CONSEJERÍA DE SALUD

Andalusian Public Health System

II Comprehensive Mental Health Plan for Andalusia 2008-2012

JUNTA DE ANDALUCIA

II Comprehensive Mental Health Plan for Andalusia 2008-2012

ANDALUCÍA. Plan Integral de Salud Mental (2º. 2008-2012)
II Comprehensive mental health plan for Andalusia 2008-2012 [Archivo de ordenador] : Andalusian Public Health System / [autoría, Valmisa Gómez de Lara, Eulalio (coord.) ... et al.].. – [Sevilla] : Consejería de Salud, [2008]
1 disco compacto CDROM ; en una carpeta de 21 cm
1. Andalucía. Plan Integral de Salud Mental (2º. 2008-2012) 2. Salud mental 3. Planes y programas de salud 4. Andalucía I. Valmisa Gómez de Lara, Eulalio II. Andalucía. Consejería de Salud III. Título
WM 30

Autoría:
Valmisa Gómez de Lara, Eulalio (coordinador)
Alén Fidalgo, Manuel
Amo Alfonso, Mercedes
del Pino López, Rafael
Díaz del Peral, Domingo
Fernández Regidor, Gonzalo
Fornieles García, Yolanda
García-Cubillana de la Cruz, Pablo
Rodríguez Rodríguez, Manuel
Ruiz García, Ana
Sánchez García, Lourdes

Edita: Junta de Andalucía. Consejería de Salud
Diseño y maquetación: OBEMEDIA S.C.

List of participants

Management:
del Pino López, Rafael (Director)
Rodríguez Rodríguez, Manuel
Valmisa Gómez de Lara, Eulalio
Amo Alfonso, Mercedes
García-Cubillana de la Cruz, Pablo

Technical Editorial Committee:
Coordination:
Valmisa Gómez de Lara, Eulalio
Members:
Alén Fidalgo, Manuel
Amo Alfonso, Mercedes
del Pino López, Rafael
Díaz del Peral, Domingo
Fernández Regidor, Gonzalo
Fornieles García, Yolanda
García-Cubillana de la Cruz, Pablo
Rodríguez Rodríguez, Manuel
Ruiz García, Ana
Sánchez García, Lourdes

Expert Groups:
Communication:
Fernández Regidor, Gonzalo (Coordinator)
Mena Jiménez, Ángel (Secretary)
Contreras Sánchez, Juan
Fernández López, Mercedes
León Maqueda, Antonio
Pérez Rojano, Rocío
Tristán Romero, Falina

Prevention and Promotion of Mental Health in the General Population
Ariza Conejero, Maria José (Coordinator)
Cano Valero, Mercedes (Secretary)
Díaz Gavira, Concepción
Fuentes Caro, Irene
Jiménez Escalante, Francisco
Moreno Muela, Margarita
Reina Reina, Carmen Lucia
Sánchez Pellón, Elsa

Health Promotion for People with Mental Illness
García Santos, Juan de Dios (Coordinator)
Fernández Portes, Luis (Secretary)
Blanco Aguilar, Javier
Fernández Sánchez, Carmen
García Iraola, Marisol
Pérez Delgado, José Manuel
Ponce Hernández, José Antonio

Gender and Mental Health
Jiménez García Bóveda, Rosa (Coordinator)
Luque Budía, Asunción (Secretary)
Alba Pérez, Teresa
Amo Alfonso, Mercedes
Cano Caballero Gálvez, Dolores
Estebanez Morales, Dori
Moya Morales, Miguel
Ruiz Pérez, Isabel
Sáez Méndez, Hilario

Organisation and Service Portfolio
Valmisa Gómez de Lara, Eulalio (Coordinator)
Ramírez Benítez, José Indalecio (Secretary)
Carrasco García, Aurelio
Hernández Esteban, Fernando
Moreno Corona, Cristina
Perona Garcelán, Salvador
Soler Pelegrín, Rosa

Social Support Systems
López Álvarez, Marcelino (Coordinator)
López Pardo, Andrés (Secretary)
Acosta Díez de los Ríos, Miguel
Arévalo López, José Manuel
Becerra Martín, Francisco
García Guadix, Valle
González Álvarez, Sergio
Jiménez González, Soledad
Ramírez Chía, Eleuteria

Child and Adolescent Care
Sánchez García, Lourdes (Coordinator)
Gravan Morales, María José (Secretary)
Báez López, Marta
Barba Rodríguez, Pilar
García Túnez, Pablo
Herrera Rodríguez, Manuel
Ianez Rodríguez, Antonio
Martínez de Salazar Arboleas, Alma Dolores
Pulido Díez, Juana
Rodríguez Natal, Isabel
Sánchez Vázquez, Vicente
Vidal Verdú, Maria Luisa

Early Detection and Intervention of Psychosis
Ibáñez Rojo, Vicente (Coordinator)
Maestro Barón, Juan Carlos (Secretary)
Alba Marín, Inmaculada
de la Higuera Romero, Jesús
Gil Álvarez, Manuel
Gómez García, Maria Dolores
González Acien, Cristina
Gutiérrez Blanco, Raquel

Intensive Community Treatment
Huizing, Evelyn (Coordinator)
González Bellido, Celedonia (Secretary)
Anguita Duarte, Fátima
Laviana Cuetos, Margarita
López Robledillo, Manuel
Palenciana Herrerías, Gines
Rivas Guerrero, José Fabio

The Prison Population
Guerrero Romero, Antonio José (Coordinator)
Doña Díaz, Alvaro José (Secretary)
García Téllez, Jorge Miguel
Mañas Olmo, Teresa
Ortega Bazanta, Luis
Sánchez Moyano, José Manuel
Vidal Carballo, José

Epidemiology
del Río Noriega, Francisco (Coordinator)
Moreno Kustner, Berta (Secretary)
Fornieles García, Yolanda
Gay Pamos, Eudoxia
Guillén Enríquez, Javier

Personality Disorders
Rueda Lizana, Mercedes (Coordinator)
Moreno Aranda, Manuel (Secretary)
Gómez Reyes, Isabel
Jiménez Egea, Aurora B.
Márquez Delgado, Alicia
Plaza del pino, Maria Dolores
Ruiz Sicilia, Leonor
Vallejo Jiménez, Felipe

Immigrant Population and Social Exclusion
Río Benito, María Jesús (Coordinator)
Jiménez Casado, Carmen (Secretary)
García de Sola, Adolfo
González Aceituno, Pedro
Martín Díaz, Emma
Martínez de Salazar Arboleas, Alma Dolores
Rouch, Minna
Sayed Ahmad Beiruti, Nabil
Tejedor de Santamaría, Elena

Assessment and Information Systems
García-Cubillana de la Cruz, Pablo (Coordinator)
Carmona Calvo, José (Secretary)
Carmona Jurado, Raquel
González Villalba, Asunción
Retamar Parra, Manuel
Velardo Hernández, Ana

Training and Professional Development
Lorenzo López, Dolores (Coordinator)
Rojo Villalba, Matilde (Secretary)
Iglesias Salas, Rosario
Martínez García de Castro, Manuel
Ramírez Esteban, Manuela
Rodríguez Martínez, Magdalena
Rodríguez Morilla, Felipe
Roldán Maldonado, Gloria María

Promotion of Research
Villagrán Moreno, José María (Coordinator)
Lamote de Grignon Querol, Esteban (Secretary)
Díez Patricio, Antonio
Luque Luque, Rogelio
Mayoral Cleries, Fermín
Salvador Carulla, Luis
Torres González, Francisco
Vázquez Morejón, Antonio José

Clinical Evidence in Mental Health
Ruiz García, Ana (Coordinator)
Bordallo Aragón, Antonio (Secretary)
Blanco Venzala, Matilde
Jiménez Estévez, Juan Francisco
Romero Cuesta, Javier
Sánchez Sánchez, Francisca
Soriano Peña, Maria Felipa

Preparation of the Report: "Epidemiological Surveillance of Chronic Illnesses: Mental Health Indicators"
Mayoral Cortés, José Mª
Durán Pla, Enric
Pérez Morilla, Esteban
Rodríguez Moreno, Elisa

Collaborators:
Bono del Trigo, Águila
Carmona López, Guadalupe
Caro Martínez, Araceli
González Villalba, Asunción
Hedo Moreno, Germán
Mendoza García, Oscar J.
Pérez Romero, Carmen
Valcárcel Cabrera, María del Carmen
Vega Monclús, Evelia

Contents

Presentation

A Comprehensive Plan is a medium-term planning instrument. Its development alone does not guarantee the achievement of the goals laid out in it, but by defining the goals, establishing priorities and setting out courses of action and concrete activities it will allow for an overall vision of the objectives being aimed towards and the tasks that will need to be carried out.

The first Comprehensive Mental Health Plan for Andalusia 2003-2007 (I PISMA, *Plan Integral de Salud Mental de Andalucía*) was developed using this approach. Nine courses of action were covered in this Plan, which over its duration lead to noticeable progress in various fields:

- The development of citizen information and communication actions to raise public awareness about the stigma associated with mental illness.

- Strengthening of the mental health care network, seeing a significant increase in resources with regards the opening, expansion and remodelling of health care facilities and the inclusion of new professionals.

- Growth of specific resources for social support managed by the Andalusian Public Foundation for Social Integration of People with Mental Illness (FAISEM, Fundación Pública Andaluza para la Integración Social de Personas con Enfermedad Mental), which has almost doubled available residential places and has increased the coverage of all its programmes.

- Improvement in the accessibility of all community mental health units and an increase in home care.

- Advances in the implementation of a clinical management model which has led to almost 68% of the mental healthcare network professionals working to this model.[B]

- A boost to continuity of care via the extension of the development and implementation of new Integrated Care Pathways (ICP)

A] This advance is reinforced by the recent approval of Decree 77/2008, of 4 March, for the administration and functional organisation of the mental health services in the Andalusian Health Service (SAS), which consolidates this method as a new organisational structure for mental health facilities. The decree can be found here: http://www.sas.junta-andalucia.es/principal/documentosAcc.asp?pagina=pr_normativas3_22

- Promotion of citizen participation and advances in the consolidation of the user and family movements.

- Development of training, research and knowledge management strategies as a foundation on which to base advances in mental health care and knowledge.

The assessment of the I PISMA and the experience gained from its development have channelled into this second Comprehensive Mental Health Plan for Andalusia 2008-2012 (II PISMA). The main principles for this second Plan are quality improvements, equality and efficiency of health services, aimed at public awareness of mental health in the Andalusian population, prevention of the illnesses and improvements to the care of patients and their families.

Specifically incorporating the principle of equality into the Plan requires a commitment to work towards the reduction of inequalities (including gender inequalities), the protection of the most vulnerable (paying special attention to guaranteeing the rights of those who suffer from a mental illness) and respecting the cultural identity in the Andalusian society, which is becoming more and more culturally diverse.

Furthermore, the promotion of citizen participation is considered to be one of the basic components proposed by the WHO for achieving health equality. The community model for mental health care implemented in Andalusia already established amongst its principles, the involvement of patients and their families in the treatment process and their active participation in mental health services. This second Plan aims at taking this all another step further with the incorporation of the recovery approach, which thereby will create a process of personal growth which is more significant than the mere disappearance of symptoms.

Another aspect incorporated into this Plan is the focus on professionals, by promoting professional career, training and research possibilities, together with organisational measures focused on enhancing and optimising the organisation's human capital.

I want to express my gratitude to all those who collaborated in the preparation of this document. This has involved huge participation both from the diverse groups of professionals involved in mental health care, and from related citizen associations and scientific societies.

This second Comprehensive Mental Health Plan for Andalusia 2008 – 2012, which is based on the first one, is ambitious in its goals and will be generous in its results. This is our task and our pledge.

María Jesús Montero Cuadrado
Regional Minister of Health from the Government of Andalusia

1

Introduction

Caring for those with mental disorders is a priority for the Andalusian Public Health System (SSPA, Sistema Sanitario Público de Andalucía) not only in terms of the occurrence and prevalence of mental illness, but with regards to the personal suffering caused and the impact on family members and society, as well as in terms of the complexity and cost of the treatment and rehabilitation processes.

Since it began in 1984, and over the course of over two decades, the process of psychiatric reform in Andalusia has brought about an increase in resources and the commitment and effort of professionals from the different care networks of the Andalusian Health Service (SAS, Servicio Andaluz de Salud) in approaching mental health problems. It is based on the community care model, which is, in turn, based on the following: the multidisciplinary work teams, the continuity of care, the joint working culture with primary health care and the development of cross-cutting programmes. Over recent years, mental health care based on the community model has been enriched by the possibility of recovery. This new idea involves a real process of personal change to enable the individual to get their life back on track, helping them regain their skills as much as possible both as an individual and as a member of the community, regardless of their symptoms or problems.

Over its duration, the first edition of the Comprehensive Mental Health Plan 2003-2007 (I PISMA) has become a reference framework from which improvements have been introduced to the coverage and quality of health care and aftercare given to the Andalusian population with mental health problems. Adapting services to the users' needs and the commitment to continue developing a community-based model were two of the key objectives which lead to the development of different strategic courses of action. Some of these are listed below:

– The increase and diversification of professional and structural resources and more efficient and effective organisation and management of these resources.

- The commitment of joint work with Primary Care
- The development of comprehensive care programmes for patients with severe mental illness in the community.
- Increase of home care
- Coordinated care between the different care levels and non-health sectors
- Stimulation for participation of users, family members or professionals, both at an individual level and as a group.

As the first Plan has expired and been evaluated, this second Comprehensive Mental Health Plan for Andalusia 2008-2012 (II PISMA) has been developed keeping in mind what was achieved over the last five years, as well as the analysis of the current mental health situation in Andalusia and the references and recommendations of national and international bodies[B]. The Plan has also relied on contributions from work produced by diverse expert groups (17 working groups with the participation of approximately 150 people, comprising professionals from the various mental health-related fields, and patients and their family members) and from the opinions and expectations of those groups for whom the Plan is designed.

B] Some of these recommendations are laid out in the "European Mental Health Declaration" (Helsinki, January 2005), signed by the Ministries of Health of the 52 member states in the WHO/Europe and the "National Health System Mental Health Strategy" (2006) by the Ministry of Health and Consumer Affairs of the Spanish Government.

II

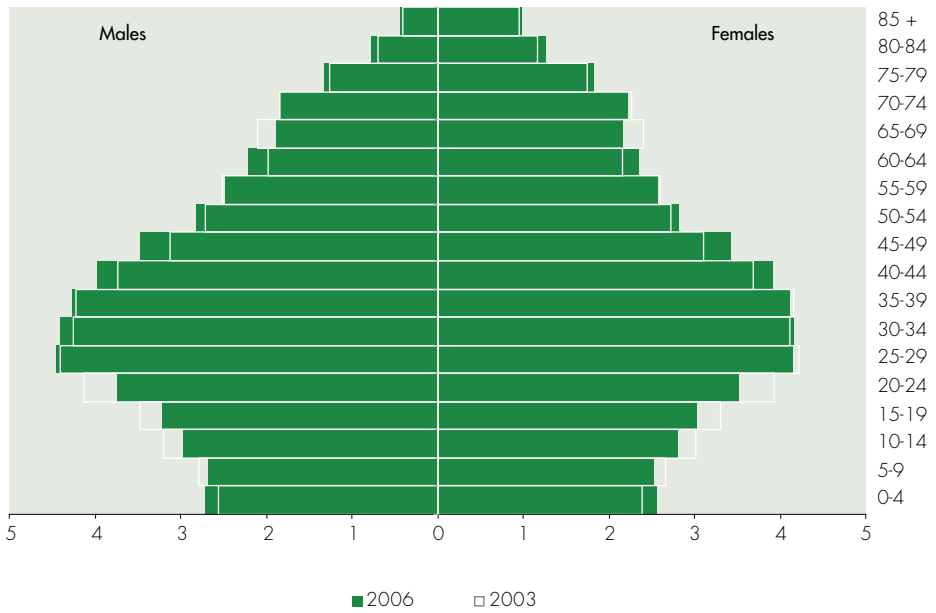
DESCRIPTION OF THE SITUATION

1.- MENTAL HEALTH IN ANDALUSIA

1.1. DEMOGRAPHY

In 2006, according to the Andalusian Institute of Statistics (IEA, Instituto de Estadística de Andalucía)[1], the population of the Autonomous Community of Andalusia was 7,975,672 inhabitants, of which 49.63% were male (3,958,565) and 50.37% were female (4,017,107). The population had increased 4.85% with regards to 2003, which saw the population of Andalusia at 7,606,848 inhabitants (graph 1).

Graph 1: Age profile of Andalusia, 2003-2006.



Source: Review of the Municipal Register of Inhabitants on 1 January 2003 and 2006. Andalusian Institute of Statistics.

Family networks

According to the Survey into Dependency and Solidarity in Family Networks in Andalusia, carried out in 2005[2], at that time there were 679,088 people in this region who required some type of assistance in carrying out their daily lives, but there were no figures regarding the number of persons who required specific help due to mental health problems.

The provision of care and assistance to people with a severe, long term mental illness fundamentally falls to the family members. Studies show that the profile of a carer is usually female, generally a wife or daughter between 50 and 65 years of age, a housewife and with an average cultural level[3]. The assignment of the carer to the role is not accidental. Cultural preconceptions linked to the traditional roles of gender are what condition a woman to fill the role of carer of her ageing or sick family members.

Immigrant Population

Although migration is not in itself a cause of mental disorder, it can be considered as a significantly stressful situation due to the possible uprooting of a person, the experience of sorrow or grief and the risk of social exclusion for the immigrant population. In addition, the growing number of people in this group creates a new challenge for the SSPA, not only because of possible language barriers, but also due to social and cultural differences, including those linked with a person's conception of health and illness, and possible variations in the understanding of what constitutes mental or physical disability[4].

According to the 2006 census, 6.13% of the Andalusian population were foreign (a total of 488,928 people) of which 266,149 were male and 222,779 were female[1].

1.2 SOCIAL PERCEPTION OF MENTAL ILLNESS

Mental illness and its sufferers are still seen in a negative light by today's society. There is still a stigma attached to mental illness, and discrimination and lack of respect are still rife with regards the human rights and dignity of these people. International organisations such as the UN, the WHO and the EU have made the fight against and the eradication of this stigma one of their priorities for health and social policies.

One aspect of social stigma is the generalised idea that mental disorders are "severe and for life", when in fact with the correct help and treatment, total recovery is possible in most cases, whilst in other situations remission or an adequate degree of functionality or stability can be achieved[5].

As well as increasing personal suffering and social exclusion, stigmatisation can impede access to housing and employment and can even make the sufferer reluctant to seek help out of fear of being "labelled". With this in mind, the European Commission is asking for a change in society's attitudes towards mental health which will allow for the integration of those people affected into all areas of life (personal, work and social)[6].

1.3 MENTAL ILLNESS RISK FACTORS

There is hard evidence surrounding risk factors and their links with the development of mental disorders. Risk factors can be personal, family related, social, economic and environmental and can frequently combine thereby having an accumulating effect. The interaction of biological, psychological and social factors can even lead to a transfer of mental disorders between generations, especially episodes of depression or anxiety[7].

The following are amongst the most frequent risk factors for poor mental health: poverty, lack of social networks, social exclusion (as that suffered by certain groups such as homeless people and the prison community), racial discrimination (which frequently affects immigrant populations) [7], employment situation, work-related stress or unstable employment[8].

From a gender perspective, women present additional risk factors. As well as the socioeconomic differences (as a group overall, women are less well off), women suffer more frequently from violent situations, subordinate relationships and the consequences of role accumulation, given the frequent unequal distribution of tasks (including the role of carer)[3]. Studies carried out amongst mistreated women have found that these women have a higher tendency towards post-traumatic stress disorder, anxiety attacks, phobias, substance abuse, somatisation, chronic pain, depression and risk of suicide[9].

Mental health is also interrelated with physical health. For example, cardiovascular disease can produce depression, and vice versa. In addition, both of these can also be related through common risk factors such unhealthy lifestyles. This interrelationship (physical/mental health) is of particular relevance in the ageing process due to the association of specific factors such as chronic or terminal illnesses, loneliness, economic instability and/or the lack of social networks[10].

With regards to suicide, the most significant risk factors are depression and schizophrenia, recent or historical social stress factors, history of suicide in the family and close friends and limited access to psychological help. These problems are particularly common in older people, in many cases linked to risk factors such as physical or mental illness, disability, loss of close friends or family, loneliness, lack of social networks, undesirable living conditions or inactivity[11].

1.4. SELF-PERCEIVED MENTAL HEALTH

Data from the 2003 and 2007 Andalusian Health Surveys show that the frequency of people in Andalusia who ***declare*** to suffer from nervousness, depression or other mental disorders (at the time of performing the survey) had increased from 1.5% to 2.3%. This increase was more significant in women, where the figures increased from 1.9% to 3.4%, whilst the figures for men went from 1.5% to 2.3% during this period.

According to the 2006 National Health Survey[12], 14.9% of the Andalusian population **over the age of 15** professed to having suffered from "depression, anxiety or other mental

disorders" over the last 12 months (8.4% males and 21.2% females), which is almost exactly the same as the figures for people who state to have been diagnosed by professionals (8.8% and 20.7% respectively). According to the data from this survey, 13.7% of Spaniards over the age of 15 declared to have suffered from some of these problems (19% female and 8.1% male), putting Andalusia in sixth place nationwide in order of frequency.

In Andalusia, 20.1% of the population **over the age of 15**[C] presented a risk of suffering from some type of mental pathology, (14.6% males and 25.4% females). In Spain overall, these percentages increased to 21.3% (26.8% females and 15.6% males), which puts Andalusia in eleventh place with regards the other autonomous communities.

In both surveys (national and Andalusian) it can be seen that in the younger groups the risk of poor mental health is similar for both genders. This risk increases with age and the differences between genders also increase. Likewise, this risk generally decreases with an improvement in the level of education and income. In all cases, women present a higher risk of suffering from a mental illness.

An explanation for these gender-related differences in which a worse mental state is generally self-perceived in women, (as is also the case with other socio-demographic variables), would require the analysis of variables such the role of socio-cultural factors linked with gender, and within them, subordinate relationships or violence, to which part of this group are subjected.

In the **child** population[D] in Andalusia, 21.7% of minors between the ages of 4 and 15 (25.7% girls and 17.8% boys) present risks of suffering from poor child mental health which is similar to the national percentage (22.1%). Hyperactivity and behavioural disorders are the mental health problems which involve a higher risk of occurrence in the child population in both genders. These are followed by emotional symptoms and relationship difficulties with classmates; however, there is a lower incidence of these.

1.5. MENTAL ILLNESS IN ANDALUSIA

1.5.1. Prevalence in Europe and Spain

The analysis of lifetime prevalence[E] of the mental disorders included in the ESEMeD study[13] has shown that 1 in every 4 Europeans over the age of 18 (25%) will suffer from one of the mental disorders studied over the course of their lives[F], whilst in Spain, this figure is slightly less (19.5%).

C] The questionnaire used corresponds to the abbreviated version of 12 items from the General Health Questionnaire – GHQ.

D] The questionnaire used is the Strengths and Difficulties Questionnaire -SDQ-. The person completing the questionnaire is the person at home who is most aware of aspects referring to child health care and condition.

E] Lifetime prevalence: proportion of the people who at some time in their lives have experienced the disorder being studied, in this case, mental illness.

F] This study included anxiety and emotional disorders and alcohol abuse.

With regards yearly prevalence[G], 9.6% of the European population and 8.5% of the Spanish population have suffered from some of the mental disorders included in this study in the last year.

The most frequent of these disorders, both in Europe and Spain, is anxiety with a prevalence of 6.4% and 6.2% respectively.

It is to be noted that in all anxiety and mood related disorders, the yearly prevalence figures for women are more than double those of men. However, this is inverted when looking at disorders caused by alcohol abuse.

Based on the results of the ESEMeD-Spain study, it can be estimated that in Andalusia in 2006 some 677,932 people were suffering from some of these mental disorders, of which 79,757 were considered severe[H], with an average of 81.4 days per year of inability to carry out daily activities[14].

With regard to the Severe Mental Illness (SMI)[I] there are no studies with homogenous methodology which allow for an estimation of SMI prevalence in the population, although they do allow for an assessment of the morbidity evaluated by physicians in mental health facilities. Nevertheless, there is consensus that between 1.5 and 2.5 of every 1000 people in the general population suffer from these types of disorders[15].

1.5.2. Suicide and mental illness

EIn 2006 in Andalusia, mortality due to suicide represented 1.16% of the total deaths in the Autonomous Community[16].

Suicide was more prevalent in males than in females (13.97 and 4.33 per 100,000 inhabitants respectively in 2006), as in other western countries. Figures are higher as age increases for both genders, but above all in males over 64 years of age. In the latter group, figures for the European population place Andalusia above national percentages [17].

1.5.3. Incapacity for work and mental illness

The data from the 2007 Andalusian Health Survey shows that people who are disabled or incapacitated make up a special risk subgroup for suffering from mental health issues, with figures that are clearly higher than the rest of the categories in self-perceived and diagnosed (self-declared) mental health.

G] Yearly prevalence: proportion of people who have experienced the disorder being studied, in this case, mental illness, over the last twelve months.

H] According to severity level classifications from the ESEMeD study.

I] According to the definition of Integrated Care Pathway: Severe Mental Illness established by the Regional Ministry of Health of the Government of Andalusia.

With regards to leaves, between May 2006 and April 2007[J], 5.76% of leaves in Andalusia (41,051 from a total of 712,553) corresponded to leave due to mental disorders[K], (some 13.40 people per 1000 working inhabitants). 76% of the absences from work due to mental disorder over this period were caused by Anxiety, Depression and Somatisation[L].

The average duration of leaves due to mental disorder is three months, (92.60 days) which is slightly above the average duration for leaves due to other reasons (87.8 days).

It is important to point out that most people with SMI have limited access to employment and therefore, there are few cases in which a person would find themselves in the situation of taking actual disability leave.

1.5.4. Prison population and mental illness

In comparison with the general public, people in prison suffer between 2 and 4 times more from psychotic disorders and major depression, and they are almost 10 times more likely to suffer from antisocial personality disorders[18].

The WHO estimates that in western societies, the incidence of psychiatric disorders is up to 7 times higher in the prison population, with a higher incidence of severe psychiatric problems and adaptive disorders.

According to a study carried out in 2006 in Spain by the Directorate-General for Penitentiary Institutions (*Dirección General de Instituciones Penitenciarias*)[20], 13.5% of people in prison showed psychiatric disorders with no associated drug abuse, 12.1% had dual pathology and 24.0% showed drug dependency or abuse with no psychiatric pathology.

The main mental disorders suffered by people in prison[M], excluding the consumption of drugs on an isolated basis, are emotional disorders (12.8%), personality disorders (9.4%) and psychotic disorders (3.4%). The figures found are generally similar to other studies in this area[18].

With regard to suicide attempts, 2.7% of the imprisoned population attempted suicide in one year.

1.5.5. The homeless and mental illness

In Spain, estimates indicate that there are approximately 100,000 homeless people[21]. Of these, 19.54% live in Andalusia, (82.7% of those are male and 17.3% are female), with

J] SIGILUM Information System, Regional Ministry of Health.
K] Diagnosis codes 290-310. International Classification of Diseases.ICD-9.
L] Diagnosis codes according to the definition of the Integrated Care Pathway for Anxiety, Depression and Somatisation (ADS). Regional Ministry of Health
M] The diagnostic classification used in the study covered the following categories: psychotic disorders, emotional disorders, personality disorders and other diagnosis.

an average age of 38[22]. Looking at the national figures, 48.2% of homeless people are foreigners (43.6% from Africa and 37.5% from Europe).

Internationally, studies show that the prevalence of severe mental illnesses in homeless people is between 25%-35% [23]. If other disorders are included, such as anxiety, personality disorders and drug abuse/dependency, the figures can rise to 80%[21].

In Spain, data collected in 2007[23] reflects that 34% of this group suffers from psychiatric pathology, with the most common disorders being schizophrenia (9.2%), mood disorders (9.7%) and personality disorders (5.5%). The figures also reflect that mental health illnesses are more prevalent in women[24].

According to a study carried out in Andalusia in 2006[25], 36% of the homeless interviewed had sought medical attention at one point due to a mental pathology, with the amount of women being higher (40% compared to 35.5%).

1.6. MORBIDITY TREATED

1.6.1. Primary Health Care

According to a study from 2004, approximately 11% of the total population of Andalusia had been seen by Primary Care facilities due to some kind of mental health problem, with an average of 17.54 visits per patient per year (15.5 for men and 19.0 for women). For all age groups, with the exception of the under 18s, the percentage of women was higher than men and the majority also had other comorbidities.

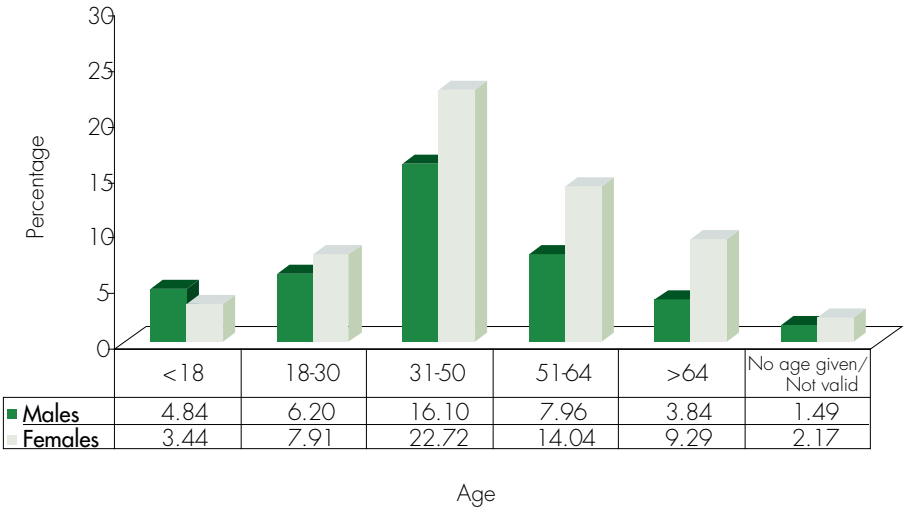
The most common diagnoses in this study were Anxiety, Depression and Somatisation (ADS) (54.8%), whilst 3.35% had a Severe Mental Illness (SMI)[N]. Of the people who sought care for ADS, almost 75% of them were women, mainly between the ages of 31 and 50 (28.54%). In the case of the population seen for SMI, 58.86% were male and 41.14% were female.

1.6.2. Atención especializada de salud mental

During 2006, 198,955 people attended the Community Mental Health Units (USMC, *Unidades de Salud Mental Comunitaria*). 59.56% of them were female and 40.44% were male. The age and gender distribution can be seen in graph 2.

N] Selection of diagnosis codes according to the definition of Integrated Care Pathway for Anxiety, Depression and Somatisations (ADS) and Severe Mental Illness (SMI). Regional Ministry of Health.

Graph 2: People seen at Community Mental Health Units according to age group and gender. SSPA, 2006..

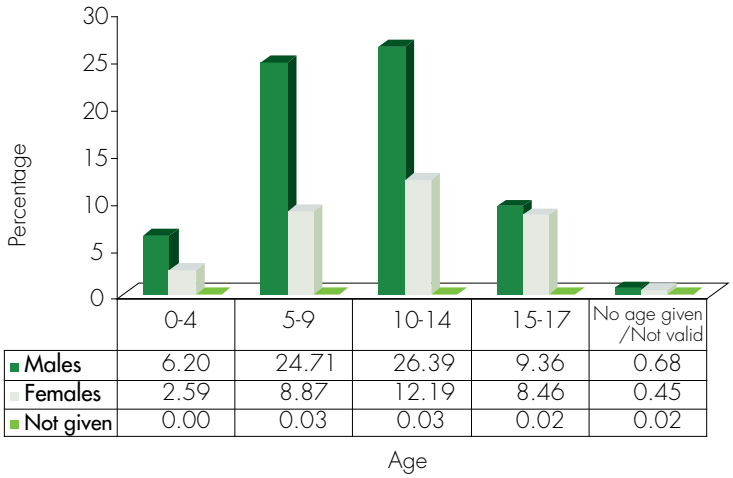


	<18	18-30	31-50	51-64	>64	No age given/ Not valid
Males	4.84	6.20	16.10	7.96	3.84	1.49
Females	3.44	7.91	22.72	14.04	9.29	2.17

Source: Andalusian Mental Health Information System.

In the Child and Adolescent Mental Health Units (USMI-J, Unidades de Salud Mental Infanto-Juvenil), the number of people under 18 who were seen in 2006 was 12,892, of which 67.4% were boys and 32.56 were girls. The age and gender distribution can be seen in graph 3. This distribution coincides with the studies carried out on mental disorders in childhood and adolescence.

Graph 3: People seen at Child and Adolescent Mental Health Units, according to age group and gender. SSPA, 2006.



	0-4	5-9	10-14	15-17	No age given /Not valid
Males	6.20	24.71	26.39	9.36	0.68
Females	2.59	8.87	12.19	8.46	0.45
Not given	0.00	0.03	0.03	0.02	0.02

Source: Andalusian Mental Health Information System.

During 2006, 10,262 patients were hospitalised in SSPA hospitals due to mental disorders[○], of which 56.19% were male and 43.81% female. Most of the people hospitalised were in the 31-50 age group (29.66% males and 21.18% females).

The morbidity treated in the various mental health facilities in Andalusia is described below:

a) Community Mental Health Units

Table 1 details the distribution by diagnostic group of the people seen at Community Mental Health Units (USMC, Unidades de Salud Mental Comunitaria).

Table 1: People seen at Community Mental Health Units according to diagnostic group. SSPA, 2006.

CIE-10	Diagnostic Group	Number	%	Rate per 100,000
F40-F49	Neurotic disorders	65,048	32.69	815.58
F30-F39	Mood / Humour disorders	41,287	20.75	517.66
F99	Unspecified mental disorder	41,158	20.69	516.04
F20-F29	Schizophrenic disorders and delusional ideas	20,424	10.27	256.08
F60-F69	Personality disorders	7,568	3.80	94.89
F90-F98	Child and adolescent disorders	5,731	2.88	71.85
F00-F09	Organic disorders	3,709	1.86	46.50
-	No psychiatric pathology	3,672	1.85	45.04
F70-F79	Mental retardation	3,653	1.84	45.80
F10-F19	Disorders due to psychotropic substance use	3,093	1.55	38.78
F50-F59	Physiological dysfunctions and somatic factors	2,964	1.49	37.16
F80-F89	Development disorders	648	0.33	8.12
TOTAL		198,955	100.00	2,494.52

Source: Andalusian Mental Health Information System.

When analysing by gender, the more frequent diagnoses in males are disorders due to substance abuse (83.45%), development disorders (74.69%), child and adolescent disorders (65.05%) and schizophrenic disorders and delusional ideas (64.42%).

○] Mental illnesses and disorders: Diagnosis-Related Groups (DRG) 424-430.

The most common diagnoses in females are behavioural disorders associated with physiological dysfunctions and somatic factors (75.00%), mood disorders (71.28%) and neurotic disorders (67.61%).

The number of consultations made at USMC has increased by 12.52% since 2003. Amongst the diagnostic groups which have had a higher increase in consultations, as well as the group classed as "no psychiatric pathology" (with 185.96% increase), is the group with personality disorders (with an increase of 49.38%) and the group with schizophrenic disorders and delusional ideas (with 33.49% increase).

b) Child and Adolescent Mental Health Units

Of the people seen at the USMI-J, 36.08% were diagnosed with behavioural and emotional disorders started in childhood and adolescence and 21.45% were diagnosed with a non-specific mental disorder. Neurotic disorders also stand out at 13.54%, and development disorders at 12.29%.

Of the people seen for behavioural and emotional disorders which started in childhood and adolescence, 40.9% presented hyperkinetic disorders, 17.0% conduct disorders and 15.3% emotional disorders which had started in childhood.

With regards gender and the diagnostic group of the population seen at the USMI-J, girls were diagnosed much more frequently with behavioural disorders related to physiological dysfunctions and somatic factors (73.22%) and mood disorders (57.51%). However, the more common diagnoses for boys were development disorders (83.33%), disorders from childhood and adolescence (75.69%), as well as metal retardation (69.82%) and schizophrenic disorders and delusional ideas (66.18%).

c) Acute Inpatient Mental Health Units

From 2003 to 2006 the number of hospitalisations due to mental illnesses was maintained at a more or less constant level (10,970 and 10,262 respectively), which corresponds to a little less than 2% with regards the total hospitalisations over this period, with an average hospital stay which varied between 15 and 16 days.

The group of patients with the most number of admissions to hospital in 2006 was the group with psychotic disorders, which constituted 60.95% of the total hospitalisations for mental health. In second place was the group of patients with personality and impulsive disorders, which counts for a little more than 10% of admissions.

d) Mental Health Therapeutic Communities

The progress of care activities in Mental Health Therapeutic Communities that currently exist in Andalusia is summarised in table 2. The increases observed are fundamentally explained by the increase of resources throughout this period.

Table 2: Development of care activities in Mental Health Therapeutic Communities. SPA, 2003-2006.

	Year 2003	Year 2004	Year 2005	Year 2006	% Variation 03-06
Complete hospitalisation					
Patients	319	314	325	351	10.03
Stays	60,947	62,682	69,743	70,735	16.05
Day hospital programme					
Patients	392	430	484	557	42.09
Stays	32,125	34,683	36,502	39,483	22.90

Source: Mental Health Programme. Directorate-General for Health Care. Andalusian Health Service

e) Mental Health Day Hospitals

The number of people seen at Mental Health Day Hospitals and the lengths of stay are reflected in table 3. The high percentage of variation in both cases can mainly be explained by the opening of four new day hospitals over this time period.

Table 3: Development of care activities in Mental Health Day Hospitals. SSPA, 2003-2006.

	Year 2003	Year 2004	Year 2005	Year 2006	% Variation 03-06
Admissions	523	681	751	762	45.68
Registrations	298	372	451	557	86.91
Patients	1,045	1,081	1,391	1,596	52.72
Stays	27,878	32,771	35,973	44,758	60.54

Source: Mental Health Programme. Directorate-General for Health Care. Andalusian Health Service.

f) Mental Health Rehabilitation Units

Table 4 shows the development of care activities in this type of unit.

Table 4: Development of care activities in Mental Health Rehabilitation Units. SSPA, 2003-2006.

	Year 2003	Year 2004	Year 2005	Year 2006	% Variation 03-06
Admissions	405	670	533	446	10.12
Registrations	159	228	328	330	107.54
Patients	1,552	1,678	1,830	1,946	25.38
Stays	65,253	78,350	81,112	87,322	33.82

Source: Mental Health Programme. Directorate-General for Health Care. Andalusian Health Service.

1.6.3. Emergency care for mental health problems

Emergency care for mental health issues is set up in the SSPA in a similar way to other emergencies[P]. Therefore, the urgent and emergency demand is attended to by the Critical and Emergency Care Facilities within primary health care (DCCU-AP, Dispositivos de Cuidados Críticos y Urgencias en Atención Primaria), the Critical and Emergency Care Services at hospitals (SCCU-H, Servicios de Cuidados Críticos y Urgencias en Hospitales) and the emergency teams.

No data currently exists to enable us to measure the real magnitude of emergency care provided to people with mental health problems in SSPA centres.

1.6.4. Use of psychoactive drugs

The data from the 2003 and 2007 Andalusian Health Surveys shows an increase in the **self-declared consumption** of antidepressants, tranquilizers and hypnotic drugs both in men and women. During this period, the use of antidepressants increased from 2.5% to 4.3% in the Andalusian population, reaching 6.4% in women and 2.2% in men in 2007. In that year, 4% of the Andalusian population referred to taking tranquilizers (5.40% of women and 2.60% of men) and 3.10% to taking hypnotic drugs (4.10% women and 2.10% men).

Information has also been analysed in relation to the use of psychoactive drugs **on prescription and withdrawn** from pharmacies. This analysis refers to prescriptions in primary care and specialised surgeries, and does not include hospital pharmaceutical consumption. The total packs of psychoactive drugs in 2006 represents 10.48% of the total drugs consumed.

The anxiolytics group is the one showing a higher DDI[Q] rate. In 2006, 47.42 people per 1000 inhabitants received this type of drug on a daily basis. Antidepressants were in second place with a daily consumption rate of 40.01 per 1000 inhabitants. Both groups of psychoactive drugs are the ones which have seen the highest increases in consumption since 2003.

1.6.5. People seen by the social support network of the Andalusian Public Foundation for Social Integration of People with Mental Illness (FAISEM)

People seen by the social support network of FAISEM[R] are also seen at the SSPA mental health facilities, thus keeping a strong level of cooperation between both service networks.

P] Resolution 261/2002, of 26 December, on emergency care, hospital transfers and admissions of psychiatric patients by the Andalusian Health Service

Q] Daily Defined Dose per Inhabitant, which indicates how many people per 1000 inhabitants in the community section studied receive standard treatment on a daily basis. The Daily Defined Dose (DDD) refers to the maintenance dose in adults and usually corresponds to the treatment dose as expressed in weight of active substance.

R] FAISEM's social support network is described in section 2.2.2 Specific Resources (FAISEM).

In 2007, the 68.6% of the people occupying 1,819 of the places offered by the FAISEM's housing programme (boarding houses, apartments and home support) were males with an average age of 46 (ranging between 19 and 87 years of age) and single (80.3%).

Most of the people using this programme are diagnosed with schizophrenia (85.9%), emotional disorders (5.0%) personality disorders (4.0%) and learning disability (2.4%). 1.8% had other diagnoses.

As regards employment programmes, 52.5% of the 425 people working in social firms in 2006 had a mental health disability. The people with mental illnesses in these firms were mainly men (76%), with an average age of 37 (25% under the age of 30), and the main diagnosis was schizophrenia or other severe mental illnesses (80%).

1.6.6 Immigration and mental illness

A study carried in the Poniente Almeriense district [26] of Andalusia highlighted the increase in the amount of immigrants seen at the Community Mental Health Unit in the area, rising from 72 in the year 2000 to 143 in 2004[S]. The largest group was from North Africa (36%), followed by the group from Hispanic America (26%).

When looking at gender statistics, there were no significant differences with regard to where people were from, except for the North African group, in which 58% were male and 42% were female. The main age group for both genders was between 21 and 40.

The immigrants seen mainly had adaptive disorders (44% female and 33% male), followed by emotional disorders (18% women and 11% men).

1.6.7 People admitted to the Secure Psychiatric Hospital of Seville

In 2006, 148 people from Andalusia were admitted to the Secure Psychiatric Hospital in Seville[T], which is run by the Directorate-General for Penitentiary Institutions of the Spanish Ministry of the Interior.

The most frequent psychiatric pathology was schizophrenia and delusional ideas (57.37%), followed by disorders related to psychotropic substance use (19.11%) and then personality and behavioural disorders (8.44%).

S] According to data from the Foreign Statistical Yearbook, 2006, foreigners resident in Spain represented 3.2% of the population, with estimates that in the Poniente de Almería district between 25% and 28% of the inhabitants were immigrants.

T] This hospital is only for males. Women are admitted to the Secure Psychiatric Hospital of Foncalent (Alicante). More specifically, in 2006 of the 31 people admitted to this hospital, 10 were from Andalusia.

1.6.8. People with mental illness seen by the drug dependency care network

In Andalusia, the Directorate-General for Drug Dependencies and Addictions run by the Regional Ministry of Equality and Social Welfare is the one responsible for dealing with drug dependency issues[27].

Entrance into the therapeutic system is made via Outpatient Treatment Centres with these acting as the access channel to the rest of the resources and programmes of secondary and tertiary care facilities[U].

In 2006 a total of 17,090 people were admitted to treatment in an outpatients unit due to the use of some psychoactive drug or to a non-substance dependency (gambling)[28]. 57.72% were admitted to treatment for illegal drug abuse and the rest were due to tobacco, alcohol and gambling. In this same year, 2901 protocols for referral to the secondary and tertiary care resources and programmes were received[V]. They were mainly men (87.3%), almost half of them (44.9%) between the ages of 30 and 40. The most commonly taken drug (33.3%) was a mixture of heroin and base cocaine (known as *rebujo*), followed by 25% alcohol, 19.6% cocaine and 11.5% heroin.

Of the 1019 people admitted to therapeutic community centres for drug dependencies in this year, 22.8% suffered some form of mental disorder, mainly personality disorders (10.7%), mood disorders (8.3%), anxiety disorders (7.3%) and schizophrenia or other psychotic disorders (3.9%). Since 2002 an action protocol has been followed together with the USMC and the outpatient treatment centres for drug dependencies in this group of patients[29].

1.6.9 Care for victims of gender-based violence

According to a macro survey carried out by the Women's Institute in 2006, 9.6% of Spanish women were considered to be "technically abused". In Andalusia, this percentage increased to 11.1%.

The consequences of this violence can be devastating for women. The symptoms of mental suffering are six times from common in abused women than in the population as a whole and women are five times more likely to attempt suicide, they show emotional disorders throughout and have severe mental health problems such as depression, post-traumatic stress disorder or suicidal tendencies over the course of their lives [30].

In a study by the Andalusian Women's Institute into the frequency of abuse towards the women attending the mental health services [10], 42% of women had experienced physical abuse and 52% psychological abuse. These percentages are much higher than those obtai-

U] Drug Treatment Units, Therapeutic Communities, Treatment Support Homes, Reintegration Support Homes, Day Centres and Meeting and Integration Centres.
V] Data taken from the Information System of the II Andalusian Plan on Drugs and Addiction (SiPASDA).

ned from the population as a whole; 8% physical abuse and 22% psychological abuse. The most frequent psychopathological disorders were emotional disorders (depression), somatoform disorders and personality disorders.

In Andalusia, the data obtained from a multicentre study[W] carried out on women who used the primary care services for whatever reason[X] showed that 24.6% of the women surveyed had suffered abuse (physical, sexual and/or emotional) at some point in their lives. The socio-demographic characteristics of the women who suffered abuse are similar to those in other studies carried out in Andalusia, namely women over the age of 45, separated/divorced or widowed, with low levels of education and low income[31].

The results of this study show that abuse is associated with higher mental morbidity, worse self-perception of health and a higher propensity to taking psychoactive drugs (mainly tranquillizers, antidepressants and analgesics). These results are in keeping with other international studies[31].

2. RESOURCES FOR CARE OF PEOPLE WITH METAL ILLNESS IN ANDALUSIA

2.1 MENTAL HEALTH CARE RESOURCES

Mental health care is provided by the SSPA in the same way as they deal with the population's other health problems, with the participation of the primary care network, and the specialised and emergency networks.

The effectiveness of interventions in the approach towards mental disorders requires the involvement of multidisciplinary teams which interact at the different care levels.

2.1.1. Specific facilities for mental health

Specialised care for people with mental health issues is carried out via a network of health facilities distributed throughout Andalusia. When Decree 77/2008[Y] came into force, mental

W] "Violencia contra la mujer en pareja: frecuencia e impacto en la salud física y psíquica" ["Relationship-based violence towards women: frequency and impact on physical and psychic health] (FIS, PI050594; years 2006 and 2007).

X] Information collected from a structured and self-administered questionnaire which health personnel distributed to women on a random basis for them to fill out before or after being seen by the physician.

Y] Decree 77/2008, of 4 March, on the administration and functional organisation of the mental health services in the Andalusian Health Service (BOJA [Andalusian Official Gazette no. 53 of 17 March 2008]. http://www.sas.junta-andalucia.es/principal/documentosAcc.asp?pagina=pr_normativas3_22.

health facilities were organised in Clinical Management Units dependent on the different hospital areas or health management departments.

At the end of 2007, this network comprised the following facilities:

- 76 Community Mental Health Units (USMC, Unidades de Salud Mental Comunitaria). These are the basic specialised care facilities for mental health. They provide comprehensive care to patients in the local area in form of outpatient services or home care.
- 14 Child and Adolescent Mental Health Units (USMI-J, Unidades de Salud Mental Infanto-Juvenil). The USMI-J provide specialised care, both in outpatient departments and via complete or partial hospitalisation, to children and adolescents under 18 referred from their corresponding community mental health unit.
- 19 Acute Inpatient Mental Health Units (UHSM, Unidades de Hospitalización de Salud Mental). These provide specialised services for short and long hospital stays.
- 14 Mental Health Therapeutic Communities (CTSM, Comunidades Terapéuticas de Salud Mental). These facilities are aimed at the intensive treatment of patients with SMI who require specialised mental health care, in a hospital environment where they are completely or partially hospitalised for medium term stays.
- 9 Mental Health Rehabilitation Units (URSM, Unidades de Rehabilitación de Salud Mental). The aim of these outpatient units is the recovery of social skills and reinsertion into society and employment for patients with SMI.
- 11 Mental Health Day Hospitals (HDSM, Hospitales de Día de Salud Mental). These are considered to be intermediate resources between the USMC and the UHSM. They provide specialised care on a day-hospital basis.

2.1.2. Mental health human resources

Table 5 shows the different professions which make up the multidisciplinary mental health teams per 100,000 inhabitants in Andalusia as of 2007. On a national level, the most recent data available is from 2005[32] and it shows there to be 3.6 psychiatrists, 1.9 clinical psychology professionals and 4.2 nursing professionals per 100,000 inhabitants.

Table 5: Human resources by profession and type of facility. Rates per 100,000 inhabitants. SSPA, 2007.

	USMC	USMI-J	USMH	URSM	HDSM	CTSM	TOTAL
Psychiatry	3.44	0.42	1.09	0.11	0.26	0.34	5.66
Clinical Psychology	1.72	0.38	0.20	0.21	0.20	0.30	3.02
Social Work	1.01	0.15	0.07	0.09	0.02	0.12	1.46
Nursing	1.92	0.58	2.69	0.20	0.37	1.25	7.02
Nursing Assistants	1.60	0.42	4.14	0.60	0.19	1.85	8.80
Administrative Staff	1.25	0.20	0.25	0.10	0.14	0.14	2.07
Occupational Therapy	0.00	0.15	0.04	0.12	0.11	0.15	0.57
Occupational instructors	0.01	0.04	0.10	0.22	0.20	0.55	1.12
Porters	0.01	0.00	0.52	0.02	0.00	0.47	1.03
TOTAL	10.97	2.35	9.11	1.68	1.49	5.16	30.75

Fuentes:

– Mental Health Programme. Directorate-General for Health Care. Andalusian Health Service .

– Review of the Municipal Register of Inhabitants as at 1 January 2007. Andalusian Institute of Statistics.

2.1.3. Mental Health Clinical Management Units

Over recent years, the Regional Ministry of Health and the SAS have been promoting the creation of Clinical Management Units (CMU) as an organisational structure involving health care professionals in the management of the resources used in their own clinical practices.

This management model has been adopted within mental health care. In this way, by the end of 2007, 65.03% of mental health care facilities from the network overall had been integrated in the CMU. Furthermore, the percentage of mental health professionals who were part of the CMU at the end of that year was 68%

2.2. COMMUNITY RESOURCES FOR SOCIAL SUPPORT

2.2.1. General Resources

As with the rest of the population, people with mental illnesses have the right to access each and every one of the services within the social welfare system. Amongst the most frequently used by this group of people, the following are to be noted:

– Social services (both community and specialised), via which they can gain access to general assistance and services established under the Law on the Promotion of Personal Autonomy and Care for Dependent People.

- General programmes from the educational system which aim to compensate for lack of training in general and access to employment in particular, (adult education and social guarantee programmes, etc.)
- The Andalusian Employment Service Programmes, the objective of which is to increase the employability of the unemployed (career advice, traineeship, integration support...)
- Housing support programmes for underprivileged sectors.
- Care on behalf of the Administration of Justice both in the civil and criminal aspects.

2.2.2. Specific Resources (FAISEM)

The main aim of the Andalusian Public Foundation for Social Integration of People with Mental Illness (FAISEM) is to develop social support programmes and activities for people with severe mental illness in Andalusia, in coordination with the public mental health services and with the various networks of existing services in our Community (social, employment and education services, etc.):

- Housing programme [33]: this facilitates housing with different levels of supervision and support: boarding houses, apartments, family respite locations and "day-stays" in residential units and sub-programmes of home support.
- Occupational-employment programme [34]: this promotes integration into the workplace via: occupational workshops, employment training courses, social firms (which provide opportunities for permanent, paid employment) and employment support sub-programmes in other companies in the open market.
- Free Time and Leisure Programme: developed in collaboration with the consumer movement and local institutions.
- Promotion and support programme for guardianship institutions.
- Support programme for the associative movement of families and users.
- Care programme for homeless, marginalised people with severe mental illnesses; this is developed in coordination with mental health units, social services and various community institutions.
- Care programme for the prison population with severe mental illness.

Table 6: Development of the social support resources for people with severe mental illness. FAISEM, 2003-2007.

	Year 2003					Year 2007					% Variation 2003-2007 Places X 100,000 hab.
	N° Avail.	N° Places	Places X 100,000 inhab.	% Males	% Females	N° Avail.	N° Places	Places X 100,000 inhab.	% Males	% Females	
RESIDENTIAL Programme											
Boarding Houses	22	335	4.4	69.2	30.8	47	742	9.2	68.8	31.2	109.1
Apartment	94	348	4.6	78.3	21.7	175	667	8.3	73.6	26.4	80.4
Nursing Home for the elderly places	39	216	2.8	66.2	33.8	32	151	1.9	70.4	29.6	-32.1
Guesthouse places	5	12	0.2	71.4	28.6	2	12	0.1	72.2	27.8	-50.0
Home Support		119	1.6	67.6	32.2		410	5.1	61.2	38.8	218.8
OCCUPATIONAL / EMPLOYMENT Programme											
Occupational Workshops	94	1,647	21.7	76.6	23.4	115	2,251	27.9	73.1	26.9	28.6
Vocational Training Courses	60	302	4.0	76.8	23.2	53	261	3.2	72.1	27.9	-20.0
Social Firms	9	189*	2.5	79.6	20.4	9	225*	2.8	76.2	23.8	12.7
EASS**	8	134***	1.8	68.6	31.4	8	952***	11.8	67.5	32.5	569.9
FREE TIME AND LEISURE Programme											
Social Clubs	28	840	11.0	75.2	24.8	45	1,407	17.5	70.7	29.3	59.1
Holiday Programme		885	11.6	74.3	25.7		823	10.2	67.8	32.2	-12.1
GUARDIANSHIP Programme											
Guardianship Institutions	6	542	7.1	71.3	28.7	8	655	8.1	70.1	29.9	14.1
CARE FOR HOMELESS PEOPLE WITH SMI Programme											
Places		-	-	-	-		37	0.5	74.8	25.2	

* Employed people with mental illness. ** Employment Advice and Support Services. *** N° of contracts.

Fuentes:

– Andalusian Public Foundation for Social Integration of People with Mental Illness.

– Review of the Municipal Register of Inhabitants as at 1 January 2003 and 2007. Andalusian Institute of Statistics.

2.2.3.- Mutual Support Network

The Andalusian network for mutual support relating to mental health is wide and diverse with **79** associations in 2007, most of them represented by regional institutions.

People with severe mental illness and their close relatives or friends are represented at a regional level by 2 federated organisations[Z] which comprise some 22 associations. In addition, there are another 8 independent associations of patients with mental illnesses and their families and several "monographic" associations aimed at a particular mental disorder (eating disorders, attention deficit disorder and hyperactivity, and general developmental disorders, amongst others) at a local, provincial or regional level.

Z] Andalusian Federation of Associations of People with Mental Illness and their Families (FEAFES-Andalucía), which is made up of 13 associations and an Andalusian Mental Health User Associations Platform, made up of 9 associations.

III

EXPECTATIONS FROM PEOPLE SUFFERING FROM MENTAL DISORDERS, THEIR FAMILIES AND PROFESSIONALS

With the aim of finding improvement opportunities in the quality of care, the needs and expectations of people with mental disorders, their families and professionals involved in mental health care in Andalusia have been analysed.

Seven focus groups have been set up comprising 75 users of mental health facilities and their families (people with severe mental illness and their families, people with a common mental disorder and their families and families of those under the age of 18 with a mental disorder). Two workshops have also been set up with the participation of 30 professionals, one group with SSPA professionals and the other with cross-cutting professionals (from diverse sectors related to mental health).

Table 7 uses the information obtained from these groups to summarise the demands and proposed lines of work which have been taken into consideration during the preparation of this Second Comprehensive Plan.

Table 7: Demands for the improvement of care and proposed lines of work (I).

Areas	People with mental disorders and their families	SSPA Professionals	Cross-cutting Professionals
HUMAN RESOURCES	Increase the number of healthcare professionals to reduce waiting lists and improve accessibility to facilities.	Homogenise the supply of professionals using efficacy, prevalence and population coverage criteria.	Increase the number of healthcare professionals, fundamentally psychologists and psychiatrists.
		Training for healthcare professionals in psychotherapy and skills for patient management	Mental health training plans for healthcare professionals and specific groups.
		Specialisation in childhood and adolescence for psychiatry and clinical psychology	
MATERIAL RESOURCES	Supply of resources and infrastructures in the UHSM and USMI-J to carry out activities during hospitalisation, differentiated by the age group and type of disorder	-Transparency and homogenisation in the distribution of resources -Increase of complete hospitalisation places in CTSM - Creation of new medium and long stay spaces for patients with chronic disorders	Supply of resources adapted to each patient's needs which enable comprehensive care.

SOCIAL SUPPORT RESOURCES	-Increase of occupational or day centres for people with SMI - Social and/or economic aid for the family - Respite in the form of a holiday for the families of mentally ill children - More opportunities for access to employment for people with SMI		- Increase in residential resources. - Higher valuation of the services provided by associations.
CARE FOR PATIENTS AND FAMILY	- Psychological support for the patients' families - Information about illness, diagnosis and treatment - Personalised treatment with more psychological work and psychotherapies. - More participation of families in the treatment of the illness	- Integrated approach to child-adolescent mental health, differentiating childhood from adolescence - Personalised and community care	- Comprehensive psychiatric and community care with an emphasis on psychotherapy - Improved care for: 1. The institutionalised population in day centres and homes 2. People in prison with a mental illness 3. Homeless people 4. UHSM patients

Table 7: Demands for the improvement of care and proposed lines of work (II).

Areas	Users and Family	SSPA Professionals	Cross-cutting Professionals
COORDINATION		- Collaboration spaces amongst professionals - Multidisciplinary work teams - Coordination of healthcare and social resources	- Real, effective and committed coordination between those involved. - Multidisciplinary teams. - Specific training for psychiatrists to strengthen cross-cutting coordination - Access of the mental health network to other institutions
SERVICE PORTFOLIO	- Prevention of mental health problems in childhood and adolescence - Accessibility to Primary and Specialised healthcare services.	- Psychoeducation for professionals, patients and their families - Definition of the service portfolio - Organisation of mental health services	- Prevention of child and adolescent health problems - Reduce the saturation of services - Service accessibility in afternoons and on weekends - Bring professional teams closer to rural areas.

GENERAL AND REGULATORY FRAMEWORK		-Definition of homogenous and consensual protocols, clinical guidelines and care plans. - Application of the SMI Care Pathway	Definition of protocols of prevention, detection and action objectives, as well as mechanisms to guarantee their achievement
ASSESSMENT		- Assess the achievements of I PISMA - Assess the implementation of the SMI Care Pathway	

IV

AREAS FOR IMPROVEMENT

The following areas for improvement have been extracted from the analysis of the situation so far whilst keeping in mind the regulatory and planning frameworks from the WHO, European Union, Spain and Andalusia, as well as the expectations of the groups affected and the professionals involved in mental health issues across the diverse areas involved:

- Need for commitment to mental health prevention and promotion programmes, with special emphasis on certain groups that experience inequality and are more at risk of suffering from mental disorders. Incorporating mental illness prevention into the child and adolescent population is also considered a crucial element in mental health planning.

- It is necessary to carry out actions aimed at the promotion of healthy lifestyles and preventing somatic problems in people who suffer from mental health issues and in particular, those who suffer from SMI.

- Based on the discovery that traditional gender roles and stereotypes are significant risk factors in gender-based violence and the suffering of mental illnesses, it is necessary to include the gender approach in each one of the initiatives put forward by this Plan. Furthermore, the figures relating to violence faced by women forces the different management bodies to pay comprehensive attention to the victims of these aggressions, where health care and in particular mental health care are fundamental.

- The highest prevalence of mental health problems or difficulties with regards to access to resources for certain groups (such as homeless people, prison population, people with drug dependencies, the immigrant population on occasions, etc.) justifies the inclusion of specific care strategies.

- The expectations put forward by patients and their families demand an improvement in the quality of health and social care, with a community approach which looks at the humanisation of care as a key element.

– The evolution and new demands put on the health and social systems have generated the need to analyse and adapt the existing resources and to establish a basic service portfolio which guarantees equality throughout Andalusia.

– In addition, strategies are necessary which improve cross-cutting coordination and continuity of care and which guarantee specialised care, based on the best scientific evidence available.

– The absence of some data on prevalence and incidence in our area and on physician-evaluated morbidity requires the development of information systems to facilitate their knowledge in order to improve planning and organisation of the mental health services, which is a major priority for the National Health System's Mental Health Strategy.

– There is a huge demand from sufferers and their relatives for an improvement in the quality of life of people with mental illness and protection of their rights.

– It is essential to continue moving towards the eradication of the stigma associated with the mentally ill, as it has extremely negative consequences on a sufferer's recovery process.

– Lastly, SSPA users and their families are asking for more participation in the mental health planning and decision-making processes, as it is a fundamental principle in the community model and the core of the recovery approach.

IV

GENERAL OBJECTIVES

In keeping with the needs established in the previous sections, this II Comprehensive Mental Health Plan tries to achieve the following **AIMS**:

1. Promote mental health in the Andalusian population.
2. Provide the necessary health and social support services and adapt the existing services to the needs of people with mental health issues and their families.
3. Improve the quality of life for people with mental illness and their families, and concentrate on their recovery and social inclusion processes.

To achieve these aims, the following **GENERAL OBJECTIVES** are proposed:

1 Promotion of mental health and prevention of mental illness appearance in the Andalusian population.

2 Promotion of healthy lifestyles in people with mental illness and in particular those with severe mental illness.

3 Reduction of inequalities faced by the mentally ill due to geographic, socio-economic or gender reasons.

4 Improvement in the quality of health care and social support to people with mental illness and their carers, guaranteeing accessibility, continuity of care and humanised care.

5 Improvement in the quality of life for people with mental illness and their relatives and watch over the compliance with their rights.

6 Promotion of social awareness which contributes to reducing the stigma of mental illness.

7 Promotion of an active participation of groups of patients, relatives, professionals and community consultants in each one of the development stages of the Plan.

8 Development of information systems to allow better understanding of the magnitude of mental health issues and the quality of care given, so as to then allow for the reorientation of services in accordance with people's needs.

VI

ACTION STRATEGIES

This II Comprehensive Plan consists of a total of 15 strategies which will assist in the achievement of the proposed objectives:

1 Information and communication in mental health

2 Promotion of health

3 Mental health and gender

4 Mental health and prevention

5 Health care network, organisational model and service portfolio

6 Social support to people with severe mental illness

7 Mental health care for the Andalusian population

8 Mental health care for children and adolescents

9 Early detection and intervention of psychotic disorders

10 Intensive community treatment for people with severe mental illness

11 Specific care for people with personality disorders

12 Mental health care for people at risk of social exclusion or socially excluded

13 Citizen participation and mutual support

14 Epidemiology, assessment and information systems

15 Training and professional development, research and knowledge management

For each one of these strategies there is a set of objectives which need to be reached, and a corresponding list of activities to assist in achieving them.

1 INFORMATION AND COMMUNICATION ON MENTAL HEALTH

Our culture holds many erroneous ideas and beliefs about mental health which stigmatise people suffering from such disorders, which in turn increases their suffering and that of their families.

Communication is a necessary and essential tool for changing stereotypical cultural patterns and combating the associated stigma. Communication should be developed as a key element for promoting health and preventing mental illness in individuals and the population in general.

A communication strategy is called for which is aimed at the general population, as well as at professionals and community consultants working in the field of mental health, and professionals from the media. The cross-cutting strategy must also incorporate equal treatment principles (in messages, images and language), acknowledgment of diversity and visibility of groups who can find themselves in a disadvantaged position.

Specific objectives:

1. Reduce stigma and prevent discrimination which weigh heavily on mental illness and its sufferers.
2. Increase the level of knowledge of mental illness by the general population, affected groups and professionals. More knowledge needs to be provided regarding protective factors and their consequences and a stand needs to be taken against the myths and erroneous beliefs commonly accepted by the population.
3. Guarantee a precise, integrating, respectful, non-discriminatory and egalitarian communication style for all communication actions and documents resulting from this Comprehensive Plan.
4. Improve internal communication between mental health care professionals.

Activities:

1. Develop new communication strategies with the general public about mental health, including activities for promoting mental health issues and social awareness[AA], in collaboration with the associative movement of patients, their families and close friends and the media.
2. Create awareness strategies adapted to the diverse target groups (groups of people of different ages, backgrounds, cultures, professions etc.) who are of interest for the Comprehensive Plan and diversify the action channels in accordance with these groups.
3. Organise training activities with SSPA professionals so as to include them in communication strategies.

AA] In September 2007 the project "1decada4" was started up. An initiative of the Regional Government of Andalusia, the project is about social awareness of mental illness and its sufferers. The campaign is based on four different characters suffering from mental illness (anxiety, schizophrenia, depression and severe mental illness). It involves television and cinema commercials, radio slots, press advertisements, posters, postcards and external advertising. It also has a website www.1decada4.es which is the first of its kind in Spain with information about the stigma and discrimination associated with mental health.

4. Organise training and information activities with the media professionals and students from the faculties of communication.
5. Introduce a sensitive view of gender and inequalities in messages, both with regards to content and the language and images used, so as to ensure that no sexist or discriminatory content of any kind is included.
6. Optimise the "Comunica Salud Mental" ("Mental Health Communication") platform [AB]as an internal communication space for SSPA mental health professionals.
7. Develop, implement and assess a communication plan for this Comprehensive Plan.

2 HEALTH PROMOTION

2.1- Promotion of mental health in the population

The promotion of mental health produces important benefits in the health of individuals and society in general. It favours well-being and quality of life for the population. Developing activities for the promotion of mental health involves the creation of individual, social and environmental conditions which allow for optimum psychological and psychophysiological development.

This strategy is a priority for this Plan, developing objectives and activities of a markedly cross-cutting character, aimed at favouring a better level of well-being and quality of life for the Andalusia population.

Specific objectives:

1. Promote mental health protection factors for the population in the different stages of the life cycle. The WHO recognises the following as some of the possible mental health protection factors:
    a. healthy lifestyles
    b. self-esteem
    c. feelings of self-control
    d. feelings of confidence
    e. social and conflict management skills
    f. ability to deal with stress
    g. ability to confront adversity
    h. problem solving skills
    i. adaptability
    j. positive feelings and early emotional links
    k. social support from family and friends
    l. equal roles

AB] The "Comunica Salud Mental" (CSM) platform is an internal communication space created for professionals of the Mental Health Services of the SSPA. It can be accessed via the SAS website www.juntadeandalucia.es/servicioandaluzdesalud. The CSM gives access to current news and other relevant information incorporated by Mental Health professionals. Documents can be added to the platform, information can be requested by email, searches can be carried out, etc.

2. Contribute to helping social inclusion and to minimising or eliminating social isolation, paying special attention to cultural diversity.
3. Raise awareness about the importance of developing egalitarian lifestyles which allow for the transformation of traditional gender roles and contribute to creating a healthy psychosocial environment which is safe and free from aggression and verbal violence, be it emotional or physical.
4. Boost research into new forms of intervention in the promotion of mental health, as well as the assessment of the activities that are being developed.
5. Include cross-cutting collaboration and participation in all Mental Health promotion strategies.

Activities:

1. Include contents related to the promotion of mental health and protection factors in the cross-cutting programmes for mental health promotion which are developed in educational, community and work environments.
2. Boost and support the promotion measures for a balanced diet and physical activity as defined in the *Physical Activity and Balanced Diet Plan*, and for giving up smoking, as described in the *Comprehensive Plan on Smoking in Andalusia*.
3. Together with the bodies present at a local level (councils, associations, NGOs, etc.), design cross-cutting actions for promoting the creation and maintenance of social networks.
4. Together with other sectors involved, collaborate to train consultants and professionals working in the community sector in areas related to mental health promotion.
5. Include contents related to the promotion of mental health in the relevant undergraduate and postgraduate academic curricula as well as in ongoing training activities.
6. Develop the design and implementation of a Basic Advice Technique for mental health promotion, as given by professionals in the SSPA care centres, particularly in the field of Primary Care.
7. Create a multidisciplinary and cross-cutting working group with the aim of analysing, assessing and proposing new types of intervention (new formats, channels and environments) in the field of mental health promotion.
8. Include gender and diversity perspectives in all of the initiatives and activities for mental health promotion which are developed in the scope of this Comprehensive Plan.

2.2.- Promoting health in people with severe mental illness

Sufficient knowledge currently exists to confirm that mental illnesses, and in particular, severe mental illnesses, are associated with a higher prevalence of somatic problems, a higher mortality rate for certain pathologies and a lower life expectancy than the general public.

This increase in morbidity and mortality is due, in many cases to the appearance of concurrent pathologies, the prevention, diagnosis and treatment of which is made harder due to the problems of suffering from a mental illness.

As is the case with the rest of the population, a person's lifestyle and the environment where they live can also determine their level of health.

It is therefore advisable to set out general measures for health promotion in people with mental illness and to create coordination and cooperation mechanisms amongst the different consultants and bodies involved.

Objetivos específicos:

1. Promote healthy behaviours in people with SMI.
2. Improve the environment of people with SMI so as to enable them to chose the most healthy behaviours.
3. Guarantee the same access to health promotion activities and programmes for people who suffer from SMI and their carers, as for the rest of the population.
4. Boost cross-cutting development and participation of specific health promotion strategies aimed at people with SMI and their carers.
5. Stimulate research in health and care promotion within the field of general health for people with SMI.

Activities:

1. Assess the adaptation for people with SMI of measures for the promotion of a balanced diet and physical activity as described in the *Physical Activity and Balanced Diet Plan* (basic and advanced dietary advice) and for giving up smoking (minimum and advanced, individual and group intervention) as described in the *Comprehensive Tobacco Action Plan for Andalusia*.
2. People with severe mental illness will have objectives and activities for physical health promotion (smoking habits, physical activity, balanced diet, oral hygiene, sexual health, etc.) available in their Personalised Treatment Plans
3. Development of programmes and/or activities for health promotion (informative sessions, talks, debates, etc.) and creation of resources (informative materials) adapted to their characteristics and needs and those of their families.
4. Design and develop intervention programmes regarding the environments (care homes, flats, therapeutic communities, hospitalisation units, etc.) for the promotion of healthy lifestyles to allow the option of more healthy behaviours, not forgetting the sphere of sexuality.
5. FAISEM's mental health services and social support facilities will develop a collaboration programme with the institutions and bodies involved to promote the design of specially adapted exercise plans and the use of sports facilities by people with SMI.
6. Training sessions to be carried out between primary care, mental health and other specialities, including social support facilities, regarding the most common somatic pathologies presented in people with SMI.
7. Psycho-educational programmes aimed at patients and their families will include information regarding prevention and care of the most prevalent health issues.
8. Regional studies will be carried out into the promotion of general health and care in people with SMI and into the prevalence of the most common health problems.

9. The gender perspective must also be incorporated into all the initiatives and activities for health promotion in people with SMI as developed in the scope of this Comprehensive Plan.

3 MENTAL HEALTH AND GENDER

Epidemiological studies show that certain mental disorders, especially the most frequent (depression, anxiety and somatic complaints), are most commonly found in women, becoming a serious public health problem. These types of disorders (and the high rates of associated comorbidity) are significantly associated with risk factors related to gender and to the subordination and violence which some women experience.

Added to this are the various biases to do with gender that are produced in health care models and in research products. This is partly due to the still scare awareness on the part of professional groups and the lack of integration of the gender approach in training for health care professionals.

Thus, introducing the Gender Perspective into Mental Health becomes a priority for the professional mental health care network in Andalusia and for this Comprehensive Plan.

Specific objectives:

1. Ensure the incorporation of the gender perspective into all the initiatives that are developed and promoted from this PISMA.
2. Generate a common social review which promotes and disseminates new egalitarian models and lifestyles in Andalusia, such as mental health protection factors.
3. Collaborate to overcome the gender biases which have traditionally impregnated our culture, and therefore, training, research and health promotion and prevention models, as well as health care of mental health problems.
4. Eliminate gender-based inequalities which occur in the access to resources and services.
5. Promote a balanced representation of male and female mental health care professionals when it comes to decision-making and responsibilities for the public mental health network.

Activities:

1. Creation of a permanent working group to drive this strategy and which, in an advisory capacity, collaborates and provides support and advice to the rest of the PISMA strategies or activities.
2. Develop a communication plan for the mental health and gender strategy (encompassing the general PISMA communication plan) which will act as an instrument for raising awareness in the general population, developing specific strategies for groups at a higher risk of violence and gender inequality and introduce efficient communication channels amongst professionals.
3. Develop methodological guidelines on how to incorporate the gender approach into the diverse strategies of this Comprehensive Plan

4. Develop and start up a Gender and Mental Health Training Plan aimed at all the professional groups involved in the prevention and care of mental health issues, including the diverse administrative structures.
5. Promote research in mental health from a gender perspective and develop a research line which is specific to gender and mental health.
6. Include the gender approach into the quality management systems for PISMA (with the consideration of gender equality as an explicit criteria of quality) incorporating the analysis of the problems/barriers associated with access to resources and services, the characteristics for use of these services and the satisfaction obtained from the services provided.
7. Study and implement strategies for facilitating the conciliation of personal and professional life when implementing the actions proposed by this Comprehensive Plan.
8. Reinforce coordination with the Regional Ministry of Equality and Social Welfare within the framework of promotion of gender equality and prevention and care for gender-based violence.

4 MENTAL ILLNESS AND PREVENTION

The aim of mental disorder prevention is to reduce incidence, prevalence and reoccurrence of mental disorders and to also reduce the length of time people have symptoms or are at risk of developing a mental illness, as well as the impact that mental illness has on the person affected, their relatives and society as a whole.

Specifically, the prevention of depression and suicide are two priorities of national and international mental health strategies.

For all of the foregoing, this Comprehensive Plan is committed to this strategy, which raises two complementary aspects. One is the prevention of mental health problems in the general population and the other is the improvement in the access to preventative activities offered to the population for those people who suffer from a severe mental illness.

Specific objectives:

1. Reduce the incidence of avoidable mental health problems
2. Improve early detection of mental health issues for all ages and in all social groups, especially in the most vulnerable ones.
3. Specifically tackle suicide prevention.
4. Improve accessibility to general early prevention and detection activities which are offered by the SSPA to people who suffer from SMI and their carers.

Activities:

1. Define a specific strategy for prevention, early detection and the correct handling of pathological grief in primary and mental health care consultations, and avoid unnecessary medication for normal grief processes.

2. Develop a training plan for the early detection and correct assessment of symptoms and signs of psychosocial illness, and the consequences of coexistence in environments where there is the possibility of suffering from violence, subordination or marginalisation.
3. Create a working group with the aim of reviewing the available evidence on detecting suicide risk and developing guidelines for action to include in clinical practice.
4. Design and implement a preventative advice service, standardised assessment of the extra effort of carers of people with chronic illness (including SMI) and/or dependency, and establish care plans for approaching the situation as early as possible.
5. Promote coordination and advice mechanisms for cross-cutting activities aimed at the design and development of preventative actions for the most vulnerable groups.
6. Assess the current tertiary prevention strategies (prevention of relapse and chronicity) to favour better practice for recovery and social inclusion of people with mental illness.
7. Study the barriers which are currently faced by people with SMI and their carers, to access to preventative services and early detection programmes which are offered to the general public. Design strategies to overcome them.
8. Design prevention strategies for situations of abuse and lack of protection of people with SMI (negligence, economic abuse, lack of intimacy, gender-based violence, etc.)
9. Incorporate content related to prevention of mental disorders in undergraduate and postgraduate academic curricula, as well as in ongoing training activities.

5 HEALTHCARE NETWORK, ORGANISATIONAL MODEL AND SERVICE PORTFOLIO

In keeping with the first PISMA, it is necessary to continue to boost the metal health care network with a view to consolidating a community model and advancing in the recovery approach.

This plan should consider a fresh reorganisation and standardisation of the structures and services on offer for mental health[AC] and should review the service portfolio with a view to developing a fair and efficient model adapted to the actual needs of the population.

Specific objectives:

1. Improve the mental health network and guarantee equality and accessibility in the distribution of resources, in keeping with population data, as well as in functional and organisational aspects of each mental health CMU.
2. Improve the therapeutic environment of the mental health facilities so as to guarantee humanisation of the care on offer and to favour the process of continuity of care and recovery of patients.

AC] According to international recommendations from the WHO and the guidelines set out in the Decree 77/2008 for organisation of Mental Health services.

3. Offer a unique basic portfolio of mental health services based on the actual needs and demands of the population and on scientific knowledge. The service portfolio must be adapted to the current demographic, cultural and social situation on Andalusia.
4. Standardise the service portfolio of the various mental health care facilities based on recommendations from the WHO.
5. Improve the mechanisms for effective communication, cooperation and coordination in the health system (primary care, mental health and other specialities), as well as with other institutions (FAISEM, education, justice), to guarantee continuity of care and the correct use of the services available.

Activities:

1. Increase mental health care resources, according to the information in table 8.

Table 8: Increase in mental health care resources. SSPA, 2008-2012

Facility	Increase
Community Mental Health Units	Creation of 5 new USMC.
	Increase in the supply of facultative personnel (psychiatrist and clinical psychologist) to achieve a ratio of 7 professionals per 100,000 inhabitants.
	Increase in the supply of nursing staff to achieve a ratio of 3 professionals per 100,000 inhabitants*.
Mental Health Therapeutic Communities	Creation of 2 new CTSM with a total of 40 beds and their corresponding partial hospitalisation places.
Mental Health Day Hospitals	Creation of 5 new HDSM with a total of 100 places.
Acute Inpatient Mental Health Units	Supply of 60 beds in UHSM.

*The ratio developed can be modified based on the relevant population's characteristics in the different USMC, as well as functional and organisational aspects of the respective mental health CMU.

2. Review the therapeutic environment (space, ward dynamic and interaction) of the various mental health facilities and develop and implement an improvement plan for each of mental health CMU.
3. Create a service portfolio organisational working group, so as to develop a unique basic portfolio of mental health services and to standardise the care offered in the different facilities.
4. Add to the mental health service portfolio the elements required for achieving the objectives of this Plan.
5. Apply the *European Service Mapping Schedule "ESMS"*[AD] for the standardisation of the description of mental health services and the development of a detailed map of these services in Andalusia.

AD] The ESMS is an instrument designed for the standardised description of European mental health services (Johnson et al., 2000) which have been translated and adapted for the Spanish population (Salvador-Carulla et al.,2005).

6. Once the basic mental health service portfolio is developed as put forward by this strategy, establish new ratios of resources (human, material and structural) which allow for its achievement.

VI

6 SOCIAL SUPPORT FOR PEOPLE WITH SEVERE MENTAL ILLNESS

In its list of proposals with regards to the relevant health care interventions, the Integrated Care Pathway for Severe Mental Illness includes the provision of programmes and resources for social support aimed at facilitating permanent action of people affected in the community via support provided in areas such as housing, occupation, employment, leisure, guardianship, etc.

In Andalusia these programmes are managed by FAISEM in close collaboration with the mental health services of the SSPA.

This second Plan aims at making progress in the development of these programmes, using as a reference, key values such as: the search for an increase in quality of community care oriented towards recovery; efficient cross-sectional coordination; increased user, professional and family participation; the universalisation of the benefits within the framework of the progressive implementation of the Law on the Promotion of Personal Autonomy and Care for Dependent People.

Specific Objectives:

1. Increase the coverage of the various social support programmes with the guarantee of equality (both territorial and of gender)
2. Increase the quality of benefits of the different programmes and adapt them to the development of technical knowledge as well as to the values characterising community care.
3. Promote coordination between health care and specific social support programmes as a basic pillar of care.
4. Improve coordination with the services reliant on the Regional Ministry of Equality and Social Welfare within the framework of the System for the Promotion of Personal Autonomy and Care for Dependent People.
5. Promote coordination with the consumer movement as well as with employment support services, the educational system and justice administration.
6. Make advances in knowledge with regard to care needs and results of social support interventions, incorporating the gender perspective with a view to favouring the process of recovery of the patients.

Actividades:

1. Adapt the supply of social support resources in accordance with the quantitative forecasts for the period 2008-2012 which are detailed in table 9.

Table 9: Increase in social support resources FAISEM 2008-2012

Programme	Facility/ Sub-programme		Increase 2008-2012	Situation forecast for 2012	
				Places	Places/100,000
Housing	Boarding Houses		458	1,200	15.0
	Apartments		533	1,200	15.0
	Home Support		778	1,200	15.0
	TOTAL		1,799	3,600	45.0
Occupational-employment	Workshops		149	2,400	30.0
	Vocational Training Courses		39	300	
	Social Firms*		125	350	
	EASS**	Teams	7	15	
		Patients	548	3,000	37.5
		Contracts	548	1,500	
Leisure and Free Time	Social Clubs		993	2,400	30.0
Care programme for homeless people with SMI	Provincial Programmes			8	
Guardianships	Guardianship Institutions			8	

* Job positions for people with SMI.

** Employment Advice and Support Service.

2. Install measures to favour the access of women suffering from SMI to the specific programmes for equal opportunity social support in collaboration with the Mental Health services.
3. Apply the FAISEM's Quality Plan to social support programmes.
4. Execute, implement and evaluate the annual cooperation agreements with the Andalusian Health Service.
5. Develop joint action procedures between community social services, mental health services and FAISEM services for the inclusion of the Personal Care Programme for Dependent People with Severe Mental Illness into the Personalised Treatment Plan[AE].

AE] Law 39/2006 for the Promotion of Personal Autonomy and Care for Dependent People develops the Personal Care Programme (PCP) for people in a situation of dependency and with right to assistance laid out by this Law. In Andalusia, the procedure for understanding the degree of dependency and the assignment of benefits from the PCP is regulated by Decree 168/2007, of 12 June (BOJA no.119; of 18 June 2007). The PCP, which is developed by the Community Social Services, should be used together with the more encompassing Personalised Treatment Plan (PTP) from the Integrated Care Pathway for Severe Mental Illness.

6. Develop specific annual agreements with the different family and user associations and the education, employment and legal services.
7. Develop collaboration agreements between different institutions, FAISEM, the mental health services and the consumer movement with the aim of involving people with severe mental illnesses in the world of art and culture, physical activity and sport, in the natural areas where these activities are performed.
8. Design and carry out a training plan aimed at social support professionals, as well as at other sectors which are involved in the social care of people with SMI.
9. Design and develop research studies which go into depth about the care needs and results of social support intervention.

7 MENTAL HEALTH CARE FOR THE ANDALUSIAN POPULATION

In order to guarantee comprehensive and integrated care for mental health problems in the Andalusian population, ensuring the continuity of interventions provided by the care network, the promotion of management via integrated care pathways (ICP) is a priority of this Plan

Furthermore, it also aims to answer care demands generated by daily life issues, avoiding the medicalisation of social discomfort, which is a problem that is becoming increasingly more common and of particular relevance for women.

Objetivos específicos:

1. Guarantee health care for mental health problems based on continuity of care, on the best available scientific evidence and on the principles of the recovery approach.
2. Improve accessibility to the most suitable health care level and the quality of care provided in each one of the health care levels which tackle mental health problems.
3. Ensure a health care system which guarantees the protection of personal dignity and safeguards the rights of patients and their carers.
4. Structure and promote cooperation between primary care and other specialities to tackle mental health disorders and care requirements generated by socialisation models, gender-based role and job distribution and the problems and situations of daily life.
5. Include the gender perspective in mental health care models and ensure the correct level of care is provided, with regards to gender, for mental health problems and problems derived from situations of gender inequality and sexual harassment or violence.

Activities:

1. Carry out awareness raising and training activities aimed at incorporating the recovery approach into the community care model provided for people with mental health problems in the SSPA.
2. Promote the implementation and extend the cover of the ICP related to the PISMA.

3. Systematically review and bring up to date the existing ICP and the currently used clinical practice guidelines, using the best available evidence and always keeping in mind the gender perspective.
4. Annual assessment of the quality standards of ICP using the established information systems.
5. Using participatory techniques to analyse the pathologies that require the development of ICP due to their prevalence, seriousness and/or intervention complexity and promote their development.
6. Study the existing barriers for access to the health care services for those who suffer from mental illnesses and promote the development of corrective measures, paying special attention to those groups cared for by other non-healthcare institutions (e.g. people with learning disability and mental illness, old people with mental illness in nursing homes, etc.).
7. In collaboration with the Andalusian Critical and Emergency Care Plan, develop action guidelines for use in mental health emergency situations.
8. Using a participatory methodology (primary care, mental health and citizenship) to develop informative materials which can help people to confront the difficulties presented by daily life.
9. Develop and disseminate action guidelines amongst health professionals to deal with situations of grief and which guarantee the no medicalisation of normal grief, which is unnecessary, and the early detection and correct handing of pathological grief at the correct level of care.
10. Start up training programmes aimed at implementing a care model which allows the "demedicalisation" of the usual daily-life problems and conflicts and promote the rational use of medication in the sphere of mental health.
11. Incorporate into the diagnostic and therapeutic protocols and algorithms elements which aim to reduce the gender bias in diagnostic accuracy and therapeutic effort. Also include sentry and specific questions on inequality, sexist beliefs, gender roles and sexist violence in the general clinical practice into medical records.
12. In collaboration with the Andalusian Comprehensive Oncology Plan and in the context of the mental health network, carry out specific, combined intervention strategies which guarantee the development of the psychological support programme for people who suffer from oncological diseases and their families.
13. Promote the implementation into the mental health network of the health care protocol to deal with violence against women, based on the recommendations of the Inter-territorial Board for Health and adapted for the Autonomous Community of Andalusia.
14. Establish objectives in the Clinical Management Agreements which guarantee that people with SMI, as well as their carers, have equal access to their rights as users of the SSPA: free choice, informed consent, participation in clinical decisions, privacy, accessible and understandable information, and right to register on the Living Will register.

8 CHILD AND ADOLESCENT MENTAL HEALTH CARE

VI

Childhood and adolescence are stages in human development which due to their complexity, specificity, environmental needs and the vulnerability to social changes, require different treatment to adults.

Therefore, within the strategic lines of mental health, it is important that the differences are always explicit and that cross-cutting actions are developed for health promotion, early detection and intervention in the most severe and prevalent pathologies. That is why this Comprehensive Plan follows a specific line aimed at this section of the population.

Specific objectives:

1. Incorporate the perspective of mental health promotion and prevention into the initiatives aimed at childhood and adolescence.
2. Promote mental health protection factors and reduce the risk factors in family, school, community and health environments.
3. Guarantee cross-cutting coordination and favour comprehensive care to mental health problems in children and adolescents.
4. Adapt the resources and care models to the specific needs of each age group (childhood and adolescence) with a gender and diversity approach.
5. Complete and homogenise the mental health resources and service portfolio for children and adolescents in the Autonomous Community.
6. Promote collaborative work between families and schools to give continuity of care to minors, avoiding interruptions to development and learning.

Activities:

1. Development of agreements between the Regional Ministries of Health, Education, Equality and Social Welfare and Justice and creation of a follow-up committee which helps provide answers to childhood and adolescence issues which require cross-cutting intervention.
2. Coordination of PISMA actions with other initiatives such as the Humanisation Plan for the Andalusian Perinatal Care Service, the Youth Training and Information Strategy called "Forma Joven" and other developed by the Andalusian public health service.
3. Performance of training and informative activities for parents and teachers aimed at the promotion of health and the prevention of mental illness.
4. Development of a *"Child and Adolescent Mental Health Care Programme in Andalusia"* which reflects the conceptual foundations and care model, care resources and requirements, the cross-cutting cooperation needed in this field and the assessment and improvement strategies.
5. The service portfolio for child and adolescent mental health care should include outpatient, day-hospital and complete hospitalisation programmes where there are separate areas for children and adolescents based on the characteristics of each development stage.

6. Development and implementation of combined action protocols between primary health care, mental health care and other institutions who work in the field of care for minors, so as to guarantee continuity of care and cross-cutting and cross-level coordination.
7. Revision and update of the ICP related to child and adolescent mental health and development of new processes and sub-processes for those pathologies which require them.
8. Development of mechanisms for coordination and collaboration between the professionals in the different sectors acting in the Early Care Programme to allow for the optimisation of action development related to the care of Pervasive Developmental Disorders (childhood autism and others).
9. In the primary care facilities for minors, the early detection of psychosocial risk situations will be included with special attention to those cases where a parent or close relative suffers from a severe mental illness.
10. Carry out an epidemiological study into the current care situation for child and adolescent mental health which will allow for understanding, assessment and proposition of future actions using quality and equality criteria.

9 EARLY DETECTION AND INTERVENTION OF PSYCHOTIC DISORDERS

It is known that the first 3 to 5 years of development of psychosis (known as the critical period) are determining for prognosis. In spite of this, many cases are detected or begin to be treated much later, after years of personal and family suffering and when a severe deterioration in family and social life has already occurred.

Therefore, programmes are required for both early detection and assertive treatment which will ensure, during the first years of the illness, the provision of quality interventions based on the best available evidence and which are aimed at the recovery of family, education and work life, as well as at family support and cooperation.

Specific objectives:

1. Guarantee a comprehensive, evidence-based programme for early detection and intervention of psychosis aimed at recovery which will be assertively developed with continuity of care for at least the first three years of illness.
2. Improve coordination, facilitate the exchange of information and unify action criteria within all the fields involved (health, equality and social welfare, education, justice system, family, consumer movement, etc.)
3. Provide training in this area for the professional groups involved.

Activities:

1. Study and preparation by a cross-cutting working group of a consensus proposal for early detection and intervention of psychosis in Andalusia which deals with care quality standards and service coordination and reorganisation needs.

2. Drafting of a sub-process for the early stage of psychosis within the framework of Severe Mental Illness.
3. The mental health CMU will carry out the organisational changes necessary to guarantee quality health care to people with prodromal symptoms or a first episode of psychosis, and their families.
4. Within the PISMA training plan, the CMU will develop training activities on early detection and intervention of psychosis, aimed at professionals from different sectors working in mental health.
5. The mental health CMU will promote facilities for cross-cutting and cross-level coordination so as to guarantee the local implementation of the psychosis early stage sub-process.
6. In collaboration with the different levels and sectors involved, training actions will be developed aimed at the different groups of professionals participating in activities for the early detection and intervention of psychosis.

10 INTENSIVE COMMUNITY TREATMENT FOR PEOPLE WITH SEVERE MENTAL ILLNESS

The programmes of intensive community treatment aim to offer public health care in the natural environment of people with SMI whose needs cannot be completely met by the usual mental health services.

It is a way of organising access to public health care for people with SMI who have "highly complex" problems (for example, patients with disruptive behaviour or that are socially isolated, abandoned or have low compliance with treatment). The programmes are not treatment themselves, but they are the vehicle which facilitates treatment, rehabilitation, care and necessary support, using a multidisciplinary and cross-cutting team that are suitably trained.

Although this group of patients is seen by the existing public health network in Andalusia, it is necessary to provide a new boost to improve the care they receive. It is for this reason that this Plan incorporates intensive community treatment programmes as one of its strategic lines.

Specific objectives:

1. Establish treatment and intensive community care programmes from the mental health CMU for people with SMI which is difficult to manage, adapting the characteristics of the community care model to the existing mental health situation in Andalusia, based on the best available scientific evidence.
2. Precisely define the inclusion criteria for accessing these programmes, determining entrance and exit limits and guaranteeing access equality.
3. Provide the care network with the necessary resources for carrying out these programmes.

4. Guarantee suitable coordination between the administration and cross-cutting facilities involved in the care of this patient group which will enable continuity in the development of their treatment plan.

Activities:

1. Create a working group to develop regional guidelines using the objectives and activities from the intensive community treatment programmes, based on the care pathway for SMI and on the functional model for assertive community treatment, and to define inclusion criteria for access to the programmes.
2. Identify the human resources and organisational changes required to develop these programmes.
3. Implement intensive community treatment programmes in the mental health CMU according to the regional guidelines.
4. Offer a specific training plan for professionals who participate in the intensive community treatment programmes.
5. Develop agreements in the heart of the provincial and central cross-cutting committees[AF] for improvement of the development of these programmes, ensuring that each entity has the necessary involvement for their development.

11 SPECIFIC CARE FOR PEOPLE WITH PERSONALITY DISORDERS

The increase in the incidence of Personality Disorders (PD)[AG] currently presents an important health problem for their clinical complexity, difficulties in early diagnosis, frequent unsatisfactory response to the treatments available and a lack of clear proposals for multidisciplinary therapeutic intervention.

The severe cases of PD generate a high level of suffering, both for the person concerned and their family. There is also a high care load which frequently produces poor results. At the same time, professionals feel that they lack the adequate skills, training and resources to provide suitable care.

It is therefore necessary to have an efficient, therapeutic, cross-cutting approach with the view to increasing the quality of care and therefore, the quality of life of people with PD and their families.

Specific objectives:

1. Understand the prevalence of personality disorders in the general population and in those seen in SSPA, as well as the use of public health resources for this group of patients.

AF] Bodies for cross-cutting coordination at a provincial and regional level with the participation of FAISEM representatives from the mental health services of the SSPA and the Regional Ministry for Equality and Social Welfare.

AG] People seen in the USMC with Personality Disorders during 2003 and 2006 have increased 35%, from a rate of 70.5 people per 100.000 inhabitants in 2003 to 94.9 in 2006.

2. Promote early detection and intervention of PD in adults and of the initial signs of PD in adolescents.
3. Offer cross-cutting, specialised and differentiated care to people with PD in the public health network.
4. Promote research and improve the training of the professional groups involved in the care of people with PD.

Activities:

1. Carry out an epidemiological study into PD in the Andalusian population.
2. Form a working group to create a sub-process for PD within the framework of the ICP of Severe Mental Illness which, amongst others, focuses on the following elements: detection and assessment of needs, intervention modes, organisation of services, training and research needs, etc.
3. Prioritise the implementation of early detection and intervention strategies in primary and mental health care, as outlined in the PD sub-process.
4. Develop and put in place a specific permanent training programme for PD which is aimed at the professional groups involved in the care of people with PD.

12 MENTAL HEALTH CARE FOR PEOPLE AT RISK OF SOCIAL EXCLUSION OR SOCIALLY EXCLUDED

Those people who are socially excluded or at high risk of being so are the homeless, certain immigrants and other people who live in a serious, unstable situation. The risk of exclusion is higher in certain groups of people, such as those with drug dependencies and people who have been or still are in prison or in youth detention centres, those who suffer from some type of mental disorder, or those who due to their vulnerability to these potential exclusion situations, are at risk of being excluded. Various studies show a higher prevalence of mental illnesses in these groups.

These groups all have difficulties in exercising their rights as citizens and they also have problems in accessing mental health services where they do not always receive care adapted to their needs.

Specific objectives:

1. Promote and improve cross-cutting coordination with the organisations that care for people at risk of social exclusion or socially excluded.
2. Facilitate a comprehensive approach which guarantees continuity of care for people who are socially excluded and have mental health problems, considering the particular needs of each group.
3. Improve accessibility to mental health services.
4. Improve knowledge about incidence and prevalence of mental disorders in each of the groups.

Activities:

1. Mental Health service professionals will participate in cross-cutting coordination spaces together with institutions and organisations working with homeless people.
2. Support from the mental health and social integration services to create "Low Demand Day Centres" for people who are homeless and suffer from mental illness.
3. Adapt and contextualise the mental health intervention programmes to biological, physiological, social and cultural characteristics, as well as to the beliefs and values held by immigrants with mental illness, always keeping the gender perspective in mind.
4. Informative materials will be translated, adapted and disseminated to allow the immigrant population access to mental health services.
5. Carry out research which makes accurate information available about the prevalence, incidence and mental health care requirements for the prison population, with the necessary degree of disaggregation for detecting inequalities.
6. Develop a joint action programme together with penitentiary institutions, health and social services and the consumer movement aimed at the recovery and social inclusion of imprisoned people with mental illness.
7. The mental health CMU with prisons located in their service area will develop, together with health services in those prisons, ongoing training programmes to guarantee a suitable qualification level of professionals caring for imprisoned people with mental health problems.
8. Review and bring up to date, together with the Directorate-General for Drug Dependencies of the Regional Ministry of Equality and Social Welfare, the Protocol of Combined Action between Community Mental Health Units and Drug-Dependency Outpatient Treatment Centres.

13 CITIZEN PARTICIPATION AND MUTUAL SUPPORT

Community care for mental health problems has to actively integrate the participation of the users and their families.

The patient's input in the decision-making process with regards their health entails promoting their independence and responsibility, improving their acceptance and compliance with treatment and favouring their recovery process, understanding that this requires the construction of a meaningful, satisfying life plan, defined by the patient, independently of the development of their symptoms or problems.

The families, associations and voluntary bodies have an important job, both in the process of treatment and recovery of the ill person and in the field of raising the awareness and understanding of citizens about mental illness care, respecting the rights of people with mental disorders and the social and employment integration of this group.

Specific objectives:

1. Promote active participation of the users and their families in each and every one of the development fields of this Comprehensive Plan.
2. Support the associative movement of families and foster consolidation of the consumer movement with the aim of strengthening their voice when dealing with public administrations and other regional organisations.
3. Ensure equal conditions of citizen participation for those groups of patients and their families who find themselves disadvantaged (SMI, immigrant population, residents in ZNTS, etc.)
4. Boost cooperation with the consumer movement in the development of mutual support programmes, social awareness and promotion of volunteers.
5. Promote the participation of mental health professionals in activities developed for the consumer movement and vice versa.

Activities:

1. Provincial Mental Health Participation Boards are created with representation of the associative movement of users and their families and of professionals from the different mental health CMU and FAISEM.
2. Facilitate the creation of user associations in the provinces where integration into the Andalusian Platform of Mental Health User Associations has still not been developed.
3. Carry out positive actions to ensure that the groups of patients and families who are at a disadvantaged situation are fairly represented in the spaces for participation generated by this Comprehensive Plan.
4. Carry out joint activities to raise awareness and educate society on mental health and disorders and promote awareness about the rights of people suffering from these disorders.
5. Collaborate with associations towards the promotion and training of volunteers via educational programmes aimed at improving knowledge, developing skills and fostering a positive attitude towards mental illness.
6. Promote collaboration with the consumer movement to develop training actions to help acquire the necessary skills for care and self-care in the affected groups of people (patients, families and carers).
7. Carry out annual regional events with the participation of the mental health services, social support programmes and the user and family movements.
8. Design and develop an agreement which formalises the participation of the user and family movement in the follow-up and assessment of this Comprehensive Plan.

14 EPIDEMIOLOGY, ASSESSMENT AND INFORMATION SYSTEMS

Development, follow-up and assessment of the proposals put forward by this Comprehensive Plan require the availability of the necessary epidemiological information in order to understand and quantify the actual magnitude of mental health problems in the Andalusian population, as well as of information regarding care activities carried out, and all of this

with a sufficient degree of disaggregation so as to identify where the main breaches and inequalities lie.

Adequate health information systems are also required, including particular case records. For this purpose, digital medical history will be a fundamental source of these information systems.

Lastly, an epidemiological surveillance system is required which allows for understanding the impact of this Comprehensive Plan in terms of health results.

Specific objectives:

1. Understand the prevalence of mental disorders in Andalusian women and men.
2. Make advances in the awareness and distribution of mental health protection factors and risk factors for mental disorders in the Andalusian population.
3. Improve awareness about morbidity evaluated in the health and social services and about the characteristics of the patients (disability, dependency, associated family burden, clinical-care needs, etc.), incorporating social stratification variables which allow for gender analysis and other possible causes of inequality.
4. Guarantee that all the information regarding mental health is integrated into DIRAYA[AH], and that the exchange of authorised information occurs between other related information systems (FAISEM, Drug Dependency Care Network, etc.).
5. Understand the impact of this Comprehensive Plan in terms of health results.

Activities:

1. Perform a research project into the prevalence of mental disorders and their risk factors in the Andalusian population.
2. Inclusion and exploitation of samples representative of Andalusia in national and European epidemiological research projects.
3. Carry out research studies to assess the care needs of patients from a perspective of diversity and equality.
4. Encourage research studies framed by the new mental health models which will enable the deepening of knowledge of the mental health protection factors and how they are distributed in the Andalusian population.
5. Create a regional case record of schizophrenia and other related disorders.
6. The working group "Mental Health Assessment and Information Systems" will review and propose contents for the DIRAYA structural, citation and clinical modules. It will also work on proposals for epidemiological, structural, process and result indicators which will be the submitted to the DIRAYA Improvement Committee for analysis, approval and implementation.

AH] DIRAYA is the information system used by the SSPA as a support tool for health care information and management.

7. Design and development of sensitive indicators and suitability of the recording systems with the incorporation of social stratifiers to allow the measurement of inequality reduction both in the health processes and results.
8. The hospital areas will implement their DIRAYA citation and clinical modules in all the mental health facilities.
9. Access to epidemiological and accessibility indicators (demand, activity and delay) which are derived from the information systems, will be given to the different levels of the organisation.
10. Study the facilities required for facilitating the exchange of authorised information between the SSPA information systems and other organisations linked with mental health.
11. Design and develop an assessment methodology which (as well as structural and procedural indicators) incorporates the definition of health result indicators, in collaboration with the Epidemiological and Occupational Health Service from the Regional Ministry of Health.

15 TRAINING AND PROFESSIONAL DEVELOPMENT, RESEARCH AND KNOWLEDGE MANAGEMENT

15.1.- Training and Professional Development

Training of the various professional profiles should be focused towards the acquisition and constant updating of the skills required for offering the best possible service to people with mental illness and to their carers. It should also adapt to the needs of each health organisation and its services and professionals and focus towards the objectives of this Comprehensive Plan.

Therefore, improving the quality of training (ongoing, undergraduate and postgraduate), adequately managing resources, promoting professional development in a skill-based environment and integrating the needs of professionals have become the core for this strategy.

Specific objectives:

1. Improve the quality of training and guarantee ongoing training aimed at the community model and the strategic lines of this Comprehensive Plan which will meet the multidisciplinary needs of the health professional groups.
2. Incorporate innovative educational methodologies in the training process: use of new technologies, exchange of professionals, training periods, etc.
3. Establish the training priorities of the diverse professional profiles which are involved in mental health care in accordance with the approaches of this PISMA.
4. Improve planning, programming and dissemination of the training activities carried out by the Mental Health Programme, the CMU and other public institutions (EASP, IAVANTE, and IAAP), guaranteeing equal access for professionals.

5. Organise the training process based on the needs arising from the professional competence map of the various care units, and in line with the accreditation procedure for professional competence levels.
6. Promote and collaborate with training aimed at other professional groups involved in mental health care (Social Support Programmes, Social Services, Education, Justice System, etc.).
7. Incorporate the gender and diversity perspectives into all the training actions put forward by this Comprehensive Plan.

Activities:

1. The working group "Training and Professional Development" will design and put into motion the actions for annually assessing and prioritising the needs for ongoing training of the various professional groups, guaranteeing the participation of CMU in the development of the training strategy.
2. Annual planning will be carried out which will meet ongoing training needs detected and a calendar of training activities accredited by the Regional Ministry of Health will be disseminated during the first quarter of the year.
3. Specialised training will be revised and a proposal for improvement will be put forward which will incorporate the new multi-professional training units via areas of specific training of mental health specialities (psychiatry, mental health nursing and clinical psychology) and those which may be necessary to create. All of this taking into consideration the training in teaching skills for training specialists' tutors.
4. The mental health CMU will boost the offer in mental health training activities within the ongoing training programmes in the hospital areas and primary care districts.
5. Promotion of improvement in the training on offer from the Educational and Psychotherapeutic Unit of Granada (linked to the Mental Health Day Hospital, within the Virgen de las Nieves Hospital Area) which provides training in the field of psychotherapy to SSPA professionals and Clinical Psychology, Psychiatry and Family Medicine postgraduate students.
6. Promotion of collaboration in training actions with the professional groups linked with mental health and who carry out their activities outside the scope of the SSPA
7. Work towards increasing collaboration with universities and other institutions related to undergraduate and postgraduate education to favour the inclusion of mental health training in accordance with the priorities of the Comprehensive Plan in the academic curricula of the different degrees.
8. Review the competence maps of the different professions and specialities related to prevention and care of mental health problems so as to guarantee inclusion in training programmes of all the content required to carry out the proposals put forward by this Comprehensive Plan.
9. Design and incorporation of assessment criteria for the impact of training and its cost-effectiveness.
10. Inclusion of training objectives in the clinical management agreements of care units.
11. Work towards the identification of a network of training experts in the area of mental health and in development of a mental health training bank for the Andalusian Public Health System.

15.2.- Research

This Comprehensive Plan aims at boosting research initiatives to allow for a better understanding of mental illness and those elements that can favourably influence the quality of care, thereby promoting research oriented towards achieving health results and the reduction of inequalities, as well as promoting cooperative research and the development of research networks.

VI

Specific objectives:

1. Assess the status of research in mental health in Andalusia and develop priority research lines in keeping with the contents of this Plan.
2. Promote research training in the field of mental health.
3. Promote the incorporation of research activities into the mental health care network.
4. Promote cooperative and network research.

Activities:

1. Carry out an analysis of the research done into mental health in Andalusia, including the elements, resources, projects and publications available, as well as the identification of research lines, groups and networks.
2. Creation of a regional Mental Health Research Support Unit appointed to the Mental Health Programme aimed at training and advice on research.
3. Include teaching activities aimed at the research of training actions coordinated by the Mental Health Programme, in postgraduate education and in ongoing training programmes.
4. Promote the introduction of research methodologies which are sensitive to socio-cultural diversity and gender, both in understanding and avoiding biases, and in the selection of topics to approach.
5. Promote the recognition of research in the SSPA management tools (programme contracts, clinical management agreements, professional career, competence mapping, professional performance, staff management, etc.)
6. Promote the construction of research networks in Andalusia and the participation in national and international networks.
7. Promote cross-cutting and multidisciplinary cooperation in research activities.
8. Develop a virtual platform for communication between professionals and research teams.
9. Promote the dissemination of research results to the wider scientific community and the general public.

15.3.- Knowledge Management

Knowledge management in the health sector has the goal of searching, selecting, analysing and re-elaborating the extensive information available to make the knowledge and practices available to the community as a whole to then bring value to the improvement in the quality of health care in the population.

The National Health System's Mental Health Strategy (2006) recommends the use of Protocols and Clinical Practice Guidelines to reduce unjustified variability, to adapt the expenses

and to improve the continuity of care. A critical point it mentions is *"the absence of virtual spaces and platforms where scientists can safely and efficiently share and consolidate data and knowledge"*.

It is therefore necessary to mark out a course of action which provides the agents involved in mental health care with access to relevant information, knowledge and tools which enable the incorporation of best practices into care for people who suffer from a mental disorder.

Specific objectives:

1. Promote the incorporation of the best available evidence into clinical practice and extend the culture of evidence-based care in the mental health care network.
2. Favour communication and exchange of information, knowledge and experiences between all the consultants involved in the care of people with mental disorders.
3. Encourage active participation of professionals in the development and dissemination of evidence in mental health care.

Activities:

1. Consolidation of the working group "Knowledge Management" appointed to the Mental Health Programme, and creation and set up of local groups in each CMU for the management and follow-up of the mental health clinical evidence strategy and the implementation of activities.
2. Development and implementation of a stable training programme on the update of knowledge and tools for the search and selection of relevant information for the clinical practice.
3. Provide all the mental health facilities with the equipment and infrastructure necessary to access the internet and intranet which can be used in surgeries and will ease the search for clinical information.
4. Creation and development of a virtual platform on the internet which acts as a support for the objectives and activities of this strategy and which allows the dissemination and exchange of knowledge amongst professionals in the mental health network.
5. Incorporate into the available spaces for ongoing training, contents related to search, assessment and transmission of evidence within daily clinical activity
6. Inclusion in the Clinical Management Agreements of the objectives related to the mental health knowledge management strategy

VI

VII

FOLLOW-UP AND ASSESSMENT

1. Assessment of the proposed objectives and strategies:

The assessment of the objectives set out in this Plan will be carried out by assessing the strategies which are most closely linked with each of them (table10). To this end, a set of indicators were defined for each one of the proposed strategies and activities.

Objective 1: Strategies 1, 2, 3, 4, 7, 8, 12, 13, 14 and 15
Objective 2: Strategies 1, 2, 3, 4, 6, 10, 12, 13 and 15
Objective 3: Strategies 3, 6, 7, 8, 9, 10, 11, 12, 14 and 15
Objective 4: Strategies 3, 5, 6, 7, 8, 9, 10, 11, 12 and 15
Objective 5: Strategies 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13 and 15
Objective 6: Strategies 1, 2, 3 and 13
Objective 7: Strategies 1, 3, 6, 13 and 15
Objective 8: Strategies 3, 5 and 14

2. Implementation follow-up:

A complete report will be carried out on a yearly basis into the situation of each one of the strategies from the Plan. It will be submitted to the Regional Ministry of Health, which is the body responsible for following up on the level of achievement of the objectives.

3. Health results:

Over the course of the Plan, a health result assessment methodology will be developed using the available information on mortality, morbidity, health surveys and information systems and specific registers.

4. Provincialisation:

This second PISMA aims to raise the assessment and follow-up of the different strategies to a provincial level. The progress reports will therefore reflect the development of each one of the strategies in the context of each province (and their implementation in each one of the mental health CMU) and of the provincialised health plans.

5. The Comprehensive Plan Follow-up Committee:

Assessment reports will regularly be submitted to the Comprehensive Plan Follow-up Committee.

Using data regarding the level of achievement of the objectives and the assessment of the degree of development of the proposed implementation plan, the Committee will take relevant decisions regarding the identified areas for improvement.

6. Autonomous Board for Social Representation:

With a view to the follow-up and assessment of this second PISMA, an Autonomous Board will be created and will act as assessor and consultant, with representation from the Regional Ministry of Health, SAS, FAISEM, the associated movements of patients and their families and scientific societies linked with mental health.

7. Functional coordination structure planned:

For the efficient development of the actions planned, the Plan will count on its own coordination structure which in turn will run the committees and relevant working groups.

VII

VIII

REGULATORY FRAMEWORK

From the set of national and autonomous regulations in force, this Comprehensive Mental Health Plan is based on the following:

- Spanish Constitution of 27 December 1978. (BOE [Spanish Official Gazette] no. 311, of 29 December 1978). http://www.boe.es/boe/dias/1978/12/29/pdfs/A29313-29424.pdf

- Organic Law 2/2007, of 19 March, for the amendment of the Andalusian Statute of Autonomy (BOE no. 68, of 20 March 2007). http://www.boe.es/boe/dias/2007/03/20/pdfs/A11871-11909.pdf

- Law 14/1986, of 25 April, on General Health (BOE no. 102, of 29 April 1986). http://www.boe.es/boe/dias/1986/04/29/pdfs/A15207-15224.pdf

- Law 2/1998, of 15 June, on Andalusian Health (BOJA [Andalusian Official Gazette] no. 74, of 4 July and BOE no. 185 of 4 August 1998). http://www.juntadeandalucia.es/servicioandaluzdesalud/principal/documentos.asp?pagina=pr_normativas2_3

- Law 41/2002, of 14 November, for the basic regulation of patient's autonomy and of rights and obligations regarding clinical information and documentation. (BOE no. 274 of 15 November 2002). http://www.boe.es/boe/dias/2002/11/15/pdfs/A40126-40132.pdf

- Law 51/2003, of 2 December, for equal opportunities, non-discrimination and universal accessibility of disabled people. (BOE no. 289 of 3 December 2003). http://www.boe.es/boe/dias/2003/12/03/pdfs/A43187-43195.pdf

- Organic Law 1/2004, of 28 December, on Comprehensive Protection Measures against Gender-Based Violence. (BOE no. 313, of 29 December 2004). http://www.boe.es/boe/dias/2004/12/29/pdfs/A42166-42197.pdf

» In Andalusia, the specific development of strategies against gender-based violence is regulated by Law 13 /2007, of 26 November, (BOJA no. 247 of 18 December 2007). http://juntadeandalucia.es/boja/boletines/2007/247/d/updf/boletin.247.pdf

– Law 39/2006, of 14 December, for the Promotion of Personal Autonomy and Care for Dependent People. (BOE no. 299 of 15 December 2006). http://www.boe.es/boe/dias/2006/12/15/pdfs/A44142-44156.pdf

» In Andalusia, the procedure for the recognition of the dependency situation and the right to the benefits from the System for Autonomy and Dependency Care is regulated by the Decree 168/2007, of 12 June. (BOJA no. 11, of 18 June, 2007). http://juntadeandalucia.es/boja/boletines/2007/119/d/updf/d3.pdf

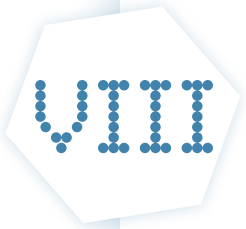
– Royal Decree 1030/2006, of 15 September, establishing the common service portfolio of the National Health Service (BOE no. 222 of 16 September 2006). http://www.boe.es/boe/dias/2006/09/16/pdfs/A32650-32679.pdf

– Organic Law 3/2007, of 22 March, for effective equality between women and men. (BOE no. 71 of 23 March 2007). http://www.boe.es/boe/dias/2007/03/23/pdfs/A12611-12645.pdf

» In Andalusia, its specific implementation is regulated by Law 12 /2007, of 26 November, (BOJA no. 247 of 18 December 2007). http://juntadeandalucia.es/boja/boletines/2007/247/d/updf/boletin.247.pdf

– Decree 77/2008, of 4 March, for the administrative and functional organisation of mental health services within the scope of the Andalusian Health Service (BOJA no. 53 of 17 March 2008). http://juntadeandalucia.es/boja/boletines/2008/53/d/updf/d12.pdf

This Comprehensive Plan gathers and develops the provisions established by the aforementioned regulations. It has also been developed taking into consideration the principles of the III Andalusian Health Plan. (http://www.juntadeandalucia.es/salud/principal/documentos.asp?pagina=institucional_PAS) and of the II Andalusian Public Health System Quality Plan (http://www.juntadeandalucia.es/salud/library/plantillas/externa.asp?pag=\salud\contenidos\iiplancalidad\II%20Plan%20de%20Salud.pdf).


VIII

IX

EXECUTIVE SUMMARY

The care of people with mental disorders is a priority for the Andalusian Public Health System (SSPA). The Comprehensive Mental Health Plan for Andalusia 2008-2012 (II PISMA) is aimed at the achievement of three health-related goals and eight general objectives which are developed via 15 strategies, each one of which entails its own specific objectives and activities for achievement. In total, II PISMA has 84 specific objectives and 149 actions.

All the incorporated proposals have resulted from an exhaustive analysis of the mental health situation in Andalusia (both regarding the magnitude of the problem and the analysis of the existing resources). Furthermore, the regulatory and planning framework of the WHO, the EU, Spain and Andalusia have been taken into consideration, as have the expectations of the people affected by mental health issues and the diverse groups associated with the mental health sector.

The development of the Plan has also relied on contributions from work carried out by diverse groups of experts, made up of approximately 150 people, both professionals from the diverse areas related to mental health and patients and their families.

This cross-cutting Comprehensive Plan incorporates the principle of equality, which requires a commitment to working towards the reduction of inequalities (including gender inequalities), the protection of the most vulnerable (paying special attention to guaranteeing the rights of those who suffer from a severe mental illness) and respect for the cultural identity in the Andalusian society, which is becoming more and more culturally diverse.

Furthermore, the promotion of citizen participation has been considered to be one of the basic components. The community model for mental health care implemented in Andalusia already established amongst its principles the involvement of patients and their families in the treatment process and their active participation in mental health services. This second Plan aims to take this all another step further by incorporating the recovery perspective.

In addition, this Plan sets out the importance of cross-cutting action, constantly promoting activities which ease cooperation with other sectors playing a role in the promotion of mental health and in the care and recovery of people suffering from mental health problems and their families (including social and employment integration).

All of this also takes into consideration the available scientific evidence for developing the recommendations and the financial feasibility of those recommendations, attempting to obtain sufficient resources to sustain the system.

To summarise, the proposed Strategies are as follows:

1. A communication strategy is called for which is aimed at both the general public and professionals and community consultants working in the mental health field, as well as media professionals, which will help combat the stigma, promote health and prevent mental illness, contributing to the improvement of the quality of care.

2. A change in perspective is being promoted in mental health care systems, which is moving away from a care experience almost completely focused on the provision of services, and instead moving towards a care system which takes the promotion of mental health much more into consideration, developing objectives and activities of a markedly cross-cutting nature, oriented towards favouring the highest degree of well-being and quality of life for the Andalusian population. Furthermore, the aim is to promote general health in people with mental illness by creating facilities for coordination and cooperation amongst the different consultants and bodies involved in the care of these people.

3. The gender perspective has been introduced in mental health as a work tool to detect the inequality between men and women, to assess the way in which this conditions people's emotional balance and mental health, as well as moving towards the implementation of equal roles in family, work and social environments which contribute to the mental health of the current and future population.

4. Cross-cutting preventative actions are developed which is an aspect that is already included in the community model principles, but has little presence in daily practice. Two complementary aspects are approached. One is the prevention of mental health problems in the general population, and more specifically, the prevention of depression and suicide, and the other is improving access to preventative activities offered to the population to people who suffer from severe mental illness.

5. It is necessary to boost the metal health care network with a view to consolidating a community model and advancing in the perspective of recovery. Together with the increase of resources, this plan aims to carry out the reorganisation and standardisation of the structures and revise the mental health service portfolio with a view to developing a fair and efficient model which is adapted to the actual needs of the population.

6. Advances in the development of social support programmes, keeping as reference key values such as the search for increasing quality based on community care models, which are oriented towards recovery and citizenship; an efficient cross-cutting coordination; increased participation of users, professionals and families; and the universalisation of the benefits within the framework of the progressive application of the Law for the Promotion of Personal Autonomy and Care for Dependent People.

7. Comprehensive care for mental health problems in the Andalusian population is guaranteed by the health services, ensuring the continuity of interventions. For this to happen, integrated care pathways are being promoted, as are improvements to accessibility and response to the care demands generated by daily life, avoiding the medicalisation of social discomfort, which is a problem that is becoming increasingly more common and of particular relevance for women.

8. A strategy for specific child and adolescent mental health care is proposed, with special emphasis on the promotion and prevention of mental health in these age groups, as well as on cross-cutting coordination and training for professional groups.

9. Programmes for the early detection and intervention of psychosis are introduced which aim to reduce the amount of time the illness goes untreated. Assertive treatment programmes are also to be introduced which ensure that quality interventions are made during the first years of illness based on the best available evidence.

10. There is a boost in the development of intensive community care programmes which aim to offer public health care in a natural environment to people with SMI whose needs cannot be completely met by the usual mental health services, with the aim of improving the quality of the care received as well as reducing the risk of chronicity.

11. Given the social repercussions associated with personality disorders, the development of specific care programmes is put forward based on the therapeutic, cross-cutting approach of proven efficacy, with a view to increasing quality of care and therefore, the quality of life of patients and their families.

12. A specific strategy is developed to care for the mental health problems presented by people who are socially excluded or at risk of being in such a situation, with a markedly cross-cutting nature, especially aimed at the improvement of accessibility for this group.

13. Advances are being made in a strategy to allow active participation of users and their families, via support of the consumer movement and the promotion of programmes for mutual support, social awareness and promotion of volunteers.

14. Actions are designed to obtain the necessary epidemiological information to understand and quantify the magnitude of mental health problems in the Andalusian population, as well as information relating to the care activity carried out by the different SSPA facilities. The integration of DIRAYA is fostered and the challenge will be to design a system for epidemiological surveillance which will allow for understanding of the impact of this Comprehensive Plan in terms of health results.

15. Lastly, the development of training, research and knowledge management strategies is planned as cross-cutting strategies which allow advances in knowledge and which facilitate the development of activities and the achievement of the objectives put forward by this Comprehensive Plan.

In addition, this Plan is committed to transparency via the dissemination of its future assessments, both with regard to the degree of implementation and actual health results.

IX

Bibliography

1. Instituto de Estadística de Andalucía. Revisión del Padrón Municipal de habitantes. Available at: http://www.juntadeandalucia.es/institutodeestadistica/

2. Instituto de Estadística de Andalucía. Andalucía: dependencia y solidaridad en las redes familiares. Seville: IEA 2006. Available at: http://www.iea.junta-andalucia.es/mapa/subtema0311.htm

3. Ministerio de Sanidad y Consumo. Estrategias en Salud Mental del SNS 2006. Madrid. El Ministerio; 2007.

4. Sayed-Ahmad, N et al (Coord.). Salud mental en la inmigración. Colección Inmigración y Salud. Granada Escuela Andaluza de Salud Publica 2008.

5. European Parliament Resolution: "Improving the mental health of the population. Towards a strategy on mental health for the European Union". 2006.

6. Commission of the European Communities. Green Paper: Improving the mental health of the population. Towards a strategy on mental health for the European Union. Brussels, 2005.

7. The World Health Organization. Prevention of mental disorders. Effective interventions and policy options. Summary report. The World Health Organization: Geneva, 2004.

8. McDaid (Ed). Mental Health in Workplace Settings. Consensus paper. Luxembourg: European Communities; 2008. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/mental_health_en.htm

9. Plazaola-Castaño J, Ruiz I,: Violencia contra la mujer en la pareja y consecuencias en la salud física y psíquica. Auxiliary Clin. (Barc.) 2004; 122 (12): 461-7.

10. Jané-Llopis E, Gabilondo A. (Eds). Mental Health in Older People. Consensus paper. Luxembourg: European Communities; 2008. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/mental_health_en.htm

11. Wahlbeck K, Mäkinen M. (Eds). Prevention of depression and suicide. Consensus paper. Luxembourg: European Communities; 2008. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/mental_health_en.htm

12. Ministerio de Sanidad y Consumo. Encuesta Nacional de Salud 2006. Available at: http://www.msc.es/estadEstudios/estadisticas/encuestaNacional/home.htm

13. ESEMeD/MEDHEA 2000. Prevalence of mental disorder in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. Acta Psychiatr Scand 2004; 109 Supl. 420: 1-64.

14. The WHO World Mental Health Survey Consortium. Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys. Jama 2004; 2; 291 (21): 2581-90.

15. Consejería de Salud de la Junta de Andalucía. Proceso Asistencial Integrado Trastorno Mental Grave. Seville: La Consejería; 2006.

16. Instituto de Estadística de Andalucía. Defunciones según causa de muerte. Available at: http://www.juntadeandalucia.es/institutodeestadistica/

17. Instituto Nacional de Estadística. Defunciones según causa de muerte. Available at: http://www.ine.es.

18. Fazel S, Danesh J. Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys. Lancet 2002; 359: 545-50.

19. Sociedad Española de Sanidad Penitenciaria. Atención primaria de la patología psiquiátrica dual en prisión. Available at: http://www.sesp.es/pdf/consenso_ap_patologia_psiquiatrica_dual.pdf

20. Dirección General de Instituciones Penitenciarias. Estrategia global de actuación en Estudio sobre salud mental en el medio penitenciario. June 2007.

21. Tronchoni M, Aparicio V, García E, Noriega M. Prevalencia de patología mental entre población sin hogar. Cuadernos de Psiquiatría Comunitaria 2003; 3 (2): 129-147.

22. Instituto Nacional de Estadística. Encuesta sobre las personas sin hogar 2005. Available at: http://www.ine.es.

23. Cáritas española. Documento Base Campaña sin techo 2007: por una salud digna para todos. Available at: http://www.caritas.es/Componentes/ficheros/file_view.php?Njc5OQ%3D%3D

24. Portero M, Utrilla MJ. Personas sin Hogar y Salud. Cáritas Española, Documentación Social nº 127.

25. Defensor del Pueblo Andaluz. Vivir en la calle. Informe especial de la situación de las personas sin techo en Andalucía. Available at: http://www.defensor-and.es/informes/ftp/vivirenlacalle/vivir_en_la_calle.pdf

26. Asociación Andaluza de Neuropsiquiatría. Inmigración y Salud Mental. Córdoba, cuaderno técnico/2; 2006.

27. Consejería para la Igualdad y Bienestar Social. Fundación para la Atención e Incorporación Social. Memoria de actuaciones 2006. Available at: http://www.fundacion-fada.org/memoria/memoria_actuaciones_2006.pdf

28. Consejería para la Igualdad y Bienestar Social. Observatorio Andaluz sobre Drogas y Adicciones. Informe sobre el indicador admisiones a tratamiento en Andalucía 2006. Available at: http://www.juntadeandalucia.es/igualdadybienestarsocial/export/Drogodependencia/HTML/archivos/Informe_Tratamiento_2006.pdf

29. Consejería Asuntos Sociales. Protocolo de actuación conjunta entre equipos de salud de distrito y centros de tratamiento ambulatorio de drogodependencias. Sevilla: La Consejería; 2002.

30. Ruiz-Jarabo C, Blanco P. La violencia contra las mujeres: prevención y detección, cómo promover desde los servicios sanitarios relaciones autónomas, solidarias y gozosas. Madrid: Díaz de Santos; 2006.

31. Raya L et al. La violencia contra la mujer en la pareja como factor asociado a una mala salud física y psíquica. Atención Primaria 2004; 34 (3): 117-27.

32. The World Health Organization. Mental Health Atlas 2005. Geneva: 2005. Available at: http://www.who.int/globalatlas/default.asp

33. Fundación Andaluza para la Integración Social del Enfermo Mental. Criterios para el desarrollo del programa residencial. Documento de Trabajo nº 1. 2ª Edición. Seville: FAISEM, 2005. Available at: www.faisem.es

34. Fundación Andaluza para la Integración Social del Enfermo Mental. Criterios para el desarrollo del programa ocupacional-laboral. Documento de Trabajo nº 2. 2ª Edición. Seville: FAISEM; 2005. Available at: www.faisem.es

Abbreviations

AC: Autonomous Communities.
ACG: Adjusted Clinical Groups.
ADG: Ambulatory Diagnosis Groups.
ADS: Anxiety, Depression and Somatisations.
CAD: Child and Adolescent Disorders.
CI: Confidence Intervals.
CIS: Clinical Interview Schedule.
CMU: Clinical Management Unit.
CTSM: Comunidad Terapéutica de Salud Mental [Mental Health Therapeutic Community].
DCCU-AP: Dispositivos de Cuidados Críticos y Urgencias de Atención Primaria [Primary Care Critical and Emergency Care Facilities].
DDD: Defined Daily Dose.
DDI: Daily Dose per Inhabitant.
DRG: Diagnosis-Related Groups.
EASP: Escuela Andaluza de Salud Pública [Andalusian School of Public Health].
ED: Eating Disorders.
EPES: Empresa Pública de Emergencias Sanitarias [Public Health Emergency Company].
ESEMED: European Study of the Epidemiology of Mental Disorder.
ESMS: European Service Mapping Schedule.
FAISEM: Fundación Pública Andaluza para la Integración Social de Personas con Enfermedad Mental [Andalusian Public Foundation for Social Integration of People with Mental Illness].
FEAFES: Federación Española de Agrupaciones de Familiares y Personas con Enfermedad Mental [Spanish Federation of Associations of People with Mental Illness and their Families].
HDSM: Hospital de Día de Salud Mental [Mental Health Day Hospital].
HP: Homeless people.
ICD-10: International Classification of Diseases, 10th Review.
ICD-9: International Classification of Diseases, 9th Review.
ICP: Integrated Care Pathway.
IEA: Instituto de Estadística de Andalucía [Andalusian Institute of Statistics].
INE: Instituto Nacional de Estadística [Spanish National Institute of Statistics].
MDS: Minimum Data Set.
MHA: Mental Health Area.
MHP: Mental Health Programme.
NGO: Non-Governmental Organisation.

OR: Odds Ratio.
PD: Personality Disorders.
PISMA: Plan Integral de Salud Mental de Andalucía. [Comprehensive Mental Health Plan for Andalusia].
PTP: Personalised Treatment Plan.
SAS: Servicio Andaluz de Salud [Andalusian Health Service].
SCCU-H: Servicios de Cuidados Críticos y Urgencias de Hospital [Hospital Critical and Emergency Care Services].
SISMA: Sistema de Información de Salud Mental de Andalucía [Andalusian Mental Health Information System].
SMI: Severe Mental Illness.
SSPA: Sistema Sanitario Público de Andalucía. [Andalusian Public Health System]
UDB: User Database.
UHSM: Unidad de Hospitalización de Salud Mental [Acute Inpatient Mental Health Unit].
UN: The United Nations.
URSM: Unidad de Rehabilitación de Salud Mental [Mental Health Rehabilitation Unit].
USMC: Unidad de Salud Mental Comunitaria [Community Mental Health Unit].
USMI-J: Unidad de Salud Mental Infanto-Juvenil [Child and Adolescent Mental Health Unit].
WHO: World Health Organization.
ZNTS: Zonas con Necesidad de Transformación Social [Areas in Need of Social Transformation].

JUNTA DE ANDALUCIA