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What is This?
Integrating Research and Practice: Distractions, Controversies, and Options for Moving Forward

Eileen Gambrill

Abstract
Integrating practice and research is vital in all helping professions in order to offer the most ethical, evidence-informed interventions to clients. This article describes some avoidable distractions that hinder integration, discusses controversies related to integration, and describes options for moving forward, including making wasted resources visible, use of an Environmental Deprivation Scale, and courage training.

Keywords
integration, evidence-based practice, implementation, ethics, problem framing

Minimizing gaps between research, policy, and practice in the real world is an ongoing challenge in all helping professions. This applies also to professional education. Literature highlights related challenges (e.g., Gorman & Huber, 2009; Jewell & Bero, 2008; Lewandowsky, Ecker, Seifert, Schwarz, & Cook, 2012; Straus, Tetroe, & Graham, 2009) and provides valuable ideas (e.g., Evans, Thornton, & Chalmers, 2011 – see Testing Treatments interactive; Oxman, Lavis, Lewin, & Fretheim, 2010). Variations in use of interventions for similar concerns continue (Wennberg, 2002, 2011). Gaps between what is done and what should be done based on research findings are mostly unknown. Attention to system-wide characteristics has been shown to be vital and is explored in papers delivered at this conference. Related research suggests that only by system-wide efforts can headway be made. An example is the importance of continued coaching regarding vital skills. Research illustrates that if one ingredient is missing in a system-wide program, the entire effort may be compromised. This article suggests points of agreement as well as avoidable distractions that hinder progress. Controversies are noted including the relative contribution of common factors to positive outcomes compared to specific interventions, and a variety of avoidable gaps which hamper the use of research to help clients are then suggested. Finally, I propose a path ahead focused on revealing ignored gaps and taking advantage of additional opportunities to understand and minimize them. Rigorous reviews such as those of the Cochrane and Campbell Collaborations often reveal our ignorance about the effectiveness of interventions. I suggest that the most important obstacle to integration of research and practice is lack of attention to ethical obligations.

Points of Agreement
There is agreement that gaps exist between what research suggests is effective and what practitioners offer clients and what policies are used. (The nature and size of these gaps remain mostly unknown as discussed later in this article.) Drawing on practice-related research is described in our code of ethics as an ethical obligation (National Association of Social Work [NASW], 2008). Council on Social Work Education’s Educational Policy and Accreditation Guidelines call on social workers “to use research findings to improve practice, policy, and social service delivery” (2.1.6; Educational Policy and Accreditation Standards, 2008, p. 5). There is agreement that political, social, and economic inequities in society create much of the avoidable suffering clients experience (e.g., Adler & Stewart, 2010; Stansfeld, Clark, Rodger, Caldwell, & Power, 2011; Yoshikawa, Aber, & Beardslee, 2012), yet, paradoxically, most interventions focus on individuals and families, ignoring environmental factors related to clients’ problems as discussed later in this article. Although we would also agree that individual differences along a myriad of dimensions affect lives and their potential, including the potential for well-being.

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we disagree about their relevance for selection of evidence-based practices (EBPs; see later discussion).

Other points of agreement include the little time available for informed decision making in today’s world of managed care and limited resources. These lacks are obstacles to integrating research and practice. We would also agree that social workers are confronted with requests for help that differ greatly, including need for concrete services such as money for food and rent and responding to troubled, troubling, and very dependent behavior often labeled as chronic “mental illness.” Often, there is no help they can offer except a hand across the aisle. My students work in vastly different settings ranging from a Veteran’s Administration hospital offering manualized dialectical behavior treatment (DBT) to veterans, to outreach workers who offer help to the homeless in San Francisco, to hospital social workers who have 15 min per week to see each patient. We would also agree that social workers help thousands of clients each day.

Avoidable Distractions Regarding Minimizing Gaps

A number of avoidable distractions drain time, money, and effort from identifying and closing gaps between research and practice. One is continuing misrepresentation of the philosophy and process of EBP as described in original sources (e.g., Sackett, Richardson, Rosenberg, & Haynes, 1997; Straus, Glasziou, Richardson, & Haynes, 2011). Misrepresentations and distortions continue as a seven-headed hydra, ignoring readily available content in original sources (Gambrill, 2011; Thyer, 2013). This encourages avoidable confusions between the process of EBP and the EBPs approach in which certain interventions are mandated to be used and/or claimed to be effective, which is the focus of implementation reports at this conference. Misrepresentations of science (guessing and critically testing) also continue. For example, publications criticizing science and the process of EBP as described in original sources often assert there is a search for certainty. Not so, as reading original sources clearly indicate. Describing what is old as new is another avoidable distraction as in the claim that “data mining” is new when it is decades old (Thyer, 2013). Why would we choose to confuse practitioners and misrepresent contributions of both past and current scholars? We have used scarce money and time to promote avoidable distractions resulting in fewer resources to devote to helping clients. Time spent distorting positions and fielding straw man arguments can be better spent on minimizing gaps that can help us to offer client services that most likely help them and least likely harm them. And avoidable distractions compromise recognition of shared interests such as decreasing avoidable suffering.

Another source of avoidable distraction consists of misleading changes in the model of evidence-based practice. For example, Bellamy et al. (2013, p. 1) describe a “transdisciplinary model of evidence-based behavioral practice.” Unlike the model in Haynes, Deveraux, and Guyatt (2002), showing use of clinical expertise to integrate information from diverse sources when making decisions, practitioner expertise is moved into a subsidiary role in the figure illustrating their model. Clinical expertise comprises a complex set of knowledge and skills with a related extensive literature showing that there are many different kinds of biases and different decision-making styles in integrating data from multiple sources.

Controversies Related to Integration of Practice and Research

A number of controversies hamper success in integration.

What is Evidence?

There are many kinds of “evidence.” The nature of the question should guide the kind of evidence needed. Thus, I am not sure it is very useful to pose the question “What is evidence?” in the absence of a clear question. The question will suggest whether qualitative research and/or quantitative research is (are) needed. Discussions of whether quantitative or qualitative methods are best without knowing the question are distracting rather than helpful. Fielding inflated claims based on quantitative research rightly encourages critiques of such claims on the part of those who are drawn to qualitative research (although the most devastating critiques have been published by those who apply critical standards to all research). Inflated claims regarding what questions qualitative methods can answer create a reasonable backlash in response. As always the question is, “Does the method used match the question raised?” Davies (2004) suggests that a broad view of evidence is needed to review policies including (1) experience and expertise, (2) judgment, (3) resources, (4) values, (5) habits and traditions, (6) lobbyists and pressure groups, and (7) pragmatics and contingencies.

Differences in opinion regarding how to measure outcome influence opinions about the question: “What is evidence?” Consider controversies regarding the use of the Hamilton Depression Scale to assess outcome (e.g., Antonuccio, Burns, & Danton, 2002). Davies (2004) suggests the following six kinds of research related to the evidence of policy impact: (1) implementation, (2) descriptive/analytical, (3) attitudinal, (4) statistical modeling, (5) economic/evaluative, and (6) ethical. Outcomes regarding implementing research should include both subjective and objective indicators; self-report of clients and helpers may not reflect what actually occurs (e.g., Schnelle, 1974).

When to Act on the Evidence

Governmental agencies often mandate agency use of what they view as EBPs, assuming that this will contribute to helping clients. As illustrated by papers given at this conference, this will only help clients if the EBPs are suitable for clients seen and are implemented effectively, which requires attention to all staff levels and ongoing coaching and monitoring (e.g., Bertram, Blase, & Fixen, 2014; Metz, Bartley, Ball, Wilson,
Naoom, & Redmond, 2014). Agency mandate to use a certain intervention labeled “evidence based” may conflict with a practitioner’s reasoned decision regarding what to do. This dilemma reflects the key role of clinical expertise in making decisions. The consideration of individual differences in characteristics and circumstances is a key step in the process of EPB (see Table 1 in Thyer 2014). Each helper, together with her or his client, must evaluate the extent to which research applies to their situation. How much attention to individual differences is required and given in the EPBs approach, and if missing, are opportunities to help clients lost? Administrators should collect information regarding the frequency of and reasons for well-argued deviations from manualized prescriptions as well as information regarding outcomes. Such data can provide important information about the need for tailoring EPBs to consider individual differences in client characteristics and circumstances and resources available. Concerns about whether to act on the evidence highlight the role of individual differences in relation to the effectiveness of an EPB and the related question as to whether and how much discretion practitioners should have in making decisions.

What Kinds of Claims Should Receive Most Attention?

Integration of practice and research is possible for a variety of different kinds of claims that arise in the helping professions including claims about problems (e.g., What is a problem? What is its prevalence? What kind of problem is it?—how should a problem be framed), assessment measures, risks, the effectiveness of intervention, the accuracy of outcome measures, costs and benefits, and harms. We can examine the integration efforts to determine the degree of attention given to different kinds of claims with what consequences. Most attention in social work and psychology has focused on EPBs—claims regarding the effectiveness of interventions (e.g., multisystemic therapy more effective than other interventions?; Litell, 2008). Integration of practice and research is important in relation to all kinds of claims that affect client’s lives.

Lack of attention to integration of practice, policy, and research regarding problem selection and framing (how complaints and problems are viewed in terms of causes and related potential remedies) has resulted in lost opportunities to help clients to enhance the quality of their lives. (See e.g., critiques of a psychiatric framing of problems, e.g., Kirk, Gomory, & Cohen, 2013; Whitaker, 2002.) Social workers provide most of the mental health services to clients today in the United States. They are required to give clients psychiatric diagnoses in many settings for third-party payment. Social work education programs promote this medicalized view of problems in living that focuses on the individual (Lacasse & Gomory, 2003). This focus on the individual obscures the effects of environmental factors including toxic pollutants to which the poor are more exposed and quality and quantity of learning opportunities (Staats, 2012). In a direct clash to values described in the codes of ethics, we find social workers daily translating distress caused by environmental deprivations into psychiatric maladies—converting life’s trials into brain disorders. Even the reflective practitioner may have to chain himself or herself to the mast as did Ulysses to avoid the relentless framing of (mis)behaviors and distress as brain diseases.

Common Factors Versus Specific Interventions

There is controversy regarding the relative contribution of common factors (i.e., warmth, empathy) compared to specific interventions to achieve positive outcomes (e.g., Wampold, & Budge, 2012).

Common Elements Compared to Manuals

Common elements derived from manuals that are related to positive outcomes have received increasing attention as an alternative to the use of a manualized intervention (e.g., Chorpita, Becker, & Daleiden, 2007).

Whether to Emphasize the Process of EPB or EPBs

EPBs have captured the day as reflected in the professional literature. There is a striking failure to describe the process of EPB in many (even most) publications. An exception is the clear distinction made between the process of EPB and the empirically supported treatments (EST) approach by Thyer (2014). What approach would result in the most positive outcome for clients?

How Much Attention to Devote to Ethical Obligations to Clients

Our code of ethics describes obligations of social workers, most of which are not met, such as involving clients as informed participants. Failure to implement the relatively weak guidelines in the NASW code of ethics reflects concerning lapses and underlying controversies. For example, most clients are involved as uninformed participants, regarding the risks and benefits of recommended methods and the risks and benefits of alternative methods.

How and in What Ways to Involve Clients

There are differences of opinion regarding how and to what degree clients should be involved in research, including its planning, in making decisions about their lives, and in evaluation of outcome. Clients are usually involved as uninformed or uninformed participants regarding the evidentiary status of recommended interventions. Epstein (2013) lamented the lack of practitioners at annual conferences of the Society for Social Work Research. What about the lack of clients? To my knowledge clients were not included in any of the presentations.
Different Views Regarding the Learning Potential of Social Workers

Another controversy concerns the capabilities of professionals. In a discussion of "research-minded practitioners," McBeath and Austin (2014, p. 1) suggest one view:

This analysis focuses on those individuals who have "a capacity to critically reflect on practice to develop researchable questions, a capacity to be informed by knowledge and research related to social work values, and a capacity to understand research designs and related methodologies in order to theorize about practice" (Austin, Dal Santo, & Lee, 2012, p. 176) and who engage in research using available data to improve their understanding of their own practice and organizational service delivery strategies.

Shouldn't all professionals have "a capacity to critically reflect on practice" and "a capacity to be informed by knowledge and research related to social work values" and "a capacity to understand research designs and related methodologies in order to theorize about practice"? Can't social workers develop skills in "health literacy" that are being taught to consumers of service? A capacity connotes a fixed amount, like a bucket to be filled up. The bucket theory of learning was discarded decades ago (Perkinson, 1993). An alternative view, one supported by empirical literature, is that all people, including social workers, can learn new skills and acquire new motivations, given facilitating learning opportunities (Staats, 2012).

Whether Social Workers Should Engage in Research

Most social workers do not engage in research in their everyday practice. This may be becoming increasingly so in the face of cutbacks in services. Where is the time to come from when you have high caseloads and spend ever more time entering data into a computer rendering ever less time for face-to-face contact with clients (Munro, 2011)?

Responsibilities of Professional Education Programs

Professional education programs are a key venue to create knowledge, skills, and values that forward integration of practice, policy, and research. To what degree do such programs do so? In A Dream Deferred, Stoet, Karger, and Carrillo (2010) present a bleak picture of social work education, noting that many schools have an open enrollment policy (they accept any student that applies) and that the graduate record examination scores of social work students are near the bottom of all subjects. However, if students are accepted, professional schools have an obligation to produce graduates with the skills required to help clients with the problems they confront. Do they do so? Literature on learning shows the capacity of all living creatures to learn (e.g., Staats, 2012). Do we draw on this in our educational programs? (See prior discussion of different views regarding the learning potential of social workers.) What percentage of social work students graduate knowing the difference between the process of EBP and the EBPs approach (e.g., Norcross, Beutler, & Levant, 2006) and who are skilled in carrying out the process of EBP as documented both in class and in agency placements? What percentage of faculty who teach related content (e.g., practice classes) is skilled in the process of EBP and is well informed about the potentials and concerns with the use of EBPs? What percentage of schools which claim to have an EBP program graduate students who demonstrate use of such skills with high fidelity on the job?

Avoidable Gaps Related to Implementation

A number of avoidable gaps hinder success in decreasing gaps between research and practice. Controversies about what gaps matter most affect progress in integration.

Many Gaps Remain Unknown

The nature of complaints and problems and how they are framed influences the possibilities for integration. The greater the gap between what research suggests concerning the cause of client complaints and the kinds of intervention selected, the less likely are positive outcomes. What percentage of interventions offered to clients in an agency matches case conceptualization of causes? We do not know this. In what percentage of the cases are case conceptualizations accurate? We do not know this. We do not know the percentage of opportunities social workers have to honor different kinds of ethical obligations (e.g., informed consent) and on what percentage they act ethically. The unknown nature of the gaps refer not only to use of a specific intervention (or use of common elements, Chorpita et al., 2007) but also to what some consider the more important components of interpersonal helping-common factors such as warmth, empathy, and the therapist-client alliance (e.g., Norcross, 2011; Wampold & Budge, 2012). For example, we know little about how many social workers offer common factors at high levels and how many offer them at low levels and to what effect (see later discussion). We know little about the gaps related to other kinds of decisions including assessment of risk, and planning for generalization and maintenance of gains. We know little about the extent to which social workers create and take advantage of opportunities to minimize avoidable suffering of individual clients since we do not capture this in any systematic way and use the information to advocate for needed changes.

Gaps in Harvesting Questions of Concern to Clients and Professionals

The process of EBP was first described over 20 years ago. Key in this process is identifying questions related to information needs that arise at the coal face. We still have done little or nothing to capture these questions of key concern to clients and practitioners. What small efforts have taken, illustrate that practitioners do not know what clients' questions are—clients must be asked, as was a foster youth who, when asked, said "Why do they make me put all my belongings in a black plastic
bag when I leave one home to go to another?" We should collate these questions and determine whether those that arise most often have any related research. Speaking of opportunities for "data mining," here are rich opportunities, foregone on a daily basis.

Gaps in Opportunities to Identify Decisions Made and Their Outcomes

A social worker makes scores of decisions each day. Yet we know very little about the population of decisions made, when, why, and with what outcome. Rzepnicki and her colleagues (2012) have applied decision analysis to try to understand decision points and what went wrong using detailed descriptions contained in death reports from the Inspector General of the State of Illinois.

Vagueness in Place of Clarity in Many Venues

Vagueness in description of what social workers actually do to what effect hampers integration in a variety of ways. Descriptions of implementation efforts given at this conference contain too little detailed descriptions of exactly what was done, why, by whom, and with what outcome. This kind of information is needed for many reasons including training.

Little Attention to Avoidable Errors Including Errors in Problem Framing

There is remarkably little attention in the social work literature to errors—avoidable and not (for an exception see Munro, 1996). There is an extensive literature on errors in medicine and many other areas. Do social workers not make errors that affect clients' lives? We emphasize clients’ experiences of oppression and discrimination and encourage social workers to pursue social justice yet often do not educate them about the effects and limitations of a psychiatric framing of human distress and give them the tools to avoid this (such as conducting a functional analysis; Layng, 2009).

Lost Opportunities to Honor Ethical Obligations to Clients

Such lost opportunities include failure to involve clients as informed participants and failure to accurately inform them concerning the nature of their miseries. Little attention is given in social work to harming in the name of helping. Do social workers harm fewer people than other professions? Or, is harm hidden and ignored? How many social workers bamboozle clients into thinking they have a mental disorder when client depression and anxiety are related to environmental stressors such as unemployment, lack of health care, high crime neighborhoods, and living in slum landlord housing? Dubbing such clients as "mentally ill" is deeply dehumanizing. We can and should do better. How many children are needlessly and harmfully labeled as having attention-deficit hyperactive disorder (ADHD) and placed on medication (Olfman & Robbins, 2012)?

Lost Opportunities to Expose and Decrease Avoidable Suffering

Social workers are on the front lines of service. They see most vividly the suffering that results from social policies and economic systems that affect life opportunities. Social work students are clearly concerned about injustice and oppression. Do we help them to be effective witnesses to avoidable suffering through the data they collect in their everyday work that is collated and shared with all interested parties including clients and even the newspapers (see earlier discussion). We should harvest this information, perhaps by creating an index of avoidable suffering. There is a failure to blow the whistle on ineffective, inadequate, and harmful services.

A Path Ahead

I suggest neglected opportunities for "Bridging the Gap" in this last section.

Clearly Describe and Attend to all Vital Gaps

This conference emphasizes gaps between practice and research. We are encouraged to take advantage of the evidentiary status regarding claims about interventions. When we look closely, what we find is often alarming (e.g., Thyer & Pignotti, 2010; Pignotti & Thyer, 2012). Many kinds of gaps influence opportunities for clients to enhance the quality of their lives. The nature, size, and consequences of most gaps remain unknown (see prior discussion). Although there are many exceptions (e.g., Dodge, 2006), translational science designed to forward implementation focuses on effectiveness questions. Gaps between practice and research occur in relation to all kinds of questions and related claims that arise in the helping professions, including how problems are framed (the accuracy of proposed causes), the accuracy of favored assessment frameworks and measures, about harm, and how to measure effectiveness. What percentage of social workers ignore environmental factors related to client distress? Why not have each client complete a brief Environmental Deprivation Measure (Gambrill, 2014) based on related research (e.g. Abramovitz & Albrecht, 2013; Bailey, Spratt, Pickering, Goodlad, & Shucksmith, 2004)? Completing this for every client will balance a focus on individuals created by a psychiatric diagnosis (required for third-party payment) as well as serve as a source of information regarding stressors clients confront. Even the National Institute of Mental Health now calls for abandoning the Diagnostic and Statistical Manual of Mental Disorders (2013; Insel, 2013). What percentage of suffering clients experience do social workers actually "see"? What percentage of practitioners obtain feedback from clients following every session using a brief rating form? Those who do have better outcomes than those who do not (see Owen & Imel, 2010).
To what degree do we take advantage of the extensive literature on learning (e.g., Daniels, 2000; Staats, 2012)? Implementation reports presented at the conference illustrate the use of key components such as coaching (e.g., Metz, 2013). Yet social workers often report they are left on their own without consistent coaching and feedback. To what degree do we take advantage of research regarding the influence of organizational culture and climate on implementation? Here too, reports presented at this conference illustrate attention to systemic factors. Do gaps remain? If so, what kind? What percentage of graduates of social work programs possess and use the skills needed to help clients and take steps to improve the quality of services offered to clients (e.g., to identify, describe, expose, and advocate for services most likely to help clients attain outcomes they value)? Some clinical concerns require high levels of competency as suggested in the quote below:

As with compassion, it is hard to imagine a place where wisdom is more necessary than in psychotherapy with severe, complex, and suicidal people. Therapeutic wisdom requires that therapists have the requisite knowledge and skill to apply treatment interventions that work, the ability to provide these interventions in a manner suited to the individual and his or her goals, and the willingness to admit when the therapist's interventions are not the most effective and efficient available. For a DBT therapist treating high-risk clients with complex, severe disorders, wisdom involves finding the middle path between change and acceptance (Linehan & Lungu, 2012, p. 218).

How many clients are harmed because of avoidable lapses in educating students how to integrate practice and research?

Quality of field placements differ vastly. What range should be permitted? We can draw on research concerning professional education to discover ideas that offer direction for positive changes. Is it time to initiate a new accrediting agency? Richard McFall and his colleagues were so concerned about the poor quality of advanced degree programs in psychology that they created a new accrediting organization which is now officially recognized (Baker, McFall, & Shoham, 2008). The Psychological Clinical Science Accreditation System focuses on the quality and outcomes of scientific training of doctoral-level clinical psychologists. The potential impact of a curriculum on client welfare is illustrated by a comparison of child welfare staff who completed a web-based critical curriculum on medication (CriticalThinkRx) with staff who did not (Cohen, Lacasse, Duan, & Sengelmann, 2013). The proportion of medicated children declined in the former group.

**Strengthen and Draw on Ethical Obligations**

Ethical obligations are described in the NASW Code of Ethics (2008). These ethical obligations should be strengthened as Thyer (2014) suggests and used as a guide for integrating research, practice, and policy. Offering services to clients or requiring them to participate in services that have been shown to be ineffective or harmful is not ethical. Social workers learn little about the history of harming in the name of helping in social work as well as in other professions. Not accurately informing clients about the evidentiary status of services offered or forced on clients is unethical. How many clients referred by social workers to psychiatrists for medication are accurately informed regarding the effects of medication? How many are given information suggested by Cohen and Jacobs (2000)? We should make "No decision about me without me" (www.gov.uk) an everyday reality by involving all clients as informed participants (see Entwistle, Sheldon, Sowden, & Watt, 1998).

**Value 1: Service.** "Social workers' primary goal is to help people in need and to address social problems." Helping people requires identifying needs and offering services most likely to benefit them. Exactly what are these needs? What percentage of people who have a need have we identified? What steps do we take to do so? Social problems include poverty, domestic violence, crime, unemployment, lack of housing, and so on. We have an opportunity to gather and collate data from the interactions between practitioners and clients concerning questions. What kind arise most often? Is there any related research? If so, are we using it? If not, shouldn't we conduct some? As suggested earlier, we have an opportunity to create and use a brief Environmental Deprivation Measure based on research allowing social workers to note environmental circumstances related to psychological distress such as lack of a steady income, lack of access to health care, poor educational opportunities for children, lack of day care, lack of affordable housing, discrimination, and lack of inexpensive, convenient transportation. Most mental health services are provided by social workers who are required to assign psychiatric labels to clients' problems as "brain diseases." So doing may chip away at the most caring heart, choking off social workers' attention to the role of environmental circumstances in creating anxiety, depression and aggression.

**Value 2: Social Justice.** "Social workers challenge social injustice." Social workers are urged to pursue social change on behalf of vulnerable and oppressed individuals and groups. Data gathered from an Environmental Deprivation Measure can be used to highlight inequities and press for needed changes.

**Value 3: Dignity and worth of the person.** Here, social workers are urged to "treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity... Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs." Treating clients with respect includes accurately informing them of the evidentiary status of recommended assessment and intervention methods and means of evaluating outcome. This applies both to voluntary and to involuntary clients. Indeed, one could argue that it applies even more to the latter since they are forced into contact with social workers. Most social work...
services offered are of unknown evidentiary status. Ethical obligations to clients require sharing this information in a supportive manner drawing on a well-reasoned theory to suggest options.

Value 4. Importance of human relationships. Here, we find “social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations and communities.” How many social work students graduate with high-level skills in proving common factors such as empathy? Do they take advantage of the science of behavior (e.g., Staats, 2012)?

Value 5. Integrity. This principle states that “Social workers behave in a trustworthy fashion.” Social workers are urged to practice in a manner consistent with “the profession’s mission, values, ethical principles and ethical standards” (see other values). However, what’s good for the goose does not seem to be good for the gander. For example, in a study by Gambrill and Gibbs (2002) only about 4% of social work students wanted their physicians to rely on “what fits your personal style” when making recommendations about intervention concerning their health care; 62% reported relying on this criteria when making decisions about clients.

Value 6. Competence. “Social workers practice within their areas of competence and develop and enhance their professional expertise.” But what does this mean? How would we tell the difference between a competent social worker and one who is not competent? What steps do we take to do so? What percentage of social workers are competent to offer the services they provide? Will asking about self-efficacy give us accurate answers? The review by Baumeister, Campbell, Krueger, and Vohs (2003) suggests that it will not. Our tendency to have inflated self-assessments also suggests the limitations of this approach (Dunning, Heath, & Suls, 2004). Accuracy of self-assessment of competency compared to observed competence was found to be lowest in physicians who were the least skilled and most confident (Davis et al., 2006). This raises caution about relying on self-reports of what was done to what effect. Do surveys asking social workers how skilled they are implementing EBP provide accurate results?

Harness Practitioner Caring About Clients

In reading the papers for this conference, I was struck with the absence of attention to harnessing the deepest source of motivation to decrease gaps that affect client’s opportunities: caring about clients. For example, in figure 3 in McClellan and Austin (2014) entitled “core practitioner capacities and influences” we find no mention of caring. We find “curiosity, critical thinking and critical reflection” but no mention of the concern of practitioners for the suffering of clients and their significant others and related sources of iniquities.

Clearly Describe What is Done to What Effect: The Importance of Clarity

Many sources of vagueness contribute to gaps between practice, policy, and research although, as Popper (1994) suggests, we should never pursue precision for its own sake. For example, in reports of implementation efforts, we need detailed case examples of exactly what trained staff did in what situations. What was the population of decisions made? What specific sources of assessment information were used most frequently? When was coaching required? How often was it offered compared to how often it was needed? Did staff have discretion to alter manualized methods and if so, under what circumstances? That is, what modifications occurred and how often? What was the population of discretionary behaviors? Were both subjective and objective outcome measures used? What sources were relied on? How valid are they? Did data from different sources correspond (e.g., from service providers and clients, from subjective and objective reports)? Use of single-case designs for each client/family allows us to see unique patterns of outcomes. Is there graphed data for each family regarding each outcome pursued as well as group data. We need examples as detailed as those given in Foster Care: The Alameda Project by Stein, Gambrill, and Wiltsie (1978) in which 40 pages describe three case examples. This kind of detail is also important for training.

Vagueness is also a problem in professional education in terms of lost opportunities to integrate research and practice. I have read many evaluations by supervisors of students’ work in the field. These forms are required and students pass or fail based on the reports. These reports are remarkably vague; they are filled with phrases such as “student is making good progress,” “student is doing well,” and “student is open to new learning opportunities.” And, process rather than outcome is typically focused on. They are characterized by mystery concerning exactly what the student did over many months of work in the agency to what effect. Here are examples of specific behaviors related to integration of practice, research, and policy:

1. Student initiated and maintained a journal club in her agency that completed 10 searches of questions of concern to the agency over the semester; see attachments to review quality.
2. Student brought to supervisors two systematic reviews regarding services used in her agency.
3. Student accurately pointed out lack of match between case conceptualization and intervention used on 20 occasions.

Ideally, we would know for each student offering direct services to clients in each field placement the following: the number of clients seen each week, the profile of desired outcomes for each, and who desired them, questions posed regarding information needs, outcomes selected for focus and criteria used to select them, assessment framework used for each client and what assessment
measures (if any) were used, what intervention methods were used to what effect, how many sessions were held with whom, and exactly what was done, what significant others were included and how, what referrals were made and how and to what effect, what resources were needed and not available, what outcomes resulted, what plans were made for generalization and maintenance of any positive gains and what plans were needed for follow-up and what occurred with this. Outcome data should be represented in graphs when appropriate. Students should submit at least three detailed case examples of clients with whom they have worked including follow-up data if available.

**Require All Social Workers to Develop Critical Thinking Knowledge, Skills, and Dispositions Including Detection of Human Service Propaganda**

Many factors that encourage gaps between practice and research are directly related to ignoring knowledge, skills, and values related to critical thinking (arriving at well-reasoned beliefs and actions) including skill in critically appraising research. Critical thinking dispositions, knowledge, and skills are integral to evidence-informed practice and policy. Related knowledge, skills, and dispositions have been clearly described (e.g., Gambrill, 2012a, 2013; Paul, 1993; Paul & Elder, 2014), yet we do not draw on them systematically to forward integration of practice, policy, and research, for example, by helping social workers avoid fallacies and cognitive biases that hamper integration. Educational Policy 2.1.3 calls on social workers to be “knowledgeable about the principles of logic, scientific inquiry, and reasoned discernment. They use “critical thinking augmented by creativity and curiosity.” (Educational Policy and Accreditation Standards, 2008, p. 4). As many have noted, critical thinking is radical. Questions are always appropriate when the goal is to discover accurate answers and fallacies used as illicit attempts to block critical discussion are always out of order (Walton, 2008). We have been reluctant to draw on our code of ethics to encourage related behaviors such as blaming the whistle on propaganda in the helping professions such as inflated claims of effectiveness. Distortions of disliked views, hiding counter-evidence to preferred views, and hiding evidence for disliked views are common propaganda methods that interfere with integration. Teaching critical thinking knowledge, skills, and values can help social workers and clients to avoid common fallacies and biases that result in avoidable gaps between research and practice. This should include attending to common fallacies such as ad hominem arguments and begging the question, and cognitive biases such as confirmation biases, status quo bias, hindsight bias, and overconfidence (Gambrill, 2012a & b).

Thinking critically encourages attention to how we ourselves, and our clients, are influenced by the media and the biomedical industrial complex by a problem framing that is not evidence informed and that does not match our values—concern for altering environmental sources of personal distress and inequities. To avoid abandoning clients by being lured into the agendas of others (e.g., Kirk et al., 2013), we must use our critical thinking skills to spot propaganda that diminishes clients’ opportunities.

**Give Students Repeated Opportunities to Integrate Research, Policy, and Practice**

Currently, we teach research and practice as well as courses on human behavior and the social environment separately. Should we move to case-based or problem-based learning as used in medicine which offers students repeated guided opportunities to integrate information regarding client characteristic and circumstances and related research (e.g., see Srinivasan, Wilkes, Stevenson, Nguyen, & Slavin, 2007)?

**Encourage Use of Single-Case Designs**

Monitoring outcome is associated with positive outcomes. Such monitoring offers timely feedback to inform decisions about “what to do next.” Web-based programs are available for graphing data and smartphone apps can be used to collect and visualize data.

**Attend to Problem Framing**

Szasz (2007) argues that we live in a therapeutic state in which the government, medicine, and allied industries such as Big Pharma work together to control behavior by defining what is healthy and what is not, what is deviant and what is not (e.g., see also Conrad, Mackie, & Mehrrota, 2010; Kirk, et al., 2013; Stid, 2012). Medicalization rules the day, not only in the media, for example in direct to consumer advertising of prescription medicines, but also in many schools of social work and in professional publications. The rhetorical nature of the term “mental illness” is overlooked (Szasz, 1987) and (mis)behaviors are claimed to be “brain diseases.” Consider the statement emphasized in a sidebar in Generalized anxiety disorder (Marker & Alward, 2012, p. 33): “The treatment of diabetes can be a useful metaphor for understanding the treatment of GAD.” Does the metaphor of diabetes capture causes of anxiety? If not, what is our obligation regarding integration of research and practice? Doesn’t decreasing gaps between what research suggests about the causes of anxiety and what a medicalized view implies require emphasizing alternative more informed views?

Failure to pay attention to how problems are framed (e.g., as psychological, biological, social and/or biopsychosocial) creates avoidable gaps between research and practice. Framing (mis)behavior as a brain disease results in the choice of biomedical interventions. Consider ADHD. The diagnosis of youth as having ADHD has reached such great proportions, with millions of youth being so diagnosed and placed on medication, that this topic has even hit the front pages of the New York Times (2013). Almost “one in five high school age boys in the United States and 11 percent of school-age children over all have received a medical diagnosis of ‘ADHD’” (Schwartz & Cohen, 2013, p. 1; based on data from the Federal Centers for Disease Control and Prevention). About two thirds of those with a current diagnosis received prescriptions for stimulants like Ritalin and Adderall (see also Olifman & Robbins, 2012;
Timimi & Leo, 2009). Is this framing consistent with research concerning related behaviors and the context in which they occur? If social workers want to take advantage of research that helps them to do more good than harm, then much more attention should be paid to problem framing.

Differences in performance (e.g., in school) are framed as a problem to be addressed via medication. Moral and ethical conflicts and dilemmas are defined as mental illnesses (Szasz, 1987, 2007). Acceptance of this medicalized problem framing is clear in what are promoted as “evidence-based treatments for mental health.” The very terms “health” and “treatment” show how far the fox has his nose in the tent. We have allowed the biomedical industrial complex to define our humanity. Social work has chosen to follow the lead of psychiatry in focusing on individual characteristics such as “mental disorders,” typically ignoring environmental problems. We too, like clients, are affected by our environments. The relative dearth of evidence-informed interventions addressing sources of environmental distress, compared to such interventions that focus on the individual, show the enormous influence of the biomedical industrial complex on problem framing.

Reveal Avoidable Suffering to Enhance a Sense of Urgency

The most important data collection that should occur to encourage integration is to identify, describe, expose, and advocate for changes in environmental circumstances related to avoidable miseries including changing dysfunctional and harmful patterns of service. Most social work academics and social workers are removed from witnessing much (most?) avoidable suffering, some of which is intense. The avoidable suffering regarding living beings is so intense as to barely be capable of watching. (See for example Hogwash: Big Ag’s ban on caging pregnant pigs is just for show, Mother Jones, 2013.) The related video was made by an undercover investigator sent to a Smithfield owned hog farm by the Humane Society of America. Where are the videos of children, youth, and adults in residential facilities and day care settings? We know experiences of avoidable suffering are a daily reality. I suggest that the single most important step that we can take to decrease gaps between research and practice is to identify, describe, and expose related avoidable suffering and advocate for its decrease. Research efforts are opportunities to decrease this suffering. Perhaps this framing would reduce the huge cross rate of research characterized by a poor match between questions and methods used to answer them. Perhaps the most important kind of “data mining” consists of bearing witness to and informing others about avoidable suffering of clients and avoidable failures to act on the part of involved parties including administrators. Singer (1978) suggests that ignoring client suffering and harmful practices reflects callousness.

We need more research documenting kinds and intensities of avoidable suffering; a focus on well-being may obscure our understanding of avoidable suffering and decrease opportunities to remove it. Many forms of avoidable suffering are hidden. Making these more vivid by witnessing and measuring them may be a major source of motivation for professionals and students to integrate research findings into their practice. What data are more important to mine than to document and expose avoidable suffering and to take concerted steps to decrease this? There is a lot of bad news out there. Perhaps this is why we fear to look. But, we must look. We must be outraged. We must work together with clients to take whatever steps we can to reduce avoidable miseries. That is our call. That is our work.

Understanding a problem is a first step in trying to address it. Popper (1994) suggests that all life is problem solving. Vagueness in describing the consequences of not integrating research and practice will hinder efforts. We need detailed descriptive data that we do not have as suggested in the sections earlier, including the nature and frequency of questions that arise at different service points in different venues. We need a brief form completed for each client that captures sources of environmental deprivation such as lack of day care, lack of convenient affordable transportation and health care, lack of good schools, honest police, employment and housing opportunities, and lack of recreational opportunities (see prior discussion).

Develop Competencies in Common Factors

There is a spirited debate regarding the relative contribution of common factors to outcome compared to the specific interventions used. Common factors refer to “variables found in most therapies regardless of the therapist’s theoretical orientation such as empathy, warmth, acceptance, encouragement of risk taking, client and therapist characteristics, confidentiality of the client–therapist relationship, the therapeutic alliance or process factors” (Lambert & Barley, 2002, pp. 17–18). Lambert and Barley (2002) describe percentage improvement as a function of different therapeutic factors: expectancy 15%, common factors 30%, techniques 15%, and extra therapeutic change 40%. Unexplained variance accounts for 40% of total outcome. Extra therapeutic factors include spontaneous remission, fortuitous events, and social support. They include factors outside counseling that contribute to improvement. Improvement (or its lack) is also related to client characteristics, such as motivation to change and environmental circumstances. Clients differ in access to social support including friends, family members, and self-help groups. Based on his review of related literature, Wampold (2006a, p. 204) sums up his views as follows: “... in clinical trials, the variability of outcomes due to therapists (8%-9%) is larger than the variability among treatments (0%-1%), the alliance (5%), and the superiority of an EST [empirically established treatment] to a placebo treatment (0%-4%) making it the most robust predictor of outcome of any factor studied, with the exception of the initial level of severity” (see also Wampold, 2006b; Wampold, Imel, & Miller, 2009).
Involv e Clients in All Venues Including Advocacy Efforts and Research

Now we spend lots of money on gathering together heads of agencies. We wine and dine them at conferences. We send them material. We ask them what they need. Let's spend more resources on asking clients what they need. Let's escape the unempathic framing that people are responsible for problems such as environmental stressors and should "pop a pill" and instead help them to form coalitions to address avoidable inequities. We should take advantage of valuable Internet sites and social media such as Twitter to inform clients about the evidentiary status of services and tools such as decision aids (Brownlee, Hurley, & Moulton, 2011). Every school of social work should work together with community members and funding sources to initiate store front facilities in neighborhoods that serve as hubs to offer services and to gather information about the needs of individuals, families, neighborhoods, communities, and organizations.

Make Avoidable Waste Visible: Create and Use a Waste Index

Avoidable gaps between information available and what is used to help clients to enhance the quality of their lives is a waste. Actions that contribute to such waste include distortions of positions that hinder accurate understanding and inaccurate claims regarding the evidentiary status of problem framing, accuracy of assessment frameworks/measures, effectiveness of intervention methods, and validity of outcome measures. There is a concerning overlap between the goals and strategies used in advertising and what we see in the professional peer-reviewed literature (Gambrill, 2012b). Do clients benefit from this marketing? Avoidable waste also occurs via censorship—promoting questionable claims by hiding well-argued alternative views. For example in an exploratory study Gambrill and Reiman (2011) illustrated the propagandistic framing of "social anxiety disorder" in peer-reviewed published reports of controlled trials and the inability of peer reviewers to detect such propaganda. Ioannidis (2005) suggests that most published research findings are false. Many studies cannot be replicated (Lewandowsky et al., 2012). There will always be unavoidable waste. Avoidable waste is not inevitable. If we counted up the money consumed by research studies that could not address questions pursued, this surely would be in the billions. Concerns regarding peer review resulted in initiation of a conference held every 4 years on peer review and biomedical research. The seventh conference was held in Chicago, September, 2013. A Meta-Research Innovation Center (METRICS) has recently been established at Stanford University to decrease waste in research and increase quality of research.

Offer Courage Training

Advocating for clients requires speaking up rather than remaining silent in the face of discrimination and oppression. It requires taking action to stop unfair agency practices that harm rather than help clients. Making decisions that contribute to client well-being will require questioning claims made by supervisors, professors, and by authors of articles in professional journals and books. Raising questions that affect clients' lives is vital in a learning organization that values client safety and maximizes quality of services. There is an increasing emphasis on practice policy and policy practice, encouraging advocacy for clients. Focusing on helping clients will help us to have the courage to raise questions.

Conclusion

The bottom line in minimizing gaps between available research findings and what is drawn on, is the extent to which quality of life for clients is enhanced. This places client outcomes front and center. How much avoidable suffering continues because of gaps? What kind of gaps are there? Which ones are most important in terms of affecting quality of life for clients? How many clients’ lives are brighter as a result of closing gaps? A focus on client outcome—what changes or not and how, for clients and significant others—will direct us toward choices that minimize avoidable suffering. Closely related to a focus on client outcome is attention to ethical obligations, for example, for informed consent.

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