

# Chapter

# 12



## CLINICAL PRACTICE GUIDELINES— A DECISION MAKING TOOL FOR BEST PRACTICE?

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In the past decade, there has been an increasing emphasis on quality and accountability in the field of therapeutic recreation. This interest in demonstrating the effectiveness and quality of services has given rise to many articles and conference proceedings that address these critical issues. One of the many steps that must be taken in a profession in order to enhance the quality of service delivery is to have standardized approaches for client interventions. As Connolly and Keogh Hoss stated, "The validity of a profession lies in the common practices instituted by the practitioners based on client diagnostic need" (1991, p. 119). While the development of common practice can occur in several different ways, thus far in the field of therapeutic recreation, the emphasis has been placed on protocol development (Connolly & Keogh Hoss, 1991; Ferguson, 1991; Hood, Krinsky, & Selz, 1995; Hood, Mattiko, & Krinsky, 1994; Knight & Johnson, 1991; Olsson, 1990) and on the development of clinical practice guidelines (Hood, Krinsky, & Selz; Hood, Mattiko, & Krinsky; Joint Commission, 1993).

This issue of standardization in the delivery of health-related services is a concern for all health-care providers. Clinton, McCormick and Besteman (1994) reported that "in the past two decades, health services researchers have identified significant variations in the management of specific health conditions" (p. 30). They further suggested that although some variation in practice is both acceptable and expected, too much variation can be interpreted as ineffective patient care or as inefficient use of health-care dollars.

Researchers believe that practice variations occur, in part, because there is no strong consensus among practitioners about what constitutes best practice in specific circumstances. When faced with contradictory reports in the health-care literature, clinicians generally rely on their own professional judgement or the judgement of their peers when making practice decisions (p. 30).

### Definition of Terms

While there is relatively less debate about the usefulness of developing descriptions of standard practice, there is still much debate as to what these descriptions should include and how they should be developed. In fact, there is little consensus in the medical field as to what these descriptions of standardized practice might be called. The terms "protocol," "practice policies," "practice standards," "critical pathways," "CareMaps™" and "clinical practice guidelines" have all been used somewhat interchangeably within the health-care literature and, as such, require definition.

#### Protocol

In the past ten years, the term "protocol" has received a great deal of attention within the therapeutic recreation literature. That literature has contained some discussion concerning the relationship between program descriptions and protocols. Connolly and Keogh Hoss (1991) defined program description as the documentation of interventions and expected outcomes, however, in their definition of protocols, they linked the program description with standardized interventions. In discussing protocols, they stated that:

Given a specific diagnostic need or problem, a particular protocol may be developed and tested and used with consistency to lead to a particular predetermined outcome that is defined as alleviating or remediating the identified diagnostic-related need or problem. Protocol, then, becomes a means of responding in consistent practice patterns to commonly identified patient needs (p. 119).

However, when examining definitions of the term "protocol" within the therapeutic recreation literature, there is disagreement over the relationship between protocols and program descriptions. Knight and Johnson (1991) clearly indicated that protocols are more than program descriptions by stating that:

Protocols are a group of strategies or actions initiated in response to a problem, an issue, or a symptom of a client. They are not programs or program descriptions that typically describe Therapeutic Recreation, but are approaches or techniques that will lead to expected treatment outcomes. These strategies or actions are used to define the therapeutic recreation intervention. They describe what we do to achieve outcomes or desired states (p. 137).

There are several authors whose definitions of the term "protocol" do not clearly separate protocols from program descriptions. Olsson (1990) described protocols as "a set of very specific instructions, regulations, and requirements that govern an agency's Recreational Therapy practice and when implemented produce specific treatment outcomes" (p. iii). Ferguson (1991), in his descriptions of protocols, identified content areas for protocols, stating that "there are three primary features or characteristics of a protocol: 1) there is a specifically identified need or problem, 2) a set of procedures or instructions is listed and 3) a set of pre-determined outcomes are included" (p. 6). Neither of these definitions appear to clearly differentiate the term protocol from program description.

In examining the literature in therapeutic recreation and health care, it is apparent that the term "protocol" seems to refer primarily to standardized, systematic intervention descriptions designed and delivered to attain predetermined client outcomes. However, in the medical field, the term "protocol" can also refer to a standardized research procedure designed to determine the effectiveness of a particular intervention. This differentiation has important implications for therapeutic recreation in the way that the terminology is used. The profession must be clear on what is meant by the terminology it uses, and that meaning must be communicated clearly to others to avoid confusion or misrepresentation. A research procedure is quite different from a standardized intervention description!

There is a substantial connection between the two definitions however. Systematic intervention descriptions are necessary to set the stage for formal research endeavors designed to determine the effective of the intervention-efficacy research. In fact, James, Chassin, Goldberg, King, and Todd (1993) actually combined the two definitions, suggesting that a protocol is a document that has enough detail and definition regarding the intervention procedures to allow for practice recommendations and measurement.

### Practice Policies

Eddy (1990) defined practice policies as "preferred recommendations issued for the purpose of influencing decisions about health interventions" (p. 3077). Practice policies describe appropriate ways of making clinical decisions. Eddy further distinguished three levels of practice policies based first on the degree of professional certainty about the outcomes of a particular clinical practice, and second on the patient's preferences for that practice's predictable results. He indicated that "standards" represent the highest level of certainty about the outcomes combined with "virtual unanimity among patients about their desirability" (p. 6). A standard is a relatively strict rule that governs decision making within a given situation and intervention. "Guidelines" are "clinical interventions that have well-documented outcomes, but whose outcomes are not clearly desirable to all patients" (p. 6). They therefore should be used for decision making in most cases but may need to be modified for individual patients. Finally, "options" describe "medical interventions for which outcomes are not known, patient preferences are not known, or about

which patients are indifferent. Options are neutral with respect to recommending a particular intervention” (p. 6)—they simply provide a list of possible, credible treatment alternatives.

### Critical Pathways/CareMaps™

The term “critical pathways” emerged from the case management movement in nursing and refers to the overall management of a patient’s care. “Critical pathways are clinical management tools that organize, sequence, and time the major interventions of nursing staff, physicians, and other departments for a particular case type, subset, or condition” (Bergman, 1994, p. 74). A typical critical pathway contains clinical interventions that will be undertaken by the members of the multidisciplinary team, goals and objectives for the client, and a timeline for implementation (Lumsdon & Hagland, 1993). Rather than focusing on the interventions provided by a particular professional group, critical pathways trace the set of interventions provided by the whole multidisciplinary team (Bergman). CareMaps™ are simply “more elaborate critical pathways that show the relationships of sets of interventions to sets of intermediate outcomes along a time line. They merge standards of care with standards of practice in a cause-and-effect relationship across time” (Bergman, p. 74).

### Clinical Practice Guidelines

Currently the term “clinical practice guideline” seems to be the most widely used and accepted term within the health-care arena. Howard and Jenson (1999) suggested that the terms “practice protocols, standards, algorithms, options, parameters, pathways, and preferred practice patterns are nuanced terms broadly synonymous with the concept of clinical practice guidelines” (p. 284).

The term “clinical practice guideline” has been defined by the Institute of Medicine as “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances” (1990, p. 27). The American College of Physicians offers the following definition of clinical practice guidelines:

Practice guidelines are simply a means of providing knowledge, derived from a scientific analysis of the practice of medicine, in a useful format to physicians, patients, and others about the best use of health-care resources. Guidelines, when viewed in this manner, can take a variety of forms and can be tailored to a variety of purposes. . . . They can be a “gold standard”—to which all could aspire but not all will attain—or they could be a floor: the means of screening for unacceptably poor care. Guidelines might be robust, because they are based on thorough and compelling evidence. Or, they might simply represent the best available information about the current state of the art, thereby leaving more room for judgment and adaptation, while suggesting targets for further clinical research (American College of Physicians, as cited in National Quality of Care Forum, 1993, pp. 396-397).

Clinical guidelines are the distillation of the best collective thinking from the literature, from practicing clinicians, and from academics on how to treat a particular medical situation. Guidelines are targeted to individual interventions, while critical pathways and CareMaps™ are focused on the patient care activities of entire multidisciplinary teams (Bergman, 1994).

Over the course of the last ten years, one of the primary forces in the development of clinical practice guidelines within the medical community has been the Agency for Health-Care Policy and Research (AHCPR). This agency was created in 1989 and is funded by the Department of Health and Human Services to assist in the development of guidelines by private organizations. The AHCPR was developed with two specific missions in mind:

It must initiate studies to measure the outcomes of common health-care interventions, and it must generate practice guidelines that codify research and consensus findings regarding best health-care practices (James et al., 1993, p. 4).

Bergman (1994) stated that the AHCPR guidelines are based on extensive literature reviews and subjected to scrutiny by peer reviewers, and to on-site clinical evaluations by potential users. "They also incorporate analyses of the use and cost of health-care resources, and assessments of the feasibility of implementation" (p. 71). To date, the AHCPR has developed over 22 guidelines for use in general medical practice (e.g., acute pain management, urinary incontinence in adults, and pressure ulcers in adults).

In addition to individual hospitals, health insurance groups, and other private companies, practice guidelines have been developed by a variety of professional organizations, including the American Psychiatric Association (e.g., substance use disorders, schizophrenia), the American Psychological Association (e.g., eating disorders, depression), the American Academy of Child and Adolescent Psychiatry (e.g., evaluation of youth who have been physically or sexually abused), and by the American Medical Association (with over 1600 practice guidelines available through them).

Interestingly, one common criticism of the existing practice guidelines raised by allied health professionals is that the guidelines do not address behavioral and psycho-social factors in the development and resolution of illness (Ewalt, 1995). "For example, despite research demonstrating the relationship between social support and the quality and length of life, such social and behavioral factors have not regularly entered the equation in clinical practice guidelines" (p. 293). Therefore, it would seem unlikely that the AHCPR or any other group developing general medicine guidelines will include issues relevant for therapeutic recreation interventions. Coupled with the fact that the development of clinical guidelines in allied health professions has occurred very slowly, if at all (Howard & Jenson, 1999), this information leads to the conclusion that the responsibility for defining best practice in therapeutic recreation and for developing clinical practice guidelines lies with the profession itself. As a member of the American Psychological Association stated:

We need to develop better accountability mechanisms, primarily in the form of practice guidelines and outcome measures. . . . the professional [psychology] practice community finally recognizes the need to develop and implement practice guidelines. While we ought not to be putting guidelines in place that foreclose an individual psychologist's clinical judgment. . . . for the profession itself to develop practice guidelines actually protects us; no one knows better how to develop guidelines for psychological service delivery than we do (Nickelson, 1995, p. 369).

### **Benefits of Developing and Using Clinical Practice Guidelines**

There are a variety of terms used to describe standardized procedures for service delivery, however, clinical practice guidelines seems to be the most widely used and accepted term within the medical profession and within the allied health fields. And although the development of clinical practice guidelines is very challenging, there are some strong arguments for the necessity of developing guidelines. "Clinicians, policy makers, and payers see guidelines as a tool for making care more consistent and efficient and for closing the gap between what clinicians do and what scientific evidence supports" (Woolf, Grol, Hutchinson, Eccles, & Grimshaw, 1999, p. 527).

Woolf et al. (1999) outlined a comprehensive set of benefits for developing and using clinical practice guidelines. The first set of benefits related to outcomes for patients or clients, and the second set of benefits related to outcomes for professionals.

#### **Benefits for Clients**

There is some evidence that suggests the development and use of guidelines actually improves the health outcomes for patients. "Guidelines that promote interventions of proved benefit and discourage ineffective ones have the potential to reduce morbidity and mortality and improve quality of life, at least for some conditions" (Woolf et al., 1999, p. 528). Howard and Jenson (1999) also supported this notion, suggesting that using guidelines can increase empirically based practice and improve client outcomes.

The use of clinical practice guidelines also improves the consistency of care for clients. There is a great deal of evidence that suggests that clients with identical clinical problems receive different care depending on their clinician, hospital, or location. This problem exists across health care—for physicians as well as other health-care providers. This is a particularly important issue within the field of therapeutic recreation, in that there are such vast differences in philosophy and educational preparation for therapeutic recreation practitioners. Moreover the kinds of client problems that are addressed in therapeutic recreation tend to be psychosocial in nature and are not as amenable to standardization as other biomedical treatment needs. These issues combine to directly impact the types of interventions used with

clients. In fact, this problem was one of the driving forces behind the protocol development movement in therapeutic recreation. Woolf et al. (1999) stated "guidelines offer a remedy, making it more likely that patients will be cared for in the same manner regardless of where or by whom they are treated" (p. 528).

All of the clinical guidelines developed by AHCPR have a consumer version available for the recipients of health-care services. These versions facilitate informed consumer decision making and allow clients to make educated, informed choices about health care, thus becoming more active participants in their own care (Howard & Jenson, 1999). Woolf et al. (1999) stated that:

Guidelines empower patients to make more informed health-care choices and to consider their personal needs and preference in selecting the best option. Indeed, clinicians may first learn about new guidelines (or be reminded of oversights) when patients ask about recommendations or treatment options (p. 528).

The final benefit linked to client well-being is at a public policy level. Woolf et al. (1999) suggested that the development of guidelines can influence public policy by calling attention to poorly recognized health problems, clinical services, and preventive interventions and to neglected patient populations and high-risk groups. Services that may have not been previously offered may be made available as a result of newly released guidelines. In addition, guidelines can influence third-party payers to cover certain procedures that had not been previously covered. Woolf et al. stated:

Clinical guidelines developed with attention to the public good can promote distributive justice, advocating better delivery of services to those in need. In a cash-limited healthcare system, guidelines that improve the efficiency of health care free up resources needed for other (more equitably distributed) health care services (p. 529).

### **Benefits for Practitioners**

Howard and Jenson (1999) and Woolf et al. (1999) also delineated a set of benefits for developing and using guidelines for practitioners. Howard and Jenson suggested that the development and use of guidelines can greatly enhance professional preparation activities in that future professionals can be trained in the procedures outlined in the guidelines. They stated that "published guidelines could be effective teaching tools and further the aims of clinical education by promoting specific clinical practices consistent with the best empirical evidence and clinical experience" (p. 290).

The development of clinical guidelines also can assist practitioners in making well-informed clinical decisions. They offer direction and recommendations for practitioners who are uncertain about how to proceed in a certain situation. They impact outdated practices by challenging beliefs about best practice. They provide

authoritative, evidence-based recommendations that reassure practitioners about the appropriateness of their treatment approaches (Woolf et al., 1999). In fact, clinical practice guidelines can help bridge the gap between practice and research (Howard & Jenson, 1999). Guidelines offer an accessible way for practitioners to use research results in their everyday practice.

Clinical practice guidelines support quality-improvement activities in that they can provide the reference point for audits and reviews. They also provide a common starting point in designing quality-assessment tools, in that the starting point is based on reaching agreement on how patients should be treated (Woolf et al., 1999), and encourage more cost-effective and accountable practice (Howard & Jenson, 1999).

Individuals who are interested in research on efficacy and treatment interventions also benefit from clinical practice guidelines in that an examination of existing guidelines can highlight areas that are lacking in empirical support. The method of guideline development that emphasizes systematic reviews of the literature and practice can focus attention on key research questions and can highlight the gaps in the literature. Moreover the process of reviewing the literature related to a particular issue can help solidify and pull together the knowledge base, particularly in controversial practice areas (Howard & Jenson, 1999).

Finally, guidelines can prompt government or private payers to reimburse for certain services. This particular outcome of guideline development and use can either be a benefit or a drawback. It can benefit practitioners who need support in order to implement a particular intervention. Guidelines also can be used by practitioners to gain "ownership" of particular procedures or may be used to justify unnecessary procedures (Woolf et al., 1999).

It would seem that the benefits of developing and using clinical practice guidelines are overwhelming, yet there are still relatively few guidelines developed, particularly in the allied health-care fields. Clearly, even though the benefits of guidelines are evident, there are still major barriers to developing and using them. A delineation of the challenges inherent in the development and use of clinical practice guidelines will provide guidance for clinicians and researchers who are interested in this issue.

### **Challenges in Developing Clinical Practice Guidelines**

In health care, and specifically within the field of therapeutic recreation, there are several issues related to the development and use of clinical practice guidelines. The first set of challenges relate to the development of these documents and all the accompanying decisions. The second set of challenges relate to implementation, use, and evaluation of guidelines.

#### **Development Challenge #1: Who is Responsible for Guideline Development?**

*The Challenge.* One of the key issues regarding the development of clinical practice guidelines in any professional field is determining who are the decision makers and leaders of the initiative. In many situations, initiatives related to professional practice, development, and advocacy come from the professional organization. Yet, in

the field of therapeutic recreation, there are currently two professional organizations with different resource bases and slightly different mandates. Recently, these organizations have agreed to work together on some issues under the auspices of the Alliance for Therapeutic Recreation, and it would seem reasonable to expect that if this clinical guideline initiative comes from a professional organization, it should be a joint effort from both organizations. On the other hand, as demonstrated by other health-care professions, guideline development also can arise from governmental agencies and private companies. Each of these approaches has both strengths and weaknesses in terms of the quality of the guidelines developed and the utility of those guidelines to practitioners.

*Points to Ponder.* Brook (1996) discussed the issue of who develops clinical practice guidelines. He compared development initiated by public agencies and development initiated by private interest groups or individuals. He suggested that there are several problems with guideline development arising from professional organizations and other private interest groups. He stated:

Guidelines produced by some managed care plans, specifically societies, or proprietary firms are likely to be subject to stringent bottom-line concerns about the cost of producing the guidelines; and thus such organizations are unlikely to devote sufficient resources to summarizing the published work. Guidelines paid for by firms who have products to sell probably will spend more time addressing how these products can be used, as opposed to how these products should not be used. Guidelines produced by single-specialty societies are likely to emphasize the underuse of services provided by these societies, as opposed to both overuse and underuse. Guidelines paid for by proprietary firms are not likely to be placed in the public domain (p. 1006).

Brook (1996) also reported on the difficulties faced by the AHCPR, a publicly funded agency, in their clinical-practice, guideline-development process. As previously mentioned, the AHCPR was developed specifically to develop guidelines within the medical community. Yet even this independent group was criticized for the process that was undertaken. The agency was criticized for taking too long to develop the guidelines and for using a process that was "biased" because it used a panel of experts/committee rather than a structured group process. Brook summarized the dismantling of the AHCPR:

The agency took a serious hit when the results of the process were used by a few surgeons who did not like the guidelines (and by various people who did not like the agency in general) to launch a campaign to defund the agency. Even though the guideline process involved many physicians and physician organizations throughout the country and resulted in many articles in peer-reviewed journals, the profession as a whole did not step up to the plate and apply equal pressure to Con-

gress to keep the agency in the guidelines business. And thus the agency, to protect its funding for other scientific activities, agreed to forego the development of further guidelines (p. 1005).

The issue of who takes the lead in guideline development is an important one in terms of the quality of the guidelines developed and in terms of the degree to which professionals will use guidelines. Dracup (1996) recommended that regardless of which group accepts responsibility for developing guidelines, the guidelines must come from a national group and adopt a nationwide focus. She suggested that national guidelines are more likely to be based on the latest, most comprehensive scientific evidence and expert analysis.

*A Therapeutic Recreation Example.* Both the American Therapeutic Recreation Association (ATRA) and the National Therapeutic Recreation Society (NTRS) have committees and/or task forces that are devoted to the development of descriptions of best practice (clinical practice guidelines). Each organization has, however, conceptualized the task and the outcome differently. As a result, each organization has a product, or "protocols," but they look very different and were developed with completely different procedures.

*Questions for Reflection.* There are clearly some significant benefits to having a professional organization or organizations take on the leadership in clinical practice guideline development. First, professional organizations have a large membership of practitioners, educators, and researchers. Thus, locating individuals who are willing to take on a leadership role may be facilitated through professional organizations. In addition, the involvement of a wide variety of individuals seems to be an important component to guideline development, and professional organizations typically have information about professional practice experience and expertise of their members. Finally, professional organizations may have some financial support for the process, which can be important in terms of accessing a wide variety of individuals and researching a broad base of literature.

On the other hand, there may be drawbacks to having the initiative arise from a professional organization. First, the primary purpose of clinical practice guidelines is to improve client care, and if the process is initiated and controlled by a professional organization (whose primary function is to further the interests of the profession) is there a conflict of interest? The second concern is the influence of professional philosophy on the development and content of clinical practice guidelines, particularly in light of differing philosophies between organizations. How can clinical practice guidelines reflect practice for all therapeutic recreation specialists if they represent one particular approach or practice model to therapeutic recreation service delivery?

If the initiative does not arise from a professional organization, then who assumes responsibility and leadership for the development of clinical practice guidelines? Is it the responsibility of academics and researchers within the field? Is it the responsibility of therapists who already may be struggling to maintain their positions in the health-care arena? Is there some organization or private agency willing to develop guidelines within the field?

## Development Challenge #2: What Process of Guideline Development Should Be Adopted

*The Challenge.* In addition to determining the decision makers regarding clinical practice guideline development, the process used to develop the guidelines must be addressed. In many professions, including medicine, there are a variety of groups developing clinical practice guidelines—some governmental agencies, some commercial agencies, and some professional groups. James et al. (1993) indicated that for medicine, in addition to the AHCPR, professional groups, health-care purchasers, and commercial enterprises are working on developing practice guidelines—many with different objectives, different definitions, different levels of sophistication, and unequal quality in the final products. In all likelihood, the process used to develop these guidelines varies, and perhaps as a result, the kind of information included in the guidelines also will vary. Conceivably, even the credibility of guidelines varies based on the development process.

*Points to Ponder.* The strategies adopted by organizations and agencies developing guidelines seem to be very similar. The AHCPR guidelines are based on: (a) extensive literature reviews, (b) an expert panel review by experienced clinicians, and (c) are subjected to assessment by peer reviewers and on-site evaluations by potential users.

Howard and Jenson (1999) suggested that in social work, “guidelines should be developed by groups with expertise and experience relevant to the focal practice area” (p. 287). They go on to identify some important questions about the composition of the expert panels including the issue of client representation on the panels, the involvement of other professions in the panel, and the size of the panels. “A panel that is extremely heterogeneous may be unable to reach consensus, whereas a narrowly constituted panel may be viewed as self-serving and insensitive to the needs of some groups of guideline users” (p. 287). The selection of an appropriate panel chairperson is seen to be critical in this process in terms of group-facilitation skills and awareness of the critical issues facing clients.

Dracup (1996), in her discussion of guideline development in nursing, also addressed the importance of the composition of the panel of experts. She suggested that when reviewing the quality of a guideline, the reader should check for any conflicts of interest within the panel of people who created the guideline and note whether the panel reflects an appropriate level and mix of expertise.

Once a panel is constituted, then the scientific literature must be reviewed for relevant material. Some guidelines weight their clinical recommendations according to the quality of the supporting evidence (such as randomized clinical trials vs. case studies). Howard and Jenson (1999) also recommended that the process of development should include an analysis of the costs and benefits of alternative-treatment approaches, personal and social costs, and outcomes associated with the interventions under consideration.

A review of the processes used by other professions in developing guidelines suggested that the process is quite similar across agencies and countries (American Psychiatric Association, 1997; Canadian Medical Association, 1999; Howard &

Jenson, 1999; Matillon & Goldberg, 1997; New South Wales Health, 1999). However, there are some difficulties in implementing the process that have implications for clinical practice guideline development in therapeutic recreation.

*A Therapeutic Recreation Example.* The Protocol Development Committee of ATRA adopted one particular process of guideline development. This committee identified two important stages of clinical practice guideline (protocol) development. First, it was deemed necessary to identify those client treatment needs that were considered by professionals to be most appropriate for therapeutic recreation intervention and that were most important for client progress or recovery. This was done using a Delphi procedure and a nationwide panel of experts (Hood & Krinsky, 1997–98). Second, the process of guideline development for the identified critical client need was undertaken by: (a) reviewing literature within and outside of the field about the treatment issue being addressed, (b) involving practitioners and researchers in the process of translating the literature into practice options, (c) creating a document outlining the theory and interventions addressing the client problem, and (d) reviewing the final product by another panel of experts made up of practitioners and researchers.

*Questions for Reflection.* One of the fundamental assumptions of guideline development and use is that literature does exist that supports the professional practices described. In therapeutic recreation, there is little evidence for the efficacy of the services provided. Therefore, what is the basis of the development of clinical practice guidelines? Is the use of theory acceptable when there is no research evidence available? Can support be drawn from literature and theory in other fields for professional practices in therapeutic recreation? To what extent can practitioners' testimonies and beliefs about best practice guide the process of practice guideline development? What are the implications of using theory-based guidelines versus research-based guidelines?

Howard and Jenson (1999) suggested that "the input of clinicians is essential to frame the issues to be covered and to fill the gaps left by a research base of limited breadth and generalizability" (p. 288). Moreover, they indicated that for professions such as social work (which parallels therapeutic recreation in many ways), guideline development must begin with "the practice wisdom of expert and esteemed practitioners" (Jackson, 1999, p. 331) which then guide the research agenda for the profession with the goal of developing evidence-based practice guidelines. Dracup (1996) supported this notion, stating:

If minimal scientific evidence is available, then guidelines are based on the consensus of experts. These guidelines are less compelling than those based on scientific evidence from clinical trials, but they still represent valid recommendations that are more reliable than practicing based on tradition (p. 42).

Dracup (1996) further recommended that guidelines that do arise from evidence-based practice should be accompanied by clear descriptions of the quality of

evidence for each recommendation. The American Psychiatric Association (1997) practice guideline for schizophrenia identified three levels of "clinical confidence regarding the efficacy of treatment," which are based partially on the source of the information/recommendations: I—recommended with substantial clinical confidence; II—recommended with moderate clinical confidence; and III—may be recommended on the basis of individual circumstances. One question that faces the field of therapeutic recreation, which has limited empirical support for the efficacy of its services, is, What is the implication of developing and disseminating guidelines that may have virtually no "level I" ratings? What impact might this have on the credibility of the field and therapeutic recreation professionals? What impact might this have on the ability to obtain reimbursement for services?

A second fundamental question related to developing clinical practice guidelines is how to determine where the starting point is in the development process. Should the focus be on diagnosis as the starting point, as is the norm in medicine? Or should the focus be on psychosocial issues that may cross diagnostic groups? Within the field of therapeutic recreation, there has been some discussion of this issue in the various protocol development committees. In the most recent work of ATRA, the Protocol Development Committee decided to focus on client treatment needs rather than diagnostic group. The committee suggested that some of the interventions identified to address a particular client treatment need may be appropriate for use with a variety of clients within different diagnostic groups. However, in order to facilitate the development of a panel of experts and to access content expertise, the committee began its initial work in the area of alcoholism treatment. It was suggested that once the practice guideline was developed focusing on a particular group of clients, it would then be possible to determine if those interventions were appropriate for the same client treatment need within other populations. The difficulty in this approach is that the use of the clinical practice guideline then becomes less standardized and is based more on clinical judgment than if the guideline focused on diagnosis. In therapeutic recreation, should the process follow the lead of the medical profession in terms of developing guidelines to address specific issues with a specific population? Or should the process continue to focus on treatment needs that may cross diagnoses?

In addition to determining the starting point in developing clinical practice guidelines, a secondary concern is the privacy of the client treatment needs checked. The AHCPR indicated in their materials that the selection of topical areas for guideline development was based on an extensive set of criteria, some of which were: the incidence in the general population, costs associated with care, controversy or uncertainty about the effectiveness of available clinical strategies, potential to reduce variation in the treatment of patients, availability of scientific data to support the study, and potential opportunities for rapid implementation, potential to improve clinical decision-making (Agency for Health-care Research and Quality, 1999).

In social work, the discussion has also occurred about which issues to address in guideline development. Hayward and Laupacis (1993) suggested that highly

prevalent, costly disorders about which clinical uncertainty prevails should top the list of issues to address, particularly when effective treatment of those disorders might yield significant improvements in clients' clinical outcomes.

The ATRA Protocol Development Committee decided that a panel of experts should be compiled to review a comprehensive list of client treatment needs. The committee selected the general population of alcoholism within which to start this process. The panel participated in a sequential, structured mailing technique (a Delphi procedure) in which they were asked to prioritize and agree upon the most important client treatment needs to address. This prioritized treatment need (poor coping skills) was then used as the basis for the development of a guideline (Hood & Krinsky, 1997-98).

### Development Challenge #3: What kind of information is required in a practice guideline?

*The Challenge.* The third major issue related to developing clinical practice guidelines is determining what kinds of information needs to be included in the guideline and what level of detail is required. Several organizations have developed outlines of expected content of a guideline. Frequently, these targeted areas vary both in terms of content and in the degree of specificity required. However, the Canadian Medical Association (1999) and the U.S. National Library of Medicine (Hayward et al., 1993, p. 732) have adopted a standardized outline of a clinical practice guideline:

- Objective: the primary objective of the guideline, including the health problem and the targeted patients, providers, and settings
- Options: the clinical practice options considered in formulating the guideline
- Outcomes: significant health and economic outcomes considered when comparing alternative practices
- Evidence: how and when evidence was gathered, selected, and synthesized
- Values: disclosure of how values were assigned to potential outcomes of practice options and who participated in the process
- Benefits, harms, and costs: the type and magnitude of benefits, harms, and costs expected for patients from guideline implementation
- Recommendations: summary of key recommendations
- Validation: report of any external review, comparison with other guidelines, or clinical testing of guideline use
- Sponsors: disclosure of the person(s) who developed, funded, or endorsed the guideline

The American Psychiatric Association's *Practice Guideline for the Treatment of Patients With Schizophrenia* (1999) identified the following content areas:

1. Summary of Recommendations
  - A. Coding System

- B. General Considerations
- 2. Disease Definition, Natural History, and Epidemiology
  - A. Clinical Features
  - B. Natural History and Course
  - C. Epidemiology
- 2. Treatment Principle and Alternatives
  - A. General Issues
  - B. Psychiatric Management
  - C. Pharmacological Treatments
  - D. Electroconvulsive Therapy
  - E. Specific Psychosocial Interventions
  - F. Other Social and Community Interventions
  - G. Treatment Settings
- 3. Formulation and Implementation of a Treatment Plan
  - A. Acute Phase
  - B. Stabilization Phase
  - C. Stable Phase
  - D. Special Issues in Caring for Patients with Treatment-Refractory Illness
- 4. Clinical and Environmental Features Influencing Treatment
  - A. Psychiatric Features
  - B. Demographic and Psychosocial Issues
  - C. Concurrent General Medical Conditions
- 5. Research Directions
- 6. Individuals and Organizations that Submitted Comments
- 7. References

Even though the kinds of information required in a practice guideline have been identified, there remains some debate as to the level of detail required to make a guideline usable yet accessible to practitioners. Howard and Jenson (1999), in their article on the future of practice guidelines in social work, identified criticisms with the guideline movement related to the level of detail included in the guidelines. "Criticisms of guidelines usually center on concerns about whether guidelines will foster 'cookbook' practice that ignores the needs of individual clients" (p. 289). Berger and Rosner (1996) stated that "practice guidelines may conflict with . . . [clinician] responsibility and individual patient interests by prescribing unreasonably circumscribed care plans, particularly when they are inflexible, of limited quality, and enforced" (p. 2053).

Conversely, James et al. (1993) suggested that many of the available guidelines in medicine lack enough detail to allow direct implementation. Dracup (1996) stated that "crafting precise guidelines is sometimes difficult because of the array of exceptions that might apply to a particular recommendation. Guideline authors try to remedy this problem by making general recommendations, which can lead to

imprecise use. This ambiguity could lead [a practitioner] to apply a guideline incorrectly” (p. 44). James et al. suggested that the potential user must add the detail and definition that will allow the guideline to be implemented.

*Points to Ponder.* Jackson (1999) suggested that “the content of these guidelines must be flexible, reflect interdisciplinary practice, and address the multiple roles that social workers play with clients and their families” (p. 331). She further suggested that guidelines should provide information and assistance to the decision-making process but not prescribe treatment interventions. “They should not be too restrictive or prescriptive, and they should require tailoring the intervention to the client’s needs and informed wishes” (p. 332).

Ewalt (1995), in her discussion of social-work guidelines, suggested that one of the problems with the guidelines being developed in medicine is that they do not address the behavioral and psychosocial factors in the development and resolution of illness. The medical guidelines provide an ordered list of options to use in treatment, and they primarily focus on the cause or the primary symptoms of the illness. It could be argued that the more concrete the client problem is, the easier it would be to develop a detailed description for service. In therapeutic recreation, where the focus is often on the psychosocial issues that may be secondary outcomes of the illness or disability, it may be extremely difficult to design step-by-step procedures to address these issues. The related psychosocial issues may be so impacted by individual factors and the context in which the client is embedded that a document that provides more generalized direction and guidance may be the most appropriate. Clinical practice guidelines are not designed to provide a step-by-step outline of service delivery—they are developed only to assist practitioners in making decisions about appropriate interventions. The decision for the intervention must still rest on the practitioner’s expertise and judgment. Clinical practice guidelines are not a replacement for professional competence and decision making.

The National Guideline Clearinghouse, a public resource for evidence-based clinical practice guidelines, addresses the issue of how to use guidelines in their disclaimer:

These guidelines are not fixed protocols that must be followed, but are intended for health-care professionals and providers to consider. While they identify and describe generally recommended courses of intervention, they are not presented as a substitute for the advice of a physician. . . . Individual patients may require different treatments from those specified in a given guideline. Guidelines are not entirely inclusive or exclusive of all methods of reasonable care that can obtain/produce the same results. While guidelines can be written that take into account variations in clinical settings, resources, or common patient characteristics, they cannot address the unique needs of each patient nor the combination of resources available to a particular community or health-care professional. Deviations from clinical practice guidelines may be justified by individual circumstances. Thus, guide-

lines must be applied based on individual patient needs using professional judgment. (Retrieved Sept. 20, 1999 from the World Wide Web: <http://www.guideline.gov>).

Roberts (1996) made the following statement about the specificity of guidelines, implying that the use of clinical judgment in combination with an outline of best practice is not only positive, but desirable:

If guidelines are “cookbook medicine,” remember that even the best chef starts with a cookbook. The difference between the good and the best is often the subtle use of spices. The spice of medicine—intelligent reasoning and clinical intuition—and the art of medicine will not be supplanted by guidelines (p. 87).

*A Therapeutic Recreation Example.* Within the ATRA Protocol Development Committee, there was extensive discussion as to the type of content and level of detail to be included in the clinical practice guideline document. The committee decided to include an extensive discussion of the theoretical underpinnings of coping-skills training as an important part of the final document. This decision was made based on the lack of empirical support for the efficacy of coping-skills training within therapeutic recreation. The document included an introduction with the following statement:

The first section provides the conceptual and theoretical background for coping skills interventions in addictions treatment. This section is included primarily to provide the user of the document with the knowledge underpinning interventions in this area and arises directly from the desire to address the a theoretical nature of many therapeutic recreation interventions. This information may be useful in providing a rationale for the role of therapeutic recreation in addressing lack of coping skills in addictions treatment (Hood & Krinsky, 1998, p. 1).

The second major part of the document included an overview of intervention strategies that could be used to address poor coping skills, prefaced with the following statement:

The second section of the document is the actual therapeutic recreation [guideline] for lack of coping skills. This section is the more practical application of the theories from which the interventions arise. It was not the intent of the Committee or ATRA to provide a “cookbook” approach to service delivery, therefore this document provides direction for service delivery (including potential content areas, intervention strategies, assessment suggestions, etc.), however, it does not provide actual descriptions of programs or sessions. It is assumed that

each therapist will bring to their service delivery unique backgrounds, skills, and styles, and this information is meant to provide direction and consistency within the field of therapeutic recreation (Hood & Krinsky, 1998, p. 1).

*Questions for Reflection.* So the primary question remains, What are the relative merits of having guidelines which require the use of substantial clinical judgment and expertise, and protocols that provide a step-by-step, sequential outline of "if-then" statements to guide service delivery? Once the field of therapeutic recreation determines the level of detail required in guidelines, what kinds of information would be important to include in therapeutic recreation practice guidelines? Should the therapeutic recreation profession be following the model of other professions or developing its own?

### **The Implementation Challenge: How Can We Get Practitioners to Use Guidelines Consistently, Skillfully, and in Combination With Clinical Judgment?**

In reviewing the literature related to guideline development, it has been noted consistently that a major problem with the guideline movement lies not in the area of developing guidelines (although there are obviously challenges inherent in that process), but in the difficulties involved in getting practitioners to use the guidelines once they are developed. Howard and Jenson (1999) suggested that "historically, far more energy and funding have been devoted to the process of developing guidelines than to activities designed to increase guideline use" (p. 289). They also stated that practitioners are "slow to adopt interventions of established effectiveness because they receive little training in empirically supported treatment methods, do not read outcome literature, find research results difficult to apply, tend to consider all [therapies] equally effective, and because clients are uninformed" (p. 289).

Some of the concerns that arise when thinking about using clinical practice guidelines include: (a) how can the profession encourage practitioners to use guidelines; (b) how will the profession monitor who is and who is not using the guidelines; (c) what are the training needs of practitioners who will use the guidelines; (d) how will the profession handle conflicting information in guidelines from various professions/organizations; and (e) how can professionals balance individualized treatment with standardized approaches to practice.

#### **Implementation Challenge #1: How Can Practitioners Be Encouraged to Use Guidelines?**

*The Challenge.* One of the most difficult issues facing the guideline movement is getting practitioners to accept and adopt clinical practice guidelines in their daily practice. Anderson (1993), in his summary of the work done by the AHCPR on methods of disseminating guidelines, stated that "strategies for successfully implementing practice guidelines are as important as those for creating sound and acceptable guidelines" (p. 755).

Kirk (1999) suggested that one of the major reasons practitioners do not use guidelines is that the guideline documents are so complex and difficult to review. He suggested that guidelines must not only be carefully studied but also remembered and used appropriately by practitioners. Is it realistic to expect that a community of practitioners who typically have trouble reading and reviewing the research literature will have the time or interest to review a sometimes 75-page-long document? Kirk suggested that it is completely unrealistic to expect that most practitioners would read these documents:

Why would a busy practitioner, rather than a student or scholar, take the considerable time to read and master its [63 page APA document] content? If practitioners generally do not subscribe to academic journals or read research articles, why will they read guidelines? One reason would be if guidelines helped to simplify the decision of what to do with a client by offering concrete, specific suggestions about what works and what is to be avoided (Kirk, p. 304).

He also indicated that an additional problem with guideline use is that concrete suggestions are not present in most guidelines due to the fact that research evidence almost always shows mixed results with regard to the typical kinds of interventions used in social work (and in therapeutic recreation as well).

Howard and Jenson (1999), in their review of the literature of practice guidelines, suggested the following strategies for changing practitioner behavior: "small group consensus building, involvement of key opinion leaders in local modification of national guidelines, feedback and clinical auditing, and other methods that involve significant levels of interpersonal interaction" (p. 289). In an effort to increase access to their guidelines, the AHCPR published guidelines in several formats to gain widespread dissemination to different audiences. The Agency published patient guides in English and Spanish, a Quick Reference Guide for Clinicians (a shorter version of the full report), and the full Guideline Report (World-Wide Web: <http://www.guideline.gov>). In addition, guidelines from various organizations are now available on the World-Wide Web and through various other computer applications.

*A Therapeutic Recreation Example.* The process adopted by the Protocol Development Committee of ATRA incorporated some of these issues related to involving various groups of practitioners and educators in the development of guidelines and thus encouraging their engagement in the use of the product. Some of the further work undertaken to operationalize the practice guideline interventions into program descriptions for research and evaluation purposes has also incorporated the involvement of various practitioners (Carruthers & Hood, 1999). In this project, practitioners were recruited to review, implement, and collect evaluation data on a program developed based on the coping-skills practice guideline. These practitioners, as a result, are quite committed to the program and to the issue of coping-skills training in therapeutic recreation for clients with alcoholism.

*Questions for Reflection.* The question however, remains, if, as a field, the profession is successful in developing guidelines that describe best practice in given situations with given clients, how can the profession determine if practitioners are using the guidelines? How can the profession encourage practitioners to use the guidelines? Should the profession monitor who is using them and who is not? If so, how would the profession monitor use? Should there be an incentive plan for individuals who use them? Should there be some disciplinary process for individuals who do not follow them? What are the legal liability issues related to endorsing guidelines? What are the liability concerns related to not using published guidelines for practice in the field?

Beyond the problem of encouraging practitioners to use guidelines is the issue of competency. In therapeutic recreation, there is a certification process in place, however, how would the development of guidelines impact educational programs and the certification process? It is one thing to develop a document that identifies treatment interventions and processes for specific client issues, but how does the profession ensure that the people who are using the guidelines are skilled in the content included? Should the profession be developing concurrent training and professional education programs to complement the guidelines being developed? Who would take the lead in this initiative? Is it the responsibility of the groups developing the guidelines to also work to ensure the competency of the individuals using the guidelines?

The final set of questions related to practitioner use of guidelines is the impact of new guidelines on existing practice patterns. If guidelines are developed that alter the way practitioners offer therapeutic recreation services—perhaps by updating the types of interventions used or by expanding the theoretical base of the field—how can the profession encourage experienced practitioners to modify their services? Are these practitioners going to be willing to adopt guidelines that significantly alter their practice? Is the therapeutic recreation profession likely to encounter the same response as the AHCPR did when practitioners criticized the guidelines and effectively put the organization out of the guideline business?

### **Implementation Challenge #2: What is the Best Way to Handle Conflicting Guidelines?**

*The Challenge.* In some instances, there may be more than one set of guidelines present to guide practitioner decision making, and practitioners face a dilemma as to which ones to use. A hospital or region may have certain guidelines concerning the approach to a particular problem that may not be parallel to those from other groups or other organizations. Dracup (1996) suggested that the decision as to which guideline to follow should be based on a review of the supporting evidence for each guideline, and a careful consideration of the qualifications and backgrounds of the authors of the guidelines, including an examination of potential conflicts of interests (or vested interests) by the authors and an examination of their qualifications related to the practice area addressed in the guideline.

*Questions for Reflection.* In therapeutic recreation, it is most likely that the other guidelines would come from allied health-care professions such as occupational therapy, social work, and nursing. The issue then becomes one of scope of practice. To what extent will guidelines reflect the scope of practice as commonly accepted in therapeutic recreation? And to what extent will guidelines expand or modify this scope of practice? The profession needs verbal spokespersons to advocate for the role of therapeutic recreation, as outlined in the guidelines and in the professing scope of practice, for the treatment of our clients.

### **Implementation Challenge #3: How Does One Balance The Desire for Individualized Care with Standardized Services Descriptions?**

*The Challenge.* One of the criticisms leveled against the guideline movement is the conflict between moving toward standardized practice and the desire to provide individualized services. Dracup (1996) suggested that guidelines cannot cover every clinical situation; each patient is unique, and many conditions are too complex to be reflected easily in a single set of recommendations. In addition, “a patient could have concomitant conditions that make following the clinical guideline for his or her primary condition inappropriate” (p. 44).

Howard and Jenson (1999) discussed this issue with regard to social work. They indicated that guidelines have been greeted skeptically by most social work practitioners. They refer to Meyer’s (1996) criticism of the guideline movement: “Practice by prescription is not practice based on the assessment of client need” (p. 104). It is imperative, therefore, to emphasize that guidelines do allow for justifiable deviations from accepted practice.

*Questions for Reflection.* In therapeutic recreation, practitioners often pride themselves on treating each client as a unique individual who brings both abilities and limitations to every situation. If the profession pursues the guideline movement, how can it balance the desire for individualized services for clients with a standardized guideline for practice? Moreover, how does the profession prevent guidelines from becoming the panacea and resulting in less necessity for clinical judgment and expertise? It seems important to recognize that clinicians already rely on implicit or internal guidelines to make their practice decisions and that these guidelines address contextual factors and person-by-situation interactions as they impact on the selection, application, and effectiveness of interventions (Howard & Jenson, 1999). It may be that the question of the relationship between individualized treatment and standardized descriptions of care is unnecessary, as skilled, creative practitioners will always rely on clinical judgment, intuition, and experience when providing services.

### **Summary**

In conclusion, clinical practice guidelines definitely have the potential to dramatically impact therapeutic recreation services. These potential impacts, while incorporating the possibility of negative outcomes, seem to be overwhelmingly positive for both clients and the profession. Regardless of the challenges faced in developing

guidelines, the field of therapeutic recreation must move forward with the other allied health professions in developing their own guidelines for service delivery. Without this development, many of the psychosocial needs of clients may go unaddressed or unsatisfactorily addressed. The major challenge lies in defining and carrying out a quality process of guideline development, implementation, and testing within this field.

### Discussion Questions

1. How important is it to develop clinical practice guidelines in the field of therapeutic recreation? Along with this, what are the benefits and limitations of guidelines? Who do they benefit? Or whom do they limit? What are the reasons for the lack of existing therapeutic recreation guidelines?
2. What are the pros and cons of the development of clinical practice guidelines by individuals, professional organizations, private entities, accrediting agencies, insurance companies, and/or governmental agencies?
3. What information is required in a clinical practice guideline? What level of detail is necessary? What are the implications of too much detail or too little detail? To what extent can the therapeutic recreation profession justify relying on clinical judgment in practice? What is the starting point in the guideline development process?
4. What should be the basis of clinical practice guidelines in therapeutic recreation? Can they be based solely on research? Where will the profession of therapeutic recreation find the research to support this kind of initiative? In what ways can material from other professions or other disciplines be used in therapeutic recreation clinical practice guidelines? What are the implications of using theory-based guidelines versus research-based guidelines? What are the legal implications of developing and using guidelines based on expertise or "best practice?"
5. How can the profession encourage practitioners to use clinical practice guidelines? How can the use or non-use of guidelines be monitored? How can incentives be provided to facilitate practitioner-use of guidelines? Or should there be incentives at all? How should the profession respond to the non-use of practice guidelines once they are developed?
6. How can the profession ensure that the people who are using the guidelines are skilled in the content included in the guidelines? Who assumes responsibility for continuing education efforts related to the guidelines? How can professional preparation programs be encouraged to address the content areas within practice guidelines?
7. How do practitioners handle situations where TR guidelines conflict with the guidelines of other professionals? How do guidelines relate to the scope of practice? What are the implications of differing definitions of scope of practice within therapeutic recreation on guideline use?
8. What role will you, the reader, play in clinical guideline development and implementation within the field of therapeutic recreation?

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