Original

Humanization in mental health plans in Spain

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A R T I C L E   I N F O

A B S T R A C T

Introduction: Mental health (MH) care has important challenges, especially in the field of humanization. Our objectives were to identify the humanization measures in MH plans of the Spanish autonomous communities (AC) and the priorities to be developed in this area.
Material and methods: A large and multidisciplinary group of people involved in MH care participated in a consensus, according to a modified Delphi method, based on «design thinking», in three phases: (1) identification of humanization measures in MH plans of AC; (2) analysis of the implementation of these measures; and (3) identification of humanization priorities in MH.
Results: Fourteen of the 17 AC have current MH plans. They contained four types of humanization measures: (1) improvement of the quality of care; (2) promotion of user participation; (3) campaigns against stigma and discrimination; (4) caring for especially vulnerable people. Implementation of measures ranged from 6.3% (i.e.: specific budget) to 100%, with an average of 64.1%. We identified priority issues, operationalized in 5 proposals: (1) information campaigns; (2) multidisciplinary meeting forums; (3) platforms of support entities; (4) strategies on MH education; (5) humanization in study plans.

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Conclusions: Some MH plans include humanization among their objectives, but partially. The implementation of humanization proposals such as those identified in this study is essential to achieve a high-quality MH care.

Introduction

Psychiatric care in Spain has undergone significant changes in recent decades, both in terms of legislation and concept, with the purpose of establishing a model of care for people with mental health problems (MH), integrated into the social and healthcare network and guaranteeing care of equal quality and excellence to that provided to people with other health problems.[1]

Among the changes that have taken place in the care of MH problems in recent decades are the integration of psychiatry with the rest of medicine; improved knowledge of the pathophysiological bases of symptomatology; the discovery of genetic risk factors for different psychopathological dimensions and mental disorders; the integration of more effective and efficient psychotherapeutic techniques, and the development of safer and better tolerated drugs.[1,2]

María Moliner's "Dictionary of Spanish Use" defines "humanise" as: "to make something more humane, less cruel, less hard for mankind".[3] In the context of health and social-health care, humanisation implies an approach to the person with health problems as a person and not as a problem or illness, in terms of human quality, promoting empathy and a holistic approach.[4–7] Of course, MH must be included in this humanisation process. Humanisation is not restricted to healthcare professionals in contact with patients, but affects the culture of healthcare organisations, administration and healthcare policies.[4,5]

Humanisation is both in the spirit and the letter of the documents that underpin the framework of MH care, such as the UN Declaration of Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care,[8] the UN Convention on the Rights of Persons with Disabilities[9–11] or the World Health Organisation's Global Mental Health Action Plan 2013-2020 (according to which "regardless of age, gender, socio-economic status, ethnicity or sexual orientation, and in accordance with the principle of equity, people with mental disorders should be able to access, without risk of impoverishment, essential health and mental health care services that enable them to recover and enjoy the highest attainable standard of health"[12]).

However, despite this progress, there are still many challenges, especially in the field of humanisation of MH care, which the various MH plans and strategies, both at national and regional level, are attempting to resolve. In Spain, the latest National Health System (NHS) MS strategy is that of 2009-2013.[13] Currently, and after more than 8 years of fruitless work, a new NHS MS strategy "promoted under the basic principles of respect and autonomy and the recovery of the rights of people with MS problems"[14] is in the process of being drawn up. It is to be hoped that this new plan will prioritise the promotion of emotional well-being in all areas, promote the participation of people with SM problems and their families, taking into account their needs, expectations, experiences and relationship with the social environment, and highlight education for SM as a tool to combat any kind of stigmatisation. This is in line with international recommendations for the humanisation of MH care.

In this context, this study presents the results of a project guided and organised by the HUMANS Foundation, whose objectives were: 1) to identify, through expert consensus, which measures and actions related to humanisation are included in the MH plans of the Autonomous Communities (ACs) of Spain; 2) to analyse the implementation of humanisation measures and actions in each of the different MH plans and strategies of the ACs, and 3) to identify, through expert consensus, common and priority key points when designing and implementing a common and homogeneous strategy for quality and sustainable MH, which takes into account, above all, people with MH problems and their environment, and which provides the necessary and most appropriate resources for the promotion of their recovery.

Methods

The HUMANS Foundation promoted and developed this project between September 2018 and February 2019. The HUMANS Foundation is a foundation made up of leading professionals and institutions from the social and healthcare world, whose main objective is to facilitate humanisation processes in healthcare organisations, in professional attitudes and in the organisational processes of healthcare centres.

The working group of this project was made up of professionals in the field of MH, users of the MH network, patient and family associations, heads of institutions and politicians and social agents involved MH care throughout Spain. The project was developed in sequential phases in accordance with the following objectives

Firstly, the group of experts identified the measures and actions related to humanisation that are included in the different MH plans of the Autonomous Regions. This task included the analysis of the current situation of the Autonomous Regions' strategic MH plans in relation to the humanisation of healthcare. The collection of contributions from each expert was carried out using a modified Delphi method based on Design Thinking. Design Thinking is a process that focuses on solving the real needs of people, involving them in the solution from the beginning of the process by understanding their concerns and providing solutions adapted to the user.

Secondly, with the aim of analysing the implementation of humanisation measures and actions in the MH plans and strategies of the ACs, the heads of all the ACs were asked to complete a survey, agreed by the working group, on their perspective in relation to "humanisation in MH". The survey included the following questions (Table 1): 1) Does your Autonomous Community have an MH plan with a specific section on humanisation? 2) Is there a line or action plan on humanisation in the current MH plan of your AC?, 3) Does the word humanisation appear in the mission, vision or values in the current MH plan of your AC?, 4) Does your AC have specific budget items aimed at promoting the humanisation of MH care? 5) Does your Autonomous Community have a specific person in charge of the plan or actions related to the humanisation of MH care? 6) Does your Autonomous Community have training programmes aimed at training all health and non-health personnel in contact with people with mental illnesses on MH? 7) Does your C.A. include training programmes aimed at health professionals related to the humanisation of health care in MH? 8) Does your C.A. have any measures aimed at encouraging the participation of people with MH problems and their relatives/relations in the

Table 1
Perspectives on humanisation in MH: a survey of those responsible for MH plans in the Autonomous Regions.

Variable	No. Of ACs with affirmative answer, (% between given responses)	AND	ARA	AST	CAN	CANT	CAT	CLM	CyL	EXT	GAL	BI	LR	MAD	MUR	NAV	BC	VAL
1. MH Plan specific section on humanisation	9 (56,3)	Yes	No	No	Yes	No	Yes	Yes	N/C	No	Yes	Yes	Yes	Yes	No	No	No	Yes
2. Existence of a strategy or action plan on humanisation in the current MH plan.	13 (76,9)	Yes	No	No	Yes	Yes	Yes	Yes	N/C	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
3. Presence of the word humanisation in the mission, vision or values of the current MH plan.	5 (31,3)	No	No	No	No	No	No	Yes	N/C	No	No	Yes	Yes	Yes	No	Yes	No	No
4. Specific budget lines aimed at promoting the humanisation of health care in MH	1 (6,3)	No	No	No	No	No	No	No	N/C	No	No	No	No	Yes	No	No	No	No
5. Specific person(s) responsible for the plan or actions related to the humanisation of health care in MH	1 (6,3)	No	No	No	No	No	No	No	N/C	No	No	No	No	Yes	No	No	No	No
6. Training programmes aimed at the training of all health and non-health personnel in contact with people with mental illness on the MH plan.	16 (100)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/C	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7. Training programmes aimed at health professionals related to the humanisation of health care in the field of MH.	12 (85,7)	Yes	Yes	No	Yes	Yes	N/C	N/C	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/C	Yes	No
8. Measures aimed at encouraging the active participation of people with MH problems and their relatives/relations in service improvement plans.	16 (100)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/C	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9. Protocols/procedures/guidelines related to the humanisation of health and social care in MH.	4 (25,0)	No	No	No	No	No	No	No	N/C	No	No	Yes	No	Yes	No	Yes	Yes	No
10. Measures aimed at the establishment of ways to reduce the number of mechanical restraints.	14 (87,5)	Yes	Yes	Yes	Yes	Yes	Yes	N/C	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
11. Measures aimed at the promotion and encouragement of the rights of people with MH problems in therapeutic decisions.	10 (62,5)	Yes	No	Yes	No	No	Yes	No	N/C	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No
12. Arrangements for proper coordination between the judiciary and MH services.	7 (43,8)	No	No	Yes	Yes	Yes	No	Yes	N/C	No	No	No	No	Yes	Yes	No	Yes	No
13. Measures to facilitate the participation of people with MH problems and/or family members/relations in the design of initiatives related to the humanisation of MH.	12 (80,0)	Yes	No	No	Yes	Yes	Yes	Yes	N/C	No	N/C	Yes	Yes	Yes	Yes	Yes	Yes	Yes
14. Proposals for activities aimed at the attention and humanisation of care for people with mental illness who are particularly vulnerable and at high risk of social exclusion.	16 (100)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/C	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes
15. Measures aimed at reducing stigma towards people with MH problems.	16 (100)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/C	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

AND: Andalusia; ARA: Aragon; AST: Asturias; CAN: Canary islands; CANT: Cantabria; CAT: Catalonia; ACs: Autonomous Communities; CLM: Castilla-La Mancha; CyL: Castilla y León; EXT: Extremadura; GAL: Galicia; BI: Balearic Islands; LR: La Rioja; MAD: Community of Madrid; MUR: Murcia; NA: Navarra; N/C: no comment; BC: País Vasco; MH: Mental health; VAL: Community of Valencia.

plans for the improvement of services? 9) Does your AC have protocols/procedures/guidelines related to the humanisation of MH care, 10) Does your AC have specific measures aimed at reducing the number of mechanical restraints? 11) Does your C.A. have measures aimed at promoting and encouraging the rights of people with MH problems with regard to therapeutic decisions? 12) Does your C.A. have an agreement aimed at promoting adequate coordination between the judiciary and MH services? 13) Does your C.A. include measures to facilitate the participation of people with MH problems and/or family members/relations in the design of initiatives related to the humanisation of MH? 14) Does your local authority's MH plan include proposals for activities aimed at the attention and humanisation of care for people with mental illness who are particularly vulnerable and at high risk of social exclusion?, and 15) Does your local authority's MH plan include measures aimed at reducing stigma towards people with MH problems?

The questionnaire used to answer the second objective was developed by a multidisciplinary group based on the MH plan of one of the communities with an MH strategy.

Thirdly, a broad, multidisciplinary group of people involved in MH care (users of the MH network, patient and family associations, MH professionals, institutional and political decision-makers and social agents involved in MH care throughout Spain), proposed, after consensus, the key common and priority points that should be included in a common and homogeneous strategy for quality and sustainable MH, which takes into account, above all, people with MH problems and their environment, and which provides the necessary and most appropriate resources for the promotion of their recovery.

The multidisciplinary working group was made up of 21 people (12 men and 9 women) from Andalusia, Catalonia, Valencia, Extremadura, Galicia, Madrid and the Basque Country, and included professionals from health management, psychiatry, clinical psychology, nursing and social work, and representatives of associations of people with mental illness and MH problems and associations of relatives of people with mental illness and MH problems.

The multidisciplinary group discussion began with the identification of those involved in the humanisation of health care in MH. The technique used in this case was the so-called stakeholder map. This technique allows us to identify all the profiles involved in the specific field where it is applied. The aim is to gain a deeper understanding of the environment surrounding people with MH/citizenship problems in the field of MH. The stakeholders identified were: associations of people with SM problems and family members; psychiatric hospital care; primary care; research consortia; public sector employers and private sector employers; nursing staff; addiction/addictive behaviour specialists; community pharmacies; physiotherapists; security forces; media, administration and services staff; transport staff; education/education professionals; law enforcement agencies; emergency professionals; clinical psychologists; psychiatrists;, those responsible for the management and planning of MH care; prison health staff; the judicial system; scientific societies and professional associations; occupational therapists; social workers; universities (especially degrees in health sciences), and private health insurance. Once the stakeholder map was obtained, the group work continued, using the Point of View technique. This technique helps to synthesise the needs of people with MH problems/professionals and the cause of these needs, with the aim of carrying out a further study to find out how we could provide a solution to the issues raised.

The consensus processes were carried out, after the application of the modified Delphi method based on Design Thinking, by working in focus groups, composed of the members of the multidisciplinary group, with a Pareto analysis and Ishikawa (or fishbone) diagram, followed by sharing.

Results

Identification of the measures and actions related to humanisation included in the mental health plans of the autonomous communities

The analysis of the current situation of the autonomous communities' strategic plans for mental health in relation to the humanisation of healthcare showed that of the 17 Spanish Autonomous Communities, 14 have humanisation plans and these are: Andalusiía,[15] Aragon,[16] Asturias,[17] Canary Islands,[18] Cantabria,[19] Castilla-La Mancha,[20] Catalonia,[21] Community of Madrid,[22,23] Community of Valencia,[24] Extremadura,[25] Balearic islands,[26] La Rioja,[27] Murcia[28] and Navarre.[29] The plan for Galicia, which is currently under preparation, is expected to be published soon.

The group of experts identified the actions promoting humanisation in the MH plans of the different ACs and classified them into 4 groups: 1) Humanisation and improvement of the quality of care in MH, 2) Promoting the participation of users and relatives in the care of their MH, 3) Combating stigma and discrimination against people with mental illness and 4) Extending care and humanising the care of people with mental illness who are particularly vulnerable and at high risk of social exclusion.

The analysis carried out has shown that the majority of the Autonomous Regions' MH plans and strategies do not include lines of action directly identified as humanising. However, they do contain humanising approaches in several of their strategic lines of action.

Table 1 lists the main humanisation actions present in the ACs' MH plans, organised into 2 groups: 1) actions aimed at people with MH problems and carers and 2) actions aimed at the social and healthcare environment.

Analysis of the implementation of humanisation measures and actions in each of the different mental health plans and strategies of the Autonomous Communities

Sixteen out of the 17 Autonomous Communities responded to the questionnaire. Table 1 shows the responses of each of the Autonomous Regions to the questionnaire. The degree of implementation in the ACs ranged from 6.3% (e.g. specific budget) to 100% (e.g. training plans), with an average implementation rate of 64.1% of the ACs.

Identification of key common and priority points for a common and homogeneous strategy for quality and sustainable mental health care

The working group identified the following key common and priority issues that any quality MH strategy should take into account:

- Humanisation in MH should be considered as a key and transversal axis in all MH strategies, as well as in all areas of care intervention, planning, management and participation in both the phytosanitary field and in the health care partnership. To this end, the working group proposes: a) establishing quality controls and measurable and objective indicators related to human rights, authorised consents, patients' prior instructions; b) using satisfaction and perceived quality questionnaires for professionals in health and social-health institutions, as well as for the people cared for and their families or close relatives.
- Coordination protocols between health and social services should be developed or improved, so as to jointly establish care "maps or routes" where accessibility, equity and continuity of care help

to sustain both systems and favour intervention for people in situations of vulnerability, risk and social exclusion.

- MH plans and strategies should include a specific budget for the design and implementation of humanisation plans, as well as identify a person responsible for the plan.
- The MH plans and strategies and the programme-contracts of each of the centres must include concrete indicators that allow the achievement of the proposed objectives in relation to humanisation in MH to be assessed, proposing corrective measures and evaluating them on an ongoing basis. The provision of health services to people with MH problems presents areas for improvement. These include: a) training of all healthcare professionals who care for people with SM problems; b) protocolisation and study of voluntary interventions in general and mechanical restraint in particular; c) proposing the creation of the category of SM nurse specialist as a key figure in humanised care in all Autonomous Regions, d) implementation of questionnaires on the patient's experience as a user of health services, and e) improving compliance with legislation on data protection for people with SM problems.
- The experience of the ACs that have established humanisation protocols, procedures or guidelines should be implemented, with the necessary adaptations, in the rest of the ACs.
- The perspective of people with mental illness and their families should be included in the humanisation strategy of MH services.
- Residential structures for patients with severe mental disorders require a review to improve their conditions and promote care based on humanisation. Training of primary care teams (doctor, nurses, social work) in SM could be improved, especially with regard to combating the stigma of people with SM problems and mental illness. Primary care teams should be given sufficient time, beyond the resolution of the demand for care, to carry out community-based MH education activities.
- Table 2 provides a summary of the main humanisation actions in the MH plans.

Discussion

Advocacy for the humanisation of health care has been present in the medical and allied professions, with greater or lesser success, for centuries and, above all, since the mid-20th century.[30,31] However, despite the significant efforts made in recent years to improve care in the field of MH,[32,33] MH plans and strategies have not incorporated humanisation among their main objectives or lines of action, or have done so only very recently and only in some cases. For this reason, the results of this study are of particular importance, as they put on the table the current situation of humanisation in the different MH plans of the Autonomous Regions of Spain and propose, on the basis of a plural and multidisciplinary working group, a roadmap for improving the humanisation of MH care that should be a pillar of the expected MH strategy being prepared by the Spanish Ministry of Health.

Humanisation is a trendy word. It appears in medical congresses and conferences, it is talked about in debates and round tables. The administrative and political structure of several Autonomous Regions has created general directorates dedicated to the humanisation of healthcare.[34] However, humanisation must go beyond documents and become action in health plans, it must serve as a spearhead in the fight against the stigma and discrimination at a social and general health level that many people with MS problems still experience because they have MS problems.[35] It must be the basis for the defence of a respectful and empathetic therapeutic relationship as the axis of healthcare activity,[36,37] and promote the identification of healthcare priorities with people with MS problems and their families at the centre of the activity.[38] Carlos Mañas

Gómez has eloquently reminded us of this: "If the humanisation of psychiatric healthcare does not materialise via the senses (with a sincere look, with a complicit tone of voice...), capable of baptising a two-way communication between the affected person and the specialist, it is an incomplete humanisation".[39]

Initiatives such as the present project[1] or the consensus document on the humanisation of care in short psychiatric hospitalisation units, promoted by the Madrid Psychiatry Society Madrid,[39] favour the implementation of humanisation measures with a real impact on clinical practice and health and social-health care activity.

The results of this study will serve as a starting point for the design of future programmes and strategic plans that will make it possible to achieve objectives, such as raising awareness of the need to humanise in the field of the MH in the social and healthcare environment. They will also make it possible to extend humanisation to the entire health care system, promote equity and homogeneity in the implementation of humanisation policies in the field of health care and encourage the participation of all institutions and agents involved in the humanisation process. This participation should include in the design and planning of strategies, the encouragement of evaluation and monitoring of humanisation projects, and the knowledge and shared experience of humanisation in the field of health and well-being. These objectives will be achieved through the identification of good practices and through consultation with ACs, or by defining perceived quality indicators on what we mean by humanised MH care.

In this paper, the review of the MH strategies at national and regional level, the discussion with experts and patient associations in the field of the MH and the contribution of those responsible for the regional strategic plans have made it possible to highlight that there are efforts at national and regional level aimed at improving the health care of people with MH problems and carers in the field of the MH. These efforts are heterogeneous and, although they present great strengths, it is necessary to continue working to improve the health and social care of people with MH problems and carers in the field of MH. With regard to humanisation, although most of the plans and strategies do not contain lines of action directly identified as humanising (only 9 Autonomous Regions have a specific section on humanisation in their MH plan), they do contain humanising approaches in several of their strategic lines.

The study has shown that there is a need to establish a comprehensive and coordinated response of the health and social sectors to the challenges related to the humanisation of the MH area, paying special attention to the promotion, prevention, treatment, rehabilitation, care and recovery of people with MH problems and support for caregivers.

The main areas for improvement detected by the group of experts focus on communication with people with MH problems, training for both healthcare and non-healthcare staff in contact with people with MH problems, improvement of both inpatient and outpatient spaces, reduction (with the ultimate aim of eliminating them) of coercive measures (including mechanical restraint). 87.5% of the ACs that responded to the questionnaire for the second objective (i.e. 14 out of 16) stated that they included measures aimed at reducing the number of mechanical restraints. This is a good starting point, and the efforts of the ACs to establish channels of dialogue with the judiciary are also commendable. But this is insufficient. Further progress needs to be made in improving the conditions of care for people with MH problems. As emphasised by several recent studies and the 2019 World Health Organisation (WHO) report on ending seclusion and mechanical restraints, the minimisation (with the horizon of zero) of mechanical restraints requires the availability of sufficient human resources, the continuous improvement of MH training, the presence of strategies to fight for diversity and against discrimination and stigma, the existence of

Table 2
Main humanisation actions in MH plan.

Areas	Aimed at people with MH problems and carers	Aimed at the healthcare environment
Humanisation and improvement in the quality of MH care	Education and training of people with MH problems and carers in relation to their physical health. Encourage the involvement of people with MH problems and family members in improvement plans in both community MH services and inpatient services. Promote associating and information for people with MS problems, family members and relatives about associations and support tools. Information and counselling for people with MH problems, family members and their relatives about resources and/or medical, psychosocial and social treatments to deal with their life situation.	Identification of MH centres and hospital centres, reception standards, service portfolio, and of each and every member of the care team. Humanisation of both outpatient and inpatient areas. Increased range of activities for people with MH problems and their families and/or relatives. Availability of spaces outside the health care setting for young people at risk or with MH problems. Creation of open hospitalisation units for people with MS problems. Standardisation of quality criteria for inpatient units and outpatient centres. Improved explanation of prescription and treatment guidelines. Greater involvement of community/proximity pharmacies in the education of people with MS problems and monitoring of adherence to treatment. Include attention to SM problems from social services in strategies for chronicity and social health care. Establishment of measures aimed at reducing/avoiding the number of mechanical restraints and coercive measures using these parameters as quality indicators. Reduce involuntary hospitalisations and coercive methods, using these parameters as quality indicators. Include in the management pacts indicators of humanisation in SM. Include functional recovery, quality of life, empowerment and insertion of people with MH problems. Improve the care of people with MH problems and their families by non-care staff. Training on MS for all health, social-health and non-health staff in contact with people with MS problems. Effective coordination between the different health and social-healthcare devices. Improve accessibility to services and health care for people with mental illness. Creation of a National Plan for the Prevention of Suicide.
Advance in the participation of users and family members in their MH care.	Establishment of self-help, educational and/or health information groups for family members and relatives to learn about the family member's MH problem. Train people with MH problems, family members and/or relatives in decision-making skills and competences. Encourage the participation of people with MH problems and their relatives in decision-making. Train people with MH problems, family members and/or relatives in the humanisation of MH. Promote the figure of the "patient-expert" as a tool for help.	Establishment of a suggestion box and evaluation of the care received in all structures providing care for people with MS problems. Provide satisfaction surveys and complaint and thank you forms. Improve the information provided to people with MH problems and to their family members. Facilitate access to the multi-professional team for people with MH problems, family members and/or relatives. Use (and design) instruments to measure the perception of the humanised care offered by the different professionals and from the perspective of people with MH problems. Facilitate the participation of people with MH problems, family members and/or relatives in inclusive activities in their environment.

Table 2 (*Continued*).

Areas	Aimed at people with MH problems and carers	Aimed at the healthcare environment
Fight against stigma and discrimination against people with mental illness.	Establish actions aimed at reducing self-stigma. Establish actions aimed at empowering people with MH problems..	Bring community MH services closer to the ambulatory care of the rest of the specialities and/or promote the community care of MH services in standardised settings where the rest of community health care is carried out. Adapt the vocabulary and news related to MH in the general press. Train staff in contact with MH problems and other sectors for stigma reduction. Train staff in training (MIR, PIR, EIR, etc.) and future health professionals (Health Sciences and Social Sciences graduates). Train staff in contact with MH problems and other sectors in stigma reduction. Train staff in training (MIR, PIR, EIR, etc.) and of future health professionals (Health Sciences and Social Sciences degrees). Education for children and young people to reduce stigma at an early age. Promotion and encouragement of the rights of people with MS problems with a view to advance planning decisions, especially in voluntary admissions, hospitalisations or mechanical restraints. Media campaigns and social media activism aimed at raising awareness of MH and promoting positive MH. Public awareness campaigns of people known to have suffered from MH disorders. Establishment of specific measures for training and employment of people with SM problems.
Maximise the attention and humanisation of care for people with mental illness who are particularly vulnerable and at high risk of social exclusion.	Training in care and specific support for family members on management and skills for the care of these people with MH problems. Identification and care of people with MDS who live alone, have no family support and/or refuse social support, as well as working in collaboration with general social services and social emergency services. Training in health care and health promotion to promote self-care. Generate positive discrimination systems that facilitate access to the care network for people with severe and long-lasting mental illness in situations of social exclusion. Promote the figure of community mental health nurses.	Adaptation of hospitalisation units to the geriatric population and to children and adolescents.. Adaptation of differentiated spaces in SM services for adults and children/adolescents. Greater coordination and development of co-responsibility mechanisms with social services for comprehensive primary care with continuity of care. Greater coordination with the resources of other social protection systems that affect the quality of life of patients: education, housing, employment, justice, etc. Promoting primary and secondary prevention programmes in childcare centres and schools. Coordinated interventions to follow up on employment, academic or quality of life projects. Programmes to improve accessibility to healthcare for people with dual pathology, intellectual disabilities and ASD. Specific programmes targeting homeless people with MH problems. Improvement of care network facilities that guarantee privacy and reduce stress for people with MS problems. Reinforcement of care and support resources in structures such as flats with different levels of supervision for people with severe and long-lasting MH problems to avoid family and/or close relatives' attrition and claudication; and to promote independent life projects.. Establish an evaluation mechanism focused on people with severe mental illness to assess the situation of multifunctional dependency and who require dependency assessments.

ASD: Autism Spectrum Disorder; MH: Mental Health; SMD: Severe mental disorder.

adequate physical and architectural spaces and the adoption of legislation adapted to the framework of the Convention on the Rights of Persons with Disabilities.[40–42] Furthermore, we must take into account the results, and their important ethical implications, of recent research carried out in our country by healthcare professionals who are particularly sensitive to this issue. These studies indicate that mechanical restraints are associated with involuntary admissions,[43] and that this type of admission is associated with an increased risk to one's own life or that of others, greater overall severity and more positive psychotic and manic symptoms.[44,45] According to the European EUNOMIA study 15%-40% of admissions in Europe are involuntary. Within this category, 30%-50% of involuntary admissions receive mechanical restraint at some point during their admission. This means that between 4.5 and 20% of people admitted to an acute psychiatric unit receive mechanical restraint. This wide range can also be seen in the different figures between Autonomous Regions. For example, mechanical restraint was applied to around 15 of persons admitted to an acute psychiatric unit in Andalusia,[46] while in the Basque Country it was 6%.[45] Perhaps these figures are influenced by the fact that some inpatient units are open and therefore may be more trained in de-escalation technique. In fact, recent studies on the effect of the application of a de-escalation protocol on the reduction of mechanical restraints have demonstrated its efficacy in Andalusia and Catalonia.[46,47] In relation to this, it has been pointed out that coercion in clinical practice is associated with an increase in substance use.[48] Therefore, the eradication of coercive methods in clinical practice, the fight against substance use as a general policy, the creation of early detection programmes[49] and education in schools would be excellent strategies.

In relation to training on the MH, it is important to recognise that 100% of the 16 Autonomous Regions that responded to the questionnaire for the second objective have training programmes aimed at training on the MH of all healthcare and non-healthcare personnel in contact with people with mental illness. This is a strength of our public health system. And it contrasts with the situation reported by the WHO on the insufficient human resources in the health and non-health fields with training in MH in the world.[12] The WHO Mental Health Action Plan (2013-2020) includes, among the actions proposed, "contributing to the training of health personnel to learn to recognise mental disorders".[12]

The reflections provided by those responsible for the strategies in the Autonomous Regions make it possible to identify more specifically humanising measures within the existing strategic lines of the MH plans,[15–29] as well as measures or actions that are being developed outside the plans. All the strategies coincide in directing their actions towards reducing stigma, improving the care elements to which those involved have access and increasing the participation of people with MS problems, their families and relatives in the decisions that affect them. With regard to this last point, 100% of the 16 Autonomous Regions that responded to the questionnaire for the second objective reported having measures aimed at encouraging the active participation of people with MH problems and their relatives/relations in the plans to improve services. This can again be seen as a strength of our public health system.

This review of MH strategies has brought to light the general lack of budgetary allocations for MH plans. The economic endowment of the lines, measures or actions related to humanisation in MH needs greater availability of resources in order to achieve the established objectives.

The success of MH plans, including that of humanisation strategies, requires, as the multidisciplinary working group concludes, the development and use of indicators associated with the strategic lines and objectives, as these are necessary for the correct evaluation of the monitoring and results of the plans.

This study is not without limitations. The questionnaire used to respond to the second objective ("analysis of the implementation of humanisation measures and actions in each of the different Autonomous Regions' MH plans and strategies") does not include questions that could be highly relevant, such as the existence of open hospitalisation units. This could introduce a bias in the assessment of this objective. To minimise the risk of this bias, the questionnaire was agreed by the working group, which was multidisciplinary and representative of the Spanish state. Furthermore, this study analyses the humanisation measures included in the MH plans. This leaves out of focus some humanising measures and strategic lines of action that are not included in an MH plan.[50–52] In order to include these actions, the survey completed by the heads of the Autonomous Regions (table 1) collected information on humanising measures or actions that are being developed within and outside the MH plans.

Analysis of these points has made it possible to identify common and priority key aspects that any quality MH strategy should take into consideration. Key aspects that could be materialised in 5 proposals for action:

1. To carry out a nationwide dissemination campaign with a clear and direct slogan in favour of MH and the prevention of suicidal behaviour that has resonance in the media and social networks with the collaboration of well-known personalities who contribute their experience and support to other people who are going through similar circumstances.
2. Promote forums for professionals, patients, families and/or carers to meet and develop a fruitful dialogue that can lead to improved treatment and care in the form of respect for dignity, rights and empathetic treatment in social and health care with the aim of eliminating coercive measures, holistic and personalised care.
3. Create a platform of support entities that will serve as a network to generate shared experience, coordinate resources and have a presence and its own voice in the governing bodies.
4. Implement a health education plan on MH from school age onwards. To this end, having patient-expert or experienced patient programmes is one of the most effective ways of bringing peer support to people in vulnerable situations.
5. Incorporate the development of competencies and skills in the therapeutic relationship in the curricula and continuing education of social and health professionals, so that the person is incorporated as an expert in their own health, the protagonist of their life plan and the main agent of care.

Conflict of interests

Elena de las Heras Liñero received funding as a speaker and consultant for Jannsen, Lundbeck and as a speaker for Adamed.

Celso Arango received funding as a consultant or speaker from Acadia, Angelini, Boehringer, Gedeon Richter, Janssen Cilag, Lundbeck, Minerva, Otsuka, Roche, Sage, Servier, Shire, Schering Plough, Sumitomo Dainippon Pharma, Sunovion and Takeda.

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