Mental Health Care in Spain: From Psychiatric Reform to Community-based Care within the “State of Autonomies”

Juan D. Molina, M.D.1,2,3, Manuel Durán-Cutilla, M.D.3,4,
Yolanda Pérez-Ros, M.D.1, Gabriel Rubio, M.D.2,5,6,7,
Francisco López-Muñoz, M.D.6,7,8,9*

Nowadays Spain where is a country that lives in democracy, is integrated into the European Union and with a universal coverage and free healthcare services. Being carried out from a community model, mental health care has been coordinated with social services and the antidrug agency network. But until now the process has been complex. In this overview, the authors are describing the process of psychiatric reform since the late 1970s, when was coinciding with the end of the dictatorship, and the creation of the “State of Autonomies.” As in this peculiarity of the territorial ordination of the country, Spain has had mental health plans of each of the 19 autonomous entities. As an example, we are illustrating two the mental health organizations – one of the richest autonomous communities, Madrid, and one of the poorest autonomous communities, Andalusia – to explain and analyze how they have applied the community model and coordination with other services.

Key words: State of Autonomies, psychiatric care system, Madrid, Andalusia

Introduction

Spain is mostly located on the Iberian Peninsula in Europe. The country’s mainland is bordered to the south and east by the Mediterranean Sea; to the north and northeast by France, Andorra, and the Bay of Biscay; as well as to the west and northwest by Portugal and the Atlantic Ocean. Spanish territory also includes two large archipelagoes, the Balearic Islands in the Mediterranean Sea and the Canary Islands off the African Atlantic
coast, two cities, Ceuta and Melilla, on the African mainland. With an area of 505,990 km² (195,360 sq. mi), Spain is the largest country in Southern Europe, the second largest country in Western Europe and the European Union, and the fourth largest country in the European continent.

By population, Spain is the sixth largest in Europe and the fifth in the European Union. Spain’s capital and largest city is Madrid; other major urban areas include Barcelona, Valencia, Seville, Malaga, and Bilbao. Spain’s autonomous communities (CCAA, comunidad autónoma) are the first level administrative divisions of the country. They were created after the current constitution came into effect (in 1978) in recognition of the right to self-government of the “nationalities and regions of Spain.” Along with the 17 CCAA, two autonomous cities which are also first-order CCAA territorial divisions – Ceuta and Melilla (www.recursostic.educacion.es/secundaria/edad/3esohistoria/para_pdf/quincena12.pdf) [1].

Native Spaniards make up 88% of the total population of Spain. After the birth rate was plunged in the 1980s and Spain’s population growth rate was dropped, the population was again trended upward, based initially on the return of many Spaniards who had emigrated to other European countries during the 1970s, and more recently, fueled by large numbers of immigrants who make up 12% of the population. The immigrants originate mainly in Latin America (39%), North Africa (16%), Eastern Europe (15%), and Sub-Saharan Africa (4%) (www.ine.es/prensa/cp_2017_p.pdf) [2].

Spain is a parliamentary democracy and constitutional monarchy (www.congreso.es/consti/constitucion/indice/titulos/articulos.jsp?) [3]. It is a major developed country and a high income country, with the world’s 14th largest economy by nominal gross domestic product (GDP) and 16th largest by purchasing power parity. It is a member of the United Nations (UN), the European Union (EU), the Eurozone, the Council of Europe (CoE), the Organization of Ibero-American States (OEI), the Union for the Mediterranean, the North Atlantic Treaty Organization (NATO), the Organization for Economic Co-operation and Development (OECD), the Organization for Security and Co-operation in Europe (OSCE), the Schengen Area, the World Trade Organization (WTO), and many other international organizations.

The Particularities of the Spanish State: the Constitutional Model of a State of Autonomies

Constitution and legal system

Spain is a parliamentary monarchy with a civil law system which is rooted in Roman law and whose main characteristic is that its central principles are codified into a referable system, which is the predominant source of law. Spain is a member state of the EU. The Spanish constitution (1978) creates three levels of government – central, 17 CCAAs, and municipal governments (Article 137) [4].

Article 43 of the 1978 Spanish constitution establishes the rights to health protection and healthcare for all citizens [5]. Regulation of the actions to enable exercise of the rights to health protection are set out in a set of regulations with the rank of acts – general health act (1986), act on the cohesion and quality of the national health system (2003), act on guarantees and rational use of medicines (2006), general health act (2011), as well as royal decree-law on emergency measures for the sustainability of the national health system and improvement of quality and safety (2012).
Five fundamental principles and criteria enabling the exercise of the rights are:

- Public funding, universal coverage, and free healthcare services at the time of use.
- Defined rights and duties, for citizens and public authorities.
- Political decentralization of healthcare devolved to the CCAAs.
- Provision of comprehensive healthcare, striving to attain high levels of quality duly evaluated and controlled.
- Integration of the different public structures and health services, under the national health system.

**National health system**

Spain has a publicly funded health system. Publicly funded health care is financed with general revenue raised through state, provincial and municipal taxation. Therefore, the Spanish state grants its people the rights to health services by relying mostly on the public sector (71%). Hence, this system of financing healthcare results in a universal national health service: every Spanish citizen is guaranteed healthcare, as the costs are covered mostly by the state. The remaining 29% is privately funded through “voluntary” payments (www.msssi.gob.es) [6].

In the Spanish state, as a consequence of the general health act (1985), the national health system (NHS) is decentralized, therefore, the competencies in health matters are transferred to 17 CCAAs, and those of the cities autonomous of Ceuta and Melilla under the coverage of the national institute of sanitary management (INGESA), dependent on the ministry. The NHS is configured as a coordinated set of health services from the central government administration and the CCAA that integrates all healthcare functions and benefits for which public authorities are legally responsible.

The general health act (1985) establishes coordination mechanisms, such as the interterritorial council and recognizes the rôle of the NHS in determining goals or common minimum objectives in promotion, prevention, protection and health care, as well as the general establishment of minimum, basic and common criteria for evaluating the effectiveness, and performance of programs, health centers and services [7].

**Mental Health in the Spanish National Health Strategy**

In 2006, the national health strategy was approved in a consensual manner by all the CCAAs, and a common framework was established for the improvement of mental health care and for the advances in the implementation of the community mental health care model in an equitable way in the country (www.msssi.gob.es/organizacion/sns/planCalidadSNS/docs/saludmental/MentalHealthStrategySpanishNationalHS.pdf) [8].

But in this sense, the reality of our country differs from the situation in other states in the EU. Although with common objectives, so many forms of mental health management coexist as CCAA. The care processes are different, the name of the services, their function, their location, and their reception protocols are diverse. The evolution of them since the psychiatric reform has been varied. They share objectives and a common vision, but the way they are developed is uneven.

**Spanish psychiatric reform**

The social circumstances that occurred in Spain in the mid-1960s, with some forward-thinking cultural trends, constituted the germ of the subsequent psychiatric reform against closed institutions. That included the so-called movement of the “anti-psychiatry.”
As soon as the end of the Dictator Francisco Franco Bahamonde’s regime was approaching, the struggle to change the paradigm of mental health care had intensified until the mid-1970s. Some mental health institutions were pioneers of this deinstitutionalization process (the Mental Institute of La Santa Cruz, the Psychiatric Hospital of Conxo and the Psychiatric Hospital of Oviedo) (www.pestadistico.inteligenciadegestion.msssi.es/) [9].

After the Dictator Franco’s death in 1975, the political transition to democracy began in Spain. The first local elections took place in 1979, making possible for cities such as Barcelona, Madrid, Valencia, or Seville to join this movement and subsequently some of the newborn CCAAs began to take the lead.

This psychiatric reform was conceived in six stages. Starting from psychiatry centralized in asylum, it would be necessary to generate a motivation for such reform. The next stage would focus on seeking political initiatives that promote it and thus unlock the system based on institutionalization to develop a progressive implementation of community services. While health care focused on the community model is generalized, programs would be developed to finally reach the consolidation of the model [10].

One of the remarkable characteristics of the psychiatric reform in Spain is that it coincides in time with three favorable factors:

- As we mentioned before, it took place in a context of transformation of society, after a civil war (1936-39) and 40 years of dictatorship, that devastated the intellectual, scientific and technical landscape, especially the psychiatric one.
- It was carried out within the reform of social welfare benefits and the general health act (LGS, 1986), which established an NHS, universal and decentralized in the CCAA.
- Its late initiation after other countries allowed to know the errors and problems of other reforms begun much earlier [11]. That helped include starting the development of the services of rehabilitation and social reintegration necessary for an adequate integral attention of the mental patient’s problems, and looking for the necessary coordination with the social services (LGS, Art. 20) [12].

One of the most important milestones of the reform is the integration of all mental health services into specialized care in a single network in each health area, in connection with primary care (gateway to the system), and coordination with local services of social attention. In addition, there is a change in the care organization with objective being to shift the focus of mental health care to community teams: services are now called “mental health services” instead of psychiatric services. The community is considered not only as a user, but as an active agent in the planning-programing process and as a generator of resources that must be in line with the specifically technical ones. Specific public health criteria are assumed, such as community diagnosis, positive discrimination, work with populations at risk, continuity of care, and consideration of hospitalization as an exceptional moment of treatment.

The development of the reform has been tremendously unequal, due to the characteristics of the Spanish regional map and the mental health subsystem (competences, transfer calendar, regional political wills, professional commitment): A “fast track” process was implemented in “historical CCAAs” with health care responsibility transferred to Catalonia in 1981, Andalusia in 1984, the Basque country and Valencia in 1987, Galicia and Navarra in 1990, as well as the Canary Islands in 1994. A “slow process” was used elsewhere, so it was not until 2002 that the process
was completed [11]. It should also be pointed out the insufficiency of resources for attention to chronicity and the precariousness of community programs (continuity of care, attention in crisis, prevention, etc.).

What objectives have been achieved in these years of psychiatric reform? On the one hand, a unified service portfolio has been created that guarantees preventive, care and rehabilitation mental health services. Likewise, an NHS mental health strategy has been launched with participation committees that give cohesion and power to the community model. They have been implemented in psychiatric units of general hospitals, acute care units, and emergency 24 hours.

The number of beds in monographic hospitals has been reduced significantly. There has also been an increase in the quality of both structures and facilities, clinical practice and novel experiences in the management of services. A unified mental health network has been created by passing all existing services to be the responsibility of a single administrator, initially INSALUD, in many cases, and as health competencies are decentralized, the CCAA themselves. Creation of an extensive network of mental health centers, enhancing available community outpatient resources and multidisciplinary teams and incorporation of other professions (psychology, nursing, social work, etc.) [13]. A strong movement of family members and users has developed, and special attention has been paid to the accredited speciality trainings of doctors, psychologists, and nurses. But according to the latest data published, Spain has 4,862 psychiatrists (in 2016). The ratio is 10.46 per 100,000 inhabitants), which is one of the lowest ratios among countries of the European Union (www.appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do).

**Social and health services coordination**

The attention to mental disorders requires interventions that are not only health or medical, but have a social implication (e.g. psychosocial rehabilitation services, supported housing, home care, benefits). Throughout the nation, there are different mental health care settings with different denominations that are not always the responsibility of the health ministries of the different CCAAs.

As in many other European countries, the diversity of denominations, and functional dependence of this type of services are high among the different CCAAs [14]. In some cases, there are differences in the extent to which health and social services are integrated. Some of these services depend on the ministry of health or health and welfare, but in many cases, this does not happen. Sometimes they are responsibility of the social welfare ministries and are managed through the municipal social services by 486 community mental health centers across the country or arranged with private entities. On other occasions, they depend on grants to non-profit entities, or public social-health foundations [15].

The communication and coordination between the health and social or socio-health are not always close. Shared information systems are rarely available, and the complex range of government structures (regional, provincial, county and local) and the absence of a specific department for mental health within the Spanish ministry of health contribute to multiply coordination problems. Regardless of whether mental health services and social services are coordinated through an intersectoral agency, as in Andalusia or operate independently as in Catalonia or Madrid, the coordination difficulties are still present. But in different forums, and in normative documents such as the mental health strategy of the NHS or in autonomous mental health plans, the shortcomings
in this area are recognized, and work is done to improve this situation.

**Involvement of other areas**

The application of the mental health community model implies the need for intervention from other areas that in the Spanish state are administered by non-health administrations [16]. This is the case of the management of welfare benefits, medical care for prisoners, the promotion of employment or housing needs. In the autonomous area, promotion and prevention sometimes depend on departments differentiated from those dedicated to health care.

**Mental Health Strategy of the Spanish National Health Strategy**

In addition to setting common goals, the mental health strategy has provided a space for coordination and intercommunication in mental health among the different agents involved. It has a scientific committee in which 19 scientific societies and two entities of relatives and persons with mental illness participate. It also has an institutional committee in which each one of the CCAAs participates with a delegate, normally through its departments dedicated to health care in mental health. It also includes the home office (holds the competences in penitentiary matters), the institute for the elderly and social services, and different departments of the ministry of health, social services and equality (information systems, quality, public health, action plan on drugs, woman affairs office) (www.msssi.gob.es/en/organizacion/sns/docs/Spanish_National_Health_System.pdf) [17, 18].

The mental health strategy was approved by the national health system inter-territorial council (CISNS) in December 2006 (www.msssi.gob.es/organizacion/consejoInterterri/docs/actividadCisns06.pdf) [19]. The monitoring and evaluation committee (CSE) has worked on the implementation and improvement. This committee brings together the institutional committee (IC) and the technical committee (TC) in preparing the strategy in 2006.

The main principles and values of the community model of mental health care set out in the first edition of this strategy and on which the strategy is based, supported by the general health act (1986) and by the ministerial commission for psychiatric reform (1985) [7] include autonomy (ability of the service to respect and promote the independence and self-sufficiency of individuals), continuity (ability of the care-providing network to provide treatment, rehabilitation, care and support on an uninterrupted basis on a lifelong basis known as longitudinal continuity, and coherently, among the services of which they are comprised meaning transversal continuity), accessibility (ability of a service to provide care to the patients and the family members thereof when and where they need it), comprehensiveness (implementation of all the basic facilities of a service in each health district). Recognition and realization of the right to receive care within the full range of needs caused by the mental disorder in question), equity (distribution of the health and social resources of adequate quality and proportional in quantity to the needs of the population in accordance with explicit, rational criteria), personal recovery (includes the recovery of health in the strict sense and of the consciousness of citizenship despite the disability caused by the disorder in question), accountability (recognition on the part of the health institutions of their responsibility to patients, family members and the community), quality (characteristic of the services
which is aimed at continuously heightening the probability of achieving the desired outcomes by using tested procedures).

The preparation of the strategy document has been based on the 2005 Helsinki Declaration and Action Plan which was endorsed by all member states of the World Health Organization (WHO) European Region, and European commitment, which is in line with European policies [20] in this area as settled in the European Green Paper as response to the Declaration and a further WHO policy and practice report. When establishing priority contents, Spain has considered the latest recommendations of the committee of ministers to member states of the EU regarding the need to implement measures to reduce social discrimination of the mentally ill, encourage the promotion of the physical health of the mentally ill and the mental health of the population, encourage training in the field of mental health of non-health professionals (social workers, social leaders, people from the area of citizen security and civil protection, teachers, etc.) and finally to generate social awareness about those negative consequences derived from the mental disorder on which we can intervene effectively and efficiently from areas that are not specifically sanitary.

Economic Crisis and Mental Health in Spain

One of the characteristics of any economic crisis is the empowerment of socio-economic factors that are associated with poorer mental health (poverty, low educational levels, fragmentation and social inequality or unemployment). Thus, people in situations of unemployment or poverty present a risk, greater than the general population, of depression, alcoholism or suicide. On the other hand, debts and housing payment problems lead to an increased risk of suffering from common mental disorders [21].

In Spain, the report of the Spanish society of public health and health administration (SESPAS) (www.sespas.es/informe2002/cap15.pdf) [22, 23] of 2014 states that, according to the IMPACT study, the most common mental disorders have increased significantly in primary care (PC) consultations between 2006 and 2010: 19.4% in major depressive disorders, 8.4% in generalized anxiety disorders or 7.0% for disorders of alcohol dependence or abuse. There is also a considerable increase in the consumption of psychotropic drugs, especially antidepressants, whose consumption was increased by around 10% in four years, between 2009 and 2012.

The SESPAS report shows an important controversy regarding the evolution of mortality due to suicide in the period of crisis in Spain. For example, in the CCAA of Andalusia, the adjusted suicide rates obtained from the statistics of deaths according to the cause of death of the national statistics institute (INE) have varied little between 2002 and 2012 without appreciating a significant increase, although in men the values of the Andalusian series are considerably larger than relative to the nation’s global.

The Organization of Mental Health Care System Explained by Two Very Different Autonomous Communities: Madrid and Andalusia

To try to explain the organization of mental health care within the state of the autonomies of Spain, we will take as example two CCAAs with differentiated characteristics. First of all, one of the richest communities, with a high density of
population and that includes the country’s capital, Madrid. Second, we will explain how to organize mental health management in another autonomous community, Andalusia, which is one of the largest, but also with a per capita income lower than many other regions. There are similarities and differences between the two, especially in the integration and coordination of social services and anti-drug agencies with the mental health network.

**Autonomous Community of Madrid**

The CCAA of Madrid is located in the center of the peninsula, and it is the third most populous in Spain with 6,549,979 (2018) inhabitants. Its capital is the city of Madrid, which is also the capital of the country.

It is also the most densely populated CCAA. Madrid’s economy is of roughly equal size to Spain’s first, Catalonia. Madrid thus has the highest GDP per capita in the country (32,723 euros) (www.comunidad.madrid/publicacion/1354547577692) [24], far ahead of the largest Spanish region, Andalusia, and was the main receptor of foreign investment in the country. The community ranks 34th amongst all European regions (evaluated in 2002), and 50th among the most competitive cities-regions worldwide (www.madrid.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-) [25], ahead of Barcelona and Valencia. Its citizens have diverse origins, and Madrid is the province with the highest number of residents born outside its territory and with the largest foreign population (13.32%).

**Structure and resources in mental health**

The mental health services network provides specialized care to the population of the CCAA of Madrid in accordance with the general health zoning. This makes possible a greater accessibility to the services and a guarantee in the continuity of the sanitary and social health care throughout the illness process.

Outpatient mental health services are the access route to services by the population. Except in cases of urgent need for care, they are usually through the primary mental health centers (CSM). These services are distributed throughout the health districts of the community of Madrid with one or more points of consultation, covering both the adult population, as well as children and adolescents care.

Based on a clinical evaluation by a qualified professional, a treatment plan for the disorder is established, which may include ambulatory care, day hospitalization for both adults and children / adolescents or psychiatric hospitalization for children, adolescents and adults. Throughout the care process, depending on the need of the clinical situation, these modes of attention can be used interchangeably.

For those patients who need it, a specific program of rehabilitation and social reintegration is available in each district and health area. It has specific assistance units such as day centers, rehabilitation centers or social clubs. There is an important collaboration of the CCAA of Madrid department of social services, which has a network of rehabilitation resources coordinated with mental health services.

Urgent care is covered in two ways. On the one hand by the mental health outpatient services in their normal operating hours and by the emergency services of the reference hospitals of the health area, where there is always specialized personnel 24 hours a day. The set of mental health care resources is part of an integrated network that allows the flow of patients between the different
units and programs, both outpatient and partial and complete hospitalization [26].

In recent years there has been a process of moving mental health services to hospital. But until that moment, the psychiatric and mental health care devices were structured at two levels – care unit and resources shared by various health care units.

Each functional care unit should organize the structure and mechanisms necessary to ensure adequate coordination with the centers and social care resources dependent on the public social care network for people with severe and lasting mental illnesses of the ministry of family and social affairs.

**Creation of a “regional mental health coordination office”**

It was created by virtue of Decree 1/2002, of January 17, 2002, which established the organic structure of the ministry of health of the community of Madrid. The function of the coordination office is to provide scientific and technical support in matters of mental health assistance to the Madrid health service. It does so through the functions of advising, planning and evaluating the services with the development of standards and establishment and monitoring of indicators common to the entire system. All this must be done taking into account the current mental health plan and the guidelines that the health authority determines at...
all times. The operation of the regional mental health coordination office is carried out with its own team with the support of expert committees.

In the Mental Health Strategic Plan (2010-2014) (www.comunidad.madrid/publicacion/1142669081933) [27] one of its main objectives was the rational use of psychotropic drugs through the development of strategies that increase the quality, effectiveness and safety of psychopharmacological treatments. In addition, the pursuit of a significant number of objectives of the Plan was pursued. Especially those related to organizational changes in the mental health care structure, with full integration into the general health network. The “Prevention of Suicide in the Community of Madrid” Program was also promoted and the foundations for the “Fight against Stigma and Discrimination associated with people with Mental Illness” were established.

Coordination with social services

In addition, the health resources network of mental health is coordinated with specific resources for the treatment of addiction disorders of the anti-drug agency and the Madrid Health Institute of Madrid City Council.

The public social network for people with mental illness had, at the beginning of 2015, a total of 6,064 places in 204 centers and specialized social care resources. These resources work to support the care, rehabilitation and integration of people with severe and lasting mental illness. They work in close coordination and in a complementary way with the health network of attention to mental health, with the aim of ensuring comprehensive care.

Some of these resources are managed by the health service of the CCAA of Madrid and others have administrative dependency of the Ministry of Social Policies and Family of the central government of Spain (www.comunidad.madrid/sites/default/files/doc/sanidad/asis/12_junio_plan_de_salud_mental_2018-2020.pdf) [28]. One of the main objectives of the successive mental health plans is to maintain the global coordination between the health network of mental health services and the public network of “Social Care for People with Severe and Lasting Mental Illness” of the regional ministry of social policies and family. It is intended in this way to achieve comprehensive health care for people with serious mental disorders.

Community-based long-term mental health care plan (PCC)

It is aimed at the care of patients with severe mental illness (SMI) and is organized as a multi-professional and longitudinal care process for patients who present deterioration, deficits or disability in relation to their mental illness. These patients require, or are expected to require, continuous multidisciplinary care and/or the simultaneous or successive use of several health and social resource units. Among its main objectives is to overcome or reduce the symptoms and disabilities of these patients and reach the highest possible level of personal autonomy and social participation.

The development of the social care network, with the sustained growth of resources, and the creation of “socio-community support teams”
(EASC), in coordination with the psychosocial care centers (PCCs) of the CSMs, has meant a reinforcement for the continuity of care and the home care. Unfortunately, after more than 20 years with hardly any increase in the number of professionals assigned to the social teams of the CSMs, there is an overflow situation. This is having a negative impact on the coordination of comprehensive care of the cases and creates a difficulty for the adequate optimization of the Social Care Network centers and resources [29].

**Autonomous Community of Andalusia**

Andalusia is located in southern Spain. It is the most populous (8,379,820, in 2017) and the second largest in area of the CCAA in the country (Institute of Statistics and Cartography of Andalusia) but the GDP per capita of Andalusia (17,651 euros) remains the second lowest in Spain. The population is concentrated, above all, in the provincial capitals and along the coasts, but is aging although the process of immigration is countering the inversion of the population pyramid.

**Organization of mental health care in Andalusia**

Specialized care for people with mental health problems is carried out through a network of health units, distributed throughout the CCAA and structured, in 15 mental health areas, whose portfolio of services includes ambulatory and home care, day care programs and hospitalization. After Decree 77/2008 [30], of administrative and functional management of mental health services in the scope of the Andalusian Health Service, the mental health units are organized in clinical management units depending on the different hospital areas or areas of health management the organization in the CCAA was established at different levels, as opposed to the model before the psychiatric reform of a single institution, and includes the following units:

**Community mental health units (USMC):**

They are the basic units of specialized attention to mental health, constituting their first level of attention. The rest of the mental health care units of the USMC are coordinated, providing comprehensive care to patients within their population in ambulatory or domiciliary.

**Child and adolescent mental health units (USMI-J):**

They provide specialized care, both in the outpatient setting and in full or partial hospitalization, to the child and adolescent population under age, derived from the community mental health units in their sphere of influence.

**Mental health rehabilitation units (URSM):**

Its objective is the recovery of social skills and the social and labor reintegration of patients with severe mental disorder in an outpatient setting. They are derived from their USMC.

**Mental health day hospitals (HDSM):**

They are mental health care units, configured as intermediate resources between the UMSC and the mental health hospitalization units. They provide specialized care, in a day hospitalization regime, to patients referred from the community mental health units in their area of influence.

**Inpatients units in general hospitals (UHSM):**

The inpatients units provide specialized care in full hospitalization and short stay.
Mental health therapeutic communities (CTSM):

They are mental health care units aimed at the intensive treatment of patients with severe mental illness, derived from the community mental health units of their sphere of influence, which require specialized mental health care, under full or partial hospitalization, half stay.

Social support

In Andalusia, social support resources for people with SMI are managed by the Andalusian Public Foundation for the Social Integration of People with Mental Illness (FAISEM). This public institution was created in 1993 and is linked to the Ministries of Health, Equality and Social Welfare, Employment and Economy and

![Figure 2. Outline of the Mental Health Network and its relations with social health resources in Andalusia. EBAP, Primary Care Unit; USMC, Community Mental Health Unit; UHSM, Psychiatry Inpatient Unit USMI-J, Child and Adolescent Mental Health Unit; URSM, Mental Health Rehabilitation Unit; HDSM, Mental Health Day Hospital; CTSM: Mental Health Therapeutic Community; UTS, Social Work Unit; FAISEM: Andalusian Public Foundation for the Social Integration of People with Mental Illness. Source: NHS Primary Care Information System (2009)
Finance and financed through the budgets of the CCAA.

Its objective is to develop programs that are oriented to cover the difficulties or shortcomings of people with serious mental disorders. They focus on accommodation, employment, daily activity and social relations (residence, occupational-occupational, leisure and free time, promotion and support for tutelary entities and the associative movement, and care for people with SMIs in situation of marginalization/homeless and prison population with SMIs. They are also in charge of social support activities in coordination with public mental health services and with the different service networks existing in the autonomous community (social services, employment, education, etc.) [31].

Health care for drug users

In Andalusia, the general directorate under the Ministry of Equality and Social Welfare has been assigned the powers relating to action in the field of drug addiction. Since 2002, there was a joint action protocol between the community mental health Units dependent on the Andalusian health service and the outpatient drug addiction treatment centers, which was reviewed and updated during the validity period of the II comprehensive mental health plan of Andalusia 2008-2012, and continued in the III comprehensive mental health plan in Andalusia 2016-2020 [32].

Conclusion

After the path opened by the psychiatric reform in Spain and the beginning of the transition to a community care model, the differences generated by the state of the autonomies have meant that in the same country there are as many programs and ways of applying the strategies as different regions has the nation.

Among the difficulties in carrying out the mental health strategies at the national level and in the CCAA, a series of factors appear. First, the history and the peculiar circumstances of each community. Second, the resistance to change of some mental health professionals.

The “political will” of the governments of the CCAA in their relationship with the central government of the nation, with the ideology of the party in government and the pressure exerted by the associative movement.

Perhaps due to the economic crisis and the difficult coordination between autonomous communities, the new update of the strategy (assumed for the period 2015-2019) (www.msssi.gob.es/gabinete/notasPrensa.do?id=3789) [33] that will establish the priorities for mental health for the next five years is still pending ratification. Specifically, the new national strategy for mental health introduces the fight against suicide as one of the main strategic lines, with the aim of reducing this behavior with efforts in prevention and early detection. It includes other lines of action that involve a novelty, such as attention and intervention with families, improvement of information systems, autonomy and patient rights or the participation of social agents and institutions.

Acknowledgement

All authors declare no conflicts of interest in writing this article.

References


26. Guide to Mental Health Care Resources. Specific Centers and Services Mental Health. Madrid: