Barcelona Mental Health Plan 2016-2022

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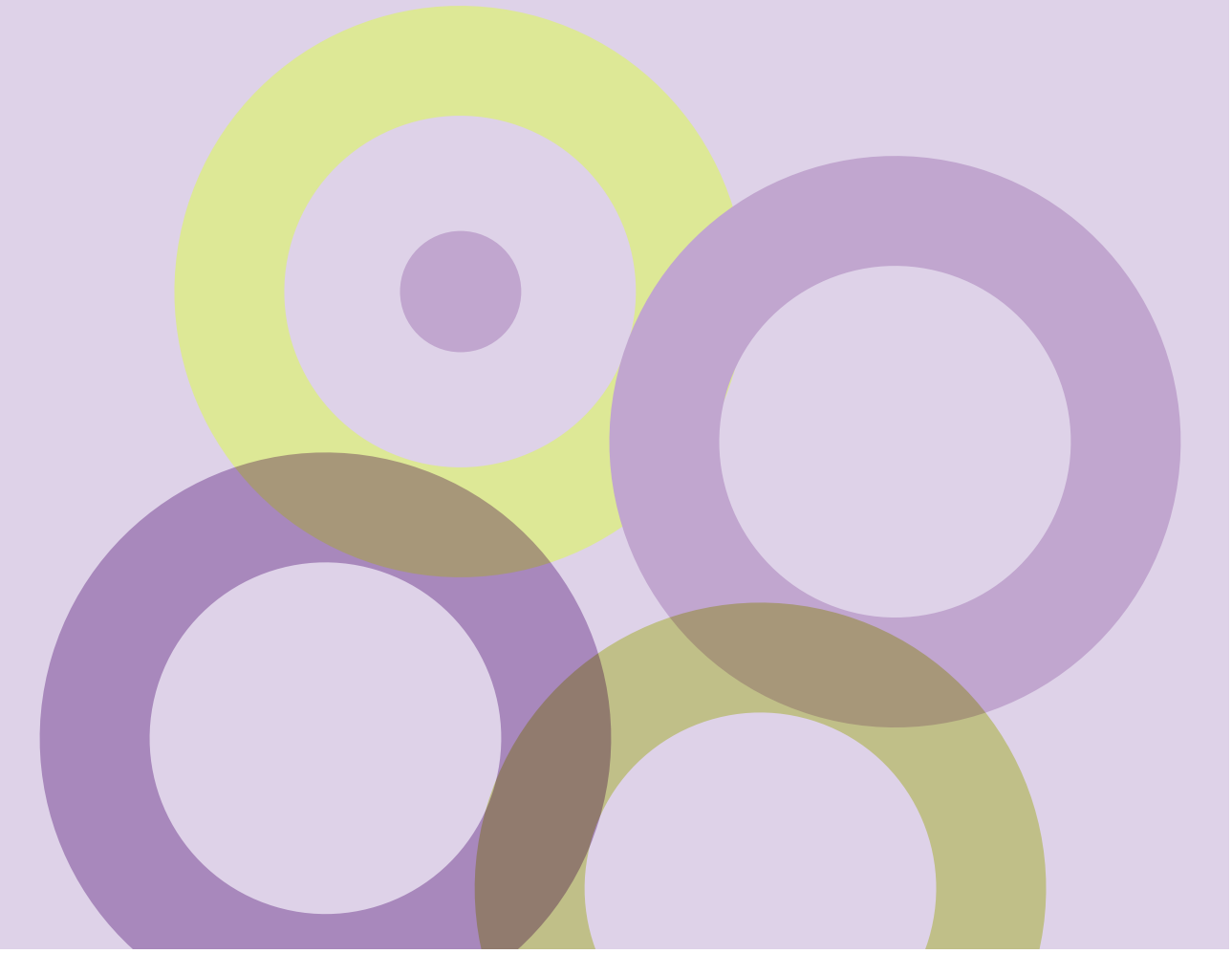

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PRESENTATION

For Barcelona City Council improving psychological well-being and mental health is a political priority in the construction of a more inclusive Barcelona. The Barcelona Mental Health Plan 2016-2022 is our tool for achieving this.

The Barcelona Mental Health Plan is a strategy that represents a shared commitment between institutions and social entities in order to develop actions designed to prevent and improve mental health care and to enable people and families affected to participate in a city respecting their rights with equal opportunities and without discrimination, in a city respecting their rights.

That is why we need to work for a city that guarantees the social rights of its citizens, such as quality employment, housing, social protection or health. The fight against inequalities must be a priority in order to provide effective equality of opportunities. Unfortunately, the recession, recent policies of deregulation and budget cuts have jeopardised these rights and inequalities have widened, making the lives of many people more precarious and vulnerable and, as a result, increasing psychological discomfort.

In order to make progress in the execution and follow-up of the lines of action included in the Plan, we have chosen to use collaborative work models, while maintaining spaces for cooperation in which to share knowledge and experiences that help us in the political aspects of mental health in our city, with a particular focus on neighbourhoods with a bigger concentration of vulnerability factors.

We will advance towards ensuring that the highest number of stakeholders possible is committed to these objectives, as mental health is an issue that affects everyone. We have the obligation to respect this commitment if we want to make Barcelona a city that promotes rights and well-being.

We want a city where children, adolescents and the young adult population can properly plan and enjoy their life projects. A city where respect and proper treatment for the elderly is guaranteed, active ageing is promoted and autonomous living is encouraged. A city where there is no discrimination based on sex, sexual orientation, age, place of birth, illness and/or functional diversity.

We want to make Barcelona a fairer, more equitable city that ensures greater welfare and quality of life for everybody. A city of social rights. A city of people, for people. A city committed to mental health. To that end, commitment at the municipal level to mental health is indispensable.

Laia Ortiz Castellví
Deputy Mayor
Area of Social Rights

Social Rights

Barcelona Mental
Health Plan
2016-2022

Mental health is an urgent matter that must be addressed in our city. The *Barcelona Health Report 2016* highlighted when it comes to city residents aged 18 to 64 that 16.3% of males and 19.1% of females suffer from a mental disorder. This is an issue that affects everyone.

This is the first Mental Health Plan to be drawn up for the city of Barcelona, though there are many stakeholders with experience in working to improve mental health in the city. For over 30 years, civil society entities have been providing support to the people affected and their families, as well as working towards prevention and promoting mental health.

This plan is in alignment with the policies and recommendations promoted by other institutions, such as the Catalan Government (Comprehensive Care Plan for People with Mental Disorders and Addictions), the European Commission and the World Health Organisation (WHO).

This is a shared city strategy, based on a far-reaching participatory process that includes the voices of municipal political groups, various sectors of the City Council (health, employment, housing, education, social services, etc.), entities and organisations providing mental health services, professional and scientific organisations, and other institutions such as the Barcelona Public Health Agency, the Barcelona Health Consortium, the Barcelona Education Consortium and the Catalan Ministry of Health.

It is a plan that includes specific lines of action and articulates various stakeholders with the capacity to address mental health in the city. It places a special emphasis on children, adolescents and young adults, and provides for a comprehensive approach to mental health.

Its main mission is to promote mental health and prevent and address mental disorders, in order to improve the psychological well-being and overall quality of life of the entire population. Its principles include equity and the reduction of social inequalities in health, territoriality and, therefore, work on the ground in the various districts and with the community, as well as the recognition of rights, equal opportunities and non-discrimination of people with mental disorders.

There is still a lot of work to do, but we are committed to continuing to work together in order to move forward in executing the proposed lines of action. At the same time, we have the challenge of turning Barcelona into a city committed to the good mental health of its citizens.

Gemma Tarafa Orpinell
Commissioner for Health

Social Rights

Barcelona Mental
Health Plan
2016-2022

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1.
INTRODUCTION

Mental health has become a primary goal in the European Union, given that some 15% of the population is estimated to suffer from some sort of mental disorder in the course of their lives. The great transnational political goals need to be shaped in accordance with the individual territory where they will be implemented. That is why we must make an effort to include operational factors in the general strategies and transfer proposals identifying the actual problems to the local areas, to find the best way to deal with them in order to improve the mental health of our citizens.

In that context, as part of the framework of Barcelona City Council's health policies, a shared city strategy has been developed to provide a framework for the prevention, promotion and delivery of healthcare. Within this process, the contribution of the stakeholders involved in mental health, be it from a personal, family or professional point of view, has been fundamental, as they are the protagonists of political action.

Similarly, the improvement of the population's mental health requires action in the closest spheres of people's everyday lives. So territorialisation, or adapting strategies to local specificities, is a fundamental tool as the different needs of each neighbourhood must be taken into consideration, as well as possible inequalities relating to mental health, in order to respond to the real expectations and needs of citizens.

By offering a Mental Health Plan that provides for fundamental, action-based strategies, Barcelona City Council intends to move forward in pursuing the objectives, methodology and measures that will have to be put in place to achieve real change that ensures the overall welfare of the population, especially of those who live in situations of greatest vulnerability. The Plan will be rolled out in timed phases, and provides for periodic assessment in order to make the necessary adjustments to achieve its successful implementation.

The stakeholders that have taken part in the development of the Barcelona Mental Health Plan, include, first and foremost, the Barcelona Public Health Agency (ASPB) with the creation of a conceptual framework and a study on the state of mental health and its determinants in the city. In parallel, an Advocacy Group made up of representatives of social entities working in mental health, from different municipal sectors, the Barcelona Health Consortium (CSB) and the Catalan Ministry of Health, prepared a document laying out the basis of the Plan. That document identifies the facts and challenges in mental health that the city must address, as well as guidelines for proposals to be pursued in different areas of the council's activity, such as health, employment, housing, education or social services, among others. Likewise, we have taken into account public proposals gathered from three specific sessions on mental health during the Municipal Action Plan (PAM) discussion process along with those entered on the digital platform decidim.barcelona.

Finally, it has been almost 30 years since Barcelona implemented its first Action Plan against Drugs, under which the “Barcelona Model for Responding to Drug Problems” was drafted, tackling the problem and paving the way for successive action plans. The Barcelona Mental Health Plan has taken this model into account during its production, and it integrates the guidelines set out in the 2013-2016 Barcelona Drug Action Plan.

2.
POLICIES AND STRATEGIES FOR MENTAL HEALTH

2.1. Mental health policies in Europe

2.1.1. From the Helsinki Declaration to the 2013-2020 European Action Plan

In 2005, the member states of the European region of the World Health Organisation (WHO), the European Commission and the Council of Europe signed in Helsinki the **Mental Health Declaration for Europe** (Resolution EUR/RC55/R2), which incorporated mental health as a priority in the European agenda. This document recognises the promotion of mental health, and the prevention and treatment of mental disorders as fundamental objectives for the protection and improvement of the well-being and quality of life of the entire population (World Health Organisation, 2005).

The Helsinki Declaration identifies mental health as a public health issue and urges it to be included as an integral part of other public policies related to human rights, social care, education and employment. It also encourages member states to design comprehensive, evidence-based mental health policies to improve the mental well-being of the entire population and to promote the inclusion of people with mental disorders. In that regard, the Declaration prioritises the following strategic lines of action:

- The prevention and promotion of mental health for the entire population, with specific actions for each stage of life.
- The fight against stigma and discrimination, guaranteeing human rights and the dignity of individuals.
- Access to primary care and the provision of services in the community for people with mental health disorders.
- Better training for mental healthcare professionals.
- The establishment of alliances and coordination between sectors.
- The promotion of research into mental health and the assessment of interventions for the generation of new evidence.

In accordance with the commitments established in Helsinki, and in response to the evolution of the specific mental health needs of the European region, the WHO Regional Office for Europe has produced the **European Mental Health Action Plan (2013- 2020)**. This Plan complements the WHO global mental health plan for Europe and is consistent with the objectives of the European policy framework on health and well-being (Health, 2020). It also adheres to the United Nations Convention on the Rights of Persons with Disabilities (2008) and incorporates the conclusions of the European Pact for Mental Health and Welfare signed in 2008 (World Health Organisation, 2013b).

The strategic direction set out in the European Action Plan covers prevention and the promotion of mental health, with a particular focus on the most vulnerable groups, and the development of community care services within a context of guaranteeing human rights (World Health Organisation, 2013b).

In addition, it prioritises the need to reduce social inequalities in mental health and the implementation of effective and secure interventions in collaboration and coordination with other non-health sectors.

To achieve these goals, the WHO lists a number of **principles for the design of effective local interventions**, taking into account the social determinants of mental health (Allen et al., 2014). Those principles are as follows:

- Proportionate universalism: interventions proportional to the disadvantage of the population and not focused solely on the most vulnerable or most disadvantaged groups.
- Cross-sector approach: interventions need to take into account the potential impact on mental health of actions in various sectors, such as education, employment, health and housing.
- Life cycle perspective: interventions relevant to each life stage (childhood, adolescence, adulthood, senior citizens), taking into account the various determinants.
- Interventions from birth: in order to guarantee the best possible start to life for all children, with actions aimed at supporting their parents.
- Interventions to promote physical health: good physical health is a key factor in good mental health.
- Long-term policies: social determinants of mental health can only be addressed with sustainable, long-term policies.
- Equity in mental health in all policies: to ensure that decisions taken in all sectors do not cause an increase in inequalities in mental health.
- Action informed by local knowledge: with data systems to help prioritise prevention, promotion and improvement of mental health interventions.

2.1.2. Recommendations on policies to reduce the impact of the financial crisis on mental health

Numerous studies have confirmed the negative effects of financial crises on the mental health of the population (Uutela A., 2010). In order to address the impact of the crisis on the mental health of the European population, the European Psychiatry Association (EPA) has identified two areas in which it recommends interventions: a) social protection systems and b) the promotion and improvement of mental healthcare (Martin-Carrasco et al., 2016).

a) Systems of social protection

Since there is a close relationship between poverty and mental health, systems of social protection need to be improved in order to combat the effects of a

long-term recession (Allen, 2004), with actions adapted to each life stage. To that end, the EPA recommends the following strategies:

- Provision of financial support: measures are needed to relieve debt and falls in family income.
- Combating unemployment and precarious work: active employment policies, such as career guidance and placement programmes, must be implemented, rather than systems based solely on the provision of subsidies (Diamond and Lodge, 2013). These programmes must also integrate people with mental disorders (Marino, 2014).
- Address precarious housing: includes programmes to fight against mortgage foreclosures and to offer transitional housing for those who have already lost their homes, in order to avoid situations of homelessness. Programmes should also be aimed at preventing people from being forced to leave their homes and having to live with relatives or friends (Phua, 2011).
- Measures to reduce social inequalities: community participation must be promoted to create ties and avoid social isolation. Given that the population of children, the elderly and single people with dependent children, mainly women, are especially vulnerable groups in facing the financial crisis, family protection programmes and support for parental skills must be implemented.

b) Promotion and improvement of mental healthcare

In most European countries, care for mental health problems through health services is insufficient and inefficient because of the lack of resources allocated by governments. In addition, there are also inequalities in access to these resources (Martin-Carrasco et al., 2016). To improve mental healthcare, the EPA sets forth the following strategies:

- Speed up processes to improve mental healthcare. In that regard, the EPA highlights measures such as the creation of a network of specialised community services, the expansion, or at the very least maintenance, of mental healthcare coverage and coordination with social services, prioritising those that are on offer to people affected by the crisis.
- Improve coordination between primary care and specialised care. Specific actions such as suicide prevention programmes, group support for people that are unemployed, in serious debt or in situations of gender-based violence, short interventions for people with alcohol problems and programmes to address common mental health disorders, such as anxiety and depression, must be offered (Martin-Carrasco et al., 2016).
- Boost prevention and promotion of mental health. The prevention and promotion of mental health activities have shown their clinical effectiveness, especially those aimed at children and adolescents (Jané-Llopis, Barry, Hosman and Patel, 2005; Min, Lee and Lee, 2013) and their cost-effectiveness

(Knapp M., 2011). It is therefore necessary they be incorporated both in primary care and in specialised services.

- Adopt support and communication strategies. Experts in mental health and representatives of the media should develop guidelines to prevent suicides related to the news items shown during times of crisis (Niederkrotenthaler, 2014). Likewise, media campaigns should be developed to combat the stigma associated with mental health disorders (Bawaskar, 2006).

2.2. Mental health policies in Catalonia

The Catalan government, in its 2005-2007 Health Plan, established mental health as one of its priority areas. In order to make make this a reality, the **Master Plan for Mental Health and Addictions (PDSMA)**, drawn up in collaboration with the affected people, families, mental health providers and the Catalan Ministry of Health, was approved in 2006. Subsequently, it set out the **Comprehensive Care Plan for People with Mental Health Disorders and Addictions** to determine the model to be followed in cases of mental disorder and addictions.

2.2.1. Master Plan for Mental Health and Addictions (PDSMA)

The PDSMA promotes a community-based, cross-sector model of mental healthcare, which aims to integrate the rehabilitation and social insertion of people with mental health disorders, from prevention and promotion of mental health to treatment, as well as supporting their relatives. To that end, the PDSMA sets forth strategic lines of action that can be grouped into three main areas: a) promotion of mental health and the prevention of mental health disorders and addictions; b) care and treatment of mental health problems and c) improvement of management systems and healthcare practices.

a) The promotion of mental health and the prevention of mental health disorders and addictions. This area includes the roll-out of interventions for prevention and promotion across the health and education sectors, with a focus on the most vulnerable segments of the population, such as children, adolescents and the elderly. Programmes should address the consumption of alcohol and other drugs in the adolescent population, taking into account the different patterns of consumption among girls and boys, as well as projects to prevent suicide or tackle stigma, among others.

b) Care and treatment of mental health disorders. This includes interventions aimed at improving early detection of mental health disorders through primary care, by training healthcare professionals. It also points to the need to involve people with mental disorders and their families in the care network, with a range of services to guide them and guarantee their rights. It also aims at developing a care system that integrates the various networks and services that exist within Catalonia.

c) Improvement of management systems and healthcare practices. This area includes objectives such as involving healthcare providers in management systems and the continuous training of care staff. It also highlights the promotion of research and an assessment culture to offer evidence-based care.

2.2.2. Comprehensive Care Plan for People with Mental Health Disorders and Addictions

The Comprehensive Care Plan for People with Mental Health Disorders, passed in 2010 by the Catalan government, is the strategy that defines the Catalan model for mental health and addictions. The Plan was led by the Ministry of

the Presidency in order to give maximum political visibility to mental health, and saw participation from the various ministries involved (Health, Education, Social Action, Justice and Work) along with social organisations in the mental health sector.

The actions prioritised in the 2014-2016 period focus especially on children and adolescents, and are included in the following strategic lines:

- Promotion of mental health and the fight against stigmatisation: through awareness programmes and campaigns.
- Improved care for children and adolescents with mental disorders: through joint interventions from health, educational and social services that pursue early detection in tackling mental disorders alongside the professionals involved in the various sectors.
- Promotion of rights and improvement of care: by putting in place protocols to deal with emergencies, transfers or involuntary hospitalisation of people with mental health disorders, and offering training for the professionals involved.
- Support for families caring for people with mental health disorders: through the roll-out of a portfolio of care services to include training to empower people with mental health disorders and their families, ensuring that activities aimed at families do not reinforce the stereotype of women as caregivers.
- Community inclusion of people with addictions and serious mental health disorders: through the roll-out of basic social services such as housing services (residences, supported-living and help towards being autonomous in their own homes), or social clubs and community action in the field of culture.
- Job placements for people with severe mental disorders: through the definition of a job placement model for people with mental disorders that integrates personalised insertion pathways, supported-working in the ordinary jobs market and aid for organisations that place people with mental disorders.
- Specialised care in the judicial and criminal fields: through specific interventions for people in situations of deprivation of liberty (prison) or subject to security measures, with a special focus on children and adolescents.
- Promotion of associations and participation of people with mental health disorders and their families: by involving organisations in the sector in the design of public policies in mental health and better coordination of services.

2.3. Towards a Mental Health Plan in Barcelona

The Barcelona Health Survey (2011) highlighted that when it comes to city residents aged 15 years and over, 11.1% of males and 16.8% of females are at risk of suffering a mental disorder. In addition, the impact of the financial crisis, which began in 2008, and austerity measures on the social determinants of health have increased social inequalities and poverty among the city's population. The groups most affected by the crisis include children, adolescents and young adults (Rajmil, 2015) and the evidence shows that exposure to situations of deprivation and social inequality during childhood is associated with worse results in health, and in mental health in particular, in the short, medium and long term (Irwin, 2007). The earlier the exposure, the more irreversible and definitive are the negative effects (Irwin, 2007). In addition, there has also been an increase in mental health problems and addictions, especially alcohol abuse, in families with unemployed people and/or with mortgages (Gili, 2013).

In light of this situation, the Commissioner for Health at Barcelona City Council has established improved mental healthcare and integration for people with mental illness as a strategic line of action for the 2016-2019 term of office. In order to achieve this goal, the City Council has promoted a municipal mental health plan that involves all those organisations with effective capacity for action and involvement in its implementation.

Although this is the first time Barcelona City Council has established a specific strategy to address mental health and its determinants, there are many stakeholders with a tradition of working to improve health in Barcelona. As such, among other functions, the Barcelona City Council Department of Health has defined the criteria for promoting health policies and reducing inequalities in health, as well as defining the collaboration with health entities in the city to build shared strategies. The Barcelona Public Health Agency (ASPB) is charged with knowing the state of health of the population and the factors that determine it, as well as the actions to be taken to prevent, maintain and improve the health of the city's population. The Barcelona Health Consortium (CSB) is leading the way in planning and managing the city's health services to allow a more comprehensive approach to the care that citizens receive. Moreover, it is worth mentioning the work on mental health carried out by the Municipal Institute for People with Disabilities (IMPD), with activities to promote and care for people with mental illnesses, and to improve their quality of life and social integration. In addition, within the city there is a wide range of organisations that work in the field of mental health from a range of approaches.

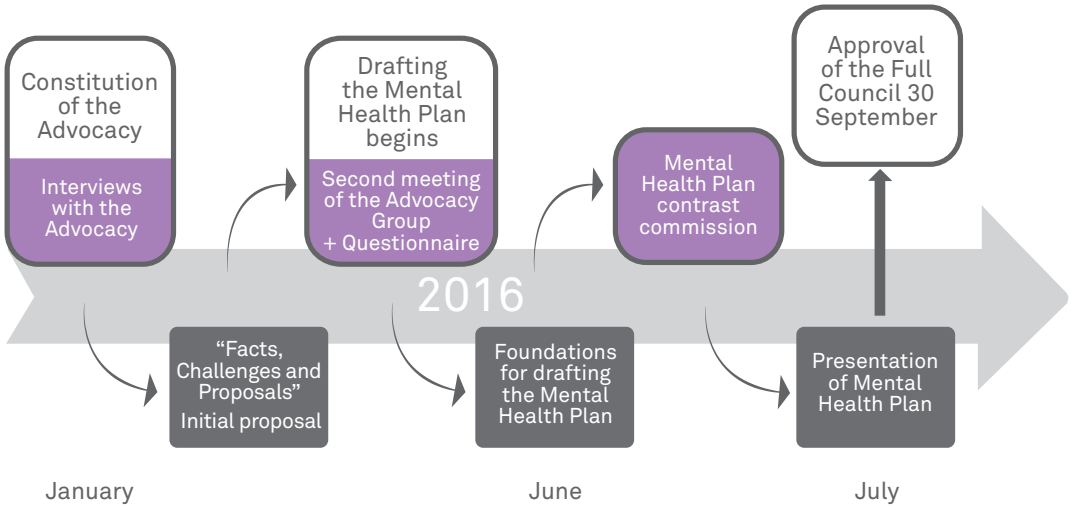
In that regard, the Mental Health Plan is an opportunity to define a common strategy, between the institutions and social organisations in the city, in order to learn, coordinate and increase the municipal assets for the prevention and promotion of mental health and give better care to people with mental illnesses as well as their families, with actions in the health, social, labour, educational and housing spheres, among others.

In order to draw up the Plan, a working group has been created consisting of representatives from the administration, the organisations of those affected and their families, service providers and experts. This group is behind the creation of a Mental Health Board as an instrument for participation and shared responsibility between the various stakeholders participating in the strategy. During this process, the aim was to distinguish the steps in mental health taken with children, adolescents and young adults, and particular care has been given to make women's voices heard.

For the first time, the Mental Health Plan gives the city a common frame of reference for the different sectors involved in improving the psychological well-being of the population. It is an opportunity to give more visibility to mental health in the municipal political agenda and to promote the participation and collaboration of all the stakeholders involved in the process.

3.
PLAN METHODOLOGY: STAKEHOLDERS AND ACTIONS

The process of drawing up the Mental Health Plan is based on a participatory methodology, involving the various sectors of the City Council and social organisations that provide mental health services in the city. Below is the outline of the working process that has been followed, by the contents and the work carried out.



Firstly, an Advocacy Group was created consisting of the political groups and different sectors of the City Council, autonomous bodies, social entities, service providers and professional and scientific organisations, and a first meeting was formalised on 11 January 2016, marking the beginning of work towards developing the city's Mental Health Plan. During the months of January to March 2016, 36 in-depth interviews were held with members of the Advocacy Group, which were oriented towards drafting a document containing the foundations for the Mental Health Plan. This document, entitled Facts, Challenges and Proposals, includes a description of the situation in the city and identifies eight challenges with a high level of agreement among those interviewed, for the management of mental health in the city, as well as a first draft of proposals divided by field. In addition, in order to identify proposals, the results of the debates held as part of the Municipal Action Programme (PAM) 2016-2019 were taken into account, and more specifically, the minutes of various sessions: "The Mental Health Plan: the view of the people affected", "Mental health in childhood and adolescence" and "The Mental Health Plan: the view of professionals", along with the proposals related to mental health recorded on the decidim.barcelona platform. In parallel to this process, the City Council consulted key voices from different sectors and other administrations to detect needs in mental healthcare, and drafting of the final document of the Mental Health Plan began.

On 9 June 2016, the second meeting of the Advocacy Group was held, which put forward the document “Facts, Challenges and Proposals” to be validated, and the Plan’s strategic lines were presented. After this meeting, an online questionnaire was sent to prioritise the lines of action identified in the initial document. At the same time, both documents were presented at the Health Councils of various districts as well as the Health Group of the Municipal Social Welfare Council for discussion. On 4 July, the Mental Health Plan was outlined at a contrast committee, made up of some of the people taking part in the Advocacy Group, and the driving lines of action in the Plan, and their oversight, were presented. Finally, the Mental Health Plan was finalised and presented on 20 July at a plenary session of the Mental Health Board with other participants.

4.
MENTAL HEALTH IN BARCELONA

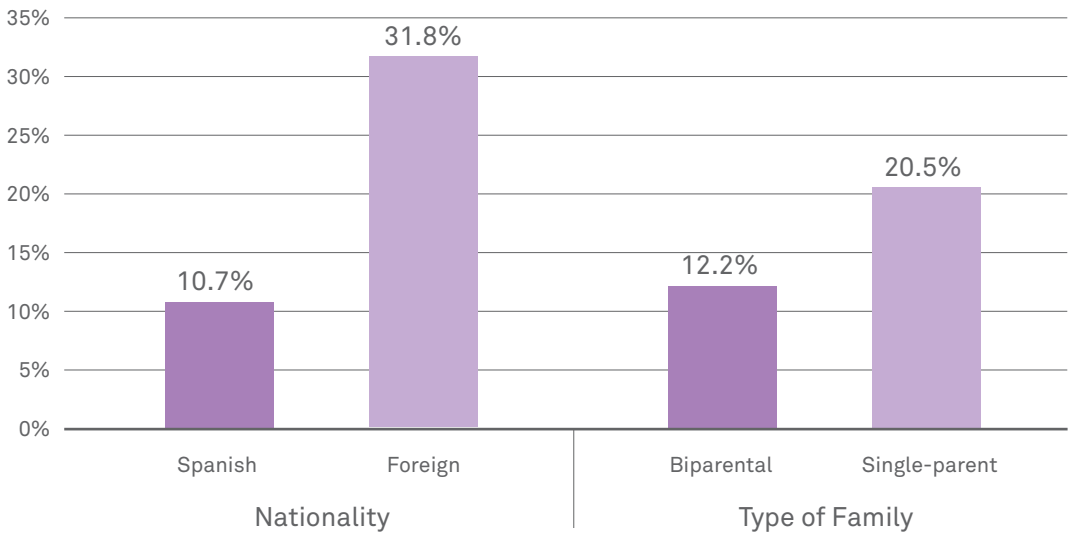
4.1. Social determinants of mental health

Childhood and adolescence

In 2014 in Barcelona, people under the age of 15 represented 13.3% of the population. These minors live in 139,293 households, a figure that represents one in five households in the city. Of those, 12.6% are single-parent households. The situation of homes with minors is very different depending on the level of income, the place of residence and the employment situation or academic level of the parents.

Adverse living conditions during childhood are associated with mental health problems. According to data from the children and families barometer in Barcelona in 2014, with regard to the economic level, 27.9% of households with minors claimed to have difficulties or many difficulties to get by, and this percentage reaches 50 % in the case of single-parent homes, mainly headed up by women. One out of every ten households with minors does not think they will be able to make their mortgage payments or pay rent in the next three years, a figure that doubles in the case of single-parent homes. In fact, 13.4% of households with minors have been late making their mortgage or rent payments in the last 12 months. In the case of single-parent households, this percentage rises to 20.5% and, in the case of foreign-born households, 31.8% (see Figure 1). As for the job situation, in 8.1% of households with children under the age of 16, neither the father nor the mother are in paid work, a figure that rises to 29.9% in households where parents have only primary education.

Figure 1. Percentage of households with under-16s that have been late making their mortgage or rent payments in the last 12 months. Barcelona children and family barometer (2014).



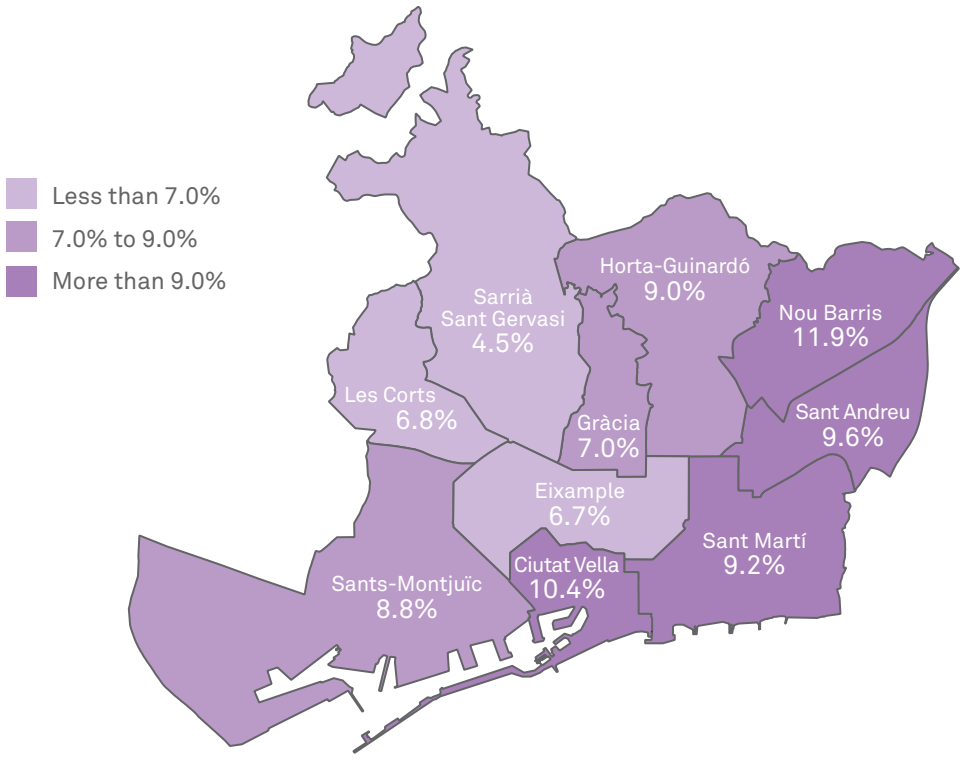
Bullying at school can have a major impact on the mental health of children and adolescents. The 2012 FRESC report offers information on bullying at school according to sex and school year. In general, boys are more often involved in

bullying at school than girls, especially in the role of bully. The highest percentage of victims are to be found among younger pupils. About 10% of pupils in 2nd year ESO (13-14 years old) claim to have been the victims of bullying.

Adults

Unemployment is related to poor mental health. According to the Active Population Survey, in January 2016 there were 105,400 unemployed people in Barcelona, 57.3% of whom were women. The unemployment rate in Barcelona was 13%, and was higher in women. Long-term unemployment in particular is associated with poor mental health. In January 2016, 49.4% of unemployed people in Barcelona had been looking for work for two years or more while the proportion in 2007 was just 8.1%. The percentage of unemployed people varies according to the district of residence. In January 2015, the districts with the lowest registered unemployment were the most prosperous: Sarrià-Sant Gervasi, L'Eixample, Les Corts and Gràcia, with values ranging from 4.5% in the former and 7% in the latter. In contrast, the districts of Sants-Montjuïc, Horta-Guinardó, Sant Martí, Sant Andreu, Ciutat Vella and Nou Barris surpass the city average, with percentages between 8.8% in Sants-Montjuïc and 11.9% in Nou Barris, a percentage that is equivalent to 2.6 times that of Sarrià-Sant Gervasi (see Figure 2).

Figure 2. Unemployment rate of the population aged between 16 and 64 by district. Barcelona, January 2015.



Source: Produced by the Department of Employment, Business and Tourism Studies at Barcelona City Council, based on data from Barcelona City Council Statistics Department.

Elderly people

In 2015, almost 90,000 people aged 65 or older lived alone, of which 77% were women. These figures are especially relevant if one considers that loneliness in older women is frequently related to depressive states. The mental health of the elderly is also related, as in other age groups, with economic vulnerability, with the risk of poverty greater among women. From 2006 until 2012, the percentage of people 60 years and older with incomes lower than the public multiple effect income indicator (IPREM) fell from 30.1% to 22.8%. Even so, in Barcelona in 2012 almost 100,000 people aged 60 or over earned less than €532.51 per month. The territorial distribution of this group is uneven (see Table 1): Ciutat Vella and Nou Barris are the districts with most people in this situation (more than 30%), while at the other extreme, we find Les Corts (15.3%) and Sarrià-Sant Gervasi (10.5%).

Table 1. Level of income of people aged 60 or over. Barcelona, 2006-2012.

	2006			2012		
Districts	Population aged 60 or over	Income < IPREM	%	Population aged 60 or over	Income < IPREM	%
1. Ciutat Vella	23,376	9,883	42.3	19,508	6,407	32.8
2. Eixample	73,858	17,744	24.0	73,799	12,881	17.5
3. Sants-Montjuïc	44,977	15,784	35.1	45,699	12,176	26.6
4. Les Corts	22,143	4,792	21.6	25,116	3,838	15.3
5. Sarrià-Sant Gervasi	37,164	5,654	15.2	39,196	4,127	10.5
6. Gràcia	32,629	8,974	27.5	32,913	6,468	19.7
7. Horta-Guinardó	47,084	16,121	34.2	49,173	12,945	26.3
8. Nou Barris	47,132	18,319	38.9	47,722	14,824	31.1
9. Sant Andreu	35,303	10,341	29.3	38,796	9,137	23.6
10. Sant Martí	55,093	18,599	33.8	58,798	15,333	26.1
Barcelona	**418,759**	**126,211**	**30.1**	**430,720**	**98,136**	**22.8**

Source: Produced by the Department of Research and Knowledge, Quality of Life, Equality and Sports Area, Barcelona City Council, based on the database of the elderly persons' Pink Card.

IPREM: public multiple effect income indicator. Barcelona Municipal Register. Barcelona City Council.

4.2. The state of mental health in Barcelona

Childhood and adolescence

According to data from the 2012 FRESC survey on secondary school students, the prevalence of probable psychological suffering is between 5 and 7% among adolescents. These percentages decrease with age for boys, whereas this reduction only occurs from 2nd to 4th year of ESO (13-16 year olds), with a subsequent increase in the 2nd year of Batxillerat (17-18 years) and intermediate-level vocational training cycles for girls. The percentage of students with possible psychological suffering by school year is higher among girls than among boys, with percentages of around 15-16% and 10-13%, respectively (see figures 3 and 4).

Figure 3. Prevalence of psychological suffering among adolescent boys by school year. 2012 FRESC Report.

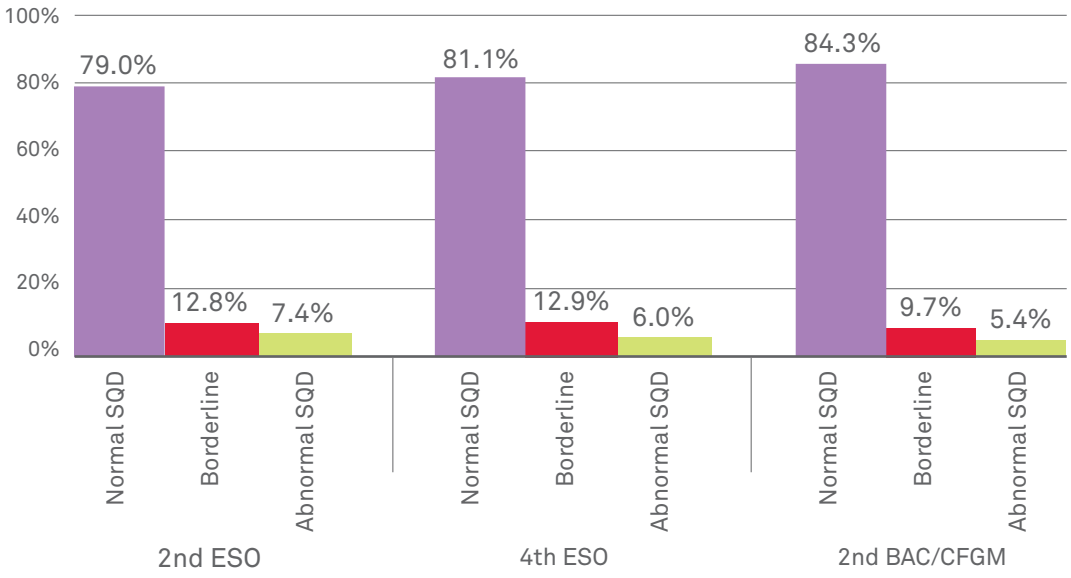
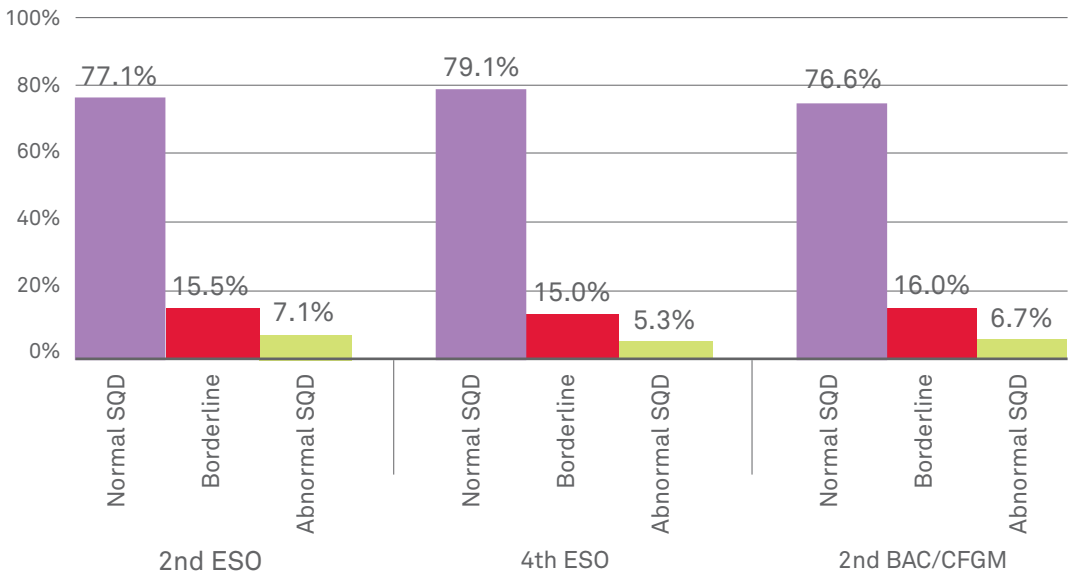


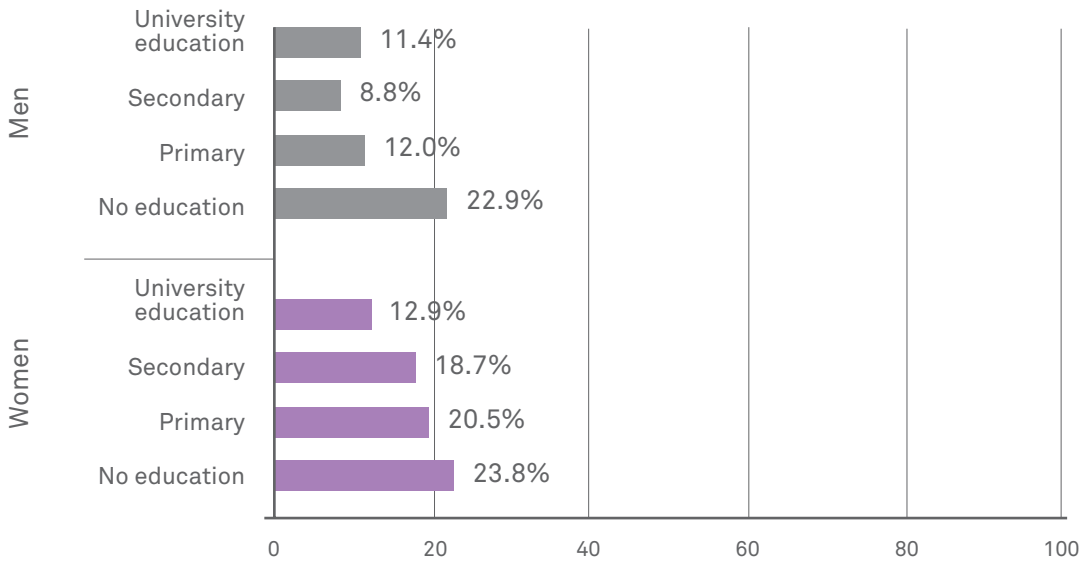
Figure 4. Prevalence of psychological suffering among adolescent girls by school year. 2012 FRESC Report.



Adults

In the latest edition of the Barcelona Health Survey (ESB), in 2011, 16.8% of women and 11.1% of men aged 15 or older were at risk of psychological suffering. In recent years, men have always shown values lower than women, with a stable trend in both sexes. Among women, increased age is accompanied by an increase in the prevalence of psychological suffering, whereas men do not see a gradient based on age. We can see, therefore, that the highest prevalence of psychological suffering corresponds to women aged 65 or older, at 21%. Correlation is observed with level of studies in both sexes, with people with a lower level of studies at greater risk of psychological suffering, up to 23.8% of women and 22.9% of men without studies (see Figure 5).

Figure 5. Risk of psychological suffering by level of studies and sex. Population aged 15 or over. ESB 2011. Percentages standardised by age.



4.3. Mental healthcare in Barcelona

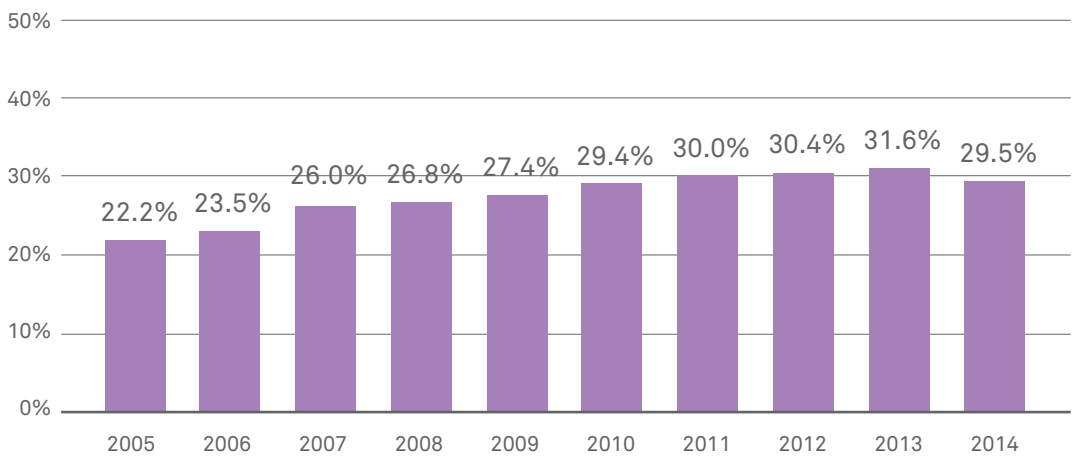
Childhood and adolescence

According to data from the basic minimum record of mental health data, 10,517 minors received care in 2014. In 2014, 61.5% of people attending mental health centres for children and young people (CSMIJ) were male.

Adults and elderly people

In 2014, 42,704 people were attended to by the mental health centres for adults (CSMA), of whom 60.6% were women, in contrast to the trend for children. In recent years, the increase in people treated is in addition to an increase in severe mental disorders. The figure of 22.2% of adults with severe disorders treated in 2005 rose to 29.5% in 2014 (see Figure 6).

Figure 6. Percentage of over-18s treated at mental health centres with severe mental disorders (TMG). Barcelona 2001-2014.



Source: Basic minimum record of mental health data CMBD_SM). CatSalut

5.
RESULTS AND PROCESS OF DRAFTING THE PLAN

5.1. Challenges identified in mental health

The document titled Facts, Challenges and Proposals, the result of the collaborative production process described in the methodology section, serves as the basis for the Mental Health Plan and points out the aspects related to mental health in which the people interviewed showed the greatest agreement. Below, we describe briefly the eight city challenges identified, with a broad consensus. They are as follows:

Challenge 1:

Guarantee living spaces and protection for children in order to offer them the stability, affection and confidence they need to grow and work to strengthen their coping capabilities

In this challenge, we describe the importance of investing in actions to prevent and promote child mental health, within the family and school environment, in order to ensure good base conditions. It also covers the protection of children from situations of traumatic experiences and continued stress due to the impact they can have throughout their life cycle, with a particular focus on children in situations of increased vulnerability.

"Families must receive support if we wish to ensure all children have the opportunity to grow up strong and resilient. (...) Parents must be given instruments to be able to generate quality links with their children".

Challenge 2:

Generalise the emotional and social learning necessary in adolescence and provide new listening, counselling and support services for this collective

Adolescence is considered a vital moment of increased vulnerability, due to the physical and hormonal changes experienced and the constant search for social acceptance. This vulnerability during adolescence can be exacerbated by the migration process. For this reason, emotional education through schools is necessary, alongside promotion of healthy habits, participation in educational leisure and bringing listening and counselling services to the spaces where they most commonly interact. It is also necessary to raise awareness against the stigmatisation of mental health, as it is at this stage that adults' attitudes towards mental disorders are configured.

"Schools are key. They are the only public service that have the potential to reach children, adolescents and young people."

Challenge 3:

Provide earlier, more intensive, higher quality care to children and young people with the greatest mental health difficulties

Care for children and adolescents presents certain limitations. There are difficulties in accessing children's and young people's mental health centres (CSMIJ) and the intensity of treatments is low. There are also few residential and respite resources for children, adolescents and their families. On top of that, care is often interrupted in the transition from childhood mental health services to those of adults. Finally, it is noted that mental disorders are one of the main risk factors for suicide among the adolescent and young adult population.

"We need faster access to high-quality services."

Challenge 4:

Promote lifestyles and relationships that promote strength and well-being

Community activity is considered fundamental in the protection and promotion of mental health. Socialising, helping and supporting our peers, is crucial in fortifying our mental health. Physical activity also promotes good mental health and represents an opportunity to establish links and enjoy social relationships.

"As a city, we need to promote lifestyles and relationships that generate personal strength: facilitating sociability, personal relationships, physical activity..."

Challenge 5:

Recognise and articulate all the resources to support people in situations of increased mental, social, cultural and personal vulnerability

We need to look after the mental health of those groups that are most vulnerable, such as immigrants and ethnic minorities, the long-term unemployed, elderly people or people in situations of poverty or at risk of exclusion. The deficits in our primary healthcare services include: limited scope for therapeutic interventions, the lack of intercultural competencies of professionals and a lack of knowledge of community resources as an alternative to medication. Also, there is little coordination between these centres and the social services in the area. Finally, it is essential we incorporate the gender perspective into the design and planning of mental health interventions.

"Primary care needs support to demedicalise everyday complaints. Many problems – loneliness, integration of immigrants, isolation, dependence, etc. – can be solved by making changes. And it is currently difficult or impossible to solve them due to a lack of knowledge or articulation of social resources."

Challenge 6:

Promote the autonomy of people with mental disorders, recognising their abilities and providing them with the personalised support they require for social inclusion

Employment, housing and social relationships are fundamental in the social inclusion of people with mental disorders. However, the rigidity of the benefits system, the stigmatisation of the disorder and the reduction of available resources, due to the financial crisis, represent a major obstacle to accessing and maintaining a job, a home and friends. Interruptions in mental healthcare and territorial differences have been detected in terms of the availability of services, treatments and support. We must also offer comprehensive answers and collaborative work among professionals. Likewise, there is a deficit in our responses to those with mental health disorders that also present other situations such as, for example, drug use and/or homelessness.

"We know that the will to heal on its own is not enough. We have to learn to take care of people in all spheres: life, work, housing... And to do so with those around us, the family, the community. And the city as a whole."

Challenge 7:

Improve support and recognition for those who care for relatives with problems

People with mental health problems are mainly cared for by the immediate family. Women usually bear most of the burden of providing care. This excessive burden combined with deficits in care resources have a repercussion on the emotional well-being of families that, in some cases, results in the people involved giving up. For that reason, professional (psychological, psychiatric and rest) support services and information about the resources available to the families of people with mental disorders must be offered, as well as recognising the care burden and avoid gendered roles.

"The role of families in the detection of problems, treatment and support in recovery must be recognised by professional services. And we must provide the family with the support, guidelines and services they need."

Challenge 8:

Protect rights and ensure treatment of people with mental health problems in all contexts

People with mental disorders suffer from the consequences of discrimination and the stigma associated with them. This negative attitude, often reinforced by the media, has implications in all areas of intervention, such as the lack of recognition of the disorder or delays in access to care and support services. On the other hand, certain actions in the public system, faced with emergencies or forced internment, can increase this stigma. As far as possible, the right of people with mental disorders to take their own decisions about treatment must be respected.

"We must end the stigmatisation of mental illness. It is the main barrier to seeking help or detecting those at risk of mental disorder or mental illness. Without ending the stigma, mental health problems will remain hidden and cause suffering to many of the people who suffer them."

5.2. Focal points in drafting the Plan

Most of the people interviewed understood that this Plan was an opportunity to put forward solutions and lay the necessary groundwork to make progress in the field of mental health. To that end, those interviewed highlighted the following lines of action on which the Plan should place greatest emphasis:

a) Boost prevention and promotion of mental health: Invest more resources in the promotion of health as a process to help people control and improve their health. This would help reduce the prevalence of mental disorders in the medium and long term, as well as the need for services and more intensive, more expensive support. However, most resources have traditionally been allocated to the care and treatment of mental disorders. The lack of recognition in service portfolios given to preventive and community interventions, such as emotional support groups for unemployed people or parenting skills programmes, has resulted in an unequal, unstable and, in some cases, insufficient landscape.

b) Prioritise care for children, adolescents and young adults: there was unanimity in the urgent need to focus efforts on care for children, adolescents and young adults with mental disorders of varying levels of complexity and severity. People pointed out insufficient accessibility to services, as well as issues in the intensity and continuity of the care offered to these groups. On the other hand, it is important we bear in mind the effectiveness of prevention and promotion of health at this stage in the life cycle.

c) Tackle area inequality in the distribution of health resources: In recent years, and as a result of the financial crisis, social inequalities have increased in Barcelona. These inequalities are also reflected in health, with systematic differences between different socio-economic and geographical groups. In Barcelona there are neighbourhoods that require greater attention due to the concentration of vulnerability factors (urban deficiencies, housing, jobs, facilities, and health services, among others), as these lead to greater mental health issues.

d) Increase the intensity of psychological care in specialised services: Those interviewed agreed that, although care is offered to people with mental disorders in specialised services, the extent of follow-up and support for psychological interventions is low, and we therefore need to guarantee a portfolio of equitable services adapted to the reality on the ground.

e) Provide personalised support to promote the full inclusion of people with severe mental illnesses: The impact of the financial crisis has increased the suffering of the population and the difficulties faced in the social inclusion of people with mental disorders.

   In that regard, they stressed the need to provide personalised support aimed at people with mental disorders in different areas such as employment, housing and leisure, which is why work across sectors and administrations is key.

f) Take advantage of the Plan as an opportunity to make progress in: The process of drawing up the Plan and the constitution of the Advocacy Group are a great opportunity to make mental health more visible in the public agenda, to build a unique vision and to share a common language across the different sectors and services involved As such, we consider cooperative leadership, cross-sectoral work and the creation of stable frameworks for dialogue and exchange between professional teams, entities and services as key aspects. To that end, Mental Health Boards could be created in the districts to strengthen community work with organisations, services, people and families affected on the ground. Additionally, the importance of implementing evidence-based interventions and assessing them is highlighted. The training and care of healthcare professionals has also been described as an essential element that must be taken into account throughout the process.

6.
MENTAL HEALTH PLAN

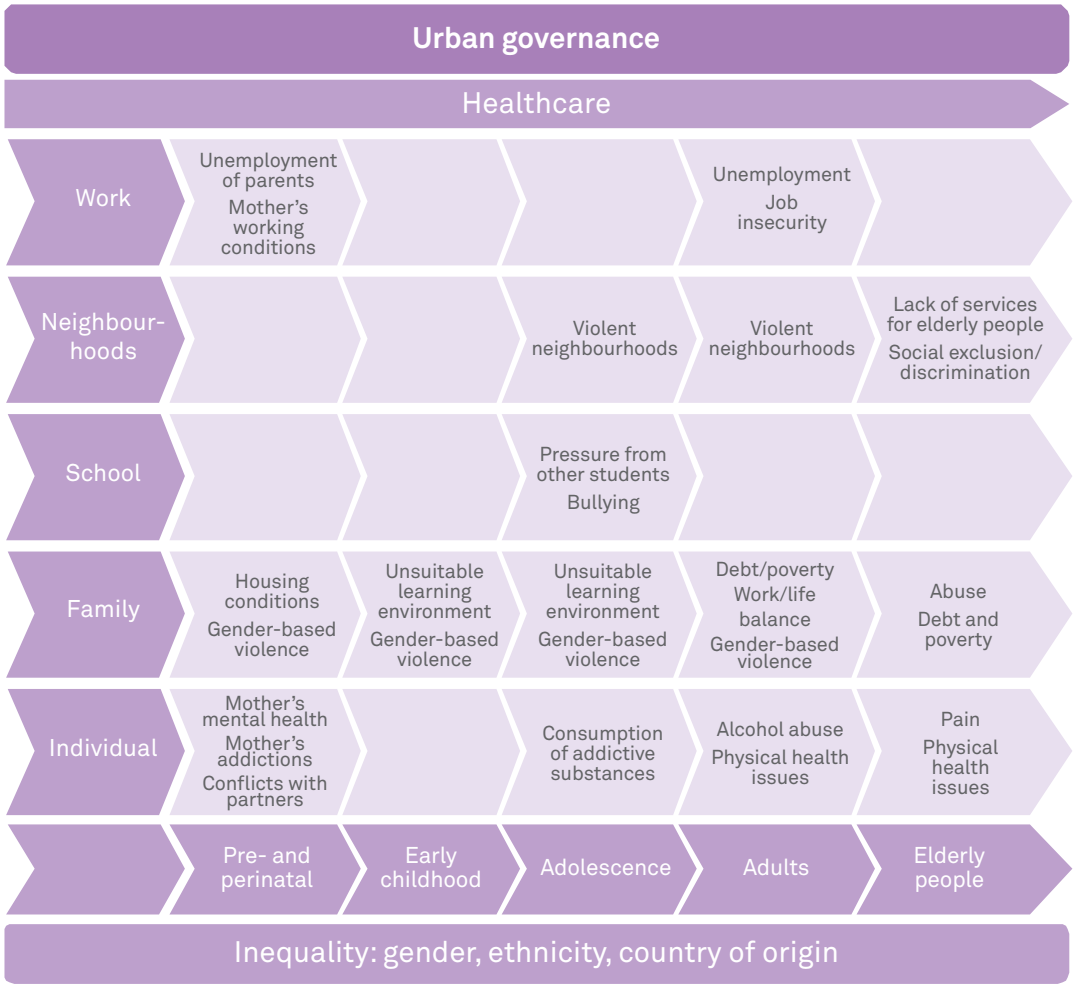
6.1. Conceptual framework

Mental health is defined as a state of well-being in which the individual is conscious of their own abilities, can deal with the usual tensions of life, can work productively and fruitfully and contribute to their community (World Health Organisation, 2013a). The **determinants of mental health** and mental disorders include not only individual characteristics, but also social, cultural, economic, political and social factors such as national politics, social protection, standard of living, working conditions or the social support of the community. Exposure to adversities in early childhood is a well established preventable risk factor for mental disorders (World Health Organisation, 2013b). Many common mental health disorders are strongly associated with social inequalities and there is a correlation where mental health gets worse as social class is more disadvantaged (Allen et al., 2014).

To improve people's mental health, it is essential we act to improve the conditions of daily life with a life cycle perspective, starting at the prenatal stage and continuing into early childhood, later childhood and adolescence, adults and the elderly (Kieling et al., 2011). By taking action throughout the various life stages, we can provide opportunities to improve the mental health of the population and reduce the risk of suffering mental disorders associated with inequalities. Interventions must be universal, aimed at the whole population but proportionate to their needs. They must also be present at all levels of governance and across sectors. That means nursery, primary and secondary schools, vocational training centres, universities, workplaces, neighbourhoods and families all need to be involved to achieve a happier society (Allen et al., 2014; World Health Organisation and Fundaçao Calouste Gulbenkian, 2014).

Figure 1 presents a conceptual framework of the determinants of mental health throughout the life cycle, based on that proposed by the WHO (World Health Organisation, 2012). The framework integrates the determinants of mental health throughout the life cycle, as well as the setting and the nature of interventions.

Figure 1. Social determinants of mental health throughout the life cycle. Modified from WHO 2012.



Source: Artazcoz L, Pasarín M, Borrell C. Pla de salut mental de Barcelona. Marc conceptual. Barcelona: Barcelona Public Health Agency; 2016.

6.2. Mission and governing principles

The mission of the Barcelona Mental Health Plan is to promote mental health and prevent and address mental disorders in order to improve the psychological well-being and overall quality of life of the entire population.

All the actions set out in the Barcelona Mental Health Plan include the following principles:

- Prioritising children, adolescents and the young adult population. This Plan places special emphasis on actions aimed at children, adolescents and young adults, as exposure to situations of deprivation and social inequality during childhood is associated with worse results in health, and in mental health in particular, in the short, medium and long term.
- The comprehensive approach Mental health interventions will be addressed from a holistic point of view, taking into account the problems associated with mental disorder and the socio-economic and cultural factors that determine it.
- Equity and reduction of social inequalities. All the actions in this Plan will be careful not to increase social inequalities or inequalities based on gender, age, ethnicity or where people live, while guaranteeing equity in distribution and access to resources and treatment in the different specialised services.
- Territorial perspective. The actions of the Plan incorporate territoriality, or the aspect of geography, as a basic principle for its development. Close, community-based work is essential for prevention, promotion and caring in mental health.
- Gender perspective and intersectionality. The gender perspective must be included systematically in the design, planning, execution and assessment of the Plan's actions. This means taking into account not only socio-cultural differences between women and men, which can bring about different results in mental health and affect the efficacy of interventions, but also their differentiated living conditions and needs in order to combat social inequalities associated with gender. In addition, the intersection of gender with other inequality focuses, such as social class, ethnicity, age, sexual orientation and functional diversity, among others, must be taken into account.
- Interculturality. The actions included in the Plan aim to incorporate the intercultural perspective as a cross-cutting principle, in order to recognise and respect diversity and ensure interaction between cultures, community harmony and equity.
- Equal opportunities free of discrimination. People with mental disorders have rights and as such must be respected and see equal opportunities with the rest of the population guaranteed, avoiding situations that may entail their stigmatisation and other discrimination and creating opportunities for social inclusion.

- Shared responsibility, coordination and participation in management of the Plan. Although responsibility for the Plan corresponds to Barcelona City Council, there are other institutions, within its competence framework, that are jointly responsible. This forces the establishment of mechanisms for coordination and frameworks for networking to ensure the implementation and effectiveness of its actions. Participation and cross-sector work are also included, with working groups to give a voice to those affected and their families.
- Mainstreaming. All municipal policies have an impact on health and for this reason the perspective of health, and of mental health in particular, must be included from the design to the assessment of all the actions of the various municipal sectors. The interdepartmental nature of the Barcelona Mental Health Plan posits a cross-sectoral working process that involves coordination with other municipal plans.
- Knowledge and assessment for continuous improvement and innovation. Knowledge in mental health offers us elements to help prioritise actions, as well as to adapt and formulate new actions based on the evidence. To introduce improvements to the process and to learn about the effectiveness and social impact of actions in the Plan, assessment must be incorporated from the very moment of planning, with specific objectives and indicators. Likewise, regular presentation of this information must be included as an exercise of transparency and accountability towards citizens.

6.3. Validity and timeline

The validity of the Barcelona Mental Health Plan is six years (2016-2022) in order to leave a sufficient time frame for its implementation. As such, a schedule for implementation has been established for each line of action, which is classified in three bands:

- **Ongoing**: actions that are already being carried out.

- **Short term**: actions that must be carried out in the 2016-2017 period.

- **Medium term**: actions to be carried out in the 2018-2022 period.

6.4. Structure of the Plan

The Barcelona Mental Health Plan includes the main guidelines and objectives to be carried out during the 2016-2022 period. Next, for each strategic line, we present the objectives and lines of action that make up the Barcelona Mental Health Plan, as well as which department, organisation or sector is responsible[1].

STRATEGIC LINE 1:

Improve the psychological well-being of the population and reduce the prevalence of mental health problems, addressing the social and cultural determinants of mental health, with a lifecycle and equity perspective, with a particular focus on the most vulnerable groups.

Improving mental health and reducing the risk of mental health problems requires action to be taken on the various factors involved. The determinants of mental health include not only genetic predisposition and individual characteristics, such as the ability to manage thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and social factors such as national policies, social protection, standard of living, working conditions and the social support of the community. This strategic line includes lines of action that are universal but proportional to the level of need, prevention and health promotion aimed at having an impact on the various settings of people's daily lives, in accordance with the life cycle and equity perspective.

[1] *Responsibility for all the lines of action of the Mental Health Plan falls to the different sectors and departments of Barcelona City Council, except in those where responsibility is specified as otherwise. In this section, the abbreviations used correspond to the following bodies:*

IMEB: Barcelona Municipal Institute of Education
ASPB: Barcelona Public Health Agency
IBE: Barcelona Sports Institute
CEB: Barcelona Education Consortium
CJB: Barcelona Youth Council
ICUB: Barcelona Institute of Culture
CSB: Barcelona Health Consortium
CAGG: Barcelona Advisory Council for the Elderly
IMPD: Municipal Institute for People with Disabilities
DGAIA: Department of Child and Teenage Support Services

GOALS:

Goal 1.1. Promote the mental health, resilience and emotional well-being of the population throughout its entire life cycle.

Goal 1.2. Promote healthy habits and prevent mental disorder among children, adolescents and young adults, ensuring the best start to life and being sensitive to cultural differences.

Goal 1.3. Guarantee safe, healthy environments through the prevention and promotion of mental health among adults.

Goal 1.4. Ensure decent living conditions to promote active and healthy ageing among the elderly.

LINES OF ACTION:

Goal 1.1. Promote the mental health, resilience and emotional well-being of the population throughout its entire life cycle.

Lines of action	Execution period	Responsibility
Family		
1. Prevent and intervene in evictions, coordinating with the courts to offer mediation between the parties and decent rehousing options.	Ongoing	Housing
2. Offer rehabilitation grants to reverse lack of housing, improve thermal insulation, etc.	Ongoing	Housing
3. Award 2,000 public housing units to vulnerable groups.	Short term	Housing
4. Reinforce the mechanisms for early detection and treatment of children, adolescents, adult women and elderly women in situations of sexist violence and/or sexual abuse and other violence and abuse.	Ongoing	Feminisms and LGBTI/ Childhood/ IMEB/CEB

Lines of action	Execution period	Responsibility
Family		
5. Promote an emergency monetary supplement for disadvantaged families.	Short term	Social Rights/ Social Services
Community		
6. Develop specific programmes for each stage of life, the promotion of physical activity and healthy leisure.	Ongoing	ASPB/ IBE/ IMEB/ CEB/Social Rights/CJB/ Participation/ Districts/ Organisations
7. Promote volunteering and participation in the city's associations and, in particular, in the neighbourhoods prioritised due to the existence of inequalities in health.	Ongoing	Childhood/ IMEB/ Participation/ Districts/Young People/CJB/the Elderly
8. Promote interventions to prevent gender-based violence in the field of leisure, digital networks and the media.	Ongoing	Feminisms and LGBTI
9. Promote local services (civic centres, libraries, etc.) among citizens and promote them as natural spaces to foster healthy leisure, socialisation and emotional well-being.	Ongoing	ICUB/IMEB/ Communication/ Districts/Library Consortium
10. Facilitate social prescriptions from primary healthcare centres with the support of a catalogue of community services and resources.	Ongoing	Health/ ASPB/ CSB/ Government of Catalonia (Health)

Goal 1.2. Promote healthy habits and prevent mental health problems among children, adolescents and young adults, ensuring the best start to life and being sensitive to cultural differences.

Lines of action	Execution period	Responsibility
Family		
11. Reinforce programmes for the prevention and early detection of mental disorders in mothers, from pregnancy to early childhood.	Short term	Health/CSB/ Government of Catalonia (Health)
12. Implement a programme to develop parenting skills at the 98 municipal nursery schools, family spaces in social services and other community spaces.	Ongoing	ASPB/IMEB/ Social Services
13. Allocate urgent social assistance for single-parent families receiving financial support for minors from 0 to 16 years.	Ongoing	Area of Social Rights
Schools		
14. Promote emotional education in the city's primary and secondary schools.	Ongoing	ASPB/CEB/ Young People/ Organisations
15. Support organisations that carry out eating disorder prevention programmes to improve early detection and pathways in the city's schools.	Ongoing	Health/CEB/ Organisations/ IMEB
16. Bring forward programmes to promote healthy habits (quitting smoking, alcohol and drugs, healthy eating, physical activity, improving sexual and affective health and promoting rational use of new technologies and video games) at primary and secondary schools in the city.	Ongoing	Health/ASPB/ IMEB/CEB/ Organisations

Lines of action	Execution period	Responsibility
17. Incorporate the gender perspective into the design of new preventive programmes and the promotion of mental health, as well as in the implementation and evaluation of current programmes.	Ongoing	ASPB/CEB/CSB/ Feminisms and LGBTI/Government of Catalonia (Health)/IMEB
18. Implement programmes for the prevention and tackling of any type of violence, conflict or harassment (sexual, sexual orientation, bullying in schools, etc.) in the city's schools and sports centres.	Ongoing	Feminisms and LGBTI/CEB/IBE/ Young People/ IMEB/Childhood
19. To promote, in a coordinated way, success at school with specific, pre-working age programmes for young people.	Ongoing	Barcelona Activa/ IMEB/CEB/ Young People
Work		
20. Develop specific action plans against unemployment and to guarantee the quality of youth employment.	Ongoing	Barcelona Activa/ Young People
Community		
21. Grant financial aid to carry out holiday activities as part of the "T'estiu molt" campaign for children and adolescents from disadvantaged families.	Ongoing	Childhood
22. Provide technical assistance to promote youth associations, with special attention to those groups vulnerable to suffering discrimination.	Ongoing	IMEB/Young People/CJB/ Feminisms and LGBTI/ Immigration/ Participation/ Districts
23. Promote and create new services for listening, counselling and support in areas where adolescents socialise, with professionals who can lead the way with this group.	Short term	Health/Young People/Districts
24. Promote and create new care and support services for adolescents and young adults in situations of crisis and/or emergencies.	Medium term	Health/Young People/CJB

Goal 1.3. Guarantee safe, healthy environments through the prevention and promotion of mental health among adults.

Lines of action	Execution period	Responsibility
Work		
25. Promote employment plans and programmes to improve the abilities of unemployed people, especially in cases of long-term unemployment, and promote entrepreneurship by combating inequalities, fighting gender-related job insecurity and promoting a local, plural economy.	Ongoing	Barcelona Activa
26. Promote measures to reconcile work and personal life in different organisations.	Ongoing	Barcelona Activa/ Cooperative, Social and Solidarity Economy Services and Consumption Department
27. Advise organisations to facilitate the handling of psychosocial risk factors in the workplace with programmes to promote occupational health and safety.	Ongoing	Health/ASPB
Family		
28. Open up access and promote support services for families caring for people with mental health issues through the Network for Support to Caring Families.	Ongoing	Health/ASPB/ CSB/Social Services/ Organisations

Goal 1.4. Ensure decent living conditions to promote active and healthy ageing among the elderly.

Lines of action	Execution period	Responsibility
Family		
29. Promote actions to promote good and proper treatment and respect towards the elderly.	Ongoing	Elderly/Social Rights/CSB/ Government of Catalonia (Health)
30. Reinforce and assess the impact of the Barcelona Age-friendly city commitment, promoted by the World Health Organisation (WHO).	Ongoing	Elderly people/ Social rights / Social participation/CAGG/ Organisations
31. Prepare a city strategy for families that care for ill or dependent people.	Ongoing	Health/Social Services
Community		
32. Fight against stereotypes and prejudices towards the elderly, ensuring adequate and dignified representation of ageing and the elderly in institutional communication and the media.	Ongoing	Elderly people/CAGG/ Communication
33. Advance and support programmes for the promotion of learning among the elderly.	Ongoing	Elderly people/ Social Rights
34. Promote physical activity for the elderly.	Ongoing	ASPB/IBE/Social Services
35. Reinforce programmes to prevent situations of loneliness and unwanted isolation among the elderly, especially those who are elderly and have mobility difficulties and/or architectural barriers.	Ongoing	Health/ASPB/ Social Rights/ Elderly people/ Organisations/ Government of Catalonia (Health)

Lines of action	Execution period	Responsibility
Family		
36. Promote the empowerment of elderly women in the city through participation in the governing bodies of associations and facilities for the elderly.	Ongoing	Elderly people/ Social Rights
37. Constitute a financial support scheme of grants for female pensioners with non-contributory pensions.	Short term	Social Services/ Social Rights

STRATEGIC LINE 2:

Ensure there are safe, effective and accessible services to meet the physical, psychological and socio-cultural needs of people with mental health problems and their families.

Care services for people with mental health problems must be available within the community to ensure easy access and guarantee comprehensive care (health, social and educational) that is coordinated across resources, in order to provide respectful and attentive care. Likewise, treatments must be safe, rigorous and effective, taking into account the needs of the most vulnerable groups and their social and cultural specificities. This strategic line includes lines of action to guarantee the provision of care centres for people with mental health problems, as well as to recognise and support their families. We should also integrate actions to train and raise awareness of professionals. In order to promote the social inclusion of people with mental health problems, actions will be included to facilitate their access to work and housing and to promote their civic and cultural participation.

GOALS:

Goal 2.1. Improve responses to the needs of people with mental disorders.

Goal 2.2. Provide care early on that is sensitive to the socio-cultural diversity of the city, with resources to support young people, adolescents and young adults, paying special attention to those groups with the greatest vulnerability.

Goal 2.3. Promote access and maintenance of employment and housing services to facilitate the social inclusion of people with mental disorders, while guaranteeing respectful and attentive treatment.

Goal 2.4. Guarantee the active participation of people with mental disorders in the civic, cultural and recreational life of the city.

LINES OF ACTION:

Goal 2.1. Improve responses to the needs of people with mental disorders.

Lines of action	Execution period	Responsibility
38. Reinforce and update the mental health care facilities within the community, with special attention to chronic issues and the integration of addictions.	Short term	Health/CSB/ Government of Catalonia (Health)
39. Increase and adapt mental health services and reinforce the figure of the Individualised Services Plan (PSI) within the neighbourhoods prioritised due to the existence of social inequalities in health.	Medium term	Health/CSB/ Government of Catalonia (Health)
40. Improve the articulation of primary care with specialised services and training of professional teams.	Short term	Health/CSB/ Government of Catalonia (Health)
41. Intensify preventive care within primary health and specialised centres in order to demedicalise.	Short term	Health/CSB/ Government of Catalonia (Health)
42. Facilitate access and increase the intensity of psychological therapy in the city's mental health network.	Short term	Health/CSB/ Government of Catalonia (Health)
43. Develop, expand and assess care and monitoring programmes and services to guarantee the transition between specialised centres (children and adults).	Short term	Health/CSB/ Government of Catalonia (Health)
44. Develop care and follow-up programmes for people with mental disorders after hospitalisation.	Short term	Health/CSB/ Government of Catalonia (Health)
45. To disseminate and improve application of the protocol for action in urgent cases, with the participation and formation of the Barcelona City Police Force (GUB).	Short term	Health/Safety

Lines of action	Execution period	Responsibility
46. Expand and improve the specific care programme for homeless people with mental health problems and/or dual pathologies.	Short term	Health/Social Services/Social Rights
47. Promote support services and therapeutic treatment for people with mental health problems and dual pathologies, with a social dimension.	Short term	Health/Social Services/CSB/ Government of Catalonia (Health)
48. Promote action by on-the-ground social workers in the detection of people with mental health problems.	Ongoing	Health/Social Services
49. Intensify the implementation of policies for the prevention and early detection of the risk of suicide (follow-up of the Suicide Risk Code and territorial implantation of the care pathways for depressive disorders).	Short term	Health/CSB/ Government of Catalonia (Health)
50. Guarantee support and accompaniment after suicide for families affected.	Short term	Health/CSB/ Government of Catalonia (Health)/ Organisations
51. Expand support programmes (mutual support and emotional support groups) for people in a situation of particular vulnerability (long-term unemployment, in precarious housing circumstances, elderly people, etc.).	Short term	Health/IMPD/ CSB/Government of Catalonia (Health and Work, Social Affairs and Families)/ Organisations
52. Reinforce support devices and services for recently arrived people, refugees and immigrants.	Ongoing	Immigration/ Social Services/ Organisations
53. Implement a strategy of cultural mediation within the prioritised neighbourhoods in primary healthcare centres and specialised.	Short term	CSB/Government of Catalonia (Health)

Lines of action	Execution period	Responsibility
54. Expand and disseminate support programmes and services (mutual help groups, emotional support and respite services) for relatives of people with mental health problems.	Ongoing	Health/Social Services/CSB/ Government of Catalonia (Health and Work, Social Affairs and Families)/ Organisations
55. Incorporate care and support for families in the circuits and protocols of different mental health care services.	Short term	Health/CSB/ Government of Catalonia (Health and Work, Social Affairs and Families)
56. Support projects that promote the empowerment of people with mental health problems and their families, in the priority districts of Barcelona.	Ongoing	Health/IMPD/ Government of Catalonia (Health)/ Organisations/ Districts
57. Implement a training programme to provide municipal staff with the necessary knowledge to work in an inclusive way with people with mental health problems.	Short term	HR Training of the City Council and autonomous organisations
58. Carry out a training programme for mental health professionals in intercultural competences for the care of ethnic minorities, refugees and immigrants.	Ongoing	Health/ Immigration/ Government of Catalonia (Health)
59. Inform and systematise mental health training for professionals in cultural mediation.	Medium term	Health/ Immigration
60. Support organisations that work in the field of offering listening services, information and emotional well-being.	Medium term	Health/ Organisations

Goal 2.2. Provide care early on that is sensitive to the socio-cultural diversity of the city, with resources to support young people, adolescents and young adults, paying special attention to those groups with the greatest vulnerability.

Lines of action	Execution period	Responsibility
61. Guarantee a portfolio of services that is equitable and adapted to the reality of each district between the various CSMIJs and expand the provision of resources, in order to reduce the current waiting lists, increase the frequency and intensity of the treatments.	Medium term	Health/CSB/ Government of Catalonia (Health)
62. Reinforce and extend the Network of Open Centres for Assisting Children and Teenagers in Barcelona.	Ongoing	Social Services/ Social Rights/ Childhood
63. Promote the network of Childhood Development and Early Care Centres (CDIAP) in Barcelona by linking up with different childcare services.	Short term	IMPD/CSB/ Government of Catalonia (Health)/ Organisations
64. Use new methodologies to promote interventions aimed at children, adolescents and young adults with mental disorders and/or with relatives with mental disorders, in the priority neighbourhoods due to the existence of social inequalities in health.	Short term	Health/CSB/ Districts/ Organisations
65. Develop pilot programmes to improve support and social inclusion aimed at adolescents and young adult population with dual pathologies.	Short term	Health/CSB/Social Services/IMPD Government of Catalonia (Health)/ Organisations
66. Ensure the review of the goals of the Comprehensive Care Plan pilot for people with ASD and extend it to some of the city's districts.	Short term	Health/CSB/ Government of Catalonia (Health)

Lines of action	Execution period	Responsibility
67. Ensure the review of the Protocol for the management of childhood and juvenile ADHD in the Catalan healthcare system, so that it is based on scientific evidence with maximum consensus across the professional sector.	Short term	Health/CSB/ Government of Catalonia (Health)
68. Expand support programmes for children in a situation of particular vulnerability (minors in the protection system, minors who have suffered abuse, minors from migrant or refugee families, unaccompanied minors, etc.).	Short term	Social Services/ Government of Catalonia (DGAIA and Work, Social Affairs and Families)
69. Reinforce school support and second-chance schools, to ensure the inclusion and academic continuity of children and young people with mental disorders or those who have suffered them.	Short term	Health/CEB/ Participation/ IMEB/Districts
70. Guarantee the regular presence of a psychologist and a social worker in high schools in neighbourhoods prioritised due to the existence of social inequalities in health, in order to guarantee their education.	Short term	Health/IMEB/ CEB
71. Guarantee articulation networks across CDIAP, CSMIJ and support and counselling services, such as EAP, in the city's educational centres to improve the prevention, detection and early care for children and adolescents.	Short term	Health/Social Services/CSB/ CEB/Government of Catalonia (Health)/IMEB/ IMPD
72. Facilitate instruments, training and counselling for the prevention of mental health disorders in professional teams that work with children and adolescents (schools, young spaces, etc.).	Ongoing	Young People/ Districts
73. Provide training for early detection for professional teams working with children and adolescents (schools, young spaces, etc.) and guarantee immediate response with relevant figures.	Medium term	Young People/ CSB/CEB/IMEB/ Childhood

Goal 2.3. Promote access and maintenance of employment and housing services to facilitate the social inclusion of people with mental disorders, while guaranteeing respectful and attentive treatment.

Lines of action	Execution period	Responsibility
Access to jobs and maintaining them		
74. Design and implement a package of measures, specific to people with mental disorders, which assures access to general or specialised programmes for counselling, guidance, training and follow-up based on job placement pathways.	Short term	Barcelona Activa
75. Extend specific projects for workplace insertion for young people with mental disorders in districts with neighbourhoods prioritised due to the existence of social inequalities in health, by expert organisations.	Short term	Government of Catalonia (Health and Work, Social Affairs and Families)/ Organisations/ Barcelona Activa
76. Promote and articulate municipal workplace insertion instruments, alongside those of Inclusive Barcelona Network (for workplace inclusion of people with disabilities).	Ongoing	IMPD/Social Rights/ Organisations/ Barcelona Activa
77. Consolidate workplace insertion of people with mental disorders in the ordinary market.	Ongoing	IMPD/ Organisations/ Barcelona Activa
78. Promote work programmes with support from organisations.	Ongoing	IMPD/ Organisations/ Barcelona Activa
79. Incorporate social clauses in the administrative procurement of Barcelona City Council.	Ongoing	Administrative Procurement Coordination Department/ Barcelona Activa
80. Promote public procurement model using companies working for the inclusion of people with mental disorders.	Ongoing	Administrative Procurement Coordination Department/ Barcelona Activa

Lines of action	Execution period	Responsibility
Housing services		
81. Facilitate access to supported living housing for people with mental disorders.	Medium term	Barcelona Gestió Urbanística SA
82. Promote the incorporation of flats in the Social Emergency Committee for people with mental disorders.	Short term	Housing/Social Services
83. Incorporate mental health organisations in access to the call for housing awards for social inclusion organisations.	Medium term	Housing
84. Articulate housing measures with programmes for support, monitoring and mentoring for the maintenance of housing and autonomous living in the home.	Medium term	Government of Catalonia (Work, Social Affairs and Families)
85. Develop the Housing First programme for homeless people with mental disorders and/or dual pathologies.	Ongoing	Social Rights/ Social Services
86. Study other models of housing and shared-living that adapt to the plurality of situations of people with mental disorders.	Medium term	Health/Social Services/ Government of Catalonia (Work, Social Affairs and Families)
87. Support entities with independent living projects for people with mental disorders, according to the established protocols.	Ongoing	Health/IMPD/ Organisations
88. Help elderly people with mental disorders to have access to residential resources and dignified, proper, respectful treatment.	Medium term	Government of Catalonia (Health, Work, Social Affairs and Families)

Goal 2.4. Guarantee the active participation of people with mental disorders in the civic, cultural and recreational life of the city.

Lines of action	Execution period	Responsibility
89. Identify cultural, leisure activities, sports, etc. in the city for people with mental disorders, propose them as good practice, strengthen them and expand them in districts with neighbourhoods prioritised due to the existence of social inequalities in health.	Short term	Health/ICUB/ Participation/ Districts/IBE
90. Include the mental health perspective in the design of general workshops at civic centres and train the teaching staff.	Medium term	Health/IMPD/ ICUB
91. Increase support for leisure activities, culture, sports, etc., for the inclusion of people with mental disorders that are carried out in community services (civic centres, libraries, etc.).	Ongoing	Health/IMPD/ ICUB/IMEB/ Participation/ Districts/ Library Consortium
92. Provide specific leisure centres and a specialised monitoring service for children, adolescents and young adults with mental disorders in the "T'estiu molt" holiday activity campaign.	Ongoing	IMPD
93. Organise cultural events in which people with mental disorders are the protagonists, and programme them as part of the cultural life of the city.	Ongoing	Health/ ICUB/IMPD/ Participation/ Districts/ Organisations
94. Support organisations with inclusive cultural and leisure projects for people with mental disorders run in both health and community services.	Ongoing	Health/ IMPD/ ICUB/ Organisations

STRATEGIC LINE 3:

Guarantee respect for the rights of people with mental health problems while offering access to opportunities for achieving a good quality of life, and fighting against the stigmatisation and discrimination they are subjected to.

People with mental health problems face stereotypes and prejudices that are associated with mental disorders, the result of a misunderstood social conceptualisation of mental health. This involves exposure to a high degree of stigma, which is one of the main causes of discrimination and social exclusion. Stigma prevents the enjoyment of good quality of life for people with mental disorders and makes it difficult for them to recover. Not only does it influence self-esteem, it also conditions relationships with families and is the main barrier to accessing work, housing and effective treatment. In addition, stigma is also a violation of human rights. Actions to tackle this entail reinforcing the rights of people with mental disorders and equal opportunities with the rest of the population, awareness campaigns along with direct contact and knowledge, recognising the contributions to society made by people with mental health issues.

GOALS:

Goal 3.1. Defend rights and equal opportunities, and fight discrimination against people with mental disorders by tackling the associated stigma.

LINES OF ACTION:

Goal 3.1. Defend rights and equal opportunities, and fight discrimination against people with mental disorders by tackling the associated stigma.

Lines of action	Execution period	Responsibility
95. Prepare and disseminate a catalogue of rights for people with mental disorders and train the various professionals involved.	Short term	Health/CSB/ Social Rights/ Government of Catalonia (Health)
96. Create an ombudsman for patients and relatives.	Medium term	Health/CSB/ Government of Catalonia (Health)
97. Promote treatment pacts or agreed treatments.	Medium term	Health/CSB/ Government of Catalonia (Health)
98. Promote campaigns and support the fight against stigma of people with mental disorders, recognising and valuing expert organisations in this field.	Ongoing	Health/ IMPD/CSB/ Communication/ Government of Catalonia (Health)/ Organisations
99. Reinforce neighbourly community projects that promote contact with people with mental disorders.	Ongoing	Social Services/ Organisations
100. Strengthen associations of people with mental disorders, as well as their families, to promote their empowerment.	Ongoing	Health/ Participation/ Government of Catalonia (Health)/ Organisations
101. Incorporate the rights of children with mental disorders into the Children's Rights Network.	Short term	Childhood/ Social Rights/ Government of Catalonia (Health)/ Organisations

STRATEGIC LINE 4:

Ensure the mechanisms necessary for proper governance of the Plan, for effective, fluid communication and for the establishment of systems and networks that generate knowledge to be applied to actions taken.

Including mental health involves the collaboration and coordination of different stakeholders for proper governance of the process, from municipal and regional government to recognition of the outstanding role played by social organisations in this field. Likewise, we need to promote research and training in mental health in order to generate knowledge for the design and implementation of effective interventions based on evidence. The lines of action included are aimed at stimulating the collaboration and coordination of the various stakeholders involved, ensuring the creation of spaces and circuits to establish frameworks of relationship and mutual learning, in order to lead the process in a participatory way and share knowledge and best practices to design mental health actions.

GOALS:

Goal 4.1. Promote information and knowledge about mental health in order to support the formulation, monitoring and assessment of specific policies and programmes.

Goal 4.2. Promote the creation of spaces for consultation and exchange of knowledge to promote dynamics and networking efforts in mental health.

LINES OF ACTION:

Goal 4.1. Promote information and knowledge about mental health in order to support the formulation, monitoring and assessment of specific policies and programmes.

Lines of action	Execution period	Responsibility
102. Develop a map of mental health assets, by stage of life and by district, to recognise the activities carried out by the different administrations and expert organisations.	Short term	Health/ASPB/ CSB/Districts/ Organisations
103. Design a mental health information system for the planning, monitoring and assessment of different interventions in mental health.	Ongoing	Health/ASPB/ CSB/Other sectors of the City Council
104. Incorporate scientific evidence and praxis into the uses and methodologies of the Mental Health Plan to create a permanent research and action space.	Short term	Health/ASPB/ Other sectors of the City Council
105. Promote research into mental health and its determinants.	Ongoing	Health/ASPB/ IMPD/Research organisations/ Other sectors of the City Council
106. Formalise and revitalise the Barcelona Mental Health Commitment.	Short term	Health/ASPB/ CSB/IMPD/ Organisations

Goal 4.2. Promote the creation of spaces for consultation and exchange of knowledge to promote dynamics and networking efforts in mental health.

Lines of action	Execution period	Responsibility
107. Expand and consolidate networks and working groups with professionals from the city health, social, educational and community services, to provide comprehensive, coordinated answers in the field of mental health in the different areas prioritised.	Ongoing	Health/ASPB/ CSB/Other sectors of the City Council/ Districts
108. Assess the impact of the different networks and area groups for continuous improvement and systematisation.	Medium term	Health/ASPB/ CSB/Other sectors of the City Council
109. Create an intersectoral commission to incorporate the mental health perspective into all policies and monitor them.	Short term	Health/ASPB
110. Promote working groups and establish Mental Health Boards in the districts prioritised due to the existence of social inequalities in health.	Short term	Health/ASPB/ CSB/Districts/ IMPD
111. Promote the active participation of organisations of people with mental health disorders and their families in the definition and monitoring of municipal policies and actions in the field of mental health.	Ongoing	Health/IMPD/ Organisations

7.
GOVERNANCE, MONITORING AND EVALUATION

Barcelona's Mental Health Plan envisages a six-year action horizon with a global, cross-cutting vision, in which the city's mental health policies are framed in four broad strategic lines. The participatory spirit that prevailed throughout the process of drawing up the strategy is being maintained to ensure good governance. So, for a period of seven months, Barcelona City Council has promoted a cross-cutting working process led by an Advocacy Group that has included representation from different sectors of municipal action (health, employment, housing, social services, education, immigration, culture, gender and participation, among others) and different organisations with effective capacity for action and influence in the field of mental health.

City Council coordination of the Barcelona Mental Health Plan rests on the Council Health Department and the Barcelona Public Health Agency (ASPB). The Plan's executive structure consists of the following bodies:

- The Advocacy Group as the executive body tasked with implementing, monitoring and assessing the Plan's various action lines.
- The Mental Health Commitment Board as a plenary body, consisting of municipal political representation, social agents and the different administrative sectors and organisations involved in the plan, scientific and professional organisations as well as those organisations that wish to engage with the work to address the mental health problems of the city.
- Committees and working groups, which will be set up according to the action lines given priority, and the sectors and bodies involved.

To ensure the territorial rollout of the plan, Mental Health Boards will be set up mainly in the districts, with priority given to districts with social inequalities in health. Apart from becoming the bodies that will ensure the planning and management of the different lines of action in the territory, they also have the function of maintaining constant dialogue and coordinating the different stakeholders: representatives and technical staff of the district, representatives of other administrations, representatives of organisations, neighbourhood representatives and people affected, etc. The composition of the Mental Health Boards in the districts may vary depending on the lines of action prioritised or being run.

The following mechanisms and actions are envisaged with regard to monitoring and assessing the Plan:

- A system of indicators, agreed by the Advocacy Group, which must contain not only consistent indicators of measurable results, but also indicators of process and impact.
- A cross-sectoral monitoring committee, reporting to the Mental Health Board, made up of representatives from the different sectors involved in the Mental Health Plan and representatives of organisations in the mental health sector. Its functions will be to oversee development of the Plan, by achieving the

goals set by the indicators, detect new demands, create synergies to meet them, and collect the relevant indicators for monitoring and evaluating the Plan. Likewise, it will also ensure communication and dissemination of the results of the plan.

- Coordination of the Plan will draw up an annual monitoring report, with the indicators previously defined by the monitoring committee, which must be presented and passed at a plenary session of Mental Health Commitment Board and the functioning Mental Health Boards in the districts.

Two years after the Plan has been implemented there will be an intermediate evaluation of the process and the degree to which its objectives have been achieved. After six years, a final assessment will be made that will include the results of the strategy's impact. This assessment will set out the direction, priorities and lines of action to be followed in successive action plans.

8.
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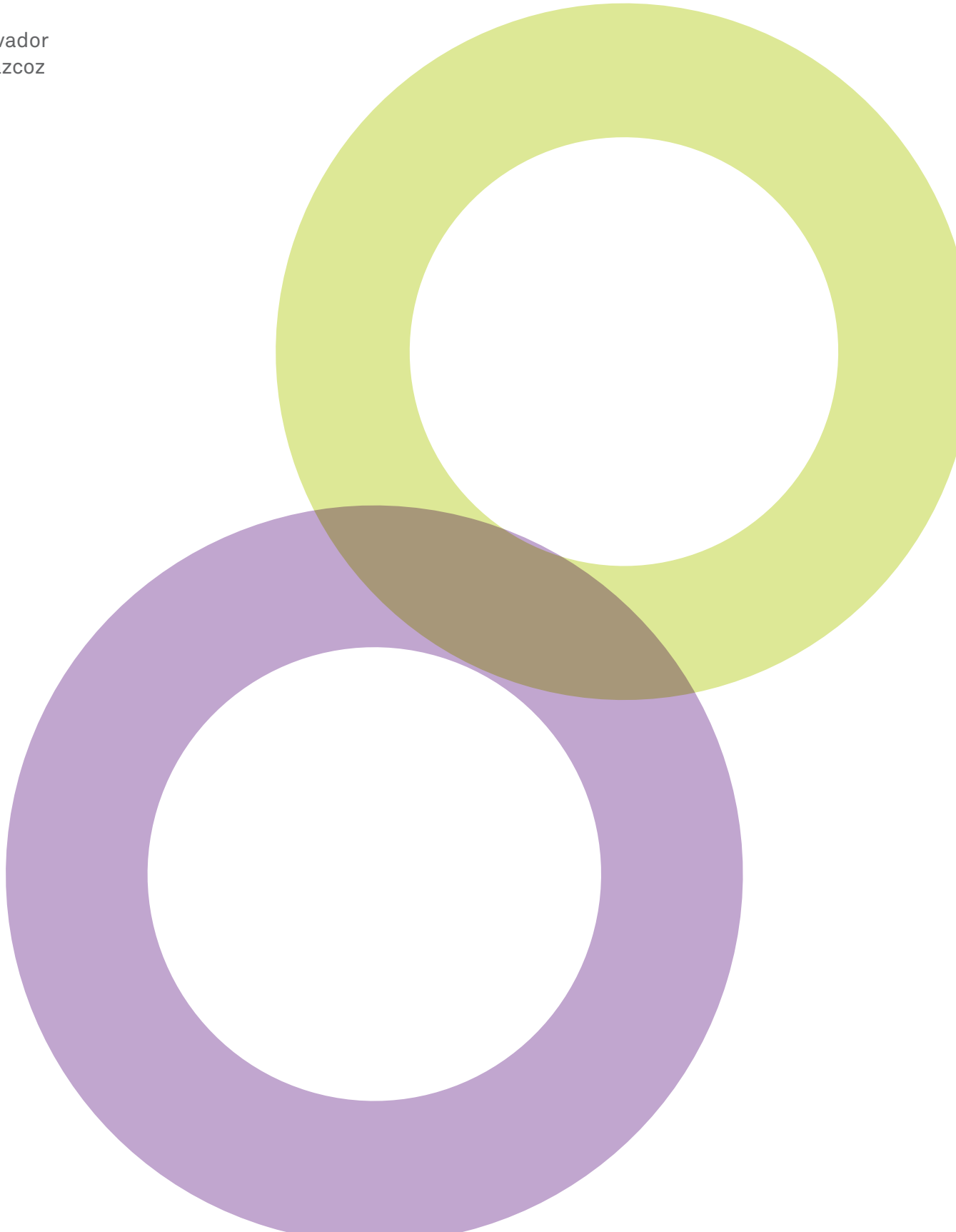
Annexe 1:

Mental health and its determinants in Barcelona

María Salvador
Lucía Artazcoz



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1.
SOCIAL DETERMINANTS OF MENTAL HEALTH

In this section we will present data on various determinants of mental health in the city of Barcelona. Starting from the conceptual framework of the social determinants of mental health, based on the framework proposed by the World Health Organisation discussed previously, several determinants have been selected that are considered especially relevant in our context. A lifecycle perspective has been followed which recognises that mental health at each stage of life is determined by its own factors, and that it is also the result of life experiences.

According to data from the Municipal Register of Inhabitants, in 2014 the population of Barcelona was 1,613,281 people, 52.6% of whom were women. These figures are very similar to those observed in the city in the early 1990s. However, the characteristics of the city's population have changed over the years.

Socio-demographic characteristics

As regards age, in recent years we have seen an increase of under-15-year-olds that has come after a major decrease of this age range during previous decades, although the numbers are still lower than those of 1991 It should be noted that the number of people between 15 and 44 years of age, both men and women, have decreased. Similarly, the ratio of people 65 years of age or older compared to those between 15 and 64 years old (senile dependence index) has also grown. This ageing of the population is especially relevant in the number of people over the age of 74, with the rate known as "overageing" (*sobreenvelliment* – the proportion of people aged 75 years or older over the group of 65 years or older) at 36.6% in men and 45.3% in women in 1991, 48.3% and 56.9% respectively in 2014.

People born outside Spain represent 22.2% of Barcelona's population. Although in recent years the number of foreigners has remained relatively stable, this is not the case with regard to the distribution by country of origin. There has been a steady increase in people born in Europe and other high income countries (from 89,008 in 2009 to 97,575 in 2014), while the number of people born in countries in South America and Central America has fallen after years of growth.

Regarding the level of studies, the falling trend in the number of people without studies or with primary studies continued and the number of people with university studies has risen, both for men and for women. This improvement in the level of studies is seen across all districts of the city, although with significant differences: half of the population in Sarrià has university studies (52.3% of men and 45.7% of women) but we only found one in ten in Nou Barris (10.4% and 13%, respectively). In the city as a whole, one in four people has primary or lower education (22.5% of men and 27% of women). However, these figures vary by district: from 7.3% of men and 11.3% of women from Sarrià to 35.2% of men and 41% of women in Horta.

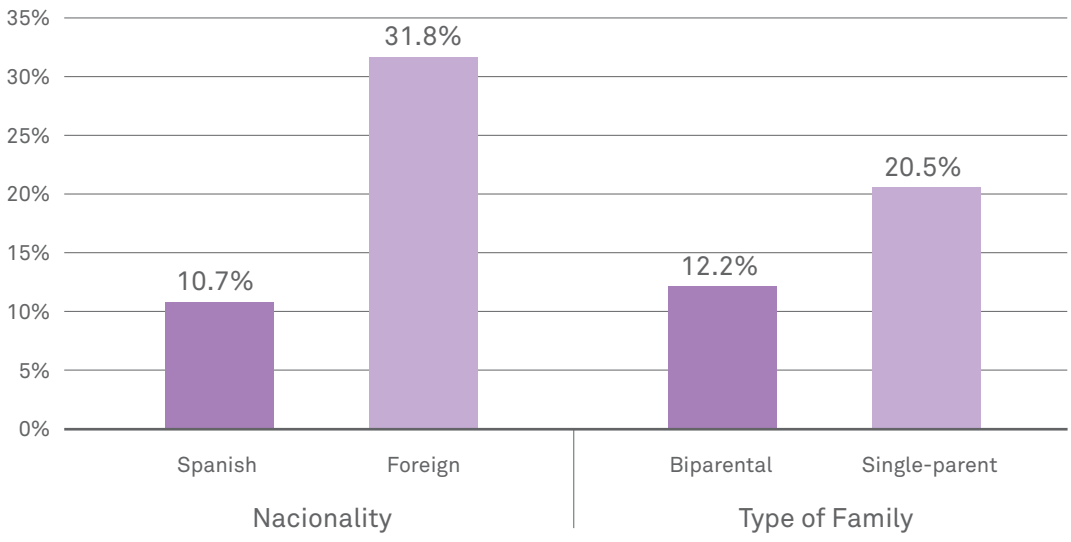
Childhood and adolescence

In 2014 people in Barcelona under the age of 15 represented 13.3% of the population. These minors are spread across 139,293 households, a figure that represents one in five households in the city. Of those, 12.6% are single-parent households. The situation of homes with minors is very different depending on the level of income, the place of residence and the employment situation or academic level of the parents.

Families

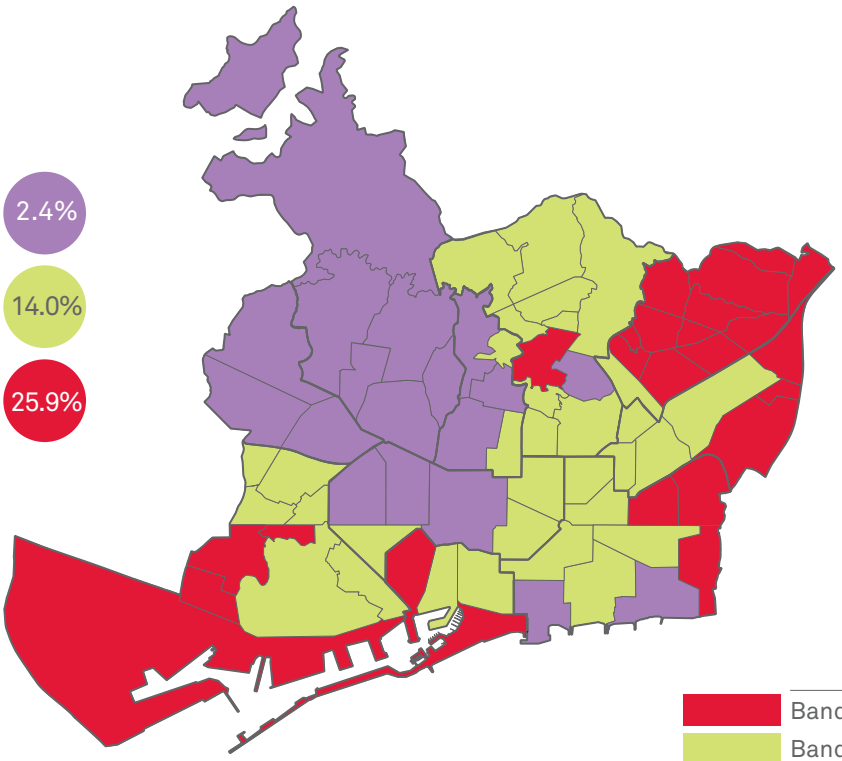
Adverse life conditions during childhood are associated with mental health problems. According to data from the Barcelona Childhood and Families Barometer in 2014, in relation to economic level, 27.9% of households with minors claim to have problems or major problems to get by. This percentage rises to 50% in the case of single-parent families. One out of every ten households with minors does not think they will be able to make their mortgage payments or pay rent in the next three years, a figure that doubles in the case of single-parent homes. In fact, 13.4% of households with minors have been late making their monthly mortgage or rent payments in the last 12 months. In the case of single-parent households, this percentage rises to 20.5% and, in the case of foreign-born households, 31.8% (see Figure 1). As for the job situation, in 8.1% of households with children under the age of 16, neither of the parents is in paid work, a figure that rises to 29.9% in households where parents have only primary education.

Figure 1. Percentage of households with under-16s that have been late making their mortgage or rent payments in the last 12 months. Barcelona Children and Family Barometer (2014).



The data also shows differences depending on the place of residence. So, 13.3% of those under the age of 16 live in families who cannot heat their houses to an adequate temperature during cold months (energy poverty), a percentage that doubles (25.9%) in the more disadvantaged districts (see Figure 2). In the city as a whole, 11% of minors are unable to enjoy leisure and sport activities on a regular basis. This percentage rises to 19.6% in low-income neighbourhoods, while it is only 4% in the highest-income neighbourhoods. These differences are also seen in academic achievement: the number of minors who are repeating or have to repeat a year in primary school is double, from 6% in neighbourhoods with greater income, compared to 12.3% in the most disadvantaged neighbourhoods.

Figure 2. Percentage of families under the age of 16 who cannot keep housing at an adequate temperature during the winter months by neighbourhood. Barcelona Children and Family Barometer (2014).



	RFD 2012
Band 1	37.5 - 69.7
Band 2	71.3 - 99.7
Band 3	102.6 - 240.7

School bullying

Bullying at school can have a major impact on the mental health of children and adolescents. The 2012 FRESC report offers information on bullying at school according to sex and school year. In general, the percentage of boys involved in bullying at school is greater than that of girls, especially in the role of bully. The highest percentage of victims are to be found among younger pupils. About 10% of pupils in 2nd year ESO (13-14 years old) claim to have been the victims of bullying. In older pupils, both 4th year ESO and 2nd year Baccalaureate and intermediate level vocational training (CFGM), the proportion of adolescents who declare themselves as bullies is higher than that of victims, with the greatest differences in boys. The prevalence of students who are victims and bullies at the same time also falls with age and is inferior to that of victims and bullies separately in all years and in both sexes (see figures 3 and 4).

Figure 3. Percentage of boys involved in school bullying by sex and school year. 2012 FRESC Report.

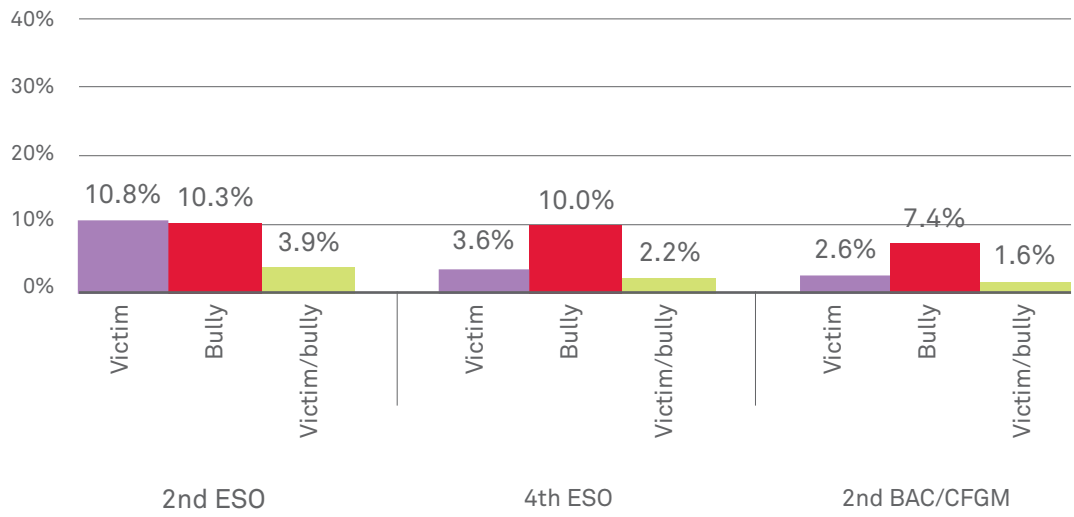
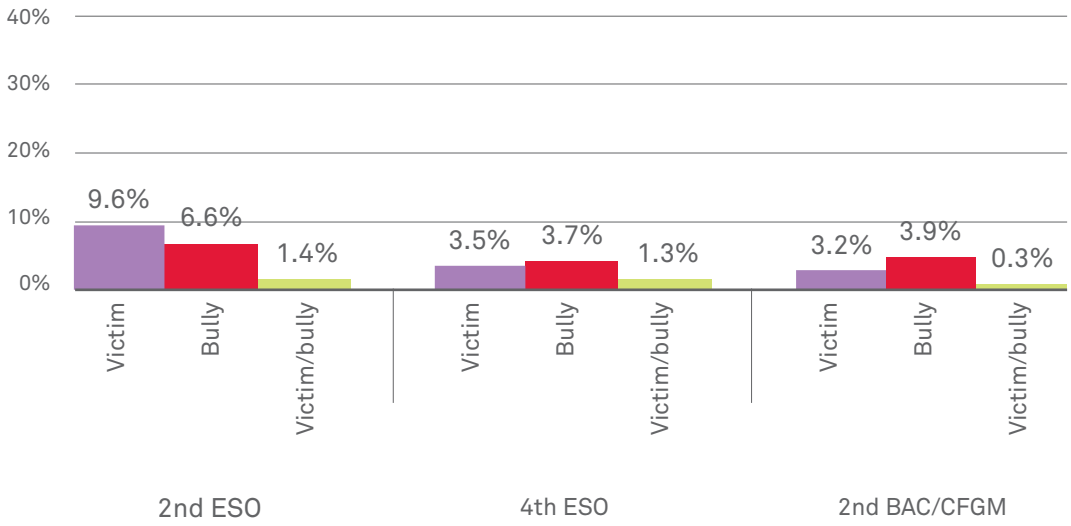


Figure 4. Percentage of girls involved in school bullying by sex and school year. 2012 FRESC Report.

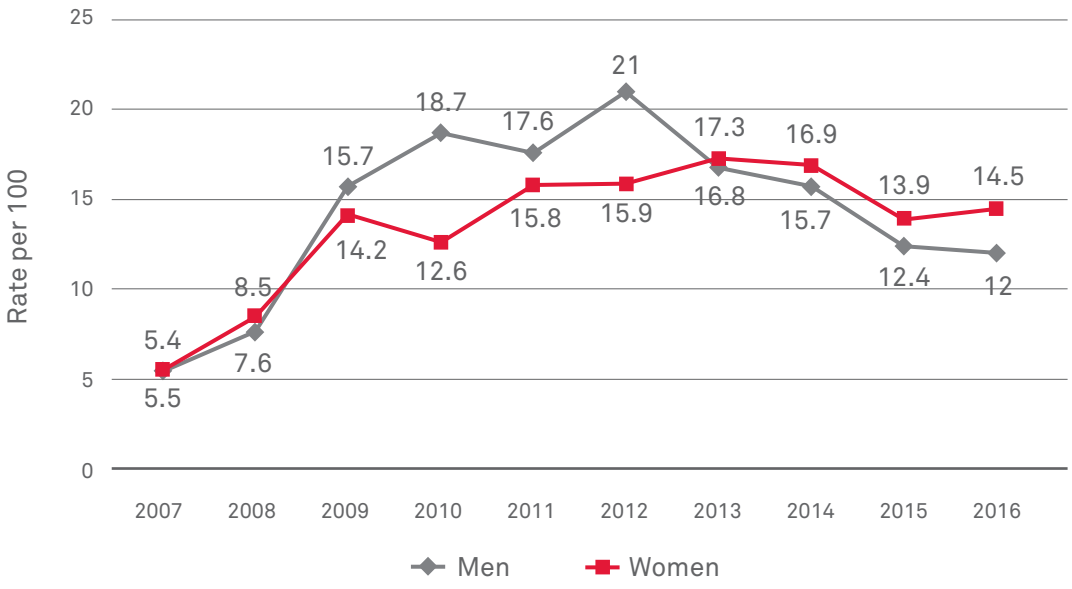


Adults

Unemployment

Unemployment is related to poor mental health. According to the Active Population Survey, in January 2016 there were 105,400 unemployed people in Barcelona, 57.3% of whom were women. The unemployment rate in Barcelona was 13%, and was higher among women. At the beginning of the financial crisis, the unemployment rate was much lower and similar in both sexes, shortly after, it increased significantly for both sexes and from 2010 to 2012 was higher among men, only to become higher again among women (see Figure 5).

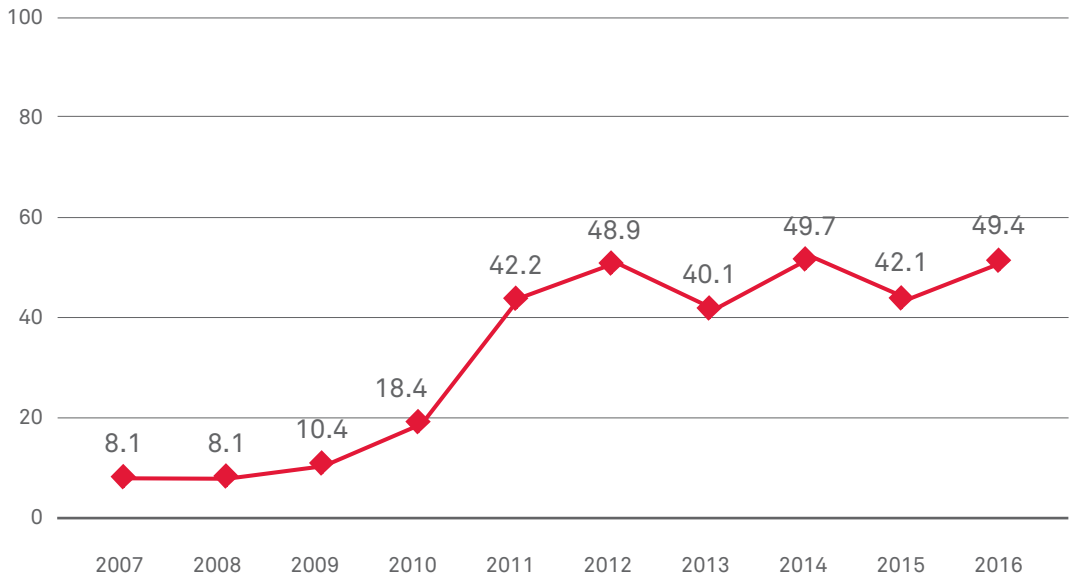
Figure 5. Evolution of unemployment rate in Barcelona (2007-2016). Active Population Survey.



Note: Rates correspond to the first quarter of the year.

Long-term unemployment in particular is associated with poor mental health. As shown in Figure 6, in January 2016, 49.4% of unemployed people were looking for work for two or more years. The proportion corresponding to 2007 was only 8.1%. On the other hand, according to the figures for registered unemployment, only 48.6% of unemployed people in the city receive benefits, a figure that is 2.1 percentage points lower than one year ago.

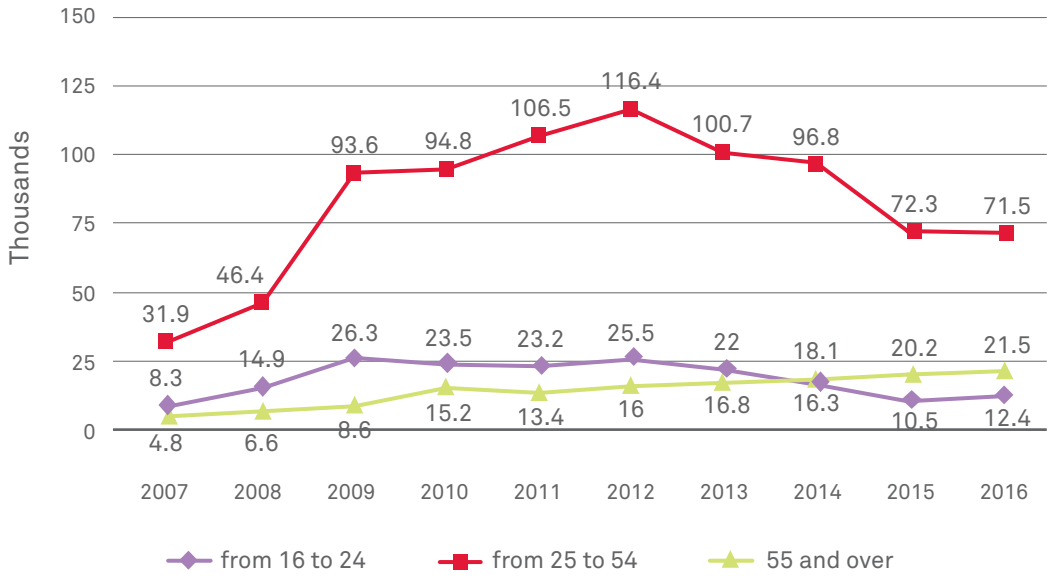
Figure 6. Evolution of the proportion of unemployed people who have been looking for work for two or more years. Active Population Survey.



Note: Rates correspond to the first quarter of the year.

Although in January 2016 the unemployment rate among young people aged 16 to 24 was very high (31.1%) compared to people aged 25 to 54 (11.7%) and those over 54 (14.9%), the number of unemployed young people is 12,400, almost half the number of unemployed people 55 years of age or older (21,500) and well below the number of unemployed people between 25 and 54 (71,500).

Figure 7. Evolution of the number of unemployed people by age group. Active Population Survey.



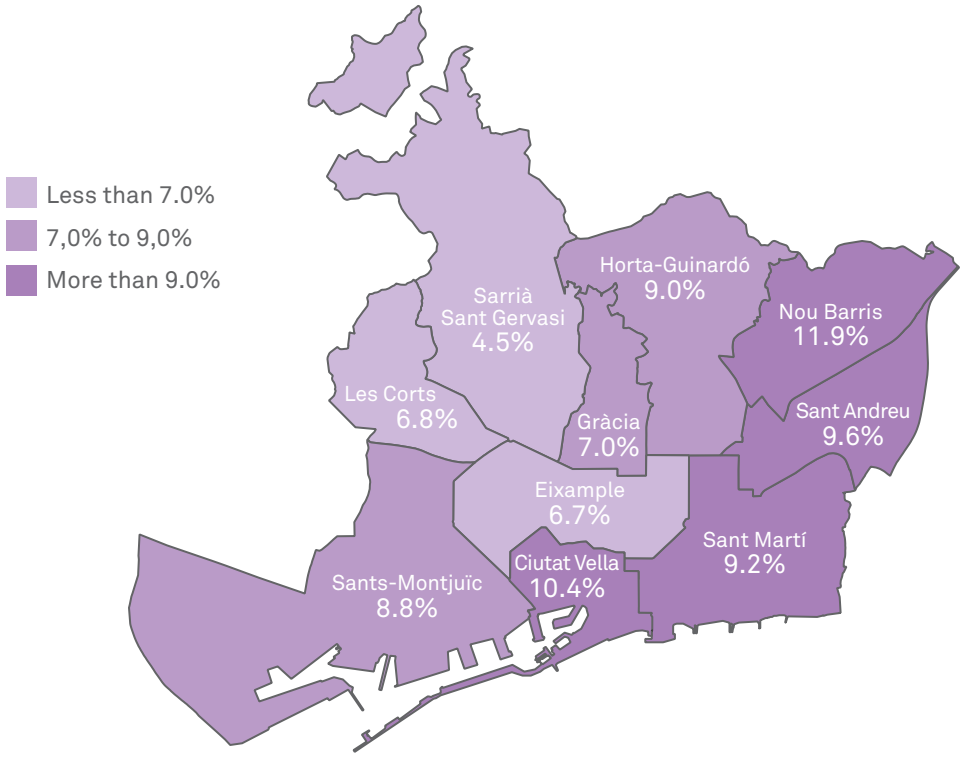
Note: Rates correspond to the first quarter of the year.

At the end of January 2015, 8.4% of the working-age population of Barcelona (16 to 64 years old) was registered as unemployed in the offices of the Employment Service of Catalonia (SOC). However, it should be taken into account that not everyone who is unemployed is registered with the SOC. Also, many groups do not appear as unemployed, for example people who are taking part in workplace insertion projects, among others. Therefore, although these figures underestimate the situation, they do give us an idea about the unemployment situation and its uneven distribution among the population of the city, not available in the Active Population Survey.

The percentage of unemployed foreigners was 17.9% and the downward trend of this group (with a significant 11.5% year-on-year reduction) was maintained, due to a lack of opportunities, which has led some of the newcomers to return to their countries of origin.

The percentage of unemployed people also varies by district of residence. Districts with a rate of unemployed people below the average for Barcelona (8.4%) were the most well-off: Sarrià-Sant Gervasi, L'Eixample, Les Corts and Gràcia, with values ranging from 4.5% in the former and 7% in the latter. In contrast, the districts of Sants-Montjuïc, Horta-Guinardó, Sant Martí, Sant Andreu, Ciutat Vella and Nou Barris surpass the city average, with percentages of unemployed people as a proportion of the working-age population between 8.8% in Sants-Montjuïc and 11.9% in Nou Barris, a percentage that is equivalent to 2.6 times that of Sarrià-Sant Gervasi.

Figure 8. Percentage of registered unemployment among population aged 16 to 64, by district. Barcelona, January 2015.



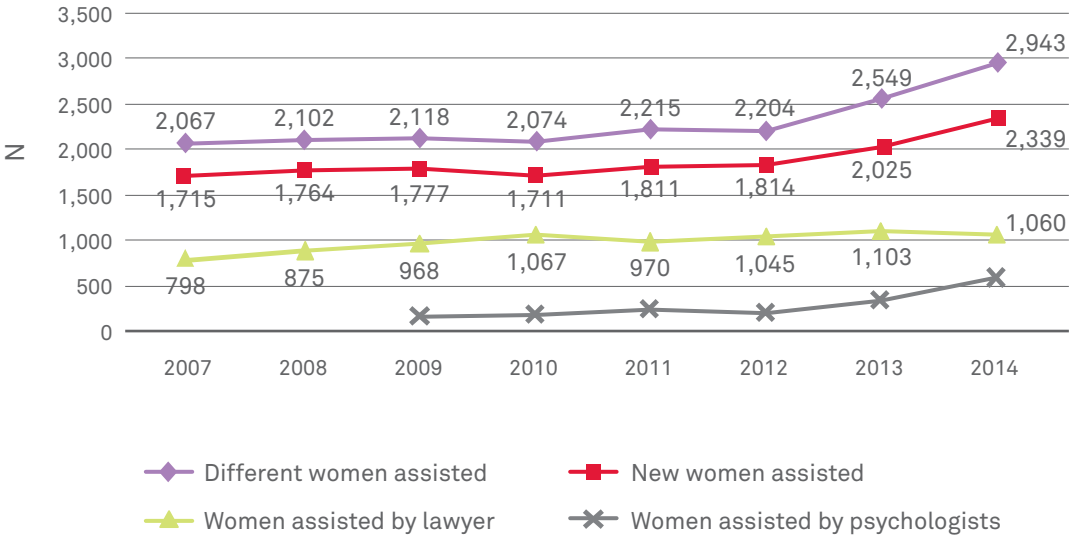
Source: Produced by the Department of Employment, Business and Tourism Studies at Barcelona City Council, based on data from Barcelona City Council Statistics Department.

Gender-based violence

Gender-based violence is a structural form of violence that is manifested both in the public and private sphere, both by people known to the victim and, to a lesser extent, people they do not know. The data of women who file a report and seek help are in fact just the tip of the iceberg, but it is a good indicator of the situation of violence suffered by a significant part of the population.

In Barcelona, the Women's Support and Information Points (PIADs) are a community-based service. There are 10 PIADs, one for each district of the city, that offer information and guidance, as well as psychological support and legal advice to female victims of gender-based violence. According to data from the 2014 report for municipal care services in cases of gender-based violence attached to the Women's Programme Directorate, in 2014, the trend from previous years continued in terms of the progressive increase in the number of women assisted at PIADs from 2012 (see Figure 9).

Figure 9. Change in the number of women assisted at PIAD in Barcelona.



Source: 2014 Report on municipal care services for gender-based violence attached to the Women's Programme Directorate.

The districts that saw highest demand in 2014 were Gràcia (12.9%), followed by Sant Martí (12%), Nou Barris (11.9%) and Sant Andreu (10.9%).

The Assistance, Recovery and Shelter Service (SARA) was created on 2 January 2014, and integrated the care provided up to 31 December 2013 by two different services of the municipal team for specific care in situations of gender-based violence: the Women's Care Team (EAD) and the Children's Support Service (SAN). SARA is the gateway to public and private emergency accommodation and long-stay resources for people experiencing situations of gender-based violence. In 2014, 1,500 family units were assisted, of which 547 (61.5%) accessed them directly. The rest, 343 family units (38.5%), were sent from other services such as Municipal Social Services, the Catalan Police Force (Mossos d'Esquadra), Justice, the healthcare network, other organisations, etc. If we compare the annual data for 2014 with 2013, there was an increase of 11.28% of children or adolescents who were treated directly with respect to 2013 (195 children or adolescents), as well as an increase of 5.8% in the family units assisted. It should also be noted that during the year 2014, 9 adolescents were assisted for the first time at the walk-in service for situations of gender-based violence, and they accessed SARA directly, unaccompanied by adults.

The socio-economic profile of women assisted shows that gender-based violence affects all social groups: 57.8% of women had pre-university studies, vocational training or a university degree, and 10.4% had completed only compulsory secondary school education, while 71.9% of women assisted in 2014 were of Spanish nationality (58.2% in 2013). Among other nationalities, 54.9% came from Latin America, 17.9% from other European countries, 16.5% from the Maghreb and 8.2% from Asian countries.

According to the Barcelona judicial mortality registry of the ASPB, in 2014 there were eight homicides of women in the city, three of which were due to violence from their partner. Mortality due to gender-based violence is probably underdeclared in this report.

Elderly people

Loneliness

Forms of living units have undergone major changes in recent decades. Since the 90s, there has been an increase in the number of people living alone in Barcelona. In 2013, 88,007 elderly people lived alone in Barcelona, 25.4% of the total population aged 65 or older. It should be mentioned that the percentages of people living alone increases as people age (see Table 1). This indicator shows a significant difference between men and women, since the loneliness index is more than double among women than among older men. In 2015, almost 90,000 people aged 65 or older lived alone, of which 77% were women. These figures are especially relevant if one considers that loneliness in older women is frequently related to depressive states.

Table 1. Elderly population living alone by age group in 2015.

	Men		Women	
65-69 years	4,960	12.8	10,428	21.4
70-74 years	4,228	12.9	11,109	26.4
75-79 years	3,425	13.4	11,917	32.6
80-84 years	3,616	15.9	15,215	40.4
85-89 years	2,623	20.1	12,355	45.6
90-94 years	1,288	27.0	5,852	44.1
95 or over	273	28.6	1,434	35.5

Source: Reading of the Municipal Register of Inhabitants on 30.06.2015. Statistics Department. Barcelona City Council.

Financial situation

The mental health of the elderly, as with the rest of the age groups, is related to financial vulnerability, with the risk of poverty greater among women. To tackle this situation in Barcelona, the Barcelona Municipal Plan for the Elderly 2013-2016 uses the level of income of people aged 60 years or older as an indicator. In particular, it calculates the percentage of this group with incomes lower than the public multiple effect income indicator (IPREM).

From 2006 and until 2012, the percentage of people 60 years and older with incomes lower than the IPREM has fallen consistently. In 2006, this figure was 30.1% and in 2012 it fell to 22.8%. Even so, in 2012 almost 100,000 people in the city aged 60 or over earned less than €532.51 per month. The territorial distribution of this group is uneven (see Table 2). Ciutat Vella and Nou Barris are the districts with the highest percentage of people in this situation (more than 30%), while on the other extreme, we find Les Corts (15.3%) and Sarrià-Sant Gervasi (10.5%).

Table 2. Level of income of people aged 60 or over. Barcelona, 2006-2012.

	2006			2012		
Districts	Population aged 60 or over	Income < IPREM	%	Population aged 60 or over	Income < IPREM	%
1. Ciutat Vella	23,376	9,883	42.3	19,508	6,407	32.8
2. Eixample	73,858	17,744	24.0	73,799	12,881	17.5
3. Sants-Montjuïc	44,977	15,784	35.1	45,699	12,176	26.6
4. Les Corts	22,143	4,792	21.6	25,116	3,838	15.3
5. Sarrià-Sant Gervasi	37,164	5,654	15.2	39,196	4,127	10.5
6. Gràcia	32,629	8,974	27.5	32,913	6,468	19.7
7. Horta-Guinardó	47,084	16,121	34.2	49,173	12,945	26.3
8. Nou Barris	47,132	18,319	38.9	47,722	14,824	31.1
9. Sant Andreu	35,303	10,341	29.3	38,796	9,137	23.6
10. Sant Martí	55,093	18,599	33.8	58,798	15,333	26.1
Barcelona	**418,759**	**126,211**	**30.1**	**430,720**	**98,136**	**22.8**

Source: Produced by the Department of Research and Knowledge, Quality of Life, Equality and Sports Area, Barcelona City Council, based on the database of the elderly persons' Pink Card.

IPREM: public multiple effect income indicator. Barcelona Municipal Register. Barcelona City Council.

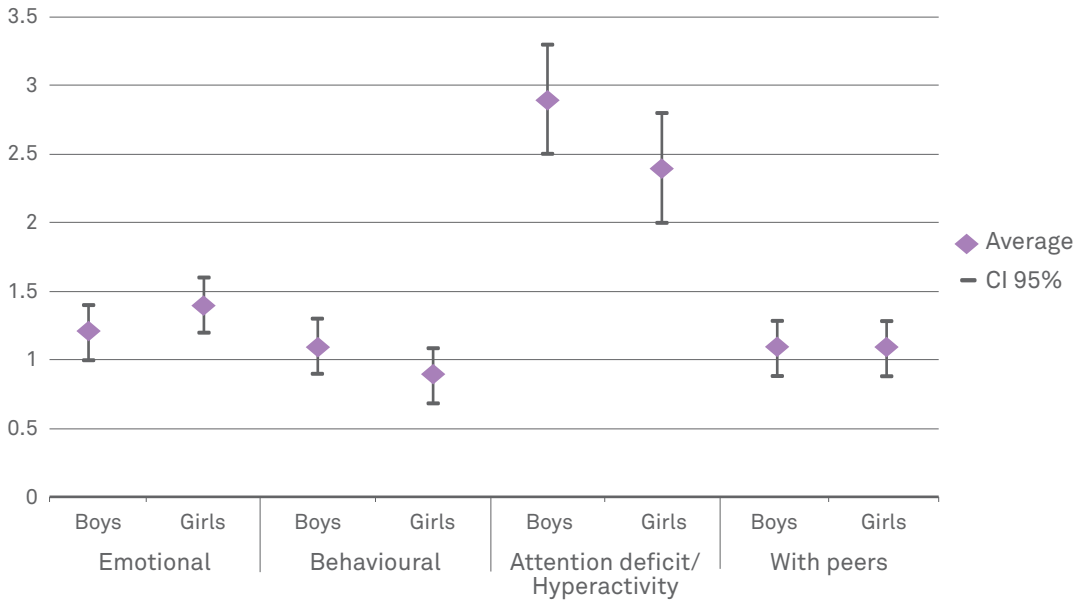
When analysing the financial situation of the elderly, the impact of social transfers must be considered. According to data from the Survey on Living Conditions (INE, 2010), before social transfers, the prevalence of risk of poverty among the elderly is 80.4%. Although this indicator is reduced after taking into account all transfers, including pensions, 19.4% of the elderly population remain in a situation of poverty. The presence of women in this group of poverty is greater due to the close relationship between economic transfers and contributions in the formal labour market.

2.
THE STATE OF MENTAL HEALTH IN BARCELONA

Childhood and adolescence

There are several questionnaires to find out about the mental health among the child population, including the Strengths and Difficulties Questionnaire-10 (SDQ). This tool is based on four types of problems: those with peer socialising, emotional problems, behavioural problems and problems of attention deficit and hyperactivity). As such, higher scores equates to more mental health problems. The Barcelona Health Survey (ESB) 2011 uses this questionnaire with the child population of Barcelona aged 4 to 14. The problems that show the highest scores are attention deficit-related, and these are more common in boys than in girls with an average of 2.9% and 2.4%respectively (see Figure 10). The rest of the problems are quite similar across the two sexes.

Figure 10. Mental health problems by sex. Population aged 4 to 14. Average score and CI 95%. ESB 2011.



The health of the adolescent population in school in Barcelona has been rated for 25 years now with the FRESC report. The SQD survey is also used in this report, but scores are global and not broken down by type of problem. According to data from the last report, the prevalence of probable psychological suffering (abnormal SDQ with a score between 20 and 40) in 2012 is between 5 and 7% among the adolescent population. These percentages decrease with age for boys (see Figure 11), whereas for girls, this reduction only occurs from 2nd to 4th year of ESO (13-16 year olds), with a subsequent increase in the 2nd year of Batxillerat (17-18 years) and mid-level vocational training cycles (see Figure 12). The percentage of students with possible psychological suffering (borderline SDQ with a score between 16 and 19) by school year is higher among girls than among boys, with percentages of around 15-16% and 10-13%, respectively.

Figure 11. Prevalence of psychological suffering among adolescent boys by school year. 2012 FRESC Report.

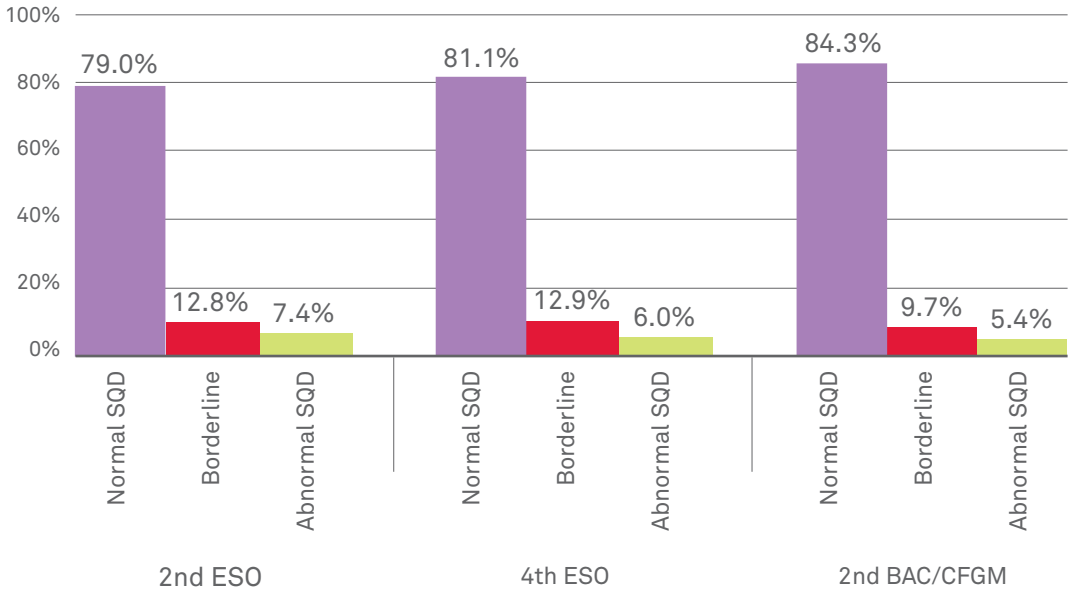
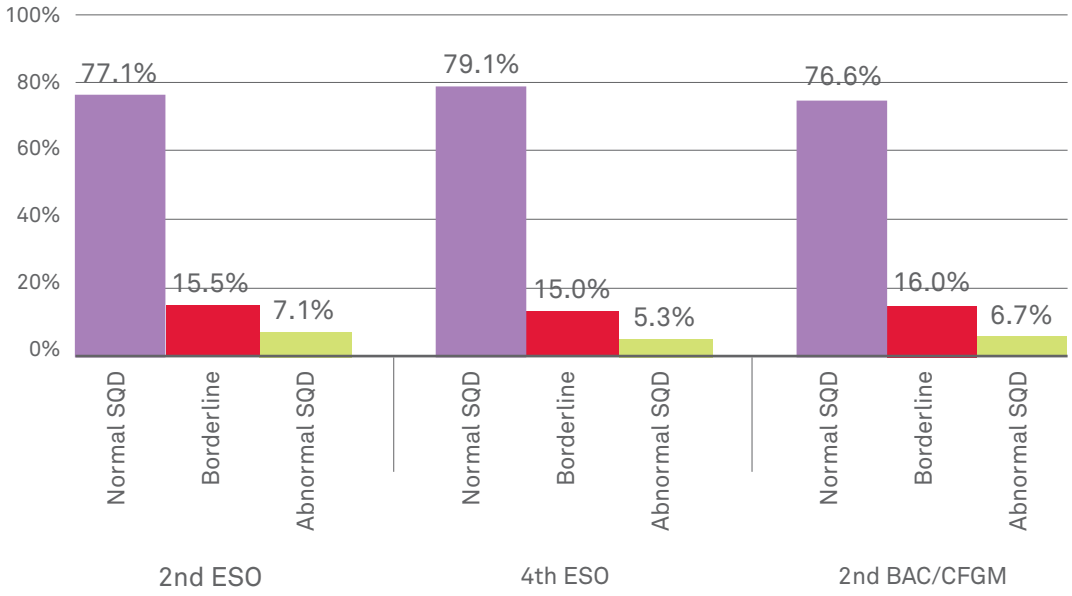


Figure 12. Prevalence of psychological suffering among adolescent girls by school year. 2012 FRESC Report.



Adolescent girls see higher prevalences of mood problems than boys of the same age (see figures 13 and 14). In both boys and girls, this proportion increases with age except in the case of boredom, which is slightly higher among younger pupils. It is worth noting that 38.7% of girls in 2nd year of Batxillerat and CFGM claim they feel nervous or tense, 34.0% claim they feel tired and 30.9% say they have problems sleeping. In boys of the same year, these percentages are 24.1%, 28.0% and 27.8%, respectively.

Figure 13. Prevalence of mood problems (often or always) by school year among boys (%). 2012 FRESC Report.

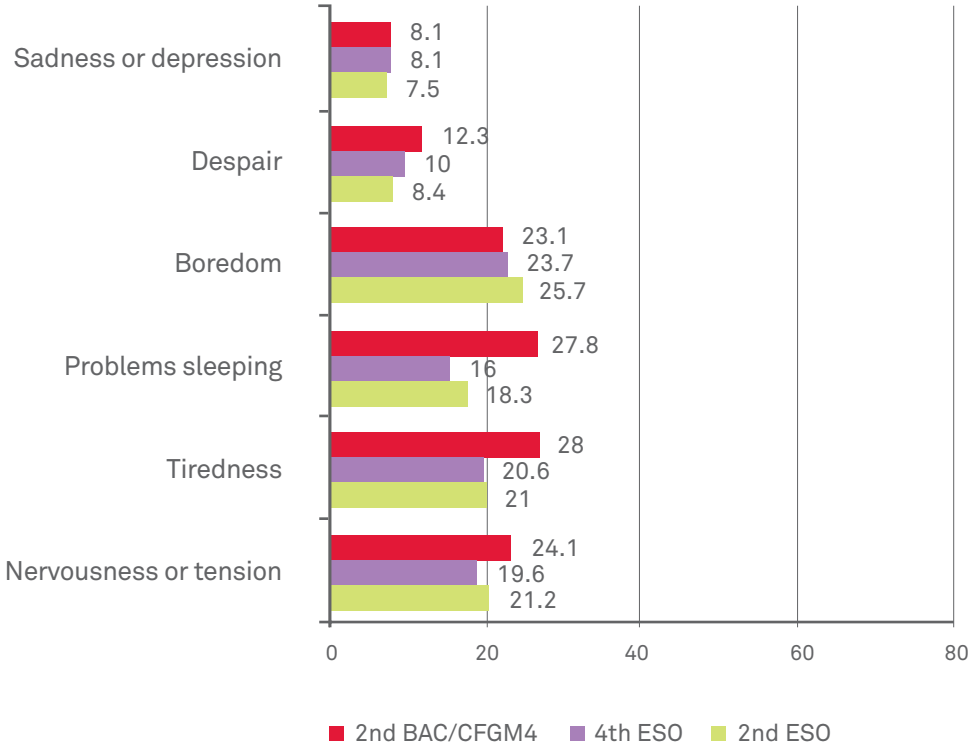
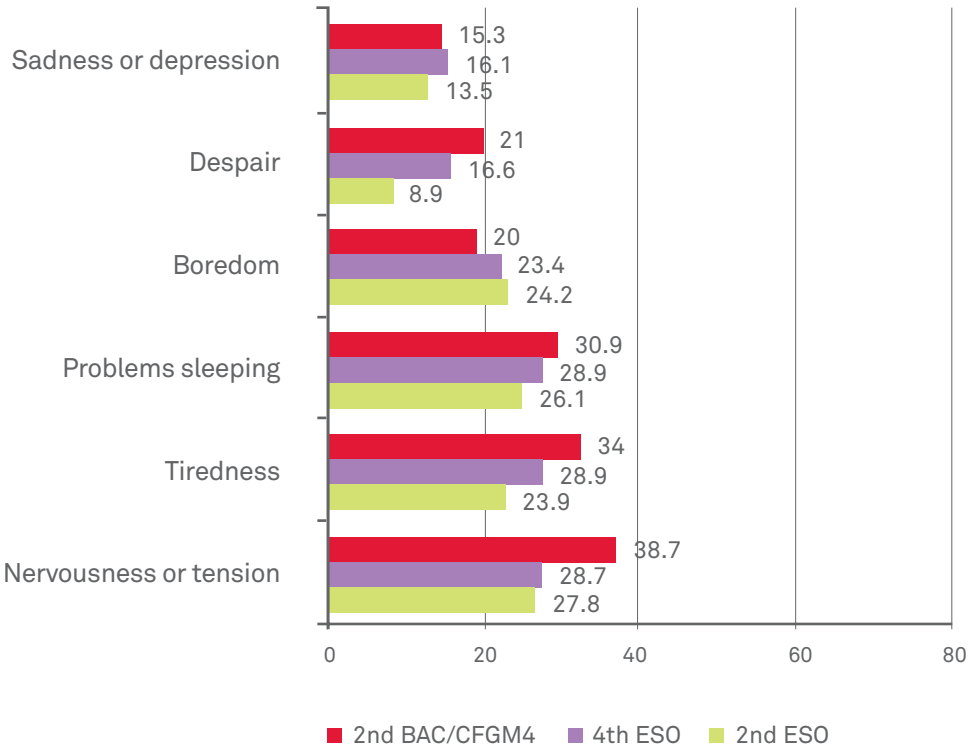


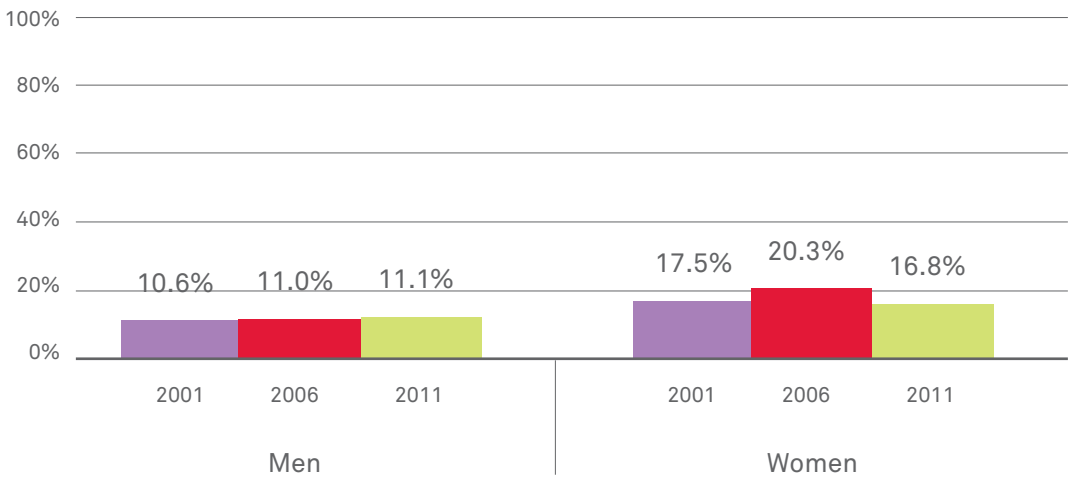
Figure 14. Prevalence of mood problems (often or always) by school year among girls (%). 2012 FRESC Report.



Adults and elderly people

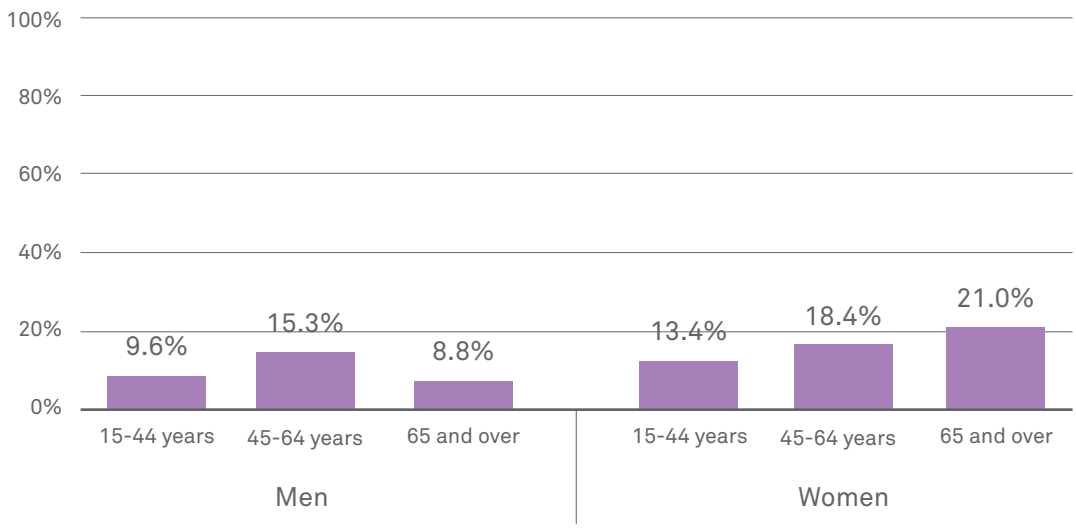
The GHQ-12 General Health Questionnaire assesses the mental health of the adult population, more specifically, it assesses psychological suffering. It is a commonly-used instrument to assess the psychological state of the general population. The ESB uses the GHQ-12 to learn about the mental health of Barcelona's adult population and its trends. In the latest edition of the ESB in 2011, 16.8% of women and 11.1% of men aged 15 or older were at risk of psychological suffering. In recent years, men have always shown values lower than women, with a stable trend in both sexes (see Figure 15).

Figure 15. Evolution of the risk of psychological suffering by sex. Population aged 15 or over. ESB 2001, 2006 and 2011. Percentages standardised by age.



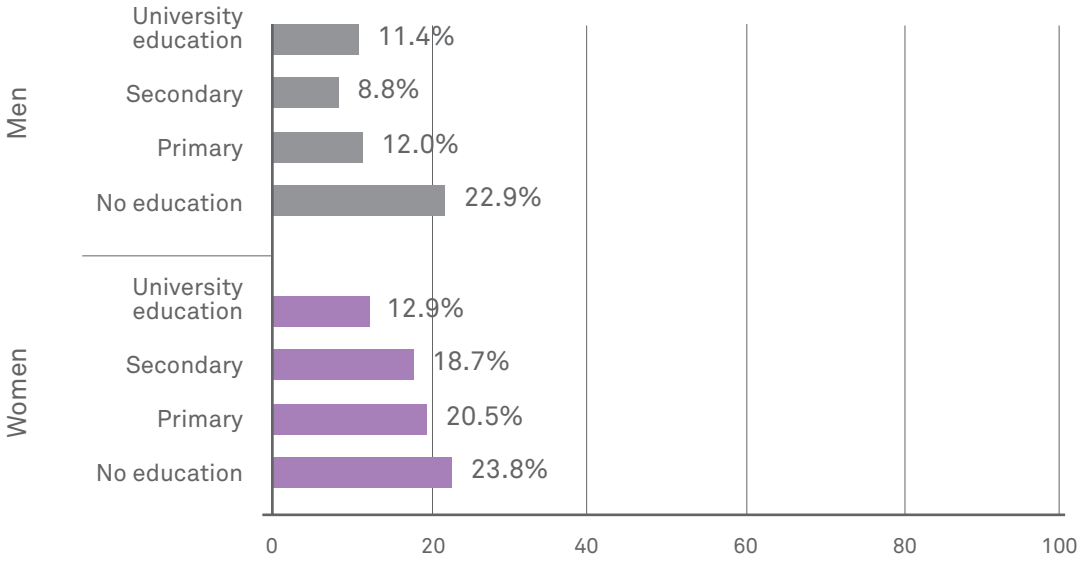
Among women, increased age is accompanied by an increase in the prevalence of psychological suffering, whereas among men no gradient based on age can be observed. We can see, therefore, that the highest prevalence of psychological suffering corresponds to women aged 65 or older, with 21% (see Figure 16).

Figure 16. Risk of psychological suffering by age group and sex. Population aged 15 or over. ESB 2011.



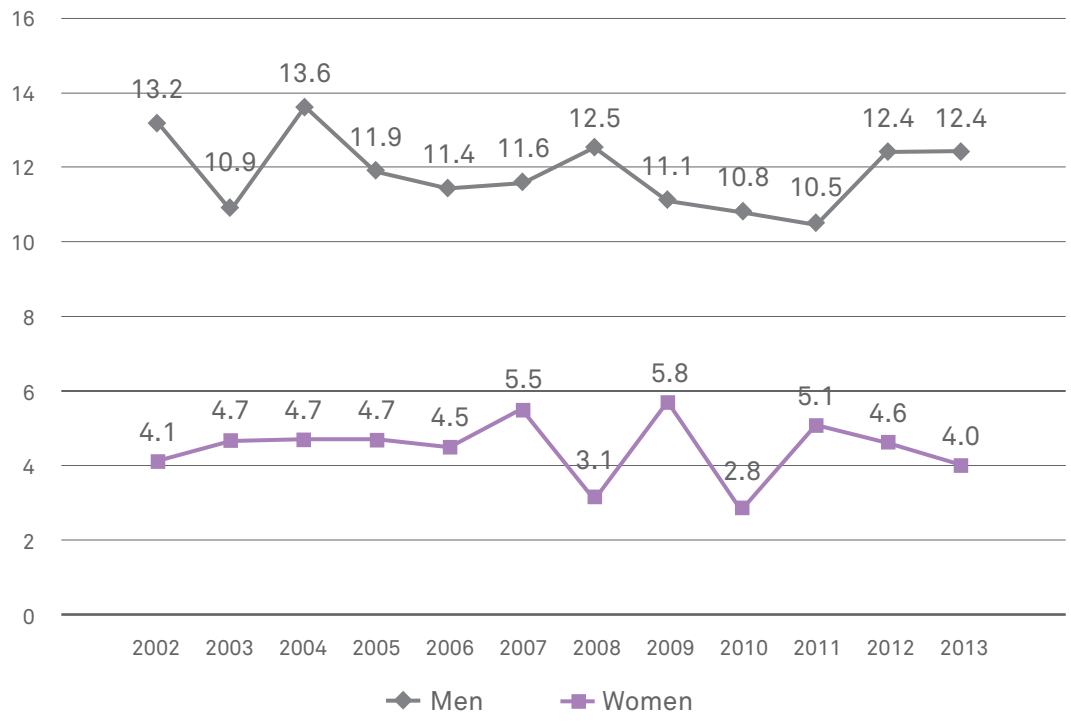
Correlation is observed with level of studies in both sexes, with people with a lower level of studies at greater risk of psychological suffering, up to 23.8% of women and 22.9% of men without studies (see Figure 17).

Figure 17. Risk of psychological suffering by level of studies and sex. Population aged 15 or over. ESB 2011. Percentages standardised by age.



With regard to the prevalence of frequent mental disorders, data from the latest ESB shows that 12.9% of women and 5.9% of men suffer depression and/or anxiety. Depression is considered one of the chronic diseases associated with a higher risk of suicide. The prevention of suicide is one of the lines of the European Action Plan for Mental Health and the 2016-2020 Health Plan of Catalonia. The Mortality Registry data allows us to obtain mortality rates due to suicide. In Barcelona these rates have remained stable in recent years, and are much higher in men than in women (see Figure 18).

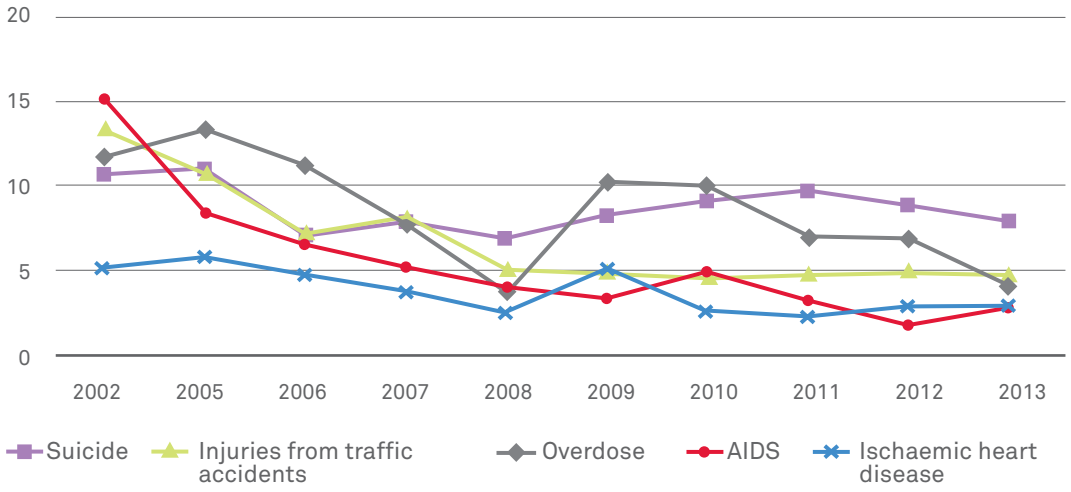
Figure 18. Evolution of mortality rates due to suicide by sex. Standardised mortality rates by age per 100,000 people. Barcelona, 2002-2013.



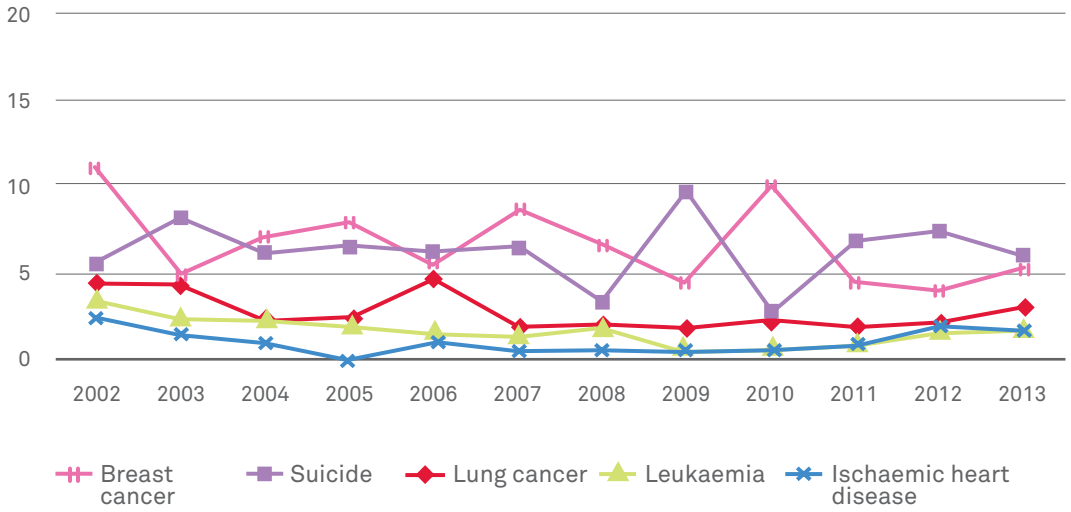
Among men aged 15 to 44 in 2013, suicide was the leading cause of mortality, although it has remained stable over recent years, which is explained by the fall in mortality due to traffic injuries and overdoses in this age group. Among women aged between 15 and 44, there is a notably low mortality rate in this group, which means the observed series are more unstable, with suicide being the leading cause of death in 2013.

Figure 19. Yearly evolution of the main causes of mortality in men and women aged 15 to 44. Standardised mortality rates by age per 100,000 people in Barcelona, 2002-2013.

Men aged 15 to 44
Standardised rate by age x 100,000 inhab.



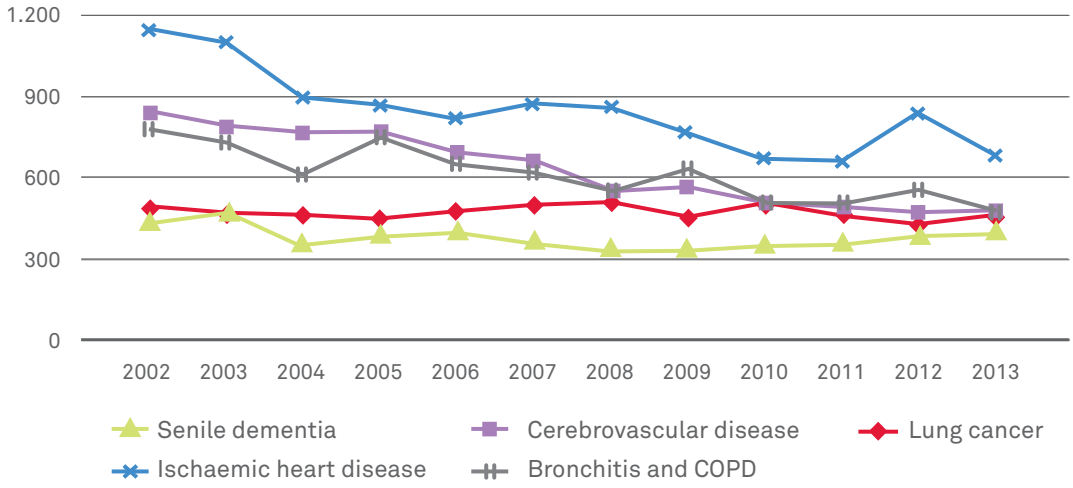
Women aged 15 to 44
Standardised rate by age x 100,000 inhab.



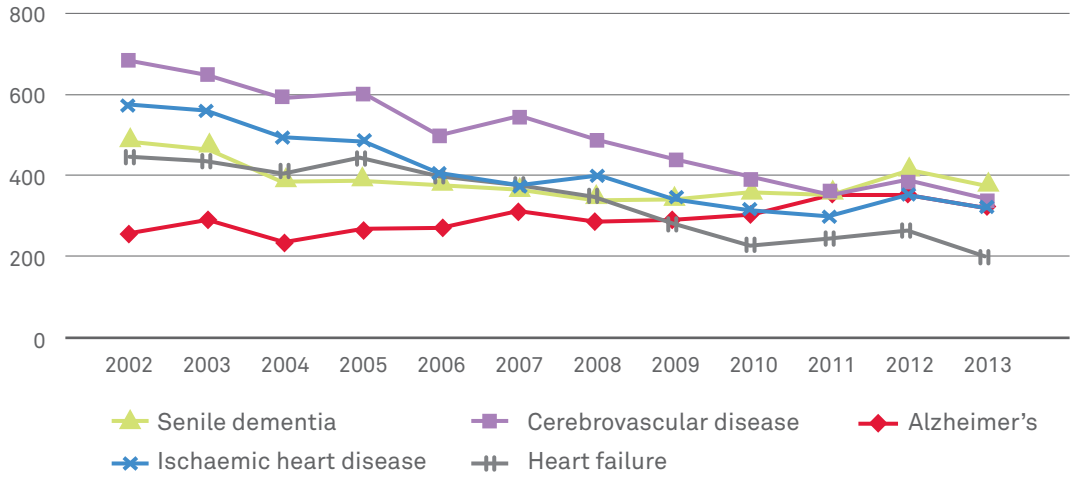
Finally, we must stress dementias in relation to the mental health of the elderly. Although it mainly affects elderly people, it is important to point out that dementia is not a normal part of ageing. Senile dementia and Alzheimer's disease are currently the main causes of death among women aged 75 years or older (see Figure 20). In this group of elderly women, mortality due to senile dementia has remained stable, while mortality due to Alzheimer's disease has shown a steady increase over the last decade.

Figure 20. Evolution of the main causes of mortality in men and women aged 65 years or older. Standardised mortality rates by age per 100,000 people. Barcelona, 2002-2013.

Men aged 75 and over
Standardised rate by age x 100,000 inhab.

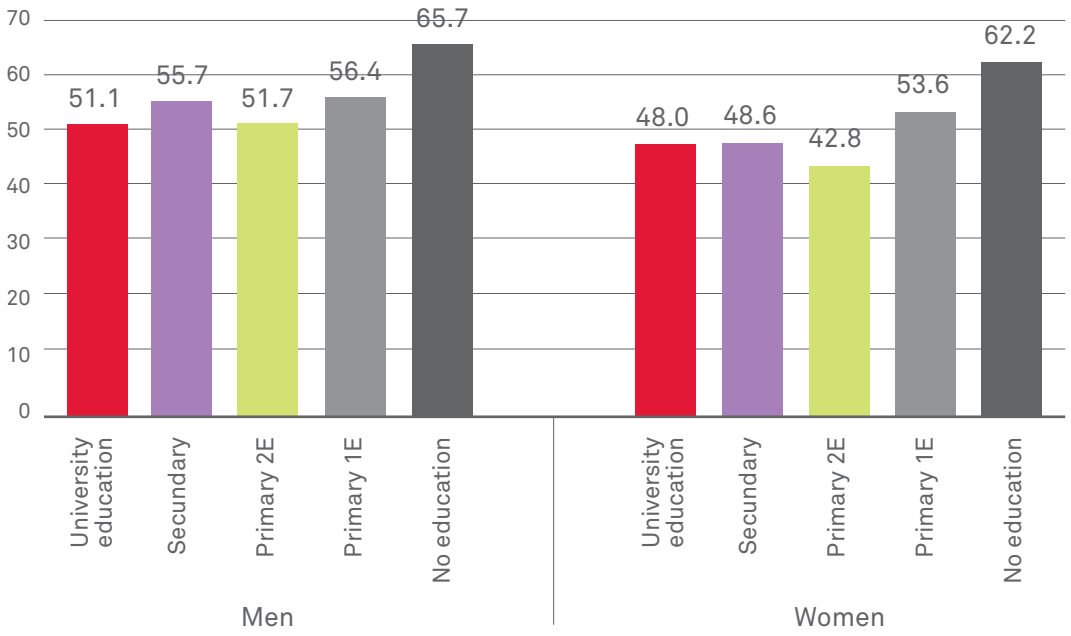


Women aged 75 and over
Standardised rate by age x 100,000 inhab.



Dementia is one of the main causes of disability in old age. The psychological and behavioural symptoms associated with dementia profoundly affect the quality of life of the people who suffer from it and that of their carers. In that regard, the burden is not distributed homogeneously throughout the population as we can see how mortality due to dementia varies depending on socio-economic level. As such, both men and women show a correlation whereby the highest mortality rates for any type of dementia affect people with the lowest educational level (see Figure 21).

Figure 21. Mortality due to dementia by sex and studies. Standardised mortality rates by age per 100,000 people. Barcelona, 2013.



3.
MENTAL HEALTHCARE IN BARCELONA

Childhood and adolescence

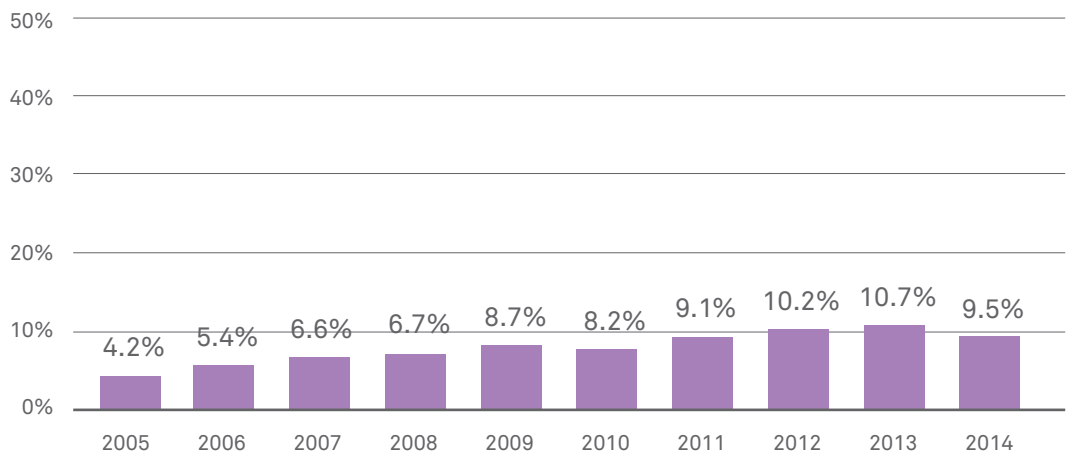
Mental healthcare for minors in the primary healthcare system is addressed by children's and young people's mental health centres (CSMIJ). According to data from the basic minimum record of mental health data (CMBD_SM), 10,517 minors received care in 2014. These figures correspond to the cumulative increase of the population treated at mental health centres between 2001 and 2014, with an increase of 112.0% among children and young people (see Figure 22). In 2014, 61.5% of people attending mental health centres for children and young people were male.

Figure 22. Population aged 18 or younger treated at mental health centres by sex. Barcelona, 2001-2014.

Source: Basic minimum record of mental health data CMBD_SM). CatSalut

Serious disorders treated among children and young people have also doubled in recent years, from 4.2% in 2005 to 9.5% in 2014 (1,099 cases) [see Figure 23].

Figure 23. Percentage of over-18s treated at mental health centres with severe mental disorders (TMG). Barcelona, 2001-2014.



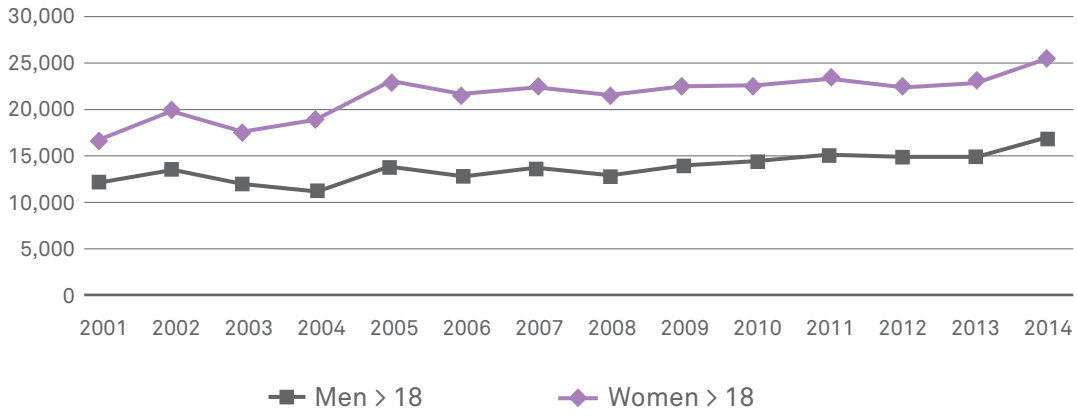
Source: Basic minimum record of mental health data CMBD_SM). CatSalut

Most notable among the mental health problems in children is attention deficit disorder and hyperactivity disorder, which accounts for 16.1% of cases, followed by other childhood psychoses, with 3.6%, mixed developmental disorder, with 2.7%, eating disorders, with 1.7%, and autistic disorders, with 1.1%. Average annual visits to CSMIJs in 2014 was 8.7 visits per patient per year, slightly higher than the figure for the rest of the healthcare region of Barcelona (7.3 visits per patient/year).

Adults and elderly people

According to data from the CMBD-SM, the percentage of the population over the age of 18 treated at adult mental health centres (CSMA) has also increased in the period between 2001 and 2014, in this case 49.6% (see Figure 24). In 2014, 42,704 people were attended by the CSMAs. Compared with children, where mostly boys are treated, at CSMAs, 60.6% of those attended in 2014 were women.

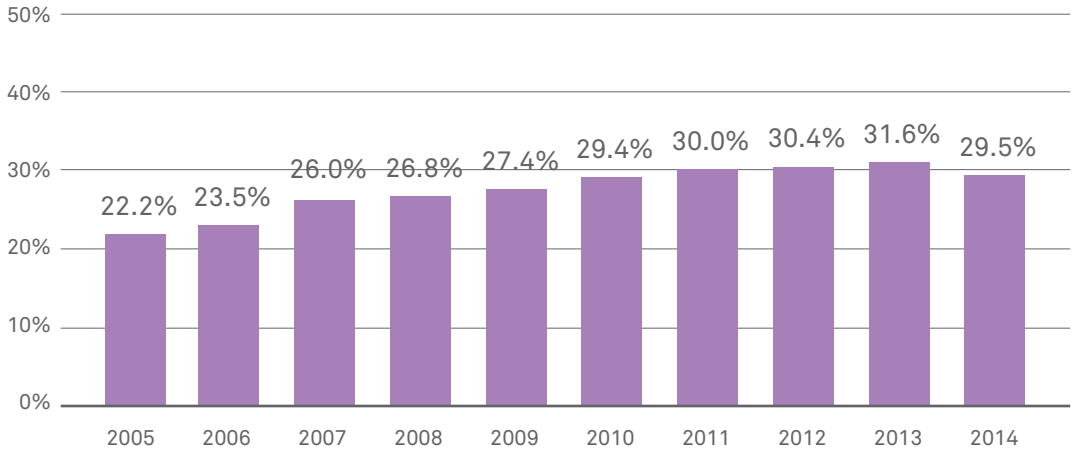
Figure 24. Population aged 18 or over treated at mental health centres by sex. Barcelona, 2001-2014.



Source: Basic minimum record of mental health data CMBD_SM). CatSalut

In recent years, the increase in people treated is in addition to an increase in severe mental disorders. The figure of 22.2% of adults with severe disorders treated in 2005 rose to 29.5% in 2014 (see Figure 24). Among the severe pathologies, we should note schizophrenic disorder, with 12.7%, and depression, with 6.6%. Food disorder also stood out as an emerging pathology, with 295 people attended at CSMAs in 2014 (0.7%), 92.2% of whom were women and 7.8% were men (see Figure 25).

Figure 25. Percentage of over-18s treated at mental health centres with severe mental disorders (TMG). Barcelona 2001-2014.



Source: Basic minimum record of mental health data CMBD_SM). CatSalut

The average of annual visits to CSMAs in 2014 was 8.1 visits per patient per year, slightly higher than the figure for the rest of the healthcare region of Barcelona (7.7 visits per patient/year). In addition to treatment in the primary healthcare system, there were also visits made to mental health hospitalisation units: 5,188 admissions in 2014 (4,488 were acute and 700 were sub-acute), compared to the 4,469 total generated in 2013.

Overall, the resources involved in mental health comprise 14 mental healthcare centres for adults, 9 for children and young people, 7 mental health hospitals or emergency services, 4 day hospitals and 1 mobile unit with a multidisciplinary team of specialised mental health support.

Mental health disorders related to work

Primary healthcare notifies mental health disorders related to work to the Barcelona Occupational Health Unit. In 2014 there were 317 cases notified, virtually the same as previous years, with an incidence of 27.4 cases per 100,000 employed men and 61.0 cases per 100,000 employed women.

These are mainly anxiety and depressive disorders, most of which affect women (69.7%). The average age in 2014 was 42.5 years, with no difference across genders. Of all the people with these health problems, 17.7% were born outside Spain, especially in South American countries (9.6%).

Support professionals and service and retail staff were the most common jobs for these problems in both sexes (23.2% of men and 26.9% of women in the first case and 22.1% of men and 25.1% of women in the second case). As for the company's business, the most frequent for men is usually hospitality and catering (restaurants and food establishments) and for women it is usually cleaning. As for the contract type, most of them tend to have indefinite contracts (86.7% in 2014). 81.8% of reported cases were on sick leave at the time of notification, while only 38.1% had been visited by the accident and work-related illnesses insurance company.

The risk factor most frequently involved is the lack of support from superiors (40.1% of cases studied), followed by a lack of autonomy (28.4%) and high psychological demands such as high volume of work and time pressure (16.7%).

4.
SOURCES OF DATA

Social determinants of mental health

Section	Source	Year
Socio-demographic conditions	Municipal Population Register	2014
Children and their families	Barcelona Children and Family Barometer	2014
School bullying	FRESC.ASPB report	2012
Unemployment in Barcelona	Evolution of registered unemployment in Barcelona. Barcelona City Council	2016
Gender-based violence	Report corresponding to municipal services for care for gender-based violence, depending on the Directorate of the Women's Programme. Barcelona City Council	2014
Loneliness of elderly people	Municipal Population Register	2014
Financial situation of the elderly	Barcelona Municipal Plan for Elderly People 2013-2016. Barcelona City Council	2012

The state of mental health in Barcelona

Section	Source	Year
Childhood and adolescence	Barcelona Health Survey. ASPB	2011
	FRESC.ASPB report	2012
Adults and elderly people	Barcelona Health Survey. ASPB	2011
	Mortality Register	2014

Mental healthcare in Barcelona

Section	Source	Year
Childhood and adolescence	Basic minimum record of mental health data CMBD_SM). CatSalut	2014
Adults and elderly people	Basic minimum record of mental health data CMBD_SM). CatSalut	2014

Annexe 2:

Challenges, Facts and Proposals

CONTENTS

1.
PRESENTATION

This document includes a primary analysis of the objectives set by Barcelona City Council in the development of the Mental Health Plan:

- Promotion of resilience, mental health and emotional well-being of the population throughout their entire life cycle.
- Support for people with mental health problems and their families.
- Active participation of people with mental health problems in all spheres (social, work and civic).

The purpose of this document is to become a key document for work in this process.

It has been drawn up based on the reflections of the members of the Advocacy Group of the Mental Health Board of Barcelona, who were interviewed between January and March 2016.

The document is structured around 8 city challenges, around which we have identified a great level of agreement.

For each of these challenges, the main elements of analysis that justify them are offered, as well as a first list of proposals provided by the people who have been interviewed.

Before this, we offer some reflections by the people that are part of the Advocacy Group about the project, which we considered relevant and which also generated a significant level of agreement.

Finally, we would like to thank everyone who was interviewed for their involvement and collaboration in this collective project.

2.
FOCAL POINTS IN DRAFTING THE PLAN

The process of drafting the Plan was an opportunity for the majority of the people interviewed to give responses and offer new horizons in order to:

- Improve prevention and promotion of mental health.
- Focus efforts on care for children and adolescents, based on the fact that good mental health throughout life is first established in childhood.
- Ensure an integrated response for people suffering from a serious mental disorder.

There is consensus in affirming that mental health problems have always existed but that the context of financial crisis in recent years (which entails job insecurity, financial problems and uncertainties in housing) has accentuated the emotional suffering of a large part of the public and It has increased the risk of developing mental disorders.

This growth in the number of people experiencing varying levels and complexities of mental health issues comes at a time when our ability to respond is especially limited.

Increasing pressure on mental health services as well as on other services (social, socio-educational, educational, etc.) has strongly affected the ability to accompany, support and contain the emotional distress and difficulties experienced by some people in Barcelona.

Improve prevention and promotion of mental health

In the medium and long term, the promotion and prevention of mental health would reduce the severity of problems and illnesses, as well as the need for more intensive, more expensive services and support. And above all, it would reduce the impact of these problems in the lives and well-being of people. However, available resources and capabilities have traditionally been allocated to the care and treatment of problems and illnesses.

Moreover, unlike care interventions, the responsibility and the initiative for promoting and preventing mental health issues (such as emotional support groups for unemployed people, socio-educational interventions with adolescents, parenting support services, etc.) are diluted across a plurality of services, organisations and systems.

The lack of recognition in the service portfolios of preventive and community benefits, which are key to accompanying and strengthening the coping capabilities of people in situations of greatest vulnerability, ends up creating an unstable, unequal and in some areas deficient landscape.

Children, adolescents and young adults as priority groups

There was unanimity in the urgent need to prioritise care for children and adolescents with mental disorders of varying levels of complexity and severity.

The people interviewed highlighted the growth in numbers and the seriousness of the situation, as well as pointing out existing deficits in the accessibility, intensity and continuity of care for these groups.

Personalised support to promote the full inclusion of people with severe mental illnesses

A third element everyone agreed on is the impact of the crisis on the difficulties of achieving the social inclusion of people with serious mental health problems and disorders.

In this context, the need to provide the personalised support these people require in different spheres (life, work, housing, etc.) is underlined through a process of work and collaboration between professionals from different fields and services.

The process of drawing up the plan: an opportunity to lay the necessary groundwork for progress

Finally, the process of drafting the plan is also seen as an opportunity to establish and consolidate the necessary groundwork for progress.

The process of drafting the plan and establishing the Mental Health Board are seen as a great opportunity to facilitate visibility of these issues in the public agenda, to build a common view of mental health across different sectors and services and to establish frameworks for dialogue, exchange and work.

In that sense, it should be highlighted that the plan requires not only additional resources but also an effort to configure a common language and clarify institutional roles and mandates, as well as strengthening coordination, horizontal work and the skills and competencies of professionals from a wide range of organisations.

As such, the most commonly mentioned concepts when it comes to characterising the necessary skills to transform the current situation were the following:

- Cooperative leadership
- A common, integrating vision on the promotion of mental health across different sectors and services, a common language
- Community-based work, in close contact with families, community and the region

- Stable frameworks for work, relationships and exchanges between professionals (such as the *Interxarxes* project) and with the local organisations and services (such as the Mental Health Boards in the districts)
- Solid, quality interventions (scientific and clinical evidence and contrasted knowledge)
- Assessment
- Training and raising awareness among professionals

Finally, most of the people interviewed indicated that we cannot overlook the need to take into account the social, economic, ecological and cultural factors that have a key impact on mental health (poverty, employment, housing, education, etc.) although they all point out that tackling all of these issues exceeds the scope of this plan.

3.
CHALLENGES

1. Guarantee living spaces and protection for children in order to offer them the stability, affection and confidence they need to grow and work to strengthen their coping capabilities.
2. Generalise the emotional and social learning necessary in adolescence and provide new listening, counselling and support services for this collective.
3. Provide earlier, more intensive, higher quality care to children and young people with the greatest mental health difficulties.
4. Promote lifestyles and relationships that promote strength and well-being.
5. Recognise and articulate all the resources to support people in situations of increased mental, social and personal vulnerability.
6. Promote the autonomy of people with mental disorders, recognising their abilities and providing them with the personalised support they require for social inclusion.
7. Improve support and recognition for those who care for relatives with mental health problems.
8. Protect rights and ensure respectful treatment of people with mental health problems in all contexts.

The Mental Health Plan should focus priorities on childhood and adolescence. It is the best investment for a happy, healthy future.

Children and adolescents must be an absolute priority.

1st CHALLENGE:

Guarantee living spaces and protection for children in order to offer them the stability, affection and confidence they need to grow and work to strengthen their coping capabilities.

1. Mental health problems are, at the moment, the main health challenge of children, both in terms of scope and the importance of their impact: school performance and professional development, the quality of interpersonal and family relationships, financial poverty and life expectancy are strongly related to mental health.

   1.1. A child with mental health problems is more likely to become a teenager and an adult with mental health problems and disorders.

   1.2. And the opposite holds true, good mental health facilitates the learning process, relationships with family, teachers and peers, as well as the ability to confront difficulties, including the transition to adolescence and adulthood and the ability to achieve one's own goals.

   1.3. There is a clear need to focus efforts in two moments: early childhood (0-6) and adolescence.

2. Family life and, in particular, the relationship with the mother is the most important factor in promoting the mental health of a child and preventing problems. The quality of this link and positive parenting skills are fundamental in the development of children.

   2.1. Although the concept of family has changed over time, in varying ways, its centrality in the experience of support and its impact on well-being is a constant.

   2.2. The need to focus efforts on parents of 0-to-6 year olds (early childhood) is clear. Relationships, patterns of behaviour, emotional responses and the social skills of children are highly conditioned at this age.

3. Interventions from the moment of pregnancy and birth are considered a priority.

   3.1. In this area, there is a clear lack of a coherent deployment of resources and support services in the region, spaces for guidance and support, not for inspecting or diagnosing, but spaces and services to welcome and provide support.

   3.2. The deployment of care and support services in the home is considered necessary for children raised at home who would otherwise have problems accessing care services.

4. The context of the crisis in recent years, and the accompanying social and labour transformations, have accentuated the difficulties of many families in offering an environment of stability, security, confidence and emotional balance that children need to grow.

   4.1. A lack of financial resources has led to an increase in family tensions and the onset of stress and emotional problems. There has been a clear rise in the number of families with incomes that are insufficient to cover basic needs, with a significant dependence on benefits or their immediate network, inadequate housing conditions and difficulties paying for basic supplies.

   4.2. The minors of families in situations of serious social insecurity are an emerging group that require special attention.

5. Support and guidance for families, especially those who face difficult circumstances, are the most important measures to ensure good starting conditions for all children.

6. The experience of traumatic events (abuse, neglect, family violence, homophobia, etc.) or continued stress all have effects later on in life and has an impact on learning, behaviour, and mental and physical health. Protecting children from these situations in all areas and environments (family, school, etc.) should be considered a priority objective.

7. It is important we proactively offer differentiated support programmes for those groups of children identified as especially vulnerable to developing mental health problems.

Families must receive support if we wish to ensure all children have the opportunity to grow up strong and resilient.

Parents must be given instruments to be able to generate quality links with their children.

PROPOSALS:

1. Guarantee living spaces and protection for children in order to offer them the stability, affection and confidence they need to grow and work to strengthen their coping capabilities.

Support for parents so they can offer their children the stability, affection and confidence they need to grow

1.1. Set up support and guidance programmes and services for parents, especially those families that face special difficulties or are more vulnerable.

- Promote educational services for early childhood and other resources to support the parenting process.
- Improve prevention, early care and the treatment of vulnerable mothers from pregnancy to early childhood.
- Creating support and care services for the home to bring support to families that opt for raising children at home (for cultural or financial reasons).

1.2. Promote programmes to develop parenting skills (improvement of communication skills, conflict management, etc.) to help families cope with and overcome problems and difficulties (break-ups, unemployment, illness, etc.) and ensure a healthy environment for children.

Generalise social and emotional learning

1.3. Provide guidance to educational communities to ensure that the everyday environments of children, especially the school environment, are environments of care, respect, participation, responsibility and equity.

- Teacher training and guidance.
- Support for initiatives to promote the value of diversity in schools.
- Support for initiatives to fight the stigma attached to mental disorders.

1.4. Increase socio-educational services that play a key role in strengthening the resilience of children.

- Expand the number of centres for children in the city, guaranteeing greater balance in geographical distribution.

1.5. Promote support programmes aimed at those collectives of children at increased risk of suffering mental health problems in order to prevent or reduce them. Identify existing programmes, promote them and create new ones to respond to current needs.

It is particularly worth mentioning:

- Minors in the protection system (DGAIA).
- Minors who have experienced or are at risk of negligence or abuse.

- Minors of parents with mental disorders (diagnosed or not), addiction or dependence.
- Minors of migrant or refugee families.
- Children who have experienced significant losses or traumas.
- Children involved in discussions about their custody.
- Children with disabilities and siblings of children with disabilities or chronic illness.

Training for professional teams

1.6. Provide expert training and advice to all professionals linked to the care of children: primary healthcare centres, schools, socio-educational services, etc.

1.7. Provide priority support and continuing education programmes to the following professionals:

- Those who are in contact with groups that present increased risk.
- All professionals involved in care before and after birth.

2nd CHALLENGE:

Generalise the emotional and social learning necessary in adolescence and provide new listening, counselling and support services for this collective.

1. Puberty and adolescence are vital moments of increased vulnerability. The process of defining and accepting one's own identity, choices about one's educational or professional future, the discovery of sexual identity, etc. These are issues that worry and often cause anxiety in adolescents. It is a time where they perceive a risk of personal failure and frustration.
2. The hormonal, physical, emotional and social changes that occur in puberty are very important sources of stress for boys and girls. These have a significant impact on self-esteem, roles, and social expectations.
3. Puberty occurs at increasingly early ages. Childhood is being reduced and adult behaviour patterns are adopted at the age of 10 or even earlier. This advanced puberty is in itself a risk factor for the development of emotional and health problems.
4. Perceptions about the degree of acceptance, respect and inclusion in everyday relationships are a very important factor of risk or mental health protection at this stage. Exclusion dynamics are significant generators of isolation and mental problems that must be tackled.
   - 4.1. The quality of relationships, especially among peers but also with family, teachers and other adult referents, is essential for the development of young people.
5. It is especially important that schools and leisure or sports organisations that make up the everyday spaces of adolescents generate and promote behaviours and relationships in a culture of care, respect, participation, responsibility and equity.
   - 5.1. Currently, the growing opportunities for interaction and the anonymity of technology brings a higher risk of all forms of bullying and harassment.
   - 5.2. The modelling role of teachers and other professionals (how they relate to each other and with pupils, how they deal with conflicts, how they deal with or cater to pupils who present problems) is key and has a clear influence throughout the environment (close relationships on an equal footing, without aggression or coercion).
6. Youth associations and educational leisure spaces also play a very important role in that they are created as free and safe spaces for adolescents to establish relationships, discuss their difficulties, strengthen their sense of belonging and exercise their responsibilities and autonomy.

6.1. This last point is important for adolescents and young people especially vulnerable to suffering discrimination dynamics, such as the LGBT community, young immigrants or children of migrant families.

7. School failure is also a risk factor that generates emotions of frustration and anguish in pupils, while placing further stress on family life and relationships with teachers.

8. In spite of difficulties, adolescents rarely ask for help or go to general support services. Providing listening and counselling services (that are confidential, accessible and non-stigmatising) is considered a priority aspect so that adolescents can express their difficulties and find guidance to address issues that concern them.

9. Their capacity for resilience in situations of conflict, violence and stress can be strengthened and improved.

9.1. Secondary schools have made a significant effort in recent years to incorporate emotional education into the curriculum and provide teens with the necessary social skills and skills to deal with conflict situations, improve their ability to solve problems and identify and manage emotions (such as anger, sadness or anxiety).

9.2. It is important to generalise these learnings and also proactively offer differentiated support programmes for those groups that identify themselves as especially vulnerable.

10. Some behavioural characteristics adolescents' lifestyles, such as a lack of physical activity, overuse of electronic devices, and especially a lack of sleep, significantly affect their emotional health and manifest as difficulties in concentration, mood swings, hyperactivity, nervousness and aggressive behaviour.

11. Consumption of cannabis has significantly increased in recent years, alongside trivialisation of usage. Young people start consuming earlier and earlier. Consequently, the problems they cause are increasingly serious.

11.1. The association between consumption of cannabis and other psychiatric disorders is especially frequent, including anxiety disorders and mood disorders, and even more severe, psychotic disorders.

12. Prevention of unsafe sexual relationships and, especially, teenage pregnancy is considered another priority aspect.

13. In adolescence, the attitudes about mental disorder that we will have as adults are formed. That is why it is important to tackle stigma and discrimination in this vital period. And, above all, we need to reinforce the value of difference.

What is done at primary and secondary schools is essential.

They are the only public service that have the potential to reach children, adolescents and young people.

PROPOSALS:

2. Generalise the emotional and social learning necessary in adolescence and provide new listening, counselling and support services for this collective.

Listening and counselling services for teens

2.1. Identify and promote new listening, support and counselling services for adolescents, with new formats: the right people, places and timing, etc., while incorporating role models in the areas where adolescents relate to each other.

Intensify preventive actions against certain risk behaviours and promote healthy lifestyles

2.2. Intensify preventive actions in relation to the consumption of cannabis, especially to delay the age they start to avoid banalisation of the subject.

2.3. Intensify preventive actions to avoid teenage pregnancy.

2.4. Increase awareness and informative actions (communication campaigns) on the relationship between certain aspects of lifestyle and emotional health.

Especially, the need to communicate the benefits for mental health and the emotional well-being of:

- physical activity
- healthy diet
- quality rest (quality and hours of sleep)
- rational use of technology

Family support, counselling and mediation

2.5. Create new support and counselling programmes for parents of adolescents and promote family mediation.

Support socio-educational services in the city to generalise social and emotional learning

2.6. Generalise the social and emotional learning necessary to improve the mental health of adolescents and young people in secondary schools and other socio-educational environments (= 1st challenge).

- Increase programmes to support emotional education and social skills.
- Promote the implementation of programmes and tools to prevent and treat situations of violence, conflicts and exclusion in educational centres.
- Incorporate techniques for relaxation and stress management as a part of physical activity.

2.7. Provide guidance to educational communities to ensure that the everyday environments of adolescents, especially the school environment, are environments of care, respect, participation, responsibility and equity.

- Teacher training and guidance.
- Support for initiatives to promote the value of diversity in secondary schools.
- Support for initiatives to fight the stigma attached to mental disorders.

2.8. Increase the socio-educational services that play a key role in strengthening the resilience of adolescents and young people, especially those in more vulnerable situations (= 1st challenge).

- Support youth associations, especially those associations that can improve their coping capabilities in cases of discrimination and the stigma associated with sexual orientation (such as the LGBT community).
- Promote participation in associations through schools.

2.9. Promote support programmes aimed at those collectives of adolescents at increased risk of suffering mental health problems in order to prevent or reduce them (= 1st challenge).

Remember:

- Minors who have experienced or are at risk of negligence or abuse.
- Minors of parents with mental disorders (diagnosed or not), addiction or dependence.
- Adolescents in situations of academic underachievement, whether or not these are linked to a precarious relationship with the education system.
- Minors from migrant or refugee families.

More training for professionals

2.10. Provide expert training and advice to all professional teams linked to adolescent care: secondary schools, socio-educational services, etc. (= 1st challenge).

- Provide support programmes and continuing education for professionals who are in contact with adolescents so they can promote emotional and social development.

Tackle stigma and provide information on mental disorders

2.11. Provide information on mental health (understand how it can be improved and preserved).

2.12. Provide information about the most common disorders (know the main symptoms and the characteristics of mental disorders) and offer guidance to seek support.

3rd CHALLENGE:

Provide earlier, more intensive, higher quality care to children and young people with the greatest mental health difficulties.

1. Care for children and adolescents experiencing difficulties with mental health of varying degrees of complexity and severity currently faces significant deficits in terms of accessibility, intensity and continuity.

   1.1. There is consensus in the need and the urgency of increasing the available resources in a manner consistent with the increase in need.

   1.2. There is also consensus in the need to review the continuity of care, support and treatment of mental health problems and disorders in children and adolescents.

2. Most mental health problems and disorders begin to manifest during childhood (75% of adult mental disorders begin before the age of 25 and 50% appear between the ages of 12 and 25).

3. The early detection and treatment of children and young people with an emerging mental health problem or disorder, in the initial phase or in any subsequent episode, is essential if we are to minimise the severity and duration of the situation and reduce its impact At present, this represents the main shortcoming of the system.

4. The first signs are expressed in schools, with problems or changes in behaviour, attention difficulties, significant changes in school performance, isolation, etc. Identifying and acting when these first signs are detected is key to preventing future episodes and reducing the associated costs.

   4.1. Teachers play a key role and, with the right knowledge, can identify the signs that may indicate or imply subsequent development problems in order to facilitate access to the most appropriate services and support.

5. Especially noteworthy is the need to detect and address early neurological and psychological development factors that generate cognitive and behavioural dysfunctions that significantly interfere with their process of becoming mature, and have an important impact on the personal, family and social spheres.

   5.1. There is a lack of educational resources to meet these needs (centres and classrooms with special treatment and professional therapeutic resources).

   5.2. The educational community is especially concerned about the increase in disruptive behaviours (conflicting attitudes and aggressiveness both verbal and physical) that may have different causes and degrees

of seriousness but which generate conflicts in the school and family environment.

6. The speed of access to support resources and the intensity of care in times of crisis are fundamental aspects in minimising the severity and duration of the situation and reducing its impact. Currently, they represent some of the main limitations of service responses.

7. The saturation of Childhood and Juvenile Mental Health Centres (CSMIJ) is considered one of the main problems that must be addressed, both in terms of access difficulties (waiting lists for examination and diagnosis) and the short intensity of treatments (frequency of visits).

8. There is agreement in pointing out the urgency of providing the city with new residential and respite resources for children and adolescents and their parents.

9. Continuity of support and care is interrupted or is very fragile at a time of significant risk for the life cycle: we need to make the transition from child health services to adult services more flexible.

   9.1. Children and young people are very vulnerable at times of change (such as the transition from primary to secondary school, from school to other settings, etc.). These transitions are more delicate still with children and young people who suffer from mental health problems (such as from care services for children to those for adults, between residential and community services, etc.).

   9.2. The professionals interviewed agreed on the need to address and make these borders more flexible in order to maximise ease and comfort, guarantee continuity of care and prevent negative effects on the person's state.

   9.3. We need to set in place pathways that facilitate continuity of care and avoid ruptures in the care relationship due to age.

10. Suicide is one of the main causes of death among adolescents and young people. Each suicide is an expression of deficiencies in the system: deficiencies in prevention, detection and treatment.

   10.1. Mortality due to suicide is a serious public health problem and has increased in recent years worldwide. Mental disorders are one of the main risk factors for suicide in Western countries.

   10.2. Suicide prevention policies are effective and have a positive impact on the reduction of mortality. These should emphasise improvement of accessibility to health services for at-risk people, along with careful monitoring during the critical period after the attempt.

> *We need faster access to high-quality services.*

PROPOSALS:

3. Provide earlier, more intensive, higher quality care to children and young people with the greatest mental health difficulties.

Effective early detection in children aged 0 to 5

3.1. Increase the resources of CSMIJs and introduce changes in their operation to reduce the current waiting lists in examination, diagnosis and treatment.

3.2. Improve the articulation between CDIAPs and CSMIJs in the prevention, detection and early care in early childhood.

3.3. Provide professional teams of working in child care services, especially those who work with groups at higher risk, training and knowledge in these subjects (for example, learn to observe children's behaviour and interpret it).

3.4. Guarantee the implementation of functional units for the early care of severe mental disorders in early childhood (such as the early care processes for people on the autistic spectrum included in the Comprehensive Plan for People with ASD).

Provide mental health services and resources in schools and other childcare services

3.5. Develop the relationship between CSMIJs and schools and other support services (EAP).

3.6. Provide professional teams with access to specialised professional support (consultations).

Integral care

3.7. Facilitate interdisciplinary work across different areas. Reinforce and improve circuits and coordination between psycho-pedagogical, social, health and mental health services.

- Extend existing positive experiences in some districts (such as the Interxarxes project) to other districts.

3.8. Ensure access to psychological therapy.

3.9. Incorporate the figure of case manager to streamline and coordinate the solutions to the needs of each case and carry out follow-up.

3.10. Establish social prescriptions as preferential for children and young people.

- Prepare a catalogue of activities that may be included in the social prescription (specifying the contact information, objectives or learning, indications, etc.).
- Train professionals about the use of these resources.

3.11. Increase the resources of support, accompaniment and work with families: Provide tools that allow them to understand and confront the difficulties associated with the processes their children are going through and give them emotional support.

3.12. Reinforce school support programmes and second-chance schools with accompaniment to ensure continuity of academic progress for children or young people who have experienced a serious mental health problem.

New care services

3.13. Generate teams to provide care and flexible support in situations of crisis and emergencies for adolescents and young adults.

3.14. Generate specialised home care programmes.

3.15. Promote a telecare service to answer family queries.

Continuity of care

3.16. Improve the process of transition between the mental health teams for children and adults: facilitate careful accompaniment and follow-up during these processes.

- Joint interviews between the professional teams for children and those for adults and the patient.
- Membership of both groups of professionals.
- Monitoring with a point of reference for the patient.

Suicide prevention

3.17. Intensify the implementation of policies for the prevention and early detection of the risk of suicide.

- Follow-up on the implementation of the suicide risk code.
- Increase the territorial implantation of the Care Pathway for Depressive Disorders.

3.18. Improve the information available (log of cases, evaluation of results, etc.).

4th CHALLENGE:

Promote lifestyles and relationships that promote strength and well-being.

1. The context of the financial crisis in recent years, which entails job insecurity, financial problems and uncertainties in housing, has accentuated the emotional suffering of a large part of the public and has increased the risk of developing mental disorders.
2. We are increasingly aware of the vulnerability factors in relation to mental health, as well as the protection factors. This knowledge can inform interventions and priorities.
3. In the community field, for example, the role of social support networks, the promotion of physical activity, volunteer activities and any other actions that make it easier to feel useful or that reinforce a feeling of belonging.
4. On an individual scale, the promotion of mental health must focus on strengthening resilience through the development of personal capacities that help us cope with situations of crisis, stress, anxiety, etc.
5. Socialising, exercise and developing our capacity for self-help is crucial in fortifying our mental health.
   - 5.1. Relational issues, social interactions and the ability to establish positive social relationships have all been highlighted by all those interviewed as a fundamental aspect in protecting and strengthening mental health at all ages.
   - 5.2. The need to promote and, where necessary, revitalise natural spaces for relating to one another in order to promote relationships of listening, help and support among individuals, create “ecosystems” for relationships and reception that facilitate communication and help to contain the emotional disorders of everyday life.
   - 5.3. The need to prevent isolation and loneliness among the elderly, but also other collectives and groups of all ages, was also stressed.
6. Practising physical activity and sport has major psychological benefits that must be promoted: it improves self-esteem and mood. Physical activity and sport are also a special opportunity to establish links and enjoy social relationships.
7. Studies show, however, that those people who would most need to benefit from the physical, psychological and social effects of practising physical activity are precisely those face the greatest obstacles in doing so: people from different groups and collectives that are in a situation of exclusion or high social vulnerability, or in a particularly difficult life situation (for example,

unemployed people), or who are caring for a relative affected by dementia or a disease that strongly conditions their autonomy.

8. Support groups have demonstrated their effectiveness in providing emotional support for people who face difficulties: caring for a sick or dependent family member, long-term unemployment, parenting without a family support network, integration into a new culture, etc.

> *As a city, we need to promote lifestyles and relationships that generate personal strength: facilitating sociability, personal relationships, physical activity...*

PROPOSALS:

4. Promote lifestyles and relationships that promote strength and well-being.

   4.1. Develop and distribute guidance and criteria aimed at managers and professionals involved in community services (civic centres, libraries, old people's homes, sports centres, leisure centres, associations, etc.) so that they can contribute to improving the health and emotional well-being of those who use the services.

   To this end, we need to ensure:

   - The creation of links and social relationships to promote positive group dynamics.
   - Understanding, value and respect for diversity (especially for those who suffer or experience difficulties with mental health problems).
   - Opportunities to feel useful (occasional or regular volunteer work, etc.).
   - Opportunities to learn and put into practice their own abilities.
   - The creation of a sense of belonging and links to the community.

   4.2. Promote and take advantage of natural spaces for relating to one another in order to promote socialising and relationships of listening and support among peers.

   4.3. Promote physical activities and sports.

4.4. Increase awareness and informative actions about the relationship between certain aspects of lifestyle and emotional health:

- physical activity.
- a healthy diet.
- quality rest (quality and hours of sleep).
- schedules and biorhythms of everyday life.

5th CHALLENGE:

Recognise and articulate all the resources to support people with increased mental, social and personal vulnerability.

1. Some collectives and groups are particularly vulnerable to mental health problems (depression, anxiety, stress).
2. Immigrants, the elderly and people suffering from poverty and precariousness are some of the groups that could most benefit from actions aimed at improving coping skills and emotional well-being.
3. In adulthood, the main risk factors are social conditions. Those who are unemployed or on long-term leave, in situations of major housing insecurity and suffering from a lack of resources to face everyday life, experience stress and anxiety.
4. The context of the financial crisis in recent years, which entails precarious jobs, financial problems and uncertainties in housing, has accentuated the emotional suffering of a large part of the public.
5. Immigrants and refugees also face unique challenges that translate into major emotional disorders (depression, anxiety, psychological disorders, etc.).
   - 5.1. The migration process entails a process of acceptance of various losses, whether forced or voluntary, of family, socio-cultural and economic references, as well as a process of acceptance by the new destination culture.
   - 5.2. Special consideration must be given to newly arrived migrant immigrants, the second generation of those born here and people without an initial support network on arrival, as well as sick people, the elderly and refugees.
   - 5.3. Many immigrants face difficulties in using care services for various reasons (cultural reasons, language barriers, etc.) and often they cannot receive the specialised treatment they require.
6. Old age is a period in which people face many losses that need to be faced (loss of status, physical and/or mental abilities, relatives and friends and the inevitability of death).
   - 6.1. Often poor mental health of the elderly (and especially depression) is conceived erroneously as an inevitable or natural part of ageing.
   - 6.2. The progressive “overageing” index means this population faces situations of vulnerability in the dynamics of social exclusion.

6.3. We can see an increase in the number of elderly people living alone in precarious social situations, with difficulties in establishing social relationships and a lack of resources to manage their daily life. Isolation and loneliness is an important issue to be addressed.

7. Public primary health services generally offer a very limited range of therapeutic interventions to help people experiencing difficulties with mental health.

8. Medication is the first and often only treatment offered to many people.

8.1. The difficulties faced in accessing psychological therapy, which is necessary to influence lifestyles or behaviours, is considered the main limitation in responses from the public system.

8.2. In any case, however, the range of services, treatments and support available, and their intensity and accessibility, vary significantly depending on location.

9. The lack of knowledge and articulation of social resources (support groups, activities in civic centres, etc.) is one of the causes of the scarce indication of these resources, which can act as a complementary "treatment" or alternative to improve the lives of people with mental health problems and to demedicalise some of the discomforts of everyday life.

9.1. All the people interviewed and, in particular, the professional teams linked to primary healthcare, pointed to the need for greater use of "social prescriptions" to help connect people experiencing difficulties with mental health with social, cultural and sporting activities in the community.

9.2. They highlighted the major benefits to health in general and, especially, the opportunity to develop social networks.

9.3. The impact of mental health disorders and problems (low self-esteem and low motivation) is also an added difficulty in getting these people to take part and connect with community services and resources (social, sports, cultural and leisure) that could be of major benefit to them.

10. Basic social services play a very important role in caring for people in situations of social and personal fragility.

10.1. The role of psychology professionals in municipal social service teams is highly rated.

10.2. Emotional support groups (for caregivers, people affected by the financial crisis or the lack of a network of relationships) are valued as another major intervention. It is pointed out that the pressure on the care system has weakened this type of response.

11. Mental health problems affect men and women differently and at different times in life. The gender perspective must be taken into account when planning preventive interventions.

11.1. For example, women are more likely than men to experience anxiety and depression, and men develop schizophrenia at younger ages.

11.2. Women's risk factors are often interlinked: caring responsibilities, higher rates of poverty, greater risk of violence and abuse, etc.

11.3. Factors that threaten one's sense of success (such as job loss) have a greater impact on men. Men also find it harder to recognise that they have a problem and seek help.

> *Primary care needs support to demedicalise everyday complaints.*
>
> *Many problems, such as loneliness, lack of integration of immigrants, isolation or dependency, can be resolved in one's immediate surroundings.*
>
> *And it is currently difficult or impossible to solve them due to a lack of knowledge or articulation of social resources.*

PROPOSALS:

5. Recognise and articulate all the resources to support people in situations of increased mental, social and personal fragility.

Linking to community support resources

5.1. Innovate in the strategies to approach and link people with mental health difficulties and problems to community services and resources that would be especially beneficial to them:

- Physical activities and sports
- Mutual support groups
- Spaces for relating and socialising (reading clubs, courses, etc.)
- Emotional education activities (resistance to frustration, stress management, learning to relax, etc.)
- Volunteer activities

5.2. Provide social prescriptions as part of primary healthcare, articulate community activities and services as a resource and complementary response and in some cases alternative to medication.

- Prepare a catalogue of activities that may be included in the social prescription (specifying the contact information, objectives or learning, indications, etc.).
- Train professionals about the use of these resources.

Specific programmes for the most vulnerable groups

5.3. Promote specific interventions to provide emotional support to long-term unemployed people, on long-term leave or in precarious housing situations (support groups).

5.4. Promote specific interventions to facilitate emotional support for immigrants and especially:

- Immigrants newly arrived in the process of integrating themselves
- Second generations born here
- People without an initial support network, sick people and the elderly

5.5. Promote services and emotional support for the elderly (support groups) to facilitate the necessary acceptance in the face of the losses and difficulties involved in ageing to enhance their skills (functional, social and emotional) and to help them through any worries.

5.6. Provide guidance to the professional teams at primary healthcare centres to demedicalise the ageing process.

5.7. Strengthen measures to avoid isolation and loneliness, particularly in high-risk groups such as elderly people living alone.

5.8. Incorporate the gender perspective into the design of preventive and detection actions.

6th CHALLENGE:

Promote the autonomy of people with mental disorders, recognising their abilities and providing them with the personalised support they require for social inclusion.

1. Employment, minimum levels of income, a stable place to live and a network of social relationships are a fundamental condition for the recovery, integration and social inclusion of people with mental health problems and disorders.

    1.1. Independent living is the goal and wish of most people with mental health problems.

    1.2. The impact of the disorder itself and the stigmatisation of the collective represent major obstacles in their accessing and maintaining work, housing and a network of social relationships.

    1.3. The financial crisis has increased the difficulties in the integration and social inclusion of people with social problems and disorders.

2. Accessing and maintaining a job is a key aspect for people with mental health problems to improve and recover. The rigidity of the benefits system, stigmatisation of the group and the difficulties in adapting jobs to the abilities of the person with a serious mental disorder are the main obstacles.

    2.1. People with serious mental health problems have high levels of unemployment. Most EU countries report employment rates ranging from 20% to 30% for this group. This situation poses a serious obstacle to full integration and entails financial dependence, poverty and marginalisation.

    2.2. The rigidity of the benefits system (insufficient flexibility to adapt to episodes that are intrinsic to mental health disorders or entail financial disincentives for people to go back to work) is considered one of the main difficulties.

    2.3. Stigmatisation of the group or tendency of families to overprotect are, beyond the impact of the disorder itself, some of the invisible obstacles to having an effective work life.

3. These difficulties have a devastating impact on the life trajectories of young people, as the impact of mental health problems is more significant during training or the beginning of employment.

    3.1. Supported work programmes (a strategy of workplace insertion in ordinary companies that facilitate mediation and the provision of support for the person and the company in order to guarantee satisfaction for all

parts of the relationship) have proven effective in helping people find jobs in the ordinary market that are appropriate to their interests and abilities.

3.2. Companies that facilitate employment in a supportive environment are also necessary alternatives for a part of this collective.

3.3. Collaborations with social projects (volunteering) can be set up as an alternative that facilitates transition to the insertion into the labour market of some people (since it implies adapting at a slower pace) and can contribute to the visibility and normalisation of the group.

4. People with severe disorders have many difficulties in maintaining or accessing a home as a result of the difficulties in maintaining the level of income or difficulties in relation to the family environment.

4.1. Stable, safe, adequate housing is key to the health and well-being of all people and conditions their ability to take part in society, to get a job and also to access the support and services that can improve their quality of life.

4.2. At the same time, the lack of stable housing often leads to a lack of contact with health services, isolation, loss of independence and, lastly, the need for increased support resources.

4.3. The inability to work entails difficulties in maintaining income and, therefore, paying rent or a mortgage.

4.4. Severe mental disorders tend to lead to personal disorders and episodes of acute need that result in a loss of home or the abandonment of the family home due to conflicts and behaviour derived from mental disorders.

5. People with mental disorders show deterioration in physical health greater than that of the population as a whole as a result of unhealthy lifestyles (smoking, alcohol, sedentary lifestyle, inadequate diet, etc.) and a deficient connection to health services.

5.1. For example, depression affects the lack of physical activity and the lack of adequate nutrition. Obesity is common and causes other complications, such as a lack of self-esteem, which aggravates the stigma.

5.2. The limitations on access to health care (a lack of referrals in primary health care, lack of prevention, etc.) should also be highlighted.

6. As for mental health care, there was agreement in positively evaluating models that prioritise insertion in the community and a combination of different types of care.

7. The increase in needs, the demand for care and a reduction of the resources available in recent years has strongly limited the scope and quality of responses.

7.1. This growth in demand has resulted in greater difficulties in accessing services (waiting lists), less intense care (frequency and duration) and less integral treatment.

7.2. The difficulties accessing psychological therapy are the main limitation of responses from the public system.

7.3. Certain geographical disparities are seen in relation to the services, treatments and support available. The nature, intensity and accessibility vary depending on the location and the service providers and care teams.

8. Care and support needs are numerous and varied, and require a global approach that comprises not only healthcare but also a range of other dimensions (family, social and work). The need to integrate responses by having professionals from different fields and services work together (social relationships, housing, employment, leisure, education and health) is key, yet responses at the moment are very fragmented.

9. Continuity of care and support at certain moments and transitions is also considered an aspect that needs to be improved.

9.1. Better coordination between the clinical services and the social and healthcare spheres is required to ensure that the person does not get "lost" in critical moments, meaning in:

- hospitalisation
- the moment after they enter the emergency room in hospital
- referrals to generalist services
- referrals by public specialists to private specialists

10. Some people with mental disorders also present serious problems and exclusions of different kinds (drug use, chronic health problems, homelessness, unemployment, etc.).

11. The city has deficits in responding to people presenting serious and complex problems.

11.1. People with complex needs and exclusions (mental disorders, substance abuse, homelessness, etc.) have difficulties accessing services, especially because it is not clear what their "primary need" is and they do not fit into the access criteria for services (behavioural problems, drug addiction, alcoholism, etc.).

11.2. Recurring, transitory admissions for different services are one way these difficulties manifest themselves.

11.3. The homeless population, living on the street or in shelters and other centres of the specific care network, are disproportionately affected by severe mental disorders and drug addiction and are often not receiving any psychiatric treatment.

We know that the will to heal on its own is not enough.

We have to learn to take care of people in all spheres: life, work and housing.

And to do so with those around us, the family, the community. And the country as a whole.

PROPOSALS:

6. Promote the autonomy of people with mental disorders, recognising their abilities and providing them with the personalised support they require for social inclusion.

Supporting access to jobs and maintaining them

6.1. Promote supported work programmes. Increase support to make it easier for people to get and keep a job in the ordinary market (supported work).

6.2. Explore new formulas to make the system more flexible and the possibility of earning both benefits and salaries.

6.3. Promote reserved hiring and the incorporation of social clauses into public procurement to facilitate work and job stability for people with mental health problems.

Affordable housing adapted to people's needs and life project

6.4. Increase the provision of affordable housing and social rentals for people with mental disorders and for special contingencies (not only for those who have a disability certificate).

6.5. Increase support programmes for housing maintenance (preventive interventions to prevent people from losing their homes: financial support for home maintenance).

6.6. Reinforce support services for autonomous living at home.

Support for the practice of healthy lifestyles

6.7. Improve the articulation of primary care centres with mental health services and the training of professional teams (emergencies, management support staff, etc.) in order to improve their capacity to respond to the needs of people with mental disorders.

6.8. Increase psychoeducational programmes to improve the lifestyles of people with mental disorders.

6.9. Promote specific socio-educational programmes to help people with mental health problems access community and leisure services (support groups, companionship, etc.).

6.10. Promote work and coordination between the different agents that intervene in all aspects of the life of the person: social relations, housing, employment, leisure, education and health.

More comprehensive, more intensive healthcare earlier on

6.11. Promote working processes to encourage the coordination and integrity of responses:

- multidisciplinary care teams
- stable frameworks for work and exchanges that provide knowledge among professionals
- define care protocols

6.12. Improve the coordination and integrity of responses for people diagnosed with disorders due to abuse and/or dependency on substances and serious mental disorder.

6.13. Generalise identification of points of contact in the management of each case.

7th CHALLENGE:

Improve support and recognition for those who care for relatives with mental health problems.

1. People with mental health problems are mainly cared for by the immediate family (parents, partner, siblings, etc.). This role is not always recognised as such.
2. These caregivers are essential for people with mental health problems and mental disorders to participate in society: manage crises, offer advice on resources, act as informal "case managers", motivate, support and monitor treatment, facilitate incomes, notify of certain symptoms, keep records of previous treatments and follow-up, etc.
3. The high emotional cost involved in this role means that families are also a group that is very vulnerable to mental health problems. Tensions due to the difficulties of living together, fear about the future, feelings of sadness, guilt, anger or denial of a reality that is difficult to face are some of the features that characterise their situation.
4. The stigma associated with mental disorder and the burden of guilt that is often associated with mental disorders increases the isolation and suffering of many families.
5. Deficiencies in care responses and resources have a serious impact on families who suffer the effects of being overburdened. In some cases, they end up giving up altogether.
    5.1. The lack of an effective and efficient response for adolescents with mental health problems strongly affects the mental health of their parents. The impotence and exhaustion brought on by the feeling of fighting alone against the problems of children in some cases results in guardianship being handed over to the administration.
6. The economic capacity of families is also seriously affected by the associated costs and the need to support people who are not economically independent.
7. The availability of psychological (support groups and/or individualised support) and psychiatric support and, when necessary, respite services, is very important. But it is also a matter of promoting the resources that already exist.
8. The difficulties accessing and communicating with health professionals, the lack of information and professional support on the problem they are facing, and the resources and treatments available are also identified as deficiencies.

9. The lack of recognition by professionals of the knowledge that families have about the situation and the state of the person they care for is another aspect that families thought needed to be improved.

> *The role of families in the detection of problems, treatment and support in recovery must be recognised by professional services.*
>
> *And we must provide the family with the support, guidelines and services they need.*

PROPOSALS:

7. Improve support and recognition for those who care for relatives with mental health problems.

   7.1. Incorporate care and support for family caregivers as an essential dimension of professional practice and care circuits and protocols.

   - Improve reception, information and guidance offered to relatives.
   - Improve families' access to professional teams that deal with mental problems or disorders.
   - Incorporate in the support or mediation offered the concepts of "patient as expert" or "relative as expert".

   7.2. Reinforce support services for families and information (mutual help groups, self-help groups, etc.).

   - Strengthen psychological support services for families.
   - Provide legal counselling services to families (management of finances and estate, monitoring options, etc.).

   7.3. Creating respite services for families.

8th CHALLENGE:

Protect rights and ensure respectful treatment of people with mental health problems in all contexts.

1. People labelled as “mentally ill” still suffer the consequences of stigma, exclusion and discrimination brought on by a diagnosis of mental disorder.
2. This negative attitude, associated with fear and often reinforced by the media, has implications in all areas of interventions:
   - It diminishes the ability of people to recognise that they have a problem.
   - It impedes access to support services that could help these people. The fear of being labelled as mentally ill causes part of the population that suffers from these problems to possibly avoid looking for help.
   - It worsens and affects treatment and recovery.
   - It accentuates other forms of discrimination (age, sexual orientation, etc.).
   - It widens the social gap with the stigmatised group, increases social exclusion, prejudice and discrimination.
   - It has very negative consequences in all aspects of the lives of the people affected: work, housing, affective relationships, access to health, etc.
3. Certain actions in the public system in the face of emergencies or forced internment can increase this stigma.
4. Respect for the autonomy and capacity of people with mental disorders and, in particular, the right, where possible, to make decisions about treatment, are points that need to be improved.
5. In the name of protecting the patient, but also in the name of the common good and public safety, the rights of people diagnosed with a mental health issue or disorder have been limited.
6. The violation of rights of interned patients and the right to make decisions about treatments are questions that need to be looked at:
   - User access to care.
   - Access of companions and/or relatives.
   - More participation from those affected in voluntary admissions and better quality of care in non-voluntary admissions.

We must end the stigmatisation of mental illness.

It is the main barrier in seeking help or detecting those at risk of mental disorder or mental illness.

Without ending the stigma, mental health problems will remain hidden and cause suffering to many of the people who suffer them in silence.

PROPOSALS:

8. Protect the rights and ensure respectful treatment of people with mental health problems in all contexts.

Tackling stigma

8.1. Promote educational activities, awareness-raising and information on the stigma regarding mental health.

8.2. Promote educational campaigns (with materials and resources) on the most common mental health problems (disorders, difficulties and illnesses) that allow a better understanding of how we can maintain good mental health, detecting the most common problems and preventing stigma.

Respect the autonomy and capacity of the sick and, in particular, the right to make decisions about services, treatments and supports

8.3. Carry out specific monitoring to avoid the violation of rights in hospital admissions and/or internments.

8.4. Promote treatment pacts or agreed treatments.

8.5. Provide training and information about the rights of people with mental disorders.

8.6. Prepare a catalogue of rights and make it known to the collective.

8.7. Create the role of the Patients' and Relatives' Ombudsman.

Empower the collective, articulate the sector and promote active participation

8.8. Promote measures to empower and organise the collective of people with mental health problems and their relatives.

8.9. Promote the active participation of organisations of people with mental health problems or mental disorders and their families in the definition of the programmes and policies that affect them.

4.
LIST OF PEOPLE INTERVIEWED

Alícia Aguilera	Head of the Youth Department of Barcelona City Council
Enric Arqués	President of the Mental Health Forum and Co-Director of the Joia Foundation
Regina Bayo	President of the Clinical Psychology, Health and Psychotherapy Section and member of the Health Sector of Barcelona en Comú and Plataforma per la Defensa de l'Atenció Pública
Anna Bermejo	Social worker from the AIXEC Cooperative Jordi Blanch Doctor and President of the Catalan Society of Psychiatry and Mental Health at Hospital Clínic in Barcelona
Pere Bonet	Doctor and Director of the Mental Health Division of the Sant Joan de Déu Hospital of the Althaia Foundation.
Miquel Casas	Doctor and head of the Psychiatry Department at Vall d'Hebron Hospital in Barcelona.
Maica Comellas	Coordinator of the EAIAs of Barcelona City Council
Joan Corbera	Primary care physician at Vallcarca and member of Salut Mental CAMFIC, Pere Virgili Health Park
Joan De Diego	Director of Orientation and Inclusive Education of the Education Consortium of Barcelona
Miquel Àngel Essomba	Commissioner for Education and Universities of Barcelona City Council
Carme Fortea	Member of the Municipal Social Services Institute
Herminia Gil	Coordinator of the Vocational Integration Network of Barcelona Activa
Maria Hernàndez	President of the Barcelona Youth Council (CJB) and member of the SinVergüenza Association.
Pilar Hilarión	Head of Projects at the Avedis Donabedian University Institute.
Lluis Isern	Doctor and member of the Catalan Mental Health Congress Foundation and the International Pschycoanalytical Association

Miquel Juncosa	Director of Obertament
Lluís Lalucat	President of Barcelona Mental Health and the Les Corts Centre for Mental Hygiene
Isabel Llorens	Head of human resources of the DAU Foundation (Mental Health Catalonia)
Fernando Martínez	User of the Associació per a la Rehabilitació de les Persones amb Malaltia Mental (AREP)
Victòria Martorell	Psychiatrist at Hospital Sant Pau
Guillermo Mattioli	Member of the Board of Governors of the Official College of Psychology of Catalonia and President of the Professional Council
Cristina Molina	Director of the Master Plan for Mental Health and Addictions of the Catalan Ministry of Health
Felisa Pérez	President of the Catalan Federation of Drug Addiction and technical director of ABD
Víctor Pérez	Director of the Institute of Neuropsychiatry and Addictions at Hospital del Mar in Barcelona.
Manel Punsoda	Director of Educational Promotion of the Municipal Institutes of Education (IMEB)
Marc Ramentol	Doctor and head of the Office of Analysis and Strategy of the Catalan Ministry of Health
Lluís San	Head of the Psychiatry and Psychology Department at Hospital Clínic in Barcelona.
Mati Sanuy	Social services psychologist from Ciutat Vella district
Àngels Soriano	Relative from Associació per a la Rehabilitació de les Persones amb Malaltia Mental (AREP).
Claudia Vàsquez	Psychologist and member of the Platform for the Defence of Public Care
Eduard Vieta	Doctor and head of the Psychiatry and Psychology Department at Hospital Clínic in Barcelona
Francesc Vilà	Social-health director of Fundació Cassià Just and Cuina Justa

Roser Vilarrubí	Head of the Promotion and Support Department of the Municipal Institute for People with Disabilities of Barcelona City Council
Edgar Vinyals	President of the Catalan Federation of 1st Person Mental Health Organisations and the Särau Association
Àngels Vives	President of the Catalan Mental Health Congress Foundation

OTHER AREAS OF ANALYSIS AND PROPOSAL THAT HAVE BEEN TAKEN INTO ACCOUNT:

- **Mental Health Plan: the view of the people affected and their relatives** (in the framework of the debate of the Municipal Action Programme 2016-2019. 7 March 2016)
- **Mental health in childhood and adolescence** (in the framework of the debate on the 2016-2019 Municipal Action Programme. 17 March 2016)
- **Mental Health Plan: the view of the professionals** (in the framework of the debate of the Municipal Action Programme 2016-2019. 21 March 2016)

Annexe 3:

Conceptual framework of the social determinants of mental health

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INTRODUCTION

Mental health is defined as a state of well-being in which the individual is conscious of their own abilities, can deal with the usual tensions of life, can work productively and fruitfully and contribute to their community (World Health Organisation, 2013a). The determinants of mental health and mental disorders include not only individual characteristics, such as the ability to manage thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and social factors like national politics, social protection, standard of living, working conditions or the social support of the community. Exposure to adversities in childhood is a well-established preventable risk factor for mental disorders (World Health Organisation, 2013b). Many mental health disorders are strongly associated with social inequalities, meaning the greater the inequalities, the higher the level of risk. Poor people in a situation of social disadvantage suffer disproportionately, but so do those in the middle class, as there is a gradient whereby mental health gets worse as social class is more disadvantaged (Allen, Balfour, Bell and Marmot, 2014).

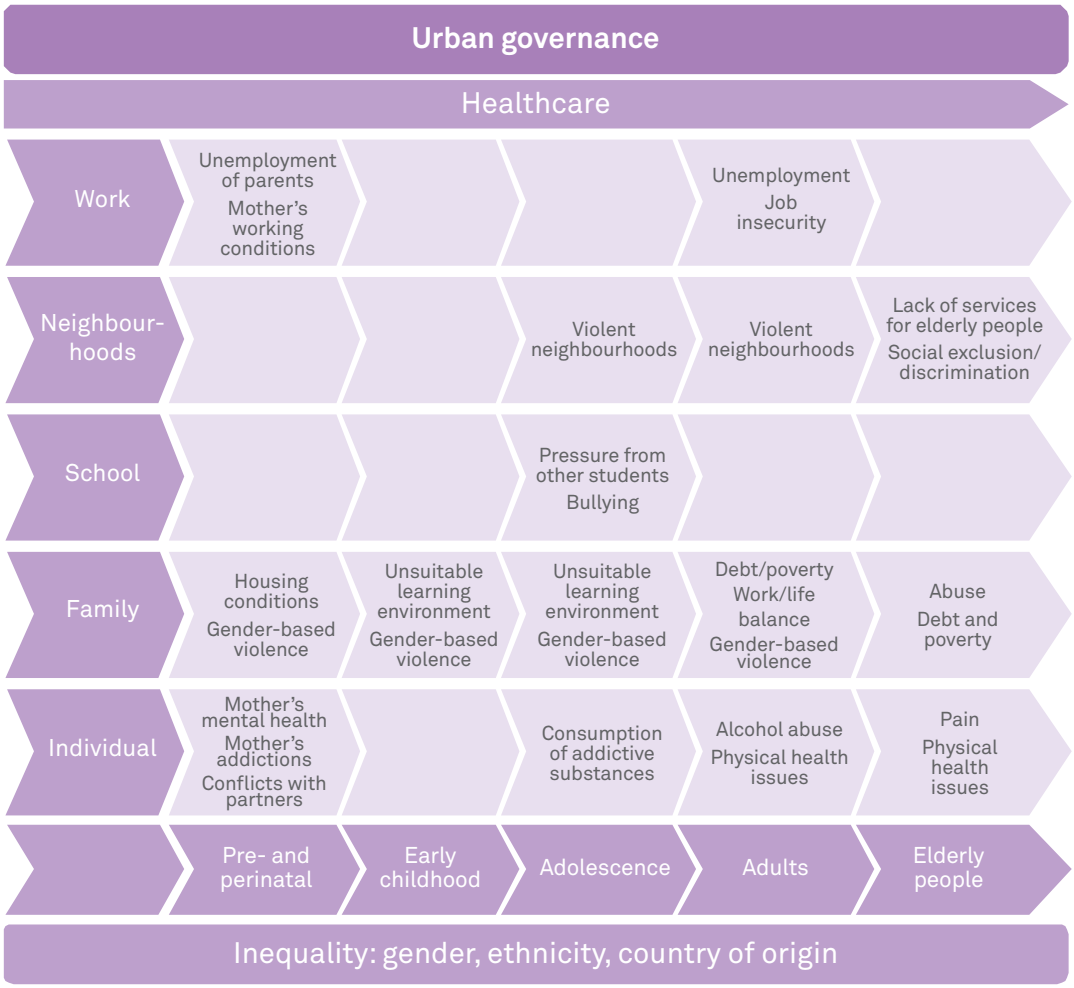
To improve people's mental health, it is essential we act to improve the conditions of daily life with a life cycle perspective, starting at the prenatal stage and continuing into early childhood, later childhood and adolescence, adults and the elderly (Kieling et al., 2011). By taking action throughout the various life stages, we can provide opportunities to improve the mental health of the population and reduce the risk of suffering mental disorders associated with inequalities. Interventions must be universal, aimed at the whole of society but proportionate to their needs. They must also be present at all levels of governance and across sectors. This means that nursery, primary and secondary schools, vocational training centres, universities, workplaces and families all need to be involved to achieve a happier society (Allen et al., 2014; World Health Organisation and Fundaçao Calouste Gulbenkian, 2014). It has been pointed out that interventions aimed at children are the most efficient (Christian Kieling et al., 2011; World Health Organisation and the Fundaçao Calouste Gulbenkian, 2014).

This report presents: 1) the framework of social determinants of mental health based on the framework proposed by the World Health Organisation (WHO); 2) evidence of the impact of the financial crisis on mental health; and 3) effective actions on social determinants that can prevent mental health problems and/or improve the mental health of the population, following the guidance of WHO (Allen et al., 2014; World Health Organisation and Fundaçao Calouste Gulbenkian, 2014).

1.
CONCEPTUAL FRAMEWORK

Figure 1 presents a conceptual framework of the determinants of mental health throughout the life cycle, based on that proposed by the WHO (World Health Organisation, 2012). The framework integrates the determinants of mental health throughout the life cycle, as well as the setting and the nature of interventions.

Figure 1. Social determinants of mental health throughout the life cycle. Modified from WHO 2012.



A life cycle perspective

To promote mental health, it is recommended we adopt a life cycle perspective that identifies the determinants of mental health at each stage of life and recognises its accumulated influence throughout people's lives, so that mental health is not only dependent on the situation at a given moment but on the accumulated exposure.

Prenatal and perinatal stage

Although they are frequently ignored, prenatal and perinatal periods are crucial for mental health. The health of mothers, their living and working conditions, as well as their habits related to health, can affect the health of the foetus and its future life. For example, the children of parents with depression have a higher risk of lower weight and growth retardation (Marmot, Allen, Bell, Bloomer and Goldblatt, 2012).

Early childhood

Adverse life conditions during childhood are associated with mental health problems (Currie, Dyson, Eisenstadt and Melhuish, 2013). There is plenty of evidence that the quality of upbringing and the living conditions of families affect the physical and emotional development of infants (R. Bell, Donkin and Marmot, 2013). Physical and emotional neglect, abuse and growing up in an environment of domestic violence can damage the development of children (Fryers and Brugha, 2013). The existence of a social gradient in the social and emotional difficulties in childhood is well documented from ages as low as three, which can be reduced through activities to promote the abilities of the parents, for example (Kelly, Sacker, Del Bono, Francesconi and Marmot, 2011).

Children need to live in a safe, protective and welcoming environment, and therefore the role that parents play is key. The support of parents is considered indispensable both in the prenatal phase and in all other stages of childhood. Deficits in writing and number skills or delinquency are in large part a consequence of experiences in early childhood. Hostile or coercive parenting behaviours have been linked to problems of self-control and aggression in minors, while warmth and good communication from parents with their children has been associated with the perception of safety and confidence among minors, which improves their development (Schofield et al., 2012). Living conditions in early childhood determine physical, psychological and social health throughout their lives.

In Barcelona in recent years, children's medical visits due to problems related to mental health have increased. The population of children and young people with serious disorders treated by health services has risen from 4.2% in 2005 to 9.5% in 2014. In total, in 2014, 10,517 people with mental health problems were attended at the CSMIJs, 997 of whom were diagnosed with severe mental disorders. Among the mental health problems in children, we can highlight attention-deficit and hyperactivity disorder (ADHD), with 16.1% (1,691 people attended), well above other serious disorders (Barcelona Public Health Agency,

2014). Most of these cases are diagnosed in early childhood. However, there has been a possible overdiagnosis of ADHD and the adverse effects of medication, which outweigh the benefits in most cases (more than 80% of cases diagnosed are light or moderate). In addition, there is a lack of studies on the effectiveness of treatments and their possible adverse effects in the long term. In these cases, conservative interventions have been recommended, such as those aimed at improving parental skills, and the results of their effectiveness are promising (Thomas, Mitchell and Batstra, 2013).

Late childhood and adolescence

Family poverty makes it difficult to provide proper learning environments in the home, for example due to overcrowding or unhealthy conditions. Parents' access to employment not only reduces poverty, but also improves families' daily routines and ensures that children grow up understanding the function of employment as part of adult life. Schools can play a key role working directly with children (Dear and Mcmichael, 2011).

Bullying at school can have a major impact on the physical, emotional and social health of children. Victims of bullying are more likely to suffer from sleep problems, enuresis, abdominal pain, headaches and depression (Gini and Pozzoli, 2009). The effects of bullying on emotional health may persist for a long time, for example with a higher risk of low self-esteem and more depressive symptoms in adulthood (Kaltiala-Heino, Rimpelä, Rantanen and Rimpelä, 2000). Victims of bullying are more likely to feel socially rejected or isolated and experience social marginalisation, as well as a more disadvantaged social position (Brown, Birch and Kancherla, 2005).

Adolescent depression is associated to adverse experiences in early childhood (Bell, Blanchflower and Rauner, 2010; Wickrama, Conger, Lorenz and Jung, 2008). Additionally, the adoption of high-risk behaviours in adolescence (which include the consumption of addictive substances) affects development (Campion, Bhui and Bhugra, 2012; Casey, Jones and Hare, 2008).

Adults

In order to understand mental health among adults, it is important to take into account the sex-based division of labour and the conditions of both paid work and the family.

Paid work

Unemployment, bad working and employment conditions and job insecurity are related to mental ill health in adult life (Artazcoz, Benach, Borrell and Cortès, 2004, 2005; Catalano et al., 2011). Loss of paid work is associated with poor mental health status, especially in the long-term unemployed and older workers (Nichols, Mitchell and Lindner, 2013; Urbanos Garrido and Lopez-Valcarcel,

2015). Job stability, control over work, and pay are factors that promote mental health (Wahlbeck, Anderson, Basu, McDaid and Stuckler, 2011).

Family

Families are often the basis of social support and provide safe environments in which people can grow and live. Poverty, and debt in particular, can increase the risk of mental ill health in parents and increase conflict between partners, something that also implies risks to children (Melzer, Fryers, Jenkins, Brugha and McWilliams, 2003).

Workload and difficulties combining work and family life are associated with psychological distress, as are a sedentary lifestyle and insufficient hours of sleep in women in our society, characterised by a traditional family model, especially in those of the most disadvantaged social classes (Arcas, Novoa and Artazcoz, 2013; Artazcoz, L, Borrell, C, Benach, 2001; Artazcoz, L, Cortés, I, Puig-Barrachina, V, Benavides, FG, Escribà-Agüir and Borrell, 2013). An important factor in the mental health of families is gender-based violence, which has been linked in numerous studies with mental health problems in both children and women (Kumar, Nizamie and Kumar, 2013).

Elderly people

The mental health of the elderly is influenced by their experiences throughout their life, as well as by their current experiences such as retirement, informal care for people with dependencies or the suffering of chronic disorders that, at the same time, depend to a large extent on the social and cultural context. As with the rest of the age groups, there is a social gradient in mental health (McCrone, 2008).

It has been documented that depressive states in men are related to chronic health disorders, while women are more frequently associated with social factors such as loneliness (Allen et al., 2014). The elderly are at greater risk of suffering from depression than younger people, a fact which is associated with specific experiences at this stage of life, such as grief and loss, the reduction of economic income, problems with physical health, or loneliness (McCrone, 2008). In addition, at this stage in life many people, especially women, become caregivers of relatives with chronic health problems or dependency situations, which can damage mental health (Carretero, Garcés, Ródenas and Sanjosé, 2009; Pinquart and Sorensen, 2006).

People in situations of vulnerability

Depending on the local context, some people and social groups may be at significantly higher risk of suffering from mental health problems. Among these vulnerable groups we often (although not always) find members of families living in poverty, people with chronic health problems, children exposed to abuse or neglect, minority groups, people subject to discrimination and violations of human rights, homosexual, bisexual and transgender people, people in prisons and those exposed to conflicts, natural disasters or other humanitarian emergencies (Herrman, Saxena and Moodie, 2005). In addition, people with mental disorders are at greater risk of vulnerability and more likely to experience disability and premature mortality, stigma, discrimination, poverty and social exclusion (World Health Organisation, 2012).

The financial crisis

Numerous studies confirm the negative effects of crises on mental health, particularly on psychological well-being, anxiety, depression, insomnia, alcohol abuse and suicide. Unemployment, debt, job insecurity, social isolation or uncertainty about housing are the main risk factors (Martin-Carrasco et al., 2016). These negative effects can be particularly relevant among groups that already had a disadvantaged situation, such as people with mental health problems, children, the elderly, immigrants or those with disadvantaged socio-economic positions (Burgard and Hawkins, 2014 ; Evans-Lacko, Knapp, McCrone, Thornicroft and Mojtabai, 2013; Vázquez, Vargas and Aller, 2014). In addition, austerity measures and poorly developed welfare states increase the negative effects of financial crisis on health (Lundberg et al., 2008; Stuckler, Basu, Suhrcke, Coutts and McKee, 2009). The few studies that exist on policies in relation to financial crises suggest that it is important to develop social protection programmes, such as active employment programmes, social support systems, programmes to protect against precarious housing and improve access to mental health services, especially in the field of primary care (Martin-Carrasco et al., 2016).

During crises, people with mental health problems do not receive adequate treatment, which can be related to cuts in health services and with the increase in the stigma associated with mental health problems in times of crisis (Martin-Carrasco et al., 2016).

Childhood and adolescence

It has been pointed out that in Spain, those most affected by the financial crisis have been children. Since 2008, the risk of poverty and economic inequality has increased in Spain, and more so among children than in the general population. The proportion of children at risk of poverty increased from 28.2% to 36.3% between 2008 and 2012. Within Europe, Spain has one of the highest proportions of children at risk of poverty. The proportion of children living in homes where all the members are unemployed increased from 6.5% in 2008 to 13.8% in 2012. The inequalities between the highest and lowest incomes rose more than 20%. The number of vulnerable families with children who asked non-governmental organisations for help to cover their basic needs has tripled since 2007. In addition, there is evidence of poorer general health and poorer mental health in minors of evicted families (Rajmil, Artazcoz, Garcia-Gomez, Flores, Hernandez-Aguado, 2015).

Adults

Among adults, unemployment, reduced income and family debts have increased the incidence of depressive anxiety and alcohol abuse amongst the unemployed and their families (Gili, Roca, Basu, McKee and Stuckler, 2013; Jenkins et al., 2008; Meltzer, Bebbington, Brugha, Farrell and Jenkins, 2013; Wahlbeck and McDaid, 2012). On the other hand, in the current context in which unemployment is very high, inequalities in the state of mental health between unemployed and employed people increase (Urbanos-Garrido and Lopez-Valcarcel, 2015), as companies can select from a large pool of people the candidates with the

best conditions, so it is more difficult to find work for groups that traditionally have difficulties finding work, for example people with health problems or with disabilities.

It has been documented that, during the crisis, many women have had to increase the number of paid work hours, and housewives have had to enter the job market to increase the income of the family unit and overcome financial difficulties. However, they do this in situations of financial vulnerability that obliges them to accept often difficult working and employment conditions, while they remain responsible for domestic and family work that, in our society, they take on with few public services or or financial aid, and with little involvement from men, even if they are unemployed (Artazcoz et al., 2014). On the other hand, with the economic crisis, involuntary part-time work has increased a lot, which means not only a reduction in income but also, particularly in continental southern European countries, precarious working conditions (Horemans and Marx, 2013).

In addition, with the current financial crisis, the combination of work and family life has been associated with mental health problems in men in countries with traditional family models, due to their traditional role as the main providers in a context of financial difficulties (Arcas et al., 2013; Artazcoz, Cortès, Puig-Barrachina, Benavides, Escribà-Agüir, Borrell, 2013).

Evictions have become a public health problem (Bennett, Scharoun-Lee and Tucker-Seeley, 2009). Two studies conducted in our context analyse the health of people with problems with access to housing assisted by Caritas (Novoa et al., 2015) and the Platform for those affected by Mortgages (Vázquez et al., J Urban Health in the press) and show how these populations have mental illness rates between 6 and 9 times higher than the general population.

During financial crises, alcohol consumption is often reduced due to economic difficulties. However, it increases among the groups most affected by the crisis. The risk factors for abusive alcohol use during the crisis are: 1) the duration of unemployment and the seriousness of the financial situation; 2) previous problems with alcohol; 3) the quality of social and family relationships; 4) collectives in a disadvantaged situation and 5) being a man, since men are at greater risk of increasing alcohol consumption during recessions (Martin-Carrasco et al., 2016).

Elderly people

Many elderly people take in their children who have lost their homes, with modest pensions, which can have a negative impact on their mental health status. In addition, cases of the financial abuse of older people are likely to increase (Fealy, Donnelly, Bergin, Treacy and Phelan, 2012).

2.
PRINCIPLES OF INTERVENTIONS AT THE LOCAL SCALE

In this section we present the principles of interventions to promote mental health and reduce disorders and inequalities in mental health in accordance with the WHO proposals (Allen et al., 2014).

Proportional universalism

One key principle is proportional universalism. Focusing only on the most vulnerable or disadvantaged groups is not enough to reduce inequalities in mental health. However, the interventions must be proportional to the degree of disadvantage.

Interventions in various sectors

The determinants of mental health operate at different levels that include the individual, the family, the community and structural determinants related to policies. Therefore, an approach based on the determinants of health means interventions in various sectors such as education, health, housing and employment. This requires the participation of various public administrations, entities, social services, volunteering and the private sector.

Life cycle perspective

A life cycle perspective has been adopted which recognises that mental health at each stage of life is determined by its own factors, and that it is also the result of life experiences. Therefore, interventions must be appropriate for the different stages of life. For example, interventions in families and schools are relevant during childhood; in adulthood, those related to employment or families; lastly, as the elderly population is increasing, interventions in advanced ages are increasingly necessary.

Interventions from birth

As part of the life cycle perspective, it is particularly important that all children have the best possible start in life. These interventions include support for parents, helping them, for example, have adequate income.

Physical and mental health

The social determinants of health influence physical and mental health. Physical health determines mental health, so the promotion of mental health must also take into account physical health.

Avoiding focusing only on the short term

An approach to promoting mental health focused on the social determinants of mental health, including a life cycle perspective, requires long-term strategies and sustainable policies.

Equity in mental health in all policies

The reduction of inequalities in mental health involves global action by the government, as well as that of various sectors. Therefore, it is important that the political decisions that are made in all sectors ensure that their programmes and strategies do not harm and potentially work to reduce inequalities in mental health. Existing instruments to assess the impact of policies on physical health should be adapted to include equity in mental health.

Local knowledge for action

In order to implement interventions to promote, prevent and improve mental health problems at the local level, it is necessary to develop information systems that include:

- Information on the prevalence and distribution of mental health problems at the local level.
- Information on the number of people with mental health problems that do not have access to adequate treatments.
- Information on the social, economic and environmental factors related to mental health. This information can be obtained through community participation, asking key people in the community. Local participatory processes help identify solutions and implement interventions.
- Knowledge of local assets and resources, including social, economic and environmental factors that can contribute to improving mental health.
- Triangulated knowledge about local assets and resources with knowledge of effective evidence-based interventions.
- Assessment of the potential impact of various local initiatives on equity in mental health (the impact they may have on the various groups).
- Synergies between interventions: information on how mental health and its distribution is influenced by interventions to improve local aspects such as education services, health services, housing, urban planning, the natural environment, transport, initiatives to generate income opportunities and community development.

3.
MULTILEVEL APPROACH

Policies to address mental health must adopt a multilevel framework that includes various areas that influence mental health and offer opportunities for the prevention and promotion of mental health.

- Global measures.
- Life cycle: prenatal and perinatal periods, childhood and adolescence, adulthood in the field of paid work and family, and old age. At all stages there is also a gender perspective.
- Families: behaviours and attitudes of parents, material conditions (income, access to resources, food, hygiene, housing, employment, etc.), employment and employment conditions, unemployment, physical and mental health of parents, pregnancy and maternal care, social support, etc.
- Community: confidence and security in neighbourhoods, community participation, crime and violence, natural and built environment, neighbourhood poverty, etc.
- Local services: healthcare and early childhood education, schools, services for adolescents and young people, health and social services, water quality and the environment, etc.
- Factors at national level: poverty reduction, inequality and discrimination, human rights, policies that guarantee access to health, education, employment and quality housing, etc.

4.
EFFECTIVE INTERVENTIONS AT THE LOCAL SCALE

Social welfare

There is a close relationship between poverty and mental health. Therefore, we need to improve social protection systems to cope with the effects of a long-term recession. In addition, the measures must respond to the various needs of the life cycle. It is important to offer social support and counselling services for people with serious financial problems such as those who have been unemployed or have significant family debts (Uutela, 2010).

Financial support

Financial support measures can be effective against situations of precariousness and social exclusion. They contribute to the resilience of families against falling revenues and debts, which is related to mental health. Special priority must be given to precarious housing situations and children's education. Also, active measures such as those aimed at getting a job or promoting the family are recommended, ahead of policies based exclusively on subsidies (Diamond and Lodge, n.d.; Martin-Carrasco et al., 2016).

Measures against unemployment and job insecurity

Uncertainty about housing

Measures must be implemented against mortgage foreclosures. In emergencies, in the case of people who have already lost housing, it is important that public administrations and NGOs collaborate to provide transitional housing and prevent people going homeless. Also, programmes should be put in place aimed at preventing people from being forced to leave their homes and having to live with relatives or friends (Phua, 2011).

Reducing inequalities

Promotion of mental health and care for mental health problems

Improved care for mental health problems

Most European countries have restructured psychiatric care systems, from institutionalised systems aimed at people with severe mental disorders to medical and psychological care throughout the population (Novella, 2010). However, healthcare for mental health problems has serious limitations in almost all countries. It has been pointed out that, in general, resources are insufficient and inefficient and that governments invest less than is necessary. In addition, there are also inequalities in access to those resources (Martin-Carrasco et al., 2016). In a recent review, the European Association of Psychiatry recommends:

1) continuing with the creation of a network of community psychiatric services; 2) increasing, or at least not diminishing, the coverage of mental health services; 3) promoting cooperation and coordination with social services, especially with those who offer care to people affected by the crisis; 4) addressing the stigma associated with mental health problems and 5) establishing a portfolio of evidence-based services and programmes (Martin-Carrasco et al., 2016).

Improve coordination between primary care and specialised care

In the context of a financial crisis, it is recommended we offer: 1) programmes to prevent suicidal ideas and behaviours; 2) group support for people in unemployment or serious debts to promote mental health and increase workplace insertion; 3) brief interventions for people with alcohol abuse and 4) programmes for common mental health problems such as anxiety and depression (Martin-Carrasco et al., 2016).

Promote mental health and prevent illnesses

There is growing evidence of the clinical effectiveness of preventive psychiatry (prevention of mental health problems and promotion of mental health), particularly in children (Jané-Llopis, Barry, Hosman and Patel, 2005; Min, Lee and Lee, 2013). Even in the current crisis, secondary and tertiary prevention can also be effective. This should be applied both to primary care and specialised services that have undergone major cuts due to the crisis (Martin-Carrasco et al., 2016). In addition, there is also evidence that this approach is efficient (Bawaskar, 2006; Schomerus, Matschinger and Angermeyer, 2006).

Adequate communication strategies

It is important that mental health be on the political agenda in tackling the crisis. It is also important we define policies supported by international organisations without a conflict of interests that can exist on a national scale. Likewise it is necessary to collaborate between representatives of the media and experts in mental health to develop guidelines aimed at preventing suicides related to news in the media during periods of financial difficulties (Solberg, Tomasson, Aasland and Tyssen, 2014). Finally, initiatives with the media to fight against stigma should be promoted (Bawaskar, 2006; Schomerus et al., 2006).

Table 1 identifies certain actions to promote mental health during childhood.

Table 1. Examples of interventions to promote mental health during childhood.

Children
Families
• Parental skills programmes • Programmes to alleviate family debt • Interventions to guarantee decent housing • Interventions to prevent and treat the mental health problems of parents • Interventions to treat the addictions of parents • Domestic violence
Schools
• Emotional education interventions • Prevention of bullying in schools • Support in schools for children with learning difficulties • Programmes to promote healthy habits (tobacco, alcohol, drugs, food, physical activity, and sexual and affective health)
Community
• Violence and crime • Healthy leisure opportunities

Table 2 identifies certain actions to promote mental health during adulthood.

Table 2. Examples of interventions to promote mental health during adulthood.

Adults
Paid work
• Workplace insertion • Promotion of decent work and prevention of precariousness
Families
• Parental skills programmes • Programmes to alleviate family debt • Interventions to guarantee decent housing • Interventions to prevent and treat the mental health problems of parents • Interventions to treat the addictions of parents • Domestic violence • Balancing work and family life
Community
• Healthy leisure opportunities • Opportunities for volunteer work

Finally, Table 3 identifies certain actions to promote mental health in the elderly.

Table 3. Examples of interventions to promote mental health in the elderly.

Elderly people
Families
• Debt and poverty • Prevention of abuse
Community
• Prevention of discrimination • Reduction of social isolation

5.
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