Clinical Practice Guidelines in the Social Sciences: Knowledge, Attitudes, and Experiences of Policy Makers and Professionals in Quebec

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List of Abbreviations

AHCPR	Agency for Health Care Policy and Research
APA	American Psychological Association
AOTA	American Occupational Therapist Association
CAP	Canadian Association of Psychoeducators
CAOT	Canadian Association of Occupational Therapists
CCMHI	Canadian Collaborative Mental Health Initiative
CCPS	Canadian Counselling and Psychotherapy
CPA	Canadian Psychological Association
CMA	Canadian Medical Association
CPGs	Clinical practice guidelines
EBP	Evidence-based practice
EBM	Evidence-based medicine
GRADE	Grading of Recommendations, Assessment, Development, and Evaluation
GIN	Guidelines International Network
INESSS	Institut nationale d'excellence en santé et en services sociaux/National Institute of Excellence in Health and Social Services
INSP	Institut National de santé publique
IOM	Institute of Medicine
ISQ	Institut de la statistique du Québec/Quebec Institute of Statistics
MFTs	Marriage and family therapists
MHCC	Mental Health Commission of Canada
NAPAQH	National Partnership for Quality Health
NSSW	National Society of Social Workers
NZGG	New Zealand Guidelines Group

NICE	The National Institute of Clinical Excellence
OCCOQ	L'Ordre des conseillers et conseillères du Québec /The Ordre of Guidance Counsellors of Quebec
OTs	Occupational therapists
OPPQ	L'Ordre des psychoéducateurs et psychoéducatrices du Québec/The Ordre of Psychoeducators of Quebec
OPQ	L'Ordre des psychologues du Québec/ The Order of Psychologists of Quebec
OTSTCFQ	L'Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec /The Ordre of Social Workers and Marriage and Family Therapists of Quebec
SIGN	Scottish Intercollegiate Guidelines Network
WHO	World Health Organization

Abstract

Clinical practice guidelines are valuable resources that are intended to guide practitioners in making decisions regarding assessment and treatment (Beauchamp et al., 2012; Field & Lohr, 1992; Graham et al., 2011). They offer solutions to inherent issues in clinical practice and provide considerable related benefits. The manner in which guidelines are developed and the quality of the guidelines themselves determine their level of utility and practicality (Alonso-Coello et al., 2010; Brouwers et al., 2010). Guidelines should be based on empirical evidence and represent best practices (Alonso-Coello et al., 2010; Hollon et al., 2014). Although their development has skyrocketed over the years (Beauchamp et al., 2011; Colón-Emeric et al., 2007), empirical research on guideline development, methodological rigour, evaluation and approval process and quality, as well as their uptake in practice, is lagging within the social science domain (especially when compared to medicine; Parry et al., 2003; Proctor et al., 2009). Obtaining the knowledge, attitudes, and experiences of policy makers who develop and approve guidelines, as well as of the professionals who are expected to use them, would provide valuable insight into these areas. To our knowledge, there are no existing studies that have examined the social science literature on professionals' knowledge, attitudes and experiences of guidelines. Therefore, research has yet to examine these factors among Quebec professionals and in the social science domain as a whole. Building on these important gaps in the literature, the current dissertation consisted of three studies which corresponded to three main objectives: 1) to document policy makers' knowledge of guideline methods and development, in addition to their attitudes, roles, and experiences of development, evaluation, approval, and adoption of mental health and social care service guidelines produced by five regulatory bodies in Quebec and for guidelines in general; 2) to examine the available literature in the social sciences concerning professionals' reported knowledge, attitudes, and uptake of mental health and social care service guidelines via a systematic scoping review; and 3) to document the knowledge, attitudes, use, and implementation of mental health and social care services guidelines produced by five regulatory bodies in Quebec and for guidelines in general. Study 1 (Manuscript 1) surveyed 34 members of the board of directors across the five regulatory bodies in Quebec and in the social sciences. The results showed that board members have variable familiarity of key components of guideline development and are unfamiliar with guideline development methods. Their attitudes toward guideline objectives were mostly positive, their attitudes and experiences toward

guideline development, evaluation, approval, and adoption processes were largely positive, and their views of guideline costs were variable. Study 2 (Manuscript 2) examined the existing social science literature specific to professionals' knowledge, attitudes, and mental health and social care service guideline uptake and related barriers and facilitators via a systematic scoping review. Peer-reviewed and grey literature was searched and systematically assessed for 35 articles using five electronic databases. The findings indicated global interest in this area over more recent years, despite the limited available research overall and poor representation of social science professions. The results also showed varied guideline topics, with a slight preference for anxiety and mood disorders. The findings revealed mixed levels of knowledge and a slight preference for positive attitudes towards guidelines among professionals. The results also showed a lack of uptake of guidelines. Various barriers and facilitators to guideline uptake were also identified; the most prominent barrier and facilitating factors were organizational restraints and training and supervision. Study 3 (Manuscript 3) surveyed 954 professionals across the five regulatory bodies in Quebec and in the social sciences pertaining to guidelines. The results illustrated that professionals were knowledgeable of guidelines and development methods. The findings also indicated mostly positive attitudes towards guideline objectives, development, and credibility. However, negative attitudes and mixed agreement was reported for some aspects of guideline development and implementation among professionals. While most guidelines were relevant to practice, some were irrelevant, suggesting the need for improved guidelines and more conscientious use of resources. The most relevant guidelines were largely used and implemented by professionals in practice. Several barriers and facilitators to guideline uptake were also found. Taken together, findings from Studies 1, 2, and 3 (Manuscripts 1 to 3) highlight the discrepancy between professionals' attitudes and the existing literature on guideline development and quality. Findings raise key concerns which emphasize the need for significant research advancements as well as necessary modifications in guideline development and uptake to help ensure optimal practices. These studies demonstrate important implications for research, theory, policy, and clinical practice.

Résumé

Les guides de pratique clinique sont des ressources précieuses qui visent à guider les praticiens dans la prise de décisions concernant l'évaluation et le traitement (Beauchamp et al., 2012; Field et Lohr, 1992; Graham et al., 2011). Ils offrent des solutions aux problèmes inhérents à la pratique clinique et offrent des avantages connexes considérables. La manière dont les lignes directrices sont élaborées et la qualité des lignes directrices elles-mêmes déterminent leur niveau d'utilité et de praticité (Alonso-Coello et al., 2010; Brouwers et al., 2010). Les lignes directrices devraient être basées sur des preuves empiriques et représenter les meilleures pratiques (Alonso-Coello et al., 2010; Hollon et al., 2014). Bien que leur développement ait monté en flèche au fil des ans (Beauchamp et al., 2011; Colón-Emeric et al., 2007), la recherche empirique sur l'élaboration de lignes directrices, la rigueur méthodologique, le processus d'évaluation et d'approbation et la qualité, ainsi que leur adoption dans la pratique, est à la traîne dans le domaine des sciences sociales (en particulier par rapport à la médecine; Parry et al., 2003; Proctor et al., 2009). L'obtention des connaissances, des attitudes et des expériences des décideurs politiques qui élaborent et approuvent les lignes directrices, ainsi que des professionnels qui sont censés les utiliser, fournirait des informations précieuses sur ces domaines. À notre connaissance, aucune étude existante n’a examiné la littérature en sciences sociales sur les connaissances, les attitudes et les expériences des professionnels en matière de directives. Par conséquent, la recherche n'a pas encore examiné ces facteurs chez les professionnels québécois et dans le domaine des sciences sociales dans son ensemble. S'appuyant sur ces importantes lacunes dans la littérature, la thèse actuelle comporte trois études correspondant à trois objectifs principaux: 1) documenter les connaissances des décideurs politiques sur les méthodes et le développement des lignes directrices, en plus de leurs attitudes, rôles et expériences de développement, évaluation, approbation et adoption des lignes directrices des services de santé mentale et de services sociaux produites par cinq organismes de réglementation au Québec et pour les lignes directrices en général; 2) examiner la littérature disponible en sciences sociales concernant les connaissances, les attitudes et l’adoption par les professionnels des directives en matière de santé mentale et de services sociaux via une revue systématique de type « examen de la portée »; et 3) documenter les connaissances, les attitudes, l'utilisation et la mise en œuvre des lignes directrices sur les services de santé mentale et de services sociaux produites par cinq organismes de réglementation au Québec et pour les lignes

directrices en général. L'étude 1 (Manuscrit 1) porte sur les résultats d'entrevues auprès de 34 membres du conseil d'administration des cinq organismes de réglementation du Québec et des sciences sociales. Les résultats ont montré que les membres du conseil ont une connaissance variable des éléments clés de l'élaboration des lignes directrices et ne connaissent pas les méthodes d'élaboration des lignes directrices. Leurs attitudes à l'égard des objectifs des lignes directrices étaient pour la majorité positives. Leurs attitudes et leurs expériences à l'égard du processus d'élaboration, d'évaluation, d'approbation et d'adoption des lignes directrices étaient largement positives et finalement, leurs opinions sur les coûts des lignes directrices étaient variables. L'étude 2 (manuscrit 2) a examiné la littérature existante en sciences sociales spécifique aux connaissances, aux attitudes, à l'adoption des lignes directrices des services de santé mentale et de soins sociaux par les professionnels, les obstacles et facilitateurs connexes via une revue systématique des examens de la portée. La littérature grise et revue par les pairs a été recherchée et systématiquement évaluée pour 35 articles à l'aide de cinq bases de données électroniques. Les résultats ont indiqué un intérêt mondial dans ce domaine au cours des dernières années, malgré le peu de recherches disponibles dans l'ensemble et la faible représentation des professions des sciences sociales. Les résultats ont également montré des sujets d'orientation variés, avec une légère préférence pour l'anxiété et les troubles de l'humeur. Les résultats ont révélé des niveaux de connaissances mitigés et une légère préférence pour les attitudes positives à l'égard des directives parmi les professionnels. Les résultats ont également montré un manque d'adoption des directives. Divers obstacles et facilitateurs à l'adoption des lignes directrices ont également été identifiés; les obstacles et facteurs facilitateurs les plus importants étaient les contraintes organisationnelles et la formation et la supervision. L'étude 3 (Manuscrit 3) a interrogé 954 professionnels des cinq organismes de réglementation du Québec et des sciences sociales concernant les lignes directrices. Les résultats ont montré que les professionnels connaissaient les directives et les méthodes de développement. Les résultats ont également indiqué des attitudes principalement positives à l'égard des objectifs, du développement et de la crédibilité des directives. Cependant, des attitudes négatives et un accord mitigé ont été signalés pour certains aspects de l'élaboration et de la mise en œuvre des lignes directrices chez les professionnels. Bien que la plupart des directives soient pertinentes pour la pratique, certaines n'étaient pas pertinentes, suggérant la nécessité d'améliorer les directives et l'utilisation plus consciencieuse des ressources. Les directives les plus pertinentes ont été

largement utilisées et mises en œuvre par des professionnels dans la pratique. Plusieurs obstacles et facilitateurs à l'adoption des lignes directrices ont également été trouvés. Globalement, les résultats des études 1, 2 et 3 (manuscrits 1 à 3) mettent en évidence l'écart entre les attitudes des professionnels et la littérature existante sur l'élaboration et la qualité des recommandations. Les résultats soulèvent des préoccupations clés qui soulignent la nécessité de faire des progrès importants en matière de recherche ainsi que les modifications nécessaires dans l'élaboration et l'adoption des lignes directrices afin de garantir des pratiques optimales. Il se dégage de ces études des implications importantes pour la recherche, la théorie, les politiques et la pratique clinique.

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Contribution of Authors

The current doctoral dissertation contains three studies and manuscripts (Chapters 2, 3 and 4). They are comprised of original knowledge and research. I am the principal author on each of the manuscripts. As such, I contributed to the conceptualization of the study design and survey development. I also conducted the comprehensive literature review, carried out the data recruitment, data collection, analyses, interpretation, wrote the manuscripts, and integrated feedback provided by the co-authors.

Manuscripts 1 and 3 are co-authored by Lyane Trépanier, Andrea Reyes, Dr. Frédéric Nault-Brière, Dr. Christian Dagenais and Dr. Martin Drapeau. Manuscript 2 (Chapter 3) are co-authored by Daniel Parker, Emily Matejko, Vanessa Dulgar, Dr. Christian Dagenais, Dr. Frédéric Nault-Brière, and Dr. Martin Drapeau.

Lyane Trépanier and Andrea Reyes, colleagues and members of our research team are second and third author, respectively, on Manuscripts 1 and 3. They participated in the conceptualization and development of the study design, survey development, as well as provided feedback and reviewed the final manuscript. Lyane Trépanier also provided instrumental guidance throughout the dissertation process.

Dr. Christian Dagenais and Dr. Frédéric Nault-Brière, members of my thesis advising committee, provided feedback regarding conceptualizing the study design. Dr. Frédéric Nault-Brière provided feedback during the survey development and piloting stages for Manuscripts 1 and 3. Dr. Christian Dagenais also reviewed and provided feedback, editorial suggestions, and approval for the final versions of all manuscripts.

Daniel Parker and Emily Matejko, colleagues and volunteers of our research team and graduate students at McGill University, are second and third authors, respectively, for Manuscript 2. They participated in the screening and charting of the data processes and creating the results tables. Daniel Parker, also participated in the data analysis process, helped compile the results and discussion, and provided editorial suggestions. Vanessa Dulgar, a volunteer, is listed a fourth author on this manuscript. She participated in the screening process for this study.

Dr. Martin Drapeau, my doctoral research supervisor, is listed as the final author on all three manuscripts. He contributed to the conceptualization of the study designs, survey development, systematic scoping review protocol, data analysis and reviewed, and provided editorial suggestions and approval for the final manuscripts and doctoral dissertation.

Chapter 1: Introduction: Literature Review

This review highlights relevant literature and places the current studies into context. Clinical practice guidelines (CPGs) are first defined and the purpose and impact of guidelines are provided. Next, the history of CPGs and their development, as well as the state of current CPGs are presented. Research on policy makers' role and experiences in the CPGs development and approval process are then reviewed, followed by professionals' knowledge, attitudes, and use, implementation, and adherence of CPGs, in addition to related theoretical models. Literature on mental health and social care CPGs, prevalence of mental illness, and related issues, are subsequently reviewed. Lastly, the gaps in the literature in light of the current research objectives are presented.

What Are Clinical Practice Guidelines?

There are three well-known definitions of clinical CPGs in the medical and social science literature. In medicine, CPGs are defined as:

> "Systematically developed statements to assist practitioners and patient decision about appropriate health care for specific circumstances" (Field & Lohr, 1992, p. 2).

Similarly, the Institute of Medicine (IOM) describes CPGs as:

> "Statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options" (Graham et al., 2011).

The Institut National d'Excellence en Santé et en Services Sociaux (INESSS)/National Institute of Excellence in Health and Social Services more recently recommended a more suitable conceptualization of CPGs for the social science domain. According to INESSS, CPGs are defined as:

> "Recommendations developed systematically and transparently by and for the stakeholders [i.e., policy makers in charge of the development and approval of the guideline process for different organizations and regulatory bodies] concerned with a specific intervention in social care. These recommendations are founded on robust scientific data supported by exhaustive contextual data and expert knowledge, particularly that of researchers, managers, social care practitioners and social care users. They are presented in a clear and concise manner" (Beauchamp et al., 2012, p. 52).

Purpose and Impact of Guidelines

CPGs are guides and educational resources that are intended to guide practitioners to obtain and use pertinent scientific evidence to support and inform their clinical practice. As such, guidelines may foster evidence-based practices in providing client care (Bandong et al., 2018). Research suggests that clinicians struggle to keep up with the increasing and most current scientific evidence that is relevant to their practice due to a lack of time (Graham et al., 2011; Grimshaw et al., 2012; Higgins & Green, 2011; McGlynn et al., 2003; Straus & Haynes, 2009; Wolf et al., 2011). CPGs help translate scientific knowledge into practice and allow clinicians quicker access to relevant scientific evidence, which in turn helps guide decision-making (Graham et al., 2011; Straus et al., 2009; Wolf et al., 2011; Wollersheim et al., 2005). They also decrease the disparity of treatment and avoidable errors and negative outcomes and increase the consistency of service care (Kredo et al., 2016; Schuh et al., 2017; Shiroiwa et al., 2016). CPGs further ensure professionalism, optimal services and outcomes in practice, and correspondingly reduce the costs of care (Audet et al., 1990; Cabana et al., 1999; Graham et al., 2000; Hollon et al., 2014; van Dijk et al., 2013).

CPGs are supposed to synthesize empirical evidence from research into a clinical process and interventions, which is a process known as knowledge translation (Wollersheim et al., 2005). Knowledge translation is used to bridge the gap between recent scientific knowledge and clinical practice (CPA, 2012). This process consists of the synthesis, transfer, dissemination, and ethical application of scientific knowledge in order to enhance services such as treatments, as well as client care and outcomes (CPA, 2012; Government of Canada, 2016). This is important when considering there is a gap between science and practice in the social sciences (Baker et al., 2008; Wampold et al., 2011), the services offered to patients are often not based on the best empirical evidence (Lilienfeld et al., 2013; McGlynn et al., 2003; Straus et al., 2009), and clinicians have difficulty keeping up with the growing available research (Graham et al., 2011; Grimshaw et al., 2012; Higgins & Green, 2011; McGlynn et al., 2003; Straus & Haynes, 2009; Wolf et al., 2011).

Guidelines may also improve professionals' knowledge, assessment, and treatment in a timely and effective manner (Graham et al., 2011; Wollersheim et al., 2005), including by decreasing the use of non-suitable interventions and approaches, as well as facilitating more appropriate and evidence-based interventions (Brouwers et al.,2010; Fervers et al., 2011; Frethem et al., 2006b; Hollon et al., 2014; Margo, 2004). The effective implementation and

dissemination of CPGs could lead to proficient, successful, and suitable treatments and services and can inform policymaking (Farquhar et al., 2002; Hollon et al., 2014; Woolf, 1992). However, the positive impact of CPGs is dependent on their methodological rigour and quality (Brouwers et al., 2010; Burgers et al., 2003; Gordon & Cooper, 2010).

Historical Perspective of Guidelines and Their Development

The inception of CPGs emerged from the dire need to systematize and standardize the medical profession in the 1970s, with the aim of regulating clinicians' behaviours and practices and to ensure quality health care (Weisz et al., 2007; Woolf, 1992). These guidelines were mainly formed via a consensus process involving expert panels and thus focused primarily on clinical judgements. The development of these initial guidelines was not based on scientific evidence nor did it involve the use of a formal methodology, such as a systematic literature search or review (Woolf, 1992). However, the guideline development process has since utilized more arduous methods; this shift was a result of reducing the disparity in practice and the evidence-based medicine (EBM) movement, which arose in the 1980s and 1990s (Davis & Taylor-Vaisey, 1997; Guyatt, 1991; Guyatt et al., 1993). The EBM movement led to evidence-based practice (EBP; Belin et al., 2002). EBP is characterized by:

> "The conscientious, explicit and judicious use of the best available research evidence to inform each stage of clinical decision-making and service delivery" (CPA, 2012, p. 7).

This also includes using research in practice while considering clinical expertise, treatment preferences, and client and cultural factors (CPA, 2012; Dozois et al., 2014). CPGs are intended to be empirically founded, to embody evidence-based practice, and to ultimately help clinicians translate scientific evidence into practice (Babione, 2010; Kratochwill & Shernoff, 2003; Rowland & Gross, 2000).

Since the 1980s and 1990s, various entities have also been established in order to foster knowledge of guideline development, dissemination and implementation in practice (Davis & Taylor-Vaisey, 1997; Harris et al., 2000; Woolf, 1993). In 1990, the Canadian Medical Association (CMA) founded the Quality of Care Committee and fostered the development of the National Partnership for Quality Health (NAPAQH) and associated conferences pertaining to CPGs development and quality processes (CMA, 1993; Carter et al., 1995a, 1995b; Davis & Taylor-Vaisey, 1997). This was in response to initiatives focused on the quality of care in light of CPGs and their role in healthcare (CMA, 1993; Carter et al., 1995a, 1995b; Davis & Taylor-

Vaisey, 1997). In 1993, the Scottish Intercollegiate Guidelines Network (SIGN) was created in an effort to enhance the quality of care and decrease the variability in clinical practice and patient outcomes through guideline development and dissemination (SIGN, 2019b). These guidelines included clinical recommendations based on empirical evidence (SIGN, 2019b). Following the 1990s, guideline development and the formulation of recommendations for practice was founded more on empirical investigations and evidence, such as randomized trials and meta-analysis studies (Tricoci et al., 2009). Since the 1990s and over the past 30 years, the production of CPGs and focus on guideline research has drastically flourished globally (Alonso-Coelle et al., 2010; Beauchamp et al., 2011; Colón-Emeric et al., 2007; Gould & Kendal, 2007; Parry et al., 2003; White & Kratochwill, 2005). Specifically, from 2000s to the present day, various guideline development methodologies have been created (Atkins et al., 2004). However, this has led to disparities in methods and multiple issues (e.g., biases and effect problems, irrelevancy to some users and clients as well as other factors that impact making decisions; Atkins et al., 2004). Consequently, in 2003, the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach was developed by the GRADE working group in order to address the disparity between the various guideline approaches and to overcome the aforementioned issues (Atkins et al., 2004; Balshem et al., 2011). The GRADE method allows for rating the quality of evidence using specific criteria and has been implemented worldwide by various organizations and associations (Alonso-Coello et al., 2016; Atkins et al., 2004; Faraday et al., 2009; Murad et al., 2014). In 2011, similar criteria were produced by IOM, previously known as the National Academy of Medicine. Specifically, the 8 criteria for trustworthy guidelines are intended to foster the advances of guideline rigour (Graham et al., 2011; Qaseem et al., 2012). These criteria include: 1) transparency of process; 2) conflict of interest; 3) guideline development group composition; 4) systematic reviews; 5) quality and strength of evidence on the recommendations; 6) articulating the recommendations; 7) external reviewers; and 8) updating guidelines (see Graham et al., 2011 for a detailed review of the criteria). These criteria are intended to guide policy makers with regards to guideline development according to best practices (Graham et al., 2011). In medicine, the National Institute for Health and Clinical Excellence (NICE), the Guidelines International Network (GIN) and the World Health Organization (WHO) also developed similar criteria (Hill et al., 2011; Qaseem et al., 2012; WHO, 2014). In Quebec, INESSS (founded in 2011) established a taskforce that created criteria

and methods for CPGs development and distribution in the social sciences (Beauchamp et al., 2012, 2015a, 2015b). The IOM and subsequent criteria and various entities have since set the stage for CPGs development (Eccles et al., 2012; Graham et al., 2011).

Who Develops Guidelines?

Numerous institutes, organizations, associations, governmental agencies and regulatory bodies worldwide have created committees consisting of policy makers or stakeholders that are responsible for guideline development, dissemination and implementation in medicine and in the social sciences (Davis, & Taylor-Vaisey, 1997; Grilli et al., 1996; Harris, et al., 2000; Kelly, & Toepp, 1992; Woolf, 1993). In medicine, examples of these entities include: the Agency for Health Care Policy and Research (AHCPR), CMA, Educ'alcool, the GRADE working group, the Institut National de santé publique (INSP)/National Institute of Public Health, NICE, SIGN, the New Zealand Guidelines Group (NZGG) and WHO. Examples in the social sciences consist of the American Psychological Association (APA), the Canadian Psychological Association (CPA), the Canadian Association of Psychoeducators (CAP), the Canadian Counselling and Psychotherapy Society (CCPS), INESSS, the National Society of Social Workers (NSSW), the Canadian Association of Occupational Therapists (CAOT) and the American Occupational Therapist Association (AOTA).

At the provincial level in Canada and specifically in Quebec, there are various regulatory bodies that have produced CPGs for professional and para-professional social science services. These entities regulate and license professionals in Quebec. These regulatory bodies include: 1) l'ordre des psychologues du Québec (OPQ)/the Order of Psychologists of Quebec; 2) l'ordre des psychoéducateurs et psychoéducatrices du Québec (OPPQ)/the Order of Psychoeducators of Quebec; 3) l'ordre des conseillers et conseillères d'orientation du Québec (OCCOQ)/the Order of Guidance Counsellors of Quebec; 4) l'ordre des thérapeutes conjugaux et familiaux et des travailleurs sociaux du Québec (OTSTCFQ)/the Order of Social Workers and Marriage and Family therapists of Quebec; and 5) l'ordre des ergothérapeutes du Québec (OEQ)/the Order of Occupational Therapists of Quebec.

These institutes, organizations, associations, and regulatory bodies aim to guide practitioners to obtain and use scientific research via CPGs in order to guide their clinical practice. Within these entities, policy makers are responsible for the development, evaluation, approval, adoption, and dissemination of guidelines. Professional regulatory bodies are

responsible for regulating and guiding authority over professional practice, including the provision of ethical and professional rules and standards. They are also liable for the legal and moral authority over their professional members, protecting the public, and overseeing the practice of their professional members (e.g., issuing and suspending professionals' right to practice and potential initiation of legal action against a clinician for malpractice; Ciquier et al., 2020). Professional members are obliged to follow the policies and guidelines produced by their regulatory body (Ciquier et al., 2020).

In Canada, regulatory bodies are usually government run entities established within each province. They are normally referred to as "Colleges" or "Orders" in Quebec. These Orders are typically composed of the President, Vice-President, the Secretary General, the board of directors, the executive committee (i.e., directors appointed by the board of directors and a representative nominated by the Professions Office in Quebec – responsible for daily administration of affairs of the Order), and administrative staff. The *board of directors* is composed of elected or nominated members, including the President and Vice-President(s), Secretary General, professional members to represent the profession, and members from the Office of Professions in Quebec to represent the public. Members typically serve a 2 to 4-year term on the board of directors. The board is responsible for the organization, functioning, and regulation of the Order and its professional members, and for establishing policies. Their duties include deciding to develop CPGs, overseeing the CPGs development process, standardized methods and procedures, and guideline evaluation process, as well as the approval, adoption, and dissemination of CPGs. Once the board of directors has decided to produce a CPGs, they select a *guideline development committee* (also commonly known as a guideline steering group, working group, or taskforce). These members are responsible for developing the CPGs and are usually researchers and/or clinicians within a respective profession. They may also include experts in the field that are relevant to the CPGs topic being developed, in knowledge synthesis or transfer, and in guideline development methods. The guideline committee members' role involve the selection, evaluation, and appraisal of empirical evidence that is used for the formulation of clinical recommendations and the final recommendations included in the CPG (Browers et al., 2010; Freitheim et al., 2006b; Oxman et al., 2006). The guideline development process consists of methodological and interactive processes (Eccles et al., 2012; Gardner et al., 2009). A guideline development process that is evidence-based uses a rigorous and systematic approach to

identifying, selecting, interpreting, and evaluating relevant research, formulating recommendations, and focuses on associating the recommendations to the supporting empirical evidence (Eccles et al., 2012; Gardner et al., 2009; Turner et al., 2008). The quality of guideline development is dependent on the validity of the methods used, the group composition (e.g., inclusion of experts in the field and topic), and social process (e.g., equal participation in discussions; Eccles et al., 2012; Gardner et al., 2009). Once the guidelines have been developed, it is the duty of the board of directors to evaluate, approve, adopt, and disseminate the CPGs to their professional members. As such, the Order (including the guideline development committee and board of directors) should produce high quality CPGs that are built on rigorous methodologies and standards, and evidence-based practices that are trustworthy.

Guidance for Guideline Development

Several guideline development methods and handbooks have been created in an effort to assist developers throughout the guideline development process, which entails evaluation, final approval, and dissemination of CPGs. These methods represent a scientific and rigorous methodological guideline development process, which is in line with the previously reviewed IOM criteria (Eccles et al., 2012; Graham et al., 2011; Qaseem et al., 2012) and are reviewed below.

In 1996, a guideline development workbook was created by NAPAQH and the national consensus conferences (CMA, 1993; Carter et al., 1995a, 1995b; Davis & Taylor-Vaisey, 1997), which was spearheaded initially by the CMA and their Quality of Care Committee (CMA, 1993; Carter et al., 1995a, 1995b). These procedures for guideline development and dissemination included: 1) selection of the clinical problem: a) ranking the order of priority, b) defining and refining the issue and c) framing the clinical issue; 2) synthesizing the data: a) literature search and b) developing a consensus; 3) developing the guidelines: a) iterating and reiterating and b) distributing the guideline to a sample of clinicians; 4) endorsing the guidelines by the sponsoring body; 5) dissemination of the guidelines; 6) encouragement of guideline implementation; and 7) monitoring and evaluation of the guideline impact (Davis, & Taylor-Vaisey, 1997).

Several other medical organizations have created procedures, guidelines, or manuals outlining methodologies for the development of CPGs. As previously mentioned, the GRADE approach was formulated in order to assess the quality of evidence (Atkins et al., 2004). Other examples include: the *CMA handbook on Clinical Practice Guidelines developed* by CMA

(Palda et al., 2007); the *GIN-McMaster Guideline Development Checklist* (Schünemann et al., 2014); the *NZGG Handbook for the Preparation of Explicit Evidence-Based Clinical Practice Guidelines* (NZGG, 2001); *Developing NICE Guidelines: The manual* (NICE, 2018); *SIGN 50: A Guideline Developer's Handbook* (SIGN, 2019a); and the *WHO Handbook for Guidelines Development* (WHO, 2010, 2014). Other analogous empirically based methodologies have also been proposed (e.g., Browman et al., 1995, Davis & Taylor-Vaisey, 1997; Shaneyfelt et al., 1999; Shekelle et al., 1999). Among these, *AGREE* is another, widely used quality appraisal method that was developed and informs the guideline development process (AGREE Collaboration, 2003; AGREE Next Steps Consortium, 2017; Brouwers et al., 2010; Siering et al., 2012).

In the social sciences, INESSS published the *INESSS Framework for Developing Practice Guides in the Social Services Sector* report (Beauchamp et al., 2012), which outlined broad guideline development recommendations for psychosocial care. This institute also proposed further recommendations and a method for guideline development in the social sciences in the *Development of Practice Guidelines in the Social and Human Sciences* (Beauchamp et al., 2015a) and the *Framework for Developing Practice Guidelines in the Social Service Sector* reports (Beauchamp et al., 2015b). INESSS's aims are to promote excellence and develop guidelines and to provide a guide for professionals in order to aid in their decision-making and ultimately, enhance practice (INESSS, 2019). These methods are intended to foster the methodological rigour in guideline development and dissemination and to safeguard the quality of CPGs. However, the existence of these methods does not necessarily mean that they are effectively utilized to produce CPGs (Alonso-Coello et al., 2010; de Haas et al., 2007; Oxman et al., 2007; Rosenfeld et al., 2009; Turner et al., 2008).

State of Existing Guidelines

The methodological rigour of the guideline development process and related empirical evidence governs the quality of a guideline (Hollon et al., 2014). In turn, the quality of CPGs directly influences the use and implementation of best practices in clinical practice (Bennett et al., 2018; Esandi et al., 2008; Lugtenberg et al., 2011; Rao & Tandon, 2017; Woolf et al., 2004). Despite the existence of several guideline development methods, the methodological rigour and quality of CPGs have been found to vary and several studies have found them to be doubtful, problematic and were not advocated for use in practice (Al-Ansary et al., 2013; Alonso-Coello et

al., 2010; Castellani et al., 2015; Esandi et al., 2008; Farrer et al., 2019; Ruszczyński et al., 2016). Similarly, empirical evidence has also been found to be seldomly used in guideline and policy development and implementation (e.g., using systematic reviews; Dobbins et al., 2004; Elliott & Popay, 2000; Lavis et al., 2002; Oxman et al., 2007; Straus et al., 2009). Few studies have examined these aspects in the social sciences (Ciquier et al., 2020; Stamoulos et al., 2014; Trépanier et al., 2017; Trépanier, 2019), however, those findings that are available are consistent with the previous medical literature. For instance, a pilot study conducted by Stamoulos et al. (2014) investigated the quality of CPGs produced by the OPQ in terms of the development tasks used. This study found various shortcomings with the guideline development, methodology and quality of the OPQ guidelines. Specifically, only some crucial tasks were used in their development and the guideline failed to meet the acceptable standards of development (Stamoulos et al., 2014). More recent studies in the social sciences also found issues with the quality of guidelines (Ciquier et al., 2020; Trépanier et al., 2017; Trépanier, 2019). This is alarming, since poor quality CPGs may lead to various adverse outcomes in practice (e.g., erroneous recommendations and misguiding clinicians, hindering client care, poor outcomes, damaging clinicians' integrity and leading to a lack of guideline use and misused resources; Bennett et al., 2018; Rao & Tandon, 2017; Woolf et al., 2004). Conversely, effective use of evidence-based methodologies for guideline development can lead to more effective and higher quality guidelines (Alonso-Coello et al., 2010; Andrews & Redmond, 2004; Graham et al., 2011; Hollon et al., 2014; Turner et al., 2008). In turn, this fosters the likelihood that guidelines are used and adhered to in practice (Alonso-Coello et al., 2010; Blozik et al., 2012; Holmer et al., 2013; Lugtenberg et al., 2009, 2011). It is evident that the idealization of the purpose of guidelines and their related benefits are conditional on the manner in which they were established and the quality of the guidelines themselves (Alonso-Coello et al., 2010; Brouwers et al., 2010; Burgers et al., 2003; Gordon & Cooper, 2010). However, very limited research in the social sciences is available regarding the states of current CPGs; further inquiry is thus warranted.

In medicine, the quality of CPGs has been substantially examined (e.g., Alonso-Coello et al., 2010; Kung, et al., 2012; Patel et al., 2016; Ruszczyński et al., 2016). Several institutes and organizations have also developed tools in order to critically appraise the quality of guidelines. A systematic review identified 40 appraisal tools for CPGs (Siering et al., 2013). Some of these

included, but were not limited to, the following: IOM's *A Provisional Instrument for Assessing Clinical Practice Guidelines* (Field & Lohr, 1992), ADAPTE's *Guideline Adaption: A resource Toolkit* (ADAPTE, 2010), AGREE (AGREE Collaboration, 2003) and AGREE-II (Brouwers et al., 2010; Siering et al., 2013). In more recent years the AGREE-II instrument was further updated and remains to be the most inclusive, validated, and elite appraisal tool for the evaluation of guidelines (AGREE Next Steps Consortium, 2017; Alonso-Coello et al., 2010; Brouwers et al., 2010; Siering et al., 2013). This instrument consists of 23 items organized according to six guideline quality domains, which include: 1) scope and purpose; 2) stakeholder involvement; 3) rigour of development; 4) clarity of presentation; 5) applicability; and 6) editorial independence (AGREE Next Steps Consortium, 2017). It also contains two items pertaining to the overall quality assessment of CPGs based on the rating of the former items (AGREE Next Steps Consortium, 2017). While this appraisal tool has been mostly used in medicine (e.g., Alonso-Coello et al., 2010; Berrigan et al., 2011; Brouwers et al., 2010; Patel et al., 2016), a few recent studies in the social sciences involving mental health CPGs have begun critically evaluating the quality of CPGs using this instrument (Ciquier et al., 2020; Trépanier et al., 2017; Trépanier, 2019). Nonetheless, further assessment of the quality of CPGs are essential. In medicine and especially in the social sciences, further investigation of the methodological rigour, guideline development, and quality of CPGs is critical.

Policy Makers Insights into Guideline Development

Policy makers are prompted to produce CPGs that are founded on empirical evidence, are trustworthy, and can be effectively applied in practice such that there are higher rates of guideline uptake in practice (Esandi et al., 2008; Hollon et al., 2014; Lugtenberg et al., 2011). The current state of existing guidelines is problematic and has revealed the need for improvements. Given that policy makers play a fundamental role in guideline development and dissemination, obtaining information on their knowledge, attitudes, and experiences towards this guideline process and quality is critical. Regrettably, literature available in this area is virtually non-existent in medicine and in the social sciences.

In medicine, there are only a few existing relevant studies (Atkins et al., 2013; Campbell et al., 2009; Kredo et al., 2018; Kryworuchko et al., 2009). The first was a qualitative study that examined the perspectives of 39 members of three advisory groups from NICE in the United Kingdom and involved a combination of chairs, healthcare professionals, service users, and

technicians concerning guideline development (Atkins et al., 2013). This study highlighted the role of the chair members, which included mediating guideline development discussions, encouraging participation of all members, and providing support and decision-making. Strategies to carry out these duties consisted of using task- and emotion-focused techniques, as well as the use of smaller groups. The majority of the chairs reported that members equally participated in the group and that there was general transparency during the process, despite the presence of biases. Specific findings related to the guideline content, including the chairs' concerns that they were based on scientific evidence and that this was dependent on the context. Most chair members also indicated that the primary goal of the guideline recommendations was speedy implementation in practice. Overall, the chairs reported mixed attitudes towards the CPGs development process. That is, some indicated satisfaction whereas others reported dissatisfaction with the process due to being rushed and a lack of time available to complete the CPGs (Atkins et al., 2013).

The second medical study was also qualitative in nature and consisted of 60 Australian policy makers of the Sax Institute of the NSW Department of Health (Campbell et al., 2009). This study highlighted the issues with empirical evidence and related barriers in the guideline development process. In particular, 63% of policy makers agreed that enhancing the use of research was needed. Despite this, the majority reported that they rarely used empirical evidence to inform the content of policies, the development, approval, and implementation processes, and their effects. Similarly, 60% used empirical evidence to evaluate fewer than 25% of the policies in a given year. Various barriers to using scientific evidence for policy making were also identified, such as insufficient skills and resources to search and access the literature, relevant evidence, consideration of local plans and policy, as well as limited time available. The study lends insight into policy makers' experiences of CPGs formulation and points to the barriers to using empirical evidence to inform policy (Campbell et al., 2009).

The third study assessed 1,664 Canadian guideline developers in medicine concerning the guideline development process for 1,360 guidelines submitted to the guideline repository in Canada from 1995 to 2002 (Kryworuchko et al., 2009). The expertise and knowledge of developers as well as various guideline development methods were emphasized. Findings concerning the most recent 630 CPGs and 652 guideline developers revealed that 94% of developers used computer-based search strategies and 94% of the CPGs were based on literature

reviews. Furthermore, only 42% published the search strategies that were used. In terms of evaluating the quality of empirical evidence used to formulate the recommendations, only 47% of guidelines were assessed, indicating that most CPGs were not evidence-based. Methods of consensus were obtained through open discussions and endorsed by 95% of guideline developers. Few guideline developers indicated assessing the effectiveness of the dissemination strategies (12%), as well as the impact of the CPGs on client outcomes (24%). The study also found that only 58% of guideline developers infrequently produced CPGs, which may indicate a lack of knowledge in guideline development and related methods. Consistent with this finding, the study also found that frequent guideline developers used more appropriate guideline development methods (i.e., 92% for computer searches, 52% for assessing the quality of evidence, 14% for assessing the impact of CPGs on outcomes, 25% for creating consumer guidance documents, and 44% for intentions to assess implementation strategies) as compared to infrequent developers (i.e., 77% for computer searches, 38% for assessing the quality of evidence, 6% for assessing CPGs impact on outcomes, 13% for creating consumer guidance documents and 29% for assessing the implementation strategies). Frequent guideline developers may thus have more expertise in these methods. All guideline developers reported using similar dissemination strategies and were likely to evaluate the effectiveness of both the implementation and dissemination strategies (Kryworuchko et al., 2009). These findings emphasize the link between guideline development methods and expertise among guideline developers, as well as inherent related issues.

Lastly, a more recent qualitative study involved individual interviews with 37 South African healthcare guideline developers concerning various medical CPGs (Kredo et al., 2018). This study found that empirical evidence, stakeholder involvement, transparency, managerial interests, collaboration among development groups, and context were key processes for the guideline development process. However, it was revealed that due to insufficient resources, guideline developers experienced various issues pertaining to soliciting stakeholder feedback and recording the process of decision-making. As such, insufficient resources interfered with their ability to implement the required guideline methodologies. Issues with power dynamic, values, politics, capacity, transparency, conflicts of interest, collaboration, and equal contribution to guideline development were also reported (Kredo et al., 2018).

In the social sciences, a recent study assessed 40 guideline development committee members concerning 17 CPGs produced by six regulatory bodies in Quebec (Trépanier, 2019). The study surveyed these members regarding their familiarity with guideline development methods, views of the guideline development process, and perceived quality of the CPGs they produced. Results from this study indicated that few guideline developers (0% to 15%) were familiar with the guideline development methods. Issues concerning the guideline development committee's composition were also highlighted; committees were mostly comprised of clinicians and members of the regulatory bodies and excluded other stakeholders, which is contrary to recommendations for guideline development committees. Further, it was found that the manner in which divergent opinions were handled were problematic and conflicts of interests were not adequately reported. Although a large number of developers (50%) agreed that the CPGs they developed should be updated, most developers indicated that: there was good collaboration during the development process, their voice was heard equally compared to others (85%), and they were encouraged to participate in the group (95%). This study emphasized discrepancies between reported methods for assessing the literature and evidence-based recommendations. In particular, few developers agreed that a comprehensive plan was developed and used to help guide a systematic search for empirical evidence (32%), suggesting a lack of evidence-based practices. Despite this, 70% reported that the CPGs they produced were founded on best practices in guideline development and 68% indicated that their guideline recommendations were founded on the best scientific evidence. The study underscored that the discrepancy between the former three items pertaining to best practices may be due to a lack of clarity concerning the meaning of best practices or evidence-based. Thus, it is emphasized that CPGs do not appear to be based on systematically examined empirical evidence.

Regardless of the guideline development issues found, 59% agreed that the quality of the guideline development process was a good example for future guideline development. It should be noted that rates were found to be statistically significantly higher among clinicians as compared to researchers (i.e., $Mdn = 4.0$ versus $Mdn = 1.5$, $U = 23.00$, $p > .001$, $r = -.48$). The study indicated that this may be due to diversity in knowledge as well as increased familiarity with formal and arduous guideline development methods (Trépanier, 2019). This study emphasized novel data concerning the role and functioning of guideline development committees, specifically in relation to their knowledge, attitudes, and experiences of the

guideline development process. Finally, this study points to the much-needed improvements in the guideline development process, including that committee members should have expertise in guideline methods.

The aforementioned studies provide insight into policy makers' experiences regarding the guideline development process. However, only Trépanier (2019) assessed policy makers' specific knowledge, views, and experiences regarding guideline development and methodologies. Barely any of the studies examined the guideline evaluation, approval, and adoption processes. Campbell et al. (2009) were the sole authors to address the guideline approval process, but only did so to a limited extent. The other four studies (Atkins et al., 2013; Kredo et al., 2018; Kryworuchko et al., 2009; Trépanier, 2019) focused on chair members and guideline developers, rather than on the board members of an organization whom are typically involved in overseeing the guideline development and the evaluation, approval, and adoption processes. With the exception of the study conducted by Trépanier (2019), which is the most relevant in terms of policy makers' knowledge, attitudes, and experiences of guideline development and related methods, these remaining studies reflected few attitudes and experiences of limited key elements involved in guideline development. Additionally, all but one of these five studies consisted of limited sample sizes (Atkins et al., 2013; Campbell et al., 2009; Kredo et al., 2018; Trépanier, 2019). The data was also attenuated for the study conducted by Atkins et al. (2013) due to the inclusion of non-policy members (e.g., healthcare professions, technicians, and service users). Furthermore, these studies addressed divergent aspects of the development process, illustrating the complexity of this process and the need to further investigate all components that are involved (i.e., methods, experiences, and expertise of policy makers).

Despite the limitations discussed above, these studies are valuable additions to the literature and highlight important issues with guideline development. This is consistent with the formerly reviewed studies (e.g., Al-Ansary et al., 2013; Ciquier et al., 2020; Dobbins et al., 2004; Stamoulos et al., 2014; Straus et al., 2009; Trépanier et al., 2017). Further investigation of the guideline development, evaluation, approval, and adoption processes is undoubtedly required given the very limited research available. Relatedly, there is a pronounced need to examine the diverse roles of guideline developers and to conduct studies that focus on group leaders, such as board of directors who oversee, evaluate, and approve the CPGs. Assessing the knowledge,

attitudes, and experiences among these members is imperative in order to inform guideline development and quality and ultimately, to foster advancements of CPGs such that they are based on the most recent and best empirical evidence. The significance of these strides, however, will be dampened if professionals in clinical practice do not actively use guidelines in their work. Hence, it is essential that professionals' use of CPGs be examined as well.

Defining Guideline Use, Implementation, and Adherence

Throughout the literature, guideline use, implementation, and adherence are often used interchangeably. However, their meanings differ. In the current dissertation, the terms utilized are based on the taxonomy referred to in the studies. *Guideline use* or *implementation* refers to the process of translating suggested guideline recommendations and content as stipulated in CPGs and integrating them into practice (Shiffman et al., 2004). *Guideline use* also consists of specific stages and includes deciding to adopt a CPG, implementing it in practice via a process and institutionalization (i.e., incorporating CPGs in routine practice; Nicholas et al., 2001). *Guideline implementation* is the second phase of the guideline use stages (Nicholas et al., 2001). The decision to use a CPG is followed by implementation (Lomas, 1993; Thomas, 1999). To implement a guideline, "involves the programs and activities that take guidelines out of the rather abstract phase of development and into the actual world of health care decision making and action" (Field & Lohr, 1992; p. 65). Implementation consists of the following 3 components: 1) awareness of guideline recommendations; 2) agreement with the approach that has been proposed; and 3) ability for adoption of the practice that is recommended (Belin et al., 2002; Cabana et al., 1999, 2000; Cruz-Correa et al., 2001). Guideline adherence is more likely to occur when these components are present (Belin et al., 2002). *Guideline adherence* is defined as:

> "A method of process quality assessment that evaluates the extent to which care is consistent with professional knowledge, either by examining adherence to specific practice guidelines or by evaluating whether care meets certain professional standards" (McGlynn, 2007, p. 227).

Professionals Knowledge, Attitudes, Use, and Implementation of Guidelines

Medical research suggests that both the implementation of empirically based CPGs and treatment outcomes are impacted by the quality of CPGs as well as the methodological rigour used to develop them (Alonso-Coello et al., 2010; Blozik et al., 2012; Hollon et al., 2014; Tudor et al., 2013). Yet, the rates of guideline use, implementation, and adherence among healthcare

professionals are mixed and mostly point to lower levels of compliance and infrequent or ineffective use (Al-Ansary et al., 2013; Gould & Kendall, 2007). While there is strong evidence for a link between professionals' knowledge, familiarity or awareness, and attitudes of CPGs and guideline use, implementation, and adherence (e.g., Alanen et al., 2009a; Constantino-Casas et al., 2011; Lovell et al., 2013; Lugtenberg et al., 2011; Yang et al., 2013), research also suggests that knowledge of guidelines and positive attitudes towards them may not necessarily lead to guideline use, implementation, and adherence in practice (Farquhar et al., 2002; Finkelstein et al., 2000; Francke et al., 2008).

Knowledge of Guidelines

Professionals' knowledge, familiarity, or awareness of guidelines have been grossly examined in medicine. Knowledge is first necessary in order to influence professionals' attitudes and use of CPGs in practice (Gross, 2001). Research suggests that healthcare professionals are commonly knowledgeable about guidelines (Alanen et al., 2009a; Flores et al., 2000; Hader et al., 2007; Pogorzelska & Larson, 2008). Research also indicates that professionals that are more knowledgeable of guidelines are more likely to have positive attitudes towards them (Alanen et al., 2009a; Hader et al., 2007; Pogorzelska & Larson, 2008; Prytys et al., 2011). For instance, a sample of 1,395 ICU workers involving physicians and nurses reported being highly familiar with CPGs (90%) and the majority of the sample also had positive attitudes towards CPGs (Pogorzelska & Larson, 2008). Similarly, a lack of knowledge leading to more negative attitudes has also been found. For instance, a national survey consisting of 600 American pediatricians found that those who had limited knowledge of CPGs tended to have more negative attitudes towards guidelines (Christakis & Rivara, 1998). Feldman et al. (1998) found that among 992 American physicians surveyed, the minority (34%) reported a lack of knowledge of depression CPGs, however indicated both positive and negative attitudes towards these guidelines.
Some research also suggests a negative association between knowledge and attitudes towards CPGs. A study surveying 1,782 Mexican physicians found that while only a minority of the sample (11%) were familiar with guidelines (i.e., most lacked knowledge of CPGs), the sample had generally positive attitudes towards them (Constantino-Casas et al., 2011). These findings suggest that the association between knowledge and attitudes is unclear and variable and may be explained by cultural or demographic factors.

In the social sciences, only a handful of studies have investigated professionals' knowledge of CPGs (Mullen & Bacon, 2004; Prytys et al., 2011; Sandström et al., 2014). However, even these studies involve both social science and medical professionals. These studies provide support for rates of mixed knowledge of CPGs among social science professionals, as well as for the relationship between knowledge and attitudes towards guidelines. For example, a qualitative study was conducted and involved 20 semi-structured interviews with nurses, social workers, and OTs and found that they generally had a high level of knowledge of the *NICE Guidelines for Schizophrenia*; 85% of the sample had mostly positive attitudes towards these CPGs (Prytys et al., 2011). Similarly, Mullen and Bacon (2004) found that the majority of American psychologists (81%) and only a minority of social workers and allied mental health professionals (40%) were familiar with CPGs. Although this study did not report a link between knowledge and positive or negative attitudes towards CPGs, it demonstrated an association between being more knowledgeable and the intention to use CPGs among professionals (Mullen & Bacon, 2004). Another qualitative study conducted by Sandström et al. (2014) involved a group of interviews with 16 Swedish OTs, social workers, development coaches, and nurses. Results from this study revealed that professionals lacked knowledge of the *National Guidelines for Psychosocial Interventions for Schizophrenia or Schizophrenia-type Symptoms* and largely maintained negative and ambivalent attitudes toward the CPGs. These findings suggest that while professionals seem to be knowledgeable of CPGs, and that this knowledge correlates with their attitudes and use of CPGs, there is variability in the association among these factors. This is consistent with the aforementioned reviewed literature in medicine and highlights the need for more extensive exploration of professionals' knowledge in the social sciences.

Attitudes Towards Guidelines

Research has provided inconsistent findings (i.e., positive and negative associations) concerning the relationship between guideline knowledge, attitudes, and use, implementation, and adherence in medical practice (Alanen et al., 2009a; Constantino-Casas et al., 2011; Lovell et al., 2013; Hader et al., 2007; Lugtenberg et al., 2011; Prytys et al., 2011; Tumiel-Berhalter & Watkins, 2006). The majority of the available literature in medicine points to healthcare professionals mostly having positive attitudes towards CPGs, with a minority holding negative attitudes of guidelines (e.g., Constantino-Casas et al., 2011; Flores et al., 2000; Pogorzelska & Larson, 2008; Radwan et al., 2017). For example, 430 Canadian oncologists were surveyed in a

national study and mostly positive attitudes of CPGs and guideline use were found (Graham et al., 2000). Similarly, a systematic review found that most healthcare professionals had positive attitudes towards CPGs (e.g., they were useful, educational, and would enhance patient care). However, a minority also reported negative attitudes towards guidelines, and included that CPGs were unreasonable, non-applicable to patients, hinder professional autonomy, were used for litigation and disciplinary actions, and were mostly utilized to reduce costs (Farquhar et al., 2002). The later finding pertaining to litigation and disciplinary action was reported, despite the fact that CPGs are not actually intended to lead to legal consequences (Hollon et al., 2014).

Throughout the literature, the bulk of medical professionals reported various positive attitudes. These included the following: CPGs were useful for practice or implementing interventions (Alanen et al., 2009a; Elovanio et al., 2000; Higashi et al., 2010; Lovell et al., 2013), they were reliable or trustworthy (Alanen et al., 2009a; Elovanio et al., 2000; Kotzeva et al., 2014), they were educational tools (Feldman et al., 1998; Ferrier et al., 1996; Graham et al., 2000; Higashi et al., 2010; Sinuff et al., 2007), they provided positive treatment outcomes (Flores et al., 2000; Pogorzelska & Larson 2008; Scott et al., 2003), they were intended to improve the quality of care (Feldman et al., 1998; Ferrier et al., 1996; Scott et al., 2003; Sinuff et al., 2007), they reduced healthcare costs (Feldman et al., 1998; Ferrier et al., 1996) and they did not limit their professional autonomy nor were they too oversimplified or rigid to apply to patients (Feldman et al., 1998; Sinuff et al., 2007). Across these studies, the percentage of healthcare professionals that endorsed these attitudes were high. For example, among 627 American pediatricians surveyed, 89% endorsed CPGs as leading to successful treatment outcomes (Flores et al., 2000), and in another study with a comparable sample size, 80% of Canadian oncologists reported CPGs were educational tools and helpful resources for practice (Graham et al., 2000).

In contrast, a small portion of the literature in medicine provided support for the finding that a minority of healthcare professionals have negative views toward CGPs (Constantino-Casas et al., 2011; Elovanio et al., 2000; Feldman et al., 1998; Flores et al., 2000; Graham et al., 2000; Higashi et al., 2010). For example, a survey which questioned 395 Canadian physicians found that fewer than 25% had negative to neutral attitudes towards CPGs (Ferrier et al., 1996). Across the literature, percentages of endorsement for negative attitudes ranged between 10% to 26% and included the following: CPGs were being used for litigation or malpractice lawsuits (Christakis

& Rivara, 1998; Feldman et al., 1998; Flores et al., 2000; Higashi et al., 2010; Pogorzelska & Larson, 2008), CPGs represented a cookbook approach and were too rigid to apply to patients (Christakis & Rivara, 1998; Ferrier et al., 1996; Graham et al., 2000; Porgorzelska & Larson, 2008) and CPGs limited professionals' autonomy and authority (Christakis & Rivara, 1998; Ferrier et al., 1996; Flores et al., 2000; Graham et al., 2000). Some studies indicated that professionals had negative views towards the guideline content, development, and use of guidelines, with percentages ranging from 10% to 77% for negative views of CPGs (Brouwers et al., 2004; Chistakis & Rivara, 1998; Constantino-Casas et al., 2011; Elovanio et al., 2000; Porgorzelska & Larson, 2008; Sinuff et al., 2007). Notably, these included: CPGs were not based on scientific evidence and the recommendations were not more important than clinical experience (Constantino-Casas et al., 2011), and that there was a lack of time, resources, and competence to use and implement the CPGs (Chistakis & Rivara, 1998; Constantino-Casas et al., 2011; Elovanio et al., 2000; Porgorzelska & Larson, 2008). Similarly, one study that surveyed 682 Japanese rheumatology physicians found that several guideline aspects and features are necessary and should be included in CPGs (Higashi et al., 2010). Overall, although a minority of professionals maintain negative attitudes or concerns, these findings suggest that most health professionals have positive attitudes towards CPGs.

Expectedly, there is limited research available in the social sciences pertaining to professionals' attitudes of CPGs. Most studies highlighted mixed attitudes towards CPGs among social science professionals (Mullen & Bacon, 2004; Prytys et al., 2011; Sandström et al., 2014). Parallel to the findings in medicine, most professionals in these studies had positive views of mental health CPGs (Mullen & Bacon, 2004; Prytys et al., 2011; Sandström et al., 2014). Commonly reported positive attitudes across these studies included the following: CPGs provided direction or guidance and were helpful or useful, enhanced professionalism, provided quality of care, enhanced treatment and practice (Mullen & Bacon, 2004; Prytys et al., 2011), were influential tools, could enhance organization (Sandström et al., 2014), and could augment knowledge and skills (Mullen & Bacon, 2004). In contrast, negative attitudes reported among these studies were endorsed by a minority of professionals and concerned CPGs being empirically based, the guideline developers' expertise, applicability of CPGs in practice (Prytys et al., 2011), the methods quality of the evidence used to create the recommendations, the reliability of the guideline development process and content, relevancy to practice, clinical

experience being more trustworthy than the empirical evidence included in the guidelines, the stakeholders involvement in the development process (i.e., lack of service users), organization for the implementation of the CPGs, access to CPGs for service users (Sandström et al., 2014), as well as the CPGs being impractical (Mullen & Bacon, 2004).

Overall, both positive and negative attitudes towards these CPGs were identified. However, it is evident that the study conducted by Sandström et al. (2014) emphasized various negative attitudes towards the guideline development process. Mullen and Bacon (2004) also found variability in terms of attitudes across diverse professions. Prytys et al. (2011) only highlighted a few positive and negative attitudes towards CPGs. All of these studies included medical professionals and focused on a few mental health guidelines (i.e., schizophrenia, substance and child abuse, and depression). Compared to medicine, the social sciences are limited with regard to research on professionals' attitudes of CPGs. Taken together, it is imperative that more thorough and in-depth examinations of social science professionals be conducted on their various attitudes toward existing mental health CPGs, providing necessary insight into their views and practices.

Guideline Use, Implementation, and Adherence

In medicine, guideline use, implementation and adherence among healthcare professionals have been extensively examined (Constantino-Casas et al., 2011; Flores et al., 2000; Lovell et al., 2013; Sinuff et al., 2007; Taba et al., 2012). Studies provide mixed findings concerning guideline use, implementation, and adherence in practice (Ebben et al., 2013; Fischler et al., 2016; Kotzeva et al., 2014; Lugtenberg et al., 2009; Wisnivesky et al., 2008). Most studies indicate that less than half of healthcare professionals use CPGs and that they are not effectively implemented (Al-Ansary et al., 2013; Ebben et al., 2013; Gould & Kendall, 2007; Lovell et al., 2013; Taba et al., 2012; Theodorou et al., 2012). Further evidence provides support for professionals mostly failing to effectively adhere to guidelines when they use or implement them and that guideline adherence is relatively low (e.g., Ardery et al., 2007; Bauer, 2002; Ebben et al., 2013; Perez et al., 2012; Radwan et al., 2017). On the other hand, some studies have found higher rates of adherence (Lugtenberg et al., 2009; Wisnivesky et al., 2008). Relatedly, research has also found a positive association between CPGs adherence and patient outcomes and services, such that higher adherence to guidelines results in greater patient satisfaction or treatment outcomes (Bauer, 2002; Gross et al., 2003; Hepner et al., 2007; van Dijk et al., 2013).

A study conducted by Oh et al. (2011) found both a positive and negative association between adherence and treatment outcomes, which were based on high or low rates of adherence.

As stated above, few studies within the social sciences have examined this topic. The limited number of studies provide support for mixed rates of guideline use, implementation, and adherence (Heiwe et al., 2011; Hetrick et al., 2011; Mudge et al., 2017; Mullen & Bacon, 2004; Tiemeier et al., 2002). That is, some studies reported infrequent use, implementation, and adherence of guidelines (Berry & Haddock, 2008; Beurs et al., 2015; Fischler et al., 2016), whereas other studies, very few in number, reported higher rates (Kosmerly et al., 2015; Nicholas, 1999; Rothrauff & Eby, 2011). For example, Heiwe et al. (2011) found that the majority of 227 Swedish professionals (75%) reported using CPGs. However, the study sample consisted of mostly healthcare professionals and only a portion of OTs. As such, it is difficult to decipher the number of social science professionals or OTs that utilize CPGs in practice. Another study assessed the reported use of CPGs among American social workers, psychologists and psychiatrists (Mullen & Bacon, 2004). This study found that only a minority of the samples (19% for social workers and 6% for psychologists) reported using CPGs (Mullen & Bacon, 2004). Given the limited literature available on this topic, it is difficult to conclude what the consensus is for frequent versus infrequent use of CPGs in the social sciences.

There is also a shortage of research in the social sciences concerning CPGs adherence. Overall, these studies have found a general lack of guideline adherence among substance counsellors (Phillips & Brandon, 2004) and psychologists (Horvath et al., 2002). A study conducted by Rosen et al. (2002) found mixed adherence rates among medical and social science professionals, including social workers and psychologists, with some elements of care being congruent with the *Alzheimer's Disease Management CPGs*, other aspects being used often, and others being highly divergent from the CPGs and recommendations. The variability in adherence rates underscores the need for further research in this area.

Barriers and Facilitators to Guideline Uptake. In an effort to better understand guideline use, implementation and adherence, various studies in medicine have examined the factors that hinder and promote their use and implementation in practice, also referred to as barriers and facilitators, respectively. Most studies discuss these factors in light of guideline use and implementation and adherence separately.

Barriers to Guideline Use and Implementation. An abundant list of barriers has been identified in the medical literature. This included organizational constraints, such as high work-demands, limited time, access and resources, negative attitudes, other professionals' views, and decreasing costs of care (Constantino-Casas et al., 2011; Flores et al., 2000; Forsner et al., 2010; Kotzeva et al., 2014; Lovell et al., 2013; Yang et al., 2013). Various other barriers to guideline use and implementation among healthcare professionals have been found (e.g., Alanen et al., 2009b; Forsner et al., 2010; Fretheim et al., 2006b; Hader et al., 2007; Shekelle et al., 2012). Although the barriers typically differed across studies, several common barriers were identified. These included addressing local context factors and resources, enhancing the methodological rigour of CPGs, developing guides, tools, and strategies for implementation purposes, conducting evaluation of professionals' performance using the guidelines and auditing procedures, as well as assessing the effectiveness of implementation strategies (Alanen et al., 2009b; Fretheim et al., 2006a; Kastner et al., 2015; Shekelle et al., 2012; Watkins et al., 2015). Similarly, barriers related to the methodological rigour of CPGs included the following: problems with stakeholder involvement, evidence synthesis based on judgment, implementation feasibility, and CPGs messages (Kastner et al., 2015).

Lack of time and issues accessing guidelines were two noteworthy barriers in particular (Constantino-Casas et al., 2011; Cullen et al., 2005; Forsner et al., 2010; Lovell et al., 2013; Taba et al., 2012; Yang et al., 2013). Indeed, a study involving semi-qualitative interviews conducted with 14 Irish GPs found that lack of time was the main barrier to guideline implementation (Cullen et al., 2005). Congruently, another study surveyed 497 Estonian physicians and found that a lack of time and available resources hindered their ability to implement the CPGs in practice (Taba et al., 2012). Organizational barriers were also reported (Cullen et al., 2005; Forsner et al., 2010; Lovell et al., 2013). For instance, a qualitative study involving focus groups and individual interviews for 28 Swedish healthcare professionals found various barriers to guideline implementation (Forsner et al., 2010). These barriers were organized according to these categories: 1) organizational resources (i.e., staff issues, lack of learning, culture, leadership, dissemination, change clinical patterns, and lack of facilitating factors); 2) healthcare professionals' individual characteristics or traits (i.e., negative attitudes of CPGs, loss of autonomy, and a lack of knowledge of CPGs); and 3) views of the CPGs and

implementation strategies (i.e., doubting the credibility of the CPGs and a lack of awareness; Forsner et al., 2010).

Lack of knowledge and negative attitudes towards CPG have also been commonly reported as barriers to guideline use and implementation (Constantino-Casas et al., 2011; Cullen et al., 2005; Forsner et al., 2010; Lovell et al., 2013; Scott et al., 2003). For example, a survey of a sample of 336 Korean psychiatrists found that lack of knowledge was the biggest barrier to the implementation of depression CPGs; other barriers included negative attitudes concerning the requirements of CPGs and guidelines limiting professional autonomy (Yang et al., 2013). As previously reviewed, knowledge and attitudes of CPGs are separate constructs related to guideline practices. However, they also serve as barriers to guideline use and implementation.

Less frequently reported barriers consisted of: a lack of support from the government, issues applying the CPGs with insurance, and disagreement with the treatments (Yang et al., 2013), absence of a mentor to provide education, inefficient computer systems, time pressures and financial aspects, questioning data applicability to patients, poor adherence to protocols (Cranney et al., 2001), and lack of research assessing enhanced quality (Flores et al., 2000). Overall, there are several barriers to guideline use, with some being more commonly reported than others. These findings indicate that professionals believe several factors get in the way of them using and implementing CPGs in practice.

Barriers to guideline use and implementation have been examined by a few studies within the social sciences (Mullen & Bacon, 2004; Rothrauff & Ebby, 2011; Sandström et al., 2014). Studies conducted by Sandström et al. (2014) and Rothrauff and Ebby (2011) found that organizational issues hindered guideline use and implementation. Specifically, Sandström et al. (2014) found that work-demands served as barriers among social workers and psychologists. Similarly, Rothrauff and Ebby (2011) found that substance abuse counsellors reported a lack of available time and resources as barriers. Other barriers identified included negative attitudes (Rothrauff & Eby, 2011) and a lack of knowledge, guideline feasibility, unpreparedness to engage in change, uncertainty about the development of evidence and its reliability, a lack of accountability of service users, users' perceptions that CPGs were too rigid, a lack of organization and dependable networks, inadequate guideline presentation, and a lack of time for guideline implementation (Sandström et al., 2014). Similarly, Mullen and Bacon (2004) identified only a few barriers among their sample of American social workers, psychologists, and

psychiatrists: a lack of awareness, questionable guideline usefulness, and a perception that the CPGs were not needed as the relevant information had already been acquired (Mullen & Bacon, 2004). Based on these findings, further investigation of barriers specific to the social science context is required.

Barriers to Guideline Adherence. In medicine, many studies have examined the barriers to guideline adherence, however, the identified barriers tend to vary across studies (Alanen et al., 2009b; Fretheim et al., 2006a; Halm et al., 2000; Maue et al., 2004; Radwan et al., 2017). Cabana et al. (1999) explained that barriers to guideline adherence may not be applicable from one context to another. Cabana et al. (1999) conducted a systematic review and the following barriers were reported: a lack of awareness, familiarity, agreement and self-efficacy, negative outcome expectancies, a lack of ability to overcome the inertia of previous practice, and the presence of external obstacles to executing the recommendations. Other studies reported low self-efficacy (Perez et al., 2012; Wisnivesky et al., 2008), a lack of positive outcome expectancy (Wisnivesky et al., 2008), low familiarity with recommendations, time constraints (Perez et al., 2012), lack of guideline applicability and knowledge, organizational constraints, patient ability (i.e., being unable to accurately perform an action or failing to attend follow-up appointments), and patient preferences (i.e., inconsistencies between the patient preferences and CPG recommendations) as barriers to the adherence to CPGs (Lugtenberg et al., 2009, 2011). A more recent study assessed 323 Palestinian family doctors and nurses concerning diabetes CPGs and found that a lack of incentive and resources as well as low trustworthiness toward CPGs were the most frequently reported barriers among primary health-care centre workers (Radwan et al., 2017). This study also found that a lack of time and guideline trustworthiness were more commonly endorsed among United Nations Relief and Work Agency workers (Radwan et al., 2017).

In the social sciences, there is limited available literature on barriers to guideline adherence. As previously described, a study found that psychologists failed to adhere to tobacco cessation CPGs (Phillips & Brandon, 2004). Barriers obtained from this study included: inadequate training or skills, an incomplete appreciation of the benefits of tobacco cessation via early intervention, the belief that smoking was not putting their client at risk and was not the client's presenting issue, and concerns that clients would not be receptive to discussions (Phillips & Brandon, 2004). It is clear that there is a vast need to examine the barriers to guideline

adherence in the social sciences.

Facilitators to Guideline Use and Implementation. In medicine, several facilitators have also been recognized. For example, local context factors have been commonly reported (Alanen et al., 2009b; Forsner et al., 2010; Hader et al., 2007). A qualitative study involving 16 Finnish nurses found that guideline implementation was dependent on specific context factors, which included: the organization (i.e. local adaption of guideline, support and personnel resources); individual factors (i.e. awareness and attitudes towards CPGs); expected outcomes factors (i.e. benefit to nurses work and patient care); and group patient factors (i.e. CPGs' topic and patient awareness of CPGs; Alanen et al., 2009b). Forsner et al. (2010) identified other local context factors influencing the implementation of CPGs among a sample of 28 Swedish healthcare professionals, such as: organizational resources, individual characteristics and views of CPGs, and implementation strategies. Other facilitative factors identified across the literature included: knowledge of CPGs, easy guideline accessibility, agreement with the guideline approach, support for clinicians' individual choices, capacity to accept the practice, clinicians' features and personal commitment, being proactive, respecting colleagues and leaders, features of practice contexts, incentives, regulations, legal financial aspects, patient features, standardized care, guideline usefulness, and provisions of support (Belin et al., 2002; Cabana et al., 1999, 2000; Cruz-Correa et al., 2001; Cullen et al., 2005; Flores et al., 2000; Hader et al., 2007; Taba et al., 2012).

Other factors pertaining to the organization, characteristics, development, and methodological rigour of CPGs have been commonly described to foster the use and implementation of CPGs. More specifically, healthcare professionals reported that guideline feasibility, simplicity and appropriate format and structure, the quality of guidelines, CPGs founded on empirical evidence, good stakeholder involvement, the use of evidence synthesis, formulating recommendations based on expert consensus, maintenance of currency in relation to novel evidence, good implementation practicality, and an informative guideline message positively impacted their use and implementation of CPGs (Cullen et al., 2005; Feyissa et al., 2019; Flores et al., 2000; Kastner et al., 2015). Similarly, a qualitative study involving semi-structured interviews with 45 Canadian medical doctors identified a variety of facilitative factors, which included that the guideline was based on scientific evidence, was interpreted well, would enhance health patient outcomes and limit risk, as well as whether change could be implemented

within the system (i.e., the availability of resources to facilitate implementation of the recommendations included in the guideline; Hader et al., 2007).

Various interventions and strategies were also found to be effective to foster the use and implementation of CPGs. These include multiple or multilayered educational interventions and collecting data, performance feedback and audits (Cullen et al., 2005; Forsner et al., 2011; Fretheim et al., 2006a, 2006b; Shekelle et al., 2012), computer reminders (Fretheim et al., 2006a), computerized decisions, educational programs, academic detailing, assigning staff to liaison services and creating support systems (Cullen et al., 2005; Watkins et al., 2015). Shekelle et al. (2012) examined the existing implementation strategies found in the literature and identified the following facilitative strategies for guideline use and implementation: using behaviour-specific language, having formats and opportunities for guideline dissemination that were related to the target population and preferences. Similarly, a recent systematic search study found that educational interventions were the most commonly used implementation strategy and most studies utilized multiple strategies in pharmaceutical settings (Watkins et al., 2015). This study also found that using computer systems for support purposes was the most effective for guideline implementation. However, their use was limited, and the strategies resulted in moderate positive outcomes (Watkins et al., 2015). Tools as facilitating factors were also identified as the following: summary booklets, educational sessions, enhancing delivery systems to provide guidance to use the CPGs (Yang et al., 2013), decision-making aids, guides for flexible use of CPGs with individual patients (Lugtenberg et al., 2011), as well as educational tools and resources specifically tailored to the guideline content and target population group.

In the social sciences, few studies have identified facilitative factors and further research in this area is required (Mullen & Bacon, 2004; Rothrauff & Eby, 2011; Sandström et al., 2014). Of the limited available literature, a few studies found that social science professionals prefer CPGs that are based on research and are open to using guidelines founded on clinical consensus. A link between being knowledgeable of CPGs and professionals' use and implementation of CPGs was revealed in this study (Mullen & Bacon, 2004). Other factors that were identified were: financial resources, training, supervision and evaluation, and implementation monitoring forms of support to foster guideline use and implementation (Sandström et al., 2014). Similarly, as previously reviewed, Rothrauff and Eby (2011) assessed 615 American substance counsellors

concerning the use of a tobacco cessation CPGs and identified obtaining instruction or training on guideline implementation as a facilitative factor.

Facilitators for Guideline Adherence. Several facilitating factors for enhancing guideline adherence in medicine have also been found (Ebben et al., 2013; Goldberg et al., 2015; Okelo et al., 2013; Sinuff et al., 2015). A comprehensive literature review organized various facilitators into the following categories: the characteristics of the guidelines (e.g., guideline format and evidence basis), the characteristics of the physician (e.g., knowledge, attitudes and agreement with guidelines) and the physicians' environment (e.g., human environment – patient and patient-physician influence and organizational environment; Saillour-Glenisson, & Michel, 2003). Similarly, a systematic review of clinicians' adherence to asthma guidelines found that tools for supporting decision making, providing feedback and audits, and acquiring clinical pharmacy support moderately helped guideline adherence (Okelo et al., 2013). Another systematic review involving healthcare settings identified several facilitators, which included: quality indicators, implementation strategies, evidence-based guideline recommendations, and providing a strong association between adherence and outcomes for professionals (Ebben et al., 2013). While some of these factors are similar, most of them varied across studies. Other facilitative factors obtained throughout the literature, included the following: patient awareness of cholesterol, patient readiness to use medication, technological innovations, clinician training, organizational support (Parker et al., 2008), and automatic computer reminders (Goldberg et al., 2015). Sinuff et al. (2015) identified various factors and strategies reported among healthcare professionals, which included: characteristics of healthcare workers (e.g., effective leadership), communication between professionals (e.g., cohesion, cooperation, being open and regular communication, using multidisciplinary teams and resources), regular education, systems focused on performance feedback and audits, reminders, continuing education, educational interventions, electronic media, and easy to use guideline formats (Sinuff et al., 2015).

Taken together, in comparison to medicine, there are very few studies in the social sciences that have investigated the barriers and facilitators to guideline use, implementation, and adherence. Considering that the effective uptake of CPGs is dependent on these factors, it is imperative that the barriers and facilitators in the social sciences be further examined.

Theories and Models for Guideline Knowledge, Attitudes, and Uptake

Several theories and models have been proposed in medicine to explain the dynamic between professionals' knowledge, attitudes, use, implementation, and adherence of CPGs in practice. Interestingly, most of these have been proposed by social science professionals. However, the majority of these frameworks are founded in the medical field (i.e., based on physicians or applied to medical contexts and CPGs). As previously reviewed above, there is mixed evidence regarding the link between knowledge and favourable attitudes among professionals and their actual use of CPGs. That is, most of the existing research supports a positive association, whereas some studies (e.g., Farquhar et al., 2002; Finkelstein et al., 2000; Francke et al., 2008) report no association. The most prominent theories and models regarding the interrelatedness of these factors are presented below.

Knowledge, Attitudes and Behaviour Model

This model was proposed by Woolf (1993). It postulates that knowledge first impacts attitudes and then the attitudes influence behaviours and guideline use (Woolf, 1993). Guideline use is most likely to occur when all three of these variables are involved and impacted. This model served as the precursor to the subsequent model developed by Cabana et al. (1999).

Barriers to Adherence Framework

Cabana et al. (1999) developed this model in order to explain how physicians' knowledge, attitudes, and behaviours are related. This model suggests that barriers to guideline adherence are derived from a cognitive factor that influences knowledge and affective factors that impact attitudes, which determines the physicians' abilities, and consequently impacts their behaviour regarding their use of CPGs (Cabana et al., 1999). The sequence is as follows: knowledge impacts attitudes and attitudes impact behaviour (Cabana et al., 1999; Woolf, 1993). There are also various barriers to knowledge (e.g., lack of guideline accessibility and time), attitudes (e.g., lack of agreement with guidelines, such as a lack of applicability to patients, and lack of self-efficacy to use guideline recommendations), and behaviours (e.g., organizational constraints and contradictory guidelines; Cabana et al., 1999).

Awareness-to-Adherence Model

This model was created by Pathman et al. (1996) and it involves four cognitive and behavioural phases and processes physicians go through in order to conform to a guideline. The phases consist of the following: 1) awareness of guidelines; 2) agreement with the guideline on a

knowledge level; 3) making the decision to adopt the guideline in practice; and 4) adhering to the guideline in appropriate contexts. Barriers and facilitators impact the movement from one stage to the next. For instance, a lack of awareness and agreement are barriers. Adoption of guidelines and adherence to CPGs can occur even if there is no agreement and can be explained by factors, such as pressure by others, demands issues, and organizational constraints, and standards (Pathman et al., 1996).

Conceptual Framework for Guideline Dissemination and Implementation

This model was developed by Moulding et al. (1999) and was founded on social and behavioural theories. This model consists of five stages and includes: 1) the assessment of a practitioner's stage of readiness to change ensures that a suitable combination of diffusion and implementation strategies are derived; 2) the assessment of specific barriers to guideline use ensures that acceptable strategies are chosen; 3) determining the appropriate level of intervention (i.e., through an evaluation of the levels of interventions that address identified barriers and stages of readiness to change in the best way); 4) designing the diffusion and implementation strategies (i.e., these can be chosen and created based on the previous evaluations); and 5) evaluation of the implementation strategies and their effectiveness in leading to physicians' behavioural change. Movement across the model stages provides promise for efficient guideline dissemination and implementation (Moulding et al., 1999).

Conceptual Framework for Variables and Strategies to CPGs Implementation Model

This model was developed by Solberg et al. (2000). The model consists of six categories that interact and that were reported as necessary by experts. These include: 1) guideline characteristics; 2) medical group characteristics; 3) organizational capability for change; 4) infrastructure for implementation; 5) external environment; and 6) implementation strategies (Solberg et al., 2000). Various strategies are intended to be used in order to best reflect the relevant categories or variables (Solberg et al., 2000).

These theories and models provide insight into the process of CPGs in practice and inform guideline development, dissemination, and implementation. Acquiring further data relevant to professionals' knowledge, attitudes, use, implementation, and adherence of CPGs in the social sciences, including barriers and facilitators, is needed to provide a better understanding of CPGs in practice and to inform a universal social science theory and model. A more cohesive

model is likely to provide meaningful research directions as well, thus bridging the gaps between research, theory, and practice.

Mental Health and Social Care Service: Prevalence, Impact, and Guidelines

While both medicine and the social sciences have developed and investigated CPGs, it is only in more recent years that the social science field has concentrated on guideline research (Alonso-Coello et al., 2010; Beauchamp et al., 2011; Gould & Kendal, 2007; Parry et al., 2003; Weisz et al., 2007; White & Kratochwill, 2005). In comparison to guideline research in medicine, the empirical investigation of CPGs in the social sciences is scarce, especially regarding mental health and social care service guidelines (Graham et al., 2000; Kirk, 1999; Parry et al., 2003; Proctor et al., 2009; Sandström et al., 2014). This is problematic when considering the high prevalence of mental health issues and the substantial negative effects on health, social, human rights, and economic areas worldwide (WHO, 2001, 2019). Specifically, it is estimated that 1 in 4 individuals will experience mental illness during the course of their lives and 450 million individuals currently are affected by a mental disorder (WHO, 2001). In Canada, 1 in 5 individuals experience mental health issues in a given year (MHCC, 2017; Smetanin et al., 2011), and 7.5 million suffer from a mental disorder (MHCC, 2017). Mental illness is the principal reason for disability (Lim et al., 2008; MHCC, 2014), with 3,811 individuals dying as a result of suicide yearly in 2018 (Statistics Canada, 2020). Mental illness has also been found to reduce life expectancy by half (Chesney et al., 2014). In Quebec, similar rates have been obtained, with 1 in 5 individuals (20%) suffering with a mental disorder and less than 50% seeking help (Government of Quebec, 2020). Most individuals who use mental health services primarily consulted with GPs, followed by psychologists and allied professionals (Lesage et al., 2006).

Mental health issues are estimated to cost the Canadian economy $51 billion every year (Lim 2008; MHCC, 2013, 2017; Smetanin et al., 2011). In 2011, estimated costs for seeking treatment, support and social care support services in Canada was $42.3 billion and included costs for health care, medication, community and social services, long term care, income support and personal expenses (MHCC, 2013). This study estimated that by 2041, costs for mental health issues will reach $290.9 billion (MHCC, 2013). While these rates do not solely account for mental health and social care services, it is clear that mental health and social care services are being used, with about 40% of Canadians who reported seeking out these services (Lesage et al.,

2006). Although, it is also known that some vulnerable individuals do not receive much needed treatment for mental health issues due to a lack of awareness stigma and accessibility issues, which can be even more damaging and can further burden the economy (Government of Quebec, 2020; Gravel & Béland, 2005; Lesage et al., 2006, 2010; MHCC, 2012, 2013, 2017). Generally, 1.6 million Canadians reported a lack of service needs being met (MHCC, 2013, 2017).

In an effort to enhance client outcomes and reduce economical costs, necessary changes are required at the public and policy levels (MHCC, 2013). In this same vein, it is vital that clinicians use evidence-based practices in order to provide effective treatment for mental health disorders. Hence, increased focus on research and development of CPGs in mental health and social care services may improve services, outcomes, and cost-effectiveness (Cabana et al., 1999; Graham et al., 2000; Hollon et al., 2014; MHCC, 2012, 2013; van Dijk et al., 2013). In the short term, this may seem to add more costs to the economy. However, if these CPGs are effectively developed and are evidence-based, then they can help reduce long term costs of care. For example, the use of these guidelines could lead to quicker assessment and treatment and earlier prevention of mental health issues, thus leading to a higher rate of return on investments and decreasing the need for mental health and social care services within other sectors (Smith & Smith, 2010).

Overview of Gaps in the Literature

The current review emphasized the significance of policy makers' and professionals' knowledge, attitudes, and experiences of mental health and social care CPGs. As such, investigating these areas would inform the current state of mental health and social care CPGs in light of methodological rigour, development, quality, and clinical practice. The review further highlighted the lack of available literature in the social sciences in all of these areas. That is, there is limited data concerning the methodological rigour, development, and quality of CPGs, as well as policy makers' familiarity of guideline methods and their attitudes and experiences of the guideline development, evaluation, approval and adoption processes. There is also limited knowledge available pertaining to professionals' knowledge, attitudes, use, implementation, and adherence of CPGs in clinical practice and related barriers and facilitators, as well as related theories and models specific to the social sciences. Of the existing studies available in the social sciences, most included other medical professionals and fail to solely focus on social science professionals; this represents a noteworthy limitation. There is also inadequate research in these

areas, especially in the context of Canada and Quebec. The general lack of guideline research investigating social science and mental health and social care service guidelines is also disquieting. This is especially true, when considering the international and local growing prevalence of mental illness and related burden at the individual, economic, and systemic levels. This is even more alarming in light of the fact that the rates of mental health issues have recently skyrocketed following the COVID-19 pandemic (Twenge, 2020), and will likely continue to affect mental health and have dire economic consequences (Pfefferbaum & North, 2020).

The Current Research

The current research, described in this dissertation, consisted of three studies intended to address the abovementioned gaps in the literature. The first objective was to obtain data and provide insights into policy makers' knowledge of guideline methods and development, attitudes, roles, and experiences of guideline development, evaluation, approval, and adoption of CPGs developed by five regulatory bodies in Quebec and CPGs in general. This was achieved through surveying members of the board of directors of the following regulatory bodies about CPGs: 1) l'ordre des psychologues du Québec (OPQ)/the Order of Psychologists of Quebec; 2) l'ordre des psychoéducateurs et psychoéducatrices du Québec (OPPQ)/the Order of Psychoeducators of Quebec; 3) l'ordre des conseillers et conseillères d'orientation du Québec (OCCOQ)/the Order of Guidance Counsellors of Quebec; 4) l'ordre des thérapeutes conjugaux et familiaux et des travailleurs sociaux du Québec (OTSTCFQ)/the Order of Social Workers and Marriage and Family Therapists of Quebec; and 5) l'ordre des ergothérapeutes du Québec (OEQ)/the Order of Occupational Therapists of Quebec.

The second research objective was to investigate the existing literature concerning professionals' reported knowledge, attitudes, use, implementation, and adherence of mental health and social care service CPGs, including related barriers and facilitators, in the social sciences. This was addressed in the second study, vis-à-vis a systematic scoping review. This allowed a more comprehensive documentation of the literature and related constructs in order to inform the development of surveys for professionals in the third study. While conducting a similar review for policy makers (as covered in Study 1, Manuscript 1) was initially considered, a preliminary search of the literature indicated this was not viable due to insufficient literature on this topic.

The third objective was to document and contribute to the understanding of professionals' knowledge, attitudes, use, and implementation of mental health and social care CPGs developed by five social science regulatory bodies in Quebec and CPGs in general. As such, the third study surveyed professional members of the OPQ, OCCOQ, OPPQ, OTSTCFQ, and OEQ regulatory bodies about CPGs. While guideline adherence is an important construct, this study only assessed guideline use and implementation. This was due to the fact that we were interested in examining the early stages of guideline practices first, which consists of guideline use and implementation (Nicholas et al., 2001). In addition, the adherence construct is also more complex and would have required a more thorough examination involving multiple questions for various CPGs and their specific recommendations. This would have required the distribution of an extremely lengthy survey, which was not feasible for the current study. The results for each study are presented in the three subsequent manuscripts. Together, these three studies contribute considerably to the limited research on CPGs and have meaningful implications for guideline development and clinical practice.

Chapter 2: Manuscript 1

(To be submitted for publication)

Surveys of board of directors: How are guidelines developed, evaluated and approved in Quebec?

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Abstract

The production of clinical practice guidelines has exploded over the last three decades in the social sciences and in medicine (Beauchamp et al., 2011; Colón-Emeric et al., 2007). These resources are developed by policy makers, associations, or other regulatory bodies worldwide. Despite the abundance of guidelines that have been produced, there is currently no existing research on those who develop guidelines that focuses on their knowledge, attitudes, and experiences of guidelines in the social sciences. This is particularly true regarding the guideline development process and evaluation, approval, and adoption of these guidelines for mental health and social care service guidelines. The current study consisted of five survey versions tailored to five Quebec regulatory bodies in the social sciences and the guidelines they produced. A total of 34 members of the board of directors of l'Ordre des psychologues du Québec (OPQ)/the Order of Psychologists of Quebec; l'Ordre des psychoéducateurs et psychoéducatrices du Québec (OPPQ)/the Order of Psychoeducators of Quebec; l'Ordre des conseillers et conseillères d'orientation du Québec (OCCOQ)/the Order of Guidance Counsellors of Quebec; l'Ordre des thérapeutes conjugaux et familiaux et des travailleurs sociaux du Québec (OTSTCFQ)/the Order of Social Workers and Marriage and Family Therapists of Quebec; and l'Ordre des ergothérapeutes du Québec (OEQ)/the Order of Occupational Therapists of Quebec were surveyed. The focus was on board members because they are responsible for initiating the development of guidelines and ultimately, their evaluation, approval, and distribution. The surveys assessed their knowledge, attitudes, and experiences regarding the guideline development and methods, evaluation, approval, and adoption process, quality, and costs. The results indicated that board members mostly reported positive attitudes towards the guideline development and evaluation, approval, and adoption process, and quality of the guidelines. However, these members also had limited knowledge of guideline development methods and other key areas involved in guideline development. Some views and knowledge concerning guideline development also varied.

Keywords: Clinical practice guidelines, guideline development, guideline evaluation, guideline approval, guideline adoption, familiarity, attitudes, board members, policy makers, social sciences

Surveys of board of directors:

How are guidelines developed, evaluated and approved in Quebec?

Clinical practice guidelines (CPGs) are intended to help professionals stay informed about recent research and promote evidence-based practice (Babione, 2010). These guidelines provide direction in the provision of optimal services and ensure professionalism (Farquhar et al., 2002; Woolf, 1992). CPGs are developed by policy makers and other organisations such as associations and regulatory bodies. Typically, these organizations are governed by a board of directors. The members of the board of directors are responsible for the CPGs produced by these organizations. In most cases, the board of directors decide whether or not to develop the CPGs, they oversee the process of guideline development, and have the authority to establish the guideline development procedures and ensure they meet the necessary standards and are enforced. As the governing authority within a regulatory body or professional association, the board members are also ultimately responsible for overseeing the process of guideline evaluation, approval, and dissemination. In Quebec, there are professional regulatory bodies in the social sciences that have published several mental health and social care service CPGs. These regulatory bodies include: 1) l'Ordre des psychologues du Québec (OPQ)/the Order of Psychologists of Quebec; 2) l'Ordre des psychoéducateurs et psychoéducatrices du Québec (OPPQ)/the Order of Psychoeducators of Quebec; 3) l'Ordre des conseillers et conseillères d'orientation du Québec (OCCOQ)/the Order of Guidance Counsellors of Quebec; 4) l'Ordre des thérapeutes conjugaux et familiaux et des travailleurs sociaux du Québec (OTSTCFQ)/the Order of Social Workers and Marriage and Family Therapists of Quebec; and 5) l'Ordre des ergothérapeutes du Québec (OEQ)/the Order of Occupational Therapists of Quebec. These regulatory bodies are responsible for exercising regulatory and supervisory authority over specific areas of practice. They support and inform their professional members in terms of professionalism and ethical conduct. They are also responsible for CPG development, evaluation, and approval, and for the dissemination and implementation of CPGs.

Over the past 30 years, there has been a progressive trend in guideline research and a vast number of published guidelines in medicine, which extends globally (Colón-Emeric et al., 2007; Gould & Kendal, 2007; Parry et al., 2003; White & Kratochwill, 2005). In contrast, research focused on CPGs in the social sciences and in particular, on specific guidelines on mental health and social service care is very limited (Graham et al., 2000; Howard & Jenson,

1999a, 1999b; Kirk, 1999; Parry et al., 2003; Proctor et al., 2009; Sandström et al., 2014). Similarly, the investigation of the processes of guideline development, evaluation, approval, and dissemination in the social sciences is virtually non-existent globally as well as in Quebec. Albeit, there are some exceptions. These include recent research examining the methodological rigour and quality of CPGs (Ciquier et al., 2020; Stamoulos et al., 2014; Trépanier et al., 2017; Trépanier, 2019) as well as the perspectives of experts in the development of CPGs in Quebec (Trépanier, 2019). These studies found clear issues with CPGs methodological rigour and development process (Stamoulos et al., 2014; Trépanier et al., 2017; Trépanier, 2019) and evidence of poor guideline quality (Ciquier et al., 2020; Trépanier, 2019). Similarly, in medicine, a plethora of evidence indicates there are various issues with the methodological rigour and development of guidelines and their quality (Al-Ansary et al., 2013; Alarcon et al., 2013; Cecamore et al., 2011; de Haas et al., 2007; Esandi et al., 2008; Tudor et al., 2013).

Investigating the aforementioned areas in the social sciences is especially important when considering the methodological rigour and quality of CPGs have been found to impact the implementation of guidelines by professionals, professional practice, and client treatment outcomes in medicine (Alonso-Coello et al., 2010; Blozik et al., 2012; Esandi et al., 2008; Hollon et al., 2014; Lugtenberg et al., 2011). Good quality CPGs have also been found to be dependent on the methodological rigour of the development process as well as the use of scientific evidence (Hollon et al., 2014), which may positively influence the implementation and adherence of empirically based guidelines (Blozik et al., 2012; Holmer et al., 2013; Lugtenberg et al., 2011). In this same vein, poor guideline development and quality may result in negative outcomes, such as prevention of guideline use and implementation and impeding client services (Bennett et al., 2018; Rao & Tandon, 2017; Woolf et al., 2004). Overall, the field of medicine appears to be well advanced compared to the social sciences with regards to guideline research. However, even in medicine, there is a lack of research on guideline development, dissemination, implementation, the roles of guideline developers and policy makers involved in the development, evaluation, and approval of guidelines (Graham et al., 2003; Grimshaw et al., 2012). Similarly, few studies have examined the knowledge, perspectives, and experiences of policy makers' regarding the guideline development and dissemination process in the field of medicine (Atkins et al., 2013; Campbell et al., 2009; Graham et al., 2003; Kryworuchko et al., 2009). Unsurprisingly, the role of policy makers in guideline development, evaluation, approval,

and dissemination and their related views and experiences has yet to be examined within the social sciences.

In an effort to advance guideline research in the social sciences as a whole and specifically in the context of Quebec, the current study surveyed the board of directors concerning the guidelines produced by the five regulatory bodies in the social sciences in Quebec. The board of directors' familiarity, attitudes, and experiences of the development, evaluation, approval, and adoption of these guidelines and those in general were solicited. Documentation of these areas are imperative in order to further inform the methodological rigour and quality of CPGs, as well as policy for mental health and social care CPGs in the social sciences and in Quebec.

Method

Participants

The participants consisted of the members of the board of directors for the five regulatory bodies in Quebec (see Table 1).

Board of Directors

The role of the board of directors include: 1) deciding to develop CPGs; 2) overseeing the development of CPGs, including having the authority to establish the development procedures for CPGs and ensuring they meet the required standards and that they are enforced; 3) overseeing the evaluation of the CPGs; and 4) deciding to approve and disseminate the CPGs to professionals (i.e., approving and allowing the CPGs to be published for use in practice by professional members). The board of directors is comprised of all elected or nominated members of the board, including the president and vice president(s) of the regulatory body. These members typically serve a 2 to 4-year term on the board. For the present study, current board members in office, members in office at the time a given practice guideline was approved and published, and all past members, were solicited.

A recruitment e-mail invitation was sent directly to 137 identifiable members (see procedures section below for recruitment methods). Of all the members contacted, 44 responded to the study, 10 of whom dropped out at the beginning of the survey. Therefore, a total of 34 participants were included in the study.

Measure

An online survey in French was developed. The online survey was then tailored to each regulatory body, thus yielding five survey versions for the board of directors. The online survey versions were tailored to the specific mental health and social care guidelines published by each respective regulatory body (See Table 1 for the list of regulatory bodies and CPGs).

Specifically, the Qualtrics survey software (Qualtrics, 2020) was used to develop and launch the surveys. The surveys were developed using the Tailored Design Method (TDM; Dillmann et al., 2014). They were also informed by a literature review that was conducted on guideline development and policy makers' knowledge, attitudes, and experiences in the development, evaluation, approval, and dissemination of CPGs in the social sciences. A survey version was initially developed in English and piloted. Next, this survey was translated into French, prior to being piloted by graduate students and faculty members from McGill University and Université de Montréal. This survey was subsequently used to create the other surveys, which were adapted to each regulatory body and relevant guidelines. All surveys were virtually the same, with the exception of the name of the regulatory bodies and guidelines.

Survey

The survey assessed the guideline development, evaluation, approval, and adoption process as well as the objectives, quality and cost of guidelines and familiarity of guideline development methods for those CPGs published by the respective regulatory body. The survey consisted of 63 statements, including a demographic section. The study focused on items concerning: Participation in guideline evaluation, approval, and adoption process for the specific CPGs produced by the regulatory body (Item 1); Objectives of guidelines (Items 2-5); General guideline development of published CPGs by regulatory body (Items 6-30); Evaluation, approval, and adoption of specific guidelines published by the regulatory body board members participate in (Items 31-44); Development and quality of guidelines published by the regulatory bodies (Items 45-47); Perceived costs of guidelines (Items 48-49); Beliefs about the regulatory bodies continuing to produce CPGs (Item 50); and Familiarity of guideline development methods (Items 51-58).

Item 1 consisted of multiple-choice options (i.e., select all that apply) of all relevant guidelines concerning participation in the guideline evaluation, approval, and adoption process or selection of the *I did not participate in the approval or adoption process for any of these guidelines* option. Items 2 to 44 were rated on a 5-point Likert scale (1 = *strongly disagree* to 5 =

strongly agree) and the *I don't know*, or *not applicable* options. Items 45 to 47 were rated on a 7-point Likert scale (1 = *very poor* to 7 = *excellent*) and an "*I don't know"* option. Items 48 to 49 were rated using a drop-down menu and options ranged from *$0* to *greater than $150,000*, or a "*I don't know"* option. Item 50 consisted of a "*yes"* or "*no"* response option. Lastly, Items 51 to 58 were rated on a 5-point Likert scale (1 = *not at all familiar* to 5 = *extremely familiar*). See Tables 4 to 12 for survey items.

This survey also involved if-then question logic algorithm. As such, this allowed for board members who participated in the guideline evaluation, approval, and adoption process and those who did not to receive only relevant subsequent survey items. In particular, board members who responded positively to participating in the guideline evaluation, approval, and adoption process for specific guidelines (Item 1) were directed to complete all possible survey items. In contrast, board members who responded negatively to this former item (Item 1), were redirected to general items regarding guidelines published by their respective regulatory body. As such, they skipped items about the specific guideline evaluation, approval, and adoption process (Items 31-44). Hence, all participants, regardless of their response for Item 1, were directed to Items 2 to 30 and then to Items 45 to 58. However, only those participants who indicated participating in the evaluation, approval, and adoption process of specific guidelines (Item 1) were directed to complete Items 31 to 44.

Procedures

The current study obtained ethical approval from the McGill University Ethics Board II (REB # 284-1216). Participants were initially recruited by contacting the Secretary Generals for the five regulatory bodies to request that they distribute the recruitment e-mails and surveys to their board members. However, only the OPPQ and OEQ agreed to disseminate the surveys and send follow-up and reminder e-mails. While, the OPQ, OCCOQ, and OEQ were unable or refused to do so (i.e., indicating that their members were sworn to secrecy in terms of their activities, that they had too many research requests at the time, or they simply did not respond after several attempts of contact, respectively). Given a limited number of obtained participants, an alternative recruitment method was used for all regulatory bodies. Specifically, the members were identified by cross-referencing the guidelines and the corresponding annual reports to locate the name of past members and current members were identified on the regulatory bodies' website. Their contact information was then obtained via the regulatory bodies' websites or using

an Internet search. Recruitment, follow-up, and reminder e-mails were then sent directly to these members. Participants received the survey version that was specific to their regulatory body and profession (e.g., psychologists received the OPQ guideline survey). As incentive, participants had the opportunity to enter a draw to win an Apple iPad mini once they completed the survey.

Data Analysis

Descriptive statistics were calculated for the demographic characteristics for all surveys separately. Survey items were analyzed either by calculating frequencies and percentages, or by calculating means and standard deviations. The means and standard deviations were calculated using all ratings (i.e., 1 = *strongly disagree* to 5 = *strongly agree*; 1 = *very poor* to 7 = *excellent*; and 1 = *not at all familiar* to 5 = *extremely familiar)* and excluded "*I don't know"* and "*not applicable"* options. Rating scores were also combined and calculated as follows: *agree* and *strongly agree*, *very good* and *excellent*, or *moderately familiar* and *extremely familiar*. Corresponding percentages were also computed. These grouped ratings represented favourable agreement of the survey items. Given the small sample sizes and virtually identical surveys, ratings obtained from all five survey versions were merged for items pertaining to guideline objectives, development, quality, and familiarity of development methods, as well as for the guideline evaluation, approval, and adoption process. Means and standards deviations and combined agreement scores were merged across all board members and regulatory bodies for these items.

Results

Demographic Characteristics

A total of 34 online surveys were completed, resulting in a response rate of 25% (34/137). Participants consisted of members of the board of directors from five professional regulatory bodies. The majority of the sample were female (68%), most obtained a master's degree as their highest degree earned (68%), followed by a doctoral degree (24%). A slight majority of respondents reported 5 or more years of experience as a board member (53%). Table 2 summarizes the demographic characteristics for the board members. Percentage of time spent on professional activities varied. Twenty-seven percent of the sample reported engaging in clinical or service activity 0-20% of the time, 24% for 21-59% of the time and 50% for 60-100% of the time for this activity. Most of respondents (68%) reported 0% of their time was spent on

research and 74% reported 0-40% for time spent on administration or management. See Table 3 for details for professional characteristics.

Survey Responses

The frequencies and percentages, means, standard deviations, as well as combined ratings for all survey items can be found in Tables 4 through 6. For Item 1, the results indicated that most of the OPQ (71%), OEQ (67%), and OCCOQ (56%), and board members did not participate in the evaluation, approval, and adoption process of the CPGs published by their regulatory body. In contrast, 67% of OPPQ and 100% of OTSTCFQ board members indicated that they participated in the evaluation, approval, and adoption process for these CPGs. These findings and the specific guidelines endorsed are presented in Table 4.

Guideline Objectives, Development, Quality, and Familiarity of Methods

All respondents completed the following items, regardless of participation in the evaluation, approval, and adoption process of the CPGs produced by the regulatory bodies. The results for the guideline objectives, development, quality, and familiarity of methods are presented below and in Table 5. Items 2 to 5 concerned the objectives of the guidelines produced by the regulatory bodies. Across regulatory bodies, most board members agreed with the majority of these items, with 94% of respondents indicating agreement with the CPGs aimed to improve the quality of service offered by professionals (Item 4), followed by to serve as norms or standards of practice that must be respected by professionals (Item 3; 92%) and to serve as educational tools for professionals (Item 2; 82%). Only 15% of board members agreed that the CPGs were aimed to make services more cost-effective (economical) (Item 4).

In terms of guideline development (Items 6-30), across the regulatory bodies, most board members *agreed* or *strongly agreed* with the bulk of the statements. Specifically, 94% of respondents agreed that the guidelines were well organized, structured, and clear (Item 6). Most were in agreement with statements representing good methodological rigour and development methods for these guidelines. The vast majority of members agreed that the CPGs were based on the most recent scientific evidence (93%; Item 10), clinical expertise (88%; Item 11), expert consensus (94%; Item 12) and in accordance with best practice in guideline development (88%; Item 13). Most members also believed that the CPGs were developed using consultation and involving experts. In this vein, the majority of respondents agreed that the CPG development process included consultation with an expert in knowledge synthesis (86%; Item 14), a credible

committee of experts (90%; Item 15), a development committee representing all stakeholders (71%; Item 16) and with external consultants (65%; Item 17). Concerning the specific guideline methods used to acquire the evidence and formulate the guideline recommendations, most respondents agreed that the CPGs involved a structured systematic method for conducting the literature search (82%; Item 19), using a systematic method to assess the scientific evidence to create the CPGs (69%; Item 20), using an informal consensus method to make final decisions regarding the final recommendations (81%; Item 22), describing a direct link between the recommendations and scientific evidence (69%; Item 23), addressing potential ethical issues that may be associated with practice in the area covered by the guideline (66%; Item 25) and providing sufficient information on how the CPGs were developed (59%; Item 18; see Table 5).

Fewer respondents were in agreement for the minority of statements. Specifically, 50% agreed that the CPGs were used to discourage suboptimal practice (Item 8), described strengths and limitations (47%; Item 24) and used a formal method of consensus to formulate the final recommendations (38%; Item 21). Very few respondents (9%) were in agreement with the guidelines being oversimplified cookbooks (Item 7). Finally, concerning guideline implementation and the impact on practice, a slight majority of respondents (53%) agreed that the CPGs discussed barriers and facilitators to implementation (Item 28) and only 26% agreed that the CPGs included a plan to assess the effects of the recommendations on practice (Item 29; see Table 5).

Items 45 to 47 were related to the quality and development of the regulatory CPGs. Most respondents believed that the development process (90%; Item 45), clinical recommendations (85%; Item 46) and overall quality of guidelines (94%; Items 47) were *very good* or *excellent* (see Table 5).

Lastly, Items 51 to 59 assessed the degree to which the board members were familiar with guideline development methods. Close to none of the board members reported being *moderately familiar* or *extremely familiar* with these methods. Only 3% of respondents indicated being *moderately familiar* or *extremely familiar* with the AGREE II method (Item 52) and 6% with NICE (Item 56) and INESSS 2012 and 2015 (Item 57), respectively. Of the methods, Items 52 (AGREE III) and 58 (IPDG) were fabricated methods used in order to assess social desirability. Only one member (3%) reported being *moderately* or *extremely familiar* with the false AGREE-III method. On average, across regulatory bodies, respondents were either 1 (*not at*

all familiar) or 2 (*slightly familiar*) with the AGREE-III method (M = 1.3, SD = .60). On average respondents indicated being 1 (*not at all familiar*) with the IPGD method (M = 1.0, SD = .00) (see Table 5).

Items 48 and 49 pertained to the perceived costs of a guideline and the maximum cost to develop a guideline, respectively. Across the regulatory bodies, the board members also provided variable responses concerning the costs. For Item 48, 62% of respondents perceived the cost of a given guideline to range from *$0 to $60,000*, with only 15% indicating from *$70,000 to $120,000* and 18% reporting *I don't know.* For Item 49, 56% of respondents perceived the maximum cost to develop a guideline to range from *$0 to $60,000*, with 15% from *$70,000 to $110,000* and 24% responded *I don't know*. Additionally, all board members, with the exception of one from the OPQ (3%), indicated "*yes"* in response to whether the regulatory bodies should continue to publish CPGs (Item 50; 97%).

Guideline Evaluation, Approval, and Adoption Process

Only respondents indicating participation in the evaluation, approval, and adoption process of the CPGs produced by the regulatory bodies completed the following items. Items 31-44 addressed the evaluation, approval and adoption of CPGs and only board members who indicated participating in this process in Item 1 completed these items (n = 15; see Table 6 for details). The majority of respondents *agree* or *strongly agree* with most of these statements, which involved that the process considered and addressed their opinions, questions, conflicts of interest and biases and sufficient time to make decisions (Items 31-35) and that they approved the guidelines (Item 37). Agreement for these items ranged from 85% to 100%. No respondents were in agreement with there being problems with the evaluation, approval and adoption process (0%; Item 36).

Items 38 to 42 as well as Item 44 assessed the board members' familiarity or expertise in the areas covered by the guidelines based on clinical and research experience and on guideline development and methods, and knowledge transfer. Most respondents reported that they had sufficient clinical expertise on the guideline topic (79%; Item 38), expertise in knowledge synthesis (77%; Item 40) and knowledge transfer and dissemination (64%; Item 41) and that they were aware of guideline development methods (73%; Item 44). In contrast, very few respondents reported that they had sufficient research expertise on the guideline topic (39%; Item 39), expertise in guideline development methods (36%; Item 42) and that they had knowledge in

guideline development that was sufficient to assess the methodological quality of CPGs (50%; Item 43; see Table 6).

Discussion

This study suggests that the members of board of directors' mostly have positive attitudes towards the development process of the CPGs produced by the regulatory bodies. The findings further highlight optimistic views and experiences of the guideline evaluation, approval, and adoption process, and the quality and recommendations of the CPGs. Familiarity of guideline topics and key aspects of guideline development were wide-ranging. However, familiarity of guideline development methods was limited. The perceived costs of CPGs were also quite consistent.

Guideline Objectives

Across regulatory bodies, most board members viewed the majority of the objectives for the CPGs published by the regulatory bodies as favourable. Specifically, most board members (94%) agreed that the guidelines are aimed to improve the quality of service offered by professionals (Item 4), with 92% of members reporting they intend to serve as norms or standards of practice that must be respected by professionals (Item 3) and 82% for guidelines serving as educational tools for professionals (Item 2). In contrast, Item 4 pertaining to CPGs being aimed to make services more cost-effective (economical) obtained limited agreement among board members (15%). To date, there is no available data pertaining to board members' views concerning the objectives of guidelines in the social sciences and in medicine. However, some comparisons can be made in light of the views of members of guideline development committees and professionals. A recent study examining the development committee members for the Quebec regulatory bodies found that 90% of members agreed that the objective of CPGs was to make suggestions to guide and inform professionals. This study also found that 77% of members agreed that the CPGs were aimed at protecting the public and 68% reported agreement with the CPGs being aimed at outlining and providing recommendations that are evidence-based (Trépanier, 2019). Some studies also indicate that professionals have positive views on CPGs objectives (e.g., Farquhar et al., 2002; Higashi et al., 2010; Sandström et al., 2014). In contrast, research in the medical field demonstrates that CPGs deemed to make services more cost-effective are those that are consistently endorsed (Feldman et al., 1998; Flores et al., 2000). Overall, these findings indicate that most board members perceive the CPGs to improve practice,

increase adherence to standards, and ameliorate educational tools. Nonetheless, board members do not believe CPGs allow for more economical services. This is surprising, since CPGs have been found not only to improve outcomes, but also to reduce health care costs (Graham et al., 2000; Hollon et al., 2014; van Dijk et al., 2013).

Guideline Development

Most board members had positive attitudes towards the guideline development process. In particular, there was agreement concerning items that addressed the CPGs organization (Item 6), purpose (Item 9), methodological rigour and guideline development process (Items 10-20, 22-23), ethical issues (Item 25), as well as accessibility (Item 26) and strategies for implementation (Items 27 and 29) and dissemination (Item 30). The percentages of agreement ranged from 59% to 94% for these items. Only 9% reported that the guidelines were oversimplified cookbooks (Item 7), suggesting that most board members perceived the CPGs to be more refined and less rigid. These findings suggest that the majority of the members of the boards of directors across the regulatory bodies perceived the methodological rigour and development process for CPGs as sound. This is somewhat surprising given that recent studies in the social sciences demonstrated shortcomings with the development, methodological rigour, and quality of some of those guidelines (Ciquier et al., 2020; Stamoulos et al., 2014; Trépanier et al., 2017; Trépanier, 2019). To date, the other CPGs included in the current study have yet to be assessed in terms of their quality. Similarly, a study examining the development committee members' views and experiences of the OPQ, OPPQ, OCCOQ, OTSTCFQ, OEQ, and the Collège des médecins du Québec (CMQ)/College of Physicians of Quebec guidelines found issues with the guideline development methods and process (Trépanier, 2019). In the medical literature, the methodological issues involved in guideline development and quality of CPGs have reliably been found to be problematic (Al-Ansary et al., 2013; Atkins et al., 2013; Campbell et al., 2009; Cecamore et al., 2011; Kryworuchko et al., 2009; Tudor et al., 2013).

Fewer board members reported agreement towards some of the guideline development items. Specifically, 50% agreed that the CPGs were used to discourage suboptimal practice (Item 8), 47% agreed that they described strengths and limitations (Item 47) and 38% agreed that a formal method of consensus was used to formulate the final recommendations (Item 21). Lower agreement (7%) was found among guideline development committee members concerning the use of a formal consensus method in the guideline development process for these guidelines and

some medical guidelines (Trépanier, 2019). Provided that this study did not assess committee members' attitudes in light of CPGs being used for suboptimal practice, nor did it evaluate whether members addressed the CPGs strengths and limitations, it cannot be fully compared to the results from the present study.

Even fewer board members (26%) were in agreement that the CPGs did not include a plan to assess the effect of them in practice (Item 29), suggesting the majority of the members disagreed with this statement. A total of 53% of board members also agreed with the CPGs discussing the facilitators and barriers to their implementation (Item 28), indicating these areas were not adequately considered for most CPGs. Correspondingly, a recent study appraised the quality of the OPQ guidelines and found that a plan assessing the impact of the guidelines on services were not addressed by any of these CPGs and only the *Autism Disorders Spectrum – Clinical Evaluation (2012)* CPGs addressed the barriers and facilitators to its application in practice (Trépanier, 2019). Similarly, a more recent study evaluated the quality of seven CPGs produced by the OPQ, OPPQ, OTSTCFQ, and CMQ and also found overall low quality rating scores for the guideline application domain; including that these CPGs inadequately addressed a plan assessing the guidelines impact on practice nor described the facilitators and barriers to the CPGs application (Ciquier et al., 2020). The remaining guidelines addressed in the current study cannot be compared given that they were not appraised by Trépanier (2019) and Ciquier et al. (2020).

The vast majority of board members within the present study perceived the overall quality and development of the guidelines and their recommendations to be quite high. These findings indicate strong favourable views towards the CPGs published by the regulatory bodies. This is consistent with the majority of findings revealed in the current study regarding the development, evaluation, approval, and adoption process of the CPGs. It is further supported by the fact that almost all the board members (97%) agreed that their respective regulatory bodies should continue to publish guidelines (Item 50). These attitudes appear to be contrary the previously reviewed literature concerning guideline development and quality for the CPGs published by the regulatory bodies (Ciquier et al., 2020; Trépanier et al., 2017; Trépanier, 2019). The optimistic views endorsed by board members may be explained by potential limited understanding and expertise with appropriate and rigorous guideline development methodology, as well as potential unfamiliarity with good quality guidelines.

Familiarity of Guideline Development Methods

All board members were also asked to rate their level of familiarity with specific guideline development methods (Items 51-58). A very small portion of the board members indicated being moderately to extremely familiar with only three of these methods (i.e., 3% for AGREE II and 6% for NICE and INESSS 2012 or 2015), suggesting a lack of familiarity. This is unlikely to be due to selection bias, since false items (i.e., Items 52 and 58) were included to assess social desirability and only one board member indicated being moderately to extremely familiar with the AGREE-III method and all respondents reported that they were *not at all familiar* with the IPDG method. The lack of familiarity of these methods among the board members may in part be explained by their lack of active focus on research. That is, 68% of the entire sample (both members participating and non-participating in the evaluation, approval, and adoption of specific CPGs) reported dedicating no time to research. The lack of familiarity of specific guideline methods is worrisome, since it would be expected that the board members responsible for overseeing CPGs would consult these methods and be knowledgeable of them. Based on the results, it appears that overall, the vast majority of the board members (participating and not participating in the evaluation, approval, and adoption process) seem to be unfamiliar with the guideline development methods. This is similar to recent findings that only 0-15% of members of the development committees for the OPQ, OCCOQ, OPQ, OTSTCFQ, OEQ, and CMQ were familiar or very familiar with the guideline development methods or manuals (Trépanier, 2019). Given that the members of the guideline development committees lacked familiarity of these methods, it was expected that the board members would also be unfamiliar with them.

Proficiency in research expertise of the guideline topics and in guideline development and methods are necessary in order to effectively participate in the evaluation, approval, and adoption of CPGs. The aforementioned findings are disquieting, since good quality CPGs are supposed to be based on scientific evidence and are contingent on sound methodological rigour of the development process (Hollon et al., 2014). This also involves the effective use of guideline development methods in order to produce scientific and rigorous CPGs (Andrews & Redmond, 2004; Beauchamp et al., 2015; Brouwers et al., 2010; Browman et al., 1995; Hollon et al., 2014). Given that board members indicated that they were not well-versed in these areas, it is unlikely that CPGs would have been based on rigorous methodologies and scientific evidence. This is

consistent with research in medicine suggesting that policy makers lack knowledge of the guideline development process and related methodological rigour and that the use of specific guideline development methods is dependent on their level of expertise in guideline development (Kryworuchko et al., 2009). As such, enhancing the knowledge or familiarity and use of the guideline development methods among policy makers is essential (Kryworuchko et al., 2009; Norris et al., 2016).

Guideline Evaluation, Approval, and Adoption Process

Rates of participation in the evaluation, approval, and adoption of CPGs were limited, consisting of 15 out 34 members. This finding is unsurprising, when considering that board members solicited in the current study included members that were in office at the time a given CPG was approved and published, and other members were not. However, overall, board members' views and experiences towards this process were positive. Most agreed that their opinions were considered and solicited (Item 31; 87%), that their questions (100%; Item 32), divergent opinions (85%; Item 33) and conflicts of interests and biases (100%; Item 34) were adequately considered and addressed. All board members also indicated agreement with regarding to having sufficient time to make decisions about the CPGs (100%; Item 35) and having approved the guidelines (100%, Item 37). None of these board members indicated that there were issues with the evaluation and approval process (0%; Item 36). Comparison of these findings to current literature is difficult as no other studies have examined these aspects of the guideline evaluation and approval process among board members. Trépanier's (2019) study represents the closest possible comparison, as it examined some of these items specifically among development committee members during the development process. This study found that the majority of committee members had high agreement concerning their opinions (85%), divergent opinions (85%), and conflicts of interests (84%) being considered and resolved, as well as 74% of these members endorsed the CPGs (Trépanier, 2019).

Self-reports of board members' familiarity of the guideline topics, knowledge synthesis, transfer and dissemination, as well as guideline development, methodological quality and related methods varied. Of those board members who participated in the evaluation, approval and adoption process, most reported that they had sufficient clinical expertise in the topics or areas covered by the guidelines, expertise in knowledge synthesis, transfer, and dissemination, and that they were aware that methods for developing guidelines exist; rates of agreement ranged from

64% to 79% (Items 38, 40, 41, and 44). Conversely, fewer board members reported having sufficient research expertise on the guideline topic, expertise in development methods and had knowledge in guideline development that was sufficient to assess the methodological quality of the CPGs, ranging from 36% to 50% (Items 39, 42, and 43). These findings may suggest that these board members have adequate familiarity or knowledge in some areas (i.e., clinical expertise for guideline topics as well as knowledge synthesis, transfer, and dissemination) and insufficient knowledge in other areas (i.e., research expertise for CPGs topics and expertise in guideline development and methods). These findings are consistent with previous items (Items 51-58) pertaining to board members' lack of familiarity of the guideline development methods. While most of these board members (73%) seem to be aware that methods for guideline development exist (Item 44), they appear to be largely unfamiliar with these specific methods. This finding is unexpected considering that development methods are common knowledge in the guideline literature and are utilized by various organizations that specialize in guideline development.

Costs of Guidelines

The perceived cost and maximum acceptable cost of a guideline among board members varied. Most board members (62%) indicated that the cost of a given guideline and the maximum acceptable cost to develop a guideline (56%) ranged from $0 to $60,000, respectively. These findings suggest that board members have some knowledge of the actual costs to produce CPGs. Based on recent findings, the reported cost of the *Assessment of Dyslexia in Children (2014) guidelines* from the OPQ was over $70,000 (Trépanier, 2019). The costs of other CPGs produced by the OPQ, as well as CPGs produced by the other regulatory bodies, have yet to be documented in the literature. The high costs of developing and disseminating CPGs (Trépanier, 2019) is exacerbated by the poor methodological rigour, development, and quality with regard to some of the current CPGs evaluated in recent studies (Ciquier et al., 2020; Stamoulos et al., 2014; Trépanier et al., 2017; Trépanier, 2019). Although the current study reported that CPGs are positively perceived in terms of methodological rigour, development, and quality, it remains unclear whether professionals actually use or implement CPGs in practice. Further examination of the costs and quality of CPGs and how these factors may contribute to professionals' work in their respective field is required.

Conclusion

The current study assessed the views and experiences of CPGs of members of the board of directors across five Quebec regulatory bodies in the social sciences. The findings revealed that the vast majority of board members have favourable attitudes of guideline objectives and development of CPGs produced by the regulatory bodies. Board members displayed positive views and experiences towards the guideline evaluation, approval, and adoption of these guidelines. These members demonstrated that they have some general familiarity of guideline development and have limited knowledge of the existing guideline development methods. Lastly, the perceived costs of guidelines were variable.

The key strength of the current study is that it is the first to document and examine members of the board of directors with regard to their role, familiarity, attitudes, and experiences toward CPGs including the evaluation, approval, and adoption of CPGs published in Quebec and in the social sciences. Relatedly, the study examined this topic across various social science professions and mental health and social care CPGs, which has until now, never been examined.

While this study contributes to the existing literature, it was limited in a few ways. The small sample size and 25% response rate hinders the generalizability of the findings and may be suggestive of selection bias. Indeed, a small number of board members participated in the evaluation, approval, and adoption of CPGs and thus this population may be underrepresented. Participants were asked to critique CPGs they directly evaluated and approved, or CPGs produced by their professional regulatory body they currently or previously served on. Although two false questions were included in the distributed surveys in an effort to deter responses based on social desirability, responses may have been biased given that most responses were favourable and were self-reported.

As previously mentioned, a limited number of the members of the board of directors participated in this study, which warrants further discussion here. First, most of the regulatory bodies (3 out of 5) did not want to distribute the surveys to their members, which may largely account for the limited participants obtained. This lack of collaboration is particularly alarming as it hinders the promotion and advancement in research. The regulatory bodies are responsible for guiding their professional members in practice, professionalism, and ethical conduct, as well as encouraging the use of evidence-based practices. Refusing to allow their members (i.e., those responsible for overseeing the development, evaluation, approval, and dissemination of their

CPGs) the opportunity to provide information and constructive feedback about this process is questionable. Conversely, we applaud the OPPQ and OEQ that encouraged the distribution of the surveys and guideline research.

Second, the study found that a large number of board members across the regulatory bodies abandoned the surveys (i.e., 10 of the 44). This further limited the number of respondents. The reasons for this are unknown; possible explanations are that some members were uncomfortable criticizing their work, did not actually participate in the development, approval, and dissemination of the CPGs in question, or were simply unavailable to participate in the study. Increased collaboration among all regulatory bodies, board of directors, professionals, and researchers is imperative in order to advance guideline research in the social sciences and in Quebec.

These limitations represent a number of important future directions. Future research should replicate the current study utilizing a larger sample to enhance generalizability and application of findings. As previously indicated, this would require the cooperation of the regulatory bodies and their board members. Another recommendation for future research includes conducting observational studies with board members and development committees. This would allow for a more comprehensive examination of the development and evaluation, approval, and dissemination process, as well as familiarity of the guideline development methods. It would likewise be valuable for the regulatory bodies to foster the knowledge of these methods via training for their board of directors and create a guidance protocol to utilize during the development, evaluation, approval, and dissemination of CPGs. Future studies may focus on studying the actual costs and benefits of all the guidelines. Lastly, examining the familiarity, attitudes, use, and implementation of CPGs of professional members, including their views of guideline development, methodological rigour, and costs would be invaluable as these research endeavors would meaningfully inform policymaking and in turn professional practice.

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Table 1

List of Regulatory Bodies and Mental Health, and Social Care Service Guidelines

Regulatory Body	Guidelines
1. l'Ordre des psychologues du Québec (OPQ)/the Order of Psychologists of Quebec	• Guidelines for the Assessment of Dyslexia in Children (2014) • Guidelines: Autism Spectrum Disorders – Clinical Evaluation (2012) • Guidelines for the Assessment of Mental Retardation (2007) • Guidelines for the Assessment of a Child in Connection with a • Request for Derogation to the Age of School Admission (2006) • Guidelines for Expert Assessment Concerning Child Custody and Access Rights (2006)
2. l'Ordre des conseillers et conseillères d'orientation du Québec (OCCOQ)/the Order of Guidance Counsellors of Quebec	• Guidelines for the Orientation and General Formation of Young People (2013) • Guidelines for Assessment Guide for Career and Guidance Counselling (2010) (English version - 2011)
3. l'Ordre des psychoéducateurs et psychoéducatrices du Québec (OPPQ)/the Order of Psychoeducators of Quebec	• Guidelines for the Assessment for School Exemption or Derogation (2015) • Guidelines for the Evaluation of a Student with a Disability or a Social Maladjustment as Part of the Determination of an Intervention Plan Under the Education Act (2015) • Guidelines for the Psychoeducational Assessment of the Person with Adjustment Difficulties (2014) • Guidelines for the Intervention Plan for a Person Staying in a Youth Center (2014) • Guidelines on the Assessment of a Person Under the YPA (2014) • Guidelines for the Evaluation of an Adolescent in Relation to a Tribunal Decision when Applying the Law Respecting the Penal Justice System for Adolescents (2014) • Guidelines for the Assessment of Mental Retardation (2013) • Guidelines for the Use of Measuring Instruments (2013)

Regulatory Body	Guidelines
4. l'Ordre des thérapeutes conjugaux et familiaux et des travailleurs sociaux du Québec (OTSTCFQ)/the Order of Social Workers and Marriage and Family Therapists of Quebec	• Guidelines for the Psychosocial Assessment in the Context of Protective Supervision, the Mandate Given in Anticipation of Incapacity and Other Protective Measures for Adults (2016) • Guidelines for the Independent Practice of Social Workers and Marital and Family Therapists (2015) • Guidelines for the Professional Practice of Social Workers in Youth Protection (2009) • Guidelines for the Professional Practice of Community Social Workers (2008) • Guidelines for Determining an Intervention Plan for a Person Suffering from a Mental Disorder or at Risk of Suicide who is Housed in a Facility of an Establishment that Operates a Rehabilitation Center for Young People with Adjustment Difficulties (2014) • Guidelines for Assessing a Person in the Context of the Director's decision for Youth Protection or of the Court Under the Youth Protection Act (2012) • Guidelines for the Decision on the Utilization of Restraint and Isolation Method Within the Law of Health and Social Services and Indigenous Populations (2011) • Guidelines for the Evaluation of a Child Not Yet Admissible to Pre-School but Who Presents with Developmental Delays to Determine the Rehabilitation and Adaptation Services that Meet their Needs (2011) • Guidelines for Evaluating a Person with a Mental or Neuropsychological Disorder as Diagnosed by an Evaluation Attested by a Trained Professional (2011) • Guidelines for the Expertise in Child Care and Access Rights (2006)
5. l'Ordre des ergothérapeutes du Québec (OEQ)/ The Order of Occupational Therapists of Quebec	• Guidelines for the Interventions Related to the Utilization of a Road Vehicle - Guide for the Occupational Therapist (2008) • Guidelines for the Restraint Measures: From Prevention to their Exceptional Use - Guide for Occupational Therapists (2006)

Table 2

Descriptive Information by Regulatory Body

	OPQ board members		OCCOQ board members		OPPQ board members		OTSTCFQ board members		OEQ board members		Total	
Variable	*N*	%	*N*	%	*n*	%	*n*	%	*n*	%	*n*	%
Gender												
Female	4	57.1	7	77.8	3	50.0	2	66.7	7	77.8	23	67.6
Male	3	42.9	2	22.2	3	50.0	1	33.3	1	11.1	10	29.4
Gender variant non-conforming and/or transgender												
I prefer not to Disclose									1	11.1	1	2.9
Years of experience as a board member												
0 – 2			1	11.1					2	22.2	3	8.8
3 – 4	3	42.9	3	33.3	2	33.3	2	66.7	3	33.3	13	38.2
5 and more	4	57.1	5	55.6	4	66.7	1	33.3	4	44.4	18	52.9
Highest diploma earned												
Bachelors					1	16.7					1	2.9
Masters	4	57.1	8	88.9	4	66.7	3	100.0	4	44.4	23	67.6
PhD	1	14.3	1	11.1	1	16.7			5	55.6	8	23.5
PsyD	2	28.6									2	5.9
Post-Doctoral												
Years holding a professional license												
0 – 5												
6 – 10					2	33.3			1	11.1	3	8.8
11 – 15			2	22.2	1	16.7	1	33.3	2	22.2	6	17.6
16 – 20	1	14.3	1	11.1	3	50.0	2	66.7			7	20.6
21 – 25	1	14.3	5	55.6					1	11.1	7	20.6
26 – 30			1	11.1					4	44.4	5	14.7
31 and more	5	71.4							1	11.1	6	17.6

Note. $N = 34$.

Table 3

Percentage of Time Spent on Professional Activities by Regulatory Body

	OPQ board members		OCCOQ board members		OPPQ board members		OTSTCFQ board members		OEQ board members		Total	
Variable	*N*	*%*	*n*	*%*	*N*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Time spent on activities												
Clinical or service												
0					2	33.3			3	33.3	5	14.7
20 or less			2	22.2	1	16.7			1	11.1	4	11.8
21 – 39	1	14.3	1	11.1			1	33.3			3	8.8
40 – 59	1	14.3	1	11.1	1	16.7	1	33.3	1	11.1	5	14.7
60 – 79	1	14.3	1	11.1	2	33.4	1	33.3			5	14.7
80 – 100	4	57.2	4	44.4					4	44.4	12	35.3
Research												
0	6	85.7	5	55.6	3	50.0	3	100.0	6	66.7	23	67.6
20 or less	1	14.3	2	22.2	1	16.7			2	22.2	6	17.6
21 – 39					1	16.7					1	2.9
40 – 59			1	11.1	1	16.7			1	11.1	3	8.8
60 – 79			1	11.1							1	2.9
80 – 100												
Administration or management												
0	5	71.4	2	22.2	1	16.7			2	22.2	10	29.4
20 or less	1	14.3	4	44.4	2	33.4			3	33.3	10	29.4
21 – 39	1	14.3	2	22.2	1	16.7	1	33.3			5	14.7
40 – 59					2	33.4			1	11.1	3	8.8
60 – 79							2	66.6			2	5.9
80 – 100			1	11.1					3	33.3	4	11.8
Teaching												
0	2	28.6	5	55.6	1	16.7			8	88.9	16	47.1
20 or less	3	42.9	4	44.4	3	50.1	3	100.0			13	38.2
21 – 39	1	14.3									1	2.9
40 – 59	1	14.3			1	16.7			1	11.1	3	8.8
60 – 79												
80 – 100					1	16.7					1	2.9

Note. $N = 34$.

Table 4

Survey Item Concerning Participation in Guideline Approval and Adoption Process

Regulatory Body/ Board Members	Selection of Guidelines	Total Responses *n (%)*
OPQ (*N* = 7)	Guidelines for the Assessment of Dyslexia in Children (2014)	1 (14.2)
	Guidelines: Autism Spectrum Disorders – Clinical Evaluation (2012)	1 (14.3)
	Guidelines for the Assessment of Mental Retardation (2007)	2 (28.6)
	Guidelines for the Assessment of a Child in Connection with a Request for Derogation to the Age of School Admission (2006)	2 (28.6)
	Guidelines for Expert Assessment Concerning Child Custody and Access Rights (2006)	2 (28.6)
	I did not participate in the approval or adoption process for any of these CPGs	5 (71.4)
OCCOQ (*N* = 9)	Guidelines for the Orientation and General Formation of Young People (2013)	2 (22.2)
	Guidelines for Assessment Guide for Career and Guidance Counselling (2010) (English version – 2011)	3 (33.3)
	I did not participate in the approval or adoption process for any of these CPGs	5 (55.6)
OPPQ (*N* = 6)	Guidelines for the Assessment for School Exemption or Derogation (2015)	3 (50.0)
	Guidelines for the Evaluation of a Student with a Disability or a Social Maladjustment as Part of the Determination of an Intervention Plan Under the Education Act (2015)	3 (50.0)
	Guidelines for the Psychoeducational Assessment of the Person with Adjustment Difficulties (2014)	4 (66.7)
	Guidelines for the Intervention Plan for a Person Staying in a Youth Center (2014)	4 (66.7)
	Guidelines on the Assessment of a Person Under the YPA (2014)	4 (66.7)
	Guidelines for the Evaluation of an Adolescent in Relation to a Tribunal Decision when Applying the Law Respecting the Penal Justice System for Adolescents (2014)	4 (66.7)
	Guidelines for the Assessment of Mental Retardation (2013)	4 (66.7)
	Guidelines for the Use of Measuring Instruments (2013)	4 (66.7)
	I did not participate in the approval or adoption process for any of these CPGs	2 (33.3)

Regulatory Body/Board Members	Selection of Guidelines	Total Responses *n (%)*
OTSTCFQ (*N* = 3)	Guidelines for the Psychosocial Assessment in the Context of Protective Supervision, the Mandate Given in Anticipation of Incapacity and Other Protective Measures for Adults (2016)	1 (33.3)
	Guidelines for the Independent Practice of Social Workers and Marital and Family Therapists (2015)	1 (33.3)
	Guidelines for the Professional Practice of Social Workers in Youth Protection (2009)	0 (0.0)
	Guidelines for the Professional Practice of Community Social Workers (2008)	0 (0.0)
	Guidelines for Determining an Intervention Plan for a Person Suffering from a Mental Disorder or at Risk of Suicide who is Housed in a Facility of an Establishment that Operates a Rehabilitation Center for Young People with Adjustment Difficulties (2014)	1 (33.3)
	Guidelines for Assessing a Person in the Context of the Director's decision for Youth Protection or of the Court Under the Youth Protection Act (2012)	1 (33.3)
	Guidelines for the Decision on the Utilization of Restraint and Isolation Method Within the Law of Health and Social Services and Indigenous Populations (2011)	1 (33.3)
	Guidelines for the Evaluation of a Child Not Yet Admissible to Pre-School but Who Presents with Developmental Delays to Determine the Rehabilitation and Adaptation Services that Meet their Needs (2011)	1 (33.3)
	Guidelines for Evaluating a Person with a Mental or Neuropsychological Disorder as Diagnosed by an Evaluation Attested by a Trained Professional (2011)	1 (33.3)
	Guidelines for the Expertise in Child Care and Access Rights (2006)	1 (33.3)
	I did not participate in the approval or adoption process for any of these CPGs	0 (0.0)
OEQ (*N* = 9)	Guidelines for the Interventions Related to the Utilization of a Road Vehicle - Guide for the Occupational Therapist (2008)	3 (33.3)
	Guidelines for the Restraint Measures: From Prevention to their Exceptional Use - Guide for Occupational Therapists (2006)	1 (11.1)
	I did not participate in the approval or adoption process for any of these CPGs	6 (66.7)

Note. *N* = 34.

Table 5

Survey Items Concerning Guideline Objectives, Development, Quality, and Familiarity of Guideline Methods for All Board Members

Variables	Total Responses *N*	*M*	*SD*	Agree and Strongly Agree *n (%)*
Guideline Objectives				
Q2. Aim to serve as educational tools for professionals.	33	4.1	1.04	27 (81.8)
Q3. Aim to serve as norms or standards of practice that must be respected by professionals.	34	4.6	.60	31 (91.2)
Q4. Aim to improve the quality of service offered by professionals.	34	4.7	.54	32 (94.1)
Q5. Aim to make services more cost-effective (economical).	34	2.5	1.20	5 (14.7)
Guideline Development				
Q6. Are well designed, organized, clear and consistent.	34	4.6	.67	32 (94.1)
Q7. Are oversimplified cookbooks.	33	1.9	.86	3 (9.1)
Q8. Are used to discourage suboptimal practice.	34	3.2	1.08	17 (50.0)
Q9. Are used to prevent professionals from engaging in engaging in malpractice.	33	3.8	.96	25 (75.8)
Q10. Were based on the most recent scientific evidence (at the time of production of the guideline).	30	4.3	.71	28 (93.3)
Q11. Were based on clinical expertise.	34	4.2	.77	30 (88.2)
Q12. Were based on expert consensus.	32	4.3	.56	30 (93.8)
Q13. Were developed in accordance with best practice in the development of guidelines.	33	4.3	.92	29 (87.9)
Q14. Involved a consultation with an expert in the development of guidelines (knowledge synthesis).	26	4.2	.86	23 (88.5)
Q15. Involved a committee of credible experts for their redaction.	31	4.4	.91	28 (90.3)
Q16. Involved a development committee consisting of members representing all stakeholders (for example, different professionals, users, etc.).	28	3.7	1.33	20 (71.4)
Q17. Involved a consultation with external consultants who were not part of the guideline development committee.	17	3.5	1.28	11 (64.7)
Q18. Provided sufficient information on how they were developed.	27	3.3	.80	16 (59.3)
Q19. Involved the use of a structured systematic method for searching the scientific literature.	22	4.0	.93	18 (81.8)
Q20. Involved the use of a systematic method to assess the scientific evidence used to formulate the recommendations.	16	3.8	.88	11 (68.8)

Variables	Total Responses *N*	*M*	*SD*	Agree and Strongly Agree *n (%)*
Q21. Involved the use of a formal method of consensus (for example, using techniques, such as the Delphi or Glaser) to formulate the final guideline recommendations.	8	3.2	.79	3 (37.5)
Q22. Involved the use of an informal consensus method (following discussion only) to make final decisions regarding the recommendations included in the guidelines.	16	4.0	.96	13 (81.3)
Q23. Described a direct association between the recommendations and the scientific evidence.	32	3.6	.98	22 (68.8)
Q24. Described the strengths and limitations of the guidelines.	32	3.2	1.14	15 (46.9)
Q25. Addressed any potential ethical issues that may be associated with practice in the area covered by each of the respective guidelines.	32	3.5	1.17	21 (65.6)
Q26. Are easily accessible and can be used in practice.	34	4.2	.93	29 (85.3)
Q27. Explained how the recommendations they contain should be implemented.	33	3.5	.91	22 (66.6)
Q28. Discussed the facilitators and potential barriers for implementing the recommendations in the guidelines.	32	3.2	1.06	17 (53.1)
Q29. Included a plan to assess the effect of the guidelines on clinical practice.	23	2.7	.64	6 (26.1)
Q30. Included appropriate dissemination strategies.	29	3.5	1.03	19 (65.5)
Development and Quality of Guidelines (How would you rate the quality of the following aspects of the guidelines? 1 = Very poor to 7 = Excellent)				*Very Good and Excellent n (%)*
Q45. The development process.	29	5.7	1.09	26 (89.7)
Q46. The clinical recommendations.	34	5.5	1.46	29 (85.3)
Q47. The overall quality of these guidelines.	34	5.8	.96	32 (94.1)
Familiarity of Guideline Methods (To what extent are you familiar with the following methods for guideline development? 1 = Not at all familiar to 5 = Extremely familiar)				*Moderately and Extremely Familiar n (%)*
Q51. AGREE I	34	1.4	.69	0 (.0)
Q52. AGREE II	33	1.3	.62	1 (2.9)
Q53. AGREE III	34	1.3	.60	1 (2.9)
Q54. GRADE	34	1.1	.22	0 (.0)
Q55. SIGN50	34	1.1	.29	0 (.0)
Q56. NICE	34	1.4	.63	2 (5.9)
Q57. INESSS 2012 or 2015	34	1.5	.84	2 (5.9)
Q58. IPGD	32	1.0	.00	0 (.0)

Table 6

Survey Items Concerning the Board Members' Participation in the Evaluation, Approval, and Adoption of Guidelines

Variables	*N* Total Responses	*M*	*SD*	Agree and Strongly Agree *n (%)*
Q31. My opinions were solicited and considered during the discussion and approval process.	15	4.4	.66	13 (86.7)
Q32. All of the questions I had about a guideline were addressed adequately.	14	4.7	.22	14 (100.0)
Q33. Divergent opinions were adequately considered and addressed.	13	4.4	.67	11 (84.6)
Q34. Conflicts of interest and biases were addressed and managed adequately.	9	4.4	.25	9 (100.0)
Q35. There was sufficient time available to the members of the board of directors to examine and make a decision concerning the guidelines.	15	4.3	.33	15 (100.0)
Q36. There were problems with the evaluation and approval process for the guidelines (for example, disagreements among members or problems with the methods used, etc.).	12	1.7	.47	0 (.0)
Q37. I approved the guidelines.	15	4.7	.12	15 (100.0)
Q38. I had sufficient clinical expertise in the specific area covered by the guidelines.	14	4.3	.87	11 (78.6)
Q39. I had sufficient research expertise in the specific area covered by the guidelines.	13	3.1	.97	5 (38.5)
Q40. I had expertise in methods of knowledge synthesis.	13	4.0	1.06	10 (76.9)
Q41. I had expertise in methods of knowledge transfer and dissemination.	14	3.6	1.58	9 (64.3)
Q42. I had expertise in the methods used to develop guidelines.	14	3.1	.78	5 (35.7)
Q43. My knowledge of guideline development was sufficient to assess the methodological quality of the guidelines.	14	3.6	1.20	7 (50.0)
Q44. I was aware that methods exist for developing guidelines.	15	3.6	.96	11 (73.3)

Bridging Manuscripts 1 and 2

Study 1 (Manuscript 1) investigated the knowledge, attitudes, and experiences of guideline development, evaluation, approval and adoption of mental health and social care service CPGs among the board of directors of the OPQ, OCCOQ, OPPQ, OTSTCFQ and OEQ. Five online surveys were developed according to each regulatory body and were administered. The study surveyed the members of the board of directors with regards to their familiarity of the guideline development and methods and costs, as well as their attitudes towards the guideline development, evaluation and approval process and quality. This study was the first to investigate these areas in the social sciences and in Quebec. However, the response rates were quite low. This was largely due to most of the regulatory bodies refusing to distribute the surveys. In an effort to expand the pool of participants, the board of directors were contacted directly via publicly available information. Regrettably, this only slightly increased the sample sizes. It was decided that the findings would be presented separately and merged together in order for the results to be interpreted in a meaningful manner. The study lends insight into the familiarity, attitudes, and experiences of 34 members of the board of directors concerning the CPGs development, evaluation and approval process in Quebec, as well as informs policymaking.

Examining the knowledge, attitudes, and experiences of CPGs of those who are intended to use and implement them is equally critical. As such, Study 2 (Manuscript 2) examined the existing social science literature on professionals' knowledge, attitudes, use, implementation and adherence and barriers and facilitators of mental health and social care service CPGs. This was realised by conducting a systematic scoping review of relevant articles. This was the first scoping review conducted in this specific area. It also advised the development of Study 3 (Manuscript 3). The results of the systematic scoping review are presented in the next manuscript.

Chapter 3: Manuscript 2

(To be submitted for publication)

Social science professionals' knowledge, attitudes, and use of clinical practice guidelines: A systematic scoping review

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We have no conflicts of interest to disclose.

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Abstract

In contrast to the medical field, there is currently a lack of available literature on professionals' knowledge, attitudes, and use of practice guidelines in the social sciences. A systematic scoping review was conducted using the Joanna Briggs Institute (JBI) reviewer's manual in order to identify articles and dissertations that examined professionals' knowledge, attitudes, and use of mental health and social care guidelines, as well as related barriers and facilitators in the social sciences. Five electronic databases were searched for peer-reviewed and grey literature. Three independent reviewers examined the articles according to the inclusion criteria and extracted data for 35 articles included in the review. Quantitative analysis was conducted for the study characteristics. The 35 articles were published between 2000 and 2019, with a steady increase and 57% published after 2010. Most were conducted in the USA (31%), with the remaining in other diverse countries. Most articles were peer-reviewed (83%), only 46% were qualitative or quantitative (29%) studies and 54% included both medical and social science professionals, with only 23% focused on a specific social science profession. Most guidelines focused on adults (92%) and guideline topics varied, with anxiety disorders being the most frequent (31%). The majority of articles discussed professionals' attitudes (66%) and use (63%) of guidelines and related barriers (63%) and facilitators (63%), with only 43% discussing guideline knowledge. Qualitative analysis was conducted for 30 of the articles. Variable guideline knowledge, a slim inclination for positive attitudes, largely infrequent use, implementation and adherence of guidelines, and several barriers and facilitators were found. Evidence gaps and implications for research, practice, and policy are also discussed.

Keywords: Clinical practice guidelines, knowledge, attitudes, guideline use, barriers, facilitators, social sciences, professions

Social science professionals' knowledge, attitudes, and use of clinical practice guidelines: A systematic scoping review

Clinical practice guidelines (CPGs) are guides intended to provide support for professionals in practice in order to help ensure professionalism and optimal services. They consist of clear and succinct recommendations and are developed systematically and transparently by stakeholders for specific contexts and interventions and are based on vigorous scientific evidence (Field & Lohr, 1992; Beauchamp et al., 2012). CPGs have been developed and published worldwide for professionals in medicine and in the social sciences (Colón-Emeric et al., 2007; Gould & Kendal, 2007; Parry et al., 2003; White & Kratochwill, 2005) by various organizations, associations, and regulatory bodies. Despite this, research on CPGs in the social sciences is extremely limited compared to that of medicine, especially for guidelines involving issues of mental health and social care services (Graham et al., 2000; Howard & Jenson, 1999a, 1999b; Kirk, 1999; Parry et al., 2003; Proctor et al., 2009; Sandström et al., 2014). While CPGs in medicine have been somewhat examined in research (i.e., investigating the methodological rigour, development, and quality of CPGs and professionals' knowledge, attitudes and use of CPGs; e.g., Alarcon et al., 2013; Lovell et al., 2013; Sinuff et al., 2015), the investigation of guidelines in the social sciences regarding these areas remains scant. Relatedly, research suggests that CPGs in the social sciences were not as effective as those produced in medicine (Hollon et al., 2014)

In medicine, research indicates that there is a positive link among the following constructs: 1) professionals' knowledge, awareness, or familiarity of CPGs; 2) professionals' attitudes or attitudes towards CPGs; and 3) actual guideline use, implementation, and adherence (e.g., Alanen et al., 2009a; Graham et al., 2000; Hader et al., 2007; Lugtenberg et al., 2011). In this context, guideline use, implementation, and adherence can be characterized as the process of professionals transferring the advised guideline recommendations and content provided in the CPGs and then assimilating these into professional practice (Shiffman et al., 2004). However, having knowledge and positive attitudes of CPGs does not inevitably transfer into changes, nor does it ensure that guidelines are actually used in practice (Farquhar et al., 2002; Finkelstein et al., 2000; Francke et al., 2008). Several theories or models have been developed to explain this link in medicine, such as Woolf's *Knowledge, Attitudes, and Behaviour Model* (1993), the *Barriers to Adherence Model* proposed Cabana et al. (1999) and the *Awareness-to-Adherence*

Model developed by Pathman et al. (1996). In contrast, there are no existing models in the social sciences, with limited research on professionals' knowledge, attitudes and guideline use in this domain.

There is also some evidence suggesting that when professionals were skeptical about CPGs, guideline use was unsuccessful (Al-Ansary et al., 2013), and that CPGs were infrequently used in practice (Gould & Kendall, 2007). As such, further empirical evidence on professionals' knowledge, attitudes, and guideline use or implementation are crucial in order to facilitate their acceptability, practicality, and effectiveness (Al-Ansary et al., 2013). The aim of the current scoping review was to systematically investigate, identify, and document the various views (i.e., knowledge and attitudes), use, implementation, and adherence of mental health and social care service CPGs reported in the literature among professionals in the social sciences. The following professions were considered: psychology, psychoeducation, guidance counselling, social work, marriage and family therapy, and occupational therapy. While there was limited research on this topic, the existing research was sufficient for a scoping review study. In particular, studies (e.g., primary research papers and reviews) that included both medical and social science professionals and their attitudes and/or use of CPGs in the area of mental health and social care services among various practice settings were available in the literature. The goal was to gather all possible information from the literature on the current topic. As such, it aimed to answer the following questions: 1) What is known from the existing literature about professionals' knowledge, attitudes, and use of mental health and social service CPGs in the social science professions?; 2) What are the mental health and social care service topics covered by the CPGs?; 3) To what extent are professionals knowledgeable or familiar with CPGs?; 4) What are professionals' attitudes related to CPGs?; 5) How often are CPGs used by professionals in practice?; 6) What are the barriers to guideline use, implementation, and adherence ?; and 7) What are the facilitators to guideline use, implementation and adherence?.

Methods

A preliminary search for existing scoping reviews on the current topic was conducted using the Web of Science – Social Sciences and ProQuest Central databases, as well as Google Scholar. While there were a few existing topics broadly related to CPGs and guideline use in medicine, there was no existing scoping review that examined CPGs in the social science professions, on professionals' knowledge, attitudes, and guideline use, and on guidelines in the

area of mental health and social care services. This scoping review was the first to investigate professionals' knowledge, attitudes, and use of CPGs in the social sciences.

A systematic scoping review was then performed of studies that examined professionals' knowledge, attitudes, and use of mental health and social service CPGs in the social sciences. The scoping review method consisted of knowledge synthesis and a comprehensive recap of the available literature. The ultimate goals of this review were to map the main concepts underlying a research topic, communicate the current literature, identify the gaps in the literature, provide recommendations for future research, synthesize, and disseminate research findings for the purpose of health and public care service providers, as well as to inform future research, clinical practice and programs, and policy (Arksey & O'Malley, 2005; Peters et al., 2017). Ultimately, the current scoping review informed the perspectives and behaviours (i.e., use of CPGs) among social science professionals. Obtaining knowledge of the available evidence on this topic provided insight into improvements for guideline use in practice.

For the current review, the Joanna Briggs Institute (JBI) guidance was used. This approach focuses on evidence-based practices and represents an arduous and efficient approach for evidence synthesis (Peters et al., 2017). The JBI method consists of the following steps: 1) identifying the research objective and questions; 2) determining the inclusion criteria; 3) developing the search strategy; 4) developing the a-priori protocol; 5) searching and identifying the evidence; 6) extracting the data; 7) charting the data; 8) discussing the evidence and making conclusions and recommendations; and 9) consultation (Peters et al., 2017).

Research Objective and Questions

A broad objective was formulated based on the following premises: that the objective should signify what the study aims to do, highlights the research questions, guides the inclusion criteria, and reflects the population, concept, and context (PCC; Levac et al., 2010; Peters et al., 2017). The research objective for the scoping review was to identify and document the various reported knowledge, attitudes, and use of mental health and social care service CPGs reported among professionals in the social sciences. In this case, the *population* consisted of the professionals in the social science professions (i.e., psychology, psychoeducation, guidance counselling, social work, marriage and family therapy, and occupational therapy). The *concept* included professionals' knowledge, attitudes and use, implementation, and adherence of CPGs.

The *context* was defined as the social science professions and guidelines that focused on mental health and social care services and any or all practice settings.

The primary research question was: 1) What is known from the existing literature about professionals' knowledge, attitudes and use of mental health and social care service CPGs in the social science professions? Sub-research questions were also devised as they focused on aspects related to the PCC and were helpful in mapping of the evidence (Peters et al., 2017). The sub-questions included: 2) What are the mental health and social care service topics covered by the CPGs?; 3) To what extent are professionals knowledgeable or familiar with CPGs?; 4) What are professionals' attitudes related to CPGs?; 5) How often are CPGs used by professionals in practice?; 6) What are the barriers to guideline use, implementation, and adherence ?; and 7) What are the facilitators to guideline use, implementation and adherence?. The research questions were created by two researchers, based on the gaps in research and the research objective.

Inclusion and Exclusion Criteria

Two researchers determined the preliminary inclusion and exclusion criteria. The inclusion criteria were developed based on the JBI guidance conditions (i.e., must match the title, objectives, questions, and PCC; Peters et al., 2017). They were further reviewed and refined prior to and during the search and screening process (Levac et al., 2010). The criteria were applied in order to screen sources of information available in the literature, which included articles and dissertations. The final inclusion criteria consisted of the following: 1) sources that focus on professionals in the social science domain; 2) sources that consist of medical health professionals, only if social science professionals are also included; 3) sources including all ages and sexes/genders; 4) sources consisting of any knowledge, attitudes and/or use of CPGs among the professionals in the social science domain (see above); 5) sources focused on professionals' knowledge, attitudes and/or use of CPGs that are specific to mental health and social care service; 6) sources involving professionals in any practice setting, as long as it was within the social sciences; and 7) articles published in English and French (i.e., since the research team was proficient in these languages and to prevent the costs of translation). Exclusion criteria encompassed the following: 1) studies did not include professionals in the social sciences and in psychology, psychoeducation, guidance counselling, social work, marriage and family therapy, and occupational therapy; 2) studies only included medical health professionals; 3) studies did

not focus on professionals' knowledge, attitudes and/or use of CPGs among the social science professions; 4) studies focused on professionals' knowledge, attitudes and/or use of guidelines that are not specific to mental health and social care services; and 5) articles not published in English or French. All sources of evidence were included.

The JBI method requires the development and use of an a-priori scoping review protocol outlining the study plan (Peters et al., 2017). While a protocol was developed and utilized the JBI protocol requirements, it was not registered for the review.

Information Sources and Search Strategy

The 3-step strategy proposed by JBI (Peters et al., 2017) was implemented independently by two reviewers. The search terms and strategy were reviewed and refined throughout the process (Levac et al., 2010; Peters et al., 2017). First, an initial limited search with two databases was conducted: Web of Science – Social Sciences and ProQuest Central; the words and index terms were analyzed. Second, an extensive search using keywords and index terms for published and grey literature was conducted in the electronic databases Web of Science – Social Sciences and ProQuest Central (i.e., published literature) and Theses Canada, ProQuest Dissertations and Theses Global, and Open Grey (i.e., grey literature) from their launch date to June 2019. The final search terms used were based on refining the keywords and index terms from the initial and second searches and were finalized during the search strategy process. Consultation with a librarian specialized in reviews was also conducted. The search algorithms consisted of a combination of terms including: *guideline*, *mental health*, *social care*, *social sciences*, *guideline use*, *attitudes,* and *knowledge*, as well as social science professions and related synonyms that were joined together (see Appendix). Three main algorithms were used to search all databases, with the exception of Theses Canada. The algorithm was broken down to only a few key terms and searched separately for this database. The reviewers documented the number of retrieved sources, search terms, and strategy at each step. All retrieved sources were also downloaded and documented, and the references were added into Excel. Duplicate sources were removed prior to the screening process. Third, additional sources were identified by examining the reference list of the retrieved articles.

Screening

Three reviewers were involved in independently screening the articles at 2 levels using the inclusion and exclusion criteria, pre-determined search terms, and search strategy. First, two

reviewers screened the titles and abstracts (double title/abstract screening – level 1) and selected the articles to be included in the full-text screening (Arksey & O'Malley, 2005; Levac et al., 2010; Peters et al., 2017). Additional sources were identified, screened and included by the reviewers via hand-searching the reference lists of the sources included after the level 1 screening. Second, the full-text articles were reviewed by three reviewers for inclusion in the study (double full-text screening – level 2; Arksey & O'Malley, 2005; Levac et al., 2010; Peters et al., 2017). At both phases, the reviewers documented whether they included or excluded the sources based on the inclusion and exclusion criteria and the reasons for exclusion when necessary in an Excel worksheet. The reviewers also discussed the process at the start, middle, and end of the screening phases in order to ensure there were no issues, to refine the search strategy, and arrive at consensus as to which sources should be included (Levac et al., 2010; Peters et al., 2017). However, refining the strategy was not required as there were no issues and no disagreements. A final list of the sources for inclusion were compiled. These sources are indicated by asterisks in the reference section.

Data Collection and Charting the Data

Data relevant to the current review's research questions were extracted from the articles and transferred into a charting form. The charting form was developed in the protocol stage and was refined during the screening and extraction process (Levac et al., 2010; Peters et al., 2017). The charting form reflected the characteristics of the studies included in this review (i.e., authors, reference, publication year, origin, source, article type, aims and purpose, study population, location of care, methodology, and main results). Information related to the research questions was also extracted and documented (i.e., knowledge, attitudes, and use of CPGs, and barriers and facilitators). Given the length of this form and space limitation, it has not been included. Interested readers may contact the primary author for the charting form.

Prior to extracting the data for all eligible studies, the reviewers piloted the charting form and independent extracted data for three studies in order to ensure all possible relevant findings would be charted. This was then reviewed by another member of the research team. The research team discussed the extraction process and form and compared results in order to ensure the appropriate data would be extracted and that it would be in line of the research objectives and questions, and to determine whether the form should be refined (Levac et al., 2010; Peters et al., 2017). As stated above, the form did not require additional modifications. Next, the data were

extracted independently by two reviewers (Higgins & Deeks, 2008; Levac et al., 2010; Peters et al., 2017). Two reviewers then compared and discussed the results and arrived at consensus. Minor disagreements were resolved by the third reviewer. The third reviewer then revised the data and made minimal corrections after consultation with the reviewers. The charting form was finalized and converted into a Word table.

Data Analysis

First, a quantitative frequency analysis was performed by two reviewers using the extracted study characteristics (Peters et al., 2017). The distribution of the studies characteristics were calculated by frequency and percentages in Excel. Second, as suggested by Levac et al. (2010), an inductive thematic content analysis was performed by two reviewers. The NVivo 12 software (QSR International Pty Ltd, 2018) was used to perform Braun and Clarke's (2006) thematic analysis approach. Using this approach, the reviewers used the data obtained from the charting form and analyzed the data according to pre-determined main categories that were based on the research questions, study aims and PCC (i.e., professionals' knowledge, attitudes, and use of CPGs, and barriers and facilitators). The reviewers evaluated the data and independently identified and documented an initial code list within each of the main themes. A list of codes was then compared and finalized and definitions for each code were created. Next, the reviewers independently reviewed the data and applied the codes, prior to comparing and combining them. The data excerpts and codes were reviewed, and the themes and their respective definitions were merged, refined, and renamed based on their similarities. The themes, number of articles for each theme, and references were presented in a table.

Results

Search Strategy and Screening

A total of 3700 sources were obtained from the search. All duplicate sources within and across databases were removed prior to the screening and some sources were not available electronically, yielding 1143 sources (i.e., published sources, $N = 181$ and grey sources, $N = 962$). After the level 1 screening, 55 sources were included and an additional 3 sources were acquired by hand-searching the reference lists of these articles, thus 58 sources were considered for the level 2 screening. A total of 35 sources were included after the level 2 screening (see Figure 1).

Study Characteristics

All 35 articles meeting criteria were published between the years 1997 and 2019, with the majority (57%) being published after the year 2010 (see Table 1). There was no time limitation on article publication dates within our search. The United States was the country in which the highest number of studies were conducted (11 articles; 31%) and only one article (3%) was conducted in more than one country (i.e., the UK and Australia). The majority of the articles were published in peer-review journals (29 articles; 83%), while the remaining six (17%) were doctoral dissertations (i.e., grey literature). Most articles used either a qualitative (16 articles; 46%) or quantitative framework (10 articles; 29%), with one article using mixed methods (3%). Many of the studies (19 articles; 54%) focused on a mix of both medical and social science professionals (e.g., psychologists, psychiatrists, GPs, and nurses). Eight articles (23%) focused solely on one type of social science population, while 11 articles (31%) specified no population, often as they were literature reviews or editorial or theoretical papers.

Across the articles, the general aims were to inform, develop, and assess various aspects of CPGs. Of the various aims reported, most articles had more than one aim, with the most common being assessing and informing guideline use and implementation (23 articles; 66% and 16 articles; 46%, respectively), while the remaining minority of studies represented other aims (see Table 2).

Thirty articles (86%) reported a location of care (with some studies that reported more than one location). Five articles (14%) did not include a location as they were editorials. There were many different locations of care in which the CPGs were being investigated, with mental health services (6 articles; 20%) being the most prevalent (see Table 3).

Fifteen articles (43%) discussed professionals' knowledge with CPGs. A total of 23 of the included articles (66%) discussed attitudes of CPGs. Similarly, 23 of the articles (66%) focused on guideline use. Finally, 22 of the articles (63%) discussed perceived barriers and 22 articles (63%) discussed perceived facilitators to CPGs (see Table 4).

What are the Mental Health and Social Care Service Topics Covered by the CPGs?

A wide variety of guideline topics were examined across the included articles, many of which focused on various mental health disorders. The vast majority of the CPGs focused on adult populations (32 articles; 91%). Anxiety disorders in general and specific anxiety disorders (e.g., GAD and social anxiety) yielded the largest number of articles (11; 31%). Following this, mood disorders (7 articles; 20%) and schizophrenia (6 articles; 17%) received the highest

amount of focus. Although the majority of the articles discussed one specific guideline topic (21 articles; 60%), some focused on multiple guideline topics (8 articles; 23%), while the remainder focused on CPGs in general (6 articles; 17%; see Table 5).

Qualitative Data

A total of 30 of the 35 articles were subjected to thematic analysis relating to professionals' reported knowledge, attitudes, use, facilitators, and barriers of CPGs in the social sciences. Five articles were excluded from this analysis, as they did not outline specific data in these areas. The articles only presented author's opinions about some of these areas (Hage et al., 2007; Kendall et al., 2012; Wambach et al., 1999), or they did not include any data on these areas as reported by professionals (Bauer, 2002; Moreno & Moriano, 2016b). While this data was documented during the charting of data process, it was excluded from the thematic analysis, since the objective of the review was to document professionals' reported knowledge, attitudes, and use of CPGs from research. The results of the thematic analysis were structured according to the five sub-research questions and corresponding pre-determined main themes. The themes are presented below according to each sub-research question and in Table 6.

To What Extent are Professionals Knowledgeable or Familiar with CPGs?

Only a minority of studies (n = 14; 47%) reported on professionals' knowledge towards CPGs. A list of these studies and detailed thematic results are included in Table 6. The most common theme related to knowledge of CPGs was a lack of awareness of guidelines (Beurs et al., 2015; Campos, 2011; Dijk et al., 2012, 2015; Mudge et al., 2017; Nicholas, 1999; Poitras et al., 2012; Prytys et al., 2011; Rhodes et al., 2010; Sandström et al., 2014). In contrast, professionals' good knowledge of CPGs was the second most commonly identified theme (Beurs et al., 2015; Campos, 2011; Dijk et al., 2012, 2015; Krug, 2007; Mudge et al., 2017; Nicholas, 1999; Prytys et al., 2011; Rhodes et al., 2010; Sandström et al., 2014).

Following this, the third most commonly reported theme related to the various sources of learning that foster professionals' knowledge of CPGs (Beurs et al., 2015; Campos, 2011; Davis, 2001; Dijk et al., 2015; Mudge et al., 2017; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Rhodes et al., 2010). Examples included participating in professional courses and development activities (Davis, 2001; Mudge et al., 2017), training, education, or continuing education on the guideline topic (Phillips & Brandon, 2004; Poitras et al., 2012) and team meetings (Rhodes et al., 2010). Using interventions or training was also found to lead to positive effects on professional's

knowledge of CPGs (Beurs et al., 2015; Dijk et al., 2015). Consistent with this theme, Beurs et al. (2015) assessed the effect of using an intervention – training via an e-learning training program by peers – on a group of professionals in the Netherlands with regard to the implementation of a Dutch multidisciplinary suicide prevention guideline. Professionals, in either an experimental group or control group, consisted of a combination of 303 psychologists, nurses, psychiatrists, and others. This study found that after 3-months, the majority of professionals (85%) in the experimental/intervention condition indicated having read the summary of the CPGs, while the majority of professionals in the control condition had not read them and indicated an unawareness of the guidelines even being published (Beurs et al., 2015).

A few of the articles also captured factors negatively affecting knowledge of CPGs, such as a lack of guideline content knowledge due to guidelines being non-user friendly and uninformative, and a lack of formal training (Beurs et al., 2015; Campos, 2011; Davis, 2001; Mudge et al., 2017; Phillips & Brandon, 2004; Rhodes et al., 2010). Some studies also outlined the impact of knowledge on CPGs use, implementation and adherence (e.g., unknowledge of guideline content led to a lack of confidence in using them in practice; Beurs et al., 2015; Campos, 2011; Dijk et al., 2012; Mudge et al., 2017; Rhodes et al., 2010).

What are Professionals' Attitudes Related to CPGs?

A large number of articles reported on professionals' attitudes towards CPGs (n = 19; 63%). Positive attitudes (Campos, 2011; Davis, 2001; Dijk et al., 2012, 2015; Glass, 2007; Krug, 2007; Leven et al., 2012; Michie et al., 2007; Nicholas, 1999; Poitras et al., 2011, 2012; Pruijssers et al., 2015; Prytys et al., 2011; Sandström et al., 2014) and negative attitudes (Callahan, 1996; Dijk et al., 2012; Glass, 2007; Hetrick et al., 2011; Hutschemaekers, 2003; Krug, 2007; Leven et al., 2012; Mudge et al., 2017; Poitras et al., 2011, 2012; Prytys et al., 2011; Sandström et al., 2014) were the most frequently identified themes. Several positive attitudes were reported and included: professionals' general agreement and support of the CPGs (Davis, 2001; Dijk et al., 2012, 2015; Krug, 2007; Leven et al., 2012; Nicholas, 1999; Poitras et al., 2011, 2012; Pruijssers et al., 2015; Prytys et al., 2011), the usefulness, importance, and relevancy of guidelines to practice (Glass, 2007; Krug, 2007; Poitras et al., 2012; Sandström et al., 2014), and positive attitudes regarding guideline development (e.g., the format was easy to read and comprehend and were credible and evidence-based; Campos, 2011; Glass, 2007; Leven et al., 2012; Poitras et al., 2011; Prytys et al., 2011; Sandström et al., 2014). Several studies reported

professionals' positive attitudes concerning the positive impact CPGs have on practice (Michie et al., 2017; Poitras et al., 2011, 2012; Pruijssers et al., 2015; Prytys et al., 2011; Sandström et al., 2014), including enhancing collaboration and coordination among teams (Poitras et al., 2012; Prytys et al., 2011; Sandström et al., 2014) and a positive impact on clinician roles (Pruijssers et al., 2015).

In contrast, the negative reported attitudes included those regarding the impact of the CPGs on professionals (e.g., less professional autonomy and job dissatisfaction; Dijk et al., 2012) and the need to change current practice and behaviours by using the guidelines and related challenges (Callahan, 1996; Sandström et al., 2014)), as well as the impact on professional practice (e.g., lacking relevancy and practicality to practice, such as settings and clients – that is, complex client presentations, CPGs lacking applicability, lacking appropriate interventions, neglecting delivery support and case management needs; Callahan et al., 1996; Hetrick et al., 2011; Krug, 2007; Poitras et al., 2011, 2012; Prytys et al., 2011).

Some articles also outlined professionals' attitudes concerning the adherence or non-adherence of CPGs in practice (Dijk et al., 2012, 2015; Glass, 2007; Michie et al., 2007; Nicholas, 1999; Phillips & Brandon, 2004; Pruijssers et al., 2015; Sandström et al., 2014). For example, a few studies found that despite professionals' having positive views towards CPGs (e.g., useful guides and can foster collaboration), they did not feel pressure, nor did they want to adhere to them in practice (Dijk et al., 2012, 2015; Rothrauff & Eby, 2011; Sandström et al., 2014). A few studies indicated that some professionals had negative views of CPGs (e.g., rigid, inflexible, complicated, lack reliability of evidence or relevance to practice) and thus lacked motivation to use or adhere to them (Phillips and Brandon, 2004; Sandström et al., 2014). Contrary to this, some studies reported that professionals had positive views of CPGs (e.g., guideline agreement) and intended to adhere to them, or were already doing so (Dijk et al, 2015; Michie et al., 2007; Nicholas, 1999; Pruijssers et al., 2015).

How Often are CPGs Used by Professionals in Practice?

A large number of articles (n = 20; 67%) documented professionals' reported use of CPGs. Here, the most common theme that emerged was professionals' reports of their low guideline use, implementation, and adherence (Berry & Haddock, 2008; Beurs et al., 2015; Campos, 2011; Dijk et al., 2012, 2015; Fischler et al., 2016; Hammond et al., 2005; Hetrick et al., 2011; Kosmerly et al., 2015; Nicholas, 1999; Phillips & Brandon, 2004; Prytys et al., 2011;

Rhodes et al., 2010; Rothrauff & Eby, 2011; Sandström et al., 2014; Tiemeier et al., 2002). For example, one study reported that of 615 substance abuse counsellors across five settings, more than 50% indicated *never* or *not often* with regard to using or implementing the Public Health Service Tobacco Cessation Guidelines (Rothrauff & Eby, 2011). In contrast, several articles focused on professionals' reports of high guideline use, implementation, and adherence (Beurs et al., 2015; Dijk et al., 2012, 2015; Fischler et al., 2016; Kosmerly et al., 2015; Nicholas, 1999; Rhodes et al., 2010; Rothrauff & Eby, 2011; Stergiou-Kita, 2011; Tiemeier et al., 2002). For instance, Rhodes et al. (2010) found that 68% of mental health professionals reported using the NICE guidelines for Depression and CBT some or most of the time, with 24% of professionals always using the guidelines in practice. A few articles also presented professionals reports of inconsistent guideline use, implementation, and adherence (i.e., high or low rates depending on the context and conditions; Berry & Haddock, 2008; Hetrick et al., 2011; Kosmerly et al., 2015; Mudge et al., 2017; Nicholas, 1999; Rhodes et al., 2010; Rothrauff & Eby, 2011; Tiemeier et al., 2002).

Some articles outlined the reported effects of training, interventions, strategies, or systems on professionals' guideline use, implementation, and adherence (e.g., e-learning training and using guideline implementation strategies; Berry & Haddock, 2008; Beurs et al., 2015; Dijk et al., 2012, 2015; Fischler et al., 2016; Krug, 2007; Nicholas, 1999; Rhodes et al., 2010; Williams & Hazell, 2009). Generally, these studies provided support for both positive and negative influences on professionals' guideline use due to utilizing training or interventions.

What are the Barriers Related to Guideline Use, Implementation, and Adherence?

The majority of the studies (n = 22; 73%) presented professionals' reported barriers to guideline use, implementation, and adherence, with a number of barriers identified. The most common of these were organizational constraints (Berry & Haddock, 2008; Callahan, 1996; Glass, 2007; Hammond et al., 2005; Hetrick et al., 2011; Leven et al., 2012; Michie et al., 2007; Mudge et al., 2017; Nicholas, 1999; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Prytys et al., 2011; Rhodes et al., 2010; Rothrauff & Eby, 2011; Sandström et al., 2014; Stergiou-Kita, 2011) and context specific issues (i.e., specific issues that are directly linked to the context of clinical practice, such as the guideline not being relevant with a clinical context or client; Callahan, 1996; Davis, 2001; Dijk et al., 2012; Hetrick et al., 2011; Leven et al., 2012; Mudge et al., 2017; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Prytys et al., 2011; Rhodes et al.,

2010; Tiemeier et al., 2002; Williams & Hazell, 2009). Several studies also outlined reports of the clinicians' or facilities' lack of motivation to change (i.e., with regards to using CPGs and their recommendations, such as using the guidelines rather than their clinical experience; Fischler et al., 2006; Hetrick et al., 2011; Leven et al., 2012; Mudge et al., 2017; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Prytys et al., 2011; Rothrauff & Eby, 2011; Sandström et al., 2014; Stergiou-Kita, 2011; Williams & Hazell, 2009).

Some studies indicated professionals had negative attitudes towards CPGs, such as disagreements with CPGs (Callahan, 1996; Dijk et al., 2012; Leven et al., 2012; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Prytys et al., 2011; Rothrauff & Eby, 2011; Stergiou-Kita, 2011; Tiemeier et al., 2002; Williams & Hazell, 2009), client related barriers (i.e., client variables or characteristics that hinder guideline use; Berry & Haddock, 2008; Dijk et al., 2012; Hetrick et al., 2011; Leven et al., 2012; Mudge et al., 2017; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Rhodes et al., 2011; Stergiou-Kita, 2011; Tiemeier et al., 2002), lack of training and supervision (Berry & Haddock, 2008; Glass, 2007; Hetrick et al., 2011; Leven et al., 2012; Michie et al., 2007; Mudge et al., 2017; Nicholas, 1999; Phillips & Brandon, 2004; Poitras et al., 2012; Rhodes et al., 2010; Stergiou-Kita, 2011), guideline feasibility (i.e., the guideline is unfeasible and its use and implementation in practice is hindered; Davis, 2001; Dijk et al., 2012; Glass, 2007; Hetrick et al., 2011; Leven et al., 2012; Mudge et al., 2017; Poitras et al., 2012; Rhodes et al., 2010; Sandström et al., 2012; Stergiou-Kita, 2011) and a lack of knowledge (Glass, 2007; Hetrick et al., 2011; Leven et al., 2012; Mudge et al., 2017; Phillips & Brandon, 2004; Poitras et al., 2011; Rhodes et al., 2010; Stergiou-Kita, 2011; Williams & Hazell, 2009). Some articles also outlined reports of poor guideline quality (Callahan, 1996; Davis, 2001; Dijk et al., 2012; Glass, 2007; Hetrick et al., 2011; Rhodes et al., 2010; Stergiou-Kita, 2011), lack of collaboration and teamwork (Davis, 2001; Fischler et al., 2006; Mudge et al., 2017; Poitras et al., 2012; Prytys et al., 2011; Stergiou-Kita, 2011), lack of professionals' confidence to use CPGs (Leven et al., 2012; Michie et al., 2007; Phillips & Brandon, 2004; Rhodes et al., 2010; Stergiou-Kita, 2011; Williams & Hazell, 2009) and a lack of available implementation strategies (Davis, 2001; Glass, 2007; Mudge et al., 2017; Williams & Hazell, 2009).

What are the Facilitators Related to Guideline Use, Implementation, and Adherence?

A large number of articles (n = 20; 67%) also outlined professionals' reported facilitators to guideline use, implementation, and adherence. Training and supervision was the most

commonly reported facilitating factor to foster guideline uptake among professionals (i.e., professionals' receiving adequate training and supervision of CPGs and their use, access to colleagues experiences with good practices, as well as enhancing their professional skills and competencies; Berry & Haddock, 2006; Beurs et al., 2015; Davis, 2001; Dijk et al., 2012; Glass, 2007; Krug, 2007; Leven et al., 2012; Michie et al., 2007; Moreno & Moriana, 2016a; Mudge et al., 2017; Rhodes et al., 2010; Rothrauff & Eby, 2011; Sandström et al., 2014; Stergiou-Kita, 2011; Williams & Hazell, 2009), followed by collaboration and teamwork (Berry & Haddock, 2008; Beurs et al., 2015; Callahan, 1996; Davis, 2001; Dijk et al., 2012; Fischler et al., 2016; Leven et al., 2012; Mudge et al., 2017; Sandström et al., 2014).

Some articles documented other facilitators to guideline use, which included tailored guideline implementation (i.e., tailoring to the client's needs and provision of care; Berry & Haddock, 2008; Dijk et al., 2012, 2015; Michie et al., 2007; Moreno & Moriana, 2016a; Mudge et al., 2017; Williams & Hazell, 2009), guides, tools, and strategies for guideline implementation (Campos, 2011; Dijk et al., 2012; Fischler et al., 2016; Leven et al., 2012; Moreno & Moriana, 2016a; Williams & Hazell, 2009), support (i.e., from colleagues, supervisors, and the government for training of and the use of CPGs and financial support for resources to foster guideline use; Leven et al., 2012; Sandström et al., 2014; Williams & Hazell, 2009), evaluation and monitoring of performance and feedback for using CPGs (Dijk et al., 2012; Fischler et al., 2016; Leven et al., 2012; Sandström et al., 2014), and good quality CPGs (Callahan, 1996; Campos, 2011; Leven et al., 2012; Stergiou-Kita, 2011). Some articles also included clinicians' accessibility to CPGs (Campos, 2011; Leven et al., 2012; Mudge et al., 2017), local contexts and policy (e.g., relevancy of CPGs to specific contexts and clinical settings, considers diverse cultural, organizational, client needs, legislation, resources and government policies and resources for CPGs use; Dijk et al., 2012; Poitras et al., 2011; Stergiou-Kita, 2011) and clinicians' positive beliefs towards CPGs (Davis, 2001; Krug, 2007; Stergiou-Kita, 2011) as facilitating factors.

Discussion

A systematic scoping review of 35 articles on professionals' knowledge, attitudes, use, implementation, and adherence of CPGs, as well as the barriers and facilitators pertaining to the use of CPGs for mental health and social care within the social sciences specifically was conducted. The primary aim was to answer the main and sub-research questions. The secondary

aim was to document and identify the gaps in the literature. The results emphasize a steady increase in articles published over the years and subsequently from 2010. This may suggest an increase in research interests for this topic in the past decade. However, a small number of sources were included in the current review. This provides further support for the claim that research on CPGs in the social sciences is limited compared to that of medicine (Graham et al., 2000; Parry et al., 2003; Proctor et al., 2009; Sandström et al., 2014) and especially for professionals' knowledge, attitudes and use of CPGs (Alarcon et al., 2013; Lovell et al., 2013; Sinuff et al., 2015). Relatedly, more than half the studies included professionals from the social sciences and medicine, with very few exclusively focusing on a specific social science profession; some professions were not captured at all (i.e., psycho-educators and marriage and family therapists). Few articles were obtained for psychology, counselling, social work, and occupational therapy. These findings imply that the social science professions are not adequately represented in the current literature, highlighting the significance of the current study. Also, a slight majority of the articles were conducted in the USA, with a few in Canada and other European and Oceanian countries. This may suggest that there is an international research interest in professionals' knowledge, attitudes, and experiences of CPGs in the social sciences. The findings highlight a lack of research in this area, an inadequate depiction of these professions, and limited relevant studies conducted globally. This review also aimed to address sub-research questions involving CPGs topics, knowledge, attitudes, and use, and barriers and facilitators. They are addressed below.

Existing Guideline Topics

Various guideline topics concerning mental health and social care services were identified. This is unsurprising, when considering an abundance of CPGs have been produced globally in medicine and the social sciences (Colón-Emeric et al., 2007; Gould & Kendal, 2007; Parry et al., 2003; White & Kratochwill, 2005). However, prior to the current review, the cohesive documentation of the guideline topics in the social science literature was virtually non-existent. The topics covered across the articles varied considerably, ranging from chronic pain and traumatic brain injury and some more focused on treatments (e.g., CBT), or professional, ethical or multicultural issues (Dijk et al., 2015; Krug, 2007; Poitras et al., 2012; Prytys et al., 2011; Stergiou-Kita, 2011). However, a slight majority of articles focused on anxiety disorders, followed by mood disorders and schizophrenia. This indicates that these issues may be of

particular research and clinical interest and more CPGs may have been produced in these areas given their global popularity. Almost all the articles consisted of guidelines for adult populations, with a minority focused on children and adolescents. It is possible that there is a lack of guideline development and/or investigation of CPGs for children and adolescents in the social sciences. Consistent with this notion, the social science field is behind that of medicine in terms of examining mental health and social care CPGs (Graham et al., 2000; Proctor et al., 2009; Sandström et al., 2014).

Knowledge of Guidelines

Less than half of the articles focused on the knowledge of professionals about CPGs. Our findings indicate that professionals' knowledge of guidelines varies, suggesting that the majority of the articles imply professionals' lack awareness versus good knowledge of CPGs (e.g., Beurs et al., 2015; Campos, 2011; Mudge et al., 2017). These findings are contrary to data obtained in medicine, indicating more consistent knowledge of CPGs (Alanen et al., 2009a; Flores et al., 2000; Hader et al., 2007; Pogorzelska & Larson, 2008). Further inquiry of knowledge of CPGs in the social sciences may provide clarity. Correspondingly, other related factors were identified in the review. Particularly, factors that hinder knowledge (e.g., problems with guideline usefulness, clarity, accessibility, training; e.g., Campos, 2011; Davis, 2001; Mudge et al., 2017; Rhodes et al., 2010) and learning sources (e.g., continuing education and meetings on CPGs) that foster knowledge were also documented in this review (e.g., Beurs et al., 2015; Poitras et al., 2012; Rhodes et al., 2010). Addressing these factors via academic and professional training may foster knowledge of CPGs. However, further inquiry in this area is warranted.

Attitudes Towards Guidelines

Several articles focused on professionals' attitudes towards CPGs. Most of the studies highlighted professionals' positive attitudes of CPGs (e.g., professionals generally valued and supported guideline use, perceived them as useful and relevant, and had favourable views of guideline development and their impact on practice; e.g., Campos, 2011; Dijk et al., 2012, 2015; Pruijssers et al., 2015). However, almost just as many articles focused on professionals' negative attitudes towards CPGs, most of which were the opposite of the positive attitudes (e.g., Hetrick et al., 2011; Hutschemaekers, 2003; Sandström et al., 2014). In medicine, most research indicates that the majority of health practitioners have positive attitudes towards CPGs, with a minority of them maintaining negative attitudes (e.g., Constantino-Casas et al., 2011; Farquhar et al., 2002;

Flores et al., 2000; Pogorzelska & Larson, 2008). Similarly, the current review suggests the presence of both negative and positive attitudes toward CPGs, with slightly more positive attitudes among mental health and social care professionals.

The commonly reported positive and negative attitudes towards CPGs in medicine are similar to those documented in this review (e.g., useful versus not useful, reliable versus unreliable, not limiting versus limiting autonomy, good versus poor guideline development and quality, and positive versus negative impact on practice; Alanen et al., 2009a; Constantino-Casas et al., 2011; Farquhar et al., 2002; Feldman et al., 1998; Flores et al., 2000; Graham et al., 2000; Higashi et al., 2010; Lovell et al., 2013; Lugtenberg et al., 2009, 2011; Pogorzelska & Larson 2008; Scott et al., 2003; Sinuff et al., 2007). This may suggest that medical and social science professionals have parallel views of CPGs. However, this list is not exhaustive and other attitudes have been found in medicine that were not obtained in the current review (e.g., concerns with litigation and disciplinary actions against health professionals; Christakis & Rivara, 1998; Feldman et al., 1998; Higashi et al., 2010). Thus, further examination of professionals' attitudes in the social sciences is needed.

Uptake of Guidelines

Several articles presented reports of professionals' use of CPGs. Of these, most discussed the general lack of guideline use, implementation and adherence (e.g., Berry & Haddock, 2008; Beurs et al., 2015; Fischler et al., 2016). In contrast, a minority indicated higher use (Kosmerly et al., 2015; Nicholas, 1999; Rothrauff & Eby, 2011). Some articles presented mixed and inconsistent reports of use, implementation, and adherence of CPGs (e.g., Hetrick et al., 2011; Mudge et al., 2017; Tiemeier et al., 2002). These findings suggest mixed rates of guideline use. However, due to the majority of articles indicating infrequent guideline use, it appears that there is more support for a lack of guideline use, implementation, and adherence among social science professionals. This seems consistent with findings obtained in medicine, implying variable reports of guideline use, implementation, and adherence (e.g., Lugtenberg et al., 2009; Oh et al., 2011; Wisnivesky et al., 2008). However, the bulk of research has also found that most healthcare professionals are not using CPGs, nor have they effectively implemented or adhered to them (e.g., Ardery et al., 2007; Ebben et al., 2013; Perez et al., 2012; Theodorou et al., 2012). Further evaluation of the rates of guideline use in the social sciences is necessary in order to obtain lucidity regarding the mixed rates of guideline use. Some studies also discussed a positive

and negative impact of training, interventions, strategies, or systems on guideline use, implementation and adherence among professionals (e.g., Dijk et al., 2012, 2015; Fischler et al., 2016; Williams & Hazell, 2009). These findings may shed light into the prevention and enhancement of guideline use, implementation, and adherence in practice. However, the lack of available studies in these areas is an inadequacy.

Linking Guideline Knowledge, Attitudes, and Uptake

The current review examined professionals' knowledge, attitudes, and use of CPGs separately. Interestingly, the thematic analysis revealed some overlap. Some articles in each main theme addressed the following: 1) the impact of professionals' knowledge on guideline use, implementation, and adherence (e.g., Beurs et al., 2015; Campos, 2011; Dijk et al., 2012); 2) the impact of attitudes on guideline use, implementation, and adherence (e.g., Glass, 2007; Hutschemaekers, 2003; Krug, 2007); 3) negative attitudes of CPGs as a barrier to guideline use (e.g., Leven et al., 2012; Phillips & Brandon, 2004; Poitras et al., 2011, 2012); and 4) clinicians' positive beliefs towards CPGs serving as a facilitator (e.g., Davis, 2001; Krug, 2007; Stergiou-Kita, 2011). These findings are similar to previous research and models in medicine, which may suggest a link between knowledge, attitudes and guideline use, implementation and adherence, and barriers and facilitators (Cabana et al., 1999; Forsner et al., 2010; Pathman et al., 1996; Solberg et al., 2000; Woolf, 1993). There was one exception: the current review did not capture the relationship between knowledge and attitudes (i.e., greater knowledge leads to positive attitudes towards CPGs), as has been found in medicine (Alanen et al., 2009a; Cabana et al., 1999; Pathman et al., 1996; Hader et al., 2007). In the social science literature, data on the link between knowledge, attitudes, and experiences of CPGs is lacking, and represents an important research limitation.

Barriers to Guideline Use, Implementation, and Adherence

Commonly reported barriers to guideline use, implementation, and adherence primarily consisted of organizational constraints (e.g., high work-demands and lack of time and resources; e.g., Hammond et al., 2005; Rothrauff & Ebby, 2011; Sandström et al., 2014). This finding is consistent with what has been reported in various studies (Constantino-Casas et al., 2011; Forsner et al., 2010; Lovell et al., 2013; Taba et al., 2012) and models in medicine (Cabana et al., 1999; Moulding et al., 1999; Pathman et al., 1996; Solberg et al., 2000). The less commonly reported barriers in this review, such as negative attitudes, guideline feasibility and knowledge,

and poor guideline development and implementation issues (e.g., Leven et al., 2012; Michie et al., 2007; Rhodes et al., 2010), have also been identified in medicine (Constantino-Casas et al., 2011; Kastner et al., 2015). However, in medicine, a lack of knowledge and negative attitudes were the most commonly identified barriers (Constantino-Casas et al., 2011; Lovell et al., 2013; Scott et al., 2003). Other barriers not found in this review were identified in medicine (e.g., other professionals' views concerning CPGs and decreasing healthcare costs; Flores et al., 2000; Yang et al., 2013). Further identifying barriers in the social sciences would be valuable.

Facilitators to Guideline Use, Implementation, and Adherence

Many of the identified facilitators to guideline use, implementation, and adherence are the inverse of the reviewed barriers. Training and supervision regarding CPGs was the most commonly reported facilitator (e.g., Dijk et al., 2012; Glass, 2007; Stergiou-Kita, 2011). Collaboration and teamwork, guides, tools, and guideline strategies, evaluation and monitoring of performance and feedback, good quality guidelines, support, guideline accessibility, local contexts and policy, and clinicians' positive beliefs towards CPGs (e.g., Leven et al., 2012; Stergiou-Kita, 2011; William & Hazell, 2009) were additional facilitators. Most of these factors were found in medicine and reliably fostered guideline use and implementation (e.g., local context factors, such as organizational resources, methodological rigour of CPGs, guides, tools and implementation strategies, and evaluation of performance and auditing; Alanen et al., 2009b; Fretheim et al., 2006a; Kastner et al., 2015; Shekelle et al., 2012). In medicine, the effectiveness of implementation strategies has also been evaluated (Watkins et al., 2015). Given the shortage of research on facilitators in the social sciences, studying the effects of implementation strategies and other factors would be useful (Bermejo et al., 2009).

Strengths and Limitations

To our knowledge, the current review is the first systematic scoping review conducted on professionals' knowledge, attitudes, use, implementation, and adherence of CPGs, as well as the barriers and facilitators in the social sciences. The review provides a synthesis of knowledge in the form of a descriptive and thematic analysis, which can advise professionals' understanding, attitudes, and uptake of CPGs. These findings have the potential to guide research and inform policy and practice.

However, this study has a number of limitations. The review included a small number of articles. This was due to the lack of available literature on the current topic. Consequently, the

generalizability of the conclusions drawn from this study may be limited. It is also possible that some studies were omitted due to database selection bias, as only a few survey studies were included in the review. A more exhaustive review of the literature may have been obtained if additional databases were used. Moreover, the studies included in the present review were conducted across only a handful of countries (e.g., Canada, U.S.). Thus, findings could have been impacted by cultural biases and caution should be taken when extending results to other cultural contexts. Finally, due to the nature of the available literature, it was not possible to obtain information on all social science professions.

The current review nonetheless documented professionals' knowledge, attitudes, and use of mental health and social care service CPGs in the social sciences for psychologists, counsellors, social workers, and occupational therapists. Given the lack of existing literature, data concerning psychoeducation and marriage and family therapy were not obtained. Despite this, the review reports valuable information, lending insight into the ethos of the social science field in light of this topic and informing future research endeavors and policy. The current study highlighted the following: 1) diverse guideline topics (i.e., mainly one topic, adult and anxiety disorders population); 2) variable levels of guideline knowledge; 3) slight preference for positive versus negative attitudes of CPGs; 4) infrequent use, implementation, and adherence of CPGs, with a minority of support for higher rates; 5) several guideline barriers, with organizational restraints as the most prominent; and 6) various guideline facilitators, with training and supervision about CPGs being the most salient.

Several gaps in the literature were highlighted in this review, which underscores the need for significant developments in future research. It is recommended that future research further investigate professionals' knowledge, attitudes, use, implementation, and adherence of CPGs, as well as the related barriers and facilitators. A variety of professions within the social sciences specifically should be examined in more depth. Increased representation of the entire field and of each social science profession, including psychoeducation and marriage and family therapy, should be obtained as these professions were not captured in the present review.

It is also recommended that future research assess the abovementioned variables using a more international approach. For instance, relatively few articles in this review were conducted in Canada and some countries were not accounted for. This would allow to obtain perspectives and experiences that are more representative of Canadian social science professionals and inform

differences in regions and types of professions. Conducting research cross-country would account for cultural similarities and differences and advise a CPGs framework for the social sciences.

In this same vein, future research could focus on evaluating existing mental health and social care CPGs, particularly those focused on children and adolescent populations, as well as assessing multiple guidelines within a given profession and other guideline topics. It is suggested that future research further identify the barriers and facilitators to guideline use and evaluate the effectiveness of the facilitating factors, such as implementation strategies. Order, organizations, and work settings could then address the existing barriers to guideline use in developing and disseminating CPGs and encourage the facilitators in practice. Also, it is recommended that research investigate guideline knowledge, attitudes, and use via survey and focus group studies involving both professionals and policymakers. Finally, once the literature in the social sciences concerning guidelines flourishes, it would be beneficial to conduct other scoping and systematic reviews on this topic. Future research could inform the development of a unified social science model, guideline development policies, dissemination, and implementation, as well as clinical practice, and ultimately, effective treatment.

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Table 1

Study Characteristics

Variable		Frequency (N = 35)	Percentages (%)
Year of publication			
	1995 – 1999	3	8.6
	2000 – 2004	5	14.3
	2005 – 2009	7	20.0
	2010 – 2014	12	34.3
	2015 – 2019	8	22.9
Country			
	USA	11	31.4
	UK	7	20.0
	Netherlands	7	20.0
	Canada	5	14.3
	Australia	2	5.7
	Spain	2	5.7
	New Zealand	1	2.7
	Sweden	1	2.7
Publication source			
	Peer-reviewed	29	82.9
	Grey literature	6	17.1
Article type			
	Qualitative study	16	45.7
	Quantitative study	10	28.6
	Mixed method	1	2.9
	Review	5	14.3
	Editorial paper	1	2.9
	Theoretical paper	1	2.9
	Rejoinder	1	2.9
Study population			
	Multiple populations (mixed social sciences and medical professionals)	19	54.3
	Multiple populations (social sciences only, no medical professionals)	1	2.9
	Occupational therapists	2	5.7
	Psychologists	3	8.6
	Counsellors	2	5.7
	Social workers	1	2.9

Table 2

Summary of Reported Aims/Purposes

Variable	Frequency (N = 35)	Percentage (%)
Assessing CPGs use/implementation	23	65.7
Informing CPGs implementation/use	16	45.7
Assessing professionals' attitudes of CPGs	12	34.3
Informing CPGs adherence	9	25.7
Assessing CPGs adherence	9	25.7
Development or application of guideline implementation strategy/frame	6	17.1
Assessing professionals' knowledge of CPGs	6	17.1
Informing guideline development	5	14.3
Assessing guideline usefulness	4	11.4
Developing CPGs	3	8.6
Assessing guideline use on practice/outcome/competency	1	2.9

Table 3

Summary of Location of Care

Variable	Frequency ($N = 35$)	Percentage (%)
Not applicable (review, editorial, etc.)	5	14.3
Applicable (discussed location of care)	30	85.7
	($N = 30$)	
Mental health service/setting	6	20.0
Hospital	4	13.3
General social care clinical setting	4	13.3
Community mental health center	3	10.0
NHS trust (specialized service)	2	6.7
Medical clinic	2	6.7
Psychiatric department	2	6.7
Nursing home	2	6.7
School	2	6.7
Addiction treatment facility	2	6.7
Specialized mental health center	2	6.7
Public youth mental health service	1	3.3

Table 4

Summary of Professionals' CPGs Knowledge, Attitudes, Use, Barriers, and Facilitators

	Articles That Discussed Topic		Articles That Did Not Discuss Topic	
Variable	Frequency	Percentage (%)	Frequency	Percentage (%)
Knowledge	15	42.9	20	57.1
Attitudes	23	65.7	12	34.3
Use	23	65.7	12	34.3
Barriers	22	62.9	13	37.1
Facilitators	22	62.9	13	37.1

Note. $N = 35$.

Table 5

Summary of Guideline Topics

Variable		Frequency (N = 35)	Percentage (%)
Population			
	Adults	32	91.4
	Children and adolescences	3	8.6
Guideline focus			
	One specific guideline type	21	60.0
	Several specific guidelines	8	22.9
	Guidelines in general without specific topics	2	5.7
	Guidelines in general with specific topics	4	11.4
Guideline topic			
	Anxiety disorders – General and specific (i.e., Panic disorders, social anxiety, OCD, PTSD and GAD)	11	31.4
	Mood disorders – Unipolar depression	7	20.0
	Schizophrenia	6	17.1
	Substance abuse	4	11.4
	General mental health	3	8.6
	Family-based interventions	3	8.6
	Stroke	2	5.7
	Dementia	2	5.7
	Back pain	2	5.7
	Suicidality	2	5.7
	Medications	2	5.7
	CBT	2	5.7
	Professional and ethics	2	5.7
	Bipolar disorder	1	2.9
	Mixed diagnosis – co-morbidity	1	2.9
	Eating disorders	1	2.9
	Prevention	1	2.9
	Communicating difficult news	1	2.9
	Specific treatments (e.g., ECT)	1	2.9
	Multicultural issues	1	2.9
	Occupational health/therapy/vocational	2	2.9
	Body dysmorphic disorder	1	2.9
	HIV	1	2.9
	Prenatal care	1	2.9
	Intellectual disabilities	1	2.9
	Traumatic brain injury	1	2.9

Table 6

Professionals' Guideline Knowledge, Attitudes, Use, Barriers, and Facilitators

Main Themes	Sub-Themes	Studies in the Theme (*n*)	References
Knowledge		14	(Beurs et al., 2015; Campos, 2011; Davis, 2001; Dijk et al., 2012, 2015; Krug, 2007; Mudge et al., 2017; Nicholas, 1999; Poitras et al., 2011, 2012; Phillips & Brandon, 2004; Prytys et al., 2011; Rhodes et al., 2010; Sandström et al., 2014).
	Lack of awareness of CPGs	10	(Beurs et al., 2015; Campos, 2011; Dijk et al., 2012, 2015; Mudge et al., 2017; Nicholas, 1999; Poitras et al., 2012; Prytys et al., 2011; Rhodes et al., 2010; Sandström et al., 2014).
	Good knowledge of CPGs	9	(Beurs et al., 2015; Campos, 2011; Dijk et al., 2015; Krug, 2007; Mudge et al., 2017; Nicholas, 1999; Prytys et al., 2011; Rhodes et al., 2010; Sandström et al., 2014).
	Sources of learning that foster knowledge of CPGs	9	(Beurs et al., 2015; Campos, 2011; Davis, 2001; Dijk et al., 2015; Mudge et al., 2017; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Rhodes et al., 2010).
	Factors negatively affecting knowledge of CPGs	5	(Campos, 2011; Davis, 2001; Mudge et al., 2017; Phillips & Brandon, 2004; Rhodes et al., 2010).
	Impact of knowledge on guideline use, implementation, and adherence	5	(Beurs et al., 2015; Campos, 2011; Dijk et al., 2012; Mudge et al., 2017; Rhodes et al., 2010).
Attitudes		19	(Callahan, 1996; Campos, 2011; Davis, 2001; Dijk et al., 2012, 2015; Glass, 2007; Hetrick et al., 2011; Hutschemaekers, 2003; Krug, 2007; Leven et al., 2012; Michie et al., 2007; Mudge et al., 2017; Nicholas, 1999; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Pruijssers et al., 2015; Prytys et al., 2011; Sandström et al., 2014).
	Positive attitudes	14	(Campos, 2011; Davis, 2001; Dijk et al., 2012, 2015; Glass, 2007; Krug, 2007; Leven et al., 2012; Michie et al., 2007; Nicholas, 1999; Poitras et al., 2011, 2012; Pruijssers et al., 2015; Prytys et al., 2011; Sandström et al., 2014).

Main Themes	Sub-Themes	Studies in the Theme (*n*)	References
Attitudes	Negative attitudes	12	(Callahan, 1996; Dijk et al., 2012; Glass, 2007; Hetrick et al., 2011; Hutschemaekers, 2003; Krug, 2007; Leven et al., 2012; Mudge et al., 2017; Poitras et al., 2011, 2012; Prytys et al., 2011; Sandström et al., 2014).
	Use, implementation and adherence	8	(Dijk et al., 2012, 2015; Glass, 2007; Michie et al., 2007; Nicholas, 1999; Phillips & Brandon, 2004; Pruijssers et al., 2015; Sandström et al., 2014).
	Improvements	6	(Campos, 2011; Hutschemaekers, 2003; Krug, 2007; Leven et al., 2012; Mudge et al., 2017; Sandström et al., 2014).
	Purpose of the use of CPGs	4	(Hutschemaekers, 2003; Michie et al., 2007; Prytys et al., 2011; Sandström et al., 2014).
Use		20	(Berry & Haddock, 2008; Beurs et al., 2015; Campos, 2011; Dijk et al., 2012, 2015; Fischler et al., 2016; Hammond et al., 2005; Hetrick et al., 2011; Kosmerly et al., 2015; Krug, 2007; Mudge et al., 2017; Nicholas, 1999; Phillips & Brandon, 2004; Prytys et al., 2011; Rhodes et al., 2010; Rothrauff & Eby, 2011; Sandström et al., 2014; Stergiou-Kita, 2011; Tiemeier et al., 2002; Williams & Hazell, 2009).
	Low guideline use, implementation and adherence	16	(Berry & Haddock, 2008; Beurs et al., 2015; Campos, 2011; Dijk et al., 2012, 2015; Fischler et al., 2016; Hammond et al., 2005; Hetrick et al., 2011; Kosmerly et al., 2015; Nicholas, 1999; Phillips & Brandon, 2004; Prytys et al., 2011; Rhodes et al., 2010; Rothrauff & Eby, 2011; Sandström et al., 2014; Tiemeier et al., 2002).
	High guideline use, implementation and adherence	10	(Beurs et al., 2015; Dijk et al., 2012, 2015; Fischler et al., 2016; Kosmerly et al., 2015; Nicholas, 1999; Rhodes et al., 2010; Rothrauff & Eby, 2011; Stergiou-Kita, 2011; Tiemeier et al., 2002).
	Effects of training, interventions, strategies, or systems on guideline use, implementation and adherence	9	(Berry & Haddock, 2008; Beurs et al., 2015; Dijk et al., 2012, 2015; Fischler et al., 2016; Krug, 2007; Nicholas, 1999; Rhodes et al., 2010; Williams & Hazell, 2009).
	Inconsistent guideline use, implementation and adherence	8	(Berry & Haddock, 2008; Hetrick et al., 2011; Kosmerly et al., 2015; Mudge et al., 2017; Nicholas, 1999; Rhodes et al., 2010; Rothrauff & Eby, 2011; Tiemeier et al., 2002).

Main Themes	Sub-Themes	Studies in the Theme (*n*)	References
Barriers		22	(Berry & Haddock, 2008; Callahan, 1996; Davis, 2001; Dijk et al., 2012; Fischler et al., 2006; Glass, 2007; Hammond et al., 2005; Hetrick et al., 2011; Leven et al., 2012; Michie et al., 2007; Mudge et al., 2017; Nicholas, 1999; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Prytys et al., 2011; Rhodes et al., 2010; Rothrauff & Eby, 2011; Sandström et al., 2014; Stergiou-Kita, 2011; Tiemeier et al., 2002; Williams & Hazell, 2009).
	Organizational constraints	17	(Berry & Haddock, 2008; Callahan, 1996; Glass, 2007; Hammond et al., 2005; Hetrick et al., 2011; Leven et al., 2012; Michie et al., 2007; Mudge et al., 2017; Nicholas, 1999; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Prytys et al., 2011; Rhodes et al., 2010; Rothrauff & Eby, 2011; Sandström et al., 2014; Stergiou-Kita, 2011).
	Context specific issues	13	(Callahan, 1996; Davis, 2001; Dijk et al., 2012; Hetrick et al., 2011; Leven et al., 2012; Mudge et al., 2017; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Prytys et al., 2011; Rhodes et al., 2010; Tiemeier et al., 2002; Williams & Hazell, 2009).
	Clinicians or facilities lack of motivation to change	12	(Fischler et al., 2006; Hetrick et al., 2011; Leven et al., 2012; Mudge et al., 2017; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Prytys et al., 2011; Rothrauff & Eby, 2011; Sandström et al., 2014; Stergiou-Kita, 2011; Williams & Hazell, 2009).
	Negative attitudes towards CPGs	11	(Callahan, 1996; Dijk et al., 2012; Leven et al., 2012; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Prytys et al., 2011; Rothrauff & Eby, 2011; Stergiou-Kita, 2011; Tiemeier et al., 2002; Williams & Hazell, 2009).
	Client related barriers	11	(Berry & Haddock, 2008; Dijk et al., 2012; Hetrick et al., 2011; Leven et al., 2012; Mudge et al., 2017; Phillips & Brandon, 2004; Poitras et al., 2011, 2012; Rhodes et al., 2011; Stergiou-Kita, 2011; Tiemeier et al., 2002).
	Lack of training and supervision	11	(Berry & Haddock, 2008; Glass, 2007; Hetrick et al., 2011; Leven et al., 2012; Michie et al., 2007; Mudge et al., 2017; Nicholas, 1999; Phillips & Brandon, 2004; Poitras et al., 2012; Rhodes et al., 2010; Stergiou-Kita, 2011).
	Guideline feasibility	10	(Davis, 2001; Dijk et al., 2012; Glass, 2007; Hetrick et al., 2011; Leven et al., 2012; Mudge et al., 2017; Poitras et al., 2012; Rhodes et al., 2010; Sandström et al., 2012; Stergiou-Kita, 2011).
	Lack of knowledge	9	(Glass, 2007; Hetrick et al., 2011; Leven et al., 2012; Mudge et al., 2017; Phillips & Brandon, 2004; Poitras et al., 2011; Rhodes et al., 2010; Stergiou-Kita, 2011; Williams & Hazell, 2009).

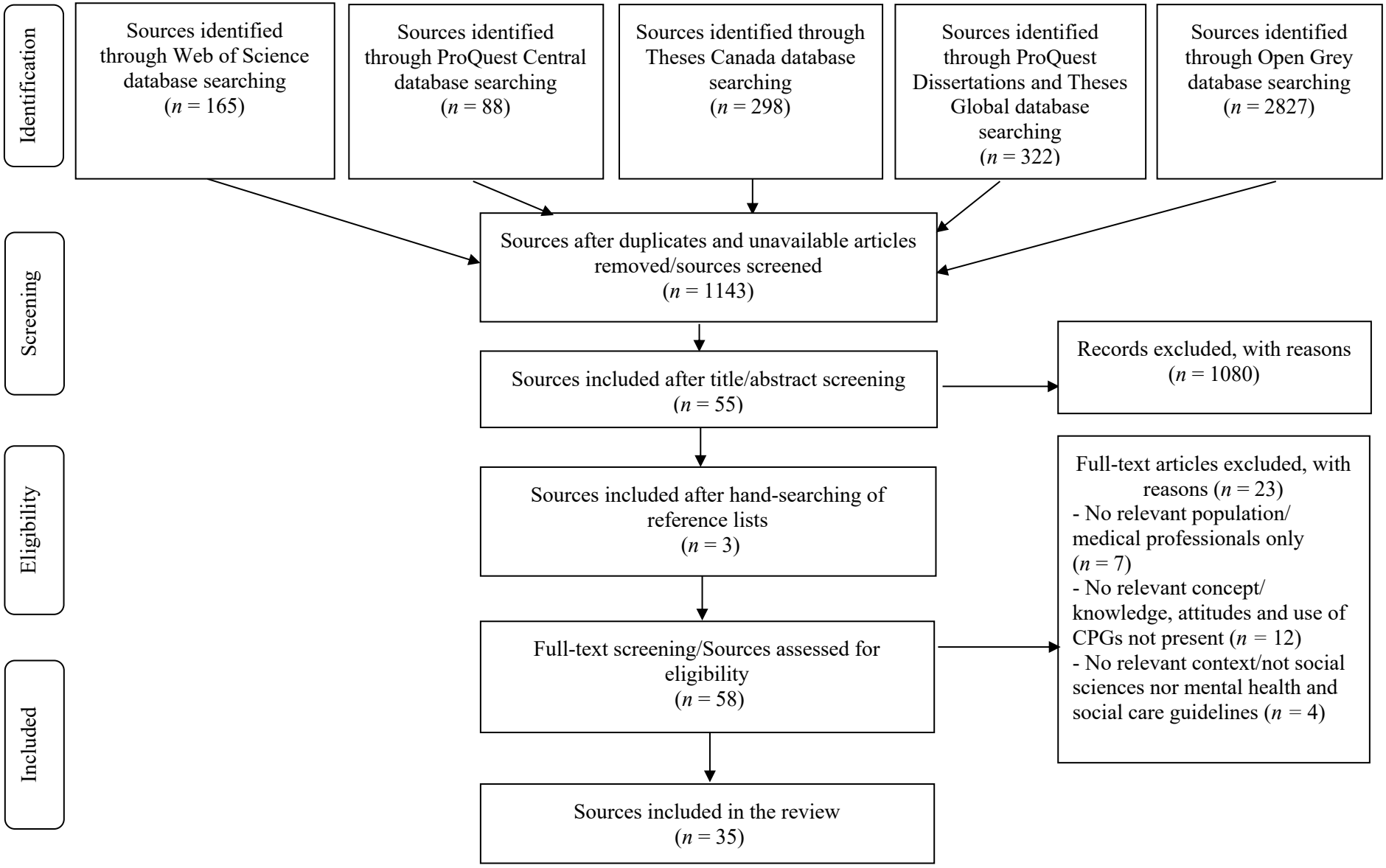
Main Themes	Sub-Themes	Studies in the Theme (*n*)	References
Barriers	Poor guideline quality	7	(Callahan, 1996; Davis, 2001; Dijk et al., 2012; Glass, 2007; Hetrick et al., 2011; Rhodes et al., 2010; Stergiou-Kita, 2011).
	Lack of collaboration and teamwork	6	(Davis, 2001; Fischler et al., 2006; Mudge et al., 2017; Poitras et al., 2012; Prytys et al., 2011; Stergiou-Kita, 2011).
	Lack of confidence	6	(Leven et al., 2012; Michie et al., 2007; Phillips & Brandon, 2004; Rhodes et al., 2010; Stergiou-Kita, 2011; Williams & Hazell, 2009).
	Lack of guideline implementation strategies	4	(Davis, 2001; Glass, 2007; Mudge et al., 2017; Williams & Hazell, 2009).
Facilitators		20	(Berry & Haddock, 2008; Beurs et al., 2015; Callahan, 1996; Campos, 2011; Davis, 2001; Dijk et al., 2012, 2015; Fischler et al., 2016; Glass, 2007; Krug, 2007; Leven et al., 2012; Michie et al., 2007; Moreno & Moriana, 2016a; Mudge et al., 2017; Poitras et al., 2011; Rhodes et al., 2010; Rothrauff & Eby, 2011; Sandström et al., 2014; Stergiou-Kita, 2011; Williams & Hazell, 2009).
	Training and supervision	15	(Berry & Haddock, 2006; Beurs et al., 2015; Davis, 2001; Dijk et al., 2012; Glass, 2007; Krug, 2007; Leven et al., 2012; Michie et al., 2007; Moreno & Moriana, 2016a; Mudge et al., 2017; Rhodes et al., 2010; Rothrauff & Eby, 2011; Sandström et al., 2014; Stergiou-Kita, 2011; Williams & Hazell, 2009).
	Collaboration and teamwork	10	(Berry & Haddock, 2008; Beurs et al., 2015; Callahan, 1996; Davis, 2001; Dijk et al., 2012; Fischler et al., 2016; Leven et al., 2012; Moreno & Moriana, 2016a; Mudge et al., 2017; Sandström et al., 2014).
	Tailored guideline implementation	6	(Berry & Haddock, 2008; Dijk et al., 2012, 2015; Michie et al., 2007; Mudge et al., 2017; Williams & Hazell, 2009).
	Guides, tools, and strategies for guideline implementation	6	(Campos, 2011; Dijk et al., 2012; Fischler et al., 2016; Leven et al., 2012; Moreno & Moriana, 2016a; Williams & Hazell, 2009).

Main Themes	Sub-Themes	Studies in the Theme (*n*)	References
Facilitators	Evaluation and monitoring of performance and feedback	4	(Dijk et al., 2012; Fischler et al., 2016; Leven et al., 2012; Sandström et al., 2014).
	Good quality CPGs	4	(Callahan, 1996; Campos, 2011; Leven et al., 2012; Stergiou-Kita, 2011).
	Support	3	(Leven et al., 2012; Sandström et al., 2014; Williams & Hazell, 2009).
	Clinicians accessibility to CPGs	3	(Campos, 2011; Leven et al., 2012; Mudge et al., 2017).
	Local contexts and policy	3	(Dijk et al., 2012; Poitras et al., 2011; Stergiou-Kita, 2011).
	Clinicians positive beliefs towards CPGs	3	(Davis, 2001; Krug, 2007; Stergiou-Kita, 2011).

Note. $N = 30$.

Figure 1

Flow Chart Diagram of Literature Selection Process and Search Results



Bridging Manuscripts 2 and 3

Study 2 (Manuscript 2) illustrated the lack of available research on professionals' knowledge, attitudes, and experiences of CPGs in the social sciences. It revealed that there are very few studies examining these areas in the social sciences, and thereby highlighted the gaps in the literature. Nonetheless, key findings and existing data related to these constructs were documented. Findings provided direction for the subsequent study. That is, it informed the development of the surveys for Study 3 (Manuscript 3), which elicited data concerning professionals' knowledge, attitudes, use, and implementation of the same CPGs produced in Quebec evaluated in Study 1 (Manuscript 1).

Building on the first two studies, Study 3 (Manuscript 3) investigated the social science professionals' knowledge, attitudes, use, and implementation of mental health and social care service CPGs produced by the OPQ, OCCOQ, OPPQ, OTSTCFQ, and OEQ regulatory bodies in Quebec, as well as guidelines in general. To our knowledge, no other study has previously examined this topic in light of CPGs produced in Quebec and in the social sciences. Ours represents the earliest investigation of its kind. It involved the administration of online surveys to professional members in Quebec (i.e., psychologists, guidance counsellors, psychoeducators, social workers, MFTs, and OTs).

In particular, five survey versions tailored to each profession and regulatory body were created. The study surveyed professionals in terms of the relevancy of the CPGs produced by the regulatory bodies, their current or past guideline use, reasons for lack of guideline use, attitudes towards the CPGs purpose and use, development and implementation, as well as the perceived objectives, credibility, and costs of CPGs in general. This study informs guideline use and implementation among social science professionals' in Quebec as well as policymaking. The findings of this investigation are presented in the subsequent manuscript.

Chapter 4: Manuscript 3

(To be submitted for publication)

Surveys of professionals: How are guidelines perceived, used, and implemented?

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Abstract

Despite the profusion of clinical practice guidelines worldwide, there is a lack of research examining professionals' knowledge, attitudes, use, and implementation of mental health and social care guidelines in the social sciences. Such data is needed to obtain a better understanding of guidelines in general as well as their applicability in practice. Five online surveys adapted to five regulatory bodies in the social sciences and relevant guidelines were administered. The surveys assessed professionals' knowledge, attitudes, and use of guidelines, including guideline purpose, development, and implementation. Surveys also assessed the barriers and facilitators related to the use of the regulatory body guidelines, in addition to the objectives, credibility, and costs of guidelines in general. A total of 954 professionals (296 psychologists, 60 counsellors, 97 psychoeducators, 42 social workers and marriage and family therapists, and 459 occupational therapists) completed the surveys. Overall, the results suggested that most professionals perceive guidelines developed by the regulatory bodies as relevant for practice. Findings indicated some variability in professionals' past and current use of guidelines, however professionals mostly used the guidelines. Most professionals demonstrated having knowledge of guidelines and displayed positive attitudes toward the various guideline facets, including their purpose, development, implementation, objectives, and credibility. Professionals' attitudes toward the perceived costs of guidelines in general were diverse. The current study advises important considerations for policy, clinical practice, and future endeavors for guidelines in the social sciences.

Keywords: Clinical practice guidelines, knowledge, attitudes, guideline use, guideline implementation, guideline purpose, development, professionals, social sciences

Surveys of professionals: How are guidelines perceived, used, and implemented?

Clinical practice guidelines (CPGs) are recommendations regarding specific situations and interventions, founded on rigorous scientific data and developed by stakeholders in a systematic and transparent manner (Field & Lohr, 1992; Beauchamp et al., 2012). They are aimed at advising professionals in various contexts about current research and empirically-based practices. They provide support with decision-making, improve professionalism, and aid in the provision of the best possible services (Farquhar et al., 2002; Woolf, 1992). The development of CPGs is overseen and produced by policy makers and various other organizations, including professional associations and regulatory bodies. These organisations disseminate guidelines to their members, guide them in terms of ethics and appropriate conduct, and regulate practices.

In recent years, there has been a vast production of CPGs universally, in both medicine and in the social science fields (Colón-Emeric et al., 2007; Gould & Kendal, 2007; Parry et al., 2003; White & Kratochwill, 2005). In medicine, numerous studies have examined CPGs, including the guideline development, approval and dissemination process, as well as the methodological rigour and quality of guidelines, and policy maker's knowledge, views, roles, and experiences with CPGs (e.g., Alarcon et al., 2013; Atkins et al., 2013; Esandi et al., 2008; Tudor et al., 2013). There is however a lack of research in the area of mental health and social care service guidelines (Graham et al., 2000; Howard & Jenson, 1999a, 1999b; Parry et al., 2003; Proctor et al., 2009; Sandström et al., 2014), with the exception of a few studies (e.g., Ciquier et al., 2020; Stamoulos et al., 2014; Trépanier et al., 2017; Trépanier, 2019). These studies suggest that there are issues with the methodological rigour and quality of these guidelines (Ciquier et al., 2020; Stamoulos et al., 2014; Trépanier et al., 2017; Trépanier, 2019). This is concerning given that the potential benefits of CPGs largely depend on the quality of the guideline development process and of the actual guidelines (Alonso-Coello et al., 2010; Brouwers et al., 2010; Burgers et al., 2003; Gordon & Cooper, 2010). Additionally, a high-quality guideline development process involves suitable methodologies and rigorous strategies that are vital for successful guideline dissemination, use, and implementation (Alonso-Coello et al., 2010; Ansari & Rashidian, 2012; Blozik et al., 2012; Norris et al., 2011). Therefore, further research on CPGs within the social sciences is warranted.

Similarly, there is limited research on social science professionals' knowledge, attitudes, use, and implementation of CPGs (Graham et al., 2000; Howard & Jensen, 1999a, 1999b; Horvath et al., 2002; Parry et al., 2003; Proctor et al., 2009; Sandström et al., 2014). Most studies have focused on *both* social science and medical professionals and only included a selected few of the social science professions (e.g., Phillips & Brandon, 2004; Prytys et al., 2011; Sandström et al., 2014). The evidence derived from these few studies has been inconsistent and provides limited support for the association between social science professionals' knowledge, attitudes, and use of CPGs. The nature of this area of research also differs greatly than that of medicine. Indeed, the knowledge, attitudes, and experiences of medical professionals regarding CPGs (i.e., guideline use, implementation and adherence) have been thoroughly examined (e.g., Alanen et al., 2009; Flores et al., 2000; Graham et al., 2000; Lovell et al., 2013; Yang et al., 2013).

Evidence suggests that knowledge of CPGs enhances the likelihood of positive attitudes towards guidelines and consequently enhances guideline use among healthcare practitioners (e.g., Alanen et al., 2009; Hader et al., 2007; Lugtenberg et al., 2011). However, some studies suggest that healthcare professionals question the value of CPGs and fail to effectively use them in their clinical practices (e.g., Al-Ansary et al., 2013; Gould & Kendall, 2007). Therefore, the translation of knowledge and favourable attitudes of CPGs into actual guideline use in practice is dubious (Farquhar et al., 2002; Finkelstein et al., 2000; Francke et al., 2008). Further research of these variables is required as they have yet to be examined within the social sciences, and to elucidate the previous findings.

The current study surveyed professional members vis-à-vis mental health and social care service CPGs produced by the five regulatory bodies in the social sciences in Quebec for the following professions: 1) psychology; 2) guidance counselling; 3) psychoeducation; 4) social work and marriage and family therapy (MFTs); and 5) occupational therapy (OTs). The objective was to document the professionals' knowledge, attitudes, and use of these guidelines and CPGs in general. This study aimed to bridge the gap in the existing literature and to improve the state of the research by extending investigation to professionals working in the social sciences. Findings will ultimately advise guideline use and implementation, and lead to important advancements in clinical practice and policymaking.

Method

Participants

Participants included psychologists, guidance counsellors, psychoeducators, social workers and MFTs, and OTs currently licensed by their respective regulatory bodies. These include: 1) l'Ordre des psychologues du Québec (OPQ)/the Order of Psychologists of Quebec; 2) l'Ordre des psychoéducateurs et psychoéducatrices du Québec (OPPQ)/the Order of Psychoeducators of Quebec; 3) l'Ordre des conseillers et conseillères d'orientation du Québec (OCCOQ)/the Order of Guidance Counsellors of Quebec; 4) l'Ordre des thérapeutes conjugaux et familiaux et des travailleurs sociaux du Québec (OTSTCFQ)/the Order of Social Workers and Marriage and Family Therapists of Quebec; and 5) l'Ordre des ergothérapeutes du Québec (OEQ)/the Order of Occupational Therapists of Quebec. A recruitment email-invitation and newsletter advertising the study were sent to all professionals directly from each regulatory body using their respective registry of licensed members. Based on the regulatory bodies' most recent annual reports, the number of current members at this time were: 8,773 psychologists (OPQ, 2019), 2,624 guidance counsellors (OCCOQ, 2019), 5,040 psychoeducators (OPPQ, 2019), 14,361 social workers and MFTs (OTSTCFQ, 2019) and 5,654 OTs (OEQ, 2019). A recruitment e-mail was also sent directly to some OPQ members, using a list compiled from a study previously conducted by our research team consisting of 1,338 members. Of the professionals initially contacted, 1,340 responded to the survey (psychologists, n = 437; guidance counsellors, n = 80; psychoeducators, n = 154; social workers and MFTs, n = 64; and OTs, n = 605). A total of 386 individuals abandoned the survey early on. Thus, a total of 954 participants were included in the study (psychologists, n = 296; guidance counsellors, n = 60; psychoeducators, n = 97; social workers and MFTs, n = 42; and OTs, n = 459).

Measure

Five online surveys were developed and tailored to the respective regulatory bodies, professions, and mental health and social service guidelines (see Table 1 for a list of the regulatory bodies and CPGs). The Qualtrics survey platform (Qualtrics, 2020) was used to produce and disseminate the online surveys. The Tailored Design Method (TDM; Dillmann et al., 2014) and a scoping review on professional' knowledge, attitudes, use, implementation, and adherence of CPGs in the social sciences (Stamoulos, 2020) were used to develop the surveys. An initial survey was first developed and piloted in English and was then translated and piloted in French. Piloting was completed by graduate students and faculty members at McGill

University and University of Montreal. Additional surveys were subsequently developed and were nearly identical to this initial version.

Survey

The survey consisted of 48 statements, including a demographic section. The study assessed professionals' views in terms of guideline relevancy, use, implementation, development of CPGs produced by the regulatory bodies, as well as the objectives, credibility, and costs of CPGs in general. Item 1 consisted of multiple-choice options and involved selecting the guideline that addressed a domain or topic most relevant to informing ones' practice or selecting *None of these practice guidelines are relevant to my practice* option. Participants that indicated none of the CPGs were relevant skipped Items 2, 3, and 6 to 32 (see below). Item 2 consisted of a "*yes"* or *"no"* response option regarding the specific use (current or past) of the guideline selected in Item 1. Participants that indicated "y*es"* to Item 2, were directed to Items 4 and 5 and all subsequent items. Participants that indicated "*no"* to this item, were directed to Item 3 and all subsequent items, except Items 6 to 32 which were skipped as no guideline use was selected. Item 3 consisted of multiple-choice options regarding the reasons for not using guidelines. This item was only displayed for participants who indicated not using the CPGs for Item 2. Items 4 and 5 consisted of descriptive open-ended questions and assessed the barriers and facilitators to guideline use for the CPGs produced by the regulatory bodies. Items 6 to 32 assessed the purpose and use, development, and implementation of the CPGs produced by the regulatory bodies. Items 33 to 41 examined the objectives and credibility of guidelines in general. Items 6 to 41 were rated on a 5-point Likert scale, ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*), or the *I don't know* option. Finally, Items 42 and 43 comprised of drop-down menu options, ranging from *$0* to *greater than $150,000,* or *I have no idea,* or *I don't know* options. Additionally, familiarity or knowledge of CPGs were assessed by Items 3 and 15. Please refer to Tables 4 to 9 for survey items.

Procedures

The current study received ethical approval from the McGill University Ethics Board II (REB # 284-1216). The Secretary Generals of the five regulatory bodies were contacted to request distribution of the surveys to their members. All regulatory bodies agreed and either distributed the recruitment e-mail, follow-up, and reminder e-mails directly to their members, or included an invitation for the study in their monthly newsletter. In an effort to increase the

number of participants, some of the regulatory bodies agreed to re-distribute the recruitment e-mail and advertise the study. An e-mail list for Quebec psychologists obtained from a previous study was also used for recruitment. Participants could be entered into a draw to win an Apple iPad Mini.

Data Analysis

Descriptive statistics for the demographic information for all surveys were calculated. The items were analyzed via frequencies and percentages or by combining *agree* and *strongly agree* ratings, which represented agreement and calculating the corresponding percentages. Combined ratings were based on grouping the responses across guidelines for each respective profession and regulatory body for guideline purpose, development, and implementation items. The amalgamated ratings were also calculated separately for each profession and were combined for all professions for the guideline objectives and credibility in general. Items 4 and 5 were descriptive questions and were analyzed separately by grouping data based on common themes and calculating frequencies and percentages. For items 4 and 5, only barriers and facilitators with 5% endorsement and more are reported below.

Results

Demographic Characteristics

Across the online survey versions, 954 were completed. The largest sample consisted of OTs (n = 459), followed by psychologists (n = 296), psychoeducators (n = 97), guidance counsellors (n = 60), social workers (n = 40), and social workers and MFTs (n = 2; i.e., holding both professional licenses).

Psychologists

Most of the sample (78%) identified as female, 22% male, 1% chose not to disclose, and one individual described themselves as queer. Fifty-two percent reported a master's degree as their highest academic degree, 24% a PhD degree, 19% a PsyD degree, 2% a post-doctorate degree, and 2% indicated "*other"*. In terms of years holding a professional license, 26% had held a license for 0 and 10 years, 37% for 11 to 20 years, 23% for 21 to 30 years, and 14% held a license for more than 30 years (see Table 2). Forty-one percent of the sample reported working primarily in a private setting (i.e., private practice individual or group), 9% in an academic setting, 34% in a public setting (i.e., hospital, government agency, community or center), and

17% indicated "*other"* settings (e.g., school board and correctional services; see Table 3 for full details on work activities).

Guidance Counsellors

Eighty-seven percent of the sample identified as female, with 13% male. Most (92%) reported a master's degree as their highest obtained degree, 5% a PhD degree, and 2% a bachelor's and post-doctoral degree, respectively. Forty-eight percent reported holding a professional license for 0 and 10 years, 30% for 11 and 20 years, 22% for 21 and 30 years, and 0% had their license for more than 30 years (see Table 2). Of the sample, 27% reported working primarily in a private setting, 47% in an academic setting, 15% in a public setting, and 11% in *"other"* settings (e.g., vocational school and veteran's rehabilitation; see Table 3).

Psychoeducators

A total of 88% of the sample were female and 12% were male. In terms of education, most of the sample reported obtaining a master's degree (64%) as their highest degree, 28% a bachelor's degree, 5% *"other"*, 2% a PhD degree, and 1% a post-doctorate degree. Fifty-four percent of the sample reported holding a professional license for 0 to 10 years, 30% for 11 and 20 years, 12% for 21 to 30 years, and 4% had their license for more than 30 years (see Table 2). Only 10% indicated working primarily in a private setting, 13% in an academic setting, with 45% in a public setting, and 27% in *"other"* settings (e.g., school board and addiction center; see Table 3).

Social Workers and MFTs

Eighty-three percent of the sample identified as female, with 8% as male. A total of 62% of the sample identified a bachelor's degree as their highest obtained degree, 36% a master's degree and 2% indicated *"other."* Of the sample, 55% percent indicated holding a professional license for 0 to 10 years, 29% for 11 to 20 years, 14% for 21 and 30 years, and 1% had their license for more than 30 years (see Table 2). Only 10% of the sample reported working primarily in a private setting, 5% in an academic setting, with the majority (67%) in a public setting and 19% in *"other"* settings (e.g., Center for research and detention; see Table 3).

OTs

The majority of the sample (92%) identified as female, with 8% male. Most identified either a bachelor's degree (49%) or master's degree (46%) as their highest obtained degree, 3% indicated *"other",* and 1% a PhD degree and post-doctorate degree, respectively. Thirty-six

percent reported holding a professional license for 0 to 10 years, 38% 11 to 20 years, 20% for 21 to 30 years, and 7% had their license for more than 30 years (see Table 2). Fourteen percent reported working primarily in a private setting, 5% in an academic setting, 55% in a public setting, and 27% in *"other"* settings (e.g., INESSS and law firm; see Table 3).

Survey Responses

Relevancy of Guidelines

Item 1 inquired as to the guideline that professionals found to be most relevant to informing their practice. Fifty percent of the sample of psychologists (n = 149) reported that none of the OPQ guidelines were relevant to their practice, versus 50% (n = 147), indicating one of the CPGs was relevant. The most endorsed guideline was the *Autism Spectrum Disorders – Clinical Evaluation (2012)* CPG (18% of the entire sample, N = 296; 37% of the sample endorsing CPGs, n = 147). Among guidance counsellors, the majority of the sample (n = 48; 80%) reported that at least one of the guidelines were relevant to practice, with only 20% (n = 12) indicating that none of the CPGs were relevant. The *Assessment Guide for Career and Guidance (2010-2011)* CPG was the most endorsed (53% of the entire sample, N = 60; 67% of the sample endorsing CPGs, n = 48). Most psychoeducators (n = 92; 95%) reported that one of these CPGs were relevant to their practice, with only 5% (n = 5) of the sample indicating the CPGs were not relevant. The most commonly endorsed was the *Psychoeducational Assessment of the Person with Adjustment Difficulties (2014)* CPGs (70% of the entire sample, N = 97; 74% of the sample endorsing CPGs, n = 92), with no respondents endorsing the *Evaluation of an Adolescent in Relation to a Tribunal Decision… (2014)* CPG as relevant. Most social workers and MFTs (n = 34, 81%) endorsed one of the guidelines as relevant to practice, with only 19% (n = 8) indicating no CPGs were relevant. All these CPGs were endorsed to some degree, with the exception of the *Professional Practice of Community Social Workers (2008)* and *Determining an Intervention Plan for a Person Suffering from a Mental Disorder or at Risk of Suicide… (2014)* CPGs, with 0% of the sample endorsing them. The most endorsed CPGs were *Psychosocial Assessment in the Context of Protective Supervision…(2016)* 21% of the entire sample, N = 42; 26% of the sample endorsing CPGs, n = 34) and *Evaluating a Person with a Mental or Neuropsychological Disorder…(2011)* (21% of the entire sample, N = 42; 26% of the sample endorsing CPGs, n = 34). Lastly, among OTs, 70% of the sample (n = 321) endorsed one of the guidelines, with 30% (n = 138) indicating none of the CPGs were relevant to practice. The most

endorsed were the CPGs for *Interventions Related to the Utilization of a Road Vehicle…(2008)* (51% of the entire sample, $N = 459$; 73% of the sample endorsing CPGs, $n = 321$) and *Restraint Measures…(2008)* (19% of the entire sample, $N = 459$; 27% of the sample endorsing CPGs, $n = 321$; see Table 4).

Use of Guidelines Produced by Regulatory Bodies

Item 2 assessed the current or past use of the specific guidelines selected in Item 1. A total of 67% of participants ($N = 642$) across all professions responded to Item 2. Seventy-seven percent ($n = 112$) of psychologists reported *"yes"* to Item 2, indicating that they used the CPGs reported as relevant to their practice. Most guidance counsellors ($n = 32$; 67%), psychoeducators ($n = 70$; 76%), social workers and MFTs ($n = 27$; 79%), and OTs ($n = 253$; 79%) also reported using these CPGs (see Table 5).

Reasons for Not Using Regulatory Bodies Guidelines and Lack of Familiarity

Item 3 addressed the reasons why participants did not use any of the regulatory body CPGs. Only participants who indicated *"no"* in Item 2 received this question. A total of 144 respondents answered this item; four participants left this item blank. The most common reason for not using the CPGs was not knowing that the guidelines existed, which was reported by most social workers and MFTs (71%) and a slight majority of psychoeducators (57%) and psychologists (55%), with only 20% of guidance counsellors and 31% of OTs endorsing this reason. Across professions, 41% of professionals reported not knowing the CPGs existed. A total of 50% of OTs and 47% of guidance counsellors reported *"other"* reasons as the most common reason. These reasons included a lack of time and relevance for OTs and guidance counsellors. OTs also reported forgetting to consult them and guidance counsellors indicated a lack of easy access to CPGs (see Table 5).

Guideline Purpose, Development, and Implementation

Items 6 to 32 assessed guideline purpose (Items 6 to 10) for respondents that indicated they used a specific guideline published by the regulatory bodies in Item 2 and the development (Items 11 to 28) and implementation of the CPGs (Items 29 to 32). These items were only rated for the respective guideline that was selected for a given participant that indicated it was relevant and used in practice. Slightly fewer respondents completed these items compared to Item 2, which was attributed to the analyses excluding the *"I don't know"* ratings and a minority of missing responses. These items were rated for all five of the OPQ guidelines, for both the

OCCOQ guidelines, 5 out of the 6 OPPQ guidelines, 8 out 10 of the OTSTCFQ guidelines, and all two of the OEQ guidelines (see Table 4). Ratings were first calculated separately for each guideline within each profession and regulatory body and then were merged together to represent combined agreement ratings for all CPGs within a given profession and regulatory body. Frequencies and combined agreement ratings are presented by each set of guidelines corresponding to each profession and regulatory body in Table 6.

Psychologists. The results below represent ratings across all OPQ guidelines (see Table 4 for a list of these CPGs). In terms of guideline use, 90% of respondents indicated that they *agreed* and *strongly agreed* with Item 6, that the guideline is useful, informs, and improves their practice for the OPQ guidelines. Most respondents (75%) were in agreement with Item 10, that the guideline is used to prevent professionals from engaging in professional malpractice. Conversely, 56% of respondents were in agreement with Item 9, that the guideline is used to discourage suboptimal practice. Item 7, that the guideline is an oversimplified cookbook and Item 8, that the guideline is too rigid to be applicable to specific clients and contexts, were both rated low, with 16% and 10% of respondents indicating agreement, respectively.

A number of items that assessed guideline development were endorsed favourably by a large portion of respondents. In particular, the combined *agree* and *strongly agree* ratings ranged from 67% to 92% for items concerning the OPQ guidelines' organization, clarity, and structure (Item 11) and methodological rigour and development process (Items 12-19 and 21). The latter set of items related to the foundation of the guidelines, as well as the methods and the individuals involved in development of the guidelines (i.e., evidence, clinical and expert consensus, a familiar development method, expert consultation, involved a credible and development committee and used a structured systematic method for searching the literature). Item 20 concerned the guidelines providing sufficient information as to how they were developed and 56% of respondents agreed with this item. Similarly, agreement was provided by 56% for Item 23, which related to the involvement of an informal method of consensus for making decisions about the final guideline recommendations.

Item 22 concerned the involvement of a formal method of consensus for the final guideline recommendations. Few respondents were in agreement with this item (38%). This may have been due to a smaller number of respondents obtained for this particular item, since several indicated the *"I don't know"* option or skipped this item altogether. Item 24 pertained to the

involvement of a systematic method to assess the scientific evidence used to formulate the guidelines; only 48% of respondents agreed with this item. Items 25-28 were related to whether the guidelines described or addressed important issues, such as the strengths and limitations of the CPGs, potential ethical concerns and conflicts of interest and bias. These were endorsed less, with agreement ratings ranging from 33% to 42%.

Items 29 to 32 related to the implementation of the OPQ guidelines. A total of 63% of respondents agreed with the fact that the CPGs explained how their recommendations should be implemented in practice (Item 29). Most respondents (90%) were in agreement with the guidelines being easily accessible and used in practice (Item 30). Fewer respondents (35%) agreed with the CPGs discussing the facilitators and potential barriers to implementing the guideline recommendations (Item 31). Only 19% for Item 32 agreed that the CPGs included a plan to assess the effects of the guidelines on practice (see Table 6 for details).

Guidance Counsellors. Ratings across both of the OCCOQ guidelines are reviewed below (see Table 4 for a list of these CPGs). Items 6 to 11 pertained to the use of the OCCOQ guidelines. Most respondents (84%) reported that they *agreed* or *strongly agreed* with the guidelines being useful, informing, and improving their practice (Item 6). Fewer respondents agreed with the items related to the guidelines being used to prevent professional malpractice (Item 10; 41%), used to discourage suboptimal practice (Item 9; 36%), being an oversimplified cookbook (Item 7; 22%) and being too rigid to apply to specific clients and contexts (Item 8; 16%).

With regard to the guideline development items, the majority of respondents reported higher ratings of agreement for items pertaining to the consensus process, such as expert consensus (Item 14; 93%) and clinical consensus (Item 13; 90%). Similarly, 89% of respondents also agreed with the guideline being based on the most scientific evidence (Item 12) and 81% reported agreement for the guideline being developed according to best practices in guideline development (Item 16). A large number of respondents (89%) also agreed with the guidelines having involved a committee of credible experts for its redaction (Item 18). Most respondents 88% agreed with the guidelines being well designed, organized, clear, and coherent (Item 11). Sixty-seven percent of respondents reported agreement for the guidelines using a structured and systematic method for searching the literature (Item 21). Lastly, 60% reported *agreeing* or

strongly agreeing with the CPGs having used a method of development that they knew well (Item 15).

Slightly fewer respondents agreed with items pertaining to guidelines involving consultation with an expert in knowledge synthesis (Item 17; 59%), a development committee representative of stakeholders (Item 19; 59%), as well as the CPGs having provided adequate details on how it was developed (Item 20; 59%) and that they used an informal consensus method for decisions about the final recommendations (Item 23; 54%). In contrast, fewer respondents were in agreement for items related to the CPGs having used formal methods of consensus (Item 22; 40%), included different intervention options for the problem addressed by the guidelines (Item 24; 44%), and systematic methods to assess scientific evidence used to create the recommendations (Item 25; 40%). Even fewer respondents (ranging from 26% to 37%) agreed with items about CPGs having addressed their strengths and limitations, potential ethical issues, and conflicts and biases (Items 26-28).

Most respondents (84%) reported agreement for the CPGs being easily accessible and used in practice (Item 30). Fewer respondents (58%) agreed with the CPGs providing an explanation about how its recommendations should be implemented (Item 29). Only a few respondents (41%) responded favourably to Item 31, that the guideline discussed the facilitators and potential barriers to implementation of recommendations, and fewer respondents (31%) agreed that the CPGs included a plan to assess the effect of its use on clinical practice (Item 32; see Table 6 for results).

Psychoeducators. The results indicated below are for the combined ratings across all the OPPQ guidelines that respondents indicated as relevant and being used in practice (See Table 4 for a list of these CPGs). This excludes the ratings for the *Guidelines for the Evaluation of an Adolescent in Relation to a Tribunal Decision when Applying the Law Respecting the Penal Justice System for Adolescents (2014)*, as no participants responded to items for this guideline. The majority of respondents (93%) agreed with the OPPQ CPGs being useful and having informed and improved their practice (Item 6) and 62% were in agreement with the CPGs being used to prevent professional malpractice (Item 10). Only 29% were in agreement with Item 9, that the guideline was used to discourage suboptimal practice. Additionally, 17% were in agreement with Item 8, that the guideline was too rigid to be applicable to specific clients and

contexts. Respondents agreement with the CPGs being an oversimplified cookbook (Item 7) was scarce (7%).

Most respondents agreed with the various items pertaining to guideline development (Items 11-18 and 21). Of these, 92% were largely in agreement with the CPGs being developed according to best practices in guideline development (Item 16), followed by 88% for the guidelines being based on clinical expertise (Item 13) and 87% for the CPGs being based on the most scientific evidence (Item 12). Item 11 pertained to the organization, structure and clarity of the guidelines, which was endorsed by 86% of respondents. A large number of respondents also agreed with items related to the CPGs being founded on expert consensus (Item 14; 83%), involving a credible committee of experts (Item 18; 82%), involving the use of a guideline development method they knew well (Item 15; 80%), involving the use of a structure systematic method for searching the literature (Item 21; 77%) and involving a consultation with an expert in knowledge synthesis (Item 17; 74%). Agreement for Items 25 (57%) and 19 (49%) related specifically to the development and methodological rigour of the CPGs (i.e., the use of systematic methods to assess the evidence used to devise the guideline recommendations and the involvement of a guideline development committee representing all stakeholders). Similarly, 57% of respondents indicated agreement for Item 20, pertaining to the CPGs providing information about the guideline development process, with slightly fewer (51%) for Item 27 relating to addressing potential ethical issues in the CPGs.

Most respondents (94%) reported higher ratings for Item 30, which stated that the CPGs were easily accessible and used in practice. A total of 83% were in agreement with Item 29: the guidelines explain how the recommendations should be implemented. Fifty percent of the respondents reported that the CPGs discussed the facilitators and potential barriers to implementing the CPGs recommendations. Even fewer respondents (38%) reported agreement about the guidelines including a plan to assess the effect of the CPGs in practice (Item 32; see Table 6 for results).

Social Workers and MFTs. The results below represent the merged ratings for most of the OTSTCFQ guidelines (see Table 4 for a list of these CPGs), with the exception of two CPGs: *Guidelines for the Professional Practice of Community Social Workers (2008)* and *Guidelines for Determining an Intervention Plan for a Person Suffering from a Mental Disorder or at Risk of Suicide who is Housed in a Facility of an Establishment that Operates a Rehabilitation Center*

for Young People with Adjustment Difficulties (2014). Most respondents (85%) reported that the CPGs produced by the OTSTCFQ were useful and informed and improved their practice (Item 6). A total of 78% of respondents positively endorsed Item 10: the guidelines were used to prevent professionals from engaging in professional malpractice. Sixty percent agreed with the CPGs being used to discourage suboptimal practice (Item 9). Lastly, of the guideline use items, few respondents (22%) agreed that the guideline was an oversimplified cookbook (Item 7) and being too rigid to apply to specific clients and contexts (Item 8), respectively.

Items 11 to 19 and 21 pertained to guideline development and the majority of respondents were in agreement with them, ranging from 75% to 86%. Of these, a constellation of items was related to how the guidelines were founded (i.e., based on scientific evidence, using clinical expertise, expert consensus, the use of development method that is familiar and that is based on best practices for development and used a structured systematic method for searching the evidence in the literature; Items 12-16 and 21). Notably, Item 13 related to the CPGs being based on clinical expertise received the highest number of respondents (86%). A second group of items concerned consultation (i.e., with experts in knowledge synthesis, a committee of credible experts, and a development committee representative of all professionals and users; Items 17-19). Most respondents (74%) were in agreement with the guidelines in terms of easy accessibility and use in practice (Item 30), with 54% who agreed with Item 29 (i.e., CPGs explain how recommendations are implemented). Only 30% were in agreement for Item 31 about the CPGs discussing facilitators and barriers to implementation, with very few (9%) having agreed with Item 32 that the CPGs included a plan to assess the effect of its use in practice (see Table 6 for results).

OTs. The following results capture all OEQ guidelines (see Table 4 for a list of these CPGs). A total of 92% of respondents were in agreement with Item 6 concerning the OEQ guidelines being useful and informed and improved their practice. Sixty-five percent endorsed guidelines are used to prevent professionals from engaging in professional malpractice (Item 10). Fewer respondents were in agreement for Item 9 concerning CPGs being used to discourage suboptimal practice (43%), Item 8 pertaining to the guidelines being too rigid to be applicable to specific clients and contexts (29%), followed by even fewer (11%) for Item 7 (i.e., CPGs being an oversimplified cookbook).

With regards to the items specific to guideline development, most respondents (88%) indicated agreement with Item 12, which concerned that the CPGs was based on the most scientific evidence, followed by 86% for Item 18 regarding the involvement of a credible committee of experts and 82% for Item 16 pertaining to the guidelines being developed according to best practices in guideline development. Items 11, 13, 14, 17 and 21 related to the organization and format of the CPGs, being based on clinical expertise and expert consensus, as well as involving consultation with an expert in knowledge synthesis and using a structured systematic method in searching the literature. These items were endorsed by 62% to 76% of respondents.

Several of the guideline development items obtained lower ratings. Thus, fewer respondents agreed with items related to involvement of methods of methodological rigour (Items 19, 22, 23, and 25), knowledge of development methods (Item 15), use of development committee, methods of consensus, including options for interventions (Item 24), providing details on the development method (Item 20), strengths and limitations of the CPGs (Item 26), ethical concerns (Item 27) and conflicts of interest and biases (Item 28). Percentages ranged from 39% to 59% for these items.

Finally, a large number of respondents (73%) agreed with the CPGs being easily accessible and used in practice (Item 30). Sixty-seven percent reported agreement for the guidelines explaining how the recommendations should be implemented in practice (Item 29). In contrast, only 33% and 11% of respondents were in agreement with Item 31 (i.e., discusses facilitators and barriers to implementation) and Item 32 (i.e., includes a plan to assess the effect of the guideline on clinical practice), respectively (see Table 6 for results).

Comparison of Familiarity of Guideline Development Methods Across Professions

Of professionals that reported using guidelines (Item 1; n = 494; 77%), most professionals agreed that the regulatory body CPGs involved the use of development methods that they knew well (Item 15), with 70% for psychologists, 60% for guidance counsellors, 80% for psychoeducators, and 62% for social workers and MFTs. However, only 35% of OTs agreed with this item (see Table 6).

Barriers and Facilitators to Use of Guidelines Produced by the Regulatory Bodies

All participants received Items 4 and 5 pertaining to barriers and facilitators to guideline use, respectively. Out of the entire sample (N = 954), 802 participants responded to the barriers

item, with 152 skipping this question. A total of 9 barriers to guideline use were identified across professions and varied quite a bit. However, some barriers were endorsed by more respondents. Forty-nine percent of psychologists and 31% of OTs mostly endorsed barrier 1, that the existing guidelines are not relevant to their current practice, activities, and overall clinical reality and there is a lack of essential available guideline topics. Across professions, 34% endorsed barrier 1. Fifty percent (50%) of social workers and MFTs, 39% of psychoeducators and 34% of guidance counsellors endorsed barrier 2, that professionals lack time to read or consult with guidelines in practice due to clinical responsibilities. A total of 19% of psychologists, 9% of guidance counsellors, 17% of psychoeducators, 8% of social workers and MFTs, and 5% of OTs reported *"no barriers"* to guideline use (see Table 7 for results).

A total of 776 respondents answered Item 5 (facilitators) and there were 178 missing responses. Across professions, 10 facilitating factors were identified. These factors were also diverse and only some factors were more frequently described. Thirty-two percent of social workers and MFTs, 31% of OTs, 29% of psychologists, 22% of guidance counsellors, and 21% of psychoeducators endorsed facilitator 1, that guidelines are realistic, applicable, and relevant to professionals' practice, activities, topics, goals, specificity, and clinical reality. This was the most frequently (29%) endorsed facilitator across most of the professions. *"no facilitators"* were reported by 11% of psychologists, 8% of guidance counsellors, 5% OTs, 4% of psychoeducators, and 3% of social workers and MFTs (see Table 8 for detailed results).

Objectives, Credibility, and Costs of CPGs in General

The following items pertained to objectives (Items 33-36), credibility (Items 37-41) and costs (Items 48-49) of CPGs in general and were presented to all participants. Across professions, most respondents (94%) agreed with Item 34, that CPGs aim to serve as norms or standards of best practices that must be respected by professionals, with 92% support for CPGs aimed to improve the quality of service (Item 35). The majority of respondents (86%) were in agreement with Item 33, that guidelines aim to serve as educational tools for professionals. Only a few respondents (16%) reported agreement for Item 36, that CPGs aimed to make services more cost-effective or economical.

In terms of what factors make a guideline credible, the majority of respondents agreed with all items (ranging from 80% to 95%), with the exception of one (Item 39; that a CPG is developed and published by not-for-profit organizations and parapublic institutions that are

governmental or para-governmental). The highest percentage (95%) was obtained for Item 41, the *"other, please specify"* option. Across the professions, examples of the other factors that affect credibility included: 1) that the CPGs were developed in collaboration with specialized professionals, organizations, and settings (e.g., universities, research groups with high standards in terms of publication, expert researchers, scientific groups, and research institutions); 2) that they were empirically-based (e.g., use credible references) and founded on sound and scientific development methods and clinical practice; 3) that they consider various contexts; and 4) that the guideline is globally accepted. A high percentage of support (89%) was also obtained for Item 37, that CPGs being developed and published by a regulatory body or order makes a guideline credible. A total of 80% of respondents indicated agreement with CPGs being developed and published by professional associations (Item 38), with 82% for CPGs being developed and published by government institutes or organizations dedicated to promoting excellence and producing guidelines (Item 40). Higher ratings of agreement for Item 37 concerning the regulatory bodies were obtained for almost all the professions (86% for psychologists, 98% for guidance counsellors, 94% for psychoeducators, 90% for social workers and MFTs) compared to Item 40 pertaining to institutes or organizations (72% for psychologists, 68% for guidance counsellors, 74% for psychoeducators, and 68% for social workers and MFTs). This was not the case for OTs who indicated greater agreement for CPGs being more credible when developed by institutes (92%) compared to a regulatory body (89%). Agreement ratings for Items 38 and 40 were generally more similar across all professions. Only 47% were in agreement with Item 39, that CPGs being developed and published by not-for-profit organizations and parapublic institutions that are governmental or para-governmental make a guideline credible (see Table 9).

The responses for items pertaining to costs were widespread. For Item 48, 39% of respondents perceived the cost of a guideline to range from *$0 to $80,000,* with 24% reporting a range between *$80,000 to $150,000 or greater*. A total of 34% indicated the *"I don't know"* option. Item 49 assessed the perceived maximum cost to develop a guideline. Forty percent (40%) of respondents reported that the maximum cost should be between *$0 and $80,000* and 19% ranging from *$80,000 to $150,000 or more*. Lastly, 37% selected the *"I don't know"* option.

Discussion

The current study aimed to assess the knowledge, attitudes, use, and implementation of professionals toward mental health and social care guidelines developed by the Quebec regulatory bodies in the social sciences and toward CPGs in general. Most professionals viewed the CPGs produced by the regulatory bodies as relevant for practice and some CPGs were more frequently endorsed. The majority of professionals indicated previous or current use of and positive attitudes towards CPGs. Most professionals had knowledge of CPGs and development methods. Several barriers and facilitators to CPGs use were also found. Finally, most professionals agreed with the guideline objectives and factors that make a guideline credible in general. The perceived costs of CPGs also varied.

Guideline Relevancy

The study found that the majority of professionals perceived those CPGs produced by their respective regulatory body as relevant to informing their practice. The only exception was for psychologists, with 50% indicating that none of the OPQ guidelines were relevant. The CPGs being produced by the OPQ may therefore target only some of their professional members. There seems to be a need to develop more CPGs that are applicable to other topics. Within each profession, most of the CPGs were endorsed to some degree, with some guidelines being perceived as more relevant than others. The variability in rates of guideline relevancy among professionals may be explained by their area of expertise in practice. Not all professionals specialize in the areas covered by the exisiting guidelines in Quebec. Only a minority of psychologists (37%) endorsed the *Autism Spectrum Disorders – Clinical Evaluation (2012)* CPGs, which was the highest percentage compared to any of the other OPQ guidelines, providing further support that the CPGs are not relevant for most psychologists. However, this may also be due to the fact that not all psychologists specialize in the area of Autism. Conversely, most guidance counsellors (67%) endorsed the *Assessment Guide for Career and Guidance (2010-2011)* CPGs, and most psychoeducators (74%) endorsed the *Psychoeducational Assessment of the Person with Adjustment Difficulties (2014)* CPGs, as the most relevant. The majority of OTs (73%) endorsed the *Interventions Related to the Utilization of a Road Vehicle…(2008)* guidelines as most relevant. These findings suggest that professional members view these CPGs as more applicable to their practices. However, some CPGs were not endorsed at all by psychoeducators and social workers and MFTs, indicating that they are not being used

because they are not relevant to their practice. This may guide the regulatory bodies to develop more relevant and practical CPGs, thereby improving the cost-effectiveness of CPGs.

Guideline Use

Most professionals indicated previously or currently using the most relevant CPGs in their practice, with 79% of social workers and MFTs and OTs, 76% of psychologists and psychoeducators, and 67% of guidance counsellors reporting use. Generally, rates of guideline use, and implementation were mixed among social science and healthcare professionals (Ebben et al., 2013; Fischler et al., 2016; Gould & Kendall, 2007; Kosmerly et al., 2015; Stamoulos, 2020, see Study 2 of this thesis). However, the majority of studies suggest that most healthcare professionals do not use CPGs and that they are not effectively implemented (Al-Ansary et al., 2013; Gould & Kendall, 2007; Lovell et al., 2013; Sinuff et al., 2007; Stone et al., 1999; Taba et al., 2012). Contrary to this, the current study may provide support for higher rates of guideline use, with a minority of professionals not using CPGs, which ranged from 21% to 33% across professions. The reasons for a lack of guideline use varied by profession. The most commonly reported across professions was a lack of knowledge that the CPGs existed, with 71% of social workers and MFTs, 57% of psychoeducators, and 55% of psychologists agreeing with this statement. The lack of knowledge is a commonly reported barrier to guideline use (Lovell et al., 2013; Mudge et al., 2017; Scott et al., 2003) and may suggest potential problems with training and guideline dissemination.

Knowledge or Familiarity of CPGs

A handful of studies in the social sciences concerning guideline familiarity reported generally diverse rates which varied by profession (Beur et al., 2015; Mullen & Bacon, 2004; Prytys et al., 2011; Sandström et al., 2014; Stamoulos, 2020). In the current study, most professionals (67% to 79%) reported using the CPGs produced by the regulatory bodies, suggesting their familiarity with these CPGs. However, among the minority of professionals indicating a lack of guideline use (21% to 33%), most social workers and MFTs (71%) and psychoeducators (71%), and a slight majority of psychologists (55%), reported not having used these CPGs due to being unaware that they existed in the first place. Fewer guidance counsellors (20%) and OTs (31%) who reported not using the CPGs, also indicated this lack of knowledge. Across professions, a total of 41% who did not use the guidelines, also indicated this issue. The

findings mostly provide support for professionals being knowledgeable of CPGs, with a minority of professionals being unaware that CPGs exist.

Most professionals who used the CPGs (77%) indicated that they were quite familiar with the guideline development methods (Item 15), with 70% of psychologists, 80% of psychoeducators, 60% of guidance counsellors, and 62% of social workers and MFTs, and 35% of OTs endorsing this item. This finding lends support to most professionals being knowledgeable of CPGs with regards to their development. In the current study, most professionals who used the CPGs had knowledge of the CPG development methods and displayed positive attitudes toward the development process (as discussed below).

Attitudes Towards Guidelines

Consistent with other studies in the social sciences (Dijk et al., 2012, 2015; Pruijssers et al., 2015; Stamoulos, 2020, see Manuscript 2 of this thesis) and in medicine (Constantino-Casas et al., 2011; Farquhar et al., 2002; Pogorzelska & Larson, 2008), the current study indicates a dominance of positive attitudes of CPGs among professionals, with a minority endorsing negative attitudes. Most professionals (84% to 93%) displayed positive attitudes towards the CPGs, agreeing that guidelines are useful, informative, and improve practice (Item 6), which is similar to findings from previous studies in the social sciences (Dijk et al., 2012, 2015; Glass, 2007; Krug, 2007; Mullen & Bacon, 2004; Poitras et al., 2012; Sandström et al., 2014; Stamoulos, 2020, see Manuscript 2 of this thesis). In the current study, most professionals (75% of psychologists, 62% of psychoeducators, 78% of social workers and MFTs, and 65% of OTs) also perceived the guidelines are used to prevent malpractice (Item 10). However, only a minority (41%) of guidance counsellors had this perception. In medicine, studies found that professionals are concerned about CPGs being used for litigation, disciplinary actions, or malpractice lawsuits against professionals (Christakis & Rivara, 1998; Feldman et al., 1998; Flores et al., 2000; Higashi et al., 2010; Pogorzelska & Larson, 2008), despite CPGs not being intended for use in legal actions (Hollon et al., 2014). This may be similar to the current study's finding that guidance counsellors lack agreement on CPGs preventing malpractice.

A small portion of professionals (ranging from 7% to 22%) also perceived the CPGs as an oversimplified cookbook (Item 7). Similarly, only a few professionals (from 10% to 29%) were in agreement that the CPGs are too rigid to be applicable to specific clients and contexts (Item 8). This latter finding is consistent with one recent review, which suggests that a minority

of social science professionals perceived CPGs to lack applicability to many clients (Stamoulos, 2020). Overall, these findings suggest that most professionals perceive CPGs to be sophisticated, less rigid, and more applicable to practice. These results are inconsistent with the findings obtained from studies in medicine, however, which describe CPGs as a cookbook approach that are too simplistic and rigid to utilize in practice (Christakis & Rivara, 1998; Feldman et al., 1998; Graham et al., 2000; Porgorzelska & Larson, 2008; Sinuff et al., 2007).

Lastly, attitudes of CPGs being used to discourage suboptimal practice (Item 9) were more variable across professionals, with percentages ranging from 29% to 43% for psychoeducators, guidance counsellors, and OTs, and higher agreement among social workers and MFTs (60%) and psychologists (56%). These findings suggest that most professionals are in agreement about how CPGs should be used; that is, that they should not be used to safeguard against poor practices but should be implemented as a means of fostering optimal services. The variability in findings with regard to the differing rates of agreement across professionals may be explained by differences in how the statement was interpreted. In the social sciences, some studies have demonstrated that CPGs are perceived as promoting optimal outcomes in practice (Michie et al., 2007; Pruijssers et al., 2015; Prytys et al., 2011; Sandström et al., 2014). However, a recent review also found some professionals had both positive and negative attitudes towards the impact of guidelines on practice (Stamoulos, 2020). While CPGs are defined as resources that are intended to guide professionals and ensure optimal services (Farquhar et al., 2002; Woolf, 1992), the intended purpose of CPGs may not be fully clear to all professionals.

Professionals displayed positive attitudes toward most of the items concerning the guideline clarity, development, and rigour in this study, which is consistent with findings from existing research in the social sciences (Glass, 2007; Leven et al., 2012; Poitras et al., 2011; Prytys et al., 2011; Sandström et al., 2014; Stamoulos, 2020). In the current study, agreement concerning the CPGs being well designed, organized, clear, and coherent (Item 11) were obtained by 76% to 89% across professionals. Most professionals agreed with item 12 (CPGs were based on the most scientific evidence) and Item 21 (CPGs used a structured systematic method for searching the literature), ranging from 75% to 91% and 62% to 77%, respectively. Similarly, a recent scoping review found that social science professionals view CPGs as well-structured, easy to understand, and evidence-based (Stamoulos, 2020). A recent study by Trépanier (2019) surveyed 40 guideline developers regarding some of these same CPGs and

found high agreement with Item 12 of the current study. However, Item 21 of the current study is incongruent with this former study (Trépanier, 2019). These findings suggest that professionals' have favourable views towards these CPGs, despite the fact that those developing the CPGs have reported issues concerning the empirical foundation and strategies used to produce them (Trépanier, 2019). Other studies have also identified issues with the methodological rigour and quality of some of these CPGs (Ciquier et al., 2020; Stamoulos et al., 2014; Trépanier et al., 2017; Trépanier, 2019).

The specific details concerning professionals' attitudes towards consensus, methods, and involvement of experts in guideline development has not been thoroughly examined in the social sciences. However, Mullen and Bacon (2004) found that most mental health professionals agreed that CPGs were solely based on research (ranging from 13% to 43%) and that a slight majority of professionals would use CPGs based on professional consensus (ranging from 50% to 63%). A limited number of studies have also indicated that professionals are concerned about how guideline evidence is acquired, how guideline recommendations are formulated, as well as the reliability of the guideline development process (Mullen & Bacon, 2004; Prytys et al., 2011; Sandström et al., 2014). These findings contradict those of the current study, which demonstrated agreement across professions for the methods of consensus that were used during guideline development, with 74% to 90% of professional having agreed with CPGs involving clinical consensus (Item 13) and 78% to 93% for expert consensus (Item 14). Most professionals were largely in agreement that the CPGs were developed according to best practices in guideline development (Item 16; 78%-92%), that they involved a consultation with an expert in the development of guidelines (knowledge synthesis; Item 17; 59%-82%) and that they involved a committee of credible experts for the guideline redaction (Item 18; 82%- 92%). Item 16 is comparable to Trépanier (2019) study that found that most guideline developers agreed (70%) that some of the CPGs were developed using best practices in guideline development.

Other items were more variable in terms of agreement. For example, 75% of social workers and MFTs and 60% of psychologists and guidance counsellors were in agreement with the CPGs involving a development committee consisting of members representing all stakeholders (Item 19), however only 53% of OTs and 49% of psychoeducators were in agreement. This finding suggests that at least some professionals are uncertain versus certain about the composition of the development committee. A few studies have critically appraised

some of the CPGs examined in the current study using the AGREE-II tool (Ciquier et al., 2020; Trépanier et al., 2017; Trépanier, 2019). These studies found lower quality ratings for stakeholder involvement for the majority of the CPGs and indicated a lack of inclusion of all stakeholders in the guideline development process (Cinquier et al., 2020; Trépanier et al., 2017; Trépanier, 2019). These findings suggest that the attitudes of OTs and psychoeducators concerning Item 19 are more consistent with the quality ratings of the former studies, compared to the other professionals. In the current study, agreement for the CPGs providing sufficient information on how it was developed (Item 20) was mixed, with 59% of guidance counsellors, 56% of psychologists, 51% of psychoeducators, 36% of OTs, and only 30% of social workers and MFTs. This indicates a general lack of transparency of the guideline development procedures that were used for some CPGs, with more clarity among the CPGs for psychologists and guidance counsellors than other professions. These findings suggest that attitudes toward guideline development are dependent on the specific profession.

Fewer professionals (40% to 57%) agreed that the CPGs involved the use of systematic methods to assess the scientific evidence used to formulate the recommendations (Item 25); psychoeducators accounted for the highest rate of agreement on this item (i.e., 57%). Similarly, Trépanier (2019) critically appraised the OPQ guidelines using the AGREE-II instrument and found low quality scores for a related item within the rigour of development domain (i.e., the method for formulating the recommendations were clearly described in the CPGs). Albeit, this finding is only relevant to psychologists and the OPQ guidelines. Likewise, 24% to 56% of professionals agreed that CPGs involved the use of an informal consensus method as a means of making final decisions about guideline recommendations (Item 23); psychologists accounted for the highest rate of agreement of this particular statement (i.e., 56%). This finding is inconsistent with the high agreement ratings (75%) reported among guideline developers for the use of an informal consensus method for some of these CPGs (Trépanier, 2019). Agreement for the statement that CPGs include different intervention options for a specific problem (Item 24) ranged from 30% to 59%, with OTs displaying the highest rate of agreement (i.e., 59%). Trépanier (2019) mostly found low-quality ratings for the OPQ guidelines' presenting different interventions options item, which is part of the clarity of presentation quality domain. This is consistent with the agreement reported among psychologists in the current study for Item 24 (i.e., 40%). Similarly, Trépanier et al., (2017) critically evaluated the *Assessment of Dyslexia in*

Children (2014) guideline from the OPQ and this item obtained one of the lowest quality rating scores. In contrast, Ciquier et al. (2020) assessed seven OPQ, OPPQ, OTSTCFQ, and CMQ guidelines and identified higher quality ratings for this domain for most of the CPGs, with one exception, the *Guidelines for the assessment of youth as part of a court order decision under the Youth Criminal Justice Act (2014)* from the OPPQ. Although, this former study only presented quality rating scores for the overall domains and did not report the scores for the item pertaining to the CPGs clearly presenting the different intervention options.

Low agreement was elicited for the remaining items pertaining to CPGs using a formal method of consensus for guideline recommendations (Item 22; 13%-43%), describing the strengths and limitations of the guideline (Item 26; 26%-42%), addressing all potential ethical issues (Item 27; 36%-51%), and mentions and addressed conflicts of interest and biases (Item 28; 24%-35%). Consistent with the findings for Items 22 and 26, Trépanier (2019) found lower rates of agreement (7%-33%) among the OPQ, OPPQ, OCCOQ, OTSTCFQ, OEQ, and CMQ guideline development committee members for similar survey items. Item 28 is also congruent with former study, which indicated that conflicts of interest were inadequately reported in the CPGs (Trépanier, 2019). Similarly, a recent study found that the strengths and limitations of the OPQ guidelines and conflicts of interests have been poorly addressed in these CPGs (Trépanier, 2019), with the exception of *Assessment of Dyslexia in Children (2014) guideline.* While low quality rating scores were obtained for the item concerning that the strengths and limitations of the guidelines were addressed, higher quality rating scores were found for the conflicts of interest item (Trépanier et al., 2017; Trépanier, 2019). Similarly, Ciquier et al. (2020) also and discovered very low-quality scores for the editorial independence and rigour of development domains for some of the OPQ, OPPQ, OTSTCFQ, and CMQ guidelines, which included items specific to strengths and limitations of the CPGs and addressing conflicts of interest. These findings also indicate that most professionals had less agreement with these items and thus hold a predominantly negative attitude towards the CPGs with respect to these specific aspects of the guideline and development. As such, some critical components for effective guideline development are missing from most of these CPGs.

Only some of the guideline implementation and applicability items were rated favourably. Across professions, agreement that CPGs explained how their recommendations should be implemented in practice (Item 29) was reported by 53% to 83% of professionals, with

the lowest percentage obtained for social workers and MFTs. This finding indicates that most professionals view the CPGs as adequately explaining guideline implementation strategies. CPGs produced by the OTSTCFQ represent the exception, as approximately half of social workers reported these guideline implementation strategies as adequately addressed. Most professionals agreed (73%-94%) that CPGs were easily accessible and used in practice (Item 30). It is essential that a sound and rigorous guideline development process is used to ensure that CPGs are easily accessible and can effectively be used and implemented in practice (Alonso-Coello et al., 2010). This includes that CPGs are applicable to practice, contain implementation strategies, and can be easily used. Conversely, some implementation and applicability items were viewed more negatively by most professionals. Very few professionals agreed with the CPGs discussing the facilitators and potential barriers to implementing the recommendations (Item 31), with percentages for all professions ranging from 30% to 50%. Similarly, a minority of professionals were in agreement that the CPGs included a plan to assess the effects of the guidelines on practice (Item 32), with percentages ranging from 9% to 38%. This is problematic given that CPGs are intended to reduce cost effectiveness and improve services and outcomes (Graham et al., 2000; Hollon et al., 2014; van Dijk et al., 2013).

Taken together, the present findings suggest mixed attitudes towards the implementation and applicability of CPGs. Some recent studies lends insight into actual guideline quality in terms of applicability. The first study critically evaluated the *Assessment of Dyslexia in Children (2014) guideline* from the OPQ using the AGREE-II instrument and identified that one of the lowest quality domain score was for the guidelines' applicability (Trépanier et al., 2017). The second study critically appraised the OPQ guidelines also using the AGREE-II instrument and found that they lacked applicability (i.e., ease of use, addressed treatment of possible barriers and facilitators, strategies for use and implementation, and resource implications for applying the guideline, and included monitoring/auditing criteria; Brouwers, et al., 2010; Trépanier, 2019). However, these findings can only be compared to the current findings pertaining to psychologists, as the quality of the CPGs produced by the other regulatory bodies were not evaluated by Trépanier et al. (2017) and Trépanier (2019). Hence, agreement among psychologists for these items were consistent with the findings obtained across all professions (i.e., Item 29, 63% for OPQ CPGs explaining how they should be implemented in practice; Item 30, 80% for the CPGs were easily accessible and used in practice; Item 31, 35% for CPGs

discussed the facilitators and potential barriers to implementing the recommendations; and Item 32, 19% for CPGs included a plan to assess the effects of the CPGs on practice). Items 30, 31, and 32 of the current study are inconsistent with the quality ratings reported in Trépanier et al. (2017), however Item 29 is consistent, suggesting higher quality agreement. Items 29 and 30 of the current study are inconsistent with the quality ratings of the former study by Trépanier (2019), however, are consistent with Items 31 and 32 indicating lower quality agreement. Overall, the current study finding suggest that psychologists have mixed levels of quality agreement concerning the applicability of the OPQ CPGs, whereas the former studies emphasize that these CPGs generally lacked applicability. Similarly, a third recent study by Ciquier et al. (2020) critically appraised seven of the OPQ, OPPQ, OTSTCFQ, and CMQ guidelines and found low quality ratings scores for the guideline applicability domain. However, this study only reported the overall scores for the applicability domain for each CPGs, rather than the scores for the specific items within this domain, and not all the regulatory bodies' CPGs were assessed. Nonetheless, in the current study, agreement among psychologists, psychoeducators, and social workers and MFTs were congruent across these professions (i.e., Item 29, 54%-83% for CPGs explaining how they should be implemented in practice; Item 30, 74%-90% for the CPGs were easily accessible and used in practice; Item 31, 30%-50% for CPGs discussed the facilitators and potential barriers to implementing the recommendations; and Item 32, 9%-38% for CPGs included a plan to assess the effects of the CPGs on practice). These findings are somewhat inconsistent with the overall lower quality ratings reported in the former study (Ciquier et al., 2020). Comparison of these findings to the current findings are only relevant to psychologists, psychoeducators, and social workers and MFTs and for some of the CPGs. This is because some of the CPGs produced by these and other regulatory bodies have not yet been critically evaluated using the AGREE-II instrument. However, another recent study by Trépanier (2019) shed some light on the applicability of the other CPGs and related professions that were not captured in the former studies. This study surveyed 40 members of the guideline development committees regarding the development of some of CPGs developed by the OPQ, OPPQ, OCCOQ, OTSTCFQ, OEQ, and CMQ and also found lower rates of agreement (25%-53%) for items pertaining to the CPGs applicability.

In the current study, the attitudes towards guideline development and methodological rigour were viewed as generally positive. This indicates that most professionals believe that the

CPGs are of high quality and are trustworthy. However, previous studies which have reviewed some of the same CPGs as in the present study have also found issues with the methodological rigour, development process, and overall quality of CPGs in the social sciences (Ciquier et al., 2020; Stamoulos et al., 2014; Trépanier et al., 2017; Trépanier, 2019). There is a clear discrepancy between professionals' favourable views of some of these CPGs and the poor quality of their development and of the CPGs themselves. Since the Orders are supposed to provide guidance in practice and empirically-based and reliable CPGs for their members, then professionals may expect that these guidelines are of high quality and can be trusted. This further suggests that professionals may have more positive attitudes than they should, and guideline use in practice could be challenging. Indeed, the outcome of using guidelines in practice are conditional on the methodological rigour, development, and quality of CPGs (Burgers et al., 2003; Gordon & Cooper 2010; Hollon et al., 2014) and poor-quality CPGs can have adverse outcomes (Bennett et al., 2018; Rao & Tandon, 2017; Woolf et al., 2004). Thus, it is imperative that all CPGs are evaluated using AGREE-II and are compared to the findings obtained in the current study.

Barriers and Facilitators to Guideline Use

The current study provides an inclusive list of various barriers and facilitators to guideline use. These factors varied considerably within professions and produced low endorsement percentages. This could be due to the descriptive nature of the items, which may have reduced the likelihood that professionals evaluated all possible factors. Additionally, only a few barriers and facilitators were more frequently endorsed. The most commonly described barrier was that existing CPGs were not relevant (Barrier 1; 34% across professions and higher rates for psychologists (49%) and OTs (31%)). Other professionals (social workers and MFTs, psychoeducators, and guidance counsellors) indicated a slightly higher endorsement for lacking time to read or consult with CPGs due to clinical responsibilities (Barrier 2; ranging from 34%-50%). As expected, the most common facilitator was the inverse of the most frequently identified barrier; across professions, 29% of professionals indicated that CPGs are realistic, applicable, and relevant to professionals' practice, activities, topics, goals, specificity, and clinical reality (Facilitator 1; ranging from 21%-32%). The aforementioned barriers and facilitating factor, as well as the other barriers and facilitators that were identified in the current study were also found in some studies in the social sciences (e.g., Berry & Haddock, 2008; Dijk et al., 2012; Fischler et

al., 2016; Leven et al., 2012; Mudge et al., 2017; Stamoulos, 2020, see Manuscript 2 of this thesis) and have been consistently found in medicine (e.g., Constantino-Casas et al., 2011; Forsner et al., 2010; Kastner et al., 2015; Lovell et al., 2013; Taba et al., 2012). Few professionals indicated no barriers and facilitators to guideline use, providing further support for various factors that hinder use and improvements that are needed to foster use.

General Objectives, Credibility, and Costs of Guidelines

The bulk of professionals perceived all but one of the objectives of CPGs in general as favourable. Most professionals agreed that guidelines are aimed at serving as norms or standards of practice that should be respected (Item 34; 94%), educational tools (Item 33; 85%) and to improve the quality of service offered by professionals (Item 35; 92%). This is somewhat consistent with the limited studies available in the social sciences, indicating that CPGs are perceived as educational tools that improve practice (Prytys et al., 2011; Mullen & Bacon, 2004; Sandström et al., 2014). Although, there is no current known documentation of whether those professionals' view CPGs as standards that should be respected. Interestingly, in the current study, most professionals perceived CPGs as being aimed at serving as norms or standards of practice. This is despite the fact that CPGs are not standards of practice and instead are only suggestions. This findings suggests that professionals may not fully understand the objectives of CPGs.

In medicine, a systematic review of professionals' perceptions on CPGs found that guidelines were viewed as useful and educational and were thought to enhance the quality of care (Farquhar et al., 2002; Ferrier et al., 1996; Graham et al., 2000; Higashi et al., 2010; Sinuff et al., 2007). Interestingly, most professionals displayed a lack of agreement concerning whether CPGs are aimed at making services more cost-effective and economical (Item 36;16%). This is contrary to studies in medicine, which have found that CPGs are perceived to reduce health care costs (Feldman et al., 1998; Flores et al., 2000). There are no other existing findings relating to professionals' views on the cost-effectiveness of CPGs in the social sciences.

Professionals reported agreement concerning most of the factors that make a guideline credible. Highest agreement (95%) was elicited for the *other* option, such as CPGs being developed in collaboration with specialized professionals, organizations, and settings, as well as being empirically-based and clinically-based, using sound development methods, and being applicable to various contexts and accepted globally. This finding suggests that most

professionals believe there are critical factors that make guidelines credible, which extends to factors beyond the limits of those who produce them. Most professionals agreed that CPGs published by a regulatory body or order (Item 37; 89%), government institutes or organizations dedicated to promoting excellence and producing guidelines (Item 40; 82%), and professional associations (Item 38; 80%) enhances the credibility of a guideline. This indicates that professionals trust their regulatory bodies, as well as their respective institutes and associations, to provide them with appropriate guidance. When examining the ratings for specific professions, it is clear that the CPGs are perceived as more credible when produced by their own regulatory bodies (ranging from 86%-98%), as compared to when CPGs are produced by associations (ranging from 63% to 86%) and institutes (ranging from 68% to 72% for all professions except for OTs). OTs were the only profession who indicated that CPGs developed by institutes (92%) would be more credible than other associations (86%) and regulatory bodies (89%). It is expected that most professionals would inherently trust their regulatory bodies to develop and publish empirically-based and good quality CPGs. As previously reviewed, studies have found that the methodological rigour, development, and quality of some of these CPGs seem to be subpar (Ciquier et al., 2020; Stamoulos et al., 2014; Trépanier et al. 2017; Trépanier, 2019). In order to improve CPGs and ensure they are in fact trustworthy, all credibility factors should be considered by co-guideline development teams. These teams should involve the regulatory bodies, associations, and institutes or organizations, such as INESSS, which focus on fostering excellence and developing CPGs in the social sciences.

Lastly, a slight majority perceived the cost of a guideline and maximum reasonable costs for developing a guideline to be equal or less than $80,000. However, the costs were wide-ranging, suggesting that professionals are uncertain about the costs of CPGs. This is surprising, since professionals pay fees as members of their regulatory body that contribute to the production of these CPGs (Trépanier, 2019). It should be made clear what the fees cover and what the costs are. The regulatory bodies should ensure that professionals are clear about the costs associated with the development of CPGs.

Strengths and Limitations

To our knowledge, this is the first study to examine: a) the mental health and social care CPGs as perceived and used by social science professionals in Quebec; b) multiple professions

simultaneously and via five different surveys; c) CPGs produced by social science regulatory bodies in Quebec; and d) various related concepts related to CPGs in general.

While this study represents an important step forward, it is not without limitations. Mainly, the current study was limited with regard to its generalizability. The response rates were low for all surveys (ranging from 2%-8%); while the regulatory bodies were cooperative with distributing the surveys and data collection was extended, a narrow response rate was still obtained. It should also be noted that OTs and psychologists made up the largest samples, and thus the remaining social science professions were underrepresented. Based on the Orders *2019 Annual Reports*, the current study samples for OTs and psychologists are representative of their respective professional population (i.e., licensed OTs and psychologists at the time the surveys were completed; OPQ, 2019; OEQ, 2019). However, this was not the case for psychoeducators, guidance counsellors, and social workers and MFTs, which consisted of smaller samples (OPPQ, 2019; OCCOQ, 2019; OTSTCFQ, 2019). Lastly, all results were based on self-reports and were thus subjected to response bias.

Conclusion

The current study documented vital information on the views and practices of psychologists, guidance counsellors, psychoeducators, social workers and MFTs, and OTs, with regard to CPGs produced by the Quebec regulatory bodies and CPGs in general. In sum, most professionals have knowledge and positive attitudes of CPGs, and utilize them in their practices. The study highlighted potential areas for guideline enhancement and addressing the barriers and facilitators to guideline use, which may in turn inform policymaking and improve practice. Awareness, positive attitudes, and use of CPGs does not necessarily mean that CPGs are of good quality and based on rigorous methodologies. As such, a more direct evaluation of these constructs and their relationship, and the quality of these CPGs is needed.

Future research should replicate the current study using larger sample sizes to ensure generalizability of findings and to increase representation from various social science professions. Acquiring more collaboration from professionals is necessary and may require decreasing work-demands to allow for more research activities. Assistance from the regulatory bodies is also crucial in order to promote the importance of CPGs research and to encourage participation. Other suggestions for research include: a) conducting studies that examine specific constructs in more detail (e.g., level of guideline knowledge, frequency of use, adherence of

recommendations, and more relevant CPGs topics) as well as the relationship between these constructs; b) using surveys or observational studies and asking professionals to rate the barriers and facilitators identified in the current study see if agreement is more consistent; c) developing focus groups to discuss guideline views and experiences with all relevant stakeholders (i.e., professionals, board of directors, guideline development committees, and clients).

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Table 1

List of Regulatory Bodies and Mental Health, and Social Care Service Guidelines

Regulatory Body	Guidelines
1. l'Ordre des psychologues du Québec (OPQ)/the Order of Psychologists of Quebec	• Guidelines for the Assessment of Dyslexia in Children (2014) • Guidelines: Autism Spectrum Disorders – Clinical Evaluation (2012) • Guidelines for the Assessment of Mental Retardation (2007) • Guidelines for the Assessment of a Child in Connection with a • Request for Derogation to the Age of School Admission (2006) • Guidelines for Expert Assessment Concerning Child Custody and Access Rights (2006)
2. l'Ordre des conseillers et conseillères d'orientation du Québec (OCCOQ)/the Order of Guidance Counsellors of Quebec	• Guidelines for the Orientation and General Formation of Young People (2013) • Guidelines for Assessment Guide for Career and Guidance Counselling (2010) (English version – 2011)
3. l'Ordre des psychoéducateurs et psychoéducatrices du Québec (OPPQ)/the Order of Psychoeducators of Quebec	• Guidelines for the Assessment for School Exemption or Derogation (2015) • Guidelines for the Evaluation of a Student with a Disability or a Social Maladjustment as Part of the Determination of an Intervention Plan Under the Education Act (2015) • Guidelines for the Psychoeducational Assessment of the Person with Adjustment Difficulties (2014) • Guidelines for the Intervention Plan for a Person Staying in a Youth Center (2014) • Guidelines on the Assessment of a Person Under the YPA (2014) • Guidelines for the Evaluation of an Adolescent in Relation to a Tribunal Decision when Applying the Law Respecting the Penal Justice System for Adolescents (2014) • Guidelines for the Assessment of Mental Retardation (2013) • Guidelines for the Use of Measuring Instruments (2013)

Regulatory Body	Guidelines
4. l'Ordre des thérapeutes conjugaux et familiaux et des travailleurs sociaux du Québec (OTSTCFQ)/the Order of Social Workers and Marriage and Family Therapists of Quebec	• Guidelines for the Psychosocial Assessment in the Context of Protective Supervision, the Mandate Given in Anticipation of Incapacity and Other Protective Measures for Adults (2016) • Guidelines for the Independent Practice of Social Workers and Marital and Family Therapists (2015) • Guidelines for the Professional Practice of Social Workers in Youth Protection (2009) • Guidelines for the Professional Practice of Community Social Workers (2008) • Guidelines for Determining an Intervention Plan for a Person Suffering from a Mental Disorder or at Risk of Suicide who is Housed in a Facility of an Establishment that Operates a Rehabilitation Center for Young People with Adjustment Difficulties (2014) • Guidelines for Assessing a Person in the Context of the Director's decision for Youth Protection or of the Court Under the Youth Protection Act (2012) • Guidelines for the Decision on the Utilization of Restraint and Isolation Method Within the Law of Health and Social Services and Indigenous Populations (2011) • Guidelines for the Evaluation of a Child Not Yet Admissible to Pre-School but Who Presents with Developmental Delays to Determine the Rehabilitation and Adaptation Services that Meet their Needs (2011) • Guidelines for Evaluating a Person with a Mental or Neuropsychological Disorder as Diagnosed by an Evaluation Attested by a Trained Professional (2011) • Guidelines for the Expertise in Child Care and Access Rights (2006)
5. l'Ordre des ergothérapeutes du Québec (OEQ)/ the Order of Occupational Therapists of Quebec	• Guidelines for the Interventions Related to the Utilization of a Road Vehicle – Guide for the Occupational Therapist (2008) • Guidelines for the Restraint Measures: From Prevention to their Exceptional Use – Guide for Occupational Therapists (2006)

Table 2

Demographic Information

	Psychologists		Guidance Counsellors		Psychoeducators		Social Workers and MFTs		OTs		Total	
Variable	*N*	*%*	*N*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*N*	*%*
Gender												
Female	229	77.4	52	86.7	85	87.6	35	83.3	420	91.5	821	86.1
Male	64	21.6	8	13.3	12	12.4	7	16.7	37	8.1	128	13.4
Gender variant non-conforming and/or transgender												
Prefer not to disclose	2	.7							1	.4	3	.3
Prefer to describe myself	1	.3									1	.1
Highest diploma												
Bachelors			1	1.7	27	27.8	26	61.9	226	49.2	281	29.5
Masters	155	52.4	55	91.7	62	63.9	15	35.7	211	46.0	495	51.9
PhD	71	24.0	3	5.0	2	2.1			6	1.3	79	8.3
PsyD	57	19.3									57	6.0
Post-Doctoral	6	2.0	1	1.7	1	1.0			3	.7	11	1.2
Other	5	1.7			5	5.2	1	2.4	13	2.8	30	3.1
Missing	2	.7									1	.1
Years licensed												
0 – 5	31	10.5	14	23.3	29	29.9	11	26.2	89	19.4	174	18.2
6 – 10	47	15.9	15	25.0	23	23.7	12	28.6	77	16.8	174	18.2
11 – 15	44	14.9	12	20.0	12	12.4	7	16.7	96	20.9	171	17.9
16 – 20	67	22.6	6	10.0	17	17.5	5	11.9	76	16.6	171	17.9
21 – 25	34	11.5	8	13.3	12	12.4	4	9.5	57	12.4	115	12.1
26 – 30	33	11.1	5	8.3			2	4.8	34	7.4	74	7.8
31 and more	40	13.5			4	4.1	1	2.4	30	6.5	75	7.9

Note. $N = 954$.

Table 3

Professional Work Characteristics: Primary Work Setting and Percentage of Time Spent on Activities

	Psychologists		Guidance Counsellors		Psychoeducators		Social Workers and MFTs		OTs		Total	
Variable	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*N*	*%*
Primary work setting												
Private practice, Individual	99	33.4	16	26.7	8	8.2	4	9.5	34	7.4	161	16.9
Private practice, group	22	7.4			2	2.1			28	6.1	52	5.5
University	12	4.1	6	10.0	2	2.1	1	2.4	22	4.8	43	4.5
High school	10	3.4	17	28.3	11	11.3	1	2.4	1	.2	40	4.2
CEGEP	3	1.0	5	8.3							8	.8
Hospital setting	42	14.2	1	1.7	5	5.2	2	4.8	106	23.1	156	16.4
Government agency or Organization	13	4.4	2	3.3	17	17.5	8	19.0	54	11.8	94	9.9
Community non-profit Group	6	2.0	6	10.0			1	2.4	3	.7	16	1.7
Community mental health center / CLSC	39	13.2			26	26.8	17	40.5	87	19.0	169	17.7
Other	50	16.9	7	11.1	26	26.8	8	19.0	123	26.8	214	22.4
Missing									1	.2	1	.1
Time spent on activities												
Clinical or service												
0	9	3.0	1	1.7	2	2.1			35	7.6	47	4.9
20 or less	17	5.7	5	8.3	2	2.1	4	9.5	20	4.4	48	5.0
21 – 39	7	2.4	2	3.3	6	6.2	1	2.4	7	1.5	23	2.4
40 – 59	16	5.4	12	20.0	11	11.3	5	11.9	20	4.4	64	6.7
60 – 79	54	18.2	22	36.7	26	26.8	5	11.9	49	10.7	156	16.4
80 – 100	193	65.2	18	30.0	50	51.5	27	64.3	328	71.5	616	64.6
Research												
0	245	82.8	35	58.3	59	60.8	32	76.2	381	83.0	752	78.8
20 or less	36	12.2	20	33.3	30	30.9	7	16.7	52	11.3	145	15.2
21 – 39	11	3.7	4	6.7	3	3.1			4	.9	22	2.3
40 – 59	4	1.4	1	1.7	2	2.1	1	2.4	6	1.3	14	1.5
60 – 79							1	2.4	7	1.5	8	.8
80 – 100					3	3.1	1	2.4	9	2.0	13	1.4

	Psychologists		Guidance Counsellors		Psychoeducators		Social Workers and MFTs		OTs		Total	
Variable	*N*	%	*n*	%	*n*	%	*n*	%	*n*	%	*N*	%
Administration or management												
0	154	52.0	12	20.0	34	35.1	21	50.0	274	59.7	495	51.9
20 or less	92	31.1	26	43.3	34	35.1	8	19.0	108	23.5	268	28.1
21 – 39	34	11.5	10	16.7	21	21.6	6	14.3	25	5.4	96	10.1
40 – 59	7	2.4	8	13.3	6	6.2	5	11.9	17	3.7	43	4.5
60 – 79	2	.7	2	3.3	1	1.0	1	2.4	12	2.6	18	1.9
80 – 100	7	2.4	2	3.3	1	1.0	1	2.4	23	5.0	34	3.6
Teaching												
0	202	68.2	36	60.0	67	69.1	29	69.0	275	59.9	609	63.8
20 or less	56	18.9	16	26.7	24	24.7	9	21.4	164	35.7	269	28.2
21 – 39	20	6.8	3	5.0	6	6.2	2	4.8	6	1.3	37	3.9
40 – 59	9	3.0	3	5.0			1	2.4	7	1.5	20	2.1
60 – 79	4	1.4	2	3.3			1	2.4	3	.65	10	1.0
80 – 100	5	1.7							4	.75	9	.9

Note. $N = 954$.

Table 4

Survey Item (Q1) Concerning Most Relevant Guideline to Inform Practice

Regulatory Body/Professionals	Selection of Guidelines	Total Responses *n (%)*
OPQ/Psychologists	Guidelines for the Assessment of Dyslexia in Children (2014)	26 (8.8)
	Guidelines: Autism Spectrum Disorders – Clinical Evaluation (2012)	54 (18.2)
	Guidelines for the Assessment of Mental Retardation (2007)	43 (14.5)
	Guidelines for the Assessment of a Child in Connection with a Request for Derogation to the Age of School Admission (2006)	7 (2.4)
	Guidelines for Expert Assessment Concerning Child Custody and Access Rights (2006)	17 (5.7)
	None of these guidelines is relevant	149 (50.3)
OCCOQ/Guidance counsellors	Guidelines for the Orientation and General Formation of Young People (2013)	16 (26.7)
	Guidelines for Assessment Guide for Career and Guidance Counselling (2010) (English version – 2011)	32 (53.3)
	None of these guidelines is relevant	12 (20.0)
OPPQ/Psychoeducators	Guidelines for the Assessment for School Exemption or Derogation (2015)	1 (1.0)
	Guidelines for the Evaluation of a Student with a Disability or a Social Maladjustment as Part of the Determination of an Intervention Plan Under the Education Act (2015)	6 (6.2)
	Guidelines for the Psychoeducational Assessment of the Person with Adjustment Difficulties (2014)	68 (70.1)
	Guidelines for the Intervention Plan for a Person Staying in a Youth Center (2014)	2 (2.1)
	Guidelines on the Assessment of a Person Under the YPA (2014)	2 (2.1)
	Guidelines for the Evaluation of an Adolescent in Relation to a Tribunal Decision when Applying the Law Respecting the Penal Justice System for Adolescents (2014)	0 (.0)
	Guidelines for the Assessment of Mental Retardation (2013)	11 (11.3)
	Guidelines for the Use of Measuring Instruments (2013)	2 (2.1)
	None of these guidelines is relevant	5 (5.2)

Regulatory Body/Profession	Selection of Guidelines	Total Responses *n (%)*
OTSTCFQ/Social workers and MFTs	Guidelines for the Psychosocial Assessment in the Context of Protective Supervision, the Mandate Given in Anticipation of Incapacity and Other Protective Measures for Adults (2016)	9 (21.4)
	Guidelines for the Independent Practice of Social Workers and Marital and Family Therapists (2015)	6 (14.3)
	Guidelines for the Professional Practice of Social Workers in Youth Protection (2009)	2 (4.8)
	Guidelines for the Professional Practice of Community Social Workers (2008)	0 (.0)
	Guidelines for Determining an Intervention Plan for a Person Suffering from a Mental Disorder or at Risk of Suicide who is Housed in a Facility of an Establishment that Operates a Rehabilitation Center for Young People with Adjustment Difficulties (2014)	0 (.0)
	Guidelines for Assessing a Person in the Context of the Director's decision for Youth Protection or of the Court Under the Youth Protection Act (2012)	1 (2.4)
	Guidelines for the Decision on the Utilization of Restraint and Isolation Method Within the Law of Health and Social Services and Indigenous Populations (2011)	1 (2.4)
	Guidelines for the Evaluation of a Child Not Yet Admissible to Pre-School but Who Presents with Developmental Delays to Determine the Rehabilitation and Adaptation Services that Meet their Needs (2011)	4 (9.5)
	Guidelines for Evaluating a Person with a Mental or Neuropsychological Disorder as Diagnosed by an Evaluation Attested by a Trained Professional (2011)	9 (21.4)
	Guidelines for the Expertise in Child Care and Access Rights (2006)	2 (4.8)
	None of these guidelines is relevant	8 (19.1)
OEQ/OTs	Guidelines for the Interventions Related to the Utilization of a Road Vehicle - Guide for the Occupational Therapist (2008)	86 (18.7)
	Guidelines for the Restraint Measures: From Prevention to their Exceptional Use - Guide for Occupational Therapists (2006)	235 (51.2)
	None of these guidelines is relevant	138 (30.1)

Note. $N = 954$.

Table 5

Survey Items Concerning Specific Guideline Use (Q2) and Reasons for Non-Guideline Use (Q3)

	Psychologists (*N* = 147)		Guidance Counsellors (*N* = 48)		Psychoeducators (*N* = 92)		Social Workers and MFTs (*N* = 34)		OTs (*N* = 321)		Total Responses (*N* = 642)
Variables	*N*	*%*	*n*	*%*	*n*	*%*	*N*	*%*	*N*	*%*	*N (%)*
Q2. Use											
Yes	112	76.2	32	66.7	70	76.1	27	79.4	253	78.8	494 (77.0)
No	35	23.8	16	33.3	22	23.9	7	20.6	68	21.3	148 (23.0)
	Psychologists (*N* = 33)		Guidance Counsellors (*N* = 15)		Psychoeducators (*N* = 21)		Social Workers and MFTs (*N* = 7)		OTs (*N* = 68)		Total Responses (*N* = 144)
Q3. Reasons for non-guideline use											
I do not find the guidelines add anything to what I already know	2	6.1	5	33.3	4	19.1	0	.00	13	19.1	24 (17.0)
I do not trust the guidelines	1	3.0	0	.0	0	.0	0	.0	0	.0	1 (.7)
I did not know these guidelines existed	18	54.6	3	20.0	12	57.1	5	71.4	21	30.9	59 (41.0)
Other: please Specify	12	36.4	7	46.7	5	23.8	2	28.6	34	50.0	60 (42.0)

Note. A total of 4 responses were skipped by participants: 2 for psychologists, 1 for guidance counsellors and 1 for psychoeducators for Q3.

Table 6

Frequencies and Combined Agreement Scores for Purpose, Development, and Implementation of Regulatory Body Guidelines

	Psychologists/ OPQ Guidelines		Guidance Counsellors/ OCCOQ Guidelines		Psychoeducators/ OPPQ Guidelines		Social Workers and MFTs/ OTSTCFQ Guidelines		OTs/ OEQ Guidelines	
Variables	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*
Purpose										
Q6. Is useful, informs and improves my practice.	110	99 (90.0)	32	27 (84.4)	70	65 (92.9)	26	14 (53.9)	248	229 (92.3)
Q7. Is an oversimplified cookbook.	108	17 (15.7)	32	7 (21.9)	69	5 (7.3)	27	20 (74.1)	246	26 (10.6)
Q8. Is too rigid to be applicable to specific clients and contexts.	108	11 (10.2)	32	5 (15.6)	69	12 (17.4)	23	7 (30.4)	244	71 (29.1)
Q9. Is used to discourage suboptimal practice.	102	57 (55.9)	28	10 (35.7)	66	19 (28.8)	22	2 (9.1)	231	100 (43.3)
Q10. Is used to prevent professionals from engaging in professional malpractice.	106	79 (74.5)	27	11 (40.7)	66	41 (62.1)	26	14 (53.9)	239	155 (64.9)
Development										
Q11. Is well designed, organized, clear and coherent.	110	98 (89.1)	32	28 (87.5)	70	60 (85.7)	26	21 (80.8)	246	188 (76.4)
Q12. Was based on the most recent scientific evidence (at the time of the guideline).	104	95 (91.4)	26	23 (88.5)	63	55 (87.3)	20	15 (75.0)	208	183 (88.0)
Q13. Was based on clinical expertise.	100	81 (81.0)	29	26 (89.7)	65	57 (87.7)	21	18 (85.7)	202	150 (74.3)
Q14. Was based on expert consensus.	90	74 (82.2)	28	26 (92.9)	59	49 (83.1)	18	14 (77.8)	168	133 (79.2)

Variables	Psychologists/OPQ Guidelines		Guidance Counsellors/ OCCOQ Guidelines		Psychoeducators/OPPQ Guidelines		Social Workers and MFTs/ OTSTCFQ Guidelines		OTs/ OEQ Guidelines	
	N responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*
Development										
Q15. Involved the use of a development method that I know well.	90	63 (70.0)	20	12 (60.0)	49	39 (79.6)	13	8 (61.5)	139	48 (34.5)
Q16. Was developed according to best practices in guideline development.	81	72 (88.9)	21	17 (81.0)	47	43 (91.5)	18	14 (77.8)	146	119 (81.5)
Q17. Involved a consultation with an expert in the development of guidelines (knowledge synthesis).	57	46 (80.7)	17	10 (58.8)	38	28 (73.7)	11	9 (81.8)	92	70 (76.1)
Q18. Involved a committee of credible experts for its redaction.	78	72 (92.3)	28	25 (89.3)	45	37 (82.2)	17	14 (82.4)	141	121 (85.8)
Q19. Involved a development committee consisting of members representing all stakeholders (e.g., different users, professionals, etc.).	57	34 (59.7)	22	13 (59.1)	35	17 (48.6)	12	9 (75.0)	102	54 (52.9)
Q20. Provided sufficient information on how it was developed.	86	48 (55.8)	29	17 (58.6)	55	28 (50.9)	20	6 (30.0)	163	59 (36.2)
Q21. Involved the use of a structured systematic method for searching the scientific literature.	61	40 (65.6)	15	10 (66.7)	39	30 (76.9)	8	6 (75.0)	89	55 (61.8)

Variables	Psychologists/OPQ Guidelines		Guidance Counsellors/ OCCOQ Guidelines		Psychoeducators/OPPQ Guidelines		Social Workers and MFTs/ OTSTCFQ Guidelines		OTs/ OEQ Guidelines	
	N responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*
Development										
Q22. Involved the use of a formal method of consensus (for example, using techniques, such as the Delphi or Glaser) to formulate the final guideline recommendations.	37	14 (37.8)	10	4 (40.0)	16	2 (12.5)	7	3 (42.9)	47	14 (29.8)
Q23. Involved the use of an informal consensus method (following discussion only) to make final decisions regarding the recommendations included in the guidelines.	41	23 (56.1)	13	7 (53.9)	17	4 (23.5)	9	3 (33.3)	65	25 (38.5)
Q24. Includes different intervention options for the problem addressed by the guideline.	98	40 (40.8)	32	14 (43.8)	64	19 (29.7)	25	10 (40.0)	232	136 (58.6)
Q25. Involved the use of a systematic method to assess the scientific evidence used to formulate the recommendations.	52	25 (48.1)	10	4 (40.0)	30	17 (56.7)	12	5 (41.7)	88	36 (40.9)
Q26. Described the strengths and limitations of the guideline.	85	36 (42.4)	28	8 (28.6)	52	17 (32.7)	21	6 (28.6)	160	41 (25.6)

Variables	Psychologists/ OPQ Guidelines		Guidance Counsellors/ OCCOQ Guidelines		Psychoeducators/OPPQ Guidelines		Social Workers and MFTs/ OTSTCFQ Guidelines		Occupational Therapists/ OEQ Guidelines	
	N responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*	*N* responses	Agree and Strongly Agree *n (%)*
Development										
Q27. Addressed all potential ethical issues that may be associated with practice in the area covered by the guideline.	90	36 (40.0)	30	11 (36.7)	57	29 (50.9)	25	9 (36.0)	217	86 (39.6)
Q28. Mentions that conflicts of interest and biases have been addressed and noted.	64	21 (32.8)	19	5 (26.3)	34	12 (35.3)	15	4 (26.7)	102	24 (23.5)
Implementation										
Q29. Explains how the recommendations it contains should be implemented.	104	65 (62.5)	31	18 (58.1)	64	53 (82.8)	26	14 (53.9)	233	156 (67.0)
Q30. Is easily accessible and can be used in practice.	109	98 (89.9)	32	27 (84.4)	69	65 (94.2)	27	20 (74.1)	248	181 (73.0)
Q31. Discusses the facilitators and potential barriers to implementing the recommendations in the guideline.	89	31 (34.8)	29	12 (41.4)	58	29 (50.0)	23	7 (30.4)	200	65 (32.5)
Q32. Includes a plan to assess the effect of the guideline on clinical practice.	67	13 (19.4)	26	8 (30.8)	42	16 (38.1)	22	2 (9.1)	159	17 (10.7)

Note. Responses and combined ratings for guidelines for each respective profession / regulatory body were grouped together.

Table 7

Identified Barriers for Guideline Use (Q4)

	Psychologists (*N* = 216)	Guidance Counsellors (*N* = 53)	Psychoeducators (*N* = 77)	Social Workers and MFTs (*N* = 40)	OTs (*N* = 416)	Total responses (*N* = 802)
Variables	*n (%)*	*n (%)*	*n (%)*	*n (%)*	*n (%)*	*N (%)*
1. Existing CPGs are not relevant to professionals' current practice, activities and overall clinical reality and there is a lack of essential available guideline topics.	106 (49.1)	13 (24.5)	11 (14.3)	11 (27.5)	128 (30.8)	269 (33.5)
2. Professionals' lack of time to read or consult with CPGs in practice due to clinical responsibilities.	8 (3.7)	18 (34.0)	30 (39.0)	20 (50.0)	105 (25.2)	181 (22.6)
3. CPGs have problematic formatting and structure.	3 (1.4)	3 (5.7)	6 (7.8)	5 (12.5)	72 (17.3)	89 (11.1)
4. Lack of guideline access and availability and navigation of guidelines.	8 (3.7)	5 (9.4)	2 (2.6)	5 (12.5)	63 (15.1)	83 (10.3)
5. CPGs are outdated, with regards to recent research, are not frequently updated/have old dates, and are inaccurate (e.g., not in line with DSM-5, or not in line with changes in laws regulations and ministry directives).	26 (12.0)	1 (1.9)	2 (2.6)	3 (7.5)	41 (9.9)	73 (9.1)
6. CPGs lack applicability, flexibility and practicality.	7 (3.3)	4 (7.6)	13 (16.9)	6 (15.0)	42 (10.1)	72 (9.0)
7. Professionals' lack of time required to implement guideline recommendations.	0 (.0)	1 (1.9)	11 (14.3)	8 (20.0)	46 (11.1)	66 (8.2)
8. Lack of knowledge of CPGs or their usefulness, not knowing the guidelines exist or forgetting they exist or about the content or to use them.	14 (6.5)	5 (9.4)	4 (5.2)	3 (7.5)	34 (8.2)	60 (7.5)
9. CPGs content lack clarity, succinctness, details and information, and are too general or basic, non-user friendly and difficult to understand.	6 (2.8)	3 (5.7)	2 (2.6)	2 (5.0)	30 (7.2)	43 (5.4)
No barriers.	40 (18.5)	5 (9.4)	13 (16.9)	3 (7.5)	22 (5.3)	83 (10.3)

Table 8

Identified Facilitators for Guideline Use (Q5)

	Psychologists (*N* = 198)	Guidance Counsellors (*N* = 51)	Psychoeducators (*N* = 76)	Social Workers and MFTs (*N* = 37)	OTs (*N* = 414)	Total responses (*N* = 776)
Variables	*n (%)*	*n (%)*	*n (%)*	*n (%)*	*n (%)*	*N (%)*
1. Guidelines that are realistic, applicable and relevant to professionals' practice, activities, topics, goals, specificity, and clinical reality.	58 (29.3)	11 (21.6)	16 (21.1)	12 (32.4)	128 (30.9)	225 (29.0)
2. Ease of guideline accessibility and availability and navigation of the document.	22 (11.1)	5 (9.8)	7 (9.2)	7 (18.9)	123 (29.7)	164 (21.1)
3. Regular communication by the order about CPGs. existence revisions and reminders via emails, mail, info-letters, press releases, social networks, and better promotion, advertising, and dissemination of guidelines.	22 (11.1)	6 (11.8)	8 (10.5)	5 (13.5)	52 (12.6)	93 (12.0)
4. Regularly update, review, and revise the guidelines (e.g., recent scientific evidence, in collaboration with the DSM-5 and ministry of health directives, be subjected to professional review and yearly updates).	29 (14.6)	2 (3.9)	9 (11.8)	3 (8.1)	48 (11.6)	91 (11.7)
5. Clarity of CPGs (i.e., easy to read and understand).	9 (4.5)	6 (11.8)	6 (7.9)	1 (2.7)	65 (15.7)	87 (11.2)
6. Official and accessible training, education, coaching and supervision on guidelines, their use and adaptation and of their topics and they be offered in the workplace and throughout academic studies.	16 (8.1)	5 (9.8)	14 (18.4)	6 (16.2)	43 (10.4)	84 (10.8)
7. CPGs that are more synthesized/concise and short.	7 (3.5)	4 (7.8)	6 (7.9)	3 (8.1)	49 (11.8)	69 (8.9)
8. Having sufficient time available in work schedule to consult the CPGs and for implementing them in practice.	6 (3.0)	5 (9.8)	19 (25.0)	9 (24.3)	28 (6.8)	57 (7.3)
9. CPGs are recognized, promoted and supported by specific organizations, associations, and work settings.	3 (1.5)	0 (.0)	6 (7.9)	5 (13.5)	30 (7.2)	44 (5.7)
10. Developing networks for sharing between professionals regarding guideline use and engaging in collaboration and teamwork.	5 (2.5)	1 (2.0)	1 (1.3)	2 (5.4)	28 (6.8)	37 (4.8)
No facilitators.	22 (11.1)	4 (7.8)	3 (3.9)	1 (2.7)	19 (4.6)	49 (6.3)

Table 9

Survey Items Concerning Objectives and Credibility of Guidelines in General

	Psychologists		Guidance Counsellors		Psychoeducators		Social Workers and MFTs		OTs		All Professions	
Variables	*N*	Agree and Strongly Agree *n (%)*	*N*	Agree and Strongly Agree *n (%)*	*N*	Agree and Strongly Agree *n (%)*	*N*	Agree and Strongly Agree *n (%)*	*N*	Agree and Strongly Agree *n (%)*	*N* Total Responses	Total Agree and Strongly Agree *n (%)*
Objectives												
Q33. Aim to serve as educational tools for professionals.	275	228 (83.0)	57	46 (80.7)	93	86 (92.5)	40	37 (92.5)	447	384 (85.9)	912	781 (85.6)
Q34. Aim to serve as norms or standards of practice that must be respected by professionals.	277	258 (93.1)	58	50 (86.2)	91	90 (98.9)	42	40 (95.2)	451	429 (95.1)	919	867 (94.3)
Q35. Aim to improve the quality of service offered by professionals.	282	269 (95.4)	58	49 (84.5)	93	87 (93.5)	42	38 (90.5)	451	409 (90.7)	926	852 (92.0)
Q36. Aim to make services more cost-effective (economical).	242	43 (17.8)	55	4 (7.3)	85	19 (22.4)	36	6 (16.7)	422	59 (13.9)	840	131 (15.6)
Credibility												
Q37. Is developed and published by a regulatory body or order (e.g., Order of Guidance Counselors of the Quebec)	279	239 (85.7)	59	58 (98.3)	94	88 (93.6)	40	36 (90.0)	449	401 (89.3)	921	822 (89.3)
Q38. Is developed and published by professional associations (e.g., the Canadian Psychological Association)	276	217 (78.6)	57	39 (68.4)	90	57 (63.3)	39	28 (71.8)	443	380 (85.8)	905	721 (79.7)
Q39. Is developed and published by not-for-profit organizations and parapublic institutions that are governmental or para-governmental (e.g., Educ'alcool).	276	99 (35.9)	55	26 (47.3)	87	32 (36.8)	40	20 (50.0)	438	243 (55.5)	896	420 (46.9)
Q40. Is developed and published by government institutes or organizations dedicated to promoting excellence and producing guidelines (e.g., INESSS).	273	197 (72.2)	56	38 (67.9)	92	68 (73.9)	38	26 (68.4)	447	409 (91.5)	906	738 (81.5)
Q41. Other: please specify	27	27 (100.0)	2	2 (100.0)	7	5 (71.4)	4	3 (75.0)	37	36 (97.3)	77	73 (94.8)

Chapter 5: General Discussion

There is a clear gap between science and clinical practice (Baker et al., 2008; Wampold et al., 2011). Services being provided to clients are not always based on best practices (Lilienfeld et al., 2013; McGlynn et al., 2003; Straus et al., 2009) as professionals are too busy to stay on top of the most recent scientific evidence (e.g., Graham et al., 2011; Grimshaw et al., 2012). CPGs represent a bridge between this apparent gap; they have the potential to substantially improve the quality of services provided to clients, while minimizing the burden placed on professionals to stay informed about evidence-based practices. Whether or not this is achieved in real life is conditional on the methodological rigour and quality of CPGs, as well as their uptake in practice (Alonso-Coello et al., 2010; Blozik et al., 2012; Brouwers et al., 2010; Gordon & Cooper, 2010). The aim of the current research was to acquire insight into these areas based on the existing literature and firsthand knowledge, attitudes, roles, and experiences of board members involved in the production of CPGs and the intended professional users in the social sciences.

Summary of Key Findings

The first study (Manuscript 1) surveyed 34 board members concerning their knowledge, attitudes, roles, and experiences of guideline development, evaluation, approval, and adoption of mental health and social care service CPGs published across five Quebec regulatory bodies, and CPGs in general. Study 1 (Manuscript 1) showed a general lack of familiarity of guideline development methods among board members who did and did not participate in the CPGs evaluation, approval, and adoption process. Very few board members reported being familiar with these methods, with only 3% for AGREE-II and 6% for NICE and INESSS 2012 and 2015 methods. Members also reported largely being unfamiliar with the other methods. This is surprising when considering that various guideline development methods and handbooks are well-known and were widely disseminated at the time that these CPGs were developed (e.g., AGREE; AGREE Collaboration, 2003). Interestingly, most members reported no time to research, which may explain the general lack of knowledge of guideline development methods. The lack of familiarity of these methods implies that they were not used in the actual development of the CPGs. This is worrisome, given that guideline development methods are essential for the development of empirically-based and rigorous CPGs (Beauchamp et al., 2015; Brouwers et al., 2010; Hollon et al., 2014).

Study 1 (Manuscript 1) also revealed that 73% of board members who participated in the guideline evaluation, approval, and adoption process reported being aware that CPGs development methods existed, despite the fact that they were largely unfamiliar with them. This may be explained by a lack of motivation or interest, or perhaps insufficient time and incentive, to learn about and use such resources. The study also showed that most members involved in the evaluation, approval, and adoption process (15 out 34) had expertise in some key elements involved in this process and guideline development (i.e., clinical expertise of CPGs topics and expertise in knowledge synthesis, transfer, and dissemination). However, they were also lacking expertise in other critical areas (i.e., research expertise of CPGs topics, expertise in methods used to develop the CPGs, and expertise in guideline development that was adequate to evaluate the methodological quality of the CPGs). These findings highlight discrepancies between the members' expertise in guideline development, which is concerning.

The board members' general lack of familiarity with guideline development methods and expertise in some vital areas in guideline development, suggest that the guideline development process and quality of the CPGs produced by the regulatory bodies are at risk of being dubious. Despite the members' lack of familiarity with these methods and expertise in some areas, most members also indicated appropriate guideline development and methods were used for the CPGs. They further reported that the regulatory bodies should continue to publish CPGs. These findings are inconsistent. Knowledge of these methods and expertise in guideline development are necessary in order to ensure that suitable guideline development and methods are used. This was not the case in the current study. Effective guideline development is contingent on the methodological process used to acquire evidence, the guideline development methods, the validity of the methods used, as well as the evidential basis for recommendations, which is influenced by the expertise of policy makers (Eccles et al., 2012; Gardner et al., 2009; Kryworuchko et al., 2009). The use of suitable guideline development methods and rigorous strategies in the guideline development process are necessary to produce evidence-based and good quality CPGs (Alonso-Coello et al., 2010; Andrews & Redmon, 2004; Beauchamp et al., 2015; Brouwers et al., 2010: Hollon et al., 2014). Because board members are in charge of overseeing guideline development, evaluation, approval, and adoption processes, they should be taking measures to ensure that the guidelines they endorse and approve are sound and evidence-based (Hollon et al., 2014). It is thus imperative that board members increase their familiarity

and use of these methods and rely on true experts in all necessary areas of guideline development. This would help ensure the production of the best possible CPGs (see also Kryworuchko et al., 2009; Norris et al., 2016).

Study 1 (Manuscript 1) also found that board members reported positive views of the CPG processes. This is fitting of the ideal social group process involved in guideline development (Eccles et al., 2012). Indeed, the board members reported that their opinions (including those that were divergent) and questions, conflicts of interests, and biases were all sufficiently considered and addressed; they noted that they had enough time to make decisions concerning the CPGs and approved them (85%-100%). Issues with the process were not identified by any of the board members. Given the lack of research on board of directors' knowledge, attitudes, and experiences of the guideline development, evaluation, approval, and adoption processes, this first study represents a significant contribution to the literature.

The second study (Manuscript 2) was a systematic scoping review and illustrated findings concerning the state of current literature regarding the knowledge, attitudes, use, implementation, and adherence of mental health and social care service guidelines among professionals in the social science field. The apparent gaps in the literature were identified, and the barriers and facilitators to guideline uptake were assessed. The review included a total of 35 sources (i.e., articles and dissertations), with more than half involving healthcare professionals as their primary focus. Among these, some social science professions (i.e., psychologists, counsellors, social workers, and OTs) were poorly represented in the literature, while other social science professions, such as psychoeducators and MFTs, were not included whatsoever. Although the articles were conducted across various countries, revealing a global interest in this topic, a small majority were conducted in the USA (31%) and only a few (14%) in Canada. A slight majority of articles also focused on anxiety disorders (31%), followed by mood disorders (20%). This was expected given the high prevalence of these disorders worldwide (i.e., 3.6% for anxiety and 4.4% for mood disorders; WHO, 2017). Most of the articles focused on adult populations (91%), with only a few on children and adolescents (9%). This discrepancy may be reflective of insufficient production of child and adolescent CPGs. Together, these findings emphasize the significant lack of research in the social sciences globally, including in Canada, and insufficient representation of relevant professions and mental health and social care service CPGs within the field. These findings suggest that although CPGs have flourished over the years (Gould & Kendal, 2007;

Parry et al., 2003; White & Kratochwill, 2005), research on CPGs remains limited and must be fostered further within the social sciences, in Canada and internationally (e.g., Graham et al., 2000; Proctor et al., 2009; Sandström et al., 2014).

Study 2 (Manuscript 2) also found mixed rates of knowledge of CPGs among professionals, which is contrary to the extant medical scholarship suggesting professionals are knowledgeable of CPGs (e.g., Hader et al., 2007; Pogorzelska & Larson, 2008). Most articles (*n* = 14) also emphasized professionals having positive attitudes toward CPGs in terms of their use, relevancy, and guideline development and influence on practice. However, almost just as many studies (*n* = 12) reported negative attitudes toward CPGs, which suggests a slight preference for positive attitudes. Most of the articles (*n* = 16) presented professionals' lack of guideline use, implementation, and adherence, with a minority (*n* = 10) reporting higher rates and slightly fewer articles (*n* = 8) providing mixed or inconsistent rates. These findings pertaining to professionals' attitudes and guideline uptake are similar to prior work in medicine (e.g., Constantino-Casas et al., 2011; Farquhar et al., 2002; Lugtenberg et al., 2009; Theodorou et al., 2012). Despite the fact that research within the social sciences is still emerging, the existing evidence suggests that professionals' attitudes of and uptake of CPGs within the social sciences and in medicine fields may be parallel. It is possible that the guideline process evokes similar attitudes or reactions and behaviours among professionals, regardless of their field of work or despite working in different contexts.

Consistent with previous theoretical models (e.g., Cabana et al., 1999; Pathman et al., 1996; Solberg et al., 2000), the thematic results showed that various studies illustrated the association between professionals' knowledge, attitudes, and guideline uptake, as well as the impact of related barriers and facilitators. The review illustrated that most of the articles reported organizational restraints as a barrier to guideline uptake (*n* = 17). The most commonly reported facilitators to guideline uptake were training and supervision concerning CPGs (*n* = 15). These findings extend knowledge from previous models, by showing the similarities in light of social science professionals. However, it would be fruitful to assess additional barriers and facilitators such as costs and others' views of CPGs (Flores et al., 2000; Yang et al., 2013) within the social sciences, as these were not examined in the present review (i.e., Manuscript 2). The specific relationship between professionals' knowledge and attitudes was also not identified in the current review. However, this relationship has been found in prior research and models (e.g., Alanen et

al., 2009a; Cabana et al., 1999; Woolf, 1993). Further investigation of professionals' knowledge, attitudes, and guideline uptake, as well as related barriers and facilitators, is undoubtedly warranted as it would elucidate some of the mixed reported findings and would add to the existing theoretical models. The underdeveloped state of the literature further underscores the contributions of Manuscripts 1 (described above) and 3 (summarized below), as they each represent important research advancements.

The third study (Manuscript 3) surveyed and provided findings for 954 professionals (i.e., psychologists, guidance counsellors, psychoeducation, social workers and MFTs, and OTs) regarding their knowledge, attitudes, use, and implementation of mental health and social care CPGs produced by five Quebec regulatory bodies and CPGs overall. Most professionals reported a general knowledge of guidelines and development methods, and use of CPGs, as well as positive attitudes towards them. The current study showed that most professionals were familiar with and used the CPGs produced by their respective regulatory body (67%-79%). This result may suggest that guideline use and implementation, and familiarity are associated. However, the current study did not perform analyses to examine this relationship. Interestingly, knowledge that CPGs existed was identified as a facilitator to guideline uptake. In contrast, a lower percentage of professionals reported that they did not use the CPGs (21%-33%) because they lacked knowledge about CPGs (41% across professions; 55%-71% for each profession). A lack of knowledge was also reported by some professionals as a barrier to guideline uptake. The current study provides support for the the key constructs outlined in existing theoretical models, such as guideline familiarity or knowledge and uptake (e.g., Cabana et al., 1999; Pathman et al., 1996; Solberg et al., 2000). However, further research is necessary to examine the relationship between these constructs. Having knowledge of CPGs could possibly direct their use and implementation in practice. However, the relationship may also be bidirectional. As such, using CPGs may enhance the level of knowledge or familiarity of them and could further foster subsequent uptake. The degree of knowledge or familiarity of CPGs that is necessary for actual guideline uptake is unclear, however. Perhaps, simply having knowledge that CPGs exist is sufficient to propel their use. Alternatively, extensive knowledge of CPGs may be required prior to their uptake. The current study also found that most professionals who reported using CPGs also indicated being familiar with guideline development methods (62%-80% for all professionals except OTs). However, the relationship between guideline use and familiarity with these

methods was not specifically examined and relevant analyses were not conducted. Fewer OTs reported being familiar with these methods (35%), despite them using CPGs (79%), which may suggest that other factors determine the uptake of CPGs.

Study 3 (Manuscript 3) also found that most professionals who reported being familiar with and using the guidelines also maintained mostly positive attitudes, with some negative attitudes toward CPGs. However, the variation in OTs' attitudes towards CPGs development was more pronounced, indicating a relatively equal mix of positive and negative attitudes towards guideline development and related methods. Despite these mixed attitudes toward CPGs, OTs also reported high rates of general knowledge of and use of CPGs and were generally unfamiliar with CPGs development methods. Therefore, it appears that having knowledge of and positive attitudes toward CPGs may not guarantee their use in practice (e.g., Farquhar et al., 2002; Finkelstein et al., 2000; Francke et al., 2008). Since no analyses were performed to examine the associations between knowledge, attitudes, and use of guidelines, then investigation of the link between these and related variables is warranted, as proposed by the *Barriers to Adherence Framework* (Cabana et al., 1999). These may include the barriers (e.g., lack of time and relevancy of CPGs) and facilitators (e.g., relevancy of CPGs and training and supervision) identified in the current study. Other variables could include professionals' personal characteristics or trustworthiness of the CPGs and of the entities that produced the guidelines.

Across professionals, the majority also had predominantly positive attitudes towards the CPGs produced by the regulatory bodies, with a minority reporting some negative attitudes. These findings are parallel to the findings obtained in Study 2 (Stamoulos, 2020). In particular, the current study revealed that across professionals, most perceived the CPGs to be useful and impact practice, more refined, less rigid, and applicable to practice. There was also general agreement concerning the clarity and presentation (e.g., CPGs were well designed, organized, clear and coherent), and development and methodological rigour (e.g., based on recent scientific evidence and best practices in guideline development) of CPGs. These findings suggest that the CPGs are perceived to be valuable and are of good quality with respect to some vital areas involved in guideline development.

Study 3 (Manuscript 3) also showed that more negative attitudes were obtained across professionals for aspects involved in the guideline development process (i.e., CPGs used a formal method of consensus, described strengths and limitations, and addressed potential ethical

issues and conflicts of interests and biases). These findings suggest that key areas in guideline development were not used or were not addressed in the CPGs. This implies potential problems with the guideline development process, methodological rigour, and methods used or with the transparency of the guideline development process. The latter would indicate that more details should be included in CPGs concerning the development process. Regardless, this may further indicate issues with the methodological rigour in guideline development and quality of these CPGs. Some recent studies in the social sciences have raised similar issues (Ciquier et al., 2020; Stamoulos et al., 2014; Trépanier et al., 2017; Trépanier, 2019; Stamoulos, 2020; see Manuscript 1 of this thesis). The current study also showed variability in agreement ratings across the professions (positive and negative attitudes) for some other critical elements involved in the guideline development process. These included: CPGs outlining sufficient information concerning how it was developed and involvement of a development committee representing all stakeholders, an informal consensus method, a systematic method, and different intervention options for problems. These results indicated that some key guideline development areas were addressed and/or utilized, and others were not, depending on the profession and specific guideline. This suggests that there are both strengths and weaknesses within the CPGs development process.

Mixed attitudes were also obtained for guideline implementation and applicability. The applicability and implementation of CPGs is essential in terms of quality development and in order to ensure cost-effectiveness and the provision of optimal services (Brouwers, et al., 2010; Graham et al., 2000; Hollon et al., 2014; Trépanier et al., 2019). Most professionals perceived that the CPGs explained how the recommendations should be implemented (53%-83%) and that they were easily accessible and used in practice (73%-94%). The results indicate that the implementation strategies, access, and application of CPGs in practice appear to be adequately addressed. However, fewer professionals reported that CPGs discussed the facilitators and potential barriers to implementing recommendations (30%-50%) and included a plan to assess CPGs' effects on practice (9%-38%), suggesting these aspects were inadequately considered. CPGs should address all the fundamental elements involved in the guideline implementation and applicability domain in order to ensure effective uptake of CPGs and positive outcomes in practice. These findings are somewhat consistent with prior research in the social sciences, suggesting similar issues with some of the CPGs (e.g., Trépanier et al., 2019).

In light of the current study's findings and former research (Ciquier et al., 2020; Stamoulos et al., 2014; Stamoulos, 2020; Trépanier et al., 2017; Trépanier, 2019), using the CPGs is questionable. Given that the benefits of CPGs are dependent on the methodological rigour, development, and quality of guidelines themselves (Burgers et al., 2003; Gordon & Cooper, 2010; Hollon et al., 2014), then using potentially poorly developed and quality CPGs can lead to dire consequences (Bennett et al., 2018; Rao & Tandon, 2017; Woolf et al., 2004). This is disquieting, when considering that in the current study, most professionals reported high rates of guideline use (67%-79%).

Study 3 (Manuscript 3) also examined guideline use and relevancy. Across professionals, most reported that one of the CPGs produced by their respective regulatory body were relevant for informing their practice (70%-95% for guidance counsellors, psychoeducators, social workers and MFTs, and OTs). However, 50% of psychologists reported that one of the CPGs produced by the OPQ were relevant, with 50% also indicating none of the CPGs were relevant. This is unsurprising given that the CPGs endorsed most by psychologists were those pertaining to the *Autism Spectrum Disorder – Clinical Evaluation (2012)*. While the majority of the other professionals endorsed most of the CPGs to some degree, a higher percentage of endorsement was reported for some CPGs versus others. However, some CPGs were not endorsed at all by psychoeducators and social workers and MFTs. Overall, these findings suggest that some of the CPGs produced by the regulatory bodies are relevant for most professionals, are less relevant for psychologists, and not relevant at all for psychoeducators, social workers, and MFTs. The variability in guideline relevancy among professionals could be due to some guideline topics being relevant to their area of expertise, while others are not. Based on the results obtained for guideline use and relevancy of CPGs, it is possible that the degree of CPGs relevancy may dictate whether or not the guidelines are used in practice. However, analyses examining this relationship were not performed for the current study. Interestingly, one of the main barriers and facilitators to guideline use and implementation reported among professionals related to the relevancy of CPGs. This may suggest that the relevancy of the CPGs for informing practice could be a central component of professionals' use and implementation of guidelines. Taken together, it is imperative that the needs and degree of relevancy of specific CPGs be assessed prior to their development, thereby improving the cost-effectiveness of CPGs and fostering guideline use and implementation.

The current study also found that the vast majority of professionals perceived their regulatory bodies as credible and reliable sources of empirically-based and good quality CPGs (89%). Professionals' attitudes may therefore not only be shaped by their knowledge and in this case of development methods, but on other critical factors, such as trustworthiness of regulatory bodies. Professionals also seemed to trust government institutes or organizations dedicated to promoting excellence and producing guidelines (82%) and professional associations (80%). Interestingly, OTs endorsed the institutes over the other entities, including the OEQ. The reason for this is unclear. However, this may be due to negative attitudes or experiences with the CPGs or with the OEQ. Alternatively, OTs may simply be aware that institutes such as INESSS have more expertise in producing best practice CPGs. Notably, almost all professionals (95%) perceived that multiple factors were necessary for a reliable guideline. These factors included: collaboration involving multiple stakeholders, experts, and entities (e.g., institutes, organizations, and regulatory bodies), sound methodological rigour and development, applicability to many settings, and international acceptance. These findings suggest that credibility of CPGs and entities, as well as other factors are essential for ensuring professionals trust the guidelines enough to use and implement them in practice.

Implications and Contribution to Knowledge

Research, Theory, and Policy. The current dissertation contributes to knowledge in the area of mental health and social care CPGs in the social sciences in several significant ways. Research on CPGs has prospered in medicine, while it has fallen behind the social sciences (Alonso-Coello et al., 2010; Beauchamp et al., 2011; Parry et al., 2003; White & Kratochwill, 2005). The present thesis is the first to examine and document various areas in the social sciences in this regard and therefore represents a major advancement in the literature. This includes the following: 1) the knowledge, attitudes, roles, and experiences of guideline development and evaluation, approval, and adoption of CPGs among board of directors for CPGs produced by the regulatory bodies in Quebec and generally, CPGs within the social sciences; 2) the existing social science literature pertaining to professionals' knowledge, attitudes, and uptake of CPGs, as well as related barriers and facilitators; and 3) the knowledge, attitudes, use, and implementation of CPGs, in addition to the barriers and facilitators among professionals, for CPGs developed by the regulatory bodies in Quebec and general CPGs in the social sciences.

The first study illustrates the current state and functioning of members of the board of director in Quebec and informs policy on guideline development, methodological rigour, and quality of CPGs. It points to both the strengths and weaknesses in these particular guideline areas. As such, this work provides valuable information for advising current and future guideline development, evaluation, approval, and adoption processes and policy in general. Relatedly, various discrepancies were found in terms of expertise, attitudes, and experiences of the former processes that should be addressed. There is a need for board members to familiarize themselves with the existing guideline development methods and related research and enhance their competence in all vital aspects involved in guideline development. In this same disposition, guideline and the board of directors' committees may benefit from selecting members who are experts in these relevant areas. Similarly, collaboration between board members, professionals, and various entities that specialize in guideline development and dissemination, would lead to more comprehensive and effective policy and ensure more cost-effective use of resources. In turn, guideline development, dissemination, and uptake would be further enhanced. Lastly, existing theoretical models pertaining to knowledge, attitudes, and experiences of CPGs have only been developed and applied to professionals. To our knowledge, these have never been applied to the context of policy makers and in particular, board members. Thus, the current research also attempted to integrate the findings for board members into the related frameworks pertaining to the individual constructs: knowledge, attitudes, and behaviours (see Cabana et al., 1999; Pathman et al., 1996; Solberg et al., 2000; Woolf, 1993) and may be useful for extending these models beyond the ones proposed for professionals.

The second study depicted the existing ethos of social science literature on CPGs and professionals. It further emphasized the lack of available research in this area and related limitations which may guide future research. It advises critical aspects for understanding professionals' perspectives and experiences of CPGs in current practice. Building off of this, the third study demonstrated the current state of professionals' in the social sciences in Quebec regarding their views and uptake of CPGs in general and those developed by regulatory bodies. The second and third studies emphasized similarities and differences in terms of professionals' knowledge, attitudes, and guideline uptake in light of existing research. These studies inform policy in terms of guideline development and uptake. The existing theoretical models (Cabana et al., 1999; Pathman et al., 1996; Solberg et al., 2000; Woolf, 1993) pertaining to knowledge,

attitudes, and guideline uptake have been applied to healthcare professionals, despite largely being developed by social science researchers.

The current research was the first attempt to contextualize the social science literature in light of the key constructs involved in the existing theoretical models and specifically, for social science professionals in general and specifically for those in Quebec. This work provides some support and highlights differences in these theoretical models based on the existing literature from Study 2 (Manuscript 2). It further provides support for the related key constructs based on the data obtained in Study 3 (Manuscript 3). It further exemplifies the start of merging the gaps between research and these theories. As such, findings from Studies 2 and 3 (Manuscripts 2 and 3) may represent the beginning stages of unifying the current models or developing separate theoretical models that are unique to social science professionals concerning mental health and social care service CPGs in general and in Quebec. This may not only inform future research and theory, but also informs policy for guideline development, dissemination, and uptake of CPGs in practice. This may include preventing barriers and fostering facilitators to guideline uptake and enhancing training and education regarding CPGs for professionals globally and more locally in Quebec.

Clinical. The current findings stress the prospective benefits for using CPGs in clinical practice and for improving client outcomes. The systematic scoping review (Study 2, Manuscript 2) highlighted variable rates of CPGs uptake among professionals, with a preference for low rates. In contrast, Study 3 (Manuscript 3) emphasized higher rates of guideline use and implementation among professionals, suggesting that the state of CPGs uptake in Quebec may differ compared to other areas worldwide. Social science professionals in Quebec generally seem to be using CPGs in practice and for the most part perceive them to be beneficial. However, there may be inherent issues with these CPGs, indicating that their use in practice may not be advisable. As such, further evaluation of existing CPGs and improvements in guideline development, evaluation, approval, adoption, and quality of CPGs is necessary in order to ensure best practices. In turn, this would improve guideline uptake and enhance their benefits in clinical practice.

As previously reviewed, there is a lack of research examining CPGs in Quebec. The existing literature emphasizes issues regarding guideline development, methodology, and quality. The current thesis revealed a number of inconsistencies, which suggests a need for caution when

using the current CPGs produced by the Quebec regulatory bodies. While professionals in Quebec view their regulatory bodies and other entities as trustworthy, and while the CPGs developed by them are credible, professionals surveyed in the current research were found to perceive the reliability of CPGs to extend to other factors beyond these entities. Therefore, improvements regarding guideline development and quality and collaboration, such as the use of co-guideline development groups involving multiple stakeholders and entities, would be valuable and would enhance the credibility of CPGs. Additionally, Study 3 (Manuscript 3) points to the potential lack of relevancy of some of the existing CPGs developed by Quebec regulatory bodies, suggesting that the production of novel CPGs and diverse topics may be required. Studies 2 and 3 also identified various barriers and facilitators to guideline uptake, suggesting that these factors need to be further addressed at the institutional, organizational, and professional levels. Part of this may include collaborative support and academic and professional training regarding CPGs and their uptake in practice.

Research Strengths and Limitations

Various strengths and limitations warrant consideration for the current research findings. These set of studies represent innovative research in the context of the social sciences. They are the first to survey board of directors' and professionals' knowledge, attitudes, roles, and experiences of mental health and social care service CPGs in Quebec, as well as the first to conduct a systematic scoping review on CPGs and professionals in the social sciences. Studies 1 and 3 investigated various social science professions, regulatory bodies, general CPGs, and CPGs produced in Quebec. These studies also examined multiple related constructs via several surveys tailored to each profession and entity. Study 2 (Manuscript 2) provided a comprehensive synthesis and highlighted the limitations of the existing social science literature and thus guided the development of Study 3 (Manuscript 3).

Despite the contributions these three studies provide to the literature, there are a few limitations to note. The survey studies were based on self-reports and subject to response bias. Mostly positive attitudes were obtained in these studies, which may relate to board members' and professionals' biases with regard to critiquing the CPGs they participated in developing. Study 1 (Manuscript 1) included false items to assess for social desirability; based on these items, biases were not detected. Selection bias may have been present for Study 3 (Manuscript 3), however, as false items were not included in this study. Biases in recall or inaccurate recall

could have also impacted the nature of the findings. Data selection bias may have been present for Study 2 (Manuscript 2; the systematic scoping review) and may have led to the unintentional exclusion of some relevant articles. This issue could be mitigated in future studies through the use of more extensive or supplementary databases. Some countries were also not represented in the systematic scoping review and thus the findings could represent cultural bias. Moreover, guideline adherence among professionals and familiarity of CPGs in general were not thoroughly assessed due to space limitations and specific research interests in Study 3 (Manuscript 3). As a result, useful and more detailed information regarding the variability of some findings is not available.

Additionally, the current research predominantly examined the key constructs involved in existing theoretical models separately. Study 1 (Manuscript 1) and Study 2 (Manuscript 3) did not examine the relationship between knowledge, attitudes, and experiences of CPGs among board members and professionals, respectively. While Study 2 (Manuscript 2) mainly investigated these individual constructs based on the current literature, it also provided some support and highlighted differences for the existing theoretical frameworks.

Lastly, limited sample sizes were obtained across all studies. Study 1 (Manuscript 1) included a small sample size and response rates were low. The regulatory bodies were not particularly supportive in the distribution of the board members surveys for Study 1 (Manuscript 1), hindering our ability to obtain larger pool of participants. Study 2 (Manuscript 2) included a limited number of articles, albeit this was due to the lack of available literature on this topic. The review also did not capture all social science professions and thus some professionals were not embodied. While Study 3 (Manuscript 3) obtained larger sample sizes (as there was more support from the regulatory bodies), response rates were also low, and some survey versions obtained larger sample sizes than others. As such, some populations, contexts, and cultures may have been underrepresented. Taken together, the generalizability of findings may be limited. Improved collaboration between researchers, professional, and board members, and the regulatory bodies is necessary for future research and advancements in CPGs research in the social sciences and in Quebec.

Future Directions

The aforementioned implications and limitations highlight potential areas for future research. In general, replication of the current survey studies is necessary, in addition to

increased sample sizes, addressing potential biases, and ensuring all populations are adequately represented. Relatedly, further investigation of mental health and social care service CPGs in the social sciences is warranted not just in Quebec, but also internationally. This includes critically appraising the quality of these CPGs, their development, methodological rigour, evaluation, approval, and adoption processes further. Information on CPGs uptake in practice, as well as the acquisition of more information from the board of directors, guideline development committee members, professionals, and regulatory bodies is undoubtedly needed. The latter can be obtained using survey, observation, or interview formats, in addition to focus-group studies with multiple stakeholders, including perspectives and experiences of clients. Further investigation of the credibility factors pertaining to CPGs may also inform the guideline development process and allow for creation of more effective and trustworthy guidelines.

Once further guideline research in the social sciences is obtained, conducting other systematic scoping reviews would be useful. Reviews focusing on professionals, board members, guideline developers, and client's knowledge, attitudes, and experiences of CPGs would be particularly informative and would add to existing theoretical models. Future investigators may consider examining guideline adherence rates, as these were not assessed in Study 3 (Manuscript). Relatedly, further investigation of professionals' general knowledge of CPGs and barriers and facilitators to CPGs uptake would be valuable. Research should examine the relationship between knowledge, attitudes, and experiences and investigate other possible mediating factors. Other important considerations for future research include the costs and benefits of CPGs and relevant guideline topics for professionals in general and in Quebec. This would ensure that costs and resources are appropriately allocated and used effectively. Similarly, surveying professionals about their main expertise would allow for the development of more relevant CPGs for clinical practice.

Conclusion

The current dissertation describes the knowledge, attitudes, and experiences of CPGs for board of directors and professionals in Quebec, as well as the overall social science literature on professionals' knowledge, attitudes, and uptake of CPGs. The present thesis provides some support for existing research and for the key constructs within theoretical models applicable to policy makers and professionals in the social sciences. It highlights both the strengths and weaknesses of current CPGs and the literature as a whole. Further investigation and replication

are warranted in order to extend this research and obtain clarification concerning some variability in the current research findings. Guideline research in these areas inform policy and ensure more optimal CPGs.

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Appendix

Search Strategy, Algorithms and Keywords

A) Web of Science – Social Science Index
- Limit to (English and French language) and (1990-2019 years)

1. TITLE AND TOPIC: ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance) AND (mental health OR social care OR social service* OR social care service* OR social science* OR psycholog* OR social work* OR occupational therap* OR counsel* OR guidance counsel* OR family therap* OR marriage therap* OR couple* therap* OR psychoeducat*) AND (use OR implement* OR adhere* OR compliance*))

Number of Records: 105

2. TITLE AND TOPIC: ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance) AND (mental health OR social care OR social service* OR social care service* OR social science* OR psycholog* OR social work* OR occupational therap* OR counsel* OR guidance counsel* OR family therap* OR marriage therap* OR couple* therap* OR psychoeducat*) AND (perception* OR view* OR attitude* OR perspective*))

Number of Records: 54

3. TITLE AND TOPIC: ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance) AND (mental health OR social care OR social service* OR social care service* OR social science* OR psycholog* OR social work* OR occupational therap* OR counsel* OR guidance counsel* OR family therap* OR marriage therap* OR couple* therap* OR psychoeducat*) AND (knowledge or aware* or familiar*))

Number of Records: 6

Total Records for Web of Science Database: 165

B) ProQuest Central
- Limit to (English and French language) and (1700-2019 years)

1. TITLE AND SUBJECT: ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance) AN (mental health OR social care OR social service* OR social care service* OR social science* OR psycholog* OR s work* OR occupational therap* OR counsel* OR guidance counsel* OR family therap* OR marriage therap* OR therap* OR psychoeducat*) AND (use OR implement* OR adhere* OR compliance*))

Number of Records: 8

2. TITLE AND SUBJECT: ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance) AN (mental health OR social care OR social service* OR social care service* OR social science* OR psycholog* OR s work* OR occupational therap* OR counsel* OR guidance counsel* OR family therap* OR marriage therap* OR therap* OR psychoeducat*) AND (perception* OR view* OR attitude* OR perspective*))

Number of Records: 5

3. TITLE AND SUBJECT: ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance) AND (mental health OR social care OR social service* OR social care service* OR social science* OR

psycholog* OR social work* OR occupational therap* OR counsel* OR guidance counsel* OR family therap* OR marriage therap* OR couple* therap* OR psychoeducat*) AND (knowledge or aware* or familiar*))
Number of Records: 0

4. TITLE AND SUBJECT: ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance))

Number of Records: 75

Total Records for ProQuest Central Database: 88

C) Theses Canada
- All searches were limited to (English and the French language separately and then combined) and (1965-2019 years)
- The following keywords were searched separately as this database does not use advance searches (i.e., only one search box) and does allow combining multiple keywords at the same time.

TITLE KEYWORDS AND SUBJECT KEYWORDS:
1. Clinical practice guideline (*Number of Records:* 14); 2. practice guideline (*Number of Records:* 22); 3. Guideline (*Number of Records:* 42); 4. Guidance (*Number of Records:* 207); 5. Clinical practice guidelines and social sciences (*Number of Records:* 0); 6. Practice guideline and social sciences (*Number of Records:* 0); 7. Guideline and social sciences (*Number of Records:* 0); 8. Guidance and social sciences (*Number of Records:* 0) 9. Clinical practice guideline and mental health (*Number of Records:* 0); 10. Guideline and mental health (*Number of Records:* 0); 11. Guidance and mental health (*Number of Records:* 0); 12. Clinical practice guideline and social care (*Number of Records:* 0); 13. Practice guidelines and social care (*Number of Records:* 0); 14. Guideline and social care (*Number of Records:* 0); 15. Guidance and social care (*Number of Records:* 0); 16. Clinical practice guidelines and social service (*Number of Records:* 0); 17. Practice guidelines and social service (*Number of Records:* 0); 18. Guideline and social service (*Number of Records:* 0); 19. Guidance and social service (*Number of Records:* 0); 20. Clinical practice guideline and psychology (*Number of Records:* 0); 21. Practice guideline and psychology (*Number of Records:* 0); 22. Guideline and psychology (*Number of Records:* 0); 23. Guidance and psychology (*Number of Records:* 0); 24. Clinical practice guideline and social work (*Number of Records:* 0); 25. Practice guideline and social work (*Number of Records:* 0); 26. Guideline and social work ((*Number of Records:* 0); 27. Guidance and social work (*Number of Records:* 0); 28. Clinical practice guideline and occupational therapy (*Number of Records:* 0); 29. Practice guideline and occupational therapy (*Number of Records:* 0); 30. Guideline and occupational therapy (*Number of Records:* 0); 31. Guidance and occupational therapy (*Number of Records:* 0); 32. Clinical practice guideline and counselling (*Number of Records:* 0); 33. Practice guideline and counselling (*Number of Records:* 0); 34. Guideline and counselling (*Number of Records:* 0); 35. Guidance and counselling (*Number of Records:* 3); 36. Clinical practice guideline and guidance counselling (*Number of Records:* 0); 37. Practice guideline and guidance counselling (*Number of Records:* 0); 38. Guideline and guidance counselling (*Number of Records:* 0); 39. Guidance and guidance counselling (*Number of Records:* 0); 40. Clinical practice guideline and family therapy (*Number of Records:* 0); 41. Practice guideline and family therapy (*Number of Records:* 0); 42. Guideline and family therapy (*Number of Records:* 0); 44. Guidance and family therapy (*Number of Records:* 0); 45. Clinical practice guideline and marriage therapy (*Number of Records:* 0); 46. Practice guideline and marriage therapy (*Number of Records:* 0); 47. Guideline and marriage therapy (*Number of Records:* 0); 48. Guidance and marriage therapy (*Number of Records:* 0); 49. Clinical practice guideline and couple therapy (*Number of Records:* 0); 50. Practice guideline and couple therapy (*Number of Records:* 0); 51. Guideline and couple therapy (*Number of Records:* 0); 52. Guidance and couple therapy (*Number of Records:* 0); 53. Clinical practice guideline and psychoeducation (*Number of Records:* 0); 54. Practice guideline and psychoeducation (*Number of Records:* 0); 55. Guideline and psychoeducation (*Number of Records:* 0); 56. Guidance and psychoeducation (*Number of Records:* 0); 57. Clinical practice guideline and use (*Number of Records:* 0);

58. Practice guideline and use (*Number of Records:* 0); 59. Guideline and use (*Number of Records:* 2); 60. Guidance and use (*Number of Records:* 3); 61. Clinical practice guideline and implement (*Number of Records:* 0); 62. Practice guideline and implement (*Number of Records:* 0); 63. Guideline and implement (*Number of Records:* 0); 64. Guidance and implement (*Number of Records:* 0); 65. Clinical practice guideline and adhere (*Number of Records:* 0); 66. Practice guideline and adhere (*Number of Records:* 0); 67. Guideline and adhere (*Number of Records:* 0); 68. Guidance and adhere (*Number of Records:* 0); 69. Clinical practice guideline and compliance (*Number of Records:* 0); 70. Practice guideline and compliance (*Number of Records:* 0); 71. Guideline and compliance (*Number of Records:* 0); 72. Guidance and compliance (*Number of Records:* 0); 73. Clinical practice guideline and perceptions (*Number of Records:* 0); 74. Practice guideline and perception (*Number of Records:* 0); 75. Guideline and perception (*Number of Records:* 0); 76. Guidance and perception (*Number of Records:* 0); 77. Clinical practice guideline and view (*Number of Records:* 0); 78. Practice guideline and view (*Number of Records:* 0); 79. Guideline and view (*Number of Records:* 0); 80. Guidance and view (*Number of Records:* 0); 81. Clinical practice guideline and attitude (*Number of Records:* 0); 82. Practice guideline and attitude (*Number of Records:* 0); 83. Guideline and attitude (*Number of Records:* 0); 84. Guidance and attitude (*Number of Records:* 0); 85. Clinical practice guideline and perspective (*Number of Records:* 0); 86. Practice guideline and perspective (*Number of Records:* 0); 87. Guideline and perspective (*Number of Records:* 0); 88. Guidance and perspective (*Number of Records:* 1); 89. Clinical practice guideline and knowledge (*Number of Records:* 1); 90. Practice guideline and knowledge (*Number of Records:* 1); 91. Guideline and knowledge (*Number of Records:* 2); 92. Guidance and knowledge (*Number of Records:* 0); 93. Clinical practice guideline and aware (*Number of Records:* 0); 94. Clinical practice guideline and awareness (*Number of Records:* 0); 95. Practice guideline and aware (*Number of Records:* 0); 96. Practice guideline and awareness (*Number of Records:* 0); 97. Guideline and aware (*Number of Records:* 0); 98. Guideline and awareness (*Number of Records:* 0); 99. Guidance and aware (*Number of Records:* 0); 100. Guidance and awareness (*Number of Records:* 0); 101. Clinical practice guideline and familiar (*Number of Records:* 0); 102. Clinical practice guideline and familiarity (*Number of Records:* 0); 103. Practice guideline and familiar (*Number of Records:* 0); 104. Practice guideline and familiarity (*Number of Records:* 0); 105. Guideline and familiar (*Number of Records:* 0); 106. Guideline and familiarity (*Number of Records:* 0); 107. Guidance and familiar (*Number of Records:* 0); 108. Guidance and familiarity (*Number of Records:* 0);

Total Number of Theses Canada Database Records: 298

D) ProQuest Dissertations and Theses Global
- Limit to (English and French language) and (1997-2019 years)

1. TITLE AND SUBJECT: ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance) AND (mental health OR social care OR social service* OR social care service* OR social science* OR psycholog* OR social work* OR occupational therap* OR counsel* OR guidance counsel* OR family therap* OR marriage therap* OR couple* therap* OR psychoeducat*) AND (use OR implement* OR adhere* OR compliance*))

Number of Records: 1

2. TITLE AND SUBJECT: ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance) AND (mental health OR social care OR social service* OR social care service* OR social science* OR psycholog* OR social work* OR occupational therap* OR counsel* OR guidance counsel* OR family therap* OR marriage therap* OR couple* therap* OR psychoeducat*) AND (perception* OR view* OR attitude* OR perspective*))

Number of Records: 3

3. TITLE AND SUBJECT: ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance) AND (mental health OR social care OR social service* OR social care service* OR social science* OR psycholog* OR social work* OR occupational therap* OR counsel* OR guidance counsel* OR family therap* OR marriage therap* OR couple* therap* OR psychoeducat*) AND (knowledge or aware* or familiar*))

Number of Records: 0

4. TITLE AND SUBJECT: ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance))

Number of Records: 318

Total Number of ProQuest Dissertations and Theses Global Database Records: 322

E) Open Grey
- (No option to use title and subject as specifiers. Only the terms were entered)
- Limit to (English and French language) and (1980-2019 years)

1. ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance) AND (mental health OR social care OR social service* OR social care service* OR social science* OR psycholog* OR social work* OR occupational therap* OR counsel* OR guidance counsel* OR family therap* OR marriage therap* OR couple* therap* OR psychoeducat*) AND (use OR implement* OR adhere* OR compliance*))

Number of Records: 253

2. ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance) AND (mental health OR social care OR social service* OR social care service* OR social science* OR psycholog* OR social work* OR occupational therap* OR counsel* OR guidance counsel* OR family therap* OR marriage therap* OR couple* therap* OR psychoeducat*) AND (perception* OR view* OR attitude* OR perspective*))

Number of Records: 178

3. ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance) AND (mental health OR social care OR social service* OR social care service* OR social science* OR psycholog* OR social work* OR occupational therap* OR counsel* OR guidance counsel* OR family therap* OR marriage therap* OR couple* therap* OR psychoeducat*) AND (knowledge or aware* or familiar*))

Number of Records: 0

4. ((clinical practice guideline* OR practice guideline* OR guideline* OR guidance))

Number of Records: 2396

Total Number of Open Grey Records: 2827