Clinical Practice Guidelines in Clinical Psychology and Psychotherapy

Glenys Parry,* John Cape2 and Steve Pilling2,3
1 University of Sheffield School of Health and Related Research, Sheffield, UK
2 Camden and Islington Mental Health and Social Care Trust, St Pancras Hospital, London, UK
3 British Psychological Society Centre for Outcomes Research and Effectiveness, Department of Clinical Health Psychology, University College London, London, UK

Evidence-based clinical practice guidelines have proliferated over the past two decades. Few are limited to psychological therapies or are targeted at clinical psychologists and psychotherapists – the UK guideline Treatment Choice in Psychotherapy and Counselling is a major exception. However, psychological therapies will increasingly be considered alongside medical treatments in diagnosis-specific guidelines. There has been interest and debate about the place of guidelines in the psychological therapies, with views ranging from scepticism to enthusiasm. This paper defines clinical practice guidelines, describes major guideline programmes internationally, examines guidelines of specific interest to psychologists and psychotherapists, explores issues in their implementation, reviews evidence for their effectiveness in changing practice and improving therapy outcomes and draws out implications for practice. Guidelines are only one aspect of informing psychologists and psychotherapists about best practice. They need to be supplemented by other clinical support methods and with methods of monitoring what is actually done in practice. Copyright © 2003 John Wiley & Sons, Ltd.

INTRODUCTION

Health care professionals are living in the age of evidence-based guidance. There has been a remarkable proliferation of clinical practice guidelines over the last two decades. Citrome (1998) reported over 1800 catalogued guidelines and Cluzeau, Littlejohns, Grimshaw and Feder (1997) identified 472 guidelines in just five clinical areas – coronary heart disease, asthma, breast cancer, lung cancer and depression.

Psychologists and psychotherapists have often used the term ‘guidelines’ when describing recommendations based on clinical experience or unsystematic reviews. Examples include Horvath (1993) on enhancing motivation in therapy of addictive behaviour; King, Heyne, Gullone and Molloy (2001) on using emotive imagery in treatment of childhood phobias; Kovitz (1998) advising novices on conducting psychodynamic therapy; Kramer (1986) on terminating open-ended psychodynamic therapy; Leibenluft and Goldberg (1987) on short term inpatient psychotherapy; Lipsius (1991) on combining individual and group psychotherapy; and Poey (1985) on conducting brief psychodynamic group therapy.

This type of clinically-based guideline gives procedural advice for psychological therapies rather...
than disorder-specific recommendations. Whilst they tend to address important clinical dilemmas and have value in clinical training and practice, they rarely meet criteria for systematically developed clinical practice guidelines based on research evidence.

Guidelines also exist, targeted at psychologists and psychotherapists, which claim to be based on evidence, but which have not been systematically developed. Many of these can be found on Internet websites, and should be used with caution.

In contrast, very few systematically developed research-based guidelines have been targeted at clinical psychologists and psychotherapists or deal with psychological treatments. A major exception to this is the UK guideline on treatment choice in psychological therapies and counselling (Department of Health, 2001a). However, medically oriented guidelines increasingly include psychological treatments. Examples include eating disorders (American Psychiatric Association Work Group on Eating Disorders, 2000), schizophrenia (American Psychiatric Association, 1997) and bipolar disorder (Kahn, Carpenter, Docherty, & Frances, 1996).

Despite the lack of research-based psychological therapy guidelines, there has been extensive interest and concern among psychologists and psychotherapists both about the guidance provided to others about psychological therapies and about the potential applicability of such guidance to the practice of psychological therapists themselves.

Psychologists have criticized psychiatric guidelines for understating the case for empirically supported psychological therapy (Craske & Zucker, 2001; Hollon and Shelton, 2001), overstating the case for medication (Persons, Thase, & Crits-Christoph, 1996) and neglecting the importance of patient preference in choosing one type of treatment over another (Munoz, Hollon, McGrath, Rehm, & VandenBos, 1994).

Guidelines attract a wide range of responses from psychological therapists, from outright scepticism to enthusiasm – even seeing them as a way of defending and preserving psychotherapeutic interventions in public health care systems (Shaner, 2002).

This paper defines clinical guidelines, describes their development and evaluation, gives an overview of major guideline programmes, examines guidelines of specific interest to psychologists and psychotherapists and explores issues in their implementation. Finally, we review evidence for the effectiveness of guidelines and draw out practice implications.

DEFINITIONS, DEVELOPMENT AND TYPES OF GUIDELINES

Clinical practice guidelines (Department of Health, 1996a; Woolf, Grol, Hutchinson, Eccles, & Grimshaw, 1999) are classically defined as ‘systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances’ (Field & Lohr, 1990, p. 38). These guidelines set out the specific clinical processes that are expected to lead to optimal outcomes for the specific circumstances and patients under consideration. Most common in both physical and mental health settings have been disease- or condition-based guidelines (e.g. the assessment and management of depression in primary care; Agency for Health Care Policy Research, 1993) and problem-based guidelines (e.g. the management of violence in clinical settings; Royal College of Psychiatrists, 1998). In contrast, intervention guidelines (e.g. smoking cessation guidelines; Wetter et al., 1998; treatment choice in the psychological therapies; Department of Health, 2001a) have been less common.

Clinical practice guidelines differ from standard literature reviews, chapters and textbooks in the manner of their construction. Their development is systematic and explicit, usually involving a representative guideline development group and a systematic approach to identifying, evaluating and incorporating evidence in the guideline. Both evidence from research, taken from existing or specially commissioned systematic reviews and evidence of clinical opinion obtained from structured consensus methods are used in developing the guideline recommendations, with guidelines varying in how research and clinical opinion are weighted and combined. A key factor of clinical guidelines is that the evidence base (research and structured clinical opinion) for each recommendation is clearly indicated, so users of the guideline can evaluate this.

In length, guidelines may vary from a single page to a short book and often brief and longer versions are produced. In addition, versions for patients are increasingly common. For example, the UK Department of Health Treatment Choice in Psychological Therapies and Counselling clinical guideline has a main 62-page version and an accessible practitioner 8-page version (Department of Health, 2001a). In addition a related advice booklet for patients incorporated material from the evidence-based guideline (Department of Health, 2002).
Clinical guidelines may be developed by local groups of clinicians, national bodies or agencies (both professional and governmental) and sponsored by these groups or by commercial organizations (especially pharmaceutical companies). In the past, most guidelines have been developed locally. For example, in the UK in 1997, Cluzeau et al. found that only 21 of 472 guidelines in five clinical areas of national priority were national. They argued for national guideline coordination. The same group advised local clinicians not to develop guidelines but to concentrate on effective dissemination and implementation strategies (Littlejohns et al., 1999). In the UK, such arguments have led to the development of a national body, the National Institute of Clinical Excellence (NICE) with systematic and formal processes for health technology assessments, cost-effectiveness review and guideline commissioning.

The main target audience for national guideline programmes has been generalists – general medical practitioners, family practice and internists. The role of these practitioners requires them to make clinical decisions over widely differing domains and they accordingly have the greatest need for easily accessible sources of guidance. Also, their numbers are such that modest improvements in practice have potential to translate into significant population benefit. The clinical decisions they have to make are, however, often different from those of specialists. In this respect clinical guidance that is useful for generalists (e.g. on whether a patient might be suitable for referral for psychological therapy) is often less useful to specialists, who may need guidance on how most effectively to provide the psychological therapy. Unfortunately the evidence base for intervention guidelines is invariably less secure.

**MAJOR GUIDELINE PROGRAMMES**

The 1990s saw a significant increase in the number of guidelines generally, with an increasing number focusing also on psychological treatment. In many cases these were led by professional organizations, for example, the American Psychiatric Association which in the 1990s produced guidelines on a range of disorders including depression (a common starting point for many psychological treatment guideline programmes) and specialty groups, for example the International Traumatic Stress Society (Foa, Keane, & Friedman, 2000). In contrast, the American Psychological Association eschewed the development of clinical guidelines preferring to produce criteria on their evaluation and appropriate use (APA, 2002).

The development of psychological treatment guidelines has tended follow a pattern for guidelines more generally. That is, they were often originally the product of specialist societies or special interest groups. However, increasing concern has been expressed about the quality, reliability and independence of such guidelines (Audet, Greenfield, & Field, 1990; Grilli, Magrini, Penna, Mura, & Liberati, 2000). Grilli et al. undertook a systematic review of ‘specialty guidelines’ which focused on three areas; those of professional and stakeholder involvement; identification of primary evidence; and appropriate grading of recommendations. Of 431 guidelines only 5% were rated adequate in these three areas. They argued for a more multi-disciplinary approach with explicit and transparent methods and programmes based on international standards of good practice, such as are set out by Lohr (1998).

The focus on methodological development is exemplified in the development of the Appraisal Guideline Research and Evaluation Collaboration (AGREE) an international research collaboration aimed at the harmonization of guideline development methods (www.agreecollaboration.org). AGREE’s membership comprises many of the prominent national guideline development groups and methodologists. In a recent systematic review from the AGREE group, Burgers, Grol, Klazingha, Maleka and Zaat (2003) provided evidence for increasing commonality of guideline development method and appraisal. Examples of the common approach to methods can be seen in the publications of the Scottish Intercollegiate Guidelines Network (SIGN 2000) of a guideline developer’s handbook (SIGN, Publication No. 50, www.sign.ac.uk), the guidance from the National Health and Medical Research Council (NHMRC, 1999) of Australia and the recent guidance from NICE (NICE, 2001).

Burgers et al. (2003) also described some differences in the programmes, where, perhaps not surprisingly, the approach taken to dissemination and implementation reflected the different structures of the health care systems in which they were developed. Many European countries and other countries such as Australia have favoured the development of nationally coordinated or supported programmes of guideline development (see Burgers et al. (2003) for a list of many of these programmes). However, in the United States the posi-
tion is more complex and reflects the demands of the health care system, including the role of third party insurers in developing their own treatment guidelines alongside professional organizations, specialty groups and government organizations. This has led to very considerable duplication of guidelines often covering the same area. For example, a search on the National Guidelines Clearing House Website (see below) identifies 170 guidelines concerned with some aspect of the treatment and management of depression. Following the problems faced by the Agency for Health Care Policy Research in the United States, the solution adopted by its successor organization, the Agency for Health Research and Quality, has been to stop development of clinical practice guidelines at a national governmental level. Instead they have established (in conjunction with the American Medical Association and American Association of Health Plans) the National Guideline Clearing-house which provides a comprehensive database of evidence-based clinical practice guidelines and related documents. This provides health care professionals and others with an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation and use. (www.guideline.gov). The Agency has also drawn attention to the problem of guidelines becoming out of date and hence invalid, when the evidence on which they were based is superseded. Ortiz, Eccles, Grimshaw and Woolf (2002) studied 17 AHRQ guidelines and found only three were sufficiently valid to be retained. Their guideline on Depression in Primary Care was one of the seven that were found so obsolete as to warrant withdrawal.

Where nationally co-ordinated programmes exist for guideline development they tend to fall into two broad groupings. The first group, as exemplified by NICE in England or the NHMRC in Australia are governmental organizations with strong professional support or underpinning. For example, in the case of NICE, six professionally-led collaborating centres have been established. Each focuses on a specialty area but is funded nationally and using a common nationally agreed method (NICE, 2001). The National Collaborating Centre for Mental Health is the unit primarily charged with development of mental health guidelines for England and is jointly led by the clinical effectiveness units of the Royal College of Psychiatrists and the British Psychological Society. The NICE programme has a strong emphasis on multi-professional approach, extensive patient involvement and an explicit requirement to examine cost effectiveness. This focus on cost effectiveness is often a characteristic of nationally funded programmes and is also an explicit requirement of, for example, the government-funded programmes of France (Agence Nationale d’Accréditation et d’Evaluation en Sante) and Sweden (Swedish Council on Technology Assessment in Health Care). Government-sponsored bodies explicitly set up for the purpose of guideline development often have strong links with professional organizations. For example, SIGN is a government supported inter-professional alliance and NICE develops its guidelines through links with the professional bodies.

The second broad group of nationally co-ordinated guideline programmes is those located within professional organizations, for example, the Association of the Scientific Medical Societies in Germany. These tend to place less emphasis on cost effectiveness but it would be wrong to see this as a simple and categorical distinction. For example, the Finnish Medical Society Duodecim, a professional organization, lists cost effectiveness as a key reason for guideline development.

Whatever the particular location of the guideline development programme many programmes seek to develop strong links with professional organizations in order to facilitate implementation. In some cases this approach is well developed; for example, the general practice mental health guideline implementation programme developed in Australia (Penrose-Wall & Harris, 2000). In time the development of patient-specific guidance drawn from the original clinical practice guideline, may also become an important driver in support of implementation.

In addition to methodological developments, there has been an increasing tendency to focus on multi-modal approaches to treatment within a single guideline. Such guidelines are usually problem or disorder focused and the psychological treatment is embedded in a broad-based approach to assessment, treatment and management. This is the approach taken by national guideline development programmes and is likely to be increasingly the case. It contrasts social, organizational, psychological and pharmacological approaches to treatment and management more sharply than previous approaches. It also goes beyond the relative effectiveness (both clinical and cost) of different interventions to highlight patient preference, the value placed on different outcomes, the availability of appropriate levels of evidence and the
capacity of services to deliver the range of interventions recommended. This approach requires guideline developers to consider carefully combined or stepped approaches to care, which demand complex judgements to be made about the relative benefits to be obtained from individual treatments.

A major advantage of such an approach is that it enables clinical guidelines to relate more closely to the experience of patients as they enter and move through a health care system. The guideline aims to provide a common reference point to guide treatment choice on the basis of the best available evidence. It may also help to support implementation at a local level, providing recommendations about the relative benefits of treatment that would otherwise be difficult to collate locally.

However, the multi-modal approach also brings a number of problems. It is particularly important to ensure wide ownership from a range of professional and stakeholder groups and that the most robust and transparent of methods of evidence identification and synthesis are used. Where this is not the case problems can arise; this can be seen for example, in the response of psychologists (see for example, Hollon & Shelton, 2001) to the American Psychiatric Association guideline on the treatment of depression (APA, 2000a,b). This was developed by a uni-professional group with an emphasis on consensus methods and a number of psychologists questioned the process and conclusions, suggesting that psychological treatments were rated less effective as they might have been. The focus on specific disorders or diagnoses can also be problematic as many people do not present with problems that easily fit the guideline. This problem is found with both multi-modal and single treatment approaches.

In most national guideline development programmes depression, anxiety and schizophrenia feature in the list of guidelines undertaken with depression the most common. (For example, depression scored 170 ‘hits’ on the National Guideline Clearinghouse website, compared to 138 for anxiety and only 14 for schizophrenia.) However, many of the guidelines were concerned with the treatment and management of anxiety or depression in the context of another disorder, for example cardiac rehabilitation or chronic pain.

Given the different methods adopted in the development of these guidelines it is difficult to predict the impact of multi-modal guidelines on the types of recommendations that emerge on psychological treatment. A possible indication of the future direction may be obtained from a comparison of American Psychiatric Association guideline on schizophrenia produced in 1997 (APA, 1997) and that produced by NICE in 2003 (Kendall et al., 2003). In part the difference between them reflects differences in methodological approaches and the dates of their publication (and as a consequence the available evidence). This is perhaps best indicated by the differing recommendations for the use of CBT in schizophrenia. Whereas the APA guideline did not recommend the routine use of CBT for schizophrenia the NICE guideline does, probably reflecting the increasing evidence available since the literature review was conducted for the APA guideline (completed in 1993). However, on social skills training the reverse is true with the APA guideline recommending the use of social skills training, an approach which is not supported by the NICE guideline. In contrast to the position with CBT, this however does not reflect a changing evidence base but rather a different interpretation of the available evidence. Provisional evidence suggests that psychological interventions will continue to have a significant role in multi-modal treatment for mental health disorders and perhaps an increasingly important role in multi-modal guidelines for physical health disorders. Again this will have major implications for the demand for effective psychological interventions.

GUIDELINES FOR PSYCHOLOGISTS AND PSYCHOTHERAPISTS

The precursor to UK guidelines for psychologists and psychotherapists was a strategic review of policy on psychotherapy services published by the Department of Health in 1996b. This review and Roth, Fonagy and Parry (1996) proposed the same model of evidence-based psychotherapy, which emphasizes collaboration between researchers, clinicians and those commissioning services. This approach can be briefly summarized as follows.

- Psychological therapists develop new approaches, building on existing theory, knowledge and practice.
- Promising new therapies are formally researched to establish efficacy, but also field-tested in large samples in natural service systems.
- Both research evidence and clinical consensus inform clinical practice guidelines, in order to clarify where general statements can (or cannot) be made about best practice.
• Standards derived from research-based guidelines are set and clinical audit is used to check they are achieved.
• Skills deficits revealed by audit are addressed by training.
• Outcome benchmarking has a role to play in improving patient care.

In addition to proposing this model, the Department of Health review recommended that those responsible for commissioning psychological therapies should not fund services or procedures where there is clear empirical evidence that they are ineffective. It suggested that a commissioning strategy should drive forward the agenda of evidence-based practice by moving investment towards those psychology, counselling and psychotherapy services which meet five standards:

1. They have adopted clinical guidelines for standard practice.
2. The guidelines are informed by the findings of research and service evaluation.
3. They specify the patient groups for which the service is appropriate.
4. They monitor outcomes for innovative treatments.
5. They audit key elements of standard practice.

More recently, the Eastern development centre of the National Institute for Mental Health in England (NIMHE) has published a set of standards for good practice in delivery of psychological therapies (2002). These are based on 10 principles derived from an informally developed consensus, rather than a research base or a formal consensus-generating methodology. One of these principles emphasizes the use of evidence-based approaches to provision of psychological therapies and recommends that therapies lacking an evidence base should only be provided in the context of a formal research study.

Developments in the United States place a greater emphasis on ‘empirically supported treatments’, where criteria are set for which forms of psychotherapy have good evidence of efficacy (Chambless, 1993). This initiative was contentious (Elliott, 1998). Although it was supported by many researchers (Barlow, 1996; Crits-Christoph, 1996), others were highly critical (Garfield, 1996; Henry, 1998; Shapiro, 1996a) on both scientific and pragmatic grounds.

It is important to note that the Department of Health in England (1996b) explicitly eschewed a model of evidence-based psychotherapy that simply lists ‘validated’ treatments. This was partly on the grounds that it is a misleading use of research evidence. This approach fails to take account of strong evidence that although therapy types and specific techniques have an influence on outcome, they do not account for much of the variance in outcome, and that all successful psychotherapies share many common factors (Norcross, 2002). However, for some, evidence-based psychotherapy implies that each separate psychotherapy type, with its theoretical base and set of specific techniques, is treated as if it were a drug. Like a pharmacological substance, each therapy would be tested against placebo or the standard treatment in a randomized clinical trial, in order to have its safety and efficacy established. The temptation to move in this direction remains strong, despite strong empirical evidence for common factors across psychotherapies and the comprehensive attack on the drug metaphor in psychotherapy research mounted by Stiles and Shapiro (1994).

The British guideline Treatment choice in psychological therapies and counselling (Department of Health, 2001a) was commissioned because of concerns that in routine general practice, referral decisions were not commonly made on the basis of research evidence or even expert clinical opinion. Hence the type of psychological therapy received may be inappropriate, leading to less effective care and wasted resources, in a situation where demand exceeds supply and waiting lists are long.

The scope of the guideline was extremely broad, including evidence on any psychological therapy including counselling, for a range of common mental health problems and four common physical problems with psychological components. This includes depression, anxiety, social anxiety and phobias, post traumatic disorders, eating disorders, obsessive-compulsive disorders, personality disorders, chronic pain, chronic fatigue, gastrointestinal disorders and gynaecological problems. It excluded a number of other disorders for which psychological therapies may be helpful – mental health problems in childhood and adolescence, psychoses including schizophrenia, mania and bipolar disorder, alcohol and other drug addictions, sexual dysfunction and paraphilias and organic brain syndromes.

The guideline recommendations were developed over a 2-year period by a multidisciplinary group under the auspices of the British Psychological Society. They were based on three sources of evidence: a systematic review of existing reviews and
meta-analyses, supplementary review of research evidence appearing more recently than those reviews and structured expert consensus. The guideline incorporated service user feedback, was subject to independent peer review and was formally appraised against criteria for guideline quality. About half the recommendations are general considerations, for example, on recommended length of therapy, the impact of patient and therapist characteristics and the importance of the therapeutic alliance irrespective of therapy type. The other recommendations are for first-line therapies for specific conditions, and some contraindications. Although closer to the concept of ‘empirically supported treatments’ than the 1996b Department of Health policy statement, the guideline explicitly warns against assuming that absence of evidence implies evidence of ineffectiveness, particularly in a field where very few studies demonstrate relative rather than absolute efficacy.

ISSUES FOR GUIDELINES IN PSYCHOLOGY AND PSYCHOTHERAPY

Research Base

Evidence-based clinical practice guidelines depend on there being a body of research that can be used to assist clinical decisions. The psychological therapies, for a type of intervention that does not benefit from development and evaluation funding from industry (pharmaceutical companies) or usually from dedicated research charities, is blessed with an extensive research literature. However, there are significant gaps in the research evidence and some have questioned whether results from randomized trails can be used to assist practice decisions (Aveline, 1997).

Most research has been conducted on short-term and structured forms of psychotherapy (Roth & Fonagy, 1996), with gaps in the research evidence for many types of therapy, especially longer ones. The most significant gap is in eclectic and integrative therapies, where the therapist uses a range of techniques and procedures in response to individual patient need. Such approaches are not often researched because of the difficulty of specifying and standardizing the intervention, yet may be the most common forms of therapy practised (Milan, Montgomery, & Rogers, 1994; Zook & Walton, 1989).

Research on the effectiveness of psychotherapy has most commonly been carried out on relatively tightly defined populations in order to maximize internal validity (Shapiro, 1996b). This leaves the guideline developer and user of a guideline uncertain as to the extent to which the research is generalizable to patients who might have been excluded from a typical efficacy trial because of multiple co-morbidities (Aveline, Shapiro, Parry, & Freeman, 1995). A fuller picture emerges when results of efficacy trials are supplemented by effectiveness studies using representative clinical populations (e.g. Guthrie et al., 1999; Shadish, Malt, Navarro, & Phillips, 2000) and practice-based evidence gathered through Practice Research Networks (Audin et al., 2001).

Condition-based Versus Intervention Guidelines

Most clinical practice guidelines in medicine are disease- or condition-based guidelines of the form ‘What are the most effective treatments/interventions for condition X?’ The American Psychological Association Empirically Supported Treatment guidelines (Chambless, 1993) are of this form (the most appropriate treatment for specified DSM IV defined conditions) as are approximately half of the recommendations in the UK Treatment Choice in Psychological Therapies and Counselling Guideline (Department of Health, 2001a).

Condition-based guidelines are appropriate to the practice of medicine where practice decisions are primarily about choice of intervention (e.g. type of drug to prescribe and/or type of therapy to refer to) and the practitioner does not have responsibility for quality control of the intervention itself. It is the pharmaceutical company that is responsible for the quality of the drug prescribed and the therapist referred to (whether physical therapist or psychotherapist) who is responsible for the therapy provided. The physician’s decision is limited to choice of the most appropriate intervention.

Psychological therapists, in common with physical therapists and surgeons, as well as deciding on type of intervention (type of operation or therapy), are responsible for the quality of the intervention delivered. Effectiveness to the patient depends as much or more, on the skilful undertaking of the intervention by the practitioner over time as in choice of the most appropriate intervention/procedure. In the UK, the public enquiry into the Bristol paediatric cardiac surgery deaths that led to major changes in health quality regulation (Department of Health, 2001b) were not the result of sur-
geons choosing the wrong operation, but from inadequate technique. In another example from surgery, the development of keyhole surgery and evidence for its effectiveness led to an increase in surgical complications as a result of surgeons starting to practise the new techniques without having acquired sufficient skill (Rogers, Elstein, & Bordage, 2001).

Intervention guidelines define the steps required in the skilful practice of an intervention over time. Treatment manuals used in successful trials of psychological therapies, although drawn up for a different purpose, are a form of clinical practice guidelines for carrying out that intervention. Such manuals are now available for a wide variety of psychotherapies (Addis, 1997; Najavits, Weiss, Shaw, & Dierberger, 2000; Wilson, 1998) and teaching programmes based on these manuals are increasingly delivered (Calhoun, Moras, Pilkonis, & Rehm, 1998).

Formal measures of therapist competence (Chevron & Rounsaville, 1983) are another potential source of intervention guidance. Methods include the assessment of case formulations or psychodynamic interpretations (Crits-Christoph, Cooper, & Luborsky, 1988; Silberschatz, Fretter, & Curtis, 1986) and of whole sessions using formal rating scales (Barber & Crits-Christoph, 1996; Bennett & Parry, 2003; Vallis, Shaw, & Dobson, 1986; J.E. Young & A.T. Beck, unpublished data). The use of these rating scales in practice is not dissimilar to process guidance; therapeutic skills and tasks are derived from professional consensus (in some cases, using structured methods) and specified with clarity and precision in a way that can be rated reliably. Where these measures have been found to predict clinical outcome (Crits-Christoph et al., 1988; Shaw et al., 1999) there is an evidence base for their use. Evidence related to measures of the therapeutic alliance (Martin, Garske, & Davis, 2000; Safran & Muran, 1996) can be similarly incorporated.

Systematic appraisal of these sorts of evidence in the future will allow therapy process intervention guidelines to be developed that go beyond shared clinical wisdom. The source and quality of evidence (whether research or consensual) for each recommendation in an intervention guideline needs to be explicit as in other guidelines.

Patient Views

The scope and content of clinical practice guidelines has generally been determined by health professionals. However, the issues that concern patients and are important for patients to be reflected in guidelines, may well be different from those of professionals (Bussing & Gary, 2001; Teno, Casey, Welch, & Edgman Levitan, 2001). Patients, for example, have very different views from medical professionals on the relative merits of antidepressant medication and counselling and psychological therapies (Priest, Vize, Roberts, Roberts, & Tylee, 1996). This has been suggested as one reason why treatment of depression by general medical practitioners is often at variance to guideline recommendations (Kendrick, 2000), while giving patients information and choice about treatment may improve guideline adherence (Dwight-Johnson, Unutzer, Sherbourne, Tang, & Wells, 2001).

Involvement of patients and users in guideline development groups is now much more extensive (NICE, 2001) and where the influence of patient groups is considerable they are likely to alter the scope and emphasis of the guideline. Where patients and user representatives were the majority in a guideline development group, for the patient information booklet based on the UK Department of Health Treatment Choice in Psychological Therapies Guidelines (Department of Health, 2002), they wished to focus on a range of areas not reflected in the practitioner guideline (Department of Health, 2001a). For example, they placed much more emphasis on minimizing harm from therapist incompetence or abuse.

Misuse of Guidelines

Guidelines may be misused by practitioners, by managers and funders of services, and by patients. Each may insist on following a guideline recommendation when an alternative course of action would be more clinically appropriate. Guidelines are designed to assist practitioners and patients in making complex clinical judgements and not to replace the judgement process (Baker, 2001; Haynes, Devereaux, & Guyatt, 2002). Clinicians retain both clinical freedom to do something different and responsibility for their judgements. This point is strongly made by advocates of evidence-based medicine (Sackett, Rosenberg, Gray, & Haynes, 1996). Practitioners and patients need to decide if the circumstances of the patient and point of therapy are such that the guideline recommendations are appropriate. Slavish adherence to guideline recommendations (i.e. 100% adherence) is as likely to reflect poor clinical practice as
clinical decisions never being in accordance with guidelines.

Only including evidence of costs and effectiveness in guideline development may make their application more problematic. Berg, Meulen and van den Burg (2001), based on a study for the Royal Dutch Medical Association, argue that explicit attention should also be given to ethical and political considerations. They used an exploratory qualitative method to explicate clinicians’ normative considerations. Similarly, Boyce, Harris and Penrose (2002), describing the RANZCP programme of guidelines development, assert that guidelines must reflect a fit between clinician aspirations, the evidence, and consumer expectations if they are to be adopted into routine service delivery.

EVIDENCE FOR EFFECTIVENESS OF GUIDELINES

There is evidence now from a number of systematic reviews that clinical practice guidelines can both influence practice and result in better health outcomes for patients (Bauer, 2002; Effective Health Care, 1994; Grimshaw & Russell, 1993). The review of Bauer (2002) is specifically on guidelines in mental health.

Studies of the effectiveness of guidelines in mental health have most commonly been on depression in primary care, in particular on the AHCPR (1993) depression guideline. There is an issue of how applicable to a primary care setting are guidelines developed from research in secondary or tertiary care. This has been highlighted by Schulberg et al. (1995) who found in a study of guideline implementation that although the application of the guideline was feasible, it was complex, with only 33% of primary care depressed patients assigned to receive antidepressant medication completing the full regimen recommended by the AHCPR guidelines.

Although this and similar depression guidelines (American Psychiatric Association, 2000 a,b) include reference to psychological therapies, the aspects of guideline adherence usually examined in studies of guideline effectiveness are recognition of depression and medication management. As there is evidence that adherence to guideline recommendations is generally lower for recommendations that are more complex (Grilli & Lomas, 1994), it is likely that it will be easier to show impact of guidelines on medication management and recognition of depression than on more complex areas of psychological intervention. The very few study reports which have included an attempt to assess uptake of primary care depression guideline recommendations on psychological therapies (Baker, Reddish, Robertson, Hearnshaw, & Jones, 2001; Brown et al., 2000; Wells et al., 2000) only mention this in passing, with too few details to allow adequate evaluation. We have been unable to find any studies that have evaluated the impact of clinical practice guidelines on the practice of psychological therapists.

Passive dissemination of guidelines alone (e.g. by post) has little or no effect (Freemantle et al., 2000; Lomas, 1991). Even well-resourced, national guidelines, published in multiple media, can fail to reach, let alone impact, their target audience (Feldman et al., 1998; Rix et al., 1999). In the field of mental health, Bauer’s (2002) review of 41 quantitative studies of adherence to guidelines suggested that guideline adherence is not high without specific intervention, and that those interventions that improve adherence are typically multifaceted and resource-intensive ones. He found mixed results of the impacts of adherence on clinical outcomes and noted that adherence tends to return to pre-intervention levels over time.

The disappointing results of passive implementation of depression guidelines has led to calls for a range of approaches including provider education, dedicated resources, structured care programmes and systematic follow-up of patients’ treatment adherence and clinical outcomes (Simon, 2002). In the broader guidelines field, a substantial literature has developed on strategies that facilitate the uptake of guidelines by clinicians (Effective Health Care, 1994, 1999; Grimshaw & Russell, 1994; Moulding, Silagy, & Weller, 1999; Wensing, van der Weijden, & Grol, 1998). Two of the more effective strategies identified from these reviews are educational outreach with individual practitioners (termed ‘academic detailing’ in the US literature; Soumerai, 1998; Thomson O’Brien et al., 2002) and patient-specific reminders to use the guideline (e.g. computer prompt or note on the patient’s file; Cannon & Allen, 2000).

In mental health more specifically, Rollman, Gilbert, Lowe, Kapoor and Schulberg (1999) describe an example of an electronic medical record (EMR) to disseminate the AHCPR depression guideline to primary care doctors. Educational outreach in particular has been used in a number of studies showing impact on GP antidepressant prescribing (Brown et al., 2000; Freemantle et al.,
likely anyway to achieve better outcomes (Bauer, 1997). Where studies do find an association with adherence or through enhanced therapeutic input (Katon et al., 1995, 1996, 2001; Katzelnick et al., 2000; Wells et al., 2000). However, since these multifaceted approaches also involve organizational changes to practice and additional resources (e.g. patient self-help materials, nurse case managers, psychiatric consultation and brief psychological therapy), it is unclear whether the improved clinical outcomes were mediated through guideline adherence or through enhanced therapeutic input of other kinds.

Results from naturalistic studies on the relationship between receiving guideline-adherent mental health treatment and clinical outcomes are mixed. Some studies showed improved outcomes for patients receiving guideline-adherent treatment (Fortney, Rost, Zhang, & Pyne, 2001; Melfi et al., 1998; Revicki, Simon, Chan, Katon, & Heiligenstein, 1998; Rost, Williams, Wherry, & Smith, 1995), others show no difference in outcomes (Druss & Rosenhack, 1997; Rost et al., 1998; Schulberg et al., 1997). Where studies do find an association with outcome, there are other possible explanations, such as that patients who are amenable to and capable of complying with their care may be more likely anyway to achieve better outcomes (Bauer, 2002).

It is plausible that different ways of facilitating implementation of guidelines and different combinations may be more effective depending on the particular practitioner and practice circumstances. In a study of guidelines for management of depression in general medical practice, Baker et al. (2001) found that tailoring methods to overcome obstacles to change identified for individual general practitioners was more effective in changing practice than blanket dissemination methods and was associated with reduced depression in patients treated. There are now a number of theoretical analyses, often based on psychological theories of change, as to how guideline implementation strategies might be tailored to specific practitioner and practice circumstances (Firth-Cozens, 1997; Limbert & Lamb, 2002; Marteau, Sowden, & Armstrong, 1998; Moulding et al., 1999; Robertson, Baker, & Hearnshaw, 1996).

CONCLUSIONS

It is important to recognize that clinical guidelines are only one aspect of informing psychologists and psychotherapists what might be best to do. Guidelines, even when supported by the best implementation practices, need to be supplemented by other clinical support methods and with methods of monitoring what is actually done in practice and its response on the patient (Cape & Barkham, 2002; Roth et al., 1996). For example, Whipple et al. (2003) described the use of feedback regarding client progress and clinical support tools (CSTs) in psychological therapy in routine practice, finding that patients stayed in therapy longer and had superior outcomes when these problem-solving methods were used.

Having said this, the impact on practitioners of research-based clinical guidelines is likely to increase in the future. In the UK this is well under way with the dissemination of the Treatment Choice in Psychological Therapies and Counselling guideline (Department of Health, 2001a) and the current development of a suite of NICE mental health guidelines each incorporating recommendations on psychological therapies (www.nice.org.uk).

In the UK, we see a danger that health service managers, required by policy makers to implement NICE guidelines, might take a simplistic approach to ensuring compliance. For example, the recommendation that people with positive symptoms in schizophrenia should have access to cognitive...
behaviour therapy presents a difficulty when there are insufficient practitioners with the skills required to implement the methods to the standards that were found effective in the original research. Such an apparently simple recommendation in fact has implications for many parts of the complex mental health care system. Changes are required in the practice and roles of psychologists, doctors, nurses, in how teams function, in commissioning of workforce training, in the use of resources and in the organization of care delivery. There is as yet almost no research evidence on the wider systemic impact of implementing guideline recommendations through health services management. For the average clinician in relation to a high quality, nationally adopted guideline, the emphasis is shifting from ‘should I use it?’ to ‘under what circumstances will I not use it?’ On the other hand, managers need to be aware that there is a sizeable proportion of individuals for whom they are not applicable. In this environment, educating practitioners, managers and service funders in the uses and limitations of such guidelines will be essential.

Guideline recommendations that particular psychological therapies be provided will be fruitless unless competent practitioners are available to deliver them. We see the need for the development of new kinds of intervention guidelines for psychological therapies, supplementing the condition-based guidelines currently favoured by funders of new kinds of intervention guidelines for psychological therapies. Successfully delivering them requires in part skilful undertaking of an intervention as much as, or in fact more than, the choice of the intervention.

REFERENCES


overview of systematic reviews of interventions to promote the implementation of research findings. British Medical Journal, 317, 465–468.


