Preparing Current and Future Practitioners to Integrate Research in Real Practice Settings

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Author's Notes:

A paper prepared for presentation at the conference titled *Bridging the Research and Practice Gap: A Symposium on Critical Considerations, Successes and Emerging Ideas,* to be held at the Graduate School of Social Work, University of Houston, Houston, Texas, April 5-6 2013. Correspondence concerning this paper may be addressed to B. A. Thyer, Ph.D., LCSW, College of Social Work, Florida State University, 296 Champions Way, Tallahassee, FL 32306 or via email at Bthyer@fsu.edu

Preparing Current and Future Practitioners to Integrate Research in Real Practice Settings

The topic I was asked to address, *Preparing Current and Future Practitioners to Integrate Research in Real Practice Settings*, can be interpreted as involving at least two different tasks. One is to reinforce the use of the best quality available evidence by social work practitioners, in the process of making decisions with clients regarding the assessment and intervention methods they use. In other words, to promote the uptake of empirically-based research knowledge by social work practitioners. A second meaning of my paper's title refers to promoting social work practitioners' design and conduct of original research in their own practice settings. This is a very old issue for our field. Social worker Rona Levy wrote an article in 1981 titled *On the nature of the Clinical-Research Gap: The Problem with Some Solutions.* Obviously her solutions did not work out very well, since we are all gathered here today addressing the same difficulty. In 1992 the Columbia University School of Social Work sponsored a similar conference on the theme of "Research and Practice: Bridging the Gap", chaired by Professor Mark Mattaini, and resulting in a special issue (July, 1992) of the brand new journal *Research on Social Work Practice.* In fact, early this year the *Journal of Social Work Education* published a similarly themed paper titled *Bridging the Gap Between Research, Evaluation, and Evidence-based Practice* (Davis, Gervin, White, Williams, Taylor, & McGriff, 2013).

Our disciplinary history suggestions some reasons why the gap persists. For example, in the very first issue of the NASW's journal *Social Work*, Preston and Mudd (1956) asserted "It is our conviction that the average social agency...should not undertake

research" (p. 38) and "it is not feasible to conduct formal research in the run-of-the-mill social agency..." (p. 39). They explain that the average MSW social worker is trained to work with people, not abstract ideas, and that they possess an intuitive and artistic nature which not lend itself to the more logical reasoning needed for undertaking social work research. More contemporary views seem to support this view. Just last month, Gitterman and Knight (2013) published an article wherein they stated that "...evidence continues to suggest that practicing social workers lack the skills and expertise necessary to operate from an evidence-based foundation." (p. 72), and we now find that our Council on Social Work Education Accreditation Guidelines minimize the teaching of the actual *conduct* of research, in lieu of preparing students to be skilled in locating, research and critically analyzing research. The only research skills specifically required to be taught to actually *do* is to evaluate practice outcomes (Council on Social Work Education, 2008). So, 55 years ago it was claimed that MSW students were constitutionally ill-disposed to be involved in research, and today our CSWE does not require that a range of research skills be taught to our students. And we wonder why there is a gap?

In acknowledging that there is indeed a gap between the assessment and intervention methods commonly used in social work practice, and what research has to say about various these methods, the two meanings of my topic can be viewed as bridging the gap from different directions. Picture a partially completed bridge, extending out over a valley. At one end of the bridge we have hard working practitioners standing on the incomplete span, and on the other end we have researchers. Many in each group are milling about aimlessly, doing nothing, others are nailing boards and being busy, trying to extend their end of the span outwards towards their colleagues on

the other side of the valley, but what they are building is flimsy and cannot support any weight. Some are consulting engineering science, designing a high quality bridge and laying foundations and erecting strong girders, slowly extending outwards and closing the gap. But they are making hesitant progress, and are impeded in their work by others who disagree with their philosophical assumptions, the basic design they are working from, and who try and dismantle what little progress is being made. Not they have any better ideas on how to build a sturdy bridge, merely that they are unhappy with the direction things are going. In fact, these people like the gap as it is, and if anything wish to widen it, not close it.

I assume that most of this audience would like to work to close the gap, to build a bridge, so that two-way traffic between research and practice can flow more smoothly, and be less liable to traffic jams and the occasional pile-up. I have devoted a considerable portion of my career towards integrating research and practice in both senses described above, encouraging practitioners to make greater use of existing research findings, and to encourage practitioners to engage in research in their own practice settings. I have also attempted to encourage academic researchers to engage in more practice-relevant studies, and 23 years ago founded a social work journal to further all these purposes. I will review some ways which seem to have successful in bridging the gap, drawing upon some of my own experiences, as well as those of others.

Encouraging Practitioner Use of Existing Research Findings

Although our field has long exhorted social workers to rely upon the findings of social and behavioral science research (see Table 1), these exhortations alone, like New Year's resolutions, have not proven to be very effective. Over the past 30 years or so

there have been three distinct developments which attempted to encourage practitioners to make greater use of existing research (reviewed in Thyer & Myers, 2011). The first of these models, chronologically, was called empirical clinical practice (ECP), as developed by social workers Siri Jayaratne and Rona Levy (1979), through their book by the same name. Influenced by the successes of behavior therapy, ECP focused on teaching social workers to evaluate their own practice outcomes using single-case research designs, and to preferentially select interventions from those which research had previously shown to be helpful. This book stimulated a great deal of interest and writing in social work journals, (reviewed in Reid, 1994), and lead in 1982 to the CSWE including in its accreditation standards the mandate that students be taught research designs suitable for the evaluation of their own practice. An attenuated version of this standard remains to this day, with the result that several generations of BSW and MSW students have been taught something about the use of single-case research designs, even though the ECP model is now mainly of historical interest.

A second development originated in psychology and is known as the Empirically-Supported Treatments (EST) initiative. A task force within Division 12 (Clinical Psychology) of the American Psychological Association was formed by David Barlow in 1992 and charged with the task to creating some justifiable research standards which could be used to designate a given psychotherapy as empirically validated. With some acrimonious wrangling this was done and the standards appear in Table 2 (insert Table 2 about here). With these standards in place, the Task Force began the task of reviewing the available evidence pertaining to various psychotherapies, and comprising lists of so-called empirically-validated treatments. The term was later changed to empirically-

supported, and the current phrase is research-supported treatments, although the acronym of EST remains widely used. The expectation is that psychotherapists should consult these lists and make use of these ESTs, in lieu of psychotherapies not on the list. This EST initiative remains alive today, and its current information can be found on this Division 12 (Clinical Psychology) website (http://www.div12.org/PsychologicalTreatments/index.html). Although this remains a useful resource to learning about ESTs, the EST project itself has been largely superseded by a separate development known as evidence-based practice (EBP). There are many problems with lists of supposedly empirically-supported treatments - the file drawer problem disposes studies with negative findings to be less likely to be submitted for publication, or to be accepted for publication. Funders may suppress or bury studies which do not support interventions they are invested in. And basing a decision of support on a limited number of positive studies ignores the possibility that an even greater number of negative studies may be published. The use of *p* values as an indicator of 'difference' ignores the magnitude or clinical significance of any observed differences, a problem which the routine reporting of effect sizes can sometimes mitigate.

EBP originated in the early 1990s among a group of physicians who wished to place the routine practice of medical care on a sounder research footing. They developed a five-step process model, depicted in Table 3 (insert Table 3 about here), aimed at helping clinicians make decisions about the care of individual clients (Strauss et al., 2011). EBP has rapidly spread across the health and human services fields where it is having a significant positive impact. The principles of EBP were introduced into the social work literature 14 years ago by Eileen Gambrill (1999) and it continues to be

remarkably influential. This brings use full circle to the theme of bridging the gap. EBP is a highly sophisticated practice model which is aimed at exactly that purpose. I believe it is highly congruent with social work values and principles, and if we wish to promote social work practitioners consulting the available research evidence in helping them to make important practice decisions with their clients, accurately teaching the EBP model is one very useful way to do this.

Please note that EBP is a five-step decision-making *process.* It is historically and conceptually quite different that the EST movement, and in fact there are rightly nothing called evidence-based *practices* in the EBP model, since such a designation would incorrectly elevate research evidence above the other essential features of the EBP model, factors such as client preferences and values, available resources, one's clinical expertise, professional ethics, etc. Nowhere in the real EBP literatures will you find lists of approved treatments, such as you find in the EST model (Thyer & Pignotti, 2011). EBP does not tell practitioners what to do, in terms of the provision of client services. It provides a structure on how we, in conjunction with our clients, can obtain enough information so as to decide what to do. The epitome of evidence in EBP, systematic reviews published by the Cochrane and Campbell Collaborations, summarize the available evidence and draw legitimate conclusions as to the evidentiary base of practice methods. But they *do not* assert that a given intervention should or should not be used. In the real EBP model, it is easily conceivable that a practitioner would provide a less well-supported intervention over one with greater evidence, and still be practicing completely consistently as an evidence-based social worker.

Each of the above initiatives, ECP, EST, and EBP, originated in different disciplines and are quite different from each other. The two former approaches have largely been superseded by the EBP model, which appears to be thriving across the health care, educational, criminal justice and other human service fields. For example, about 10% of the leading-ranked academic social work programs now include the phrase 'evidence-based practice' in their mission statements (Holosko, Winkel, Crandall, & Briggs, 2013). Although EBP continues to be frequently misrepresented and distorted in the social work literature (see Webb, 2002; Thyer, 2013), the model seems to have considerable appeal and application within our field. Given the large literature on EBP in social work, I will not elaborate upon it further except to note that EBP almost *defines* the integration of using contemporary research findings into practice, and its wide-spread application would do much to "Bridge the Gap".

What else can be done to encourage practicing social workers to draw upon research findings to help decide what social work services to provide? We should be more proactive in insisting the clients have a right to effective treatments, where such interventions are known to exist (Myers & Thyer, 1997). This should be construed as both an ethical mandate, but also a legal one. Here is what the NASW Codes of Ethics has to say, related to this issue:

"3.02 Education and Training

(a) Social workers who function as educators, field instructors for students, or trainers should provide instruction only within their areas of knowledge and competence and

should provide instruction based on the most current information and knowledge available in the profession.

4.01 Competence

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. *Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.*

(c*) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.* " (NASW, 1996, emphasis added).

I judge these standards to be relatively weak in terms of promoting clients having access to research-supported interventions. Seeking additional guidance, in 2008 I wrote the NASW ethics office and asked for written answers to the following three questions:

"1. Is a social worker who provides an intervention that lacks any scientifically credible evidence that it helps clients, acting unethically?

2. Is a social worker who provides and intervention that scientifically credible studies have shown to be ineffective, acting unethically?

3. Is a social worker who provides an intervention that scientifically credible studies have shown to be harmful to clients, acting unethically?"

I pointed out in my letter the precedent the NASW established, at least in regard to questions #2, namely their own position statement of 1992 which dealt with the issue of so-called reparative therapies targeting Gays and Lesbians. This remarkably ethically advanced statement asserted:

> "Proponents of reparative therapies claim - without documentation - many successes. They assert that their processes are supported by conclusivve scientific data which are in fact little more than anecdotal. NOCOGLI (NASW's National Committee on Lesbian and Gay Individuals) protests these efforts to 'convert' people through irresponsible therapies...empirical research does not demonstrate that...sexual orientation (heterosexual or homosexual) can be changed through these so-called reparative therapies."

I asked in my letter "If reparative therapy was deemed unethical in part because of the lack of scientific evidence of its effectiveness, what are the implications of such a standard for other therapies similarly lacking a strong evidentiary foundation?" I anxiously awaited a reply. Months passed. Eventually I got a response. I was told that the NASW's Office of Ethics and Professional review did not provide written replies to ethical queries. Instead I was advised to call their office and a staff member could help point out to me sections of the NASW Code of Ethics which bore on my questions.

Frankly, I was shocked. My professional association declined to provide a written answer to the ethical suitability of social workers providing therapies which research had demonstrated to be harmful. This was very disappointing to me, and shortly thereafter I

allowed my NASW membership to lapse after 30 years Contrast these relatively weak NASW ethical standards with those from a related discipline, applied behavior analysis:

"2.10 Treatment Efficacy

a. The behavior analyst always has the *responsibility to recommend scientifically supported most effective treatment procedures*. Effective treatment procedures have been validated as having both long-term and short-term benefits to clients and society.

b. *Clients have a right to effective treatment* (e.g., based on the research literature and adapted to the individual client.)

4.07 On-going Data Collection.

The behavior analyst collects data, or asks the client, client-surrogate, or designated others to collect data needed to assess progress within the (treatment) program.

4.08 Program Modifications

The behavior analyst modifies the program on the basis of data." (Behavior Analysis Certification Board, 2010)

Or consider some stronger guidelines found within the practice of medicine:

"Opinion 8.20 - Invalid Medical Treatment

The following general guidelines are offered to serve physicians when they are called upon to decide among treatments:

(1) Treatments which have no medical indication and offer no possible benefit to the patient *should not be used*.

(2) *Treatments which have been determined scientifically to be invalid should not be used*

(4) Among the various treatments that are scientifically valid, medically indicated, legal, and offer a reasonable chance of benefit for patients, the decision of which treatment to use should be made between the physician and patient." (American Medical Association's Code of Ethics, downloaded from http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page? on 27 March 2013)/

The internationally respected World Medical Association has established its own widely adopted ethical code called the *Declaration of Helsinki*. The final standard of this document reads as follows:

> 35. In the treatment of a patient, where proven interventions do not exist or have been ineffective, the physician, after seeking expert advice, with informed consent from the patient or a legally authorized representative, may use an unproven intervention if in the physician's judgment it offers hope of saving life, re-establishing psychosocial or physical well-being or alleviating suffering. Where possible, this intervention should be made the object of research, designed to evaluate its safety and efficacy. In all cases, new information should be

recorded and, where appropriate, made publicly available." (downloaded from http://www.wma.net/en/30publications/10policies/b3/ on 27 March 2013)

It is clear that proven interventions are the default treatment option, according to this ethical code, and unproven treatments are only to be provided under carefully circumscribed situations and with informed consent, and even then the use of single-system research designs would seem to be called for to systematically evaluate clinical outcomes.

Medical ethics also proscribe the use of placebo therapies.

"The use of placebos in routine clinical practice with the specific intent to deceive the patient is unethical, and represents a violation of Section 2 of The Principles of Medical Ethics which calls for honesty in all professional interactions." (American Psychiatric Association, 2009, p. 64). Thus, even benign therapies known by the practitioner to be non-specific in their effects and not demonstrably useful above and beyond their placebo influences, are prohibited in medicine.

I believe that these stronger ethical guidelines found in related disciplines such as behavior analysis and medicine are admirable and provide much greater assurance that clients will be provided with genuinely effective services, as opposed to placebo-treatments, pseudoscientific ones or magical therapies (Thyer, 2013b). Were social work to adopt similar standards, and enforce them, this would help bridge the gap between service and science.

Relatedly, I would like to see lawsuits filed by clients with a problem for which there are known effective treatments, who were not provided those therapies, in lieu or receiving interventions with minimal or no credible research support. Social workers providing services lacking a credible research foundation, for client problems which enjoy such support (e.g., anxiety disorders, depression, substance abuse, developmental disabilities, etc.) should be sued for malpractice. If one or more lawsuits of this nature would to be successful, this would dramatically reduce the provision of ineffective, harmful, or pseudoscientific treatments, which would be a good thing.

Insurance companies should increasingly demand that social workers provide accurate descriptions of the interventions they provide, and only reimburse for services aimed at particular client problems, which are supported by credible scientific research. Similarly, federal, state and private agencies should mandate the application of the EBP model (which is NOT the same thing as mandating the use of particular treatments) for use with their clients, and ethics complaints can be filed with the NASW or state licensing board against social workers who provide unproven interventions, pseudoscientific treatments, or magical therapies to clients who have a problems which have proven amendable to effective practices. This latter initiative could be construed as negative EBP. Positive EBP consists of promoting appropriate science-based services. What I call negative EBP consists of proactively discouraging ineffective services, in client circumstances where effective services have been developed. Both forms of client advocacy are needed.

What I am suggesting may be seen as strong medicine, but these recommendations are completely consistent with the NASW Code of Ethics, which states

"5.01 Integrity of the Profession

(a) Social workers should work toward the maintenance and promotion of high standards of practice.

(b) Social workers should uphold and advance the values, ethics, knowledge, and mission of the profession. Social workers should protect, enhance, and improve the integrity of the profession through appropriate study and research, active discussion, and responsible criticism of the profession." (NASW, 2008).

Encouraging Practitioners to Engage in Research Themselves

There are several points of leverage which can be used to encourage individual practitioners to conduct research within their own agencies. Focusing our research training on evaluation designs which are client and agency-friendly is a good start. This would include content on single-case designs and nomothetic pre-experimental and quasi-experimental designs. Rather than implying that anything less than the supposed 'gold standard' of a randomized controlled trial is somehow inadequate, we should teach practitioners to use evaluation designs that are suitable to answer pragmatic practice-related questions, such as:

1. Did my client improve after treatment?
2. Did our agency's clients improve after services?
3. What is the long-term status of our clients, after services?

These forms of evaluation questions are extremely important for agencies to answer, yet most agencies, in my experience, have no credible data to answer them. As long as we avoid questions involving causal inference, simple designs are very capable of answering

such simple questions, and we can encourage our students and practitioners to undertake them, perhaps as practicum projects (see Thyer & Myers, 2007; Thyer, 2012).

Behavior needs reinforcement in order for it to be sustained. For practitioners, one positive reinforcer which I have found to be very powerful is the promise and subsequent receipt of authorship of a social work research article in a peer-reviewed publication. This is a low cost way of recruiting practitioners (and students) to collaborate with you and can be a win-win situation for all parties. Researchers gain access to agency-based data, practitioners are mentored in the design and conduct of a study, and ultimately the knowledge base of our field is expanded via publication. I have found it pays to be generous with allocating authorships and in the ordering of authorship. No one wants to work with a stingy colleague.

Encourage practitioners to submit proposals for presentation at the annual meeting of the *Society for Social Work and Research*, and other professional organizations. If accepted, help them obtain funds to attend, or present the work yourself if you are a co-author and they cannot make the trip.

Offer continuing education and in-service training workshops on practice-related research, and on scholarly publishing, to agencies in the local community, and offer to collaborate with attendees in undertaking agency-based research. This collaboration can range from full-blown partnership, or less intensely, providing consultation, design or statistical, or maybe simply critiquing a draft paper a practitioner has written and offering editorial feedback or ideas on what journal to submit to. Offer to revise manuscripts practitioners have given up on, to see if they can be salvaged.

Academics can use the not inconsiderable leverage of their position to encourage doctoral students to undertaken intervention research as their dissertation project. The late distinguished Professor Sheldon Rose supervised over a dozen randomized controlled trials of group therapy, produced by his Ph.D. students at the University of Wisconsin at Madison and he wrote a very useful article on how to mentor students to design and conduct such studies (Rose, 1988). That same year Diane Harrison and I published an article in the same journal encouraging the same thing, that doctoral students be proactively encouraged by major professors to undertake completing their dissertation by conducting research on social work practice (Harrison & Thyer, 1988).

Encouraging Researchers to Engage in More Practice-Relevant Research

I believe there are compelling reasons for social work academics who teach clinical practice, and for researchers who teach about intervention research, including single-system research designs, to themselves possess social work practice credentials such as the LCSW or equivalent qualification in one's given state or jurisdiction. This serves two purposes. An academic with a strong practice background, and experience in being a clinical social worker, is perhaps more likely to be focused on research on social work practice, as opposed to theory-testing, surveys, or correlational studies. Another advantage for the faculty member to be a LCSW is the added credibility they have in the classroom with students. Many of my students are shocked to learn that that many of their faculty are not licensed, and cannot legally practice what they teach. Such a situation would not permitted in other health-care professions based in university contexts, fields such as nursing, law, medicine, accounting, pharmacy, clinical or counseling psychology. Paradoxically, our Council on Social Work Education has

issued a position statement arguing *against* states requiring the licensure of social work faculty. Despite this position paper, according to the 2011 CSWE statistics on social work education, 48% of full-time social work faculty already hold the LCSW and a further 24% have the lesser LMSW qualification (see CSWE, 2012, downloaded from http://www.cswe.org/File.aspx?id=62011 on 27 March 2013). These optimistic statistics, with 72% of faculty already professionally licensed, are based upon program-provided self-report data, and their accuracy is unknown. However it may be that as licensure has assumed greater significance within the larger profession, a larger proportion of faculty are obtaining suitable licensure. This is a good thing.

I also believe it important that faculty who teach intervention research, either using group designs or single-system designs, to themselves have some actual experience in the design, conduct *and* publishing of such studies. Just as we expect that someone who teaching child practice to have had some practice experience with children, youth, and their families, or that a faculty member who teaches a course on group therapy to themselves have experience in leading therapy groups, faculty who teach research lead best by example, and that example is by publishing empirical research themselves. Professor Allen Rubin at the University of Texas at Austin is a sterling example of someone who teaches research and publishes research textbooks, but also regularly contributes empirical studies to our journals.

Some Bridge-Builders

The theme of bridging the gap between practice and research is an old one within our profession. We need not be embarrassed at our slow progress. Our good friends the psychologists, despite their close to 80-year tradition of conducting laboratory-based

experimental research prior to moving into professional practice, find themselves in the equally uncomfortable position of learning that clinical psychologists rely more on personal experiences than on scientific research to guide their practice (Begley, 2009). Social work, emerging from the decidedly non-experimental traditions of the settlement house and friendly visiting, can be proud of its relative progress. In keeping with the principles of social learning theory, I would like to highlight the accomplishments of a few academic social workers who I judge to exemplify bridging the gap in an extremely successful manner.

Gail S. Steketee

Dr. Steketee earned her masters and Ph.D. in social work from Bryn Mawr College. She is now Dean and professor of social work at Boston University, and over the course of her career as a clinical researcher she has written over 150 peer-reviewed journal articles, over 50 book chapters, and has authored or edited over a dozen books. Dr. Steketee has focused her intervention research on the assessment and treatment of persons meeting the criteria for obsessive-compulsive disorder (OCD), post-traumatic stress disorder, and, more recently, compulsive hoarding. One of her client self-help books, *When Once is not Enough,* soundly based upon social learning and cognitive-behavior theory and behavior therapy techniques, was independently evaluated in a randomized controlled trial and it was found to yields substantial clinical benefits to clients with OCD, benefits equivalent to those obtained via therapist-conducted behavior therapy. What a marvelous gift to the field of mental health - to help develop for a seriously disabling condition an effective treatment that clients and family members can conduct themselves! Dr. Steketee has received grants, mostly from the National

Institutes of Health, totaling over $2 million. Naturally she is a licensed clinical social worker. Her publications are uniformly of the highest quality and regularly appear in such superlative high-impact journals as the *Archives of General Psychiatry, Psychopharmacology Bulletin, Clinical Psychology Review, Journal of Consulting and Clinical Psychology,* and the *American Journal of Psychiatry.* Almost all her articles are original primary studies involving the assessment and treatment of clients. Her's is a remarkable oeuvre and a wonderful example of 'Bridging the Gap".

Myrna Weissman

Myrna Weissman is a professor of epidemiology the Department of Psychiatry at Columbia University's School of Public Health. She has the M.S.W., and subsequently earned a Ph.D. in epidemiology and public health at Yale University. She is perhaps best known for her work in developing a form of treatment called Interpersonal Psychotherapy (IP). IP was one of the earliest developed manualized psychotherapies (Klerman & Weissman, 1984), and she recently published an updated version called *A Clinician's Guide to Interpersonal Psychotherapy* (Weissman, Markowitz, & Klerman, 2007). IP has been extensively tested and most certainly ranks as a strongly research-supported psychosocial treatment. She is the recipient of numerous awards and honors for her extensive publications in the areas of psychotherapy outcome studies and the etiology, epidemiology and genetics of mood and anxiety disorders. Like Dr. Steketee, Professor Weissman's works have appeared in leading psychiatric, medical, public health, and psychology journals, including the *Proceedings of the National Academy of Sciences.* She has authored over a dozen randomized clinical trials, many involving under-represented groups such as African women, and Hispanics. In 2006 she published a

comprehensive national survey of psychotherapy training in psychiatry, psychology and social work, finding that credible didactic training opportunities and supervision to learn research-supported treatments was relatively rare in all three disciplines, and rarest of all in MSW programs (Weissman et al., 2006). We have considerable justification to look with pride upon Dr. Mryna Weissman and her contributions to science and to research on practice.

Stephen E. Wong

Unlike Drs. Steketee and Weissman, Dr. Wong has taken a different role as a bridge-builder. He received his MSW from the University of Washington and his Ph.D. in applied behavior analysis at Western Michigan University. Rather than undertaking large scale RCTs to evaluate practice, he has extensively used single-system research designs in his practice and consulting with agencies, to conduct small-scale outcome studies with individual clients. Dr. Wong is with the social work program at Florida International University and he bases his intervention research on the operant theory favored by behavior analysts (see Wong, 2012). He has published extensively in the field of caring for individuals with psychosis, autism, and developmental disabilities. He has authored over 30 articles, most of which involve evaluating the results of psychosocial interventions with clients, using single-system designs. In addition he has written 15 book chapters in social work, psychiatric, and psychological volumes, and in 1984 his groundbreaking work in the ethical use (and curtailment) of restraint and seclusion as behavior management techniques in psychiatric hospitals (Liberman & Wong, 1984) received the Manfred S. Guttmacher award for the most significant contribution to the literature in the field of forensic psychiatry. He is clinically qualified as a Board

Certified Behavior Analyst and has held administrative positions as a program director of research and clinical service units at hospitals in Texas, New Mexico and Florida. Dr. Wong is a bridge-builder of a different sort, but one I esteem most highly as an equally-valuable approach to bridging the gap.

Gerard Hogarty

The late Gerard Hogarty possessed the MSW and he did not have a doctorate in social work or in any other field. Nevertheless he was a full Professor of Psychiatry at the University of Pittsburg School of Medicine where he pioneered in the development of family psychoeducational approaches to caring for persons with schizophrenia. He conducted some of the earliest trials comparing the outcomes of treatment involving medication treatment with and without social casework services. Over the course of his career he published, astonishingly in my opinion, over 50 studies in the *Archives of General Psychiatry*, many of which were RCTs, and many with him as the first author. Over time, his work on the family psychoeducational approach lead to his developing and testing a more sophisticated treatment called Personal Therapy (PT), and to the subsequent publication of a treatment manual (Hogarty, 2002) based upon the positive outcomes obtained for PT relative to medication alone, supportive counseling, or family psychoeducation alone. Professor Hogarty's research on practice has lead to significant improvements in the lives of persons with chronic mental illness and for their families. He too has contributed mightily to bridging the gap between social work practice and research findings. His too was a different path, a non-doctoral path, yet with clinical acumen and sophisticated research skills he accomplished far more towards bridging the gap than most of us could ever help to attain.

Summary

I have provided some suggestions for bridging the gap, to promote practitioners accessing contemporary research findings relevant to their practice decisions, and to their actually undertaking small scale evaluation studies of their own practice and their agency's programs. I have offered some ideas to encourage social work academics to become more involved in research on social work practice, and suggested some policies which could be adopted by individual social workers and by our professional organizations to make research-supported interventions more widely available, within the framework of evidence-based practice. I shared some thoughts on how our profession can (and should) be more proactive in curtailing the promiscuous delivery of unproven therapies, therapies shown not to work, therapies known to be harmful, and magical treatments. A multifaceted approach is obviously called for. Although the picture could not be called rosy, nevertheless that progress is being achieved is undeniable. We now have a greater number of high quality journal outlets which actively seek to promote research on social work practice. We have a thriving professional association, the *Society for Social Work and Research*, which provides a high-quality conference and networking opportunities for social work researchers. The job market for our doctoral graduates seems pretty favorable and our Ph.D. students are learning sophisticated statistical methods unheard of 30 years ago. The Campbell Collaboration regularly publishes high quality systematic reviews (SRs) in the field of social welfare, and the larger Cochrane Collaboration similarly publishes many SRs in the field of health care, many of which are relevant to social work practice.

The field enjoys a growing cadre of established practitioner-researchers, several of which I highlighted towards the end of my paper, individuals who simultaneously juggle the balls of teaching, research, publishing, external funding, and critical thinking, and who produce high-quality publications which compare favorably with those produced by experts in related fields such as psychology and psychiatry. I acknowledge that my language and examples may have focused too much on clinical practice, research, and mental health issues. These areas are my own background, and clinical social workers are the largest provider group for mental health care in the United States. It is understandable that the greatest progress in bridging the gap is occurring in this arena. However we have grounds for optimism for predicting that more macro areas of social work, such as community and policy-practice, will similarly yield to the flow of progress moving social work in the direction in being more of a science-based discipline. Witness, for example, the emergence of the *Coalition for Evidence-based Policy,* the journal *Evidence & Policy,* and journalist David Brooks' (2013) recent column calling the present generation of young people *The Empirical Kids,* who "...have embraced the policy revolution; they require hypotheses to be tested, substantiated, and then results replicated before they commit to any course of action." Sounds like good ideas to me.

I will close with a quote from former First Lady and Secretary of State, Hillary Clinton, and her husband President Bill Clinton: "There are some people...who can't be confused by the facts. They just will not live in an evidence-based world. And that's regrettable." (H. Clinton, 2013). Her husband agrees with her: "I think two and two makes four, not three or five. I'm an evidence-based guy. We are trapped in a reality-based world." (Bill Clinton, 2007). Bridging the gap relies on evidence, to be able to

critically distinguish effective social work services from ineffective one. We have the tools. Primary studies. Meta-analyses. Systematic Reviews. Group and single-system research designs. Evidence-based practice. Lets go to work and finish that bridge.

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Table 1

*Opinions on the Importance of Evaluation Research**

- "To make benevolence scientific is the great problem of the present age." (Toynbee, 1912, p. 74)
- "Social science and its applications must share the spirit , if not the strict technique, of the exact sciences. The elements of scientific approach and scientific precision must be back of all social reform which hopes to weather the storms." (Todd, 1920, p. p. iv)
- I appeal to you. . . . Measure, evaluate, estimate, appraise your results, in some form, in any terms that rest upon something beyond faith, assertion, and “illustrative case.” State your objectives and how far you have reached them. . . . Out of such evaluations will come, I believe, better service to the client. (Cabot, 1931)
- Employment of scientifically approved and tested techniques will ensure the profession the confidence and respect of clients and the public...(Strode, 1940, p. 142)
- "The scientific approach to unsolved problems is the only one which contains any hope of dealing with the unknown." (Bertha Kapen Reynolds, 1942, p. 20)
- The third type of research, evaluative studies of welfare programs and the activities of practitioners, are the most important of all. (Angell, 1954, p. 169)
- [S]ocial work is not a science whose aim is to derive knowledge; it is a technology whose aim is to apply knowledge for the purpose of control. Therefore, on the research continuum social work research falls nearer to the applied end, because its purpose of practical knowledge. (Greenwood, 1957, p. 315)
- Evaluation and client feedback are not only necessary for effective service delivery, but are an ethical requirement of the profession. Systematic methods must be developed to assess whether social workers are helping, harming, or doing nothing for the people they serve. (Rosenberg & Brody, 1974, p. 349)
- Social work has no more important use of research methods than assessment of the consequences of practice and policy choices. . . . [S]mall scale, agency based studies are worthwhile if they succeed in placing interest in effectiveness at the center of agency practice and when they create a critical alliance between practitioners and researchers. (Mullen, 1995, pp. 282–283)

- Studies are needed on the effectiveness of psychosocial intervention, including interventions previously tested under ideal controlled conditions, in real-world health care systems. (Ell, 1996, p. 589)

- Research on actual service interventions is the critical element in connecting research to the knowledge base used by professional practitioners. . . . [T]he issue now is one of developing investigations of social work intervention initiatives, studies that go beyond descriptions and explanatory research. (Austin, 1998, pp. 17, 43)

- We need to establish a research agenda for social work. . . . And intervention studies must be high in priority to such an agenda. (Rosen, Proctor, & Staudt, 1999, p. 9).

- We need to test our nobel intentions with research...The first reason is to be sure we are supporting something that is really helpful [and not harmful]. (Allen Rubin, 1999, p. 281)

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*quotes cited from Thyer (2010).

Table 2

*Criteria for Empirical-Validated Treatments**

1. At least two good between group design experiments demonstrating efficacy in one or more of the following ways:
    - A. Superior (statistically significantly so) to pill or psychological placebo or to another treatment.
    - B. Equivalent to an already established treatment in experiments with adequate sample size.

Further Criteria:

III. Experiments must be conducted with treatment manuals.

IV. Characteristics of the client samples much be clearly specified.

V. Effects must have been demonstrated by at least two different investigators or investigating teams.

*from Chambless et al. (1998). Update on empirically validated therapies, II. *The Clinical Psychologist, 51*(1), 3-16.

Table 3

The Steps of Evidence-based Practice

- Step 1: Convert the need for information (about prevention, etiology, treatment, etc.) into an answerable question.
- Step 2: Track down the best evidence with which to answer that question.
- Step 3: Critically appraising that evidence for its validty (closeness to the truth), impact (size of the effect), and applicability (usefulness in our clinical practice).
- Step 4: Integrating the critical appraisal with our clinical expertise and with our client's unique preferences, values and circumstances.
- Step 5: Evaluating our effectiveness and efficiency in executing steps 1-4 and seeking ways to improve them both for next time.

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*paraphrased slightly from Straus et al. (2011). *Evidence-based medicine: How to practice and teach it.* (p. 3). New York: Churchill Livingstone.