Linking Research to Action for Youth Violence Prevention: Community Capacity to Acquire, Assess, Adapt and Apply Research Evidence

Jennifer C.D. MacGregor, PhD,¹ Anita Kothari, PhD,¹ Karen LeMoine, MSc,² Judith Labelle, BScN²

ABSTRACT

OBJECTIVES: Community-based organizations (CBOs) are important stakeholders in the health system, providing many valuable community-based programs and services. However, limited efforts have been made to encourage CBOs to incorporate research evidence into service provision, and their capacity to do so is not well understood. Therefore, the primary goal of this research was to examine CBOs' perceptions of: 1) the frequency of using research and other forms of evidence related to youth violence prevention, and 2) their capacity to acquire, assess, adapt and apply research evidence.

METHODS: CBOs involved in youth violence prevention completed a survey (n=35) and/or attended a focus group (n=16). Survey questions were adapted from the Canadian Health Services Research Foundation's "Is Research Working for You?" tool.

RESULTS: CBOs' reported use of and capacity to acquire research evidence was high. CBOs reported possessing the structures, processes, and organizational culture needed to apply research evidence in decision-making. Assessing research evidence was a challenge for CBO staff, although many have external experts who can effectively do so. Generally, CBOs reported adequate capacity to adapt (i.e., synthesize, contextualize, and present) research evidence. Adapting research evidence for use in particular populations or geographical areas presented a considerable challenge.

CONCLUSION: Although many barriers and socio-political complexities make linking research to action challenging, we found that CBOs generally feel competent and well equipped. Our findings support the viability of extending the push for evidence-based health care to community contexts so that the most effective programs and services for Canadians can be offered.

KEY WORDS: Translational medical research; evidence-based practice; health services; needs assessment; community-based participatory research; violence

La traduction du résumé se trouve à la fin de l'article.

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The field of Knowledge Transfer and Exchange (KTE) has grown rapidly in the last decade.^{1,2} Increasingly, researchers are examining how best to move findings from health research into the hands of those who can use them, while service-providers and decision-makers want to learn how research evidence can improve the work they do and the decisions they make.³ Recent years have also seen an increased recognition of the importance of providing evidence-based services for young people in particular (e.g., www.whatworksforchildren.org.uk, childhealth.cochrane.org). Unfortunately, when it comes to KTE, there has been a lack of attention to the community-based context, where many services for Canadian youth are provided. The vast majority of health research, systematic review, and KTE research is focused on clinical contexts, which may not adequately address the unique issues faced by community-based organizations (CBOs).^{2,4} CBOs, which deliver services "with communities and populations often at the centre of intervention efforts" (p. 1),² operate within a complex and unpredictable socio-political climate. Navigating funding systems and meeting expectations for evaluating and reporting service outcomes are just a few of the challenges CBOs face as they attempt to solve complex, globally-recognized health issues facing young people, such as substance use, obesity, mental health, and violence. Furthermore, there has not been a concerted effort by health systems to support CBOs in their efforts to link research to action.⁴⁻⁶

There is limited published research on CBOs' use of, or capacity to use, research evidence. However, such baseline information is

crucial to the development of successful KTE initiatives for community-based contexts. Two relevant studies to date have used an established measure^{7,8} focusing on four areas of research evidence capacity: acquiring (i.e., finding and accessing research evidence), assessing (i.e., critically appraising quality of research), adapting (i.e., to other formats or contexts), and applying (i.e., possessing structures, processes and culture needed to apply the research). Findings thus far provide a somewhat dismal picture of CBOs' capacity. Wilson and colleagues⁹ found the capacity of CBOs in the HIV/AIDS sector to be low in all four areas, but noted that CBOs possessed some qualities of organizational culture required to apply research evidence. Another study¹⁰ examined the capacity of community-based mental health provider organizations by asking executive directors and practitioners to indicate whether their organization could access (i.e., acquire), assess, adapt, and apply research evidence "not well", "somewhat well", "well", or "very well". The most common response for each of the four areas was "somewhat well". A third study¹¹ began with the objective to examine the capacity of rural mental health service providers to acquire, assess, adapt and apply research evidence. However, the purpose of

Author Affiliations

1. Faculty of Health Sciences, Western University, London, ON

2. Health Services, Region of Peel, Brampton, ON

Correspondence: Jennifer C.D. MacGregor, Faculty of Health Sciences, Western University, Arthur and Sonia Labatt Health Sciences Building, Room 222, London, ON N6A 5B9, Tel: 519-681-2111, ext. 88109, Fax: 519-850-2432, E-mail: jencdmacgregor@gmail.com

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Table 1. Services Provided by CBOs Participating in Survey (Phase 1; n=33) and Focus Groups (Phase 2; n=16)

Type of Service	% CBOs Providing Service, Phase 1 (n)	% CBOs Providing Service, Phase 2 (n)
Crime prevention	27.3% (9)	31.3% (5)
Community/neighbourhood development	45.5% (15)	43.8% (7)
Education	54.5% (18)	56.3% (9)
Family/parenting support	54.5% (18)	50.0% (8)
Health promotion	48.5% (16)	62.5% (10)
Housing and shelter	21.2% (7)	12.5% (2)
Law and justice services	39.4% (13)	31.3% (5)
Mental health services	45.5% (15)	56.3% (9)
Mentoring programs for children/youth	45.5% (15)	50.0% (8)
Recreation	36.4% (12)	25.0% (4)
Social skills development for youth	66.7% (22)	68.8% (11)
Youth violence prevention	54.5% (18)	56.3% (9)
Other	30.3% (10)	25.0% (4)

the project was modified when the researchers learned that the challenging, crisis-oriented nature of the rural mental health setting meant service providers had pressing day-to-day concerns that needed to be addressed before they were ready to consider how research could inform their work.

Overall, it appears that CBOs require support in building their capacity to link research to action. However, there is little research from which to draw. This research gap is troublesome given that CBOs are important stakeholders in the health system, providing many valuable community-based programs and services^{5,12} that ultimately serve to improve the health and well-being of Canadians, including young people.

The current project

In fall 2011, a section within the Region of Peel Health Services Department that supports the issue of youth violence prevention commenced a KTE Plan to support local CBOs in their capacity to link research evidence to programs and service delivery and make evidence-informed decisions. The end goal is to achieve the highest quality programming and service delivery to Peel residents. Peel Region comprises two cities and one town in Southern Ontario, Canada. It is the home of almost 1.3 million residents and has a large growing immigrant population with culturally-sensitive health and social services needs. As a first step, the Region of Peel staff invited the first and second authors to collaborate on an assessment of youth-serving CBOs in Peel; this needs assessment draws on the action cycle of the knowledge-to-action (KTA) framework.¹³ The goal of this paper is to add to the limited literature on community-based KTE by examining CBOs' perceptions of: 1) the frequency with which they currently use research and other forms of evidence related to youth violence prevention, and 2) their capacity to acquire, assess, adapt and apply research evidence.

METHOD

The assessment was carried out in two phases: 1) a survey, and 2) focus groups. Using convenience sampling, participants were recruited from a list of known CBOs in Peel. Organizations were deemed relevant if they were involved in youth violence prevention in some capacity. For example, potential participating CBOs included local justice services, youth-serving agencies and workgroups, parks and recreation departments, and school boards.* Ethics approval for this project was received from Western University's Office of Research Ethics.

* Although not traditionally considered CBOs,¹² the latter two were recognized as valuable local stakeholders in youth violence prevention and thus were invited to participate.

Phase 1: Survey

In March 2012, a package of materials was mailed to managers and executive directors at 45 CBOs in the Region of Peel. The package included a cover letter describing the project and providing a link to the online questionnaire, an Information and Consent Letter, a paper copy of the survey (with stamped envelope for its return), and a \$10 coffee shop gift certificate as a thank you for participation. Participants were encouraged to complete the survey with input from their staff† and had the choice to complete it online or via mail-back paper copy. Consent to participate was implied through completion of the survey.

We included questions adapted from the Canadian Health Research Foundation's tool "Is Research Working for You?"^{7,8} to measure CBOs' perceptions of their capacity to acquire, assess, adapt, and apply research evidence. Descriptive analyses were conducted using SPSS 20.0 and the descriptive analysis functions available through the online survey tool.

Phase 2: Focus groups

In May 2012, after survey data collection, the same 45 CBOs were invited to participate in a focus group. Focus groups were conducted by an external moderator, and a single interview (with an individual unable to attend a focus group) was conducted by the first author. Questions focused on participants' use and views of different types of evidence, barriers to using research evidence, as well as other related topics not reported in this paper. The interview and focus groups were audio-recorded and then transcribed. The first and second authors analyzed the data qualitatively using a mostly deductive strategy based on the areas of capacity in the CHSRF tool while still being open to emerging ideas expressed by participants. All transcripts were reviewed a second time to ensure comprehensive coding using new categories. Codes were developed and applied manually, organized using word processing software and verified through team discussion.

Participants

In total, 35 organizations participated in the Phase 1 survey, 18 online and 17 by paper copy.‡ The majority of participating CBOs (80%, n=28) operate with a full-time staff of more than 10. Only 9% (n=3) employ fewer than 5 full-time staff members and 11% employ 5-10. Along these lines, 82% (n=27) of the CBOs serve

† The unit of analysis in this study is the organization. Participants indicated the extent to which they obtained input from their staff to complete the survey. The majority (68%, n=23) did "receive some input from staff", while some "received a lot of input from staff/staff helped to complete survey" (18%, n=6) and others "did not obtain any input from any staff" (15%, n=5).

‡ A manuscript reporting other results from this dataset is under review elsewhere.

Table 2. Evidence Sources Used by Participating CBOs, Phase 1 (n=35)

Evidence Source (evidence type)	1 = Never	2 = Seldom	3 = Sometimes	4 = Often	No Response
Research evidence (research)	0	2.9% (1)	22.9% (8)	74.3% (26)	0
Local context or issues (contextual)	0	0	8.6% (3)	88.6% (31)	2.9% (1)
Community/client needs and preferences (contextual)	0	2.9% (1)	5.7% (2)	91.4% (32)	0
Political preference (contextual)	31.4% (11)	25.7% (9)	20.0% (7)	11.4% (4)	11.4% (4)
Experiential knowledge (experiential)	0	0	25.7% (9)	68.6% (24)	5.7% (2)
Colleagues sharing ideas (experiential)	0	0	25.7% (9)	65.7% (23)	8.6% (3)
Current organizational practices (experiential)	0	2.9% (1)	20.0% (7)	74.3% (26)	2.9% (1)
Other	0	0	5.7% (2)	11.4% (4)	82.9% (29)

Table 3. Where Participating CBOs Look to for Research, Phase 1 (n=35)

	Don't Do	Do Poorly	Do Inconsistently	Do With Some Consistency	Do Well
We look for research in academic journals	0	5.7% (2)	37.1% (13)	45.7% (16)	11.4% (4)
We look for research from organizations (such as Statistics Canada, Centre for Addiction and Mental Health, Public Safety Canada, etc.)	0	2.9% (1)	11.4% (4)	57.1% (20)	28.6% (10)
We learn from topic-specific listservs	5.7% (2)	14.3% (5)	28.6% (10)	34.3% (12)	17.1% (6)
We learn from conferences and forums	0	0	8.6% (3)	45.7% (16)	45.7% (16)
We look for information on websites	0	2.9% (1)	8.6% (3)	40.0% (14)	48.6% (17)
We work with researchers through formal and informal networking meetings	2.9% (1)	5.7% (2)	20.0% (7)	31.4% (11)	40.0% (14)
We get involved with researchers as host, decision-maker, partner or sponsor	8.6% (3)	8.6% (3)	25.7% (9)	31.4% (11)	25.7% (9)
We learn from peers through formal and informal networks to exchange ideas, experiences and best practices	0	0	5.7% (2)	37.1% (13)	57.1% (20)

over 750 clients annually. Only 6% (n=2) serve fewer than 250 clients and 12% (n=4) serve between 250 and 750. Two CBOs did not respond to this question. Youth/adolescents (ages 12-24) were the primary clients for most organizations (87%, n=31), although other groups were also served (e.g., families). All but five CBOs reported funding from multiple sources (e.g., private donations, federal grants, etc.). The most common type of service provided by the CBOs in our sample was “social skills development for youth” (67%, n=22; see Table 1).

Two focus groups, about 1.5 hours each, were conducted in Phase 2. In total, 14 CBOs were represented, with 7 participants attending the first session, 8 attending the second, and 1 interview. The majority of Phase 2 participants were from CBOs with more than 10 employees (75%, n=12), although two had less than 5 (12.5%) and two had 5-10 (12.5%). Similarly, the majority served more than 750 clients (75%, n=12). Three participants (18.8%) came from CBOs serving 250-750 clients (data unavailable for one participant). The types of services provided by the Phase 2 CBOs are shown in Table 1.

RESULTS

Current use of research evidence

All 35 CBOs reported using research evidence “to make decisions about programming, service delivery, or policies,” and the majority (74.3%, n=26) reported using it “often”. Nonetheless, CBOs reported using many other types of evidence to inform their work as well (see Table 2). Phase 2 findings corroborated the survey finding that different types of evidence are used by CBOs. Indeed, some participants found it difficult to say which type of evidence (research, experiential, or contextual) was most valuable to them:

“...they are all important. That's sort of like asking a question like which leg of the chair is more important, right?” (I1/9)

“I think for us, [it's]... pretty tough to disentangle the three... we've got the evidence of what's working but our experiential for who, what, whose

on the ground and what's the population ... or the clients we're looking to and then under what conditions is really that contextual piece and I don't think we ever want to separate those three...” (P6 - FG1/14)

“It's hard to pick one from them, really really hard... for me, it's almost like a toolbox that you have to use what is working in that context so if I was to pick, I guess it would be contextual but it's really a marriage of all three.” (P7 - FG1/13)

Acquiring research evidence

The examination of the CBOs' current use of research evidence suggests that acquiring this type of evidence is not a major problem. Moreover, CBOs reported acquiring research evidence in many different ways (see Table 3). However, the methods that CBOs were most likely to “do well” were: learning from conferences/forums (45.7%, n=16), looking for information on websites (48.6%, n=17) and learning from peers through formal/informal networking (57.1%, n=20).

Corroborating the survey results, difficulty accessing research evidence was not a pronounced theme in Phase 2, although a few comments demonstrated that *awareness* of the existence of research evidence can be a challenge for some. In addition, many participants felt that there were times when the research evidence they wanted to access simply did not exist:

“... we have some evidence around certain things that we can do but certainly not all mental health issues is there an evidence based practice for, so you sort of target the ones where you know that there is something that you can focus on...” (P3 - FG2/25)

“We have great research that tells us something but it's not necessarily research that tells us what to do differently in order to make an improvement...” (P7 - FG2/26)

Assessing research evidence

In general, the assessment of research evidence appeared to be a greater challenge than its access for the participating CBOs. Many (63.6%, n=21) reported that they have “arrangements [either per-

Table 4. Participating CBOs' Capacity to Adapt Research Evidence, Phase 1 (n=35*)

Our organization has enough skilled staff with time, incentives and resources to:	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Present research results concisely and in accessible language	0	40.0% (14)	14.3% (5)	31.4% (11)	14.3% (5)
Synthesize in one document all relevant research, along with information and analyses from other sources	0	40.0% (14)	20.0% (7)	28.6% (10)	11.4% (4)
Link research results to key issues facing our decision-makers	0	11.4% (4)	28.6% (10)	45.7 (16)	14.3% (5)
Provide recommended actions to our decision-makers	0	5.7% (2)	28.6% (10)	51.4% (18)	14.3% (5)
Our organization has arrangements with external experts to:					
Present research results concisely and in accessible language	0	5.0% (1)	5.0% (1)	75.0% (15)	15.0% (3)
Synthesize in one document all relevant research, along with information and analyses from other sources	0	15.0% (3)	10.0% (2)	60.0% (12)	15.0% (3)
Link research results to key issues facing our decision-makers	0	15.0% (3)	10.0% (2)	60.0% (12)	15.0% (3)
Provide recommended actions to our decision-makers	0	15.0% (3)	5.0% (1)	65.0% (13)	15.0% (3)

* For the first set of questions above, n=35, for the second, n=20 (those who skipped these questions and/or do not have arrangements with external experts were excluded from this analysis).

manent or on an as-needed basis] with external experts who use critical appraisal skills and tools to assess methodology and evidence reliability; and to compare methods.” However, the remaining CBOs had no such arrangement (33.3%, n=11), weren't sure (3%, n=1) or did not respond (5.7%, n=2). Many CBOs (45.7%, n=16) had roles within their organization (including research students or roles at the corporate level) “that have a job description and/or skills requirement to do critical appraisal of research,” although many did not (51.4%, n=18) or were unsure (11.4%, n=4). Only 6 CBOs (17%) reported having neither staff nor external experts with the skills to do critical appraisal of research.

CBOs were also asked to rate the ability of their staff to assess research evidence using a 5-point scale (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree). Specifically, they rated the extent to which they agreed with the statement: “Staff in our organization have critical skills and tools for evaluating the quality of methodology used; and reliability of specific research by identifying related evidence and comparing methods and results.” Many participants (40%, n=14) were ambivalent and chose the midpoint of the scale, although others were confident in their staff's ability to assess research (34.3% agreed, n=12; 8.6% strongly agreed, n=3). Some CBOs did not feel they had sufficient staff to assess research (2.9% strongly disagreed, n=1; 14.3% disagreed, n=5), however, among those six CBOs, four had arrangements with external experts to do so. The challenge of assessing research evidence was not a predominant theme in the Phase 2 data.

Adapting research evidence

In general, Peel CBOs reported adequate capacity to adapt – that is, synthesize, contextualize, and present – research evidence. When it comes to the extent to which CBOs have “enough skilled staff with time, incentives and resources” to adapt research evidence, their reported strengths lie in linking research results to key issues facing their decision-makers (60% agreed or strongly agreed, n=21; see Table 4) and providing recommended actions to their decision-makers (66% agreed or strongly agreed, n=23). In contrast, many CBOs believe their staff are lacking in the ability to effectively present (40% disagree, n=14) and synthesize research results (40% disagree, n=14). Among CBOs having arrangements with external experts, the capacity for adapting research is very good (see Table 4).

Phase 2 findings were somewhat inconsistent with the survey results in that Phase 2 CBOs did not discuss difficulties in synthe-

sizing or presenting research evidence.[§] However, adapting (or contextualizing) research for their own local context was seen as a major challenge for many Phase 2 participants:

“... so what that I've got a ton of evidence sitting there on how to stop youth violence? I don't know what my own youth violence issues are in the Region of Peel because I don't have access to data... So what that I have evidence, what... am I supposed to do with it?” (P5 - FG1/28-29)

“... that's something that's very difficult when you actually look at the evidence based studies out there, they're often under really set conditions that would never actually work in real life [AGREEMENT] and again they're very different context [AGREEMENT] ... we're very unique so I think that's a big challenge, you know, pulling studies out that may or may not be relevant or may not be realistic for our population or our purposes is a tricky, tricky nut. [AGREEMENT]” (P6 - FG1/6)

Echoing the Phase 2 finding that adapting evidence for local contexts is challenging, among five research to practice content areas, Phase 1 participants saw the following areas as most “useful and relevant”: “how to adapt evidence-based programs to local contexts” (76.5%, n=26) and “how and when to target interventions and programs to specific populations” (76.5%, n=26; participants could choose multiple content areas, total n=34).

Applying research evidence

Overall, it appears that most CBOs in our sample believe they have the structures, processes, and organizational culture in place to promote and use research evidence in their decision-making (see Table 5). For example, most CBOs agreed or strongly agreed that “research is a priority in [their] organization”. In other words, most participating CBOs reported that the value placed on research evidence is reflected in the actions of staff, management, and decision-makers. Nevertheless, in Phase 2, participants raised several barriers, or practical constraints, that made using research evidence difficult, such as time:

“...when we are working with the community, sometimes we don't have time to, I don't want to say that we don't think, we think, but we don't have time to discuss, to...to analyze, see the pros, the cons because everything is hurry hurry hurry...” (P3 - FG1/8)

§ As Barwick et al.¹⁰ note, the CHSRF conceptualization does not include adapting research for local context or populations. Unfortunately, our survey did not include questions focused on CBOs' capacity to adapt research for their own local context.

Table 5. Participating CBOs' Capacity to Apply Research Evidence, Phase 1 (n=35)

Statement	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Using research is a priority in our organization	0	14.3% (5)	17.2% (6)	31.4% (11)	37.1% (13)
Our organization has committed resources to ensure research is accessed, adapted and applied in decision-making	0	25.7% (9)	20.0% (7)	34.3% (12)	20.0% (7)
Staff are involved in discussions on how research evidence relates to our main goals	0	20.0% (7)	14.3% (5)	45.7% (16)	20.0% (7)
We communicate internally in a way that ensures that information is exchanged across the entire organization	0	8.6% (3)	14.3% (5)	51.4% (18)	25.7% (9)
Our corporate culture values and rewards continuous quality improvement with resources to support these values	0	11.4% (4)	17.1% (6)	40.0% (14)	31.4% (11)
When we make major decisions, we usually allow enough time to identify researchable questions and obtain, analyze and consider research results and other evidence	2.9% (1)	11.4% (4)	42.9% (15)	28.6% (10)	14.3% (5)
Our management team evaluates the feasibility of each option, including the potential impact across the organization, as well as on clients, partners and other stakeholders	0	0	20.0% (7)	51.4% (18)	28.6% (10)
Decision-makers in our organization give formal consideration to any recommendations from staff who have developed or identified high-quality and relevant research evidence	2.9% (1)	2.9% (1)	37.2% (13)	31.4% (11)	25.7% (9)
Staff and appropriate stakeholders contribute evidence; and they know how that information will be used	0	14.3% (5)	35.3% (12)	37.1% (13)	14.3% (5)
Staff who have provided evidence and analysis usually participate in decision-making discussions	2.9% (1)	8.8% (3)	20.0% (7)	54.3% (19)	14.3% (5)
Staff and appropriate stakeholders are informed of how available evidence influenced the choices that were made in our organization	0	8.8% (3)	41.2% (14)	35.3% (12)	14.3% (5)

"I think time is a huge one for us, [AGREEMENT] it's the time to review the research but also, we have staff that sit at different community tables. It's that time staff need to take to kind of communicate what they're hearing at both community tables with the rest of the agency..." (P7 - FG1/28)

DISCUSSION

This multi-method investigation sheds light on the extent to which CBOs report using and having the capacity to use research evidence in their service provision. We found that CBOs' strengths lie in the areas of acquiring and applying research evidence, whereas assessing and adapting research evidence were more challenging. Results from the two phases were quite consistent. However, an exception was that Phase 2 did not echo the Phase 1 finding that many CBOs do not feel confident in their staff's ability to adapt research evidence to different formats; this type of adapting simply did not come up in discussions, perhaps because other issues were seen as more problematic or interesting to talk about.

Findings from this convenience sample may have limited generalizability to other community-based sectors or jurisdictions. Like all self-report instruments, results from the survey may have been subject to social desirability bias. We attempted to minimize such bias during the focus groups by using an external moderator and by not permitting Region of Peel staff (third and fourth authors) to participate in the discussions. A preliminary presentation of results to Peel CBOs served as a means to member-check, ensuring findings were plausible. Despite these efforts, social desirability bias may have inflated participants' responses. Nevertheless, the variability we found across areas of capacity (in both quantitative and qualitative data) points to where improvement efforts should be directed.

Some of our findings are difficult to interpret in light of past work. Compared to Wilson et al.'s⁹ research on the HIV/AIDS sector, Peel CBOs appear quite skilled at acquiring research from various sources. A noticeably greater percentage (45.7%) of Peel CBOs reported accessing research in peer-reviewed journals "with some consistency" compared to the Wilson et al. sample (20%). Peel

CBOs were also more likely to report that they "did well" at accessing research through organizations (i.e., grey literature), websites, and formal/informal networking (28.6%, 48.6%, and 40%, respectively) compared to the HIV/AIDS sector CBOs (4%, 0%, and 8%, respectively).⁹ Compared to Barwick et al.'s¹⁰ examination of children's mental health providers, our findings, particularly regarding acquiring and applying research evidence, are also more optimistic. Such differences may reflect discrepancies between organizational size/structure, sector or region, and it is difficult to judge which findings are more representative of Canadian CBOs' use and capacity. In light of the fact that the Region of Peel initiated partnership with the first and second author to begin a KTE project, it could be that the Region of Peel is simply more ready to use research. Regardless, the increasing number of community-based initiatives focused on linking research to action (e.g., www.communityresearchethics.com, www.project-oracle.com) suggests CBOs are becoming more research evidence "savvy". Indeed, our findings regarding applying research coincide with Wilson et al.'s conclusion that CBOs have strengths when it comes to organizational cultures supporting the use of research evidence.

In addition to serving as baseline capacity levels for evaluation of the KTE Plan, this research contributes to the scant literature on community capacity for research use and lends a new perspective to the community-based KTE climate. As per the KTA framework,¹³ the next step is to tailor and implement interventions. Taking a step back, however, we acknowledge our assumption that appropriate, high-quality research-based evidence even exists, or that this is the best type of evidence that can be used to prevent youth violence. We invite further "outside-the-KT-box" thinking to support youth in communities. Perhaps one way may be to develop new strategies to synthesize the range of available knowledge (e.g., experiential, contextual, research) relevant to community-based practice. Another strategy might be to strengthen the capacity of those CBOs who do gather their own contextually-relevant data (e.g., through surveys) to support a more rigorous process.

|| No other quantitative comparisons between our findings and those of Wilson et al. can be made, as different response scales were used.

CONCLUSION

Although many barriers and socio-political complexities make linking research to action challenging, we found that, in some areas of capacity, this particular sample of CBOs feel competent and well equipped, but might need support in the area of adapting research to local context. CBOs play a crucial role in the health of Canadians. Our findings are encouraging and support the viability of extending the push for evidence-based health care to community contexts so that the most effective programs and services for Canadians can be offered.

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RÉSUMÉ

OBJECTIFS : Les organismes communautaires sont d'importants acteurs du système de santé et offrent de nombreux programmes et services communautaires très utiles. Cependant, on fait peu d'efforts pour inciter ces organismes à intégrer les données probantes issues de la recherche dans la prestation de services, et leur capacité de le faire est mal comprise. C'est pourquoi notre objectif principal était d'examiner les perceptions des organismes communautaires à l'égard de : 1) la fréquence de l'utilisation de la recherche et d'autres formes de données probantes liées à la prévention de la violence chez les jeunes et 2) la capacité de ces organismes d'acquiescer, d'évaluer, d'adapter et d'appliquer les données probantes issues de la recherche.

MÉTHODE : Des organismes communautaires faisant de la prévention de la violence chez les jeunes ont répondu à un sondage (n=35) et/ou assisté à un groupe de discussion (n=16). Les questions du sondage étaient adaptées de l'outil « La recherche vous réussit-elle? » de la Fondation canadienne de la recherche sur les services de santé.

RÉSULTATS : L'utilisation déclarée des données probantes issues de la recherche par les organismes communautaires et leur capacité d'acquiescer ces données étaient élevées. Ces organismes ont déclaré posséder les structures, les processus et la culture organisationnelle nécessaires pour appliquer les données probantes issues de la recherche à la prise de décisions. L'évaluation de ces données de recherche était difficile pour le personnel des organismes communautaires, bien que beaucoup fassent appel à des experts indépendants pour faire ce travail efficacement. Dans l'ensemble, les organismes communautaires ont dit avoir une capacité suffisante pour adapter (résumer, mettre en contexte et présenter) des données de recherche. L'adaptation des données de recherche pour les utiliser auprès de populations ou dans des zones géographiques particulières présentait cependant des difficultés considérables.

CONCLUSION : De nombreux obstacles et complications sociopolitiques font qu'il est difficile de lier la recherche à l'action, mais nous constatons que les organismes communautaires se sentent généralement compétents et bien équipés. Nos constatations confirment qu'il est viable de militer pour que l'on étende la prestation de soins de santé fondés sur les preuves au milieu communautaire, afin que les programmes et services les plus efficaces puissent être offerts à la population canadienne.

MOTS CLÉS : recherche translationnelle; pratique fondée sur des éléments probants; services de santé; évaluation besoins; recherche participative communautaire; violence