Subject Networks of Cooperative Research in Health
SNS	National System of Health
TDAH	Attention Deficit Disorder and Hyperactivity
TMC	Common Mental Disorders
TMG	Serious Mental Disorders
EU	European Union

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