

*Portuguese Republic*

PORTUGAL

*Portuguese Republic*

EFFECTIVE AND HUMANE MENTAL HEALTH TREATMENT AND CARE FOR ALL

KEY ACHIEVEMENTS

1. Detailed analysis and report of the situation of Mental Health in Portugal (2007) by the National Commission for Evaluation of Mental Health,
2. Consensus on a broad approach for mental health amongst key stakeholders,
3. Finalisation of the new Mental Health Policy and Plan for 2007-2016,
4. Establishment of a national mental health coordinator position in the Ministry of Health,
5. Commitment for integrating mental health into General Hospitals (creation of new mental health units) and Primary Health Care (training and support of staff in major and minor health centres),
6. Building of a coalition between formal health services, NGOs, mental health service users and families to support the treatment and rehabilitation.

NEXT MAJOR STEPS

1. Continue the implementation of the mental health policy and plan.
2. Establishment of a national mental health budget.
3. Strengthening human resources in local mental health services in remote areas.
4. Establishment of a training program for key professionals working in the community
5. Development guidelines for Community Mental Health Teams
6. Creation of a new Child and Adolescent Mental Health Teams
7. Development of a new quality assurance policy for services.
8. Implementation of certified guidelines in routine practice.
9. Training of general practitioners in Primary Health Care.
10. Establishment of prevention programs against stigma, suicide, depression and for the support of vulnerable groups.

Potential partners and donors interested in supporting the **WHO 'Mental Health Improvement for Nations Development' Project** or any aspects of the implementation of the mental health policy and plan in Portugal should contact the World Health Organisation:

Prof. Caldas de Almeida ■ Dr Michelle Funk ■ Dr Matt Muijen

THE PROJECT

OVERVIEW

The epidemiological data on mental health disorders in Portugal is scarce, but we can reasonably estimate that it is similar to other European countries (Eurobarometer, 2003; European Brain Council Report, 2005). In contrast, only 1.7% of the population seeks help in the health services in contrast with the expected 5 to 8 %.

The majority of resources are concentrated in the 3 major Portuguese cities, and the allocation of resources to other parts of the country has proved difficult. The psychiatric hospitals still consume the majority of resources (83%), despite evidence indicating that community based services are more effective and acceptable for users and families.

The analysis also shows positive aspects in the last decade's development. Portugal was one of the first European countries to adopt a national law (1963), allowing the geographical distribution of services with mental health centres in all districts and had the emergence of important movements, such as social psychiatry and the liaison with primary care.

However, more remains to be done and with this in mind an important first goal was to develop and implement a new mental health policy and plan, emphasizing the following principles:

- Mental Health services must be integrated in the general health system.
- People with mental disorders must be respected on their rights, including adequate care, housing, employment and the protection from all forms of discrimination.
- Care must be provided in the less restrictive setting possible.
- Services must be coordinated and integrated in a way that can assure continuity of care.
- Comprehensiveness – Each service must include a wide variety of programs to address the special needs for mental health care.
- Users and families must be involved in the planning and development of the services they benefit. Families must be considered partners in the delivery of care and stimulated to participate, receiving the adequate training and education.
- Protect the highly vulnerable groups (eg. children, adolescents, elders and people with disabilities).
- Accessibility and equality to mental health services despite age, gender, residence, social or economical situation.
- Recovery – conditions must be created to assure the self-determination and seek for an individual path, from the people with mental health problems.

MAJOR MILESTONES

1963: First Mental Health Law defined Mental Health Centres for all districts (local level) and regional mental health services for children and adolescents.

1985/1989: First programs for the reorganisation of mental health services: creation of mental health centres in the metropolitan areas, as well the implementation of a national information system for mental health.

1992: Integration of all mental health centres in general hospitals. Due to the lack of technical and financial autonomy, the development of community mental health services was interrupted.

1994: Appointment of a **Commission for the Mental Health Study** with the participation of a wide variety of sectors involved in the mental health care delivery. This Commission organized a National Mental Health Conference held in 1995. This conference defined the important draft that would origin the basis of the new Mental Health Law (36/1998) and Decree (35/1999).

1998/1999: New Mental Health Law and Decree: Defined the principles that govern involuntary admissions, and the rights for people with mental disorders. Also defined are the principles of services organization (considering the majority of services as local mental health services and defining the specialized regional services), as well the rules for the articulation between social and health services.

2006: Establishment of the **new National Commission for Mental**, created by the Ministry of Health, in order to develop a new mental health policy and plan

2006: National Commission requests WHO support to undertake WHO-AIMS and Quality assessment

2007: New Mental Health Policy and Plan The new Mental Health Policy and Plan traces the current national context of mental health and establishes the objectives and actions planned for 2007-2012. One of the major challenges lies on the ability to reallocate services from psychiatric hospitals to community based mental health services. The major objectives of the National Mental Health Policy and Plan are:

- 1) Assure equal access to care,
- 2) Promote and protect human rights in people with mental health problems,
- 3) Reduce the impact of mental health disorders and promote positive mental health,
- 4) Promote the decentralisation of mental health services allowing community delivery of care,
- 5) Promote the integration of mental health services in the general health services at the levels of primary care, general hospitals and community network.

2008: Creation of a National Coordination Body for Mental Health, empowered to assure the implementation and monitoring of the National Mental Health Policy and Plan.

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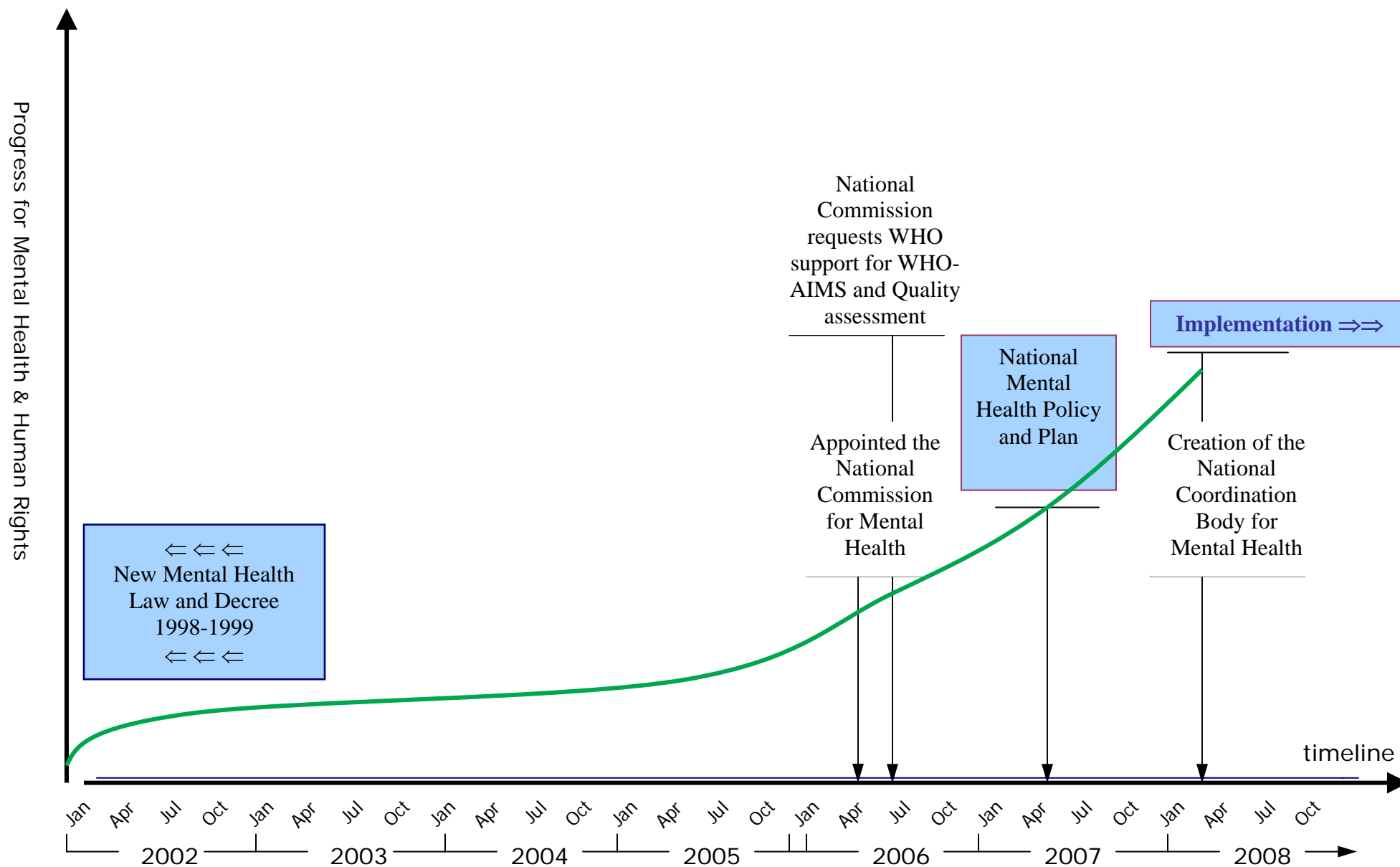
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LINKS TO OFFICIAL DOCUMENTS

- Office of High Commissioner for Health (ACS) – Health Ministry: www.acs.min-saude.pt/en
- National Coordinating Body for Mental Health: www.acs.min-saude.pt/en/national-coordinations
- The National Mental Health Plan, 2007 (*in Portuguese*): <http://www.acs.min-saude.pt/2008/01/18/plano-accao-servicos-de-saude-mental?r=771>
- Mental Health Law 36/98 (*in Portuguese*): <http://www.acs.min-saude.pt/pt/coordenacoes-nacionais/saudemental/documentos-de-referencia>
- Mental Health Decree-Law 35/99 (*in Portuguese*): <http://www.acs.min-saude.pt/pt/coordenacoes-nacionais/saudemental/documentos-de-referencia>



THE CONTEXT

① COUNTRY DEMOGRAPHIC AND SOCIOECONOMIC PROFILE



Portugal is a country in southwestern Europe on the Iberian Peninsula, with a population of around 10 million people, a density of 114.78 people per sq. km and an annual population growth of 0.5% (European Observatory – Health Systems and Policies, 2007).

Its capital is Lisboa (Lisbon).

The largest religious group is **Roman Catholic** (comprising approximately 84% of the population). The main language used in the country is **Portuguese**.

The adult literacy rate is 95.8% for men and 92.0% for women (UNESCO, 2005¹).

Figure 1: Geographical location and map of Portugal. The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

(Source: <http://www.cyberschoolbus.un.org/infonation/index.asp>)

The proportion of the population under the age of 15 years is 15.9% and the proportion of population above the age of 65 years is 16.6% (UNESCO, 2006). The **life expectancy at birth** is **74** years for males and **81** years for females.

(2006, UNESCO)

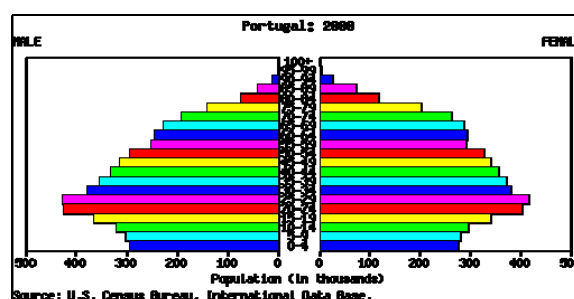


Figure 2: Age pyramid (Portugal, 2000)

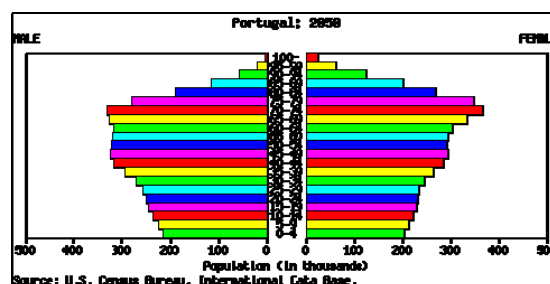
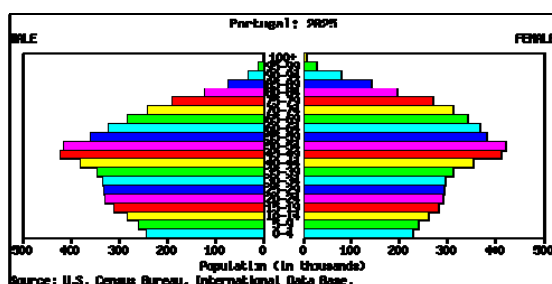


Figure 3: Age pyramids (Portugal, Projections for 2025 and 2050)

(Source: <http://www.census.gov/cgi-bin/ipc/idbpys.pl?cty=PO&out=s&ymin=250&Submit.x=12&Submit.y=10>)

The country is a **high-income group country** (based on World Bank 2004 criteria¹). The health budget represents 9.2% of the GDP. More than half the workers are employed in services.

The *per capita* total expenditure on health (at international dollar rate) is 1618\$. The *per capita* government expenditure on health is 1116 international \$ (2004; WHO, 2006b).

② CONTEXTUAL FACTORS INFLUENCING MENTAL HEALTH NEEDS AND SERVICES

There are several factors that may have impacted on the mental health of the population over the last decades, even though there is scarce evidence published in the literature (Barros, 2007). Demographic changes in Portugal seem to have followed global trends in socioeconomic conditions comparable to those in other countries in the past. Recent projections show that the Portuguese population may still show a slight rise during the next decade but will start decreasing from 2010 onwards.

Ageing population: The increase in the percentage of people over 65 years old and the decrease of the population under 15 years of age will result in a “double ageing” effect. Portugal may expect an increase of psychogeriatric problems among the older population in the near future, as well as the need to develop appropriate services for them.

Urbanization: While in 1970 only 25.9% of the population lived in urban areas, this rose to 29.4% in 1980, 46.7% in 1990, 53.0% by 2000, and 55.1% by 2004. Though this is noticeably below average compared to other EU Member States (approximately 70%), it has nevertheless resulted in some difficulties in terms of access to mental health services for the people living in rural areas.

Migration: The migration of the population from the interior to the coastal cities has been steadily on the increase over the last 20 years. Large suburban areas were built to hold the influx of internal and external immigrants. The fast expansion of these suburban neighbourhoods is changing the traditional family/social networks that prevailed in the rural settings, thus increasing the sense of isolation and non-integration. The Portuguese mental health care system is still struggling to address some of the specific challenges presented by recent legal and illegal immigration from Brazil and central and Eastern Europe, as well as the more traditional immigration from Africa.

Poor economic growth and unemployment: Over the past decade, the Portuguese economy has faced a period of very low growth, with the most visible effect being the increase in the government budget deficit, as well as a rise in unemployment levels. This has a high impact on psychiatric morbidity, as demonstrated by the results of the Eurobarometer (2003).

¹ Source: <http://web.worldbank.org> (last accessed: 13/02/2008).

Health disparities and inequality: In the last 3 decades the health status of the Portuguese population has improved significantly. Improvements in health status seem to be associated with increases in human, material and financial assets devoted to health care, as well as to a general improvement in socioeconomic conditions. However, there is still some concern over regional disparities, particularly between urban-coastal and rural-interior regions. The latter had, and continue to have, the worst health conditions. Rural regions are also the poorest in the country. Health inequalities are associated with economic and social factors, such as income, living conditions, unemployment and health care (coverage, utilization rates, among others). Probably due to these factors, Disability-Adjusted Life Expectancy (DALE) levels in Portugal are worse than the average for EU15 members, both for men and for women.

► **Poverty:**

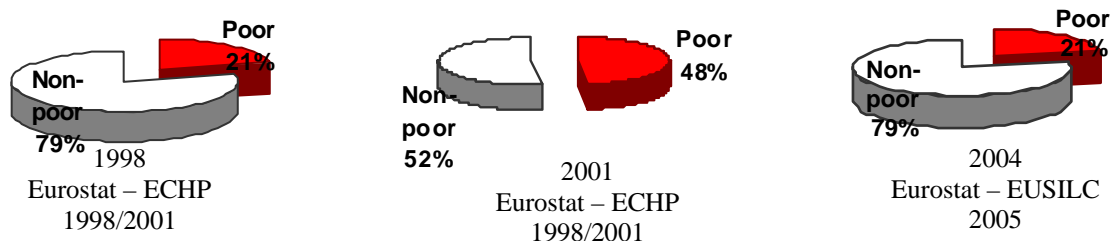


Figure 4: Poverty level in Portugal, Eurostat – ECHP 1998/2001, EUSILC 2005 (Carlos Farinha Rodrigues)

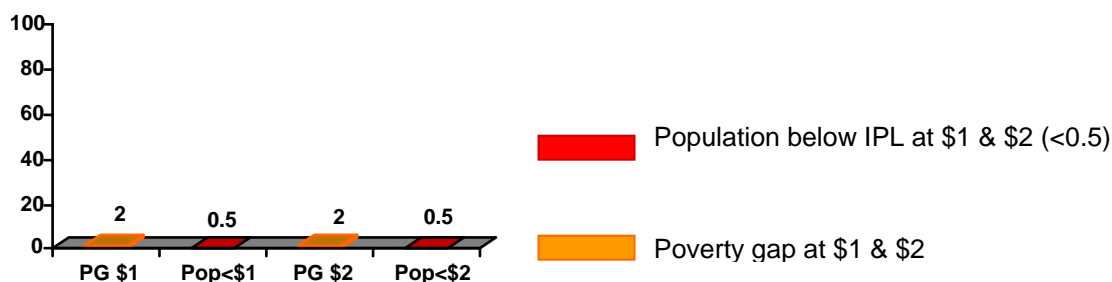


Figure 5: Poverty levels and poverty gaps² in Portugal (1994), international poverty lines (IPL) at \$1 and \$2 (World Development Indicators, 2006).

(Source: <http://devdata.worldbank.org/wdi2006/contents/Section2.htm> [table 2.7.: Poverty]).

² The poverty gap is the mean shortfall from the poverty line (counting the nonpoor as having zero shortfall), expressed as a percentage of the poverty line. This measure reflects the depth of poverty as well as its incidence.

Human Development Index (HDI)³ (Portugal HDI 2005 = 0.897, ranking 29/177):

While figure 6 shows HDI trends over time, figure 7 shows how, in this specific national context, HDI relates to GDP (how much economic wealth is transformed into development at the population level).

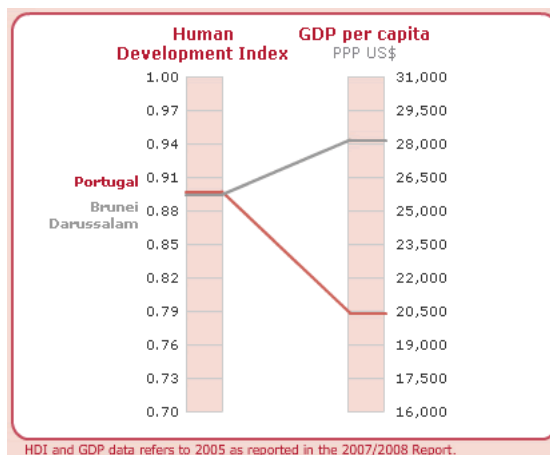
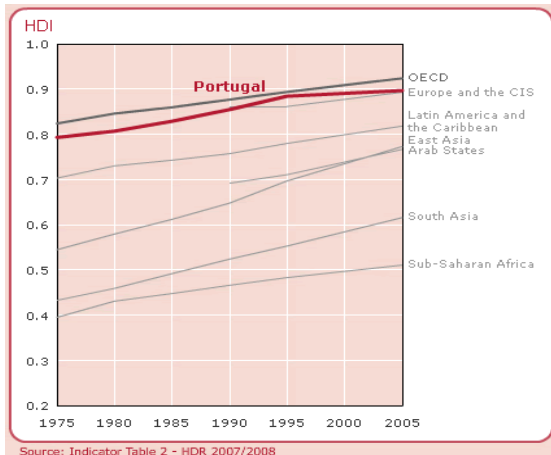


Figure 6: Human Development Trends (1975-2005)

(Source: UN Development report 2007/2008. url: http://hdr.undp.org/hdr2006/statistics/flash/statistics_trends.cfm)

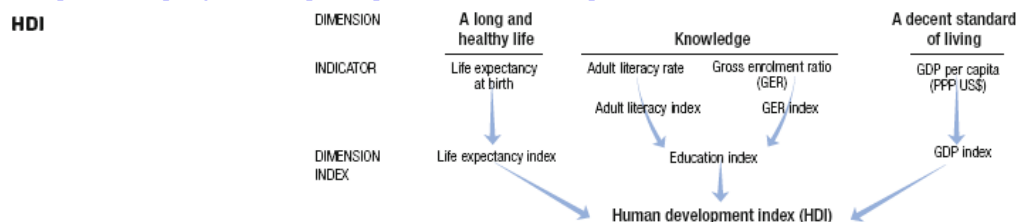
Figure 7: From HDI to Income (2005)

(Source: UN Development report 2007/2008. url: http://hdr.undp.org/hdr2006/statistics/flash/statistics_hdi.cfm)

³ The Human Development Index (HDI) is an indicator, developed by UNDP, combining 3 dimensions of development: a long and healthy life, knowledge, and a decent standard of living (see figure below).

Source: Human Development Report 2006 (UNDP), Technical Note 1.

url: http://hdr.undp.org/hdr2006/pdfs/report/Technical_notes.pdf



③ BURDEN OF MENTAL DISORDERS AND TREATMENT GAP

► **Epidemiological data:** No national or regional psychiatric morbidity survey has ever been carried out in Portugal, making it difficult to describe the mental health of the population, assign mental health priorities and organize services in order to meet people's needs. In the last decade most studies have been directed at the alcohol and drug-abuse fields.

Source: http://ec.europa.eu/health/ph_determinants/life_style/mental_eurobaro.pdf

Based on the data from the European Brain Council Report – Costs of Disorders of the Brain in Europe (2005), it has been indirectly estimated that 1,557,054 (16.07% of the adult population - 18 to 65 years) have a mental disorder in Portugal. 528.122 people (5,09%) suffers from Affective Disorders (including Mild Depression), 981.766 (9,46%) from Anxiety Disorders, and 54.166 (0,52%) from Psychotic Disorders in Portugal.

Source: <http://www.europeanbraincouncil.org/publications/>

In the Eurobarometer 2003 Portugal ranked in third place in the occurrence on MHI-5 (Mental Health Inventory – Ware, 2000) cases by country (29.3%), after UK and Italy. The occurrence of MHI-5 cases by gender, age, and income were also very significant in Portugal, comparing with the other EU-15 countries.

http://ec.europa.eu/health/ph_publication/eurobarometers_en.htm

There is a large gap between the number of people affected with mental disorders and those receiving treatment: While the estimated prevalence of people with mild, moderate and severe mental disorders is 1,557,054 (16.07%), the number of people with any mental disorder receiving treatment in psychiatric mental health services belonging to the public and social sectors (National Mental Health Report, 2005) was estimated to be 168.389 (1.7%).

<http://www.acs.min-saude.pt/wp-content/uploads/2008/01/relatorioplanoaccoservicossaudemental.pdf>

► **Suicide:** Portugal has one of the lowest suicide rates in Europe (11.1/100.000 – 2003), but the rates doubled from 1998 (5.6) to 2003 (it is not clear if this is due to a real increase or to better reporting). Source: <http://www.spsuicidologia.pt/>

The highest rates occur in men and over the age of 75 (68.1/100.000 – 2002). Where geographic distribution is concerned, there are significant regional asymmetries in the suicide rate, which attains its peak in the Southern region of the country, Alentejo, (84,47/100,000). Possible determinants for this phenomenon include age (60% > 60 years old), gender (74% male), widowhood, social isolation, low social class and school level, serious somatic illness and a family history of suicide. Research in this field showed a significant link between parasuicide and certain psychiatric disorders, such as major depression, alcohol dependence, schizophrenia and borderline personality disorders.

Source: Portuguese Suicidology Society, 2006. <http://www.spsuicidologia.pt/>

► **Alcohol:** In terms of alcohol misuse, although the general population consumption of ethanol (l/year) is falling slightly (1985-17.1, 1995-14.6, 2000-13, 2003-9.38), Portugal continues to be among the countries with the highest *per capita* consumption in the world, and this is one of the most serious public health problems currently facing the nation with consequences on, for example, the Rate of Road Traffic Accidents Involving Alcohol (21.45/100.000 in 1999 – European Health for All Database, WHO, see <http://www.euro.who.int/hfadb>).

► **Drug use:** Cannabis is the most used substance in Portugal and heroin is the substance most commonly associated with legal problems. Highlighting the data from student population, the mean age of drug use is 14 years old and lifetime prevalence of substance use is 12%, with Cannabis on the top of the list (ESPAD, 2005).

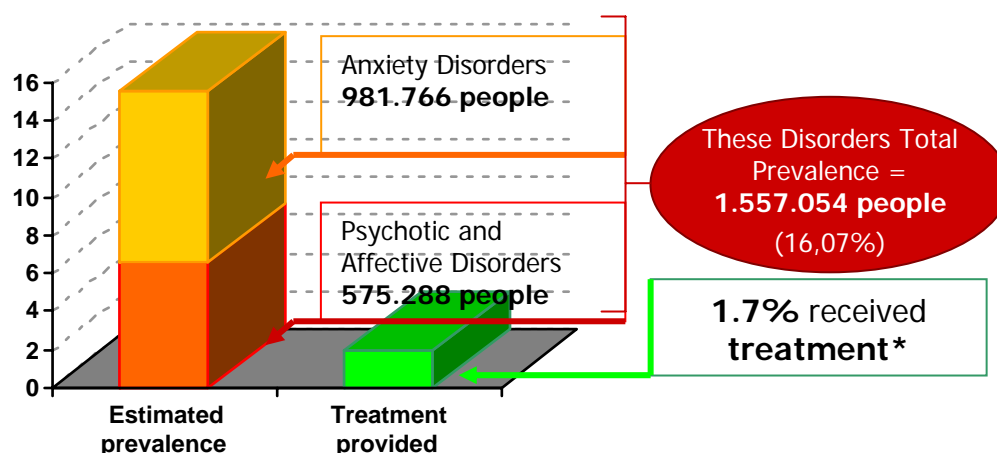


Figure 8: Treatment gap for people with the specified mental disorders in Portugal.

*This refers to 1.7% of the total number of people with a mental disorder (including mild cases), receiving treatment

④ THE MENTAL HEALTH SYSTEM

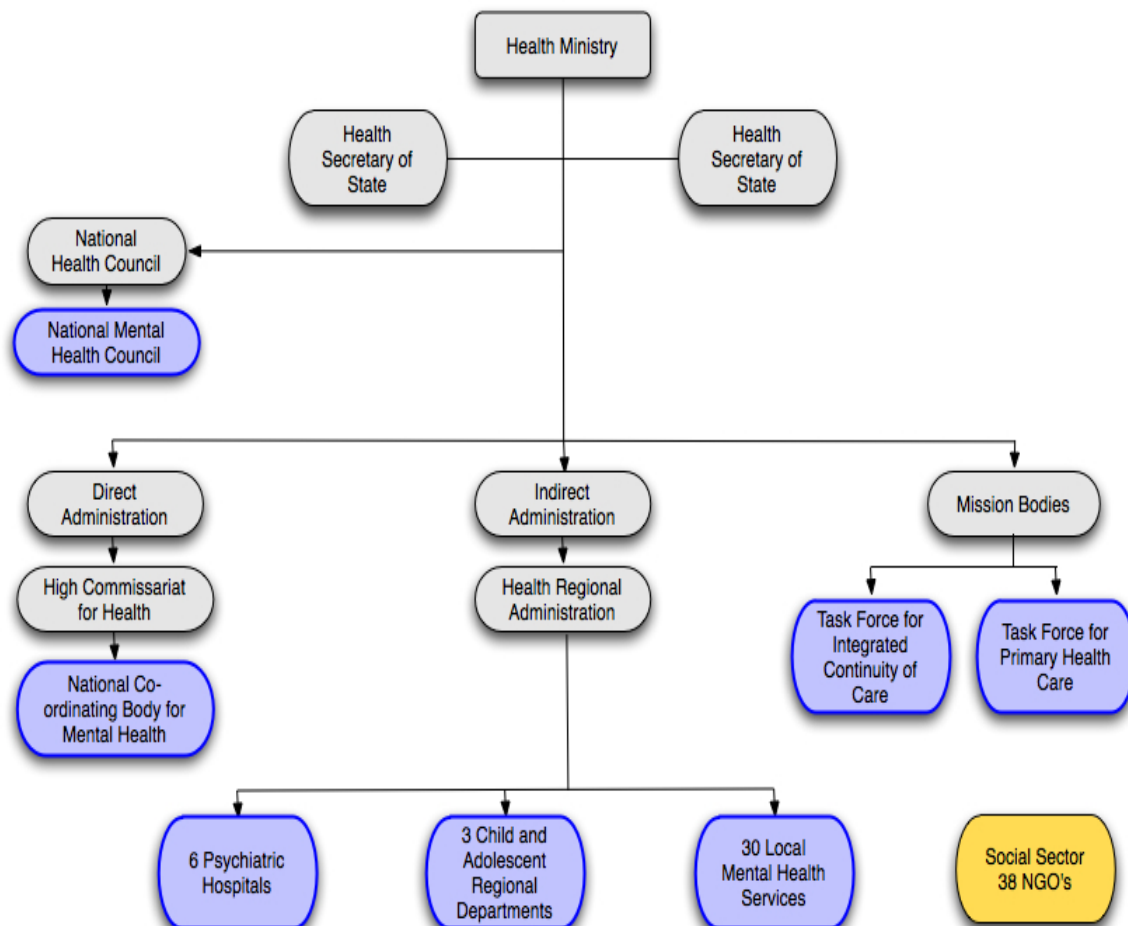
Evolution of the Portuguese general health care system: Up until the 1960's healthcare was fragmented and was provided by a mixture of facilities, which were concentrated in the major cities along the coastline. The system did not enjoy adequate transversal co-ordination and was under-financed which led to inadequate health cover and thus some very unfavourable health indicators.

Driven by the country's democratisation (1974), a National Health Service was created in 1979. It offered universal free access, was based on the English model and took over all the different services and bodies that had thus been disjointed. From then onwards, and with the increased financial backing provided by the country's entry into the European Community in 1986, the level of cover offered to the population increased significantly and the general health indicators underwent a very marked improvement in a short period of time⁴.

Despite these undoubtedly positive aspects regarding general health, due to lack of planning and consistent support in the improvement of mental health services, Portugal is still lagging behind in this field in relation to other European countries. Today, many of the Mental Health Services are located in the *Local Mental Health Services*, but most of the financial resources (83%) are spent in inpatient care.

⁴ The 2000 World Health Report (WHO) ranked Portugal 12th among 191 countries on the basis of a conjugated system of five indicators: the population's overall level of health, which it primarily measures using the DALE (Disability Adjusted Life Expectancy) index; the fairness of the distribution of the level of health among the country's inhabitants; the system's response capability; the allocation of this response according to people's economic levels; and justice in the economic contributions people have to make.

Figure 9: Organizational structure of the current Mental Health System in the general health system in Portugal (2008).



➡ Coordination

The organization of the mental health services in Portugal is based on the following scheme:

- the mental health services are organised by level (local, regional) and are inter-connected with one another via the Hospital Referral Network, which also uses a “catchment area” model to ensure links with the health centres;
- the basic care-providers are the *Local Mental Health Services*. They are located in departments belonging to general NHS hospitals, which in turn work in conjunction with the health centres in the same geographic area. They also incorporate specific teams whose function is to provide child psychiatric care;
- in addition to these units the country has six *psychiatric hospitals*, in which the number of places has been progressively falling. In addition to outpatient and inpatient care, they also provide long-term care for the chronically mentally ill;
- there are three *forensic units*, which are located in psychiatric hospitals and together contain a total of 135 beds;
- in the area of drug addiction assistance is provided by a specific body, the Institute for Drug Dependence (IDT), which does not formally work in conjunction with the mental health services, although the latter are responsible for care in situations that require inpatient stays (e.g. psychotic episodes, dual diagnoses).
- care in the alcohol-misuse field is provided by *alcohol-abuse intervention units* (local level), which operate in conjunction with the three *Regional Alcohol Abuse Centres*, also belonging to IDT – one each in the Northern, Central and Southern RHA’s (regional level).

Since 2008, there is an acting National Mental Health Coordination Body in the High Commissariat for Health, empowered to assure the implementation of the National Mental Health Plan as well as the co-monitoring of all the tasks assigned, offering representation for mental health in Portugal.

➡ Legal framework, policies and plans

Legislation

Portugal was one of the first European countries to adopt a national law (1963) in accordance with the principles of defined catchment areas, which enabled the creation of mental health centres in every district and the appearance of various important movements, such as social psychiatry and connection with primary healthcare.

New mental health legislation, approved in the 1990s (Law no.36/98 and Law Decree no. 35/99) reinforced this capital, in accordance with internationally accepted principles in the area of mental health. The creation of decentralized services was a development that had a very positive impact in the improvement of accessibility and quality of care, enabling responses closer to the population and a greater interaction with health centres and community agencies. The coverage of the national territory for these services is still far from complete, but comparing the current situation with that of 30 years ago, important steps have been made.

Another positive aspect was the development of psychosocial rehabilitation programmes and structures, created at the end of the 1990s, as part of the EU's Programme Horizon (Dispatch 407/98) and of employment support legislation. Although of limited scope, these programmes represented a significant break with the prior situation, in which residences in the community and social organizations for the seriously mentally ill were entirely nonexistent in Portugal.

Policy and Plan

A new National Mental Health Policy and Plan (2007-2016) has been developed (<http://www.acs.min-saude.pt/2008/01/18/plano-accao-servicos-de-saude-mental?r=1218>) with the following objectives:

- Ensure equal access to quality care for everyone with mental disorders in the country, including those belonging to especially vulnerable groups;
- Promote and protect human rights of people with mental disorders;
- Reduce the impact of mental disorders and contribute to the promotion of mental health of the population;
- Promote the decentralization of mental health services, so as to enable care provision closer to people's homes and to facilitate greater participation by communities, people with mental disorders and their families;
- Promote the integration of mental healthcare into the general health system, at the primary care level as well as in general hospitals, so as to ensure continuity of care and facilitate access and reduce institutionalization.

Key elements of the Mental Health Policy and Plan are summarized in point-form in Appendix 1.

➡ **Financing:** Although there is no specific budget for mental health, some data exist regarding costs in mental health services. The total mental health expenditure (2005) was calculated in € 229.380.764. A rough estimate points to less than 3,5% of the General Health Budget.

➡ Human Resources for Mental Health

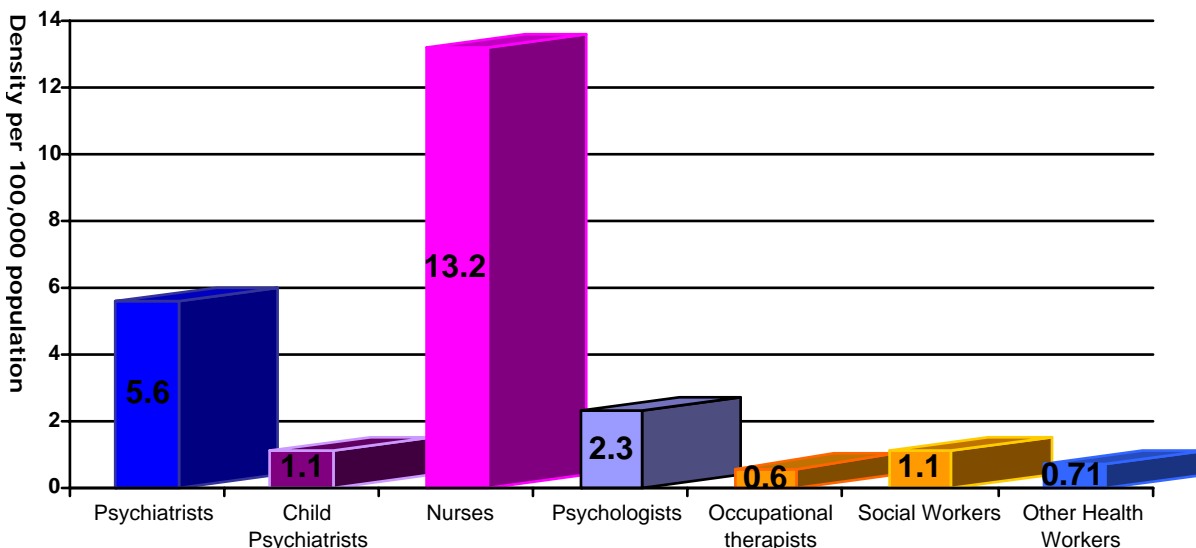


Figure 10: Human Resources for Mental Health Portugal (2007): Psychiatrists and Child Psychiatrists count does not include information from one General Hospital.

(Source: National Mental Health Report 2007 <http://www.acs.min-saude.pt/2008/01/18/plano-accao-servicos-de-saude-mental?r=771>)

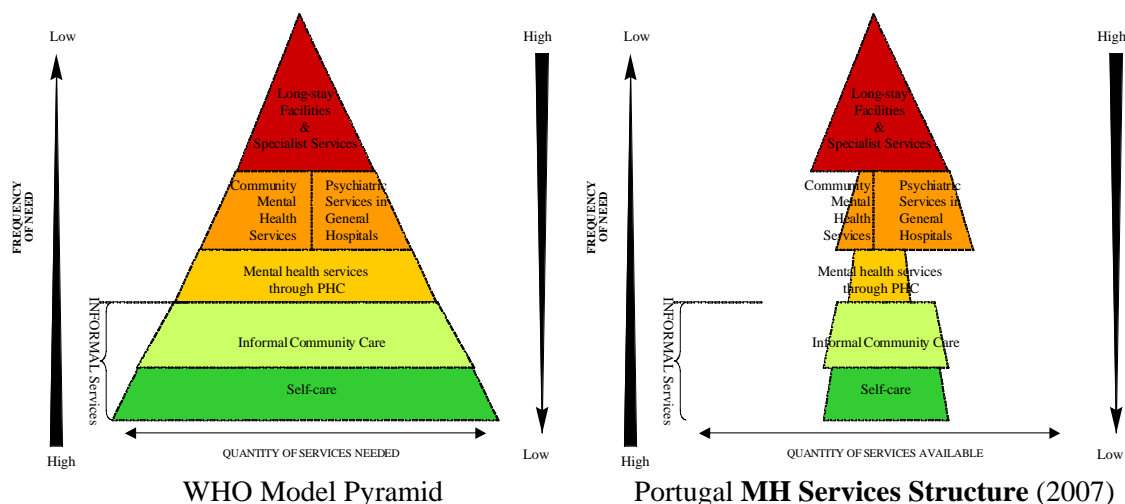
There is a high asymmetry in the human resources distribution with a high concentration of psychiatrists in the 3 major cities of Portugal and a discrepancy of distribution in Mental Health Services belonging to General Hospitals (1.1/25.000) compared to Psychiatric Hospitals (2.6/25.000). This situation is difficult to justify given that only 24% of the total patients were treated in psychiatric hospitals and 71% of consultations were carried out in general hospitals.

No incentives are currently provided to retain mental health workers in needed areas.

Table 1: Training and work for mental health professionals in Portugal

Human Resources	Training available in Portugal		Currently working in Portugal	
	Degree courses	CPD ⁵	Density (per 100,000 population) ⁶	Number currently working in mental health ⁷
Mental Health workers				
■ Psychiatrists	Yes (5 years)*	Yes	5.6	556
■ Child Psychiatrists	Yes (5 years)*	Yes	1.1	103
■ Neurosurgeons	Yes (6 years)*	Yes	--	--
■ Neurologists	Yes (5 years)*	Yes	--	--
■ Psychiatric nurses	Yes (+2 years)	Yes	13.2	1302
■ Psychologists	Yes (5 years)	Yes	2.3	226
■ Occupational therapists	Yes (4 years)	Yes	0.6	59
■ Social workers	Yes (4 years)	Yes	1.1	108
General Health Workers				
► Physicians	Yes (6 years)	Yes	350	39
► Nurses ⁸	Yes (4 years)	Yes	517	--
► Pharmacists ⁹	Yes (4 years)	Yes	90.1	--

➡ Mental Health Facilities and Services


Figure 11: The global shape of mental health services: WHO Model vs Portugal

⁵ Continuing Professional Development.

⁶ Source: National Mental Health Report 2007 <http://www.acs.min-saude.pt/2008/01/18/plano-accao-servicos-de-saude-mental?r=771>

⁷ Source: National Mental Health Report 2007 <http://www.acs.min-saude.pt/2008/01/18/plano-accao-servicos-de-saude-mental?r=771>

⁸ Annual Report of the National Nurses Association. (2007).

⁹ Reported by the National Pharmacists Association.

* After Medical Graduation.

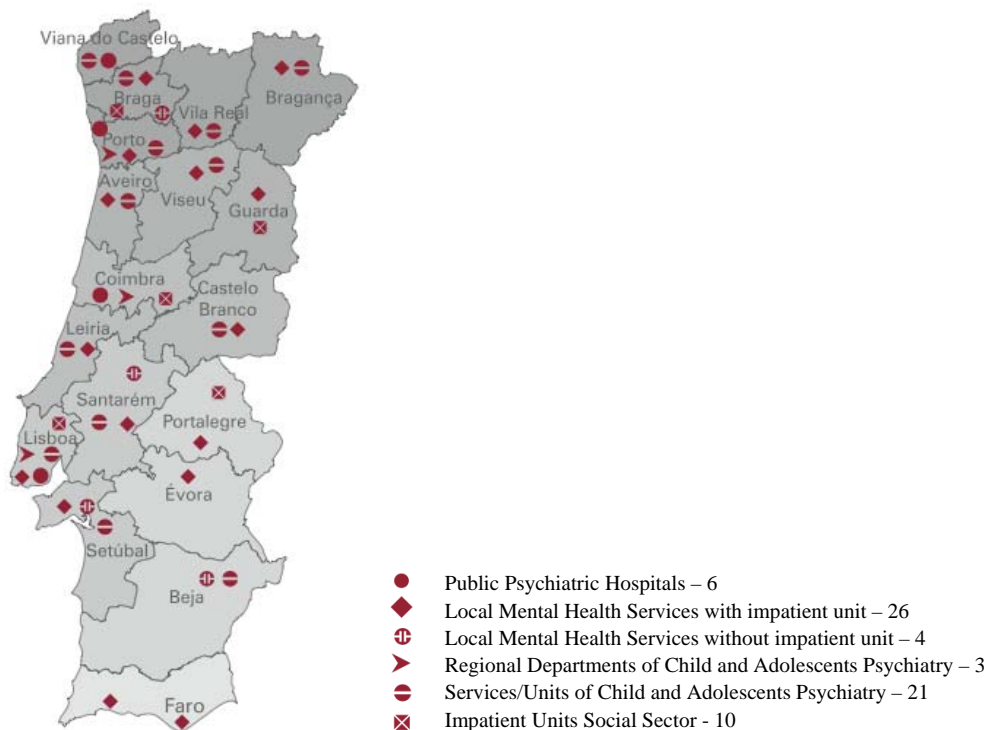


Figure 12: Mapping of the main Mental Health Facilities and Services in Portugal (National Mental Health Policy and Plan2007)

Description of services at each level of care

▪ Long Staying Facilities & Specialist Services (2005 data)

In Portugal there are in 6 Public Psychiatric Hospitals, 1 in Porto, 2 in Lisbon and 3 in Coimbra, with a total of 1.713 beds available. Of these beds 1109 are for long-term inpatients and 604 are for acute patients. They are responsible for catchment areas with a total population of 2.222.618 (39.929 patients¹⁰). There are 7.945 patients followed in Child and Adolescent Psychiatry specialized services. In 2005, the total adult outpatient attendances was 157.248 and the admissions to inpatient units was 8.250. There were also 70.417 people in attendance at day-hospital sessions. The occupancy rate was 63% for acute patients and 79% for long-term patients. Of the total number of people receiving treatment and care (168.369 people – 1.7% of total population) only 24% attended facilities in psychiatric hospitals (first attendance rate: 9%).

¹⁰ Doesn't include information from 1 Psychiatric Hospital.

As an example, one psychiatric hospital has both an inpatient unit with 164 beds (with 2,940 inpatient episodes/year), and outpatient services. The total staff for these services include 40 psychiatrists, 20 psychiatry residents, 119 nurses, 5 occupational therapists, 12 psychologists and 11 social workers, assisting a population of about 600.000.

A typical outpatient service in a psychiatric hospital provides treatment and care (including consultation, medication, psychotherapy and family intervention) for people with severe and mild psychiatric conditions (49,000 outpatient episodes/year, i.e., 196/day)

Concerning the structure of mental health teams, most services continue to rely on a small number of psychologists, nurses, social workers, occupational therapists and other non-medical professionals, focused on the traditional model of psychiatric inpatient units.

The quality of services, according to the assessment made with the WHO evaluation tools, lies at a level below 'reasonable'. In comparison with the inpatient units, the quality of outpatient services is even lower.

The areas of quality requiring particular attention relate to human resources (provision, distribution, interdisciplinary composition of the staff) as well as to administrative organization. Source: (National Mental Health Plan <http://www.acs.min-saude.pt/2008/01/18/plano-accao-servicos-de-saude-mental?r=1218>)

■ Psychiatric Services in General Hospitals (2005 data)

Portugal (Mainland) has 30 Local Mental Health Services belonging to general hospitals (of these, 26 have inpatient units and 4 do not), with a total of 1010 beds available. Of these beds 255 are for long-term inpatients and 755 are for acute. These services are responsible for catchment areas of a total population of 7,646,725 (118,838 patients¹¹)¹².

A typical **inpatient** service in a general hospital in Portugal has 400 inpatients per year. Staff typically includes 2 psychiatrists, 2 psychiatry residents, 30 nurses, 1 occupational therapists and 1 psychologist. The number of psychiatrists working in the university hospitals (Oporto, Lisbon and Coimbra) is much higher.

¹¹ Doesn't include information from 4 General Hospitals.

¹² The total adult outpatient attendances in 2005 was 350.935. Child and adolescent outpatient attendances were 34.266. Admissions to inpatient units were 11.233. There were also 48.124 day-hospital sessions and 62.360 emergency-room admissions. The occupancy rate was 81% for acute patients and 88% for long-term patients (first attendances rate in Mental Health Services in General Hospitals: 12%).

A typical **outpatient** service in a general hospital provides treatment and care (including consultation, medication, psychotherapy, family intervention and home visits) for people with severe and mild psychiatric disorders (12.000 contacts/year).

The majority of resources continue to be concentrated in Lisbon, Oporto and Coimbra. Services created in various parts of the country, with excellent facilities, only operate partially, and in some cases there are units still to be opened, as it has been not possible to secure staff, who still remain concentrated in hospitals in major urban centres.

Many local mental health services still revolve around hospitalization, outpatient clinics and, sometimes, day hospital, as there are no community mental healthcare teams to take on integrated case management, crisis intervention and programs for families.

■ **Community Mental Health Services**

Currently there are no formal community mental health services in Portugal. Prior to 1992 there were Community Mental Health Centres in all Portuguese Districts, but the funds for these have since been absorbed into the General Hospitals, and have consequently lost their functional and financial autonomy, thus no longer offering a full range of mental health services.

Hospitalization continues to eat up the majority of resources (83%), while all scientific evidence shows that interventions in the community, closer to people's homes, are much more effective and acceptable to people with mental health problems and their families.

■ **Mental Health Services through Primary Health Care**

Despite the fact that there is no data available about treated prevalence, family doctors provide care to people with common mental health disorders (i.e. depression, anxiety).

Several local mental health services belonging to general hospitals deliver outpatient care in the Primary Health Care Centres (PHCCs).

In Portugal there is still a total of 7 full-time psychiatrists working in PHCCs. These professionals belong to the PHCC, and are independent from the LMHS. They just provide care to people with common mental disorders, and their places will be extinguished after their retirement.

■ **Informal Community Care / NGOs**

Portugal has seen a major increase in the number of NGOs working in the area of mental health since the 1990's. There are 62 organizations which include Consumer (3%), family (13%), mental health worker (30%) and mixed groups (ie. involving each of the above-mentioned groups) (54%).

The main activities of these NGOs include:

- Involvement in policy making (42%)
- Advocacy for Patient's rights (76%)
- Public Awareness raising/ Information dissemination (68%)
- Promoting cooperation and partnerships (78%)
- Supported Employment (76%): The cooperation with the Portuguese Public Employment Services which began in the early 90's allowed NGOs to substantially invest in this area, which still today represents the most significant activity of the majority of these organizations. Supported employment includes professional training, help in seeking employment and support for employees. The government does not directly support the NGOs but gives financial support to companies that employ people with mental health problems. The government also gives support for supported residences and Social Occupational Units.

Source:

http://portal.iefp.pt/portal/page?_pageid=297,1&_dad=gov_portal_iefp&_schema=GOV_PORTAL_IEFP

Other current important interventions by NGOs include social support, counseling, individualized support, family support, social skills training, leisure and occupational activities. Areas that have not received as significant attention, so far, include legal support, SOS lines, and support in the area of housing.

However, this situation is about to change. The recently established of the National Programme of Integrated Continuous Care (a joint venture between Ministry of Labour and Social Solidarity and of the Ministry of Health) aims to offer integrated services to all patients suffering from (non-mental health related) chronic illnesses and disability who have health and social needs. In the near future the National Programme will also incorporate integrated services for people with severe mental illness or psychosocial disability, particularly for those who cannot live independently. A major focus will be on housing.

Currently, there are 54 community programmes/structures managed by NGOs and financially supported by the government, with a capacity for 992 people. The number of human resources involved in these community services is 547. The community structures and residential facilities are organized in five typologies (proportion of these different structures in brackets) :

- 1 - Full Supported Residences (9%)
- 2 - Medium Supported Residences (10%)
- 3 - Low Supported Residences (3%)
- 4 - Social-Occupational Units (62%)
- 5 - Self-Help Groups (16%)

The National Coordination Body for Mental Health is working, in partnership with the Task Force for Integrated Continuity of Care - Ministry of Labour and Social Solidarity, to increase the network of residential structures for people with mental disorders.

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Appendix 1

Key Elements of the Mental Health Policy and Law (2007-2016)

The Mental Health Policy and Plan document aims to define strategies that promote the organization of services proposed by mental health law. These include:

- 1) Development of the national network of local mental health services (LMHS) and determine the type of care to be provided by these services, eg. establishing links with primary care and support for common mental disorders; creating support programme for elderly patients and prevention programme in the areas of depression and suicide.
- 2) Development of services and programmes for the recovery and deinstitutionalization of the Seriously Mentally Ill The aim of this strategy (involving a partnership with Ministry of Labour and Social Solidarity and of the Ministry of Health) is to provide integrated continuous care to people with severe mental illness who cannot operate independently. This care will be delivered through case management by qualified therapists; convalescence units; residential units (Centres for Independence Training, Full Support, Intermediate Support and Minimum Support); social Integration Units; and home care support teams
- 3) Development of Regional Mental Health Services (RMHS) needed to complement Local Services in specific areas;
- 4) Coordination of the restructuring of psychiatric hospitals to ensure that responses currently assured by these hospitals are transferred to other services.

Specific Programmes

Forensic patients. Mental health care for forensic patients is provided by three services (Lisbon, Oporto and Coimbra). Future operations in this area are currently being determined in negotiations between the Ministries of Justice and of Health. A Mental Health and Justice Taskforce focuses on a number of issues including mental healthcare provision for convicted forensic patients and other persons with mental illness within the judicial system such as children and adolescents.

Care for vulnerable groups: The homeless as well as victims of violence are a particular focus in relation to the provision of care for vulnerable groups. Mental health programmes for the homeless are being developed by responsible teams within Local Mental Health Services (LMHS). In collaboration with the Commission for Citizenship and Gender Equity the LMHS are developing projects in the area of domestic violence.

Prevention programmes for depression, anxiety and suicide: These programmes include telephone help lines for people living in isolation, as well as strategies involving restriction of access to common methods of suicide..

Programmes for early childhood. These programmes include prenatal counseling, early intervention, parental training, prevention of domestic violence and infant abuse, family intervention and conflict resolution.

Education programmes on mental health at school age: These programmes include raising awareness among teachers, prevention of youth violence, counseling for children and adolescents with specific problems, prevention of drug abuse, personal and social development programmes, prevention of suicide and eating disorders.
