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Care quality from the perspective of human rights as perceived by mental health professionals in Gran Canaria: a qualitative study

Cira Febles-Arévalo[1,2*], Jose Juan Martín-Domínguez[1,2], Rafael García-Montesdeoca[1,2], Rocío Hidalgo-Quevedo[2] and Francisco Navarro-Vázquez[3]

Abstract

Background Mental health facilities and other medium and long-stay hospital wards have been associated with poor quality care and human rights violations. This idea has led us to do this qualitative research.

Objective To explore how the health care professionals working at the medium and long-term hospitalisation services of the Network of Mental Health Facilities of Gran Canaria (*Red de Salud Mental de Gran Canaria*) perceive, from the human rights standpoint, the quality of the care that they provide, identifying the different attitudes, values and knowledge of the professionals involved.

Methods An exploratory, descriptive qualitative research conducted through 17 semi-structured interviews and 4 focal groups. The areas discussed are based on the *QualityRights* assessment toolkit. After collecting the data, the contents of the narratives were analysed.

Results The respondents identified the lack of health care resources and social support, the predominant paternalism in the care provided and the prevailing biomedical approach as the main causes that erode the respect for human rights. In this context, an improvement in the professionals' training seems to be one of the potential solutions to address this issue.

Conclusions Analysing and doing research about the provision of human-rights-based care to individuals with mental health conditions in the institutional setting leads professionals to think about the care they provide. It is believed that the involvement of professionals in this research can serve as a catalyst for reflection and, potentially, for changing attitudes.

Keywords Quality of care, Human rights, Mental health, *QualityRights*, Inclusion, Mental health recovery

*Correspondence:
Cira Febles-Arévalo
cira.febles@gmail.com
[1]University of Las Palmas de Gran Canaria (ULPGC), C/ Juan de Quesada, 30, Las Palmas de Gran Canaria 35001, Spain
[2]Department of Psychiatry, Hospital Universitario de Gran Canaria Dr. Negrín, Barranco de la Ballena s/n, Las Palmas de Gran Canaria 35010, Spain
[3]Preventive Medicine and Public Health, Gerencia de Atención Primaria, Servicio Canario de Salud, Las Palmas de Gran CanariaC/ Luis Doreste Silva, 36-44, 35006, Spain

Background

The United Nations Organization (UN) finds that long-term care facilities are inherently incompatible with human rights [1]. It has been proven that the individuals living or that have lived in institutional settings such as prisons, foster care facilities and psychiatric hospitals are highly vulnerable [2, 3]. The longer they live in a disadvantageous setting, the higher their likelihood to suffer from health problems [4].

In this regard, mental health facilities and other hospital stay services have been associated with poor quality care and human rights violations [5]. In order to consolidate the interventions aimed to reduce the coercive measures, a change in the organisational culture is required, paying more attention to the recovery of the individuals and promoting human rights [6]. Therefore, over the past few decades, different assessment tools have been developed and implemented in order to improve the patients' protection, such *QualityRights*, developed by The World Health Organization (WHO), based on the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) [7, 8].

After the Mental Health Regulation Reform (*Reforma Psiquiátrica*) was enacted in Spain, significant efforts have been made to dignify and protect the rights of the people with mental health conditions. In the Canary Islands, the enactment of *Ley 11/1994 de Ordenación Sanitaria de Canarias* (Health Care Regulation Act of the Canary Islands) resulted in the establishment of the Health Care Service of the Canary Islands (*Servicio Canario de Salud*) in 1994, an autonomous entity comprising several central and territorial bodies. Since this Act transferred the competences of the former national health care administration (*INSALUD*) to the Regional Ministry of Health of the Government of the Canary Islands, *Servicio Canario de Salud* took over the mental health care competences.

For the long-term hospitalisation of individuals, in 2007, the patients hospitalised in the Active Rehabilitation Wards, located in the former psychiatric facilities of *Hospital Psiquiátrico de Gran Canaria*, were transferred to the Clinical and Rehabilitation Unit of *Hospital Juan Carlos I*. The Medium-Term Stay Ward was opened up in 2008.

Gaining and promoting a Human Rights perspective in mental health care is essential to enhance the recovery of individuals. This process begins with an exploration of the current situation. Consequently, this study focuses on understanding the perception of the professionals that provide care to individuals with complex mental health needs in a medium and long-term care facility in Gran Canaria.

Methods

Study design

A qualitative methodology was used in the preparation of this study. Specifically, this is an exploratory, descriptive study with a phenomenological approach.

Scope of the study and recruitment of respondents

This study was conducted at *Hospital Juan Carlos I* in Gran Canaria, Spain, a medium and long-term care facility used for the hospitalisation of individuals with complex mental health needs.

Considering that, from a historical standpoint, psychiatric institutions and other medium and long-term hospital facilities are associated with the violation of human rights, this study was carried out in an attempt to analyse the situation and to understand the perception of the health care professionals working at this hospital, as well as to provide food for thought.

Data collection

In order to gain a wide range of perspectives and opinions, from the human rights standpoint, on the quality of the care provided, a total of 51 respondents (13 men, 38 women) were recruited.

The data were collected through semi-structured interviews and focal groups amongst the professionals providing care in the medium and long-term stay wards of the Network of Mental Health Facilities of Gran Canaria. For both types of wards, a script with specific questions were prepared. However, both the sequence and the questioning were changed according to the respondent and the development of the session. The script was prepared based on the areas covered by the WHO's *QualityRights* toolkit.

The sample was arranged using a purposive, non-probabilistic method, in order to cover an entire social-structural representation of the professionals involved in the mental health care setting, making a difference between the different professional roles that comprise the multidisciplinary team: nurses, head nurses, nursing assistants, psychiatrists, psychologists, social workers, occupational therapists and monitors. The sociodemographic characteristics of the participants can be found in the table below (Table 1).

As part of the selection criteria, the following inclusion criteria were established: professionals who comprise the multidisciplinary team of the devices under study, who consent to participate and sign the informed consent. As exclusion criteria: individuals not currently working in the services.

4 focal groups were established: 2 groups made up of nursing assistants and 2 groups made up of nurses. These focal groups had an average duration of 90 min. The groups included 6 to 10 professionals. 12 nurses and 17

Table 1 Sociodemographic characteristics of the participants

Variable	Category		*n*	%
Service	Medium-term stay		12	23,53
	Long-term stay		39	76,47
Sex	Female		38	74,51
	Male		13	25,49
Professional category	Psychiatrist	Female	2	3,92
		Male	5	9,8
	Psychologist	Female	3	5,88
		Male	1	1,96
	Head nurse	Female	3	5,88
		Male	-	
	Nurse	Female	6	11,76
		Male	6	11,76
	Nursing assistant	Female	17	33,33
		Male	-	
	Social worker	Female	2	3,92
		Male	-	
	Occupational therapist	Female	2	3,92
		Male	-	
	Monitor	Female	3	5,88
		Male	1	1,96
Data collection method	Semi-structured interview		22	43,13
	Focal groups		29	56,87

nursing assistants took part in the focal groups. All the group sessions took place between January and February 2020. Besides, 22 interviews were completed with 7 psychiatrists, 2 occupational therapists, 4 psychologists, 3 head nurses, 4 monitors and 2 social workers. These interviews were conducted between May 2019 and February 2020, except for 2 interviews, which had to be postponed until June 2021 due to the restrictions resulting from the COVID-19 pandemic. Both the focal groups and the interviews took place in the meeting room of the hospital, in order to facilitate the professionals' participation.

The focal groups were recorded using a video camera, whereas the semi-structured interviews were audio-recorded only. The focal groups were video-recorded to capture the group dynamics in a comprehensive manner. The video allows for the documentations of nonverbal communication which complements verbal content and aids in interpreting nuances.

Data analysis

To assess the data collected, the specific narratives, i.e., the direct statements expressed by the professionals were analysed and their meaning was described. For this purpose, a content analysis was conducted.

All the interviews and focal groups were transcribed into text. The researchers became familiar with the data by listening to the audio recordings and reading the transcriptions several times. As the researchers became more and more familiar with the data, a systematic approach was used to reduce the volume of data without excluding those data that were considered significant, as well as to classify the data into more manageable topics and to reorganise the information collected. To categorise and code the data, the contents of the narratives were divided into meaning categories and subcategories, following the areas covered by the *QualityRights* toolkit. Finally, these data were further analysed, interpreted and summarised, extracting meaning units based on the topics that were discussed in the narratives - autonomy, coercion, paternalism, stigma, training, evolution, etc.

Methodological quality

In order to ensure the validity of the study, a methodological triangulation was performed: to collect the data, both semi-structured interviews and focal groups were conducted. A further triangulation was performed with regards to the respondents, since the study results were analysed and subsequently confirmed during an official presentation in the reference hospital. The theoretical saturation principle was also implemented - study units were chosen until no sufficiently new data in the narratives were collected.

Ethical considerations

This study was conducted in accordance with the principles of the Declaration of Helsinki and the applicable legislation in Spain, following the provisions of Ministerial Order SAS/3479/2009 regulating observational studies. The study design was approved by the Ethics Committee and the Research Unit (*Unidad de Investigación*) of *Hospital Universitario de Gran Canaria Doctor Negrín* (reference number: 2018-230-1). Written informed consent was obtained from all participants, ensuring confidentiality and anonymized data processing.

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Results

The data collection and the narrative contents analysis were performed using a script based on the WHO's *QualityRights* assessment toolkit, which covers five areas based on the UNCRPD. An introductory category on the concept of Human Rights has been added.

Category 0: "Human rights concept"

This section explores the general concept and its association with the people with mental health problems (Table 2).

General concept

The respondents showed their difficulties to define Human Rights. They usually link Human Rights to other concepts, especially **dignity**. Other values such as the respect for others were also mentioned and linked to the limits of individual freedom.

Human rights in connection with individuals with mental health problems

In this case, this topic was mainly associated with **autonomy** or loss of autonomy, highlighting the relationship between autonomy and paternalism.

Some situations of **stigma** were detected, highlighting that it poses barriers and hinders the full recognition of mental health problems. On the other hand, the respondents suggested that **autonomy** should be respected by promoting **inclusiveness.**

Category 1: "Adequate standard of living (Art. 28 of the UNCRPD)"

This category was organised based on the publication by Fernández & Mogollón, which makes a difference between "*hard*" and "*soft*" infrastructure [9] *(*Table 3*).*

Hard infrastructure

This section analyses the conditions of the facilities.

The professionals focused on the **comfort**, highlighting that the conditions were acceptable.

They also pointed out some disadvantages such as heat, the vertical layout and arrangement of the building, the limited personalisation of the areas and the monotonous menu provided. The layout of the facilities follows a hospital-type model, without taking into account the **specificity** involved in the recovery-oriented care.

Since many respondents had previously worked in the psychiatric hospital, their perception was associated with the positive **evolution** that the mental health care facilities have experienced after the enactment of the Mental Health Regulation Reform.

Soft infrastructure

This sections assesses the respect for privacy, the stimulating features of the environment and the development of a personal and social life to the full.

This section discussed the **rules** established in the institution, finding two polarised groups of professionals: one group advocates the implementation of clear, strict rules of coexistence, whereas the other group supports the flexibilisation of the rules, in order to avoid paternalist, non-rehabilitating attitudes.

Negative feedback was collected regarding the **personalisation** and **privacy** of the facilities. In this regard, the professionals rejected the hospital dynamics frequently seen in long-term stay facilities.

Most professionals considered that **integration** in the community is a strategy to be strengthened and also pointed out that **stigma** is an element that hinders integration.

Category 2: "Right to the enjoyment of the highest attainable standard (Art. 25 of the UNCRPD)"

This section delves into issues related to the professionals' skills, their motivation to establish/maintain support networks, the information provided and the examinations of the physical health (Table 4).

Table 2 Highlights from experiences and perceptions expressed in category 0

Subcategory 0.1		
Dignity	*a decent life… I think dignity is the most important factor… a person should feel himself/herself worthy of respect, with regards to himself/herself and his/her life*	Psychologist 3
	minimum rights for the mere fact of having been born and being recognised as a human being…	Nurse 4
Subcategory 0.2		
Autonomy	*combining this —i.e., the respect for human rights— and non-voluntary actions, the fact of forcing a person to receive a treatment, the fact that people cannot be in control of themselves and the fact that we justify this in a thousand ways… this poses some dilemmas to me*	Psychologist 4
	… The general objectives must be ambitious and always ideal. Rights are global, unquestionable and general for everyone. However, we must then consider every single case individually to avoid unprotecting those that are really in need. One should consider whether every single case requires the type of support that society or professionals should provide in a supportive manner	Psychiatrist 1
	I think one of the alternatives (to avoid stigmatisation) should be to let them take part and make them see that a mental health problem can be as any other organic medical condition	Nurse 12
Stigma	*They are not respected as other individuals. Sometimes, with the intention to favour and help people, we take decisions that have an impact on their lives and that limit or result in a conflict with what we consider as Human Rights*	Psychologist 4
Inclusiveness	*Society should be prepared to treat everyone equally, whether individuals with deficiencies or with skills*	Monitor 3

Table 3 Highlights from experiences and perceptions expressed in category 1

Subcategory 1.1		
Comfort	*The areas are very dark. The brightest areas seem to be the rooms*	Monitor 1
	Repetitive menus. Dietetically balanced, but you end up getting tired of them	Monitor 4
Personalisation/ privacy	*It must be difficult to live with someone who is not a member of your family and you have not chosen*	Head nurse 2
	The telephone is in the corridor and there is no privacy during the conversations…	Psychiatrist 5
	The facilities lack a place to have sex, to avoid having to hide from the others	Monitor 4
	…this is not necessary, but this would turn the space into a cosier environment… it is not a kind, pleasant area to be in and make things…	Psychologist 4
Stigma	*(closed access to relatives) "I think this is partly due to the staff's fear. To some degree, because of the patients' privacy, but they have the same privacy in the Psychiatry, Neurology and Pneumology wards… He/she is your family member. We would all want to know where he/she is… And, if he/she is fine, why can't you enter that area?"*	Nursing assistant 3
Specificity	*I think the vertical structure is not helpful in the relationship…*	Social worker 1
	If we want to foster the relationships between the different mental health facilities, they must be designed for this purpose…	Nurse 4
Evolution	*(improvements in comparison to the former psychiatric hospital) "The fact of having large rooms with many patients. In this facility, the patients live in double or individual rooms"*	Nurse 8
Subcategory 1.2		
Rules	*There must be a basis of discipline and rules. Otherwise, they will encounter huge issues the day they leave these facilities…*	Nursing assistant 12
	We have hospital rules… An individual that has been here for a two or three-year rehabilitation period is not the same as someone that has been here for 20 years… Starting from the fact that everyone is different and we cannot provide the same care to everyone. However, rules are the same for everyone. It is true that we should have minimum rules, but perhaps we should get used to not having the same rules for everyone	Nurse 3
	I think that, in general, many rules are unnecessary. I wish we were able to truly open up the doors (of the floors) and the patients did not have to be strictly subject to breakfast, lunch and dinner schedules… If they had more freedom to go out and come back in. I think this would really enhance the rehabilitation of the individuals	Social worker 1
Self-criticism	*(using the community services) "at the end of the day, it depends on good will, on the fact that some people want to do it and are motivated to do it…*	Psychologist 4
	We should work more with the community, carry out activities outside with the patients, open up our doors and work in more normalised places, or try to become involved in other environments in a different way. And I am not only talking about the patients, but also about the professionals.	Head nurse 1

Qualified staff and quality services

The respondents reported the existence of **organisational barriers** and lack of **resources** that hinder the coordination between the services of the Network of Mental Health Facilities and other social support institutions. An increase in the number of staff members would help enhance the array of activities offered, provide individualised care and promote an active participation.

When discussing the **work environment**, the respondents suggested that all the members of the multidisciplinary team should be included in the decision-making processes and the professionals should reflect on the situations experienced. Feeling that one takes part and is supported in the decision-making process enhances uncertainty tolerance and risk assumption. The respondents requested more **training** in order to expand their knowledge and to continue to improve care, both in terms of mental health and human rights.

Comprehensive, individualised rehabilitation plan directed by the user and pharmacotherapy

This subcategory has been arranged based on the assistance relationship (AR) put forward by Bermejo: authoritarian, democratic-cooperative, paternalistic and empathetic-participative [10].

The data collected suggest that the predominant assistance relationship is **paternalistic**, oriented at the individual but with a directive, little participative approach. This was seen as **an area for improvement**: the users-patients should have a more active participation in everything related to their rehabilitation plan, which suggests that more **democratic** and **empathetic** assistance relationships should be established.

For the pharmacological therapy, the respondents mentioned that the approach tends to be **authoritarian.** The fear that treatment adherence may be challenging, together with the belief that the individual's decision-making capacity is reduced, results in the adoption of directive, problem-centred behaviours.

Table 4 Highlights from experiences expressed in category 2

Subcategory 2.1		
Organisational barriers	*If we could arrange the services in such a way that the unstable patients could be cared by a small group of the staff, we would have no excuses to close the doors*	Psychiatrist 4
	he continuation of the rehabilitation therapy is very difficult when it depends on external institutions	Psychiatrist 6
Resources	*We cannot manage to meet all the specific needs of each individual*	Psychologist 3
	The portfolio of services that includes psychosocial rehabilitation should be funded by the Health Department and not by the patients' pensions/social benefits. This would make it easier to carry out those activities that would let them become reintegrated into the community…	Psychiatrist 6
Work environment	*When you are a member of a team, everyone's decisions must be considered. A consensus must be reached. This is not the case here. The nursing staff is on one side and the medical practitioners on the other*	Nursing assistant 1
	…When you hold a meeting to take a decision, you can see everyone's point of view. This makes you see the patient in a holistic way. This helps you see the person with a lot of skills and possibilities that you cannot see on your own.	Psychiatrist 6
	Between the fact of assuming unacceptable risks and not taking any risk there is a wide range of possibilities, provided that the risks are assumed based on professional criteria.	Nurse 3
Training	*Training on human rights would improve the care that the patients receive: they would feel that we take them into account, that we are not so paternalistic…*	Psychiatrist 2
Subcategory 2.2		
Authoritarian	*Some things are done the way they have to be. We do not negotiate them.*	Psychologist 4
Paternalistic	*Sometimes, a patient does not agree with some decisions, but we understand that, due to his/her situation, those decisions will be beneficial in the long term and we try*	Psychiatrist 5
Democratic	*Considering what we have, we provide them with a range of possibilities, but these possibilities are at an organised level. We have improved, but there is still a long way to go*	Head nurse 3
Empathetic	*Patients have the right to be informed about the medication, always trying to reach an agreement. We put forward the treatments and they tell you the treatment they are more comfortable with and the objectives that they consider the medication should meet.*	Psychiatrist 3
Room for improvement	*We are in an openness stage, creating meeting spaces for general coordination where the patients have a place where they are listened to.*	Social worker 2
Evolution	*There is a lot of negotiation and it was not the case before. In my opinion, the new generations are more clear about their options and they have a different way of expressing what they want. They search for information on the Internet and we usually clarify these topics in the office.*	Head nurse 3
Subcategory 2.3		
Organisational barriers	*I think we should have some activities about sexuality. They are younger and younger and more sexually active*	Head nurse 2
	I think interventions are more individualised. We do not have programmes	Psychologist 3
Room for improvement	*We start programmes and ideas but they do not go further. I think it is important for the patients to feel that this work continues. We cannot provide the patients with information about activities and then they are not carried out*	Psychologist 3

An **evolution** has taken place — the individuals hospitalised develop attitudes aimed to demand information and increase their knowledge, in order to try to take autonomous decisions.

Availability of general and reproductive health services

The respondents emphasised the **organisational barriers** resulting from the lack of health promotion programmes and the need to include sexual health programmes. These interventions are usually performed at an individual level. Therefore, group management is considered as an **area for improvement**.

Category 3: "Right to exercise their legal capacity and the right to personal liberty and security (Art. 12 and 14 of the UNCRPD)"

This section explores the aspects related to the exercise of the patients' legal capacity and the access to support in order to ensure their making of decisions (Table 5).

The users'/patients' preferences as a priority

Replacing the individuals in the adoption of their own decisions shows a self-evident **paternalistic** style or approach. This has been justified by referring to the patients' incapacity to take decisions due to their psychopathological state or by considering that these patients were more vulnerable than other types of patients. In both cases, the respondents identified that this overprotection is a self-defence strategy against potential legal repercussions. The difficulties to tolerate uncertainty

Table 5 Highlights from experiences expressed in category 3

Subcategory 3.1		
Paternalistic	*This is the medical health facility that I consider as the least horizontal, due to the perception of patient's vulnerability that we have here*	*Nurse 3*
	Sometimes we take decisions without taking into account the patients' opinion, but this is because the rehabilitation process has proven that the decision that they would choose would be wrong	*Psychiatrist 6*
	Many patients could take their own decisions, but this is prevented due to our own fears	*Psychologist 2*
Democratic	*I think that, based on the severity of their medical condition, they can be explained and informed about their disease and about the programme established to help them. Then they can take their decisions*	*Monitor 3*
Empathetic	*…understanding very well what suffering from a physical illness means to that patient and how that can affect his/her psychic stability. We have to listen to them*	*Psychiatrist 4*
	In general, they are provided with support. To keep the capacities and skills of those who still have them and to try to improve those of the patients who don't	*Psychiatrist 1*
Subcategory 3.2		
Paternalistic	(complaints) "*some are feeling well and they can let us know, whereas others, because of fear or other reasons, do not tell us and we cannot know them either*"	*Monitor 3*
Proposal for improvement	*On many occasions, we have had the voucher to go to an activity outside and the patient did not know that we had planned that activity for that day. … We have to inform the patients and an informed consent is required. This is an intervention*	*Nurse 3*
Subcategory 3.3		
Accessibility	*…there are cases of patients legally incompetent who are probably not as protected as they should be. We cannot easily reach the guardians or tutors of those patients and we need to deal with an external entity that fails to facilitate this access*	*Head nurse 2*
Resources	*With regards to the public institutions, you must keep calling them constantly for them to come. The period of time elapsed from the very moment we file a claim to the moment when they answer it has nothing to do with the actual timeline that we need"*	*Head nurse 1*
Authoritarian	*There are tutors/guardians that believe that they are the owners of the patients and not their legal representatives. Not the ones who should make their lives easier. Sometimes, they do quite the opposite*	*Nurse 5*
Paternalistic	*When they ask for information, they are provided with it, but sometimes we invalidate the patients when they make complaints. You are also given little information because it is understood that this would slow down the entire process"*	*Psychiatrist 2*
Empathetic	*That is why we have all the time in the world - to discuss and speak. To explain, to understand the specificities and unique features of the treatment*	*Psychiatrist 4*
Self-criticism	*The awareness about the disease… the thing is that you are ill, you suffer from a medical condition… at the end of the day, this invalidates the patient even more… An ill person is someone who is in bed. But here, they are not ill. How can you integrate someone who is ill into the community? This is a contradiction. I think that sometimes we emphasise this too much*	*Occupational therapist 1*
	We have always had the myth of "incompetency - mental disorder equals incompetency. Have we taken leaps forward? Absolutely. However, there is still a long way to go	*Psychiatrist 3*

situations lead to the need to minimise the level of assumable risks. The respondents also mentioned that the lack of time prevents them from prioritising the users'/patients' preferences.

The **empathetic** style involves an individual-centred approach that promotes his/her participation. The respect for the individuals' capacity to take their own decisions emphasises the importance of admitting the meaning that they attribute to their mental health problems and experiences and the actions arising from such problems and experiences.

Promotion of the free, informed consent

The respondents recognised situations where the patients lacked information regarding the organisation of the rehabilitation activities, assuming their interest in participating in such activities or refusing alternatives, which gives rise to a paternalistic assistance relationship.

The professionals lack knowledge to define the concepts of "*advance care decision planning*" and "*planning of end-of-life wills*" and they usually mix them up.

As **an area for improvement**, the respondents suggested that an informed consent procedure should be officially established for the rehabilitation interventions.

Exercise of the patients' legal capacity and necessary support

The situations that question this capacity were related to **accessibility** difficulties and scarcity of social support **resources**. The lack of coordination with the external institutions and the delay in the legal proceedings hinder the individualisation of the care and the patients' own decision-making processes. Instead of supporting the full exercise of the patients' legal capacity, the patients' protection and replacement is seen in most of the cases, showing an **authoritarian** style.

The relationship becomes **paternalistic** when the information is provided only when it is requested or when the complaints expressed by the hospitalised individuals are invalidated.

The eagerness to make patients become aware about their mental problem was a reason of **self-criticism** amongst the professionals, who considered that this disease-centred approach has invalidating connotations and may contradict the objectives of community integration.

Category 4: "Protection against torture or Cruel, inhuman or degrading treatment or Punishment, and also against Exploitation, violence and abuse (Art. 15 and 16 of the UNCRPD)"

This section deals with issues related to the treatment, the use of isolation or physical restraint methods and the patients' access to claim procedures (Table 6).

Abuse-free

The use of behaviour modification techniques as a learning method involves using **authoritarian** and **paternalistic** styles. Some respondents upheld that punishment is a way to reach self-responsibility. Other respondents put forward a contingency-based learning technique.

The formal coercive procedures such as isolation and mechanical restraints are the most visible. Other measures such as persuasion and threats usually go unnoticed [11]. In this study, the use of mechanical restraints was considered as infrequent, whereas the respondents state that isolation was used as an alternative and considered that this proves a positive **evolution** of the service. Some professionals engaged in some **self-criticism**, pointing out some non-formal measures used.

Other expressions of **self-criticism** were observed regarding the improvement of the communication skills

Table 6 Highlights from experiences expressed in category 4

Subcategory 4.1		
Authoritarian	*When the patient has violated the rules, they have been put on pyjamas… this would be a physical restriction, but more open than not letting them go outside*	Psychologist 1
	(not being paid for the failure to attend a workshop) "in this case, I do not find this is wrong, as this is also a measure to foster one's own responsibility. I mean, I am not forcing you to attend the workshop, but if you fail to attend it, you will not be paid. If you do not go to work, you are not paid"	*Nurse 1*
Paternalistic	*Isolation without physical restraints is used, either in the nursing area or in their room so that they can calm down*	Psychiatrist 7
Democratic	*The staff should become more and more aware of the fact that, when they talk to a patient, they are talking to an equal, from all the points of view. Only with the specificity that this is an individual with a mental disorder*	Psychiatrist 4
	the privileges that we have… to be able to take the decision… I want to and I can do it. Whether you make a mistake or not, you learn. This is something that we restrict to them	*Monitor 3*
Empathetic	*This human interaction is also a part of the rehabilitation and healing process. The process does not only entail pills or a regulated activity, but an emotional involvement… It does not mean to lose one's asepsis or empathy*	Psychiatrist 4
	…somehow to try to restrain them by accompanying them	Psychologist 4
Self-criticism	*We always think about the physical part, but what about the verbal? The way we say things can also have an impact on our patients*	Psychologist 2
Evolution	*There was one bed with the physical restraints ready to be used. They are no longer there. The tool used to place the restraints is now used to place bags and umbrellas*	Psychologist 4
Subcategory 4.2		
Resources	*(needs in moments of crisis) "and one group of nurses to deal with that specific patient as long as necessary"*	Nursing assistant 13
	we are using mechanical restraints with one patient because we do not have a shorter bed. This sort of issues could be solved	Psychologist 3
Stigma	*it is wonderful, no physical restraints… When the patient can reason and you talk to him/her but, when a patient cannot reason and there is no way for him/her to listen to you, what do you do?*	Nursing assistant 17
Empathetic	*How do you care for a patient? By interacting with him/her. The more you are with him/her, the fewer things happen*	Psychiatrist 4
Self-criticism	*We have had some disagreements amongst professionals and this has resulted in patients having serious agitation crises that ended up with physical restraints. I think this was due to clashes between different professionals*	Head nurse 1
Subcategory 4.3		
Organisational barriers	*They complain, but they do not make those complaints official. They do not know how to do it. They find it very difficult to do*	Nurse 3
Democratic	*This has been facilitated, they have been provided with advice and have been referred to the Patient Service*	Occupational therapist 1
Stigma	*They become conformist afterwards… They tell you: "Why would I do this? They will tell me that I am crazy*	Nursing assistant 2

of the professionals. These respondents suggested that an **empathetic** or **democratic** therapeutical relationship should be established, respecting the patients' right to take decisions, as a tool to facilitate the patients' recovery.

Use of alternatives to isolation and/or physical restraints in order to lessen the gradual increase of potential crises

The lack of **resources** was the main reason used to justify the use of coercive measures. The respondents suggested that the staff number should be increased in order to improve the accompaniment of the patients and that training on verbal de-escalation skills should be developed.

The opinions arguing that the individuals in critical situations are not capable of engaging in dialogue constitute practices of **stigma** and perpetuate the use of mechanical restraints, excluding the possibilities of using alternatives. Long-term stays allow the professionals to get to know the patients in depth and this facilitates early, individualised interventions that respect their will and preferences.

As an expression of **self-criticism**, the respondents pointed out that the work environment is an element of the context that should be considered in moments of crisis. The use of mechanical restraints was related to the value of the institution and the availability of resources. The use of restraints results in emotional unease amongst the professionals, highlighting that a further reflection on this topic is required.

Prevention of cruel treatment

The main **barriers** detected were the individuals' lack of knowledge about the procedure that they must follow to file claims and complaints and their fear of potential consequences. When a patient actively requests to file a claim, a **democratic** style is adopted, providing him/her with information and advice.

The respondents considered that most of the individuals usually choose to not file claims because they believe that their mental health problem is associated with a loss of credibility.

Category 5: "Right to live independently and be included in the community (Art. 19 of the UNCRPD)"

This section explores the individuals' rights to control their lives through the creation or establishment of support measures intended to promote their inclusiveness *(*Table 7*)*.

Support in access to a place to live and resources to live in the community

The respondents identified **organisational barriers** that hinder the de-instutionalisation of the patients. An improvement in the coordination of the services with the families and the **resources** (accommodation, economic funding and support) would promote the patients' participation in all the fields of social life.

The hospital setting favours **paternalistic** control attitudes and segregation and has an adverse effect on the patients' right to self-determination and social interdependence.

The persistence of the **stigma** in society results in discrimination and exclusion, perpetuating the patients' dependence and institutionalisation. Some respondents argued that the recovery of individuals with a history of long stays in mental health facilities was unfeasible.

Access to and support in education and employment opportunities

The answers provided evidence about the lack of **resources** focused on the **specific** needs of the people with psychosocial disability. Unprotected employment and precarious work generate insecurity and vulnerability, hinder the individuals' autonomy and cause situations of social isolation and exclusion. Even though the professionals perceived a positive **evolution** with regards to the past, the situations of **stigma** endure.

Support in participation, political life and exercise of the right of freedom of association

The respondents pointed out associative activities and mutual support as a tool to foster **integration**. The aim of having a collective support space is to enjoy the right to live independently and be included in the community.

Discussion

The aim of the study is to get to know and understand how the professionals providing mental health care at the medium and long-term stay facilities of the Network of Mental Health Facilities of Gran Canaria perceive human rights. For this analysis, the *QualityRights* assessment toolkit was used. This study reveals the persistence of a predominantly paternalistic care approach in medium- and long-term hospitalization settings for people with mental health problems.

Desviat points out that the care provided to people with mental health problems continues to be based on a biomedical, paternalistic approach [12]. According to this, one of the most significant findings in this piece of research is the predominant paternalistic style. Traditionally, based on the Hippocratic principles, the clinician-patient relationship was characterised by this style, but it started to shift to a more participative, horizontal, symmetric approach [13]. However, as observed in this study and as set out by Pifarré et al., the still widespread idea that mental health conditions entail a reduction or even an annulment of an individual's own decision-making skills contributes to perpetuate this relationship

Table 7 Highlights from experiences expressed in category 5

Subcategory 5.1		
Organisational barriers	*It is necessary to foster the coordination between the services… and there is no coordination space where the services can discuss the needs of an individual*	Head nurse 2
	a more progressive transfer would be advisable… to avoid such an abrupt change, i.e. switching from being in a very protective institution or in a network supporting the patient to being at home without so much support	Psychiatrist 6
	the services would facilitate the integration by using a support network. Teams visiting and following up the patient…	Monitor 1
	…the family members of the patients are really the ones that should be educated… the family lacks information…	Nursing assistant 13
Resources	*The main difficulties, the access to employment. In order to access to a decent dwelling, the financial benefits that they receive are very poor. With this amount you cannot meet your basic needs and this results in difficulties*	Psychiatrist 2
	There is no sufficient structural or social support for them to have a continuation…	Nursing assistant 3
	We are facing situations of loneliness… A network of social support is required	Psychiatrist 1
Paternalistic	*We care for the patients very much. We are very wary of spoiling all the work that has been done, all the recovery of that patient… because we find they are fragile*	Psychologist 4
Stigma	*They are chronic patients. You cannot intend to reintegrate them into society. Let's face it as it is… but you cannot reach the end of the path*	Nursing assistant 17
	Society usually puts a mark on you. Perhaps they don't know how to face it… or they may encounter difficulties when other people look or stare at them…	Monitor 2
Subcategory 5.2		
Resources	*Not only work is everything… You have been hospitalised for many years and now you are on your own and with one job. It is the lack of community resources*	Nurse 3
	Work gives people dignity… The involvement here is not the same as in other autonomous communities in terms of employment protection	Nurse 12
	Although we have an employment support plan, I think it is still small	Psychiatrist 1
Stigma	*The fact of having a mental health diagnosis already closes you the door*	Social worker 2
Evolution	*Little by little, we have started to be on the right track in terms of work integration, thanks to the programmes that the patients take part in. They get information from the National Employment Department…*	Social worker 1
Subcategory 5.3		
Integration	*The patient association can help them meet people that have suffered and gone through the same as them. The association can provide not only institutional support, but also social support*	Occupational therapist 1
Room for improvement	*It would be important for the associations to merger with the patients hospitalised at these facilities and promote those going out and those coming in. More interactions to make no differences between those who are hospitalised and those who are not*	Psychiatrist 4

style [14]. Besides, Polanco et al. argues that the long-term contact with these individuals underestimates their skills [15]. Furthermore, another factor is involved in this aspect: the vulnerability of the human being, which extends to the citizens' ethics, solidarity and care [16]. It is necessary to acknowledge and try to solve this vulnerability, not only in connection with a mental disorder or potential damage, but also when the other does not recognise an individual. Under vulnerability situations, overprotective attitudes that hinder the full recognition of the other person are frequently observed. This should not interfere with the individual's autonomy, but the individual should be provided with access to the necessary support required to develop his/her full potential. In line with this, in Spain, the Act *Ley 8/2021*, which amends the civil and procedural legislation established to help persons with disabilities exercise their legal capacity, has resulted in a change in the promotion of the patients' autonomy [17]. For the decision making, the said Act promotes a model of support in comparison to the usual replacement model, discarding the excessive paternalistic protection that surrounds the persons with disabilities. As Ochoa et al. have put it, overprotection develops undervaluing and invalidating behaviours that may result in learned defencelessness situations [18]. This type of passive coping strategy is one of the characteristics of the stigmatising behaviours, involves resignation and entails a barrier for the honest expression of one's feelings, thoughts and opinions [19, 20]. This compares to the passive communication style put forward by Blázquez & Moreno: "To give in to the others' will […] To let others take decisions on your behalf; to fail to taken action, waiving your own rights and surrendering to others' rights. To give in the others' wishes. To avoid conflicts at all costs" [19].

Promoting inclusiveness in the community is a strategy intended to ensure the patients' rights [4, 21]. Furthermore, as set out by Correa Urquiza, the practices in community mental health facilities also consist of creating collective spaces and strategies to foster well-being, care and social support [22, 23]. Therefore, it is essential to review the structure of the system and to make a financial investment in community resources, providing the necessary support to allow the individuals to fully participate in all the areas of social life [21, 24, 25].

With regards to stigma, the professionals proved to be sensitive in detecting it in the general population, as well as the barriers that it entails for the patients' inclusiveness. Also, when the patients visit medical services, the professionals perceive that the symptoms reported by the patients are trivialised and mistakenly attributed to their mental health disorder. This behaviour is consistent with the findings of other studies and is known as "*diagnostic overshadowing*" [26]. However, the respondents did not identify the stigma behind the paternalistic, overprotective attitudes that take place at the hospitals, except for some exceptions that are used to point out such behaviour and are considered as an aspect to be improved.

Some therapeutic nihilism attitudes, with low recovery expectations, have been observed. As a result, only the basic needs of the individuals are addressed, because it is usually thought that making an effort to consider the other is useless, objectifying the patients and identifying them as individuals with a passive, dependent role [27]. In this regard, it must be noted that hope is considered as one of the basic components of recovery, as it provides the essential, motivating message that individuals can and actually overcome the barriers and hurdles that they face [28, 29]. That is, placing hope on the recovery of the individuals has a positive impact on their process.

A particularly noteworthy and promising finding is the emergence of *self-criticism* as a subcategory in the analysis. This reflects a willingness among some professionals to critically reflect on their own practices, acknowledging tensions, contradictions, and opportunities for improvement. Such openness to self-reflection represents a window of opportunity for promote a shift toward more rights-based and person-centred care. Encouraging these spaces for critical reflection can facilitate individual and institutional change.

Most of the professionals advocating the existence of a clear regulatory framework were nursing assistants, whereas those that seek a flexibilisation of the regulations have a more heterogeneous training. This finding suggests that education and training are a significant variable. This finding makes us wonder whether the everyday, familiar-like relationships with the patients, which is typical of the care provided by nursing assistants, has also an impact on the perception of these professionals regarding the need for more specific regulations.

The answers given by the professionals that worked in the former psychiatric hospital indicate that, in general, they see an improvement in comparison to the practices of the past. This perspective may be a bias in the objectivity of the current assessment, since the progress reached may make it difficult for them to identify aspects to be improved.

Regarding the limitations of this study, it must be that it was noted possible to describe in detail the large volume of information collected. In any case, the authors have made their best efforts to condense all the information and provide a summary as complete as possible, in a way that reflects the diversity of perspectives found. On the other hand, it is important to mention the researchers' lack of prior experience in qualitative research, as this study marked their first approach to this methodological field. Despite this, guidance was provided by experts in the area.

Although the sampling method used is appropriate for qualitative studies, it is important to emphasize that the results of this research are not generalizable to the other contexts.

With regard to social desirability bias, it is understood that it was not a significant limiting factor, given the richness and critical nature of many of the narratives.

This research has been conducted within the hospital setting. It would be interesting to extend this research to community-based, non-hospital facilities and analyse the impact of the type of institution on the different relationship styles.

Conclusions

This study reveals the persistence of a predominantly paternalistic care approach in medium- and long-term hospitalization settings for people with mental health problems. Although professionals acknowledge progress compared to the past, practices that limit individuals' autonomy are still observed, with a tendency toward overprotection and decision-making substitution. This attitude is sometimes justified by fear of possible legal consequences or difficulty tolerating uncertainty, highlighting the need to move towards more participatory, person-centered models aligned with human rights principles.

The study also identifies structural and organizational limitations, such as a lack of human and material resources, which hinder the individualization of care as well as the development of non-coercive alternatives. Furthermore, the stigma present both in the community and within care services continues to pose a barrier to recovery and social inclusion for people with mental health conditions.

These findings underscore the need to increase ongoing professional training in human rights and recovery-oriented care models. Additionally, it is essential to revise and adapt public policies to ensure the promotion and respect of service users' autonomy, dignity, and social inclusion, along with greater investment in community-based resources and programs that foster patients' active participation in their own recovery process.

Finally, it is believed that the involvement of professionals in this research can serve as a catalyst for reflection and, potentially, for changing attitudes.

Abbreviations

AR	Assistance Relationship
UN	United Nations Organization
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organization

Supplementary Information

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Supplementary Material 1

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Author contributions
Cira Febles Arévalo has been the principal investigator. She has participated both in the conception and design of the study, as well as in the data collection, the analysis and interpretation of the data, the drafting, the critical review and the approval of the final version to be published. Jose Juan Martín Domínguez participated in the conception of the study, as well as in the data collection, the analysis and interpretation of the data, the drafting, the critical review and the approval of the final version to be published. Rafael García Montesdeoca took part in the data collection, the analysis and interpretation of the data, the drafting, the critical review and in the approval of the final version to be published. Rocío Hidalgo Quevedo worked both in the data collection, the analysis and interpretation of the data and in the drafting, the critical review and the approval of the final version to be published. Francisco Navarro Vázquez participated in the conception and design of the study, in the analysis and interpretation of the data, as well as in the drafting, the critical review and the approval of the final version to be published.

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Data availability
The datasets used and/or analysed during the current are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
This study was conducted in compliance with the principles established in the Declaration of Helsinki and with the applicable legislation in Spain, in accordance with the provisions of Ministerial Order SAS/3479/2009 concerning the conduct of observational studies. The study design was approved by the Ethics Committee and the Research Unit (*Unidad de Investigación*) of *of Hospital Universitario de Gran Canaria Doctor Negrín*. The Ethics Committee reference number is 2018-230-1. Written informed consent was obtained from all participants, ensuring confidentiality and anonymized data processing.
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Consent for publication
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