Trust in pathways? Professionals' sensemaking of patient pathways in Norwegian mental health services

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Trust in pathways? Professionals' sensemaking of patient pathways in Norwegian mental health services

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Abstract

Background: In January 2019, the official launch of new guidelines within specialist mental health services and substance abuse treatment in Norway took place, with treatment organized according to structured patient pathways. The pathway system introduced maximum lengths for assessment, treatment, and evaluation and the coding of the different steps. The system was based on overall goals to improve services by focusing on user participation, coordinated patient flow, avoidance of unnecessary waiting time, more equal services independent of geographic location, and greater emphasis on somatic health and lifestyle.

The purpose of our study was to examine the implementation of patient pathways within mental health services, and more specifically how trust emerges and influences the final outcome.

Methods: Our study included four outpatient clinics for adults in four community health centres in different parts of Norway. The informants consisted of treatment personnel, leaders, and pathway coordinators, and data were collected through qualitative group and individual interviews.

Results: The results indicated four distinct themes or reactions towards the patient pathway system. These themes were unclarity regarding the overall goals and content of the patient pathway; increased coding, registration and administrative work, which professionals experienced as stressors; an IT and journal system that did not correspond with the coding of the patient pathway; and an unrealistic distinction between assessment and treatment. All of the above encouraged health professionals to reduce the importance of patient pathways, as well as increase their resistance towards health authorities.

Conclusions: To understand how and why health professionals made sense of the patient pathway, theory on trust can be used to show how professionals within health care interpret the implementation of patient pathways as a desire to control more areas and work practices within mental health care, leading to their distrust towards the new system

Trial registration: Not neccessary

Keywords: Patient pathway, sensemaking, trust, mental health

Background

In recent years, national guidelines in health care have been produced at an increasing rate, and managers are expected to promote these guidelines and their implementation in clinical

work [1]. Mental health care is seen as a difficult service to manage in regard to the implementation of change and new innovations [2, 3]. Furthermore, new guidelines often require new information systems within hospitals, which is portrayed as notoriously problematic because these systems interfere with health professionals usual workflows and because the anticipated benefits take time to materialize [4, 5].

The process of implementing patient pathways in mental health started in autumn 2018 with national and regional introduction conferences, and a national plan for implementation from 2018–2020 [6] was sent out to the regional health authorities. Organizing health care services through standardized clinical pathways (CPs) occurs in several areas of Norwegian health care, with the implementation of CPs within cancer treatment as the largest national introduction of standardized service production [7]. In January 2019, the official launch of the new guidelines within specialist mental health services and substance abuse treatment in Norway took place, with treatment organized according to structured patient pathways. The pathway system introduced maximum lengths for assessment, treatment, and evaluation. The pathway system did not introduce new patient rights but emphasized the following different measures as means to achieve the overall goal and the motive behind the patient pathway system: increased user participation, coordinated patient flow, avoidance of unnecessary waiting times, more equal services independent of geographic location, and greater emphasis on somatic health and lifestyle. To determine whether the goals of coordinated patient flow have been achieved, a coding battery was developed with codes defining the type of pathway, type of events, outcome of the clinical decision, outcome of the performed activities, and outcome of the termination of the patient pathway. The codes are registered by the therapist or by administrative staff.

Despite having clear strategic goals, the Directorate of Health was reticent about the execution of patient pathways, leaving the interpretation and accomplishment to be done by

each hospital or unit within specialist mental health care.[1] Furthermore, there was already much resistance towards the new organization from health professionals working within mental health services [8].

The process through which organizational actors attempt to explain, interpret and relate to new innovations or implementations has become a critically important topic in the study of organizations and is often theorized as sensemaking [9]. The ability of organizational actors to make sense of such events or issues has been linked to change and its outcomes [11-13]. One issue that is especially relevant for outcomes of implementation projects within healthcare is trust. Trust has been seen as fundamental for quality healthcare, new implementations, and outcomes in many national and local healthcare contexts [14-16.

To understand how trust emerges and influences the implementation of patient pathways, we suggest that a fruitful way forward when analysing the complex implementation process is to combine theory on sensemaking with theory on trust. Sandberg and Tsoukas [20], in their review of 147 articles using sense-making theory, report that only one article applied sensemaking in combination with theory on trust and that there was a need for further research combining the two theories. In our study, we study how health professionals who work in an outpatient clinic made sense of the implementation of patient pathways and how this sensemaking affected issues of trust.

How do mental health professionals make sense of patient pathways, and how does issues of trust affect the process of implementation?

Theoretical outlook

Formatert: Innrykk: Venstre: 1,27 cm

[1] The Norwegian Directorate of Health, National plan for implementation of patient pathways 2018–2020

Understanding change. Making sense of implementations

Sensemaking theory has been utilized in several studies examining change and implementation processes [21, 22]. Within health care, Kristiansen et al. [23] show how nurses use sensemaking to deal with contradicting logics. Apker [24] elaborates on how nurses make sense of the managed care era within a US hospital, and Ericson [25] demonstrates the need for sensemaking in understanding strategic change processes in a Swedish hospital.

A central element in much sensemaking research is an overall focus on the individual and the need to understand complex and confusing circumstances and turn them into comprehendible situations that enable purposeful action [9, 20, 21, 26, 27]. Sensemaking directs both cognitive and social mechanisms for coping with new or unexpected events, as well as with ambiguity and incongruity within organizations, and it explains actors' behaviour in practice [9, 23]. The experience of equivocality leads individuals to extract and interpret environmental cues. Much current research on how sensemaking occurs is focused on three sets of interweaving processes: perceiving cues (noticing), making interpretations and engaging in action [21, 22].

In this way, sensemaking becomes the key mechanism of social interaction. Focusing on ongoing processes that rationalize organizational behaviour, sensemaking helps to resolve incongruity in ways that enable activity to occur [21]. Moreover, it is natural to assume that individuals utilize sensemaking as a strategy when interpreting new innovations or change projects, in line with Weick's [28] initial theory, which suggests that sensemaking is initiated when something new or surprising challenges existing frames of reference [20-22, 30]. Moreover, in recent years, repeated calls have been made regarding the need to include both material embedding and relational practice in theory because of the former, one-sided focus on the individual as the sole actor in these processes [20, 27, 31, 32]. The critical sense-

making perspective tries to not only explain sensemaking as an internalized and individualized way of seeking coherence and meaning but also explain how this meaning already exists in subjects, objects, values and practices understood when individuals take on different roles and identities when interpreting them. Furthermore, this approach comprehends sensemaking as a holistic practice where the context and the environment are integral [20, 21, 31, 32].

Trust within mental health care

Traditionally, trust has played an important role in the relationship between the state, health care practitioners, and patients [33-35]. This is elaborated by Rowe and Calnan [36], who conclude that the meaning and enactment of trust within health care is influenced by wider social structures, particularly by top-down policy makers and the introduction of different governance and performance management strategies. We utilize Gulati and Nickerson's [37] definition of trust as the expectation that another organization can be relied on to fulfil its obligations, to behave in a predictable manner and to act and negotiate fairly even when the possibility of opportunism is present [37-39]

Research within the field of mental health has, for the most part, explored trust between patients and clinicians [1, 40]. However, several theoretical studies on organizations elaborate how trust relations in the workforce, both between providers and between providers and managers, also have the potential to influence patient-provider relationships and their levels of trust [33].

This view has been elaborated by several researchers, including Szulanski [41], and explored further by Elwyn et al. [42] within health care. In Szulanski's [41] model on knowledge transfer and implementation in healthcare, the motivation of the source and credibility are important factors for success or failure [41]. Furthermore, this means that

trusting the messenger in the implementation of guidelines is important for both organizations and their members. Thus, it seems reasonable to propose that the same trust needs to exist among governmental agencies realizing national guidelines, health care services and the professionals involved [41]. For a consideration of how trust affects these relationships, an assessment of the interests of the source, or trustor, is important [43]. This is in line with Sandstrøm et al.'s [1] research on the implementation of guidelines within mental health care, in which the authors conclude that *regardless of from whom guidelines are released, they are unlikely to be utilized or implemented in the care of patients if those further down in the hierarchy do not trust the source* [1].

Elaborating the role of trust within health care systems, one must be observant of institutions, the number of relationships that must be managed to deliver outcomes, and the importance of developing shared meanings to sustain delivery [43, 44]. This development of meaning is central from the sense-making perspective and requires further elaboration in understanding its relation to trust.

Critical sensemaking and trust. Bridging the gap

Fuglsang and Jagd [45] investigate the relations among trust, institutions and sensemaking and, more specifically, examine how sensemaking may serve as a bridge between institutional contexts and interpersonal trust processes. There is a lack of theoretical perspectives that see the institutional bases of trust as emerging through micro strategies of social interaction. The critical sensemaking perspective, introduced by Mills et al. [46] and eaborated further by Aaroma et al. [47], addresses this research gap and provides a framework for understanding how individuals make sense of their environments at a local level while acknowledging power relations in the broader societal context. By examining contexts, the critical sensemaking framework creates space for a discussion of how different

policy implementations, such as patient pathways, in which individuals operate affect the cues they extract and how they make sense of different events. Critical sensemaking therefore shifts the focus to how organizational power and dominant assumptions privilege some identities over others and create them as meaningful for individuals. Employees may also be encouraged to draw upon cues from their work environment and reflect an identity privileged through other similar organizations or a broader social context. Critical sensemaking positions the context as a link between dominant social values and individual action [46, 47] Furthermore, issues of power and identity and critical sensemaking that address these issues must be incorporated into the analysis.

Conceptualizing how trust influences sensemaking may be a useful way forward. Möllering's [48] understanding of how trust influences relations could provide further knowledge into how and why trust is important within new implementation projects. He indicates three elements when explaining why trust depends less on the individual trustee and more on the social norms and values in which the actions are embedded. The elements of familiarity, calculated interest, and compatible norms and values render trust. More specifically, it is the normative structures that influence trust [48]. In enabling an understanding of trust therefore means becoming familiar with these normative structures. One way to do this is to look towards these structures within the field of mental health care that exist during the time of the implementation of patient pathways. A trend that has developed over the last decades is viewing different governance and policy arrangements, such as NPM aiming at developing structures, policies and processes [49, 50], as a mistrust of health professionals and as a threat towards professional value discretion and autonomy [8, 51, 52]. New policies therefore do not affect organizing as much as they influence trust by impacting identity, skills, and the prioritizations of professionals and managers [15, 53, 54].

In sensemaking, “individuals, drawing on identity resources, act on cues, influenced by trust, and enact new, sensible environments as they do so” [21]. This enables a context that affects which cues are extracted and, second, the interpretation of the extracted cues [28].

Analysing the outcome of the implementation of patient pathways therefore means conceptualizing the theories presented in a more comprehensible framework. Such a framework is found in Figure 1, Sense making and trust

Methodology

To understand a phenomenon, in this case the implementation of a pathway, and how different actors make sense of the phenomenon, a multiple case study is a fruitful methodological approach [55]. In this study, in-depth individual and focus group interviews with health professionals working in four different outpatient clinics for adults were performed. Qualitative interviews are a well-established and effective method of data collection and are particularly suitable for obtaining information on informants' experiences and perceptions [56]. Focus groups provide a wide variety of data regarding the concept being studied [57] and can help people explore and clarify their perspectives to a greater extent than is possible in individual interviews [58].

Study setting and sample

In Norway, mental health services are public and organized together with general health services at the municipal level and specialist level. Hospitals and specialized mental health services are run by 19 health trusts owned and instructed by four regional health authorities on behalf of the state as owners [59]. The specialized mental health services currently comprise 66 community mental health centres (CMHCs), consisting of outpatient clinics, mobile teams and inpatient wards [59].

Our study included four outpatient clinics for adults in four CMHCs in different parts of Norway. The informants consisted of treatment personnel, leaders, and pathway coordinators.

The CMHCs were invited to the study by sending a formal request addressed to the leader, who distributed the invitation to treatment personnel and pathway coordinators. An overview of the participants is given in Table 1.

Table 1.

	Outpatient clinic no I	Outpatient clinic no II	Outpatient clinic no III	Outpatient clinic no IV
Individual interviews with treatment personnel, pathway coordinators and leaders	Psychiatrists: 2 Psychologists: 7 Others: 2	Pathway coordinator (nurse): 1	Leader (nurse): 1 Pathway coordinator (social worker): 1	Leader (nurse): 1
Group interviews with treatment personnel – some of them leaders of teams or units/departments	Psychiatrists: Psychologist: Other:	Psychiatrists: 1 Psychologists: 4 Nurses: 3 Others: 3	Psychologists: 5	Psychiatrist: 1 (in training) Psychologists: 4 Nurse: 1 Others: 3

Data collection

The interviews were collected between May and November 2019 and took place face to face, with one or two researchers visiting the clinic. Individual interviews lasted between 40 and 60 minutes, and focus group interviews lasted 90 minutes.

The informants were asked about their attitudes towards and experiences with the pathway system and the implementation process and how the system influenced their everyday work.

All the interviews were audio-recorded and transcribed.

Ethical issues

Approval for the project was provided by the Norwegian Centre for Research Data (NSD). The gathering of data followed the ethical guidelines of the NSD, including obtaining written informed consent for the interviews and explaining the purpose of the study.

Data analysis

The interview transcript were first read in their entirety and later imported into NVivo qualitative software. The data were analysed utilizing systematic text condensation [60], where codes were created based on the data and were concentrated on the main themes from the interview, namely, positive and negative expectations regarding patient pathways, negative and positive experiences with the implementation process, and experiences concerning the pathways influencing one's everyday work practices. Codes were subsequently clustered to form descriptive themes, for example, "increased time spent coding work processes." Furthermore, the descriptive themes that were related were clustered together to form analytical themes, for example, "Patient pathways lead to increased administrative work." All included themes were grounded in the text throughout the analysis.

Results

This study sought to elaborate on the sensemaking that health professionals experienced during the first ten months of the implementation of patient pathways within four outpatient

clinics in Norwegian specialist mental health services. The results indicated four distinct themes or reactions towards the patient pathway system. These themes were unclarity regarding the overall goals and content of the patient pathway; increased coding, registration and administrative work, which the professionals experienced as a stressor; an IT and journal system that did not correspond with the coding of the patient pathway; and an unrealistic distinction between assessment and treatment. The elements frustrated the professionals, and as a consequence, they developed different coping strategies that encouraged them to make sense of patient pathways so that everyday work could continue. The analysis showed how sensemaking circulated around two cues within the outpatient clinic. One cue was to await further action, and the other was to recognize that they were already doing the necessary work. Both cues led to actions of avoiding and reducing the importance of the system. When understanding these issues, an analysis utilizing Møllering's theory on trust, three elements were found to influence trust and distrust: calculated interest, familiarity, and compatible norms and values. All the elements were guided by an overall idea that the goals behind the patient pathway system were to gain more control through activities in the clinic, something that health professionals interpreted as distrust from the political level. Some of the patient pathway measures also had the potential to influence the core of the work, i.e., autonomy, which led to further distrust and influenced the implementation negatively.

Patient pathways, what are they?

> *"There has been so much talk about the visions and goals behind the pathway, why it is so important. But what does it look like in the clinic? No one really knows it seems…"*

An important idea behind the pathway system was a reorganization of mental health services that would increase quality, efficiency, and equality. Some of the overall goals, such

as how to implement increased user participation and how to enrol users, were open for interpretation, to be defined and executed by each mental health service unit.

Enrolment was meant to be the job of the leader of the outpatient clinic. The leader's role varied, with different degrees of involvement and ways to be involved in the role. A main impression from the outpatient mental health units in our sample was the employees' different ways of reducing the importance of the pathway system. For example, this was done by emphasizing that the pathway system did nor represent new ideas, but instead – as one among many health providers explained, it was "*something we are already doing and have been doing for many years.*"

The leaders did not differ significantly from the treatment personnel in terms of this view. Another strategy among the leaders found in the very early phase of the implementation was to await what would happen:

"The pathway, well, I don't like it at all, I must say. We already have too much to do. However, I try not to show this to the professionals. It's my job not to rock the boat, so when they ask me about it, I just tell them to await things."

This strategy of awaiting further action made the health professionals uncertain about the content of the patient pathway and its place in the organizational landscape. This uncertainty was dealt with by many professionals, as this psychologist stated:

"Patient pathways were a bit like, it was a lot of work, and kind of, what is this? We didn't really know what is was, and we spent a great amount of time on figuring out what it was, and there was a lot of scepticism, and they said this and this date, but the date was changed several times."

The above quotation illustrates how the implementation of the pathway system led to confusion about the content and about its meaning and position within a mental health care

unit. When trying to cope with this confusion, some asked their leader for answers; one psychologist said,

> "*I don't really know what the pathways are, and when I ask my manager about this, we are just told to wait. So, it is in the back of my mind as something I should have more knowledge about and do more about, but the common idea is that we just don't talk much or do that much about it*."

The informant stated that she felt uncertain about what the patient pathway is and how to implement it in her everyday work practices. It was quite common that health professionals kept the patient pathway "in the back of their minds" as something they should do. The message from the leader was to wait. One reasoning behind ignoring the patient pathway was that as long as the clinic was not measured based on patient pathway activities, it was not considered important. As one leader (and psychologist) stated,

> *"I do not care that much about the patient pathways to be honest. Before we were being measured on things that have a financial impact; I really do not think anyone cares about it."*

Mental health outpatient services have had major capacity and resource issues in recent decades. The number of referrals has been steadily increasing, meaning that the professionals who work there experience much stress due to heavy workloads (1–4). The following quote from a psychologist elaborates this reasoning further: "*It takes too much time and energy. It becomes frustration. We have a bunch of referrals, so many that we do not even have any room for new patients within this clinic. And on top of all of that, they are implementing a patient pathway, and all these different messages. It's just a mess, really."*

Codes, registration, and deadlines

The previous section showed that the overall goals of the pathway system were difficult to integrate into health professionals' daily work. The sensemaking of the idea and content of the patient pathway was partly to ignore it and focus on things that were more urgent and mattered more to the provider. However, there were things that became more visible if they were ignored, such as registration of codes for patient pathway activities.

> *"... None of these codes are anchored on how mental health work actually takes place. First, treatment is difficult to plan in detail because the effect of treatment and the patient's progress is unpredictable. Second, providing treatment is time consuming and may last for months and years for some patients."*

Many professionals thought that the workflow presented in the pathway system and the codes involved did not correspond with an actual timeline for mental health patients. Moreover, statistics based on the codes registered – when, for example, deadlines are not met – could be traced to the therapist's work, without attention to all kinds of reasons behind the codes, e.g., patient no-show, holidays, rotation in inpatient wards, access to a specialist to make a clinical decision. All these elements caused stress by imposing a rigid time system without taking into consideration that breaks often occur and are more generic than the pathway system accounts for. A psychologist expressed the following opinion that was shared by many of our informants:

> *"The deadlines between action points are way too short. I often see that I have negative time breaks, and there could be many reasons for this, maybe its summer holiday, the patient is sick, etc. This does not count as legitimate time breaks [in the coding system], so I'm punished for that."*

The timeline and following deadlines therefore did not reflect work as it unfolds within an outpatient clinic. The consequences this had were an overall feeling of frustration towards the system and an experience of being "stressed by the patient pathway."

An IT and journal system that do not function optimally

Registration of the new codes for patient pathway activities became a problem for several reasons. The lack of an anchoring for time use as it unfolds in the treatment facilities was vital; however, this was not the only issue. A severe problem was that the different electronic journal systems in the clinics did not correspond completely with the new codes and timeframes. The practical implications were that deadlines were followed manually one way or another by the therapist, for example, by keeping an account for each patient. The frustration this caused was immense.

> *"The coding. Oh, where do I begin. All these new deadlines are supposed to be coded by an IT system that does not correspond with the new coding. So, everything needs to be written down and remembered by each treatment provider. I mean, come on. What's the point?"*

For practitioners with many patients, this meant a large amount of extra work.

> *"I have 25 patients at any time, and the computer system does not tell you about the deadlines, so we need to write it down in a paper book that we are told not to use, so I get quite stressed about it, frankly…"*

In addition to extra work, this manual "book-keeping" – which could be done using an Excel sheet or the therapist's Filofax – also caused stress due to privacy concerns. A more comprehensive and overarching problem that required sensemaking was that the ideal workflow for a patient pathway interfered with professional values of discretion and autonomy. This will be elaborated more in-depth in the final section.

Unrealistic distinction between assessment and treatment

The pathway involves a distinction between the period of assessment and the treatment period, with a deadline of six weeks to finish assessment and give the patient a diagnosis. Many professional dilemmas related to this were presented by the health professionals, who claimed that in real life, these two periods fluctuate and often overlap. Additionally, many providers had a negative reaction to the patient pathway system's emphasis on the use of formal schemes and standardized questions, for example, in the first meeting with the patient. It was a concern that this could negatively impact the relationship between patients and treatment providers.

> *"Some of the questions are a bit harsh to start with. Like suicidal thoughts, and if they have experienced abuse. My job is to evaluate the patient and create a safe space, which means sometimes waiting to ask some questions. And sometimes important information for the diagnosis is not given before many months have passed and the patient feels safe enough and trusts me with this kind of information. So, this distinction between diagnosis and treatment is not anchored in reality."*

Being a psychologist means being guided by strong, professional values of autonomy and discretion. The relation between the provider and patient and the accommodation and organization of this relation is of particular importance within mental health treatment (see f.ex [61]). This means providing a space of trust. Many professionals expressed a concern that the patient pathway invaded this discretionary space, as the following psychologist explained:

> *"The relation between patient and provider is the most important element when it comes to healing. Research shows that it is much more important than the methods we use. This relation means creating a safe space where the patient is free to show all kinds of emotions and reactions. To show sides of him or her that maybe no one else*

gets to see. This means creating a space of trust where the patient decides what to share and when to share it."

The quote clearly shows that the therapeutic conversation influences the relationship and mechanisms of trust. Having the autonomy to organize this relation is of vital importance. However, the patient pathway has the potential to influence this by dictating that the first encounters are centred around assessment and diagnostic practice. This approach could influence professionals' experience of autonomy, as a psychologist explained as follows:

"If a patient has troubles with sleep, the patient pathway states I must wait at least four consultations before I can do something about it because the assessment and diagnostic practice must happen first, even if the patients are obviously depressed and have major sleep issues."

The quote clearly states that diagnostic practice sometimes needs to come second for professionals to be able to provide help with more acute matters. However, the patient pathway does not take this into consideration when providing deadlines for assessment and diagnostic practice.

Another matter that was expressed was that the work practices consist of two distinct tasks, namely, patient treatment and administrative work, imposed to comply with rules and regulations from the authorities. This distinction also influences the implementation of the patient pathway because matters of coding fall into the category that does not follow work related to patient treatment. This was further elaborated by the following psychologist:

"…actually, everything I do on the computer, I just do it because I have to. I see some benefits when it comes to writing a journal, but the journal gets poorer when I focus too much about what needs to be in it than what is relevant for the patient and his or her continuous treatment. The same with coding; a lot of the questions are irrelevant.

My self-management is mostly about trying to minimize time spent on what is imposed but irrelevant. This means not spending too much time on diagnostic accuracy, correct coding – those things. Just get it over and done so that I can spend time on patients and not be here [at the clinic] until seven o'clock every day."

The paper thus far has discussed the introduction of the patient pathway and the issues related to the implementation; these topics were summarized by one of the psychologist interviewed:

"The most negative part concerning the patient pathways is the implementation work. It is rock solid rotten. The IT system was not ready, the content was not ready, it was not tested in a pilot project before it was implemented on a national level. Nothing works; it has been 6 months, and they are still putting things in and out. And the IT system is not operational. It should have been tested beforehand, it's just a mess."

The issues above all describe an implementation that is not functioning optimally, regardless of which perspective one understands it from. A more thorough understanding of the issues that occurred and why this was happening is made clear in the following discussion, where the elements of trust and distrust are emphasized as vital.

Discussion

Making sense of the patient pathway

Making sense of the patient pathway by avoiding and reducing its importance

"*There is something problematic about the fact that we are asked to do a whole lot of extra things, including more coding, more questions, more evaluation and stuff, without anything being added. We need to learn a whole new way of organizing our*

work, new systems, new codes, in addition to everything else we are working on. I don't understand how we are going to make it work…"

First and foremost, *sensemaking is an explicit response to chaos, which generates "an undifferentiated flux of fleeting sense impressions"* [62]. This chaos creates the need to make sense of something, and while doing this, restore the order that allows everyday work to continue. Professionals working in mental health outpatient clinics deal with high workloads, a large amount of responsibility and work that is mentally demanding. Their elaborations of how sense is made when experiencing issues that cause frustration and stress [28] show how individuals looks for cues to cope with the experience.

As the data clearly show, the implementation of the patient pathway caused frustration for the participating health providers. The results show that two main cues were to be found within these services. The first cue was *to await further action*. The second cue was to recognize that *we are already doing the necessary work*. Both cues led to overall sensemaking that indicated the professionals should ignore the content of the patient pathway because "*plausible explanations shape sensible situations: they normalize the breach, restore expectations, and enable projects to continue"* [9]. In this way, the health professional could continue their everyday work.

However, despite the cues on ignoring further involvement with the patient pathway, many health professionals expressed that they still kept the patient pathway in the back of their minds. Regarding this matter, professionals still experienced the patient pathway as a mental burden that they needed to make sense of. When cues on how to deal with something do not make sense in their environment, individuals might look for cues elsewhere [28, 62]. Critical sensemaking states that cues on what to prioritize are to be found in the context in which professionals are operating. This context means understanding issues considering rules and regulations provided by the government and the system of registration and control of

health services administered by the Norwegian Directorate of Health. Why one choose to ignore the patient pathway system was explained by the following psychologist,

> "*The directorate hasn't started measuring activities from the pathway yet; in addition to this, there are no directly financing resources related to this. If this were to happen, we'd need to take another approach. But for now, I just try to spend minimum time on the content."*

who interpreted and made sense of the lack of measurement and financial activities as a cue to ignore matters related to the patient pathway.

Making sense of threats to professional autonomy by fooling the system

> "*There are many short turns to make. For instance, one can continue assessment when the patient is in the treatment phase if you are not done in the six weeks that the pathway requires."*

An important matter of concern was that the patient pathway generates issues that influence professional autonomy by dictating when professionals should provide assessment and diagnostic practice and when the treatment phase should start. More precisely, the distinction between assessment and treatment in the patient pathway system as well as the rigid manuals all have the potential to influence health professionals' autonomy and potentially negatively influence treatment.

Furthermore, there is a potential to interpret the patient pathway as a threat to professional identity, and as Sutcliffe states, "*identity and identification provide clear frames of reference from which judgements and interpretations fan out"* [63].

The potential interruption of professional autonomy and the subsequent relationship between a health professional and patients is understood as something that potentially threatens mental health professional work. When this occurs, health professionals make sense

of the pathway system so that the threat towards their professional identity is eliminated. The way this is performed in an outpatient clinic is understood as the use of different decoupling mechanisms aiming to maintain professional autonomy in daily practice and meetings with new patients. Therefore, the same actions that preserve discretion and autonomy discredit the system upon which the patient pathway is built. Therefore, the cue that follows is to ignore parts of the patient pathway in line with the conclusion of the previous analysis.

Patient pathways and trust

> *"There is something problematic about the fact that we are asked to do a whole lot of extra things, including more coding, more questions, more evaluation and stuff, without anything being added. We need to learn a whole new way of organizing our work, new IT systems, new codes, in addition to everything else we are working on."*

Sutcliffe [63] states that *when enacting order into the ongoing circumstances from which they extract cues and make plausible sense retrospectively, people act their way into knowing* [63].

Regarding the issues related to patient pathways, the fundamental question is why the patient pathway needs to be made sense of when the pathway is designed to improve the issues that are faced in mental health services. The analysis thus far has shown that ignoring the pathway is more important than actively engaging in it. Therefore, in regard to Sutcliffe and the act of knowing, an examination of the pathway's relation to trust will help us understand why sensemaking occurs.

Elaborating on Møllering's theory on trust shows how the issue of trust also depends on social norms and values, thus offering an explanation of how the pathway system was interpreted, understood, and made sense of in matters of trust and distrust. Furthermore,

529 Møllering's three elements of calculated interest, familiarity and compatible norms and
530 values are of particular importance and will be further elaborated.
531
532 *Trust and calculated interest*
533 *"All this coding and administration, everything that is involved with the patient*
534 *pathway, is just based on an idea that the government does not trust us or understand*
535 *what we are doing. They want to control us."*
536 First and foremost, the pathway system is based on ideas of standardization [64, 65]
537 and new public management [66], where increased control and efficiency are some of the
538 guiding goals. In addition, professionals within health care interpret standardization and the
539 subsequent measures from the health authorities as control over professionals [66]. Thus,
540 health professionals interpret a calculated interest in more control over services as a mistrust
541 towards the professionals working in those services, illustrated above by a psychologist and
542 manager in one of the outpatient clinics.
543 Firstly, this mistrust was expressed by the health professionals as having to defend
544 their work practices and the amount of time spent on different procedures and an overall idea
545 of the need to control mental health professionals. Many expressed that they did not believe
546 that the intentions behind the patient pathway system were to improve the services but rather
547 to be in more control of the services.
548 Secondly, the way the patient pathway system unfolded was characterized by mixed
549 messages and a lack of a clear and coherent strategy, as seen from the health professionals'
550 point of view. This became apparent when the computer system was not sufficient for the
551 new coding tasks. All these issues were understood as calculated interest (gaining more
552 control through measures), leading to increased mistrust.
553

Trust and familiarity

"(.) the people who started this have no idea what they are doing. As if we didn't do our best before. We do that all the time. We have to learn new things that have nothing to do with patient treatments, like where to register the first meeting [with the patient]. It just doesn't make sense. The action points [in the patient pathway system] do not take into consideration other issues–it's just a mess, and it's only because they [the Directorate of Health] do not trust that we do our job correctly." (psychologist)

Familiarity is understood as the general premise that prior interaction creates "familiarity" and in turn enables organizations to develop confidence in each other's trustworthiness [37]. The relationship between the health authorities and mental health services in Norway is characterized by a general reciprocal scepticism towards each other's intentions, something that makes implementing policy involving change within this sector difficult [8]. The context of increased control and management over the services within this field is based on several legislative changes during the last decades [67, 68], where the government is aiming for more transparency. This context is in some ways characteristic in the implementation of the patient pathways, and this familiarity (recognizing this context) clearly expressed itself as mistrust from the health professionals involved.

The analysis shows that the elements of familiarity and calculated interest all bring about a sense from mental health professionals of not being trusted at the political level. This increased the stress and ambiguities experienced by professionals and led to distrust towards the patient pathway and their developers. However, the issues of trust also had ripple effects on the professionals' work practices, which needs to be understood more thoroughly.

Trust and compatible norms and values

Work within an outpatient mental health clinic is characterized by several elements, such as unpredictability, difficulties in planning treatment and a high degree of discretion and autonomy, because each patient needs individual care. All these elements are based on strong, professional values on which treatment and care rest. First, the elements of autonomy and individuality collide with some of the intentions of the pathway system, such as efficiency, equality and standards. This makes the implementation of these measures difficult, as Sutcliffe [63] explains, when the actors involved, understand, judge and interpret the patient pathways from a professional identity. Therefore, the elements of the pathway system that do not correspond to their professional identity will be interpreted accordingly. In addition, as Calnan and Rowe [69] describe, new policies affect the organization as much as they influence trust when influencing identities, skills, and prioritizations performed by professionals and managers [69]. It became clear during our interviews that some of the elements of the patient pathway system could influence the core of the professionals' work in providing trust and safety in the alliance between provider and patient. This was seen as especially problematic and further increased the issues of mistrust towards the political level because the professionals believed that the pathway system did not take their work practices into consideration and was grounded on other values, skills and prioritizations than those that existed or those they wanted to exist within mental health services.

All these issues explain how the pathway system required overall sensemaking in an attempt to eliminate its importance within the outpatient clinic.

Conclusions

The implementation of the patient pathway during the first year could hardly be regarded as a success. Despite the issues that current mental health services face and the attempt to solve some of them through the patient pathway system, the introduction was met with much

603 resistance. The issues of distrust from professionals working within mental health services
604 towards politicians responsible for different arrangements to be implemented in health care,
605 such as standardization and evidence-based medicine, were further reinforced by the
606 introduction of the patient pathway system. While health professionals agreed on its overall
607 goals such as greater user participation and better coordination, their emphasis, worries and
608 perspectives were first and foremost on what they perceived to be controversial and
609 challenging about the system – the measures, coding and increased administrative work and
610 less time dedicated to patient treatment. We asked how mental health professionals made
611 sense of the pathways and how issues of trust affected the implementation. Our findings and
612 analysis show that the issues of trust, or more precisely the issues of distrust affect how
613 mental health professionals make sense of the patient pathway by reducing its importance
614 within the organization. These issues of trust has further implications because it seems that
615 the measures that affects distrust and resistance towards the pathway, namely the coding and
616 administrative work overshadows some of the PP overall goals, such as greater user
617 participation and better coordination, which was indeed, shared by mental health
618 professionals. The issues of trust, thus, partly guides which matters to focus on, and therefore
619 affects the outcome of the implementation. The causality between trust and sensemaking has
620 in our study been examined from a linear perspective, and an elaboration on, if, and how,
621 sensemaking affects trust could be an area for further research.
622
623 **List of abbreviations**
624 PP: Patient Pathway
625 NPM: New Public Management
626
627 **Declarations**

Ethics approval and consent to participate

Norwegian centre for research data approved the data collection in ref no 280027 and provided me with guidelines to follow regarding written consent. All ethical guidelines were met.

Consent for publication

Following Norwegian centre for research data`s guidelines on anonymization in publication.

Availability of data and materials

Not applicable

Competing interests

none

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Authors' contributions

Both authors discussed the results and contributed to the final manuscript. TNT conceived and designed the theoretical background model, the result part and analytic section. MAa contributed with data and designated the methodology section. Both authors read and approved the final manuscript.

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653 The main author, TNT is current a Phd candidate at the University of Bergen, and The Mohn
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Figure legends

Figure 1. Trust and sensemaking

Trust and sensemaking

Figures

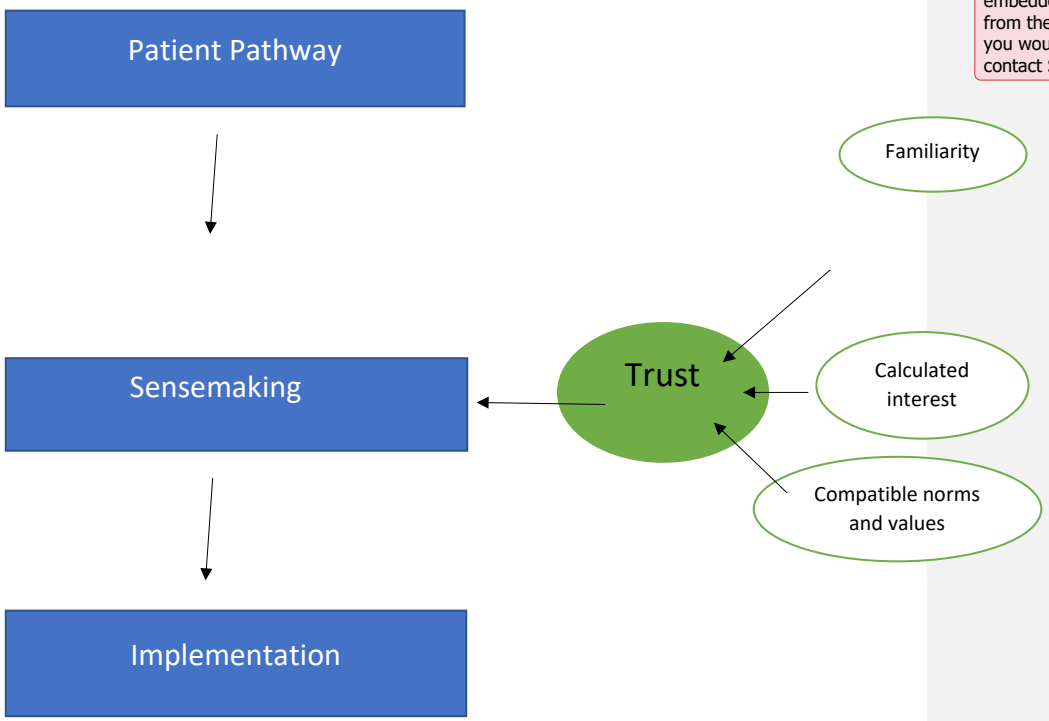

Figure 1

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