Country Profile "**SPAIN**"

Suicide and Suicide Prevention: Key Facts and National Priorities

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1. Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL 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 (promoting community health services) and
- suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises 6 Work Packages (WPs), 4 horizontal WPs and one for each best practice. **WP6 on suicide prevention** aims to support improvement in knowledge and quality of suicide prevention services. Defined elements of SUPRA should be transferred and pilot implemented at national/regional level, suicide prevention strategies in participating countries developed i.e. revised.

The present country profile is one of the major deliverables of the JA, presenting national priorities for suicide prevention embedded in contextually relevant facts. It summarizes results of the national Situation and Needs Assessment (SANA), lists lessons learned, recommendations and prioritized measures for suicide prevention. It includes challenges and opportunities as well as outlining next steps necessary to scale-up i.e. promote national/regional suicide prevention activities. The country profile is a basis for strategy formulation, for decision-making and a declaration of commitment to suicide prevention.

2. Context

2.1 Country, Health and Social System

Spain includes most of the Iberian Peninsula and is a unitary state made up of 17 Autonomous Communities 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), it shares 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 (after Germany, France and Italy), and the fourth largest country on the European continent after Russia, Ukraine and France.

The Spanish economy suffered an 11% drop (GDP) in the 2020 Pandemic. This is the biggest collapse in activity in 85 years due to the restrictions imposed by the authorities to try to contain the spread of the coronavirus. It has suffered other important crises such as the oil crisis (1973), the devaluation of the peseta (1992-1993) and the Great Recession due to the "real estate bubble" (2008-2013).

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Table 1: Population structure (2022): 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 had 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 and 17 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 dependent on the public authorities. It is a system coordinated between the Health Services of the State Administration and the Autonomous Communities. 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 Law 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.

2.2 Mental Health System

Mental health care in Spain includes the diagnosis and clinical monitoring of mental disorders, psychopharmacotherapy, individual, group or family psychotherapies (excluding psychoanalysis and hypnosis), electroconvulsive therapy and, where appropriate, hospitalisation. 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 of childhood/adolescence, mental health disorders derived from situations of risk or social exclusion, and information and counselling to the people linked to the patient, especially the main caregiver [9].

The new NHS Mental Health Strategy (2022-2026) [10] is the result of a dialogue between health professionals, scientific societies, people with their own experience in mental health and family members through different organisations. Within the framework of the protection, promotion and respect for human rights as a response to issues related to mental health, the document incorporates new strategic lines, includes current recommendations on mental health, proposes objectives and the development of an evaluation system agreed with the Autonomous Communities, which will enable the scope of the strategy to be measured. It also includes an analysis of the impact of COVID-19 on mental health, with a special focus on the most vulnerable groups.

The strategy is accompanied by a Mental Health Action Plan (2022-2024) which will be co-financed by the Autonomous Communities and the Ministry of Health and has a budget of 100 million euros, through the General State Budget, of which approximately 80% will be distributed to the Autonomous Regions during the years 2022, 2023 and 2024. It consists of 6 strategic lines: reinforcement of human resources in mental health, optimisation of comprehensive mental health

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care in all areas of the NHS, raising awareness and combating the stigmatisation of people with mental health problems through campaigns and training, prevention, early detection and attention to suicidal behaviour, tackling mental health problems in contexts of greater vulnerability and prevention of addictive behaviour with and without substances [11].

The data on total expenditure on specialised mental health care in Spain for the NHS for 2017, estimated on the basis of different sources :Statistics on Specialised Care Centres and the Register of Specialized Health Care-The Minimum Basic Data Set (RSH-MBDS), are close to 4% of the total expenditure on specialised care. Table 2 shows the calculated data broken down by type of hospital [10]. 45,058 million euros in total costs of mental health problems (4.2 % of GDP), were divided into: 14,415 million euros in direct costs in health care, 12,318 million euros in direct costs in social security programmes and 18,325 million euros in indirect costs related to reduced labour productivity [12]. For income and housing, generic health supports are received, but not specific to mental health. For legal support, social care is only partially supported. Expenditure on mental health care in hospitals of the NHS in 2017 can be seen in Table 2.

Table 2. Expenditure on mental health care in NHS hospitals (2017)

	Expenditure on mental health care in hospitals	Total expenditure on specialised care in hospitals	% of total
Acute hospitals*	945.452.666	38.806.337.865	2,44 %
Medium and long stay hospitals**	14.195.519	742.650.465	1,91 %
Mental health and drug addiction hospitals	521.133.334	521.133.334	100 %
Total	1.480.781.519	40.070.121.664	3,70 %

* Calculated on the basis of the cost per hospital process in the NHS (RSH-MBDS) for hospitalisation and by latest annual forecast cost for outpatient and day hospital activity.
** Calculated using the estimated latest annual forecast cost for psychiatric stays, day hospital and consultations plus the estimated percentage of emergencies (proportional to other modalities).
Source: Ministry of Health. Specialised Care Information System (SIAE,*Sistema de Información de Atención Especializada*)/ RSH-MBDS [13]

On the other hand, data on the ratio of involuntary admissions to the total number of admissions to psychiatric units in general hospitals are not collected at the national level. No data are currently reported on the continuity of care of people discharged from hospitalisation for mental health problems, but most of the Autonomous Communities include it in clinical guidelines and it is part of the objectives of the procedures established for continuity of care in community mental health networks.

In Spain, Mental Health Centres are outpatient resources for the care of psychiatric patients in a specific geographical area (catchment area) [14]. It is one of the main establishments of the so-called Community Mental Health. The Mental Health Centre is made up of a multidisciplinary team such as psychiatrists, clinical psychologists, social workers and nursing staff. They are integrated and articulated within the care circuit, establishing a system of coordination that enables the continuity of care of the user's therapeutic plan. It also supports primary health care through disease prevention programmes.

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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	12014	30,57
	Admissions	4486	11,41
Psychiatric wards/units in general hospitals	Wards/units*	150	-
	Beds	5132	13,06
	Admissions	79491	202,29
Mental health inpatient facilities specifically for children and adolescents	Facilities	-	-
	Beds	-	-
	Admissions**	9898	10,84

*Source: SIAE , year 2021, public and private hospitals. Number of general hospitals with inpatient activity in the speciality of psychiatry.
**Source RSH-MBDS, year 2021, public and private hospitals; age: 0-19 years [14]
- There are no published national records

3. Suicide and Suicide Prevention

3.1 Situation Analysis (SA)

Figure 1: Suicide rate (2021): by age groups and sex [15].

Source: National Institute of Statistics (INE,2021 *Instituto Nacional de Estadistica*)

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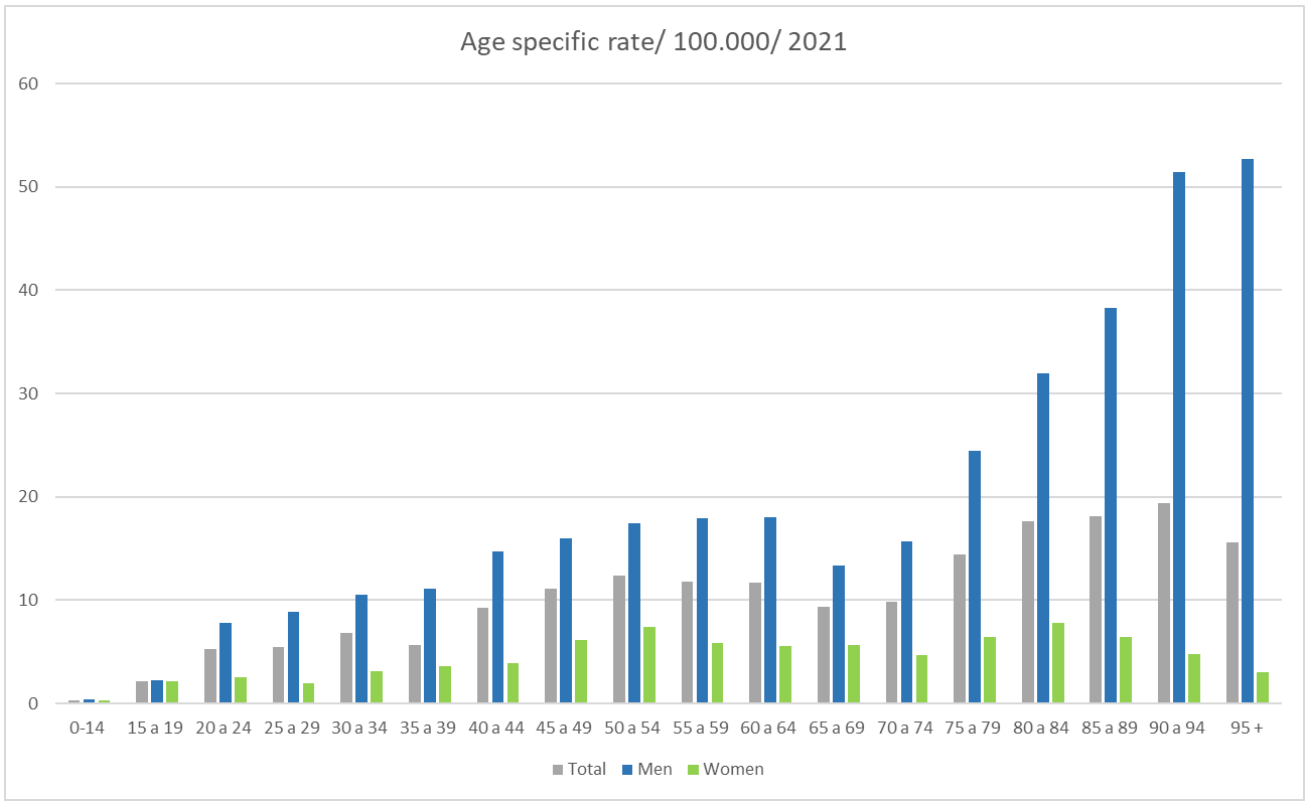
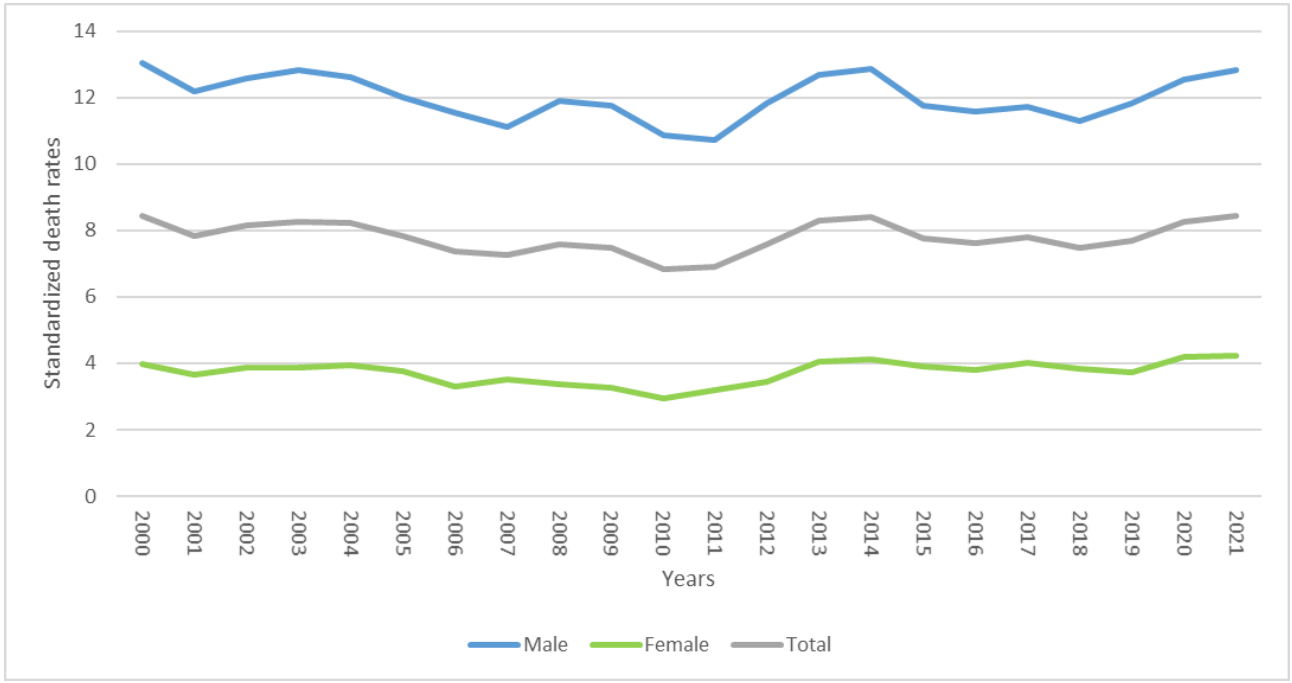


Figure 2. Suicide deaths trend, 2000-2021, by sex [16].

Source: INE 2022



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- In 2021, suicide remained the leading cause of external death, with 4003 deaths, 1.6% more than in 2020. The risk of suicide increases with age, especially in men, with the highest rates in men over 75 years of age (*Figure 1*). So far this century, the suicide mortality rate has shown a downward and fluctuating trend in the first decade, but an upward trend in the second decade (*Figure 2*). Between 2000 and 2020, the rate fell from 4.1 to 3.9 in women and from 14.6 to 12.5 in men. The decline is mainly due to the significant decrease observed in people aged 75 and over, as this is the age group with the highest suicide mortality rate with an increasing trend since 2018.

- INE issues quarterly, half-yearly or annual press releases to publicise the information in its database. Each year it issues a summary of deaths by cause of death and death rates, by age, sex and Autonomous Communities, including data on suicide [18]. The Spanish Foundation for Suicide Prevention in its observatory section and the National Platform for the Study and Prevention of Suicide also issues annual reports on the situation of suicide at national level and by Autonomous Community, with data from INE [19, 20].

Table 4: Most common methods of suicide: by age group and sex [20]

Sex/Age	0-15*	15-39	40-59	60-79	80+
Women	1.defenestration (X80) 2.hanging (X70)	1. hanging (X70) 2. defenestration (X80) 3. Poisoning other drugs, medicines (X64)	1. hanging (X70) 2. defenestration (X80) 3. Poisoning other drugs, medicines (X64)	1. defenestration (X80) 2. hanging (X70) 3. Poisoning other drugs, medicines (X64)	1. defenestration (X80) 2. hanging (X70) 3. drowning (X71)
Men	1.hanging (X70) 2.defenestration (X80) 3.Moving Object (X81)	1. hanging (X70) 2. defenestration (X80) 3. moving object (X81)	1. hanging (X70) 2. defenestration (X80) 3. poisoning sedatives, antiepileptics, psychotropics (X61)	1. hanging (X70) 2. defenestration (X80) 3. Weapon shot (X73)	1. hanging (X70) 2. defenestration (X80) 3. drowning (X71)

Source: : INE 2021

* The age range for data collection according to the Spanish INE is separated from the age of 15 years and not from the age of 19 years.

Historically, hanging is the most frequently used method of suicide (47.5%) according to INE 2021 (Table 4), followed by defenestration (24.68%) and in third place self-inflicted poisoning by drugs, medicines or psychotropic drugs. Separated by sex, in men, the most common method (52.95%) is hanging, secondly defenestration (21.2%) and in third place poisoning by other drugs, biological substances or psychotropic drugs (6.1%). In women it is jumping from a high place in 34.86%, followed by hanging and poisoning by biological substances and psychotropic drugs. It is noteworthy that in the age range over 80 years, drowning is the third most used method in both genders. With respect to age, the major differences between men and women are in the 15-39 age range, the third most used method in men is throwing at moving objects compared to poisoning in women, and in the 60-79 age range, the third most used method is shooting a firearm in men compared to poisoning in women.

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Groups most vulnerable to suicide:

As we observe in the statistical data, the differences between genders and by age, make adolescence and the elderly into groups of special vulnerability. According to groups of experts and associations of first-person users, severe mental disorder associated with stigma is a group of special vulnerability in our country. As we can see in *Box 1*, other categories at social level are unemployed, social exclusion, gender violence, drugs, prisons, etc.

One of the most important actions of the Ministry of Health for the suicide prevention action plan is the creation of a suicide register. As explained, the aim is to "develop accurate records of completed suicides with the necessary socio-demographic variables to identify vulnerable groups; and also a register and monitoring of risk factors leading to suicide" [10,11].

Box 1. Groups most vulnerable to suicide

Group 1 :Severe mental disorder

Group 2 according to INE 2021: children/adolescents and elderly, male sex.

Group 3 social: unemployed, risk of exclusion, immigrants, prisons, gender-based violence, conflicts, gender identity.

Group 4: suicide survivors, drugs

According to national expert groups and first-hand users the most common barriers are (*box 2*): help-seeking, lack of information, stigma and unfounded myths. Demand for services is a consistently perceived barrier. It is important to note that waiting times and difficulties in being referred to specialised services were the most commonly reported barriers by users in surveys conducted in some Autonomous Communities. Most of the studies reviewed highlight the consequences of lack of knowledge about seeking help (not knowing where or how to seek help). It is considered essential to ensure the flexible provision and availability of community services that facilitate help-seeking for patients and families (e.g. offering care services in schools and primary care centres).

Box 2. Most common barriers people face when seeking psychosocial help

Barrier 1 :Long waiting time for first mental health visit
Barrier 2 :Mental health stigma
Barrier 3 :Difficulty in continuity of care in mental health care
Barrier 4 :Unequal accessibility in areas and Autonomous Communities
Barrier 5 :Lack of knowledge and silence

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Table 5: Hospitalization due to self-harm: year (2021), by age group and sex (Number of contacts and rate per 10,000 inhabitants)*

	0-19		20-39		40-59		60-79		80+	
	N	rate	N	rate	N	rate	N	rate	N	rate
female	2173	4,92	1639	3,07	2493	3,33	903	1,77	219	1,21
male	393	0,83	1175	2,16	1863	2,50	673	1,49	273	2,54

*Number of contacts in hospitalisation in NHS and private centres. Contacts were selected from episodes with a primary or secondary diagnosis according to ICD10ES of the following categories:
- X71 to X83.
- Or from diagnoses: T36-T65 ending in 2A (intentional self-harm).
See codes at: https://eciemaps.mscbs.gob.es/ecieMaps/browser/index_10_mc.html
Source: Data obtained by the Ministry of Health through the RSH-MBDS [15].

Table 6: Most common methods of self-harm with or without a suicidal intent by age group and sex (2021)

Sex/Age	0-19	20-39	40-59	60-79	80+
female	1.Non-opioid analgesics, antipyretics and antirheumatics 2. Antiepileptics, sedative-hypnotics and antiparkinsonian drugs 3. Psychotropic drugs not elsewhere classified	1. Antiepileptics, sedative-hypnotics and antiparkinsonian drugs 2. Psychotropic drugs not elsewhere classified 3. Non-opioid analgesics, antipyretics and antirheumatics	1. Antiepileptics, sedative-hypnotics and antiparkinsonian drugs 2. Psychotropic drugs not elsewhere classified 3. Non-opioid analgesics, antipyretics and antirheumatics	1. Antiepileptics, sedative-hypnotics and antiparkinsonian drugs 2. Psychotropic drugs not elsewhere classified 3. Non-opioid analgesics, antipyretics and antirheumatics	1. Antiepileptics, sedative-hypnotics and antiparkinsonian drugs 2. Psychotropic drugs not elsewhere classified 3. Non-opioid analgesics, antipyretics and antirheumatics
male	1. Antiepileptics, sedative-hypnotics and antiparkinsonian drugs 2.Non-opioid analgesics, antipyretics and antirheumatics 3. Psychotropic drugs not elsewhere classified	1. Antiepileptics, sedative-hypnotics and antiparkinsonian drugs 2. Psychotropic drugs not elsewhere classified 3. Non-opioid analgesics, antipyretics and antirheumatics	1. Antiepileptics, sedative-hypnotics and antiparkinsonian drugs 2. Psychotropic drugs not elsewhere classified 3. Non-opioid analgesics, antipyretics and antirheumatics	1. Antiepileptics, sedative-hypnotics and antiparkinsonian drugs 2. Psychotropic drugs not elsewhere classified 3. Non-opioid analgesics, antipyretics and antirheumatics	1. Antiepileptics, sedative-hypnotics and antiparkinsonian drugs 2. Non-opioid analgesics, antipyretics and antirheumatics 3. Psychotropic drugs not elsewhere classified

Number of contacts in hospital in NHS and private centres in 2021. Contacts have been selected from episodes that have had a principal or secondary diagnosis according to ICD10ES of the following categories:
- X71 to X83.
- Or from diagnoses: T36-T65 ending in 2A (intentional self-harm).
See codes at: https://eciemaps.mscbs.gob.es/ecieMaps/browser/index_10_mc.html
Source: Data obtained by the Ministry of Health through the RSH-MBDS [15].

In 2022, the Ministry of Health launched the suicide hotline 024. It is a national suicide hotline, free, confidential and available 24 hours a day, 365 days a year. It is a telephone line to help people with suicidal thoughts, ideations or risk of suicidal behaviour, their families and relatives, through emotional support by means of active listening on the part of the professionals who attend to them without replacing the health professional [22].

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The national availability of psychosocial/psychiatric crisis services (0-24h) is the psychiatric emergency service in most general hospitals in Spain [23]. In case of an imminent life-threatening emergency, you can call directly to the emergency telephone 112/061 [24].

Continuity of care after an attempt at self-harm is an important pillar of the national suicide prevention strategy and is implemented in most of the Autonomous Communities. The aim is to ensure that patients at risk of suicide do not prematurely abandon treatment when moving from one device to another. In this context, the National Strategy wants to implement the Suicide Risk Code (SRC) and within the Joint Action WP6, there are 3 regions in Spain that already have SRC.

Another line of action is the training of primary care professionals and other community agents in the detection of risk and the therapeutic management of the clinical interview, as well as the identification of the main current and lifelong risk factors, the identification of warning signs and myths surrounding suicide and the criteria for the referral of patients with suicidal ideas from primary care to the different mental health services and facilitating the implementation of a coordination channel with social and mental health services for the prevention of suicidal behaviour. Guidelines have also been published on the prevention of self-harm in schools, which include a training plan for teachers on the prevention of such behaviour. Numerous associations of mentally ill people and their families provide training courses and workshops on the prevention and treatment of suicidal crises.

In the strategic plans of the Autonomous Communities, in addition to the strategic line of suicide prevention, the development of programmes for vulnerable groups is envisaged. Most of these programmes develop awareness-raising and dissemination activities on aspects related to the promotion of mental health, such as work on empowerment, participation and equality and support for the dissemination and implementation of actions to combat stigma, programmes to facilitate access to leisure, culture and nature, activities aimed at fostering employability and promoting full inclusion in the labour market, among others. There are also "Support for rehabilitation with mental illness" programmes in prisons where they are given the opportunity to participate in activities that favour the promotion of mental health and the prevention of exclusion. These programmes also work with associations of users and families of mental disorders at community or national level [25]. On the other hand, the Ministry of Equality works very actively for a society free of gender violence with programmes and strategic lines to be implemented in the different ministries [26]. An important step in Spain was the Law 8/2021 of 2 June on the reform of civil and procedural legislation to support people with disabilities in the exercise of their legal capacity under equal conditions of all human rights [27].

There are associations to help suicide survivors at Autonomous Community level, some of them pioneers, such as the Association of Survivors of Suicide of Catalonia (DSAS,*Después del Suicidio, Asociación de Supervivientes*), which was created in 2012 with the aim of creating a space for the accompaniment and support in the mourning of survivors of death by suicide. These associations have spread to more Autonomous Communities in Spain.

With regard to measures restricting the use of lethal means, there are: Royal Decree 2487/1998 and 2283/1985, which regulates the aptitude reports necessary to obtain licences, permits and weapons cards, Royal Legislative Decree 6/2015, of 30 October, which approves the revised text of the Law on Traffic, Circulation of Motor Vehicles and Road Safety, Royal Legislative Decree 1/2015, of 24 July, which approves the revised text of the Law on Guarantees and Rational Use of Medicines and Health Products. The texts can be found in the Official State Gazette (BOE, *Boletín oficial del estado*) [28].

At the level of social rights, the Autonomous Communities have passed Social Services laws, which must guarantee social services, promotion and social insertion. Primary care also includes emergency and urgent social programmes and care for sectors and groups with specific social problems

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(homeless people, drug addicts, etc). This set of services make up the Specialised Social Services, which constitute the second level of care.

In September 2020, on the occasion of World Suicide Prevention Day, the Ministry of Health published a guide of recommendations for the media. This document, agreed between information professionals and health professionals, aims to be a text to help those who have to transmit information about suicide. It includes the main recommendations and evidence on the subject [29].

Spain issues the Annual Report of the NHS, which aims to provide an overview of the state of health of the population and the functioning of the public health system, including brief data on suicide. The INE is mainly responsible for recording data on the causes of death in the population, with a special section on deaths by suicide (number, sex, ages, regions, method, rates), which are obtained from the records of the Legal and Forensic Medicine Institutions of the different Autonomous Communities. In the INE, the data on suicide has a lag of 2 years [30].

3.2 Needs Assessment (NA)

The National SWOT was conducted through the group of participating affiliated entities (Autonomous Communities of Andalusia, Catalonia, Madrid, Navarra and the Basque Country) led by the community of the Region of Murcia as the beneficiary entity. With the support of the Ministry of Health, other regions (Galicia, Extremadura, Balearic Islands, Asturias, Cantabria) joined the SWOT analysis on the basis of the guiding questions on Strengths, Weaknesses, Opportunities and Threats, and based on the review and investigation of the SANA results. The SWOT results are presented in Table 6.

Table 7: National SWOT Analysis

Strengths	Weaknesses/Needs
1. Mental Health National Strategy 2022-2026 2. Inter-regional collaboration 3. Ministerial support to link strategies at the national level. 4. Own budget for the Suicide Prevention Action Plan 5. Universal health care in primary care 6. Socio-sanitary coordination framework established in the Autonomous Communities	1. Lack of homogeneity in attention to suicidal behaviour and absence of a National Suicide Prevention Plan due to Territorial Model of Spain 2. Difficult access to good quality epidemiological data 3. Lack of research with a broad perspective on suicide prevention 4. Focus on indicated and selective prevention, with a lack of attention to universal prevention 5. Lack of postvention activities 6. Lack of human resources in mental health care and primary care 7. Little training and awareness about suicide among health professionals and other key stakeholders 8. Excess of prescription of psychoactive drugs and easy access to highly toxic drugs

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Opportunities	Threats
1. Suicide prevention as an international public health priority 2. Lines of funding in public policies on mental health and suicide prevention 3. Collaboration initiatives between European countries underway: JA Implemental with the participation of Spain through 6 Autonomous Communities. 4. International consensus on the public health approach to suicide prevention 5. Areas for improvement and courses of action identified and recommended by the WHO: information systems, access to the media and collaboration and community networks 6. Growing social and media interest and awareness of mental health and suicide prevention, especially after the pandemic 7. Associative movement involved	1. Lack of specific funding 2. Difficulty of coordination with the legal sphere 3. Insufficient socio-health resources 4. Inadequate treatment of information 5. Approach closely associated with mental health 6. Insufficient participation of non-institutional groups 7. Social determinants: loneliness, exclusion, supports

4. Reflection on SANA results

According to the results in Table 7, we have a wide margin for improvement with respect to suicide prevention in our country. In the absence of a National Suicide Prevention Plan in the medium term, each Autonomous Community must fit the suicide prevention line of the National Mental Health Strategy 2022-2026 into its economic and organisational resources, where a great disparity will arise with respect to the lines of implementation according to the needs analysis of each Autonomous Community. It should be remembered that health competences have been transferred to the Autonomous Communities and that many of them have already developed their own suicide prevention strategies, although the degree of implementation varies significantly from one region to another. Many of these approved strategies lack a specific budget, making their deployment very complicated.

One of the most important challenges is to obtain reliable and up-to-date data regarding deaths by suicide, suicide attempts and self-harm from various agencies including the Institutes of Legal Medicine and Forensic Medicine, the RSH-MBDS as well as non-official expert-led registries.
Inter-institutional coordination with sectors such as education, media, primary health care, social and health care resources, high vulnerability groups, employment and training are key as multi-causal models of suicidal behaviour are not relegated to the health care setting but to public health as highlighted by the WHO.

The improvement of the organisation of the mental health services themselves is noteworthy, and we will focus on developing the SRC in the participating communities as a pillar of the continuity of care for people who make self-harming attempts and whose point of entry is the emergency services of general hospitals. Catalonia is a pioneer community with experience in the implementation of SRC, which will serve as a guide for the lessons learned.

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Other areas of development would be oriented towards training, provision of financial resources for new lines of action and specialised staff, involvement of stakeholders, and programmes for awareness raising, social support, help for suicide survivors and the fight against stigma. Political changes are always present and can slow down progress. Box 3 shows the main lines of national implementation with the Quick Wins and by participating regions.

Box 3. Prioritized measures for National & Regional Implementation

OVERARCHING MEASURE: DRAFT STRATEGY FOR SUICIDE PREVENTION.

Strategic Area 1: Coordination and Organization

- Creation of JA ImpleMental working group on suicide prevention drafts a strategy for suicide prevention.
- Coordination of actions and cooperation with stakeholders including Ministry

Strategic Area 2: Support and treatment

- Gatekeeper training
  - REGIONAL QUICK WIN BASQUE COUNTRY: deployment of the "BIZI" suicide prevention training program for non-health professionals in the Basque Country.
  - REGIONAL QUICK WIN MADRID: training course in suicide prevention and early detection for health professionals.
  - REGIONAL QUICK WIN ANDALUSIA: training course on suicide prevention in the municipalities of the province of Cadiz.
- implementation of SRC in Autonomous Communities working in ImpleMENTAL.
  - Regional QUICK WIN Draw up a basic protocol to guarantee a homogeneous SRC procedure among all the Autonomous Communities working in Iimplemental.
- Postvention services
  - REGIONAL QUICK WIN CATALONIA (Lleida): Coordination with the territorial association of survivors to implement a programme for people who have lost a family member, close person or patient to suicide.

Strategic Area 3: Restriction of Means

- REGIONAL QUICK WIN CATALONIA: Update of the procedure for suicide prevention in an inpatient unit (Lleida)
- REGIONAL QUICK WIN MURCIA: Update of the procedure for suicide prevention in psychiatric units in the region.

Strategic Area 4: Awareness and Knowledge

- REGIONAL QUICK WIN MURCIA: update and dissemination of the murcia suicide prevention website

Strategic Area 6: Quality Assurance -Expertise and Databases

- Initiation of a working group (national JA ImpleMENTAL group, Ministry, RSH-CMBD) for the homogenisation of suicide attempt codes.
- REGIONAL QUICK WIN NAVARRA: improvement of the records of completed suicides in the Community of Navarra.

! Quick wins - easy to implement actions; not expensive, within the control of the team, have visible effects and animpact on high-risk groups

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5. Next steps

For strategic area 1: We will begin cooperation with the ministry in the review of a homogeneous database among the communities participating in the JA and create a working group to adapt the current national strategy to the SUPRA JA Implemental actions.

For strategic area 2:

- Quick Win: There are three communities that begin in May 2023 with the training of health professionals and professionals from other sectors in their respective regions.
- The Draft of a joint protocol for a suicide risk code at the national level led by the communities that represent the Spanish WP6, will be developed throughout 2023 and 2024.
- The beginning of the coordination with the Lleida regional suicide survivors association for the implementation of the care program will take place from June 2023 to November 2023.

For strategic area 3: Murcia and Lleida, the procedure will be updated to avoid deaths by suicide admitted to the psychiatric unit as a Quick Win action before November 2023.

Concerning strategic area 4: Quick Win: the Murcia region will carry out an update of the Murcia suicide prevention web page including updated information, resources on suicide prevention and taking actions to promote dissemination, awareness.

For strategic area 6: a working group will be formed, which will be made up of representatives of the Autonomous Communities that make up the Spanish National WP6, representatives of the Ministry of Health and members of the International Classification of Diseases (ICD) technical coding unit for the different diagnostic entities, in this case with suicide attempts. This measure will be carried out throughout 2024. The initial actions will be:

- Constitution of the working group for the homogeneity of diagnoses of suicide attempts in all the Autonomous Communities.
- Initiate the first steps on dialogues of feasible objectives.
- Collection of current codifications in the different Autonomous Communities to reach the same criteria
- Preparation of a list of ICD diagnoses on suicide attempts.
- Implementation in national registries.

As a Quick Win for strategic area 6, in the community of Navarra the records of death by suicide will also be developed and improved .

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6. References

1. Eurostat: Population on 1 January 2022 by age and sex [Web. Available]. [cited 2023 Mar 20]. Available from: https://ec.europa.eu/eurostat/cache/countryfacts/
2. National Institute of Statistics (INE): population residing in Spain, data from July 1, 2022 (Provisional).[Web]. Available from: https://www.ine.es/dyngs/INEbase/es/operacion.htm?c=Estadistica_C&cid=1254736176951&menu=ultiDatos&idp=1254735572981
3. Eurostat. Healthy life expectancy based on self-perceived health. 2020. Retrieved February 01, 2023. [Web]. Available from: https://ec.europa.eu/eurostat/databrowser/view/hlth_silc_17/default/table?lang=en
4. Eurostat. Gini coefficient of equivalent disposable income - EU-SILC survey. 2022. Retrieved April 14, 2023. [Web]. Available from: https://ec.europa.eu/eurostat/databrowser/view/ilc_di12/default/table?lang=en
5. Eurostat. Total health care expenditure. 2020. Retrieved April 14, 2023. [Web]. Available from https://ec.europa.eu/eurostat/databrowser/view/tps00207/default/table?lang=en
6. Ministry of Health: administrative organization and provision of services. Retrieved in March 2023. [Web]. Available from: https://www.sanidad.gob.es/home.htm
7. Spanish Constitution. State Agency Official State Gazette. Available from: https://www.boe.es/legislacion/documentos/ConstitucionCASTELLANO.pdf
8. General Health Law (Law 14/1986 of April 25) (BOE 102 of 4-25-1986). Ministry of Health. Madrid, 1986. Available from: https://www.boe.es/buscar/pdf/1986/BOE-A-1986-10499-consolidado.pdf
9. Ministry of Health: attention to mental health. 2023. [Web]. Available from: https://www.sanidad.gob.es/profesionales/prestacionesSanitarias/CarteraDeServicios/ContenidoCS/3AtencionEspecializada/AE-7-SaludMental.htm
10. Ministry of Health. Mental Health Strategy of the National Health System period 2022-2026. 2022. Available from: https://www.sanidad.gob.es/organizacion/sns/planCalidadSNS/docs/saludmental/Ministerio_Sanidad_Estrategia_Salud_Mental_SNS_2022_2026.pdf
11. Mental Health Action Plan 2022-2024. Mental Health Strategy of the National Health System 2022-2026. General Sub-directorate of Care Quality. General Directorate of Public Health. Ministry of Health 2022. Available from: https://www.sanidad.gob.es/organizacion/sns/planCalidadSNS/docs/saludmental/PLAN_ACCION_SALUD_MENTAL_2022-2024.pdf
12. OECD/EU (2018).Health at a Glance: Europe 2018: State of Health in the EU Cycle, OECD Publishing, Paris/EU, Brussels. Available from: https://doi.org/10.1787/health_glance_eur-2018-en
13. Ministry of Health. Statistical information on hospitals. Statistics of Specialized Care Health Centers. Specialized Care Information System (SIAE).[Web]. Available from: https://www.mscbs.gob.es/estadEstudios/estadisticas/estHospiInternado/inforAnual/homeESCRI.htm

Co-funded by the European Union's Health Programme
under Grant Agreement No. 01035969 /JA-02-2020 [HADEA]

14. Statistical Portal Register of Specialized Care Activity-RAE-CMBD. Ministry of Health. 2021. [Web] Available from: https://pestadistico.inteligenciadegestion.sanidad.gob.es/publicoSNS/S/rae-cmbd
15. National Statistics Institute (INE). Suicide rates by age and sex per 100,000 inhabitants of each group. [Web] Available from: https://www.ine.es/jaxi/Datos.htm?tpx=55324#!tabs-tabla
16. National Statistics Institute (INE). Statistics on Deaths by Cause of Death 2020. Available at: https://www.ine.es/dyngs/INEbase/es/operacion.htm?c=Estadistica_C&cid=1254736176780&menu=ultiDatos&idp=1254735573175
17. National Statistics Institute (INE). Deaths by Cause of Death Year 2021 (definitive data) and first semester 2022 (provisional data): press release. [Web]. Available from: https://www.ine.es/prensa/edcm_2021.pdf
18. Spanish Foundation for the Prevention of Suicide. Visited in April 2023. Available from: https://www.fsme.es/observatorio-del-suicidio/
19. National platform for the study and prevention of suicide. Visited in April 2023. Available from: https://www.plataformanacionalsuicidio.es/
20. National Statistics Institute (INE). Suicides by means of employee, sex and age. 2021. [Web]. Available at: https://www.ine.es/jaxi/Datos.htm?tpx=55318#!tabs-tabla
21. Ministry of Health: Line 024. Visited April 2023. [Web]. Available from https://www.sanidad.gob.es/linea024/home.htm
22. National Catalog of Hospitals. Ministry of Health. 2021. Available from: https://www.sanidad.gob.es/ciudadanos/prestaciones/centrosServiciosSNS/hospitales/docs/CNH_2022.pdf
23. Spain Mental Health Confederation. Visited in March 2023. [Web] https://consaludmental.org/.
24. Government Delegation against Gender Violence. Visited in April 2023. Available from: https://violenciagenero.igualdad.gob.es/
25. aw 8/2021, of June 2, which reforms civil and procedural legislation to support people with disabilities in the exercise of their legal capacity. Available from: https://www.boe.es/buscar/pdf/2021/BOE-A-2
26. Official state bulletin. Available at: https://www.boe.es/
27. Recommendations for the treatment of suicide by the media. Support manual for its professionals. Ministry of Health. 2020. Avalaible from: https://www.sanidad.gob.es/profesionales/excelencia/docs/MANUAL_APOYO_MMCC_SUICIDIO_04.pdf

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- Fundación para la Formación e Investigación Sanitarias de la Región de Murcia (FFIS)

- Servei Català de la Salut/Gestió de Serveis Sanitaris (CatSalut)

- Servicio Andaluz de Salud (SAS)

- Fundación Progreso y Salud (FPS)

- Servicio Navarro de Salud –Osasunbidea(SNS-O)

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- Servicio Madrileño de Salud (SERMAS)

- Servicio Vasco de Salud (Osakidezta)

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