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Knowledge, Attitudes and Practices of the Mental Healthcare Providers regarding the Evidence-Based Practice in the Gaza Strip

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Dedication

To Palestine, the earth that is worth living for in Darwish's poems and my heart

To my mother the pretty, the smart and the very good-hearted

To my dad, the hard worker, the struggle, and the strong-willed

To my husband, the supportive, the lover, and my best friend

To Rita and Marian; my daughters, my inspiration, and my biggest motive

To my sisters, the strong, the independent, and the most beautiful ever

To my brother, my friend, my mirror, and my favourite man ever

To my mother-in-law who took care of my family during studying hours

To my father-in-law who saw me as a small version of him; the hard worker

To Radwa Ashour, to her words, to her emotions that totally overwhelmed me

With Love

Sally Suhail Saleh

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With respect

Sally Suhail Saleh

Declaration

I certify that this thesis submitted for the degree of master, is the result of my own research, except where otherwise acknowledged, and that this thesis or any of its parts has not been submitted for higher degree to any other university or institution.

Signed:

Sally Saleh

Date: 5 /6/2021

Abstract

Evidence-based practice is spreading in many healthcare disciplines. One of its main features is the reliance on the partnership among the three fundamental components, the best research evidence, the clinician expertise, and the client preference. This study is a mixed method one that includes both quantitative and qualitative components. A total of 135 participants (66 men, 69 women) participated in the quantitative part with a response rate of 83.3%, and 10 participants joined the qualitative part. The quantitative component followed the census approach in which the researcher recruited all the mental healthcare providers in the Gaza Strip. The method of sampling for the qualitative part was purposive sampling. The quantitative data was collected via online questionnaire. The qualitative data was collected through face-to-face interviews. The reliability of the total scale is very good as the alpha Cronbach= 0.756. The quantitative data was analyzed using the SPSS software by conducting descriptive, frequency, and inferential statistics. The qualitative data was analyzed via the content thematic analysis using the NVivo software to find out the most common themes and codes.

Findings show that those who had up to bachelor degree represented 37.7% of the respondents, and those who had postgraduate studies represented 62.3%. Most of the participants (78.5%) were graduated from local universities, and 77.8% of the participants were working in technical positions. The results show that 81.5% of the participants used the evidence- based practice during the daily practice, but the frequency and the sources of evidence were not sufficient. The overall knowledge score among the participants was 66.05% and the overall attitude score toward the evidence- based practice was 60.76%. The overall practice score was 71.27%, but the actual implementation was not good enough.

The qualitative results showed that the knowledge, attitudes and practices are not systematic nor sufficient to fulfil the mental health needs. In addition, they were humble and depended on personal motives mainly. The institutional factors were obvious in inhibiting the evidence- based practice due to the lack of sufficient infrastructure, poor system for the evidence- based practice, lack of policies, unsupportive management, and poor culture. The institutional barriers to implement the evidence- based practice included lack of policies, and absence of good appraisal system. The individual barriers to implement the evidence- based practice included poor research and statistical analysis skills and lack of knowledge about the evidence- based practice and its significance. The inferential statistics show that there were no significant differences in relation to the age, residency, profession, type of university or the profession type indicating that issues around evidence-based is a cross-the-board.

The study concluded that the knowledge, attitudes, and practices about the evidence- based practice needs further improvement and development through initiating supporting policies and strategies that promote the use of evidence base in daily practices.

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List of Abbreviations

ANOVA	Analysis of Variance
APA	American Psychiatric Association
CBT	Cognitive Behavioral Therapy
COVID-19	Corona Virus Disease 2019
DSM V	Diagnostics Statistical Manual- V
DT	Dietetical Therapy
EBP	Evidence-based Practice
GCMHP	Gaza Community Mental Health Program
GDP	Gross Domestic Product
GO	Governmental Organization
KAP	Knowledge, Attitude, Practice
KII	Key Informant Interview
KM	Kilometer
M&E	Monitoring and Evaluation
mhGAP	Mental Health Gap Action Program
MOH	Ministry of Health
NGO	Non- Governmental Organization
OPT	Occupied Palestinian Territory
PCBS	Palestinian Central Bureau of Statistics
PFA	Psychological First Aid
PTSD	Posttraumatic Stress Disorder
SD	Standard Deviation
SPSS	Statistical Package for the Social Sciences
UN	United Nations
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNRWA	United Nations for Relief and Works Agency for Palestinian Refugees in the Near East
US	United States
WHO	World Health Organization

Chapter one

Introduction

Evidence-based practice (EBP) is spreading in popularity in many healthcare disciplines (Sheridan & Julian, 2016). One of its main features is the reliance on the partnership among the three fundamental components. The first component is the best evidence which is usually found in clinically relevant research that has been conducted using sound methodology. The second component is the clinical expertise that refers to the clinician's accumulated education, experience and clinical skills. The third component is the patient's values which are the unique preferences, concerns and expectations each patient brings to a clinical encounter (Heneghan et al, 2017).

Healthcare is in need of change. Most of the professionals and health care organizations as well policy-making bodies are emphasizing on the importance of evidence-based practice (McCartney et al., 2016). Using this approach to clinical care that incorporates the conscientious use of current best evidence from well-designed and conducted studies, a clinician's expertise, and patient values and preferences, health care providers can provide care that goes beyond the status quo (Fung & Linn, 2015). Health care that is evidence-based and conducted in a caring context leads to better clinical decisions and patient outcomes (Grove & Gray, 2018).

Following two decades of research, the scientists worked on improving the client outcomes and enhancing the recovery process for persons with severe mental illness by providing effective mental health services (Dang & Dearholt, 2017). Unfortunately, the implementation of interventions that have been shown to be effective by evidence-based practices lags significantly behind the actual knowledge. Individuals with severe mental

disorders such as schizophrenia are unlikely to receive treatment with basic evidence-based practices in routine mental health settings (Schneider et al., 2016).

This study is an organized trail to understand the evidence-based practice in the mental healthcare service in the Gaza Strip from the mental healthcare provider 'perspectives. The study focuses on the mental healthcare provider' own knowledge, attitudes and practices related to the EBP during their daily work within their organizations that may encourage or inhibit the implementation of the EBP. The importance of the study is gained from seeking inputs from the key component of the mental healthcare services provision about their perspectives and implementation of the EBP, in addition to other factors that affect the EBP.

1.1 Research Problem

The mental health services represent a core part of the provided healthcare services in Palestine, but there are many challenges that still face the mental healthcare services provision. Those challenges include lack of effective research, poor monitoring and evaluation system, lack of scientifically updated protocols for assessment and management of mental health problems, lack of qualified human resources, and poor infrastructure (Marie, Hannigan, & Jones, 2016). Till now, there is no systematic data on the knowledge, the attitudes and the practices of the mental healthcare providers regarding the evidence-based practice in the Gaza Strip. There is gap in knowledge related to how much mental health provider are aware about EBP, how they perceive it and to what extent they use it in daily practices. So, this study focuses on assessing the knowledge, the attitudes, and the practices of the evidence-based practice in mental healthcare services in the Gaza Strip in order to provide the policy makers with evidence-based data that helps to prepare short- and long-term plans related to reinforcing the knowledge, the attitudes and the practices of

the mental healthcare providers and implementing the evidence-based practice to improve the quality of the provided services.

1.2 Aim

This study aims at assessing the knowledge, attitudes and practices of the mental healthcare providers regarding the evidence-based practice in the mental healthcare services in the Gaza Strip in order to improve the use of evidence-based practice and optimally reinforce the quality of the provided services which might have positive impact on clients.

1.3 Objectives

1) To assess the level of knowledge, attitudes and practices of the mental healthcare providers regarding the evidence-based practice in the Gaza Strip.
2) To identify the strengths and the weaknesses in the evidence-based practice in the mental health services in the Gaza Strip.
3) To examine variations in knowledge, attitudes and practices of the mental healthcare providers in reference to the personal and institutional variables.
4) To set recommendations to improve the evidence-based practices in the mental health services in the Gaza Strip.

1.4 Research questions

1. What is the level of knowledge of the mental healthcare providers regarding the evidence-based practice in the Gaza Strip?
2. What are the attitudes of the mental healthcare providers regarding the evidence-based practice in the Gaza Strip?

3. How much do the mental healthcare providers practice the evidence-based in their work in the Gaza Strip?
4. What is the relationship between the knowledge, the attitudes and the practices and demographic characteristics (age, gender, educational level, residency, workplace, university….) of the mental healthcare providers in the Gaza Strip?
5. What are the weaknesses of the evidence-based practice in mental health services in the Gaza Strip?
6. What are the strengths of the evidence-based practice in mental health services in the Gaza Strip?
7. What are the lessons learnt and key achievement of the evidence-based practice in the mental health services in the Gaza Strip?
8. What are the recommendations to improve the evidence-based practice in mental health services in the Gaza Strip?

1.5 Context of the study

The Gaza Strip is known as one of highest densely populated areas globally with more than 2.1 million people living in 365km^2 in overloaded areas exceeding 5400 persons/Km (Palestinian Central Bureau for Statistics, 2021). It is considered as one of the most devastated areas in the world, as it reached unprecedented levels of poverty, unemployment and economic hardships, especially after the three consecutive offensives that took place by the Israeli Occupational Forces (Manzanero et al., 2021). The history of Palestine is marked by conflict over the one hundred years ago due to challenging political context that exerted stressful effects on the Palestinians psychological wellbeing and lifestyles (Marie, Hannigan & Jones, 2016).

The humanitarian situation in Gaza has been deteriorating since 2006; when the Islamic Resistance Movement HAMAS won the election (Dunning, 2016). Since that time, a political and economic blockade has been imposed on the Gaza Strip, in addition to the human rights violations that are already imposed by the Israeli Occupational Forces. The situation became much worse after the three offensives that took place in 208/2009- 2012 and 2014, as they caused a high number of martyrs and injured people that overloaded the burden of the already loaded health system (El-Khodary, Samara & Askew, 2020).

The United Nations (UN) reported that most people and mental health institutions in the Gaza Strip are still struggling to deal with the challenges resulted from the 2014 offensive, the imposed siege and the previous difficult conditions (United Nations Office for Coordination of Humanitarian Affairs, 2019).

The hostilities worsened an already dire humanitarian situation driven by the ongoing Israeli blockade and the unresolved internal Palestinian division (Khamis, 2015). Consequently, Gazans are at risk of experiencing the consequences of an on-going trauma, stress, despair, hopelessness, helplessness, and lack of security. As a result, mental health disorders including posttraumatic stress disorder, generalized anxiety disorder (Thabet, Thabet, & Vostanis, 2015), depressive disorders, and substance use disorders are becoming more common among the population (Mana et al, 2015).

The siege has affected all fields of the Gazans' lives, and the humanitarian situation is alarming. The basic human needs were denied, goods import and export were restricted, and people to travel from and into Gaza were denied. In addition, the quality of the infrastructure has been deteriorating leading to extreme deterioration in the economic status of the Gaza population (United Nations Office for the Coordination of Humanitarian Affairs, 2018).

This combined suffering of the Israeli Occupational Forces violations, isolation, siege, and the internal Palestinian division has left Gaza in a stifling economic situation as several public health services such as health, water, and sanitation were red flagging, and the unemployment rate was alarmingly increasing (AbuHabib et al, 2020).

As a result of the chronic economic and political hardship, mental health problems represent one of the largest but least acknowledged health problems in the occupied Palestinian territory (OPT). The mental health problems among the Palestinian population resulted from the combined and accumulated sufferings from the human rights violations, the imposed siege, the recurrent military attacks, and the changed social dynamic of the Palestinian house (Marie, Shaabna & Saleh, 2020).

Interestingly, the mental health problems in Palestine remain underreported, under-treated, and the mental health services underfunded as well as those services are unable to meet the burden of the mental health needs of the population. There is a significant lack of well-skilled human resources and sufficient infrastructure resources, in addition to absence of sustainable funds from the internal and external resources (Jordans et al., 2021).

The mental health services in the Gaza Strip are provided by several bodies including the Ministry of Health, the Non-Governmental Organizations, and the private sector. The Ministry of Health (MOH) is considered as the main body of mental health services provision in the Gaza Strip through its six community mental health services centers and the psychiatric hospital. The mental healthcare providers in the Gaza Strip provide different levels of mental health services including the specialized mental health services, the focused non-specialized mental health services, strengthening the community and family support services and protection and counseling services (MOH, 2019).

1.6 Palestinian Healthcare System

The Palestinian healthcare system works under pressure due to several factors including the political instability, the blockade, the rapid growth of population, the lack of internal resources, the donor's agenda, the poor revenues and the lack of basic materials (UNOCHA, 2019). Moreover, the fragmentation and lack of coordination between the different healthcare providers make it worse, in addition to the lack of quality protocols for primary, secondary and tertiary healthcare services (MOH, 2019).

The health system in Palestine is in a transitional stage and facing specific contextual challenges linked with the occupation and political conflict (AlKhaldi et al., 2018).

However, the Palestinian healthcare system is still working to improve the quality of health for the population, and the health indicators are better than the health indicators of the neighboring countries. It was shown in a previous research those Palestinian hospitals operating in Gaza Strip perform at a relatively acceptable level, and the performance of non-governmental hospitals is better with higher degree of total quality management implementation than the governmental hospitals (Baidoun, Salem & Omran, 2018). Several factors have strengthened the Palestinian healthcare system including the high level of commitment by health sector staff, the active role of UNRWA and other NGOs, the contribution of civil society, the national health insurance system that covers two thirds of the population and the good accessibility and coverage of the majority of the healthcare services (MOH, 2019).

Healthcare is a basic right for all citizens, and it is primarily the role of the government to assure high quality healthcare services. The total health expenditure including the governmental sources and other sources reached 10.7% of GDP (1.419 million US Dollars) in 2019. The major contribution is from the out of pocket presented by 41%, while the

government covers 37%. The non-governmental organizations cover 18%, and the private sector covers around 3% (MOH, 2019).

Health services delivery in Palestine is managed by four main bodies; the government, UNRWA, NGOs and the private sector. The government through ministry of health is the major body as it serves as a provider and regulator according to the Public Health Law (Keelan, 2016). The roles of MOH are regulating and supervising the provision of healthcare provision, planning the healthcare services in coordination with the different stakeholders, enhancing health promotion, developing the human resources, managing and disseminating the health information and ensuring national health expenditure being allocated according to population needs (MOH, 2019). The total number of primary healthcare centers in Palestine until 2019 are 743 (583 in West Bank and 160 in Gaza), and hospitals are 81 (51 in West Bank including East Jerusalem and 30 in Gaza) (MOH, 2019). In the Gaza Strip, an evidence-based Medicine Unit was established in February 2011 with the cooperation of the deans of both local medical schools at the time. The EBM Unit's wide mission was to promote EBM among health professionals through various activities, including lectures, workshops, conferences and training courses for both undergraduates and postgraduates (Elessi, Mokhallalati & Madbak, 2011).

1.7 Mental Health Services

Mental healthcare services are provided by the government, UNRWA, the non-governmental sector, and the private sector. Governmental mental healthcare services are offered through the Bethlehem Psychiatric Hospital, Gaza Psychiatric Hospital, and several community mental health centers that are distributed in Palestine governorates. The Bethlehem Psychiatric Hospital is located in the West Bank, which has a bed capacity of 320 patients, of whom 30% are chronic epileptic patients. The Gaza Psychiatric Hospital

was established in 1979 and rehabilitated in 1994 has 40 beds (MOH, 2019). Both hospitals use a traditional biological approach, with conventional pharmacological therapies and electroshock therapy. However, patients and their families tend to lack confidence in psychiatric hospitals, which are usually seen as custodial institutions in which troublesome and frightening people are sequestered (Hattab, et al., 2021). Despite the presence of several healthcare providers, the MOH is the regulator and the supervisor of the other providers' work as the Palestinian public health law indicates. The MOH has neither a mental health policy nor a comprehensive plan that addresses both ongoing care for the severely mentally ill and services for those affected by the traumas and losses of the conflict. Fifteen community mental health clinics are run as part of primary healthcare services by doctors and nurses who don't have specialized training in psychiatry (Diab et al., 2018a).

In 2008, the General Directorate of Mental Health was established to assure the comprehensiveness and the quality of services. There are six community mental health services located in the five governorates of the Gaza Strip. The first established center was Al Sorani Community Center in 1995, then Khanyounis Community Center in 1996, Al Zawaideh Community center in 2005, Rafah Community Center in 2006, North Area Community Center in 2008, and West Gaza Community Center in 2008 (MOH, 2019). The interventions that are provided by the mental healthcare organizations in the Gaza Strip include primary prevention services, secondary prevention services, and tertiary prevention services. The primary prevention services focus on health promotion and awareness media campaigns, while the secondary prevention services focus on providing medical therapy and psychotherapy to those diagnosed with mental illness. The tertiary prevention services focus on rehabilitating those affected by the mental illness and aim at re-integrating them in the community (Diab, et al., 2018b)

1.8 Operational definitions

1- **Mental Health:** the researcher defined the mental health as the ability to adapt to the external and the internal stressors and perform very well in the daily life functions.

2- **Evidence-based practice:** the researcher defined the evidence-based practice as all clinical or decision- making practices that are based on updated research evidence, the clinical expertise, and the client preference.

3- **Mental healthcare provider:** the researcher defined the mental healthcare provider as any healthcare practitioner who had mental health background and worked in organizations that provide mental healthcare services for the purpose of improving an individual's mental health or treating mental disorders.

Chapter Two

Literature Review

2.1 Conceptual framework

The conceptual framework that shaped the different aspects of the study depended on three factors that may affect the knowledge, the attitudes and the practices of the mental healthcare providers regarding the evidence-based practice in the Gaza Strip. It was shown in the literature that there are several variables associated with implementation of the EBP in healthcare settings, which suggests the complexity of the implementation of EBP. The first one is the personal factors that include the demographics, the EBP perception and the self-motivation. The second one is the institutional factors that include the available education and training programs, the work infrastructure and the regulation and policies. The third one is the barriers to the EBP that may include personal barriers and institutional barriers.

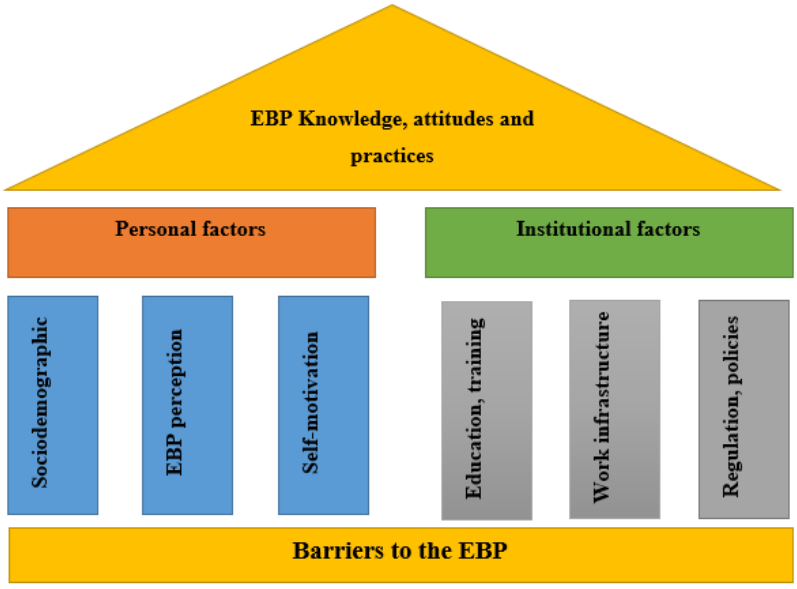

Figure (2.1) Shows the conceptual framework of the study.

2.1.1 The KAP of the evidence- based practice

The KAP of evidence-based practice are the dependent variables that entails three main components in the decision-making process in the clinical practice. The first component is the accumulative knowledge and skills via university education, formal or informal trainings. The second component is the attitude that reflects one's perspective and opinion. The third component is the practice that refers to the actual implementation of the EBP during daily work.

2.1.2 The personal factors

The study addressed a set of independent variables that were proposed to influence the KAP about the EBP in different degrees and directions. The conceptual framework was built to three basic assumptions; the first one is the knowledge, attitudes and practices usually stem from the inner beliefs and are driven by the personal perspectives,

The following part addresses the possible personal factors:

The Demographic factors: represent personal chrematistics including; age, marital status, residency, profession, place of work, profession type, type of the university of the last qualification, educational level. Those factors explore the possible influence of the self and context on the KAP of the EBP.

The EBP perception: represent one's belief and perspectives toward the significance of the EBP in improving the prognosis of the clients and the general outcome on the health system. This factor is expected to influence the attitude toward the EBP, and consequently the practice.

The self-motivation: represent the individual's own motivation and learning tendency to learn about new things. This factor is expected to influence the EBP by enhancing the mental healthcare provider's desire to be engaged in new and updated management plans. In addition, this factor has a strong relationship with the changeability; the higher self-motivation; the increased changeability.

2.1.3 The institutional factors

The second assumption is the institutional support either the formal or the informal plays the most significant factors that inhibit or encourage the EBP in health settings.

The following part addresses the possible institutional factors:

The education and training: cover university education, formal training and informal training. This includes education and training on the EBP details, and education and training thar are based on evidence too. This factor is expected to influence the EBP by enhancing the knowledge and skills related to the EBP. The more quality based education, the more enhanced implementation of the EBP.

The work infrastructure: represent the work infrastructure that support the EBP implementation including the availability of computers, laptops, smartphone, strong internet connection, updated library, access to international journals and good working conditions. This factor is expected to have a great influence on the implementation of the EBP as it is a core part of the institutional physical support.

The regulation and policies: reflect the administrative parts of the institutional factors including presence of regulations and policies that regulates the EBP and obligate the EBP implementation in the organizations. Furthermore, it includes the presence of a specialized evidence-based unit and monitoring ad evaluation unit that sets the strategic goals,

outcomes, outputs, and the indicators to assure the good tracking according to the agreed indicators. Moreover, this factor includes the availability of good appraisal system that considered the EBP implementation as one of highly appreciated section.

2.1.4 Barriers to the EBP

The third assumption is that there are several challenges and obstacles that face the implementation of the EBP. The study addresses the factors that may inhibit the EBP either at the level of the personal factors or the institutional factors.

2.2 Literature Review

2.2.1 Evidence- based practice

Evidence-based practice (EBP) was defined as the conscientious and judicious use of current best evidence in conjunction with clinical expertise and patient values to guide healthcare decisions (Grove & Gray, 2018). There are different levels of the evidence based on the strength of the methodology. The best one is the randomized controlled trials followed by the case-control studies. The case series and expert's opinion are considered as a weak evidence as they cannot be generalized (Hain & Keer, 2015).

When enough research evidence is available, the practice should be guided by research evidence in conjunction with clinical expertise and patient values (Dobson & Dobson, 2018). Occasionally, a sufficient research base may not be available, and health care decision making is derived principally from non-research evidence sources such as expert opinion and scientific principles. As more research is done in a specific area, the research evidence must be incorporated into the EBP (Wong et al, 2015).

2.2.2 Steps of Evidence-Based Practice

The steps of the EBP starts from asking the right question, searching in the literature, evaluating the evidence critically, implementing the research findings, and evaluating the progress (Brownson et al., 2017). There are five defined steps to apply the evidence- based practice in healthcare. The first one is to ask clinical questions in PICOT format which stands for population, interest, comparison, outcome and time. The PICOT format includes mentioning the population of interest, the intervention of interest, the comparison intervention or groups, the outcome and the time. The second step is to search for the best evidence among the high standards libraries. The third step is to critically appraise the evidence-based on the used methodology, the results, the journal's reputation, the author's reputation, the relevance and the targeted population (Echevarria & Walker, 2014). The fourth step is to apply the evidence following the ethical considerations and taking into account the patient preference. In addition, the provider should consider the affordability, the applicability and the accessibility of the intervention. The fifth step is to assess the performance after implementing the evidence in order to improve the further application of the evidence keeping up-to-date with the published literature (Abbade et al., 2016).

2.2.3 Levels of Evidence-Based Practice

The level of evidence-based practice varies according to the methodology**.** There are four levels of the evidence-based practice. Level 1 that is considered as the strongest type of the evidence and involves the meta- analysis, the systematic reviews, the experimental studies and the randomized clinical trials (Murad et al., 2016). Level II that includes the quasi-experimental studies. Level III that includes the non-experimental studies that depends on the description of the variables of interest. The strongest descriptive studies are the case-control studies followed by the cohort studies and the cross-sectional studies (Friesen et al.,

2017). Level IV includes the clinicians and experts' opinions that could be in the form of clinical practice guidelines or consensus panels (Rousseau & Gunia, 2016).

2.2.4 Evidence- based practice in health settings

Gaining knowledge and skills in the EBP process provides the clinicians with the tools needed to assure the best client's outcome. Key elements of a best practice culture are EBP mentors, partnerships between academic and clinical settings, clearly written research, time and resources, and administrative support (Hall & Roussel, 2020).

Despite the availability of evidence-based protocols for the majority of health diseases, the actual implementation in daily care delivery is still vague and not consistent among all healthcare providers (Yarber et al., 2015).

The lack of research on the outcomes and the implementation made it harder to adopt the EBP or impose it on the health organizations (Wolffe et al., 2019). The practice will made safer by putting what is learned from research into practice (Lemieux et al., 2018). The implementation of the EBP is a complex process that needs the coordination between the client's preference, the professional expertise and the best available research. In addition, it requires the presence of policies and the strategies that regulates the implementation phase (Rith-Najarian, Daleiden & Chorpita, 2016).

2.2.5 Evidence- based practice in mental healthcare services

The mental health disorders are prevalent with some variations worldwide, and the psychotherapy is one of the main treatment approaches that are followed to manage the mental health clients. Despite their significance, there are not sufficient research that support the psychotherapy use for all mental health disorders, and this increased the focus on the need for evidence-based psychotherapies (Walker, McGee, & Druss, 2015).

The American Psychological Association developed a policy on the EBP of psychotherapy based on the three components of the EBP; the best research evidence, the clinician expertise and the client's preference (Townsend & Morgan, 2017). The best research evidence refers to the information extracted from the best research methodology studies including meta-analyses, randomized controlled trials, case-control studies, cohort studies, single-case reports, systematic case studies, and clinical observation (Craighead & Dunlop, 2014). The policy emphasizes on the use of the EBP in clinical decision making, setting the management plan, fostering the therapeutic alliance, and getting the best possible outcomes (Blease, Lilienfeld, & Kelley, 2016). This policy ensures that the psychotherapy effectiveness is affected by the client characteristics, the developmental history, the personal strengths, the economic status, the perceived concerns, personality structure, the social support, and family and sociocultural factors (Brimhall et al., 2016). Up to the 1950s, research into the efficacy of psychoanalysis was limited to subjective observational studies reported by Freud and other eminent professionals. Such studies are open to bias and are deviated from the best scientific approaches (Essali, 2017a)

There are several advantages of the EBP for the mental healthcare providers and the clients (Rousseau, & Gunia, 2016). It is more ethical and consistent with the medical practice to act based on relevant data that is based on research and evidence rather than rely solely on the personal opinions that are affected by the personalities and interests. The EBP can complement the clinical expertise when making judgements and can guide the management approach to better prognosis (Van et al., 2019).

Applying evidence-based principles ensures that providers use the best existing evidence as a starting point, while simultaneously affording them flexibility to each client (Hunsley & Mash, 2010). Adoption the evidence-based practice ensures that the healthcare providers

can critically appraise the data available and implement it considering the individual client circumstances (Essali, 2017b). When the evidence is appraised and fully understood, providers can decide if and how to incorporate it into practice (Greenhalgh, Howick, & Maskrey, 2014). In addition, using evidence-based psychotherapies helps providers determine the best treatment plans especially during situations in which there are limited data or experience. In fact, for clients who suffer from multiple medical and psychiatric comorbidities, using evidence-based treatments offers providers a starting point to develop complex treatment plans (Gone, 2015).

The expertise of the mental healthcare providers plays a significant role in determining the adherence to the EBP as the more expertise the mental healthcare providers has, the less updated to the new knowledge, guidelines, or standards of care, the poorer clients progress, and the more resistant to change (Kelloway, 2017).

Mental health services research in the Arabic region needs significant development and improvement as there is a near absence of effective mental health research with lack of evaluation studies on the quality of the mental healthcare services (Maalouf et al., 2019). The menta healthcare services face several challenges related to the political instability and poor developmental programs in the Arab countries, however researchers in the Arab countries tried to design model of care for the mental healthcare services that is suitable to the cultural background and sensitive to the religious beliefs (Hamaideh, 2016).

It was previously published that despite the emphasis on the use of evidence in mental health, most psychiatrists and mental healthcare providers are still unfamiliar with the methods and philosophy of EBP (Rojjanasrirat & Rice, 2017).

In addition, research shows that the mental healthcare providers' knowledge about the EBP is humble and does not result in evidence- based practice to the majority of the clients, and there is a ten years lag between the actual practice and the research findings (Malik, McKenna & Plummer, 2015). This lag resulted in actual waste of time, efforts and resources, and undermined the client's progress and outcomes (Alshehri et al., 2017).

There is a significant gap between the knowledge obtained from the clinical trials and the effective management of mental health disorders (Barzkar, Baradaran, & Koohpayehzadeh, 2018). This gab was described by the mental health providers who use the psychotherapy as a treatment modality without evidence research about the applicability of the conducted clinical work (Connor et al., 2017). The question about the effectiveness of the psychotherapy models is still raised due to the lack of structured monitoring measures, and lack of sufficient knowledge about the available international guidelines and resources (Reichenpfader, Carlfjord, & Nilsen, 2015).

2.2.6 The personal factors

The personal factors are core components that affect the knowledge, the attitudes and the practices of healthcare providers regarding the EBP (Djulbegovic & Guyatt, 2017). The sociodemographic factors including the years of experience, the age, and the type of work were associated with better implementation of the EBP, in addition to the engagement into research activities and the better perceived personal ability to use research evidence in practice (Connor et al., 2017). In a similar context, the sociodemographic factors including higher educational background, more years of clinical nursing experience, current position as a manager or educator, more experience in nursing research activity, and education in research methodologies were associated with enhanced skills and knowledge in clinical nursing settings, and client' outcome as well (Tomotaki A, Fukahori H, Sakai I, 2020).

Interestingly, that education level was related to the knowledge and the practice of the EBP suggesting that several professional education programs increased the emphasis on the skills needed to implement EBP, however the attitude is mostly affected by the culture around (Baatiema et al., 2017).

Several research studies presented the correlation between the age and the knowledge toward the EBP (Kalavani, Kazerani, & Shekofteh, 2018) as the older the professional, the less knowledge about the EBP (Townsend & Morgan, 2017). The motive to changes and the learning tendency tended to be better with younger age professionals (Orta et al., 2019). Furthermore, it was found in the literature that the EBP perception, and intrinsic self-motivation to implement the gained knowledge and skills may predict EBP future implementation among the nursing students (Underhill et al, 2015). The higher motivation and learning tendency, the higher level of knowledge, attitudes and practices of the EBP in a health setting (Heneghan, et al., 2017). Preliminary research found that the learning tendency and motivation are highly associated with the EBP in health settings (Rousseau & Gunia, 2016). In addition, there is a strong relationship between the attitude toward the EBP and the self-efficacy which is presented by the one's belief in his/her ability to provide quality-based services (Schiele et al., 2014).

The personal experience and the inner motivation were the core factors that improved the knowledge and attitude toward the EBP (Malik, McKenna, & Plummer, 2015). As part of the personal factors, a previous study presented that changeability as a component that is related to the degree of flexibility to accept change. The study showed that having a high rate of changeability acts as a facilitator to improve the EBP in health settings (Awan, Siddiquei, & Haider, 2015). In addition, the greater the perceived benefits about the

outcomes would enhance the EBP, and the greater the costs would undermine it (Dobson & Dobson, 2018).

2.2.7 The institutional factors

In addition to the personal factors that are associated with the EBP, the institutional factors are considered as a main block for the implementation of EBP in healthcare settings. The EBP implementation require institutionalization by setting a clear and sustainable long-term structure for the EBP that cannot rely only on the personal efforts but entails all possible factors that may have an impact (Shelton, Cooper, & Stirman, 2018). Research found that specific institutional constructs influence adoption and sustainability of new practices. Those constructs include institutional culture, institutional climate, and implementation climate (Locke et al, 2019), and studies from health settings suggested that the institutional constructs are highly predictive of the EBP implementation (Sayer et al, 2017).

The investment into the EBP infrastructure was the predominant factor to the implementation in major Chinese hospitals. The study participants described the institutional support and the infrastructure as the engines for enhancing the EBP in health settings (Hong & Chen, 2019). A systematic review on 49 articles concluded that the presence of policies and procedures, in addition to sufficient data and research resources was marked as the heart of the EBP in healthcare settings (Shafaghat et al., 2021). Similarly, the availability of strong internet connection in the mental health organizations motivate the employees to look for new research via online resources (Abdulwadud et al., 2019). Moreover, sufficient resources including the technology infrastructure for the EBP and physical working conditions make it easier to replace the daily clinical practice by new evidence- based practice (Kozleski, 2017). A previous research suggested that the presence

of digital sources of evidence is one of the building blocks of effective EBP in any organization that enhances the informatics of evidence (Bonham et al., 2014).

Importantly, the human resources component plays a significant role in closing the gap between the research and the practice in health settings via capacity building that focus on both the knowledge and skills that support the sustainable EBP implementation (Brownson, Fielding, & Green, 2018). Interestingly, engaging the frontline workers in decision-making and EBP discussions is a strong factor that reinforce the frontline workers' beliefs and trust in the proposed new interventions (Barry et al., 2019).

In addition, the supervisor- supervisee relation play a significant role in enhancing the implementation of EBP, and the positive leadership is associated with more favorable clinician attitudes toward adopting EBP (Padmanabhan et al., 2019). The non- financial incentives including motivation, appreciation and leadership including the transformational and the transactional styles present a core component of enhancing the positive attitude toward the EBP in mental health settings (Ryan, 2016). The leadership is important in the adoption of new innovations across a range of institutional contexts (Breytenbach, ten Ham-Baloyi, & Jordan, 2017). Research suggested that taking motivation measures can appropriately reinforce positive work behaviors and a greater sense of trust in the supervisor-supervisee relationship and lead to greater openness toward adopting evidence-based practices (Parker-Jenkins, 2018).

2.2.8 Barriers to the evidence- based practice

The barriers to the EBP are wide and numerous. A previous research categorized the barriers to institutional and individual based. At an institutional level, the main issues identified were evidence-based practice was of a low management priority, poor dissemination of the new guidelines, absence of plans for professional development, and

poor infrastructure. The institutional factors play a significant role in enhancing the EBP in mental healthcare services and absence of clear policy and standards undermine the implementation (Knaak, Mantler, & Szeto, 2017). The infrastructure is crucial in maintaining long-term and quality based EBP in mental health settings including the technology-related infrastructure or learning-suitable climate (Bach-Mortensen, Lange, & Montgomery, 2018). The informational support via training and engaging in regular discussion play an important role in setting the responsibility of the professionals toward improving their work procedures and outcomes (Williams, Perillo & Brown, 2015).

At the individual level, the main issues were the personal motivation, the lack of clarity about roles and practice, and the poor understanding of research methodology and statistical analysis (Fiset, Graham, & Davies, 2017). Interestingly, the poor quality of life and lack of satisfaction regarding life conditions were found to be an obstacle to adhere to the EBP especially in conflict areas (Farokhzadian, Khajouei & Ahmadian, 2015).

In a previous research, the participants indicated that stigma, human resource shortages, fragmented service, and lack of research capacity for implementation contribute to the current mental health treatment gap (Wainberg et al., 2017). In addition, research barriers, lack of resources, lack of time, inadequate skills, and inadequate access, lack of knowledge and financial barriers were found to be the most common barriers to EBP (Sadeghi-Bazargani, 2014).

Moreover, a study with community nurses showed that the most significant barriers were poor technology facilities, poor client cooperation and difficulties in influencing changes within health settings (Malik, McKenna & Plummer, 2015). The poor cooperation of the client and his/her preference affect the implementation of the EBP negatively due to the fear of using new method and being subjected to experience (Harvey & Gumport, 2015).

Furthermore, another research suggested a number of barriers that include the rapid rate of medical knowledge development that are hard to be followed, and the increased workload compared to the working hours (Wainberg et al., 2017).

The lack of awareness about the significance and impact of the EBP is one of the challenging but easily to overcome by training and awareness; people cannot implement any act if they don't believe in (Hall et al., 2019). Limited time for retrieving and interpreting research and for applying research to individual patients has been cited by numerous authors as a major reason clinician do not incorporate evidence in their practices (Camargo et l., 2018).

Chapter Three

Methodology

This chapter aims at clarifying the procedures that the researcher followed in order to achieve the objectives of the study. The researcher clarified the study design, the study population, the study period, the study sampling, the study instruments, the data collection procedures, the response rate, the data entry and analysis procedure, the scientific rigor of the tools, the ethical considerations, and the limitations of the study that the research followed throughout all the phases of the study.

3.1 Study design

The design of this study is cross sectional triangulated study. Methodological triangulation provides a combination between quantitative and qualitative paradigms to validate findings from one method with another and to enhance understanding of the facts on the ground (Donovan & Sanders, 2005).

3.2 Study settings

The study was conducted in the mental health organizations in the Gaza Strip including the governmental mental health organizations that work under the umbrella of the Ministry of Health involving both the psychiatric hospital and the six community centers. In addition, the study involved nine local and international non-governmental organizations that provide mental health services to the population.

3.3 Study population

For the quantitative part: The study population included all mental health providers who work either at MOH or NGOs; their total number is 179.

For the qualitative part: The study population was the key informants who work either at MOH or NGOs and work in senior and policy making positions.

3.4 Inclusion criteria

The individual was considered eligible based on the following criteria:

1. Works at an organization that provide mental health services.
2. Works as a mental healthcare provider.
3. Has a degree in medicine, nursing, psychology, social work or occupational therapy.

3.5 Exclusion criteria

1. Work at any organization other than the MOH or NGOs.
2. Volunteer or students at the targeted organizations.
3. Does not have a mental health background but administrative background.

3.6 Study period

This study was initially proposed in May 2020. The research proposal has been submitted to and defended in the front of the School of Public Health assigned committee in June 2020. At its development, the research proposal described the entire process and the preliminary designs of the data collection, data analysis methods and tools. Upon the approval, the researcher developed the required tools depending on the literature. The researcher has consulted a group of ten experts at the arbitration stage before the finalization of the tool; all of them have responded. The arbitration stage lasted for five weeks including refining of tools in the light of reviewers and the academic supervisor's feedback. In August 2020, a peer was asked to propose Arabic translation of the tool. In September 2020, the researcher applied translation-back translation method and consulted a second peer to ensure language appropriateness. In doing so, the researcher tested the

questions with three other individuals who are not familiar with the English language. The purpose was to ensure Arabic-Arabic easiness and appropriateness.

Early in September 2020, the tool was ready to go for data collection. Piloting took place between 11 and 14 September 2020. Actual data collection started on 26 September through 26 October 2020.

Initial analysis of quantitative data was done between October and November 2020 prior to the last stage of data collection and validation which took place in December 2020 and January 2021(Qualitative data collection stage). Compiling results and reporting started before and in parallel to qualitative data collection. The researcher extracted findings, created descriptive tables and performed inferential statistical analysis, and then explained findings through linking them to relevant pieces of the literature and inputs obtained during the KIIs.

3.7 Study participants

For the quantitative part: The quantitative part of the study depended on the census approach as we targeted all mental healthcare providers who were fit to the inclusion criteria in the targeted organizations; MOH and NGOs. The total number of the mental healthcare providers was 161 participants, while the number of who actually responded was 135 participants. The response rate is 83.3%. The lists of the mental healthcare providers were taken from the organizations, and they were contacted one by one.

For the qualitative part: The sampling was non-probability purposive sampling as we needed to understand the institutional factors and personal factors that may affect the evidence-based practice in the mental health services from the key informants. We recruited ten key informants from either the MOH or NGOs who work in senior and policy

making positions. We selected the participants in a way that represented the mental health organizations and covered men and women in the targeted organizations.

3.8 Study instruments

For the quantitative part: The researcher collected the quantitative data using a questionnaire that was developed by the researcher based on the literature review, the objectives, the experts' expertise and the work expertise. The questionnaire was self-administered and formatted based on the five-point Likert scale. The questionnaire was administered as an online google form, and it covered the following parts:

- The demographic data
- The use of the EBP, the knowledge about EBP
- The attitude regarding the EBP, the practice of EBP
- The institutional factors of the EBP
- The barriers against the EBP
- The suggested recommendations

After formulating the draft of the questionnaire, the researcher contacted ten experts for validation. The researcher took the experts' comments and feedback into consideration in order to prepare the final questionnaire. The questionnaire was built in English, and it was translated and back translated by two professional translators in order to preserve the validity of the items in both languages; the English and the Arabic. The researcher piloted the use of the questionnaire to assess the reliability and validity of it, and the researcher modified according to the results of the pilot phase. Annex (1) and (2) show the questionnaire in Arabic and English.

For the qualitative part: The researcher conducted an individual semi-structured interview with ten key informants from both the MOH and NGOs. The interview protocol was developed by the researcher based on the literature review and the academic supervisor's feedback. The initial results of the quantitative part were taken into consideration, and the researcher tried to fill the gaps from the quantitative part by in-depth discussions. The interview protocol consisted of twelve major questions that aimed at assessing the knowledge, attitude and practices of the mental healthcare providers in the targeted organizations, in addition to the institutional factors, the barriers and the recommendations. The researcher prepared twelve major questions but elaborated on them according to the objectives of the study and the flow of the discussion. Annex (3) and (4) show the interview protocols.

3.9 Scientific Rigor

3.9.1 Reliability:

For the quantitative part: To ensure reliability during the pilot study, the researcher prepared a guide for the data collection procedure to ensure standardization and to reduce filling errors. Checking and verification the filled questionnaires have been done at the end of each data collection day, so error identification, correction and prevention were more feasible. The psychometrics of the questionnaire were tested twice through the statistical analysis software Statistical Package for Social Sciences (SPSS) and indicated high reliability (Cronbach's Alpha coefficient was 0.756). Reliability of the actually collected data of each domain and the total scale are presented below.

Table (3.1): Reliability estimates for domains and the entire scale

Domain	Cronbach's Alpha
Knowledge domain (12 questions)	0.603
Attitude domain (20 questions)	0.696
Practice (16 questions)	0.659
Institutional factors (12 questions)	0.908
Barriers (32 questions)	0.917
Total scale reliability	0.756

For the qualitative data, an expert was asked to suggest a sample and to review the schedule. A peer has assisted re-analyzing the data and recorded transcripts to minimize the effect of the researcher's subjectivity. Minutes were taken during the KII and also digital recording took place in the five KIIs.

3.9.2 Validity:

For the quantitative part: the questionnaire (English and Arabic versions) was constructed through a series of procedures that were based on the international literature in order to best serve the study objectives. Then the constructed tool was validated through ten expert reviewers who advised regarding internal content validity and appropriateness for statistical analysis in order to ensure content related validity. Translation and reverse translation have been conducted. Arabic translation was tested by two relevant individuals prior to piloting. The questionnaire was nicely formatted in order to ensure face validity. This included appealing layout, logical sequence of questions, clarity of instructions such as skipping and professional production. Also, general reliability, validity and trustworthiness (for the quantitative) measures were implemented including;

- Interviewing large sample
- Standardization of tools

- Referring to internationally recognized tools
- Daily checking and verification
- Standardization of implementation
- Peer and members check

For the qualitative part, the followings were done to assure trustworthiness. First, the researcher sent the interview protocol to five experts to assure that they cover all the required dimensions, in addition to the feedback from the academic supervisor. Then, a member check was done to assure accuracy and transparency of the transcripts during the interviews. Prolonged engagement was done as the researcher tried to probe for answers and cover all the interview dimensions properly. In addition, recording the interviews enhanced tracking up facts and re-check the accuracy of the transcripts.

3.10Pilot Study

For the quantitative part, 20 respondents were interviewed to fill the questionnaire. The researcher recruited the respondents who had the same characteristics of the target group. This aimed at exploring the appropriateness of the study instruments, the clarity of meanings and rating, the time it takes to fill the questionnaire in, and to expect response rate. As a result, few rephrasing and explanations were added to some questions, and the twenty filled questionnaires were excluded from the study.

Furthermore, it aimed at ensuring the appropriateness of the psychometrics of the tool and to validate the collected information. Reliability analysis was performed and results were reassuring; therefore, these questionnaires were included in the final set of data collection tool.

For the qualitative part, one KII was conducted with a male participant in Gaza City who works in a senior position in NGO. As a result, questions were rephrased and ordered differently.

3.11 Ethical considerations

In this study, carefulness has been exercised to ensure that the rights of the participants are protected. The Modified International Code of Ethics Principles (1975), known as the Declaration of Helsinki, which is adopted by the World Medical Assembly were followed and an official letter of approval to conduct the research was obtained from the Helsinki Committee- Gaza Strip and has been mentioned in Annex 5. In accordance with the Principles of the Helsinki Ethical Declaration, every participant in the study received a complete explanation of the research purposes, method, and confidentiality. Every participant in the study knew that participation in the research was optional. Written consent on the google form was obtained from the participants who participated in the study; the google form questionnaire was programmed not to continue the questionnaire if the participants choose not to participate. Additionally, formal permission for taking notes and tape recording of the KIIs were obtained. Last but not least, to increase the responses" credibility, the researcher adhered to the Ethical Code Principles, through providing and maintaining anonymity and confidentiality. The researcher assumed that other ethical rights were protected through respect for people and respect for truth.

3.12 Data collection

The researcher started data collection after getting the necessary approvals from the Ministry of Health and the NGOs, in addition to the ethical approval from the Helsinki Ethical Committee and the academic supervisor.

For the quantitative parts, the researcher prepared the questionnaire after a series of validation and piloting procedures. Then, the researcher contacted the heads of the targeted organizations to provide her with the lists of the professionals. The researcher prepared a google form to be used in data collection. The researcher contacted the participants via phone to explain the study aims and methodology and to get their provisional approval to participate. After that, the researcher sent SMS to the participants that contained the link of the questionnaire and the consent form. Three days after, the researcher sent another SMS to remind the participants to fill the questionnaire. The researcher informed the participants that they can ask her for any inquiry.

For the qualitative part, the researcher prepared the KII protocol and validated it via consulting five experts and the academic supervisor. The researcher recruited the sample, and scheduled the interview explaining the study aims, methodology, and confidentiality issues. Thirty minutes before the interview, the researcher sent reminders via SMS, and she conducted the interview starting from the verbal consent, introducing questions, ice-breaking questions, major questions, minor questions, and closing. The researcher tried to probe during the interview in order to elicit the interviewee' perspectives about the EBP in the mental healthcare services. The researcher recorded, transcribed and analyzed the interviews to reflect the main themes of the them.

3.13 Response rate

All sample members were called for voluntary participation based on an informed consent from each one of them before administration of any tool. For the quantitative part, the response rate reached 75.4% (135 responded out of 179). Also, all interviewees who were invited to participate in the KIIs had positively responded.

3.14 Data entry and analysis

***For the quantitative part*:** throughout the data collection, the researcher reviewed the results on the google form on a continuous basis. Data entry model has been designed and questionnaires and variables were coded and entered into the developed database using the computer software program SPSS version 23. Open ended questions were entered and coded using the Excel software. The process of data entry was performed in two days as the researcher got the data entered on an excel sheet automatically from the google form. Then, data cleaning was performed through checking the frequencies of all variables and looking for illogical values.

General frequencies were done to figure the responses and to identify missing data for each question. Data recording and computation have been performed where negatively phrased questions have been converted when means were calculated. Thus, the overall scaling went in a logical direction; higher values indicate positive situations (e.g., presence of favorable items or absence of unfavorable items). In addition, central tendency measures were performed including descriptive frequencies, mean, median, mode, standard deviation (SD) and frequency tables. The researcher used inferential analysis to test the statistical significance of differences. An in-dependent t-test was used to compare the knowledge, attitudes, and practice of EBP mean scores of the in-dependent variable with two categories such as gender. One-way Analysis of Variance (ANOVA) test was used to compare the knowledge, attitudes, and practice of EBP mean scores of the in-dependent variable with more than two options such as governorates. Additionally, correlation test was applied to associate the overall knowledge, attitudes, and practice of EBP score with independent continuous variables such as age. Moreover, stepwise multiple regression was applied to identify the best predictors of the overall the

knowledge, attitudes, and practice of EBP score among the studied independent variables. The statistical difference is regarded as significant when the P value equals or below 0.05.

For the qualitative part: interviews were recorded, transcribed and entered into NVivo, a computer program that assists in the analysis of textual data by facilitating textual analysis and interpretation by means of various coding procedures. The analysis of the data focused on the content of the participants' perspectives, opinions, and experiences. The analysis was conducted using the categorizing process in thematic analysis (Glaser & Strauss, 1967). This process of categorization involved open coding, selective coding, comparison and categorization and re-reading and modifying. In open coding interviews transcripts were repeatedly read and key issues mentioned by respondents were noted. In selective coding key phrases, statements and comments were labelled and categorized according to their content with the assistance of the NVivo. Categories were then created by identifying similarities and differences in the content of the statements that were labelled. Finally, the researcher modified the structure of the findings by re-reading the original narratives and modifying the analyzed data accordingly. NVivo was used to call up all the linked data within each category for the final examination to ensure that the model developed in the analysis accurately represented the data. The above process resulted in a composite list of overarching themes that represented the knowledge, attitudes and practice toward the evidence-based practice in the mental health services in the Gaza strip, in addition to the institutional factors that may affect the EBP and the barriers to implement it.

3.15 Study Limitations

The researcher faced a significant limitation presented by the refusal of the GCMHP to collaborate in the quantitative data collection. The researcher contacted the Director General of GCMHP officially to get his permission to collect the data from the

professionals, but he refused to cooperate after three weeks waiting. The academic supervisor tried to help to seek permission, but GCMHP insisted not to cooperate for unclear purposes which led to affecting the response rate negatively.

Furthermore, the community spread of the COVID-19 pandemic in the Gaza Strip occurred late in August; one month before the data collection. As a result, the accessibility to the target group was negatively affected. The researcher tried to overcome this problem by approaching the target group through alternative ways including phone calls, online questionnaire and SMS. Moreover, the mental health needs and gaps were changed at the time of data collection due to the COVID-19 pandemic, which may affect the results. Based on that, the researcher recommends conducting a study on the EBP during emergency situations.

In addition, the study is an analytical study that represents moderately strong evidence, so the researcher recommends conducting other studies with a stronger degree of evidence.

Moreover, the researcher was working at Gaza Community Mental Health Program during the data collection time, so possible bias may be obvious. For that, the researcher tried to maximize the means of objectivity in order to get highly accurate and objective data, and she was supervised closely by the supervisor.

Chapter Four

Results and discussion

The results of this study were consolidated from the responses of the study participants and verified through in-depth discussions with purposefully selected individuals who participated in ten individual semi-structured interviews.

The following sections provide an overview of demographic characteristics of the study sample. As the reader moves on, more analytical results show up to describe the knowledge, the attitudes and the practices toward the evidence- based practice of the mental healthcare providers in the Gaza Strip. In addition, the results show the institutional factors and the barriers that affect the EBP. The descriptive tables illustrate the results compiled from the total respondents (N=135) unless otherwise indicated.

4.1 Descriptive statistics

4.1.1 Demographic characteristics:

The total number of the quantitative part of the study's participants was 135; 51% were men and 49% were women. The percentage of women in the study is different from the percentage of women among the health workers in Gaza governmental organizations presented by 29% (PCBS, 2019). This could be related to the gender mainstreaming policies that the organizations adopt, and improved the educational level of women in the Gaza Strip (Aburaida, 2021). The average age of them was 36.38 years (SD= 8.38), the minimum age was 22 years and the maximum age was 59 years. Of them, 30.4% aged from 19 to 30, 45.9% aged from 31 to 40, 15.6% aged from 41 to 50, and 8.1% aged from 51 to 59.

Of the participants, 14.8% lived in North Gaza governorate, 40.7% lived in Gaza governorate, 24.4% lived in the middle zone governorate, 11.9% lived in Khan Younis governorate, and 8.1% lived in Rafah governorate. The geographic distribution of the participants in the five governorates of the Gaza Strip is relatively similar except for Khanyounis governorate (PCBS, 2020), and this is due to refusal of several participants to fill the questionnaire in Khan Younis.

Table (4.1): Distribution of responses by the demographic characteristics (N= 135)

Item	Category	NO	%
Gender	Male	66	48.9%
	Female	69	51.1%
Age group	19- 30 years	41	30.4%
	31-40	62	45.9%
	41-50	21	15.6%
	50-59	11	8.1%
	Mean= 36.38, SD= 8.38		
Residency	North Gaza Governorate	20	14.8%
	Gaza Governorate	55	40.7%
	Middle Zone Governorate	33	24.4%
	Khan Younis Governorate	16	11.9%
	Rafah Governorate	11	8.1%
Marital Status	Not married	31	23%
	Married	104	77%
Educational level	Up to bachelor degree	51	37.7%
	Post graduate studies	84	62.3%
Type of the university of the last qualification	Local university	106	78.5%
	University from Arab country	23	17%
	International University	6	4.4%
Current job	Psychiatrist/ physician	12	8.9%
	Psychologist	61	45.2%
	Social worker	24	17.8%
	Psychiatric nurse/ nurse	38	28.1%
Place of work	Ministry of Health	105	77.8%
	Non-governmental organizations	30	32.2%
Type of profession	Managerial	5	3.7%
	Technical	105	77.8%
	Both	25	18.5%
Position	General practitioner	105	77.8
	Head of unit	11	8.1%
	Head of department	19	14.1%
No of clients	0-30 clients	93	68.8%
	31-60	22	16.2%
	61-90	7	5.2%
	>90	13	9.8%
	Mean= 34.14, SD= 16.432		

As indicated in table 4.1, the majority of them 77% were married, while 23% were not married. Regarding the highest education level they reached, 37.7% had up to bachelor degree level and 62.3% had postgraduate degree level. Most of them represented by 78.5% got their highest educational degree from a local university, while 17% participants got it from an Arab university and 4.4% got it from an international university. This is consistent with the Gaza context as people cannot travel abroad to study in international universities due to the movement restrictions. The profession of the participants varies as 8.9% participants were psychiatrists, 45.2% were psychologists, 17.8% were social workers, and 28.1% were psychiatric nurses. The distribution of the participants based on their profession is similar to the distribution that was published by the General Directorate of Mental Health that works under the umbrella of the Palestinian Ministry of Health (MOH, 2020).

As table 4.1 shows, they worked in different organizations; 77.8% worked in the Palestinian Ministry of Health, 32.2% worked in several non- governmental organizations. Most of them represented by 77.8% were engaged into technical work, 3.7% were managerial employees, and 18.5% were both technical and managerial employees. The majority of them represented by 77.8% worked as general practitioners, 8.1% worked as heads of units, and 14.1% worked as heads of departments. The average number of clients that the participants deal with on a weekly basis was 34.13 clients (SD= 16.403), the majority 68.8% dealt with 0-30 clients weekly, 16.2% dealt with 30-60 clients weekly, 5.2% dealt with 60-90 clients weekly, and 9.8% dealt with more than 90 clients weekly.

4.1.2 The use of evidence- based practice in mental healthcare services

The results showed that 81.5% participants used the evidence- based practice in their work in mental healthcare services provision, while the remaining did not. The frequency of the

use of the evidence-based practice among those who indicated they used it varied as 54.4% participants used it most of time, 22.8% used it sometimes, 15.8% participants used it all the time, 7% participants used it rarely. In addition, 17.1% of the participants indicated that they used it on the last day, 34.2% of the participants used it in the last week, 27.9% used it in the last month, and 20.7% used it in the last three months. Although the majority of the participants indicated that they use the evidence, the frequency of using it is not satisfactory. This is consistent with the results of the qualitative part as 45-year female mental health provider indicated*; "at my workplace, the use of evidence varies as some use it regularly on daily basis, some use it occasionally, and some do never use it"*.

Regarding the reasons for the use of the evidence- based practice, around two thirds of the participants (65.5%) used it for diagnostic purposes, 53.1% used it for client care modality purposes, 52.2% used it for treatment purposes, 30.1% used it for drug-related purposes and 1.8% used it for other purposes including health promotion and awareness purposes. A 46- old male mental health provider mentioned, "*We usually look for e-articles to find out possible available treatment methods as they change very fast*".

Regarding the source of looking for the EBP, 56.4% of the participants used the book journals and textbooks as a source of evidence, 12.7% used online journals, 23.6% used search engines, 0.9% used university websites and 5.2% used other sources of evidence including the organization protocols and trainings in some mental health topics. Interestingly, the qualitative results showed that the main source of the evidence was the internally validated protocols that were developed by the organizations' employees with some sort of support from external experts who assisted in adapting the international protocols to the Palestinian context with limited supervision on the implementation phase. The majority of them mentioned the DSM V as a source of EBP in mental health for the

first time, and the exact articulation around the DSM V reflected their work's context and the limited EBP resources in their organizations. They said that they relied on the DSM V in assessment and diagnosis, and they had enough training on the DSM V by external experts in psychiatry. They also mentioned that they used several psychotherapy protocols including the Cognitive Behavioral Therapy and Dialectical Therapy after getting training from external experts, a 53-year male mental health provider indicated, "we *refer basically to the clinical procedures manual that was developed by our organization, in addition to the DSM V, CBT manual, DT manual and the family therapy manual that were adapted to our context"*.

Regarding the motives behind the use of the EBP as table 4.2 shows, 76.1% were motivated by the work requirements, 60.2% were motivated due to personal efforts, 15.9% were motivated due to management support, 8% were motivated by the peer effect, and 0.9% were motivated by other factors including the moral motives and the feeling of responsibility as they mentioned. Consistently with the qualitative results, the respondents mentioned that their motives toward the EBP stemmed from their beliefs in its highly effective outcomes at the beneficiary and managerial levels. In addition, they considered their learning tendency and motivation as prominent roots for the positive attitude they showed toward the EBP. Contrasting to the quantitative results, they complained that the managerial bodies were not supportive in terms of financial and non-financial incentives, and there were not written obligation nor written policy that regulated the EBP in their workplaces, a 43-year female mental health provider reported, "*we apply the EBP as an individual effort that is not sufficiently appreciated from the managers. We apply it because we want to help the clients in a better way and reinforce our skills in diagnosis and assessment".*

Table (4.2): Distribution of responses by the use of evidence- based practice

Item	Category	NO	%
Ever used the Evidence based practice in your work	Yes	110	81.5%
	No	25	18.5%
The frequency of using the EBP	Most of time	62	54.4%
	Sometimes	26	22.8%
	Rarely	8	7%
	Not at all	18	15.8%
The last time of using the EBP in work	Last day	19	17.1%
	Last week	38	34.2%
	Last month	23	20.7%
The reason of using the EBP in work	Treatment purpose	59	52.2%
	Diagnosis	74	65.5%
	Medication related	34	30.1%
	Care modality	60	53.1%
	Others	2	1.8%
The source of evidence	Book journals and textbooks	62	56.4%
	Online journals	26	23.6%
	Search engines	14	12.7%
	University website	1	0.9%
	Others	7	5.2%
The motive to use the EBP	Personal effort	68	60%
	Work requirement	86	76.1%
	Influence of others	9	8%
	Support from the management	18	15.9%
	Others	1	0.9%
The frequency of looking for scientific articles on e-resources	Not at all	14	10.4%
	Less than 3 times weekly	78	57.8%
	From 3 to 6 times weekly	40	29.6%
	More than 6 times weekly	3	2.2%
The frequency of looking for scientific articles in libraries and books	Not at all	31	23%
	Less than 3 times weekly	83	61.5%
	From 3 to 6 times weekly	19	14.1%
	More than 6 times weekly	2	1.5%
Ever received training in the EBP	Yes	109	80.7%
	No	26	19.3%
Presence of clinical guidelines workplace	Yes	80	59.3%
	No	55	40.7%
	I don’t know	0	0
Ever participated in a clinical audit before	Yes	85	63%
	No	50	37%
Ever participated in a research study before	Yes	85	63%
	No	50	37%

Similar to the study findings, the personal experience and the inner motivation were the core factors that improved the knowledge and attitude toward the EBP (Malik, McKenna, & Plummer, 2015). As part of the personal factors, a previous study presented that changeability as a component that is related to the degree of flexibility to accept change. The study showed that having a high rate of changeability acts as a facilitator to improve the EBP in health settings (Awan, Siddiquei, & Haider, 2015). In addition, the greater the perceived benefits about the outcomes would enhance the EBP, and the greater the costs would undermine it (Dobson & Dobson, 2018). Supportive resources and leadership can facilitate the changes into each organization and make it easier to overcome the common daily practice and replace it by an EBP (Kozleski, 2017). Leadership emerges as salient in the public health sector, with recent research showing that positive leadership in mental health agencies is associated with more favorable clinician attitudes toward adopting EBPs (Padmanabhan et al., 2019). Interestingly, adopting the participatory approach and engaging the frontline workers in the EBP discussions seemed to be a strong factor that reinforced the frontline workers' beliefs and trust in the proposed new interventions (Barry et al., 2019).

Regarding the frequency of looking for scientific articles on e- resources, 57.8% looked for scientific articles on e- resources less than 3 times weekly, 29.6% from 3 to 6 times weekly, 10.4% never looked for scientific articles on e-resources, and 2.2% more than 6 times weekly. Moreover, 61.5% looked for scientific articles on books less than 3 times weekly, 14.1% from 3 to 6 times weekly, 23% never looked for scientific articles on e-resources, and 1.5% more than 6 times weekly. A 46- old male mental health provider indicated, "*people don't like to read, who still reads*!"

Of the participants, 80.7% received training in the evidence- based practice, and 19.3% did not. In addition, 59.3% participants indicated that there were clinical guidelines at their workplaces while the remaining indicated that there were not. Furthermore, 63% participated in conducting clinical audits and research studies before. Compared to the qualitative results, the respondents indicated that they and their colleagues did not receive either formal or informal training on the EBP. Some of them received training on the research methodology as part of the capacity building plan of their organizations, but the training was not enough to reinforce their knowledge and skills in the research field due to the lack of future vision, monitoring, and sustainability of those training; as they mentioned. On the other hand, they reported that all mental health related training they received were based on evidence; as they assumed. The variation between the quantitative result and the qualitative results can be related to the misinterpretation of the question; the respondent considered the mental health trainings that based on international guideline as an EBP training, a 45- year male mental health provider mentioned, *"we did not have a specific training on the EBP, but all of the mental health training we have are based on evidence. We were not trained on the basics of the EBP, the levels of it, nor how to look for it*".

The participants mentioned the DSM V, the Mental Health Gap Action Program (mhGAP), the Psychological First Aid manual (PFA), and the CBT manual as examples for the limited clinical guidelines they had at their workplaces. Similar to previous research, the adherence to the use to clinical guidelines remains low resulting in suboptimal client care and waste of resources (Ament et al., 2015). Despite that the clinical guideline became a familiar and integral part of the clinical practice, the professionals still prefer their own experience over the evidence approved treatment modalities (Slade et al, 2016).

Interestingly, the participants mentioned that those resources were adapted by committees that consisted of mental healthcare provider to fit the Palestinian context, and this adaptation was individual's expertise based. They declared that there were not specific scientific committees that were responsible to prepare the clinical guidelines and supervise the clinical work in an organized systematic manner; the existing committees worked irregularly in response to unclear managerial needs, a 45-year female mental health provider reported, *"actually there are some clinical guidelines, but they are not updated or imposed on the professionals. External experts with mental healthcare providers adapted them to the context without clear long-term vision or implementation guide".*

4.1.3 Knowledge about the evidence-based practice

The overall knowledge among the participants regarding the evidence-based practice was 66.05% (minimum= 25%, maximum = 96.43%, SD= 11.02%). The overall knowledge is the mean of the seven items of the knowledge domain. The knowledge of the participants varied; 16.1% of them strongly disagreed that the EBP is only updating the information via reading resources, 67.7% disagreed, 0% did not know, 14.5% agreed, and 1.6% strongly agreed. In addition, 0% of them strongly disagreed that the EBP is the conscious, explicit and judicious use of current best evidence in making decisions about the care of patients, 0.7% disagreed, 5.2% did not know, 48.9% agreed, and 45.2% strongly agreed.

Table 4.3 shows that 0.7% of them strongly disagreed that the EBP is composed of best research practice evidence, patient's preference, and therapist expertise, 2.2% disagreed, 11.9% did not know, 56.3% agreed, and 28.9% strongly agreed. Moreover, 2.2% of them strongly disagreed that they are aware about the steps of applying the EBP, 7.4% disagreed, 25.2% didn't know, 57.8% agreed, and 7.4% strongly agreed Also, 1.5% of

them strongly disagreed that they are aware about the levels of the EBP, 9.6% disagreed, 25.2% didn't know, 57.8% agreed, and 5.9% strongly agreed.

In addition, 0.7% of them strongly disagreed that they understand the research methodology, 4.4% disagreed, 22.2% didn't know, 59.3% agreed, and 13.3% strongly agreed. Finally, 0.7% of them strongly disagreed that they know several search engines that help to seek the best research evidence, 5.2% disagreed, 23.7% didn't know, 58.5% agreed, and 11.9% strongly agreed.

Table (4.3): Distribution of responses by the knowledge about the EBP

Item		Strongly disagree	Disagree	I don't know	Agree	Strongly agree	Mean%
I think that EBP is only updating information via reading resources	NO	22	91	0	20	2	29.44%
	%	16.1%	67.7%	0%	14.5%	1.6%	
The EBP is the conscious, explicit and judicious use of current best evidence in making decisions about the care of patients	NO	0	1	7	66	61	84.63%
	%	0	0.7%	5.2%	48.9%	45.2%	
EBP is composed of best research practice evidence, patient's preference, and therapist expertise	NO	1	3	16	76	39	77.59%
	%	0.7%	2.2%	11.9%	56.3%	28.9%	
I am aware about the steps of applying the EBP	NO	3	10	34	78	10	65.19%
	%	2.2%	7.4%	25.2%	57.8%	7.4%	
I am aware about the levels of EBP	NO	2	13	34	78	8	64.26%
	%	1.5%	9.6%	25.2%	57.8%	5.9%	
I understand the research methodology	NO	1	6	30	80	18	70.00%
	%	0.7%	4.4%	22.2%	59.3%	13.3%	
I know several search engines that help me to seek the best research evidence	NO	1	7	32	79	16	68.89%
	%	0.7%	5.2%	23.7%	58.5%	11.9%	
Overall Knowledge= 66.05%							

Contrasting to that, the qualitative results show that most of the respondents indicated that the term "evidence- based practice" was a new term, and they were not familiar with it, however they assumed they could guess its meaning based on the words used and their expectations. A 28- old female mental health provider, "*actually it is my first time to know this term, but I can guess what is it about. I expect that it is about using the updated protocols and textbooks; that's what I think*".

It was previously published that despite the emphasis on the use of evidence in mental health, most psychiatrists and mental healthcare providers are still unfamiliar with the methods and philosophy of EBP (Rojjanasrirat & Rice, 2017). In addition, research shows that the mental healthcare providers' knowledge about the EBP is humble and does not result in evidence- based practice to the majority of the clients, and there is a ten years lag between the actual practice and the research findings (Malik, McKenna & Plummer, 2015). This lag resulted in actual waste of time, efforts and resources, and undermined the client's progress and outcomes (Alshehri et al., 2017). They expected that the term is about using the new updated protocols and guidelines in assessment and management of clients. In addition, they reported that the EBP could mean applying the latest treatment modalities based on the textbooks and the online journals rather than the expertise of the professionals. They agreed that the expertise of the professionals was neither classified as an EBP nor the use of the old guidelines, a 42-year male mental health provider mentioned, "*Actually, the term is new to me, and I don't have enough knowledge about. It is easy to understand its meaning; it is mostly about using the updated protocols in assessment and management instead of relying on own expertise".*

Furthermore, contrasting to the quantitative results, they reported that their colleagues at their organizations did not know the term as a single meaningful approach, and they expected that they would also guess the meaning without actual knowledge. They reported that they had a very humble knowledge of the steps of applying the EBP, the levels of the EBP, the trusted resources of the EBP, and the research methodology. Their modest knowledge about the EBP was not organized, simple, and not based on evidence as they did not have a training on it, and their knowledge was based basically on the interpretation of the wording components. A 42- old male mental health provider said, "*we don't know the details of the EBP as we were not trained on how to look for the best evidence or its steps and levels*".

4.1.4 Attitude toward evidence- based practice

The overall attitude among the participants regarding the evidence-based practice was 60.76% (minimum= 32.14%, maximum = 84.62%, SD= 10.6%). The overall attitude is the mean of the fifteen items of the attitude domain. Of the participants, 0% of the participants strongly disagreed that application of EBP is crucial to apply the best patient care, 0% disagreed, 6.7% didn't know, 48.9% agreed, and 44.4% strongly agreed. In addition, 0% of them strongly disagreed that EBP application in mental health can reduce the stigma, 3% disagreed, 9.6% didn't know, 54.8% agreed, and 32.6% strongly agreed.

Furthermore, 0.7% of them strongly disagreed that EBP should be an integral part of clinical practice, 0.7% disagreed, 12.6% didn't know, 51.1% agreed, and 34.8% strongly agreed. Moreover, 20.4% of them strongly disagreed that previous clinical expertise is more crucial than the EBP in choosing the assessment and management plans, 52.7% disagreed, 0% didn't know, 24.7% agreed, and 2.2% strongly agreed. Also, 7.8% of them strongly disagreed that adoption of EBP is a waste of time and additional burden on the mental health provider, 21.4% disagreed, 0% didn't know, 58.3% agreed, and 12.6%

strongly agreed. Consistent with the qualitative results, the respondents indicated that the EBP would be interestingly important in the mental healthcare services provision, as it would improve the assessment and management methods which would improve the quality of the services accordingly. They believed that adopting the EBP approach in their organizations would add a scientific value to the provided services, and this would help in systemizing the work effectively. In addition, they expressed their support for considering the EBP as an integral part of the clinical practice that should be disseminated among all of the professionals. Furthermore, they reported that adopting the EBP would be time, effort, and resources saving not consuming and not a burden but an asset for the mental health provider, a 37-year female mental health provider indicated," *from our organization's expertise, we highly support the EBP and we try to fully adopt it. It helped to improve the quality of work and save time and effort*".

In a similar study, respondents stated they held generally positive attitudes and beliefs regarding EBP, with a majority contending that: they agreed or strongly agreed that EBP is necessary 90%, literature is useful to practice 82%, EBP improves the quality of patient care 79%, and evidence helps in decision making 72%. Sixty-one percent of the respondents stated they either disagreed or strongly disagreed that using evidence in practice places unreasonable demands on them (Saunders & Vehviläinen-Julkunen, 2016).

Table (4.4): Distribution of responses by the attitude toward EBP

Item		Strongly disagree	Disagree	I don't know	Agree	Strongly agree	Mean%
Application of EBP is crucial to apply the best patient care	NO	0	0	10	66	60	33.87%
	%	0%	0%	6.7%	48.9%	44.4%	
EBP application in mental health can reduce the stigma	NO	0	4	13	74	44	61.65%
	%	0	3%	9.6%	54.8%	32.6%	
EBP should be an integral part of clinical practice	NO	1	1	17	69	47	38.35%
	%	0.7%	0.7%	12.6%	51.1%	34.8%	
Previous clinical expertise is more crucial than the EBP in choosing the assessment and management plans	NO	28	71	0	33	3	42.99%
	%	20.4%	52.7%	0%	24.7%	2.2%	
Adoption of EBP is waste of time and additional burden on the mental health provider	NO	11	29	0	79	17	38.38%
	%	7.8%	21.4%	0%	58.3%	12.6%	
I prefer to use trusted and used methods in my organization instead of adopting new method	NO	17	75	0	41	3	54.25%
	%	12.6%	55.3%	0%	30.1%	1.9%	
I am interested in using the EBP in my daily practice	NO	1	3	21	91	19	34.46%
	%	0.7%	2.2%	15.6%	67.4%	14.1%	
I have the motivation to learn new things	NO	1	1	4	59	70	23.66%
	%	0.7%	0.7%	3%	43.7%	51.9%	
I believe I have enough expertise to manage my clients without the need to review the available evidence	NO	15	67	0	47	6	84.44%
	%	11.2%	49.5%	0%	34.6%	4.7%	
I would like to learn about the EBP via informal trainings	NO	6	25	23	57	24	79.26%
	%	4.4%	18.5%	17%	42.2%	17.8%	
I would like to learn about the EBP via formal training in my work	NO	2	3	9	69	52	79.63%
	%	1.5%	2.2%	6.7%	51.1%	38.5%	
I think that I would use the EBP if I were younger	NO	18	75	0	37	5	72.96%
	%	13.1%	55.6%	0%	27.3%	4%	
I think that integrating the EBP in university curriculum is just a burden on the students	NO	15	39	0	70	11	86.3%
	%	11%	29%	0%	52%	8%	
I would apply the EBP in my work if I got financial incentives	NO	29	68	0	33	5	62.59%
	%	21.6%	50.5%	0%	24.3%	3.6%	
I would apply the EBP If I got non-financial incentives like acknowledgement by my supervisors	NO	30	80	0	14	1	80.74%
	%	29.5%	58.9%	0%	10.7%	0.9%	
Overall attitude= 60.76%							

In addition, 12.6% of them strongly disagreed that they prefer to use trusted and used methods in my organization instead of adopting new methods, 55.3% disagreed, 0% didn't know, 30.1% agreed, and 1.9% strongly agreed. Furthermore, 0.7% of them strongly disagreed that they are interested in using the EBP in my daily practice, 2.2% disagreed, 15.6% didn't know, 67.4% agreed, and 14.1% strongly agreed. Moreover, 0.7% of them strongly disagreed that they have the motivation to learn new things, 0.7% disagreed, 3% didn't know, 43.7% agreed, and 51.9% strongly agreed. In a qualitative study, Freeman and Sweeney (2001) provided several quotations that illustrated the range of emotions associated with increasing the use of evidence in practice. Words that were used to describe implementation of clinical evidence were "anxious," "hard work," "risky," and "hassle."

Also, 11.2% of them strongly disagreed that they believe they have enough expertise to manage their clients without the need to review the available evidence, 49.5% disagreed, 0% didn't know, 34.6% agreed, and 4.7% strongly agreed. In addition, 4.4% of them strongly disagreed that they would like to learn about the EBP via informal training, 18.5% disagreed, 17% didn't know, 42.2% agreed, and 17.8% strongly agreed. Furthermore, 1.5% of them strongly disagreed that they would like to learn about the EBP via formal training, 2.2% disagreed, 6.7% didn't know, 51.1% agreed, and 38.5% strongly agreed. Preliminary research found that the learning tendency and motivation are highly associated with the EBP in health settings (Rousseau & Gunia, 2016). In addition, there is a strong relationship between the attitude toward the EBP and the self-efficacy which is presented by the one's belief in his/her ability to provide quality-based services (Schiele et al., 2014).

Moreover, 13.1% of them strongly disagreed that they would use the EBP if they were younger, 55.6% disagreed, 0% didn't know, 27.3% agreed, and 4% strongly agreed. Also,

11% of them strongly disagreed that they think that integrating the EBP in university curriculum is just a burden on the students, 29% disagreed, 0% didn't know, 52% agreed, and 8% strongly agreed. In addition, 21.6% of them strongly disagreed that they would apply the EBP in their work if they got financial incentives, 50.5% disagreed, 0% didn't know, 24.3% agreed, and 3.6% strongly agreed. Finally, 29.5% of them strongly disagreed that they would apply the EBP in their work if they got non-financial incentives, 58.9% disagreed, 0% didn't know, 10.7% agreed, and 0.9% strongly agreed. The non- financial incentives including motivation, appreciation and leadership including the transformational and the transactional styles present a core component of enhancing the positive attitude toward the EBP in mental health settings (Ryan, 2016). This is congruent with the notion that leadership is important in the adoption of innovations across a range of institutional contexts and technologies (Breytenbach, ten Ham-Baloyi, & Jordan, 2017).

On the other hand, they believed that clinical expertise is crucial in mental healthcare services provision but not enough nor effective for many reasons. First, they considered the clinical expertise is an individual based in terms of development and utilization, and each professional has her/his own experience and interpretation for the experience. Second, there was no guarantee on the outcome of the clinical expertise due to the lack of effective monitoring and evaluation. Third, the updating of the clinical expertise was questionable and mostly it stopped at a time point as they expressed, a 53-year male mental health provider mentioned, "*we have good expertise, but we don't know how effective it is. In addition, the expertise differs from person to person and depends on the individual own's perceptions and knowledge. We actually repeat our expertise over years".*

Moreover, the respondents welcomed formal and informal training that could enhance their knowledge and practice of the EBP in their work, and they expressed their deep

welling to learn new treatment guidelines and practice updated healthcare modalities. Furthermore, they believed that the poor trust in the institutional management is another root for their support for the EBP. Although the respondents showed a positive attitude toward the EBP, they mentioned that a large number of their colleagues were not supportive of adoption of the EBP in their workplaces, and they would show great resistance to it. They indicated that the number of the colleagues who supported the EBP would be much lower than those who did not due to several factors. First, they believed that age presents a core factor for enhancing the positive attitude toward the EBP as the old-aged professionals preferred to depend on their expertise and old used methods, and refused clearly the application of the newly updated protocols. Those colleagues believed that their clinical expertise is the main factor that guides their work, and they felt upset, unappreciated and anxious when they were criticized for this. Second, they indicated that the lack of knowledge about the EBP and its significance presents a barrier on persuasion of the colleagues on the need to adopt the EBP. Third, the devastated working conditions and economic hardship of the professionals that included the insufficient salaries and poor income limited the professionals' interest to getting the basic needs only. They believe that the EBP is a luxury and they didn't care about this; they needed their salaries first, a 42-year female mental health provider indicated," *the employees are demotivated as the working conditions are really bad and they don't get their salaries. They are helpless and hopeless and not motivated to improve their work outcomes*". Fourth, they mentioned the burnout and the poor motivation as important factors that strengthened the desire to resist the change; they reported that the change is hard by nature and the personality of their colleagues did not accept it easily, a 45-year female mental health provider mentioned," *change is hard; this is a reality. It is easier to resist it rather than cope and adapt"*.

4.1.5 Practice of evidence-based practice of the mental healthcare providers

The overall practice among the participants regarding the evidence-based practice was 71.27% (minimum= 25%, maximum = 92.86%, SD= 11.20%). The overall practice is the mean of the seven items of the practice domain. Regarding the practice of evidence- based in the mental health services, 0% of them strongly disagreed that they search for the best evidence using the e- resources, 4.4% disagreed, 8.1% didn't know, 60% agreed, and 27.4% strongly agreed. In addition, 0% of them strongly disagreed that they search for the best evidence using available resources and protocols, 6.7% disagreed, 8.1% didn't know, 63% agreed, and 22.2% strongly agreed. Furthermore, 0.7% of them strongly disagreed that they share the best evidence with my colleagues, 1.5% disagreed, 14.1% didn't know, 58.5% agreed, and 25.2% strongly agreed. Moreover, 0% of them strongly disagreed that they apply the best evidence in my work with my patients, 2.2% disagreed, 14.8% didn't know, 60.7% agreed, and 22.2% strongly agreed.

Table (4.5): Distribution of responses by the practice of the EBP

Item		Strongly disagree	Disagree	I don't know	Agree	Strongly agree	Mean%
I search for the best evidence using the e- resources	NO	0	6	11	81	37	77.59%
	%	0%	4.4%	8.1%	60%	27.4%	
I search the best evidence using the available books and protocols	NO	0	9	11	85	30	75.19%
	%	0%	6.7%	8.1%	63%	22.2%	
I share the best evidence with my colleagues	NO	1	2	19	79	34	76.48%
	%	0.7%	1.5%	14.1%	58.5%	25.2%	
I apply the best evidence in my work with my patients	NO	0	3	20	82	30	75.74%
	%	0%	2.2%	14.8%	60.7%	22.2%	
I feel hesitated to try a new approved method	NO	14	60	0	60	0	44.79%
	%	10.4%	44.8%	0%	44.8%	0%.	
I criticize and discuss the management plans with my colleagues using evidence	NO	1	4	23	90	17	71.85%
	%	0.7%	3%	17%	66.70%	12.60%	
I compare my work against international guidelines	NO	1	72	32	76	19	69.44%
	%	0.7%	5.2%	23.7%	56.3%	14.1%	
Overall practice= 71.27%							

Also, 10.4% of them strongly disagreed that they feel hesitated to try a new approved method, 44.8% disagreed, 0% didn't know, 44.8% agreed, and 0% strongly agreed. In addition, 0.7% of them strongly disagreed that they criticize and discuss the management plans with my colleagues using evidence, 3% disagreed, 17% didn't know, 66.7% agreed, and 12.6% strongly agreed. Finally, 0.7% of them strongly disagreed that they compare my work against international guidelines, 5.2% disagreed, 23.7% didn't know, 56.3% agreed, and 14.1% strongly agreed. The practice of the healthcare provider is strongly linked to the presence of an organizational policy as the better disseminated policy, the better show of practice (Brownson et al., 2017).

Consistently, the respondents assumed that they showed good practice of the evidence-based in their workplaces, however they indicated before that they didn't know the exact meaning and the basics of the EBP. In addition, they indicated that the application of the EBP was not a systematically structured process in their workplaces. They reported that they applied the EBP in several forms and actions based on their own interpretation. A 53-old male mental health provider emphasized; "*although we are not trained on the EBP, we regularly follow the international guidelines and rely on the updated protocols*". In a similar study, the results showed that the use of outcome monitoring system that integrates the client data, promotes the research studies, and operates the clinical audits is decreasing despite the approved ineffective health services that are not based on evidence (Bruns et al., 2016).

They said that they relied on the DSM V in assessment and diagnosis, and they had enough training on the DSM V by external experts in psychiatry. They also mentioned that they applied several psychotherapy methods including the Cognitive Behavioral Therapy and Dialectical Therapy after getting training from external experts, a 42 old male mental

health provider said; "*the DSM V is our holy book in the daily practice*". In a study of the posttraumatic stress .disorder clients, the researchers showed that there several validated guidelines for the management of the PTSD, however the actual management is highly selective and depends on the provider's desire and experience (Osei-Bonsu et al., 2017).

Furthermore, they mentioned that after the training, the experts conducted supervision sessions to assure the good implementation of the training skills and knowledge, however this lasted for a short period and the implementation became an individual matter. Moreover, they reported that their workplaces developed several guidelines that based on the international guidelines with several modifications that made it adaptable to the Palestinian culture. The mental health providers worldwide use several guidelines for the CBT, family therapy, and psychodynamic therapy as the main management for mental health problems (Beidas et al, 2015). However, randomized clinical trial should be done to evaluate the mental health approaches and guidelines in order to formulate strong evidence-based data that can support the application of the mental health interventions (Bakker et al., 2016).

The participants indicated that the senior professionals were engaged in adapting the international guidelines that were related to the most common mental health disorders, and those internally adapted guidelines were disseminated to other professionals. However, the resource of those guidelines was not clear, there was not a plan to update them, and there was no monitoring plan to assure the implementation, a 28-year female mental health provider reported, "*The senior psychiatrist revised the international guidelines and disseminated them to us. We were not engaged, and we don't know the process of adapting them. I guess it's based on the senior psychiatrist's expertise*".

Moreover, the respondents declared that they did use to search for the best evidence, and in case they did they used Google not a trusted EBP resource. In addition, they did not look for the EBP in textbooks or libraries as there were not updated libraries in their workplaces, and this was not of the institutional culture, a 46 old male mental health provider indicated, "*no one use the libraries, we just take a rest there. We sometime google things that we doubt about*".

They indicated that their workplaces conduct irregular meetings to discuss the management plans of the clients and case conferences to share the updated knowledge. They declared that those meetings were not organized and depended on the manager's own effort, and the discussion depended on the manager's search not against international guidelines, a 46-year female mental health provider reported, *"We conduct case conferences and scientific days to discuss the latest treatment modalities, but this is irregular and not planned*".

The evidence-based practice ensures that the consumer is shared during decisions related to his/her health. Importantly, the health provider should be engaged in decision making process that is related to his/her own daily practice manner (Carman & Workman, 2017). Healthcare providers worldwide complain of the poor shared decision- making processes that inhibits their motivation to improve their daily practice using the new treatment modalities (Thompson- Leduc et al., 2015).

4.1.6 Institutional factors affecting the evidence- based practice

Regarding the institutional factors that affect the evidence- based practice, participants reported that 45.05% of the institutional factors were good enough to enhance the EBP in their organizations. Research found that specific institutional level constructs influence adoption and sustainability of new practices. Constructs of particular interest include

institutional culture, institutional climate, and implementation climate (Locke et al, 2019), and studies from health discipline suggested that the institutional factors are highly predictive of the implementation (Sayer et al, 2017). Furthermore, 17% of the respondents indicated that their workplaces were not supported by desktop computers that can be used by the employees, while 44.4% indicated that there were but not enough, and 38.5% indicated that there were enough. In addition, 34.1% of the respondents indicated that their workplaces were not supported by laptops that can be used by the employees, while 39.3% indicated that there were but not enough, and 26.7% indicated that there were enough. A previous research suggested that the presence of digital sources of evidence is one of the building blocks of effective EBP in any organization that enhances the informatics of evidence (Bonham et al., 2014). Due to the strong impact of the infrastructure on The EBP implementation, institutionalization by setting a clear and sustainable long-term structure for the EBP is an asset to positively operate all the possible factors (Shelton, Cooper, & Stirman, 2018).

Table (4.6): Distribution of responses by the institutional factors

Item	Category	NO	%
My workplace is supported by desktop computers that can be used by the employees	No	55	40.70%
	Yes, not enough	53	39.30%
	Yes, enough	27	20%
My workplace is supported by laptops that can be used by the employees	No	18	13.30%
	Yes, not enough	70	51.90%
	Yes, enough	47	34.80%
My workplace is supported by smartphones that can be used by the employees	No	66	48.90%
	Yes, not enough	46	34.10%
	Yes, enough	23	17%
My workplace provides me with access to internet	No	71	52.60%
	Yes, not enough	43	31.90%
	Yes, enough	21	15.60%
My workplace trained me on the use of computer and internet software	No	74	54.80%
	Yes, not enough	41	30.40%
	Yes, enough	20	14.80%
My workplace provides me with free access to online international libraries	No	66	48.90%
	Yes, not enough	51	37.80%
	Yes, enough	18	13.30%

Item	Category	NO	%
There is an updated library in my workplace	No	71	52.60%
	Yes, not enough	42	31.10%
	Yes, enough	22	16.30%
My workplace provides me with updated protocols regarding assessment and management of clients	No	68	50.40%
	Yes, not enough	47	34.80%
	Yes, enough	20	14.80%
My workplace engaged me in discussions related to the assessment and management of clients	No	44	32.60%
	Yes, not enough	64	47.40%
	Yes, enough	27	20%
There is a written policy on the use of EBP in my organization	No	41	30.40%
	Yes, not enough	64	47.40%
	Yes, enough	30	22.20%
There is adequate monitoring of the use of EBP by the management	No	22	16.30%
	Yes, not enough	69	51.10%
	Yes, enough	44	32.60%
The use of EBP is part of the annual employee's evaluation	No	55	40.70%
	Yes, not enough	53	39.30%
	Yes, enough	27	20%
My workplace mandates the use of EBP in my work	No	18	13.30%
	Yes, not enough	70	51.90%
	Yes, enough	47	34.80%
My workplace provides me with additional time to look for the best available evidence	No	66	48.90%
	Yes, not enough	46	34.10%
	Yes, enough	23	17%
My workplace takes measures to encourage the use of EBP	No	71	52.60%
	Yes, not enough	43	31.90%
	Yes, enough	21	15.60%
I had learned about EBP in my university	No	74	54.80%
	Yes, not enough	41	30.40%
	Yes, enough	20	14.80%
The curricula in my university follow the international guideline	No	66	48.90%
	Yes, not enough	51	37.80%
	Yes, enough	18	13.30%
My colleagues respect and appraise those who apply the EBP in my workplace	No	71	52.60%
	Yes, not enough	42	31.10%
	Yes, enough	22	16.30%
There is a monitoring and evaluation department at my organization	No	3	2.22%
	I don't know	15	11.11%
	Yes	107	79.26%
There are performance indicators in your organization	No	28	20.74%
	I don't know	35	25.93%
	Yes	72	53.33%
Your organization track them regularly	No	3	2.22%
	I don't know	15	11.11%
	Yes	107	79.26%
Your management discuss the progress achieved against these indicators	No	28	20.74%
	I don't know	35	25.93%
	Yes	72	53.33%
Overall institutional factors= 45.02%			

Moreover, 56.3% of the respondents indicated that their workplaces were not supported by smartphones that can be used by the employees, while 22.2% indicated that there were but not enough, and 21.5% indicated that there were enough. Furthermore, 25.2% of the respondents indicated that their workplaces didn't provide them with access to the internet, while 37.8% indicated they provided them with access but not enough, and 37% indicated that they provided them with enough access to the internet. Similarly, the availability of strong internet connection in the mental health organizations was not sufficient to enhance looking for new e-articles (Abdulwadud et al., 2019).

Of the participants, 48.9% indicated that their workplaces did not train them on the use of computer and internet software, 26.7% indicated that they trained them but not enough, and 24.4% indicated that they trained them enough. In a similar study, the capacity building and training showed a strong effect on the EBP implementation, and there is not sufficient capacity building programs to enhance the employee's knowledge and skills (Brownson, Fielding, & Green, 2018).

Furthermore, 67.4% of the respondents indicated that their workplaces didn't provide them with access to the online international libraries, while 19.3% indicated they provided them with access but not enough, and 13.3% indicated that they provided them with enough access to the online international libraries.

Of the participants, 76.3% indicated that there was not an updated library in their workplaces, 14.8% indicated that there was an updated library but not enough, and 8.9% indicated that there was enough updated library. Moreover, 40.7% of them reported that their workplaces did not provide them with updated protocols regarding assessment and management of the clients, 39.3% reported that they provided them but not enough, and 20% reported that they provided them with enough updated protocols. A Chinese study

described the institutional support and the infrastructure as the engines for enhancing the EBP in health settings (Hong & Chen, 2019). A systematic review on 49 articles concluded that the presence of policies and procedures, in addition to sufficient data and research resources was marked as the heart of the EBP in healthcare settings (Shafaghat et al., 2021).

Also, 13.3% of them reported that their workplaces did not engage them in discussions regarding assessment and management of the clients, 51.9% reported that they engaged them but not enough, and 34.8% reported that they engaged them in an enough way. Interestingly, engaging the frontline workers in decision-making and EBP discussions is a strong factor that reinforce the frontline workers' beliefs and trust in the proposed new interventions (Barry et al., 2019).

Of the participants, 48.9% reported that there was not a written policy on the use of the EBP in their workplaces, 34.1% reported that there was but enough, and 17% reported that there were enough policies. In addition, 52.6% reported that there was not adequate monitoring of the EBP in their workplaces, 31.9% reported that there was but enough, and 15.6% reported that there was adequate monitoring.

On the hand, they indicated that there were not written policies that organize the clinical work sufficiently; there were only scattered guidelines without a structured policy. In addition, the EBP was not clearly mentioned in the clinical guidelines they had. A 53- old male mental health provider; "*actually there are not specific guideline for each disorder, but we have several training materials on the management of mental health disorder*".

Moreover, implementing the clinical work that is based on evidence was not of the job description nor the requirement as it was not stated in the official documents in their organizations. Also, the EBP was not part of the employee's annual appraisal, and those

who individually used it actually did not get neither financial nor non-financial incentives. All motivation and appreciation they got depended on the manager's own personality, not an appreciation policy in their workplaces, and their work was not considered in the promotion procedures either. A 28- old female mental health provider stated, "*the so-called EBP depends on the personal motives. There is no system for it or appraisal based on to what level you follow it*".

Of the participants, 54.8% indicated that the use of EBP is an integral part of the annual employee's evaluation, 30.4% indicated that it is but not enough, and 14.8% indicated that it is enough integral part. Moreover, 48.9% of them reported that their workplaces mandate the use of EBP in their workplaces, 37.8% reported that there is not enough mandate, and 13.3% reported that there is enough mandate to use the EBP in their workplaces. Of the participants, 52.6% indicated that their workplaces don't provide them with additional time to look for the best evidence, 31.1% indicated that they provide them not enough, and 16.3% indicated that they provide them with enough time to look for the best evidence. In addition, 50.4% indicated that their workplaces don't take measures to encourage the use of EBP in their workplaces, 34.8% indicated that they take measures but enough, and 14.8% indicated that they take enough measures. Consistent to the above findings, research suggested that taking motivation measures can appropriately reinforce positive work behaviors and a greater sense of trust in the supervisor-supervisee relationship and lead to greater openness toward adopting evidence-based practices (Parker-Jenkins, 2018). In addition, research suggested that the supervisor-supervisee dyad is a potentially important point of influence in affecting attitudes toward adopting evidence-based practice. A 46-old male mental health provider stated," *the motivation from the supervisor totally depends on your personal relationship with him/her not your work or commitment*".

However, in order to change attitudes and practice, leaders must persevere in the change process, and multiple hurdles to change should be expected and allowed for (Finley et al., 2015). Moreover, 32.6% indicated that they have learned about the EBP in my university, 47.4% indicated that they have learned but enough, and 20% indicated that they have learned enough. A 42-old male mental health provider mentioned, "*I have never heard about it during my university study*".

Furthermore, 30.4% indicated that curricula in their universities did not follow the international guidelines, 47.4% indicated that their universities followed the international guidelines but not enough, and 22.2% indicated that their universities followed the international guideline in a sufficient manner. Regarding the monitoring and evaluation in the targeted organizations, 9.6% of the respondents indicated that there is a monitoring and evaluation department at their workplaces, 11.1% indicated that there is not an M&E department, 79.3% indicated that they don't know.

In addition, 20.7 % of the respondents indicated that there are performance indicators at their workplaces, 25.9% indicated that there are no performance indicators at their workplaces, and 53.3% indicated that they don't know. Furthermore, 38% of the respondents indicated that their workplaces track performance indicators regularly, 0% indicated that they don't track them, and 62% indicated that they don't know. Also, 35.2% of the respondents indicated that the management discussed the progress achieved against the indicators at their workplaces, 0% indicated that they don't, and 64.8% indicated that they don't know. Consistently, the respondents reported that there were not EBP units in their workplaces that are responsible to implement and supervise the evidence- based practice in their workplaces. In addition, they declared that there were monitoring and evaluation units that were responsible to monitor and evaluate the activity progress against specific indicators cleared at the strategic plans of their workplaces, but they were not

aware about the indicator used. They reported that the M&E work was limited to the workers in the units, and the professionals were not engaged in setting the strategic and the M&E plans; they just got previously prepared plans and were ordered to follow. A 43-old male mental health provider stated,

> "*There is a monitoring and evaluation unit but we are not engaged into the preliminary discussions in setting the plans. They provide us with the indicators and they ask us to follow without even explaining the description of the indicators. We are just implementors"*.

Regarding the infrastructure that supports the EBP, the responses varied according to the type of the organization. The results showed that the governmental organizations suffer from poor unsupported infrastructure compared to the non-institutional structure. The respondents from the GO indicated that the employees were not provided by computers, laptops, smartphones, not access to international libraries; only the managers were supported by computers or laptops. On the other hand, the respondents from the NGOs reported that each employee was provided by a computer or laptop that had strong internet connection, but they were not supported by access to international libraries. All of them indicated that there were libraries in their workplaces that were not updated nor visited by any. The respondents mentioned that their workplaces trained all of the employees on the basics of computer use including the Microsoft office software and typing skills. This; as they indicated, was a first step to computerize the work totally in their workplaces. The culture of the organizations regarding the EBP was obvious from the respondents' perspectives. They thought that the culture generally was not supportive enough due to the lack of self-confidence and confidence of other colleagues to make the changes. They indicated that they and their colleagues had sufficient qualifications to improve the work, but no one had the initiation to start, and those who initiated were mocked, criticized and

underestimated by others. In addition, they indicated that the working environment was really frustrating which can be related to the poor life conditions and the economic hardship in the Gaza Strip. A 43-old male mental health provider said,

> *" The EBP is a luxury for the mental health workers in Gaza. How do you ask employees to function in an outstanding manner while you don't provide them with their minimal rights including the salary and the good working conditions? This is really luxury*".

Furthermore, there was a lack of ongoing professional development opportunities for the employees that were limited only to specific staff who had senior positions. The poor participation and lack of effective engagement in decision making made the trust between the frontline workers and the managers even poorer.

4.1.7 Barriers to the evidence-based practice in mental healthcare services

The results showed variations in the barriers of evidence- based practice; 9.6% of them considered the insufficient time as not a barrier, 30.4% considered it as a weak barrier, 33.3% considered it as a moderate barrier, and 26.7% considered it as a strong barrier. Limited time for retrieving and interpreting research and for applying research to individual patients has been cited by numerous authors as a major reason clinician do not incorporate evidence in their practices (Camargo et l., 2018). In addition, 5.9% of them considered the lack of awareness and knowledge on the use of EBP as not a barrier, 22.2% considered it as a weak barrier, 34.8% considered it as a moderate barrier, and 37% considered it as a strong barrier. The lack of awareness about the significance and impact of the EBP is one of the challenging but easily to overcome by training and awareness; people can implement any act if they don't believe in (Hall et al., 2019).

Moreover, 5.9% of them considered the lack of training as not a barrier, 14.8% considered it as a weak barrier, 33.3% considered it as a moderate barrier, and 45.9% considered it as a strong barrier. The informational support via training and engaging in regular discussion play an important role in setting the responsibility of the professionals toward improving their work procedures and outcomes (Williams, Perillo, & Brown, 2015). A 45-old female mental health provider, "*I think that if you train people, they will have enough knowledge and skills, and they will implement the EBP in a better way*".

Table (4.7): Distribution of responses by the barriers to the EBP

Item	Not a barrier		Weak barrier		Moderate barrier		Strong barrier	
	NO	%	NO	%	NO	%	NO	%
Insufficient time	13	9.6%	41	30.4%	45	33.3%	36	26.7%
Lack of awareness and knowledge on the use of EBP	8	5.9%	30	22.2%	47	34.8%	50	37%
Lack of trainings on EBP in my work	8	5.9%	20	14.8%	45	33.3%	62	45.9%
Lack of access to international libraries	7	5.2%	14	10.4%	36	26.7%	78	57.8%
Poor internet connection	8	5.9%	26	19.3%	37	27.4%	64	47.4%
Lack of motivation	9	6.7%	16	11.9%	37	27.4%	73	54.1%
Not being part of the organization culture	10	7.4%	24	17.8%	47	34.8%	54	40%
Lack of written policy and systematic method to use EBP in my work	7	5.2%	24	17.8%	47	34.8%	57	42.2%
Poor statistical understanding	10	7.4%	31	23%	55	40.7%	39	28.9%
Poor knowledge of the research methodology	16	11.9%	35	25.9%	43	31.9%	41	30.4%
Poor evaluation and appraisal ability	12	8.9%	34	25.2%	55	40.7%	34	25.2%
Language barriers	19	14.1%	34	25.2%	43	31.9%	39	28.9%
Not being part of the job requirements or the employee annual evaluation	13	9.6%	29	21.5%	48	35.6%	45	33.3%
Lack of personal desire to use the EBP	25	18.5%	36	26.7%	33	24.4%	41	30.4%
Poor trust in the updated treatment protocols	21	15.6%	39	28.9%	43	31.9%	32	23.7%
Poor cooperation of the clients	15	11.1%	37	27.4%	33	24.4%	50	37%
Overall barriers= 65.47%								

Furthermore, 5.2% of them considered the lack of access to international libraries as not a barrier, 10.4% considered it as a weak barrier, 26.7% considered it as a moderate barrier, and 57.8% considered it as a strong barrier. Also, 5.9% of them considered the poor internet connection is not a barrier, 19.3% considered it as a weak barrier, 27.4% considered it as a moderate barrier, and 47.4% considered it as a strong barrier. The infrastructure is crucial in maintaining long-term and quality based EBP in mental health settings including the technology-related infrastructure or learning-suitable climate (Bach-Mortensen, Lange, & Montgomery, 2018).

Regarding the lack of motivation, 6.7% considered it as not a barrier, 11.9% considered it as a weak barrier, 27.4% considered it as a moderate barrier, and 54.1% considered it as a strong barrier. Regarding not being part of the institutional culture, 7.4% considered it as not a barrier, 17.8% considered it as a weak barrier, 34.8% considered it as a moderate barrier, and 40% considered it as a strong barrier. In addition, 5.2% of them considered the lack of written policy and systematic method to use EBP in the workplace as not a barrier, 17.8% considered it as a weak barrier, 34.8% considered it as a moderate barrier, and 42.2% considered it as a strong barrier. Consistent with that, the institutional factors play a significant role in enhancing the EBP in mental healthcare services and absence of clear policy and standards undermine the implementation (Knaak, Mantler, & Szeto, 2017). A 46- old female mental health provider stated, "It is a ma*tter of decision. If the organization decided to adopt the EBP, it will be adopted formally for sure*".

Furthermore, 7.4% of them considered the lack of statistical understanding as not a barrier, 23% considered it as a weak barrier, 40.7% considered it as a moderate barrier, and 28.9% considered it as a strong barrier. Moreover, 11.9% of them considered the poor knowledge of research methodology as not a barrier, 25.9% considered it as a weak barrier, 31.9%

considered it as a moderate barrier, and 30.4% considered it as a strong barrier. Also, 8.9% of them considered the poor evaluation and appraisal ability as not a barrier, 25.2% considered it as a weak barrier, 40.7% considered it as a moderate barrier, and 25.2% considered it as a strong barrier. A 28- old female mental health provider indicated, "*we don't have enough knowledge on the research methodology and EBP appraisal methods. In addition, the statistics is a big problem for us*". Many health care professionals have argued that they lack the expertise to assess the validity of evidence or the knowledge of how to obtain relevant information (Khammarnia et al., 2015).

Regarding the language barriers, 14.1% considered it as not a barrier, 25.2% considered it as a weak barrier, 31.9% considered it as a moderate barrier, and 28.9% considered it as a strong barrier. Regarding not being part of the job requirements, 9.6% considered it as not a barrier, 21.5% considered it as a weak barrier, 35.6% considered it as a moderate barrier, and 33.3% considered it as a strong barrier. In addition, 18.5% of them considered the lack of personal desire as not a barrier, 26.7% considered it as a weak barrier, 24.4% considered it as a moderate barrier, and 30.4% considered it as a strong barrier.

Furthermore, 15.6% of them considered the poor trust in the updated protocols as not a barrier, 28.9% considered it as a weak barrier, 31.9% considered it as a moderate barrier, and 23.7% considered it as a strong barrier. Finally, 11.1% of them considered the poor cooperation of the clients as not a barrier, 27.4% considered it as a weak barrier, 24.4% considered it as a moderate barrier, and 37% considered it as a strong barrier. This is consistent with previous research that indicated that the poor cooperation of the client and his/her preference affect the implementation of the EBP negatively due to the fear of using new method and being subjected to experience (Harvey & Gumport, 2015). A 53- old male mental health provider said; "*the mental health providers feel afraid from trying new*

methods as well as the clients; they think you are weird and not well-skilled if you tried to use something that is out of the trend".

Consistently, the respondents mentioned several barriers to the evidence- based practice in the mental healthcare services either at the institutional level or the personal level. They reported that the lack of institutional systems that mandate and support the EBP in their workplaces was the first and the most significant barrier. They said that they could not blame the employees as there was no system for the EBP that included written policy, clear strategic plan, clear and disseminated indicators, effective scientific committee, updated protocols, effective M&E system, supported infrastructure, motivation measures and importantly employee's safety, a 46- old female mental health provider mentioned," *adoption of the EBP needs just a decision. The high administrative bodies should make the decision and everybody will follow*".

They also reported that their organizations should be responsive to the contextual changes that occur around including the COVID-19 pandemic and the newly changed mental health needs accordingly. Their organizations as they stated were not responsive enough to the political issues that affected the employee's needs significantly. The employees turned into basic needs researchers not creative productive persons in their workplaces. In addition to the institutional barriers, they indicated that several personal barriers limited the EBP in their workplaces including the lack of desire to change, the age barrier that made the expertise over the evidence, the lack of knowledge on the EBP, the poor knowledge in the research methodology and the statistical understanding, the poor evaluation and appraisal skills and the poor mental health of the professionals themselves who suffer from the shared stressors with the Gaza population, and the additional stressors of their work. The poor quality of life and lack of satisfaction regarding life conditions was found to be an

obstacle to adhere to the EBP (Farokhzadian, Khajouei, & Ahmadian, 2015). Similarly, a previous research categorized the barriers to institutional and individual based. At an institutional level, the main issues identified were evidence-based practice was a low management priority, problems with dissemination, inadequate systems for personal and professional development, difficulties in the management of innovations, and accessing evidence and resource constraints. At the individual practice level, the main issues were motivation, a lack of clarity about roles and practice, and a culture of practice which emphasizes 'routine' patient care (Fiset, Graham, & Davies, 2017). Globally, the majority of those who need mental health care worldwide lack access to high-quality mental health services. Stigma, human resource shortages, fragmented service delivery models, and lack of research capacity for implementation and policy change contribute to the current mental health treatment gap (Wainberg et al., 2017). In addition, Research barriers, lack of resources, lack of time, inadequate skills, and inadequate access, lack of knowledge and financial barriers were found to be the most common barriers to EBP (Sadeghi- Bazargani, 2014). In addition to that, a study with community nurses showed that the most significant barriers were poor computer facilities, poor patient compliance and difficulties in influencing changes within health settings (Malik, McKenna & Plummer, 2015). Moreover, research suggested a number of barriers that include the rapid rate of medical knowledge development, inadequate access to clinically relevant information at the point of need, increased workload and patient complexity, and difficulty translating the evidence for use with a particular patient (Wainberg et al., 2017).

4.2 Inferential analysis

4.2.1 Differences of the Knowledge, attitude and practice due to the gender variable

The researcher conducted inferential statistics in order to find out possible relationships between the knowledge, attitude and practice of the EBP and the gender variable. The

results showed a statistically significant relationship between the knowledge and the gender of the participants after conducting an independent T test as the mean among men was 68.5% and among women was 63.6% (t= 2.56, p value= 0.011, equal variance assumed at sig 0.975). However, the relationship between the attitude and the gender variable was not statistically significant after conducting independent T test as the mean among men was 61.823% and among women was 59.75% (t=,1.131 p value=, .259, equal variance assumed at sig= .235). In addition, the relationship between the practice and the gender variable was not statistically significant after conducting independent T test as the mean among men was 72.84% and among women was 69.77% (t=,1.602 p value=, .112, equal variance assumed at sig= .174). This can be explained by the engagement of men into formal and informal training that enhanced their knowledge about the EBP and their low load compared with women who suffer from high load of responsibility outside work and decreased motivation to improve their knowledge. However, when it comes to actual practice, the institutional factors that are already deteriorated play a significant role on both genders to result in insignificant differences.

Table (4.8): Differences in the knowledge, the attitudes and the practices of the mental healthcare providers in relation to the gender.

Dependent variables	Gender	N	Mean	SD	T	Sig
Knowledge	Man	66	68.5155	10.59412	2.56	0.011
	Woman	69	63.6991	10.97873		
Attitude	Man	66	61.8253	11.21506	1.131	0.259
	Woman	69	59.7581	9.95527		
Practices	Man	66	72.8445	9.71913	1.602	0.112
	Woman	69	69.7723	12.34813		

4.2.2 Differences of the Knowledge, attitude and practice due to the residency variable

The researcher conducted ANOVA test in order to find out the possible relationships between the knowledge, attitude and practice of the EBP and the residency variable. The knowledge in Gaza Governorate was the best represented by 74.5% followed by the middle governorate represented by 65.5%. The attitude was the highest in Gaza Governorate represented by 65.5% followed by the middle governorate represented by 61.5%. The practice was the best in the Gaza Governorate represented by 75.5% followed by the North Gaza Governorate presented by 70.5%. The results showed statistically not significant relationship between the knowledge, attitude and practice and the residency variable as p value = 0.613, 0.700, 0.543 respectively. This can be explained by the same characteristics between the five governorates of the Gaza Strip, and the same working conditions too.

Table (4.9): Differences in the knowledge, the attitudes and the practices of the mental healthcare providers in relation to the residency.

Dependent variables	Independent variables	N	Mean	SD	F	Sig.
Knowledge	North Gaza	20	64.50%	10.5	2.15	.613
	Gaza Governorate	55	74.50%	11.3	3.05	
	Middle Governorate	33	65.50%	12.5	6.15	
	Khanyounis Governorate	16	64.50%	8.4	8.15	
	Rafah Governorate	11	63.50%	7.8	7.04	
Attitude	North Gaza	20	59.50%	12.8	6.05	.700
	Gaza Governorate	55	65.50%	11.4	5.14	
	Middle Governorate	33	61.50%	9.6	6.15	
	Khanyounis Governorate	16	59.50%	10.2	6.89	
	Rafah Governorate	11	57.50%	14.2	3.48	
Practice	North Gaza	20	70.50%	12.6	5.07	.543
	Gaza Governorate	55	75.50%	14.1	7.01	
	Middle Governorate	33	69.00%	10.6	8.56	
	Khanyounis Governorate	16	69.50%	11.2	5.39	
	Rafah Governorate	11	70.50%	11.3	4.15	

4.2.3 Differences of the Knowledge, attitude and practice due to the educational level variable

Independent T test was conducted in order to find out the possible relationships between the knowledge, attitude and practice of the EBP and the educational level variable. The average knowledge and practice among the postgraduates were 70.5% and 76.5% respectively compared to who had just up to bachelor degree. The results showed a statistically significant relationship between the knowledge and practice and the educational level variable as p value = 0.008, 0.041 respectively. Mental healthcare providers with postgraduate education showed better knowledge and practice. However, the results showed a statistically not significant relationship between the attitude and the educational level as p value= 0.104. That education level was related to knowledge and practice, suggesting that within recent years all professional education programs, regardless of the degree offered, have increased emphasis on the skills needed to implement EBP, however the attitude is mostly affected by the culture around (Baatiema et al., 2017).

Table (4.10): Differences in the knowledge, the attitudes and the practices of the mental healthcare providers in relation to the educational level.

Dependent variables	Independent variables	N	Mean	SD	T	Sig.
Knowledge	Up to bachelor degree	51	62.50%	10.2	0.89	.008
	Postgraduate education	84	70.50%	12.4	0.45	
Attitude	Up to bachelor degree	51	55.50%	10.8	0.56	.041
	Postgraduate education	84	66.50%	9.5	0.78	
Practice	Up to bachelor degree	51	66.50%	13.1	0.89	.104
	Postgraduate education	84	76.50%	12.5	0.34	

4.2.4 Differences of the Knowledge, attitude and practice due to the university type variable

ANOVA test was conducted in order to find out the possible relationships between the knowledge, attitude and practice of the EBP and the university type variable. Those who got their latest qualification from international university had the best knowledge, attitude and practice followed those got their latest qualification from Arab university and local university. The results showed statistically not significant relationship between the knowledge, attitude and practice and the university type variable as p value = 0.346, 0.919, 0.666 respectively. Actually, the graduates from the international universities are assumed to have better KAP about the EBP, but this is not apparent in this study. This is may be related to the poor institutional formal and informal support that make all graduates under the same poor system.

Table (4.11): Differences in the knowledge, the attitudes and the practices of the mental healthcare providers in relation to the university type.

Dependent variables	Independent variables	N	Mean	SD	F	Sig.
Knowledge	Local university	106	59.50%	12.2	3.15	.346
	Arab university	23	68.20%	10.666	4.15	
	International university	6	70.50%	11.4	5.48	
Attitude	Local university	106	54.00%	8.66	6.34	.919
	Arab university	23	60.20%	9.6	1.34	
	International university	6	68.50%	10.4	2.48	
Practice	Local university	106	64.50%	8.766	2.05	.666
	Arab university	23	70.50%	13.1	7.05	
	International university	6	78.50%	10.66	4.11	

4.2.5 Differences of the Knowledge, attitude and practice due to the profession variable

ANOVA test was conducted in order to find out the possible relationships between the knowledge, attitude and practice of the EBP and the profession variable. The results showed statistically not significant relationship between the knowledge, attitude and practice and the profession variable as p value = 0.469, 0.209, 0.226 respectively. The statistically insignificant relationship between KAP and the profession variable can be referred to the type of the university of the highest education and curricula. There is no specialized mental health subspeciality, and there is only one curriculum that are provided for the different types of the profession regardless their basic background.

Table (4.12): Differences in the knowledge, the attitudes and the practices of the mental healthcare providers in relation to the profession variable.

Dependent variables	Independent variables	N	Mean	SD	F	Sig.
Knowledge	Psychiatrist/ physician	12	65.50%	9.66	5.568	.469
	Psychologist	61	74.50%	10.235	6.48	
	Social worker	24	65.50%	8.55	3.148	
	Psychiatric nurse/ nurse	38	60.50%	8.634	5.698	
Attitude	Psychiatrist/ physician	12	62.50%	10.23	4.79	.209
	Psychologist	61	60.50%	12.65	7.48	
	Social worker	24	59.50%	9.67	5.68	
	Psychiatric nurse/ nurse	38	60.50%	7.88	3.01	
Practice	Psychiatrist/ physician	12	70.50%	12.33	4.012	.226
	Psychologist	61	75.50%	12.89	5.15	
	Social worker	24	69.00%	11.56	8.45	
	Psychiatric nurse/ nurse	38	69.50%	10.99	7.146	

4.2.6 Differences of the Knowledge, attitude and practice due to the profession type variable

ANOVA test was conducted in order to find out the possible relationships between the knowledge, attitude and practice of the EBP and the profession type variable. Those who work in managerial positions had the best knowledge, attitude and practice followed by those who work in both managerial and technical positions, and those who work in technical positions only. The results showed statistically not significant relationship between the knowledge, attitude and practice and the profession type variable as p value = 0.810, 0.172, 0.707 respectively. Those who work in managerial positions are more aware about the work requirement, work development plan, the policies and regulation, and they are more engaged in trainings and conferences.

Table (4.13): Differences in the knowledge, the attitudes and the practices of the mental healthcare providers in relation to the profession type variable.

Dependent variables	Independent variables	N	Mean	SD	F	Sig.
Knowledge	Managerial	5	70.50%	12.235	4.125	.810
	Technical	105	59.50%	10.553	8.16	
	Both	625	68.20%	8.99	5.658	
Attitude	Managerial	5	68.50%	10.25	6.314	.172
	Technical	105	54.00%	15.22	4.123	
	Both	625	60.20%	8.364	2.59	
Practice	Managerial	5	78.50%	10.789	3.158	.707
	Technical	105	64.50%	12.45	8.45	
	Both	625	70.50%	8.966	7.45	

4.2.7 Differences of the Knowledge, attitude and practice due to the position variable

ANOVA test was conducted in order to find out the possible relationships between the knowledge, attitude and practice of the EBP and the position variable. The results showed statistically not significant relationship between the knowledge, attitude and practice and the position variable as p value = 0.210, 0.370, 0.119 respectively. The knowledge of the general practitioners is better that the head of units and departments as they provide services for the client daily and directly, and they need to update their knowledge based on their daily observations and results.

Table (4.14): Differences in the knowledge, the attitudes and the practices of the mental healthcare providers in relation to the position variable.

Dependent variables	Independent variables	N	Mean	SD	F	Sig.
Knowledge	General practitioner	105	72.40%	12.235	2.563	.210
	Head of unit	11	65.20%	10.553	1.593	
	Head of department	19	60.50%	8.99	.856	
Attitude	General practitioner	105	62.50%	10.25	5.24	.370
	Head of unit	11	56.80%	15.22	2.368	
	Head of department	19	63.20%	8.364	2.016	
Practice	General practitioner	105	74.50%	10.789	.639	.119
	Head of unit	11	62.00%	12.45	8.56	
	Head of department	19	78.00%	8.966	.568	

Chapter Five

Conclusion and recommendations

5.1 Conclusion

This study aimed at exploring the knowledge, the attitudes and the practices of the mental healthcare providers toward the EBP in the Gaza Strip, in addition to the possible factors affecting it. There is a good knowledge and a positive attitude toward the EBP in the mental healthcare services, but this was not reflected sufficiently on the daily practice. The frequency of reading trusted resources of evidence was not sufficient to be updated with the rising knowledge. Furthermore, the resources for knowledge that the mental healthcare providers use were not actually evidence- based. They commonly depended on the shared internal protocols that were adapted to the Palestinian context with assistance of external experts. The mental healthcare providers were trained on the adapted psychotherapy protocols but there was not enough supervision on the implementation. Moreover, there were not regular updates that are based on the clinical evidence and client's outcome. In addition, the sources of knowledge that they used were very limited to some international guidelines including the DSM V, the PFA, the CBT manual, and the family therapy manual. The participation of the mental healthcare providers in research studies and clinical audits was totally an individual experience for postgraduate certificates and personal gains. Commonly, the mental healthcare providers used the evidence for diagnosis and treatment purposes, and they were motivated based on personal motives and moral responsibility toward the clients. Despite mentioning the work requirement as one of the significant motives behind the EBP, the professionals indicated that it was about the client's care and progress not the managerial support and motivation. The managerial support and motivation were not prominent as motives, instead they appeared as antagonists to the EBP due to the inappropriateness, insufficiency, and instability.

The knowledge about the EBP was humble and unorganized. The mental healthcare providers and the managers didn't recognize the EBP as an approach that should be embedded in the healthcare system, their knowledge about it depended on assumptions and suggestions. They believed that it is about using the updated protocols and treatment modalities in daily practice, and they assumed that it was against the individual expertise. They believed that the clinical expertise cannot be a reference to the daily practice due to several factors including the individualism, the lack of knowledge about the effectiveness and efficiency, the poor updating measures, and the lack of sharing and dissemination. The basics and the details about the EBP were not well-known by the mental healthcare providers; they had very superficial knowledge about the levels, steps, and resources of EBP. The EBP contains three components; the research evidence, the clinical expertise, and the client preference. The client preference component was not known as a part of the EBP, instead they acted like the client is just a receiver who does not have the qualification to share in decisions related to his/her health status.

Although the knowledge about the EBP among the mental healthcare providers was really humble, they showed very positive attitude toward the EBP. They believed that the EBP can enhance the quality of care through improving the effectiveness, the efficiency and the impact of the provided services. In addition, they believed that the EBP can have a role in reducing the stigma toward the mental health/illness among the community if it was based on scientific evidence. They believed that people like to be argued using numbers and facts, and this is the job of the EBP. The motivation to learn new things was common among the mental healthcare providers, but there were several barriers and challenges to go on depending on the individual learning tendency and motivation. The financial incentives looked to be an important factor that would reinforce the EBP in the mental healthcare services, in addition to the non-financial incentives. The non-financial incentives included

giving additional time to the employee to look for evidence and appraise own work, in addition to managerial support and appreciation. Although the mental healthcare providers didn't believe that the clinical expertise is not an alternative nor a base to the evidence, they reported that they have a special belief in themselves as qualified and skilled enough to practice. This could be related to the self-confidence and the response bias encountered. The majority of the mental healthcare providers did not receive formal or informal training in the EBP; they just received training on the research methodology without application not supervision on, however, they expressed their willingness to participate in formal or informal training directly related to the EBP. Moreover, the majority of them did not have courses on the EBP during the university college, and they thought that this could be a burden on the students. Contrasting to that, they believed that the EBP would not be a burden on the employee not in terms of time nor in terms of efforts.

As a result of the unorganized knowledge and attitude toward the EBP, the practice was also humble and based on an individual experience. There was a strong self-confidence about the daily practice of the EBP, however there was no objective measure for that. The mental healthcare providers depended on their knowledge and the internally adapted protocols as a reference for the diagnosis and treatment matters without actual engagement and participation in setting and preparing the protocols.

The institutional factors were the most prominent factors in enhancing the EBP in the mental healthcare services. The study findings showed that the institutional factors should be pushed toward improving the infrastructure, the EBP structure, the culture, and the monitoring and evaluation bodies. The technology needed for the EBP was not-well maintained due to the lack of desktops, laptops, smartphones, and maintained internet connection. This was explained by poor economic status that the authorizing government

suffers from due to the imposed siege, and the internal division consequences the managerial bodies deal with the EBP as a luxury and not a priority to get funds for; this leads to paying attention away from the EBP. In addition to that, the managerial bodies didn't provide the employees with updated physical libraries nor access to international libraries. There are physical libraries that are not updated and not actively used. There are no written policies on the EBP nor documented standards of operations that regulate the EBP in the mental healthcare services. Furthermore, the managerial bodies didn't provide the employees with training on the EBP nor engage them in regular discussions related to improving the daily practice. There were meetings that were held but not regularly and without clear purpose. In addition, engaging the employee in discussions depended heavily on the employer-employee relationship which results in unstructured unstable, and insufficient outcomes. The institutional culture toward the EBP was relatively supportive, but actually not enough due to humble knowledge and attitude. The presence of monitoring and evaluation units in the mental healthcare organizations was not sufficiently activated. There were M&E units with a number of employees, but there were not well-established M&E plans with clear standardized indicators that are followed and tracked regularly. In addition, there were no EBP units nor specific scientific committees that were responsible for preparing the protocols, updating the existing, supervising the implementation, and assuring sufficient engagement of the employees.

The barriers toward the EBP were categorized into two types; the institutional and the personal barriers. The institutional factors appeared as core factors that play a significant role in enhancing the EBP in the mental healthcare services. The lack of organized EBP body that regulates the EBP starting from the capacity building, supporting the infrastructure, disseminating updated guidelines and protocols, presence of strong M&E bodies not ending to enhancing the supportive culture for the EBP. The personal factors

that looked to inhibit the EBP were affected significantly by the institutional factors and included the personal desire, the learning tendency, the motivation, the qualification, the research methodology skills, the statistical understanding, and the evidence appraisal abilities.

5.2 Recommendations

5.2.1 General recommendations

- Although the evidence- based practice is an approach that was approved of its significance in enhancing the effectiveness and efficiency of mental health services, it is not well-adopted by the mental health organizations in the Gaza Strip. Policy makers and influencers should promote the evidence-based practice as an integral part of the mental health service provision in a systematic and structured way.
- The personal motivation plays a significant role in enhancing the knowledge, attitudes and practices of the EBP. There should be institutionalized strategies to enhance the motivation among the mental healthcare services providers to use the evidence.
- Policy makers should take promotional actions within the managerial arrangements in the organizations in order to reinforce the use of evidence in the mental health services. This includes considering the EBP as part of the job description, working policies and the annual appraisal and rewarding system, rewards for the committed professionals.
- Policy makers should enhance the institutional factors significantly starting from improving the work places to motivating the professionals sufficiently.

5.2.2 Specific recommendations

- Policy makers should act to improve the knowledge of the mental healthcare providers regarding the EBP especially the basics, levels and appraisal methods of the EBP.

Enhancing the knowledge of the professionals should be based on a systematic and sustainable plan that includes several activities; formal training, on the job training, supervision, scientific days, workshops, conferences, case discussions…..etc.

- Policy makers should pay attention to the living conditions of the employees in order to shift their attention from the basic living needs to improving quality of work. Moreover, specific financial support on a regular basis should be provided to the employees who are committed to use the evidence effectively in order to enhance their and their colleagues' motivation.
- The non-financial support from the administrative bodies would reinforce the attitude and practice toward mental health. This includes the appreciation from the managers and the engaging in decision making. Furthermore, the employer-employee relationship should be considered in terms of good communication and feedback so the employee acts very hard to improve the work outcomes. In addition, the employer should give the employees additional time to self-learn and update their knowledge.
- The education institutions should use curricula that are based on updated evidence, and they should guide the students to the EBP and the trusted resources.
- The infrastructure should be improved to enhance the EBP in the mental healthcare services. This includes updating a Health Information System starting from providing the employees with computers, laptops or smartphones, access to the international journals, and training on the use of computer and internet software.
- The working conditions are an integral part of the institutional factors that affect the EBP. Policy makers should improve the working conditions of the employees starting from the working place, the workload, the salary, the work type and any related issue.
- Presence of an effective monitoring and evaluation unit in any organization is an asset in order to track the progress and figure out the deviations on time in order to act

accordingly. The mental healthcare providers should be involved in the preliminary discussion for the M&E plan, and they should receive a detailed explanation of the M&E plan.

- There should be a special scientific committee is each organization that is responsible for preparing the guidelines and protocols in reference to the internationally validated protocols and the context. The committee should prepare a plan to update the protocols based on the international updates and the feedback from the mental healthcare provider considering the client preference as well. The committee should also take measures to enhance the clinical audit and research studies in the organization to improve the professionals' skills and enhance the work outcome as well.
- The EBP should be part of the institutional culture in order to create a supportive atmosphere that is encouraging not inhibiting. This includes enhancing the change culture via systematic activities that increase the changeability and decrease the resistance to.

5.2.3 Recommendations for new areas of research

1) Comparative study on the effectiveness of the evidence-based practice and the expertise-based practice.
2) The quality of the research studies in the mental health field in the Gaza Strip.
3) Evaluation study of the mental health services in the Gaza Strip.
4) The use of evidence in the psychiatry hospital in Gaza City.
5) In-depth qualitative study on the gaps of mental health services during emergency situations.
6) The community's perception toward the evidence- based practice in health settings.

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Annexes

Annex 1: The quantitative tool of the study- Arabic version

معرفة و توجهات و ممارسات مُقدّمي خدمات الصحة النفسية المتعلقة بالممارسة المستندة على الدليل في قطاع غزة

استمارة الموافقة

عزيزي المشارك:

أنا الباحثة سالي صالح، طالبة ماجستير في كلية الصحة العامة في جامعة القدس، أود أن أدعوك لتشارك في مشروع بحث بعنوان "معرفة و توجهات و ممارسات مُقدّمي خدمات الصحة النفسية المتعلقة بالممارسة المستندة على الدليل في قطاع غزة ."

أرجو أن تأخذ بعض الوقت لقراءة المعلومات المقدّمة لك هنا، والتي تشرح تفاصيل الدراسة، ويمكنك التواصل معي إن كان لديك أي أسئلة عن أي شيءٍ في الدراسة. علمًا بأن مشاركتك فيها طوعيةً تمامًا ولك الحرية الكاملة في رفض المشاركة. في حال رفضت المشاركة في البحث، فلن يؤثر ذلك عليك بأيّ شكلٍ من الأشكال. ويمكنك الانسحاب من الدراسة متى ما شئت حتى وإن كنت قد وافقت مسبقًا على المشاركة فيها.

تهدف هذه الدراسة إلى تقييم معرفة مُقدّمي خدمات الصحة النفسية في قطاع غزة بالممارسة القائمة المستندة على الدليل وتوجهاتهم منها، وتطبيقهم لها، وذلك من أجل تزويد صناع القرار ببيانات منهجية يمكن استخدامها كقاعدة لتحسين تطبيق الممارسة المستندة على الدليل في مجال تقديم خدمات الصحة النفسية.

نعرض عليكم مشاركتنا خبراتكم كمُقدّمين لخدمات الصحة النفسية، ويتمثّل دوركم هنا بتزويد الباحث بالمعلومات المتعلقة بأهداف الدراسة من خلال ملء الاستبانة التي ستأخذ من وقتك حوالي ١٥ إلى ٣٠ دقيقة.

على الرغم من أنّك لن تكسب أيّ فوائد شخصية من هذا البحث، إلّا أنّه سيوّفر لصناع القرار بيانات منهجية لتطوير

خطة مستقبلية، كمّا أنّه لا يوجد أي مخاطرة في المشاركة في هذا البحث.

ستُحفظ المعلومات التي نجمعها منكم في خزانةٍ مغلقة وستُعامل على أنّها معلوماتٌ سريّة. علمًا بأنّ هويتك كمشاركٍ في البحث ستظل مجهولة في حال استخدامه في أي منشورٍ أو أُطروحة.

لن تتقاضى أي شيء لقاء مشاركتك في البحث، كما أنّك لن تتحمّل أي تكاليفِ من أجله.

إذا كان لديك أي استفساراتٍ أو مخاوف حيال البحث، فلا تتردد في التواصل مع د. سالي صالح على الرقم 0597232262.

إقرار المشارك

أوافق أنا..... على المشاركة في دراسةٍ بحثية بعنوان" معرفة و توجهات و ممارسات مُقدّمي خدمات الصحة "النفسية المتعلقة بالممارسة المستندة على الدليل في قطاع غزة

التي تعدّها د. سالي صالح.

أقرّ بأنني:

- قرأت نشرة المعلومات المرفقة، وهي مكتوبة بلغةٍ أجيدها.
- أعلم أن المشاركة في هذه الدراسة طوعية ولم أُجبر عليها أبدًا.
- قد أنسحب من الدراسة في أي وقت، ولن أُعاقب او تضرر من ذلك بأيّ شكلٍ من الأشكال.
- وُضحّت كل المعلومات المتعلقة بخصوصية وسريّة واستخدام المعلومات بما يُرضيني.

توقيع الباحث

أقر بأنني شرحت المعلومات الواردة في هذا المستند ل..... وشجعته/ا وأعطيتها الوقت الكافي لطرح الأسئلة

معرفة و توجهات و ممارسات مُقدّمي خدمات الصحة النفسية المتعلقة بالممارسة المستندة على الدليل في قطاع غزة

معلومات عامة

نسألك في هذا القسم عن معلومات عامة عنك وعن عملك

م١	الجنس	☐ أنثى ☐ ذكر
م٢	العمر	
م٣	مكان الإقامة	☐ شمال غزة ☐ محافظة غزة ☐ المنطقة الوسطى ☐ خانيونس ☐ رفح
م٤	الحالة الاجتماعية	☐ أعزب/عزباء ☐ متزوج/ة ☐ مطلق/ة ☐ أرمل/ة
م٥	المستوى التعليمي	☐ الدبلوم ☐ درجة البكالوريوس ☐ الدبلوم العالي ☐ درجة الماجستير ☐ درجة الدكتوراه
م٦	نوع الجامعة التي حصلت منها على تعليمك الأخير	☐ جامعة محلية ☐ جامعة عربية ☐ جامعة دولية
م٧	المهنة	☐ طبيبة/ طبيب نفسي ☐ أخصائي نفسي ☐ أخصائي اجتماعي ☐ ممرض/ ممرض نفسي ☐ معالج وظيفي ☐ باحث ☐ أخرى ☐ حدد ----------
م٨	مكان العمل الحالي	☐ وزارة الصحة ☐ برنامج غزة للصحة النفسية المجتمعية
م٩	طبيعة العمل	☐ إداري ☐ فني ☐ كلاهما
م١٠	المنصب	☐ ممارس عام ☐ رئيس وحدة ☐ رئيس قسم ☐ أخرى : اذكرها رجاءً .....
م١١	عدد العملاء الذين تقابلهم أسبوعيًا	

م١٢	سبق لك أن طبقت الممارسة المستندة على الدليل في عملك؟ ☐ نعم ☐ لا إذا كانت إجابتك نعم، فأجب عن الأسئلة التالية من فضلك. . م١٢. ١ ما مدى تكرار استخدامك لهذه الممارسة؟ ☐ معظم الأحيان ☐ أحيانًا ☐ نادرً ☐ أبدًا م١٢. ٢ متى كانت آخر مرةٍ استخدمت فيها الممارسة المستندة على الدليل في عملك؟ ☐ اليوم الماضي ☐ الأسبوع الماضي ☐ الشهر الماضي ☐ آخر ثلاثة أشهر ☐ أخرى: حدد رجاءً..... م١٢. ٣ لماذا استخدمت الممارسة القائمة على الدليل في عملك، وفي أي جانب استخدمتها؟ يُرجى وضع إشارة عند كل ما ينطبق عليك من الخيارات. ☐ أغراض علاجية ☐ التشخيص ☐ أسباب متعلقة بالدواء ☐ تقديم الرعاية للعميل م١٢. ٤ ماذا كان مصدر الدليل؟ ☐ مجلة ورقية ☐ مجلة إلكترونية ☐ محرك البحث ☐ موقع الجامعة ☐ أخرى، حدّد رجاءً..... م١٢. ٥ ما الذي دفعك لتطبيق الممارسة القائمة على الدليل في عملك؟ يُرجى وضع إشارة عند كل ما ينطبق عليك من الخيارات. ☐ مجهود شخصي ☐ متطلبات العمل ☐ تأثير الأقران ☐ دعم من الإدارة ☐ أخرى، حدّد رجاءً.....

م١٣	كم مرةٍ تطلع علي مقالاتٍ علميةٍ منشورةٍ الكترونيًا؟	☐ أقل من ثلاث مرات في الأسبوع ☐ من ثلاث إلى ست مرات في الأسبوع ☐ أكثر من ثلاث مرات في الأسبوع ☐ ابدا
م١٤	كم مرةٍ تتطلع على مقالاتٍ علميةٍ موجودةٍ في المكتبات أو الكتب	☐ أقل من ثلاث مرات في الأسبوع ☐ من ثلاث إلى ست مرات في الأسبوع ☐ أكثر من ثلاث مرات في الأسبوع ☐ ابدا
م١٥	يُرجى ذكر محرك البحث الذي تستخدمه في حال كنت تقرأ مقالاتٍ من مصادر الكترونية.	
م١٦	هل تلقيت أي تدريبٍ في الممارسة المستندة على الدليل من قبل؟ ☐ نعم ☐ لا	
م١٧	هل يعتمد مكان عملك على بروتوكولات عالمية في تقديم الرعاية الصحية؟ ☐نعم ☐لا ☐لا أعلم	
م 18	هل شاركت في مراجعة سريرية من قبل؟ ☐ نعم ☐لا	
م 19	هل شاركت في دراسة بحثية من قبل؟ ☐ نعم ☐ لا	

مدى المعرفة عن الممارسة المستندة على الدليل

سنقيّم الآن معرفتك عن الممارسة المستندة على الدليل في مجال خدمات الرعاية الصحية النفسية

الرقم	المادة	أتفق بشدة	أتفق	لا أعلم	أعارض	أعارض بشدة
م١	أعتقد أنّ الممارسة المستندة على الدليل هي مجرد تحديث					

	للمعلومات من خلال متابعة وقراءة المصادر.					
م٢	أعتقد أن الممارسة المستندة على الدليل هي الاستخدام الواعي والحكيم لأفضل الأدلة المتوافرة فيما يتعلق باتخاذ قراراتٍ تتعلق برعاية المرضى.					
م٣	تتألف الممارسة المستندة على الدليل من كلٍ من الدراسات و الأبحاث، ورغبات المريض، وخبرة المعالج.					
م٤	أنا على دراية بخطوات تطبيق الممارسة المستندة على الدليل.					
م٥	أنا على درايةٍ جيّدة مستويات الممارسة المستندة على الدليل					
م٦	أنا على علمٍ طرق البحث المختلفة					
م7	أعرف عددًا من محركات البحث التي تُساعدني في الحصول على أفضل الأدلة للبحث.					

التوجه نحو الممارسة المستندة على الدليل في مجال الصحة النفسية

لنتحدث الآن عن موقفك تجاه الممارسة الم ستندة على الدليل

الرقم	البند	أتفق بشدة	أتفق	لا أعلم	أعارض	أعارض بشدة
ت 1	تطبيق الممارسة المستندة على الدليل مهم من أجل تقديم رعاية أفضل للمريض.					
ت 2	قد تساعد الممارسة المستندة على الدليل في مجال الصحة النفسية من تقليل الوصمة التي يعاني منها المرضى					
ت 3	يجب أن تكون الممارسة المستندة على الدليل جزءًا لا يتجزأ من الممارسة السريرية.					
ت 4	تُعتبر الخبرة السريرية السابقة أكثر أهمية من الممارسة المستندة على الدليل عند اختيار خطة التشخيص و العلاج.					
ت 5	تبني الممارسة المستندة على الدليل إضاعةٌ للوقف					

	وجهد اضافي على مزود الصحة النفسية.					
ت 6	أفضل استخدام طرائق موثوقة ومجرّبة في مؤسستي بدلًا من تبني طريقة جديدة.					
ت 7	أنا مهتم في استخدام الممارسة المستندة على الدليل في عملي اليومي.					
ت 8	عندي الرغبة في تعلم أشياءٍ وطرائق جديدة.					
ت 9	أعتقد أن لدي الخبرة الكافية للتعامل مع عملائي دون الحاجة لمراجعة الأدلة المتوافرة.					
ت 10	أرغب في تعلم الممارسة المستندة على الدليل من خلال تدريبات غير رسمية.					
ت 11	أرغب في تعلم الممارسة المستندة على الدليل من خلال تدريبات رسمية.					
ت 12	أعتقد أني كنت أرغب باستخدام الممارسة المستندة على الدليل لو كنت أصغر من الآن.					
ت 13	أعتقد أن إضافة الممارسة المستندة على الدليل إلى المنهاج الجامعي ما هي إلا إضافة جهد جديد على الطلاب.					
ت 14	سأرغب في تطبيق الممارسة المستندة على الدليل في عملي في حال حصلت على حوافز مالية.					
ت 15	سأرغب في تطبيق الممارسة المستندة على الدليل في عملي في حال حصلت على حوافز غير مالية، مثل تقدير المشرفين.					

تطبيق الممارسة المستندة على الدليل في مجال خدمات الصحة النفسية

حان الآن وقت التحدث عن استخدام وتطبيق الأدلة في عملك

الرقم	المادة	أتفق بشدة	أتفق	لا أعلم	أعارض	أعارض بشدة
ت١	أبحث عن أفضل الأدلة من خلال المصادر الإلكترونية.					
ت٢	أبحث عن أفضل الأدلة من خلال الكتب والبرتوكولات المتوافرة.					

ت٣	أشارك أفضل الأدلة مع زملائي.					
ت٤	أطبق أفضل الأدلة مع مرضاي في عملي.					
ت٥	أتردد في تجربة طرائق أثبتت حديثًا.					
ت٦	أستخدم الأدلة في نقد طرق العلاج المتوفرة ويناقشها مع زملائي.					
ت٧	أقارن عملي وأقيمت وفقًا للبروتوكولات الدولية.					

العوامل المؤسساتية

سنقيّم في هذا القسم العوامل المؤسساتية التي قد تؤثر على معرفتك وموقفك وتطبيق الممارسة المستندة على الدليل في عملك.

الرقم	المادة	نعم	لا، أبدًا	إذا كانت إجابتك نعم، فهل هي كافية ومناسبة؟ 1. نعم 2. لا
ع١	مكان عملي مجهّز بحواسيب يمكن للموظفين استخدامها.			
ع٢	يوجد في مكان عملي حواسيب محمولة يمكن للموظفين استخدامها.			
ع٣	يوجد في مكان عملي هواتف ذكية يمكن للموظفين استخدامها.			
ع٤	يوفر مكان عملي خدمة الوصول إلى الإنترنت.			
ع٥	دُرّبت في مكان عملي على استخدام الحاسوب والانترنت.			
ع٦	يوفر لي مكان عملي إمكانية الوصول إلى المكتبات الإلكترونية الدولية مجانًا.			
ع٧	يوجد في مكان عملي مكتبة تُجدد باستمرار.			
ع٨	يُزوّدني مكان عملي بأحدث البروتوكولات المتعلقة			

	بتشخيص و علاج المرضى			
ع٩	يُشركني مكان عملي في نقاشات متعلقة بتشخيص و علاج المرضى.			
ع١٠	يوجد في مؤسستي سياسة واضحة استخدام الممارسة المستندة على الدليل.			
ع11	يوجد متابعة و رصد كافٍ لاستخدام الممارسة المستندة على الدليل في مؤسستي			
ع12	إن استخدام الممارسة المستندة على الدليل جزء من تقييم الموظف السنوي			
ع13	يفرض علينا مكان عملي استخدام الممارسة المستندة على الدليل في عملنا.			
ع14	أمنح في مكان عملي وقتًا إضافيًا لأبحث عن أفضل الأدلة المتوافرة.			
ع15	يتخذ مكان عملي التدابير اللازمة لتشجيع استخدام الممارسة المستندة على الدليل.			
ع16	تعلّمت عن الممارسة المستندة على الدليل في الجامعة.			
ع17	تتبع المناهج في جامعتي البروتوكولات الدولية.			
ع18	يحترم ويقدر زملائي في العمل أولئك الذين يطبقون الممارسة المستندة على الدليل.			
ع19	يُوجد في مؤسستي دائرة المتابعة والتقييم.			
ع 20	هل يوجد مؤشرات أداء محددة في مؤسستك؟			
ع 21	إن كانت إجابتك للسؤال السابق نعم، فهل تتابعهم المؤسسة دوريًا؟			
ع 22	هل تناقش إدارتك الأداء المنجز في ضوء هذه المؤشرات؟			

العقبات التي تحول دون استخدام الممارسة المستندة على الدليل في مجال خدمات الصحة النفسية

يُرجى وضع إشارة أمام ما تعتبره عقبة تحول دون استخدام الممارسة المستندة على الدليل في مكان عملك،

وحدّد مدى شدة هذه العقبة إن وجدت.

الرقم	المادة	عقبة ضعيفة	عقبة متوسطة	عقبة شديدة	ليست عقبة
ع١	عدم توافر الوقت الكافي.				
ع٢	الافتقار إلى الوعي والمعرفة فيما يتعلق بالممارسة المستندة على الدليل.				
ع٣	قلة التدريبات على استخدام الممارسة المستندة على الدليل في مكان عملي.				
ع4	الافتقار إلى الوصول إلى المكتبات الدولية.				
ع5	ضعف الاتصال بالإنترنت.				
ع6	غياب الحوافز				
ع7	أنها ليست جزءا من ثقافة المؤسسة.				
ع8	عدم توفير توضيح مكنوب للسياسات أو طرائق منهجية لاستخدام الممارسة المستندة على الدليل في عملي.				
ع9	ضعف القدرة على فهم الإحصائيات.				
ع10	الافتقار إلى معرفة طرق البحث.				
ع11	ضعف القدرة على تقييم قوة الدليل.				
ع12	غياب مهارات اللغة الإنجليزية و حواجز اللغات الأخرى				
ع13	عدم وجودها ضمن متطلبات الوظيفة أو التقييم السنوي للموظفين.				
ع14	انعدام الرغبة الشخصية في استخدام الممارسة المستندة على الدليل				
ع١5	ضعف الثقة في بروتوكولات العلاج المحدّثة.				
ع16	ضعف تعاون العملاء				
أي عقبة أخرى لم تُذكر أعلاه.					
ما هي توصياتك من أجل تحسين الممارسة المستندة على الدليل في مجال خدمات الصحة النفسية؟					

شُكرًا لكونك جزءًا من هذه الدراسة

Annex 2: The quantitative tool of the study- English version

Knowledge, attitudes and practices of mental healthcare providers regarding the evidence-based practice in the Gaza Strip

Instruction sheet

Dear participant,

I am Sally Saleh, a master student from Al Quds University- Faculty of Public Health, and I would like to invite you to participate in a research project entitled "*The knowledge, the attitudes and the practices of the Mental healthcare providers regarding the Evidence-Based Practice in the Gaza Strip*"**.**

Please take some time to read the information presented here, which will explain the details of this study and contact me if you require further questions about any aspect of the study. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way. You are also free to withdraw from the study at any point, even if you do agree to take part.

The study aims at evaluating the the knowledge, the attitudes and the practices of mental healthcare providers regarding the evidence-based practice in the Gaza Strip in order to provide the policy makers with systematic data that can be used as a base to enhance the implementation of EBP in the mental health service provision.

We offer you to share our expertise as a mental health provider and your role is to provide the investigator with information related to the study aims by filling a questionnaire that takes from 15 to 30 minutes.

You will not get personal benefits from the research, but it will provide policy makers with systematic data to develop a future plan, also there is no risk involved in taking part of this research.

The information collected from you will be saved in a closed cabinet and will be treated as confidential. If it is used in a publication or thesis, your identity as a participant will remain anonymous.

You will not be paid to take part in the research, and there will be no costs involved for you, if you do take part.

If you have any questions or concerns about the research, please feel free to contact Dr. Sally Saleh at mobile 0597-232262.

You will receive a copy of this information and consent form for your own records.

DECLARATION BY PARTICIPANT

I……. agree to take part in a research study entitled "The knowledge, the attitudes and the practices of the Mental healthcare providers regarding the Evidence-Based Practice in the Gaza Strip " and conducted by Dr. Sally Saleh.

I declare that:

- I have read the attached information leaflet and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been

pressurized to take part.

● I may choose to leave the study at any time and will not be penalized or prejudiced in any way.

● All issues related to privacy and the confidentiality and use of the information I provide have been explained to my satisfaction.

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ *[H*e/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in Arabic and no translator was used.

Knowledge, attitudes, practices of mental healthcare providers regarding the evidence-based practice in the Gaza Strip

General information

In this section we will ask you some general questions about yourself and your work

G1	Gender	☐ Female ☐ male
G2	Age (in years)	
G3	Residency	☐ North Gaza ☐ Gaza Governorate ☐ Middle Zone ☐ Khan Younis ☐ Rafah
G4	Marital status	☐ Single ☐ Married ☐ Divorced ☐ Widow
G5	Educational level completed	☐ Diploma ☐ Bachelor degree ☐ Higher diploma ☐ Master degree ☐ PhD
G6	Type of university from which you obtained your last qualification	☐ Local university ☐ University from an Arab country ☐ International University
G7	Profession	☐ Psychiatrist/ physician ☐ Psychologist ☐ Social Worker ☐ Psychiatric nurse/nurse ☐ Occupational therapist ☐ Researcher ☐ others specify ----------
G8	Place of current work	☐ MOH ☐ GCMHP
G9	Nature of work	☐ Managerial ☐ Technical ☐ Both
G10	Position	☐ General practitioner ☐ Head of Unit ☐ Head of department other: please mention……
G11	Number of clients that you meet weekly	

G12	Have you ever used the Evidence-based practice in your work? ☐ Yes ☐ No If yes, please answer the following questions. **G12.1** How frequent do you use it? ☐ Most of time ☐ Sometimes ☐ rarely ☐ not at all **G12.2** When was the last time you have used the Evidence-based practice in your work? ☐ Last day ☐ last week ☐ last month ☐ last 3 months ☐ other: specify please……. **G12.3** Why did you use the evidence-based practice in your work-in which aspect? (Select all that apply): ☐ eatment purpose ☐ diagnosis ☐ medications related ☐ care modality **G12.4** What was the source of evidence? ☐ ks journals ☐ online journal ☐ search engine ☐ university website oth☐ specify please …….. **G12.5** Your evidence-based practice is mainly driven by (Select all that apply): ☐ ersonal effort ☐ ork requirement ☐ fluence of peers ☐ pport from the management ☐ ers: please specify……	
G13	How frequent do you look for scientific articles on	☐ Not at all ☐ less than three times weekly ☐ from 3 to 6 times weekly more than 6 times weekly

	e-resources?	
G14	How frequent do you look for scientific articles in libraries and books?	☐ Not at all ☐ less than three times weekly ☐ from 3 to 6 times weekly ☐ more than 6 times weekly
G15	If you read articles via e- resources, please mention the search engines that you usually use. ……	
G16	Have you ever received training in the EBP? ☐ Yes ☐ No	
G17	Are there clinical guidelines at your workplace? ☐ Yes ☐ No ☐ I don't know	
G18	Have you ever participated in a clinical audit before? ☐ Yes ☐ No	
G19	Have you ever participated in a research study before? ☐ Yes ☐ No	

Knowledge about EBP

Now, we will assess your knowledge about the evidence- based practice in the mental healthcare services

NO	Item	Strongly disagree	disagree	I don't know	Agree	Strongly agree
K1	I think that EBP is only updating					

	information via reading resources					
K2	I know that the EBP is the conscious, explicit and judicious use of current best evidence in making decisions about the care of patients					
K3	EBP is composed of best research practice evidence, patient's preference, and therapist expertise					
K4	I am aware about the steps of applying the EBP					
K5	I am aware about the levels of EBP					
K6	I am conscious about the research methodology					
K7	I know several search engines that help me to seek the best research evidence					

Attitudes toward EBP in mental health services

Let's talk now about your attitude toward evidence- based practice

NO	**Item**	**Strongly disagree**	**disagree**	**I don't know**	**Agree**	**Strongly agree**
A1	Application of EBP is crucial to apply the best patient care					

A2	EBP application in mental health can reduce the stigma					
A3	EBP should be an integral part of clinical practice					
A4	Previous clinical expertise is more crucial than the EBP in choosing the assessment and management plans					
A5	Adoption of EBP is waste of time and additional burden on the mental health provider					
A6	I prefer to use trusted and used methods in my organization instead of adopting new method					
A7	I am interested in using the EBP in my daily practice					
A8	I have the motivation to learn new things					
A9	I believe I have enough expertise to manage my clients without the need to review the available evidence					
A10	I would like to learn about the EBP via informal trainings					
A11	I would like to learn about the EBP via formal training in my work					

A12	I think that I would use the EBP if I were younger					
A13	I think that integrating the EBP in university curriculum is just a burden on the students					
A14	I would apply the EBP in my work if I got financial incentives					
A15	I would apply the EBP If I got non-financial incentives like acknowledgement by my supervisors					

Practices related to EBP in mental health services

It's time to talk about your use and practice of evidence in your work

b	**Item**	**Strongly disagree**	**disagree**	**I don't know**	**Agree**	**Strongly agree**
P1	I search for the best evidence using the e- resources					
P2	I search the best evidence using the available books and protocols					
P3	I share the best evidence with my colleagues					
P4	I apply the best evidence in my work with my patients					

P5	I feel hesitated to try a new approved method					
P6	I criticize and discuss the management plans with my colleagues using evidence					
P7	I compare my work against international guidelines					

Institutional factors

In this section, we will assess the institutional factors that may affect your knowledge, attitudes and practices of evidence- based practice in your work

NO	Item	Yes, and enough	Yes, not enough	No
I1	My workplace is equipped with desktop computers that can be used by the employees			
I2	My workplace is supported by laptops that can be used by the employees			
I3	My workplace is supported by smartphones that can be used by the employees			
I4	My workplace provides me with access to internet			
I5	My workplace trained me on the use of computer and internet software			
I6	My workplace provides me with free access to online international libraries			
I7	There is an updated library in my workplace			
I8	My workplace provides me with updated protocols regarding assessment and management of clients			

I9	My workplace engages me in discussions related to the assessment and management of clients			
I10	There is a written policy on the use of EBP in my organization			
I11	There is adequate monitoring of the use of EBP by the management			
I12	The use of EBP is part of the annual employee's evaluation			
I13	My workplace mandates the use of EBP in my work			
I14	My workplace provides me with additional time to look for the best available evidence			
I15	My workplace takes measures to encourage the use of EBP			
I16	I had learned about EBP in my university			
I17	The curricula in my university follow the international guideline			
I18	My colleagues respect and appraise those who apply the EBP in my workplace			
I19	There is a monitoring and evaluation department at my organization			

NO	Item	Yes	No	I don't know
I20	Are there performance indicators in your organization?			
I21	If yes, in QI21 Does the organization track them regularly?			
I22	Does your management discuss the progress achieved against these indicators?			

Barriers to the use of EBP in mental health services

Please choose if the following are considered barriers or not for you to use the EBP in your work, and choose the strength of the barrier if present.

NO	Item	Not a barrier	Weak barrier	Moderate barrier	Strong barrier
B1	Insufficient time				
B2	Lack of awareness and knowledge on the use of EBP				
B3	Lack of trainings on EBP in my work				
B4	Lack of access to international libraries				
B5	Poor internet connection				
B6	Lack of motivation				
B7	Not being part of the organization culture				
B8	Lack of written policy and systematic method to use EBP in my work				
B9	Poor statistical understanding				
B10	Poor knowledge of the research methodology				
B11	Poor evaluation and appraisal ability				
B12	Languages barriers				
B13	Not being part of the job requirements or the employee annual evaluation				
B14	Lack of personal desire to use the EBP				
B15	Poor trust in the updated treatment protocols				

B16	Poor cooperation of the clients				
	Any other barrier not mentioned above				

What do you recommend to improve the EBP in mental health service provision in your organization?

THANKS FOR BEING PART OF THE STUDY

Annex 3: The Key informant interview- Arabic version

- أرجو منك تعريفي بنفسك و ما هو دورك في المؤسسة التي تعمل فيها؟
- هل يمكننك إخباري عن الممارسة المستندة إلى البراهين في مكان عملك؟
- هل لك أن تخبرني عن الأدلة الإكلينيكية التي تستخدمونها في مؤسستكم؟ و هل تم توزيعها على الموظفين؟ ما مصدرها؟ و كم مرة تقومون بتحديثها؟ هل قمتم بتحديثها فعلاً؟ هل قمتم بتدريب الطاقم عليها؟ هل لك أن تذكر لي بعض الأمثلة؟
- هل لك أن تخبرني عن البنية التحتية للممارسة المستندة على البراهين في مكان عملك؟ مثل أجهزة الحاسوب و الحواسيب المحمولة و الأجهزة الذكية و الاتصال بالانترنت؟
- كيف تقوم مؤسستك بالتشجيع على الممارسة المستندة على البراهين بشكل رسمي؟ (السياسات و المكافآت المالية و الوقت الإضافي و تقييم الموظف و التدريب و الاجتماعات الدورية)
- ماذا عن المتابعة و التقييم؟ (هل يوجد لديكم وحدة متخصصة في المتابعة و التقييم؟ كم عدد الموظفين فيها؟ ما نوع أدوات التقييم و المتابعة التي تقومون باستخدامها؟) ماذا عن مؤشرات الأداء؟ هل تقومون بتعقبها بشكل مستمر؟
- ما هي العقبات التي تواجه الممارسة المستندة على البراهين في مكان عملك؟
- كيف يتفاعل الموظفون مع الممارسة المستندة على البراهين في مكان عملك؟ و كيف تديرون المقاومة الناتجة من بعض الموظفين؟ و ما أسباب تلك المقاومة؟
- كيف يتفاعل المرضى مع طرق العلاج الجديدة؟ و كيف تواجهون المقاومة الناتجة من المرضى؟
- ما هي مقترحاتكم لتحسين الممارسة المستندة على البراهين في خدمات الصحة النفسية في قطاع غزة؟

Annex 4: The Key informant interview- English version

- Can you introduce yourself to me? What is your role in your workplace?
- Can you tell me about the EBP in your workplace?
- Can you tell me about the clinical guidelines that you use in your workplace? Are they disseminated? What is the source of them? How frequent do you update them? How do you update them? Are the staff trained on? Can you give me examples?
- Can you tell me about the available infrastructure for the EBP in your workplace; the computers, the laptops, the smartphones, the internet connection?
- How does your organization enhance the EBP officially? (policies, financial incentives, additional time, employee's evaluation, training, regular meeting…)
- What about the monitoring and evaluation? (is there a specified unit, NO of workers, type of M&E tools…) What about the performance indicators and the adherence and tracking of progress accordingly? (
- What are the barriers that you face regarding the EBP in your workplace?
- How do the employees react to the EBP in your workplace? Can you describe the staff attitude toward the EBP?
- How do you manage the employees' resistance to the use of new methods?
- How do the clients react to change their management plan? What are the gaps that you face from the clients' side?
- What are your recommendations to improve the EBP in mental health service provision in the Gaza Strip?

Annex 5: an official letter of approval from Helsinki Ethical Committee in the Gaza Strip

المجلس الفلسطيني للبحث الصحي

Palestinian Health Research Council

تعزيز النظام الصحي الفلسطيني من خلال مأسسة استخدام المعلومات البحثية في صنع القرار

Developing the Palestinian health system through institutionalizing the use of information in decision making

Helsinki Committee

For Ethical Approval

Date: 10\08\2020 **Number:** PHRC/HC/739/20

Name: Sally Suhail Saleh الاسم:

We would like to inform you that the committee had discussed the proposal of your study about: نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:

Knowledge, Attitudes, Practices of the Mental Health Care Providers regarding the Evidence-Based Practice in the Gaza Strip

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/739/20 in its meeting on 10\08\2020 و قد قررت الموافقة على البحث المذكور عاليه بالرقم والتاريخ المذكوران عاليه

Signature

Member 10.8.2020

Chairman 10/8/2020

Member 10/8/2020

Genral Conditions:-

1. Valid for 2 years from the date of approval.
2. It is necessary to notify the committee of any change in the approved study protocol.
3. The committee appreciates receiving a copy of your final research when completed.

Specific Conditions:-

E-Mail:pal.phrc@gmail.com

Gaza - Palestine غزة - فلسطين

شارع النصر - مفترق العيون

عنوان الدراسة: دراسة حول معرفة و توجهات و استخدام مقدمي خدمات الصحة النفسية للممارسة المستندة على البراهين في قطاع غزة

إعداد: د. سالي سهيل صالح

إشراف: د. بسام أبو حمد

ملخص الدراسة

يزداد انتشار الممارسة المستندة على البراهين في العديد من المجالات الصحية. إن أحد أهم خصائصها هي اعتمادها المشترك على ثلاث مكونات رئيسية ألا و هي البرهان البحثي الأفضل و خبرة المهني و تفضيلات المريض. هذه الدراسة عبارة عن بحث مختلط يشتمل على جزء نوعي و جزء كمي. بلغ عدد المشاركين في الجزء الكمي 135 مشارك منهم 69 امرأة و 66 رجل و قد بلغت نسبة المشاركة ما يقارب 83.3%. هذا و قد شارك 10 أشخاص من صناع القرار في الجزء النوعي. كانت طريقة الاختيار في الجزء الكمي هي اختيار الكل حيث اختارت الباحثة جميع العاملين في قطاع الصحة النفسية في قطاع غزة، بينما اعتمدت الباحثة على العينة القصدية في الجزء النوعي و ذلك للوصول إلى العينة المرجوة.

تم جمع بيانات الجزء الكمي من خلال استبيان يغطي الجوانب الآتي، المعلومات الديموغرافية، استخدام الممارسة المستندة على البراهين، المعرفة عن الممارسة المستندة على البراهين، التوجه نحو الممارسة المستندة على البراهين، ممارسة الممارسة المستندة على البراهين، العوامل المؤسساتية و العقبات التي تحول دون استخدام الممارسة المستندة على البراهين و قد أظهر الاستبيان صدقاً و ثباتاً جيداً حيث بلغ معامل ألفا كرونباخ= 0.756. هذا و قد تم جمع البيانات النوعية من خلال عقد مقابلات مع ذوي الخبرة تغطي الأسئلة البحثية للدراسة. قامت الباحثة بتحليل البيانات الكمية باستخدام برنامج التحليل الإحصائي من خلال إجراء اختبارات إحصاء وصفية و اختبارات إحصاء استنتاجية، كما قامت بتحليل البيانات النوعية من خلال تحليل المحتوى باستخدام برنامج التحليل النوعي Nvivo.

أظهرت النتائج ان عدد المشاركين الكلي هو 135 مشارك منهم 69 امراة و 66 رجل. بلغت نسبة الذين حصلوا على درجة البكالوريوس أو أقل 37.3% بينما بلغت نسبة أولئك الذين حصلوا على دراسات عليا 62.7%. إن معظم المشاركين 78.5% حصلوا على شهادتهم العلمية من جامعات محلية و 77.8% من المشاركين يعملون في مهام فنية. أظهرت النتائج ان 81.5% من المشاركين استخدموا الممارسة المستندة على البراهين في عملهم اليومي لكن عدد

مرات الاستخدام و مصادر البراهين لم تكن جيدة. بلغت نسبة معرفة المشاركين بالممارسة المستندة على البراهين 66.05% لكن هذه المعرفة لم تكن منظمة او ممنهجة بل كانت مبعثرة و متواضعة. أظهرت النتائج ميول المشاركين الإيجابية نحو استخدام بروتوكولات حديثة لكن إيمانهم بخبرتهم كان أكبر من إيمانهم باستخدام طرق حديثة للعلاج. بلغت الممارسة المستندة على البراهين 71.27% بين المشاركين لكن الممارسة الحقيقية لم تكن جيدة كما أظهرت النتائج النوعية. برزت العوامل المؤسساتية كعوامل مثبطة لاستخدام الممارسة المستندة على البراهين نظراً لغياب بنية تحتية مناسبة و غياب السياسات الواضحة بهذا الخصوص. تم تقسيم العقبات التي تحول دون استخدام الممارسة المستندة على البراهين إلى عقبات شخصية تشمل غياب الدافع الذاتي و انعدام القدرات البحثية و الفهم الإحصائي، و عقبات مؤسساتية تشمل ضعف الموارد و غياب وحدة تقييم و متابعة فعالة. أظهرت الإحصاءات الاستنتاجية عدم وجود فروقات ذات دلالة إحصائية مع متغيرات العمر و الجنس و مكان السكن و المؤهل العلمي و طبيعة العمل.

خلصت الدراسة إلى أن المعرفة و التوجه و استخدام الممارسة المستندة على البراهين تحتاج إلى مزيد من التحسين والتطوير بدءاً من الجهات الإدارية الواجب عليها تنظيم الممارسة المستندة على البراهين و دمجها في العمل اليومي.