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Training and Certification for Domestic Violence Service Providers: The Need for a National Standard Curriculum and Training Approach

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Abstract

Domestic violence (DV) continues to constitute an enormous public health problem in the United States. Knowledge and understanding of the complexities involved in DV has grown significantly in recent years revealing a need for providers who have broad training in a variety of legal, safety, developmental, and clinical issues that face families impacted by DV. This paper reviews current approaches to training and the ability of such methods to adequately prepare providers. There are no national standards for providers at any level from DV advocates to batterer interventionists, to clinicians with the required hours of training in most states at an alarmingly low level. Few states require cross training for those working as victim advocates or batterer interventionists. The systems that currently provide segregated and limited training create silos of service that are less effective. A proposed set of standards and training guidelines are proposed for DV advocates, batterer interventionists, and clinicians along with a discussion of the implications of such standards for the field.

Keywords

Domestic violence; intimate partner violence; provider training; standards intervention

According to the National Intimate Partner and Sexual Violence Survey roughly 36% of women and 28% of men experience sexual or physical violence or stalking by an intimate partner (Black et al., 2011). Domestic violence (DV), used here to mean the physical, sexual, or psychological abuse of an intimate partner, is associated with a host of direct (e.g. death, rape, or injury) and indirect (e.g., lasting effects on stress related illnesses, such as cardiovascular and immune diseases) consequences to those exposed indicating an enormous public health issue in the United States (Center for Disease Control and Prevention, 2012). DV is a chronic problem that is multigenerational in nature; those exposed to DV as children are at increased risk for perpetration and victimization themselves as adults (Stith, Rosen, & Middleton, 2000). Given the extent of the problem, those who provide intervention and service to families impacted by DV are critically

important to helping stop the cycle of violence and transmission from one generation to the next. However, the training standards for those providing such interventions for families impacted by DV are lacking. No specific national standards exist for providers in any category of DV service and guidelines provided by states require a minimal number of hours of training (sometimes as little as one to two days) for those serving as DV advocates and batterer interventionists¹. This is an issue that must be addressed in order to raise the level of expertise and skill for those attempting to intervene in this very challenging field. This paper will outline the current state of training nationally and offer a set of proposed national standards for training.

Currently across the country there is a range of intervention options for those affected by DV. Services for victims (primarily for female victims) and their children and batterer interventions are the two major categories of services. Those that provide services within these programs and agencies hold a variety of roles including: victims' advocates, children's advocates, domestic violence counselors, batterer interventionists, and clinicians. A survey of training requirements for providers in different states across the United State yields variable results, with a few consistencies in instruction and knowledge. Typically, those working in victim services or batterers intervention programs (BIPs) are trained in two key areas: 1) the cycle of domestic violence, and 2) the issues of power and control in domestic violence relationships. The similarities end there. A lack of national standards creates differences in training methods, length, required supervised experience, and educational certifications. Given the amount of research and the advancement of knowledge in the area of DV in recent years, the limited nature of material covered in training for providers is of significant concern.

Consistent with the narrow overlap in content, there is very little cross training and those working with women and children generally do not work with perpetrators. It has even been suggested that some individuals working within the DV advocacy field do not believe batterers are capable of changing their behavior (Gelles, 2011). This assumption can color a provider's approach to intervention and can also be reinforced by the nature of the training provided and the limited focus of a system in which a provider works. The lack of cross-training which would allow providers to be versatile in their knowledge of issues for perpetrators, victims, and child witnesses is problematic. This silo effect creates a disconnection between DV advocates and batterer interventionists that does not fit with what we currently know in the field about the complexity of families impacted by DV. If an agency and its providers approach the problem of DV from a narrow lens, then the opportunities to assess and intervene will be limited in scope and likely less effective. This has been borne out in evaluation studies of domestic violence interventions (Babcock, Green, & Robie, 2004; Feder, 2005; Stover, Meadows, & Kaufman, 2009).

We know that men with DV continue to play an important role in their children's lives and many women choose to stay with their partners for a variety of reasons. In a community sample, 80% of victims still lived with or had contact with the perpetrator due to shared

¹This paper will use the terms "victims" "batterers" and "perpetrators" because they are commonly used and understood. However, current labels are inadequate descriptions of those families impacted by domestic violence.

children 6 months after a domestic dispute that was reported to the police (Israel & Stover, 2009). Other studies indicate upwards of 50% of women return to their partners upon leaving a DV shelter (Martin et al., 2000). A large scale survey of 3,824 men attending a court-ordered evaluation subsequent to being convicted of assault against an intimate partner revealed that 66% of the men had some type of fathering role with children under the age of 18 and most of those relationships continued following arrest (Salisbury, Henning, & Holdford, 2009). Given that many victims who meet with DV advocates in the shelter setting, community agencies, or the courts, will decide to return to live with the perpetrator, advocacy that focuses on leaving the relationship may not fit a victim's wishes or needs (Davies, 2008). In recent years there have been calls to return to some of the feminist roots of the DV advocacy movement by listening to the individual voices of battered women and what they need (Davies, 2008; Goodman & Epstein, 2008). How can advocates be responsive and helpful to victims who will return home if they do not have appropriate training or a system that supports a comprehensive approach to DV services? The complex interpersonal nature of violent relationships encompasses many aspects of social services and requires a combination of providers with consistent training. Screening, assessment and intervention with families impacted by DV that will truly provide an inclusive view of the family system and their needs requires expertise in both child and adult (perpetrator and victim) DV issues.

Summary of Current Standards for Domestic Violence Advocates

Domestic violence initiatives in the United States originated from grassroots campaigns characterized as women-helping-women and are still heavily reliant on the involvement and advocacy of a volunteer-based workforce (Wies, 2008). Domestic violence agencies have responsibility to ensure proper safety and care for victim clients and their families. To successfully fulfill such roles, significant, meaningful, and extensive training must be provided to all levels of staff and volunteers; yet funding for such initiatives is often not sufficient making implementation of training and standards difficult.

In a review of domestic violence services throughout the United States, Macy et al. (2009) found that state agencies and coalitions lack consensus on the content and extent of training staff and volunteers should receive to provide effective services to survivors. While some major components of training are consistent, the length of required training varies drastically. For example, Washington's state regulation WAC 388-61A-0350 (2010) requires a 24-hour minimum of training for staff in direct contact with clients, while the Maine Coalition requires 30 to 40 hours and Arizona requires 40 hours of training for the same service provider (Macy, Giattina, Sangster, Crosby, & Montijo, 2009).

There are general themes for competencies present throughout most DV advocacy training programs such as: an understanding of confidentiality, empathy for victims and their children, and a comprehension of dynamics of DV (Macy et al., 2009; Wies, 2008). Aside from these basic guidelines, there is variation in the depth and content of other topic recommendations and the exact content of these trainings is difficult to discern. Importantly, there are no standards outlined for how competency to provide service is measured beyond training attendance. There are no standards for education level (e.g. bachelor's degree) or

required certifications (e.g. passing an exam) that are consistent across states. Forty hours of training was on the rigorous end of the requirements. One week of training or less is all that is required for some service providers to serve as DV advocates. Given the complexities and risks associated with DV, the low standards are alarming.

Current Standards for Batterer Interventionists

Just as batterer intervention programs (BIPs) differ across the United States, the standards for batterer intervention provider training also vary. Unlike DV advocacy programs, BIPs are often court mandated leading almost every state to adopt legal codes that provide some guidelines about the necessary qualifications and knowledge areas for interventionists. These provisions entail a general framework that can be interpreted as training standards; however, they often lack substantial content.

Factors that vary among programs include: length, orientation, content/curriculum, format, leadership and philosophy (Rosenbaum, Warnken, & Grudzinskas, 2003). Further, the foundation of each program as either an education program or treatment impacts the demands, responsibilities, and expectations of providers (Geffner & Rosenbaum, 2001). When programs are defined as education rather than treatment, they do not require group facilitators to hold clinical degrees. In lieu of college courses and professional certification or licensure, a significant number of states favor “a minimum period of training (which may be as brief as one day) from a recognized program (e.g. Duluth or Emerge)” (Rosenbaum et al., 2003, p. 282). This leaves providers within these programs ill-equipped to recognize and intervene in the complex and often clinical issues that may be present for members of their BIP group.

Some states do provide significant detail related to the extent of training for BIP service providers. For example, Kentucky regulation 920 KAR 2:020, illustrates a state endorsed outline of training and qualification standards for court mandated treatment providers. It defines two types of interventionists: associate providers and autonomous providers (920 KAR 2:020, 2013). An associate provider must hold a bachelor’s degree, while an autonomous provider must have a master’s degree and certification or licensure within the state (e.g. psychology, social work). For both specified positions, the state requires a twenty-four hour domestic violence training that presents an overview of domestic violence elements, a discussion of lethality and effective safety planning, batterer intervention, and the legal aspects of DV (920 KAR 2:020, 2013). Further requirements include past supervised experience in a DV related environment. Associate providers must have 4,000 hours of experience and autonomous providers must have an additional 150 hours of supervised experience, 30 of which must be spent working with DV victims. Creating national standards such as these that will elevate the skill level of interventionists nationally is needed.

Current Standards for Clinicians

The training and supervised experience of those in clinical practice (e.g. social workers, nurses, psychologists, marriage and family therapists) allows them to provide a level of service unlike that of the DV advocate and batterer interventionists who typically do not

hold such degrees or training. A review of available guidelines for clinicians working with families impacted by DV revealed a paucity of standards. Several professional associations do provide competency guidelines, but surveys of mental health professionals suggest the need for further development of DV curriculum and training in graduate schooling (Campbell, Raja, & Grining, 1999)

The National Association of Social Workers (NASW) identifies assessment and intervention capabilities expected of providers based on recommendations from the Family Violence Prevention Fund. Additionally, the Children's Administration, a division of the Washington State Department of Social and Health Sciences, provides a holistic and comprehensive guide for practice within domestic violence populations to social workers employed with the department. Prescribed assessment competencies include discernment of safety and lethality, the ability to recognize abuse patterns, evaluation of health issues, and determination of clients' access to services (National Association of Social Workers [NASW], 2013). The NASW (2013) outlines expectations for effective communication with the client during treatment for those impacted by DV such as active listening, empowerment-based responses, and supplying appropriate information about services. Washington State has a publication based on the same principles set by the Family Violence Prevention Fund and goes beyond the scope of NASW requirements through a detailing of expectations and proper behavior when working with children, victims, and perpetrators (Ganley & Hobart, 2010). The legal restrictions placed upon practitioners, including confidentiality and a justification for specialized screening and assessment procedures, are also outlined (Ganley & Hobart, 2010).

Despite these available guidelines, a study by Danis (2003) found that 55% of surveyed licensed social workers reported having little to no academic preparation in the area of DV. Another study of social work students found graduate students felt ill-prepared to work with families impacted by DV due to a lack of quality graduate courses and experiences (Warrener, Postmus, & McMahon, 2013). Students who received less coursework and training in the area of DV reported decreased feelings of personal efficacy in working with victims of abuse (Warrener et al., 2013). These findings are concerning as they indicate clinicians who will likely come into contact with families impacted by DV through their clinical work have not received adequate training to appropriately identify, assess and intervene with these families.

The American Association of Colleges of Nursing (1999) position statement on IPV includes almost identical criteria for competency as those outlined for social workers and contains guidelines for methods of knowledge attainment and experience. Like those relevant to social workers, necessary skills such as awareness of domestic violence issues, assessment and screening procedures, and prevention measures are presented (AACN, 1999). The AACN proposal suggests the incorporation of DV training into bachelor and master's level nursing curriculums.

No specific guidelines were found for those practicing in other clinical fields like psychology or marriage and family therapy. The glaring lack of guidelines or standard curriculum and training for clinicians who will work with families impacted by DV is

startling and requires immediate attention in the field. Graduate education accreditation bodies like the American Psychological Association (APA) should implement standards for minimum curriculum and training related to family violence for clinicians given the likelihood that most practitioners will encounter DV in their clinical work.

While credentials and training needs will differ depending on the particular role of the provider, all working in the field of DV should attain basic competencies that extend beyond a simple history of DV, risk assessment and power and control theory (although these should be part of the curriculum). DV is a multifaceted problem and those it affects are an extremely heterogeneous group. Trainings that do not include topics like: trauma, substance abuse, and attachment miss important factors that contribute to understanding the phenomena of DV and its impact on all members of a family.

Developing standard competencies and means for providers to meet these educational and practical experiences is paramount. A proposed set of competencies are outlined below to provide a framework for moving the field into the direction of credentialing providers for the good of families. The proposed competencies (see Table 1) are divided into three segments: knowledge, skill, and attitudes. This division allows for expanded coverage of expertise and a means of illustrating how training components build upon one another, ultimately affecting provider competence.

Proposed Standards for Domestic Violence Advocates and Batterer Interventionists

In the case of DV advocates and batterer interventionists, it is believed that both disciplines should be held to the same standards and receive a significant amount of cross training. DV is a multidimensional issue that cannot be addressed from one sphere alone. Coordination and full understanding of the mission, values, and goals of providers for both members of the dyad are needed to provide the most effective interventions. Thus the proposed standards for DV advocates and batterer interventionists contain the same primary components (see Table 1).

An effective cross training of both DV advocates and batterer interventionists will include the same dissemination of information and transfer to job based skills. Through training with the proposed competencies, service providers will have a thorough understanding of the history of domestic violence and the batterer intervention movement. Along with the foundations of each area, a collective approach enables exposure to the frameworks and theoretical models that shape both types of agencies and topic areas that are crucial for all providers to know and apply in their work.

Further knowledge competencies focus on an understanding of the different types of DV (psychological, physical and sexual) and the impact on victims and families, notably children. Proper assessment and screening is dependent upon providers' ability to recognize what constitutes DV and the complexities involved. How the nature of the DV for that particular family influences lethality risk, financial status, and physical and psychological health are key skills needed by all providers. While a DV advocate may use this information

in intake assessments for victims to shape recommendation for services, this information is also essential for batterer interventionist attempting to establish client's abuse patterns.

Knowledge of the prevalence rates and skill in screening for mental health and substance abuse issues among DV populations seeking services is crucial to understanding clients' experiences and can affect the treatment of both victims and batterers. A solid foundation in trauma informed practices and care are needed for providers on both sides. Victims of DV have experienced trauma as a result of the relationship with the perpetrator and often have significant histories of trauma in their childhoods prior to this specific relationship. This is also true for perpetrators of DV (Whitfield, Anda, Dube, & Felitti, 2003). A lack of integration of trauma theory and intervention strategies is hugely problematic in the field. This is especially true in the area of BIPs (Kirby et al., 2012; Murphy & Ting, 2010; Taft, Watkins, Stafford, Street, & Monson, 2011). In instances when mental health issues, such as PTSD, or substance abuse are present, providers need knowledge of community services and the ability to recognize when clients' needs are beyond the scope of DV agencies or BIPS so they may make appropriate referrals. Providing a psychoeducation program to reduce violence without recognizing the mental health and substance abuse needs of the population will have limited efficacy in the long term.

Cross training and continuity between competency expectations of DV advocates and batterer interventionists creates connections between the two types of services. The connection moves providers towards a more trans-disciplinary approach to the complex issues surrounding DV, while the establishment of standards fosters accountability of programming. Requiring an increase in training hours to the level of a full semester of college level course work or a month of full-time training, would provide the amount of didactic and classroom focused training to cover the topics outlined in Table 1 and ensure providers have acquired the basic knowledge and some beginning skills through classroom role-plays, case studies, and experiential learning. Following this with supervised training within DV agencies that begins with observation of a certified provider and progresses slowly into more independent practice will provide the oversight and slow transition needed for DV advocates and BIP interventionists to practice in the most skilled and competent way.

Proposed Standards for Clinicians

The role of clinicians in DV interventions cannot be undervalued. Licensed clinicians are equipped with broad expertise in assessment, psychopathology, and treatment approaches that make them uniquely qualified to provide intervention and treatment. However, specificity of training for DV is lacking. Even those working in the DV field in a clinical capacity often lack a full complement of training in the dynamics and issues that are in play when working with families impacted by DV. Clinicians who specialize in work with adult perpetrators may lack the knowledge, skills, and training to fully understand the impact of DV on children and the clinical implications interventions with adult clients have on the family system. Clinicians who fail to adequately screen for DV and then assess for risk/lethality are potentially putting families in danger. Additionally, clinicians who serve victims and children who do not have a full understanding of the complexities of individual

offenders and think about DV in a one-dimensional way (e.g. believe all cases of DV are about power and control), miss the opportunity to understand the dynamics that may be present for their particular clients.

Similar to guidelines proposed for advocates and batterer interventionists, clinicians working in the field of DV must have a broad training in the safety, clinical and legal issues that DV cases entail. It makes sense for clinicians who are working with families impacted by DV to complete similar basic training proposed for advocates and batterer interventionists (see Table 1) to ensure they have the same knowledge. Additional specific graduate coursework and supervised experiences related to the co-occurring mental health, trauma, and substance abuse issues that are present in the population and appropriate methods of assessment and evidence based treatment approaches must be taught and practiced in a supervised setting. The impact of trauma exposure on development is a key component to this training given the consistent findings that childhood trauma exposure is associated with DV victimization and perpetration (Whitfield et al., 2003). Practical supervised experience in settings with victims, children, and offenders are needed so that clinicians may have a full understanding of the systems context and to prevent preconceived notions and stereotypes from developing. Table 1 provides a set of suggested standards that could be implemented to ensure we are training a workforce of clinicians who have specialized skills to appropriately and effectively intervene with families impacted by violence who are broadly trained and capable of intervening with any member of the family system. Coursework that will provide the knowledge base outlined, along with spending the majority of supervised training experiences in DV related settings, will ensure well trained clinicians are available to work with those seeking treatment services for DV.

Limitations

While implementation of changes to the current methods of training is ideal and will ensure the best provision of services to families, it will be a difficult transition. Considering such changes can be daunting and complicated for agencies. DV service providers and coalitions are restricted by funding sources. The kinds of services and the extent of training they can provide are often dictated by how much money they receive and from which sources. Implementation of such standards for training and education would likely result in a need to increase salaries for professionals working in the DV field, which may be cost prohibitive for some agencies. Additionally, changes may cause restrictions on the roles and duties of volunteers who may not have the time to commit to extensive training. This type of change cannot be implemented without consideration of how standards for providers may impact the ability of agencies to offer service, yet the current narrow focus of systems of service is not meeting the needs of many families.

The historical grassroots nature of the battered women's movement was built on community empowerment and less reliant on professional training or education. Changes to the standards may mean that some working in the field at present would not meet the training standards and would need additional certification to keep their positions. States would need to consider carefully how to roll out a major change in standards and how to address DV advocates or batterer interventionists who have been working the field for many years.

These individuals have a wealth of expertise and must have an opportunity to document their knowledge and skills. The reason for standards is to ensure all providers meet a minimum requirement of knowledge, skills and attitudes. Providing alternate pathways to show ability in the suggested areas to those with multiple years of experience in their position at the time of standard adoption may be one way to address this issue.

Research Implications

It is logical to assume implementation of more stringent national standards for providers would increase the knowledge level and skills of those serving DV families resulting in better outcomes, but research is required to determine if this hypothesis is correct. Research studies could examine current training policies in several states to determine impact on outcomes such as DV recidivism, repeat shelter stays, and health and mental health usage for those initiating services. Selection of states with minimal training requirements compared to those with the most stringent may provide some insight into whether increased standards yield better outcomes. Another means of studying such a change would be to implement standards like those proposed in this paper in one geographic area and compare outcomes in an area that did not make such changes. Ultimately, research can be implemented to assist in understanding the impact of additional training and supervision requirements for those working with families impacted by DV.

Clinical and Policy Implications

Certainly, implementation of national standards like the ones proposed would have major clinical and policy implications. First, Service systems working with victims and batterers are currently quite segregated. Cross-training of providers would require a substantial change in practice, but it would broaden the training and experience of those working in the field. It would necessitate BIPs that would include female facilitators (some programs already implement a model that includes a male and female facilitator for each group) and DV advocacy programs that are open to training male providers to work in conjunction with female DV advocates. Just as the female role in BIPs is incredibly important, victims services that include positive interactions with male providers can also have significant benefit. Providers with greater breadth of training would likely approach their work in a different way and have a more diverse set of methods for working with families. Second, this type of change in requirements may create a dearth of credentialed providers for a period of time. Roll out of such standards would need to be timed to allow providers to work toward certification within a given time frame as not to disrupt services. Last, greater integration of services will necessitate changes by federal funders. Combined service grants from multiple federal agencies that target cross-training will be needed. Current funding solicitations are often specific to either victim or batterer services limiting the ability of agencies to conduct cross-training.

Conclusion

Domestic violence is an incredibly complex legal, systemic and clinical issue. The perpetuation of DV in families across generations is alarming and speaks to the field's

inability to adequately intervene using the current segregated system. Those working with families impacted by DV as advocates, batterer interventionists, and clinicians currently do not have consistent standards for knowledge and training. This can lead to inadequate intervention for the very families these services are trying to help. Implementation of national standards for provider training and integration of DV related coursework and practical experiences into undergraduate and graduate training is needed and can move the field forward to better outcomes for victims and families. Credentialing bodies for clinicians need to require coursework and supervised training in DV to increase awareness and skill for those in practice who will encounter families impacted by DV in their work.

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Table 1

Proposed Standards for DV Providers

	Competencies	Acquisition
<i>General for all providers</i>	<p><i>Knowledge</i></p> <ol style="list-style-type: none"> History of DV and the battered women's movement Theory of power and control in relationships Theory of empowerment Understanding of different types of abuse (physical, sexual, psychological, economic, etc.) Understanding of the impact of violence on health outcomes (mental and physical) The impact of DV on child development and parenting The co-occurrence of substance abuse, mental health problems and child maltreatment with DV The role of trauma in families impacted by DV (e.g. victim, children and perpetrators) Confidentiality rights of clients and limits to confidentiality Framework behind batterer intervention programs Understanding of current knowledge of batterer subtypes/typologies and influence on potential treatment Familiarity with community agencies involved in DV prevention and intervention, mental health services, and substance abuse treatments Legal aspects of DV (e.g. protective and restraining orders, etc.) 	<p>1</p> <p>Minimum of 180 hours (or 12 credits) of coursework/ training focusing on competency achievement in the areas outlined (didactics, role plays, etc. in an educational setting with expert faculty trainers)</p>
	<p><i>Skills</i></p> <ol style="list-style-type: none"> Effective communication with clients and within networks Ability to professionally interact between provider spheres Assessment of batterer's violence history, power and control behaviors, and risk/lethality Safety plan development and implementation Implementation of proper coping mechanisms and self-care 	
	<p><i>Attitudes</i></p> <ol style="list-style-type: none"> Awareness of the complex relationship between victims, batterers and children 	

	Competencies	Acquisition
	<p>2 Acknowledgment that families may want to stay together and hope for change/recovery (e.g. stake in effective batterer intervention treatment)</p> <p>3 Openness to understanding the dynamics, difficulties, and issues within each individual case</p>	
<p><i>Advocates and Batterer Interventionist (psychoeducational group leaders not treatment providers)</i></p>	<p><i>Knowledge in addition to above</i></p> <p>1 DV shelter specific policies and procedures</p> <p>2 Batterer intervention program curriculum</p>	<p>2 Minimum of 2,000 hours of practical experience. Including an initial period of direct observation and gradual transition to independent functioning. Must work with DV victims, perpetrators, and child witnesses. With at least 25% of experience with each population type.</p> <p>3 Minimum of 3 hours of continuing education per year focusing on current updates in DV intervention/ knowledge</p>
	<p><i>Skills in addition to those above</i></p> <p>1 Screening of victim (adults and children) and batterers for trauma, mental health and substance abuse issues and power and control dynamics</p> <p>2 Facilitate psychoeducational or support groups related to DV</p> <p>3 Ability to refer clients to outside services when needed (case management, financial assistance, trauma, mental health, or substance abuse treatment)</p> <p>4 Court and legal advocacy related to DV</p>	
	<p><i>Attitudes</i></p> <p>1 Understanding of client's individual rights within their relationship and in seeking services, acceptance of client's experience and wishes</p> <p>2 Recognition that client's issues may fall outside the realm of advocacy or the DV advocate/ BIP interventionists skills</p>	
	<p><i>Knowledge in addition to above</i></p> <p>1 DV assessment approaches and tools</p> <p>2 Best practices in treatment and intervention for DV for each member of the family</p> <p>3 Understanding of the court-mandated treatment system as applicable to the profession</p>	
<p><i>Clinicians</i></p>	<p><i>Skills</i></p> <p>1 Assess appropriateness for various intervention approaches and whether contact/sessions with family are appropriate and safe</p> <p>2 Ability to implement best practice treatments for individuals and families (including children) impacted by DV</p>	<p>1 Completion of the basic 180 hour competency training outlined above</p> <p>2 Graduate coursework relevant to assessment and treatment of family violence (e.g. impact of violence on child development, lethality assessment, comprehensive assessment of families including: trauma, substance abuse, mental health issues and family dynamics)</p> <p>3 A minimum of 2,000 hours of supervised graduate/postgraduate field experience that includes supervised work with both batterer and victim (adult and child) populations. At least 25% of experience must be with each population type.</p> <p>4 Professional licensure (e.g. LCSW)</p> <p>5 Subsequent CEUs for discipline (e.g. social work, psychology) on most up to date research and interventions for DV (minimum of 3 per year)</p>

Competencies		Acquisition
3	Effective relationships and communication with DV advocates, batterer programs, courts, child protection and other providers who may be involved with a family.	
	<i>Attitudes</i>	
1	Openness to meeting and assessing each individual involved in a family as appropriate	

Acquisition	
Competencies	
2	Acknowledgement that individualized intervention that meets the needs of a specific case/family is needed