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Review of the evidence on knowledge translation and exchange in the violence against women field: *State of knowledge paper*

Parenting Research Centre

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Acknowledgement of Country

ANROWS acknowledges the traditional owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander elders past, present and future; and we value Aboriginal and Torres Strait Islander history, culture and knowledge.

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Review of the evidence on knowledge translation and exchange in the violence against women field: State of knowledge paper

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This work is part of the ANROWS Landscapes series. ANROWS Landscapes (State of knowledge papers) are medium length papers that scope current knowledge on an issue related to violence against women and their children. Papers will draw on empirical research, including research produced under ANROWS's research program, and/or practice knowledge.

This report addresses work covered in ANROWS research project 5.1 "State of knowledge on knowledge translation and exchange within the violence against women field". Please consult the ANROWS website for more information on this project. In addition to this paper, an ANROWS Compass is available as part of this project.

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Executive summary

Scope and purpose of this report

The Parenting Research Centre (PRC) was commissioned by Australia's National Research Organisation for Women's Safety Limited (ANROWS) to undertake a review of the evidence on knowledge translation and exchange (KTE) strategies in the field of violence against women. For the purpose of this research, the scope of 'violence against women' refers to domestic violence, including intimate partner and Indigenous family violence, and sexual assault.

The aims of the research were to:

- build knowledge about the evidence for KTE in the area of violence against women;
- compare KTE differences in the sexual assault and domestic violence sectors; and
- examine differences in KTE approaches by various practitioners within those sectors.

Knowledge translation and exchange

A consistent finding in research on education, health and welfare services is the failure to adopt and effectively implement research into practice and policy (Grimshaw, Eccles, Lavis, Hill and Squires, 2012; Mildon, Dickinson and Shlonsky, 2014; Morris, Wooding and Grant, 2011). KTE is a developing field of research that attempts to build the science of how to more effectively promote and support the use of evidence, thereby bridging the research to policy and practice gap.

Knowledge translation and exchange – the broader context

A range of theoretical models of KTE have been developed, a number of which have the potential to guide KTE initiatives. These models include: science push (Neville and Warren, 1986), demand-pull (Landry et al., 2001), dissemination (Landry et al., 2001), and interaction (Landry et al., 2008). There are a number of different KTE strategies that have been applied to try to improve the use of evidence in practice (Mildon and Shlonsky, 2011). This current review applies the categories of KTE strategies proposed by Strauss, Tetroe and Graham (2013) and further summarised by the Canadian Institutes of Health Research (CIHC, 2014), namely: educational interventions; linkage and exchange interventions; feedback interventions; electronic interventions; patient-mediated interventions; and, organisational interventions.

As well as categorising strategies by 'intervention type', they can also be organised according to the implicit or explicit mechanism which drives research uptake in different interventions (Walter, Nutley, and Davies, 2003). An example of a mechanism is social influence, where changing norms and values is a route to changing behavior. Focusing on underlying mechanisms can help to clarify beliefs that any one KTE strategy will be successful in a particular circumstance.

While the evidence regarding KTE is still developing, it has been argued that strategies should be chosen to address identified barriers to implementation (Graham et al. 2006). What is known from available evidence is that emphasis needs to be placed on interactive strategies, rather than on passive dissemination of knowledge alone (Grimshaw et al., 2001; Lavis et al., 2003). The

use of multiple strategies, rather than just one, appears to be more effective (Gira, Kessler, and Poertner, 2004; Grimshaw et al., 2001).

Grimshaw *et al.,* (2012) summarised findings from several systematic reviews and identified six potentially used KTE interventions from the broader health care system field:

- informal opinion leaders;
- educational meetings, outreach and printed materials;
- audit and feedback;
- reminders;
- tailored interventions; and
- multifaceted interventions.

Methodology

Grimshaw *et al.*, (2012) suggest that the basis of KTE should be a review or synthesis of the evidence. As such, the PRC undertook a scoping review of published studies that were relevant to the research aims. Data from relevant studies were extracted and plotted based on a data-charting form. Results from the extraction were collected, summarised and reported.

Findings of the review

There were twenty four studies that met inclusion criteria and were thus reviewed as part of this research. Twenty related to domestic violence or intimate partner violence, and four related to sexual assault. The majority of studies aimed to improve conceptual knowledge (changes in knowledge or attitudes). The most common target population among included studies was health care professionals, with few targeting other relevant groups, such as law enforcement and child protection, and only one aimed at policymakers.

Studies employed a variety of KTE strategies, with nine using multiple strategies.

- Most commonly used strategies were educational (n=18), predominantly staff training (n=17). The provision of resources and articles was also used (n=6).
- Seven studies used patient-mediated interventions (all but one through the provision of resources).
- Seven studies employed organisational interventions such as practice guidelines.
- Linkage and exchange interventions were employed in four studies.

Most studies (n=13) employed a multiple method design, and most adopted the use of a survey or questionnaire (n=17). There were few controlled study designs and few used any form of comparison group. Most were pre-post, some with longer term follow-up, and most involved small sample sizes.

A commonly reported result was improved perceived or self-reported knowledge or awareness of violence against women issues or policy/protocols (n=14). Improved reported behaviours (n=12) included the quality or rate of documentation and increased screening rates. Three studies reported a minimal change in attitudes or beliefs, and two found minimal behavioural improvement (routine inquiry and communication skills).

A number of factors affecting implementation were apparent. In five studies, staff reported feeling either discomfort in discussing violence against women or a fear of offending patients (n=5). Other barriers included a lack of time (n=4) and lack of privacy (n=3). A combination of targeted implementation strategies was considered a facilitator (n=4), as was some form of ongoing support such as prompting or refresher training (n=6).

Summary

With only a small number of studies available, the rigour of which was generally low, few firm conclusions can be made about the use of KTE strategies in the field of violence against women. Systematic reviews of the human service delivery sector more broadly suggest that the following KTE strategies may have some effect: informal opinion leaders; reminders; tailored interventions; educational interventions; audit and feedback; and multifaceted interventions. However only the latter three were identified as used within the reviewed violence against women studies. It appears that KTE strategies should ideally be tailored to address specific barriers facing specific audiences, and be multifaceted. Further high quality research is required on strategies for translating the evidence about what works in practice targeting violence against women.

Introduction

Context and scope of this research

Research aims

The aims of the research were to:

- build knowledge about the evidence for KTE in the area of violence against women;
- compare KTE differences in the sexual assault and domestic violence sectors; and
- examine differences between various practitioners within those sectors.

While scoping reviews are commonly used as a precursor to systematic reviews, or to determine the need for a systematic review, this scoping review was undertaken as a standalone study on a topic which is in its relatively early stages of development.

Research questions

To address the aims of the research, four research questions were developed:

- What KTE strategies have been used in the area of violence against women?
- How does KTE compare across different sectors and between professionals within the field of violence against women?
- What knowledge gaps exist in the KTE area in the field of violence against women?
- How does KTE in this field compare to KTE in the broader context?

Definition of violence against women for this research

For the purpose of this research, violence against women is used to describe:

Sexual assault – an assault of a sexual nature perpetrated by any person upon an adult woman.

Domestic violence – violence of any form perpetrated toward an adult woman in the context of an intimate partner or ex-partner relationship. In the case of Indigenous communities, this concept is broadened to include family violence within the home/domicile situation. While the concept of domestic violence can be considered broader than this and may include other perpetrators, and victims and witnesses, ANROWS specified a particular intereste in intimate partner violence and Indigenous family violence and so this research also focuses on these aspects. In this report, the term domestic violence is used as a general term to encompass domestic violence, intimate partner violence and Indigenous family violence, except where there is need to provide details specific to each separate form of violence.

Definition of knowledge translation and exchange for this research

A range of terms has been used to describe the concept of translating and exchanging evidence between researchers and knowledge users (Grimshaw et al., 2012). Tetroe *et al.'s* (2008) study of 33 health funding agencies found 29 different terms for knowledge translation were used.

A widely adopted and adapted definition comes from the Canadian Institutes of Health Research (CIHR). In line with previous key reviews in this area (e.g. Larrivee, Hamelin-Brabant and Lessard, 2012), we are adopting the CIHR's definition of knowledge translation as our KTE definition for this review:

> *"Knowledge translation (KT) is defined as a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system.*
>
> *This process takes place within a complex system of interactions between researchers and knowledge users which may vary in intensity, complexity and level of engagement depending on the nature of the research and the findings as well as the needs of the particular knowledge user." (Canadian Institutes of Health Research, 2014 www.cihr-irsc.gc.ca/e/39033.html)*

CIHR defines a knowledge user as:

> *"An individual who is likely to be able to use the knowledge generated through research to make informed*

decisions about health policies, programs and/or practices. A knowledge-user's level of engagement in the research process may vary in intensity and complexity depending on the nature of the research and his/her information needs. A knowledge-user can be, but is not limited to, a practitioner, policy-maker, educator, decision-maker, health care administrator, community leader, or an individual in a health charity, patient group, private sector organization, or media outlet." (Canadian Institutes of Health Research, 2014 www.cihr-irsc.gc.ca/e/39033.html)

Background

The field of violence against women

It is well established in the literature that violence against women can have a devastating impact on women's health and wellbeing (Bonomi et al., 2006; Ellsberg, Jansen, Heise, Watts and Garcia-Moreno, 2008). In particular, intimate partner violence is associated with a range of negative outcomes for women, including poorer self-reported health (Ellsberg et al., 2008), higher rates of severe and minor depressive symptoms and reduced mental and social functioning (Bonomi et al., 2006). Further, research shows women who have experienced at least one incident of intimate partner violence report significantly more emotional distress, suicidal thoughts and suicidal attempts than women who have never been abused (Ellsberg et al., 2008).

According to the 2012 Personal Safety Survey from the Australian Bureau of Statistics, rates of violence against women are extremely high in Australia. Since the age of 15, one in five women have experienced sexual violence, and one in four have experienced emotional abuse (ANROWS, 2014). This has a profound impact on the Australian economy, including costs associated with pain and suffering, health care, premature mortality, absences from work and damaged property, as well as the costs associated with children witnessing and living with violence (National Council to Reduce Violence against Women and their Children, 2009). In 2008-09 the economic impact of violence against women to the Australian economy was estimated to be $13.6 billion (National Council to Reduce Violence against Women and their Children, 2009). Further, it is estimated that if no effort is made to reduce current violence rates against women the cost per annum to the economy will increase and could be in the order of $15.6 billion in 2021-22 (National Council to Reduce Violence against Women and their Children, 2009).

The gap between research and policy and practice

Research is highly valued for its potential to improve policy and practice decisions in the domestic violence and sexual assault sectors. However, achieving the goal of evidence-informed practice and policy in this field has proven difficult.

It is recognised that there tends to be a significant time delay in implementing research findings into practice (Mildon and Shlonsky, 2011). Incorporating good quality research evidence into practice is not only slow, it can also be haphazard or incidental (Lewig, Arney and Scott, 2006).

This has prompted new fields of inquiry that have sought to identify the barriers that prevent the use of research in policy and practice (e.g. Holzer, Lewig, Bromfield and Arney, 2008). In addition, a diversity of approaches has emerged to enhance the use of evidence in practice. The field of KTE has become prominent in guiding strategies designed to increase the use of research in policy and practice.

Knowledge translation and exchange

KTE is a developing field of research that attempts to build the science of how to more effectively promote and support the use of evidence, thereby bridging the research to policy and practice gap. KTE focuses on what needs to be transferred, to whom, by whom, how, and with what effect (Lavis, Robertson, Woodside, McLeod and Abelson, 2003).

There are many possible knowledge users in the domestic violence and sexual assault fields, ranging from policy-makers to those who come into contact with victims and perpetrators. Examples include practitioners in the domestic violence and sexual assault sectors, the health care, child and family services sectors, and those working in law enforcement and education.

The following section explores some of the proposed KTE models, strategies and organising frameworks. This review focuses only on planned KTE strategies. Unplanned knowledge sharing takes place in all fields, and the strength of existing organisational and interagency culture, networks and interaction can affect the efficacy of planned KTE approaches (Humphries, Stafinski, Mumtaz and Menon, 2014).

Models of knowledge translation and exchange

There is evidence that the one-way communication of knowledge is not sufficient if that knowledge is to be accepted and applied; rather, there needs to be collaboration and communication between all stakeholders, including researchers and decision makers

(Lavis, Robertson, Woodside, McLeod and Abelson, 2003; Lomas, 2000). The degree to which researchers and research users interact will vary from no interaction to an active and equal partnership to 'co-produce' knowledge and apply that knowledge to the policy or practice environment.

There are four theoretical KTE models that are widely cited in social sciences literature (Estabrooks, Thompson, Lovely, and Hofmeyer, 2006; Landry, Amara and Lamari, 2001).

Under the *science push* model, knowledge moves in one direction, from research to practice, with the emphasis placed on the knowledge 'product' rather than the knowledge users' context (Neville and Warren, 1986). The uptake of knowledge is influenced by the characteristics of the knowledge itself. These characteristics may relate to the type of research (for example quantitative or qualitative), or could be content-related characteristics (for example, reliability or complexity).

According to the *demand-pull* model, knowledge uptake will increase if the research questions are developed by the knowledge users themselves, rather than by researchers, in order to meet the users' needs. Findings are unlikely to be used if they do not meet user expectations or desires (Landry et al., 2001).

The *dissemination* model proposes that knowledge will not be automatically used simply because it is available. Researchers should develop dissemination strategies during the early stages of research, adapting those strategies to suit their target audience's needs and context. In this model, as with the science push model, knowledge users are not involved in the knowledge production or dissemination processes (Landry et al., 2001).

The *interaction* model postulates that knowledge uptake is promoted through cooperation between researchers and users. Thus researchers' empirical knowledge and users' tacit knowledge are both incorporated into all stages of the process: from the production of the knowledge through to its dissemination and utilisation. The extent of knowledge uptake is contingent on the regularity and intensity of the interaction between research and end users (Landry et al., 2001). This model incorporates "all the dimensions of the preceding theoretical models, since it simultaneously considers the researchers' system, the users' system and all intermediation channels that can bring the two systems closer together" (Landry et al., 2008, p. 17).

It is generally recognised that no single theoretical model is sufficient to represent the complexity of the KTE process (Belkhodja, Amara, Landry and Ouimet, 2007; Estabrooks et al., 2006; Sudsawad, 2007). There are many other theoretical perspectives that can inform KTE initiatives (Estabrooks et al., 2006; Proctor et al., 2009; Sudsawad, 2007) Estabrooks *et al.,* (2006) argue that the ideal approach is a model that best fits the needs, knowledge and skills of the groups involved.

Knowledge translation and exchange strategies

There are a number of different KTE strategies that have been applied to try to improve the use of evidence in practice (Mildon and Shlonsky, 2011). Examples of strategies include web-based information and electronic communications; using 'actionable' messages tailored to the audience; publishing practice implications of research findings; education and training; face-to-face exchange through regular meetings, joint workshops, networks and communities of practice; including practitioners in the research process as part of interdisciplinary research teams; using intermediaries known as knowledge brokers who understand both roles; and co-producing programs and materials to enhance their fit with services and organisations (Mitton, Adair, McKenzie, Patten and Perry, 2007).

Straus, Tetroe, and Graham (2013) categorise KTE strategies as linkage and exchange interventions (such as knowledge brokers or communities of practice), educational interventions (e.g. continuing professional development), electronic interventions (e.g. reminders and clinical decision support systems), feedback interventions (e.g. audit and feedback), patient-mediated interventions (e.g. media campaigns or more targeted interventions) and organisational interventions (such as clinical practice guidelines). The authors of the Strauss book provide useful summaries of book content on the CIHR (Canadian Institutes of Health Research, 2011). For the purposes of this review we have applied these categories to describe the KTE strategies tested in the included studies.

Organising frameworks of knowledge translation and exchange

Many argue that it is useful to establish a categorisation of KTE activities to help systematise thinking and understanding about how to improve the use of evidence (Davies, Nutley and Smith, 2000; Nutley, Walter and Davies, 2007). However, just as there are multiple KTE strategies, there are also multiple organising frameworks for understanding KTE. They range from simple dichotomies to multi-dimensional frameworks. Three examples of organising frameworks for KTE are classifying the degree of engagement; classifying according to the type of KTE strategy used; and classifying according to the mechanisms that underpin the KTE strategy. We

describe the third framework in greater detail.

Strategies can be distinguished based on the *degree of engagement* with the potential audience (Tetroe et al., 2008), such as the 'push/pull' models described earlier. Strategies can be grouped by *type of intervention* (Walter et al., 2003). For example, categories might include written materials (including journal articles, research reports and evidence briefings), professional interventions (such as education and training, audits, reminders and feedback) or networks (including research and practitioner networks). The Taxonomy of Interventions to Achieve Practice Change developed by the Effective Practice and Organisation of Care (2002) (EPOC) group within the Cochrane Collaboration is a good example of this type of classification.

Walter *et al.* (2003) have developed a taxonomy which focuses on the underlying *mechanisms that underpin the strategies*. They propos eight mechanism categories.

Dissemination: strategies present or circulate knowledge through methods such as seminars and written materials. The aim is to inform users about the research message, with the underlying assumption that personal motivation will lead to behavioural change.

Education: interventions aim to increase users' knowledge and understanding of evidence rather than developing specific skills. These range from didactic approaches such as lectures to more interactive sessions. This approach requires more active participation from research users than dissemination strategies.

Collaboration: interventions aim to improve communication and strengthen the links between researchers and knowledge users. Methods include joint working opportunities and exchanging skills. This mechanism emphasises the importance of addressing knowledge users' contexts and bringing together explicit and tacit knowledge.

Social influence: this mechanism draws on influential others, such as opinion leaders and colleagues, to persuade knowledge users of the value of research findings. This approach is underpinned by the theory that information that "resonates with existing norms and values" (Walter et al., 2003, p.5) is more likely to lead to behavioural change.

Facilitation: strategies enable, and remove barriers to, the incorporation of research findings in policy and practice. This approach involves the provision of assistance that could be technical, financial, emotional or organisational assistance. The emphasis is on practical support to facilitate change.

Incentives: interventions use reward or encouragement so that behaviour or activities are more likely to recur. Rewards may be financial or lead to other benefits such as increased professional status. This mechanism assumes that rewards can reinforce learning, and that controlling motivation can influence behaviour.

Reinforcement: strategies encourage behaviour by providing information about that behaviour, generally through audit, feedback or reminders.

Multifaceted interventions: involving more than one intervention and multiple mechanisms. This approach draws from an understanding that multiple variables influence behaviour change.

It is now understood that passive knowledge dissemination alone is unlikely to lead to knowledge uptake; rather, strategies that require interaction between groups are more likely to be effective (Grimshaw et al., 2001; Lavis et al., 2003). Employing multiple strategies also appears to be more effective (Gira, Kessler and Poertner, 2004; Grimshaw et al., 2001).

There is less understanding of which strategies are likely to be more effective in specific contexts (Grimshaw, 2008; Grimshaw, Eccles and Tetroe, 2004; Lavis et al., 2003). Graham et al. (2006) propose identifying the obstacles to knowledge uptake in a particular context and choosing strategies that are most likely to overcome those barriers. As an example, "When the barriers are related more to the organisation of service delivery, introducing reminder systems, modifying the documentation system, changing staffing levels, purchasing equipment, or altering the remuneration process may be useful strategies" (Graham et al., 2006, p. 21).

Summary

Research on KTE is only just emerging, and is informed mostly by work in a small number of disciplines such as education and medicine (Landry et al., 2001; Mildon and Shlonsky, 2011; Mitton et al., 2007; Thompson, Estabrooks and Degner, 2006).

While a number of KTE models and strategies have been proposed, little is known about which strategies are more effective in encouraging the uptake of knowledge by specific users in specific contexts.

This study seeks to contribute to the understanding of KTE processes as they apply to the field of violence against women.

Methodology

There are now a number of methods for rigorously and systematically reviewing evidence. For this research, a scoping review methodology was the method used to conduct the review.

The aim of this research was to build knowledge about the evidence for KTE in the area of violence against women. Little was known about the extent to which there were evaluations of KTE strategies in this field. A scoping review was therefore the most suitable methodology, for the following reasons:

- Scoping reviews can be used to map areas of study where little is known about the nature of the work (Arksey and O'Malley, 2005). A scoping review was therefore appropriate for this study where the topic had not previously been extensively reviewed.
- Research questions may not be as specific or well-defined as in a systematic review (Arksey and O'Malley, 2005). The aim of this study was to explore the literature rather than seek to address a specific research question.
- Scoping reviews typically aim to scope a large field of studies rather than those limited to specific study designs, such as including only controlled trials in systematic reviews (Arksey and O'Malley, 2005). This allowed us to explore a broader range of literature.

Unlike systematic reviews, scoping reviews rarely attempt to assess the quality of studies and they may not even describe the findings of the included studies. Like systematic reviews, scoping reviews require rigorous methodology and transparency of reporting.

Search strategy

The search strategy used to conduct this scoping review was developed in consultation with ANROWS and our content experts.

Relevant literature was located through the following sources:

- Bibliographic databases.
- Consultation with experts in the field.

Search of bibliographic databases

Electronic bibliographic databases were searched for published literature on KTE in the field of violence against women. A list of searched databases appears in Table 1. Searches were limited to English and to publication years from 2000 onwards.

Search terms were selected to capture studies related to 'knowledge exchange and translation', 'violence against women', 'evaluation'. The search terms used in PsycINFO appear in Table 2, with search terms used in each database available on request.

Table 1 Bibliographic databases used to search for published literature on the evaluation of KTE in the field of violence against women.

Database
PsycINFO
MEDLINE
Cumulative Index to Nursing and Allied Health Literature (CINAHL)
Applied Social Sciences Index and Abstracts (ASSIA)
Criminal Justice Abstracts
FAMILY-ATSIS: Australian Family & Society Abstracts Database-Aboriginal and Torres Strait Islander Subset
Embase and Embase Classic
Social Work Abstracts
Education Resources Information Center (ERIC)
Sociological Abstracts
Violence and Abuse Abstracts
FAMILY - Australian Family & Society Abstracts Database

Table 2 Search terms used to search PsycINFO via OVID

	Database search terms
1	(Implement* or disseminat* or research utilisation or research utilisation or diffusion or knowledge translation or knowledge transfer or knowledge exchange)
2	((Violence or violent or abus* or assault* or homicide) adj3 (domestic or family or families or intimate or dating or home or relationship or couple*))
3	((Sex* or intercourse) adj3 (assault* or violence or violent or abuse* or crime* or forced or forcible or offense*))
4	((abus* or violent or violence or assault*) adj3 (women or woman or wife or partner* or ex-partner* or spous* or girlfriend* or man or men or boyfriend* or husband*))
5	(Rape or raped or battered or batter or batters or batterer or rapist*)
6	(male violence or gender* violence or sex* perpetrator* or sex*offender* or intimate terrorism or domestic terrorism)
7	(Evaluation* or studies or study or research or investigation* or trial* or random* or controlled clinical trial* or control group* or evaluation stud* or study design or statistical* significan* or double-blind or placebo or meta-anal* or meta anal* or metaanal* or systematic review* or synthesis of studies or study synthesis)
8	Combine 2 – 6 with OR
9	Combine 1 AND 7 AND 8

Study selection

Definitions (provided in the Introduction section) and selection criteria were developed in consultation with ANROWS to ensure that studies of greatest relevance to ANROWS's priorities were included.

Selection criteria

Inclusion criteria:

- Dated from the year 2000 onwards.
- English language.
- Content area related to violence against women as defined previously. This includes studies related to victims, perpetrators, services, service providers and policy.
- A study of any design or a review paper in the area of KTE. The study must, at minimum, report a post measure of at least one outcome.

Exclusion criteria:

- Dated prior to the year 2000.
- Non-English language.
- Papers that do not report evaluations of studies of KTE in the field of violence against women.

To accelerate the review process, books, theses, chapters and conference paper abstracts were not included. While these sources may have yielded relevant studies, time constraints did not permit their inclusion.

Database search study selection

Titles and abstracts of papers were screened to determine if they related to evaluations or reviews of KTE in the field of violence against women. Full text of studies that appeared to meet the inclusion criteria was read to determine eligibility for review.

Expert recommendations study selection

Expert colleagues in the field were consulted to obtain potentially eligible papers. Eligible papers not already located via database searches were assessed to determine their suitability for inclusion in the review.

Data extraction

Data extraction forms were developed to chart key information reported in the included studies. Information extracted from the studies included: type of violence, study objectives, theoretical models or conceptual frameworks guiding the KTE process, KTE strategies used, knowledge utilisation, design, participants, key results, determinants (barriers and facilitators) of KTE, limitations and recommendations.

Data analysis and synthesis

Extracted data were tabulated and examined for themes. Comparisons across sectors and according to different service providers were made where relevant. Findings are described using narrative synthesis so that a picture of the studies and approaches are presented. Gaps in the evidence were also sought.

Findings

Twenty four studies relating to the implementation of KTE strategies in the field of violence or sexual assault against women were identified through databases searches, with no new relevant studies found through the examination of expert recommendations. Figure 1 depicts a flow chart of papers identified in the scoping review.

The following section includes details of the studies included, information about the target population and KTE strategies used, and the study results. A summary of the data extracted from the 24 studies can be found at Appendix 1.

Study details

Of the 24 studies reviewed, 20 related to domestic violence or intimate partner violence, and four related to sexual assault. Nineteen studies related directly to the implementation of specific KTE strategies or evaluations of KTE approaches. Five studies were categorised as non-implementation studies, that is, commentaries and stakeholder surveys relating to KTE but not reporting on the implementation of a KTE strategy.

Knowledge utilisation

Types of knowledge utilisation were categorised according to Larrivee *et al.* (2012) as conceptual utilisation, which implies changes in knowledge or attitudes; instrumental utilisation aims for changes in behaviour or practice; and strategic utilisation, which aims to affect decision making to achieve strategic goals.

Among the implementation studies, the most common type of knowledge utilisation was conceptual (n=15). Seven studies targeted instrumental utilisation, primarily relating to universal screening (=5), routine inquiry (n=2) and referrals (n=2). Five studies involved both conceptual and instrumental knowledge utilisation. One study focused on sharing key research messages, and one related to the fidelity of implementation of a youth program.

Theoretical models

Only five studies reported theoretical models as the basis of the study, as outlined below. The current review was unable to report the extent to which these models affected the implementation or impact of the KTE strategies, as the studies' methodologies did not generally examine those links.

Brackley (2008) has described a study of the design and implementation of evidence-based training on domestic violence in a health setting. The model used was Achieving Outcomes: A Practitioner's Guide to Effective Prevention (Center for Substance Abuse Prevention, 2002, as cited in Brackley, 2008), a process for selecting, implementing and evaluating prevention programs. Parker and McFarlane's (1991) model to identify and help battered pregnant women was used for the program selection phase.

Wills, Ritchie, and Wilson's (2008) research described a study of comprehensive practice change to improve health professionals' detection of child and partner abuse. They drew on a number of models including the Ottawa Charter for Health Promotion (World Health Organization, 1986, as cited in Wills, Ritchie and Wilson, 2008); Soft Systems Methodology (Checkland and Scholes,

1999, as cited in Wills, Ritchie and Wilson, 2008); Force Field Analysis (Lewin, 1951, as cited in Wills, Ritchie and Wilson, 2008); The Commitment, Enrolment and Compliance Model (Senge, 1990 as cited in Wills, Ritchie and Wilson, 2008); Total Quality Management (Berwick, Enthoven and Bunker, 1992, as cited in Wills, Ritchie and Wilson, 2008); Organisational Learning (Argyris and Schon, 1996, as cited in Wills, Ritchie and Wilson, 2008); and Action Research (Eden and Huxham, 1996, as cited in Wills, Ritchie and Wilson, 2008).

Two studies used Landry *et al.'s* (2001) interaction model of knowledge translation. Wathen, Sibbald, Jack, and Macmillan (2011) explored the development and evaluation of KTE strategies to share research findings with a range of knowledge users including women's advocates, health service providers and policymakers. Salmon, Murphy, Baird, and Price (2006) evaluated the impact of an educational program on midwives' implementation of routine antenatal screening for domestic violence.

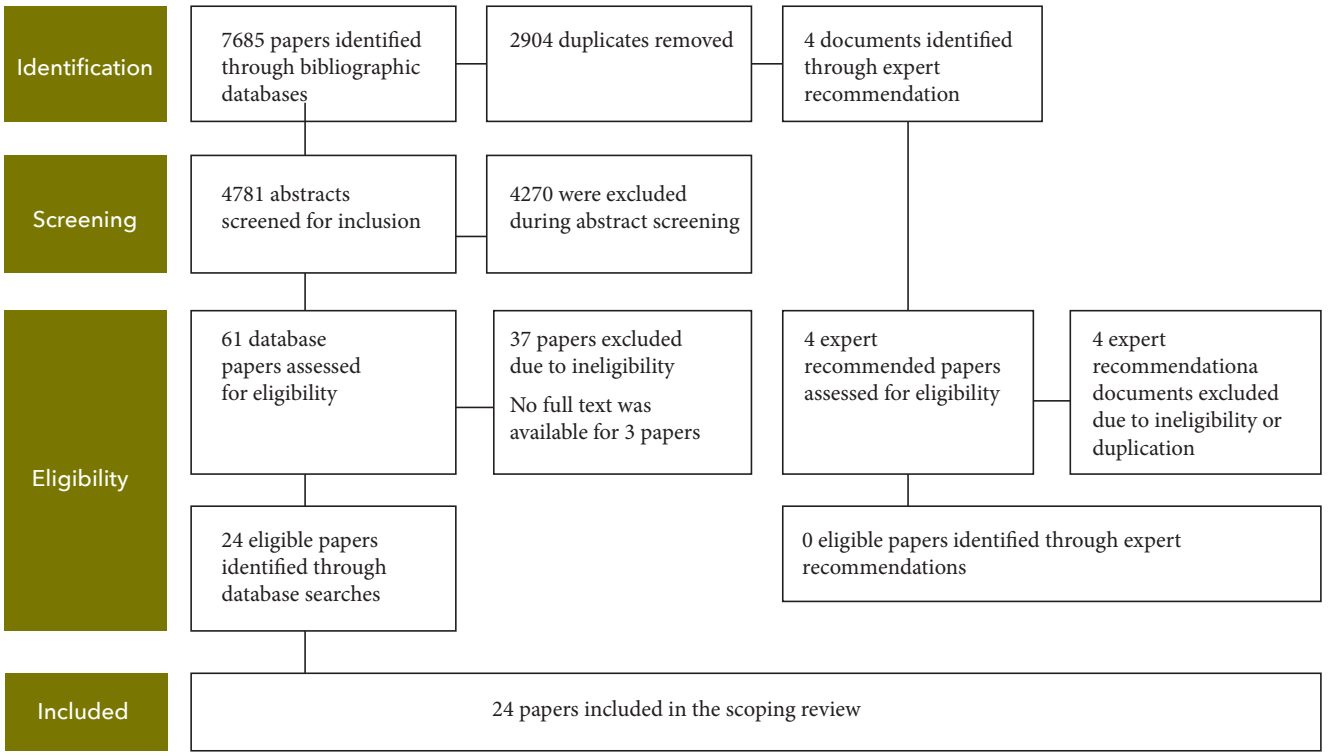
A study by Noonan, Emshoff, Mooss, Armstrong, Weinberg and Ball (2009) explored the implementation of two sexual violence prevention programs. The conceptual framework used was Klein and Sorra's (1996) model of two interconnected groups of variables: (a) innovation fit—and (b) climate for implementation.

Target population

The majority of studies targeted health care professionals (n=15). Specific professions were not always stated, however, where stated, professions included paediatric staff (n=2); nurses (n=2); mental health nurses (n=1); midwives (n=2); dentists (n=1); emergency medicine residents (n=1); and doctors (n=1). Two of the studies targeting health care professionals were in the sexual assault field.

One study focused solely on members of the public (health care patients), although a total of seven studies involved some level of public information. One study targeted frontline child protection workers, and another targeted medical students. One study in the sexual assault field targeted young people both in schools and communities. Three studies targeted a variety of professionals from health care, social work and advocacy fields. Only one study targeted policymakers. Two of the non-implementation studies targeted law enforcement professionals, of which one was in the sexual assault field.

Figure 1 Flowchart of the papers through the scoping review process



Knowledge translation and exchange strategies

Of the implementation studies, ten employed a single KTE strategy and nine used multiple strategies. The majority of studies used education interventions (n=18). These were predominantly staff training (n=17), one of which was computer-based (the dentist study). Other educational strategies included resources and articles (n=6), and follow-up visits or assistance (n=2).

Patient-mediated interventions (that aim to increase patient knowledge) were used in seven studies, all but one of which employed the provision of resources. Two studies included a public health campaign. Seven studies employed organisational interventions, generally the provision of guidelines, protocols or tools aimed to increase awareness of or adherence to a particular approach (e.g., routine screening of patients).

Linkage and exchange interventions were employed in four cases, including the use of change agents, a domestic violence response team, a community of interest, and networking and team building. There was one reported use of an electronic intervention, namely an interactive website (from the study targeting policymakers and women's advocates).

Other KTE strategies were a staff position with dedicated time to oversee implementation (n=1).

The study by Wathen *et al.* (2011) stands out, as rather than aiming to translate knowledge via training for staff in direct service provision (as most other studies did), this study employed an approach involving workshops, developing a community of interest, a website, forums, meetings, a journal publication and a media campaign to influence policymakers, health and community service providers and women's advocates. Reporting of results is mainly qualitative, with information provided about how to best translate knowledge from research into policy and practice.

Study design

Thirteen studies employed a multiple method design and eleven studies a single method approach. The most common method was the use of a survey or questionnaire (n=17). The next most common data collection methods were interview (n=12) then document audit (n=9). Other methods included focus groups (n=2), observation (including simulations and site visits), and a written knowledge test.

There were few controlled studies (no randomised controlled trials). Very few studies used any form of comparison group (e.g. other intervention, no intervention or treatment as usual). Exceptions included a U.S. study by Hsieh *et al.* (2006) who compared results from a group of dentists who received computer-assisted training in identifying and responding to domestic violence, to a control condition who did not receive the training. Results indicated that participants reported an intention to use the intervention as well as increases in perceived knowledge about what to do. Nevertheless, dentists in the treatment condition did not report improved beliefs and attitudes about domestic violence or an increased sense of efficacy in assisting victims of domestic violence.

Shye, Feldman, Hokanson and Mullooly (2004) also employed some form of control in intervention comparison. They evaluated two different versions of a multifaceted KTE intervention in a large sample of primary health care providers. The KTE intervention comprised a combination of guidelines/protocol, domestic violence response teams, written info, resources in public places, leader on task force, and time/money for staff training. The comparison group received all of these approaches plus the addition of an opinion leader or advocate for the domestic violence approach. Results revealed significant improvements in screening rates, knowledge, attitudes and reported practices of clinicians, and increases in patient satisfaction with practitioners' approach to domestic violence. The adjunctive intervention group reported additional significant improvements in awareness of domestic violence response teams (through the existence of the opinion leaders).

Most studies employed pre-post evaluation methods, generally with no or short follow-up periods. Some studies included longer term follow-up.

Study results

Some of the most common results reported were improved perceived or self-reported knowledge or awareness, specifically of domestic violence, sexual assault and related issues (n=12) or of policy and protocols (n=2). Improved reported behaviours included quality or rate of documentation (n=4); increased victim identification (n=3); increased screening rates (n=3); and improved referral/notifications (n=2). Patient satisfaction with clinical efforts was reported in two studies.

While two studies reported improved attitudes, three reported a minimal change in attitudes or beliefs. One study found low rates of routine inquiry, and another reported no improvement in communication skills.

Most used self-report of perceptions of participants (e.g. attitudes and beliefs about domestic violence), or knowledge or satisfaction with training (or with another KTE strategy). Few studies employed objective measures of outcomes (such as other-report, observation or case file audit). Exceptions included an Australian study by Boursnell and Prosser (2010) who employed the use of staff training and post-training prompts to increase emergency department nurses' knowledge of domestic violence hospital policy, and to improve nurses' understanding of their personal responsibilities in domestic violence cases and knowledge of referral options. This study used a pre-post-follow-up single group design, and as such did not include a comparison group. However, in addition to self-report measures, Boursnell and Prosser (2010) reported results using case file audit, a more objective measure of outcomes.

Another study that included the objective measure of an audit of records was Wills, Ritchie, and Wilson (2008), which used a multifaceted KTE approach to reveal increases in screening rates and reports of domestic violence by patients of health professionals working in a regional health service. The audit of client records also revealed improved quality of recording in most services, although variability in quality of recording continued to exist. In addition to the more objective results from the record audit, Wills and colleagues also reported positive perceived changes in staff confidence and skills with the KTE intervention.

Most studies involved small sample sizes, with the majority being recruited through convenience methods (e.g., clinicians present in the emergency department, participants who opted to attend training, students). Some studies did involve larger samples (e.g., Shye et al., 2004; Wills et al., 2008).

Barriers

Studies identified a range of organisational barriers to the implementation of evidence-based practices and policies in the field of violence against women, including a lack of privacy (n=3) and lack of time (n=4). Personal barriers included a lack of confidence or discomfort in discussing violence against women, including the presence of a male partner (n=3); a fear of offending patients (n=2); and forgetting to ask (n=1). One study reported that evidence may be viewed as being ambiguous or inconclusive, thus affecting implementation, and another emphasised the importance of actionable insights from research. The same study suggested that fields where professionals have strongly held practice beliefs may present a challenge to implementation of evidence-based practices.

Facilitators

A combination of implementation strategies were considered to be facilitators (n=4) to implementation of evidence-based practices and policies in the field of violence against women. Examples included training plus organisational protocols, individual-level plus organisational strategies, and the combination of training and practical experience. Two studies reported the importance of interactive relationships with peers. Some form of ongoing support, supervision or prompting was viewed as a facilitator (n=4), as was refresher training (n=2) and having knowledgeable or dedicated staff available (n=1). One study found that making training compulsory and having an implementation budget were facilitators. Some level of adaptability or local flexibility was reported as a facilitator by four studies.

Discussion

The aim of this scoping review was to explore the evidence for KTE in the area of violence against women, compare KTE in the sexual assault and domestic violence sectors, and examine any differences in approaches between practitioners within those sectors.

Summary of review findings

Findings from our review of 24 studies revealed a limited evidence base in KTE strategies within the fields of domestic violence and sexual assault. The majority of the studies targeted domestic violence and were aimed at health care professionals, with few targeting other key personnel in this field such as law enforcement and welfare, and none targeting policy makers. Educational strategies, in particular staff training, were used in the highest proportion of studies and a small number also utilised resource and article provision. Interventions employed were patient-mediated, organisational interventions or linkage and exchange interventions.

Of the small number of studies available, there were few examples of quasi-experimental research studies that employed some form of comparison group to control for extraneous effects that were not due to the KTE intervention itself. Most of the studies adopted a pre-post-test repeated measures design (sometimes with a medium duration follow-up period) to facilitate identification of within-subject changes following the KTE intervention.

The review findings within the context of the broader knowledge translation and exchange evidence

In lieu of detailed and rigorously evaluated evidence for KTE strategies specifically for promoting evidence-based practice in the domestic violence and sexual assault fields, we can look to other areas of human service delivery to identify KTE strategies that have evidence for effectiveness in changing policy or practice. A large number of systematic reviews of KTE exist, and there are a small number of seminal "reviews of reviews" that further synthesise the available evidence to produce increasingly credible evidence of the effectiveness (or otherwise) of various KTE strategies. Grimshaw and colleagues (e.g. Grimshaw, Eccles, Lavis, Hill and Squires, 2012) have conducted a number of these meta-reviews, focused primarily on use of KTE strategies to improve policy and practice in health care service delivery.

Grimshaw *et al.* (2012) have summarised the findings from a number of systematic reviews identified by the Cochrane EPOC group, focusing on professional behaviour change strategies to improve health care systems and service delivery. They emphasise that the evidence for the effectiveness of particular strategies in overcoming barriers to implementation is incomplete. Nevertheless, their summary of potentially useful KTE interventions is as follows:

Informal opinion leaders who are positioned at the heart of interpersonal communication networks. Their leadership arises from social accessibility and competence rather than any formal position or status. This strategy was not reported in any of the studies in the current scoping review.

Educational meetings, outreach and printed materials Meetings including conferences, workshops and traineeships and can be didactic or interactive. Larger effects were associated with interactive meetings or meetings that were a mixture of interactive and didactic (Grimshaw, Eccles, Lavis, Hill, and Squires, 2012). Educational outreach aims to change practice. It involves a trained individual providing training in the practice setting.

The current review on KTE strategies in the violence against women field found that educational interventions were the most commonly used, which reflects the findings of other reviews (see Larrivee et al. (2012). This may reflect the fact that educational meetings and materials, in particular, are relatively low cost and feasible in most settings (Grimshaw et al., 2012).

Audit and feedback involves measuring actual clinical performance, for example, through medical records audits or patient observations. Feedback is an important element in this strategy for creating change.

Document audits formed part of the design of outcome measurement in some of the studies included in the current scoping review. However, they did not involve feedback to the target population and did not form part of the KTE strategy itself.

Reminders are used to prompt the target population to perform a specific action or remind them of certain information, particularly in relation to individual patient care. Such prompts could be made electronically, through medical records, or through interaction with peers.

No studies from the current review identified reminders as a KTE strategy.

Tailored strategies are those that are designed specifically to address potential barriers to change.

This strategy was not identified in the current review.

Multifaceted interventions (of which there were nine in the current review) should consider how the individual strategies will interact to maximise benefits.

Research gaps on knowledge translation and exchange in the violence against women field

A number of gaps in the research have been highlighted through this scoping review. There is scant information available about KTE in the field of violence against women. This is further limited by the lack of rigorous experimental studies and systematic reviews on this topic. Our capacity for making useful comparisons between the domestic violence and sexual assault fields was restricted due to limited available studies, particularly in the area of sexual assault. Similarly, the lack of evidence limits capacity to make comparisons across relevant sectors working in the violence against women field and between the vast range of professionals in this area. Although sought, this review identified no KTE studies in the area of Indigenous family violence.

The limited range of relevant studies presented KTE strategies which were used mainly with health care professionals. This presents a significant research to practice and research to policy gap as the potential users of KTE in the field of violence against women are considerably broader than health care professionals.

A further gap is in the types of KTE interventions that have evidence within the field of violence against women. While six KTE interventions with evidence in the health care sector were identified by Grimshaw *et al.* (2012), only three of these evidence-based strategies have been tested in the field of violence against women. Further rigorous study is required to determine which of the strategies work best within this field.

Study design, analysis and reporting limitations did not allow for an examination of the impact of interventions based on theoretical models and the potential impact the use of these models may have had on KTE strategies or outcomes.

Limitations of this review

The findings of this scoping review should be considered within the context of several limitations inherent within a review of this nature and due to time constraints. The purpose of a scoping review is to map out ill-defined, broad or new topics of research. As such they do not typically involve detailed analysis of study rigour or intervention effectiveness in the way a full systematic review would. An examination of the effectiveness of included interventions was not within the scope of the current review.

To accelerate the review process, several limits were imposed on the review only English language publications and publications dated after 2000 were included; no grey or unpublished literature was sourced; and books, theses, chapters and conference abstracts were not included. In addition, we did not examine reference lists or contact authors for further studies or data. As a result, some relevant studies may have been missed.

Databases were selected in collaboration with ANROWS and the expert consultants. It is possible however that other relevant databases such as PubMed, CINCH, AGIS, APAIS may have identified additional studies.

Future directions

Despite these limitations, this review has employed rigorous methods to search for and select published studies from a wide range of databases and we are confident that the majority of relevant studies have been identified. This said, the review identified few studies that employed rigorous designs. In the absence of, ideally, replicated randomised controlled trials (or other

forms of experimental designs) with large samples, few firm conclusions can be made about the use of KTE strategies in changing policy and practice in response to violence against women.

Therefore, while there is a growing body of evidence about the usefulness of various KTE strategies for changing practice, "our evidence on the likely effectiveness of different strategies to overcome specific barriers [to implementation of innovations] remains incomplete" (Grimshaw et al., 2012, p. 1). Further investment in the high quality evaluation of approaches to translating the evidence about what works in practice related to violence against women is certainly required.

Similarly, further investment in the systematic synthesis of findings from these evaluations is required. There is a strong argument that our decisions about what interventions to adopt or what KTE strategies to employ should be made based on a large pool of evidence which has been synthesised and analysed. As Grimshaw notes, "the basic unit of knowledge translation should usually be up-to-date systematic reviews or other syntheses of research findings" (Grimshaw et al, 2012, p.1). Individual studies, even well controlled ones (e.g. randomised controlled trials) or studies involving large sample sizes, rarely provide sufficient basis upon which to make judgements about practice and policy changes. Individual studies may encompass some level of bias that, if used in isolation, may provide misleading conclusions about the effectiveness of KTE strategies. Without a solid evidence base of individual studies to draw from, systematic reviews of the collective research on a topic cannot be conducted, therefore conclusive statements about the effectiveness of particular KTE strategies are not possible.

In contrast to other areas of human services policy and practice, most notably in health care, we have not invested in knowledge synthesis activities to facilitate the availability of good evidence regarding the effectiveness of KTE strategies in violence against women or timely access to evidence to inform practice in this area.

In the absence of increased investment in such evaluations and syntheses of the literature, our understanding of how best to influence practice and policy change regarding violence against women, remains compromised.

Conclusion

This review has mapped the limited literature available on KTE in the field of violence against women. KTE evidence from the broader literature has also been summarised and comparisons made to the violence against women studies.

In the absence of a more systematic analysis of the violence against women literature, practitioners and policymakers can be guided by the broader KTE evidence, in particular, interventions in common between the broader field and the violence against women studies.

Appendix: Tabulated data extracted from scoping review reports

Implementation studies (studies relating to the implementation of specific KTE strategies or evaluations of KTE approaches)

Domestic Violence

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
Berger et al., (2002)	"To obtain information about pediatric resident and staff knowledge, attitudes, and screening practices related to DV." (p. 803) "To implement a DV education program." (p. 803) "To evaluate whether the program resulted in changes in 3 domains." (p. 803)	Conceptual and instrumental utilisation (universal screening). Health care professionals.	**Education intervention** • 4 x 30 minute didactic session • articles set as pre-reading • 90-minutes teaching sessions with 15-min didactic, 12-minute teaching session and 45-min role-play session (with common scenarios). List of DV resources. **Patient-mediated intervention** DV posters in waiting area.	Pre-post survey design: • DV knowledge. • Attitudes and barriers to screening. • Screening practices. • Prior training. • Prior identification of DV cases. **Participants** Hospital based pediatric residents, clinic faculty and nurse practitioners (n=84).	"The brief education program demonstrated that is possible to improve the frequency with which pediatricians screen for DV during well-child care visits." (p. 807) "Strong correlation between attendance at the educational sessions and change in reported DV screening practices points to educational sessions more likely cause the change." (p. 807) Change based on physician report only (no direct observation or videotaping).

1 Types of knowledge utilsation are categorised according to Larrivee et al. (2012): conceptual utilisation; instrumental utilisation; strategic utilisation.

2 Strategies are categorised according to Larrivee et al. (2012): educational interventions; linkage and exchange interventions; feedback interventions; electronic interventions; patient-mediated interventions; organizational interventions.

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
Thurston et al., (2009)	To study the implementation of DV screening protocols in an urgent care clinic. "To identify implementation issues that might need to be addressed." (p. 519) To inform future implementation in hospital emergency departments.	Instrumental utilisation (universal screening). Nursing staff at a Community Health Centre urgent care clinic.	**Education intervention** • training on DV screening for nursing staff. • training was offered to physicians and support staff but none chose to attend. Training included: • information on guideline development; definitions and terms; overview of nurses' role; procedures; and information on community resources. • education on possible personal impact and past experiences that might be raised for nurses by the DV screening process. Information that help was available in the form of managerial support and the Employee Assistance Program. **Organisational intervention** Nurses received copies of the Health Centre Domestic Violence Guidelines, which covered the purpose of universal screening, ways of asking about DV, advice about when screening should be avoided, goals of, and steps in, intervention, documentation and confidentiality, interagency conflict resolution, and education resources. A *Domestic Violence Resources Binder* was available in the clinical nurse educator's office. It included the Guidelines, a decision tree, sexual assault response information,	Data about the activities, characteristics and outcomes of the universal DV screening protocol were obtained through the multiple methods of observation, document reviews, interviews, and calculated screening rates as reported in patient charts and chart reviews. Data were gathered from 60 respondents, representing a minimum of 41 individuals as any one person might have participated in more than one of the different formats. **Participants** 41 nursing staff (registered nurses and licensed practical nurses) at a Community Health Centre urgent care clinic.	"The documentation and screening rates were viewed as the indicators of success of this implementation initiative." (p. 520) "Documentation rates (the number of visits for which information about screening was recorded) were high from the outset and during the last months of the evaluation period, resulting in an overall rate of 93%." (p. 521) "Nurses achieved a 39% screening rate (the number of visits in which a patient was asked about DV), with the highest rate, 52%, recorded in the last month for which data were reviewed. In visits in which patients were asked, DV was reported 3,101 times, which was a 16% disclosure rate." (p. 521) **Challenges of Screening in Urgent Care Settings** • "Learning how to ask the DV question in a fast-paced setting in a way that adequately conveyed the importance of the issue in a caring and positive manner." (p. 521) • Concern that the screening process might throw patients "off guard" if only seeking care for a minor complaint (eg sore throat). • Issues with privacy in urgent care settings. • Specific patient populations being more challenging to screen, including patients with language and cultural differences, patients with mental health problems, patients with children, older people, and patients who "would not disclose what nurses considered obvious DV." (p. 522) • "Nurses felt uncomfortable offering resource cards to patients who reported that DV was not an issue in their lives." (p. 522) **Approaches to Problem Solving and Action** • "Timely changes to the DV protocol implementation." (p. 522)

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
			contacting the Department of Child Welfare, DV publications, and a section for confidential comments/ questions. **Patient-mediated intervention** DV resources were placed in every exam room. Wallet-size resource cards listing DV services were in triage areas and exam rooms. Posters placed in the waiting area informed patients of the implementation of the screening protocol. Brochures on DV and the resource cards were displayed in waiting area and exam rooms.		• Creation of an "Implementation Discussion Group composed of the Centre's staff (primarily nurses), to provide a forum for discussing improving and maintaining routine screening." (p. 522) • Changes made to original DV screen question to focus it on patients' immediate health and safety concerns. • The separate screening "form was often not fully completed" screening questions were therefore "included on the main patient assessment form with the other standard questions about patient health. Both documentation rates and screening rates increased after this, and remained higher in the months for which data were reviewed." (p. 523) • "A 1-hour protocol refresher was incorporated into nurses' annual recertification course, to address concerns that the original training did not prepare them for the experience of asking about DV." (p. 523) • "Having knowledgeable and dedicated staff on site to address problems as they arose was important." This was "preferable to an external contact who may not have understood the unique ways in which the Centre operated or may not have been able to respond quickly." (p. 523) • "Screening and documentation rates increased after question was included on the regular patient assessment form, an indication that structural/ organisational issues may be just as important as individual-level factors." (p. 524) • The urgent care clinic was considered "one of the best places to implement a population-based strategy" due to the "number of patients seen in this urgent care setting , the availability of mental health staff, the links to community programs, and approach to problem-solving." (p. 524)

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
Szilassy et al., (2013)	To contribute to the evidence base by evaluating the outcomes of short-course interagency training in England on DV and child protection. These courses aim to: • address the interrelationship between these issues together with interagency and inter-professional collaboration; • increase awareness of the links between DV and child abuse and the impact on children, young people and family members; • promote earlier intervention to prevent risk situations; • focus on interagency procedures and local developments; • promote understanding of how all agencies can communicate and work together.	Conceptual utilisation. Staff with a frontline responsibility for the protection and safeguarding of children.	**Educational Intervention** Course objectives were: • review definitions of DV; • reflect on the incidence of DV locally and nationally; • investigate assessment process and good practice guidance in relation to DV and child protection; • develop ability to assess risk in relation to children who are in families where DV is prevalent; • gain understanding of the interagency approach to working with families who have experienced DV; • develop ideas to improve own practice • identify ways to keep themselves safe. Courses used interactive learning and teaching methods; presentations of case studies drawn from child abuse inquiries; research findings; and statutory guidance. They included videos of parents and children talking about the effects of living with DV. Time was allowed for discussion and exploration of personal attitudes to DV. Focus on multi-agency work: • identify the strengths and challenges of working inter-professionally. • understand where agencies featured in the process from referral to de-registration on the statutory child protection register. • emphasise the contribution of different agencies to assessment and intervention planning.	Evaluation used a repeated-measures design with a double baseline. Questionnaire: • demographics; • attitudes toward, and knowledge of, DV; • effects of DV on children, knowledge of relevant child protection policies and procedures, confidence in their use. Questionnaires were completed 3 times: 6 weeks before the start of the training at registration for the course; at the beginning of the course; and at the end. Participants were followed-up 3 months later. Data were collected from 10 courses in different parts of England, enabling the assessment of outcomes for each independently. **Participants** 177 staff out of an approximate 250 (71%) elected to participate in the evaluation. 98 evaluation participants (55%) returned pre-course questionnaires. Only 26 (15%) responded to the follow-up questionnaire.	"Study provides evidence that interagency training can (a) promote an understanding of the roles and responsibilities of professionals working in different organisations, including the legal frameworks and interagency procedures to safeguard children; and (b) increase the ability to identify signs of DV and the particular power dynamics associated with it, which act to counter beliefs that mothers are responsible for ending the violence." (p. 1380) Participants strongly agreed that there was a direct link between child abuse and DV. They were significantly more likely to feel confident in taking action, whether talking to abused women and perpetrators or referring to appropriate agencies. "This evaluation provides preliminary evidence that a short, interactive course for professionals from different disciplines can have a positive effect on self-rated attitudes towards DV, increased knowledge of its effects on children, knowledge of child protection policies and procedures, and self-confidence in responding to safeguarding issues" (p. 1380) **Recommendations** Research is needed to find a more effective method for following up course participants to find out whether effects are sustained and knowledge is embedded in practice. Participants' managers or supervisors could provide some evidence of the latter. It would be valuable to have some evidence of benefits of the training for clients/patients.

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
Boursnell & Prosser (2010)	To improve "staff awareness of DV and encourage practice developments so that nurses in the Emergency Department increased their capacity to identify women and children whose presentation may be related to these issues." (p. 36) Study is Australian based.	Conceptual and instrumental utilisation (universal screening). Health care provider (nurses).	**Education intervention** • 60 min training workshop in use of a tool to assist with recognising and responding to "victims" of DV. • video of DV presentation used to stimulate practice discussion • visual reminder to staff of pathway positioned throughout the ED. • occasional prompts on site by trainer during visits.	An unvalidated pre/post test instrument consisting of eight questions. This test was designed specifically for the project based on the NSW health policy and procedures for identifying and responding to DV. The tool allowed the participants to rate feelings/ perceptions of their knowledge in relation to DV: • indicators of DV; • responsibilities in relation to DV; • how to respond to children living with DV; • appropriate local referral options. Tests were completed prior to training, one month post training and 6 months again after that. A file audit was conducted pre- and post-training: indicators of performance in ED of staff in asking and documenting concerns about DV. • What information is being recorded in ED about DV? • How well is this information being recorded in file notes? • How accurate is recording and does it accurately reflect what has happened, e.g. information and questions asked of patients?	**Awareness of DV policy**: "nurses self-reported awareness of the DV policy increased significantly after they had completed the training program." (p. 40) **Awareness of responsibilities to DV: "**data showed that prior to training, half of the nurses (52%, n=25) said that they were not aware of their responsibilities in DV cases. However, when they completed the post training surveys, at 1 and 6 months after training this had decreased to only one staff member continuing to report lack of awareness of these responsibilities." (p. 41) **Responding to indicators of DV: "**A significant number of participants categorised themselves as undecided, indicating that they were not sure about the answer to the question or that the question needs modification if this is to be repeated." (p. 41) **Knowledge about referral: "**These results support the need for training as prior to training 73% of nurses (n=36) did not know how or where to refer patients. After training that reduced considerably (27%, n = 6) and remained relatively steady 6 months afterwards (32%, n = 13)." (p. 41) The results show that nurses who participated in the project felt that their knowledge about DV had increased and that this self-identified improvement continued for at least six months following training. Nurses also reflected that ongoing access to a purpose designed 'pathway' supported practice development. The ongoing relationship between VAN staff and ED staff is deemed in the success of this project and concurs with the literature which suggests that training focusing on fostering knowledge and skills is necessary but institutional protocols also must be implemented to create behaviour change." (p. 42)

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
				• How can information be gathered more effectively? **Participants** Over 80% (49 of 61) of ED nursing staff were trained in how to use the DV pathway. All nurses who attended training completed the pre-training test (n= 49). Of these, 22 (44.9%) completed the first post-test and 19 (38.8%)of the original group completed the second. Decreasing numbers of nurses completing post-tests is reflective of the high turnover of staff within the ED. Most ED participants in this project were Registered Nurses (84% pre-test, 86% first post-test, 89% second post-test). The others were enrolled or student nurses.	The self-reported increase in confidence about recognition of DV by ED nurses' concurs with other studies (Campbell et al., 2001) that show that the ED clearly represents a site with potential for improving the capacity of nurses to identify and respond to DV outcomes. However, as identified in this study similar to McMurray (2005) visual prompts are essential and can be a constant reminder of the need to think about DV when dealing with presentations in the ED (McMurray, 2005)." (p. 42) "This project shows that a difference that can be made in practice if a well planned and tailored training package is backed up with a locally adapted tool." (p. 43)
Kwon-Hsieh et al., (2006)	"Tested the effectiveness of a tutorial designed to educate dentists in identifying and responding to DV." (p. 1) Specific aims: • "provide a brief multimedia tutorial to educate dentists to recognise and respond to DV;	Conceptual utilisation. Dentists.	**Educational intervention** Created an interactive, multimedia computer-based tutorial tailored to dental professionals to present the intervention.	Two-group controlled trial, examined the impact of the tutorial on practicing dentists. • DV assessment instrument (24 items, intervention, knowledge, attitudes about DV); • Jefferson Scale of Physician empathy – pre intervention and post test. **Participants** A convenience sample of dentists recruited from attendees at a conference.	"Results suggest that the intervention effectively improved dentists' intentions to practice ADVR intervention. It also improved perceived knowledge both of DV and of how to help victims." (p. 7) "The tutorial was less effective in changing dentists' beliefs and attitudes regarding DV. However, even though dentists may not believe that they can help those who experience abuse, they are willing to try." (p. 7) Findings suggest that by "improving intended behaviors and knowledge regarding DV, the multimedia tutorial can be an effective medium for preparing dentists to triage for DV." (p. 7)

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
	• determine the effectiveness of the tutorial in improving the knowledge, attitudes and behaviour scores of dentists in an intervention group relative to a control condition; • examine the relationship of empathy scores with knowledge, attitudes and behaviour scores regarding DV." (p. 3)				**Limitations** There were several limitations to this study. "A convenience sample of dentists willing to take the tutorial for a small reimbursement introduces a potential bias." (p. 7) "The posttest immediately followed the tutorial, so long term effects were not assessed." *p. 7* There was "no follow-up to ask participants whether the tutorial helped in their clinical practices." (p. 7)
Edwardsen & Morse (2006)	"To examine the educational impact of IPV resource materials placed in public restrooms in a hospital ED, on awareness of community resources and the perceived beneficial nature of this resource literature." (p. 973)	Conceptual utilisation. Adult patients and visitors in a public hospital.	**Patient-mediated intervention** Resource materials, mounted on a wall by a sink in a single occupancy restroom. Pamphlet and resources cardholders displaying information on a battered women's advocacy agency, and a batterers' counseling service.	A 10-question survey instrument was developed by the lead author to measure whether the participants noticed, read, or retained information from the pamphlet and cardholders. Five-minute structured interviews were completed upon exiting restroom. A convenience sample was conducted on 13 consecutive evenings. **Participants** 51 patients and 71 visitors (n = 122). 71% female and 29% male.	"Sixty-five (53%) of participants noticed the literature or cards. Ten (8%) read the materials. Seven (6%) retained a copy of the literature. Nineteen (16%) acknowledged knowing someone who could benefit from the information. Nine (7%) revealed that some of the information was new to them." (p. 971) "Placing intimate partner violence resource pamphlets and cards in a medical setting is one means of educating the community and promoting violence prevention." (p. 971) "Passive education with displayed pamphlets should not be perceived as a sufficient means to address partner violence in a medical setting but merely one of many methods until routine inquiry can be more consistently performed by knowledgeable clinicians." (p. 979) **Limitations** "Passive education with displayed pamphlets should not be perceived as a sufficient means

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					to address partner violence in a medical setting but merely one of many methods until routine inquiry can be more consistently performed by knowledgeable clinicians." " (p. 973)
Edwardsen & Dichter (2011)	"To assess Veterans Affairs mental health providers' understanding of intimate partner violence (IPV) and the perception of patient benefit of routine inquiry and service referral. The impact of an instructional curriculum was also examined following an interactive training." (p. 1260)	Conceptual utilisation. Mental health providers.	**Educational intervention** Seven-hour training.	Pre-test and post test (immediately after training). Knowledge, attitudes, and efficacy were measured with an adaptation of an educational assessment tool designed by Lynne Short and used with permission. Knowledge was assessed with a 31-item measure (risk factors, warning signs, safety plan, appropriate inquiry, perpetration). Attitudes were measured with a 9-item questionnaire (cultural factors, documentation of suspicion of abuse, patient autonomy). Skills were measured with an 8-item measure (protocol awareness, policy awareness, camera availability, referral knowledge). **Participants** 73 participants (80% female).	"There were no differences between participants' views of the seriousness of IPV in the community or their practices before or after the training. However, participants scored significantly higher on the knowledge and efficacy measures after the training." (p. 1260) "Following an educational intervention, providers demonstrated more knowledge and efficacy regarding routine inquiry and referral for IPV. Barriers to universal implementation still warrant attention." (p. 1260) **Limitations** Sample size and drop-out rates were attributed to limited participation due to ongoing clinical responsibilities or incomplete participation because of unknown time conflicts. Some participants left the training before the completion of the lecture and role-play. Accordingly, these individuals did not submit a post-test. Future research with the VHA population should identify key educational elements of continuing education curriculum on IPV to maximise instructional time investments. Some sites reported that 7 hours was too long to release health care providers from patient care. Also, because of the number of males who participated, potential gender differences in the reception of the curriculum could not be assessed. Ongoing studies are needed to assess the translation of understanding, attitudes, and knowledge into behavioral change.

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					Because this was a pre- and post-evaluation, the study could not assess whether the efficacy improvement translated into practice.
Gadomski et al., (2001)	"To implement and evaluate a multifaceted DV management program in a rural health network involving 3 hospitals and 19 regional sites located in Central New York State." (p. 1046)	Conceptual and instrumental utilisation (screening, referrals) Health care professionals	**Educational intervention** 20 trainers trained for 1 day per week for 5 weeks (medical, psychological, legal and social aspects to managing DV). 20 trainers, in turn, targeted staff in their work for shorter training. Bi-monthly newsletter. **Organisational intervention** Clinical protocol for identification management and referral for DV was distributed to all sites to reinforce training. **Patient-mediated intervention** Patient-education materials were designed for each location including a resources and education booklet for DV victims. Bathroom posters listing local and state DV numbers. Public health campaign: following the training period of the project, a public health education campaign was conducted. Radio and print advertisements (message focused on recognising full spectrum of DV, effects of DV and promotion of public disapproval and actions to take).	A questionnaire designed by the Centers for Disease Control to measure knowledge, attitudes, beliefs, and intended behaviours of health care providers in relation to DV was administered to 380 health care professionals, with a follow-up survey completed two years after the intervention.	"A comprehensive training program for health care providers can increase their self-efficacy in responding to DV victims." (p. 1045) "This study showed significant changes in the knowledge, attitude, beliefs, and behaviors of health care providers following a multifaceted intervention. However, it is difficult to attribute the changes observed to any one component of the intervention or to any of the demographic characteristics or experiences for which data were collected. In addition, how these self-reported changes relate to the outcomes experienced by victims interacting with the health system is unknown." (p. 1050) "The response rate for the pre-post intervention surveys were 67% (n=380) and 56% (n=273), respectively. Two scales were correlated in the baseline survey: self-efficacy (related to DV response) and familiarity with referral resources. Reporting of victim identification in the preceding year increased from 36% to 39%. Those with training were more likely to have identified a victim within the year. Among the 232 respondents with complete data, multiple analysis of variance demonstrated statistically significant overall improvement across all scales." (p. 1045) "Significant increases from pre- to post-test were found in screening, workplace resources, making referrals, provider self-efficacy, victim autonomy, victim understanding, legal requirements, staff preparation, and too busy/ can't help." (p. 1045)

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
Shye et al., (2004)	To compare the effectiveness of two quality improvement approaches to enhancing the secondary prevention of DV in primary health care settings.	Conceptual and instrumental utilisation (routine Inquiry about DV exposure of female patients and mothers of paediatric patients at health maintenance visits). Health care practitioners.	*Basic Implementation Strategy (BIS)* **Educational intervention** **Organisational intervention** **Patient-mediated intervention** A guideline with a routine inquiry rather than a universal screening approach, recommending that primary care clinicians routinely ask about DV exposure of female patients and mothers of paediatric patients. DV response teams (eg nurses, social workers, female doctors) to intervene with identified DV-exposed people. Half-day conference to train DV response team members and other clinicians. Articles: (i) the clinician's role in response to DV for the HMO's local medical journal; (ii) signs and dynamics of DV, encouraging HMO members to discuss DV problems with their primary care clinicians, for the HMO's member newsletter. Information cards about community resources for DV victims placed in restrooms. Printed materials, including patient brochures and pocket reminders for clinicians about screening, safety assessment, safety planning, and community referral resources.	Pre/post study design comparing 2 interventions. *Clinician Self-Administered Questionnaires* (pre- and post-intervention. They elicited data on DV-related knowledge, attitudes, and reported practices (KAP). *Patient Telephone Surveys.* Trained interviewers conducted 10-minute structured telephone interviews with female patient subjects pre- and post-intervention to obtain data on socio-demographic characteristics, rates of clinician inquiry about DV, rates of DV disclosure, and satisfaction with the HMO's efforts to address DV problems. **Participants** The study setting was a large, not-for-profit group practice HMO in the northwestern United States. *Clinician Subjects* eg paediatric and OB/gyn physicians, physician assistants, nurse practitioners (n = 273). *Female Patient Subjects.* Health maintenance visits by women 18-45 years to clinicians during the pre- or post-intervention evaluation period identified through the HMO's appointment and encounter databases. Final sample sizes were n=1925 and n=1979 for the pre-	"Both strategies resulted in significant improvements in rates of clinician inquiry about DV and in most clinician KAP measures." (p. 706) "Substantial sustainable improvement in secondary prevention of DV in primary care is feasible in an HMO primary care setting using existing organisational mechanisms and current staff levels." (p. 706) "Pre-intervention, ¾ of clinicians supported the routine inquiry approach to DV detection." (p. 712) "The proportion of clinicians in either the "action" or "maintenance phase" stage of readiness to routinely inquire about DV exposure rose from 16.7% at baseline to 35.9% at follow-up. All mean KAP scores except for general knowledge about DV improved between baseline and follow-up." (p. 712) "Exposure to the ABIS was associated with significantly greater improvement only on process of change and pros of routine inquiry." Also, "at follow-up, 78.8% of ABIS clinicians knew about their medical office's DV response team compared with 48.8% of BIS arm clinicians." (p. 712) "Women's satisfaction with the HMO's efforts to address DV problems rose dramatically during the study period; the proportion of respondents who were "very" or "somewhat" satisfied rose from 38.5% at baseline to 64.2% at follow-up." (p. 712) **Recommendations** Clinician behaviour change be viewed as a process of organisational cultural change to be undertaken over the long term using multifaceted implementation strategies that employ techniques consistent with accepted theories of behaviour change.

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			HMOs allotted 4 hours per month to the paediatrician co-chair of the task force to oversee implementation. Funds for materials to support staff training and purchase cameras for documenting abuse. No funds were available to support office staff time dedicated to implementation activities. *Augmented Basic Implementation Strategy (ABIS)* **The addition of linkage & exchange intervention** Giving medical office social workers paid time to assume a structured role as DV social change agents. The role involved (1) conveying information to clinicians about DV prevalence and risk markers, dynamics of abusive relationships, etc; (2) advocating an active primary care clinician role in secondary prevention; (3) elucidating the appropriate goals of screening and intervention activities; (4) modelling secondary prevention skills (eg asking patients about DV, danger assessment, etc). These activities were undertaken in department meetings and individual academic detailing style contact with clinicians.	and post-intervention respectively. Response rates for surveys were 85.8% (n=1652) pre-intervention and 80.7% (n=1598) post-intervention.	There is a need "to investigate and address the special barriers to screening that exist in the paediatric setting." (p. 706) A decentralised approach (here implementation responsibility was delegated to local medical office managers) gave staff flexibility to develop implementation strategies to suit their particular clinical settings, with the potential for the "emergence of local initiatives and opinion leaders. Its weakness is that if barriers to the desired change are substantial, the change simply may not happen." (p. 714) There are " implications for policy decisions of HMOs about the level of resources needed to achieve DV-related organizational goals." (p. 713) "Further progress in DV secondary prevention might be achieved through greater involvement of non-clinician staff (e.g. medical assistants) in routine inquiry, and by increasing environmental cues that encourage women to self-disclose abuse." (p. 715)

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Toprak Ergonen et al., (2007)	To measure the effectiveness of an interactive DV course given to university students.	Conceptual utilisation. Medical students.	**Education Intervention** Two-hour DV course. The learning objectives were to make medical students question their personal prejudices on DV, to create awareness on the issue, and to inform about physician's responsibilities and legislation. Students worked in two groups, on two cases (violence against women and violence against children). Afterwards, an interactive lecture was given on violence against women and children, physicians' gender-based prejudices and responsibilities, and international medical associations' relevant recommendations.	Pre, post (1 month later) and follow up (6-8 months later) questionnaires. The questionnaire consisted of student characteristics and knowledge questions on DV. 8 MCQs and 12 true–false type questions. Additionally, wo questions reflecting students' personal experience on physical DV and their opinions on the integration of this topic in medical education. **Participants** Year five university medical students that attended the forensic medicine course in the April-July 2004 period. N=30 (approximately 15 students in each group) Nineteen out of the total 30 students included in the study group were female (63.3%) and 11 students were male (36.7%); their mean age was 23.23(±0.90).	"The course increased students' knowledge level and led them to question their physical DV experiences." (p. 443) "Highest average score was observed 1 month after the course. This was followed by the average score of the third test given 6– 8 months later. The lowest average score was obtained in the pre-course test." (p. 444) "There was a statistically significant difference between the average scores of pre-test and second test. There was a statistically significant difference between the scores of test questions on the description and frequency of DV, child abuse, the legal status in our country and the responsibility of physicians." (p. 443) "A statistically significant increase was found in the average scores obtained in the second and third tests compared to pre-test."(p. 443) "Compared to pre-test, the average scores obtained in the second and third tests were higher."(p. 444) Also statistically significant, "the percentage of students who said they had experienced physical DV increased from a 36.7% pre-course level to 50.0% after the course. This finding led to the consideration that the course increased awareness on DV." (p. 444) "All participants evaluated the integration of DV in medical curriculum as necessary." (p. 444) **Recommendations** "Based on the observation that average scores tended to decrease over time in the after course period, and aiming to produce physicians capable of managing DV cases in future professional life,

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					educational improvements for the following years were planned to support retention of knowledge and behavioural changes. For year five curriculum, the addition of other interactive educational methods like role plays, and for year six an advanced training session consisting of approaching DV victims and flow charts on their diagnosis, treatment and rehabilitation, is planned." (p. 444)
Grafton et al., (2006)		Conceptual utilisation. Public health nurses	**Educational intervention** Seven hour training	Pre-test and post test (immediately after training), 7-hour training. Knowledge, attitudes, and efficacy were measured with an adaptation of an educational assessment tool designed by Lynne Short and used with permission. Knowledge was assessed with a 31-item measure (risk factors, warning signs, safety plan, appropriate inquiry, perpetration). Attitudes were measured utilising a 9-item questionnaire (cultural factors, documentation of suspicion of abuse, patient autonomy). Skills were measured with an 8-item measure (protocol awareness, policy awareness, camera availability, referral knowledge). **Participants** 73 participants (80% female).	

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Brackley (2008)	To describe a project that designed and implemented evidence-based training on DV in a county health system. To evaluate its effectiveness on patient outcomes. The Safe Family Project was designed to improve care to victims of DV by using a logic model to direct and evaluate the project.	Conceptual and instrumental utilisation (identification and referral). Clinicians/ practitioners in health (nurses and social workers).	**Educational intervention** The training aimed to improve the identification, safety, treatment, and referral/follow up of victims and perpetrators of DV by: (1) developing specific training strategies for different areas of the county health system; (2) building institutional support for the project; (3) printed and visual materials for patients and clinicians in English and Spanish; (4) creating CQI to monitor the ongoing system response (Swenson-Britt et al., 2001); (5) connecting the project institution-wide and bridging it into community. A video titled 'More than Words' was used in training. **Theoretical models:** The Achieving Outcomes Logic Model – Developed by the United States Department of Health and Human Services, Substance Abuse Mental Health Services Administration - the Center for Substance Abuse Prevention (2002) follows these steps: 1) needs and assets assessment; 2) capacity building; 3) program selection; 4) implementation and assessment; 5) final evaluation.	Investigators measured outcomes by evaluating the impact of parts of the program on staff; the success of the training workshops; and an increase in identification of abuse and number of referrals as measured by diagnostic coding, charting, and photography. Note - The 'DV survey' developed by Doepel et al., (1994) was completed by staff prior to training. This survey was developed to determine the impact of training on the attitudes and behaviour toward DV along with its detection and treatment by healthcare providers who may or may not have had personal and professional experiences with violence. The Doepel survey measures three aspects of behaviour: knowledge, skills, and attitudes. **Participants** 631 staff attended the classes on DV. Staff were within the EC and obstetrical-gynaecological areas.	***Immediate Goals*** **Educational Intervention –** "The percentage of staff with DV training rose from 56% to 93%. Staff knowledge on DV improved from 4.7 to 6.5 on 10 items. In other words, following training, they averaged 65% correct responses, whereas prior to training, they chose only 47% of the right responses. The staff also improved on the 10 skill items with scores rising from 5.4% to 6.4%. However, scores related to self-rated attitude toward victims decreased slightly from 126 to 119 on a 7-point Likert type scale of 26 items." (p. 24) **Participant satisfaction –** "Staff received the Safe Family training with very positive results. Evaluations from the Train-the-Trainer workshops revealed overwhelmingly positive responses to video, speakers, and the topic; 78 out of 85 attendees completed the scale. These participants gave the Train-the-Trainer workshop a positive rating of 3.5 on a scale of 4." (p. 24) **Diagnostic Coding –** "Diagnostic coding, which allows identification of cases across the system, is increasing. However, it is still not at the expected level. In charts where DV appeared, physicians still used the diagnosis of assault as the primary code. This is partly due to the templates used in the EC for charting." (p. 24) **Quality of chart/photography –** "Chart audits of patients seeking treatment for DV show improved documentation and patient counselling with 100% referral to the battered women's shelter. In addition, community agencies report receiving patients who have been referred for care. Overall, investigators found a vast improvement in documentation of DV by nursing and social work. In 100% of identified

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			Parker and McFarlane's (1991) model was used for the program 1) needs and assets assessment; 2) capacity building; 3) program selection; 4) implementation and assessment; 5) final evaluation. Parker and McFarlane's (1991) model was used for the program selection phase. Parker, B., & McFarlane, J. (1991). Identifying and helping battered pregnant women. *American Journal of Maternal Child Nursing*, 16(3), 161–164.		cases, appropriate referrals and education were documented. Now, photographs of injuries are being used as a documentation tool, and the number of photographs in the vault has increased from 0 to more than 100 sets. As a result of the Project, one unexpected discovery occurred in cases where substance abuse is involved: The tone of documentation has changed. Although the hospital has ready access to licensed chemical dependency counsellors, the staff made few referrals. Nor were referrals made for these patients in cases of DV. It may be that, in cases where alcohol involvement is an issue, providers fail to identify associated DV and to intervene." (p. 24-25) ***Intermediate goals*** "Systemic change and community involvement helped move the Safe Family Project toward success. Community partnerships led to development of the San Antonio Safe Family Coalition (SASFC), along with a cooperative agreement to develop and evaluate a coordinated community response in order to prevent intimate partner violence (IPV)." (p. 25) **Numbers of referrals to community services** – "Prior to training sessions, staff documented patient education 42% of the time. Out of 32 identified DV cases, staff documented referrals to the battered women's shelter only seven times. Post-training, staff reviewed referrals via chart audit and by report from community partners receiving clients. The reports were largely anecdotal but powerful. Women reported feeling protected and encouraged to get help. Where before they felt blamed, now they felt empowered. Staff called in personnel from the district attorney's

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					office to write Orders of Protection on site. Advocates provided detailed information about what to anticipate when seeking services. Agencies receiving clients developed a clear picture of how DV is treated by providers. Changes in provider behavior were viewed as an improvement by these agencies." (p. 22)
Wills et al., (2008)	"To test whether a comprehensive practice change approach used in Hawke's Bay District Health Board (HBDHB) could lead to improved detection of child and partner abuse in our district health board." (p.93)	Instrumental utilisation (universal screening). Health care professionals – all staff working with women and children in a mid-sized regional health service.	**Educational intervention** "A full-day training is provided including lectures, interactive sessions and modelling and practising risk assessment using role play. Staff are taught to routinely include a question about partner abuse in their social history and the 'dual assessment 'model is taught." (p. 94) Training involves staff from community agencies, to allow opportunity for direct questioning and introduce clinicians to the staff to whom they will be making referrals. Refresher training is offered on a service-by-service basis annually and as necessary. Advanced training is offered annually to key senior staff and internal champions within each service. Resources for staff: Literature folders, posters, community directory, child abuse flipchart, laminated flowcharts of child and partner abuse intervention, cue cards that attach to the staff's ID badge. **Organisational intervention** "Documentation has been important	Pre-post evaluation of training. Audit of clinical record (6176 records) • to assess whether routine questioning for partner abuse had been performed (a +/-tick box in the record); • to assess rates of partner abuse disclosure; • appropriateness of referrals; • quality of assessment of child and partner abuse when identified. Audit of Family Violence Accessory File, records of women presenting with assault at ED. Interviews – 85 interviews of 60 staff to assess barriers and enablers of practice change. **Participants** More than 700 staff were trained (in 38 full day training sessions).	"After training clinicians are more confident to identify, assess and refer abuse, but require ongoing support and training. Advanced and refresher training evaluations suggest that these sessions also effectively increase staff knowledge and comfort with identifying and managing child and partner abuse. The number of notifications from HBDHB to CYFS (Department of Child, Youth and Family Services) increased from 10 per quarter to 70 per quarter. Documentation audits suggest that the quality of information within clinical records and referrals to CYFS is increasing, particularly for history/ risk assessment and discharge summaries. CYFS also report that notifications are appropriate and informative, and that interagency relationships are strengthening. Screening for partner abuse is increasing in most services, with rates between 6% and 100% recorded during the 2005/06 years , although there is considerable variability in the rate of screening between services still. The number of women disclosing abuse is increasing, as is the amount of referral information provided." (p. 95) "Identification of partner abuse increased from 30 to 80 per 6-month period. Routine questioning rates for partner abuse vary between services." (p.92)

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			standardised and amended to include a tick box prompting staff to screen for partner abuse and standardised forms to record history and findings when child abuse is suspected or identified (Child Abuse Record Form) and when partner abuse is disclosed (Family Violence Accessory File)." (p. 94) **Patient-mediated intervention** Posters and pamphlets in clinical and waiting areas, wallet sized safety plans and local agency support cards are provided when partner abuse if disclosed. General: "Redefining success in partner abuse as empowerment and allowing the victim to control the actions they take has been an and ongoing focus of the FVIP." (p. 94) **Models drawn from included:** The Ottawa Charter for Health Promotion; Soft Systems Methodology; Force Field Analysis; The Commitment, Enrolment and Compliance Model; Total Quality Management; Organisational Learning; Action Research		**Barriers** "Organisational barriers to routine questioning for partner abuse include lack of privacy to screen, lack of time/ being too busy and not knowing the outcomes of intervention. Personal barriers to questioning include discomfort with the question/lack of confidence to ask, fear of offending the woman and forgetting to ask." (p. 95) **Facilitators** "Organisational enablers include feedback and supervision, prompts and refresher training. Personal enablers include personal determination, positive feedback from women regarding screening and staff developing their own 'patter' with the intervention. Staff indicated that the more they ask the questions the more comfortable they become; their level of comfort appears to correlate to their rate of screening. Interviewee responses suggested that, as they became more comfortable with asking the routine question for partner abuse, they became more proactive in seeking opportunities to ask and their rate of questioning increased. Subsequent interviews with staff suggest that they also find this a helpful way of conceptualising the relationship between their level of comfort and rate of screening. Staff are proud of their expanded skills and report having greater job satisfaction from being able to respond appropriately when abuse is disclosed."(p. 95-96)

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Wathen, Sibbald, Jack & MacMillan (2011)	The purpose of the project was to develop and evaluate KTE strategies to share research findings with policymakers, health and community service provides and women's advocates. "Specific research questions were: 1. How do recipients of research evidence perceive the utility of specific KTE strategies in the area of violence against women? 2. What factors, according to those receiving research evidence, influence the uptake, sharing, and use of the new knowledge? 3. And what kinds of use are made of research findings? We also reflect on the 'lessons learned' from this longitudinal project that might be applicable to KTE efforts and evaluation more broadly." (p. 3)	Policy makers, health and community service providers and women's advocates. Research reports: • IPV screening effectiveness trial • Educating Health Care Providers to identify and respond to abuse • Public awareness and services • MacMaster VAW Research Program Projects and Publications; • Women's Views, Experiences & Needs for Woman Abuse Screening • Health Care Providers' Knowledge, Attitudes and Practices to	***Phase 1: Research Messages*** **Educational intervention** Workshops about key messages from research: Stakeholder workshops and half day workshops with facilitated discussion focused on 'what are the implications of these findings' and 'what should happen next'. **Electronic intervention; linkage & exchange intervention** Online community of interest. Interactive website. ***Phase 2: Results of Screening Trial*** Key message development. **Education intervention** Family violence knowledge exchange forum. Day-long meeting, 76 stakeholders. Focus on high-level key messages and discussion of policy and practice implications. **Patient-mediated intervention** Media. Publication of screening trial in JAMA. **Theoretical model** Interaction model of knowledge translation. *Landry R, Amara N, Lamari M: Utilization of social science research knowledge in Canada. Research Policy 2001, 30(2):333-349.*	A longitudinal cross-sectional design, applying concurrent mixed data collection methods was used to describe and assess KTE processes and their impact on the types of knowledge utilisation. Phase 1 examined the process for developing initial research messages and sharing them with stakeholders at an interim point in the research program. • Key message development through a review of research program reports to identify relevant findings. Key messages were identified using a structured, iterative process, including input from the research team and policy makers/ funders; • Stakeholder workshops and evaluation; • Half day workshops with facilitated discussion focused on 'what are the implications of these findings' and 'what should happen next'. Evaluation survey immediately post workshop (n=75), an online follow-up survey about 3 mths post workshop (n=33) and in-depth telephone interviews about 6 mths post workshop; • Development of an online community of interest; • Interactive website	"This longitudinal, mixed methods approach to evaluating the KTE process and its outcomes is rare in the literature, and, to our knowledge, has not been reported in violence research." (p. 11) **Talk, trust and time** – "participants valued the opportunity to meet with researchers, provide feedback on key messages, and make personal connections with other stakeholders." (p. 1) "Importance of personal relationships to facilitate KTE not a new finding and more recent work highlights the fact that highly interactive relationships significantly facilitate the adoption of tailored KTE innovations." (p. 11) **Assessing knowledge use.** "A number of factors specific to the knowledge itself, stakeholders' contexts, and the nature of the knowledge gap being addressed, influenced the uptake, sharing, and use of the research." *p.1.* "In terms of how participants reported using the research findings, a few interesting observations can be made (acknowledging small subsamples). First, following the 2006 workshops, while some participants did report using the findings, all indicated that this was at the conceptual or symbolic level, which is not surprising given the type of information presented–descriptive/epidemiological studies and an RCT that was more about process than outcome. After the 2009 forum, where results and recommendations about screening were presented, there were more (though still few) examples of instrumental use, along with conceptual and symbolic use. *Use was specifically related to both the types of decisions being made, and to where people were in the decision process: for those actively making decisions, specific instrumental applications were described;*

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
		Woman Abuse Screening • Patterns of Screening for Woman Abuse in Public Health Practice • Population Attitudes Towards Screening • Meta-Analysis of Risk Correlates for Woman Abuse • Development of the Risk Indicator Tool (RIT) for Woman Abuse • Public Health Nurses' Roles in Asking About	Assumed that effective KTE would require initiating and assessing 'various disorderly interactions occurring between researchers and users' and understanding that researchers and knowledge users (broadly defined) are two communities, or in the case of our identified stakeholder groups, multiple communities.	Phase 2 focused on uptake and use of the final results of the screening trial. • Key message development. Build on ones in phase 1; • Family violence knowledge exchange forum; • Day-long meeting, 76 stakeholders. Focus on high-level key messages and discussion of policy and practice implications, Forum evaluation with survey, analysis of small group transcripts, participant follow-up survey and follow-up interviews; • Media; • Publication of screening trial in JAMA led to significant media interest. **Participants** Policymakers, health and community service provides and women's advocates. This is not a cohort of individuals followed across time, but rather individuals who self-selected participants at these various points in the study 190 stakeholders were invited to the 2006 workshops and 82 attended; 217 were invited to the forum, and 76 attended;	*for those planning to make or requiring support for previous decisions, use was at a more conceptual or symbolic level– i.e. to 'justify' or 'convince.' Consistent with previous literature, however, it is not surprising that instances of reported instrumental use were infrequent, especially among these kinds of stakeholders."* (p. 12) "The types of knowledge use changed across time, and were specifically related to both the types of decisions being made, and to stage of decision making; most reported use was conceptual or symbolic, with few examples of instrumental use. "Participants did report actively sharing the research findings with their own networks. Further examination of these second-order knowledge-sharing processes is required, including development of appropriate methods and measures for its assessment. Some participants reported that they would not use the research evidence in their decision making when it contradicted professional experiences, while others used it to support apparently contradictory positions. The online wiki-based 'community of interest' requested by participants was not used." (p. 1) "In summary, a number of factors influenced the uptake, sharing, and use of new research knowledge related to identification, in healthcare settings, of women exposed to violence. These factors are: • specific to the information itself; • characteristics of those receiving the messages; • characteristics of their knowledge use contexts;

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
				139 stakeholders (34%) were invited to both events, and 15 (8.9%) attended both. A wide range of settings and roles were represented, with 56% of participants reporting having multiple decision-making roles, and a significant number reporting an overlap between clinical/ service delivery and planning/ administrative roles.	• the nature of the knowledge gap being addressed. In particular, the factors that stood out, as reported by participants, included the potential concordance or discordance between the kind of (research-based) evidence that our studies provided, and other kinds of knowledge, including practice-based experiences, in determining knowledge uptake, sharing, and use. Related to this, the nature of the research area– where beliefs are often strongly held–makes KTE a particular challenge. Perhaps hindering the overall process was the potential for some of our results to be viewed as ambiguous or inconclusive, which may have presented the opportunity for multiple interpretations and applications of the 'bottom line.' Finally, while there was some indication that specific stakeholder setting (e.g. organisational versus individual practitioner; policy versus clinical) influenced the potential use and impact of the findings, sub-samples were too small to explore this more fully." (p. 14)

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
Salmon et al., (2006)	"A feasibility study to evaluate the effect of an educational program on midwives' knowledge, skills, attitudes and implementation of routine antenatal enquiry for DV." (p. 6)	Conceptual and instrumental utilisation (routine enquiry). Midwives.	**Educational intervention** Advertised as mandatory and took place over a normal 7.5-hr working day. Groups ranged in size, from eight to 12, with a mean group number of 10. Two trainers were present undertaking different elements of the teaching and group work that centred on the following elements: background information on pregnancy and DV; skills-based learning; dissemination of national and local policy guidance on inter-agency responses to DV; and practical advice and resources for women who presented with a positive disclosure **Theoretical model** Interaction model of knowledge translation. *Landry R, Amara N, Lamari M: Utilization of social science research knowledge in Canada. Research Policy 2001, 30(2):333-349.* Assumed that effective KTE would require initiating and assessing 'various disorderly interactions occurring between researchers and users' and understanding that researchers and knowledge users (broadly defined) are two communities, or in the case of our identified stakeholder groups, multiple communities.	The 79 participating community midwives completed a 38-item questionnaire at three points during the study, at pre-test immediately before the program, at post-test immediately after and at 6 months follow-up. The questionnaire was divided into a number of sections that reflected the content and learning outcomes of the program. Many of the items included were closed questions or focused on respondents completing agreement scales. However, there were a number of open questions where respondents were asked to share their perceptions around practice. The following areas were examined. • Knowledge of DV; • attitudes of DV and routine enquiry; • efficacy beliefs (perceived confidence and knowledge base). At follow up only, midwives were asked to rate a range of barriers and sources of support which inhibited or facilitated inquiry; and report number of clients who had disclosed old or new violence since introduction of routine enquiry. **Participants** Midwives (n=79).	"The program was positively received by participants, particularly in relation to an increased awareness and confidence in dealing with DV. …associated with improvements in knowledge, attitudes and efficacy at post-test. These changes declined but remained above pre-test levels at 6 months follow-up. Levels of current and previous experiences of abuse obtained by midwives were predicted by past experience of dealing with the issue and efficacy scores immediately after and at 6 months after program delivery. Rates of enquiry after program introduction were lower than anticipated, with midwives routinely asking only 50% of the time. However, the key barrier identified was the presence of a male partner." (p. 6-7) "Implications for practice: The effect of routine enquiry for DV on midwifery role development needs further exploration before universal introduction. Seeing women alone at least once during a pregnancy would clearly increase opportunities for directly asking about violence and allowing safe disclosure. Where enquiry is introduced, midwives should be given access to validated educational programs and structured ongoing support if enquiry is to be sustained over time. Although further evaluations are necessary, it may be advisable to focus on skills- based programs that increase midwives' confidence and prioritise support and safety aspects for midwives and women during enquiry about DV." (p. 7)

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
Protheroe, Green, Spiby (2004)	"To evaluate the impact on midwives of a training program designed to increase their awareness and understanding of violence against women from men they know." (p. 94)	Conceptual utilisation. Midwives.	**Educational intervention** 3 hour training session followed by a 2/3 month reflective practice period before attending a 1 day training session. Content focused on helping midwives to understand DV and addressing the midwife's role in caring for women experiencing DV.	Cross-sectional survey using semi-structured interviews. **Participants** 55 midwives who attending training – 26 agreed to participate in study.	"Participants reported greater awareness and understanding of DV, and an increased likelihood of identifying and supporting women, partly through improved knowledge of other helping agencies. However, there was considerable uncertainty over issues of confidentiality and documentation. Practical difficulties were raised in implementing training within the midwifery role; these included time and privacy." (p. 94)

Sexual Assault

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
McLaughlin et al., (2007)	To determine the baseline competence level of resident knowledge and treatment of sexual assault patients. To demonstrate the effectiveness of focused training sessions at increasing resident competence.	Conceptual utilisation. A multimodal education and assessment model which aims to build the competence of emergency medicine residents in the treatment of victims of sexual assault. Emergency medicine residents	**Educational Intervention** • The content of the educational intervention was determined by the objectives and practice standards of the SANE program. • "The educational intervention lasted 8 hours and included didactic sessions, hands-on practice with the standard sexual assault evidence kit, usually for 1 hour, and interviewing practice using role players." (p. 490) • "The sessions occurred in January and February 2004." (p. 490) • "The 8-hour session was split up into 1 4-hour session on the first day and 2 x 2-hour sessions on the second day." (p. 490) • "The role-playing sessions consisted of pairs of residents who practiced interviewing each other while they were supervised by a member of the expert panel." (p. 490) Learning Objectives: • Incidence of Sexual Assault • Development of SANE • SANE Examination • SANE Evidence • Legal Aspects and Prosecution of Sexual Assault Cases.	The design included pre-test, intervention, and re-test at 6 months. The 4 assessment tools were a written knowledge test, evidence collection on a mannequin-based simulator, a simulated standardized patient interview, and the quality of a written ED note on the patient. In addition, resident satisfaction post-course was surveyed by using a 5-point Likert scale and 7 questions addressing various aspects of the training program: clarity of course objectives, success in meeting objectives, relevance to medical practice, knowledge improvement, skill improvement, course effect in changing residents' attitudes, and appropriateness of time for material. **Participants** 27 postgraduate years (PGYs) (4 participants were excluded so final sample was 23). 1-3 emergency medicine residents at an urban academic medical centre in a city with an active SANE program since 1996. Experienced SANE nurses with at least 1 year of experience were used	"Emergency medicine residents training in an urban center with an active SANE program had limited knowledge and skills in the treatment of victims of sexual assault. [The] …multimodal educational intervention increased residents' knowledge and evidence collection skills to levels equivalent to that of experienced providers in a SANE program." (p. 489) "Compared with pre-intervention assessments, significant post-intervention improvements by residents were apparent at 6 months in written knowledge… and in evidence collection. The improvement in the written examination was spread across all areas of the test. Performance on standardized patient-interview-based communication skills did not change after the intervention... The quality of the written notes improved by 10%... Resident post-intervention written test knowledge was similar to that of the experienced SANE providers." (p. 492) Residents were highly satisfied with the course, with an average score across the satisfaction questions of 4.4 out of 5. **Recommendations** This study design "…allows other centers to develop a similar task-oriented approach to this area of education. Although [the] evaluation was not designed to test the effectiveness of the training among patients, [the authors] believe that the training and forensic evidence collection skills will have spill-over effects

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
			• Acute and Follow-up Care	to collect baseline knowledge data for comparison	for similar patients, such as patients with a history of DV or interpersonal assault. The educational intervention is only the first step in… residents' education about the treatment of sexual assault patients. Attitudes are difficult to change and are not likely to be entirely changed through didactic- and scenario-based learning" (p. 493-494). Practical experience and personal connections with patients are required. Residents will be participating in actual SANE cases by observing SANE examinations and collecting forensic evidence in a real case. The combination of didactic session and ongoing practical experience "… has improved the quality of the resident education experience in caring for these patients." (p. 494)
Noonan et al., (2009)	To understand how promising strategies can be disseminated widely, by examining the adoption and implementation of two sexual violence prevention programs in new settings. The programs are: *Men of Strength (MOST) Clubs* and *Expect Respect*. Following dissemination of the programs, two research questions were asked:	Implementation of two sexual violence prevention programs. Youth in school and community settings. Both programs employ a mentoring and role-modelling approach. *Expect Respect*: a school-based program with multiple components	**Education interventions** Each new adoption site received training and technical assistance from the original program developers. Each originating program delivered their standard 2-day training protocol to new adoption sites, which included in-person didactic and role-playing exercises. Training content covered program philosophy, key materials, logistics, and operations. Post-training, individual technical assistance varied across program and site.	Interviews with stakeholders investigated the factors and dynamics related to the adoption and implementation of these programs. The research team worked with the program developers to create measures of the fidelity of implementation, which were then administered at each site. Measures included: • program adoption interview • program fidelity instrument and interview. **Participants** *Expect Respect* support groups were disseminated to 15 new classrooms	**What are the individual, organizational, and institutional characteristics associated with adoption of this evidence-based program?** "Interviews with those involved in the adoption decision revealed the following: • those adopting these programs had a prevention orientation and were looking for resources to support this perspective; • organisations chose to adopt programs that are consistent with their culture, values, and philosophy—factors that may be more important than the program's empirical basis. In other words, *innovation fit* may be more important than anything else." (p. 68S) These findings suggest that matching a program's orientation with the philosophical foundations of implementation sites may increase both the rate of adoption and the degree of fidelity. "Given the

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
	1. What are the individual, organisational, and institutional characteristics associated with adoption of this evidence-based program. 2. What factors influence implementation with fidelity to the original model?	including support groups for at-risk youth. *MOST Clubs:* support groups for boys or young men in discussions about masculinity, relationships, and alternatives to violence. Clubs are convened in both school and community settings.	*Conceptual framework* Klein and Sorra's (1996) model of two interrelated sets of variables: (a) *innovation fit*—and (b) *climate for implementation*	in the state of Ohio. Support group facilitators were n=15. *MOST Clubs* were disseminated to six new sites (school and community) in the state of California. Group facilitators were n=6. Group facilitators tended to have prior experience working with adolescents and/or running groups.	importance of organisational– program match, it maybe useful to cultivate and support environments that are conducive to adoption and implementation, thus enhancing the *climate for implementation*." (p. 68S) **What factors influence implementation with fidelity to the original model?** "The qualitative and quantitative findings suggest • Implementation with substantial fidelity is possible. • Fidelity is increased as the result of careful staff selection, training, contact between program developers and facilitators, and ongoing technical assistance. • Deviations from fidelity (adaptation) can be benign or beneficial when done with a purpose and when adaptation does not threaten the underlying program theory. It remains to be tested whether adaptation changes program efficacy... • Adaptation may be appropriate when the implementation site serves a population which represents a cultural and/or developmental deviation from the original…" program population. (p. 68S) **Recommendations** • "The scale of dissemination and replication in this research is relatively small. Additional challenges will occur when programs are adopted…" (*p. 68S*) at large numbers of sites. Lessons should be learned from the private sector re: maintaining quality, eg in the case of franchising.

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
					• "…finding the balance between total fidelity and unrestrained adaptation remains a challenge." (*p. 68S*) Research identifying the relative contribution of individual program components (core components analysis) can help. • Organisations should feel empowered by the knowledge that effective programs exist and that they can be implemented with fidelity. "Fidelity should be viewed as multidimensional— organisations implemented some dimensions with higher fidelity than others." (p. 68S) • Adaptation "…is inevitable. Future research should identify the core components…. that are essential to program outcomes… Generically, these core components are associated with the key elements of the program theory." (p. 68S) Specifically determining the critical elements would be useful if wide dissemination is likely. • Future research should assess the effectiveness of processes designed to increase fidelity. For instance, training dosages and modality, technical assistance, and quality control.

Reference	Study objectives	Type of knowledge[1] & target population	KT strategies[2]	Study design & participants	Results
Parekh et al. (2005)	"To develop and implement an education program capable of addressing the needs of doctors wishing to practice sexual assault medicine." (p. 122) "…to provide a template for effective medical education in this speciality that [could be used] by other medical professionals working in this field." (p. 121)	Conceptual utilisation. Doctors wishing to practice sexual assault medicine.	**Educational intervention** An 'in-house' education program, participation in an external university course. "Core elements were: forensic evidence collection, assessment and management of injuries, prevention of sexually transmissible infections and pregnancy, counselling and emotional support." (p. 121) The curriculum was based on peer-reviewed research findings in the disciplines of medicine, basic science and the law. Session topics covered the physical, psychological and legal aspects of sexual assault medicine Participants were encouraged to identify deficits in their knowledge, so that these could be included in the program. Examples of requested sessions included the needs of adolescents and male survivors. **Linkage & exchange intervention** Team-building and networking activities. **Organisational intervention** Protocol development.	Semi-structured interview and a questionnaire to evaluate participant satisfaction and knowledge acquisition. The program was evaluated by measuring attendance at, and satisfaction with, the in-house education session; participation and achievement in the university course; retention rates; identification of program deficits; self-assessment of forensic specimen collection knowledge and techniques; review of court reports; feelings about court appearances and production of protocols. **Participants** Seven doctors participated in a 16-session program conducted by the director and nurse coordinator with help from local forensic, legal and medical experts.	"All doctors successfully completed the Certificate in Forensic Medicine, and reported satisfaction with the program and their increased knowledge…" (p. 121) "All doctors reported exponential increases in knowledge, especially related to the forensic aspects of sexual assault care." (p. 126) However, the net benefit of the program could not be estimated as participant knowledge was not evaluated pre-program. The combination of in-house education and University enrolment appeared powerful. The in house component had local relevance, took prior learning into account, and was flexible in being able to provide for any knowledge deficits. Doctors also benefited from interacting with each other, staff and presenters. The university component provided a 'big picture' view of sexual assault medicine. "The authors believe that the education program has made a substantial contribution to the high retention rate... As many of the doctors work in general practice, they reported appreciating the opportunity to interact with peers. The program was limited by the lack of opportunities for peer review." (p. 126) Local government support was found to be a crucial element in success, with a training budget and participation in the education program made compulsory and part of doctor contracts.

Non-implementation studies (commentaries and stakeholder surveys relating to KTE but not reporting on the implementation of a KTE strategy)

Domestic Violence

Reference	Study objectives	Type of knowledge & target population	Study design & participants	Results
Allen et al., (2007)	"…examined individual and organisational level characteristics related to health care providers' implementation of a desired reform in the community response to [DV]." (p. 103)	Conceptual and instrumental utilisation (universal screening). Implementation of universal screening for DV in community health care setting. Health care in health care settings.	Survey of 209 health care professionals in 12 health care settings: Nurses, doctors, midwives, social workers, physical therapists in clinics, hospitals, public health, mental health providers. 86% were female. Provider survey: • Frequency of engagement in various screening practices. • Beliefs about DV as a health care issue and about the screening process. • Capacity to screen, in particular perceived skills and knowledge of and comfort with the screening process. • Training background in DV. • Perceptions of organisational support for screening in their setting. Administrator Interview: Existence of various policies in each health care setting (presence of written policy regarding DV screening), whether standardised instruments were used etc.	"Both individual and organisational level characteristics are related to the implementation of routine screening for [DV]… fostering individual providers' knowledge, skills, comfort and beliefs *as well as* creating an organizational climate for the implementation of screening are critical components in the successful diffusion of this reform. Consistent with previous research… the current study indicates that in spite of national mandates and local reform efforts, providers are not in the practice of engaging in routine screening for DV. Fewer than half of the providers sampled indicated that they screen for DV *most* or *all of the time*." (p. 114) "… This study found that **individual-level factors** (beliefs, knowledge, skills and comfort) are related to provider screening practices [bold added]." (p. 114) Such as: • "those who held more positive beliefs about the value and appropriateness of screening in health care settings were more likely to engage in screening practices" (p. 114-115) • in contrast, "beliefs about DV as a health care issue did not emerge as a significant predictor of providers' implementation of screening practices." (p. 115) Holding beliefs that are positive to addressing DV as a health care issue, is not sufficient to ensure implementation.

Reference	Study objectives	Type of knowledge & target population	Study design & participants	Results
				• "…providers' perceived capacity to screen was significantly positively related to the frequency of screening... Providers' perceived capacity to screen also mediated the relationship between the breadth of providers' training and the extent to which they screened, suggesting that training may play a critical role in the implementation process by increasing not only providers' knowledge and skills, but also their confidence and comfort level." (p. 115) **Organisational changes:** • "….organisations viewed by providers as being more supportive of screening were more likely to have staff that implemented screening practices." (p. 115) • "…providers were more likely to screen in settings that had written screening policies; standardised procedures for screening, safety, and subsequent intervention… enforcement procedures for staff…. and brochures and posters on display." (p. 115) • "…supports previous findings that the implementation of institutional protocols for [DV] screening, in addition to the training of providers, looks to improve identification rates in comparison to training alone." (p. 115) • "…the breadth of setting characteristics that support screening in a given organisation was positively related to the extent to which providers were implementing desired practices" (p. 116) – more support is better. Not sure if this is cumulative or about the unique tools. • Study "…does not indicate which features of organisational settings are vital in the promotion of screening practices; organisations tended to have more than one support in place and all types were related to implementation." (p. 116)

Reference	Study objectives	Type of knowledge & target population	Study design & participants	Results
				Recommendations Previous research (Klein and Sorra, 1996) "…suggest that the extent to which there is an *innovation-values fit* regarding a particular reform will influence the extent to which staff engage in a new practices." (p. 115)Therefore, and given finding of those who hold more positive belief about the value and appropriateness of screening are more likely to do it, suggested that "direct participation in decision-making can increase ownership in the final outcome, [org] leaders might actively engage providers in designing policies, procedures, and instruments that address their concerns about the screening process itself… in addition to directly addressing concerns, stereotypes and fears about engaging in screening practices." (p. 115) The study "…further emphasises that training (which typically focuses on fostering knowledge and skills), although necessary, is not sufficient to foster the implementation of new practices systems-wide; corresponding organisational changes are essential." (p. 115)

Reference	Study objectives	Type of knowledge & target population	Study design & participants	Results
Brunetto and Farr-Wharton (2005)	To examine the impact of resources, accountability, management practices and organisational culture on the implementation of a DV policy within an Australian state police department. *Primary research question*: What is the impact of management and new public management (NPM) on the implementation of the domestic violence policy within Australia? *Secondary research questions:* Impact of NPM on resources & accountability: a. How does the level of resources accompanying a new policy affect the response of police officers to that new program? b. "How does the accountability accompanying a new policy affect the response of police officers to the new program?" (p. 224) Impact of management: a. "How do management messages (from different levels of the hierarchy) accompanying a new policy affect the response of police officers to a new program?" (p. 225)	Conceptual and instrumental utilisation. Implementation of a DV policy. Police officers; DV stakeholders (representatives from government departments and local community groups).	Mixed methods design: Interview with key stakeholders (DV counsellors, legal aid, senior police officers). Review of relevant state documentation in relation to addressing DV. Focus group with senior sergeants (first line managers) to identify key issues: Four groups comprising 5 sergeants and senior sergeants were randomly invited to attend a half hour session. Also a focus group with DV stakeholders. Questionnaire for constables/ senior constables and fist line managers developed by modifying a number of validated test bank items. A number of the independent variables used in the Johlke and Duhan's (2000) validated instrument for measuring "supervisor communication practices and service employee job outcomes" were used to test the impact of communication variables on police officers' decision to implement the DV program in full. Questionnaires - 180 useable questionnaires returned (of 400 distributed). **Participants** 180 police officers; male =129, female=551.	**Quantitative analysis results** **Impact of communication variables on the decision by police officers to fully implement the domestic violence program:** The findings suggest that there is a significant relationship between the combination effect of "communication frequency", "informal communication mode", "indirect communication content", "bi-directional communication flows", "ambiguity regarding clients, supervisors and ethical issues" and the decision by police officers to fully implement the domestic violence program. The significant factors contributing to the decision to implement were "ambiguity relating to clients" and "bi-directional communication". **Impact of management variables in explaining whether the DV program was implemented in full**: The results indicate that there was a significant relationship between the combination effect of "level of resources", "accountability", "cultural beliefs" and "management style" and the decision by police officers to fully implement the domestic violence program. Two significant factors contributing positively to whether the program was implemented were "level of resources" and "organisational culture". The significant negative factor contributing to the implementation process was the management practices. In addition, the means for the variables suggests that police officers perceive that they are not implementing the domestic violence program in full with the contributing factors being management practices, accountability, resource levels and organisational culture. **The effect of communication variables on moderating how police officers perceive implementation factors:** The communication variables do mediate how police officers perceive implementation factors.

Reference	Study objectives	Type of knowledge & target population	Study design & participants	Results
	The impact of organisational culture: a. "How does the established organisational culture of police officers affect their response to a new program?" (p. 225) b. "What is the impact of police officers' level of satisfaction with communication processes (frequency, indirect, informal and bi-directional) with first line managers (sergeants) on whether they implement the DV program when attending a domestic dispute?" (p. 227) c. "Does police officers' level of satisfaction with communication variables mediate their experience in relation to implementation variables (management practices (at different levels of the hierarchy) and the established cultural values, norms and practices of the police officers in addition to NPM factors – levels of resources and accountability)?" (p. 227)		Age = <30 years n=64, 31-45 years n=104, >45 years n=12. DV stakeholders: one senior, one middle and one lower management police officer, three representatives from relevant government departments and two representatives from local community groups.	The significant factors were "communication frequency", "informal communication mode", "ethical ambiguity", "level of resources" and "organisational culture". Hence, over 40 per cent of the decision to implement the domestic violence program is dependent on the way communication variables mediate the way police officers perceive implementation factors (management practices and the established culture in addition to NPM factors affecting resourcing and accountability practices). **Qualitative analysis results** **"Review of official documentation:** A review of the literature suggests that a community group comprising thirteen organisations was formed in the region to protect victims and hold perpetrators responsible for domestic violence in the region. In 1997, the police service committed to two phases of a strategy determined by the local community task force. Phase 1 included a "Faxback crisis intervention program" which required police officers attending a domestic dispute to provide a faxback form to the aggrieved. Upon returning to the station the police officer was expected to fax the form to a community group that was set up to assist victims. In addition, the attending police officer was expected to record the action taken on the DV index (Logan River Valley Integrated Community Response to Domestic Violence Group, 1998). An initial review of compliance by police officers with the Faxback program suggests a 57 per cent compliance rate for the first six months followed by an improved rate of 76 per cent for the following half year (Elliott, 2001, p. 23). The improved rate occurred because accountability was increased. The accountability took the form justifying why the police officer had attended a call-out but had not taken any action. A meeting followed this with the sergeant (first line manager of a

Reference	Study objectives	Type of knowledge & target population	Study design & participants	Results
				police station) where the police officers actions were discussed (Elliott, 2001)." (pp. 231-233) **Focus groups with managers:** "*How they communicated new policies/ protocols to their staff:* In all cases, first line managers used a mixture of face-to-face, e-mails, phone and fax to get their messages across. All shifts began with a regular meeting where issues of concern for both police officers and the (senior) sergeants were raised. As such, most of the communication was verbal. These information sessions complemented written documentation and training manuals associated with the implementation of a new policy. Each manager stated that his or her police officers received some training at the district level with regard to a new policy." (p. 233) *"How they knew that a new policy had been implemented:* The responses were unanimous that the accountability was very rigid, all police officers had to be compliant whether they personally believed in a policy or not" "Hence, the key factor identified as instrumental in implementing the DV policy was accountability." (p. 233) *"What was the biggest problem they faced in doing their job efficiently and effectively:* The responses varied in terms of detail; however, each referred to workload/ accountability issues. Managers argued that police officers complained bitterly about cumbersome reporting processes associated with inputting data for domestic disputes and traffic accidents. In both cases, the problem of having to write the same information on a number of screens (for different data bases) during the reporting process was perceived as significantly compromising the efficiency of police officers. In turn, police officers believed that the high adminis-

Reference	Study objectives	Type of knowledge & target population	Study design & participants	Results
				trative workload associated with these two types of crimes compromised their effectiveness in attending to other matters within an acceptable timeframe." (p. 233) "In summary, the findings suggest that the onerous accountability is causing ill feeling about attending domestic disputes." (p. 234) **"Focus group with DV stakeholders:** The first question asked participants to comment on how they felt that policing had changed in relation to domestic disputes in the past five years. Government department and community representatives were unanimous in their comment that now that police officers are accountable in relation to their responses to a domestic dispute, more victims are protected and over time the community and police acceptance of DV will lessen." (p. 234) "Hence, the findings suggest that there have been improvements in police process; however, community and government groups think there is still room for improvement. The second question asked senior police officers to comment on why they thought DV stakeholders might think that there is still a long way to go in terms of ensuring that the policy was fully implemented by police officers in relation to domestic disputes. The responses from the senior police officers suggested that whilst police officers did meet accountability requirements; the young age, limited experience and training of police officers perhaps resulted in poor decision-making by police officers attending disputes such that "some of them are going to slip through the nets". (p. 234) "Hence, there appears to be more issues in relation to the implementation of DV that cannot be addressed by more accountability; instead issues relating to training and the effectiveness of present practice need attention." (p. 235)

Reference	Study objectives	Type of knowledge & target population	Study design & participants	Results
Minsky-Kelly et al., (2005)		Instrumental utilisation (screening and referral). Health care providers. The health care setting in which the study took place is an integrated health care system consisting of two hospitals and a large multispecialty practice located in a medium-sized, midwestern community serving a population of more than 150,000.	The present study assesses barriers to identification and referral of DV victims by staff at a health care institution following a 3-hr DV training program in which 752 health care providers participated. Focus groups were conducted with staff following training.	"Overall, the present findings support the conclusions of Campbell et al., (2001) that achievement of changes in actual clinical practice requires the modification of institutional policies and procedures that may inhibit implementation of such practices. Findings from the present study represent an initial effort to identify the types of institutional and systemic barriers and department-specific barriers that may frustrate such efforts." (p. 1300) "The present study found that barriers to implementation of DV screening and referral protocols generally fell into five themes for the health care system studied: (a) questions about the appropriateness and value of screening given patient presentation and clinical setting, (b) inadequate provider expertise resulting in feelings of frustration, (c) concerns about time and workload priorities, (d) concerns about the process of screening, and (e) concerns about the outcome and efficacy of screening. In looking at the various categories of responses to focus group interviews, it is also interesting to compare responses by staff in different departments. Perhaps certain clinical settings present specific barriers needing targeted process improvement efforts by program administrators. There may be valuable lessons to be learned from settings in which staff identify fewer screening barriers." (p. 1293)

Reference	Study objectives	Type of knowledge & target population	Study design & participants	Results
Kothari, Sibbald & Wathen (2014)	To determine the extent to which an international public health network built effective partnerships among its members, with a focus on the knowledge user partner perspective.	PreVAil network – (preventing violence across the lifespan). The Network aims to: 1. increase understanding and knowledge about the links between mental health impairment, substance abuse, gender, and exposure to child maltreatment and intimate partner violence, in Canada and internationally; 2. develop interventions to prevent or reduce child maltreatment, intimate partner violence, and subsequent mental health problems; 3. develop and promote an integrated research and knowledge translation agenda among a network of investigators and key stakeholders.	"The objectives of this mixed methods study were to examine the: i) quality and ii) initial impacts of the partnerships within the PreVAiL network. Data were collected in 2011 and 2012, two years after the network became operational." (p. 3) Mixed-methods study consisted of a questionnaire and semi-structured interviews. The questionnaire examined communication, collaborative research, dissemination of research, research findings, negotiation, partnership enhancement, information needs, rapport, and commitment. The interviews elicited feedback about partners experiences with being part of the network. **Participants** There were approximately 75 people on the project team (trainees, partners, and researchers), who were invited to attend the annual meeting. Those present at the meeting (n=57) were invited to complete the PIQ. All 22 partners (representing 19 partner organisations) were invited to participate in the semi-structured interviews, representing the knowledge user perspective.	"Five main findings were highlighted: 1. knowledge user partner involvement varied across activities, ranging from 11% to 79% participation rates; 2. partners and researchers generally converged on their assessment of communication indicators; 3. partners valued the network at both an individual level and to fulfill their organizations' mandates; 4. being part of PreVAiL allowed partners to readily contact researchers, and partners felt comfortable acting as an intermediary between PreVAiL and the rest of their own organization; 5. application of research was just emerging; partners needed more actionable insights to determine ways to move forward given the research at that point in time." (p. 1)

Sexual assault

Reference	Study objectives	Type of knowledge & target population	Study design & participants	Results
Lord and Rassel (2000)	"(1) to compare the processes used by several North Carolina law enforcement departments in the investigation of sexual assault cases with a set of effective procedures identified by Epstein and Langenbahn (1994) and (2) to examine the influence of agencies' variables and relationships with rape crisis centers on the departments' methods of investigating sexual assaults." *p.74* "These practices, or reforms, include specialized sexual assault investigative units, in-house victim/ witness advocates, acceptance of anonymous reports from victims who do not wish to prosecute, written procedures, multiple interviews, confidentiality of the victim from the media, specialized training for investigators as well as patrol officers, and specific criteria for the selection of investigators." (p. 67)	Law enforcement departments with autonomous sexual assault centres. These centres serve sexual assault victims and educate the community about rape and rape prevention. They have not been combined with other services (eg domestic violence) and are not operated by a government agency.	• Site visit and follow-up telephone interviews with law enforcement investigators from thirty-four departments. • Supporting documents such as organisational charts, written investigative procedures, and report forms. • Each agency's history of interagency cooperation was examined. **Participants** Counties with autonomous sexual assault centres were selected (n=9). Investigators from all nine sheriff's departments, and the police departments of twenty-five towns and cities in these nine counties, were interviewed. Departments varied in size from five to several hundred officers.	• "Law enforcement departments in North Carolina appear to prescribe to some of Epstein and Langenbahn's procedures. The majority of those departments studied accept and receive third party and blind reports, obtain multiple interviews from victims, maintain victims' confidentiality, and provide sexual assault training to investigators; however, few have a specialized unit for sexual assault nor have selection criteria for such an investigator or unit. Few have victim advocates, written procedures, or train patrol officers who usually arrive at the rape scene first." (p. 84) • "Agency profile variables do not appear to be significantly related to the implementation of Epstein and Langenbahn's effective procedures." (p. 84) • "An effective relationship with rape crisis advocates does appear to be correlated with the existence of written procedures, a specialized investigator/unit and the use of blind reports." (p. 84) **Factors impacting implementation** • "departments with active relationships with the rape crisis centers in their communities are more likely to have specific investigators assigned to handle sexual assaults. Few departments attempt to budget an in-house advocate for victims, but many report their reliance on the rape crisis volunteers to support the victim throughout the criminal justice process and beyond. In many cases, police officers or sheriff's deputies serve on the boards of rape crisis centers. In fact, law enforcement officials in some areas were active in helping to establish the local rape crisis center." (p. 85) • "The evidence indicates that the implementation of some of these reforms was influenced by the departments' interaction with the rape crisis centers." (p. 86) • Research shows that "the type of sexual assault case investigated and prosecuted in a county directly reflects the opinions and attitudes of the community, whose citizens compose the juries. A district attorney is not likely to try a case that he or she believes will be lost. In turn, law enforcement is not likely to expend large amounts of resources investigating cases that are not likely to be prosecuted." (p. 86) • "High profile feminist groups helped elect district attorneys in one county in the study when the candidates for the office promised to prosecute more sexual assaults. Unlike some counties where citizens often refuse to believe that a sexual assault occurred, law enforcement officials in this county include in their definition of rape, attacks on women who are intoxicated and assaults occurring on a date or in high risk areas." (p. 85)

Reference	Study objectives	Type of knowledge & target population	Study design & participants	Results
				Recommendations • "A number of law enforcement reforms described by Epstein and Langenbahn would require department administrators to give sexual assault victims and the investigation of their assaults a priority higher than what currently exists. Research focusing on specific procedures of investigation and criteria for effectiveness appears to be sparse in the area of sexual assault investigation and support of the rape victim. Epstein and Langenbahn have pioneered a search for excellence in sexual assault investigation that needs to be expanded in future research efforts." (p. 86) • "Law enforcement departments often measure the success of their investigative activities by the number of cases that they are able to close. With sexual assault cases, this means of evaluation does not include the victim's needs, and more specifically, often omits victims whose assaults do not meet the definition of sexual assault established by the law enforcement department. As a human service agency, law enforcement departments need to explore new ways of measuring their abilities to meet victims' needs." (p. 87)

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