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Assessing quality of care and observance of human rights in residential mental health facilities in Greece through the WHO QualityRights tool kit

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In this paper, we present and reflect upon the process of evaluating two residential mental health facilities in Thessaloniki, Greece, through the WHO QualityRights tool kit. The QualityRights tool kit is a structured process for assessing quality of care and human rights in mental health and social care facilities, in accordance with the United Nations Convention on the Rights of Persons with Disabilities (CRPD), introduced by the World Health Organization in 2012. We have piloted the use of the Toolkit in two supported accommodation facilities, a hostel and a service supervising independent living in apartments, for individuals with long-term severe mental health problems in the region of Thessaloniki. In this paper, we present the methodology and process of evaluating the facilities, including the challenges posed to the evaluation process by restrictions due to the Covid-19 pandemic. We showcase the outcome of this evaluation through presenting a summary of the results and the ensuing recommendations for improvement. Finally, we reflect on the usefulness, appropriateness and relevance of the Toolkit for evaluating mental health care facilities in the particular context of contemporary Greece.

Keywords: Human rights; Mental health services; Quality of care; Service evaluation; WHO QualityRights tool kit.

In this paper, we outline and reflect upon the process of evaluating two mental health facilities in Thessaloniki, Greece, through the W.H.O. QualityRights tool kit.

Human rights violations are common in the field of mental health (Puras & Gooding, 2019; WHO, 2010). Persons with mental health problems face discrimination in education, accommodation and employment due to stigma. They might be refused civil rights and might be prevented from full participation in social and economic life on grounds of their mental health condition (Marks et al., 2020). Ironically, some of the worst violations take place in mental health services. Persons with mental health problems tend to have limited access to appropriate services and might be subjected to inappropriate, restrictive and even harmful treatment, including involuntary hospitalisation, restraint, isolation and invasive medical procedures (Marks et al., 2020; Szmukler & Bach, 2015).

Violations of human rights in the field of mental health have been recorded throughout the world

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(Szmukler & Bach, 2015; WHO, 2010). The development of a community-based, recovery-oriented mental health service system is thought to go in the right direction, in terms of safeguarding human rights of service users (Marks et al., 2020; WHO, 2010). In Greece, the de-institutionalisation process started belatedly and is still incomplete, with under-developed sectorisation, primary mental health care and inter-sectoral coordination (Giannakopoulos & Anagnostopoulos, 2016). The nationwide economic crisis in the 2010s increased the population mental health needs while negatively affecting mental health service provision (Giannakopoulos & Anagnostopoulos, 2016; Madianos, 2013), potentially leading to further human rights infringements. The general increase of restrictive measures due to the recent COVID-19 pandemic has raised concerns regarding its impact on human rights in mental health (Kelly et al., 2020; Rahman et al., 2021).

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) was a significant step in the direction of protecting the rights of persons with mental health problems. The Convention was established in 2006 and has been subsequently ratified by most countries. This, however, did not lead to its consistent implementation (Nardodkar et al., 2016). In order to promote mental health services and practices that respect human rights and support recovery in line with the CRPD, the World Health Organization launched the QualityRights Initiative, aiming to provide tools and operate as a hub for the dissemination of good practices (Moro et al., 2022). The *QualityRights tool kit to assess and improve quality and human rights in mental health and social care facilities* (WHO, 2012) was launched in 2012, followed in 2019 by training and guidance materials and tools (WHO, 2019a), as well as guidance on mental health law reform (WHO, 2019b) and on transforming mental health services (WHO, 2019c).

Implementation of the QualityRights initiative started with small projects in different countries. The first statewide implementation in the state of Gujarat in India demonstrated significant improvements in the quality of care and service user satisfaction and empowerment (Pathare et al., 2021). From 2019 onwards, the initiative was launched at national level in a few countries, while smaller local projects are continuing (Funk & Drew Bold, 2020). The worldwide dissemination of the initiative can be tracked in the WHO QualityRights Implementation Portal (at https://qualityrights.org). Despite the recent interest, however, few studies documenting the implementation of the project can be found in scientific literature (Morrissey, 2020; Steinert et al., 2016).

In Greece, the WHO QualityRights tool kit was implemented in 2012 by Aikaterini Nomidou, a lawyer and mental health advocate, who has been active in the regional Association of Families/Carers and Friends for Mental Health, Alzheimer's Disease and related disorders of Serres and is currently President of the Panhellenic Federation of Organisations and Associations for Mental Health, to evaluate the Psychiatric Clinic of the General Hospital of Serres (Nomidou, 2013). From 2014 to 2018, the Association for Regional Development and Mental Health (EPAPSY), an NGO active in community mental health, translated into Greek the main documents and implemented the tool kit for the evaluation of its residential units (Chondros et al., 2018). EPAPSY attempted to inform and mobilise the Ministry of Health, for a national evaluation strategy to be launched, albeit unsuccessfully. In this paper, we report on the next step in this process, the evaluation of two residential units in the region of Thessaloniki during 2019 to 2021, as part of an attempt to build capacity and to gradually expand the implementation of the QualityRights initiative in Greece.

THE WHO QUALITYRIGHTS TOOL KIT

The aim of the WHO QualityRights tool kit is to support countries in assessing and improving the quality and human rights of their mental health and social care facilities. The tool kit is based on an extensive international review by people with mental disabilities and their organisations. It has been pilot-tested in low-, middle- and high-income countries and is designed to be applied in all of these settings. It applies to "people with mental disabilities," including those with mental, neurological or intellectual impairments and those with substance use disorders. The tool kit can be used by various national and international groups and organisations. It can be used at country level, for the assessment of the mental health system, or at facility level, to assess selected facilities.

The Quality Rights tool kit is a structured process for assessing quality of care and human rights in mental health facilities. It is designed as a tool for collaborative research, engaging outside experts, facility professionals, service users and carers. More than an assessment tool, it intends to foster continuous development and empowement, whereby all parties involved engage in long-term monitoring and improving the standard of care in the facilities they partake.

It assesses the extent to which five themes, drawn from the CRPD, are addressed in the facilities under consideration: (a) The right to an adequate standard of living and social protection (Article 28 of the CRPD), (b) The right to enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD), (c) The right to exercise legal capacity and the right to personal liberty and the security of person (Articles 12 and 14 of the CRPD), (d) Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD) and (e) The right to live

independently and be included in the community (Article 19 of the CRPD). Each of the "themes" or "rights" is broken down into a series of "standards," which are further broken down into a series of "criteria." The criteria form the basis of the quality and human rights assessment. It is against the criteria that the situation in facilities are assessed, through interviews, observation and reviews of documentation.

The tool kit contains detailed instructions on how to carry out the evaluation and provides specific tools for collecting information and reporting the results, that the study adopted. Instead of presenting them here, we will outline how they were implemented in the study.

Study rationale

In 2018, we decided, in the context of the postgraduate training program in clinical psychology at the School of Psychology of the Aristotle University of Thessaloniki, to start implementing the QualityRights tool in the mental health services of the region of Thessaloniki. We planned to start with the evaluation of three mental health units, coordinated by three clinical psychology trainees, respectively. Community psychosocial rehabilitation facilities were selected in order for them to have enough commonalities for reasons of comparison. We chose to start with psychosocial rehabilitation facilities, as we expected that there would be less restrictive and challenging practices than in in-patient and acute care, and therefore the services would be more open to the process of external evaluation. In this way, we hoped to establish trust and partnerships, in order to expand evaluation to other types of mental health facilities in future years.

METHOD

Study design and process

The first step in implementing WHO QualityRights is to establish a project management team. Following the manual recommendations regarding the constitution of the team, the management team for this project consisted of Aikaterini Nomidou, mentioned earlier, Panagiotis Chondros, who was at the time president of EPAPSY, and the first author, academic staff at the School of Psychology of the Aristotle University of Thessaloniki and the trainees' academic supervisor.

The evaluation of facilities is carried out by assessment committees, that must be independent from the facilities being assessed. The committees should be multidisciplinary, bringing together people with a variety of skills and experience, including people with mental health problems, mental health professionals, human rights defenders and representatives of families and carers. Three assessment teams were set up, one for each facility. Each team consisted of the three clinical psychology trainees and members of the Association of Families for Mental Health of Thessaloniki, both mental health service users and carers. All members of the assessment teams participated voluntarily and signed a commitment to uphold ethical standards form.

The three facilities selected are (a) a mental health hostel, a residential facility with medium-level support, (b) a service supporting people to live in independent apartments, a residential facility with low-level support and (c) a cooperative, providing supported employment for people with mental health problems. All three facilities are part of the Psychiatric Hospital of Thessaloniki, which operates as an umbrella organisation for both in-patient and community mental health facilities. The clinical psychology trainees were familiar with these facilities, as they had completed training placement there during the previous year. QualityRights recommends comparison with an equivalent general health facility, and for this reason a residential facility for persons with physical disabilities was selected.

All the chosen facilities were contacted and permission was given to carry out the project. Permission was also sought and granted by the Scientific Board and Ethics Committee of the Psychiatric Hospital of Thessaloniki and the Regional Health Authority. The clinical psychology trainees leading the assessment teams introduced and explained the project to all members of the facilities involved, staff and service users and got them on board the project. It is crucial, according to the manual, to establish a sense of partnership and cooperation with all facility members concerned, emphasising the common goal to improve conditions at the facility and the need for everyone's active participation.

Common training sessions were organised for members of all three assessment teams to familiarise with rights as defined by CRPD, as well as with the use of the toolkit and the evaluation process.

A plan was drawn by the assessment teams of the evaluation methods and process for each facility. The toolkit defines three data collection methods, interviewing all parties, observation of the facility and reviewing facility documentation, and gives precise instructions on sampling and carrying out data collection. These instructions were followed closely in designing the assessment. All teams specified who would participate in each evaluation activity, the timescale for observation, the documents to be reviewed and, mainly, the numbers of participants to be interviewed.

All procedures performed were in accordance with the ethical standards of the Scientific Board and Ethics Committee of the Psychiatric Hospital of Thessaloniki and the Regional Health Authority and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Informed consent was obtained from all individual adult participants included in the study.

Data collection

Data collection started in February 2020. Very soon after, the beginning of the pandemic and the restriction and lockdown measures that followed had a significant impact on the execution of the study. The services were closed to external visitors for a long time and access was severely restricted at other times. The trainees, but mainly the users and carers members of the assessment teams, did not wish to visit the facilities for health safety reasons. The lock down and restriction measures also brought about changes in the function of the facilities themselves, and therefore risked altering the evaluation findings and conclusions. The process was drawn to a halt for a few months and significant alterations in the process and adjustments had to be made at periods when it could restart. The evaluation of the general health facility had to be abandoned, despite having completed the preparations and having obtained permission. Because of the restriction in the number of people entering the facilities, most of the data collection ended up being carried out by the psychology trainees, instead of the collaborative process planned. Fewer staff and service users were interviewed. No interviews with carers were conducted. Also, the processing of the data and writing up the report was delayed and took place to a large extent electronically. Finally and most importantly, the evaluation of the cooperative was severely impacted, ending with a very small number of interviews and observation visits, and for this reason its results are not included in this paper. Details of the data collection of the two facilities included here can be seen in Table 1.

The interviews with staff and service users are structured through a detailed interview schedule, provided by the manual, addressing all aspects of participants' experience pertaining to the criteria specified by the CRPD. There are detailed instructions in the manual regarding the sampling strategy in terms of numbers and characteristics of prospective interviewees. The original sampling plan per facility had to be revised due to the pandemic imposed restrictions; the numbers and sampling, however, in the cases of the two residential facility assessments, remained within the remit of the guidelines. Although originally planned for interviews to be conducted by all members of the assessment team, most interviews ended up being conducted by the trainees, especially those after the start of restriction measures. Despite concerted efforts in all cases to recruit family members and carers, and although some interviews were originally planned, none was finally conducted. After full briefing, consent forms were signed by all interviewees before interviews were conducted. Protecting the confidentiality and anonymity of interviewees was paramount and all necessary measures were taken.

Observation is central to assessing conditions in mental health facilities. An observation guide is provided by the manual. It is recommended that observation takes place in all parts of a facility, through both announced and unannounced visits, at different times of the day. Beyond the physical conditions, observation includes what happens at the facility, including interactions between staff and service users. The number of observation visits had to be revised down due to the restrictions in visitation

TABLE 1
Data collection

			Hostel	*Apartments*
Number of service users			15	51
Number of staff members			9	9
Interviews	Users	Planned	15	18
		Conducted	8	16
	Staff	Planned	9	5
		Conducted	6	6
	Duration		03/2020–07/2020	06/2020–10/2020
Observation	Announced	Planned	15	22
		Conducted	11	22
	Unannounced	Planned	5	3
		Conducted	2	3
	Duration		11/2019–7/2020	06/2020–10/2020
Documentation review	Facility regulation		1	1
	Facility reports		1	1
	Service user personal files		15	51
	Duration		07/2020	09/2020–10/2020
Report preparation	Number of assessment team meetings		19	10
	Duration		07/2020–01/2021	05/2021–06/2021

rights, and in most cases were conducted by the trainees. Unannounced visits were not possible after the restrictions were imposed, but some were done before. During the visits, there was unrestricted access to observing and making notes of all relevant aspects of the facility.

The assessment is complemented by reviewing documentation. This usually includes facility policies, administrative records, records of specific events and service users' files. In both facilities, the requested documentation was provided by the facility manager and was reviewed by the trainees. Notes from the reviewing process were then shared with the rest of the assessment team.

Data analysis

The WHO QualityRights reporting form for individual facilities provides a framework for the assessment team to document systematically the extent to which each of the five themes of the WHO QualityRights tool has been realised in a specific facility. According to the ToolKit instructions, all members of the assessment team should meet as soon as possible after completion of data collection and work collaboratively to integrate and compile the data from interviews, observation and review of documentation into a final report on the facility. The team score each of the criteria, standards and themes, producing tables with quantitative rankings of each of the assessment components, leading to the overall quantitative evaluation of the extent to which the facility fulfils the requirement of each theme. This is complemented by qualitative evaluation, that provides substance and detail to the rankings and portrays a comprehensive picture of the facility. Quantitative and qualitative findings are integrated into a single report.

For the evaluations reported here, the assessment teams had a series of meetings, in person and virtually, during which they worked collaboratively to produce a report for each facility, that includes extensive evaluation tables with rankings per criterion, standard and theme and supporting comments, as well as a qualitative description of the ways in which the standards were met, supplemented by relevant quotes from the interviews.

RESULTS

For reasons of brevity, we present a summary of the results in Table 2.

DISCUSSION

The implementation of the QualityRights tool kit led to interesting results regarding the quality of care and observance of human rights in the two mental health services evaluated. In what follows, we will briefly outline the conclusions of the evaluation and the recommendations for improvement that derived from it. We will then reflect on the usefulness, appropriateness and relevance of the Toolkit for evaluating mental health care facilities in the particular context of contemporary Greece.

Evaluation of the facilities: Commendations and recommendations

Both facilities were found to operate in accordance with human rights and to offer high quality services. Improvements are needed in certain areas; these are outlined below.

Residents live in appropriate housing conditions, with their basic needs covered. Their privacy is respected and they are given opportunities for a meaningful personal and social life. Improvements can be made in building maintenance, furnishing, disability access and safety procedures. More systematic information on community activities and events, as well as mobilisation of residents to participate in them, would be welcome.

Staff are well trained and experienced in mental health care and are respectful of residents. Residents' general and mental health needs are appropriately addressed. Therapeutic and psychosocial interventions are individualised, collaboratively agreed upon and reviewed with service users. Both facilities operate with a supported decision making model, whereby service users are encouraged to take responsibility of their own recovery. Psychosocial rehabilitation is strengthened by networking with supportive persons, organisations and services. The efforts towards supporting service user agency and autonomy are, however, thwarted by restricted availability of financial resources, employment opportunities and mental health and social care services.

Staff expertise can be strengthened through continuous education on rehabilitation, recovery and human rights. The therapeutic plans should be more at the centre of mental health care provision. They should be more clearly formulated, collaboratively produced and regularly reviewed. A more collaborative approach to medication adherence is also needed, whereby service users are informed and have the opportunity to discuss the effects of medication. Other treatment options should also be proposed.

Residents are protected from abuse, neglect and violence. Reported incidents are dealt with appropriately. Measures are taken to prevent involuntary hospitalisation and other forms of forced treatment. Residents are free to express their concerns and these are addressed. However, there is no formal complaint or appeal procedure and residents are not informed about their legal rights or about human rights organisations they can resort to, if they wish. Moreover, the facilities have not been externally monitored regarding quality of care in line with residents' rights. All the above should be remedied.

TABLE 2
Results

	Hostel		*Apartments*	
	Score	*Comments*	*Comments*	*score*
	A/P	*THEME 1: The Right to an Adequate Standard of Living*		A/P
1.1 The building is in good physical condition	A/P	There have been attempts to improve the building conditions. Disabled access, education on safety procedures and air conditioning in the summer need improvement		A/P
1.2 The sleeping conditions of service users are comfortable and allow for sufficient privacy	A/P	There is sufficient comfort and privacy in the bedrooms. In some cases, lack of furniture, bedding and locking cupboards		A/P
1.3 The facility meets hygiene and sanitary requirements	A/P	Many hygiene and sanitary requirements are fulfilled, such as regular cleaning, proper functioning of bathrooms, privacy in bathrooms		A/I
		The privacy of residents during bathroom use and support of those with physical difficulties needs improving	Provision of cleaning services is restricted, some wc do not lock and residents do not have free access to toiletries and cleaning materials	
1.4 Service users are provided with food, safe drinking water and clothing that meets their needs and preferences	A/F	Food, drinking water and clothing of residents are sufficient in quantity and quality, and according to their needs and preferences		A/F
1.5 Service users are able to communicate freely and their right to privacy is respected	A/P	There is free of charge confidential access to phone calls and mail. There is no wifi, but residents may use data on their mobile phones	Residents receive their mail and can communicate freely and confidentially, mainly through their mobile phones	A/F
1.6 The facility provides a welcoming, comfortable and stimulating environment conducive to active participation and interaction	A/P	The organisation of space encourages interaction between residents and accepting visitors. Common areas are appropriately furnished and there are recreational facilities		A/P
		More emphasis is needed on provision of cultural material, for example, magazines, dvds, activities etc.	Furnishing in some apartments needs improvement	
1.7 Service users are able to enjoy a fulfilling social and personal life and remain engaged in community life and activities	A/P	Staff supports interaction between residents, attending family social events and participating in community activities		A/P
		Activities in the facility should be more regular and systematic	More information on activities in the community, encouragement to participate and collaboration with other organisations are needed	
	A/P	*THEME 2: The Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*		**A/P**
2.1 Facilities are available to everyone who requires treatment and support	A/F	Treatment and support is provided to everyone who requires it. There are no access restrictions or selection criteria based on residents' personal and social characteristics		A/F
2.2 Staff are skilled and able to provide good quality mental health services	A/P	Staff members have knowledge, skills and experience regarding mental health care. There is no continuous education on rehabilitation, recovery and human rights		A/P
2.3 Treatment, rehabilitation and linkages to support networks and other services are elements of a service user driven treatment plan, and contribute to a service user's ability to live independently in the community	A/P	There are individualised treatment plans for all residents. However, they are not regularly reviewed, as required	There are no written treatment plans. Goals are set and evaluated regularly by residents and their case worker. Resident progress is reviewed in staff meetings	A/P
		Networking with services and support networks takes place according to resident needs		

TABLE 2
Continued

	Hostel		*Apartments*	
	Score	*Comments*	*Comments*	*score*
	A/P	*THEME 2: The Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*		A/P
2.4 Psychotropic medication is available, affordable, and utilised appropriately	A/P	Medication is free of charge, sufficient and appropriate. Residents should receive more information on medication effects and adverse effects, and other treatment options		A/P
2.5 Adequate services are available for general and reproductive health	A/P	Adequate general health care, through information and referral to appropriate health services. Reproductive health is addressed only when deemed relevant; this needs improvement		A/P
	A/I	*THEME 3: The Right to Exercise Legal Capacity and to Personal Liberty and the Security of Person*		**A/P**
3.1 Independent living in the community is always prioritised when decisions are made regarding admission to hospital and methods of treatment	A/P	There is an attempt to prioritise residents' preferences regarding their accommodation and mental health and support services they wish to receive		A/P
		Information on and networking with support services needs improvement	Access to accommodation facilities and mental health services is restricted by service availability	
3.2 Procedures and safeguards are in place to prevent detention and treatment without informed consent	A/P	Informed consent is the basis of any treatment in the facility. Medication adherence is prerequisite for remaining in the facility. Attempts are being made to avoid involuntary hospitalisation, when residents are in crisis. Information on legal rights regarding informed consent and involuntary hospitalisation is needed		A/P
3.3 Service users are able to exercise their legal capacity and are provided the support they may require to exercise their legal capacity	A/P	Residents decide on issues that concern them; supported decision making is practiced. Residents are supported mainly by staff and family. Networking with other support persons and human rights organisations is needed		A/P
3.4 Service users of facilities have the right to confidentiality and access to personal health information	A/P	Residents have access to their personal confidential file. Access rights and processes of other interested parties, e.g. relatives, need to be clarified and formalised		A/P
	A/P	*THEME 4: Freedoms from Torture or Cruel, Inhuman or Degrading Treatment or Punishment and From Exploitation, Violence and Abuse*		**A/P**
4.1 Service users have the right to be free from verbal, mental, physical, and sexual abuse and physical and emotional neglect	A/P	No cases of abuse or neglect by staff were reported; staff treats residents with respect. Residents are protected from any form of violence. Incidents of conflict and/or violence reported were dealt with appropriately		A/P
4.2 Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crisis situations	A/P	Some staff members are trained in de-escalation techniques. Seclusion and restraint are not used. However, the crisis management process needs to be formalised and recorded. Staff has not received training in crisis management recently		A/P
4.3 Invasive and irreversible medical procedures	N/A			N/A
4.4 Medical or scientific experimentation	N/A			N/A
4.5 Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment and other forms of ill-treatment and abuse	A/P	Residents can express their concerns to staff. There are no official complaint procedures. Information on organisations supporting human rights is not sufficient, and residents rarely contact them. There is no external monitoring of upholding human rights in the facility		A/I

TABLE 2
Continued

	Hostel		*Apartments*	
	Score	*Comments*	*Comments*	*score*
	A/P	*THEME 5: The Right to Live Independently and Be Included in the Community*		**A/P**
5.1 Service users are supported to have access to a place to live and have the financial resources necessary to live in the community	A/F	Staff inform residents on financial resources and support them in obtaining them. Access to independent living is limited by financial constraints, as most residents have very limited financial resources		A/I
5.2 Service users are able to access education and employment opportunities	A/P	Staff support interested residents to pursue education and employment. However, availability of education and employment is limited, employment conditions are poor and mobilisation of residents is low		A/P
5.3 Participation of service users fully in political and public life and the enjoyment of their freedom to associate is supported	A/P	Staff encourage residents' participation in political and public life through discussing current political and social issues and informing them on their political and voting rights		A/P
		More information on political and social events is needed	Not all residents were aware of their political and voting rights	
5.4 Service users are supported to take part in social, cultural, religious, and leisure activities	A/P	Staff encourage residents' participation in social, cultural, religious and leisure activities. However, information is not systematic, regular and varied. Resident mobilisation is low		A/F

Scores: A/F = achievement fulfilled; A/P = achieved partially; A/I = achievement initiated; N/I = not initiated; N/A = not applicable.

Evaluation of QualityRights tool kit implementation

The QualityRights tool kit addresses all three aspects of mental health services evaluation: structure, process and outcome. More specifically, it follows an approach to service quality, according to which the service structure, shaped by available resources and policies, may inform the processes of care provision, influencing in this way the outcome concerning service users (Gaebel et al., 2012; Kilbourne et al., 2010). By utilising multiple data collection sources, the toolkit provides an accurate and complete picture of the facility. Through involving all stakeholders, professionals, users and carers, and collecting their views on the facility, it also produces a more rounded view. Engaging professionals, users and carers in the management and the assessment teams creates a truly collaborative venture, in which all stakeholders are required to collaborate from an equal position, respecting their different fields of expertise. Through involving all stakeholders, both as researchers and as research participants, the evaluation process becomes educational in terms of familiarisation with issues of quality of mental health care and service user rights. In this sense, it is an empowering process for all concerned. It also builds service user and carer confidence, competence and expertise in carrying out evaluations, contributing to capacity building for user and carer participation in research and evaluation (Rose, 2015).

Notwithstanding its potential, the implementation of the tool kit enabled the detection of problems to be remedied. The tool is not adjusted to Greek culture and mental health service culture, creating the potential of misunderstandings both of terms and of the rationale of some questions. The interview contains too many and quite often too complex questions, that some persons with severe mental health problems might find difficult to engage with. There are also repetitions between sections, that could be ironed out. The tool is designed as a generic tool for use with any kind of mental health services, and adjustments would be needed depending on the type of service. This means that some adjustments might unwittingly distort the results obtained. Also, the language used is quite formal, using terminology that is difficult for interviewees to understand. Instructions for clarification of terms or specific examples that can be provided during the interview would be helpful. Finally, while the tool is meant to be a step in the process of continuous evaluation and development of mental health services, there are no guidelines on how to use the tool to provide feedback to the services and engage the service staff and users in a development process, as hoped by its creators. Generally, the tool kit is meant to provide a set of tools that may be reasonably adjusted to the various circumstances and contexts of its implementation. This necessitates providing guidelines for reasonable adjustments and mainly underlines

the importance of collaborative preparation and training of the evaluation team, before implementation.

Limitations

The limitations of the Toolkit itself and its implementation in the context of mental health services in Greece were mentioned in the section above. Further limitations were due to the COVID-19 pandemic, that impacted in the beginning of the data collection period. The pandemic related restrictions resulted in abandoning the comparative evaluation of a general health facility, significant delays in data collection, incomplete evaluation of one of the facilities and adjustments in the evaluation process of the other two, all of which might have had untoward effects in the quality of the results obtained. The pandemic might also have affected the quality of care provided and thus the result of the evaluation might not be representative of the facilities' normal functioning. Finally, the significance of the study would have been increased if a representative sample was taken from different segments of society, various types of residential services and different areas of Greece.

Contribution and future directions

The study reported here is part of the initial steps to implement this innovative approach in mental health services in Greece. The plan is to expand year by year the evaluation of the mental health facilities in Thessaloniki, and in other areas of Greece, and to push for a nationwide adoption of the QualityRights initiative, in order to promote mental health service services that provide high quality of services, in line with human rights and supportive of recovery. In this sense, this first round of implementation is crucial. First, because it is meant as a pilot that will indicate any adjustments that might be necessary for future implementation. Second, because it will build expertise and a pool of professionals, service users and carers who will be able to carry out evaluation projects in the future. Third, we hope that this first implementation will establish a culture of trust with the regional mental health services that will open the way to other services, that might be more reluctant at present, accepting being part of this process in the future. We hope that this project will form a secure basis for this development.

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