

# SOCIAL WORKERS' DESK REFERENCE

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Second Edition

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OXFORD  
UNIVERSITY PRESS  
2009

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Guidelines for clinical practice in medicine and allied health professions have proliferated exponentially over the past two decades. A search of the PubMed computerized bibliographic database of the National Library of Medicine conducted on February 1, 2008, using the search delimiter "clinical practice guidelines," identified a total of 11,627 published practice guidelines and an impressively large subset of 598 practice guidelines indexed within the prior year. In the mental health specialty area, the American Psychiatric Association (2006) recently published a 1,600-page compendium of *Guidelines for the Treatment of Psychiatric Disorders*, offering comprehensive care recommendations for diagnosis, assessment, and treatment of 13 prevalent mental health conditions. Clearly, manifest interest in guidelines has soared in medicine and the other health professions in recent years. Factors contributing to the emergence and growth of guideline development activities in the 1980s were described by Howard and Jenson (1999a) and Walker, Howard, Lambert, and Suchinsky (1994).

Although thousands of practice guidelines have been developed for health professionals, lamentably few guidelines have been specifically developed by or for human or social services workers. Nathan (2007) noted that

despite initial efforts more than a decade ago by a task force of the Society of Clinical Psychology (Division 12) to establish a list of empirically validated treatments . . . and subsequent efforts by psychologists and others to identify treatments that meet empirically supported standards . . . the American Psychological Association has not sponsored an effort to develop a set of treatment guidelines for professional psychology practice. As a result, psychologists are left with suboptimal choices: to use the American Psychiatric Association's

guidelines; to use those of other organizations, such as the Veterans Administration; or to use none. (p. 8)

Social workers are similarly disadvantaged by the absence of available professional practice guidelines, although calls for a practice guideline development initiative in social work that date back more than a decade (see special issue on practice guidelines,, *Research on Social Work Practice*, 9 [1999]).

Although practice guidelines can be expensive, time-consuming, and logistically demanding to develop, it is not altogether clear why professional psychology and social work have lagged so conspicuously behind other health professions in developing practice guidelines. However, it is likely that the availability of greater monies, a more pressing demand for accountability, and an abundance of relevant randomized controlled trials from which to construct practice guidelines account for some of the differences across health and social service professions in guideline development activity. Potential barriers to guideline development in social work were delineated by Howard and Jenson (1999b) and by the authors of papers in the special issue of *Research on Social Work Practice* devoted to guidelines just referenced.

#### DEFINITIONAL ISSUES

A number of definitions of practice guidelines have been proffered, but by far the most influential is the notion that guidelines are "systematically developed statements to assist practitioner and patient decisions about appropriate care for specific clinical circumstances" (Institute of Medicine, 1990, p. 27). Although the origins of the guideline movement in clinical medicine are apparent in the definition of guidelines, there is no obvious reason why

practice guidelines could not be developed for application in micro, mezzo, and macro social work practice contexts.

A variety of nuanced terms are broadly synonymous with the concept of practice guidelines, including practice "standards," "options," "parameters," "clinical decision rules," "preferred practice patterns," "clinical pathways," and "algorithms," to name only a few. In general, practice guidelines, options, and parameters allow considerable flexibility in their application, whereas standards, decision rules, pathways, and algorithms are often more prescriptive in nature. Careful attention should be paid to the definitions of guidelines and related constructs employed by the organizations developing them. For example, the American Psychological Association (2005) defined *practice guidelines* relatively broadly as, "recommendations to professionals concerning their conduct and the issues to be considered in particular areas of psychological practice, in contrast to *treatment guidelines*, which provide specific recommendations about clinical interventions to be delivered to clients" (p. 976).

Published guidelines are very heterogeneous in their characteristics. Some are authored by a single individual, others by a small group of self-appointed or nominated experts, and still others by a committee of several hundred clinical and research experts including representatives of pertinent client groups and professional organizations. Guidelines can run from several pages to more than 100 pages in length; offer advice based on "expert consensus" only or graded recommendations carefully tied to a meticulously weighting of the undergirding scientific evidence; and provide practice recommendations ranging from very general to highly specific in nature. Guidelines not only facilitate effective treatment but can also offer useful recommendations for optimal screening, assessment, diagnostic, prognostic, and prevention activities. The significant heterogeneity of extant guidelines, in conjunction with the sheer number of such guidelines, poses potential problems for conscientious guideline users. These issues will be addressed next in reference to guideline quality assessment.

## RISKS AND BENEFITS OF GUIDELINES

Practitioners have often greeted guideline development and dissemination efforts with apprehension and even overt hostility. Attitudinal studies

indicate that many practitioners believe guidelines will lead to reduced practitioner autonomy, "cookbook," formulaic, or "one-size-fits-all" practice, and a focus on issues (e.g., cost containment) other than those directly having to do with clients' preferences and best interests. Concerns have also been raised about practitioners' potentially increased liability to malpractice actions if non-adherence to guideline recommendations is widely accepted as an affirmative indication of failure to comply with the standard of care in a given practice area.

Countering these claims, guideline proponents contend that guidelines allow for considerable flexibility in their application, can lead to superior client outcomes through more consistent and conscientious application of demonstrably effective interventions, can promote more efficient and equitable utilization of scarce health care and social service resources, and can thereby lead to greater credibility for the social work profession. Howard and Jenson (1999a, 1999b) and Howard, McMillen, and Pollio (2003) present highly detailed discussions of putative virtues and limitations of professional practice guidelines.

In recent years, perhaps as a result of increased exposure to practice guidelines, practitioners across a range of health professions other than social work appear to have adopted attitudes more favorable to clinical guidelines. Initial concerns about health care practitioners' potentially heightened susceptibility to malpractice torts following guideline adoption have not generally been born out. In general, guideline development has become widely accepted in the health care professions and has recently been characterized as a growth industry.

## GUIDELINE QUALITY

Prominent studies have identified substantial variations in guideline quality (e.g., Shaneyfelt, Mayo-Smith, & Rothwangl, 1999). In consequence, efforts to promote greater adherence to preferred guideline development processes and to provide practitioners with a tool to judge guideline quality have received increasing attention. Particularly notable in this regard is the AGREE instrument developed for the purpose of assessing guideline quality. With regard to guideline scope and purpose, AGREE criteria assess whether the overall objective(s), practice issue(s) addressed, and clients to whom the guideline applies are specifically described. AGREE criteria pertaining to stakeholder

involvement require that individuals from all pertinent professional groups and representatives of affected client groups be incorporated into the guideline development process. Furthermore, the group of users for whom the guideline is intended should be explicitly stated, and the guideline itself pilot tested among identified end users.

AGREE criteria also require evidence of systematic literature search methods, use of explicit criteria for including evidence, and well-explicated methods for formulating practice recommendations and comprehensively considering effects, side effects, and possible risks of treatment. Also important, in this vein, are explicit links between supporting evidence and practice recommendations, external review of guidelines prior to publication and dissemination, and a carefully articulated plan for updating the guideline to ensure its currency.

AGREE standards for guideline presentation and publication assess whether practice recommendations are clearly stated, specific in nature, and readily identifiable, and if alternative options for client care are available, they are systematically raised and discussed. Finally, guidelines should address potential organizational impediments to their adoption, cost implications of their application, and key criteria by which their effectiveness can be assessed. Guideline authors should have full editorial independence from the professional, institutional, or governmental body funding development of the guideline.

For additional information regarding an important international effort to promote best practices in guideline development, readers are referred to the GRADE Working Group.

Additional questions to ask about published guidelines have been raised by Greenhalgh (2006) in her book, *How to Read a Paper: The Basics of Evidence-Based Medicine*. These include the following.

- Did the preparation and publication of the guideline involve a significant conflict of interest?
- Is the guideline concerned with the appropriate topic, and does it state clearly the target group it applies to?
- Did the guideline development panel include both an expert in the topic area and a specialist in the methods of secondary research (e.g., meta-analyst, health economist)?
- Have the subjective judgments of the development panel been made explicit, and are they justified?
- Have all the relevant data been scrutinized and rigorously evaluated?
- Has the evidence been properly synthesized, and are the guideline's conclusions in keeping with the data on which they are based?
- Does the guideline address variations in practice and other controversial areas (e.g., optimum care in response to genuine or perceived underfunding)?
- Is the guideline clinically relevant, comprehensive, and flexible?
- Does the guideline take into account what is acceptable to, affordable for, and practically possible for patients?
- Does the guideline include recommendations for its own dissemination, implementation, and regular review?

In addition to offering useful methods by which published guideline quality might be assessed and thereby increased, various theorists have forwarded criteria by which the appropriateness of the topical focus of proposed guidelines might be evaluated. Generally, it is held that the most useful guidelines address conditions currently characterized by wide and largely unexplained variations in the practice methods used to treat them, that are either costly or risky to treat or both, and where the investment in client care and outcomes is likely to be repaid in increased economic returns and improved client outcomes. Ideally, guideline development efforts should be undertaken in areas where consensus is likely achievable vis-à-vis best practice recommendations and where there is a reasonable probability that guideline recommendations can be successfully implemented. In social work, it is likely that the most effective guidelines will be developed conjointly by academics and practitioners who are working in the settings and with the client populations affected by the guidelines. Proactive consideration of these attributes by groups developing guidelines could increase the utility and quality of the resultant guidelines considerably.

#### GUIDELINE DISSEMINATION, IMPLEMENTATION, AND ADHERENCE

Experience with practice guidelines over the past decade clearly indicates that merely developing a guideline is no assurance that it will be adequately disseminated or implemented. For example, in recent years, several large surveys of practicing psy-

chologists and physicians revealed that many had not received a copy or summary of current smoking cessation treatment guidelines, were unfamiliar with their content, and did not know whether they were compliant with smoking cessation guideline recommendations or whether the guidelines themselves promoted comparatively more effective smoking cessation intervention outcomes.

A variety of methods have been employed to disseminate practice guidelines, including those approaches referred to as *passive diffusion* methods (e.g., e-mail or direct mailings to members of professional organizations or publication of guidelines in professional journals or newsletters), *active implementation* strategies (e.g., training and reliance on local professional opinion leaders to disseminate guideline information, computerized informatic reminder systems, use of clinical audit and feedback methods, administrative supports, and academic detailing—the latter consisting of outreach visits to professional practitioners designed to promote select practices), and *educational approaches* (e.g., continuing professional education and conference/workshop attendance).

Traditionally, the most widely employed and least effective guideline dissemination approaches have been those of the passive diffusion and educational type. Extensive reviews of the effectiveness of these approaches have concluded that there is weak support for didactic interventions, traditional continuing professional education, and direct mailings; moderate support for clinical audit and feedback methods and use of local peer opinion leaders; and relatively strong empirical support for computerized client care reminder systems, academic detailing, and multimodal and complex guideline dissemination interventions. Consistent conclusions were reached in a review of 41 relevant studies, which found that “evidence indicates that guideline adherence is not high without specific intervention, but that certain interventions (typically multifaceted and resource-intensive ones) improve adherence” (Bauer, 2002, p. 138).

Characteristics other than the manner and method by which they are developed and disseminated can also influence guideline adoption. Qualities of the guidelines themselves (e.g., those that do versus do not require learning new skills, that are consistent versus inconsistent with extant norms and values for practice); attitudes, professional roles, and other personal and professional characteristics of the health care and human service workers who are potential guideline users; attributes of the practice setting including incentives

for adoption of and adherence to guidelines and relevant regulatory requirements; and client factors (e.g., personal preferences, race, and socioeconomic status) can also influence the extent to which clinical guidelines are successfully implemented.

Perceived barriers to guideline adoption include perceptions that guidelines will be time-consuming and resource-intensive to develop, discourage practice innovation, promote average rather than exemplary practice, tend not to reflect local practice conditions if developed by national bodies, and rapidly become outdated. Several recent evaluations indicate that use of guidelines as part of a continuous quality improvement program can promote enhanced adherence to guidelines and superior client outcomes.

## GUIDELINE EFFECTIVENESS

Two primary questions have been raised with regard to practice guidelines: Are they effective in changing practitioners’ behaviors in the intended manner, and, given these changes, are clients’ outcomes enhanced as a result of greater practitioner adherence to guidelines? One analysis of 59 studies of guideline effectiveness (Grimshaw & Russell, 1993), noted that only 4 of 59 studies failed to report significantly positive effects of guideline implementation on processes of care. Nine of 11 studies included in this evaluation found significantly beneficial effects of guideline implementation on clients’ outcomes. Given the notable heterogeneity in the methods by which they are developed, disseminated, and implemented and the many different conditions and client/professional groups for which they have been developed, it is likely that guideline effectiveness will vary considerably. Far greater study is needed of the conditions under which guidelines can be expected to produce the most favorable outcomes possible for clients receiving care for a variety of social problems. See Agency for Healthcare Research and Quality Web site for a review of guideline effectiveness studies.

## PRACTICE GUIDELINES AND EVIDENCE-BASED PRACTICE

Clinical practice guidelines were initially identified as a promising means by which evidence-based practice could be promoted in clinical medicine. More recently, Howard, McMillen, and Pollio

(2003) and Howard, Allen-Meares, and Ruffolo (2007) called for widespread training of social work students and faculty in the methods of identifying, accessing, critiquing, modifying, and implementing practice guidelines and associated practice-relevant scholarly products, such as systematic reviews and meta-analyses. Howard et al. (2007) argued that practice guidelines are effective teaching tools for the promotion of evidence-based practice, readily accepted by students and practitioners, and widely applicable in that they do not require every student practitioner or professional social worker to acquire and maintain relatively sophisticated information science and research skills.

Some proponents of evidence-based practice in social work take a less favorable view of guidelines, contending that practice guidelines are time-consuming and expensive to develop, rarely updated, rapidly outdated, and never published in many practice areas and for many client groups in part because the empirical evidence on which they might be based is not available. Proponents of evidence-based practice who are *not* supportive of an emphasis on guideline development and guideline-based practice education in social work, call for students to be trained in the methods of evidence-based practice *per se*: formulation of important practice questions that lend themselves to computerized bibliographic searching, location of pertinent evidence via identification and appropriate searching of relevant bibliographic databases, critical appraisal of practice-relevant evidence, incorporation of obtained evidence into practice decision making and intervention delivery, and assessment of the effectiveness of implemented evidence-based interventions and modification of treatment practices as needed. Each of these five steps of evidence-based practice requires specific training and skills that all social work students and professional practitioners should learn, these theorists argue, because they provide social workers with the ability to remain current in a wide range of practice areas over the course of their careers.

Presently, it is unclear how acceptable evidence-based practice training is to social work students or professionals and how effectively, and under which conditions, students acquire skills for evidence-based practice most readily. For that matter, it is unclear how receptive students are to guideline-based practice education, although some advocates believe that many will be comparatively more receptive to secondary research products, such as practice guidelines, systematic reviews, meta-analyses,

and empirically supported manualized interventions because these products offer clinically relevant evidence-based practice recommendations but do not require that students read and critique large numbers of primary research studies.

## CONCLUSIONS AND FUTURE DIRECTIONS

Practice guidelines have proliferated widely across medicine and allied health professions, and many such guidelines are useful to social workers interested in evidence-based practice. Nonetheless, social work should initiate a guideline development movement, with the intention of developing empirically based practice guidelines in areas of core and unique importance to social work practice. Profession-specific guidelines could do much to promote better practice in social work nationally and would eventually increase the credibility and long-term viability of the social work profession.

It is currently unclear which of the many national social work organizations should sponsor a guideline development movement or whether a consortium of organizations should take on this challenge. Questions also remain about how priority areas should be identified for development of social work practice guidelines and which criteria should be employed to make such determinations.

Incipient efforts to evaluate promising new methods for incorporating clients' perspectives, cost and other economic considerations, and issues relevant to race and gender on guideline development efforts are under way. Additional investigations of these issues in relation to guideline development and effectiveness are needed. Furthermore, agency-related and other organizational and contextual factors are likely critical determinants of the extent to which guidelines are adopted by practitioners, but have received little attention in the social work or general psychosocial literatures pertaining to practice guidelines.

Over the past decade, there are indications that social workers have become significantly more supportive of a profession-wide movement to evidence-based practice, although the best methods for accomplishing this transition are the subject of considerable debate. Some proponents believe that practice guidelines are useful tools to promote evidence-based practice that appeal to students and practitioners because they are specifically focused on practice issues and do not require practitioners to become researchers or so-

phisticated consumers of research. Conversely, some critics of practice guidelines contend that given the expense and logistical requirements necessary for their development, it is unlikely many guidelines will be developed in social work. Furthermore, these critics argue that guidelines rapidly become outdated and thus, all social work students should be trained in the steps of evidence-based practice enunciated most prominently by Sackett and colleagues (Sackett, Rosenberg, & Gray, 1996). At present, the comparative acceptability, virtues, limitations, and effectiveness of these two competing (but potentially complementary) approaches to the promotion of evidence-based practice in social work remain unknown and the subject of ongoing passionate disagreement.

#### WEB SITES

- Agency for Healthcare Research and Quality. <http://www.ahrq.gov/clinic/ptsafety/chap51.htm>
- AGREE Collaboration. <http://www.agreecollaboration.org>.
- GRADE Working Group. <http://www.gradeworkinggroup.org>.
- Guidelines International Network. [www.g-i-n.net](http://www.g-i-n.net).
- National Guideline Clearinghouse. <http://www.guideline.gov>.

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