FINAL NARRATIVE REPORT

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Introduction

The RISE (Researching the Impact of Service provider Education) Project was a three-and-a half year, multi-phase project funded by the Public Health Agency of Canada (PHAC) that used a model of implementation science to understand the family violence learning needs and preferences of social work and physician trainees and licensed practitioners in Canada, as well as determine whether the Violence, Evidence, Guidance, and Action (VEGA) family violence educational resources support improvements in practitioner knowledge, attitudes, skills, and behaviours (KASB) related to recognizing and responding to family violence (including intimate partner violence [IPV], child maltreatment, and children's exposure to IPV) in clinical encounters. To guide this process, the RISE Project brought together eight national-level professional associations (hereafter referred to as "Collaborating Organizations [COs]"). Representative members from each of these organizations have provided ongoing consultation and support to the RISE Project team regarding processes for research, as well as the uptake and sustainability of the VEGA educational resources among their membership.

PHAC provided $818,509 in support for the RISE Project from November 2019 to March 2023 through the *Preventing Gender-Based Violence: The Health Perspective* investment. McMaster University provided $920,409 in in-kind support for the project during the same period.

Background

Research consistently details the negative physical, emotional, and economic consequences of IPV, child maltreatment, and children's exposure to IPV (collectively referred to as family violence) on the development and wellbeing of individuals, families, and communities.[1-4] Given the considerable overlap in the occurrence and burden associated with the various forms of family violence, advocates, practitioners and policy makers continue to make considerable investments in primary and secondary prevention. For example, in 2013-14, the World Health Organization and the National Institute for Health and Care Excellence released their first-ever guidelines for health and social services to improve their ability to respond to intimate partner violence (IPV) and sexual violence against women.[5,6] Both documents stress the need for increasing practitioner KASB related to safely recognizing and responding to these forms of violence in their practice.

A low-cost, scalable, and effective educational intervention for improving practitioner KASB related to recognizing and responding to family violence has not previously been identified. Available educational interventions have tended to focus on physical / sexual IPV; yielded inconsistent improvements in practitioner KASB; and tended to focus on physician, nurse, and dental providers / trainees in the United States, United Kingdom, and Australia.[7-10] The lack of Canadian-based interventions and evaluations is particularly relevant given federal and provincial differences in Canada's social, legal, and public health responses to family violence compared to the United States, United Kingdom, and Australia (e.g., mandatory reporting laws, training requirements in family violence).

The Violence, Evidence, Guidance, and Action (VEGA) Family Violence Education Resources were developed to address health professional education needs related to family violence in Canada; the VEGA resources are a continuing education intervention that was developed to improve practitioner KASB related to recognizing and responding to family violence in healthcare and social service encounters. The VEGA Resources are evidence informed 'suite' of modules that include online guidance, educational tools and activities related to recognizing and responding to family violence; the resources include instructional guidance, "how-to" video clips, online simulations, as well as formative feedback to enhance health and social service provider KASB in family violence. To maximize the educational possibilities and impact of VEGA, the VEGA Project team has also adapted the content and structure of the VEGA resources into a workshop that can be delivered

in a virtual or face-to-face format by two trained facilitators. The workshop and self-paced versions of VEGA can be completed within 3.5 hours, and both are guided by the VEGA Competency Framework for Recognizing and Responding Safely to Family Violence.

Importantly, VEGA was developed using an iterative design process that incorporated systematic evidence reviews of the family violence literature, environmental scans of existing training resources, consultation with experts in family violence and instructional design, as well as repeated input from clinicians and scientists belonging to 22 national health and social service professional organizations (i.e., a National Guidance and Implementation Committee) in Canada. Informal feedback from trainees and licensed practitioners has suggested that these individuals perceive improvements to their KASB following the completion of the online VEGA modules. However, a formal implementation and evaluation effort was needed to understand the scope of VEGA's potential impact, as well as the impact of the self-paced and workshop versions of VEGA. The RISE project aimed to generate this evidence using empirically validated implementation and evaluation methods.

Key Activities and Outputs

A published version of our project protocol is available here. A visual overview of our project is also available on our website. Our website is available in English and French.

The RISE Project was informed by the Active Implementation Framework (AIF), which is an evidence-based framework for efficiently and effectively integrating new innovations – such as an educational program like VEGA – into the every-day practice of healthcare and social service providers.; The AIF outlines five components for implementation and evaluation success, including: (1) a Usable Intervention; (2) Implementation Stages; (3) Implementation Teams; (4) Implementation Drivers; and (5) Quality Improvement Cycles. Briefly, a core component of the AIF, Implementation Stages, guides the entirety of implementation and evaluation efforts. Within each of the four stages are a set of processes and activities that are carefully considered to support implementation and evaluation success. Please see our website's Overview page for more details, including Figure 1.

The RISE project took place in three phases, which are detailed below:

Phase 1: Formative Evaluation (Installation Stage)

The purpose of Phase 1 was to conduct a formative evaluation to help inform the pan-Canadian dissemination and implementation of family violence education among health and social services providers, with a specific emphasis on physicians and social workers. The formative evaluation involved CO engagement and: (a) a mixed-method evaluation of family violence learning needs and preferences related to recognizing and responding to family violence among CO members; (b) the identification and development of additional tools or resources to meet CO members' learning needs and preferences related to family violence; and (c) an environmental scan to identify supplementary resources that have the potential to improve practitioner KASB related to recognizing and responding to the various forms of family violence experienced by children, youth, and their families.

A total of 102 participants (57 physicians and 45 social workers) from Ontario, Alberta, and Québec completed a qualitative interview and 350 participants (174 physicians and 162 social workers) from across Canada completed our quantitative survey. For further details about these samples, please view the infographics available on our website: Phase 1 Qualitative Interviews Demographic Information Summary Infographic and Phase 1 Quantitative Survey Demographic Information Summary Infographic.

Findings from Phase 1 of the project will be disseminated via a peer-reviewed publication, which will be linked on our website when it becomes available. A summary of our findings may also be posted on our Key Findings page. A copy of our environmental scan of family violence training materials for Canadian physicians and social workers is available here.

Phase 2: User-Testing with Trainee and Licensed Physicians and Social Workers (Initial Implementation Stage)

The purpose of Phase 2 was to pilot the implementation of VEGA with trainee and licensed physician and social work members of our COs in Ontario, Alberta, and Québec through the application of user-testing methodology. This pilot work aimed to determine: (a) the usability of the self-directed VEGA intervention (i.e., the extent to which CO members can achieve their family violence learning goals with effectiveness, efficiency, and satisfaction); and (b) the extent to which changes to self-directed VEGA are necessary to optimize VEGA usability.

A total of 40 participants (19 physicians and 21 social workers) from Ontario, Alberta, and Québec completed a VEGA user-testing session.

Findings from Phase 2 of the project will be disseminated via a peer-reviewed publication, which will be linked on our website when it becomes available. A summary of our findings may also be posted on our Key Findings page.

Phase 3: Implementation of VEGA Using a Mixed-Method, Open Trail Design (Initial Implementation Stage)

The purpose of Phase 3 was to evaluate the acceptability and feasibility of conducting a cluster randomized controlled trial in Ontario, Alberta, and Québec to evaluate the effectiveness of self-directed and workshop formats of VEGA to improve the health care and social service practitioners KASB related to recognizing and responding to family violence in their clinical encounters.

After two rounds of recruitment, final enrollment in this phase of the study was as follows: one clinic each in Ontario (n = 16/22 practitioners; 73%), Alberta (n = 5/14 practitioners; 36%), and Quebec (n = 7/18 practitioners; 39%).

Findings from Phase 3 of the project will be disseminated via a peer-reviewed publication, which will be linked on our website when it becomes available. A summary of our findings may also be posted on our Key Findings page.

Indigenous Cultural Safety Subproject:

In addition to the three project phases described above, we engaged in a subproject designed to understand the key elements related to supporting Indigenous cultural safety when concerns or disclosures of family violence arise in health care encounters. This subproject consisted of two components, the first being a systematic scoping review examining cultural safety principles and strategies for supporting Indigenous families affected by family violence. A published version of this review is available here.

The second component of this subproject was a qualitative descriptive study that used semi-structured interviews with Indigenous healthcare and social services providers working on Six Nations of the Grand River reserve to understand their perspective about : (a) whether or how VEGA supports cultural safety in health care encounters that involve Indigenous individuals or families for whom family violence may be a concern; and (b) any needed changes s for improving cultural safety components within VEGA. A published version of this study is available here.

Project Outcomes

Our Phase 1 findings suggested that there is an important need for education on how to safely recognize and respond to family violence among healthcare professionals (i.e., physicians and social workers) in Canada. Most Phase 1 participants reported that they had received very little to no formal training on these topics as part of their training, and many stated that they felt ill-equipped to handle clinical situations involving family violence. Qualities that were seen as desirable in training opportunities on family violence included context specificity; interactivity, with opportunities for engagement and discussion; and practicality. Moreover, many practicing physicians and social workers indicated that they would be more inclined to participate in training opportunities that were accredited as continuing education credits by their provincial and/or national governing bodies. Of note, however, is that continuing education requirements do not apply to medical residents or social work trainees (unless they are also practitioners); thus, for these current trainees, training opportunities could instead be integrated into existing curricula at both the undergraduate and postgraduate levels.

Phase 2 of our project did not identify any critical usability challenges with the VEGA self-directed modules; however, participants provided helpful suggestions related to the outcomes, user interface, and content of the training. The VEGA self-directed modules were perceived to be best suited for introductory (i.e., baseline) learning as part of continuing education credits. As a result, participants identified additional learning needs related to complex clinical scenarios. Additionally, given that most participants suggested that they would be most likely to use VEGA as a quick-reference resource, they suggested providing VEGA content in shorter, easier-to-access formats that highlight key information that is not specific to case examples, which could be provided via infographics that can be easily searched and/or downloaded for storage on devices).

Phase 3 of our project revealed that randomly selecting primary care clinics for an acceptability and feasibility trial was not tenable. Twenty-four potentially eligible clinics (eight per province) underwent our recruitment protocol; 16 were deemed ineligible due to insufficient size, two were closed indefinitely, three declined enrollment, and three were unresponsive. After revising one of the clinic eligibility criteria to having $\geq$ 10 patient-facing staff and shifting to purposeful sampling procedures, three primary care clinics and their patient-facing staff enrolled in this study within 4.5 weeks, one each in Ontario (n = 16/22; 73%), Alberta (n = 5/14; 36%), and Quebec (n = 7/18; 39%). Enrolled clinics did not agree to be randomly allocated to a VEGA modality or indicated that it was not feasible to do so; thus, two of the three clinics completed self-directed VEGA while the other opted for workshop VEGA. Leadership support for participation, including protected time to complete self-directed or workshop VEGA, was described by staff and clinic directors as an essential factor for staff enrollment and participation. Participants reported that research components were acceptable and feasible, with some indicating that the pre-intervention questionnaire reinforced their motivation to participate.

Our Indigenous cultural safety subproject continued to reinforce the historical injustices and violence experienced by the Indigenous communities with which we worked as part of this project. As a result, we worked to create a collaborative, community-driven approach to research with our Indigenous partners, which is critical for respecting intergenerational experiences of trauma and violence, structural racism, and colonialism. These principles informed our communication and collaboration with community leadership and members, as well as our project activities. Our findings from this subproject also demonstrated the need to center Indigenous peoples and perspectives in the development and implementation of cultural safety approaches, to acknowledge and address historically contingent causes of past and present family violence, including colonization and related state policies, and to transform knowledge and power relationships at the provider, organization, and government levels.

Collectively, our qualitative findings would support that practitioners find VEGA to be both relevant and valuable as an educational resource for learning

about family violence. More broadly, our experiences throughout this project have reinforced that building and maintaining trusting and respectful relationships with providers, clinics, and healthcare organizations is one of the most important factors in successfully generating and disseminating education on family violence and researching its impacts. Leadership support for participation, including protected time to complete VEGA, was described by staff and clinic directors as an essential factor for staff enrollment and participation. In addition to the provision of financial and credentialing incentives, as well as protected time, our work aligns with evidence from implementation science that hybrid implementation-effectiveness research approaches that intentionally engage the intended users of the education (e.g., primary care clinics, independent contractors of health services, etc) in local-level planning of implementation and evaluation activities are likely a key strategy to increase health professional participation in family violence education and associated research.

Collaborating with various professional associations has been critically important in facilitating the success of our project. We aimed to approach all collaborations with the principles of equity (i.e., fairness), collegiality (i.e., cooperative relationships), collaboration (i.e., cooperative actions), and integrity (i.e., ethics and honesty). Our eight COs played an important role in helping disseminate information about Phases 1 and 2 of our project, ensuring that our requests for participation reached relevant physician and social worker groups in Canada. In Phase 3, we engaged representatives from the College of Family Physicians of Canada to discuss our recruitment strategies as they evolved and to seek guidance when we were experiencing challenges with recruitment. We are very grateful for the role that our COs played in making this project a successful and are thankful for their commitment despite the challenges imposed on healthcare organizations during the COVID-19 pandemic.

Next Steps

In consultation with the VEGA Project Team, findings from Phases 2 and 3 of this project will help inform changes to the VEGA Family Violence Education Resources. We anticipate that there will be an opportunity for VEGA workshops to be adapted to serve as a more advanced form of training on family violence, which was suggested by research participants in Phases 2 and 3 of our work. More specifically, experienced clinicians recommended that self-directed VEGA could serve as a precursor to a VEGA workshop, so that the workshop could involve more interactive and role-play components. Additionally, the workshop could be amended to a consultation-type session that would be delivered by VEGA personnel and would involve participants bringing challenging family violence-related cases for discussion and guidance that is based on VEGA principles of recognition and response.

Given our challenges with recruitment throughout this project but especially in the final phase with primary care clinics, the conduct of a full-scale cluster randomized controlled trial of VEGA in the primary care setting warrants caution. However, we are interested in detailing some of the acceptability and feasibility challenges we faced in a written commentary, which we feel would be of benefit to others who conduct family violence research and the scientific community at large.

This project has informed several other funded projects that are currently underway. Examples include RISE with Residents (funded by a Royal College of Physicians and Surgeons of Canada Medical Education Research Grant) and RISE with Veterans (funded by the Atlas Institute for Veterans and Families). Interest in the possibility of VEGA implementation and evaluation activities has been received from many sectors having a role in the prevention of family violence; we anticipate future collaborations with those in hospital settings, child and youth advocacy centres, child welfare organizations, the violence against women service sector, child and youth mental health organizations, among others. Finally, despite the challenges noted, a promising aspect of our research was that learners (e.g., social work students, medical residents) who participated in our study were often very keen to learn more about family violence. They also appeared more likely to find the VEGA resources useful and many had protected time available to participate in such

educational opportunities, whereas practicing clinicians often did not. We therefore believe that promoting self-directed VEGA resources towards learners who are new to the area of family violence may have a valuable role to play in healthcare and social service provider training program curricula.

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