Evaluation of the Mental Health Strategy of the Spanish National Health System
MONITORING AND EVALUATION COMMITTEE

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Manuel Gómez-Beneyto

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1. EXECUTIVE SUMMARY

The Mental Health Strategy of the Spanish National Health System (Spanish NHS) was unanimously approved by the Interterritorial Council of the Spanish NHS (CISNS) on 11 December 2006, on the agreement that a first evaluation would be made two years after its approval.

The Monitoring and Evaluation Committee, which is made up of representatives of the Autonomous Communities and the National Health Management Institute (Instituto Nacional de Gestión Sanitaria, INGESA), as well as the scientific societies most relevant in the field of the Strategy, established the evaluation methodology by general consensus.

With the aim of assessing the impact of the Strategy on the population, the indicators of the Spanish National Health Survey (ENSE), the Household Survey on Alcohol and Drugs in Spain (EDADES) and the National Survey on Drug Use in Secondary Schools (ESTUDES), the Statistics of Establishments with Inpatient Facilities (ESCRí), the Minimum Basic Data Set (MBDS) and the National Statistics Institute (Instituto Nacional de Estadística, INE) were selected, since all those indicators reflect aspects of mental health and of mental disorders in the general population.

Likewise, in order to quantify the level of achievement of the objectives in each of the Autonomous Communities (AC), it was decided to apply a qualitative evaluation method.

For that purpose, a tool was created, consisting of a set of questions that could provide an insight into the level of accomplishment of each of the Strategy’s specific objectives in each Autonomous Community at 31 December 2008.

On 11 December 2008 the AC were sent the questionnaire, which they had to complete within a two-month period. Once the responses of the AC had been received, collated and analysed, the appropriateness and accuracy of the declarations of the AC were improved through a process of face-to-face and online interaction between the representatives of the AC.

In order to express the level of accomplishment of each objective, and using the declarations of the AC as data, a four-point scale was used: objective not started, objective started, objective partially achieved and objective achieved. The scale was applied by the technical team of the Health Planning and Quality Office of the Spanish Ministry of Health and Social Policy.

The results of the evaluation showed that the level of implementation of the Strategy, as reported by the AC, is diverse and moderate. Diverse in terms of the accomplishment of each objective and between the different AC, and moderate because, with the exception of three objectives which were fully achieved and one that had not even been started, the status of the remaining objectives was either “started” or “partially achieved”.

The achieved objectives concerned aspects related to participation, health professionals’ training and research. None of the objectives concerning the population or user care was defined as achieved.
2. INTRODUCTION

At the end of 2004, on the grounds that improving the care of mental health in Spain is one of the strategic objectives of the Ministry of Health and Social Policy, the project to draw up a Mental Health Strategy for the Spanish NHS as a whole was undertaken.

The Quality Agency of the Spanish NHS called upon all the professional and citizen associations directly interested in mental health, as well as the Autonomous Communities, to reflect on whether the approach to these changes required the development of a new action framework or strategy. In that context, the Spanish NHS Mental Health Strategy was unanimously approved by the Interterritorial Council of the Spanish NHS (CISNS) on 11 December 2006, on the agreement that a first evaluation would be made two years after its approval.

For that purpose the Monitoring and Evaluation Committee (MEC) was created, made up of representatives of the Autonomous Communities (AC), the National Health Management Institute (INGESA), the General Directorate of Penitentiary Institutions, the scientific societies most relevant in the field of the Strategy and the Spanish Confederation of Groupings of Families and People with Mental Illness (Confederación Española de Agrupaciones de Familiares y Personas con Enfermedad Mental, FEAFES), in addition to, on behalf of the Spanish Ministry of Health and Social Policy (MSPS), the Directorate General for Cohesion, the Government Delegation for the National Drug Plan (Delegación del Gobierno del Plan nacional sobre Drogas, DGPNSD) and the Quality Agency, which coordinates and leads the Strategy.

The abovementioned Committee established the monitoring and evaluation system for the Spanish NHS Mental Health Strategy by general consensus.

On the basis of the priority objectives and the evaluation indicators, the Monitoring and Evaluation Committee agreed on the evaluation methodology. It designed a model for the collection of information and, in accordance with the data sources established by the AC and the Quality Agency of the Spanish NHS (Ministry of Health and Social Policy), the data collection process was started.

The deadline for the collection of information for this first evaluation was fixed on 11 December 2008, since the Strategy was approved on that exact same date two years earlier. Once all the information had been collected and the data provided had been analysed, both by the Health Information Institute (IIS) as well as by the actual Autonomous Communities and the other institutions represented, the Quality Agency drafted this evaluation report, the results of which are presented in this document per strategy line. It is important to stress that those two years of joint work between scientific societies, organisations for people with mental illnesses and their families, Autonomous Communities and the Ministry of Health and Social Policy, directed at achieving the implementation of the Spanish NHS Mental Health Strategy, made it possible to join the efforts being made towards the continuous improvement of care for mental health and, like that, to improve the quality of the services offered throughout the whole of Spain.
3. METHODOLOGY

The Evaluation of the Spanish NHS Mental Health Strategy consists of assessing the achievement of the objectives established in the Strategy. Therefore, the evaluation is composed of a series of quantitative indicators and of a report which summarises the main actions taken by the Ministry of Health and Social Policy and by the Autonomous Communities.

The Evaluation process involves the following stages:

3.1. Constitution of the Monitoring and Evaluation Committee
3.2. Approval of the qualitative report
3.3. Collection of information for the evaluation
3.4. Drafting of the evaluation report
3.5. Presentation to the Interterritorial Council of the Spanish NHS (CISNS)

3.1. CONSTITUTION OF THE MONITORING AND EVALUATION COMMITTEE

The Monitoring and Evaluation Committee was constituted on 19 May 2007 with the objective of establishing the system to monitor and evaluate the Strategy. It is made up of members of the Institutional Committee and the Technical Committee, who participated in drafting the Strategy, together with other representatives of scientific societies and patient and family organisations in the field of the Strategy who, for various reasons, could not participate in the drafting process. The Institutional Committee and the Technical Committee were maintained as the two working groups, with the following tasks:

- **Institutional Committee**: made up of representatives of all the Autonomous Communities and in charge of establishing a system for the collection of the information required for the evaluation. Its main objective was to assess the appropriateness and feasibility of the objectives set out in the Strategy.
- **Technical Committee**: coordinated by Dr Manuel Gómez-Beneyto and made up of representatives of the scientific societies and patient and family organisations, as well as independent experts appointed by the Ministry of Health and Social Policy. It is in charge of establishing both the proposed update of the objectives as well as the consequent recommended action for their achievement, as well as suggesting improvements and/or changes on the basis of the most recent scientific evidence.

The Quality Agency of the Spanish NHS, through the Health Planning and Quality Office, is responsible for the provision of the technical, logistic and administrative support required for the correct development and fulfilment of the tasks of the Monitoring and Evaluation Committee. In addition, it coordinates the collection of the information required for the evaluation of the indicators and the drafting of the Strategy's evaluation report.
Figure 1: Tasks of the Strategy’s Monitoring and Evaluation Committee

3.2 APPROVAL OF THE QUALITATIVE REPORT
The Monitoring Committee drew up a questionnaire for the collection of data that would make it possible to assess the level of accomplishment, by the AC, of the objectives that did not have a quantitative indicator. That “qualitative evaluation questionnaire” was approved by the abovementioned Monitoring Committee on 19 December 2008.

3.3 COLLECTION OF INFORMATION FOR THE EVALUATION
The information required for the evaluation of the Strategy's objectives was mainly provided by the Autonomous Communities and by the Ministry of Health and Social Policy, through the Health Information Institute (IIS), which is dependent on the Quality Agency of the Spanish NHS.

In order to collect the data -both quantitative as well as qualitative- from the Autonomous Communities, an online data-collection tool was created, which was checked with the representatives of the AC on 28 October 2008.

Once the questionnaires had been completed by the representatives of the different AC, the first draft of the evaluation report was drawn up, thereby also using the other information collected through the remaining data sources.

3.4 DRAFTING OF THE EVALUATION REPORT AND PRESENTATION TO THE INTERTERRITORIAL COUNCIL OF THE SPANISH NHS (CISNS)

The report was drawn up by the Health Planning and Quality Office (Quality Agency of the Spanish NHS – Ministry of Health and Social Policy). For that purpose, use was made of the information provided by the different AC, INGESA, the Carlos III Health Institute (Instituto de Salud Carlos III, ISCIII), the Penitentiary Institutions, as well as the information collected by the Health Information Institute (IIS) and the actual Health Planning and Quality Agency of the Spanish NHS. On 26 March 2009, once the draft of the report had been completed, it was presented to and discussed by the members of the Monitoring and Evaluation Committee for their approval, before being presented to the Interterritorial Council of the Spanish NHS (CISNS).

In June 2009 the Evaluation Report of the Spanish NHS Mental Health Strategy was presented to the Interterritorial Council of the Spanish NHS (CISNS). Figure 3 shows the timeline of the Strategy’s monitoring and evaluation process, starting on the date of its approval, i.e. 11 December 2006.
Figure 3: Timeline of the Strategy's monitoring and evaluation process

The evaluation was started 2 years after the approval of the Strategy

Objectives and evaluation indicators of the Spanish NHS Mental Health Strategy

The strategy lines are broken down into general and specific objectives, with their corresponding technical recommendations and monitoring and evaluation indicators. As is logical, not all strategy lines are equally significant and complex; therefore, their operational breakdown into general and specific objectives is not homogeneous in terms of scope (number of objectives of the strategy line) nor in relation to the diversity of the proposed interventions.

In total, 6 strategy lines with 10 general objectives and 45 specific objectives are proposed:

- **Strategy line 1**: Promotion of the population’s mental health, prevention of mental illness and elimination of the stigma associated with people suffering from mental disorders.
- **Strategy line 2**: Healthcare for patients with mental disorders.
- **Strategy line 3**: Intra-institutional and inter-institutional coordination.
- **Strategy line 4**: Training of healthcare personnel.
- **Strategy line 5**: Research in mental health.
- **Strategy line 6**: Information system on mental health.
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<td></td>
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<td></td>
<td>Beds in specialised hospitals per 100,000 population</td>
<td>EESCRE</td>
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<td></td>
<td>Social and family support</td>
<td>ENSE</td>
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<td></td>
<td>Disability attributable to a mental disorder</td>
<td>EDDES</td>
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<td>Integrated clinical practice guidelines that meet the quality criteria of the Spanish NHS</td>
<td>GuíaSalud</td>
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<td></td>
<td>Daily dose per inhabitant (DDI) of antidepressants</td>
<td>PC–IS</td>
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<tr>
<td></td>
<td>Daily dose per inhabitant (DDI) of antipsychotics</td>
<td>PC–IS</td>
</tr>
<tr>
<td></td>
<td>Daily dose per inhabitant (DDI) of hypnotics, sedatives and anxiolytics</td>
<td>PC–IS</td>
</tr>
<tr>
<td></td>
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<td>MBDS</td>
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<td></td>
<td>Treated morbidity</td>
<td>AC</td>
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<td></td>
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<td>PI</td>
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<td></td>
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<td></td>
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<td>2. Healthcare</td>
<td>Qualitative report</td>
<td>AC</td>
</tr>
<tr>
<td>3. Intra-institutional and inter-institutional coordination</td>
<td>Number of research projects</td>
<td>ISCIII</td>
</tr>
<tr>
<td></td>
<td>Mental health research network</td>
<td>ISCIII</td>
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<tr>
<td>4. Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Research</td>
<td></td>
<td></td>
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<tr>
<td>6. Information system</td>
<td></td>
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<tr>
<td></td>
<td>Report</td>
<td>Health Information Institute (IIS) - MSPS</td>
</tr>
</tbody>
</table>
Abbreviations:
ENSE: Spanish National Health Survey
EDADES: Household Survey on Alcohol and Drugs in Spain
ESTUDES: National Survey on Drug Use in Secondary Schools
MBDS: Minimum Basic Data Set
MSPS: Spanish Ministry of Health and Social Policy
INE: National Statistics Institute
EESCRI: Statistics of establishments with inpatient facilities
EDDES: Spanish Disability, Impairment and Health Survey
PC–IS: Pharmaceutical consumption information system of the Spanish NHS
PI: Penitentiary Institutions
PCIS–MH: personal health card data of the Primary Care Information System–Mental Health
AC: Autonomous Communities
ISCIII: Carlos III Health Institute
4. RESULTS OF THE EVALUATION PER STRATEGY LINE

Strategy Line 1: Promotion of the population’s mental health, prevention of mental illness and elimination of the stigma associated with people suffering from mental disorders

4.1 GENERAL OBJECTIVE 1: TO PROMOTE THE MENTAL HEALTH OF THE GENERAL POPULATION AND OF SPECIFIC GROUPS.

Indicator: Social and family support

Social and family support is understood as the outcome of the interaction between people according to perceived emotional, informative, practical and material support.

Social support

In order to assess the social support perceived by the population aged 16 years and over, the Duke-UNC questionnaire was used in the Spanish National Health Survey (ENSE). This instrument uses eleven questions to evaluate perceived social support -which does not necessarily correspond to actual support- in two areas: confidant support (the possibility of having people to communicate with) and affective support (demonstrations of love, affection and empathy).

Perceived social support is considered to be low when the total score of the questionnaire is equal to or lower than 32 points.

Figure 4: Percentage of people who consider that they receive a low level of social support

Source: Spanish National Health Survey (ENSE) 2006. Ministry of Health and Social Policy (MSPS)
Table 2: Percentage of perceived low social support, by gender and AC

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
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<td>3.2</td>
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<td>Aragon</td>
<td>2.5</td>
<td>2.5</td>
<td>2.6</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
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<td>1.8</td>
<td>1.8</td>
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<tr>
<td>Balearic Islands</td>
<td>3.4</td>
<td>4.0</td>
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<tr>
<td>Basque Country</td>
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<td>1.5</td>
<td>0.1</td>
</tr>
<tr>
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<td>4.5</td>
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<td>Cantabria</td>
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<td>1.1</td>
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<td>Castile and Leon</td>
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<td>1.6</td>
<td>1.8</td>
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<td>2.2</td>
<td>3.4</td>
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<td>Catalonia</td>
<td>4.6</td>
<td>4.4</td>
<td>4.7</td>
</tr>
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<td>Extremadura</td>
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<td>0.7</td>
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<td>Galicia</td>
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<td>3.5</td>
</tr>
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<td>Murcia (Region)</td>
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<td>Navarre (Foral Community)</td>
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<td>Ceuta-Melilla</td>
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<td><strong>National Total</strong></td>
<td><strong>3.4</strong></td>
<td><strong>3.2</strong></td>
<td><strong>3.6</strong></td>
</tr>
</tbody>
</table>

Source: Spanish National Health Survey (ENSE) 2006, Ministry of Health and Social Policy (MSPS)

As can be seen, generally speaking the perception of low social support increases as people get older. That was reported by 4.3% of men and 5.5% of women aged 75 years and over, with these being the highest values. Moreover, as age increases so does the differential between men and women, with women perceiving the lowest level of support in all groups except that of young people aged between 16-24 years.

**Family function**

To assess family dynamics, the family APGAR questionnaire was used in the Spanish National Health Survey (ENSE). That questionnaire measures the components of family functioning as regards adaptation, partnership, growth, affection and resolve. The final scores obtained are classified into three categories: good family functioning (7 to 10 points), moderately dysfunctional family (4 to 6 points) and a high level of family dysfunction (0 to 3 points).
Table 3 shows the percentage of the population aged 16 years and over with good family functioning, by gender and Autonomous Community.

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>94.0</td>
<td>94.5</td>
<td>93.6</td>
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<tr>
<td>Aragon</td>
<td>95.1</td>
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<td>Asturias (Principality)</td>
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<td>97.4</td>
<td>97.4</td>
<td>97.4</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>94.4</td>
<td>93.5</td>
<td>95.3</td>
</tr>
<tr>
<td>Cantabria</td>
<td>96.3</td>
<td>96.4</td>
<td>96.1</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>95.8</td>
<td>95.9</td>
<td>95.8</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>93.0</td>
<td>93.2</td>
<td>92.7</td>
</tr>
<tr>
<td>Catalonia</td>
<td>92.8</td>
<td>94.3</td>
<td>91.4</td>
</tr>
<tr>
<td>Extremadura</td>
<td>97.7</td>
<td>98.0</td>
<td>97.4</td>
</tr>
<tr>
<td>Galicia</td>
<td>94.2</td>
<td>94.9</td>
<td>93.6</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>89.3</td>
<td>88.9</td>
<td>89.7</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>90.7</td>
<td>91.5</td>
<td>89.8</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>91.6</td>
<td>91.1</td>
<td>92.2</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>95.1</td>
<td>95.5</td>
<td>94.7</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>93.4</td>
<td>93.9</td>
<td>93.0</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>96.5</td>
<td>98.2</td>
<td>94.8</td>
</tr>
<tr>
<td><strong>National total</strong></td>
<td><strong>93.4</strong></td>
<td><strong>93.7</strong></td>
<td><strong>93.0</strong></td>
</tr>
</tbody>
</table>

Source: Spanish National Health Survey (ENSE) 2006. Ministry of Health and Social Policy (MSPS)

In total, 93.4% of the Spanish population reported to have what is considered to be a normal functioning family, and the difference between men and women is barely noticeable.
Specific objective 1.1: “Formulate, carry out and evaluate a set of interventions for the promotion of mental health in each age group or life-stage: childhood, adolescence, adulthood and old age.”

Table 4: Interventions to promote mental health

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>No. completed</th>
<th>Completed and evaluated</th>
<th>No. in progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Programmes</td>
<td>Interventions</td>
<td>Programmes</td>
<td>Intervention</td>
</tr>
<tr>
<td>Andalusia</td>
<td>YES</td>
<td>2</td>
<td>925</td>
<td>2</td>
</tr>
<tr>
<td>Aragon</td>
<td>YES</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asturias</td>
<td>YES</td>
<td>14</td>
<td>31,216</td>
<td>0</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>YES</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Basque Country</td>
<td>YES</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>YES</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cantabria</td>
<td>YES</td>
<td>6</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>YES</td>
<td>4</td>
<td>517</td>
<td>1</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>YES</td>
<td>1</td>
<td>502</td>
<td>-</td>
</tr>
<tr>
<td>Catalonia</td>
<td>YES</td>
<td>2</td>
<td>913</td>
<td>2</td>
</tr>
<tr>
<td>Extremadura</td>
<td>YES</td>
<td>2</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>Galicia</td>
<td>YES</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>YES</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>YES</td>
<td>6</td>
<td>131</td>
<td>0</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>YES</td>
<td>3</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>YES</td>
<td>-</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>YES</td>
<td>6</td>
<td>224</td>
<td>6</td>
</tr>
<tr>
<td>Ceuta–Melilla</td>
<td>NO</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>National Total</td>
<td>16</td>
<td>46</td>
<td>34,455</td>
<td>11</td>
</tr>
</tbody>
</table>

*Intervention target population

Source: own preparation based on the information provided by the Autonomous Communities

In total, 16 AC reported that they have included actions linked to promotion in their regional mental health plans. Table 4 provides a summary of the information collected for this objective; according to this data, 46 programmes have been completed, 11 have been evaluated and 22 are in progress, involving more than 34,000 completed interventions, more than 2,000 evaluated interventions and 178 interventions in progress. Four AC have not carried out any interventions yet.

**Conclusion Specific Objective 1.1:**
Most of the AC reported that they have included interventions to promote mental health in their health plans; nevertheless, the number of evaluated interventions is low.

**Objective partially achieved**

**Recommendation: maintain objective**
Specific Objective 1.2: “Formulate, carry out and evaluate a set of interventions aimed at guiding and informing people in positions with institutional responsibility in central, regional and local government bodies about the existing relationship between actions of an institutional nature and mental health.”

Table 5: Interventions aimed at guiding and informing people in positions with institutional responsibility in central, regional and local government bodies.

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed (number)</th>
<th>In progress (number)</th>
<th>Evaluated (number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Aragon</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>Yes</td>
<td>13</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>Yes</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Basque Country</td>
<td>Yes</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>Yes</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cantabria</td>
<td>No</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Catalonia</td>
<td>Yes</td>
<td>10</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Extremadura</td>
<td>No</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Galicia</td>
<td>Yes</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>Yes</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
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<td>0</td>
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<tr>
<td>Rioja (La)</td>
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<tr>
<td>Valencia (Community)</td>
<td>Yes</td>
<td>16</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td></td>
<td><strong>10</strong></td>
<td><strong>50</strong></td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

Of all the AC, 10 reported that they have included in their health plans interventions aimed at guiding and informing people with institutional responsibility in central, regional and local government bodies, although 3 of them have not carried out any interventions yet and 2 of them have not prioritised whether or not they have started any interventions. In total, 50 interventions have been completed, 18 are currently being implemented and developed, and not a single Autonomous Community reported that it has evaluated the outcomes of the implementation of those interventions.

**Conclusion Specific Objective 1.2: started**

**Recommendation: maintain objective**
Specific Objective 1.3: “Develop, between the Ministry of Health and the AC, a set of interventions aimed at promoting mental health through the media.”

Table 6: Interventions aimed at promoting mental health through the media

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed (number)</th>
<th>In progress (number)</th>
<th>Evaluated (number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Aragon</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>Yes</td>
<td>14</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>Yes</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Basque Country</td>
<td>Yes</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cantabria</td>
<td>No</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Catalonia</td>
<td>Yes</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Extremadura</td>
<td>Yes</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Galicia</td>
<td>Yes</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>Yes</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>Valencia (Community)</td>
<td>Yes</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>Yes</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>10</strong></td>
<td><strong>27</strong></td>
<td><strong>8</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

Ten Autonomous Communities (55.5% of the total) reported that they have included these initiatives in their respective mental health plans, with 27 completed activities related to this objective and 8 still in progress. According to the information provided, only 5 of the completed activities have been evaluated; therefore, we recommend that in the future there is a greater level of involvement in the activities regarding the evaluation of the results.

Moreover, the Ministry of Health and Social Policy has not yet carried out any campaigns.

**Conclusion Specific Objective 1.3: partially started**
**Recommendation: maintain objective**

**Conclusion regarding General Objective 1:**
1: The Spanish National Health Survey (ENSE) of 2006 included, for the first time, the evaluation of “Perceived Social Support” and “Family Function”, both of which are factors related to resilience and resistance to stress.

2: It is not easy to obtain information about health promotion activities in Spain, and even less so to quantify them and know what type of activities are being carried out in specific population groups. It is fair to say that only slightly more than half of the Autonomous Communities have carried out the interventions initially proposed for the achievement of the specific objectives, and that far fewer still have evaluated those interventions.

**Conclusion: partially achieved**

**Recommendation: maintain objective**
4.2 GENERAL OBJECTIVE 2: TO PREVENT MENTAL ILLNESS, SUICIDE AND ADDICTIONS AMONG THE GENERAL POPULATION.

Indicator: Percentage of people at risk of poor mental health

The mental health of the adult population (aged 16 years and over) was assessed in the Spanish National Health Survey (ENSE) for the year 2006 using the 12-item General Health Questionnaire (GHQ-12). The threshold score of 4 out of 12 was used, since that is the threshold score used in the United Kingdom, which is the country with most experience using this tool.

This questionnaire can be used as a population-screening instrument; it detects the prevalence of probable cases of psychiatric morbidity or psychological distress by examining the condition of the interviewee over the last month with respect to his or her usual mental state. However, the GHQ-12 is suitable neither for use when making clinical diagnoses nor for the assessment of chronic disorders.

Table 7: Risk of poor health in adults (%), by gender

<table>
<thead>
<tr>
<th>National Total</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.5%</td>
<td>11.0%</td>
<td>19.9%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Spanish National Health Survey (ENSE) 2006. Ministry of Health and Social Policy (MSPS)

Table 7 shows the percentage of people at risk of suffering from poor mental health, disaggregated by gender. The highest percentage of people with the highest risk consists of women, with 19.9% compared to 11% in men, and that situation is similar in all the Autonomous Communities.

Given that the Spanish National Health Survey (ENSE) of 2006 included the evaluation of the risk of poor mental health for the very first time, it is important that the behaviour of this instrument and, therefore, of this data, be closely monitored in future versions of the Survey.
In the child population, mental health was assessed using the *Strengths and Difficulties Questionnaire (SDQ)*. This instrument detects probable cases of mental and behavioural disorders in the population aged between 4 and 15 years. It examines 5 sections related to emotional symptoms, conduct problems, hyperactivity, peer relationship problems and prosocial behaviour. In order to obtain the synthetic indicator of the risk of poor mental health, use was made of the scores considered as “probable” cases, situated as of the score of 17.

### Table 8: Risk of poor mental health in children (%), by gender

<table>
<thead>
<tr>
<th>National Total</th>
<th>Both sexes</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.96 ± 1.16</td>
<td>10.99 ± 1.50</td>
<td>12.88 ± 1.67</td>
<td></td>
</tr>
</tbody>
</table>

Source: Spanish National Health Survey (ENSE) 2006. Ministry of Health and Social Policy (MSPS)

Of the child population, 11.96% had scores that classify as at risk of poor mental health, with 12.88% in boys and 10.99% in girls. This indicator must be interpreted with caution since the ENSE of 2006 was the first to use the SDQ in Spain in a survey of this type. The data are based on a population sample and, therefore, are subject to sampling errors. The confidence intervals have been included so as to better reflect the reliability of the estimates obtained.

### Indicator: Reported prevalence of depression, anxiety or other mental disorders

Below is an analysis of the psychiatric morbidity according to the information collected in the Spanish National Health Survey (ENSE) of the year 2006. The survey asks people whether they "suffer or have suffered" from – out of a list of problems- "depression, anxiety or other mental disorders". In the case of an affirmative reply, the person is asked whether he or she "has suffered from it within the last 12 months" and whether "it was diagnosed by a doctor".

### Table 9: Reported prevalence of mental disorders (%), by gender

<table>
<thead>
<tr>
<th>National Total</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.5</td>
<td>6.6</td>
<td>16.3</td>
<td></td>
</tr>
</tbody>
</table>

Source: Spanish National Health Survey (ENSE) 2006. Ministry of Health and Social Policy (MSPS)

In the population aged 16 years and over, the reported prevalence of depression, anxiety or other mental disorders stood at 11.5%, with the difference between sexes being most striking, since it is more than twice as high in women (16.3%) as in men (6.6%).

Given the constant higher prevalence in women, the difference between sexes must be taken into account, since it suggests there is a need for specific care in this area.

### Conclusion indicator:

The self-reported prevalence of mental disorders is similar to that obtained in epidemiological studies of the general population in Spain, with a higher prevalence among women, which is usual in these studies. The variability between the Autonomous Communities is smaller than that detected using the GHQ-12, except in the case of one community which stands out for its low prevalence.
**Indicator: Disability attributable to mental disorders**

In the Spanish Survey on Disability, Personal Autonomy and Situations of Dependency (EDAD), the main variable at the core of the study is disability. For those purposes, disability is understood to mean substantial limitations in the person’s ability to carry out day-to-day activities that have lasted, or that are expected to last, more than one year, and which arise from a mental impairment.

The following table sets out the rates per 1,000 population of the disabilities with original impairments that fall under the section of mental impairments, by gender and Autonomous Community.

**Table 10: Rate per 1,000 population of disability attributable to mental impairment**

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>18.66</td>
<td>16.55</td>
<td>20.73</td>
</tr>
<tr>
<td>Aragon</td>
<td>17.91</td>
<td>13.89</td>
<td>21.90</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>23.04</td>
<td>17.67</td>
<td>27.95</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>15.79</td>
<td>12.86</td>
<td>18.71</td>
</tr>
<tr>
<td>Basque Country</td>
<td>13.67</td>
<td>12.85</td>
<td>13.51</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>15.80</td>
<td>17.67</td>
<td>13.93</td>
</tr>
<tr>
<td>Cantabria</td>
<td>14.96</td>
<td>12.81</td>
<td>17.01</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>17.92</td>
<td>14.71</td>
<td>21.06</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>15.49</td>
<td>13.97</td>
<td>17.04</td>
</tr>
<tr>
<td>Catalonia</td>
<td>15.78</td>
<td>12.24</td>
<td>19.24</td>
</tr>
<tr>
<td>Extremadura</td>
<td>17.76</td>
<td>13.48</td>
<td>21.97</td>
</tr>
<tr>
<td>Galicia</td>
<td>26.28</td>
<td>20.16</td>
<td>31.95</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>12.21</td>
<td>10.85</td>
<td>13.49</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>18.21</td>
<td>18.43</td>
<td>17.99</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>16.44</td>
<td>14.20</td>
<td>18.67</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>12.18</td>
<td>8.67</td>
<td>15.74</td>
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<tr>
<td>Valencia (Community)</td>
<td>17.91</td>
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<td>19.46</td>
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<tr>
<td>Ceuta</td>
<td>16.32</td>
<td>13.68</td>
<td>18.94</td>
</tr>
<tr>
<td>Melilla</td>
<td>20.37</td>
<td>24.79</td>
<td>16.18</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td>17.03</td>
<td>14.72</td>
<td>19.27</td>
</tr>
</tbody>
</table>


In Spain, disability attributable to mental disorders (dementias, mental disorders and intellectual impairment) affected 718.9 thousand people (absolute figures), accounting for 18.9% of the total of 3.8 million people with a disability.
It represents a rate of 17.03 cases/1,000 population, and is greater in women than in men, with rates between 19.27 and 14.72 cases per thousand, respectively.

That data is disaggregated according to the type of impairment that caused the disability, and is shown below in rate per thousand population over the age of 5 years, for Spain as a whole and by gender.

Table 11: Rates of disability* according to origin and gender

<table>
<thead>
<tr>
<th>Type of original impairment</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementias</td>
<td>7.5</td>
<td>4.1</td>
<td>10.9</td>
</tr>
<tr>
<td>Mental illness</td>
<td>3.4</td>
<td>3.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Other mental and behavioural disorders</td>
<td>3.0</td>
<td>3.1</td>
<td>2.8</td>
</tr>
<tr>
<td>Moderate intellectual impairment</td>
<td>1.2</td>
<td>1.6</td>
<td>0.8</td>
</tr>
<tr>
<td>Severe and profound intellectual impairment</td>
<td>1.1</td>
<td>1.2</td>
<td>1.0</td>
</tr>
<tr>
<td>Mild intellectual impairment</td>
<td>0.6</td>
<td>0.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Maturation delay</td>
<td>0.3</td>
<td>0.4</td>
<td>0.2</td>
</tr>
<tr>
<td>Borderline intelligence</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
</tbody>
</table>

*Rate of disability (within the mental impairments) per thousand population aged 6 years or over.


In the case of dementias, women are clearly more affected than men, whereas in the cases of the remaining mental impairments included in this section the differences between men and women are not very significant.

Table 12 shows the rate per thousand population of mental and neurological impairments according to their origin.

Table 12: Impairments (rate per thousand population) according to origin and gender

<table>
<thead>
<tr>
<th>Type of original impairment</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental impairments (total)</td>
<td>17.0</td>
<td>15.0</td>
<td>19.3</td>
</tr>
<tr>
<td>Dementias</td>
<td>7.5</td>
<td>4.1</td>
<td>10.9</td>
</tr>
<tr>
<td>Mental illness</td>
<td>3.4</td>
<td>3.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Other mental and behavioural disorders</td>
<td>3.0</td>
<td>3.1</td>
<td>2.8</td>
</tr>
<tr>
<td>Moderate intellectual impairment</td>
<td>1.2</td>
<td>1.6</td>
<td>0.8</td>
</tr>
<tr>
<td>Severe and profound intellectual impairment</td>
<td>1.1</td>
<td>1.2</td>
<td>1.0</td>
</tr>
<tr>
<td>Mild intellectual impairment</td>
<td>0.6</td>
<td>0.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Maturation delay</td>
<td>0.3</td>
<td>0.4</td>
<td>0.2</td>
</tr>
<tr>
<td>Borderline intelligence</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Source: Survey on Disability, Personal Autonomy and Situations of Dependency (EDAD) 2008
For both men and women and by age, the heavy burden of mental disorders as the cause of disability can be seen in the range included between the ages of 6 and 44 years, accounting for 1/3 of the total number of people with disabilities (table 12).

**Indicator: Percentage of people who report that they consume drugs**

Drug consumption data from the Household Survey on Alcohol and Drugs (EDADES) in Spain (the latest figures refer to 2007) are set out below.

Figure 5 shows the evolution of drug consumption (per type of substance) in recent years.

**Figure 5: Prevalence of drug consumption over the last 12 months, in the Spanish population aged between 15 and 64 years, according to gender and type of substance. 2001 – 2007**

<table>
<thead>
<tr>
<th>Type of substance</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year</strong></td>
<td>2001</td>
<td>2003</td>
<td>2005</td>
</tr>
<tr>
<td>Cannabis</td>
<td>9.2</td>
<td>11.3</td>
<td>11.2</td>
</tr>
<tr>
<td>Powder cocaine</td>
<td>2.5</td>
<td>2.7</td>
<td>3</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>1.8</td>
<td>1.4</td>
<td>1.2</td>
</tr>
<tr>
<td>Amphetamines/Speed</td>
<td>1.1</td>
<td>0.8</td>
<td>1</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>0.7</td>
<td>0.6</td>
<td>0.7</td>
</tr>
<tr>
<td>Heroine</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
</tbody>
</table>


Table 13: Prevalence of drug consumption over the last 12 months, in the Spanish population aged between 15 and 64 years, according to gender and type of substance. 2001 – 2007 Percentages
In the population aged between 15 and 64 years, the psychoactive substance with the highest consumption prevalence is cannabis, ahead of cocaine, ecstasy, amphetamines, hallucinogens or heroine. This pattern reveals differences between men and women, with the consumption prevalence of all illegal drugs being double as high in men as in women. Cocaine use by women has not increased. Overall, an increase can be seen in the consumption of cannabis and cocaine by men and only in cannabis by women. In 2007, 11.2% of the population aged between 15 and 64 years reported to have consumed cannabis during the twelve months prior to the survey (13.6% of men and 6.6% of women). In general, a decrease or stabilisation can be seen in the prevalence of psychoactive substances in recent years.

Indicator: Percentage of school-going adolescents who report that they consume drugs

According to the data obtained from the National Survey on Drug Use in Secondary Schools (ESTUDES) of 2008 for the population aged between 14 and 18 years, cannabis continues to be the substance with the highest consumption prevalence, ahead of cocaine, hallucinogens, amphetamines, ecstasy or heroine. Of the school-going population, 30.5% stated that they consumed cannabis, at 33.5% in men and 27.5% in women. The consumption prevalence of the remaining substances is lower. Figure 6 shows the consumption trends for each substance between the years 1994-2008. For all psychoactive substances the consumption prevalence was greater in the school-going population than in the adult population, and higher in men.

Figure 6: The evolution of the consumption prevalence of psychoactive substances over the last 12 months among secondary school students aged between 14-18 years (percentages) in Spain 1994-2008.

Source: MSPS. DGPNSD. National Survey on Drug Use in Secondary Schools (ESTUDES) 2002-2006
Generally speaking, no increase is seen in the consumption of illegal drugs over the period studied.

Table 14: Evolution of the consumption prevalence of psychoactive substances over the last 12 months in secondary school students aged between 14-18 years (percentages) in Spain 2002-2006.

<table>
<thead>
<tr>
<th>Type of substance</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>32.8</td>
<td>36.6</td>
<td>39.8</td>
</tr>
<tr>
<td>Cocaine</td>
<td>6.2</td>
<td>7.2</td>
<td>4.1</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>3.2</td>
<td>3.1</td>
<td>2.8</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>4.1</td>
<td>3.3</td>
<td>2.6</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>4.3</td>
<td>2.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Heroine</td>
<td>0.3</td>
<td>0.4</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Source: MSPS. DGPNSD. National Survey on Drug Use in Secondary Schools (ESTUDES) 2002-2006

Indicator: Percentage of drinkers at risk of alcohol abuse

A person is considered to be an at-risk drinker when he or she is a regular drinker, with an alcohol consumption of more than 40 g/day in the case of men and more than 20 g/day in the case of women (in the population aged 16 years and over).

Figure 7: Alcohol consumption at levels that pose a risk to health, by age group (years) and gender

Source: Spanish National Health Survey (ENSE) 2006. Ministry of Health and Social Policy (MSPS)
The table below shows the results of the Spanish National Health Survey (ENSE) of 2006, disaggregated by gender.

<table>
<thead>
<tr>
<th>National Total</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.7</td>
<td>6.8</td>
<td>2.7</td>
<td></td>
</tr>
</tbody>
</table>

Source: Spanish National Health Survey (ENSE) 2006. Ministry of Health and Social Policy (MSPS)

The percentage of people with an alcohol consumption level that is considered to pose a risk to health stands at 4.7% of the Spanish population, with that consumption being much higher in men (6.8%) than in women (2.7%).

Figure 7 shows how the age group of 45 to 54 year olds accumulates the highest percentage of this type of drinkers, reaching up to 10.4% in the case of men. Although that age group is also the group with the highest consumption among women (3.6%), the difference between men and women remains very big. That difference between sexes in this risk-posing practice is seen across all the age groups, although among young adults the difference is less marked. This indicator confirms that gender socialising leads to another alcohol consumption-related difference between men and women, and its prevention and treatment should consist of interventions centred on gender attitudes.
**Indicator: Rate of discharges due to self-harm**

The data shown in table 16 correspond to the year 2007 and concern all hospital discharges stated to involve self-harm (coded according to the ICD-9-CM classification, codes E950 to E959). The cases that caused death were excluded from the abovementioned discharges; that was done because of the existence of the specific indicator “suicide”, which assesses all deaths that occur due to that cause.

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>13.07</td>
<td>14.05</td>
<td>12.11</td>
</tr>
<tr>
<td>Aragon</td>
<td>20.21</td>
<td>17.33</td>
<td>23.07</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>28.81</td>
<td>27.64</td>
<td>29.88</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>25.08</td>
<td>21.17</td>
<td>29.00</td>
</tr>
<tr>
<td>Basque Country</td>
<td>19.20</td>
<td>15.18</td>
<td>23.04</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>0.50</td>
<td>0.59</td>
<td>0.40</td>
</tr>
<tr>
<td>Cantabria</td>
<td>23.10</td>
<td>19.84</td>
<td>26.22</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>18.58</td>
<td>16.01</td>
<td>21.09</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>11.68</td>
<td>9.38</td>
<td>14.01</td>
</tr>
<tr>
<td>Catalonia</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Extremadura</td>
<td>7.99</td>
<td>7.30</td>
<td>8.67</td>
</tr>
<tr>
<td>Galicia</td>
<td>14.95</td>
<td>12.64</td>
<td>17.10</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>14.99</td>
<td>12.31</td>
<td>17.51</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>17.60</td>
<td>14.31</td>
<td>20.97</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>12.49</td>
<td>12.69</td>
<td>12.28</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>21.33</td>
<td>16.05</td>
<td>26.69</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>0.68</td>
<td>0.67</td>
<td>0.70</td>
</tr>
<tr>
<td>Ceuta</td>
<td>5.57</td>
<td>2.78</td>
<td>8.38</td>
</tr>
<tr>
<td>Melilla</td>
<td>5.85</td>
<td>8.86</td>
<td>2.90</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>11.02</strong></td>
<td><strong>9.83</strong></td>
<td><strong>12.18</strong></td>
</tr>
</tbody>
</table>

Source: Register of Hospital Discharges (MBDS) 2007. Ministry of Health and Social Policy (MSPS)

The high variability between the Autonomous Communities leads one to think that they may be using different criteria when recording and coding this type of problems, and that in certain cases insufficient data entries may exist in the medical history and/or that they may be poorly coded.

Therefore, before any comparative analyses are made, we consider that this subject must be dealt with, with the objective of normalising it. For that purpose, this issue has been forwarded to the Technical Unit of the ICD (stable group of experts from the Autonomous Communities who collaborate with the Ministry, dependent on the Technical Committee of the MBDS) to be dealt with and improved.
**Indicator: Suicide mortality rate**

In Spain, in the year 2006 the age-adjusted suicide mortality rate (using the European population as the standard population) stood at 6.23 deaths per 100,000 population, showing a higher rate in men (10.04) than in women (2.76).

The following figure shows the evolution of that adjusted rate between the years 2000 and 2006; one can see how the differences according to gender remain constant throughout the period.

![Figure 8: Evolution of the age-adjusted suicide mortality rate, per 100,000 population](image)

Over the period between the years 2000 and 2006, the suicide mortality rate decreased slightly, with 7.2 cases/100,000 population in the year 2000 compared to 6.2 cases/100,000 population in the year 2006. As far as gender is concerned, it can be stated that mortality due to suicide is more frequent in men, with rates four times as high as those in women.

Source: Deaths according to cause of death. National Statistics Institute (INE) and own preparation by the Ministry of Health and Social Policy (MSPS)
Specific Objective 2.1: “Carry out and evaluate a set or plan of community-based interventions in areas with a high risk of social exclusion or marginalisation, with the aim of acting on the determining factors of mental disorders and addictions.”

Table 17 provides a summary of the interventions reported by the Autonomous Communities.

Table 17: Set or plan of “community-based interventions” in areas with a high risk of social exclusion or marginalisation

<table>
<thead>
<tr>
<th>AC</th>
<th>ANDALUSIA</th>
<th>ASTURIAS</th>
<th>BALEARIC ISLANDS</th>
<th>CANARY ISLANDS</th>
<th>CASTILE AND LEON</th>
<th>CASTILE-LA MANCHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Included in the Health Plan</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Title</td>
<td>Comprehensive Action Programmes in Zones with Social Transformation Needs (Zonas con Necesidades de Transformación Social, ZNTS), aimed at reducing inequalities and improving the control of the factors that determine the health of people and groups at risk of suffering from social exclusion.</td>
<td>Our Own Time (Tiempo propio), Promotion of active ageing (Promoción del envejecimiento activo)</td>
<td>Care for Carers (Atención a las personas cuidadoras)</td>
<td>Gypsy Plan (Plan gitano)</td>
<td>Mobile Mental Health Team (EMOSAM)</td>
<td>Supported Employment (ECA)</td>
</tr>
<tr>
<td>Target population</td>
<td>The ZNTS are clearly-defined urban areas in which the population suffers from structural situations of severe poverty and social marginalisation, and in which significant problems of the following type can be found: a) Housing, urban deterioration, deficit of public infrastructures, equipment and services; b) High rate of school absenteeism and failure; c) High unemployment rates together with a serious lack of professional training; d) Substantial hygiene and health-</td>
<td>Women in rural areas over the age of 50 years in towns with less than &lt;50000 inhabitant</td>
<td>People caring for dependent relatives</td>
<td>Gypsy population suffering from marginalisation (5742 people were assisted over the</td>
<td>Las Palmas de Gran Canaria, metropolitan area.</td>
<td>Tenerife</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
related deficiencies; and e) Phenomena of social disintegration.

<p>| Completed | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Evaluated | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| In progress | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |</p>
<table>
<thead>
<tr>
<th>Title</th>
<th>Neighbourhood health ((Salud en los barrios))</th>
<th>Homeless ((Sin hogar))</th>
<th>Programme for the prevention of problems arising from the consumption of drugs for young offenders</th>
<th>Family action programme for the prevention of transgressions and drug consumption by young people who pass through the youth justice services</th>
<th>Young people, drugs and transculturality ((Jóvenes, drogas y transculturalidad))</th>
<th>Exhibition ‘Coke. What?’ ((Coca. ¿Qué?))</th>
<th>Permanent shelter and urban therapeutic community for adolescents ((CAPCTUA))</th>
<th>Collaboration programme for the care of children and adolescents with mental disorders</th>
<th>Mental health care for immigrants ((SATMI))</th>
<th>Psychopathological and psychosocial care for immigrants and refugees ((SAPPIR))</th>
<th>Vall d’Hebron’s transcultural psychiatry programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target population</td>
<td>Neighbourhoods with specific needs.</td>
<td>Homeless people at risk of suffering from social exclusion and with signs of mental disorders</td>
<td>Young offenders with drug consumption problems</td>
<td>Parents with children in youth justice services</td>
<td>At-risk young people aged 16 years and over from different cultural groups</td>
<td>Young people aged 16 years and over</td>
<td>Parents, young people, professionals from the healthcare, mental health, social services, social action and education sectors, child and adolescent care team ((EAl), educational psychologists from centres and primary healthcare teams, regional and local police</td>
<td>Minors in custodial care who suffer, or are at risk of suffering, from mental disorders, and who live in residential centres under closed or semi-open regimes</td>
<td>Extra-Community immigrants in the city of Barcelona with mental health problems</td>
<td>Mental healthcare for immigrants and refugees</td>
<td>Immigrants with a mental illness</td>
</tr>
<tr>
<td>Completed</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Evaluated</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>In progress</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>AC</td>
<td>VALENCIA (COMMUNITY)</td>
<td>EXTREMADURA</td>
<td>GALICIA</td>
<td>MADRID</td>
<td></td>
<td></td>
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<tr>
<td>Included in the Health Plan</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Title</strong></td>
<td>1. Psychiatric care for children and adolescents as part of the programme for the protection of minors</td>
<td>2. Programme for the promotion of mental health in homeless people</td>
<td>Design and introduction of process management and inter-sectoral coordination with regard to a specific population: minors in custodial care who suffer from behavioural disorders or other mental health problems</td>
<td>Situation analysis and adaptation of a rehabilitation model for people with severe mental disorders in penitentiary centres</td>
<td>Early intervention for drug addicts in social emergency situations (Sisifo)</td>
<td>Community-based plans</td>
<td>Community intervention social education programme (Programa de educación social de intervención en medio abierto)</td>
<td>Day centre for the prevention of drug consumption</td>
<td>Programme for the provision of psychiatric care to mentally ill homeless people</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Target population</strong></td>
<td>Children and adolescents</td>
<td>Minors in the custodial care of the Regional Government of Extremadura</td>
<td>People with severe mental disorders being held in penitentiary centres</td>
<td>Drug addicts suffering from social exclusion, street-based</td>
<td>San Cristobal neighbourhoo</td>
<td>16 municipalities, the interventions are adapted according to the needs of the municipality</td>
<td>Vallecas neighbourhood</td>
<td>Homeless people</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete d</td>
<td>Yes</td>
<td>-</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluated</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AC</td>
<td>MURCIA</td>
<td>NAVARR E</td>
<td>BASQU E COUNTRY</td>
<td>RIOJA (LA)</td>
<td>INGES A</td>
<td></td>
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<tr>
<td>Included in the Health Plan</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Title</td>
<td>Mental Health for Immigrants (Salud Mental para Inmigrantes)</td>
<td>Healthy Habits for Immigrants (Hábitos saludables para inmigrantes)</td>
<td>Violence and drug prevention among convicts (Prevención de violencia y droga en población penada)</td>
<td>Health promotion (Promoción de la salud)</td>
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</tr>
<tr>
<td>Target population</td>
<td>The immigrant population, whether included in the census or not, in each town</td>
<td>The immigrant population, whether included in the census or not, in each town</td>
<td>Population of people who are convicted but not deprived of liberty.</td>
<td>The Gypsy population of Navarre</td>
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<tr>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td></td>
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</tr>
<tr>
<td>Evaluated</td>
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<td>-</td>
<td>-</td>
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<td>-</td>
<td></td>
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</tr>
</tbody>
</table>

In total, 15 Autonomous Communities reported that they have included in their health plans community-based interventions in areas with a high risk of social exclusion or marginalisation, although 1 has not yet started any interventions. Of the 5 AC that have not included them in their health plans, 2 have developed interventions. In total, 215 actions were completed and another 176 are in progress. Of the interventions, 168 have been evaluated.

Apart from the value of these interventions, it must be noted that most of them are not targeted at high-risk communities like, for instance, an urban neighbourhood with particularly high rates of mental disorders or violent conduct, but rather at population sectors, like women or children.

**Conclusion Specific Objective 2.1: partially achieved**

**Recommendation: maintain objective**
Specific Objective 2.2: "Carry out and evaluate a set or plan of interventions within the context of the National Drug Plan and, where appropriate, in that of the Autonomous Community, with the objective of reducing the use and abuse of addictive substances in the entire Community."

Table 18: Set or plan of interventions aimed at reducing the use and abuse of addictive substances

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>No. Completed</th>
<th>Completed and evaluated</th>
<th>No. in progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Programme(s)</td>
<td>Interventions</td>
<td>Programme(s)</td>
<td>Interventions</td>
</tr>
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<td>3,346</td>
<td>7</td>
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<tr>
<td>Aragon</td>
<td>Yes</td>
<td>14</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
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<td>6</td>
<td>60,931</td>
<td>6</td>
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<tr>
<td>Basque Country</td>
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<td>Canary Islands</td>
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<td>3</td>
<td>5</td>
<td>0</td>
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<tr>
<td>Cantabria</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>27</td>
<td>729</td>
<td>27</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>1</td>
<td>-</td>
<td>1</td>
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<tr>
<td>Catalonia</td>
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<td>10</td>
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<tr>
<td>Extremadura</td>
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</tr>
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<td>Galicia</td>
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<td>Madrid (Community)</td>
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</tr>
<tr>
<td>Murcia (Region)</td>
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<td>11</td>
<td>152</td>
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<td>Navarre (Foral Community)</td>
<td>Yes</td>
<td>1</td>
<td>39</td>
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<td>Rioja (La)</td>
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<td>Valencia (Community)</td>
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<td>4</td>
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<td>4</td>
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<tr>
<td>Ceuta-Melilla</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>National Total</td>
<td>15</td>
<td>85</td>
<td>67,614</td>
<td>70</td>
</tr>
</tbody>
</table>

Source: own preparation according to information provided by the Autonomous Communities

In total, 12 Autonomous Communities carried out interventions included in their health plans aimed at reducing the use and abuse of addictive substances, whereas 5 others and INGESÁ have not yet started any interventions.

A total of 85 programmes were completed, involving more than 67614 interventions, and of the programmes 70 were evaluated. A further 3,149 interventions are in progress.

Conclusion Specific Objective 2.2: partially achieved

Recommendation: maintain objective
Specific Objective 2.3: “Carry out and evaluate specific actions aimed at reducing the rates of suicide and depression in at-risk groups.”

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in Health Plan</th>
<th>Completed (number)</th>
<th>In progress (number)</th>
<th>Evaluated (number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
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<tr>
<td>Aragón</td>
<td>No</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>Yes</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Balearic Islands</td>
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<tr>
<td>Basque Country</td>
<td>Yes</td>
<td>1</td>
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<tr>
<td>Canary Islands</td>
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<tr>
<td>Cantabria</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>2</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>0</td>
<td>1</td>
<td>0</td>
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<td>Catalonia</td>
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<tr>
<td>Extremadura</td>
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<tr>
<td>Galicia</td>
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<td>Madrid (Community)</td>
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<td>Murcia (Region)</td>
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<td>1</td>
<td>1</td>
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<td>Navarre (Foral Community)</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Rioja (La)</td>
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<td>0</td>
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</tr>
<tr>
<td>Valencia (Community)</td>
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<td>0</td>
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<tr>
<td>Ceuta-Melilla</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>National Total</strong></td>
<td><strong>12</strong></td>
<td><strong>11</strong></td>
<td><strong>19</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>

Source: own preparation according to information provided by the Autonomous Communities

In total, 12 Autonomous Communities reported that they have included specific actions aimed at reducing the rates of depression and suicide in their health plans, although 7 AC have not carried out any interventions and 3 have only started one. A total of 19 interventions are in progress and 11 have been completed, 7 of which have been evaluated.

**Conclusion Specific Objective 2.3: started**

**Recommendation: maintain objective**
Specific Objective 2.4: “Develop interventions in Primary Care aimed at supporting families caring for and assisting people with chronic, debilitating diseases, in order to avoid the mental health problems that could arise from their role as carers.”

Table 20: Interventions in Primary Care for the provision of support to prevent mental health problems

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed (number)</th>
<th>In progress (number)</th>
<th>Evaluated (number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
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<td>Aragon</td>
<td>No</td>
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<td>0</td>
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<tr>
<td>Asturias (Principality)</td>
<td>Yes</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Balearic Islands</td>
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<td>1</td>
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<td>0</td>
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<tr>
<td>Basque Country</td>
<td>Yes</td>
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<td>Canary Islands</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Cantabria</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Catalonia</td>
<td>Yes</td>
<td>2</td>
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<td>0</td>
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<tr>
<td>Extremadura</td>
<td>Yes</td>
<td>2</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Galicia</td>
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<td>0</td>
<td>0</td>
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<td>Madrid (Community)</td>
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<td>0</td>
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<tr>
<td>Navarre (Foral Community)</td>
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<tr>
<td>Rioja (La)</td>
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<td>0</td>
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<tr>
<td>Ceuta-Melilla</td>
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<td><strong>National Total</strong></td>
<td><strong>10</strong></td>
<td><strong>14</strong></td>
<td><strong>12</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

Source: own preparation according to information provided by the Autonomous Communities

In total, 10 Autonomous Communities reported that they have included in their health plans interventions for the provision of support in Primary Care in order to prevent mental health problems, although 3 AC have not started any interventions yet. Of the interventions 14 have been completed, 12 are in progress and 3 have been evaluated.

Conclusion Specific Objective 2.4: started
Recommendation: maintain objective
Specific Objective 2.5: “Carry out and evaluate a set of actions to support the occupational risk prevention services and the occupational health committees of the Autonomous Communities, with the aim of preventing occupational stress and work-related mental disorders.”

Table 21: Actions to support occupational risk prevention services and occupational health committees

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed (number)</th>
<th>In progress (number)</th>
<th>Evaluated (number)</th>
</tr>
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<tr>
<td>Aragon</td>
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<td>0</td>
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<td>Asturias (Principality)</td>
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<td>Balearic Islands</td>
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<td>Basque Country</td>
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<tr>
<td>Canary Islands</td>
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<tr>
<td>Cantabria</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Castile and Leon</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Catalonia</td>
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<td>22</td>
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<tr>
<td>Extremadura</td>
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<td>0</td>
<td>0</td>
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<td>Galicia</td>
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<td>1</td>
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<tr>
<td>Madrid (Community)</td>
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<tr>
<td>Murcia (Region)</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Navarre (Foral Community)</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Rioja (La)</td>
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<td>0</td>
<td>0</td>
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<td>Valencia (Community)</td>
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<td>22</td>
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<tr>
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<td><strong>29</strong></td>
<td><strong>7</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

Source: own preparation according to information provided by the Autonomous Communities

In total, 10 Autonomous Communities reported that they have carried out actions to support occupational risk prevention services and occupational health committees, although 5 of those AC have either not started any interventions or have started just 1. Of the actions, 29 have been completed, 7 are in progress and 3 have been evaluated.

**Conclusion Specific Objective 2.5: started**

**Recommendation: maintain objective**
Specific Objective 2.6: “Carry out and evaluate interventions aimed at professionals with the goal of preventing professional burn-out.”

Table 22: Interventions aimed at professionals for the prevention of professional burn-out

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed (number)</th>
<th>In progress (number)</th>
<th>Evaluated (number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
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<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Aragon</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>Asturias (Principality)</td>
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<td>15</td>
<td>0</td>
<td>15</td>
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<tr>
<td>Balearic Islands</td>
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<td>0</td>
<td>0</td>
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<td>Basque Country</td>
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<td>Canary Islands</td>
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<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Cantabria</td>
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<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
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<td>0</td>
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<tr>
<td>Catalonia</td>
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<td>3</td>
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<tr>
<td>Extremadura</td>
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<tr>
<td>Galicia</td>
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<tr>
<td>Madrid (Community)</td>
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<td>Murcia (Region)</td>
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<tr>
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<tr>
<td>Rioja (La)</td>
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<td>0</td>
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<td>Ceuta-Melilla</td>
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<td>0</td>
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<tr>
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<td><strong>12</strong></td>
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<td><strong>6</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

In total, 12 Autonomous Communities have included interventions aimed at professionals with the goal of preventing professional burn-out in their health plans. In total, 22 interventions have been completed, 15 of which have been evaluated, and 6 are in progress.

**Conclusion Specific Objective 2.6: started**

**Recommendation: maintain objective**

**Conclusion regarding General Objective 2:**

Nearly half of the Autonomous Communities reported that they have carried out actions, included in their health plans, directed at the achievement of this general objective. Although the number of those actions is quite high, only very few have been evaluated: **started**

**Recommendation: maintain objective**
4.3 GENERAL OBJECTIVE 3: TO ELIMINATE THE STIGMA AND DISCRIMINATION OF PEOPLE SUFFERING FROM MENTAL DISORDERS.

Specific Objective 3.1: “The Ministry of Health and Consumer Affairs and the Autonomous Communities shall include in their plans and programmes interventions to promote the integration and reduce the stigmatisation of people with mental disorders.”

Table 23: Interventions aimed at promoting integration and reducing stigmas

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aragon</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Asturias</td>
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<td>Yes</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Basque Country</td>
<td>Yes</td>
<td>No</td>
</tr>
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<td>Canary Islands</td>
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<tr>
<td>Cantabria</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Castile and Leon</td>
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<td>Yes</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Catalonia</td>
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<td>Yes</td>
</tr>
<tr>
<td>Extremadura</td>
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<tr>
<td>Galicia</td>
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<td>Madrid</td>
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<td>Murcia</td>
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<tr>
<td>Navarre</td>
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<td>Valencia (Community)</td>
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<tr>
<td>INGESA</td>
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<td>Ministry of Health</td>
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<tr>
<td><strong>Spain</strong></td>
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<td><strong>15</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

In total, 15 Autonomous Communities as well as the Ministry have included these interventions in their plans. Moreover, 15 AC reported that they have carried out the interventions and, although the Ministry has not yet carried out any itself, it financed both FEAFES as well as other projects by the Autonomous Communities.

Conclusion Specific Objective 3.1: partially achieved
Recommendation: maintain objective
Specific Objective 3.2: “The Ministry of Health and Consumer Affairs and the Autonomous Communities shall promote initiatives aimed at reviewing and acting on the regulatory barriers that may affect the full exercise of citizenship of people with mental disorders.”

Table 24: Initiatives for the review of regulatory barriers

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aragon</td>
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<tr>
<td>Asturias</td>
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</tr>
<tr>
<td>Balearic Islands</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Basque Country</td>
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<td>Yes</td>
</tr>
<tr>
<td>Canary Islands</td>
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<td>No</td>
</tr>
<tr>
<td>Cantabria</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>No</td>
<td>No</td>
</tr>
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<td>Castile-La Mancha</td>
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<td>Catalonia</td>
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<td>Extremadura</td>
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<td>No</td>
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<td>Galicia</td>
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<td>Madrid</td>
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<td>Yes</td>
</tr>
<tr>
<td>Murcia</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Navarre</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Valencia (Community)</td>
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<tr>
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<td><strong>SPAIN</strong></td>
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<td>8</td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

In total, 10 Autonomous Communities have included this objective in their plans and 8 reported that they have carried out reviews.

**Conclusion Specific Objective 3.2: partially achieved**

**Recommendation: maintain objective**
Specific Objective 3.3: “The protocols and procedures of healthcare centres will include specific regulations aimed at promoting the integration and avoiding the stigma and discrimination of people with mental disorders.”

Table 25: Specific regulations

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aragon</td>
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<td>Yes</td>
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<tr>
<td>Asturias</td>
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<td>Yes</td>
</tr>
<tr>
<td>Balearic Islands</td>
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<td>No</td>
</tr>
<tr>
<td>Basque Country</td>
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<td>Yes</td>
</tr>
<tr>
<td>Canary Islands</td>
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<td>Yes</td>
</tr>
<tr>
<td>Cantabria</td>
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<td>No</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Catalonia</td>
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<td>Yes</td>
</tr>
<tr>
<td>Extremadura</td>
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<td>Yes</td>
</tr>
<tr>
<td>Galicia</td>
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<td>Yes</td>
</tr>
<tr>
<td>Madrid</td>
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<td>Yes</td>
</tr>
<tr>
<td>Murcia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Navarre</td>
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<tr>
<td>Rioja (La)</td>
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</tr>
<tr>
<td>SPAIN</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

In total, 12 Autonomous Communities have included this objective in their plans and 12 reported that they have established the abovementioned specific regulations.

Conclusion Specific Objective 3.3: partially achieved

Recommendation: maintain objective
Specific Objective 3.4: “People with mental disorders in an acute phase shall be admitted to psychiatric units established within general hospitals and suitably adapted to meet the needs of those patients. The Autonomous Communities will progressively adapt the infrastructures in any way necessary for the attainment of this objective.”

Indicator: Acute psychiatric beds in general hospitals per 100,000 population

Table 26 shows the rates of acute psychiatric beds in general hospitals at the close of the year 2006, categorised according to whether they are dependent on the Spanish NHS or not (Spanish NHS refers to all public hospitals, or to private hospitals in which most of the activity is for the Spanish NHS: network for public use or hospitals providing Spanish NHS-commissioned services).

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Total</th>
<th>Dep. on Spanish NHS</th>
<th>Not dep. on Spanish NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>8.05</td>
<td>7.96</td>
<td>0.09</td>
</tr>
<tr>
<td>Aragon</td>
<td>9.16</td>
<td>9.01</td>
<td>0.16</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>7.85</td>
<td>7.85</td>
<td>-</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>9.62</td>
<td>9.42</td>
<td>0.20</td>
</tr>
<tr>
<td>Basque Country</td>
<td>9.96</td>
<td>9.82</td>
<td>0.14</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>8.87</td>
<td>8.82</td>
<td>0.05</td>
</tr>
<tr>
<td>Cantabria</td>
<td>6.96</td>
<td>6.78</td>
<td>0.18</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>9.52</td>
<td>9.48</td>
<td>0.04</td>
</tr>
<tr>
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<td>11.31</td>
<td>11.31</td>
<td>-</td>
</tr>
<tr>
<td>Catalonia</td>
<td>5.84</td>
<td>5.29</td>
<td>0.56</td>
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<tr>
<td>Extremadura</td>
<td>4.66</td>
<td>4.66</td>
<td>-</td>
</tr>
<tr>
<td>Galicia</td>
<td>7.98</td>
<td>7.90</td>
<td>0.07</td>
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<tr>
<td>Madrid (Community)</td>
<td>6.96</td>
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<td>-</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>5.11</td>
<td>5.11</td>
<td>-</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>13.52</td>
<td>9.12</td>
<td>4.39</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>8.57</td>
<td>8.57</td>
<td>-</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>5.41</td>
<td>5.39</td>
<td>0.02</td>
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<tr>
<td>Ceuta-Melilla</td>
<td>8.66</td>
<td>8.66</td>
<td>-</td>
</tr>
<tr>
<td>National Total</td>
<td>7.57</td>
<td>7.38</td>
<td>0.19</td>
</tr>
</tbody>
</table>

Source: Statistics of establishments with inpatient facilities (EESCRI) 2006. Ministry of Health and Social Policy (MSPS)
In 2006, the rate of acute psychiatric beds in general hospitals stood at about 7.6 per 100,000 population, and the large majority of beds depended on the Spanish NHS. The values range between 4.7 and 13.5 beds.

The following figure shows the temporal evolution of this indicator over a period of 10 years for the Spanish NHS as a whole, using the same classification criterion as the previous case. A substantial upward trend can be seen in this type of bed, especially in recent years. It is not possible to interpret the deviation of the years 2000 and 2002 on the basis of the available information.

**Figure 9: Evolution of the rate of acute psychiatric beds in general hospitals of the Spanish NHS per 100,000 population**

Source: Statistics of establishments with inpatient facilities (EESCRI). Ministry of Health and Social Policy (MSPS)
**Indicator: Beds in specialised hospitals per 100,000 population**

The following table shows the data corresponding to the year 2006, disaggregated by Autonomous Community and the centre’s dependence or not on the Spanish NHS, according to the same criterion as in the previous case.

**Table 27: Rate of beds (total) in specialised hospitals per 100,000 population**

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Spanish NHS</th>
<th>Not Spanish NHS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>2.29*</td>
<td>12.45</td>
<td>14.74</td>
</tr>
<tr>
<td>Aragon</td>
<td>43.21</td>
<td>25.52</td>
<td>68.73</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
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<td>4.73</td>
<td>4.73</td>
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<tr>
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<td>16.43</td>
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<td>16.43</td>
</tr>
<tr>
<td>Basque Country</td>
<td>36.40</td>
<td>47.88</td>
<td>84.28</td>
</tr>
<tr>
<td>Canary Islands</td>
<td></td>
<td>6.08</td>
<td>6.08</td>
</tr>
<tr>
<td>Cantabria</td>
<td>18.57</td>
<td>69.80</td>
<td>88.36</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>5.16</td>
<td>59.19</td>
<td>64.36</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>19.22</td>
<td></td>
<td>19.22</td>
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<tr>
<td>Catalonia</td>
<td>14.44</td>
<td>54.77</td>
<td>69.22</td>
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<tr>
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<td>77.95</td>
<td></td>
<td>77.95</td>
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<tr>
<td>Galicia</td>
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<td>7.13</td>
<td>14.34</td>
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<td>38.10</td>
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<td>31.09</td>
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<td>12.98</td>
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<tr>
<td>Ceuta-Melilla</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>National Total</td>
<td><strong>12.64</strong></td>
<td><strong>23.93</strong></td>
<td><strong>36.57</strong></td>
</tr>
</tbody>
</table>

Source: EESCRI 2006, Ministry of Health and Social Policy (MSPS)

* Beds in Seville’s Penitentiary Psychiatric Hospital, which is dependent on the General Secretariat of Penitentiary Institutions, Spanish Ministry of the Interior

The following figure shows the evolution, in recent years, of beds in psychiatric hospitals dependent on the Spanish NHS.
In recent years, the Spanish NHS has evolved towards a steady and progressive decrease in this type of beds, from 20.36 per 100,000 population in the year 1997 down to 12.64 in the year 2006, whereas over that same period a much smaller decrease occurred in private “not Spanish NHS” hospitals, which went from having 25.81 beds per 100,000 population in 1997 to 23.93 beds in 2006.

Moreover, the following table shows the result of the analysis, within the beds in specialised hospitals, of how many of those beds are reserved for patients in acute conditions, showing their distribution according to Autonomous Community and comparing, for the year 2006, the overall number of acute beds in general hospitals to that of acute beds in specialised psychiatric hospitals. In both cases, the figures refer to the total number of beds (Spanish NHS and not Spanish NHS).
Table 28: Rate of acute beds in general hospitals (GH) and in psychiatric hospitals (PH), and percentage of total acute beds in GH over total acute beds

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>GH</th>
<th>PH</th>
<th>% GH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>8.05</td>
<td>1.59</td>
<td>83.5</td>
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<tr>
<td>Aragon</td>
<td>9.16</td>
<td>1.90</td>
<td>82.8</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>7.85</td>
<td>2.36</td>
<td>76.9</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>9.62</td>
<td>3.01</td>
<td>76.2</td>
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<td>9.96</td>
<td>9.07</td>
<td>52.3</td>
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<td>8.87</td>
<td>2.28</td>
<td>79.6</td>
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<td>6.96</td>
<td>10.89</td>
<td>39.0</td>
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<td>9.52</td>
<td>2.54</td>
<td>78.9</td>
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<td>11.31</td>
<td>1.47</td>
<td>88.5</td>
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<td>Catalonia</td>
<td>5.84</td>
<td>14.63</td>
<td>28.5</td>
</tr>
<tr>
<td>Extremadura</td>
<td>4.66</td>
<td>7.46</td>
<td>38.4</td>
</tr>
<tr>
<td>Galicia</td>
<td>7.98</td>
<td>0.74</td>
<td>91.5</td>
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<td>6.96</td>
<td>3.96</td>
<td>63.7</td>
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<td>5.11</td>
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<td>49.7</td>
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<td>Navarre (Foral Community)</td>
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<td>100</td>
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<td>5.41</td>
<td>2.45</td>
<td>68.8</td>
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<tr>
<td>Ceuta-Melilla</td>
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<td>-</td>
<td>100</td>
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<td><strong>National Total</strong></td>
<td><strong>7.57</strong></td>
<td><strong>4.99</strong></td>
<td><strong>60.3</strong></td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Social Policy (MSPS)

Both rates (acute beds in general hospitals and acute beds in specialised hospitals), as well as the percentage of acute beds that are located in general hospitals, reveal differences between the Autonomous Communities, ranging from less than 30% to the target value of 100%.

**Conclusion Specific Objective 3.4:** The objective, which consists of all admissions being to general hospitals, has not been fully achieved. **Started**

**Recommendation:** maintain objective
Specific Objective 3.5: “The Ministry of Health and Social Policy (MSPS) shall foster initiatives regarding coordination with the WHO, the European Union and other international bodies in the field of the promotion of integration and the battle against stigma and discrimination.”

In the year 2008 the Ministry, in collaboration with the Council of Europe, was in charge of drafting a report on fundamental freedoms, basic rights and care for mentally ill people, called *Libertades fundamentales, derechos básicos y atención al enfermo mental*. It is a systematic review of the current status of the protection of the human rights of people with mental disorders.

The European Commission’s European Mental Health Pact, which enjoyed the participation of the Ministry of Health, includes a specific section on eliminating stigma.

In April 2008 the Scottish Government, in collaboration with the WHO-Europe, organised an awareness-raising meeting on stigma, which enjoyed the participation of the Ministry, and at which the Autonomous Community of Andalusia as well as FEAFES presented interventions that they have carried out.

**Conclusion Specific Objective 3.5: partially achieved**

**Recommendation: maintain objective**
Summary of the interventions carried out by the Autonomous Communities in the context of objectives 1, 2 and 3.

After reviewing the information sent by the Autonomous Communities the following summary table was drawn up:

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>TYPE OF INTERVENTION</th>
<th>GENDER FOCUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Andalusia</td>
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</tr>
<tr>
<td>Aragon</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Asturias</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balearic Islands</td>
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</tr>
<tr>
<td>Basque Country</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cantabria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Castile and Leon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Castile-La Mancha</td>
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<td>Catalonia</td>
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<tr>
<td>Extremadura</td>
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<td>Galicia</td>
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<tr>
<td>Madrid</td>
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<tr>
<td>Murcia</td>
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<tr>
<td>Navarre</td>
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<td>Valencia (Community)</td>
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<td>INGESA</td>
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<td></td>
</tr>
<tr>
<td>SPAIN</td>
<td>32</td>
<td>15</td>
</tr>
</tbody>
</table>

A: Texts or talks published or broadcast on the radio, the press, TV, Internet and/or handed out or sent by post; B: Series of conferences or courses, with or without debates, directed at face-to-face audiences of more than 30 attendees; C: Highly-interactive workshops, directed at groups of less than 30 attendees and given by professionals specifically trained for that purpose (e.g.: school for parents of children at a high risk, training of pupils in problem-solving techniques, training in stress-busting techniques for call centre operators); D: Integrated programmes with interventions of different types and with a single objective (e.g.: suicide prevention in a zone or sector of the population, reduction of the stigma associated with mental illness among GPs); E: Others (described in "comments").
Most of the interventions carried out consist of campaigns and series of conferences and courses, whereas the number of interactive workshops, which are most effective, is very low.

**Conclusion regarding the Interventions:** started

**Recommendation:** maintain objective
Strategy Line 2: Healthcare for patients with mental disorders

4.4 GENERAL OBJECTIVE 4: TO IMPROVE THE QUALITY, EQUITY AND CONTINUITY OF CARE FOR MENTAL HEALTH PROBLEMS.

Indicator: Treated morbidity

This refers to the morbidity or prevalence treated on an outpatient basis by specialised mental health services at 31 December 2007.

In total, 14 Autonomous Communities as well as INGESA provided information concerning these indicators.

EATING BEHAVIOUR

Table 29-A: Treated morbidity of eating disorders

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Codes Used</th>
<th>Codes Used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ICD 9</td>
<td>ICD 10</td>
</tr>
<tr>
<td>Andalusia</td>
<td></td>
<td>F50.0-3</td>
</tr>
<tr>
<td>Aragon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td></td>
<td>F50.0-3/F50.9</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>307.1 / 307.50-1</td>
<td></td>
</tr>
<tr>
<td>Basque Country</td>
<td></td>
<td>F50.0 -3</td>
</tr>
<tr>
<td>Canary Islands</td>
<td></td>
<td>F.50.0-3</td>
</tr>
<tr>
<td>Cantabria</td>
<td></td>
<td>F50.0 / F50.9</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td></td>
<td>F50.0/ F 50.9</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td></td>
<td>F50.0-3</td>
</tr>
<tr>
<td>Catalonia</td>
<td>307.1 / 307.5X</td>
<td></td>
</tr>
<tr>
<td>Extremadura</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Galicia</td>
<td></td>
<td>F50.X</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>307.1/ 307.5</td>
<td></td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td></td>
<td>F50 /F50.0-1</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td></td>
<td>F50.0-3</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td></td>
<td>F50 Complete</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td></td>
<td>F50-F50.9</td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities
Table 29-B: Treated morbidity of eating disorders

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>0.014%</td>
<td>0.002%</td>
<td>0.025%</td>
</tr>
<tr>
<td>Aragon</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>0.039%</td>
<td>0.008%</td>
<td>0.069%</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>0.13%</td>
<td>0.02%</td>
<td>0.23%</td>
</tr>
<tr>
<td>Basque Country</td>
<td>0.043%</td>
<td>0.008%</td>
<td>0.078%</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>0.012%</td>
<td>0.0005%</td>
<td>0.026%</td>
</tr>
<tr>
<td>Cantabria</td>
<td>0.095%</td>
<td>0.012%</td>
<td>0.174%</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>0.029%</td>
<td>0.001%</td>
<td>0.056%</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>0.016%</td>
<td>0.004%</td>
<td>0.029%</td>
</tr>
<tr>
<td>Catalonia</td>
<td>0.018%</td>
<td>0.003%</td>
<td>0.033%</td>
</tr>
<tr>
<td>Extremadura</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Galicia</td>
<td>0.16%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>0.042%</td>
<td>0.009%</td>
<td>0.074%</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>0.005%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>0.029%</td>
<td>0.003%</td>
<td>0.055%</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>0.39%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>0.029%</strong></td>
<td><strong>0.005%</strong></td>
<td><strong>0.053%</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities
### BIPOLAR DISORDER

Table 30 A: Treated morbidity of bipolar disorder

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Codes Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>F31</td>
</tr>
<tr>
<td>Aragon</td>
<td>F31 Complete</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>296.00/296.04/296.06/296.10/296.11/296.15/296.40/296.45/296.50/296.55/296.60/296.65/296.7/296.80/296.82/296.89</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>F31 (10-19)</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>F.30-1</td>
</tr>
<tr>
<td>Cantabria</td>
<td>F30-F39</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>F31</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>F30-3/F38</td>
</tr>
<tr>
<td>Catalonia</td>
<td>296.80-1/296.4-7/296.8-1/296.89/301.11/301.13</td>
</tr>
<tr>
<td>Extremadura</td>
<td>F31</td>
</tr>
<tr>
<td>Galicia</td>
<td>296.0-1, 296.4-296.8</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>F31.0-9</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>F31</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>F31 Complete</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>F31</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>F31</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>F31</td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities
<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>0.070%</td>
<td>0.060%</td>
<td>0.080%</td>
</tr>
<tr>
<td>Aragon</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>0.058%</td>
<td>0.047%</td>
<td>0.069%</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>0.179%</td>
<td>0.15%</td>
<td>0.20%</td>
</tr>
<tr>
<td>Basque Country</td>
<td>0.126%</td>
<td>0.093%</td>
<td>0.156%</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>0.12%</td>
<td>0.14%</td>
<td>0.09%</td>
</tr>
<tr>
<td>Cantabria</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>0.551%</td>
<td>0.324%</td>
<td>0.777%</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>0.059%</td>
<td>0.044%</td>
<td>0.073%</td>
</tr>
<tr>
<td>Catalonia</td>
<td>0.088%</td>
<td>0.071%</td>
<td>0.105%</td>
</tr>
<tr>
<td>Extremadura</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Galicia</td>
<td>0.27%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>0.145%</td>
<td>0.098%</td>
<td>0.188%</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>0.09%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>0.086%</td>
<td>0.068%</td>
<td>0.103%</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>0.09%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>0.117%</strong></td>
<td><strong>0.080%</strong></td>
<td><strong>0.124%</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities
# SCHIZOPHRENIA

Table 31 A: Treated morbidity of Schizophrenia

## Codes Used

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Codes used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>F20-2/F24-5/F28-9</td>
</tr>
<tr>
<td>Aragon</td>
<td>F20 Complete</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td></td>
</tr>
<tr>
<td>Basque Country</td>
<td>F20/F200/F2000-4/F2009/F201-3/F205-6/F208-9</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>F20</td>
</tr>
<tr>
<td>Cantabria</td>
<td>F20-9</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>F20</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>F20</td>
</tr>
<tr>
<td>Catalonia</td>
<td>295.xx, 301.2x</td>
</tr>
<tr>
<td>Extremadura</td>
<td></td>
</tr>
<tr>
<td>Galicia</td>
<td>F20,F23,F25</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>CIE-9, 295 Complete</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>F20.0-9</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>F20-9</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>F20 Complete</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td></td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>F20-2/F24-5/F28-9</td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities
### Table 31 B: Treated morbidity of Schizophrenia

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>0.232%</td>
<td>0.309%</td>
<td>0.158%</td>
</tr>
<tr>
<td>Aragon</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>0.151%</td>
<td>0.199%</td>
<td>0.106%</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>0.184%</td>
<td>0.21%</td>
<td>0.14%</td>
</tr>
<tr>
<td>Basque Country</td>
<td>0.201%</td>
<td>0.252%</td>
<td>0.152%</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>0.300%</td>
<td>0.355%</td>
<td>0.239%</td>
</tr>
<tr>
<td>Cantabria</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>0.154%</td>
<td>0.184%</td>
<td>0.125%</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>0.118%</td>
<td>0.145%</td>
<td>0.090%</td>
</tr>
<tr>
<td>Catalonia</td>
<td>0.231%</td>
<td>0.289%</td>
<td>0.174%</td>
</tr>
<tr>
<td>Extremadura</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Galicia</td>
<td>0.066%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>0.165%</td>
<td>0.209%</td>
<td>0.125%</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>0.20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>0.264%</td>
<td>0.316%</td>
<td>0.212%</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>0.20%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td>0.198%</td>
<td>0.274%</td>
<td>0.156%</td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities
### MAJOR DEPRESSION

Table 32 A: Treated morbidity of major depression

**Codes used**

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Codes used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>F32.2-3</td>
</tr>
<tr>
<td>Aragon</td>
<td></td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>F32 Complete F33 Complete</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>F32.20-5 / F32.30-6</td>
</tr>
<tr>
<td>Basque Country</td>
<td>F32 - F320 - F3200, F3201 - F321 - F3210 - F3211 - F323 - F328 - F329</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>F32-3</td>
</tr>
<tr>
<td>Cantabria</td>
<td>F30-9</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>F32-3</td>
</tr>
<tr>
<td>Catalonia</td>
<td>296.2x + 296.3x + 296.82+296.90 298.0 300.4 + 300.5 / 301.12 309.0 + 309.1 311</td>
</tr>
<tr>
<td>Extremadura</td>
<td></td>
</tr>
<tr>
<td>Galicia</td>
<td>Included with bipolar disorders</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>F32.0-9 / F33.0-9</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>F32.3/F33.3</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>F32 y F33</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td></td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>F32-9</td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities
### Table 32 B: Treated morbidity of major depression

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>0.031%</td>
<td>0.028%</td>
<td>0.034%</td>
</tr>
<tr>
<td>Aragon</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>0.601%</td>
<td>0.424%</td>
<td>0.768%</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>0.246%</td>
<td>0.16%</td>
<td>0.31%</td>
</tr>
<tr>
<td>Basque Country</td>
<td>0.151%</td>
<td>0.108%</td>
<td>0.192%</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>0.176%</td>
<td>0.136%</td>
<td>0.220%</td>
</tr>
<tr>
<td>Cantabria</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>0.551%</td>
<td>0.324%</td>
<td>0.777%</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>0.120%</td>
<td>0.063%</td>
<td>0.177%</td>
</tr>
<tr>
<td>Catalonia</td>
<td>0.694%</td>
<td>0.371%</td>
<td>1.013%</td>
</tr>
<tr>
<td>Extremadura</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Galicia</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>0.053%</td>
<td>0.034%</td>
<td>0.072%</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>0.41%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>0.015%</td>
<td>0.011%</td>
<td>0.0184%</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>0.51%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>0.278%</strong></td>
<td><strong>0.162%</strong></td>
<td><strong>0.387%</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

**Indicator: Percentage of readmissions**

A readmission is considered to have occurred when a person is admitted to hospital in a non-programmed manner within a period of less than 30 days since that same person was last discharged, and for the same cause.

The following table includes all the percentages regarding psychiatric readmissions (chapter 5 of the ICD-9-CM classification) that took place, differentiated by gender.
Table 33: Percentage of psychiatric readmissions

<table>
<thead>
<tr>
<th>National total</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10.5</td>
<td>10.3</td>
<td>10.7</td>
</tr>
</tbody>
</table>

Source: Register of Hospital Discharges (MBDS) 2007. Ministry of Health and Social Policy (MSPS)

As can be seen, the percentages according to gender in the national total do not vary in any significant way.

The following figure shows the temporal evolution, for the Spanish NHS as a whole and for each gender, of the readmissions that took place as of the year 1997. It reveals small differences between genders, with women showing slightly higher values.

Figure 11: Rate of psychiatric readmissions, by gender

Source: Register of Hospital Discharges (MBDS) 2007. Ministry of Health and Social Policy (MSPS)

After a period in which the indicator followed an upward trend, a decrease of just over one percentage point can be seen as of 2002. However, that decrease not only appears to have reached a halt, but over the last two years even seems to have taken an upturn.

In any event, over the last 10 years the indicator shows an upward trend, both in men and in women.
Specific objective 4.1: “Develop and achieve the effective implementation by the Autonomous Communities, in the framework of their competences, of the healthcare services included in the services portfolio of the Spanish NHS, both in Primary Care as well as in Secondary Care”.

Table 34: Implement healthcare services included in the services portfolio

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Aragon</td>
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<tr>
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<td>Yes</td>
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<td>Castile and Leon</td>
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<tr>
<td><strong>National Total</strong></td>
<td><strong>Yes (16)</strong></td>
<td><strong>Yes (17)</strong></td>
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</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

In total, 16 Autonomous Communities reported that this objective is included in their health plans. Likewise, most AC reported that they have developed and effectively implemented the healthcare services included in the Spanish NHS’s common services portfolio.

**Measures launched**: noteworthy are the creation of Models adapted to the needs of the population; Social support programmes, especially focused on Childhood and Adolescence; Care in the natural environments of people with mental disorders; Primary Care support guides for the detection, diagnosis and treatment of mental disorders; Programmes for care regarding Addictive Behaviour, Eating Disorders, Attention Deficits, Neuropsychological deterioration due to other causes like strokes, traumas, etc.; Psychiatric consultations in Pain Units.
Specific Objective 4.1: practically achieved
Recommendation: maintain objective

Specific Objective 4.2: “Through specialised mental health services, the Autonomous Communities will establish support procedures for Primary Care aimed at the early detection and treatment of mental disorders.”

Table 35: Support procedures through specialised mental health services for Primary Care aimed at the early detection and treatment of mental disorders

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
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</thead>
<tbody>
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<td>Castile and Leon</td>
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</table>

Source: own preparation based on the information provided by the Autonomous Communities

Many of the Autonomous Communities (16 in total) reported that they have included this objective in their health plans, and they all stated that they have carried out activities in line with this specific objective.
**Measures launched:** numerous actions have been carried out, such as the inclusion of training in the detection of at-risk behaviour in family medicine residency programmes (MIR); Protocols for referral to the A&E departments of general hospitals; Clinical sessions in health centres; the creation of critical care and emergency facilities, psychiatric emergency management protocols and emergency and disaster management protocols; the receipt of users referred both from Primary Care as well as from drug addiction treatment centres, penitentiary centres and other Specialised Care services.

**Conclusion Specific Objective 4.2: partially achieved**

**Recommendation:** maintain objective
Specific Objective 4.3: “The Autonomous Communities will establish care guidelines for psychiatric emergencies and crisis situations, in collaboration with the different sectors involved.”

Table 36: Establishment of care guidelines for emergencies and crisis situations

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
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Source: own preparation based on the information provided by the Autonomous Communities

Of the Autonomous Communities, 15 reported that they have included the objective of establishing care guidelines for psychiatric emergencies and crisis situations in their health plans. Likewise, 16 AC stated that they have carried out activities in line with this objective.

Conclusion Specific Objective 4.3: partially achieved

Recommendation: maintain objective
Specific Objective 4.4: “Increase the percentage of patients with mental disorders who receive psychotherapy, in keeping with the best practices available.”

Table 37: Psychotherapy in patients with mental disorders

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Included in MA*</th>
<th>Measuring system</th>
<th>Evaluated</th>
<th>Outcome and source</th>
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<td>Yes (6)</td>
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</tbody>
</table>

*MA: management agreement or contract

Source: own preparation based on the information provided by the Autonomous Communities

Broadly speaking, the different Autonomous Communities stated that they are working on increasing the percentage of patients with mental disorders who receive psychotherapy. In total, 11 reported that they have established this specific objective in their health plans, while 10 reported that they have included it as an objective in the management agreement or contract with the mental health services. Nevertheless, despite the fact that 6 reported that they have measuring and monitoring systems, only 2 of them (i.e. 33.3%) have evaluated this objective, and only 2 have provided results for the evaluation.

Conclusion Specific Objective 4.4: started

Recommendation: maintain objective, although we recommend that the existing objective be modified so as to include a consensus-based definition of psychotherapy with minimum quality criteria.
Specific Objective 4.5: “Increase the percentage of patients with severe mental disorders who are included in a rehabilitation programme.”

Table 38: Rehabilitation for patients with severe mental disorders

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Included in MA*</th>
<th>Measuring System</th>
<th>Evaluated</th>
<th>Outcome and source</th>
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<tr>
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<td>Castile-La Mancha</td>
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<td><strong>Yes (14)</strong></td>
<td><strong>Yes (5)</strong></td>
<td><strong>Yes (4)</strong></td>
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</table>

*MA: management agreement or contract

Source: own preparation based on the information provided by the Autonomous Communities

The different Autonomous Communities reported that they are working on increasing the percentage of patients with mental disorders receiving rehabilitation. In total, 15 stated that they have established this specific objective in their health plans, while 13 reported that they have included it as an objective in the management agreement or contract with the mental health services.

Nevertheless, despite the fact that 14 AC stated that they have measuring systems, only 5 have evaluated this objective, and only 4 have provided results for the evaluation.

**Conclusion Specific Objective 4.5: started**

**Recommendation: maintain objective**
Specific Objective 4.6.: “Increase the percentage of families of patients with severe mental disorders who follow specific family intervention programmes, in order to enhance their ability to face crises and prevent relapses.”

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Included in MA*</th>
<th>Measuring system</th>
<th>Evaluated</th>
<th>Outcome and source</th>
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<td><strong>Yes (3)</strong></td>
</tr>
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</table>

*MA: management agreement or contract

Source: own preparation based on the information provided by the Autonomous Communities

In total, 15 Autonomous Communities reported that they have established this specific objective in their health plans, while 10 reported that they have included it as an objective in the management agreement or contract with the mental health services. Nevertheless, only 4 out of the 9 AC who reported that they have a measuring system have evaluated this objective, and only 3 have provided results for the evaluation.

Conclusion Specific Objective 4.6: started
Recommendation: maintain objective
Specific Objective 4.7: “Provide patients with severe mental disorders with appropriate care for their general health.”

Table 40: Appropriate care for patients with mental disorders

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
</tr>
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<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
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<tr>
<td>Aragon</td>
<td>Yes</td>
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<tr>
<td>Asturias (Principality)</td>
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<td>Yes</td>
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<tr>
<td>Balearic Islands</td>
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<td>Basque Country</td>
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<tr>
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<tr>
<td>Cantabria</td>
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<td>Yes</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>No</td>
<td>Yes</td>
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<tr>
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<td>Galicia</td>
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<tr>
<td>Madrid (Community)</td>
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<td>Murcia (Region)</td>
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<td>Ceuta-Melilla</td>
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<tr>
<td><strong>National Total</strong></td>
<td><strong>Yes (15)</strong></td>
<td><strong>Yes (18)</strong></td>
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</table>

Source: own preparation based on the information provided by the Autonomous Communities

In total, 15 Autonomous Communities reported that they have included in their health plans the objective of providing patients with severe mental disorders with appropriate care for the improvement of their general health. Moreover, all the AC stated that they have carried out activities in line with this objective.

**Measures launched:** plans to promote physical exercise, balanced diets, tobacco cessation and healthy lifestyles and to prevent metabolic syndrome in psychiatric patients; health education programmes; among others.

**Conclusion Specific Objective 4.7: partially achieved**

**Recommendation: maintain objective**
Specific Objective 4.8: “The Autonomous Communities will consider the specific specialised care needs of people with intellectual disabilities or mental disorders in their mental health plans.”

### Table 41: Specialised care for people with intellectual disabilities or mental disorders

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
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<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
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<tr>
<td>Aragon</td>
<td>No</td>
<td>Yes</td>
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<td>Asturias (Principality)</td>
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<td>Balearic Islands</td>
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<td>Castile and Leon</td>
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<tr>
<td><strong>National Total</strong></td>
<td><strong>Yes (10)</strong></td>
<td><strong>Yes (17)</strong></td>
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</table>

Source: own preparation based on the information provided by the Autonomous Communities

In total, 10 Autonomous Communities reported that they have considered the specialised care needs of people with intellectual disabilities or mental disorders in their health plans. Moreover, despite not considering it in their health plans, 17 AC are developing actions to adapt care to the needs of people with intellectual disabilities or mental disorders.

**Measures launched**: study of existing barriers and promotion of the development of corrective measures; creation of integration support centres, specific teams and units, joint training activities;
designation of supervisors, face-to-face inter-consultations, meeting areas, mobile teams, consultation programme, specific protocols and guides.

**Conclusion Specific Objective 4.8: partially achieved**

**Recommendation: maintain objective**
Specific Objective 4.9: “The Autonomous Communities will adapt their services to include specific programmes that meet the mental health needs of children and adolescents.”

Table 42: Services with specific child-adolescent mental health programmes

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
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<tr>
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<td><strong>Yes (16)</strong></td>
<td><strong>Yes (17)</strong></td>
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</table>

Source: own preparation based on the information provided by the Autonomous Communities

Comments: Most of the Autonomous Communities (16) reported that they have included in their health plans actions to adapt specific services and/or programmes to the mental health needs of children and adolescents. In total, 17 stated that they have adapted the services for this population group.

Measures launched: specific programmes, teams, units and centres; agreements between government departments at the region level, monitoring commissions; training activities aimed at mothers, fathers, teachers, etc.

Conclusion Specific Objective 4.9: partially achieved

Recommendation: maintain objective
Specific Objective 4.10: “The Ministry of Health and Social Policy will develop, together with the Autonomous Communities, a model for collaboration with public bodies from the Department of Justice and Penitentiary Institutions to improve care for people with mental disorders subject to the Penal Code and Juvenile Law, thereby guaranteeing the continuity and the equity of the care compared to the rest of the population.”

Table 43: Discharges of penitentiary patients in non-penitentiary hospitals (in %), according to year and AC

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
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<th>2005</th>
<th>2006</th>
<th>2007</th>
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<td>93.1</td>
<td>89.4</td>
<td>90.9</td>
<td>88.4</td>
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<td>94.1</td>
<td>92.0</td>
<td>93.3</td>
<td>90</td>
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<td>100</td>
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<td>88.8</td>
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<td>90.9</td>
<td>92.3</td>
<td>88.8</td>
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<td>80.9</td>
<td>72</td>
<td>80.9</td>
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<td>100</td>
<td>100</td>
<td>100</td>
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<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Extremadura</td>
<td>100</td>
<td>100</td>
<td>90</td>
<td>100</td>
</tr>
<tr>
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<td>91.6</td>
<td>88.8</td>
<td>92.8</td>
<td>91</td>
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<td>90</td>
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<td><strong>92.8</strong></td>
<td><strong>89.8</strong></td>
<td><strong>90.1</strong></td>
</tr>
</tbody>
</table>


*Catalonia has been transferred full competences in this field

In Spain, the percentage of people confined in Penitentiary Institutions, who were referred and admitted to non-penitentiary hospitals due to a psychiatric cause, was 90.1%. In general, no differences were observed over the period between the years 2004 and 2007. The Ministry of Health, the Autonomous Communities and the Penitentiary Institutions have started to directly collaborate through the incorporation of the latter into the Strategy’s monitoring committee.

**Conclusion Specific Objective 4.10: started**

**Recommendation:** extend the objective to people sentenced to penitentiary confinement by a judge.
Specific Objective 4.11: “Establish access to all therapeutic facilities or programmes, including rehabilitators, in each of the territorial healthcare structures. Those therapeutic means must be sufficient to meet the needs of the population, and the continuity of care must be ensured through an integrated network of services that includes general hospitals, and that operates in coordination with Primary Care.”

Table 44: Establish access to therapeutic facilities and programmes in all territorial healthcare structures

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
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<tbody>
<tr>
<td>Andalusia</td>
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<tr>
<td>Aragon</td>
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<tr>
<td>Asturias (Principality)</td>
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<td>Balearic Islands</td>
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<tr>
<td>Cantabria</td>
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<tr>
<td>Castile and Leon</td>
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<td>Castile-La Mancha</td>
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<td>Catalonia</td>
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<td>Extremadura</td>
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<td>Galicia</td>
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<td>National Total</td>
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<td>Yes (18)</td>
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</table>

Source: own preparation based on the information provided by the Autonomous Communities

In total, 16 Autonomous Communities reported that they have included in their health plans the establishment of, and guaranteed access to, all therapeutic facilities and programmes, and they have all developed actions in line with this objective.
Measures launched: certain Autonomous Communities stated that access can be provided through the creation of Clinical Management Units for Mental Health in all hospital areas or Health Management areas. Mental Health Rehabilitation Units were also created to help patients regain social skills and to assist their social and occupational reintegration.

Conclusion Specific Objective 4.11: partially achieved
Recommendation: maintain objective
Specific Objective 4.12: “Establish personalised care plans for all people with mental disorders receiving treatment.”

Table 45: Patients with a personalised care plan

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
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<th>Included in MA*</th>
<th>Measuring system</th>
<th>Evaluated</th>
<th>Outcome and source</th>
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<td>No</td>
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</table>

*MA: management agreement or contract

Source: own preparation based on the information provided by the Autonomous Communities

In total, 13 Autonomous Communities reported that they have set out, in their health plans, the definition of personalised care plans for people with mental disorders receiving treatment, and 14 reported that they had included it as a specific objective in management agreements or contracts with mental health services. Nevertheless, only 3 of the 7 AC that reported that they had a measuring system have evaluated this objective, and only 2 provided results for the evaluation.

**Conclusion Specific Objective 4.12: started**

**Recommendation: maintain objective**
Specific Objective 4.13: “Within community mental health teams, and with regard to long-term severe mental health disorders, create an organisational system to avoid abandonment and facilitate adherence, which includes home care and ensures the multi-sectoral management and coordination of the care process.”

Table 46: Create an organisational system to avoid abandonment and facilitate adherence and which includes home care

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>Yes (15)</strong></td>
<td><strong>Yes (15)</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

In total, 15 Autonomous Communities reported that they have defined, in their health plans, an organisational system to avoid abandonment and facilitate adherence, which includes home care for people with severe mental disorders, as well as the multi-sectoral management and coordination of the care process. Likewise, 15 AC reported that they have carried out these actions.
Measures launched: the establishment of an Organisational System to avoid abandonment and facilitate adherence, which includes home care, is organised through monitoring teams, social integration programmes, care for the family and close environment.

Conclusion Specific Objective 4.13: started
Recommendation: maintain objective
Specific Objective 4.14: “Define and implement, in each Autonomous Community, the clinical protocols for the care processes that are most prevalent and/or that involve the most complex care in the different stages of life. Both the gender perspective as well as the specific problems of certain at-risk groups will be taken into consideration.”

Table 47: Clinical protocols

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>3</td>
<td>1. Integrated care process for anxiety, depression and somatisations; 2. Integrated care process for eating disorders; 3. Integrated care process for severe mental disorders</td>
</tr>
<tr>
<td>Aragon</td>
<td>2</td>
<td>Care process for severe mental disorders; Care process for personality disorders</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>8</td>
<td>1. PCAI (Programa Clave de Atención Interdisciplinar or core programme for interdisciplinary care) for Dementia; 2. PCAI for Anxiety; 3. PCAI for Depression; 4. PCAI for Alcoholism; 5. PCAI for Chronic musculoskeletal pain; 6. Severe mental disorder programme; 7. Healthcare protocol to improve care for women who are victims of gender violence; 8. Inter-departmental protocol to improve care for women who are victims of gender violence.</td>
</tr>
<tr>
<td>Basque Country</td>
<td>N.A.</td>
<td>Clinical protocols are available for all certified care processes as guidelines for their different sub-processes (organic-psychiatric intervention, family intervention, psychosocial competence intervention, psychotherapeutic intervention). These protocols are very diverse in nature and range from the protocol for the monitoring of treatments with clozapine or lithium, to regulated intervention protocols like the integrated therapy programmes for schizophrenia. These certified care processes, which can be and have been evaluated, are the outpatient and inpatient rehabilitation processes of the hospitals of Álava, Bermeo, Zaldibar and Zamudio, which make up 100% of the outpatient and inpatient hospital psychosocial rehabilitation network in Álava and Bizkaia. The singularised schizophrenia process specifies the use of clinical practice guidelines on</td>
</tr>
<tr>
<td>Region</td>
<td>Protocols</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Protocols implemented at the regional level and applied homogeneously refer to very specific practical or organisational aspects (referral criteria, access to facilities, the indications of certain tests, the establishment of programmes and the functioning of facilities). The clinical protocols are developed, adapted and applied at the level of the health area, for example: - In collaboration with Primary Care: 1. Adjustment disorders 2. Anxiety and Depression 3. Early detection and referral during childhood. - Within the Mental Health network: 4. Severe mental disorders (adult and child) 5. Eating disorders 6. Bipolar disorder 7. Dependence on main substance 8. Dual pathology 9. Psychoeducation 10. The specifics of inter-consultations and liaising with specific hospital services.</td>
<td></td>
</tr>
<tr>
<td>Catalonia</td>
<td>Bipolar disorder; Borderline personality disorder; Mental Health and HIV; Mental health needs of people with intellectual disabilities; Clinical practice guideline for the treatment of cocaine consumption; Incipient psychosis care protocol; Protocol for consumption in adolescents; Protocol for eating disorders in Primary Care; Protocol for mental health in children and adolescents; Healthy Child Programme; Mental health support programme for Primary Care; Recommendations for the care of the most common mental health problems in primary healthcare; Personalised service plan; Specific care programme for severe mental disorders; Gender violence action protocol; Recommendations for the care of children and adolescents with severe mental disorders.</td>
<td></td>
</tr>
<tr>
<td>Extremadura</td>
<td>Anxiety disorder care protocol; Mood disorder care protocol; Care protocol for non-scheduled consultations and crisis interventions by Primary Care;</td>
<td></td>
</tr>
<tr>
<td>Region</td>
<td>Count</td>
<td>Protocols</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Galicia</td>
<td>3</td>
<td>Protocol for seclusion in psychiatric hospitalisation units; Mechanical restraint protocol; Suicide risk protocol; Behavioural disorder protocol; Involuntary transfer protocol; Agitated patient protocol; Protocol for patients suffering from depression; Protocol for patients with suicidal ideation; Protocol for patients suffering from anxiety.</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>2</td>
<td>Relaxation protocol; Rehabilitation unit processes</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>8</td>
<td>Psychiatric emergency protocol; Emergency mechanical restraint protocol; Agitated patient protocol; Protocol for the referral of patients with eating disorders from Primary Care; Action protocol for patients admitted to the psychiatric hospitalisation units; Protocol for admissions to psychiatric hospitalisation units; Dual pathology action protocol; Protocols for the establishment of pharmacological treatments; ECT protocol; Flight protocol; Safety protocol; Leave and temporary release protocol.</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>119</strong></td>
<td></td>
</tr>
</tbody>
</table>

In total, 15 Autonomous Communities reported that they have implemented a total of more than 100 clinical protocols for the care processes that are most prevalent and/or that involve the most complex care. Table 47 sets out the main protocols established by some of the Autonomous Communities.
However, it should be noted that specific objective 4.14 refers to protocols for “care processes”, in other words, to the documents that set out the clinical process management and not to clinical protocols for action in specific situations.

Conclusion Specific Objective 4.13: partially achieved

Recommendation: maintain objective; a more precise evaluation of this objective is required.
Specific Objective 4.15: “Develop, adapt or adopt and subsequently implement, in the Autonomous Communities, the use of integrated clinical practice guidelines, in accordance with the priorities and quality criteria established by the Spanish NHS.”

### Table 48: Implemented clinical practice guidelines

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aragon</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>5</td>
<td>PCAI (Programa Clave de Atención Interdisciplinar or core programme for interdisciplinary care) for Dementia. PCAI for Anxiety. PCAI for Depression. PCAI for alcoholism. PCAI for chronic musculoskeletal pain.</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Autonomous Community</td>
<td>Number of Guidelines</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>Basque Country</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Canary Islands</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Clinical Practice Guideline on Alzheimer’s disease and other dementias.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cantabria</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Basic guide to the functioning of psychiatric day hospitals; Basic guide to the functioning of psychiatric rehabilitation units; Basic guide to the functioning of psychosocial rehabilitation centres; Supportive care guidelines for mental disorders in Primary Care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Catalonia</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia and incipient psychotic disorder; Eating disorders; Pathological gambling disorders and other social addictions; Methadone maintenance programme.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremadura</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Galicia</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>CPG on alcoholism; CPG on bipolar disorder; CPG on schizophrenia; CPG on major depression; CPG on depression and anxiety in women; CPG on care for carers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Guidelines for action in Secondary Care: Intimate partner violence against women. CPG for the management of patients with anxiety disorders in Primary Care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>CPG on eating disorders; CPG on depressive disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Clinical Practice Guideline (CPG) for the management of depressive disorders in Primary Care; CPG for the management of first episodes; Psychoactive drug guide; CPG on Delirium. Multidisciplinary psychogeriatric approach. Severe dual pathology intervention; CPG for comprehensive action in severely alcoholic patients; Guidelines for the prevention of metabolic syndrome. Comprehensive care for oncology patients. CPG for action regarding agitated patients. Comprehensive care for dysthymic patients. CPG for the treatment of refractory depression. CPG on impulsive patients. Comprehensive care for ADHD. Comprehensive management of PDD.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>National Total</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities
All the Autonomous Communities reported that they have developed/adapted Clinical Practice Guidelines for different disorders or risk situations, although only 8 Autonomous Communities reported that they have implemented the use of CPGs in keeping with the priorities and quality criteria established by the Spanish NHS (GuiaSalud). The information provided suggests that the majority of the CPGs do not meet the specific criteria of GuíaSalud. The abovementioned documents drawn up by national and international agencies and bodies may be both valuable and useful, but the Autonomous Communities have not provided sufficient information for their assessment.
Indicator: Clinical practice guidelines that meet the quality criteria established by the Spanish NHS.

Between the approval of the Spanish NHS Mental Health Strategy and 11 December 2008, a total of 43 clinical practice guidelines (CPGs) were evaluated in accordance with the quality criteria of the Spanish NHS (GuíaSalud project). Of those CPGs, 14.0% (6/43) concerned Mental Health. Finally, half (3/6) of the evaluated Mental Health CPGs were included in the GuíaSalud catalogue, since they meet Spanish NHS quality criteria. Those CPGs are:

- CPG on eating disorders
- CPG for the management of severe depression in adults
- CPG for the management of patients with anxiety disorders in Primary Care

Through agreements, the Ministry of Health and Social Policy financed the preparation and development, over the period 2006-2008, of nine Clinical Practice Guidelines within the framework of the GuíaSalud Project. In 2006 (n=4), they concerned the management of depression, anxiety disorders, eating disorders and schizophrenia; in 2007 (n=4) depression in adolescents, autism, attention deficit hyperactivity disorder and severe mental disorders; and, finally, in 2008 bipolar disorder.

**Conclusion Objective 4.15: started**

**Recommendation: maintain objective**
Specific Objective 4.16: “The Autonomous Communities will have strategies aimed at increasing the quality, effectiveness and safety, and reducing the variability, of pharmacological treatments, in accordance with criteria for rational drug use.”

Table 49: Strategies for the improvement of pharmacotherapy in accordance with criteria for rational drug use

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aragon</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Basque Country</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Cantabria</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Catalonia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Extremadura</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Galicia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

| National Total             | Yes (14)                    | Yes (13)  |

Source: own preparation based on the information provided by the Autonomous Communities

Indicator: Daily dose per inhabitant (DDI) of antidepressants

<table>
<thead>
<tr>
<th>Antidepressants</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Active Population</td>
<td>20.22</td>
<td>21.11</td>
<td>21.90</td>
</tr>
<tr>
<td>Total Pensioners</td>
<td>28.95</td>
<td>30.97</td>
<td>33.08</td>
</tr>
<tr>
<td>General total</td>
<td>49.17</td>
<td>52.09</td>
<td>54.98</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Social Policy (MSPS). Directorate General of Pharmacy and Health Products (DGFPS)
Indicator: Daily dose per inhabitant (DDI) of antipsychotics

<table>
<thead>
<tr>
<th>Antipsychotics</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Active Population</td>
<td>2.20</td>
<td>2.25</td>
<td>2.30</td>
</tr>
<tr>
<td>Total Pensioners</td>
<td>6.37</td>
<td>6.74</td>
<td>7.06</td>
</tr>
<tr>
<td>General total</td>
<td>8.57</td>
<td>8.99</td>
<td>9.36</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Social Policy (MSPS). Directorate General of Pharmacy and Health Products (DGFPS)

Indicator: Daily dose per inhabitant (DDI) of hypnotics, sedatives and anxiolytics

<table>
<thead>
<tr>
<th>Anxiolytics</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Active Population</td>
<td>21.63</td>
<td>22.30</td>
<td>23.06</td>
</tr>
<tr>
<td>Total Pensioners</td>
<td>49.10</td>
<td>50.87</td>
<td>52.49</td>
</tr>
<tr>
<td>General total</td>
<td>70.73</td>
<td>73.17</td>
<td>75.55</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Social Policy (MSPS). Directorate General of Pharmacy and Health Products (DGFPS)

Over the period studied, antidepressants increased by 11.8%, anxiolytics by 6.8% and antipsychotics remained practically stable, with an increase of 1%. In all three groups of drugs the increase was more marked among pensioners; that is especially true in the case of antidepressants, which saw an increase of 14%. It would have been interesting to obtain information separately from Primary Care and Secondary Care, and disaggregated by gender.

In total, 13 Autonomous Communities reported that they have included strategies to increase the quality of pharmacotherapy in accordance with criteria for rational drug use (safety, effectiveness, efficacy, etc.). However, of those AC, 11 reported that they have fully developed the strategies and 2 others have developed interventions for that same purpose although they are not considered in their plans.

**Measures launched:** the strategies aimed at increasing the quality, effectiveness and safety, and reducing the variability, of pharmacological treatments, include, among others: demedicalising the common problems and conflicts of everyday life, promoting rational drug use, defending effective prescribing, the use of generic drugs in the case of psychoactive drugs as well and reducing pharmaceutical expenditure.

**Conclusion Specific Objective 4.16: partially achieved**

**Recommendation: maintain objective and improve information system**

It is important to continue to stress the need to guarantee the quality of therapeutic prescribing in general, and for people with mental disorders in particular, which is why the Autonomous Communities that have not yet developed these action measures (or that are currently in the process of doing so) must continue to work towards the achievement of this specific objective.
4.5 GENERAL OBJECTIVE 5: TO IMPLEMENT INVOLUNTARY RESTRAINT PROCEDURES WHICH GUARANTEE THE USE OF GOOD PRACTICES AND THAT RESPECT PATIENTS’ RIGHTS AND DIGNITY.

Specific Objective 5.1: “Draw up a general guide, with regard to good practices, on the ethical and legal aspects of the use in healthcare of any intervention method against the patient’s will.”

The Ministry, through a contract with the University of Granada, is drawing up criteria for the use of coercive measures during psychiatric hospitalisation and during the transfer to hospital. The first report, which concerns the analysis of the general legislative situation as well as that in the Autonomous Communities, has been completed, and the criteria should be established by late 2009.

Conclusion Specific Objective 5.1: partially achieved
Recommendation: maintain objective

Specific Objective 5.2: “The Autonomous Communities will define or update a protocol for involuntary transfer and hospitalisation.”

A total of 14 Autonomous Communities reported that they have included the definition and implementation of protocols for involuntary transfer and hospitalisation as a priority in their health plans. However, nearly all the AC (16) reported that they have developed protocols for action in these special circumstances. See table 50 on the next page.

Conclusion Specific Objective 5.2: partially achieved
Recommendation: maintain objective

Specific Objective 5.3: “Regulate, by means of protocols, the procedures for physical restraint, the involuntary treatment of hospitalised patients and any restrictive measure considered under the current legal system.”

In total, 14 Autonomous Communities reported that they have included in their health plans the establishment of protocols regarding the procedures for physical restraint, the involuntary treatment of hospitalised patients and any other restrictive measure considered in the context of the current legal system. Moreover, 15 AC stated that they have developed protocols for action in these circumstances. See table 51 on the next page.

Conclusion Specific Objective 5.3: partially achieved
Recommendation: maintain objective
**General Objective 5:**

**Measures launched:** the Autonomous Communities have drawn up Safety Guidelines for the collection, transfer and restraint of psychiatric patients, and have up-to-date agreements between Primary Care and other institutions like the Red Cross, the 112 emergency service and public judicial bodies. Protocols have been established for action in the event of abandonment, and mechanical and pharmacological restraint in hospitals to avoid self-harm and harm to others.

**Comments:** it can be stated that the majority of Autonomous Communities have implemented or are currently developing involuntary restraint procedures that guarantee the use of good practices and that respect patients’ rights and dignity.

**Conclusion General Objective 5: partially achieved**

**Recommendation: maintain general objective**
Table 50: Protocols for involuntary transfer and hospitalisation

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>Yes</td>
<td>Resolution 261/2002, of 26 December, on emergency care, transfer and admission of psychiatric patients. Andalusian Health Service</td>
</tr>
<tr>
<td>Aragon</td>
<td>Yes</td>
<td>No</td>
<td>Protocol for the involuntary transfer of mentally ill people</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>Yes</td>
<td>Yes</td>
<td>Protocol for the emergency care and transfer of people with a possible mental illness</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>Yes</td>
<td>Yes</td>
<td>Action protocol for the involuntary healthcare of mentally ill people</td>
</tr>
<tr>
<td>Basque Country</td>
<td>Yes</td>
<td>Yes</td>
<td>Coordination protocols with Courts for transfer and hospitalisation. They are common knowledge, but so far not all geographical areas are coordinated with the same efficacy. Coordination protocol (in progress).</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>No</td>
<td>Yes</td>
<td>Protocol for involuntary transfer and internment</td>
</tr>
<tr>
<td>Cantabria</td>
<td>No</td>
<td>Yes</td>
<td>Protocol for involuntary admission and treatment</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>Yes</td>
<td>Safety Guidelines for the collection, transfer and restraint of psychiatric patients</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>Yes</td>
<td>Action protocol for the involuntary medical transfer of people with mental disorders</td>
</tr>
<tr>
<td>Catalonia</td>
<td>Yes</td>
<td>Yes</td>
<td>Action protocol for care in emergencies, urgent involuntary transfers and admissions of people with a mental illness. Dissemination and application of the protocol in all the healthcare centres and towns. Consensus-based development of an internal action procedure for the Mossos d'Esquadra (Catalan police). Completion of a training course in the Police School of Catalonia. Signing of an agreement to ratify the said protocol by the institutions involved: the Departments of Health, the Interior and Justice of the Autonomous Government of Catalonia, the Government Delegation, the High Court of Justice of Catalonia, Barcelona Town Council, the Catalan Association of Municipalities and Counties, and the Federation of Municipalities.</td>
</tr>
<tr>
<td>Extremadura</td>
<td>Yes</td>
<td>Yes</td>
<td>Protocol for care and transfer to Mental Health Emergency services for use by Primary Care teams. Update of the agreement with the Red Cross and 112, State Security Forces and Agencies, the judicial system and Extremadura’s Health Service.</td>
</tr>
<tr>
<td>Galicia</td>
<td>Yes</td>
<td>Yes</td>
<td>Inter-institutional agreement between the Galician Departments of Health, Justice and the Government Delegation.</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>Yes</td>
<td>Yes</td>
<td>Procedure for involuntary medical transfers within the Community and in collaboration with the 112 emergency services.</td>
</tr>
<tr>
<td>Autonomous Communities</td>
<td>Included in the Health Plan</td>
<td>Completed</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Aragon</td>
<td>Yes</td>
<td>No</td>
<td>Mechanical Restraint Protocols.</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>Yes</td>
<td>Yes</td>
<td>Written procedures for the development of these actions in every Psychiatric Hospitalisation Unit.</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>Yes</td>
<td>Yes</td>
<td>Mechanical Restraint Protocol; Action protocol for involuntary healthcare</td>
</tr>
<tr>
<td>Basque Country</td>
<td>Yes</td>
<td>Yes</td>
<td>Mechanical Restraint Protocol endorsed by the corresponding bioethical committee. Guipuzkoa provides for the possibility of involuntary outpatient treatments, linked to a court and a specific judicial interpretation of civil legislation.</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>No</td>
<td>Yes</td>
<td>Mechanical Restraint Protocol.</td>
</tr>
<tr>
<td>Cantabria</td>
<td>No</td>
<td>Yes</td>
<td>Protocol for physical and chemical restraint measures</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>Yes</td>
<td>1. Audit in 100% of the Psychiatric Hospitalisation Units. 2. Creation of two focal groups with patients and relatives. 3. Development of Safety Guidelines regarding psychiatric patients</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>Yes</td>
<td>Protocols for physical restraint are available and applied in all the hospitals, including in Psychiatric Hospitalisation Units and in basic life support transport vehicles. The Strategic Patient Safety Plan includes the preparation and implementation of a</td>
</tr>
<tr>
<td>Community</td>
<td>Has Single Physical Restraint Protocol</td>
<td>Has Specific Restraint Protocol</td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------------------------------------</td>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td>Catalonia</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Guideline by Catalonia’s Bioethical Committee: Involuntary admission and the therapeutic practice of restrictive measures in psychiatric patients and demented people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremadura</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mechanical Restraint Protocol (updated in 2008). Will be evaluated using a specific indicator in management contracts.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Galicia</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development of a restraint protocol to be applied in all Psychiatric Hospitalisation Units.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mechanical Restraint Protocols in all hospitalisation centres.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mechanical Restraint Protocol. The Protocol for the coordination of action in transfers and admissions of patients suffering from a mental illness sets out instructions regarding measures restricting freedom.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mechanical restraint protocol for doctors; Mechanical restraint protocol for nurses; Protocol for the application of court authorisation for involuntary admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implementation of protocols in all the health departments: Involuntary admission protocol; Physical restraint protocol; Flight protocol; Safety protocol; Dementia protocol; Cognitive decline protocol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pharmacological and mechanical restraint protocol.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>Yes (15)</strong></td>
<td><strong>Yes (15)</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities
Strategy Line 3: Intra-institutional and Inter-institutional Coordination

4.6 GENERAL OBJECTIVE 6: TO PROMOTE THE COOPERATION AND CO-RESPONSIBILITY OF ALL THE DEPARTMENTS AND AGENCIES INVOLVED IN THE IMPROVEMENT OF MENTAL HEALTH.

Specific Objective 6.1: “The implementation by the Autonomous Communities at the institutional and inter-institutional levels of effective coordination and collaboration mechanisms that guarantee comprehensive care for people.”

Table 52: Implement effective care coordination mechanisms

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aragon</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Basque Country</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cantabria</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Catalonia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Extremadura</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Galicia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>Yes (16)</strong></td>
<td><strong>Yes (16)</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

With the aim of promoting mental health, preventing mental illness and guaranteeing comprehensive care for people with mental illnesses, most of the Autonomous Communities reported that they have...
included in their health plans the need to implement effective coordination and collaboration mechanisms at the institutional and inter-institutional levels. They all stated that they have established coordination and collaboration with the services, departments and/or centres of the different institutions (e.g. Social Welfare, Education, Employment, Justice and Public Administration, Penitentiary Institutions, Culture, Ombudsmen, etc.), patient and family associations, NGOs, etc.

**Measures launched:** these mechanisms are established through coordination efforts with centres like Social Welfare, Education, Employment, departments like Justice, Public Administration, Culture, Penitentiary Institutions, Social and Family Services, Labour, Anti-Drug Agency, Town Councils, Custodial Agencies. Likewise, bureaucracy is minimised with the aim of facilitating intercommunication, thereby creating inter-professional communication channels, facilitating the access to Miniresidencias, sheltered workshops, etc.

**Conclusion Specific Objective 6.1: in progress**

**Recommendation:** maintain objective
Specific Objective 6.2: “The establishment by the Autonomous Communities of a general framework that determines the implication and role of Spanish Law 39/2006 on the Promotion of Personal Autonomy and Care for Dependent Persons with regard to people who are dependent due to a mental illness.”

Table 53 provides a summary of the interventions reported by the Autonomous Communities

<table>
<thead>
<tr>
<th>Concept</th>
<th>Which service is responsible for the assessment of dependence (social services, healthcare services, shared)?</th>
<th>Are the assessments and characteristics of people with mental health problems clearly defined and included?</th>
<th>Are there known figures for the number of assessed people or beneficiaries?</th>
<th>Achievements made to date and opportunities for improvement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANDALUSIA</td>
<td>Community Social Services</td>
<td>Partially</td>
<td>Not among psychic impairments due to mental retardation and those caused by a severe mental disorder.</td>
<td>ACHIEVEMENTS: The gradual universalisation of social rights OPPORTUNITIES FOR IMPROVEMENT: Adapt the services offered to the needs of people with severe mental disorders</td>
</tr>
<tr>
<td>ARAGON</td>
<td>Social services</td>
<td>Yes</td>
<td>No data available</td>
<td>OPPORTUNITIES FOR IMPROVEMENT: Specifically cover people with severe mental disorders</td>
</tr>
<tr>
<td>ASTURIAS</td>
<td>Social Affairs</td>
<td>Yes</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>BASQUE COUNTRY</td>
<td>Departments for Social Action of the Provincial Councils</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>CANARY ISLANDS</td>
<td>Social services</td>
<td>No</td>
<td>No</td>
<td>OPPORTUNITIES FOR IMPROVEMENT: Specifically cover people with severe mental disorders</td>
</tr>
<tr>
<td>CANTABRIA</td>
<td>Department of Employment and Social Welfare</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CASTILE AND LEON</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Services (Department of Families and Equal Opportunities)</td>
<td>Not in a specific manner</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CASTILE-LA MANCHA**

<table>
<thead>
<tr>
<th>General Directorate of the Department of Health and Social Welfare.</th>
<th>Yes</th>
<th>Not among psychic impairments due to mental retardation and those caused by a severe mental disorder.</th>
<th>ACHIEVEMENTS: Adaptation of the evaluation procedure OPPORTUNITIES FOR IMPROVEMENT: A specific report that will be at the disposal of the team. Increase social and health benefits.</th>
</tr>
</thead>
</table>

**CATALONIA**

<table>
<thead>
<tr>
<th>Management Council of the ProdeP programme Presidency: Department of Social Action and Citizenship / Vice-presidency: Department of Health.</th>
<th>Yes</th>
<th>Not among psychic impairments due to mental retardation and those caused by a severe mental disorder.</th>
<th>ACHIEVEMENTS: The ProdeP projects as a reference model OPPORTUNITIES FOR IMPROVEMENT: The identification and inclusion of people with a severe mental illness who are not currently receiving treatment.</th>
</tr>
</thead>
</table>

**EXTREMADURA**

<table>
<thead>
<tr>
<th>SEPAD (Extremaduran service for the promotion of autonomy and care for dependent persons), attached to the Department of Health and Dependency</th>
<th>Yes</th>
<th>There is a specific mental health programme</th>
<th>Yes</th>
<th>ACHIEVEMENT: Specific funding</th>
</tr>
</thead>
</table>

**MADRID**

<table>
<thead>
<tr>
<th>Directorate General for Dependency. Department of Family and Social Affairs.</th>
<th>Yes</th>
<th>Not among psychic impairments due to mental retardation and those caused by a severe mental disorder.</th>
<th>ACHIEVEMENT: an evaluation body has been created.</th>
</tr>
</thead>
</table>

**MURCIA**

<table>
<thead>
<tr>
<th>Social services</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**NAVARRE**

<table>
<thead>
<tr>
<th>ANDEP (Navarre Agency for Dependency), Department of Social Affairs, Family, Youth and Sport</th>
<th>No</th>
<th>No</th>
<th>Improve the assessment of the aspects related to mental health</th>
</tr>
</thead>
</table>

**VALENCIA (COMMUNITY)**

<table>
<thead>
<tr>
<th>Department of Social Welfare</th>
<th>Yes</th>
<th></th>
</tr>
</thead>
</table>
In total, 14 Autonomous Communities provided information regarding this objective. Although most AC have defined and included the assessments and characteristics of people with mental health problems, it is too early to evaluate the achievements made.

Conclusion Objective 6.2: not yet started
Recommendation: maintain objective
Specific Objective 6.3: “The implementation by the Autonomous Communities, in the framework of their competences, of effective care coordination mechanisms within each regional healthcare structure, between the different healthcare and social facilities involved in the care of patients with severe mental disorders.”

Table 54: Implement effective care coordination mechanisms

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aragon</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Basque Country</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cantabria</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Catalonia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Extremadura</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Galicia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>Yes (16)</strong></td>
<td><strong>Yes (16)</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

Most of the Autonomous Communities reported that they have included the need to implement effective coordination and collaboration mechanisms at the institutional and inter-institutional levels in their health plans. They all stated that they have established coordination and collaboration with the services, departments and/or centres of the different institutions (e.g. Social Welfare, Education, Employment, Justice and Public Administration, Penitentiary Institutions, Culture, Ombudsmen, etc.), patient and family associations, NGOs, etc.

**Conclusion Specific Objective 6.3: partially achieved**

**Recommendation: maintain objective**
**Indicator: Map of mental health facilities**

For the purposes of knowing all the aspects regarding the organisational setup established by each Autonomous Community for the provision of care for mental health, as well as the resources available in each geographical area, one of the Strategy's priorities was to collect all existing information on this matter.

Thanks to the work carried out in collaboration with the Sub-commission for Information Systems of the Spanish NHS as well as with the Autonomous Community representatives of the Strategy’s Monitoring and Evaluation Committee, two documents were drawn up:

1. On the one hand, an up-to-date descriptive report of the organisational setup for the provision of care for mental health, to which was added a summary of all the different existing facilities, the functions they carry out and their locations.
2. On the other hand, a directory with all the details regarding their locations.

The directory will be analysed at some later date, with the objective of classifying the different types of facilities into different categories, thereby creating groups and providing a better overview of the resources currently available within the Spanish NHS according to type of care.
**Table 55: Rate of psychiatrists (linked to hospitals) in Spain per 100,000 population**

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Spanish NHS</th>
<th>Not Spanish NHS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>6.01</td>
<td>0.79</td>
<td>6.80</td>
</tr>
<tr>
<td>Aragon</td>
<td>8.22</td>
<td>1.42</td>
<td>9.64</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>5.20</td>
<td>0.76</td>
<td>5.96</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>8.12</td>
<td>2.10</td>
<td>10.22</td>
</tr>
<tr>
<td>Basque Country</td>
<td>4.49</td>
<td>1.89</td>
<td>6.37</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>5.68</td>
<td>0.71</td>
<td>6.39</td>
</tr>
<tr>
<td>Cantabria</td>
<td>6.07</td>
<td>1.61</td>
<td>7.68</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>6.98</td>
<td>1.29</td>
<td>8.27</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>6.86</td>
<td>0.52</td>
<td>7.39</td>
</tr>
<tr>
<td>Catalonia</td>
<td>5.97</td>
<td>4.69</td>
<td>10.66</td>
</tr>
<tr>
<td>Extremadura</td>
<td>5.59</td>
<td>1.03</td>
<td>6.62</td>
</tr>
<tr>
<td>Galicia</td>
<td>6.47</td>
<td>1.25</td>
<td>7.72</td>
</tr>
<tr>
<td>Madrid (Community)</td>
<td>5.78</td>
<td>1.45</td>
<td>7.23</td>
</tr>
<tr>
<td>Murcia (Region)</td>
<td>3.55</td>
<td>0.74</td>
<td>4.29</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>2.53</td>
<td>2.70</td>
<td>5.24</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>6.59</td>
<td></td>
<td>6.59</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>4.54</td>
<td>0.85</td>
<td>5.39</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>4.33</td>
<td></td>
<td>4.33</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>5.81</strong></td>
<td><strong>1.68</strong></td>
<td><strong>7.49</strong></td>
</tr>
</tbody>
</table>


It should be noted that these statistics only include the professionals who are in some way linked to a hospital. Therefore, at this point in time professionals who provide services in community centres that are not linked to a hospital are not included in the count, which reduces the total available figure. This situation could be remedied through the implementation of the EESCRI, which takes these situations into accounts.

From an evolutionary point of view, the figure below shows the upward trend in the total rate of psychiatrists in Spain over the last decade, from 5.63 psychiatrists per 100,000 population in 1997 to 7.49 psychiatrists per 100,000 population in 2006.
In the year 2006, there were a total of 3,299 psychiatrists (equivalent to 7.5 psychiatrists per 100,000 population) in Spain. The rate of psychiatrists per population has increased slightly in recent years, but even so the figures for Spain remain below the average rates of its European neighbouring countries (although the abovementioned issue about psychiatrists who are not linked to hospitals must be taken into account).

**Conclusion:** partially achieved. The proportion of psychiatrists in relation to the general population is not in itself an indicator of the sufficiency or quality of the human resources for mental health, and even less so when it only includes psychiatrists linked to hospitals. This figure should be considered together with those for psychologists, nurses, social workers and other professionals on mental health teams, and assessed in the corresponding care providing context.

**Recommendation:** maintain this general objective and change or update the specific objectives, i.e. with regard to the human resources available within the mental healthcare network, it would be interesting to consider the proportion of clinical psychologists, mental health nurses and social workers per population.
4.7 GENERAL OBJECTIVE 7: TO STRENGTHEN THE PARTICIPATION OF PEOPLE SUFFERING FROM MENTAL DISORDERS AND THEIR FAMILIES AND PROFESSIONALS IN THE PUBLIC HEALTHCARE SYSTEM OF THEIR AUTONOMOUS COMMUNITY.

Specific Objective 7.1: “In each Autonomous Community, develop an information strategy aimed at people with mental disorders and their families about rights and obligations, the resources and services at their disposal, and the administrative procedures to submit suggestions and complaints.”

Table 56: Develop an information strategy aimed at people with mental disorders and their families

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aragon</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Basque Country</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cantabria</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Catalonia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Extremadura</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Galicia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
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<td>Madrid (Community)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Murcia (Region)</td>
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<td>Yes</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>Yes (16)</strong></td>
<td><strong>Yes (15)</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities
A total of 16 Autonomous Communities reported that they have included the development of information channels aimed at patients with mental disorders and their families as a priority in their health plans, and 15 stated that they have completed these actions.

**Measures launched:** the technological development can clearly be seen and several AC have already developed applications through corporate websites for people with mental illnesses and their families to access information on rights and obligations, mental health resources and services, as well as the administrative procedures for the submission of suggestions and complaints. In turn, the different healthcare centres have placed the charter of rights and duties, as well as the forms to submit suggestions and complaints, at the disposal of users and family members.

Moreover, health centres have information desks where patients and their families can obtain booklets and leaflets with specific information regarding mental health. In addition, in some cases periodic user satisfaction surveys are conducted (2-3 years).

**Conclusion Specific Objective 7.1: partially achieved**

**Recommendation: maintain objective**
Specific Objective 7.2: “Implement, in each Autonomous Community, mechanisms and channels for the participation of people with mental disorders and their families in all areas of mental health, including in the planning and evaluation of services.”

Table 57: Mechanisms and channels for the participation of patients and their families in all areas of mental health

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aragon</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Balearic Islands</td>
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<td>Yes</td>
</tr>
<tr>
<td>Basque Country</td>
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<td>Yes</td>
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<tr>
<td>Canary Islands</td>
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<td>Yes</td>
</tr>
<tr>
<td>Cantabria</td>
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<td>No</td>
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<tr>
<td>Castile and Leon</td>
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<td>Yes</td>
</tr>
<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Catalonia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Extremadura</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Galicia</td>
<td>Yes</td>
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<tr>
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<td>Rioja (La)</td>
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<tr>
<td>Ceuta-Melilla</td>
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</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>Yes (16)</strong></td>
<td><strong>Yes (14)</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

In total, 16 Autonomous Communities reported that they have included in their health plans the need to implement mechanisms for the participation of patients with mental disorders and their families, and 14 stated that they have completed those actions. Many Autonomous Communities have some type of consultative/advisory body (e.g. Mental Health Advisory Council) made up of professionals involved in mental health, patients, their families and/or various user associations.
Measures launched: the creation of associations for mentally ill people and their families, agreements on social awareness, the eradication of situations of disadvantage, systems to measure the satisfaction of the users of community rehabilitation centres, the participation of family members and scientific societies in the planning and evaluation of mental health services, etc.

Conclusion Specific Objective 7.2: partially achieved

Recommendation: maintain objective
Specific Objective 7.3: “The establishment by the Autonomous Communities of mechanisms and channels for the participation of scientific and professional societies involved in mental health in the planning and evaluation of services.”

Table 58: Mechanisms and channels for the participation of scientific and professional societies involved in mental health

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
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<td>No</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>Yes (15)</strong></td>
<td><strong>Yes (14)</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

As was the case with the previous specific objective, a high number (n=15) of Autonomous Communities reported that they have included in their health plans the need to establish mechanisms for the participation of scientific and professional societies involved in mental health in the healthcare planning activities and the evaluation of services, and 14 AC have completed those actions.

**Measures launched**: psychiatric services have been evaluated on a yearly basis, mental health advisory councils have been created, working groups for the planning and evaluation of services have been
established, regional offices have held meetings with the main professional associations and societies, etc.

**Conclusion Specific Objective 7.3: achieved**
**Recommendation: maintain objective**

**Conclusion General Objective 7:** it can be stated that, in general, in recent years the different Autonomous Communities have worked to promote the participation of people suffering from mental disorders and their families, as well as professionals, in the public healthcare system.
**Strategy Line 4: Training of healthcare personnel**

4.8 GENERAL OBJECTIVE 8: TO STRENGTHEN THE TRAINING OF PROFESSIONALS IN THE HEALTHCARE SYSTEM FOR THEM TO ADEQUATELY MEET THE MENTAL HEALTH NEEDS OF THE POPULATION.

Specific Objective 8.1: “Each Autonomous Community should have at its disposal a Continuous Training Plan for all professionals in Primary Care, mental health and Secondary Care services involved in the care of people with mental disorders, in the framework of the biopsychosocial model of care.”

<table>
<thead>
<tr>
<th>Type of Professional</th>
<th>No. of activities</th>
<th>Credits</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry</td>
<td>26</td>
<td>141</td>
<td>617</td>
</tr>
<tr>
<td>Primary Care Medicine</td>
<td>21</td>
<td>43</td>
<td>443</td>
</tr>
<tr>
<td>Psychology</td>
<td>13</td>
<td>90</td>
<td>395</td>
</tr>
<tr>
<td>Nursing</td>
<td>30</td>
<td>139</td>
<td>767</td>
</tr>
<tr>
<td>Social Work</td>
<td>3</td>
<td>10</td>
<td>39</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>6</td>
<td>15</td>
<td>140</td>
</tr>
<tr>
<td>Others</td>
<td>22</td>
<td>53</td>
<td>494</td>
</tr>
<tr>
<td>Teams</td>
<td>126</td>
<td>569</td>
<td>3848</td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

With regard to the section of accredited activities that are or are not included in continuous training plans, it should be noted that most of those training activities were aimed at multidisciplinary teams (n=81), with 2,914 attendees, followed by activities aimed at psychiatric doctors (n=17), with 441 attendees.

The non-accredited training activities were primarily aimed at multidisciplinary teams, followed by medical professionals working in Primary Care and nursing.
Table 60: Non-accredited training activities according to type of profession

<table>
<thead>
<tr>
<th>Type of Profession</th>
<th>No of activities</th>
<th>Hours</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry</td>
<td>33</td>
<td>741</td>
<td>743</td>
</tr>
<tr>
<td>Primary Care Medicine</td>
<td>33</td>
<td>303</td>
<td>518</td>
</tr>
<tr>
<td>Psychology</td>
<td>16</td>
<td>730</td>
<td>481</td>
</tr>
<tr>
<td>Nursing</td>
<td>37</td>
<td>871</td>
<td>1113</td>
</tr>
<tr>
<td>Social Work</td>
<td>30</td>
<td>712</td>
<td>629</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>3</td>
<td>126</td>
<td>50</td>
</tr>
<tr>
<td>Others</td>
<td>13</td>
<td>201.5</td>
<td>233</td>
</tr>
<tr>
<td>Teams</td>
<td>122</td>
<td>2590</td>
<td>3041</td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

**Measures launched:** with the objective of having a Continuous Training Plan for all professionals in Primary Care, mental health and Secondary Care services involved in the care of people with mental disorders, in the framework of the biopsychosocial model of care, a series of courses have been promoted on new developments in psychopharmacology, emergency and disaster management, workshops, new therapies, emerging mental health needs, etc.

**Comments:** it can be stated that, in general, the Autonomous Communities have strengthened the training of professionals in the healthcare system for them to adequately meet the needs of the population with mental disorders.

**Conclusion Specific Objective 8.1: achieved**

**Recommendation:** maintain objective
Strategy Line 5: Research in Mental Health

4.9 GENERAL OBJECTIVE 9: TO PROMOTE RESEARCH IN MENTAL HEALTH
Specific Objective 9.1: “The promotion by the Ministry of Health and the Autonomous Communities of priority interdisciplinary research areas in mental health through their inclusion in calls for research projects.”

Table 61: Inclusion of priority research areas in calls for research projects by the AC

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aragon</td>
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<tr>
<td>Asturias (Principality)</td>
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<td>Yes</td>
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<td>Yes</td>
</tr>
<tr>
<td>Basque Country</td>
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<tr>
<td>Canary Islands</td>
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<td>No</td>
</tr>
<tr>
<td>Cantabria</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Castile-La Mancha</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Catalonia</td>
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<td>Yes</td>
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<tr>
<td>Extremadura</td>
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<td>Galicia</td>
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<td>Yes</td>
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<tr>
<td>Madrid (Community)</td>
<td>Yes</td>
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</tr>
<tr>
<td>Murcia (Region)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Navarre (Foral Community)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Rioja (La)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Valencia (Community)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ceuta-Melilla</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>Yes (14)</strong></td>
<td><strong>Yes (12)</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

The Ministry included Mental Health as a priority research area in 2006, 2007 and 2008 in the calls for proposals of the Health Research Fund (FIS) and in those for Health Technology Evaluation (Evaluación de Tecnologías Sanitarias). In total, 13 Autonomous Communities reported that they have included interdisciplinary research areas in mental health in their health plans, while 12 stated that they have included them among the priority research areas of the calls for project proposals for grants.
**Indicator: Research projects through calls for proposals by the Carlos III Health Institute (ISCIII)**

Table 62: Research projects* in Mental Health during the period 2006-2008

<table>
<thead>
<tr>
<th>Year</th>
<th>Applications</th>
<th>Funded</th>
<th>Rejected</th>
<th>% Funded/Applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>63</td>
<td>24</td>
<td>39</td>
<td>38.1</td>
</tr>
<tr>
<td>2007</td>
<td>61</td>
<td>24</td>
<td>37</td>
<td>39.3</td>
</tr>
<tr>
<td>2008</td>
<td>83</td>
<td>30</td>
<td>53</td>
<td>36.1</td>
</tr>
<tr>
<td>Total</td>
<td>207</td>
<td>78</td>
<td>129</td>
<td>37.7</td>
</tr>
</tbody>
</table>

*Includes: research projects (FIS) and studies on health technology evaluation and health service research (ETeS).


Over the period 2006-2008, through the calls for proposals for grants for research projects of the Programa de Promoción de la Investigación Biomédica y en Ciencias de la Salud del Plan Nacional de I+D+i 2004-2007 (programme for the promotion of research in biomedicine and in health sciences of the National R&D&I Plan for the period 2004-2007), which since 2008 has been known as Acción Estratégica en Salud del Plan Nacional de I+D+i 2008-2011 (strategic action for health research of the National R&D&I Plan for the period 2008-2011), and which is organised on a yearly basis by the Carlos III Health Institute (ISCIII), 78 projects related to mental health received public funding.
Indicator: Research projects funded through calls for proposals by the Autonomous Communities

Table 63: Research projects in Mental Health funded by the AC (2007-2008)

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusia</td>
<td>12</td>
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</tr>
<tr>
<td>Aragon</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asturias (Principality)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Balearic Islands</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Basque Country</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Canary Islands</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cantabria</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Castile and Leon</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Castille-La Mancha</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Catalonia</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Extremadura</td>
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<td>2</td>
</tr>
<tr>
<td>Galicia</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Madrid (Community)</td>
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</tr>
<tr>
<td>Murcia (Region)</td>
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<td>Navarre (Foral Community)</td>
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<td>0</td>
</tr>
<tr>
<td>Rioja (La)</td>
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<tr>
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<tr>
<td><strong>National Total</strong></td>
<td><strong>37</strong></td>
<td><strong>34</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

Moreover, the Autonomous Communities reported that over the period 2007-2008 they funded a total of 71 projects through calls for proposals for grants for research projects in the thematic area “mental health”.
Specific Objective 9.2: “The launch by the Autonomous Communities and the Ministry of Health and Social Policy of measures to promote the creation of accredited networks of research centres and groups of excellence in mental health.”

Table 64: Launch of measures to promote the creation of research networks

<table>
<thead>
<tr>
<th>Autonomous Communities</th>
<th>Included in the Health Plan</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
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</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>Yes (11)</strong></td>
<td><strong>Yes (12)</strong></td>
</tr>
</tbody>
</table>

Source: own preparation based on the information provided by the Autonomous Communities

Out of all the Autonomous Communities, 11 (61.1%) reported that they have included in their mental health plans the launch of measures to promote the creation of networks and groups of accredited research centres in the field of mental health, while 12 (66.7%) stated that they have taken action in relation to this specific objective.
Indicator: Research Network on Mental Health (existence of)

February 2008 saw the publication (in the Official State Gazette [BOE] number 48) of the Resolution of 23 January 2008, by the Secretariat-General for Health, of the Agreement for the creation of a Centre for Biomedical Network Research (Centro de Investigación Biomédica en Red, CIBER) for the thematic area "mental health", between the Carlos III Health Institute (ISICHI), the Spanish National Research Council (Consejo Superior de Investigaciones Científicas, CSIC), certain research centres of the Autonomous Communities and other centres. Like that, it was established that the Centre for Biomedical Network Research in Mental Health (Centro de Investigación Biomédica en Red de Salud Mental, CIBERSAM) would develop research activities (basic, clinical, epidemiological and related to health services) regarding:

- The epidemiology and clinical manifestations of psychotic disorders. Psychopathology. Pharmacological and psychotherapeutic treatment
- Affective disorders: diagnosis, epidemiology and treatment
- Clinical-epidemiological aspects of personality disorders
- Epidemiology and clinical manifestations of behavioural and emotional disorders
- Psychotic disorders: genetic, cellular and molecular basis
- Affective disorders: molecular, genetic and pharmacological basis
- Animal and cell models for the study of neurological and psychiatric diseases
- Early detection, adherence and response to treatment and care process evaluation
- Child and adolescent mental health
- Social issues related to mental health

The CIBERSAM is made up of 25 basic and clinical research groups from 8 Autonomous Communities and comprises a human team of approximately 300 people; throughout the year 2008, 70 professionals were contracted, and the remaining members of the groups are attached staff, who mainly research mental disorders.

Measures launched: most of the measures launched consist of the creation of projects for the monitoring of advances, new research evidence, etc.; the inclusion of teaching and research training activities; the promotion of the introduction of research methods that take gender sensitivity and socio-cultural diversity into account; studies on efficacy; and the creation of research units.

In accordance with the results presented in general objective 9, it can be said that both the Ministry of Health and Social Policy (MSPS), as well as the Autonomous Communities, have promoted the launch of measures to reinforce research in mental health, either through calls for project proposals for grants or through the creation of network research structures.

Conclusion General Objective 9: achieved

Recommendation: maintain the general objective, possibly modifying or updating the specific objectives.
Strategy Line 6: Information Systems

4.10. GENERAL OBJECTIVE 10: TO IMPROVE KNOWLEDGE ABOUT MENTAL HEALTH AND THE CARE PROVIDED BY THE SPANISH NHS.

Specific Objective 10.1: “Obtain information about the general level of mental health in the population.”

The most recent Spanish National Health Survey (ENSE, 2006) involved the use, for the first time, of validated tools (e.g. GHQ-12, SDQ) that made it possible to measure the level of mental health in the adult and child populations.

- GHQ-12, or Goldberg's 12-item General Health Questionnaire, can be used as a population-screening instrument that detects the prevalence of probable cases of psychiatric morbidity or psychological distress in the population, by examining the state of the interviewee over the last month with respect to his or her usual mental state.

- SDQ, or the Strengths and Difficulties Questionnaire, is used to detect behavioural and emotional problems in children aged between 4 and 16 years.

Conclusion Specific Objective 10.1: achieved

Specific Objective 10.2: “The availability, at the level of the Spanish NHS, of information regarding the main causes of treated morbidity.”

Information is available on treated morbidity with regard to inpatients.

Homogeneous information on treated morbidity with regard to outpatients is still not available.

Conclusion Specific Objective 10.2: partially achieved

Specific Objective 10.3: “The availability, at the level of the Spanish NHS, of integrated information about the specific organisation, facilities and resources devoted to the care of mental health.”

This objective was approached through the collection of information from the different existing facilities by the Health Information Institute (IIS), which drew up a report that was used to build the indicator “Map of mental health facilities”, which is evaluated by general objective 6 of strategy line 3, “Intra-institutional and inter-institutional Coordination.”

Conclusion Specific Objective 10.3: achieved
Conclusions General Objective 10: since the approval of the Strategy, knowledge about the population’s mental health has, to a certain extent, improved. Nevertheless, it seems necessary to insist and continue to join forces in the development of information systems that make it possible to obtain data on the main causes of treated morbidity, so as to improve the provision of services to the population in general and to people with mental disorders in particular.
5. CONCLUSIONS

Thanks to this evaluation, on the one hand the Autonomous Communities joined and unified their efforts and interventions and, on the other hand, we now have at our disposal data that could be used as a baseline for future evaluations.

We propose that the Autonomous Communities and the Ministry adapt their information systems to allow for the evaluation of the Strategy, above all with regard to treated morbidity, pharmacy data and mental health facilities.

We propose new indicators that measure the human resources of the community model: psychiatrists, clinical psychologists, mental health nurses, social workers.

We propose that the next evaluations are made every 4 years.

We propose the creation of working groups in the priority areas that the Monitoring and Evaluation Committee establishes.
# INDEX OF ABBREVIATIONS AND ACRONYMS

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AC</td>
<td>Autonomous Communities</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>ATC</td>
<td>Anatomical Therapeutic Chemical Classification</td>
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<tr>
<td>CIBER</td>
<td>Centre for Biomedical Network Research</td>
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<tr>
<td>CMD</td>
<td>Common Mental Disorders</td>
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<tr>
<td>CNH</td>
<td>Spain’s National Catalogue of Hospitals</td>
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<tr>
<td>CPG</td>
<td>Clinical Practice Guideline</td>
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<tr>
<td>CSIC</td>
<td>Spanish National Research Council</td>
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<tr>
<td>DDD</td>
<td>Defined Daily Dose</td>
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<tr>
<td>DDI</td>
<td>Daily Dose per Inhabitant</td>
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<tr>
<td>DIS</td>
<td>Diagnostic Interview Schedule</td>
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<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association)</td>
</tr>
<tr>
<td>ENSE</td>
<td>National Health Survey</td>
</tr>
<tr>
<td>ESCRI</td>
<td>Statistics of Establishments with Inpatient Facilities</td>
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<tr>
<td>ESEMED</td>
<td>European Study of the Epidemiology of Mental Disorders</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>FAISEM</td>
<td>Andalusian Foundation for the Social Integration of the Mentally Ill</td>
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<tr>
<td>FEAFES</td>
<td>Spanish Confederation of Groupings of Families and People with Mental Illness</td>
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<tr>
<td>GAF</td>
<td>Global Assessment of Functioning</td>
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<td>GNP</td>
<td>Gross National Product</td>
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<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
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<td>ICN</td>
<td>International Council of Nurses</td>
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<tr>
<td>IMSERSO</td>
<td>Institute of the Elderly and Social Services</td>
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<td>INE</td>
<td>National Statistics Institute</td>
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<td>ISCIII</td>
<td>Carlos III Health Institute</td>
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<td>LGS</td>
<td>Spanish General Health Law</td>
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<tr>
<td>MBDS</td>
<td>Minimum Basic Data Set</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>MIR</td>
<td>Medicine residency programme (Spain)</td>
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<tr>
<td>MSC</td>
<td>Spanish Ministry of Health and Consumer Affairs</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>NHS</td>
<td>National Health System</td>
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<tr>
<td>OR</td>
<td>Odds Ratio</td>
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<tr>
<td>PIR</td>
<td>Psychology residency programme (Spain)</td>
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<tr>
<td>RCP</td>
<td>Cumulative Register of Psychiatric Cases</td>
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<tr>
<td>RECESS</td>
<td>Spanish Register of Health Centres, Services and Establishments</td>
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<tr>
<td>RETICS</td>
<td>Thematic Networks for Collaborative Research in Health</td>
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<tr>
<td>SMD</td>
<td>Severe Mental Disorders</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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