Journal of Family Violence (2023) 38:1151–1163
https://doi.org/10.1007/s10896-023-00566-y

ORIGINAL ARTICLE

Voices of Experience: Development of the Flourishing Practice Model of Capabilities of Intimate Partner Violence Specialists

Katreena L. Scott[1] · Linda Baker[1] · Angelique Jenney[2] · Jenna Lopez[1] · Anna-Lee Straatman[1] · Nicole Pietsch[1] · Olivia Cullen[2] · Diamond Antwi-Mansah[3] · Karia Jones[1] · and Expert Working Group Members

Accepted: 19 April 2023 / Published online: 26 May 2023

Abstract

Purpose People experiencing intimate partner violence (IPV) often seek, or are referred to, specialized service providers such as shelter workers, counsellors in programs for children exposed to IPV, and facilitators for men's behaviour change programs. This paper discusses the process of collaborating with service providers and survivors across Canada to articulate the often-unrecognized knowledge and skills of IPV specialists.

Methods Work included a scoping review and analysis of 140 academic and practice papers, interviews with 62 expert service providers, eight Delphi-method surveys and over 70 hours of collaborative discussion with expert working groups of experienced service providers and survivors.

Results Areas of knowledge and skill were drafted based on the review of literature and analysis of interviews with experienced service providers, then rated in Delphi surveys, and discussed by expert working groups. Consensus was reached on the Flourishing Practice Model which identifies nine areas of capability shared across IPV specialists, as well as unique knowledge and skills used to support and collaborate with survivors, recognize and respond to infant, child and youth experiences of violence and intervene to end abusive behaviours. The "stem" recognizes the critical role of IPV specialist organizations and leaders in supporting service providers' capabilities. "Blank petals" are included to signify expertise that has not yet been documented and to recognize ongoing growth.

Conclusions The combination of methods and processes allowed for the integration of research and practice knowledge with survivor and service provider voices to gain deeper insight into the knowledge and skills of IPV specialists.

Keyword Intimate partner violence · workforce capacity · collaboration · competency · capability · scoping review · Delphi survey

Ending intimate partner violence (IPV) is an issue of international priority, as recognized in commitments from the World Health Organization, UNICEF and in national action plans in many countries (Government of Canada, 2022; UNICEF, 2022; World Health Organization, 2019). This priority has led to increased attention on the training, preparation, knowledge, skills and competencies of service providers and on the capacity of the IPV workforce as a whole. Although a wide range of professionals (e.g., including nurses, teachers, counsellors) need to be able to recognize IPV and provide an effective first response, survivors and their families rely predominantly on specialized service providers to create lasting safety, provide opportunities for recovery, and promote accountability and change in those who have behaved abusively. In Canada, as in many other countries, service providers who hold specialized knowledge and skills for addressing IPV generally do not have standardized positions or job titles and there is a lack of clear education paths, certificate programs, degrees, or formal training standards for this work. Service providers who might identify within a broad definition of "IPV specialist" include: shelter workers, women's advocates, victim/witness service providers, counsellors providing intervention for children

✉ Katreena L. Scott
kscot47@uwo.ca

[1] Centre for Research and Education on Violence Against Women and Children, Faculty of Education Building, Western University, 1137 Western Road, Room 1158, ON N6G 1G7 London, Canada

[2] University of Calgary, Calgary, Canada

[3] WomenatthecentrE, North York, Canada

exposed to violence, crisis line workers, facilitators of programs for men who have perpetrated violence, or members of specialized IPV teams within child protection, midwifery, hospital, probation, or settlement services.

One common route to developing and strengthening a workforce with specialized knowledge and skills, such as the ability to respond to IPV, is through the development of competency frameworks. Over the past 20 years, medical, mental health and social work fields have increasingly shifted towards articulating and using competency frameworks to describe professional practice, provide a basis for training, increase accountability, and build workforce capacity (Batt et al., Gervais, 2016). "Competencies", in these frameworks, are typically defined as the skills, knowledge, and abilities that individuals should possess when completing assigned tasks or achieving particular goals (Wong, 2020) and competency frameworks articulate the full set of knowledge, skill and abilities needed for particular roles. Although competencies are made up of discrete pieces of knowledge and skill (e.g., does a service provider have knowledge of their ethical responsibilities), competency descriptions go beyond discrete pieces to focus on the whole or "gestalt" of practice and the complex process of integrating knowledge and action within decision making (e.g., does a service provider use their knowledge and skills to act in ways that are consistent with their ethical responsibilities) (Bogo et al., 2013).

Research has shown that competencies and competency-based frameworks have a number of benefits. Competency frameworks help to understand and guide practice in complex situations that are not easily tested in randomized control trials (Jorm, 2015; Menon et al., 2009) and, it has been argued, such frameworks are important for increasing transparency and accountability and improving service outcomes (Hawkins et al., 2015). When used as a basis for education, benefits include more rapid mastery of practice-based skills, more frequent and targeted remediation of difficulties and increased confidence in learners (see review by Hawkins et al., 2015). Competency frameworks also provide a means of recognizing the unique expertise that specialists bring to collaborative work, such as contributions to multi-agency high risk coordination teams (Murphy et al., 2016; Weatherston et al., 2009). Finally, such frameworks can make it easier to intentionally plan for workforce development (Lonne et al., 2013; Mullen & Leginski, 2010), which is important in the IPV field. In many countries, including Canada, there is a scarcity of service providers in IPV. Moreover, specialist IPV services currently rely mostly on "on the job" training to develop expertise in new professionals. For example, a recent survey of Canadian specialists found that only 10% of respondents feel that they were well-prepared for their work when they started their position; many others reflected that their own training was not nearly enough (46%) (Lopez et al., 2021). In non-urban, northern, and culturally diverse settings, the problems of access to well-trained and qualified experts in addressing IPV are intensified. Competency frameworks can help alert governments to the lack of qualified service providers in a field or an area and direct investment in hiring, training, infrastructure and support resulting in better training of new service providers (Domestic Violence Victoria, 2015).

Although competency-based frameworks have a number of potential advantages, there are significant challenges and concerns in applying such frameworks to work in gender-based violence. A first major challenge is the positioning of "expertise". Competencies for a particular field or area of practice have generally been developed by recognized experts in traditional hierarchies such as academia and medicine (Wong, 2020). They are often then used as a basis for training (called competency-based education) and to evaluate whether emerging professionals are qualified to perform their roles (Gervais, 2016). This kind of "expert practice" model runs counter to much of the thinking in the IPV field. A founding philosophy of the IPV field is centering survivor experience and the valuing of voices and the participation of lay-persons, survivors of violence, and non-professionals as experts. Survivors are recognized as being the experts in their own experience and there is a deliberate effort to practice in ways that are collaborative and non-hierarchical. Knowledge has often been shared through mentorship and supervision rather than in academic literature (Sinclair, 2019). Over time, through centering of survivor experience, the field has recognized the contribution of diverse ways of knowing, responding to and resisting violence. Such expanded understanding of diversity and intersectionality made visible the experiences of diverse peoples including Black, Indigenous and People of Colour, immigrant women, disabled women, 2SLGBTQIA + community members and other diverse people. The expertise of the movement intentionally points out the ways in which race, class, ability, citizenship, gender, sexuality, and others are interlocking systems of power that differentially shape people's experiences, including the experiences of adult and child survivors as well as those who have used abusive behaviours. Recognition of expertise outside of traditional hierarchies, and more broadly of the potential harms of structural hierarchies, challenges the ways in which competency frameworks are often developed and understood.

A second concern is that competency frameworks have often been used as part of professionalization of a field, outlining the criteria needed to "qualify" for practice and minimum standards of professional accountability. Professionalization, which often involves formal credentials, control by a regulatory body and the restriction of practice to a narrow group of professional practitioners, is counter to the founding philosophies of the IPV movement that seek to

level hierarchy between those seeking and providing service (Lehrner & Allen, 2009). These challenges can be added to broader critiques of the movement towards competency-based education and practice including conceptual questions such as whether or not competencies adequately capture the complexity of practice, sufficiently emphasize anti-discriminatory, anti-racist practice, and are responsive to change over time and exist as separate, general attributes (i.e., individual characteristics) divorced from their clinical content or the contexts in which they are exercised (Hawkins et al., 2015).

Within the field of IPV, there have been a number of efforts to work with the tensions outlined above to articulate competencies in ways that take advantage of their strengths for articulating and clarifying the knowledge and skills of service providers and, at the same time, are consistent with the philosophies of the field. These efforts have used different terms to denote shifts in the ways in which knowledge, skills and abilities are articulated and in the potential use of resulting frameworks. Specifically, the term "capability" is often used in these frameworks in place of the term competency. Capability denotes that the knowledge, skills and abilities being articulated are more aspirational in nature (i.e., describing how excellent practice should look) recognizing the need for continuous adaptation, growth and improvement as opposed to identifying minimum standards of knowledge, skill and ability. Groups working to develop such frameworks have also been intentional in identifying a large range of collaborators as experts in creating such frameworks, including government representatives and non-government experts in family violence and/or sexual violence and feedback from government agencies, NGOs, professional associations and academics. Resulting frameworks have also emphasized the importance of the context of service, recognizing that individuals' ability to act "capably" is shaped by whether or not they have sufficient time, resources and institutional support.

Two of the best examples of capability frameworks in family violence are those developed in New Zealand and Australia. New Zealand's *Family Violence, Sexual Violence and Violence within Whānau Workforce Capability Framework* identifies six major domains of workforce capability in IPV and sexual violence: 1) Understanding people's experiences of family violence, sexual violence and violence within Whānau; 2) Upholding the dignity of people and their diverse cultural identities; 3) Enabling disclosures and response to help-seeking; 4) Using collective action to create safety for victims; 5) Using collective action to sustain safe behaviours of perpetrators; and 6) Working as part of an integrated team (New Zealand Government, 2017). New Zealand has also outlined capacities for working effectively with diverse people impacted by family violence and/or who use violence (New Zealand Ministry of Justice, 2021a) (E2E) and provided detailed guidance on what organizations need to deliver specialist family violence services (New Zealand Ministry of Justice, 2021b). Within Australia, the *Responding to Family Violence Capability Framework* (Victoria State Government, 2017) outlines five domains of capabilities: 1) Engaging effectively with those accessing services; 2) Identifying and assessing family violence risk; 3) Managing risk and prioritizing safety; 4) Providing effective services and 5) Advocating for legislative, policy and practice reform. Four tiers of knowledge and skills are identified, from those required of workers in universal services (tier 4) through to specialist family violence and sexual assault practitioners (tier 1). Organizations and researchers in the US and UK have also advanced work on competency and capacity frameworks (e.g., Roddy & Gabriel, 2019; Stover & Lent, 2014), though often with a less comprehensive scope.

Recognizing the promise of this work, and centering the expertise of survivors and service-providers, a non-governmental team in Canada worked over a period of two years to develop a capability framework for IPV specialist work. The initial focus of this work was the capabilities of specialist service providers addressing IPV in heteronormative relationships, specifically those working with survivors who identify as women, infants, children, and youth who experience IPV, and perpetrators who identify as men. We made this choice recognizing that the overwhelming global burden of IPV is borne by women, mostly in the context of heterosexual relationships (Burczycka, 2019; Government of Canada, 2021) and that children are also impacted by exposure to and living in families where there is violence between adult intimate partners (Gerwitz & Edelson, 2007; Holt et al., 2008). We engaged in this work with an understanding that attending to the process of creation would be as critical as the final product. This paper outlines the steps we used to identify IPV specialist capabilities and describes the outcome of this work, the Flourishing Practice Model. We provide these detailed descriptions to share with others the ways in which we worked collaboratively, centering the expertise of survivors and specialist service providers, to articulate the capabilities of IPV specialists.

Methods

In this section of the paper, we outline our seven major steps of framework creation. In doing so, we describe ways in which our creation aligned with common recommendations and processes for identifying competencies (Batt et al., 2021) and also discuss the ways in which our processes deviated, augmented, or changed processes to reflect values held by IPV specialists on the nature and location of expertise.

Step 1: Clarifying our values and inviting participation

An initial, and ongoing, part of the work to develop the Flourishing Practice Model was to reflect and act on values that are foundational to IPV service provision. Three critical values informed our work: equity and diversity, recognizing and valuing the expertise of survivors and service providers (Sweeney et al., 2009), and engaging in deep and meaningful collaboration and co-production of knowledge (Arribas Lozano, 2018; McCarry et al., 2018). It was critical to us, as research leads, to work in ways that recognized that patriarchal, colonial, racist, homophobic, transphobic, ageist and ableist structures interact to maintain inequities and contribute to who, how and why violence is perpetrated and experienced and to whose voices are, and are not, recognized as having expertise and authority. This meant that at the onset, we needed to recognize, highlight, and consider the limitations of our team. A diversity, inclusion, and equity statement was developed and shared as a foundational document. This document included critical consideration of the positionality of the research team, including how this team reflected histories of power, oppression, and social inequities in family violence work. Our statement included a commitment to not impose our work on communities, specifically recognizing that "*It would be inappropriate and potentially dangerous to impose our work on others, which we recognize comes from particular ways of knowing and may not adequately capture or represent the expertise that already exists within Canada's diverse communities. Individuals across Canada who are doing gender-based violence work will decide how to draw on, build from, or reject this framework. We will pay attention to and learn from the responses from others.*" We recognized that such actions do not replace the need for work led by Indigenous researchers and in partnership with Indigenous communities in nation-to-nation frameworks. Nor do they replace the need for leadership by and work with structurally disadvantaged individuals or groups including those who are racialized or those who are members of the 2SLGBTQ + community.

We also had to think critically about where "expertise" may be located. As discussed, many competency frameworks have relied on expertise that is seen to be located in academia, rather than in the day-to-day work of experienced practitioners and in the experience of survivors. As research leads with privilege from university positions, we felt responsible for shifting this perception, addressing oppression and inequity and creating change in the process of partnering with community-based experts. Accordingly, our work focused on the expertise of survivors and experienced service providers. We used professional and practice-based networks to identify expert working group members with experience working with:1) women survivors of IPV, 2) infants, children and youth who had experienced violence, and 3) men who have behaved abusively and who could represent the diversity of experiences across the country. We also partnered with a national organization, WomenatthecentrE, created by survivors and for survivors. Our final working group consisted of 72 experts from across the country. Just under half (46%) of the working group members had lived experience with IPV. Our expert working group members had an average of 17.3 years (SD 9.3) of experience working in IPV which considered together, brought a total of 802 years of experience working with women survivors, 569 years of experience working with infants, children and youth who had experienced IPV and 499 years of experience working with men who have behaved abusively into our conversations. Expert working group members were diverse in terms of geographic location (Fig. 1) and ethnic/cultural identities (42% self-identifying as White, 10% identifying as Indigenous, Cree, Metis, First Nations or Mi'kmaw, 6% as Black, 5% as White French language minority as well as many others).

Finally, we had to consider how we would intentionally create space for deep collaboration, which involved honoring diverse expertise and creating space for all voices in our processes and discussions. Some of the more formal steps taken to achieve this aim included: a) creation of clear memorandums of agreement; b) budgeting to ensure that expert working group members were compensated for their time; c) co-developing a diversity and inclusion statement and set of actions; d) creating guidelines for communication that named the ways in which we intend to work with each other and outlined a formal process to guide discussions in situations where discussions became tense and potentially divisive; and e) continually collecting and acting on suggestions for improvement from expert working group members. We also maintained ongoing discussion about the project aims by having working group members identify indicators that the work was proceeding well and indicators that it was going "off track". These guideposts were reviewed regularly and used by the leadership team to help guide the work.

Step 2: Scoping review of academic and practice literature

A common method initial step in developing competency frameworks is conducting a scoping review of the literature (Arksey & O'Malley, 2005; Munn et al., 2018). Peer-reviewed articles are often prioritized as sources of expertise. We recognized at the onset of our literature searches that, in the area of IPV, significant writing would have been

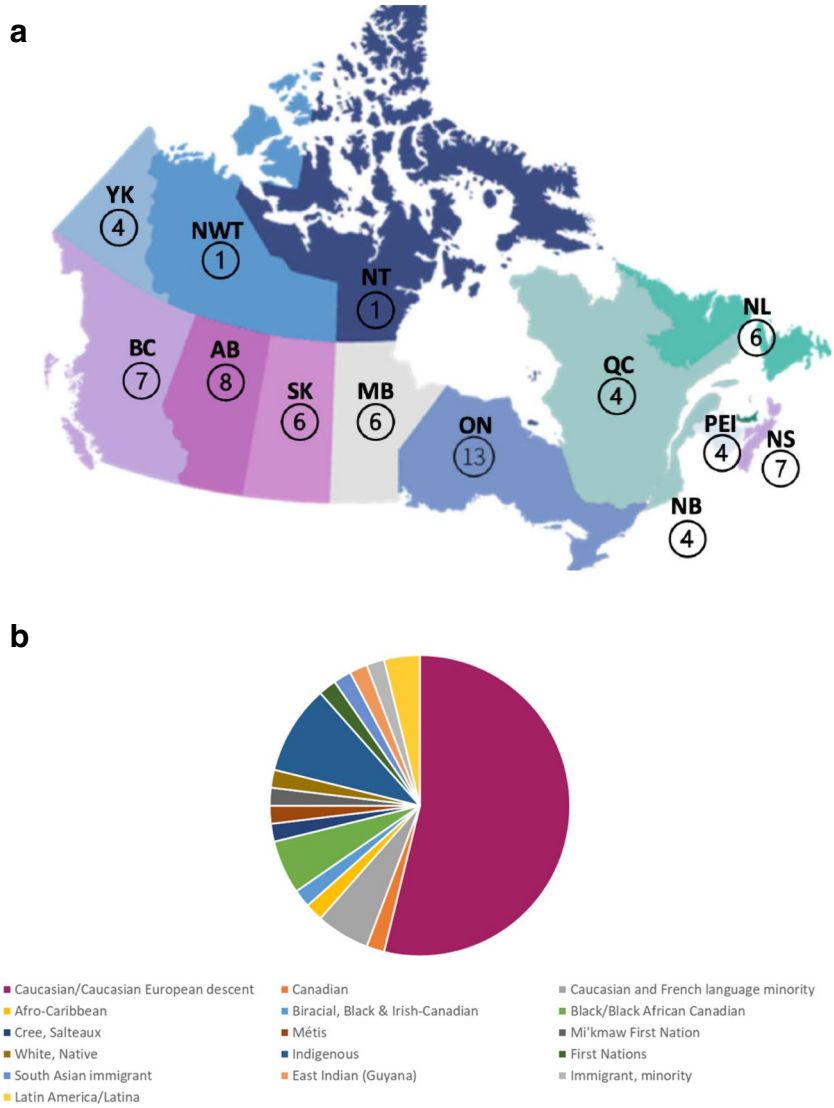

Fig. 1 Location (**a**) and self-identified ethnicity (**b**) of Expert Working Group members. **a** Number of Expert Working Group Members from each Province/Territory. **b** Self-identified ethnicity of Expert Working Group Members

done for and by service provider leaders as they develop resources to train new service providers, identify problem areas and articulate ways of work to address these issues, and create guidance for practice. These materials and documents would likely be written up as non-academic papers, reports, policies, or program guidelines and published or made available outside of traditional commercial and academic forums. We therefore needed to use an inclusive and comprehensive search strategy (Levac et al., 2010; Peters et al., 2015). Initial databases that were searched included: social work abstracts, social service abstracts, PsychInfo, SocIndex, PubMed, CINAHL, OMNI. Searches were further expanded to be as inclusive as possible of grey literature, including a Google Scholar search of the above reference terms. Our team also contacted provincial and national networks and associations to identify documents and sources potentially relevant to identifying IPV specialist competencies. In total, we identified 140 documents worthy of in-depth review (Fig. 2, panel a).

Step 3: Interviews with expert working group members

Even with an expanded literature search strategy, scoping review methods prioritize particular forms of knowing, in this case, the knowledge that is written down. However, within practitioner and survivor networks, much knowledge is shared through stories and examples, and not through written documents. Such sharing has some similarities to Indigenous ways of knowing through stories and examples, and thus methodologies relevant to capturing such knowledge were important to consider (Absolon, 2022; Kovach, 2010, 2017). Conversational and story-telling methods of gathering information involves dialogic participation

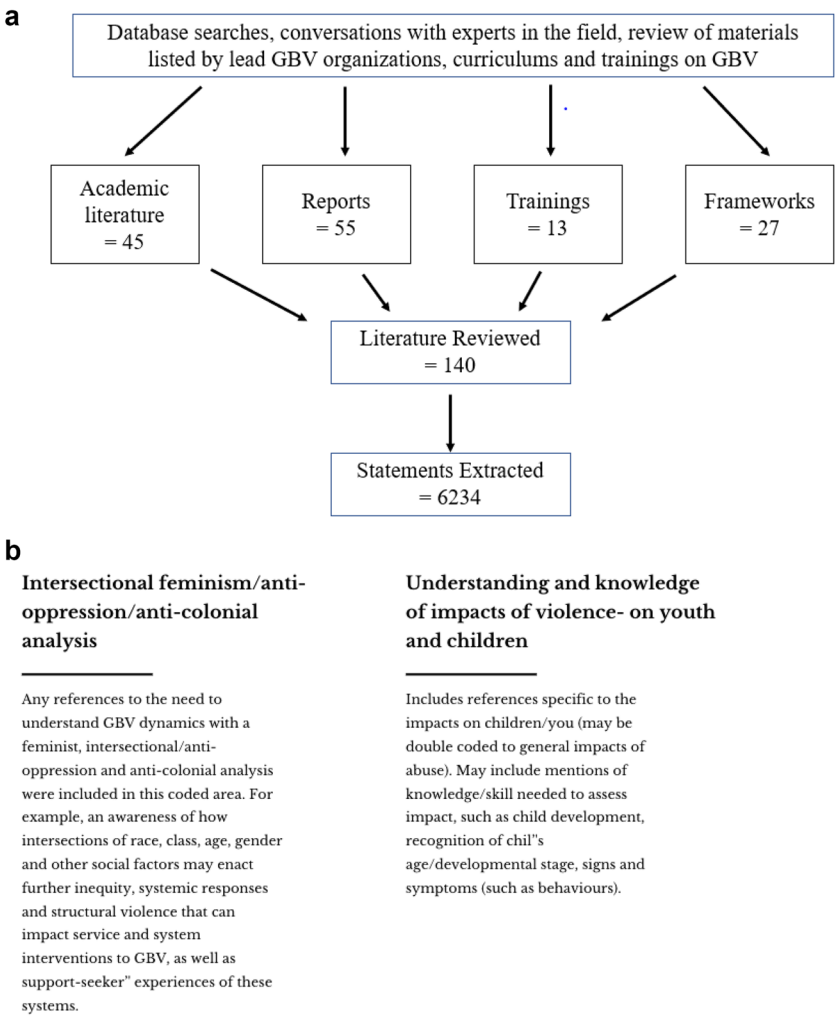

Fig. 2 Scoping review search results (**a**) and example categories (**b**)

and valuing of relationships. Recognizing the value and significance of this form of expertise, the research team engaged in interviews with 62 consenting expert working group members to explore their experiences in practice. Interviews began by asking participants to describe what they needed to know, think and do in response to a service user in a range of hypothetical situations. They then invited expert working group members to share stories of challenging situations and to reflect on the skills, knowledge, and attitudes required in order to provide effective services in these contexts. They were also asked what aspects of the situation represented the most significant struggles, how to navigate the situation, and any specialized knowledge needed when providing services in this scenario.

Step 4: Initial integration of information to create descriptions of capabilities

The next step was to use the information from the scoping review and the interviews to create an initial set of capability descriptions. This work began with the coding of the 140 documents identified in the scoping review. For these documents, all content containing references to specific skills, knowledge or abilities/attitudes were extracted for additional analysis. This process resulted in a total of 6234 individual statements that needed to be subject to analyses. Using Thematic Analysis (Braun & Clarke, 2006), our team of university and practice-based researchers coded these statements into 45 distinct categories of knowledge and skills that were summarized into item-level descriptive statements (for examples see Fig. 2, panel b).

Once this review was completed, we turned to reading interviews. Interviews were thematically coded with attention to the existing categories and item-level descriptions of knowledge and skills identified as part of the scoping review and to utterances that were not captured in these categories and item-level descriptions. Through initial readings and subsequent coding of the interviews, it was determined that, in many cases, there were high levels of overlap between experts' description of what IPV specialists needed to know, think, and do in their work and what was documented in the published literature. Notable, however, was that experts'

descriptions were much more nuanced, detailed and explicative of what knowledge and skills "looked like" in practice. There were also capability areas identified in interviews that were distinct from those in the literature. The research team incorporated all novel codes and findings from the interview data into the categories and item descriptions from the scoping review. This included both the expansion of already existing items, and the creation of new items. In total, we created over 125 distinct capability items.

Step 5: Delphi surveys

Knowledge, skill and ability items and descriptions created from the scoping review and interview analyses were sorted into broad thematic areas of complex practice that shared similar functions (e.g., engaging in advocacy). All items were then subject to iterative review in Delphi surveys. Delphi is a technique that seeks to obtain consensus on the opinions of 'experts' through a series of surveys (and sometimes focus groups or interviews), the results of which are then summarized and shared with the responding experts to inform subsequent discussion (Hasson et al., 2000). This process may be ongoing until consensus is reached. For this project, expert working group members were sent eight surveys, each of which covered one or two domains at a time (for a total of around 50 competency items per survey). For each knowledge, skill and ability item, expert working group members were asked to indicate their level of agreement (on a 5-point Likert scale) with the following statements: "This item resonates with me, it is part of what I think is important in the work" and "this item is clearly worded." Experts were invited to make comments and suggest revisions. Experts were also asked to reflect on whether each item was relevant to IPV specialist work with women survivors, children exposed and/or men who have behaved abusively (experts were asked to check all that applied) and the extent to which the items captured a "generalist" (i.e., true of all social service providers) or an IPV "specialist" area of knowledge or skill. Results of Delphi surveys were compiled into reports on level of relevance, clarity of wording and comments/suggestions for each individual item.

Step 6: Discussion and Creation of Flourishing Practice Model

The next step of model creation was working group discussions of results. In initial discussions with expert working group members we established an initial threshold for consensus at 80% agreement – in other words, we initially decided that if 80% of our working group members agreed, on the Delphi survey, on the relevance and clarity of an item and its description, we would accept it "as is" and move to discussions on areas that were more controversial. To our surprise, it was consistently the case that our expert working group members agreed, often at rates of over 90%, on the relevance of the created items to their work specifically and, more generally, to work with women, children and men and on the clarity of the item. Expert working members also tended to agree that items were clear, but additionally added comments and suggestions of greater depth, nuance, and detail to item descriptions. They also sometimes made suggestions that differed sufficiently to warrant the creation of a new item in a particular area of practice or made note of agency-level supports, policies or practices necessary for being able to practice in ways that were consistent with the item descriptions (e.g., for specialists to effectively collaborate with others to manage risk and promote safety, IPV specialist organizations need to foster relationships with other organizations working to end GBV). All items for which there were significant suggestions for improvement were brought forward to be discussed in expert working group meetings.

Discussions started by breaking expert working groups into smaller subgroups of 4 to 6 members. The session would begin by sharing the initial item, describing the survey results for the level of agreement on relevance and clarity across all working groups and noting areas of revision to wording made on the basis of survey feedback. Subgroup members then discussed the item, sharing thoughts about what needed to be improved or changed. Throughout the early parts of discussion, expert working groups met separately, one after the other, i.e., a first meeting would involve the expert working group members with women survivors, then infants, children and youth and then with men who have behaved abusively, though in later discussions, groups were combined. In either case, the same discussion would be facilitated across a minimum of two subgroups. Most suggested changes were ones that added description and nuance to the items; making more explicit what this area of knowledge or skill meant for how IPV specialists interacted with women, children and men. When discussions were less aligned across working subgroups and when changes were substantive, the final item was brought back to at least one working group for a final review.

Throughout discussions, working group members made it clear that without adequate resources and supports from institutions, core knowledge and skills could not be adequately developed or demonstrated and that theories behind best practice approaches could not be realized. Based on these discussions, the researcher team and working group members developed and discussed a set of organizational items which reflected the agency-level knowledge, resources and supports necessary for supporting good practice and that might be considered in the final capability model.

Once all of the items were fully elucidated, the research team was left with the task of creating a visual representation that would illustrate the holistic, connected, fluid and growth-oriented nature of our approach. The imagery of a flower was eventually chosen (see results). With this imagery we were able to illustrate a conceptual model where each part (the stem, core, leaves and petals) represent distinct areas of knowledge and skills. In this model, critical capabilities are represented as supporting and energizing structures. Specifically, necessary organizational supports are presented as the stem and capacities such as navigating laws and ethics and collaborating across systems as leaves. We then grouped items that were central and shared in all of the work (such as the experiences, identities, strengths, and expertise of service users) to be highlighted as the core, surrounded by the critical practice of recognizing, assessing and communicating risk. The petals then represent the specialized knowledge and skill held by IPV specialists with specific areas of practice (such as working with women, children and men) and we included blank petals to highlight areas of work still needed, signifying expertise that has not yet been documented. This image and the placement of items was again presented back to the expert working group members for discussion and feedback.

Step 7. Signing off and sharing

Over 70 working group hours were devoted to discussion of items and feedback on the developing model. Once the framework was compiled in full and the feedback and revisions of expert working group members had been incorporated, the research team engaged experts in an endorsement process which involved each expert being individually asked by a project lead whether they would like their name listed on the published framework as part of the expert working group. As reflected in the authorship of this paper, there was broad endorsement of the final set of capabilities. Expert working group members also participated in discussion of the ways in which this framework should be presented, shared, and used. Emphasis was placed on the value of having this work produced and owned, used, and shared by the broad range of service providers who contributed to its creation.

Results

Through the seven steps outlined above, a collaborative group of survivors, service-providers and research team members from across Canada's provinces and territories were able to create the Flourishing Practice Model to articulate the capabilities of specialist service providers working with: 1) women survivors of IPV, 2) infants, children and youth who had experienced violence, and 3) men who have behaved abusively (Scott et al., 2022). The final framework is available online along with a series of short videos by expert working group members describing the model and its creation (https://www.learningtoendabuse.ca/research/recognizing_critical_expertise_in_genderbased_violence_work/index.html).

The Flourishing Practice Model (Fig. 3) is supported by the *stem* – which represents the critical role that organizations need to play in making it possible for IPV service providers to develop capabilities. Included is organizational leadership on anti-racist, anti-oppressive practices, high level commitments to collaboration, organizational level recognition of the need to work across services for survivors, including child survivors, and those who have behaved abusively. This part of the model recognizes that the capabilities of IPV specialists are not solely located in the individual service provider, but must also be understood in relation to the organizational context (e.g., time, resources, leadership support) and in which they are working.

The core of the flower and the framework represents capabilities needed to work in ways that centre the experiences, identities and strengths of those seeking services. Four areas of knowledge and skill are outlined as necessary to practice in ways that center service users. First, IPV specialists need to be able to *centre the diverse and intersecting identities and cultures* of those who experience and perpetrate violence. For example, IPV specialists know that different people experience violence differently and that IPV specialist work cannot be done without a strong foundational capacity to apply an intersectional, anti-racist, and anti-oppressive approach. *Recognizing and amplifying strengths in response to violence* is a second part of this core. This section refers to capabilities to recognize and value the fact that service users are the experts of their own lives and that ways of responding to violence signify wisdom, strength, and resiliency. The *actively decolonize practice* section recognizes that to provide IPV specialist services, IPV specialists need knowledge of colonization, they need to be able to provide strengths-based services that center Indigenous cultures and identities and they need to commit, within themselves to anti-colonization. And finally, part of the core are the capabilities of IPV specialists to engage in *trauma and violence-informed practice* with a deep understanding of the impact of abuse.

The leaves of the Flourishing Practice Model represent capabilities that underlie the work of all IPV specialists. Included in this part of the model are knowledge and skills to *navigate laws and ethics* which requires legal and court-related knowledge, capabilities required to support service users who are navigating these systems and an understanding of how courts often exacerbate trauma associated with IPV; *engage in advocacy,*

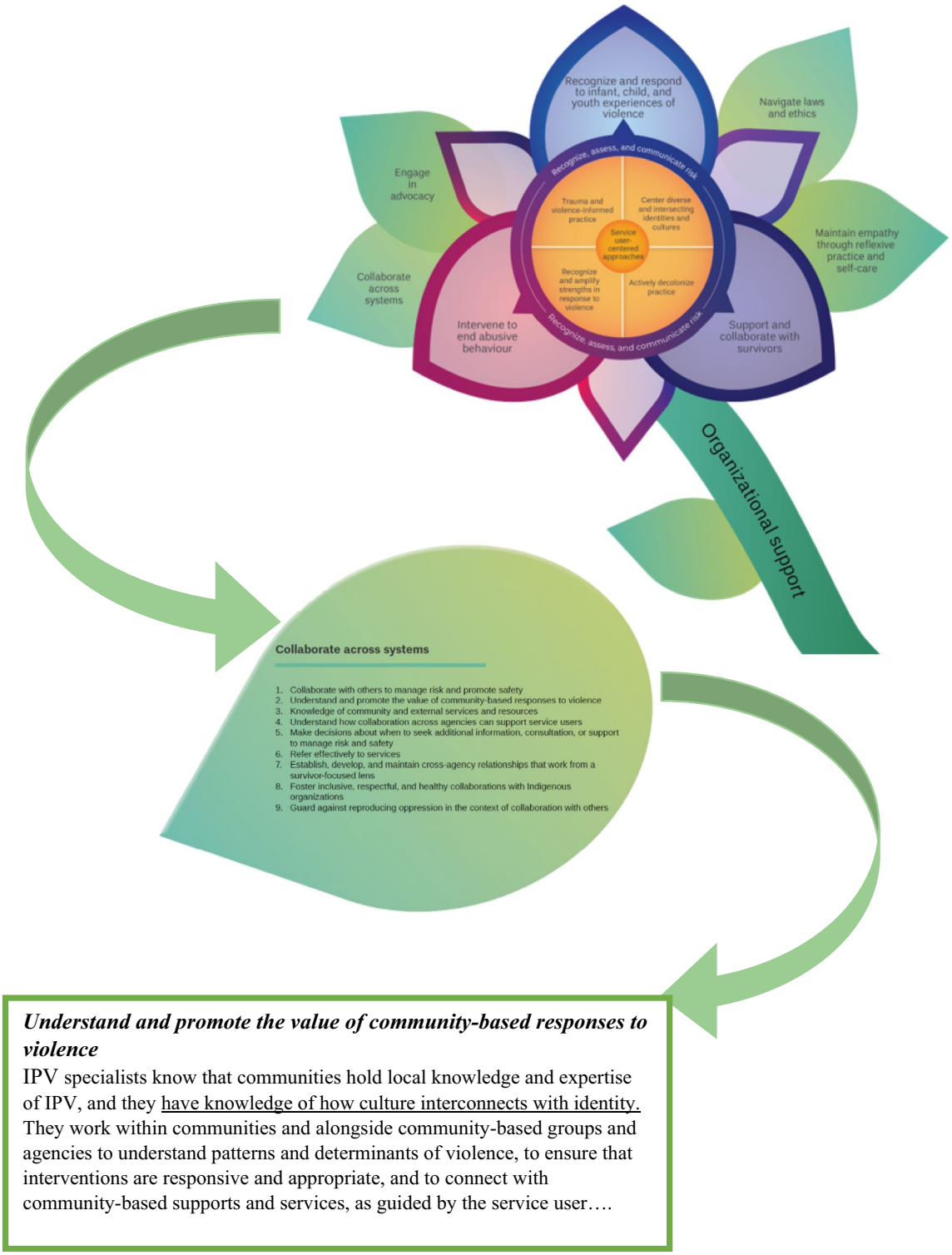

Fig. 3 Flourishing Practice Model with example of item titles and detailled item descriptions for Collaborate Across Systems.

which outlines the ways IPV specialists identify systemic gaps in policies, programs, and services and raise their voices to prompt recognition and elimination of gender-based violence, *collaborate across systems,* which recognizes the capabilities needed to provide a coordinated, holistic response to maintain the safety of service users, effectively conduct risk assessment, manage risk, and create safety and prompt collaboration of different types of services including those related to basic

needs, immigration, separation and divorce, mental and physical health, and more. The final leaf, *maintain empathy through reflective practice and self-care*, represents the knowledge that bearing witness to, and taking action against, violence, abuse, and trauma can be emotionally challenging for IPV specialists, especially when such work is done within a system that fails to recognize and respond in a socially just way to IPV and intersecting systems of oppression.

The outer core of the Flourishing Practice model diagram, *recognize, assess and communicate risk,* represents sector-wide fundamentals of risk and safety. For example, all IPV specialists have deep knowledge of risk and protective factors for IPV and an understanding that risk and safety are individual, intersectional, and dynamic, have knowledge of risk associated with different patterns and severities of abusive relationships and have skills for promoting safety and accountability. There are also aspects of recognizing, assessing and communicating risk that differ based on whether the IPV specialist works with children who have experienced IPV, women survivors, or men who have behaved abusively. The triangles that extend from the inner core represent these more specialized areas of knowledge and skill held by specific IPV service providers.

Finally, the petals of the Flourishing Practice Model represent the specialized knowledge and skill held by IPV specialists working to *support and collaborate with survivors, recognize and respond to infant, child, and youth experiences of violence, or intervene to end abusive behaviour*. The petals include knowledge and skills developed within a specific area of practice, that "grow from" the commonality in the other parts of the framework. *Blank petals* represent areas of expertise that have not yet been articulated. The current work focused on heteronormative relationships, women and children survivors, and abuse by those identifying as men. Service provider knowledge and skill for addressing violence in 2SLGBTQIA + relationships and relationships in which there are victims who identify as men were not explored. There are also many forms of GBV aside from IPV (e.g., sexual abuse, sexual harassment, forced marriage). The working groups who came together to create this model identified these as priorities for future work, as well as the following: Indigenous-led initiatives, supporting Black individuals and communities, supporting newcomer, immigrant, and refugee individuals and communities, addressing IPV in older adults, and supporting individuals with disabilities. There may be other areas as well not listed here.

Discussion

Our aim in this paper was to describe the process and outcome of working collaboratively to create the Flourishing Practice Model of the capabilities of IPV specialist service providers in Canada. In creating this framework, we made use of many of the steps, methods and strategies typically used in developing competency frameworks (Albarqouni et al., 2018; Batt et al., 2021) to instead focus on capabilities. We defined the scope of the problem, engaged experts and stakeholders, reviewed academic literature, conducted interviews, administered Delphi surveys and facilitated discussions to move toward consensus. Consistent with a capability model, the focus of this work was aspirational, in that it recognized the knowledge, skills and abilities needed for best practice and in the context of the need for continuous adaptation, growth and improvement, as opposed to minimal standards for, or limitations on, practice.

Within all steps of framework creation, we tried to practice in ways that were consistent with the values of the field. We prioritized expertise of survivors and service providers in creating our expert working groups. Survivor experiences were considered critical sources of expertise. We deliberately sought out literature outside of traditional academic forums. We recognized the value of stories from practice and used them as an additional source of information and expertise. We were intentional and deliberate about creating safe spaces for discussion and co-creation and we ensured that the final framework was owned by all that participated in its creation, and by extension, to their own practice organizations and communities. We hope that our outline of steps might serve as a model for others wishing to further this work.

The outcome of our work, the Flourishing Practice Model, has some similarities to the models developed previously in Australia and New Zealand. All frameworks recognize the importance of working in ways that centre the diverse identities understanding people's experiences of violence. All models include aspects of collaboration, risk assessment and management, working to create safety, and advocating for change. There is also some recognition in all models that service provider capabilities cannot be developed and used in isolation from institutional support (stem) and that capabilities in the field are dynamic and that the work is unfinished (blank petals). The Flourishing Practice Model differs in the level of detail it provides in descriptions of practice under each item. Specifically, in this model, each item is accompanied by nuanced and detailed descriptions of what good practice in this area looks like; a level of detail deemed essential to our expert working group members. Compared with previous models, Canadian work also places more explicit emphasis on the capabilities of IPV specialists in two areas; navigating the legal system in ways that prioritize service user safety, privacy, dignity and trust and service-provider capability to engage in reflective practice and self-care as a way of maintaining empathy.

The Flourishing Practice model also adds to previous frameworks in its specification of capabilities that are shared by, and specific to, IPV specialists who work with women survivors, infants, children and youth who have been exposed to violence, and men who have behaved abusively. The level

of shared capabilities of IPV specialists working with these three sectors was a key area of exploration during our development of this framework. In Canada, disconnects and tensions between service providers who work with women survivors, children and those working with men who have behaved abusively have been a concern in many communities. For this project, we decided it was critical to bring together experts from across these different sub-sectors of the IPV field to have conversations about shared and non-shared understandings of the knowledge and skills required to do IPV work. Our hope was to generate opportunities for relationships, support increased collaboration, and to facilitate new partnerships among experts across Canada; however, we were also concerned that bringing together women's, children's and men's service providers had the potential to entrench or widen divides between sectors. Indeed, we found that in early discussions, when discussions moved into areas of general values (e.g., IPV specialists believe in the power of human connections in healing from violence and trauma), tensions and disagreements were common. However, when we moved away from these more general discussions and instead focused on the specific knowledge, skills and actions that might be related to such values, there was a great deal more agreement and much richer exploration. Though initially cautious, as our expert working group members worked together, they became more comfortable exploring the nuances of agreement and areas where knowledge and skills might be applied differently. Overall, we discovered that specialist service providers working with women survivors, infant, children and youth living with violence and men who have behaved abusively had more in common than in conflict. Expert working groups members emerged from our work feeling enthusiastic about opportunities to work across sectors to develop and offer training and development opportunities in areas such as navigating laws and ethics, advocacy and service-user centered practice. In the words of one expert working group member:

> *After over 17 years in the field, I had the opportunity to speak and to meet so many diverse people across the country doing this work. It was exciting, and hopeful, and finding a common language, and finding where we were different, and meeting again and again and building relationships – I felt like I was part of a movement and it's given me more hope and optimism than I've had since starting this work.*

Limitations

Although taking a capability-based approach to understanding the work of IPV specialists has many strengths, we recognize that this approach also has some limitations, challenges, and risks. Competency models have been critiqued as coming from a positivist paradigm, based on reductionist principles (Bogo et al., 2013; Drisko, 2014, 2015). Moreover, competency frameworks are often associated with practice in medicine, which can be a problematic history given that early activists needed to work to displace a "medicalized" understanding of women's reactions to violence as "disordered" and instead give authority and voice to women's own understanding of their experience (Sinclair, 2019). In this work, we deliberately positioned survivors and service providers as the experts in their experience and work, which is an important counter to the ways in which competencies are often developed. We were also attentive to trying to bring as many geographically, culturally and ethnically diverse voices as possible to the discussion. However, in deciding to focus on the expertise of survivors and service provider, we did leave out other potential experts.

Further, although frameworks like the Flourishing Practice Model can be helpful to raise the profile of work in a particular field, they can also limit the work and create barriers to practice. Within services to address IPV, there is a long tradition of collaborative, service-user centered work and of peer-based models of practice. It is important that work with this framework avoid closing the door to these non-hierarchical models of practice. The Flourishing Practice Model was developed and designed with and for the field to recognize expertise that exists, promote the ability of grassroots organizations to influence government, and potentially, to provide a roadmap for skill development for IPV service providers. It was expressly not developed in service of an imposed regulatory framework.

Conclusions

Survivors and specialist service providers in IPV hold substantial expertise about the capabilities needed in a responsive workforce. Canada's Flourishing Practice Model was developed to describe these capabilities. In Canada, as perhaps elsewhere, the timing of this work is important. The IPV service providers who developed and led many of Canada's founding IPV programs and who traditionally passed their knowledge on through mentorship and supervision are aging out of the field, taking with them invaluable wisdom (Sinclair, 2019). By working in ways that valued the expertise of specialist service providers and survivors and emphasized the co-creation of knowledge, we hoped to create a framework to respectfully and collaboratively pass this knowledge into the future.

Acknowledgements Expert Working Group Members

Abi Ajibolade[4], Yennelys Alcedo[5], Tod Augusta-Scott[6], Trish Bartko[7], Angie Brenton[8], Deena Brock[9], Diana Burke[10], Michelle Buttery[10], Renee Claude Carrier[11], Clara Castillo[4], Claudia

Champagne[5], Toni Cole[4], Magi Cooper[12], Jose Desjardins[5], Laura Ducharme[7], Bentley Dubois[9], Stephanie Duggan[6], Tosha Duncan[7], Gillian Dunlop[4], JoAnne Dusel[13], Katina Feggos[14], Dawn Ferris[6], Amy Finch[14], Kim Fontaine[9], Mary Fredlund[15], Lyda Fuller, Jeanine George[4], Theresa Gerritsen[12], Valerie Goodkey[11], Michelle Green[8], Marlene Ham[4], Jo-Anne Hargrove[10], Ketsia Houde-McLennan[11], Michele Jones[12], Tim Kelly[4], Fouad Khan[4], Nigam Khanal[14], Lisa Lanyon[9], Linda Lapierre[6], Nneka MacGregor[4], Nola Mahingen[13], Krys Maki[4], Dan Meades[8], Cindy Murphy[8], Tracy Myers[12], Kara Neustaedter[9], Michele Nichol-Sawh[9], Kerry Nolan[11], Melissa Noseworthy[8], Shiva Nourpanah[6], Danya O'Malley[10], Allyson Pearce[13], Bev Poitras[13], Neena Randhawa[12], Jan Reimer[7], Sarah Roberts[12], Stephanie Robson[7], Mario Rolle[6], Wayne Schlapkohl[13], Deb Sinclair[4], Lisa Tomlinson[4],Johanna Baynton Smith[7, 12], Melanie Valente[5], Bev Walker[6], Deborah Westerburg[14], Ian Wheeliker[7], JoAnna Woode[13], Carolyn Woodroffe[7], Nicole Young[8], Julie Young-Marcellin.[4]

[4] Ontario, [5] Quebec, [6] Nova Scotia [7] Alberta [8] Newfoundland and Labrador [9] Manitoba [10] Prince Edward Island [11] Yukon Territories, [12] British Columbia [13] Saskatchewan [14] New Brunswick [15] Nunavut [16] Northwest Territories.

Correspondence on behalf of the Expert Working Group Members can be sent to Dr. Tod Augusta Scott, Bridges Institute, 676 Prince St. Truro, Nova Scotia, bridges@bridgesinstitute.org

Data Availability The data that support the findings of this study are available on request from the corresponding author, K.S.

Declarations

Conflicts of interest The authors declare that they have no conflict of interest.

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