

(PD)

Planning and Evaluation
Master Plan on Mental Health and Addictions

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Generalitat de Catalunya
Departament de Salut

(PD)

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Biblioteca de Catalunya - Dades CIP:

Pla Director de Salut Mental i Addiccions (Catalunya)

Master Plan on Mental Health and Addictions. _ (Planning and evaluation ; 6)

Bibliografia

I. Catalunya. Departament de Salut II. Títol III. Col·lecció: Planificació i avaluació. Anglès ; 6

1. Salut mental _ Política governamental _ Catalunya 2. Addictes _ Assistència psiquiàtrica _ Política governamental _ Catalunya

616.89(467.1)

© Generalitat de Catalunya. Departament de Salut

Edita: Direcció General de Planificació i Avaluació.

Pla Director Sociosanitari. Primera edició: Barcelona, diciembre de 2007

Tirada: 100 exemplars

Depósito legal: B-49168-2007

Asesoramiento lingüístico: María José Asis Garres

Maquetación: Marc Alongina

Impresión: Barcelona Digital S.L.

Synthesis

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introduction by the Minister of Health, Marina Geli, to the Master Plan on Mental Health.

Health planning is one of the most important aspects of Government policy. The high level of quality and efficiency of the Catalan health system means that the health of the people of Catalonia is among the best in the world. In this framework, the aim of health planning in the Ministry of Health is to set the strategic outlines for a continuing advance in improving the state of health, to lessen inequality and to ensure the efficiency of the health services. A special emphasis is placed on ensuring that the health services continue to contribute to the improvement in the public's health and quality of life by incorporating new scientific evidence and the views of professionals and members of the public.

The Health Plan for Catalonia is the tool used by the Government to set the priorities in health policy. The Government of Catalonia fosters the leading role of the Health Plan and strengthens it by creating Master Plans, which are used to put the policies set out in the Health Plan into operation. The Ministry of Health has prioritised six areas, based on an analysis of health, of the health services and of the socioeconomic context of the country, as Master Plans for the period 2005-07; these are mental health and addictions, oncology, vascular diseases, social-health problems, immigration and research in health sciences.

The Master Plans, adapted to Catalan reality and to the context of health finances, define the activities and the necessary organisation of services to achieve the policy goals that have been set, with an integrated view of the situation ranging from the promotion of health and the prevention of disease to rehabilitation, with diagnosis and treatment actions. The Plans define a model of care and organisation of services that is based on reality and makes it possible to continue improving the efficiency and quality of the system.

Within this context, I would like to present the Master Plan on Mental Health and Addictions, the outcome of the work of many professionals who, together with service provider institutions, patients' and families' associations and officials from the Ministry of Health, have drawn up the principal strategic and operational guidelines to achieve the objectives for health and for quality and efficiency of services.

In January 2005, in the Helsinki Mental Health Declaration for Europe, the European Union declared mental health to be a priority. The European view is based on the conviction that many of the great strategic objectives of the Union, such as the lasting prosperity of its people, solidarity and social justice, and the quality of life of the people, cannot be reached without a clear improvement in people's mental health. This Declaration explicitly states that the serious problems of mental health must be dealt with from the standpoint of public policies, in an integrating perspective that emphasises respect for human rights and the rejection of stigma and discrimination, with the introduction of promotion and prevention policies in mental health, and with the introduction of multidisciplinary and community-based care models.

The Ministry of Health wishes to prioritise the introduction of the Master Plan on Mental Health and Addictions in view of the great prevalence of mental disorders, because these health problems generate a great personal, family, social and health strain, in order to incorporate the promotion and prevention aspects of mental health, and because proper care must be guaranteed both for people with serious mental disorders and for their families.

In order to respond to these challenges in today's society, the Master Plan on Mental Health and Addictions was created. Over a three-year time span, it sets the objectives for care as well as the actions that will make it possible for these objectives to be reached.

This important tool will be accompanied by the subsequent development of the prevention and care processes and of the circuits necessary to make the strategies operational in the different regions and Health Administration Areas of Catalonia.

The Master Plan, which is accompanied by training material aimed at professionals and information for patients and families, is intended to be transparent and will publish its results systematically.

I must express my thanks to all those people who have taken part in drawing up the document for their dedication and the effort that they have put in. It is my hope and my wish that this Plan will be useful for all the professionals who work in the health system and who contribute to improving the health and quality of life of the people of Catalonia in the 21st century.

Marina Geli i Fàbrega
Minister of Health

1. Introduction

1. Introduction

1.1. Historical background

Albeit with a delay of several years, the development of psychiatric care in Catalonia has followed a similar path to that of most developed countries¹, starting from “charitable” psychiatric care financed by the Provincial Councils and based on internment in large psychiatric centres. In the seventies and eighties, a timid psychiatric reform was started in Catalonia, with the development of the first community services, but it was not until 1986, with the General Health Act 14/1986, of 25 April, that Spain integrated psychiatric care into the general health system (the National Health System).

Within the context of Spain, the Catalan health system has a series of peculiarities that make it noticeably different from the other systems. The most characteristic and frequently mentioned, is that of a public sector that in 1981 represented no more than 34% of acute hospital beds, while this proportion in Spain as a whole was 67%, that is to say almost twice as many². Of the psychiatric hospitals that existed in Catalonia in 1990, only two were in public hands, while the rest were part of a system of contracting with the provincial councils.

In 1990 an agreement was reached between Barcelona Provincial Council and the Government of Catalonia, under which Barcelona Provincial Council delegated the functions of managing the contracts that it had with different bodies for treating mental health patients in the Barcelona province to the Government of Catalonia. It was not until October 1992 that the competencies in the area of mental health of the other three Catalan provincial councils (Tarragona, Lleida and Girona) were transferred.

All of these resources were dedicated exclusively to the care of the adult population. This is why in 1989, the Government of Catalonia, through the Ministry of Health and Social Security, set up a care network specifically for children and adolescents with mental health problems, who had been excluded from the system prior to this.

The basic elements that determined the development of the psychiatric and mental health services in Catalonia are the Health Care Organisation in Catalonia Act 15/1990, of 9 July (integration of psychiatric care into the health system), and the Catalan Health Plan Decree 213/1999, of 3 August, of the Ministry of Health and Social Security, which set up the public network of mental health centres, services and establishments, which typifies the different elements that make up the mental health network. Also in 1999, an agreement was signed for the reorganisation of the services of psychiatric and mental health care in Catalonia, which prioritised the conversion of those hospitals in Catalonia that handled only psychiatric cases.

Specialist psychiatric and mental health care in Catalonia constitutes what is essentially a highly complex subsystem within the Catalan health system. The different resources and services that make up the public mental health network are organised around three basic care levels: specialised out-patient care in support of primary health care (mental health centres), hospital care (psychiatric emergencies, hospitalisation of acute cases, hospitalisation of subacute cases, mid and long-term hospitalisation, partial hospitalisation, community in-patient units, therapeutic communities and multipurpose community units), and community psychiatric rehabilitation (day centres and work insertion centres).

1. Thornicroft and Tansella (World Psychiatry Association 2002)

2. Health Care Organisation in Catalonia Act 15/1990

In Catalonia, psychiatric care is provided by a large number of providers with different characteristics (general hospitals, psychiatric hospitals, foundations, associations of professionals), which make up the Mental Health Network created by Decree 213/1999, of 3 August, of the Ministry of Health and Social Security. Currently there are more than 65 mental health service providers.

The organisation of care for drug dependence has largely been determined by the evolution of the phenomenon itself and its conceptualisation. Addictive behaviours, currently accepted by the scientific community as a mental disorder, were considered in the recent past as a moral failing, a demonstration of a lack of willpower, a socio-family pathology or even as part of a process of voluntary marginalisation.

The Catalan Drug Addiction Network (XAD) was set up as a specific, professionalised network to provide integrated care to people with disorders related to the consumption of psychoactive substances. The development of this network was one of the priorities of the Drug Dependence Plans that have been produced in Catalonia since 1986.

Law 20/1985 of prevention and care concerning substances that can lead to dependence³ was one of the pioneers in Spain and established drug addiction as a common disease that had to be treated in the health system. At the same time in Spain in 1985 the National Drugs Plan (PNSD) was set up as a government initiative under the Ministry of Foreign Affairs⁴. In the following year the Governing Board and the Technical Drug Dependence Body (OTD) were set up to perform the planning and scheduling functions of the actions mentioned in the operation of the Law.

The XAD is made up of centres that are under various bodies (local authorities, non-governmental organisations, Catalan Health Institute) and its activities are coordinated by the OTD, with the collaboration of the Ministry of Social Welfare and Family Affairs for the therapeutic communities and the reinsertion programmes.

At functional level, the XAD has been structured into four care levels, starting with primary health and social care and continuing with Care and Monitoring Centres (CAS) for drug dependence and reference units for out-patient treatment. The third level includes hospital detoxification units and therapeutic communities, and the fourth, the reinsertion centres and programmes.

Dealing with drug dependence is not simply a matter of medical care; it covers other fields of action of considerable importance such as prevention, reduction of harm, reinsertion, teaching and research and, finally, planning, organisation and coordination with other public authorities.

A third field of action is determined by services related to the integral care of people with mental illness and/or dependence which fall in the competence of social care or which arise from the collaboration between different departments of the public authorities. The social services working in housing such as supported flats or residences have increased gradually in recent years, although they are still far from meeting current needs. Likewise, a start has been made in setting up pre-work services and social clubs for the population with serious and persistent mental illness. Moreover, the Catalan Institute for Care and Social Services, of the Ministry of Social Action and

3. Official Gazette of the Government of Catalonia- No. 572-7-VIII-85

4. National Drugs Plan, Drug Consumption in Spain. See <http://www.mir.es/pnd/doc/presenta/presenta.htm>

1. Introduction

Citizenship, has specialised residences for people with learning disabilities and those with psychiatric disorders, and receives support for psychiatric care in terms of the hospitalisation and the out-patient care of these people. Also, the health system gives support to the care of minors in care who exhibit mental health problems or substance use and who are in the care of the Directorate General for Child and Adolescent Care, from out-patient to residential care.

In 2002 the Catalan Psychiatric Hospital Prison Unit was set up, which completed psychiatric and drug addiction care under the public network in Catalan prisons. In other spheres of the Ministry of Justice, such as minors and young people, there are also specific programmes and units for mental health care.

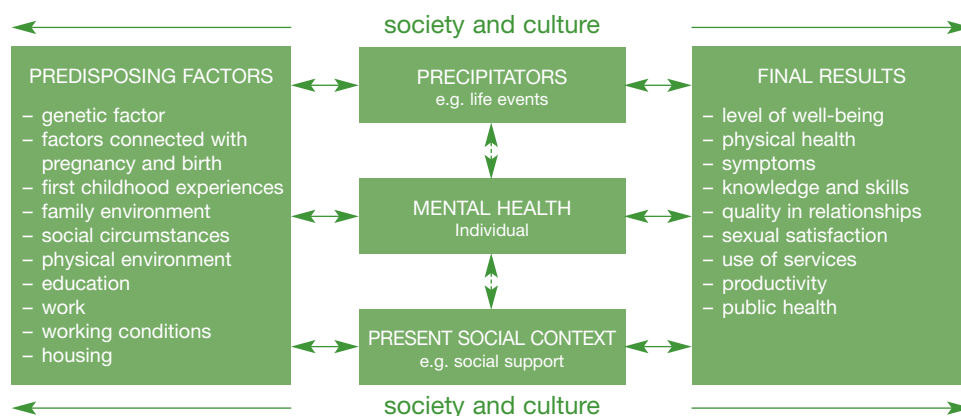
1.2. The model of the Master Plan on Mental Health and Addictions (PDSMiAd)

The Helsinki Declaration explicitly points out the need to approach serious mental health problems from a public health perspective, so as to enhance understanding of the many variables that influence the increase in suffering and difficulties of people in European countries. This malaise is the basis for the increase in mental health disorders that is expected in the coming years. From the integrative point of view, the Declaration stresses respect for human rights and the implementation of community-based multidisciplinary care models. A collaborative system for planning and organisation among the participating bodies and agents, and the commitment to assess the results of plans and interventions, are the other main points of the Declaration.

The construction of lifelong mental health (figure 1), and in particular during the first stages of psychobiological maturation, involves a dynamic so complex and full of variables that it is totally mixed up with the biography and the experience of the individual. There can be no doubt that social changes, both macroscopic and global and those of the more immediate environment (all of which are related) make a decisive impact on the particular individual, mostly imperceptibly and unconsciously.

Many of these factors, and maybe the most important of them, are not under the control of the individual person, but may be influenced by social construction, government policies and the intervention of the experts and the professionals. These factors are **biological** (such as genetic), **individual** (such as personal affective experiences), **family, social, financial, educational and environmental**.

Figure 1. The functional model of mental health



Source: Lahtinen, E., Lehtinen, V., Riikonen, E., Ahonen, J. (eds.): Framework for promoting mental health in Europe, Hamina 1999

But mental health, as a condition for health, is also a matter of interest to society as a whole because it contributes to the prosperity, the solidarity and the social justice of the whole. Policies must be formulated for work, trade, economy, education, housing, town planning, municipal services, social care and criminal justice, in such a way that they contribute to fostering mental health. It is for this reason that mental health is primarily a **public health matter**.

The commitment to the mental health of the population means, in the public health perspective mentioned, looking at linking the concepts of health and disease as a social phenomenon. The activities of **promoting health and preventing** some avoidable disorders, with strategies that range from the identification of the risk groups at different ages, to fighting against the stigma associated with mental illness, are key points of this proposal.

The high prevalence of mental disorders is related to the **rapid social transformations** that are taking place. Socio-economic transformations, such as economic, financial, political, and ethnic tensions, unemployment, poverty, migration, the lack of family and social support, loneliness and the breakdown of social networks, are circumstances that contribute to increasing the prevalence of suicide, antisocial behaviour, violence, the use of tobacco, alcohol and other drugs, depression and other mental health problems. The ageing of the population, an unprecedented success in our societies, might also bring with it a risk of increases in mental disorders, especially if the proper social and health measures are not taken. This is the way that a paradigm shift should be introduced, and in fact is being introduced, with regard to the scientific conceptualisation of mental disorders, a paradigm that takes into account the price that they represent in relation to the process of social change in which we are immersed; and although medical contributions are fundamental in the actions that must be taken, they alone cannot deal with all of the factors that are at work.

Identifying people's needs inevitably means knowing the **expectations and wishes** of users. With a conceptual framework as wide as the one that has been set, the users of the care system are diverse and have **different needs**; in other words, the particular patients who ask for care are users, but so are their families in many circumstances (children, old people, very severe patients); the population of risk groups, as a whole; the community and the personal care services, in the social, education or health fields. The broad view that we propose in order to understand mental health and to intervene where it is affected, implies **multidisciplinarity**, the convergence of many points of view and the synergy of diverse fields, disciplines and technologies.

The Master Plan also sets one objective that is no less ambitious than the rest: the **participation of users**. We must improve the active involvement of users and families in the therapeutic plans, and also the acceptance of the treatments in general, through more transparent relations and commitments between the professionals and the patients and families. We must improve the capacity for participation of their representatives in the central and local political bodies where decisions are taken. And we must look for new opportunities for participation in the services as well.

This Master Plan must therefore be based on **integration** as an objective for permanent improvement and, at the same time, as a reference model for the general process of change. Integration among the specialised networks, starting with mental health and addictions, integration in the primary care environment (the predominant place and set-

1. Introduction

ting for interventions in mental health and addictions), integration in the modalities for intervention in the specialised network itself, progressive integration with social, education and other services.

Integration is not possible without an open, shared global view, made real through the capacity **to work in networks**. The community network is the system “from which” and “in which” the phenomena of suffering and illness arise. A **community focus** in the services and in provision is probably still the most rational way of treating mental health and the multiplicity of situations that it brings about. The Master Plan should lead to a notable turnaround in the current reactive culture of our services, with a move towards a concept that is more preventive, more rehabilitative and more proactive in every intervention.

With the PDSMiAd, the services must move on from an organisation based on the **mechanism concept** to another based on the **territorially-based system of care of the person**. This should balance the range of general services with the specialised programmes, without having continually to create new mechanisms or new kinds of services. It should also refocus the services in accordance with the real needs of the users and their families, with multipurpose teams able to respond rapidly and adding a more preventive concept to them and overcome the present elements of institutionalisation, diversifying the supply and firmly reintroducing psychotherapeutic approaches at all levels of care.

2. The mission of the Master Plan

2. The mission of the Master Plan

The mission of the of Master Plan on Mental Health and Addictions is to decide, plan, execute and assess the most effective actions and the most appropriate resources to improve the mental health of the population, according to a community-based and intersectorial model, with the participation of all the different agents, integrating the social promotion of health factors and the prevention of disorders, and including treatment, rehabilitation, and the optimal insertion of individuals and population groups who suffer from mental disorders and addictions, together with support for their families.

The values behind the Plan's mission are:

- territorial equality in access and in services,
- integral and coordinated care, which means working in multidisciplinary teams,
- humanisation and quality of health action, performed by competent professionals, regarding the individual as the centre of care,
- the efficient management of resources so as to ensure the efficiency and sustainability of the system as well as its evaluation,
- professional ethics and ethics of the health organisations,
- constant research and innovation,
- increased dignity of care for people suffering from mental disorders and drug dependence and a commitment to society.

3. Organisation of the Master Plan

3. Organisation of the master plan

The Master Plan on Mental Health and Addictions has an executive group consisting of the director of the Plan, the deputy director in the field of Addictions, the president, the vice-president and the technical secretary of the Mental Health and Addictions Advisory Council and a member of the Standing Committee (figure 2).

The Standing Committee of the Mental Health and Addictions Advisory Council consists of 29 members, directly appointed, and is coordinated by the vice-president of the Advisory Council.

The Plenary Session of the Mental Health and Addictions Advisory Council consists of a maximum of 90 people, all of them experts and of recognised prestige in the field of mental health and addictions, linked to Catalan universities, to health centres, to the field of primary care, to professional colleges in the field of health sciences, to biomedical research institutions and centres, to scientific societies, to associations of patients and families, and to users' associations.

Figure 2. Structure of the Master Plans

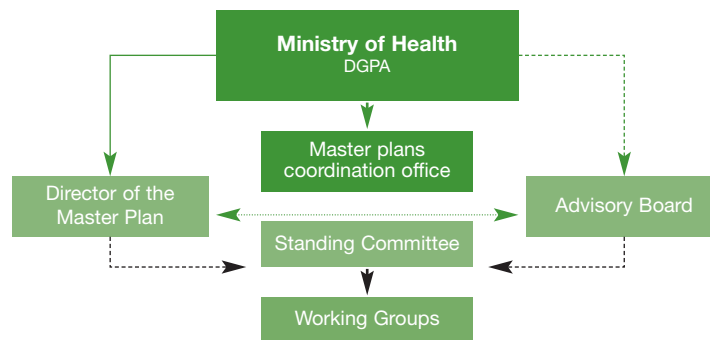


Figure from own sources

For drawing up the Plan, 4 working groups were constituted by age groups, and more than 190 professionals took part. The work was done in different phases: analysis of health, of its determinants and inequalities, analysis of the most prevalent health problems, use of resources, identification of needs, SWOT and matrix of impact, and finally, setting the strategic objectives, the lines of activity and the actions.

4. Situation analysis

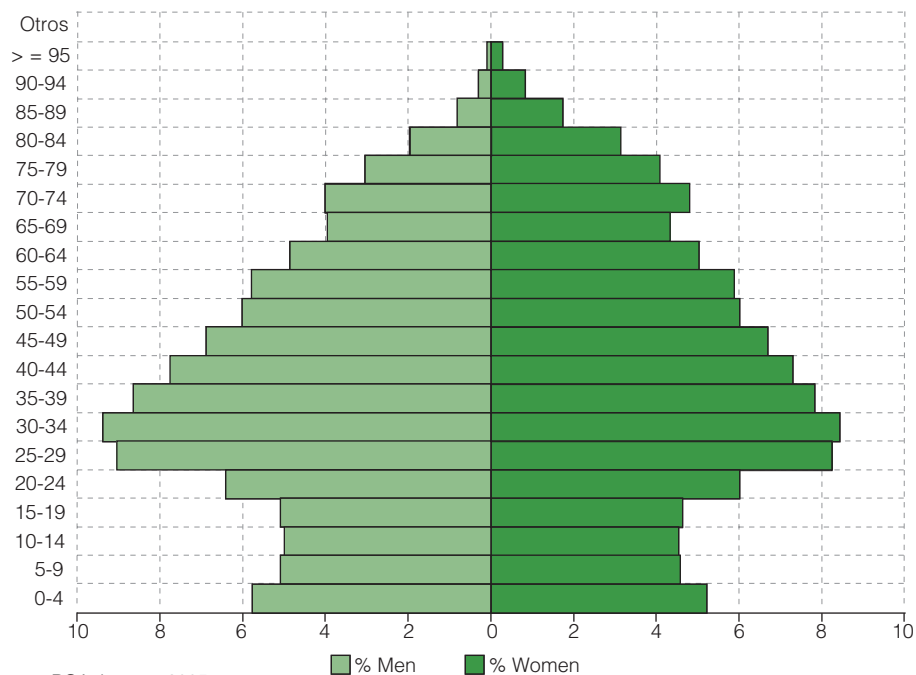
4. Situation analysis

4.1. The demographic situation

Currently, according to the Central Register of Users of the Catalan Health Service, the population of Catalonia exceeds 7 million inhabitants (women 3,610,692 and men 3,494,632) of whom 16.8% are already aged 65 or above.

The distribution by age groups (graphic 1) shows that 15.11% of the total are under 15 and 16.8% are 65 or above, which means that a population pyramid is being established which has as many people under 15 (15.11%) as people of 64 or above (16.8%).
Graphic 1. Population pyramid

Graphic 1. Population pyramid



The Barcelona region, which includes a large part of the metropolitan area (Barcelona city, part of the former centre, Barcelon s Nord, and Maresme and Costa de Ponent regions), contains almost 70% of the total Catalan population (69.21%) while the rest is distributed mainly in Tarragona, especially if the Terres de l'Ebre (9.57%) and Girona (8.99%) are added.

Demographic predictions show that at the end of the first decade of the 21st century in Catalonia, more than one and a half million people will be more than 65 years old. In any of the scenarios considered, the accentuation of demographic ageing is one of the most consistent results, a similar phenomenon to what is seen in the countries around us. So, demographic projections in Europe forecast that in 2030 more than 24% of the European population will be aged 65 or over and in Catalonia this percentage is expected to be between 18 and 26%, according to the estimated scenario.

One of the reasons for the progressive ageing of the Catalan population is the increase in life expectancy (LE). In 2003, LE at birth was 80.2 (76.9 years for men and 83.4 for women). These gender differences are maintained at all ages. At aged 65, the life expectancy of the population is still high, but many of the years that people can expect to live will be as dependent on other people to perform everyday activities. (table 8 deleted)

4. Situation analysis

4.2. The demographic situation

The state of mental health in a society is intimately connected with the general state of health and its determinants, but it is also strongly influenced by demographic, social and economic factors and by the care system itself.

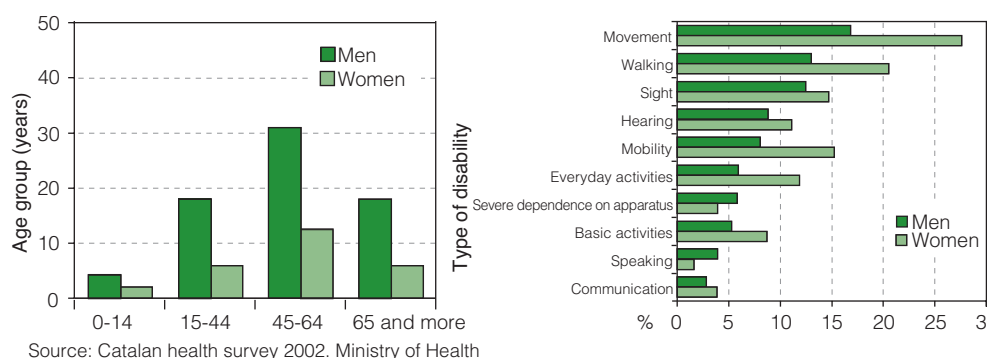
The WHO⁵ stresses the importance of the prevalence of MDs in the population and forecasts that one in every four inhabitants of the planet will suffer some form of mental or neurological disorder in the course of their lives. It also points out that two thirds of those affected by a MD will not go as far as seeking help from a health professional. Among MDs, depression is considered one of the main causes of disability⁶, it is in fourth place among the prime causes of illness and it is expected to be in second place by 2020, after ischemic cardiopathy.

The global burden of mental illness accounts for one third of the total number of years lived with disabilities (WHO, 2001). Four of the six diseases that most commonly cause disabilities are mental disorders, and depression is the third cause at world level, at 12.5%. While to a lesser degree, suicide also contributes to the calculation of the potential years of life lost (PYLL) and represents one of the main causes of premature mortality in young people, and is certainly avoidable. Also according to the WHO⁷, in Europe alcohol is the third risk factor for health (after tobacco and hypertension) contributing to 7.4% (12% for men and 2% for women) of total morbidity. Moreover, mental illnesses are a risk factor for suffering other diseases. Mental health is closely connected to physical health and social functioning.

In Catalonia, 33.2% of men and 43.6% of women of 65 and over have some disability (graphic 2). The proportion of people who state that they have one or more disabilities has shown a considerable increase since the 80s and in all groups it is greater in women than in men.

The disabilities most frequently cited are those connected with the locomotor apparatus, followed in importance by severe impairment of the sight and hearing.

Graphic 2. Population stating a disability by age group and sex and type of disability, Catalonia, 2002



91.7% of men and 96.2% of women aged 65 and over suffer from a chronic disease. After the age of 64, at practically all ages there is a noticeably higher proportion of men

5. World Health Organization. World Health report 2001: mental health: new understanding, new hope. Geneva: WHO, 2001.
 6. Murray CJL, Lopez AD. Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study. *Lancet* 1997; 349: 1498-504
 7. The World Health Report 2002. Reducing risks, promoting healthy life. Geneva; World Health Organization; 2003.

who have no chronic disease and it is women who suffer from them in the greatest numbers. Likewise, it can be seen that the proportion of women who make a negative assessment of their health is higher than that of men, whether or not in the presence of one or more disabilities and/or chronic diseases.

The International Labour Organization (ILO), in its report on mental health in the work sphere drawn up in 2000, points out the increase in the incidence of mental health problems, which affect 10% of workers, and lead to absenteeism, disability for work, and job loss.

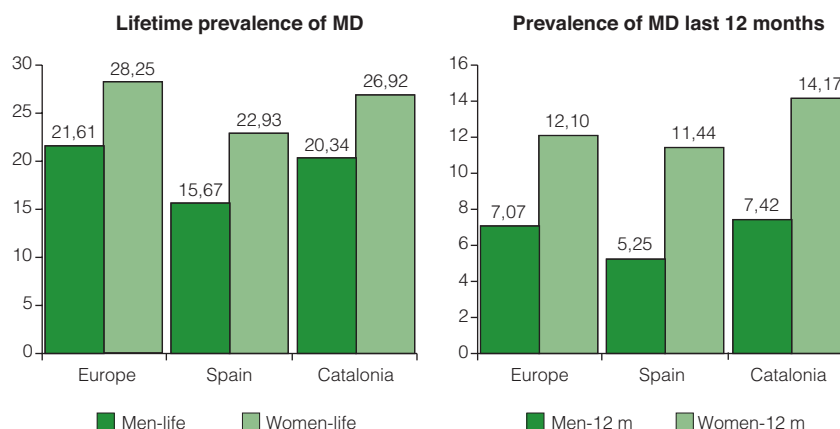
At macroeconomic level, the direct costs of mental health problems are estimated at around 3%-4% of GDP. The indirect costs at the level of lost productivity and other social costs are enormous.

In 2002 the estimated prevalence of MD from the results of the Catalan health survey⁸ (ESCA 2002) and measured as a probability of being a case according to the General Health Questionnaire-GHQ-12⁹, is 17.9% in the population of 15 years and over (20.0% in women and 15.6% in men).

By age group and sex, the probability of suffering from MD is higher in women of all age groups. According to social class, a greater prevalence of the probability of MD is observed in the more disadvantaged classes and especially in the women of these classes.

The prevalence for any disorder and any age in a lifetime is 20.34% for men and 26.92% for women, and 7.42% and 14.17% respectively for the prevalence/year according to the ESEMeD-Spain study, which forms part of a European project on the epidemiology of MD carried out in six European countries: Belgium, France, Germany, Italy, the Netherlands and Spain. In Catalonia, being a part of this project, the SAMCAT study was performed, with 1,647 people interviewed of the total of the Spanish sample (graphic 3).

Graphic 3. Prevalence of mental disorder by sex in Europe, Spain and Catalonia 2002



Graphic own preparation. Source: ESEMeD, 2002.

8. Generalitat de Catalunya. Departament de Sanitat i Seguretat Social. La salut i els serveis sanitaris a Catalunya: la visió dels ciutadans l'any 2002. Barcelona: Departament de Sanitat i Seguretat Social, 2003.
9. Goldberg DP, Cooper B, Eastwood Mr, Kedward HB, Shepherd M. A standardized psychiatric interview for use in community surveys. Br J Prev Soc Med 1970; 24: 18-23.

4. Situation analysis

According to this study, the lifetime prevalence of major depression is 15.2%, and 6.5% in the last twelve months. Anxiety disorders are 11.3% and 6.4%, respectively. With regard to sex, there is a considerably greater prevalence of these disorders among women, with rates that double and even triple those of men (table 1).

Table 1. Lifetime prevalence* of mental disorders and prevalence at twelve months, by sex. Catalonia 2002

| | Lifetime | | | At 12 months | | |
|--------------------------------|------------------------|------------------------|------------------------|---------------------|------------------------|---------------------|
| | Men | Women | Total | Men | Women | Total |
| Any mental disorder | 20,34 (16,87-23,81) | 26,92 (23,62-30,21) | 23,73 (1,27-26,19) | 7,42 (5,18-9,66) | 14,17 (11,42-16,92) | 10,9 (9,1-12,69) |
| Any mood disorder | 11,31 (8,8-13,83) | 20,39 (17,48-23,3) | 15,99 (14,05-17,93) | 4,14 (2,53-5,74) | 9,23 (7-11,46) | 6,76 (5,37-8,15) |
| Any anxiety disorder | 7,6 (5,11-10,09) | 14,85 (12,18-17,52) | 11,34 (9,45-13,22) | 3,41 (1,79-5,03) | 9,22 (7,04-11,4) | 6,41 (5,02-7,79) |
| Major depression | 10,83 (8,33-13,33) | 19,24 (16,46-22,03) | 15,17 (13,29-17,05) | 3,94 (2,35-5,53) | 8,92 (6,71-11,12) | 6,51 (5,14-7,87) |
| Dysthymic disorder | 3,07 (1,72-4,41) | 7,08 (5,29-8,86) | 5,13 (4-6,27) | 0,91 (0,18-1,63) | 3,15 (1,78-4,51) | 2,06 (1,25-2,87) |
| Generalised anxiety disorder | 1,96 (0,79-3,13) | 5,36 (3,81-6,91) | 3,71 (2,75-4,67) | 0,33 (0-0,73) | 3,15 (1,92-4,38) | 1,78 (1,13-2,43) |
| Social phobia | 1,28 (0,12-2,44) | 2,05 (0,89-3,22) | 1,68 (0,81-2,55) | 0,79 (0-1,84) | 1,33 (0,38-2,27) | 1,07 (0,29-1,84) |
| Specific phobia | 2,4 (1,08-3,71) | 4,51 (3,08-5,95) | 3,49 (2,48-4,49) | 0,82 (0,07-1,57) | 2,83 (1,64-4,02) | 1,86 (1,15-2,57) |
| Post-traumatic stress disorder | 1,12 (0,19-2,04) | 2,2 (0,98-3,43) | 1,68 (0,92-2,44) | 0,65 (0-1,35) | 0,9 (0,08-1,72) | 0,78 (0,25-1,32) |
| Agoraphobia | 0,55 (0-1,14) | 1,41 (0,49-2,32) | 0,99 (0,45-1,54) | 0,55 (0-1,14) | 1,32 (0,42-2,22) | 0,95 (0,41-1,49) |
| Panic disorder | 1,46 (0,61-2,3) | 4,98 (3,39-6,57) | 3,27 (2,36-4,18) | 0,46 (0,04-0,89) | 2,94 (1,71-4,18) | 1,74 (1,07-2,41) |
| Alcohol abuse | 6,8 (4,56-9,04) | 1,52 (0,59-2,46) | 4,08 (2,82-5,34) | 1,33 (0,34-2,32) | 0,19 (0-0,56) | 0,74 (0,23-1,26) |
| Alcohol dependence | 2,05 (0,74-3,36) | 0,42 (0-0,95) | 1,21 (0,51-1,9) | 0,32 (0-0,71) | | 0,16 (0-0,35) |

* Adjusted proportions and confidence intervals.

Source: Epidemiología de los trastornos mentales en España: métodos y participación en el proyecto ESEME-España. Actas Españolas de Psiquiatría (in press).

Graphic own preparation. Source: ESEMeD, 2002.

Among people who have suffered from an affective disorder (major depression) during the last twelve months, 55.4% have consulted a health professional for this reason and among those who suffered from an anxiety disorder this figure was 43.7%.

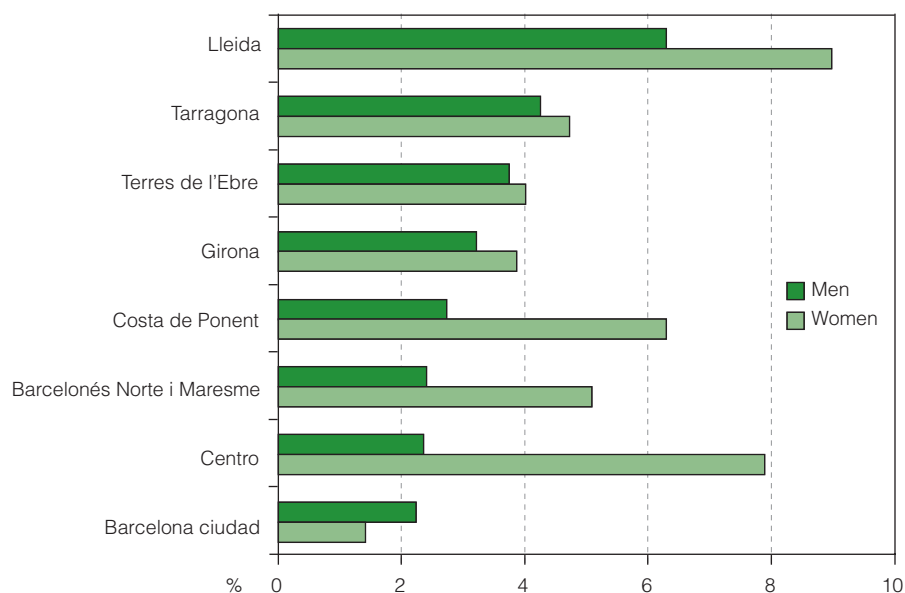
The prevalence of alcohol-related disorders (abuse and dependence) shown in this study are very low compared with for example the data obtained in the NESARC¹⁰ study, in which the prevalence of alcoholism during the last 12 months was 8.46%, it

10. Grant BF, Stinson FS, Dawson DA, Chou SP, Dufour MC, Compton W, Pickering RP, Kaplan K. Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders. Arch. Gen. Psychiatry 2004; 61: 807-816.

being the most prevalent psychiatric disorder after anxiety disorders and affective disorders. Similarly, a recent WHO¹¹ study estimates the prevalence of alcohol dependence disorder in Europe at 5% in the case of the men and 1% in women.

The latest data obtained in the 2002 Catalan health survey show that between 4.5% (6.6% of men and 2.5% of women)¹² of Catalans over 14 are risk drinkers, that is to say they consume more than 40g of alcohol a day in the case of men and more than 24g in the case of women, and have an increased risk of suffering diseases, accidents, injuries or mental or behavioural disorders. Both in men and in women, the greatest prevalence of risk consumption is observed between the ages of 45 and 64, whereas the group of 65 and over is the one that presents the lowest risk consumption. The highest risk consumption of alcohol is found in the regions of Terres de l'Ebre and Girona, while the lowest is in Barcelonès Nord and Maresme (graphic 4).

Graphic 4. Risk consumption of alcohol by health region and sex. Catalonia, 2002



Source: Catalan health survey 2002. Ministry of Health

According to the Catalan health survey, risk consumption is abnormally low considering that other studies¹³ estimate risk consumption in Europe to be around 15% of the adult population.

Different sources of information provide an idea of the epidemiological dimension of non-institutionalised drug use in Catalonia, and they confirm an increasing trend in the use of some drugs (graphics 5 and 6), such as the cannabis derivatives and cocaine, as well as the strong growth of the health problems associated with cocaine use and the maintenance of a high demand for care by consumers of opiates, in spite of the probable stabilisation of their consumption.

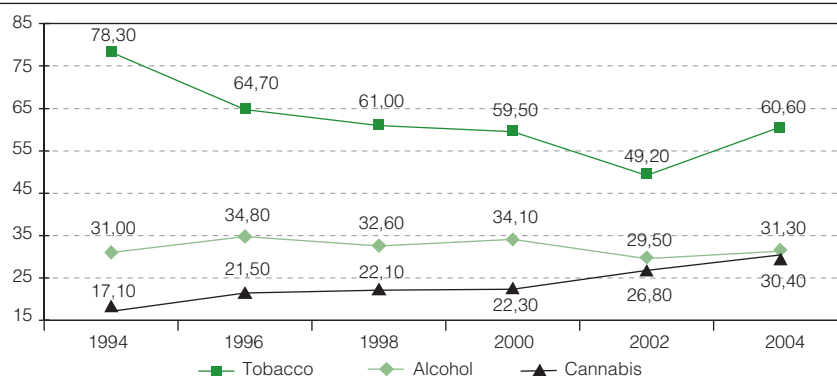
11. Rehm, J., R. Room, M. Monteiro, G. Gmel, K. Graham, N. Rehn, C. T. Sempos, U. Frick, and D. Jernigan (2004). "Alcohol." Comparative quantification of health risks: Global and regional burden of disease due to selected major risk factors, Edited by M. Ezzati, A. D. Lopez, A. Rodgers, and C. J. L. Murray. Geneva: WHO.

12. Generalitat de Catalunya. Departament de Sanitat i Seguretat Social. La Salut i els Serveis Sanitaris a Catalunya. La visió dels ciutadans l'any 2002. Barcelona: Direcció General de Salut Pública, 2003.

13. Rehm, J., R. Room, M. Monteiro, G. Gmel, K. Graham, N. Rehn, C. T. Sempos, U. Frick, and D. Jernigan (2004). "Alcohol." Comparative quantification of health risks: Global and regional burden of disease due to selected major risk factors, Edited by M. Ezzati, A. D. Lopez, A. Rodgers, and C. J. L. Murray. Geneva: WHO.

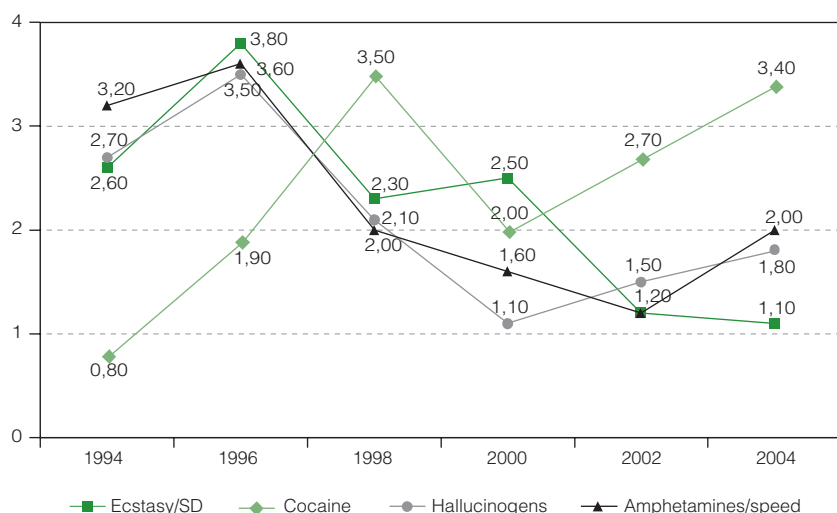
4. Situation analysis

Graphic 5. Evolution of the prevalence of tobacco, alcohol and cannabis consumption in the last 30 days (1994 - 2004)



Source: Schools survey. Ministry of Health.

Graphic 6. Evolution of the prevalence of consumption of other addictive substances in the last 30 days (1994 - 2004)



Source: Schools survey. Ministry of Health

The evolution of the prevalence of consumption of addictive substances among the school population aged 14 to 18 in Catalonia shows that alcohol is the most consumed substance, followed by tobacco, cannabis and cocaine. According to the same source, in this period (1994-2004) an increase was observed in the habitual consumption of cannabis, which is at a similar level to tobacco consumption. Sporadic and habitual cocaine consumption continues in an ascending line and the consumption of ecstasy is falling.

In terms of the evolution of substance use among the general population (aged 15-64), it is seen that alcohol and tobacco are the most consumed substances, followed by cannabis. The consumption of cocaine continues to grow and, in the 15-29 age range, a similar consumption pattern can be observed to that obtained in the school population aged 14 to 18.

The most recent report from the Catalan Observatory of New Consumption among Young People, 2003, shows some social changes that could be influencing the consumption patterns of substances such as competitiveness as a value, the increase in the stage of youth, the lengthening of the weekend, the importance of consumerism in western society and the search for immediate results.

4.3. Mortality

The mortality analysis (table 2), with regard to the causes most closely connected with mental health, shows that in Catalonia in 2003, the specific mortality rate from mental and behavioural disorders (MBD), in the 20 large groups of causes of death, is 53.15 deaths per 100,000 inhabitants, (13.8% more than in 2002).

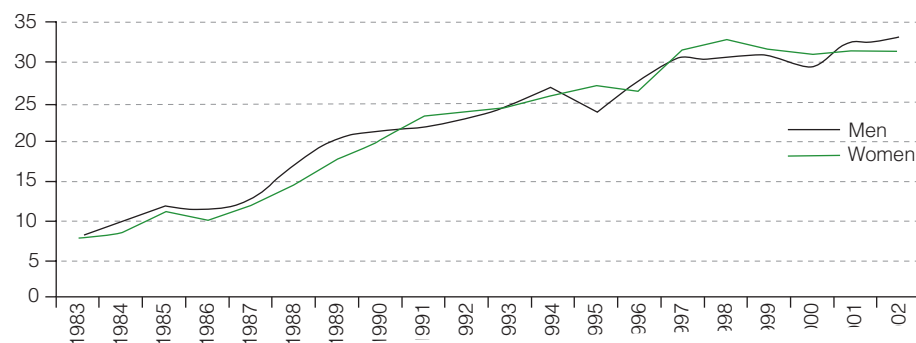
Between 1983 and 2002, deaths from MBD underwent a very considerable increase, and the progressive ageing of the population is one of the fundamental causes, as it largely affects people aged over 64 (graphic 7).

Table 2. Specific mortality rates for mental disorder, senile dementia, Alzheimer's disease, suicide and self-harm by age groups and sex (x100,000 inhab.) Catalonia, 2003

| | <1 | 1-4 | 5-14 | 15-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75-84 | > 84 | Total |
|---|----|-----|------|-------|-------|-------|-------|-------|-------|--------|----------|-------|
| Cause 37. Mental Disorders | | | | | | | | | | | | |
| Women | 0 | 0 | 0,35 | 0,78 | 1,24 | 0,98 | 0,69 | 1,13 | 3,91 | 25,02 | 148,75 | 6,60 |
| Men | 0 | 0 | 0 | 1,73 | 5,61 | 7,44 | 3,77 | 7,12 | 9,29 | 21,64 | 108,36 | 6,72 |
| Total | 0 | 0 | 0,17 | 1,27 | 3,51 | 4,26 | 2,21 | 4,06 | 6,37 | 23,68 | 136,86 | 6,66 |
| Cause 38. Senile dementia, vascular dementia and non-specific dementia | | | | | | | | | | | | |
| Women | 0 | 0 | 0 | 0 | 0,18 | 0 | 0,23 | 1,98 | 17,75 | 237,27 | 1.781,40 | 63,75 |
| Men | 0 | 0 | 0 | 0 | 0,17 | 0,19 | 0 | 1,19 | 22,15 | 250,19 | 1.337,44 | 28,68 |
| Total | 0 | 0 | 0 | 0 | 0,17 | 0,10 | 0,12 | 1,59 | 19,76 | 242,38 | 1.650,69 | 46,49 |
| Cause 39. Alzheimer's disease | | | | | | | | | | | | |
| Women | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,27 | 28,28 | 209,33 | 766,35 | 37,28 |
| Men | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,26 | 22,15 | 150,24 | 507,60 | 15,02 |
| Total | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,75 | 25,48 | 185,94 | 690,16 | 26,33 |
| Cause 71. Suicide and self-harm | | | | | | | | | | | | |
| Women | 0 | 0 | 0,35 | 1,83 | 2,49 | 4,91 | 5,76 | 3,97 | 2,71 | 7,09 | 8,33 | 3,56 |
| Men | 0 | 0 | 0,33 | 6,18 | 8,42 | 12,59 | 11,79 | 13,34 | 16,44 | 24,83 | 45,63 | 10,45 |
| Total | 0 | 0 | 0,34 | 4,06 | 5,56 | 8,81 | 8,74 | 8,55 | 8,98 | 14,11 | 19,31 | 6,95 |
| Cause 72. Homicide | | | | | | | | | | | | |
| Women | 0 | 0 | 0 | 0 | 1,24 | 0,39 | 1,38 | 0,28 | 0,60 | 0 | 1,19 | 0,57 |
| Men | 0 | 0 | 0 | 1,24 | 1,49 | 1,53 | 0,94 | 2,08 | 1,07 | 0,64 | 0 | 1,14 |
| Total | 0 | 0 | 0 | 0,63 | 1,37 | 0,97 | 1,17 | 1,16 | 0,82 | 0,25 | 0,84 | 0,85 |

Source: Servei d'Informació i Estudis. Directorate General of Health Resources. Ministry of Health.

Graphic 7. Evolution of mortality from MD. Catalonia, 1983-2002



Standardised rates per 100,000 inhabitants. Until 1999 Alzheimer's disease was included in this group.

Source: Ministry of Health. Register of Deaths.

The evolution of mortality from suicide and self-harm shows an increase in the rates for men, so during the period 1983-2002 the differential between the rates for both sexes increased. Mortality from suicide is almost four times as frequent in men as in women.

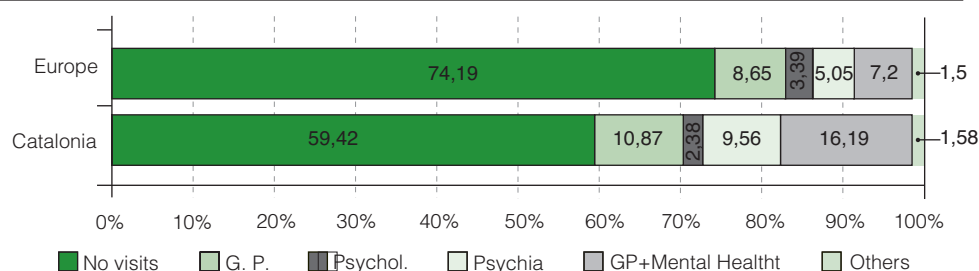
4. Situation analysis

4.4. Use of services and attended morbidity

The factors that influence the demand for services by people with some kind of mental disorder or addiction are far from clear. Self-perception of the disorder and the subjective attribution of a cause, the personal threshold between what is normal and what is pathological, the intersection with the physical symptoms, and the filter (the diagnostic and resolutive ability) of the GP are very significant factors¹⁴. In serious cases, the stigmatisation associated with mental illness and addictions could also have an important role in the concealment by the patient and the family of the condition.

In the European ESEMeD study, the most recent on the prevalence of mental disorders in the general population, it was shown that in Catalonia, of the total number of people who had shown some mental disorder in the last year, 59.42% had not contacted a health professional in the same period, while in Europe that percentage was 74.19%. Among people who had suffered from a mood disorder (major depression) in the last twelve months, 55.4% had consulted a health professional for this reason and among those who had suffered from an anxiety disorder the figure was 43.7% (graphic 8).

Graphic 8. Distribution of the population with any MD in the last year, according to the health care received in the last year. Catalonia 2002



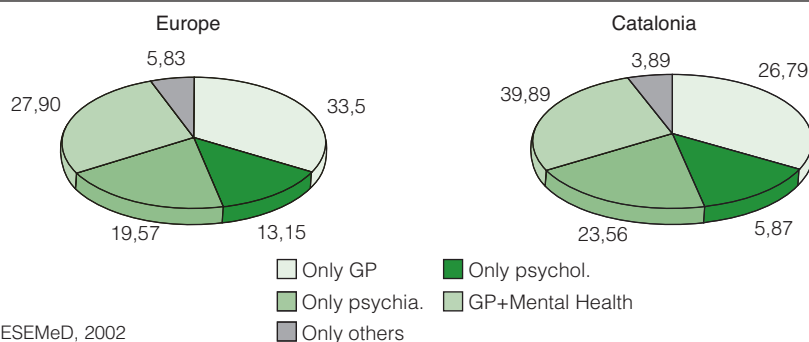
Source: ESEMeD, 2002

As can be seen in the case of Catalonia, 10.87% of people with mental disorders had made at least one contact with primary health care, whereas the European average was 8.65%. In the case of specialised care, the percentage of people with mental disorders who had made contact was 28.13% in Catalonia and 15.64% in Europe as a whole.

For the total number of people with mental disorders who had made some contact with the health system, the exclusive involvement of the GP was 26.79% in Catalonia against 33.54% in Europe. Only psychological intervention was 5.87% in Catalonia and 13.15% in Europe.

The psychiatrist alone or together with the GP, was involved in 63.45% of the cases in Catalonia, whereas the European average was 47.47% (graphic 9).

Graphic 9. Percentage of use of the different health professionals by people who have suffered a MD in the last year and have been examined by a health professional in the last year. Catalonia 2002



Source: ESEMeD, 2002

The above figures are in line with a greater percentage of use of medical drugs in the Catalan environment. The spectacular increase in the prescription of antidepressants following the appearance of SSRIs in the 90s in our environment and in Europe as a whole, now represents a formidable challenge for public health and for health expenditure. If we add to this, as the above-mentioned study and others prove, that depression and mental disorders in general are underdiagnosed and are, moreover, increasing, what is to be expected from this behaviour?

Table 3 shows that among Catalans diagnosed with major depression, 38.9% receive only treatment with drugs, 6.9% psychological treatment¹⁵ and 44.3% both types. Among those diagnosed with anxiety disorders in Catalonia, 39.8% receive only treatment with drugs (40.5% in Spain), 2.4% psychological treatment (1.7% in Spain) and 42.0% both treatments (39.4% in Spain).

Table 3. Use of psychotropic drugs at twelve months, by sex and therapeutic group. Catalonia and Spain, 2002

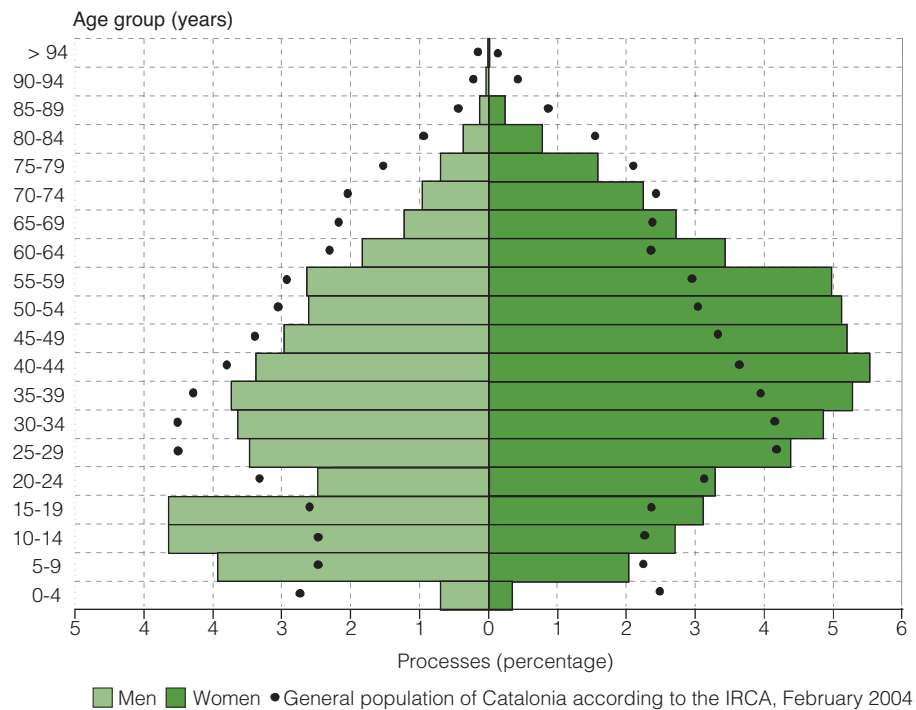
| Drug | n (%) N = 1.645 | | Comparación por sexo OR (IC95%) | |
|--------------------------------|-----------------|--------------|---------------------------------|------------------|
| | Catalonia | Spain | Catalonia | Spain |
| Any psychotropic | 340 (18,72%) | 991 (16,12%) | 2,12 (1,59-2,83) | 2,08 (1,75-2,47) |
| General use | | | | |
| Antidepressant | 119 (6,36%) | 290 (4,69%) | 3,03 (1,87-4,91) | 2,19 (1,55-3,09) |
| Anxiolytic | 247 (13,46%) | 722 (11,42%) | 2,09 (1,49-2,93) | 2,3 (1,86-2,83) |
| Antipsychotic | 32 (1,95%) | 122 (2,15%) | 0,96 (0,44-2,08) | 1,92 (1,23-2,98) |
| Mood stabiliser | 7 (0,27%) | 15 (0,23%) | 1,15 (0,24-5,59) | 0,78 (0,2-3,04) |
| Exclusive use | | | | |
| Only Antidepressant | 44 (19,34%) | 117 (17,85%) | 2,14 (0,97-4,75) | 1,03 (0,58-1,81) |
| Only Anxiolytic | 168 (75,94%) | 527 (73,62%) | 0,83 (0,41-1,67) | 1,19 (0,74-1,91) |
| Only Antipsychotic | 7 (3,72%) | 46 (7,46%) | 0,13 (0,02-0,84) | 0,69 (0,36-1,33) |
| Only Mood Stabiliser | 3 (1,01%) | 6 (1,07%) | 0,52 (0,05-6,06) | 0,37 (0,04-3,08) |
| Combined use | | | | |
| Antidepressant + Anxiolytic | 61 (74,16%) | 136 (69,21%) | 3,43 (1,01-11,61) | 1,06 (0,41-2,72) |
| Antidepressant + Antipsychotic | 6 (9,94%) | 14 (9,07%) | 0,13 (0,02-0,84) | 0,25 (0,06-0,98) |

Source: Haro JM, Palacín C, Vilagut G, Romera B, Codony M, Autonell J, Ferrer M, Ramos J, Kessler R, Alonso J. La epidemiología de los trastornos mentales en España: métodos y participación en el proyecto ESEME-España. Actas Españolas de Psiquiatría (in press).

15. At least one visit to a professional psychologist

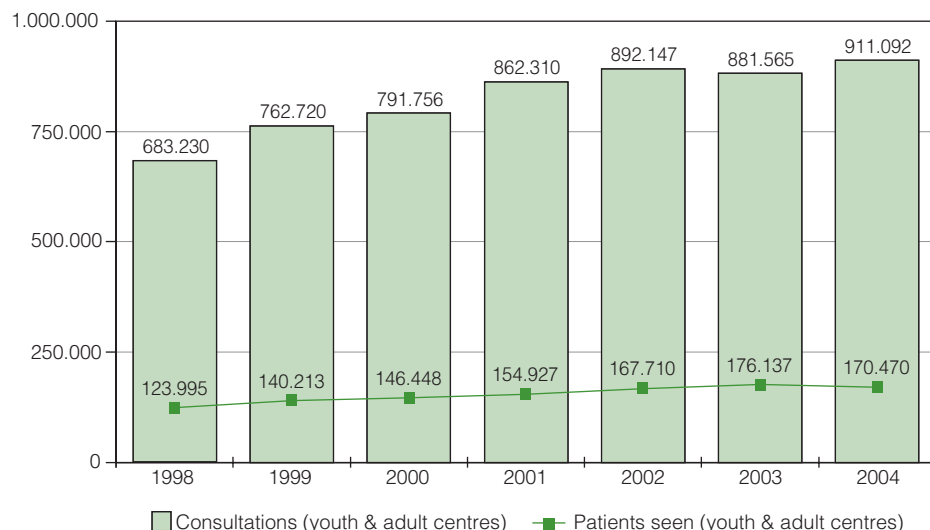
4. Situation analysis

Graphic 10.
Distribution of patients seen in mental health out-patient centres resident in Catalonia and of the population of Catalonia by sex and age group. 2003



In 2004, 170,470 patients were reported as seen by the 91 centres with out-patient psychiatric services in 911,092 consultations both in adult centres (58 centres) and in centres for children and young people (33 centres).

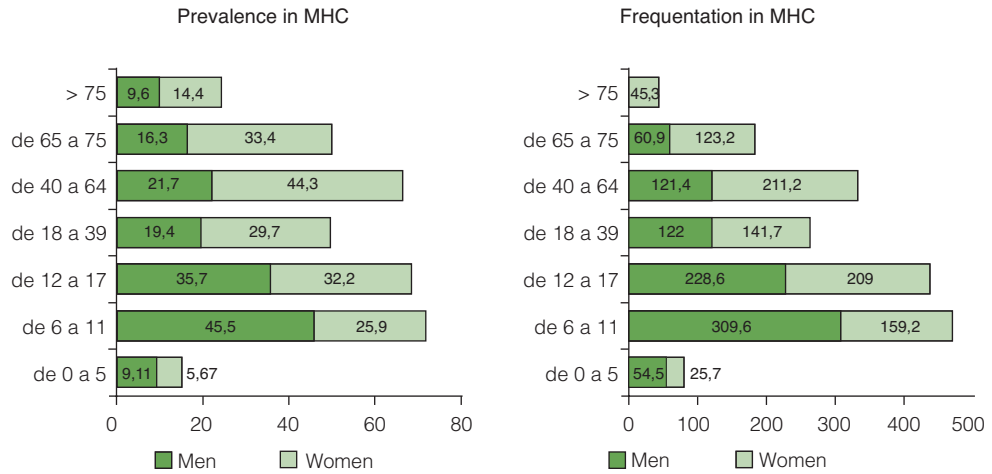
Graphic 11. Evolution of patients seen and consultations (young people's and adult centres)



Graphic own preparation

Sources: Master Plan on Mental Health and Addictions, Health Mapping Unit, CMBDSM and CatSalut reports

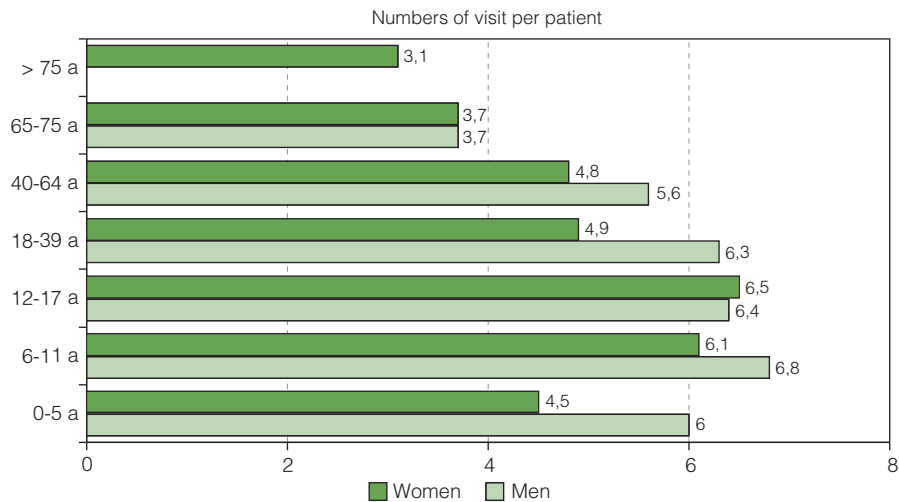
Graphic 12. Prevalence and frequentation in Mental Health Centres in Catalonia by age groups and sex. Catalonia, 2003



Graphic own preparation
Sources: Master Plan on Mental Health and Addictions director CMBDSM

The intensity of the care received is in general a little higher among men, at almost all ages, and falls considerably in the population aged over 65 (graphic 13).

Graphic 13. Consultations by patients in MHC by age groups and sex, 2003



Graphic own preparation.
Sources: Master Plan on Mental Health and Addictions, CMBDSM

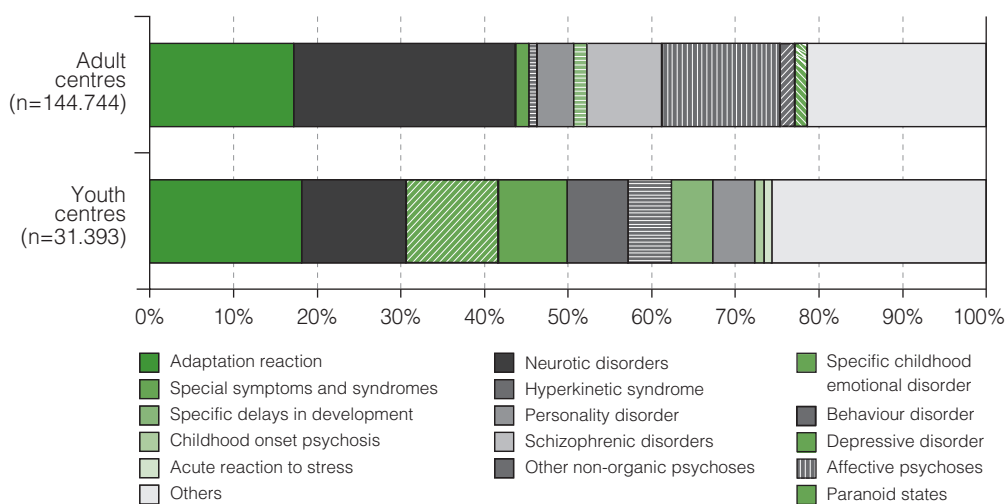
Graphic 14 shows the description of the most prevalent pathologies in centres for children and young people, and for adults. In the children's and young people's centres a great diversity emerges, which would be even greater if an 'other diagnoses' group with 25.8% of the cases had not been made, a percentage that is certainly far greater than for adults.

The diversity factor, and thus the wide range of seriousness that it can show, in such a vital stage of maturation as this, could be a positive factor in the prevention of adult pathologies.

4. Situation analysis

The diagnostic distribution of the adult population seen in the mental health centres shows less dispersion. More than 30% have diagnoses compatible with serious mental disorders, and more than 45% of the cases are neurotic disorders and/or adaptive reactions.

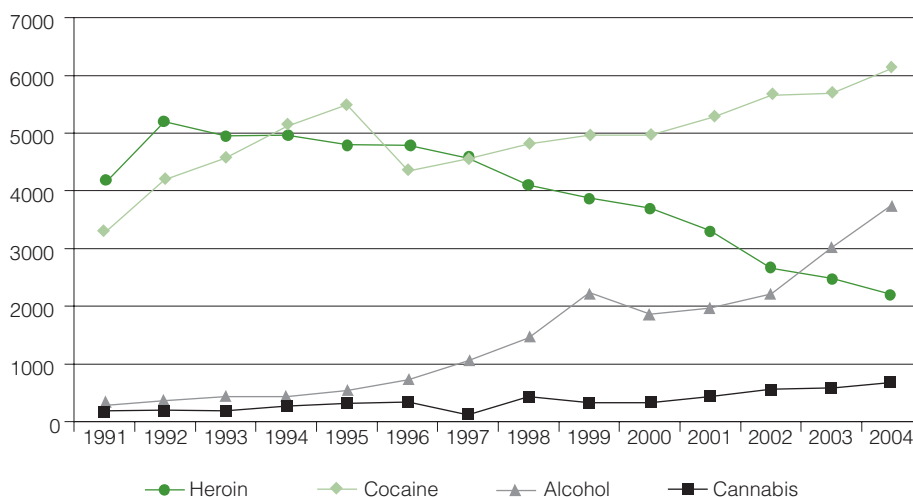
Graphic 14.
Comparison of the diagnostic categories most prevalent in youth and adult mental health centres. Catalonia, 2003



Graphic own preparation. Sources: CMBDSM

Moreover, **graphic 15** shows the evolution of the population starting treatment for substance use, confirming the decline in the consumption of heroin and the increase, with different intensities, of alcohol, cocaine and cannabis.

Graphic 15. Evolution of the start of treatment in care and monitoring centres by principal drug (1991 - 2004)



Graphic own preparation. Sources: SIDC

In terms of hospital morbidity, the number of admissions into specialist psychiatric hospitals and general hospitals with psychiatric services in 2004 was 20,651 (55% men and 45% women), although in 2004 only 89% of the centres with this activity notified the CMBDSM (table 4)

Table 4. Distribution of admissions into psychiatric hospitals and of psychiatric admissions to general acute hospitals in the public hospital network, in the ten most frequent diagnostic categories (according to ICD-9-CM), 2004

| Diagnosis (code CIM-9-MC) | Admissions to psychiatric hospitals | | Psychiatric admissions in general hospitals | | Total | |
|-----------------------------------|-------------------------------------|------|---|------|--------|------|
| | Number | % | Number | % | Number | % |
| Schizophrenic disorders (295) | 3,388 | 30.5 | 948 | 9.9 | 4,336 | 21.1 |
| Affective psychoses (296) | 2,010 | 18.1 | 1,121 | 11.7 | 3,131 | 15.2 |
| Personality disorders (301) | 1,094 | 9.9 | 430 | 4.5 | 1,524 | 7.4 |
| Other non-organic psychoses (298) | 821 | 7.4 | 373 | 3.9 | 1,194 | 5.8 |
| Adaptation reaction (309) | 650 | 5.9 | 265 | 2.8 | 650 | 3.2 |
| Neurotic disorders (300) | 485 | 4.4 | 727 | 7.6 | 1,212 | 5.9 |
| Alcohol-dependence syndrome (303) | 588 | 5.3 | 1,160 | 12.1 | 1,748 | 8.5 |
| Non-drug-dependent abuse(305) | 314 | 2.8 | 278 | 2.9 | 592 | 2.9 |
| Paranoid states (297) | 274 | 2.5 | 77 | 0.8 | 351 | 1.7 |
| Drug-dependence (304) | 183 | 1.7 | 924 | 9.7 | 1,107 | 5.4 |

Source: CMBDAH and CMBDSM. CatSalut. Report of activity 2004

The general activity, as well as the care resources, can be seen in table 29 from 1998 to 2003.

4.5. Health care resources

In 2005 the health care resources for mental health and addictions in the Catalan public network were as shown in table 5.

Table 5. Resources for mental health and drug dependence in Catalonia (2005)

| LEVEL OF CARE | Children and young people (<18) | | Adults (>18) | |
|--|---------------------------------|-------------|-----------------------------|-------------|
| | 1,346,872 inhab. (RCA 2005) | | 5,753,195 inhab. (RCA 2005) | |
| | N | Ratio | N | Ratio |
| Mental Health Centres (ratio per 100,000 inhab) | 46 centres | 3.42 | 73 centres | 1.27 |
| Day Hospitals (places per 10,000 inhab.) | 256 places | 1.90 | 422 places | 0.73 |
| Community Rehabilitation Services (places per 10,000 inhab.) | | | 1,625 places | 2.82 |
| Acute psychiatric hospitalisation / includes children's and adolescent units (beds per 10,000 habitants) | 100 beds | 0.74 | 779 | 1.35 |
| Subacute psychiatric hospitalisation / includes adolescent and subacute units and community in-patient beds (beds per 10,000 inhab.) | 20 beds | 0.15 | 512 beds | 0.89 |
| Long-stay psychiatric hospitalisation (beds per 10,000 habitants) | | | 2,897 beds | 5.04 |
| Care and monitoring centres (ratio per 100,000 habitants) | | | 61 centres | 1.06 |
| Hospital detoxification units (places per 100,000 habitants) | | | 64 beds | 1.01 |
| Therapeutic communities (places per 100,000 inhab.) | | | 337 places | 5.31 |

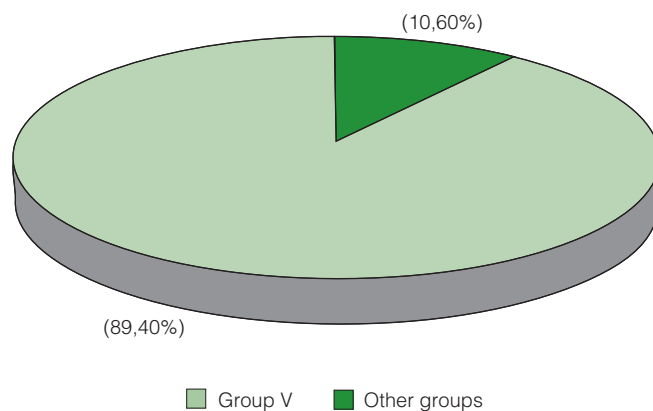
Table own preparation

4.6. Financial analysis. Estimated expenditure 2006

According to a study carried out recently¹⁶ in Catalonia, the care of patients suffering mental disorders means an expense of approximately 10.6% of the Ministry of Health's budget (purchase of services from CatSalut and consolidated ICS budget for 2006). This study analysed the expenditure generated by the diseases included in group V of ICD-9-CM (*International Classification of Diseases - 9th Revision- Clinical Modification*) and which covers mental illness, and also addictions, Alzheimer's disease and dementia.

16. Gisbert, R, Brosa M. Avaluació de la participació dels Plans Directors en la despesa sanitària del CatSalut. Barcelona, July 2006.

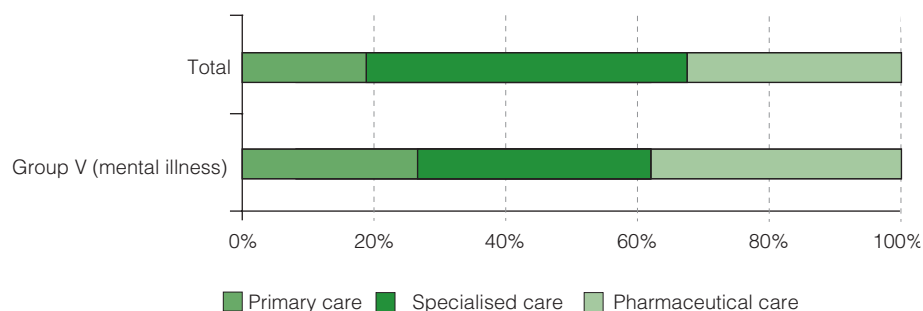
Graphic 16. Relative weight of the cost of caring for mental health problems in the total purchasing budget for services, 2006 (CatSalut - ICS)



Graphic own preparation. Source of data: Avaluació de la participació dels Plans Directors en la despesa sanitària del CatSalut (July 2006)

A more detailed analysis of this expenditure shows that 26.2% is allocated to primary care (general and specialised and rehabilitation services), 36.3% to specialised care (hospitalisation), and 37.5% to pharmaceutical care (graphic 17).

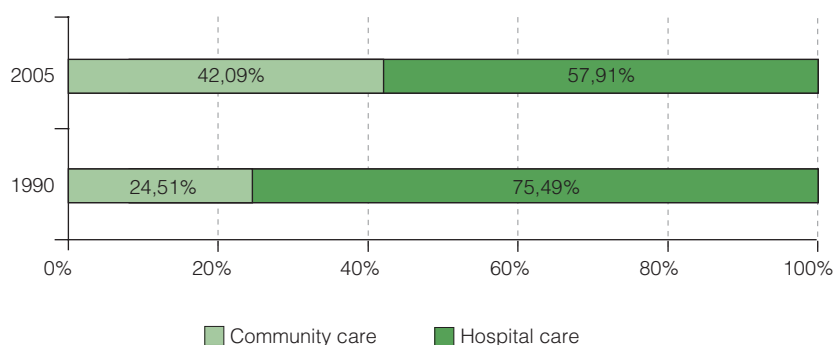
Graphic 17. Comparative distribution of mental health expenditure in relation to the global budget for services, 2006 (CatSalut - ICS)



Graphic own preparation. Source of data: Avaluació de la participació dels Plans Directors en la despesa sanitària del CatSalut (July 2006)

Finally, mention must be made of the effort that has been made since 1990 to change the weight that hospital care had hitherto had in dealing with mental illness and to advance towards a community-care model (graphic 18).

Graphic 18. Distribution of the public mental health budget (1990 vs 2005)



Graphic own preparation. Source of data: Ministry of Health – DGPA / Master Plan on Mental Health and Addictions

5. Strategic proposals

5. Strategic proposals

Based on an analysis of the situation and the review of the **opportunities** and **threats** of the environment, as well as the **strengths** and **weaknesses** of the system, the Master Plan on Mental Health and Addictions has structured its proposals into 10 strategic objectives, which are organised **vertically and transversally**.

Each of these objectives contains different **lines of action** that are developed through specific **operational objectives**, set out below.

Strategic objectives of the Master Plan on Mental Health and Addictions:

1. Promotion of mental health and prevention of mental disorders and addictions
2. Improved care of mental disorders and addictions in Primary Health Care (PHC)
3. Incorporation of a portfolio of services oriented to the needs of users on a territorial basis
4. The voice of the people affected: improving their involvement and achieving the network's commitment to their rights
5. The voice of the professionals: achieving their involvement and their improved satisfaction
6. Promoting the integrated functional organisation of mental health and addictions care networks
7. Favours the improvement of the management systems with the involvement of the providers
8. Encouraging continual training and the postgraduate teaching system
9. Strengthening epidemiological and clinical research, the evaluation of the services, and European co-operation
10. Ensuring the management of change

| 1. Promotion of mental health and prevention of mental disorders and addictions | |
|---|---|
| Line | Projects |
| <i>Line 1. Promoting mental health protection factors</i> | <ul style="list-style-type: none"> • Guide to health promotion and education activities in Primary Care Centres (PCC). • Interventions in nursery schools and primary schools (parenting schools), mother and child units and the world of leisure. • Creation of a Permanent Commission for the promotion of mental health. |
| <i>Line 2. Promoting the prevention of mental disorders and addictions at community level from an intersectorial and interdisciplinary standpoint with the active participation of users and their families</i> | <ul style="list-style-type: none"> • Support programme for parents starting in pregnancy, especially in risk populations (e.g. consuming mothers). • Mental health protocol of the Healthy Child Monitoring Programme. • Health and School Programme. |
| | <ul style="list-style-type: none"> • Early detection in Primary Care of adolescent psychopathology and substance use, warning symptoms and individual and family background. • Facilitation programme for youth access to consultation services. • Health and School Programme. • Community programme for the prevention of consumption of alcohol and other drugs. • Media cooperation project on direct and indirect advertising of alcohol and tobacco. • Educational awareness-raising programme to increase the perception of risk surrounding drug consumption. |
| | <ul style="list-style-type: none"> • Prevention programme in the work place. • Prevention of risk behaviours connected with the consumption of drugs at university. • Encouraging awareness-raising interventions with regard to the consumption of alcohol and other drugs in the leisure sphere and especially at night. • Publicising social marketing strategies to increase the perception of risk of the consumption of alcohol and other drugs. |

5. Strategic proposals

| Line | Projects |
|---|--|
| | <ul style="list-style-type: none"> • Information and training of different social agents involved in depression, anxiety, severe mental disorders, alcoholism and dementia in elderly people. • Awareness-raising of the security services about isolated or mistreated elderly people. • Awareness-raising and support of the carers of elderly people. • Awareness-raising in the media, community services and with the local public authorities, with respect to the fight against stigma. • Educational awareness-raising project in secondary schools (Health and School Programme), with respect to the fight against stigma. |
| <p><i>Line 3. Prevention of mental disorders, addictions and other risk behaviours related to the consumption of drugs in particularly vulnerable populations</i></p> | <ul style="list-style-type: none"> • Prevention project aimed at premature babies. • Prevention project for mental disorders and addictions for children of parents with mental illness and/or addictions. • Project for prevention, detection and early care of mistreated and/or abused children. • Project for prevention, early detection and intervention for children and adolescents who are doing badly at school. • Project for prevention and early detection of early pre-adolescent consumers. • Project for prevention and early detection aimed at immigrant children and children of immigrants at psychosocial risk. |
| | <ul style="list-style-type: none"> • Setting up prevention programmes aimed at adolescents with eating disorders, with prepubertal psychosis, with behavioural disorders, who are consumers of toxic substances, and with a pathologic addiction to gambling. • Project for prevention, early detection and care for drugs consumption and other associated risk behaviours in young people appearing in juvenile courts. |
| | <ul style="list-style-type: none"> • Project for prevention and early detection aimed at the following groups: <ul style="list-style-type: none"> • abused women. • the immigrant population. • the homeless. • Families who care for people with disabilities. • Programmes against the social exclusion of drug users. • Care programme for drug dependence in prisons. |
| | <ul style="list-style-type: none"> • Programmes to combat isolation. • Programmes for special care of elderly people with somatic disease and mental illness (multi-pathology). |

| 2. Improved care of mental disorders and addictions in Primary Health Care (PHC) | |
|--|---|
| Line | Projects |
| Line 1. Specific portfolio of services in mental health and addictions in primary care | <ul style="list-style-type: none"> • Clinical guidelines adapted for the most prevalent pathologies. • Screening protocol for risk consumption of alcohol ("Drink Less" Programme). • Inclusion of group activities (therapeutic and educational groups, relaxation groups, mutual assistance groups and others), therapeutic counselling, family support and short or conflict resolution therapy. • Immediate care programme for people suffering adaptive disorders linked to stressful social events or catastrophic situations. |
| | <ul style="list-style-type: none"> • Promoting continual training and competencies in mental health. • Appointing a team of professional specialists (psychiatrists, psychologists, qualified nurses) for support in primary care. • Drawing up a portfolio of mental health and addictions services. • Specific care and monitoring programme in PHC of the physical health of people with chronic mental illness. • Specific care and monitoring programme in PHC for the population with risk alcohol consumption ("Drink Less" Programme). |

| 3. Incorporation of a portfolio of services oriented to users, territorially-based | |
|--|--|
| Line | Projects |
| Line 1. Ensuring that the portfolio of mental health and addictions services is really oriented to users and their families, while encouraging a more active and community-based model of intervention | <p>Guaranteeing crisis intervention and home care.</p> <ul style="list-style-type: none"> • Improving the care of people with severe mental disorders. • Improving the care of children and adolescents with serious mental disorders. • Mental health teams to support the medical emergency services. • Application of the "Action protocol for care in emergencies, transfer and involuntary urgent admissions of people with mental illness", with the cooperation of the security forces. |
| | <p>Prioritising care for incipient psychosis and for the child and youth population with serious mental disorders.</p> <ul style="list-style-type: none"> • Generalisation of specific care programmes to the child and youth population with serious mental disorders. • Programmes for care of incipient psychosis in the framework of the new portfolio of services of the Mental Health Centres (MHC). • Multipurpose team with rapid response capacity for care of people with incipient psychosis. |
| | <p>Improving the specialised care of vulnerable populations.</p> <ul style="list-style-type: none"> • Adapting psychiatric care programmes to homeless people. • Creation of nuclei of expertise as territorial reference in the care of the immigrant population. • Extending the range of out-patient psychiatric services for people with learning disabilities (SESM-DI) and people with impaired intelligence. • Specific care Programme for abused women. • Inclusion project for people with disabling mental disorders (MD) and persistent symptoms in the Dependence Agency. |
| | <p>Guaranteeing support for families and recognition as principal carer and link with the surroundings.</p> <ul style="list-style-type: none"> • Family support programmes. • Psycho-educational family groups. • Encouraging people affected to join associations. |

5. Strategic proposals

| Line | Projects |
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| | <p>Inclusion of psychotherapy provision in the public network</p> <ul style="list-style-type: none"> • Creating an accreditation system for psychotherapy programmes. • Including psychotherapeutic actions in the functional plans of the different services of the specialised networks. <hr/> <p>Enhancing psychosocial rehabilitation in the services of the public network</p> <ul style="list-style-type: none"> • Including rehabilitation actions in the functional plans of the different services of the specialised networks. <hr/> <p>Adjusting the use of the available services to the individual needs of the patient according to a case-management model.</p> <ul style="list-style-type: none"> • Generalisation of the Individualised Services Plan (case-management) and extension of it to the adolescent population with serious mental disorders and to people with chronically evolving addiction problems. • Joint programmes of youth and adult MHCs to guarantee the continuity of care of adolescents and young people with SMD. |
| <p><i>Line 2. Improving the portfolio of services to deal with priority health problems.</i></p> | <p>Improving the portfolio of services for pervasive development disorders (PDD).</p> <ul style="list-style-type: none"> • Project for the care of pervasive development disorders, establishing relationships of cooperation with schools. • Preparation or validation of clinical guidelines for the care of PDD. • Programme for care and support of families of people affected by PDD. <hr/> <p>Improving the portfolio of services for attention deficit hyperactivity disorder (ADHD).</p> <ul style="list-style-type: none"> • Project of preparation or validation of a clinical guide to pharmacological, psychological and psychosocial treatments. • Programme for detection and intervention in substance abuse. • Programme for care and support for the families of people affected. • Cooperation with schools in psycho-educational care. <hr/> <p>Improving the portfolio of services for behavioural disorders in adolescents.</p> <ul style="list-style-type: none"> • Preparation or validation of clinical guidelines. • Coordination with schools for early detection and referral to the specialist services. • Alternative project to normal schooling. • Programmes for care of comorbidity with substance use. • Specific intensive out-patient intervention programmes in day hospitals. • Programme for care and support for the families of people affected. <hr/> <p>Improving the portfolio of services for eating disorders.</p> <ul style="list-style-type: none"> • Plan for reorganising the care of people with eating disorders (ED). <hr/> <p>Improving the care of people with attempts at self-harm.</p> <ul style="list-style-type: none"> • Protocol for detection and specific care of suicide attempts. • Register of cases. <hr/> <p>Improving the portfolio of services in relation to the care of people with psychotic disorders</p> <ul style="list-style-type: none"> • Generalisation of the SMD programme to childhood and adolescence. • Programme for specific care of incipient psychosis. • Specific intensive out-patient intervention programmes in day hospitals. • Programme for care and support for the families of people affected. <hr/> <p>Improving the care of people with pathological gambling disorders and other social addictions</p> <ul style="list-style-type: none"> • Plan for reorganising the care of pathological gambling disorders and other social addictions. |

| Line | Projects |
|------|--|
| | <p>Improving the care of adolescents with problems connected with drug consumption.</p> <ul style="list-style-type: none"> • Project for systematised care of adolescents with substance abuse or dependence, with special attention to tobacco, cannabis, alcohol and cocaine, and their families. |
| | <p>Improving the care of people with addiction to alcohol and benzodiazepines.</p> <ul style="list-style-type: none"> • Implementation and extension of the "Drink Less" programme. • Intensive out-patient treatment programmes for people with alcoholism and/or benzodiazepine dependence. Differentiating the specific needs of the elderly. • Programme for care and support for the families of people affected. |
| | <p>Improving the care of people with cocaine addiction.</p> <ul style="list-style-type: none"> • Adaptation of therapeutic programmes to the specific problems related to the consumption of cocaine. |
| | <p>Improving the care of people with heroin addiction.</p> <ul style="list-style-type: none"> • Development of resources adapted to the needs of chronic consumers. • Programme for care and support for the families of chronic consumers. • Programme of active participation of the people affected. |
| | <p>Improving the care of people with depression and bipolar disorder.</p> <ul style="list-style-type: none"> • Preparation or validation of clinical guidelines. • Project for a new portfolio of mental health services in PHC, prioritising detection, differential diagnosis with bipolar disorder and care for depression. • Greater intensity in community care (guaranteeing psychotherapy). • Functional programmes in day hospitals. • Creation of reference units for refractory pathologies. • Specific care for elderly people with depression and/or anxiety. • Support programme for the families and/or carers of elderly people with depression and/or anxiety. • Specific care programmes for elderly people with depression and/or anxiety in hospitalisation, day hospitals and day centres. • Programme for care and support for the families of the people affected. |
| | <p>Improving the care of people with borderline personality disorder (BPD).</p> <ul style="list-style-type: none"> • Preparation or validation of clinical guidelines. • Specific training. • Specific programme for care of people with BPD. • Differentiated programmes in day hospitals. • Short hospital care for risk situations, and intensive rehabilitation units with a specific programme lasting up to two years. • Project for creating specialised units for the diagnosis and treatment of the most resistant pathologies. • Programme for care and support for the families of the people affected. • Programme for detection and intervention in substance abuse. |
| | <p>Improving the care of people with severe mental disorders (Sev.MD).</p> <ul style="list-style-type: none"> • Programme for care of people with severe mental disorders and their families. • Specialist support in residences and centres for elderly people, where people with Sev.MD live. |
| | <p>Improving the care of elderly people with mental health problems (anxiety, depression, alcoholism, severe mental disorders and dementia)</p> <ul style="list-style-type: none"> • Preparation of clinical guidelines. • Specific programmes for this age group of to guarantee specialised care, both in out-patient care and in hospital. • Programme for care and support for the families of the people affected. |

5. Strategic proposals

| Line | Projects |
|--|--|
| <i>Line 3. Reorganising the current services in accordance with the new strategic needs.</i> | <p>Reorganisation of the services for care in infancy</p> <ul style="list-style-type: none"> • Functional integration of the different health care networks. • Introduction in Catalonia of the new organisational model with reference to the case of the primary health care team. |
| | <p>Reorganisation of the youth and adult mental health out-patient care services</p> <ul style="list-style-type: none"> • Project to improve accessibility to care resources for young people with problems related to drug use. • Definition of the mental health services portfolio for youth and adult mental health out-patient care services. • Improving the continuity of health care with flexibility at the break points: age, comorbidity and change of services. • Enhancing community nursing. |
| | <p>Reorganisation of day hospitals</p> <ul style="list-style-type: none"> • Redefining the triple function of the adult day hospital: <ol style="list-style-type: none"> 1. alternative to hospitalisation (pre-crisis). 2. continuity of hospitalisation of acute cases, so as to favour stabilisation and readaptation to surroundings. 3. intensive multidisciplinary out-patient treatment in severe cases. • Designing dual pathology programmes for the adult population and elderly people (currently excluded from the resource). • In children's and young people's day hospitals, offering a range of services and of specific programmes for the different pathologies of adolescence, including addictions. • Range of specialised programmes for the care of people with ED, psychotic disorders, BPD and behavioural disorders in adolescents. |
| | <p>Reorganisation of the hospitalisation of children and young people</p> <ul style="list-style-type: none"> • Reorganisation and equitable sectorisation of the hospitalisation of children and young people throughout the territory. • Adapting acute units to a more integrated and individualised intervention model. • Emergency care in cases of consumption of psychoactive substances. • Developing medium-stay intensive rehabilitation units for adolescents with serious MD and addiction problems. • Units for ED that meet hospitalisation criteria with specific programmes and specialist staff. • Incorporating consultation and liaison psychiatry into the portfolio of services of children's and young people's psychiatric units in hospitals. • Designing dual pathology programmes for the young and adolescent population. |
| | <p>Reorganisation of the hospitalisation of adults (emergencies and acute)</p> <ul style="list-style-type: none"> • Project for adaptation of acute units to a more integrated and individualised intervention model. • Programme for the care of comorbidity and dual pathology. • Project for reorganisation of treatment with electroconvulsive therapy (ECT). • Incorporating consultation and liaison psychiatry into the portfolio of services of general hospitals. • Special programmes and research programmes. • Project for reorganisation to enhance complementarity between psychiatric hospitals and the psychiatry units of general hospitals. |
| | <p>Reorganisation of the hospitalisation of elderly people (emergencies and acute)</p> <ul style="list-style-type: none"> • Project for adapting acute units, for the care of elderly people, with a more integrated and individualised intervention model. • Programme for the care of comorbidity and social health needs, with specific professional competencies. |

| Line | Projects |
|--|--|
| | <p>Reorganisation of hospitalisation units for intensive rehabilitation.</p> <ul style="list-style-type: none"> • Creation of the intensive rehabilitation hospitalisation subsystem for people with resistant serious mental disorder and associated risks. • Project for distributing these units throughout Catalonia, in conditions of safety, while avoiding excessive concentration in the premises of specialist hospitals. |
| | <p>Reorganisation of community rehabilitation services (day centres and therapeutic communities).</p> <ul style="list-style-type: none"> • Progressive conversion of the current day centres into community rehabilitation services. • Reorientation of therapeutic communities, incorporating the rehabilitation function of transition to the community of people with Sev.MD or dual pathology. |
| | <p>Planning of the services programmes and specialised units with a supra-sectorial function for resistant cases.</p> <ul style="list-style-type: none"> • Redefining specialised units and planning criteria. • Linking highly specialised programmes to training and research. |
| | <p>Specific aspects in the care of elderly people.</p> <ul style="list-style-type: none"> • Developing a specific care model to deal with the complexity of the pathologies of old people. • Setting up and articulating psychogeriatric care programmes with other health networks (primary, neurology, geriatric, social health and/or social). • The process of converting the medium-stay units of psychiatric hospitals will also have psychogeriatric social health units (mental illness patients over 65, and with associated comorbidity, people with dementia). |
| | <p><u>Operational objective 3.11</u> Reorganisation of the drug dependence therapeutic communities.</p> <ul style="list-style-type: none"> • Redefinition and differentiation of the therapeutic communities according to the typologies and needs of users. |
| | <p>Reorganisation of Hospital Detoxification Units (HDU)</p> <ul style="list-style-type: none"> • Redefinition of Hospital Detoxification Units. • Incorporation of crisis intervention. |
| | <p>Specific aspects in the care of people subjected to legal detention</p> <ul style="list-style-type: none"> • Creation of the expert psychiatric unit in cooperation with the Catalan Institute of Legal Medicine. • Reorganisation of the present system for psychiatric prison care. • Reorganisation of the present system for psychiatric and drug dependence care in young offenders' institutions. • Review and standardisation of the programme for the care of people subjected to judicial security measures in the conventional network. • Creation of centres for the care of people with drug dependence in prisons. |
| <p><i>Line 4. Encouraging an integrated management system to guarantee the continuity of health care</i></p> | <p>Providing for an integrated management system to provide the continuity of health care and making each health and social service responsible in the care process.</p> <ul style="list-style-type: none"> • Creation of Health Administration Areas: the management of resources must respond to planning based on the country's needs. • Plan of progression towards the unified medical record. • Including mental health and addictions in the capitation payment system. • Incorporating indicators in the evaluation system that evaluate the process for care and continuity of health care. • Promoting an integrated management system in Catalonia for the health and social services for the care of people with dependence (dependence care programme). • Promoting strategic alliances between providers in Catalonia. |

5. Strategic proposals

4. The voice of the people affected: improving their involvement and achieving the network's commitment to their rights

| Line | Projects |
|---|---|
| <i>Line 1. Promoting a care system and services that respect people's autonomy, that respond to their needs and that take their rights and responsibilities into careful consideration.</i> | <ul style="list-style-type: none"> • Updating and implementing the guide to involuntary internment and restrictive measures in psychiatry (Catalan Bioethics Committee). • Periodical survey of centres, professionals and users on the use of restrictive measures. • Setting quality criteria and indicators for restrictive practices. |
| <i>Line 2. Favours the active participation of the people affected as citizens</i> | <ul style="list-style-type: none"> • Involvement in the therapeutic process of people with serious pathology (psycho-education programmes). • Defining and advancing in spaces for the active participation of the families' and users' organisations with a growing perspective of empowerment in the planning and execution of the services in Catalonia. • Promoting the training of the organised users in the fields that are necessary for participation. • Encouraging the participation of the people affected in the advisory bodies. |

5. The voice of the professionals: achieving their involvement and their improved satisfaction

| Line | Projects |
|---|---|
| <i>Line 1. Increasing the satisfaction of the professionals</i> | <ul style="list-style-type: none"> • Care protocol for carers and assessment of their performance in the organisations. • Knowledge of the degree of satisfaction of the professionals or the work atmosphere of the organisations. • Continual training, based on everyday clinical practice. |
| | <ul style="list-style-type: none"> • Promoting motivating payment systems (professional career, incentives for targets or others). • Fostering the participation of professionals in the teams in the planning, management and evaluation of the projects. |
| | <ul style="list-style-type: none"> • Preparing programmes that foster promotion and prevention in health professionals with greater psychological risks or with intense contact with emotional problems. • Incorporating into the Workplace Risk Prevention Service or Health Supervision Service the evaluation of the risks related to stress at work and the early detection of mental health problems and of addictive behaviour. • Encouraging "teamwork" and spaces for reflection on the emotional aspects of health care in practice. |
| | <ul style="list-style-type: none"> • PAIMM and RETORN Programmes for health professionals with mental and/or addiction problems, especially the more complex cases. • Drawing up protocols agreed with the providers. |
| | <ul style="list-style-type: none"> • Specific training in the prevention of drug dependence and other risk behaviour. • Continual specific training in mental health and addictions, oriented basically towards cooperation and interdisciplinarity. • Cultural competencies of professionals in mental health and addictions. • Training in mental health and addictions of PHC professionals. • Accreditation of nursing training in community mental health and addictions. • Accreditation of the training of social work professionals in community mental health and addictions. • Training in mental health and drug dependence for professionals of non-health services. |
| | <ul style="list-style-type: none"> • Incorporation of ethical training into training plans. • Incorporation of legal aspects into training plans. • Guide for action in conflicts of values: guideline cases. • Guidelines for action in lawsuits. • Management of violent behaviour in clinical practice. |

| Line | Projects |
|------|---|
| | <ul style="list-style-type: none"> • Favouring the involvement of professionals in the implementation of the Plan. |
| | <ul style="list-style-type: none"> • Having an active policy for the prevention of violence by the users of the health system, while improving safety conditions and training in conflict management techniques. |

6. Promoting the integrated functional organisation of the care networks and services

| Line | Projects |
|--|--|
| <i>Line 1. Integration of the adults', children's and drug dependence mental health networks</i> | <ul style="list-style-type: none"> • Project to favour the shared management, the physical proximity of the equipment and territorial cooperation spaces. • Flexibilising the mental health services for care of people with addiction problems. • Integrated teams to support primary care. • Common programme for the care of adolescents with substance use problems. |
| <i>Line 2. Providing an integrated territorial management system of the services, in accordance with the Plan for the integrated care of people with mental illness.</i> | <ul style="list-style-type: none"> • Reorganisation and extension throughout the country of the territorial coordination commissions for children and adolescents with a disability or at risk of suffering from one. • Extension throughout the country of functional units for mother and child care. • Setting up Territorial Case Management Councils (adult population). • Setting up the referral study groups (GED) throughout Catalonia (people with learning disabilities). |

7. Favouring the improvement of the management systems with the involvement of the providers

| Line | Projects |
|---|---|
| <i>Line 1. Enhancing the culture of evaluation as a strategy for improving quality</i> | <ul style="list-style-type: none"> • Preparation of surveys to find the degree of user satisfaction. • Preparation of the methodology to respond to the necessary improvements based on the satisfaction surveys. |
| | <ul style="list-style-type: none"> • Definition of the services by processes. • Training in methodology. • Generation of indicators. • Agreed external evaluation processes. • Indicators of results to measure improvements in health. • Agreed measurement indicators to allow benchmarking between organisations. • General system of indicators of structure, process and results. |
| | <ul style="list-style-type: none"> • Evaluation of the continuity process. |
| <i>Line 2. Reduction of inappropriate clinical variability</i> | <ul style="list-style-type: none"> • Progressive preparation of the different clinical guidelines. |
| <i>Line 3. Improving clinical and epidemiological information by means of the new information and communication technologies (ICT).</i> | <ul style="list-style-type: none"> • Improving the current IT systems, support for computerisation and facilitating on-line connection. |
| | <ul style="list-style-type: none"> • Agreeing on a single computerised medical record with the providers |

8. Enhancing continual training and the postgraduate teaching system

| Line | Projects |
|--|---|
| <i>Line 1. Producing changes in the post-graduate teaching system, so as to bring the knowledge and skills of the future professionals into line with the objectives of the Plan</i> | <ul style="list-style-type: none"> • To achieve more teaching capacity in the Catalan institutions for the training of MEF (medical specialists in training) and PEF (psychology specialists in training) and nursing specialisation in mental health, dealing with the real needs of the network. • Reorienting the training of specialists along a more community line. |

9. Strengthening epidemiological and clinical research, the evaluation of services, and European cooperation

| Line | Projects |
|---|--|
| <i>Line 1. Strengthening epidemiological and clinical research</i> | <ul style="list-style-type: none"> • Encouraging research projects (genetics, neurobiology). • Research project on needs and morbidity (seen and hidden) in mental health and addictions by age groups. • Research project on risk factors of mental disorders and addictions and mental health protection factors. • Epidemiological research project on suicides. |
| <i>Line 2. Stimulating co-operation with the countries of the European Union (EU) and of the international organisations related to mental health and addictions.</i> | <ul style="list-style-type: none"> • Research project on bullying among peers. • Research project on abusers: gender, child abuse. • IMHPA project. • Enhancing the co-operation alliances and benchmarking with other European regions and countries. • Developing up-to-date common indicators for the realisation of comparative studies in the evaluation of services and results. • Facilitating and promoting participation in WHO programmes and strategies in Europe. |

10. Ensuring the management of change

| Line | Projects |
|--|--|
| <i>Line 1. Achieving equity in health care provision in Catalonia</i> | <ul style="list-style-type: none"> • Preparation of the health and social-health map of mental health and addictions. |
| <i>Line 2. Promoting the decision-making and management ability of the community and of the territory.</i> | <ul style="list-style-type: none"> • Involving the local authorities and the community network (integrated community action programme). • Proposing the creation of the Territorial Case Management Committee, with the presence of the health authority. • Defining and guaranteeing the voice of providers at central level and in the territory. |
| <i>Line 3. Promoting a system of indicators to check on risks of change.</i> | <ul style="list-style-type: none"> • Constructing a system of indicators to assess the strategies necessary to control the critical factors for success of the Master Plan. |

6. Health Map

6. Health Map

6.1. The planning criteria

The Master Plan on Mental Health and Addictions has identified the health needs of the population with regard to mental health and addictive behaviour, as well as the factors of quantitative insufficiency in the current offer, and the critical elements that determine a model of care that is hardly oriented to the real needs of users and their families.

This is the basis on which we applied the figures for usage of services in the periods 2003 and 2004, from the health information systems (CMBDH and CMBDSM), as well as the register of mental health and addictions centres and services currently contracted by CatSalut, and the current sectorisation of these services, in the three networks¹⁷. The quantitative criteria that have been proposed take into account:

- A primary differentiation and grouping of the services according to the type of demand (health problem of low, medium or high complexity of resolution), the care level and most appropriate facilities.
- The alternatives for change that are set out based on the proven scientific evidence.

International references, especially those from recent documents of the WHO Europe¹⁸ and the National Health Service¹⁹ were of value in this phase.

The planning criteria respond to the proposed model and determine a general system of resources for mental health and addictions, balanced and proportionate to the challenges that are faced. Even so, one must bear in mind the important emerging reality of health problems in this field and the possible consequences of the rapid social changes that surround us, as well as the influence of the actions proposed by the Master Plan on Mental Health and Addictions on social determinants in mental disorders and addictions. All in all, this points to the need to consider these criteria too as a whole, as a new working hypothesis to be presented to the health and social agents so that, with the new scenario, they will be capable of introducing the new health care practices and the new models of clinical management that the population needs.

Finally, we have reviewed the standards and the health care capacity of other countries and regions around us, globally whenever possible or partially, by typology of services, when we did not have access to the system as a whole. These referents were the Lombardy Regional Plan²⁰, the Strategic Plan for mental health of the Basque Country²¹ and the network of services in the Basque province of Bizkaia²², some facilities in Roussillon - Languedoc²³, Quebec²⁴, Norway²⁵, and certain WHO documents²⁶.

This process of comparison presents difficulties, because of the heterogeneity of the typologies of services, and their nomenclature. For this reason and in order to make comparison easier, during the preparation of the Map we codified and standardised the nomenclature of our services in line with the description of their functions, as is proposed

17. Youth mental health network, adult mental health network, and drug dependence care network

18. Atlas of Mental Health Resources in the World. 2001 WHO - Geneva

19. National Health Service. "Modern Standards and Service Models". Mental Health - National service frameworks (September 1999)

20. Piano Regionale Salute Mentale Regione Lombardia. Direzione Generale Sanità. Milan

21. Asistencia Psiquiátrica y Salud Mental. Plan Estratégico 2004 - 2008. Osakidetza, Servicio Vasco de Salud (October 2004)

22. Memoria de actividad 2005. Servicios extrahospitalarios de salud mental de Bizkaia (Osakidetza). Plan Estratégico de salud Mental de Osakidetza.

23. Plan de psychiatrie et santé mentale 2005 - 2008. de la France.

24. Organisation des Services de Santé mentale dans la communauté. Enseignements à tirer de la recherche évaluative. Planification - Evaluation Santé Services Sociaux. Québec (April 1998)

25. Mental Health Services in Norway. Prevention - Treatment - Care (1999 - 2008). HELSE -OG OMSORGSDEPARTEMENTET. Norwegian Ministry of Health and Care Services. January 2005

26. WHO, Mental Health Atlas 2005.

6. Health Map

by the Mental health Services Diagram (ESMS-GEMPII)²⁷. Despite these efforts, which have been recently begun in the international sphere, the final result of the resources presented by a particular care system in the field of mental health and addictions must respond more to a global balance of the model than to a facility by facility comparison.

6.2. The new organisational model

From here on, the new model of services is organised into three major fields of intervention, differentiated by problems of health, typology or complexity of the interventions, and the environment of services where these could prove most efficient (**figure 4**). This classification responds to an organisational and management perspective which we think is useful for the planning of services, and unquestionably implies a certain clinical correlation to start with, albeit limited by the frequent observation of comorbidity or of the torpid evolution of many initially mild processes.

Figure 4. The organisational model of mental health and addictions services

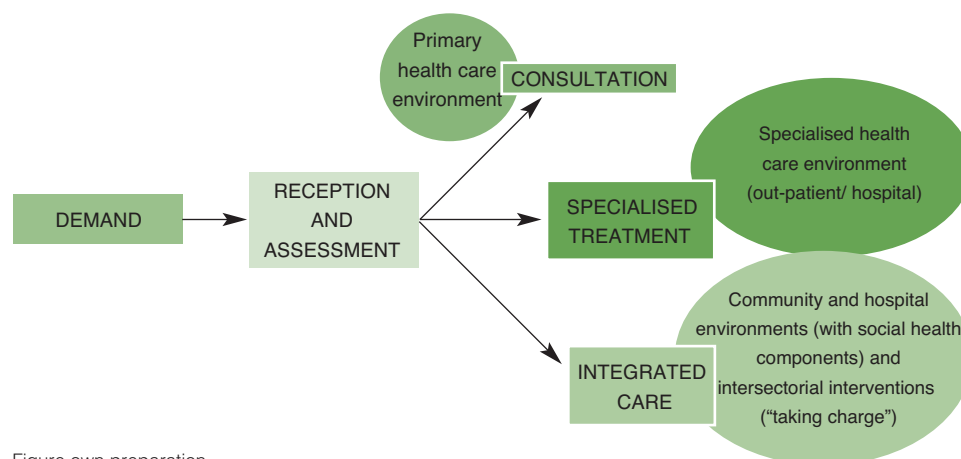


Figure own preparation.

As figure 3 shows, assessing the specific demand (the health problem) is the key function that determines the type of response. The result of the assessment contains an implicit diagnosis, not only clinical but also referring to the individual's own ability to "take charge" of their disorder (their current social functioning), and thus of the degree of professional intervention that is required. In this wide sense, relating to the intensity of resources, we can speak of low, medium or high complexity responses²⁸. The assessment should trigger a care or other system, each of which implies a focusing of the response oriented to specific goals, containing intervention modalities of different intensity, with different professional implications, made in different environments. These three fields (**table 6**) are:

- a) Interventions in Primary Health Care, with specialist support
- b) Expert specialist treatments, by programmes and clinical guidelines
- c) Integrated treatments for people with serious and persistent disorders

27. The European Service Mapping Schedule - Version GEMP II (ESMS-GEMPII - Mental Health Services Diagram. Original version: Sonia Johnson, Robert Kuhlmann and the EPCAT group. Spanish version: Cristina Romero, Luis Salvador-Carulla, Grup d'Investigació de Medicina Psicosocial - GEMP (version 4 - March 2002).

28. We refer to the complexity of integrated care rather than to the degree of specialisation and technological sophistication for the care of an uncommon process (highly specialised).

Table 6. Problems of health, services and facilities of each area of intervention

| | Health problem | Portfolio of services | Facilities |
|--|---|---|--|
| Primary Health Care (low complexity) | <ul style="list-style-type: none"> - Anxiety - Depression - Adaptive Disorders - Warning signs children -juveniles - Addictive risk behaviour - Other dysfunctions - Miscellaneous chronic diseases - Other health problems that require integrated care (somatisation, fibromyalgia, chronic fatigue, etc.) | <ul style="list-style-type: none"> - Promotion / prevention activities - Assessment of the demand - resolution - consultation - referral - Early detection - Warning signs in the children and adolescent population - Mental health activities of counselling, conflict resolution, psychiatric, psychological orientation, family orientation, groups - Integrated health for people with serious / severe mental disorders | <ul style="list-style-type: none"> - Primary Care Team - Integrated specialist support team (psychiatrist, child - juvenile psychologist, adult psychologist, mental health and addictions nurse) |
| Specialised treatment (medium complexity) | <ul style="list-style-type: none"> - Serious depression - Personality disorder - Risk of suicide - Eating disorder - Borderline personality disorder - Attention Deficit Hyperactivity Disorder - Cocaine - Alcoholism - Substance use by adolescents - Gambling - Learning disabilities | <ul style="list-style-type: none"> - Clinical guidelines by pathologies (specialisation) - Integrated offer (psychotherapy) - Intensive care - Crisis care - Hospitalisation | <ul style="list-style-type: none"> - Children and juvenile mental health centre - Adult mental health centre - Drug dependence care and monitoring centre - Specialist mental health service for people with learning disabilities - Day hospital - Emergencies / Acute |
| Integrated care (high complexity) | <ul style="list-style-type: none"> - Schizophrenia and other psychoses - Severe addictions - People with severe or serious mental disorders - Specific risk populations (social exclusion, homeless, prisoners, etc.) | <ul style="list-style-type: none"> - Integrated portfolio of services (inter-departmental): health, social, employment, etc. - Patient / family / environment interventions - Crisis and homecare - Incipient psychosis care programme - SMD/Sev.MD programmes - Rehabilitation and reinsertion - Reduction of harm/risks - Proactive modalities | <ul style="list-style-type: none"> - Mental health centre - Drug dependence care and monitoring centre - Medical emergencies service - Individualised services plan - Day hospital - Community rehabilitation services - Hospitalisation: acute, subacute and intensive rehabilitation - Community alternatives - Other programmes and specific services - Social Services - ProDep |

Table own preparation.

Thus the key aspects of the Master Plan that will impact on the organisation of the services are:

a) in the policies of the support services for Primary Health Care

- Inclusion of promotion and prevention activities, in coordination with the Public Health Agency and other agents in the community.
- Increase in the resolution capacity of Primary Health Care.
- Increase in support of the specialised network.
- Development of a specific Primary Health Care portfolio of services for mental health and addictions adapted to each territory and each community.

6. Health Map

- b) in the policies of the medium-complexity specialised care services
- Functional integration and integration into the clinical activity of the mental health and addictions networks.
 - Specialisation of the offer for health problems, with clinical guidelines based on scientific evidence.
 - Specific psychotherapy offer in the public network.
 - Intensity of care and measurement of health results.
 - Prioritisation of emerging health problems (ADHD, ED, BPD, prevention of suicide, cocaine consumption, etc.).
 - Definition, sufficiency and breadth of the programmes of partial hospitalisation.
 - More integrated and quality hospital care.
 - Updating the offer of care and monitoring centres for people with addictions.
 - Definition of the role of outside consultations in general hospitals and specialised reference units.
- c) in the policies of the integrated care services for people with long-evolution serious disorders and risk of disability.
- Increase in the care of these groups in community environments: greater intensity of care (programmes for Sev.MD and SMD, home care, ISP, home emergencies, etc.). Ensuring the continuity of health care.
 - Early and intensive care programmes for people with psychotic pathology aimed at improving the prognosis of the illness.
 - Conversion of the medium and long stay resources and adjusting the model of prolonged hospitalisation.
 - Sufficiency and reorientation of the rehabilitation services in the community.
 - Portfolio of housing, leisure, family support, educational and occupational services.
 - Cooperation with the social care services and Prodep.
 - Reorientation of prison psychiatry and a more proactive model for the care of homeless people with mental disorders and addictions.

6.3. Critical aspects for the development and adjustment of services towards the new care model

In the situation analysis made by the PDSMiAd there is wide identification of a series of critical factors for success and of difficulties that must be borne in mind in attempting to minimise any possible negative impact on the development of the new model that is being proposed. Aspects such as policies for the training and management of human resources, finance, commitment of the organisations, the professionals and the people affected, cooperation among the different care networks, the involvement of the territorial government authorities, among others, are basic elements that are fully involved in the proposal for the development of services projected in the PDSMiAd.

Health needs and changes in demand

Previous studies have shown that more than 50% of the people who suffer mental disorders and addictions over the course of a year do not contact health professionals during this time. In this regard the success of the proposals in the Master Plan on Mental Health and Addictions could lead to an increase in requests for care.

On the other hand, an emerging demand is coming into existence, related to mental suffering in general and to the presence of adverse circumstances in people's lives, which until recently did not constitute a real health need recognised as such by the scientific community. Especially in primary care, suitable tools must be available to provide a healthy response to this situation.

Another relevant aspect is the adaptation of the services system to the growing demand from immigration.

Human resources

The proposals that have been made for developing resources imply an important growth in human resources.

Moreover, these changes will also affect the traditional distribution of the professional competencies of the various groups that operate in the field of mental health and addictions, a particularly multidisciplinary sector, to which new, not strictly health-related, professions are being added.

All in all it is an extraordinary challenge for the current systems for training specialists, for continual training and, in general, for the employment and payment strategies of the sector.

Primary Health Care

A large part of success in introducing the new model will depend on the ability of primary care to take on the leading role and the responsibility in the care of a large part of the mental health problems that affect the population, with the support of specialist teams. The effectiveness of this support will also be conditional on the improvement of the general quality at the primary level.

The processes of health care: a range of services integrated at territorial level

Achieving an integrated health care offer in the territory is a very important aspect in guaranteeing equity, but could also be a complicated aspect, given the great diversity of providers, facilities and orientations of the professionals.

The establishment of strategic alliances among providers currently seems the best option to achieve an integrated range of services, based on the complementarity of the interventions.

Technological innovation in management: information technologies

A fundamental aspect in improving health care inevitably requires the incorporation of information and communication technologies into the service of the health professionals.

These technologies must allow communication systems that are integrated between the various mental health care facilities and with those of the general health system, (PC), enhancing work in networks, the availability of a single computerised medical record, or incorporating Mental Health Centres into the electronic prescription project, which is starting to be implemented in the health system.

The collaboration of the people affected

The people with mental disorders who are seen in the mental health services are citizens with the same rights and duties as others, and the charter of citizens' rights and duties published by the Ministry of Health and Social Security in 2002 is applicable to them in relation with health and health care.

The services system must promote the active participation of the people affected and make them jointly responsible, both in therapeutic plans and in territorial decision-making bodies.

6. Health Map

Table 7. Projected evolution of health care parameters

| Health care parameters | Children | | Adults | |
|---|--------------------------|------------------------------------|--------------------------|--------------------------------------|
| | Current situation (2004) | PDSMiAd | Current situation (2004) | PDSMiAd |
| New cases per year | 1.2% | 2% (0.8% PHC + 1.2% Specialist) | 0.8% | 1.6% (0.8% PHC + 0.8% Specialist) |
| Prevalence in specialist services | 2.5% | 3% | 2.4% | 2% - 2.2% |
| % of severe diagnoses in specialised care | I. | II. | 33% | 50% |
| Prevalence among people with serious mental disorders | 0.2% | 0.6% | 0.2% | 0.8% |
| Consultations per patient per year | 6.4 | 12 | 5.1 | 12 / 16 |
| Psychotherapy sessions per patient seen per year | 1.6 | 2.2 | 0.5 | 1 / 1.3 |
| Home visits per patient seen | 0.02 | 0.25 | 0.03 | 0.35 |
| Nursing visits per patient seen | 0.08 | 1 | 0.69 | 3.5 / 4 |
| Family visits per patient seen | 0.85 | 1 | 0.1 | 1 / 1.1 |

Table 8. Territorially-based services with proximity reference. Care of childhood and juvenile population. Health care capacity needs

| | |
|---|--|
| Support for primary health care | Multidisciplinary team (recommended allocation: 0.25 psychiatrist and 1 psychologist per 100,000 inhab. of general population). |
| Early children's diagnosis and treatment centres (CDIAP) | Achieving 75% cover of the critical population / 1 CDIAP per region. |
| Mental health Centres | Multidisciplinary team (recommended allocation: 1.55 psychiatrists; 2.65 psychologists; 0.5 nurses and 0.5 social workers per 100,000 inhab. of general population). |
| Care network support for drug dependence | Health care team from the HCS, support for the children and juvenile MHCs (recommended allocation: 0.34 psychologists per 100,000 inhab. of general population). |
| Day hospital | 3.5 places per 10,000 inhab. under 18. |
| Community rehabilitation services | Included in adult standards. |
| Children's and adolescent units | 1 bed per 10,000 inhab. under 18. |
| Emergencies | 1 service per children's unit |

Table 9. Territorially-based services with proximity reference. Care of adult population. Health care capacity needs

| | |
|--|---|
| Support for primary health care | Multidisciplinary team (recommended allocation: 1 psychiatrist; 1.25 psychologists and 0.75 nurses per 100,000 inhab. of general population). |
| Mental health centres | Multidisciplinary team (recommended allocation: 5 psychiatrists; 3.5 psychologists; 4 nurses and 2 social workers per 100,000 inhab. of general population). |
| Drug dependence health care centres | Multidisciplinary team (recommended allocation: 0.9 psychiatrists; 2.5 psychologists; 0.9 nurses and 0.9 social workers and 0.9 clinical auxiliaries per 100,000 inhab. of general population). |
| Day hospital | 1 place per 10,000 inhab. of adult population. |
| Community rehabilitation services | 3.5 places per 10,000 inhab. of general population. |
| Acute unit | 1.2-1.4 beds per 10,000 inhab. of adult population. |
| Emergencies | In all hospitals with acute unit. |
| Subacute unit | medical emergency team per health region. |
| | 0.8-1 beds per 10,000 inhab. of adult population. |

Table 10. Territorially-based services with proximity reference. Care of adult population. Health care capacity needs

| | |
|--------------------------------------|--|
| Individualised services plan | ISP team (recommended allocation: 1.8-2 coordinators per 100,000 inhab. of general population). |
| Community internment unit | 0.5 beds per 10,000 inhab. of adult population. |
| Intensive rehabilitation unit | 1.5 beds per 10,000 inhab. of adult population. |
| Hospital detoxification unit | 0.09 beds per 10,000 inhab. of general population. |
| Homes (flats) | 10-20 places per 100,000 inhab. of general population. |
| Homes -residences | 20-25 places per 100,000 inhab. of general population. |
| Social clubs | 1 per MHC catchment area. |
| Job insertion services | Pre-work: 15-20 places per *** inhab. of general population Job insertion: 15-20 places per *** inhab. of general population. |

Table 11. Territorially-based services with proximity reference. Care of adult population. Health care capacity needs

| | |
|--------------------------------------|---|
| Individualised services plan | ISP health care team (recommended allocation: 1.8-2 coordinators per 100,000 inhab. of general population). |
| Community internment unit | 0.5 beds per 10,000 inhab. of adult population. |
| Intensive rehabilitation unit | 1.5 beds per 10,000 inhab. of adult population. |
| Hospital detoxification unit | 0.09 beds per 10,000 inhab. of general population. |
| Homes (flats) | 10-20 places per 100,000 inhab. of general population. |
| Homes -residences | 20-25 places per 100,000 inhab. of general population. |
| Social clubs | 1 per MHC catchment area. |
| Job insertion services | Pre-work: 15-20 places per *** inhab. of general population. Job insertion: 15-20 places per *** inhab. of general population. |

7. Follow-up and evaluation

7. Follow-up and evaluation

In order to make progress in the use and analysis of the available information, and with the aim of improving the quality of health care in diseases related to mental health, it is necessary to recapitulate the indicators for assessing the evolution of mortality, the survival of this group of diseases and the control of their risk factors. The integration of this information could contribute to identifying margins for improvement in care and suggesting to managers and planners new health initiatives for the purchase and provision of services.

The choice of the follow-up and evaluation indicators is based on the principles of objectivity, validity, sensitivity, specificity and consensus. In this regard it must be borne in mind that the current information systems do not make it possible to obtain an exhaustive set of indicators. It is for this reason that, as progress and feasibility allow, the existing indicators will be perfected and others will be included that are considered necessary. For the remaining goals, which for technological, functional or conceptual reasons are not suitable for being assessed from synthetic indicators, the “ad-hoc” mechanisms and evaluation tools detailed in this document will be used.

In this regard it is important to point out that an advance in Information Technologies must be a priority for the health system.

Goals and indicators of the Master Plan on Mental Health and Addictions

1. Increase in protection factors and reduction of risk factors

| | |
|-------------|---|
| GOAL | Implementation of the Mental Health Protocol in the framework of preventive medicine activities at paediatric age in Primary Health Care |
| Indicator: | % de readmisiones hospitalarias en el plazo de 90 días después de una alta hospitalaria |
| Marker: | % of children included in the healthy child follow-up programme for primary care teams, to which the children and juvenile mental health protocol has been applied 60% of the children included in the Healthy Child Follow-Up Programme |

2. MD prevention strategies

| | |
|-------------|---|
| GOAL | Implementation of the Health and School Programme (PSiE) |
| Indicator: | % of adolescents with mental health or addiction problems, detected in the framework of the PSiE. |
| Marker: | 50% of the prevalence of mental disorders and/or addictions in the adolescent population |

3. Improving the portfolio of mental health and addictions services in PHC and enhancing the capacity for detection and resolution of PHC professionals

| | |
|-------------|---|
| GOAL | To improve the capacity for detection and resolution of PHC professionals |
| Indicator: | Rate of prevalence shown by MD in PHC |
| Marker: | 60% of the prevalence / standard year of mental disorders in the general population (15% to 16% patients with MD diagnosis) |
| Indicator: | Index of screening cover for excessive alcohol consumption |
| Marker: | 60% |
| Indicator: | Referral rate from PC to specialised care in MH |
| Marker: | 0.8% of the reference population |

7. Follow-up and evaluation

4. Model of active community intervention, especially with serious mental disorders

| | |
|-------------|---|
| GOAL | To boost detection and early intervention in serious mental disorders, with an integrated, active community model of care to forestall and decrease the risks of torpid evolution of these disorders |
| Indicator: | % of people seen with incipient psychotic disorders and severe mental disorders |
| Marker: | For the adult population: 8 per thousand inhabitants For the children and juvenile population: 0.4 per thousand inhabitants |
| Indicator: | % of cases seen in the HCC of people with alcohol dependence |
| Marker: | 1.2 per thousand inhabitants |
| Indicator: | Latency period from the first consumption of cocaine to the point where treatment is requested in specialised care |
| Marker: | To reduce the average from 9 to 7 years |
| Indicator: | General prevalence in mental health centres |
| Marker: | For the adult population: 2.2% For the children and juvenile population: 3%. |
| Indicator: | Average consultations per year, of patients seen in the MHC |
| Marker: | >12 consultations per year in the patients seen in the mental health centres |
| Indicator: | Time in Methadone Maintenance Programmes (MMP) |
| Marker: | 24 months |
| Indicator: | Rates of typology of visits, per patient per year, in adult MHCs |
| Marker: | <i>nursing visits</i> : >4 nursing visits per patient per year <i>family treatment visits</i> : 1 family visit per patient per year <i>home visits</i> : >0.33 home visits per patient per year |

5. By priority pathologies: clinical guidelines, psychotherapeutic care

| | |
|-------------|---|
| GOAL | Improving the mental health care of problems of major complexity, in the environment of specialised mental health care |
| Indicator: | % of cases seen suggestive of clinical severity |
| Marker: | 60% |
| GOAL | To increase the resolutive capacity of Mental Health Centres |
| Indicator: | Resolution index of specialised care |
| Marker: | 0.6% |
| GOAL | To improve the offer of psychotherapeutic care in the MHC |
| Indicator: | Degree of implementation of psychotherapeutic activities in the MHC |
| Marker: | <i>In adult population</i> : offer of psychotherapeutic interventions in 6% of the population seen >18 years <i>In child population</i> : offer of psychotherapeutic interventions in 11% of the population seen <18 years |

6. Reorganisation of the current services in accordance with the new strategic needs

| | |
|-------------|--|
| GOAL | To decrease readmissions to hospitalisation units |
| Indicator: | % of hospital readmissions in the term of 90 days after hospital discharge |
| Marker: | 10% |

7. Functional integration of adult, children and juvenile mental health and drug dependence networks

| | |
|-------------|--|
| GOAL | To promote the functional integration of the adult, children and juvenile mental health and drug dependence networks |
| Indicator: | Prevalence seen in children's and juvenile MHCs for problems of consumption or addictions |
| Marker: | 25% of the estimated population prevalence in Catalonia |

