The deadlock of saying 'That is what we already do!' A thematic analysis of mental health care professionals' reactions to using an evidence-based intervention

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The deadlock of saying 'That is what we already do!' A thematic analysis of mental health care professionals' reactions to using an evidence-based intervention.

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That is what we already do!

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Ethical statements

This study was approved by the Danish Data Protection Agency (2015-154) and was reviewed by the local ethics committee. Further, the study was approved by the hospital´s head of research and ward management. The study also conforms to the Declaration of Helsinki. All participants received written and verbal information about the study, and anonymity was ensured. Participation was voluntary and the participants were informed that they could withdraw at any time without any consequences. The interviewed participants all signed an informed consent form.

Authorship declaration

RJ, JC and KK designed the study. HBN and KK conducted six of the interviews. JC conducted supervision in the forensic ward and generated field notes. All authors participated in the analysis. RJ wrote the first draft. RJ, JC, HBC, KK and VZ commented on the following drafts, and all authors approved the final version to be published.

Authorship statement

All authors meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors. All authors are in agreement with the manuscript and it has not been published or submitted for publication elsewhere.

Disclosure statement

All authors declare no conflict of interests.

Abstract

Introduction: Evidence-based interventions are required in mental health nursing to improve quality and outcome for patients. However, there is a need to shed light on professionals' reactions to the use of evidence-based interventions to better understand and adjust the implementation process. **Aim:** To explore mental health care professionals´ reactions to using the evidence-based intervention Guided Self-Determination method in the care of inpatients with severe mental illness. **Method:** A qualitative study conducted in relation to an 8 months implementation program. Data collection: 9 qualitative interviews and field notes generated from supervision of the intervention. **Results:** Four themes emerged from a thematic analysis: 'The expert becomes novice', 'Theory used as a looking glass', 'Guided Self-Determination perceived as an interruption' and 'Becoming an informer of the impact of GSD'. **Discussion:** Using the themes may help leaders or researchers predict or discover the support needed by individual professionals. **Implications for practice:** When preparing implementation of an evidence-based intervention, it is important to consider adaptation and acceptability, as well as support from management and participation in supervision. Finally, it is worth to consider collecting data from trained professionals, who did not use the intervention in practice to understand barriers towards evidence-based practise.

Statement of relevance

Implementation of research-based knowledge and interventions in mental health is an increasing demand, but also a challenging task. In particular this manuscript adds to the insight in the processes professionals might go through when accepting and adopting new practice. This is of great usefulness for both the mental health nurse to better understand oneself, but also for leaders and nurses in charge of implementing new evidence-based nursing practice.

Accessible summary

What is known on this subject?

- There is a need to shed light on health care professionals' reactions to the use of the Guided Self-determination method in a mental health hospital to better understand and adjust the implementation process of evidence-based practice.

- Health care professionals´ values and beliefs play an important role when implementing evidence-based practice in real-world healthcare settings.

What this paper adds to existing knowledge?

- The study identifies opposite positions in mental health care professionals: being ready or resistant to change when implementing an evidence-based intervention. The positions are elaborated in four thematic dynamic continuums describing reactions to using the intervention.
- In addition, this is the first study to explore mental health care professionals´ reactions to using the Guided Self-Determination Method in a mental health context.

What are the implications for practice?

- When preparing implementation of an evidence-based intervention, it is important to consider adaptation of the intervention, the mental health care professionals' acceptability, support from management and participation in supervision.
- In future research, it is important to consider collecting data from MHCPs trained in using an evidence-based intervention, however not using it in clinical practice, to understand barriers towards evidence-based practice.

Keywords

Evidence-based practice, Guided Self-Determination, mental health nursing, professionals' reactions, qualitative interviews, implementation.

Background

In the last decade, there has been increasing focus and demand on making mental health nursing practice more evidence-based. Evidence-based practice (EBP) is understood as the integration of the best available research with clinical expertise and patients´ values and preferences with the purpose of improving quality of healthcare and patient outcomes (Sackett, 1996; Melnyk, 2011).

Traditionally, nursing practice has been influenced by word of mouth and textbooks, and not by research. In particular, mental health nursing is still influenced by tradition and not by research (Zauszniewski, 2004). Implementation of research requires not only support from management, but also mental health nurses' readiness to change practice, and it is challenging to change familiar and comfortable practices (Zauszniewski, 2004), moreover it is a challenge to translate research knowledge into practice (Forchuk, 2013). Further, evidence shows that health professionals´ values and beliefs play an important role when implementing EBP in real-world healthcare settings (van Sonsbeek, 2015). Incorporating research evidence into clinical practice takes on average 17 years (Morris, 2011), therefore, it is important to consider factors promoting or impeding the implementation process of evidence-based interventions. As mentioned above, one factor to consider is the health professionals' readiness to change practice and their attitudes towards the intervention. However, adaptation of the intervention into the setting also plays an important role in the implementation process (Escoffery, 2018) together with acceptability and the health professionals´ perception of the intervention (Proctor, 2011).

Between 2008 and 2011, the evidence-based intervention 'Guided Self-Determination' (GSD) was adapted to individuals diagnosed with schizophrenia (Jørgensen, 2013) and tested in a randomized trial in a population of outpatients (Jørgensen, 2015). The GSD method is a shared decision-making and mutual problem-solving method that supports patient involvement (Zoffmann, 2011), and it is developed from qualitative research reported in three grounded theories (Zoffmann, 2005;2007;2008). Originally, the GSD method was developed for and proved effective in diabetes care (Zoffmann 2004;2006). It has subsequently been adapted to various somatic and psychiatric conditions. The GSD method accomplishes focused communication, self-reflection and mutual reflection facilitated by the completion of semi-structured reflection sheets. In schizophrenia, the GSD has resulted in statistically significant reductions in psychopathology and the subscales of negative and emotional discomfort symptoms, when compared with treatment as usual in the control group (Jørgensen, 2015).

Until now, GSD research within mental health has focused on the effectiveness of the GSD method and patients´ experiences (Jørgensen, 2012). No research has yet focused on mental health care professionals´ (MHCP) perceptions to use the GSD method. Owing to lack of research within this area together with the fact that mental health nursing practice has a very short history of implementing evidence-based interventions and that implementation can be challenging. There is a need to shed light on MHCPs' reactions to the use of the GSD method in a mental health hospital to better understand and adjust the implementation process of EBP.

Aim

The aim of this study was to explore MHCPs´ reactions to using the evidence-based intervention GSD in the care of inpatients with severe mental illness.

Methods

Design

This qualitative interview study (Creswell, 2013) was part of a mixed-methods study rooted in American pragmatism (Blumer, 1986), using an explanatory sequential design (Creswell, 2018). The quantitative strand is a cross-sectional study reporting on burnout among MHCPs working in closed and open wards, and the mixed methods paper will investigate the use of the GSD method and its impact on burnout in MHCPs after 8 months. This paper reports on the results from the qualitative strand.

Study Setting

The study setting involved four psychiatric wards: one forensic and three open adult wards for patients with psychotic disorders in a Danish university hospital. The forensic ward is a closed ward for patients who have committed a crime and who need to be admitted during treatment. The three open adult wards are for patients, who have recently been diagnosed or who have been diagnosed with psychotic disorders for several years. The main focus of the hospitalization is treatment. In Denmark, rehabilitation is carried out outside hospital service. The study was conducted in relation to an implementation programme with the purpose of implementing the GSD method in clinical practice.

The Guided Self-Determination Method

The GSD method consists of semi-structured reflection sheets, which are completed by the patient and further examined through focused communication and mutual reflection between the patient and the MHCP, each of whom is entitled to have his or her own opinions and perceptions of the content (Zoffmann, 2011). The GSD method supports the patients´ reflections and focuses on assisting patients in evolving narratives about what it means to them to live with a severe mental illness in everyday life. In particular, they identify challenges and find and test solutions to these challenges in order to develop an internally motivated self-management of the illness. The reflection sheets are arranged in four stages: 1) agreement to work together, 2) your life with an illness, 3) between ideal and reality, and 4) working to change.

Guided Self-Determination training programme

A GSD training programme was conducted by the first author of this paper in January 2015 in a forensic ward and in March 2015 in three inpatient wards for people diagnosed with a psychotic disorder. The training programme for GSD facilitators consisted of 10.5 hours of education divided into two days: day 1 comprised 7.5 hours and day 2 (approximately 8 weeks later) 3 hours. Training day 1 focused on the three grounded theories: GSD research results, communication theory and the first three stages in the GSD reflection sheets. Training day 2 focused on the last stage. The didactic approach was mainly presentations with the purpose of providing the MHCPs with theoretical and evidence-based knowledge; only day 2 contained exercises to develop skills regarding the reflection sheets and communication.

The GSD facilitators were supposed to offer GSD as individual training with an instructive and flexible programme consisting of approximately 8–10 sessions, each lasting 30–60 minutes provided once or twice weekly. Even patients with a planned short admission were offered to work with the method, as each session provides both the patient and the MHCP with new insights regarding the patient´s situation.

After day 1, for 8 months 30-minute weekly or biweekly supervisions were held for all MHCPs present at each ward. The supervision was conducted by two clinical nurse specialists, who had received GSD training by the first author. The purpose of the supervision was not only to meet the MHCPs' challenges or questions, but also to focus on the three grounded theories as a framework

for the supervision to provide insight into the challenges, barriers and possibilities in the relationship between the patient and the MHCP when using the GSD method.

All MHCPs employed in the four wards were invited to participate in the training programme. In total, 72 MHCPs participated; however, 11 were not using GSD in clinical practice, as seven worked evenings or nightshifts, and interventions only take place during daytime, and five MHCPs did not participate directly in nursing care, but only in physical activity. Eight months after the GSD training, 28 MHCPs had used the GSD method in clinical practice. Seventeen MHCPs had used the GSD method with one patient, four with two patients and seven with between three and seven patients. Thirty-three MHCPs had not used the GSD method in clinical practice (10 MHCPs left the wards and 23 never used the GSD method). We have no data explaining why so many MHCPs did not use the GSD method.

Participants

Purposeful and maximum variation sampling (Creswell, 2013) was used to recruit MHCPs to an individual qualitative research interview. Purposeful sampling was applied with the aim of selecting MHCPs who would provide unique and rich information to the study about using the GSD method and maximum variation to target the range of wards included in the study together with age and years of working experience. Nine female MHCPs (five registered nurses with a bachelor degree and four social healthcare assistants) participated. Three participants worked in the forensic ward, and six worked in the three inpatient wards for people diagnosed with a psychotic disorder, two in each ward. Mean age was 47.5 years (range 30–62), mean years of working experience in psychiatry was 13 years (range 3.5–42) and mean years of working experience in the ward was 10 years (range 2–33). The participants had used the GSD method in 1–7 individual GSD courses. Nursing education in Denmark is generalist training, 3.5 years ending with a bachelor degree. Becoming a social healthcare assistant is a vocational education lasting 2 years and 8 months.

Research team

The research team were both involved in the implementation of the GSD method and the research project. The research team consisted of the authors: two researchers with a PhD (RJ, VZ) and three clinical nurse specialists with a master's degree (JC, HCN, KK). The first author RJ conducted the GSD

training, as she is a specialist in the GSD method within mental health. The GSD training programme was developed in relation to train 36 MHCPs to use the GSD method in an randomized open trial (Jørgensen, 2015), and modified for this study due to experiences and feedback from the MHCPs from the trial. In addition, two clinical nurse specialists helped conducting the data collection and supervision. All but VZ were employed at the university hospital. The clinical nurse specialists conducting the supervision and generating the field notes did it in a familiar clinical practice, but all interviews were conducted between a MHCP and a clinical nurse specialist not familiar with each other. The research team except VZ meet on a regularly basis, first to plan the study and the implementation of the GSD method, and later to analyse the data.

Data-collection

Semi-structured qualitative research interviews were collected 8 months after the theoretical GSD training, and during the 8 months, field notes were generated concurrently after supervision 2–4 times a month.

Interviews

The individual interviews were semi-structured qualitative research interviews with the purpose of providing rich and in-depth information (DiCicco-Bloom, 2006). The interviews took place at the psychiatric hospital in a private room. Three clinical nurse specialists with prior experience in qualitative research interviews conducted the interviews in accordance with an interview guide with open-ended questions covering the MHCP´s reactions towards using the GSD method in the care of patients with severe mental illness. The interviews were audiotaped and transcribed verbatim by a research secretary; the transcripts were subsequently checked by the person conducting the interview. As the interviews were conducted in Danish, all subsequent quotations are English – not verbatim translations, but translations true to what was said.

Field notes

Field notes were generated by the two clinical nurse specialists conducting the supervision immediately after each supervision. The field notes were condensed from the clinical nurse specialists´ observations and reflections from the supervision. The rationale for generating the field notes was to collect data from a bigger sample and to collect data concurrently with the use of the GSD method to support the understanding of the in-depth interviews. The field notes were hand-

written and not transcribed, and no quotations were used in the results section. The two clinical nurse specialists were both aware of the field notes being used in the analysis. The approach in observation and generating field notes was inspired from ethnography (Emerson, 1995).

Data analysis

We conducted a thematic analysis inspired by Braun and Clarke (2006), following their six steps: 1) familiarizing yourself with data, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes, and 6) producing the report. JC, HCN, KK and RJ conducted the analysis, which was iterative and occurred as a movement back and forth. Everyone participated in the first step. In step 2, an inductive approach was taken: two authors coded each interview independently of each other, followed by a consensus discussion between all four authors. In step 3, the codes were revisited and discussed according to connections, resulting in six themes: 1) the MHCP´s role, 2) meaning of theory, 3) utilization of GSD, 4) perception of GSD, 5) patient outcome and 6) challenges with patients. The themes were then deductively tested in the interview data and the field notes without resulting in new themes. Reviewing the themes in step 4 reduced the themes from six to four. At step 5, the four main themes were named and described: 1) the expert becomes novice, 2) theory used as a looking glass, 3) GSD perceived as an interruption and 4) becoming an informer of the impact of GSD. At this step it became clear that each theme could be described as a continuum, as each theme contained both a resistance to change approach and a readiness to change approach. This description was finally confirmed during the process of writing this paper (step 6). VZ participated in steps 5 and 6.

Ethical considerations

The study was approved by the Danish Data Protection Agency (2015-154) and was reviewed by the local ethics committee. Further, the study was approved by the hospital´s head of research and ward management. All participants received written and verbal information about the study. Anonymity was ensured for the MHCPs both in the field notes and in the reporting of the results. Participation was voluntary and the participants were informed that they could withdraw at any time without any consequences. The interviewed participants all signed an informed consent form. In regard to disclosure of harm or potential harm to the patients working with the GSD method reported by participants, patient safety would be prioritized and dealt with at any time.

Results

The data revealed that the MHCPs overall accounted for opposite positions: being ready or resistant to change. These positions were specified into four thematic dynamic continuums named; 1) the expert becomes novice, 2) theory used as a looking glass, 3) GSD perceived as an interruption and 4) becoming an informer of the impact of GSD. The themes described the MHCPs´ reactions to using the GSD method, which were not static, as some MHCPs showed a tendency to move in the direction of the readiness-to-change approach concurrently with use of the GSD method. The themes and the two approaches are presented in Figure 1 and elaborated in the following sections.

The expert becomes novice

This theme reflected the professionals´ reactions to acknowledging the GSD method as a new approach and themselves in a role of being a novice in using it. The immediate response from all MHCPs was that they recognized elements from the GSD method, e.g. communication, patient involvement, problem solving and the relationship between the patient and the professional, when compared to daily clinical practice.

Some MHCPs rejected GSD as a new method; they felt that they had already practiced GSD but without using the reflection sheets.

MHCP 8: *"Working with GSD is not new to me. Much of it is already in my skills".*

MHCP 3: *"When I got familiar with GSD, I said to myself, this is what we already do".*

They saw themselves as experts with several years of experience-based knowledge, not needing to use the GSD method. Experience was valued very highly, and this group included the MHCPs with the longest working experience. They only accepted bringing GSD into clinical practice, because the hospital management decided to implement it. Some also expressed that supervision was not necessary.

MHCP 1: *"It would be different if you take an inexperienced professional. I have lots of clinical experience".*

The majority of the MHCPs, however, accepted that GSD was a new intervention, in spite of the familiar elements, and acknowledged that they had to learn how to use the GSD method before being confident with the method. They also worried about spending more time than usual with the patients and leaving extra tasks for their colleagues. The MHCPs saw themselves as novices despite the fact that they had many years of clinical practice experience and reflected a lot about their own role because they felt challenged and insecure. Several hesitated when starting with the first patient. Being a novice was also an ongoing topic in the supervision.

MHCP 5: *"I have never hidden that this (using the GSD method) is new to me, and that I was reluctant to start".*

MHCP 2: *"It is tough to start working with the GSD method".*

Accepting being a GSD novice reflected a readiness-to-change approach, whereas rejecting being a GSD novice reflected a resistant-to-change approach of usual clinical practice.

The two positions as an accepting or rejecting GSD novice also appeared when MHCPs talked about difficulties or challenges in using the GSD method. The accepting GSD novices blamed themselves and their insufficiency for not succeeding with the intervention, e.g. patients refusing to participate or not filling in the reflection sheets, or being in doubt about their communication skills. In contrast, the rejecting GSD novices blamed the patients´ severe psychopathology and/or lack of illness insight. The two roles also differed regarding support from colleagues and management. The accepting GSD novice required and expected response and interests from colleagues and management and stated that improvement here was necessary. The rejecting GSD novices did not require this, seemingly relying on themselves. They did not question nor ask for any response to their way of using GSD. In accordance with that, some avoided participating in supervision with the excuse being busy with more important tasks.

Finally, fidelity in using the GSD method also differed between the two roles. The rejecting GSD novices tended to have a more laidback attitude to the method, as they would sometimes label a conversation with a patient as a GSD conversation without following the instructions from the GSD training.

MHCP 8: *"I have found my own way to use GSD".*

In contrast, the accepting GSD novices were more careful, and needed to be prepared and confident in using GSD correctly and concerned about what direction they would take with the patient.

MHCP 5: *"I look forward to getting more time to prepare, to get GSD under my skin and be more confident".*

The two positions, as accepting or rejecting GSD novices, were not static but dynamic as there for some was a tendency to move on the continuum in direction of acceptance.

MHCP 7: *"At first I thought that this is what we already do, but GSD is more structured, and it is an approach to become more aware of one´s professional knowledge".*

Accepting being a GSD novice included both an understanding of the theoretical underpinnings of the GSD method and clinical experience, when reflecting on the use of the GSD method. Rejecting being a GSD novice only included the use of clinical experience. This is elaborated in the second theme.

Theory used as a looking glass

This theme highlighted MHCPs' attitudes towards an understanding of the theoretical underpinnings of the GSD method. Most of the MHCPs had difficulties accounting for the three grounded theories with the correct terminology, both seen in supervision and the interviews. However, some managed to explain the main content with examples from their clinical practice. Again, the MHCPs took two positions of rejecting or accepting the value of theories as useful means. Again, the positions were flexible and movable, for a few in the direction of readiness of accepting the value of theories in practice.

A few MHCPs had no recollection of the grounded theories. It was a common trend that they did not acknowledge the theoretical knowledge as necessary to understand clinical practice or to use the GSD method, rather relied on themselves as important means. Only clinical experience was of value to them.

MHCP 8: *"I cannot remember that we ever talked about theories. I do not use theories; I use myself".*

The theory was accepted in two ways: perceived as knowledge used implicitly, or used consciously to understand own clinical practice.

MHCP 2: *"In my opinion, the grounded theories are great for understanding and becoming aware of how I use myself, and how the patient reacts".*

The more familiar the MHCPs became with the grounded theories and the communication theories, the more they understood the use of the GSD method. Being aware of this supported their confidence in themselves.

MHCP 3: *"The theories have helped me become aware of my own behaviour and helped me to put words to my actions and understand the rationale behind them".*

GSD perceived as an interruption

This theme embraced how the MHCPs perceived the GSD method, especially the GSD reflection sheets, as an interruption in clinical practice. The MHCPs with a resistant-to-change approach found it artificial to bring the reflection sheets into their daily practice. They also stated that GSD was a time-consuming tool. In general, they relied on their clinical experience and believed that they were already practising GSD.

MHCP 1: *"I did not use the reflection sheets with patients every time; it was mostly communication and dialogue".*

MHCP 8: "I *have no problems communicating with patients. Bringing GSD in felt enforced on me".*

This attitude towards GSD was justified when the MHCPs met challenges with the patients, who were not motivated to complete the reflection sheets. Further, they indicated many obstacles in patients to work with the GSD method but without questioning their own qualifications.

In contrast, the MHCPs with a readiness-to-change approach very quickly perceived the reflection sheets as a structured and goal-oriented tool for collaboration with the patients. They believed that all patients were able to use the GSD method if merely the MHCPs were able to adjust and plan the session, taking into consideration the patient´s psychopathology, cognitive deficits and motivation.

MHCPs who experienced GSD as a structured, goal-oriented and focused intervention also emphasized GSD as a method that supported the relationship with the patient and generated new insights about the patient and his/her challenges at every session. The MHCPs were also excited

when they discovered that GSD provided new insights about known patients with several admissions.

MHCP 4: *"GSD is a really great way to get to know the patient…to really get to know the patient".*

The more experienced the MHCPs were in using GSD, the more they perceived the interruption as positive, indeed, when they in some cases experienced that using GSD succeeded in involving patients in collaborative solutions to complex problems, which had not been solved at previous admissions.

MHCP 2: *"You take the time to be with the patient and listen, but stop giving advice all the time and instead support the patient in finding the answers himself".*

Moving on the continuum from seeing GSD as an intruding interruption to a valuable tool required the MHCPs to look at themselves in the light of the grounded theories. This was a personal challenge to most MHCPs.

Becoming an informer of the impact of GSD

This theme accounted for whether the MHCPs characterized the impact of the method in individual cases unilaterally or mutually, inclusive the perception of the patient.

Within the resistant-to-change approach, MHCPs described the GSD impact solely from their own assumptions, an I-judgement of impact without including the patient's perception. Sometimes a failed outcome was assumed to be connected with unchangeable patient dependent factors. This was especially the case when the MHCPs experienced difficulties in using GSD with patients.

MHCP 3: *"It depends on the type of patient, not everyone can do it. It is difficult to believe that they can change and they are also difficult to motivate".*

It was very quickly concluded that GSD was too difficult for patients or that severe psychopathology and/or lack of illness insight were a barrier for the patients to gain any awareness of their problems. This often resulted in the MHCPs deciding to stop the GSD sessions, a decision solely made by the MHCPs relying on their clinical experience and not in collaboration with the patient.

Oppositely, to some of the MHCPs it became evident that prior understandings about patients were challenged when using GSD, as it created opportunity for new insights into the patients. The necessity to make room for the patient, listening and avoiding providing solutions became clearer to the MHCPs.

MHCP 7: *"GSD made us both understand what the real problem was…it gave me a much deeper understanding of her".*

MHCP 3: *"She suggested most of the solutions, and I just proposed some additional ones".*

The MHCPs, who used we-judgement of benefits, emphasized insight into oneself, awareness of the actual problems, potential solutions and insight into the connections between previous behaviour and problems as important impact gained from GSD.

MHCP 2: *"He connected his life experiences to his life challenges…which made him come to the conclusion that he had a problem with alcohol".*

MHCP 4: *"The patient found the way herself, she wrote that she could manage living in her own apartment, if she continued taking her medication".*

A few MHCPs even became ambassadors for GSD as they stated that they wanted to motivate colleagues who were not confident in using GSD, because they wanted them to experience and discover the benefits themselves. Supervision actually constituted a framework for exchanging excitement towards the GSD method from enthusiastic MHCPs, who seemed to inspire the more resistant MHCPs to start using GSD and helping them see the benefits of using GSD.

It also became clear to some of the MHCPs that problems prior identified by them, without participation of the patient, were now identified and acknowledged by the patient without any conflicts when using GSD. The MHCPs found that it was an important factor for the patients to know and understand themselves and their challenges, instead of professionals making all the decisions and finding solutions.

Discussion

We consider the findings of the four themes as significant for understanding the important reactions connected with implementation of interventions in clinical practice, both in GSD and other interventions. A discontinued implementation can be explained by the patterns described in the

resistance-to-change approach. Similarly, the themes can help to discover movements in the MHCPs in the direction of a readiness-to-change approach and thus acknowledge even slight progress. Using the themes may help leaders or researchers predict or discover the support needed by individual MHCPs at an earlier stage.

To our knowledge, this is the first study to focus on MHCPs' reactions when they start using the GSD method in a mental health context. Prior to this, professionals' perspectives on using the GSD method have been explored among nurses working in diabetes care in Norway (Kolltveit, 2014). The results showed that at first replacing traditional methods with GSD made the nurses less confident and even uncertain until they regained their confidence through support from the semi-structured reflection sheets filled in by patients, and being trained through roleplay and supervision (Kolltveit, 2014). This corresponds well with the reactions of some of the MHCPs in our study. They hesitated to start using GSD and felt insecure, but using the theoretical underpinnings to understand themselves and the patients, together with the completed reflection sheets, made them more secure.

Although the MHCPs received supervision, it was not given much attention in the interviews. Only a few participants mentioned it as supportive and important. However, it was clear in the field notes that enthusiastic MHCPs inspired the more resistant MHCPs to change their attitude towards the GSD method in a positive direction. The importance of supervision as a framework for exchanging experience and engagement in fact seemed to be underestimated by the professionals and by management. Ward management would sometimes cancel supervision owing to lack of time or lack of staff. This is in accordance with findings from the study by Buus et al. (2011), who stated that participation rates in supervision in psychiatric settings are low and found that professionals appreciate supervision but do not prioritize participation. As reasons for this, they mention that they find participation emotionally challenging and that they consider it of limited importance for their clinical practice. The fact that only 28 of trained MHCPs used GSD in the 8 months after training, indicates that the implementation process could be improved, e.g. better support from management and prioritization of supervision. The latter might also support MHCPs who felt insecure in using GSD and help the rejecting GSD novices to better understand the theoretical underpinnings, as the grounded theories were used as framework in the supervision. In a Danish study, the time needed for health professionals to reach GSD certification decreased remarkably when leaders changed from having an 'accepting' to an 'active' ownership attitude to the GSD implementation (Weis, 2014). Thus, we see active ownership from the MHCP leaders as a necessary step in implementing the GSD to ensure that the GSD trainees prioritized and actually joined the

planned supervision. Effective leadership and supervision are also emphasized by Cusack et al. (2017) as important factors when implementing new practice. Further, they point towards a learning culture that value of training and education as central factors to facilitate new practice (Cusack, 2017).

However, other factors might also play an important role in improving the implementation process, e.g. adaptation of the GSD method. Within mental health, the GSD method has been adapted for outpatients and this implementation study took place in an inpatient setting. Even though the MHCPs were trained to use a flexible GSD program, further adaptation might be necessary.

The rejecting GSD novices who found GSD an intruding interruption with no benefits for the patients seemed to be locked in an I-you-distant provider dominance role (Zoffmann, 2007), where they perceived themselves to be experts with responsibility for solving the patients´ problems, based on their long clinical experience. Their perception of GSD being the same as their traditional clinical practice might be due to the fact that, in principle, they were good advocates for patient involvement and shared decision-making (SDM), yet failing to realize it in practice (Zoffmann, 2011). This is in accordance with Schön et al. (2018), who carried out a similar study investigating psychiatric staff perceptions of the implementation of a SDM tool. Although the staff also stated that SDM already was familiar to them and being used in daily practice, they described their usual practice without SDM (Schôn, 2018). This inconsistency between professionals' values and the care they actually provide might benefit from an intervention like GSD where the reflection sheets serve as supportive tools for acknowledging and learning from the patients' reflections on their way of managing their psychiatric condition.

The MHCPs, who were not able to differentiate between traditional practice and the GSD method, rejecting the theoretical underpinnings of GSD, were also the MHCPs with the longest experience. According to van Sonsbeek et al. (2015), professionals with long experience in practice seem to be more autonomous and assertive in making decisions about using evidence-based interventions rather attaching more importance to their own clinical experience than appreciating research-based interventions. This corresponds well with the MHCPs with long clinical experience in our study, as they relied on their experience-based knowledge and rejected the theoretical underpinnings. This was further supported by their statements that patients lacked willingness and ability to use GSD. The last was also a finding from the study by Schön et al. (2018). When implementing evidence-based interventions in the future, it is therefore important to show consideration for older professionals with long experience. The reverse situation was found with younger professionals with less clinical experience, as they had a more positive attitude towards evidence-based interventions

because they have had more prior exposure to these interventions during their education than older professionals (van Sonsbeek, 2015). The MHCPs accepting the GSD method as a new intervention were also the youngest.

This leads to a focus on the GSD training programme, which mainly consisted of oral presentations about the theoretical underpinnings of the GSD method, communication theory and research results. To target both MHCPs with shorter and longer experience, more practical exercises and less theory and research-based knowledge might be included earlier in the GSD training programme.

Instead of expecting every MHCP employed in a ward to use the GSD method, this might be considered an intervention that demands a certain level of education from the MHCPs supposed to use it. Another consideration could also be to ask older MHCPs and MHCPs with a resistance-to-change approach to participate in adapting the intervention and training.

Study limitations and strengths

The fact that all interviewed participants were female was a limitation, but it was not possible to include sex in the maximum variation sampling.

Another limitation of the study is that 33 MHCPs never used the GSD method. We know that 10 MHCPs left the wards, but we have no data from the remaining 23 MHCPs. As the aim of the study was to explore MHCPs reactions to use the GSD method, we consequently recruited participants who would provide rich information about using the GSD method. The results, however, revealed two approaches: the readiness-to-change approach and the resistance-to-change approach. Interviewing the MHCPs that never used the GSD method might have elaborated the resistance-to-change approach and shed further light on why MHCPs felt resistance to the intervention.

The clinical nurse specialists conducting the supervision also generated field notes. They thus had two assignments, being a supervisor in a familiar clinical practice with familiar MHCPs and a researcher with the job to generate field notes from participant observation. This might have had an impact on the field notes as the clinical nurse specialists were subjectively involved in supervision besides having to take an objective stance. To comply with this, the field notes were only used in step 4 in the analysis, reviewing the themes.

The strengths of the study were the two data sources: the field notes serving as validation of the themes emerging from the interviews, and the fact that all authors conducted the analysis together, which gave an opportunity for several critical reflections at each step of the analysis.

Conclusion

MHCPs have difficulties in changing from a familiar and comfortable practice based mainly on experience-based knowledge to a new evidence-based intervention. The awareness of the distinction between traditional practice and the GSD method and the discovery of the emerged mutual insight about the patient when using the GSD method were important motivational forces for making changes.

Implication for practice

When preparing implementation of evidence-based interventions, it is important to consider adaptation and acceptability to identify gaps and barriers in the use of the intervention, as incorporating interventions into clinical practice is a great challenge. It is also important to adapt the training to the target group, e.g. older professionals with long practice experience depend more on experience-based knowledge than research-based knowledge compared to younger professionals. To understand barriers towards evidence-based practice, future research should consider collecting data from MHCPs trained to use an evidence-based intervention but not using it in clinical practice. Finally, support from management and participation in supervision are important factors when implementing evidence-based interventions.

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Figure 1:

Mental health care professionals´ reactions to using the GSD method in a mental health context