Translating Systematic Reviews Into Policy and Practice: An International Perspective

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ABSTRACT: When it comes to investing time and money in services, governments, social service agencies, public service providers, and consumers all want to know what works. What harms? Based on what evidence? The motto of the Campbell Collaboration articulates the primary questions that drive the evidence-based movement in the social-behavioral sciences. Governments, social service agencies, public service providers, and consumers are all asking the same question: How do we know that what we pay for has a demonstrable and proven basis?

The goal of evidence-based practice (EBP) in speech-language pathology is to translate research to practice. That is, EBP seeks to provide a quantifiable and clinically defensible standard of practice. The fact is that EBP involves more than the treatment efficacy of an intervention strategy or program. EBP is but one component of a larger picture that includes policy, program administration, clinical service provisions, and consumer assessment. Before looking at the impact of systematic reviews on the various stakeholders, it may be useful to understand where and why EBP emerged.

WHERE AND WHY DID A CALL FOR EVIDENCE-BASED POLICY AND PRACTICE EMERGE?

If research is to have an impact on policy and practice, it is important to understand why the call for more evidence has come. This will help clarify the context of how research can play a role in real-life decision making. An understanding of the development of the EBP movement will lead you to recognize its global impact and influence.

EBP did not have its beginning in the United States; rather, it was a movement begun in the United Kingdom that is just now beginning to be recognized among policymakers, professionals, and consumers here in the United States. In 1975, Archie Cochrane, a British physician, challenged the U.K. medical community to justify its basis for particular practices in medicine. From Cochrane’s
work, the idea of using the best scientific evidence as a basis for clinical decisions emerged and ultimately resulted in establishment of the Cochrane Collaboration (www.cochrane.org). Although discussions of EBP in medicine have been ongoing for more than a quarter of a century, the call for a broader application of evidence-based decision making to public policy in general came in the late 1990s and was propelled by at least three separate factors (Solesbury, 2001).

First, with the fall of the Iron Curtain, the crisis in the left-wing political parties in Europe, and a move toward sustainable fiscal policy, a new international political movement emerged among center-left politicians under banners like “Ideology is out” and “What works is what matters.” The new thinking was reflected in a white paper called “Modernising Government” (Cabinet Office, 1999) that was issued by the Blair government in Britain:

This Government expects more of policy makers. More new ideas, more willingness to question inherited ways of doing things, better use of evidence [italics added] and research in policy making and better focus on policies that will deliver long term goals [italics added]. (chapter 2, section 6)

A second contributing factor was a more subtle but still important shift in the general attitude toward the public sector (e.g., health care industry). The public began behaving more like consumers of government services and began taking a more critical stance of the quality of service paid for by tax monies. All of this served to shine a spotlight on the decision-making process of government, administrators, and practitioners. With the resulting focus on “citizens’ rights” and “informed consent,” professionals were obliged to a larger degree to deliver credible answers to questions like “Why do you recommend this intervention to me?” and “What is your evidence for the effectiveness of this intervention?”

The third factor was derived from the first two, but it exerted pressure more on researchers than on other stakeholders. Research foundations and other research funding organizations slowly increased their demand for researchers to study the effects of interventions by (a) identifying and summarizing existing research, (b) providing a quantitative analysis of the magnitude of intervention effects, (c) identifying areas of research need in order to advance the intervention knowledge base, and (d) translating the findings into nonscientific terms that policymakers and clinicians alike could use to improve the delivery of needed services. The Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI) in the United Kingdom and the What Works Clearinghouse (www.whatworks.ed.gov) in the U.S. Department of Education’s Institute for Educational Science are two examples of organizations that established programs to address evidence and its dissemination across the educational spectrum.

There was at least one common consequence of all of these factors—an increased demand for documentation of the effects of public policies (i.e., documentation going beyond local knowledge; documentation that uses the soundest of research designs; documentation that is credible; and documentation using the best possible methods to identity effects). The realization of the demand for documentation of “What works?” “What harms?” “Based on what evidence?” lay the foundation for formation of the International Campbell Collaboration in 1999 (www.campbellcollaboration.org). The Nordic Campbell Center (NC2; www.nc2.net) was established a few years later in Copenhagen, Denmark. NC2 was the first regional center in the international Campbell Collaboration. The vision of the NC2 has followed that of the Campbell Collaboration—to improve the quality of social and welfare policy through the support and production of high-quality systematic reviews on the effects of public policies.

**EVIDENCED-BASED REVIEWS AND THE REALITY OF DECISION MAKING FOR POLICYMAKERS**

Systematic reviews of what works enter the decision-making process influenced by many different perspectives. Often we base decisions on a variety of definitions of what constitutes evidence. For the scientist, evidence may be a quantifiable, observable, and replicable piece of data; for the clinician, evidence might be a career of experience in intervention service delivery; and for the consumer (e.g., client), evidence is the quality of one’s life (e.g., talking with family members). These are all legitimate forms of evidence that can and should influence decisions by policymakers as well as frontline practitioners. Thus, effective intervention should include evidence drawn from sources that reflect the real world of human communication by accounting for not only the scientific evidence, but also the psychological, physical, social, and political influences. Figure 1 illustrates forms of knowledge that may be considered in the decision-making process. It is the role of the reviewer to present the evidence and the role of the policymaker and practitioner to balance the evidence with other factors.

**EVIDENCED-BASED REVIEWS AND THE REALITY OF DECISION MAKING FOR CLINICIANS**

The current lack of explicit and systematic evidence for intervention in many areas of communication disorders may operate as a barrier to effective decision making for best practice. These barriers exist for U.S. clinicians as well as our U.K./European colleagues working in a health care system. Clinicians need a credible, scientific basis for decisions regarding effective interventions regardless of the service delivery setting. In addition, a more evidence-based approach to clinical decision making has at least one more very important effect: It pushes the decision making about effective interventions for clinical practice out into the open. This should not be understood to mean that we think there are no effective interventions available. We do mean that the social service professions, such as speech-language pathology, have been slow to engage in a systematic evaluation of the research evidence of intervention effects.
As a result, there is a risk of perpetuating intervention practices that are based on the perspectives of training professionals, past practices, or the fact that better alternatives to intervention were not available. There is a need for the professions to upgrade their approach to practice decisions. Figure 2 illustrates an alternative logic model for thinking about and applying evidence to practice. Although it will not yield high-quality knowledge on the effectiveness of services, this type of simple model could inspire continuous learning and improve the quality of services.

A professional who strives to work in an evidence-based fashion places great weight on ongoing learning and competence development. A decisive factor that distinguishes the mediocre professional from the competent professional is how he or she systematically analyzes and learns from evidence as it emerges from research and clinical experience.

**EVIDENCED-BASED REVIEWS AND THE REALITY OF DECISION MAKING FOR CONSUMERS**

The first and most direct consumer is the client. An EBP approach would provide an explicit justification for implementing one particular type of intervention over another. The families of clients are also consumers in that they have expectations for the outcomes of the intervention that reflect a change in the quality of the communication skills exhibited. Others such as friends, employers, teachers, and third-party payers are also consumers in their judgment of the effectiveness of the intervention services. An evidence-based approach, if it is to be effective, needs to take into account the spectrum of consumers who are impacted by the intervention or service.

Consumer judgments may also reflect a view of the cost benefit of the intervention. The time and financial investment is no small matter to most anyone connected to an intervention program. The effectiveness of an intervention—crucial to an evaluation of the cost benefit—should be based on the best available evidence if it is to reflect best practice.

Whatever the professional circumstances of a clinician, whether practicing in a school, hospital, rehabilitation center, or private practice, it is important to realize that in the United States and abroad, there is an ethical obligation to use the best available evidence in making decisions regarding the welfare of others. Decisions should be based on a variety of factors including professional judgment and client/family needs experience. However, there is an urgent need to systematically include other forms of knowledge like research findings and summaries. All in all, there is a positive bottom line for the clinician and the use of

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*Figure 1. Forms of knowledge influencing decision making.*

evidence to guide best practices. When effective interventions are identified and implemented, clinicians, clients, and consumers benefit.

REFERENCES


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Figure 2. A logic model for evidence-based decision making—a quality circle.