Country profile Region of Murcia, Spain

Community mental health networks: key facts and national priorities

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Content

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Introduction

The EU co-funded "Joint Action on the implementation of best practices in the area of mental health", short JA ImpleMENTAL has a duration of 3 years, from October 2021 to September 2024. Detailed information can be found on the JA ImpleMENTAL project website (ja-implemental.eu). It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas:

- mental health reform (promotion of community-based health services) and
- suicide prevention.

Two national best practices, the Belgian mental health reform and the Austrian SUPRA suicide prevention programme serve as best practice examples. Selected components of these are to be prioritised and implemented in the course of JA in 14, i.e. 17 participating EU countries. JA ImpleMENTAL comprises 6 Work Packages (WP), four horizontal WPS and one for each best practice. WP5 on community-based mental health care aims to implement elements of the Belgian mental health reform, which is based on the principle of deinstitutionalisation, i.e. the transition from care provided mainly in institutions to community-based care to improve mental health outcomes and quality of life and avoid unnecessary hospitalisations. In addition, the reform is based on the principles of rehabilitation and inclusion, de-categorisation, i.e. multi-sectoral cooperation, strengthening hospital-based care to shorten stays but with more intensive treatment, and the principle of consolidation, providing funds for pilot projects.

This country profile is one of the main outcomes of the JA, and presents key data on the national and local mental health system. It summarises the results of the recent situation analysis and needs assessment (SANA), lists lessons learned, recommendations, challenges and opportunities, and describes the next steps needed to scale up and promote national/regional community-based mental health care services. The country profile provides a basis for strategy formulation, decision-making and engagement.

This country profile is based on a two-part situation analysis and a subsequent needs assessment. For the situation analysis, WP5 has developed two questionnaires, one for the situation analysis regarding to the overall health system and community-based mental health care at national level, and one for the analysis at implementation level. After data collection, countries conducted a SWOT analysis to assess needs in terms of community-based mental health care.

For SANA, part 2, a comparative study has been carried out between the population of the Region of Murcia and the country.

1 Situation Analysis (SA)

1.1 Country, National Health and Social System

Spain includes most of the Iberian Peninsula and is a unitary state made up of 17 autonomous communities (CCAA) and 2 autonomous cities (Ceuta and Melilla) with varying degrees of autonomy.

Our country is located in the southwest of Europe, with archipelagos in the Atlantic Ocean (Canary Islands) and the Mediterranean Sea (Balearic Islands), and has common borders with France, Andorra, Portugal and Morocco. Madrid is the capital of Spain and is the largest city in the country. The

population of Spain is 47,432,805 (year 2022 Eurostat) (1) and occupies an area of 505,370 km2. Spain is the fourth most populous country in the European Union.

Table 1: Population structure: year, expressed as number of persons, by age and sex (2)

	Sex		
Age group	male	female	**total**
<18	4,195,508	3,941,858	8,137,364
18 - 64	14,892,156	14,876,022	29,768,176
65+	4,149,336	5,377,929	9,527,265
Total	**23,236,999**	**24,195,806**	**47,432,805**

In 2021, Spain has got a regressive population pyramid, with a narrower base than the central area and a significant percentage of older people. It is a pyramid typical of developed countries, with low birth and death rates and very low natural growth. Healthy life expectancy at birth is 77.6 years and 17 years at age 65 (year 2020) (3). A total of 27.8% of the population is at risk of poverty and exclusion (1), with a Gini coefficient (income inequality) of 33 (4). Total health expenditure in relation to GDP is 10.71% (5).

The National Health System (NHS) (6) is made up of a set of health services that depend on the public authorities. It is a system coordinated between the Health Services of the State Administration and the Autonomous Regions. According to Article 43 of the Spanish Constitution, all Spanish citizens have the right to receive public health care (7). The NHS is regulated by the General Health Act of 1986, which establishes public, universal and free financing and guarantees equity of access to health care (8). There are two levels of care coordinated with each other: a first level of primary care and a second level of specialised and hospital care.

The competences in health and social services are transferred to the autonomous regions, so that each region manages its own budget and the organisation of health and social services.

The Ministry of Health retains the authority to plan, promote and evaluate health strategies and general social services policies.

In health, the Constitution and the general health law provide the national regulatory framework, while in social services it is the law on dependency that regulates most of the general resources (in addition to regional and local ones).

1.2 Mental Health System at national level

Mental health care in Spain includes the diagnosis and clinical monitoring of people with mental disorders, psychopharmacotherapy, individual, group or family psychotherapies (excluding psychoanalysis and hypnosis), electroconvulsive therapy and, where appropriate, hospitalization. It shall also guarantee the necessary continuity of care, including: preventive and promotional actions, treatment of chronic mental disorders and their comprehensive care, addictive behaviours (including alcoholism and gambling), psychopathological disorders in childhood/adolescence, mental health disorders derived from situations of risk or social exclusion, and information and counselling for the people linked to the patient, especially the main carer (9).

The new NHS Mental Health Strategy (2022-2026) (10) is accompanied by a Mental Health Action Plan (2022-2024) which will be co-financed by the Autonomous Regions and the Ministry of Health and has a budget of 100 million euros over 3 years.

Total expenditure data on specialised mental health care in Spain for the NHS for 2017 is close to 4% of total specialised care expenditure (table 2).

Table 2. Expenditure on mental health care in NHS hospitals, Spain. Year 2017

	Expenditure on care mental health in hospitals	Total expenditure on care specialising in hospitals	% of total
Acute hospitals	945,452,666	38,806,337,865	2.44 %
Medium and large hospitals long stay**	14,195,519	742,650,465	1.91 %
Health hospitals mental health and drug addiction	521,133,334	521,133,334	100 %
Total	1,480,781,519	40,070,121,664	3.70 %

*Calculated based on the cost per hospital process in the NHS (Minimum Basic Data Set (MBDS)) for hospitalisation and using UPA cost for outpatient and day hospital activity.
**Calculated using the estimated UPA cost for stays, day hospital and psychiatric consultations plus the estimated percentage of emergencies (proportional to other modalities).
Source: Ministry of Health. Specialised Care Information System (SCIS). MBDS (11)

Although it is a goal of most of the autonomous communities, to date there are no official data on involuntary admissions to psychiatric units.

In Spain, Mental Health Centres are outpatient care resources for the care of psychiatric patients in a specific geographical area (catchment area), made up of teams of psychiatrists, clinical psychologists, social workers and nursing staff. They are integrated within the care circuit, articulated with the rest of the devices and establishing a system of coordination that enables the continuity of care of the user's therapeutic plan as well as the recovery and social integration of the user in the community. They also support primary health care through disease prevention programmes.

Table 3: Facilities, number of beds and hospital admissions related to mental health, latest available year (2021)

Indicator at national level		number	rate per 100.000 adult/minor population
Mental health hospitals	Facilities	92	0.234
	Beds	12,014	30.57
	Admissions	4,486	11.41
Psychiatric wards/units in general hospitals	Wards/units*	150	-
	Beds	5,132	13.06
	Admissions	79,491	202.29
Mental health inpatient facilities specifically for children and adolescents	Facilities	-	-
	Beds	-	-
	Admissions**	9,898	10.84

*Source: SCIS, year 2021, public and private hospitals. Number of general hospitals with inpatient activity in the speciality of psychiatry.
**Source RAE-CMBD, year 2021, public and private hospitals; age: 0-19 years
- There are no published national registers

1.3 Population profile in pilot area

The Region of Murcia has a population of 1,531,140 people, 50% (764,852) of whom are men[1]. The population density is 135.4 inhabitants per square kilometre, with more than half of its inhabitants concentrated in the municipalities of Murcia, Cartagena and Lorca[2]. Of this population, 80.8%, i.e. 1,236,539 people, are over 18 years of age, of which 622,504 are women (50.3%). The Gross Domestic Product (GDP per capita) is 21,236 euros[3].

According to the Labour Force Survey, the temporary employment rate in 2022 was 22.9%[4], with an average net annual income of 27,027 euros (for the same year in Spain it was 30,552), a risk of poverty or social exclusion (AROPE indicator) of 33.8 (in Spain 27.8) and an unemployment rate of 13.5% (13.2 in Spain), 32.78% in people under 24 years of age (29.2% in Spain) In 2020, 153,700 people had the disability recognised by chronic illness. Of these, 69,400 men (♂), 7,900 cases had a diagnosis of schizophrenia (4,700 ♂)[5],100 bipolar disorder (3,000 ♀), 27,500 chronic depression (19,400 ♀), 22,900 chronic anxiety (15,500 ♀) and 4,700 autistic spectrum disorder (3,400 ♂)[3]. Alcohol consumption is high 81.1% population (Murcia) vs. 76.4% (Spain) including binge drinking (24.6% vs. 12.6%). Regarding other drugs[6] , the prevalence in Murcia of hypnosedative use, with or without prescription, among the population aged 15-64 years, in the last 12 months, is the highest in Spain at 19.6% (16% the Spanish average). The prevalence of lifetime use of opioid analgesics (24.2%) is also among the highest in the country.

Overall, the total number of patients seen by the Mental Health Network has grown in the last 4 years, reaching 75,072 in 2022 (13.2% more than in 2018), 9.3% of mental health patients have Serious Mental Illness (SMI) (17,000 in 2022).

1.4 Community-based mental health care at pilot level

Mental health care in Murcia depends primarily on the Regional Ministry of Health, which manages it through the "Servicio Murciano de Salud" (SMS). Specifically, there is a network of general health resources (primary and specialised care) and mental health resources, both outpatient (including rehabilitation resources) and inpatient (partial or total short or medium stay hospitalisation). On the other hand, the Regional Ministry of Social Policy, Families and Equality (RMPFE) manages the social services resources, which are also organised according to a logic of primary and specialised care. Finally, the Instituto Murciano de Acción Social (IMAS), which also depends on the RMPFE, manages the specific resources aimed at: the elderly, the disabled, the chronically mentally ill, those at risk of social exclusion or any other group requiring social protection. The resources dependent on the SMS are free of charge while those related to the IMAS may have a co-payment and are linked to the official recognition of "Dependency"[7]. Despite the individual strengths of these two systems (Health and Social

[1] Source: National Institute of Statistics. Population by communities, age (five-year age groups), Spaniards/Foreigners, Sex and Year (ine.es).

[2] Source: Murcia Regional Statistics Centre. CREM - POPULATION STRUCTURE AND DEMOGRAPHIC INDICATORS - 4. Municipal Register of Inhabitants. Evolution of the population by municipality, by sex (carm.es).

[3] Source: National Statistics Institute. Spanish Regional Accounts. SRA. Series 2000-2021

[4] Source: National Institute of Statistics. Labour Force Survey. EPA. Fourth quarter 2022

[5] Centro Regional de Estadística de Murcia. CREM

[6] Spanish Observatory on Drugs and Addictions. Statistics 2021. Alcohol, tobacco and illegal drugs in Spain. Madrid: Ministry of Health. Government Delegation for the National Plan on Drugs; 2021. 213 p

7 BOE-A-2006-21990 Ley 39/2006, de 14 de diciembre, de Promoción de la Autonomía Personal y Atención a las personas en situación de dependencia, from https://www.boe.es/buscar/act.php?id=BOE-A-2006-21990

Services), in most cases, the responses are partial, punctual, without a method of continuity, incomplete and untimely. This split logic in the responses has three particularly important effects on the lives of people with Serious Mental Illness/Addictions (SMI/A) and their families, and almost inevitably determines their fate. There is a lack of planning, delegation of responsibilities to families and/or carers, and a high risk of institutionalisation (this situation of vulnerability tends to be resolved immediately, through long-term institutionalisation processes in residential care homes).

In the Region of Murcia, community-based mental health care relies on the existence of a social-health network at the local level, institutional support, as well as strategic synergies with other services that share the same vision and mission in terms of attention to people with Serious Mental Disorder and/or Addictions (TMG/A). Regarding intersectoral collaboration, there is the Sociosanitary Coordination Protocol for people with SMI/D[8]. A structure that tries to solve the gap in care between the social and health systems, and which aims to guarantee care and continuity of care in this highly vulnerable population that is at risk of social exclusion. The Protocol (PSHC) aims to bridge the gap in care between the social and health systems, and to guarantee care and continuity of care for this vulnerable population at risk of social exclusion. In recent years, key initiatives and policies have been developed for Community Based Mental Health (CBMH) provision that have changed the way in which patients with SMI/A are supported: Law 8/2021, of 2 June[9], which reforms civil and procedural legislation to support people with disabilities in the exercise of their legal capacity, the improvement in the development of the protocol for socio-health coordination in SMI/A with the implementation in almost all the 9 health areas in Murcia, the review of agreements and contracts with local corporations, town councils and day centres, the improvement of the data collection system for people with mental illness Business Intelligence Portal (BIP) and PETRA), among others. In line with this, there is the National Mental Health Strategy 2022-2026 [10] and the "Strategy for the Improvement of Mental Health 2023-2026 of the CARM"[11] , which promote basic principles for comprehensive, multidisciplinary, intersectoral, person-centred care, promoting recovery and avoiding the risk of deinstitutionalisation. Regarding the human resources in mental health that the Region currently has, we mention that among the nursing professionals, we have 92 mental health (MH) specialists and 53 generalist nurses (total 145), although with years of experience working in the MH Network. Other professionals include two drug addiction doctors and a Euro-technician at work. The data for all Mental Health services include those of the Child and Adolescent Services.

According to the regional strategy for the improvement of mental health 2023 -2026, there is a forecast for the optimization of resources for the improvement of mental health care at the community level.

[8] https://www.murciasalud.es/recursos/ficheros/378704-protocolo.pd

9 https://www.boe.es/buscar/act.php?id=BOE-A-2021-9233

10https://www.sanidad.gob.es/organizacion/sns/planCalidadSNS/docs/saludmental/Ministerio_Sanidad_Estrategia_Salud_Mental_SNS_2022_2026.pdf

11 https://www.murciasalud.es/documents/20124/5088102/Estrategia+de+Mejora+Salud+Mental+2023-2026.pdf/6228343c-e908-c3c8-59d8-14cc3c8ef267?t=1679912457740

Table 4: Number of professionals in MH services

	In MH services (all)		In child and youth MH services (governmental and non-governmental service totals)	
	Total number	*Rate 1/10⁴*	*Total number*	
Psychiatrists	**158**	**1.0**		
Child psychiatrists			**27**	**0.9**
Mental health nurses	**145**	**0.9**	**26**	**0.9**
Psychologists	**132**	**0.9**	**18**	**0.6**
Social workers	**46**	**03**	**8**	**0.3**
Speech therapists	**0**	**0.0**	**0**	**0.0**
Occupational therapists	**38**	**0.2**	**4**	**0.1**
Others (e.g. school mental health focal points, art therapists, etc.)	**2**	**0.0**	**0**	**0.0**
Total	**521**	**3.4**	**83**	**2.8**

Mental Health services have been sectorised in relation to Primary Care services to facilitate coordination and a Joint Regional Mental Health-Primary Care Commission is to be created. However, some of the difficulties in coordination and with Social Services remain because each system uses a different and incompatible information system. However, they all send the Ministry of Health a Minimum Basic Data Set (MBDS) that compiles health data (including mental health) from all over the country.

Finally, currently more than 500 people with chronic mental illness stay in long-stay residences (dependent on IMAS) in the Region of Murcia.

2 Needs assessment (NA)

For the needs assessment process, a SWOT analysis (table 5) was carried out to reveal the facilitating factors and obstacles to be recognised in the implementation of the project. The joint implementation of the SWOT analysis made it possible to share a common vision and perception of the scenario in which the action will take place. Numerous meetings took place during the planning of the programme with the promoter group, and subsequently two specific meetings of the promoter group for the SWOT analysis.

Table 5: SWOT ANALYSIS

	STRENGTHS	WEAKNESSES
INTERNAL ANALYSIS	○ Social and health network constituted in areas of implementation and previous experience. ○ Implementation of the Socio-Health Coordination Protocol. ○ Previous training in networking within the framework of the implementation. ○ Institutional support from the Social and Health Directorate in the Mental Health Management and other entities at regional level. ○ Progress in computerised medical records. Design a computer support PETRA. ○ Mental Health Plan 2023-2026. Strategic lines. ○ Committed, trained and motivated professionals.	○ Lack of a census of Severe Mental Disorder and/or Addictions (SMI/A) and their needs. ○ Instability and overload of care in the workplaces of the professionals. ○ Insufficient funding. ○ Non-integrated computer information system. ○ Variability in clinical practice. ○ Low participation of the user and families in the recovery processes. ○ Difficulty in the continuity of care between devices. ○ Little culture of evaluation of results.
EXTERNAL ANALYSIS	○ Legislative support for the defence of autonomy, the development of social services and the defence of human rights. ○ Associative movement. First-person and family associations claiming the protection of rights. ○ New projects developed by different entities with the same target population. ○ Framework for collaboration with both public and private entities in the field of Mental Health with experience in SMI/A. ○ Greater social sensitivity towards Mental Health.	○ Fragmentation of the health and social services systems. ○ Model of care with high rates of institutionalisation. (High institutionalisation of people with SMI) ○ Stigma in SMI in the Community ○ Culture of care ”Fall on the family” ○ Uncertain future of economic sustainability. ○ Highly complex target population profile with multiple needs. ○ Numerous and complex administrative procedures. ○ Different sensitivities and predisposition towards cooperation in the multiple agents with which to coordinate.
	OPPORTUNITIES	**THREATS**

The proposed actions to counter the identified weaknesses and threats focus on:

- Identify a census of the target population with identification of needs and possible stratification to determine the intensity of the intervention.
- Unify the care model through training and the design of common tools.
- Create a catalogue of care resources at the service of the target population.
- Identify stable professionals in the teams who can offer continuity in the process.
- Prioritize the implementation of a computerized system for shared use by all the services involved in care that facilitates access and data sharing.
- Complete the implementation of the Socio-Health Coordination-SMD/A protocol in all the health areas of the Region of Murcia.
- Carry out a dissemination plan to reach and impact the largest number of people possible.
- Design of a simple and accessible evaluation plan.

3 Reflection on SANA results

Previous work has been carried out to support the implementation of the project, although there are still important issues to be resolved. The existence of a local social and healthcare network with a technical support team, as well as institutional backing, serve as a catalyst for the experience. Similarly, there are strategic synergies with other services that share the same vision and mission in terms of care for people with SMI/A.

The care network has consolidated resources that make it possible to offer alternative care. In addition, for access to information (and therefore for the evaluation and analysis of results), there has been considerable progress in computerised clinical records. The need for shared access by the different services involved in a case is noteworthy. In this sense, there is an incipient advance that may favour the coordination and evaluation of the programme of computer support (PETRA).

In terms of institutional, political, legislative and economic support, there are initiatives, strategies, laws and new sources of funding that support local initiatives and help to ensure the rights of people in vulnerable situations. It is an ethical and legal imperative that allows people with SMI/A to fully exercise their citizenship. In relation to the latter, the existence of associations in the first person and of families, demand that their fulfilment be guaranteed on the basis of co-responsibility.

Last but not least, the professionals, although they report work overload, are motivated to offer a real and comprehensive alternative to people with SMI/A.
The main barriers to the implementation of this project are:

- Fragmentation of services.
- Lack of resources to cover needs.
- SMI (Severe Mental Illness) Stigma in the Community
- Different information systems

4 Priorities

PRIORITIZED ACTIONS FOR PILOT IMPLEMENTATION

1st STRATEGIC AREA: Ensuring (strong) governance structures/mechanisms

o Sub-strategic area 1.1.: Governance conditions

a. *Mix of top-down approach (general orientation of the federal level) and bottom-up approach (use of networks/projects already existing at local level):* The methodological basis is the structure of the Social and Health Coordination Protocol for the care of people with Severe Mental Disorder/Addictions developed in the Region of Murcia, being the Base Social and Health Coordination Teams (EBCSS) the assistance axis on which the Project is based.
b. *Ensuring the legal framework and financial support*: Intersectoriality and networking are reinforced with the signing of collaboration agreements with the City Councils of each locality where the pilot project is being developed.
c. *Development of guidelines/protocols at the federal level*: design of networking and case management processes, resulting in a methodological document for the implementation of the pilot project.
d. *Development of guidelines/protocols at the federal level*: Design of PETRA guidelines.

e. *Existence of an expert coordination team at the regional level (ensures dialogue and feedback from all local implementation groups):* Formalization of a regional group for the implementation and follow-up of the Joint Action, with representatives from Health, Social Services, third sector, First Person representatives and family members.

o Sub-Strategic Area 1.2: Building (consolidating or expanding) and maintaining networks based on a cross-sectoral, multidisciplinary and recovery-oriented approach (at the pilot site).

a. *Establish cross-sectoral networks in the pilot site*:
   - Formalization of a local level Technical Group for implementation, monitoring and evaluation of the Joint Action.
   - Formalization of a small intersectoral and multiprofessional working group at each implementation site, responsible for supporting the care process.
   - Constitution of a multidisciplinary technical support team to provide support for the development of the Joint Action.

2nd STRATEGIC AREA: Development or transformation of MH services and interventions (incl. multidisciplinary approach)

o Sub-strategic area 2.1: Develop new (non-existing) OR transform/adapt existing MH services (incl. strengthening multidisciplinarity and improving the evidence base, quality, efficiency and continuity of services) in the areas of (five Belgian BP functions).

a. *Sharing information from various care systems*: it is intended, through the design and implementation of a shared computer system (PETRA), to have accessibility to information from all the agents involved in the case. In this way, data collection can be unified and its evaluation made possible.
b. *Intensive community treatment*: to establish community therapeutic accompaniment that provides comprehensive and integrated care through the figure of the "Care Referent", where the needs and support of each person assisted will be identified (transportation, training, scholarships, housing, food, etc...).

o Sub-Strategic Area 2.2: Develop/strengthen a human rights-based, user-centered approach to recovery in the delivery of services.

a. *Involvement of users/families in defining their Individualized Care Plan:* participation in each recovery process will be encouraged.
b. *Designation of a "Care Referent" as the user's individual contact person*: each person served will have the assignment of a professional to accompany in the construction and development of the inclusive life project.
c. *Definition and use of "Individual Care Plans":* this is the basic instrument that guarantees the coordinated, comprehensive and integrated action of the different protection systems (health, social services, education, labour, justice...). It is a process with a recovery and inclusive perspective, in the person's own environment, in which the person decides and participates, in which the significant aspects that he/she wants to improve and maintain are identified, including family and significant persons.
d. *Elaboration of the Mental Health Advance Decision Making Plan (PDA-SM):* a process of support and accompaniment created in the context of the therapeutic relationship, to obtain a consensual and advance action plan which, in situations of special vulnerability or transitory incapacity, takes into account the wishes of the user.

3rd STRATEGIC AREA 3: Comprehensive global stakeholder training program (in support of reform and cultural change in service delivery)

a. *Develop and implement training and capacity building for ALL relevant stakeholders (including training sessions, workshops, conferences, reflection days, seminars, thematic meetings, briefings, on-the-job training, overseas internships and coaching)*:
    - Provide training to direct care professionals on networking, recovery model and therapeutic accompaniment.
    - Training on the use of the shared computer system (PETRA).
    - Case supervision: we understand supervision in the context of the project as an analysis of professional practice. Supervision is carried out by a professional from outside the institution. It would therefore be a meta-work that is located at the interface between learning, training, education and support in an organization or institution. This makes it possible to generate reflection and facilitate the review of professional actions as well as spaces of contrast between the theoretical-conceptual framework and the daily practice of a work team.

4th STRATEGIC AREA: Continuous and intensive communication, information and awareness-raising among/to stakeholders and users (in support of reform and a culture of change)

a. *Internal communication, information and awareness raising (i.e. among stakeholders/partners)*: Dissemination at regional and local level of the project to all stakeholders (Health, Social Services, third sector, family associations...) through different means (days repots, dissemination, meetings, workshops...).
b. *External communication, information and awareness-raising (i.e. towards users and the general public):* Dissemination of the project to the general public.
c. *External communication, information and awareness-raising (i.e. towards users and the general public):* social awareness-raising and anti-stigma activities in the local area where the Joint Action is implemented.

5TH STRATEGIC AREA: Data collection, monitoring and evaluation

a. *Monitoring of the implementation process*: The progressive implementation of the good practice will be monitored through the Mental Health Information System at the regional level, the tools designed and the PETRA computer system.

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