TREATING VICTIMS OF DOMESTIC VIOLENCE

Creating, writing, and marketing a course for firefighters
and other emergency medical personel.

Fire Service Financial Management

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ABSTRACT

The problem was that there were no domestic violence training programs available for firefighters and EMS personnel. The purpose of this paper was to create a training program for firefighters and EMS personnel with the potential for marketing. The research questions were:

1. What are the goals of a domestic violence training program?
2. What is the content of a domestic violence training program?
3. Can such a course be created and delivered with the potential for marketing?

This research paper utilized Action Research.

As a civilized society, it is often uncomfortable to acknowledge the fact that battering is the single major cause of injury to women between the ages of 15 and 44 in the United States today. Although police departments receive many hours of domestic violence training, at present, there are no training courses available to firefighters and EMS personnel.

The tasked faced by this author was to create a domestic violence training program which could be delivered throughout the country. Five goals were chosen. They were:

1. to teach providers how to respond to and recognize domestic violence incidents;
2. to promote an understanding of the dynamics of the cyclical nature of the abuse syndrome;

3. to train providers to treat medical emergencies while maintaining the safety of the victim and others;

4. to teach effective assessment and interventions techniques, and

5. to encourage full cooperation between firefighter/EMS providers, law enforcement personnel, and social service providers.

After the goals of the course were established, particular modules could be selected. These included facts about domestic violence, abuse laws and a profile of the batterer. Answers to such questions as: why women stay and why men batter were also included.

Other modules selected because of their relevancy to domestic violence were the Cycle of Violence, the Battering Syndrome and the Stockholm Syndrome, as well as Crisis, Crisis Intervention, Effective Intervention and Intervention Skills. All are closely related to family issues and violence mitigation. The result of the research paper was a course for the treatment of victims of domestic violence certified by the Commonwealth of Massachusetts, Office of Emergency Services for three credit hours.

Recommendations from this research paper were that fire departments and EMS organizations throughout the country must recognize the need for members to receive adequate domestic violence training. This has been realized in part by the preliminary marketing of the training program. Several fire and EMS departments have requested the program for delivery in their organization.

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INTRODUCTION

The problem is that there are no domestic violence training program available for firefighters and EMS personnel. The purpose of this paper is to create a training program for firefighters and EMS personnel. The research questions are:

1. What are the goals of a domestic violence training program?
2. What is the content of a domestic violence training program?
3. Can such a course be created and delivered with the potential for marketing?

This research paper will utilize Action Research.

BACKGROUND AND SIGNIFICANCE

As a civilized society it is often uncomfortable to acknowledge the fact that battering is the single major cause of injury to women between the ages of 15 and 44 in the United States today (ACEP, January, 1998). Each year, between two and four million women are battered and 2,000 die as a result of these injuries.

Firefighters and emergency medical service providers must make every effort to mitigate the effects of domestic violence, in society, in our neighborhoods, in our families, and in ourselves. As emergency health care providers, with proper training, we can make a difference by helping to defuse the crisis and by providing victims of domestic violence with the care necessary for their physical and emotional needs, as well as their empowerment.

Facts illustrate the chilling truth. Domestic violence accounts for over five million injuries annually in the United States (McLeer and Anwar, 1989). In addition, approximately 25% of these women are pregnant. When examining some related statistics compiled as far back as for the year 1989, the history and magnitude of this epidemic are staggering:

21,000 hospitalizations

28,700 emergency room visits

39,900 physician visits

$44 million total annual medical costs (McLeer and Anwar, 1989).

Another study by the United States Department of Justice conducted in 1994 shows that emergency departments treated more than 243,000 people for injuries inflicted in their home by someone they knew (ACEP, January, 1998, p.2). Using the City of Boston as an example, statistics show an alarming rise in domestic violence incidents over the past several years. Incidents rose from 8,062 in 1988 to 13,429 in 1995. For the same years, Restraining Orders increased from 4,711 to 6,585 and over 50% of these were violated. The City of

Revere is not unlike Boston except on a smaller version.

Table 1

Domestic Violence Statistics for the City of Revere, 1996 - August, 1999.

Year	DV Incidents	Violations of Restraining Orders	Percentage of Orders Violated
996	866	255	29.4
1997	543	119	36.6
1998	508	131	25.7
1999	586	138	23.5

[1]

At first glance, the above percentages may not reflect the scope of domestic violence. Nevertheless, when considering the fact that there are almost two incidents of domestic violence daily, the significance changes, especially during incidents when Restraining Orders are violated. These are the times when a victim is most likely physically assaulted and responding emergency personnel are exposed to danger.

Generally, EMS providers may be first on the scene at an incident of domestic violence and most likely during the explosive phase of the incident. This time presents the greatest danger to all those present. Consequently, highly specialized training is necessary to insure the safety of all those present; firefighters, EMS providers, the victim, and any bystanders.

Although gaining more notoriety among health care professionals, domestic violence remains something not easily understood or discussed. Whether among members of the fire service or those working for ambulance companies, the topic of domestic violence is a sensitive and difficult issue to address (Moschella and Wilson, December, 1997). This is made all too clear when one considers the predominance of males who are employed in both professions. The National Fire Protection Association 1994 statistics show that there were 269,700 career male and 807,900 volunteer male firefighters in the United States. (NFPA, 1995). The numbers for female firefighters are listed as 4,500 career and between 40,000 and 60,000 volunteers (Floren, nd.).

Unfortunately, as the following section will illustrate, there is no formal training for fire service personal and EMS providers. Police training programs all mandate courses in domestic violence, yet there is an overdue and paramount need to educate the nation's firefighters and EMS personnel regarding the proper treatment of domestic violence victims (Moschella and Wilson, June, 1999).

Within a broad interpretation of Alternative Funding, the purpose of this module is to provide fire service managers with examples of "innovative sources of revenue" (FEMA, June, 1997, SM 7-3). Considering this, a training program for both firefighters and EMS personnel might be created, implemented, and furthermore, marketed throughout the country to secure additional revenues for the organization.

This is not to say that marketing such a course would be a panacea for a department's financial problems. On the other hand, it would provide for the first

time, a course of instruction for those who must respond to domestic violence incidents. Results of a training course would not, of course, reduce the numbers of domestic violence incidents. The true value of this training program would produce a better informed and prepared firefighter or emergency medical technician in the role of provider to victims of domestic violence. In addition, an aggressive marketing program might result in nationwide distribution of the course much too the benefit of the sponsoring fire department in financial income as well as notoriety.

LITERATURE REVIEW

In April, 1995, the American College of Emergency Physicians (ACEP) issued a policy statement concerning the role of EMS personal and domestic violence (ACEP, 1995). The association stated that domestic violence was a serious public health problem and as such, training in the evaluation and management of victims of domestic violence should be incorporated into the initial and continuing education of EMS personnel. At present, this objective has not been realized.

Following this statement, in 1996 the ACEP issued guidelines for the role of EMS personnel in domestic violence incidents (ACEP, 1996). One study quoted found that 67% of EMS providers surveyed had "some" training, and only 25% felt that they had "any" training in assessing the scene for potential violence (Roberts and Lawrence, 1993). The report recommended that domestic violence training should be part of initial and continuing educational programs.

It does not require a national survey or poll to see that there is little training and education for the treatment and care of victims of domestic violence. Landis and Sorenson (1997) write that the need to extend domestic violence education to prehospital providers is critical but nationally there has been little didactic instruction in the EMS curriculum. As late as 1999, Lanzilotti, Jones, Dai, and Bentzien (June, 1999) conclude that there is much room for improvement in the medical community's response to and protection of battered women. The results of their study reveal that although a majority of EMS organizations support a domestic violence policy, many have not yet put this view into practice. They add that EMS organizations, "establish a domestic violence policy; devise procedures to detect, manage and care for domestic violence patients; provide training so that personnel can implement procedures; and monitor personnel through a quality improvement program to ensure compliance with policy" (p. 65).

A quick examination of one textbook used for those taking an Emergency Medical Technician Basic course (American Academy of Orthopaedic Surgeons, 1997) reveals that the term "Domestic Violence" does not even appear in the index. In fact the two leading general paramedic textbooks, both containing more that 1000 pages, relate no specific information about spousal abuse or domestic violence (Bledsoe, Porter, and Shade, 1991, and Caroline, 1995). Researchers from the Medical College of Pennsylvania have concluded: "treating a battered woman's medical and/or surgical problems without recognizing that she has been chronically battered and without offering essential help is simply bad medical care" (McLeer and Anwar, 1989a. Education is not enough).

This lack of education concerning domestic violence not only carries the risk of personal injury but potentially exposes the EMS provider to a violent family situation, contributing to significant added personal stress (Bullock, 1997/8). The author continues that although paramedics and EMT-B's in some regions are required to maintain continuing-medical-education credits, few programs offer skills development in the area of family violence.

The District of Columbia EMS/Fire Bureau has attempted to improve paramedic and EMT training for family violence. Beginning in 1995, advanced and basic medics receive two hours training on intentional injuries with a focus on domestic violence (Denaro, 1996). The plan's main objective is to make it easier for “identified” victims of domestic violence to get coordinated care and referral, whether or not they are actually transported to the hospital. The results of the training, although significant, in that greater number of domestic violence cases were reported, did not address the actual care and treatment of domestic violence victims at the scene. This deficiency continues today.

Little research has been conducted as to how paramedics and other prehospital health care workers handle issues of interpersonal violence. Jones, Walker, and Krohmer (1995) conducting research in California, write that 59% of paramedics and EMT's were uncertain of the laws, procedures, and confidentially of reporting elder abuse. Also, 13% were uncertain about definitions of abuse and neglect and 8% did not recognize abuse at the time they saw it. In short, EMS courses must include information about interpersonal violence and supply

sufficient training regarding service providers' responsibilities in these cases (Card, 1994; American College of Emergency Physicians, 1996).

PROCEDURES

The creation of any course or training program is not an easy task. Considerable research must be conducted in order to secure the information necessary to fulfill the instructional objectives. To further compound this chore, because domestic violence is such a highly emotionally charged issue, there is perhaps less room for inaccuracy, and insensitivity.

In short, a separate curriculum must be created for those who respond to incidents of this nature. All EMS providers need to be educated in order to properly access and handle a domestic violence incident.

Faced with this important objective, experts in the field of domestic violence were sought out for their knowledge and experience. After an in depth selection process, Ms. Diane Wilson, Coordinator of Older Women's Services at the South Shore Women's Center, located in Plymouth, Massachusetts was chosen to co-author the course.

Ms. Wilson possesses a Master's of Education Degree in Counseling. In addition to her duties at the Center. She is also a domestic violence counselor advocate and a former Emergency Medical Technician. She has taught such courses as The Dynamics of Domestic Violence; The Effects of Domestic Violence on Children; Safety Planning for Women, and Sensitivity Issues

Pertaining to Victims of Domestic Violence. She is well known as one of the domestic violence experts in Massachusetts.

Having the authors now in place, the next objective was to decide on the course goals, scope of the course, length, and certification process. Based on the Commonwealth of Massachusetts, Department of Public Health, Office of Emergency Medical Services (OEMS) guidelines for continuing education, it was determined that the course would be worth either three or six hours of continuing education for all EMT levels, Basic, Intermediate, and Paramedic.

Working within the three to six hours program length, the instructional objectives for the course could now be determined. Five goals were decided upon for the training program. They were:

1. to teach providers how to respond to and recognize domestic violence incidents;
2. to promote an understanding of the dynamics of the cyclical nature of the abuse syndrome;
3. to train providers to treat medical emergencies while maintaining the safety of the victim and others;
4. to teach effective assessment and intervention techniques, and
5. to encourage full cooperation between firefighter/EMS providers, law enforcement personnel, and social service providers.

After the goals of the training program were established, both authors presented their findings and an outline at the Fire Department Instructor's Conference in Indianapolis, Indiana with the intention of receiving feedback as to

the content of the course as well as the audience for such a course. As a result of the conference, no new conclusions were drawn other than the reassurance that such a training program was long overdue. Researching and writing the course could now begin.

Several months later, the first draft of the course was completed and ready for delivery. Certification from OEMS was applied for and received. The course was then delivered to several hospitals and emergency medical organizations throughout New England in a form of trial run to further taper the program to suit the needs of firefighters and EMS providers. In addition, the *Journal of Emergency Medical Services* contacted the authors, soliciting an article to be written about the course itself as well as an historical perspective of domestic violence. Here, the authors were presented with an opportunity to explore the marketing value of such a training program. Immediately upon publication, calls desiring copies of the course and/or requests to teach the course were received. About this time it was determined that the course was ready for print.

The development of this program was not without certain limitations. Assembling such a course is difficult especially considering the fact that there are no existing programs from which to draw material. Furthermore, there is always the task of selecting just what goes into a course and what is deemed not important enough for inclusion.

First, the length of the course was not an arbitrary decision. The Commonwealth of Massachusetts, Office of Emergency Medical Services allows

the length of its courses to be either three or six hours. A three hour course was chosen for time and content.

Certain parts of any training program are essential components. Course objectives, goals and in the case of domestic violence, facts about violence to women were included for obvious reasons. Several elements were also added such as why battered women stay with their abuser; who are the men who batter; why men batter; obstacles to leaving, and can batterers change their behavior? Why women stay is the most commonly asked question at training sessions. Here it is important to understand the obstacles preventing the victim from leaving. Profiling the batterer gives the student a better understanding of characteristics common to batterers.

The second most commonly asked question at training sessions is Why do men batterer? The authors found that these questions are continuously raised among the male members of the fire service, hence its inclusion.

The actual training begins with the Cycle of Violence and progresses through the Battering Syndrome, the Battered Women's Syndrome and concludes with the Stockholm Syndrome. The Cycle of Violence helps the student to recognize the distinct patterns of behavior and be aware of the most dangerous phase of the Cycle to the victim, the EMS provider, and any bystanders.

All three battering syndromes relate specifically to domestic abuse. Since the EMS responder will encounter a victim who might be suffering from any or all of these manifestations, it became an integral part of the course.

These four psychological aspects are often seen in women who visit Women's centers. Furthermore, proper treatment of a domestic violence victim demands that the EMS provider understand what the victim is experiencing.

Domestic violence is a crisis, thereby requiring crisis intervention. Since the firefighter EMS provider may be first on the scene, he or she must be familiar with these terms. Intervention is the act of both physically and emotionally caring for the needs of the victim. Physical care of the victim is, of course, the role of all emergency medical providers, hence the decision to include it was obvious. Emotional care for the victim is less apparent, nonetheless, equally and perhaps more significant.

What follows is the presentation of effective intervention assessment techniques. The decision to include this module was an easy one based upon Ms. Wilson' s background and experience as a women's advocate. Having the opportunity to counsel a victim soon after she has been battered is important.

As a method of criteria, role playing was chosen. The aim here was to allow each student the experience of witnessing the aftermath of a domestic violence incident. Because of the highly emotional charged environment the responder will be entering, it is unlike a typical medical aid call. Therefore, practice is required for all students.

After writing the program, packaging it became a factor worth considering. The authors decided that simplicity is best. There are several components of the program package. First a training manual was written. This served the purpose of an instructor's manual in which notes could be added throughout the progress of

the course. Also, the course was put on *Microsoft Power Point* for use as audio visual material. This choice was made simply because *Power Point* is sort of the universal software employed by instructors today. From the *Power Point* slides, a master was printed to be duplicated and distributed to students taking the course for notes.

Careful consideration was given to copying excerpts from several movies dealing with domestic violence, for example, *Sleeping with the enemy* but at the time of print, copyright had not been secured from the film's producer. In addition, several domestic violence scenarios, which are discussed in the program of study could someday be taped and included in a separate video.

RESULTS

The course is entitled: "Treating Victims of Domestic Violence" and it is directed towards all EMS providers whether firefighters, police, or ambulance personnel. Certified in the Commonwealth of Massachusetts, Department of Public Health for three credit hours, the course is aimed at all levels of emergency service, Basic, Intermediate and Paramedic. Nevertheless, it is not limited to emergency medical service providers. Non EMT's also take the course.

In answer to the first question posed in this research paper, the goals of this program as presented above are:

1. to respond to and recognize Domestic Violence incidents;
2. to promote understanding of the dynamics of the cyclical nature of the abuse syndrome;

3. to treat medical emergencies while maintaining safety of the victim and others;

4. to teach effective assessment and intervention techniques;

5. to encourage full cooperation between the firefighter/EMT, law enforcement personnel, and social service providers.

Some areas covered in the body of the course are:

1. Why battered women stay
2. Why men batter
3. Obstacles to leaving
4. Need for training
5. Training EMS personnel
6. Crisis
7. Crisis Intervention
8. Effective Intervention
9. Intervention skills
10. Abuse Assessment

In addition, the course examines the facts and the problem of domestic violence. Also, other related areas are discussed such as most commonly asked questions, dispatcher's procedures and scenarios/case studies. Finally, other forms of abuse such as child, disabled, and elder are presented to the class because of their closeness to the domestic violence women's issue.

By way of introduction, students are presented with legal definitions of domestic violence and related items of significance such as what constitutes

family or household members. Following the introduction, the background and the problem of domestic violence are discussed. This includes such questions as why women stay, obstacles to leaving, why men batter, who are the men who batter, and behaviors common among men who batter. An in depth presentation of the Cycle of Violence supported by the Battering Syndrome, Battered Women's Syndrome and the Stockholm Syndrome allow each student to gain at least a basic understanding of these terms and their relevance to domestic violence.

The main body of the course is divided into several modules of varying lengths. These are entitled, crisis, crisis intervention, effective intervention, intervention skills, most commonly asked questions and finally scenarios/case studies accompanied with role play.

Students are first given a definition of a crisis. This is to ensure that the student understands that a domestic violence incident is a crisis and must be dealt with as such. Following this module, intervention techniques are presented to the class.

Crisis intervention is the act of both physically and emotionally caring for the needs of the victim. Here intervention may be predictable or unpredictable. Emotional trauma can be significantly reduced if the crisis is dealt with quickly. Responders can stabilize the victim of domestic violence and reduce the amount of trauma with immediate intervention.

Effective intervention contains several assessment techniques which begin even before the arrival of emergency personnel. Knowledge of the nature

of the call and the realization that the victim is unlike a typical medical patient should be foremost in the minds of each responder.

1. scene safety
2. provide for the victim's physical safety.
3. separate the victim from the abuser during questioning
4. assess the victim for the potential of self harm.
5. express concern.
6. empower the victim.

Every EMT Basic or Paramedic manual begins with scene safety. Safety, quite simply is the state of being safe from the risk of experiencing or causing injury, danger, or loss. It is the most important aspect of the EMS service within the parameters of emergency medical service providers. It begins with information obtained from dispatch and ends after the patient is transported to the hospital. It includes such items as scene assessment, personal safety, victim safety, and bystander safety.

Have a safety plan for all responders. Use extreme caution when attempting any type of intervention. Recognize indicators of an abusive personality:

1. constant blaming of everyone but oneself
2. obsessive behavior
3. threatening behavior
4. presents oneself as the victim
5. having friends in high places

6. paranoid/hypersensitive
7. belligerence towards authority figures
8. substance abuser
9. access to weapons

If an abuser exhibits any of the above characteristics use extreme caution and call for the police before attempting any type of involvement. Trust your gut feelings. If you think he or she is dangerous that person probably is dangerous. Do not engage in confrontation. Explain your role as an emergency medical provider.

When providing for the victim's physical safety, ask the basic question: "Are you all right?" Listen carefully in order to best judge the victim's frame of mind. Always look for the possibility of self harm, particularly if she is blaming herself by displaying a sense of shame and/or hopelessness. Never confront the abuser or victim if he is either under the influence of alcohol of drugs.

Address the medical needs of the victim but always remember that a battered person is just that, physically assaulted and usually requires treatment for her injuries. Always call to mind the emotionally charged nature and surroundings of the scene.

Separate the victim from the abuser during questioning. Provide for the victim's immediate and long-term well being. Express concern which helps to calm the victim. Do not say, "I know how you feel." Validate the victim's feelings. Assess the victim for the potential of self-harm, particularly if she is blaming herself or displaying a sense of shame and hopelessness.

Express concern which helps to calm the victim. Many women are terrified of any adult male who represents authority. Most often, the victim has been systematically isolated from all those who might offer her any form of support.

Empower the victim. Provide referrals to local Domestic Violence Prevention Centers. The victim may have difficulty with decision making and may appear either disorganized or exact and precise.

There are five intervention requirements necessary for assisting the victim:

1. safety and security
2. recognizing and responding
3. ventilation and validation
4. prediction and preparation
5. rehearsal and reassurance
6. education and expertise

Make sure the victim is safe and secure. If at all possible, separate the victim from the batterer. If children are present do not allow them to leave the scene with the batterer. If you suspect there has been an incident of domestic violence respond accordingly, even if the victim denies it.

Recognizing and responding to incidents of domestic violence can be facilitated by looking for clues from the victim or the victim's companion. Clues can also be obtained from the physical examination of the victim. Document all findings since they might be later used in court.

Assist to establish a sense of control by validating the victim. Listen and allow the individual to ventilate her feelings about just what has occurred. Do not

be judgmental. Validate her feelings and be prepared for a wide range of responses. Rehearse what has happened and what might occur next. Give positive reassurance. Be *empathetic* not *sympathetic*.

Refer the victim to appropriate agencies for assistance. Have the necessary information at hand. Provide phone numbers of the nearest Women's Center.

Included in the training manual is an abuse assessment checklist for the EMS provider. These are questions which might help to assess female patients for abuse. They are not mandatory but assist the EMS provider. Such questions are:

Do you know where you could go or who could help you if you were abused or worried about abuse? Are you in a relationship with a man who physically hurts you? Has the man you are with, hit, slapped, kicked, or otherwise physically hurt you? Are you safe now?

Depending on time restraints, a section dedicated to the most commonly asked questions regarding domestic violence is generally presented to the students. Such questions addressed are: Are most domestic violence incidents caused by alcohol or drug abuse? Isn't domestic violence often triggered by stress, for example, the loss of a job or some financial or marital problem? Don't most domestic violence occur in lower class or minority communities? What did she do to provoke him to violence? Why do so many people refuse to admit that they or their friends or relatives have a domestic violence problem?

To conclude the course, several scenarios and case studies are presented with actual role play by both the instructors and the students. This gives participants a chance to not only experience of responding to an incident of domestic violence but critique their actions as well.

Since domestic violence is not the only form of abuse found in society today, the course also exposes students to child abuse elder abuse, and disabled abuse. All are closely related to domestic violence in their nature and makeup and can be studied together.

In addition, since according to the law in many states emergency medical technicians as well as firefighters and police officers are considered mandated reporters, the course teaches students the responsibilities of a mandated reporter as well as making out reports of abuse or neglect. Ignorance of the law does not exculpate the professional.

Preliminary marketing has resulted is favorable reviews from all over the country. This has come by way of avenues ranging from phone calls to fire departments to business ads in local as well as national trade journals. At the time of this research paper, requests for the finished package have been received from numerous fire departments and EMS organizations. With a price tag of $50.00, the course will soon be ready for delivery.

DISCUSSION

A careful survey of the literature review reveals definite answers to research questions one and two. It is obvious that there is paramount need for

domestic violence training of firefighters and EMS personnel. As late as 1995, the American Council of Emergency Physicians concluded that training in the evaluation and management of victims of domestic violence should be incorporated into "initial and continuing education of EMS personnel" (ACEP, April, 1995, p.1).

Landis and Sorenson (August, 1997) a few years later, pointed out that there was little didactic training in treating victims of domestic violence. Lanzilotti et al. in 1999 concluded that although EMS organizations support domestic violence training, it had not been put into practice.

The facts generally bear out these statements out. Roberts (1993) and Jones (1995) press the issue that few EMS providers polled believe that they possess the necessary training for assessing potential domestic violence and as little as 8% could even recognize domestic violence when they saw it. The Medical College of Pennsylvania concluded that not to consider the battering aspect of a domestic violence victim is simply bad medical practice. In short, the answer as to whether or not there is a need for training firefighters and EMS personnel in treating victims of domestic violence is tragically apparent.

Landis and Sorenson reiterate the overdue need for training indicating that 14 paramedic schools surveyed stated that little instruction time was devoted to domestic violence (p. 205). This becomes clear when examining the textbooks currently employed for EMT basic and paramedic courses. Outside of perhaps a casual mentioning of the subject of domestic violence, there is no specific information of training for the effective treatment and care of domestic violence

victims. Considering this, one can conclude that there is a need for courses in domestic violence for EMS personnel. Even the Washington DC Fire/EMS Bureau's course on domestic violence is directed towards the injury aspect of the incident rather than the entire incident, including the psychological care of the victim.

In answering question two, the course goals are:

1. to teach providers how to respond to and recognize domestic violence incidents;
2. to promote an understanding of the dynamics of the cyclical nature of the abuse syndrome;
3. to train providers to treat medical emergencies while maintaining the safety of the victim and others;
4. to teach effective assessment and intervention techniques, and
5. to encourage full cooperation between firefighter/EMS providers, law enforcement personnel, and social service providers.

The answer to the third question is ongoing, but with preliminary positive conclusions. At this time, the course on treating victims of domestic violence, has been completed and is in the final stages of printing. Also, by way of the author's presentations at several conferences, in addition to several publications addressing the need for such a course, its marketing value stands at least as a possibility. Already EMS organizations and fire departments throughout the country have expressed an interest in either the delivery of the course or purchasing the course for the purpose of teaching it themselves.

RECOMMENDATIONS

From the literature review, it is obvious that there is an overdue need for domestic violence training. Numerous articles presented in this research paper call for the sufficient training of EMS personnel as part of initial and continuing educational programs. Facts corroborate this void. There is little training and education for the treatment and care of victims of domestic violence in this country. The support is there, yet nothing results.

As a result of this long overdue deficiency, a course was researched and written with the hope of filling this void. In sum and substance, the easy part has been accomplished with the completion of this course. Nevertheless, the greater task awaits.

The objective is to make this course a required part of every training program related to emergency medical services, whether first responder, basic, or paramedic. All are going to witness the effects of domestic violence, all are going to respond to domestic violence incidents, and all must be adequately prepared and trained to effectively deal with the victim, the batterer, and their children, while ensuring the physical safety of those present. It must begin immediately and can begin in the Revere Fire Department.

Together, Revere's fire chief and the training officer must recognize the need for this training program. The city's police officers spend hours of mandatory training in family violence issues and are prepared to handle a domestic violence incident. Firefighters, who also respond to these same

incidents are not prepared for what they encounter. Considering the numbers of cases in the City of Revere, the requirement for a program is quite obvious. At present, the Revere Fire Department has yet to recognize this gross void. If other organizations fail to identify this need, the Revere Fire Department must take the lead in treating victims of domestic violence. This can be accomplished by marketing such a program.

On the other hand, since the publication of the JEMS article in June, 1999, numerous calls and requests for the training manual have been made from fire departments and EMS organizations throughout the country. In addition, organizations in Massachusetts have already secured the services of the authors to teach the course in person.

In addition, the marketing program which at the time of the writing of this research program is still in its infancy should result in a greater distribution of the course. It would be expected that shortly a re-writing of the course to include more visual aids in the form of taping role playing and excerpts from movies dealing with domestic violence, for example, will help to enrich the content of the course.

These first steps, albeit small ones, have been taken by those in charge of training their personnel. Each day the number grows and with it, a greater knowledge of domestic violence. With this greater knowledge of domestic violence comes a better prepared EMS responder equipped with the skills necessary to assist with the victims of this epidemic as well as maintaining the safety of all present. It is long overdue.

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