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Knowledge translation in the field of violence against women and children: An assessment of the state of knowledge ☆

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ABSTRACT

There is a significant discrepancy between the production of the most recent research findings and the utilization of the findings by practitioners. The scientific research on knowledge translation appears to offer a promising way to close this gap. However, it is still a young and undeveloped field, particularly with regard to violence against women and children, for which there is no overview of the studies that have been done. Without such a knowledge base, it is hard to support researchers and caseworkers in the knowledge translation process, and ultimately, enhance the physical and emotional safety and well-being of abused women and children. The aim of this review of the literature was therefore to take stock of the main areas of research on knowledge translation as they apply to the issue of violence against women and children. The review found 22 studies that met the criteria for inclusion. It highlights a number of barriers to knowledge translation in the field of violence as well as the lack of diversity in the knowledge translation strategies studied. Lastly, the review underscores the urgency of the need to document research initiatives in existing research–practice partnerships as a means of expanding scientific knowledge about knowledge translation in the field of violence.

1. Introduction

The many physical and psychological consequences of violence against women (Carlson, McNutt, & Choi, 2003; Golding, 1999; Rinfret-Raynor, Riou, Cantin, Drouin, & Dubé, 2004) and children (Higgins & McCabe, 2000; Manly, Kim, Rogosch, & Cicchetti, 2001) have been widely documented in the scientific literature. In light of this knowledge, it is incumbent upon us to see that effective initiatives are taken to attenuate the consequences of the violence and ensure the physical and emotional safety of abused women and children. It is well recognized that the use of the most recent research findings, especially evidence-based findings, is a determinant of the effectiveness of interventions (Dagenais, 2006; Davies, Nutley, & Walter, 2005). Yet a major discrepancy is evident between the knowledge produced and its use by practitioners (Davies, 2006; Graham et al., 2006), a phenomenon that seems to be worldwide (Dobbins, Ciliska, Cockerill, Barnsley, & DiCenso, 2002; Saul et al., 2008). Exploring the process of knowledge translation would appear to be a promising way to close the gap.

The objective of this study was to review the literature on the translation and utilization of knowledge on violence against women and children. More specifically, the review involved describing and synthesizing the studies on this issue and conducting a critical analysis of them. As an initial step in this review, the main areas of research relating to the process of knowledge translation in the general literature are presented.

2. Background

There is no consensus about terminology among knowledge transfer researchers, with a number of terms being used to designate the same concept, and the same term often designating a number of different concepts (Graham et al., 2006; Grimshaw, 2008). For example, an international study of 33 health research funding agencies identified 29 terms used by the agencies to designate the concept of "knowledge transfer and utilization" (Tetroe et al., 2008). In Canada, the Social Sciences and Humanities Research Council of Canada (SSHRC) uses the term *knowledge mobilization* and defines it as "moving knowledge into active service for the broadest possible common good" (see http://whatiskt.wikispaces.com/Knowledge+Mobilization, accessed August 27, 2009). At the Canadian Institutes of Health Research (CIHR), the term *knowledge translation* is used to refer to "a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge—[occurring] within a

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complex system of interactions among researchers and users[1]—to improve the health of Canadians, provide more effective health services and products and strengthen the health care system" (see http://www.cihr-cihr.gc.ca/e/26574.html, accessed July 17, 2009). Of the numerous terms proposed, the one that seems to be gaining popularity in Canada is *knowledge translation* (Graham et al., 2006). Moreover, *knowledge translation* as defined by the CIHR was adopted and adapted by the World Health Organization in 2005 (Sudsawad, 2007) and by the U.S. National Center for the Dissemination of Disability Research (Graham et al., 2006). We therefore decided to use the term *knowledge translation* (KT) in this study, especially since the CIHR definition applies quite well to the field of family violence.

Among the many theoretical models of KT described in the literature, four in particular are widely cited in social science (Estabrooks, Thompson, Lovely, & Hofmeyer, 2006; Landry, Amara, & Lamari, 2001). According to the *science push model*, it is the characteristics of the knowledge produced by researchers that influence its use by practitioners or decision makers (for instance, content-related characteristics—complexity, validity, reliability, etc., or characteristics related to the type of research—basic/applied, quantitative/qualitative, etc.). This one-way model (from research to practice) emphasizes the product of knowledge rather than the users' context (Neville & Warren, 1986). The *demand pull model*, on the other hand, assumes that knowledge utilization will increase if users, rather than researchers, formulate research questions to meet specific needs. If the findings do not match user expectations or desires, they will not be used much (Landry et al., 2001). The *dissemination model* maintains that knowledge transfer is not automatic, or in other words, that just because knowledge is available does not mean it will be used. Consequently, right from the knowledge-production stage, researchers should provide for means of disseminating research findings that can be adapted to suit the characteristics and needs of their target audience. While this perspective does seem to compensate for certain limitations of the *science push model*, users are still not involved in either the production or dissemination of knowledge (Landry et al., 2001). Last, the *interaction model* postulates that it is cooperation between researchers and users and incorporation of users' tacit knowledge and researchers' empirical knowledge at all stages of the KT process (knowledge production, adaptation, dissemination, receipt, adoption, and utilization) that encourage users to apply the knowledge in their actions or decisions. In other words, knowledge utilization depends on the intensity and regularity of interactions between researchers and users (Landry et al., 2001). The latter model has the advantage of incorporating "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 recognized that the complexity of the KT process may best be represented by a combination of several theoretical models, rather than any single one (Belkhodja, Amara, Landry, & Ouimet, 2007; Estabrooks et al., 2006; Sudsawad, 2007). Indeed, a number of other theoretical perspectives noted in the literature (Estabrooks et al., 2006; Proctor et al., 2009; Sudsawad, 2007) have the potential to guide KT initiatives. As a result, the preferred models are those that best fit the expertise, beliefs, and needs of the groups involved (Estabrooks et al., 2006).

Empirical studies have measured the determinants of knowledge utilization (barriers and facilitators) as highlighted by the four theoretical models, that is, the determinants related to the *knowledge produced and to the researchers' context* (science push model), to *users' needs and to organizational characteristics* (demand pull model), to *efforts to adapt and disseminate* (dissemination model) and to *interactions between researchers and users* (interaction model) (Cabana et al., 1999; Hemsley-Brown & Sharp, 2003; Légaré et al., 2006; Milner, Estabrooks, & Myrick, 2006; Mitton, Adair, McKenzie, Patten, & Perry, 2007). A Canadian survey of over 1200 academic social science researchers on the determinants of knowledge utilization indicated that "the most important determinants of utilization are the mechanisms linking the researchers to the users, the dissemination efforts, the adaptation of research outputs undertaken by the researchers, the users' context and the publication assets of the researchers" (Landry et al., 2001, p. 333). The authors were surprised to find that the characteristics of the knowledge produced had little influence on its utilization. Like that of Landry et al. (2001), other studies also highlight the influence of interaction-model determinants on the utilization of research findings (Galano & Schellenbach, 2007; Huberman, 1994; Reardon, Lavis, & Gibson, 2006).

A variety of *strategies* have been examined to assess effectiveness in reducing the gap between knowledge produced and its utilization by practitioners. The Canadian Institutes of Health Research (CIHR) have categorized the strategies based on whether they have to do with *educational interventions* (e.g., interactivity in lectures, continuing professional development), *linkage and exchange interventions* (e.g., opinion leaders, knowledge brokers, communities of practice), *feedback interventions* (e.g., chart audit, feedback, needs assessment), *electronic interventions* (e.g., reminders, clinical decision support systems), *patient-mediated interventions* (e.g., generic health-promotion educational activities such as media campaigns or more directed interventions) or *organizational interventions* (e.g., quality improvement, clinical practice guidelines).[2] It is now known, largely thanks to the medical literature (Dobbins et al., 2002; Sudsawad, 2007), that the simple passive dissemination of knowledge (for instance, by issuing clinical practice guidelines or giving a lecture) is not sufficient to ensure its application by practitioners and that emphasis must be placed on strategies that involve some sort of interaction (Grimshaw et al., 2001; Lavis, Robertson, Woodside, McLeod, & Abelson, 2003). Furthermore, the use of a number of strategies, rather than just one, also seems to be more effective (Gira, Kessler, & Poertner, 2004; Grimshaw et al., 2001). Nonetheless, it is not clear, at the present time, which strategies should be preferred in any given context (Grimshaw, 2008; Grimshaw, Eccles, & Tetroe, 2004; Lavis et al., 2003). As a guideline, Graham et al. (2006) suggest choosing strategies on the basis of identified obstacles for the intended audience. For instance, "When the barriers are related more to the organization of service delivery, introducing reminder systems, modifying the documentation system, changing staffing levels, purchasing equipment, or altering the remuneration process may be useful strategies" (p. 21).

The utilization of knowledge has been the subject of many articles (Barwick et al., 2005, 2008; Landry et al., 2008). The literature focuses on three types of knowledge utilization in particular. *Conceptual utilization* seeks to provide food for thought on an issue (Landry et al., 2008) and implies changes in knowledge, understanding, or attitudes (Straus, Tetroe, Graham, Zwarenstein, & Bhattacharyya, 2009). When knowledge is utilized to solve concrete problems or aid in decision making (Landry et al., 2008), the process is called *instrumental utilization*, and changes in behavior or practice can be seen (Graham et al., 2006). *Strategic utilization* seeks to legitimate decision making to achieve political or strategic goals (Landry et al., 2008; Straus et al., 2009). At an empirical level, "measuring and attributing knowledge use is still in its infancy in health research" (Straus et al., 2009, p. 152). Documented measures primarily concern instrumental utilization (Landry et al., 2001). Yet, as Davies et al. (2005), point out, "Research can contribute not just to decisional choices, but also to the formation of values, the creation of new understandings and possibilities" (p. 13).

In short, the complex and iterative nature of the KT process that leads from the production of research findings to the utilization of

[1] Here, the term "users" refers to decision makers, policy makers, managers, practitioners, etc.

[2] See the CIHR web site for a list and definitions of various knowledge transfer and utilization strategies: http://knowledgetranslation.ca/ktclearinghouse. Other strategy typologies have been proposed; see for instance, Walter, Nutley, and Davies (2003).