

HOW THE OPIOID CRISIS IS IMPACTING FIRST RESPONDERS

InfoBrief



International Public Safety Association

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About

This International Public Safety Association InfoBrief was developed by the Executive Director's Policy Task Force.ⁱ The members of the Policy Task Force examined how the opioid crisis is impacting first responders from the duties they perform to their overall mental health.

The InfoBrief begins with a discussion of the opioid crisis and its financial impacts. It provides an overview of naloxone, fentanyl and first responder contact overdoses. There is also a section that discusses naloxone administration methods – including policy and legal considerations for administration. The publication concludes with how the opioid crisis is affecting first responders' mental health and actions that agencies can take to safeguard first responders' mental health.

Introduction

North America has seen significant societal changes in the last 30 years. With those changes, opioid use, whether natural and or semi-synthetic opioids has reach epic proportions. There was a major push in the early 1990's to have pain management dealt with using stronger opioids. The use of oxycodone played a major roll. Several pharmaceutical companies downplayed the addictive properties and started a major push to sell the drug which increased it's use within the public. Systemic abuse of the medication became unavoidable. There are five core prescription drugs being abused (1) hydrocodone, (2) morphine, (3) oxymorphone, (4) codeine and (5) fentanyl.

The death toll from the opioid crisis has seen a dramatic increase since the early 1990's. According to the National Institute on Drug Abuse, in 2016 alone, there were more than 64,000 deaths with more than 20,000 related to fentanyl.ⁱⁱ In Canada there were over 2,900 opioid related deaths. That equals a ratio was 8.8 per 100,000 population.

“The rate of drug overdose deaths involving synthetic opioids other than methadone, which include drugs such as fentanyl, fentanyl analogs, and tramadol, increased from 0.3 per 100,000 in 1999 to 1.0 in 2013, 1.8 in 2014, 3.1 in 2015, and 6.2 in 2016.

The rate increased on average by 18% per year from 1999 to 2006, did not statistically change from 2006 to 2013, then increased by 88% per year from 2013 to 2016.”ⁱⁱⁱ

In 2017, Canada saw from January to September there was at least 2900 opioid related deaths with 72% involving fentanyl.^{iv} The New York Times reported that there were approximately 72,000 lethal overdoses in 2017 with fentanyl being a major culprit.^v

In the late 2000's, emergency services in the United States started to see a move away from prescription opioids to heroin on the streets. This may have been due to less opioid prescriptions being available from local doctors, easier to get and heroin was less expensive. With heroin being cheaper and easier to get, and opioid prescriptions harder to get in the United States, heroin deaths spiked in a six-year period (2010-2016) from 3,300 to more than 15,400.^{vi} In the late 2000's the introduction of illicit fentanyl became a significant factor in the illicit drug world.

First responders are noting the volume of overdose calls and voicing their concerns about the stressors their workers are facing during the opioid crisis. During the 2017 Police Executive Research Forum meeting in Washington, D.C., Philadelphia Police Commissioner Ross stated, “We've had saves where the fire department and the police are both using naloxone to save two different people in the same car at the same time.”

Similarly, Baltimore County Police Chief Terrance Sheridan reported 86 overdose deaths in 2016. It was noted the overdoses were difficult to track as they are not all reported to police right away. Chief Sheridan proceeded to reflect upon an experience he had as a young deputy encountering an overdose victim. “We had a man who overdosed 20 times, and he died the 21st time. He received naloxone multiple times, but he would resist medics and police because he said they were ‘ruining his high.’ This is what we are up against.”^{vii}

Emergency room nurses are another group exposed to the vicious cycle of the opioid crisis. Nurses engage in emergency situations that involve trauma and injury on the spot. They are responsible for recognizing and treating life-threatening issues immediately. A recent study found that 25% of ER nurses reported experiencing burnout. Dimensions such as personality traits, job attitudes, exposure to traumatic events and organizational factors were considered. Further, 26% of the subjects indicated that emotional exhaustion impacted their burnout while 35% reported that depersonalization accounted for their burnout.^{viii}

Financial data

Statistics show that between 1996-2012 oxycodone sales in the United States increased from \$48 million to \$2.4 billion.^{ix} Further, written opioid prescriptions increased by 300% in a 20-year span starting in 1991, whereas in Canada the increase was an astounding 850% increase in 16 years starting in 1991.^x

The financial cost to the United States for the opioid crisis is significant. In the United States alone, it is estimated that in 2015 the cost was around \$504 billion.^{xi} In Canada the cost is estimated to be around \$8.2 billion in 2002^{xii} with estimates in 2015 closer to \$21 billion.

The cost of the opioid crisis does not just impact North America financially, within emergency services and healthcare, there are increases in PTSD, depression and suicide. Statements from colleagues like, “you see your efforts going in vain” lend to the stress that first responders are having to manage.

Naloxone explained

Naloxone, also known by the trade name Narcan, is a relative of morphine. This relative of morphine which was synthesized in the 1960’s. It was approved for use to counteract overdose situations in patients by the Federal Drug Administration in 1971^{xiii}. Naloxone acts as an antagonist with opioid receptors in the brain^{xiv}.

Naloxone appears to have a greater affinity to the brain’s opioid receptors than opioids themselves. Because of this affinity, naloxone can reverse the effect of opioids. There are no known adverse effects of naloxone administration, although it is possible that an individual could present with allergic type reactions post administration although this phenomenon is considered a rare occurrence. Naloxone also has no possibility of abuse.^{xv}

Evolution of naloxone

Naloxone was used in the clinical setting for many years as an adjunct for post-surgical recovery in hospitals or when patients experienced adverse reactions to opioids. The rapid onset of the effects of naloxone to combat lethal effects of respiratory depression of opioids quickly made it an effective tool for use in the pre-hospital setting. Ambulances began to add naloxone to their medication kits. Naloxone has spread to ambulance agencies across North America and is considered a common tool for Advanced Life Support (ALS) Paramedics to reverse respiratory depression due to opioid use or administration.

ALS Paramedics tend to be concentrated around larger communities which does not provide adequate coverage. Most of the land mass in North America is covered by Basic Life Support (BLS) ambulances.

Additionally, in the United States, Emergency Medical Technician – Basic (EMT-B) level practitioners provide most of this coverage. As late as 2015 researchers noted that there were discrepancies in the ability for EMT-B's to administer Naloxone^{xvi xvii xviii}

However, as of September 1, 2017, all but three jurisdictions in the United States had amended their ambulance care protocols to allow all but the most basic level providers to administer Naloxone. According to Kinsman and Robinson (2018), only Montana, Wyoming and Puerto Rico had any sort of limitations on their most basic level providers with respect to the administration of Naloxone.^{xix}

Law enforcement and fire departments do not fit the traditional mold for those providing what would have been more advanced life saving measures. The opioid crisis in North America has taken on two faces that have increased both the access to naloxone and administration of naloxone as a critical life-saving intervention.

Often, law enforcement and fire departments are first to arrive on the scene of a potential overdose. Both agency types are called to render aid and most agencies are trained to deliver life-saving interventions that members of the lay public are capable of with minimal training. This could be actions related to notifying the responsible agency depending on the incident that they have found when they first arrive. It could be rendering basic first aid or performing life-saving CPR.

When it comes to the opioid crisis, naloxone is the critical life-saving intervention next to providing airway support in the form of airway positioning and providing artificial respirations. This is the first face of this crisis, the second is somewhat different.

All first responders must consider the safety of the public, themselves and their brothers and sisters in arms so that they return home to their loved ones at the end of the shift. The current opioid crisis has multiple beginnings, some experts might suggest that it has been the ever-evolving war on drugs, others might suggest that the current crisis can be blamed on over prescribing of prescription opioid type pain killers. The fact is that opioids that were either legitimate prescription medications or drugs such as heroin, are no longer the same products with the same predictability.

Fentanyl

Fentanyl has a legitimate role in medicine and is typically supplied in an injectable form in the pre-hospital and hospital setting. However, fentanyl or one of its analogues present in the illicit market is a powder form and is being transported, mixed and sold in places that first responders find themselves responding to such as businesses, homes, vehicles or detention centers; not your typical illicit drug lab locations. This environment creates what could be considered a hazardous materials scene for first responders. Given this, specific knowledge, training and equipment for first responders should be considered when faced with these substances.

Fentanyl, or one of the many more powerful analogues such as carfentanil, are marketed as their cousins, oxycontin and heroin, among others. This creates a challenging situation for first responders, in that there are many unknowns about these synthetics. It is not exactly clear how often first responders encounter fentanyl and their analogues or how often they are harmed by them, but these concerns need to be addressed.

The greatest concerns of potential exposure are inhalation, ingestion, mucous membrane contact and needlesticks. The degree of risk is suggested to vary based on the route of exposure as this will alter the absorption rate of the product.^{xx} The CDC reported that skin contact is not likely to lead to an overdose unless there is exposure to large quantities of the powder over an extended period. However, the CDC has also noted that there are no established occupational exposure limits for fentanyl and fentanyl-related substances.^{xxi}

First responder exposure and contact overdoses

There is scarce, reliable data available about contact overdoses that first responders encounter. However, research conducted by CDC and NIOSH revealed an Ohio police officer accidentally overdosed during a drug call in 2017. An article from the *Washington Post* cited this same case relating that the officer overdosed following a traffic stop and the drug was believed to have been found spread out in the car. The article stated that the officer followed proper procedures for handling drugs while conducting the search, utilizing latex gloves and a mask. However, the incident became life threatening when, back at the station, he noticed white powder on his uniform and “tried to brush it off-not thinking.”^{xxii} Approximately an hour later, the officer overdosed from what police believed was contact with fentanyl through his skin. When an ambulance arrived, he was given one dose of naloxone at the station, and then three more upon arrival at a local hospital. It was reported that the officer made a full recovery and is doing well.^{xxiii}

In another case in New Jersey, two Atlantic County detectives were exposed to a negligible amount of fentanyl in 2017. According to a DEA report, one of the detectives stated, “I thought that was it. I thought I was dying. It felt like my body was shutting down.” No additional details were given on the incident. Nonetheless, the DEA released a nationwide video message to law enforcement (a “roll call video”) about the hazards of fentanyl exposure and its deadly consequences.^{xxiv}

The CDC released two interim reports regarding two separate incidents where all agencies involved were physically affected during the events. These are detailed after-action reviews that are rare in these circumstances. Although each event is slightly different, the recommendations are roughly the same. Each detailed report developed by experts in the CDC recommend the following:

1. Education regarding the risks of contact with opioids.
2. Increased situational awareness during these events and shared communication with all agencies including local communications centers.
3. Communication with local receiving hospital staff regarding the event itself.
4. Establish an official line of communication regarding the forensics at the scene.^{xxv}

Given the minimal data on the contact overdoses and accidental overdoses in the first responder community during their duties, we concur with NIOSH’s recommendations to conduct further exploration to construe the following:

1. Exactly how are first responders exposed?
2. How frequently are first responders exposed?
3. Which situations are the highest risk for exposure?
4. Which routes of exposure are most lethal?
5. What are the decontamination policies and procedures?
6. What guidance and training are first responders provided to guard against life-threatening incidents involving opioids?
7. Is there a modification of standard operating procedures available?

EMS and fire departments are, in general, used to responding to medical emergencies and regard much of the recommended PPE as standard equipment. Education regarding these situations should be specific to the environment that is typical for the agency type. Law enforcement needs to consider education about some standard practices that may need to be amended based on this new threat that frontline personnel are faced with. Taking advantage of the expertise within CDC/NIOSH should be considered as NIOSH has also offered to conduct health hazard evaluations to departments nationwide and coordinating efforts to provide a “one pager” guidance for first responders. This document can be found on the CDC website.^{xxvi}

Naloxone administration

There are several antidote products or routes of administration that agencies could consider.

- Injectable – Intravenous (I.V.) and Intramuscular (I.M.) commonly found in hospitals and offered in the Government of Alberta^{xxvii} – Take Home Naloxone Kit Program.
- The injectable products do require training to ensure proper location of the injection. Agencies should also consider the management and sustainability of a sharps program that includes management of sharps containers and disposal of the biohazard containers.
- Pre-load – Pre-loaded syringes – These are pre-measured doses where a needle or nasal atomizer only need be attached for use. Risks are associated with rupture of the glass container when used, although this should be considered a rare occurrence.
- Auto-injector – There is only one FDA approved auto injector for naloxone. This is a similar device that is often found with other life saving devices like the well-known Epi-Pen. This device provides instructions in writing on the device and audible instructions aiding the user in its use at the time it is required.
- Nasal route – This route of administration is possible though the use of a purpose made nasal administration device of which there is only one manufacturer or a nasal atomizer device which substitutes for a needle in when a syringe is used. This may be a preferred solution for many agencies due to the ease of use and likely less hesitancy of administration for those responders who may not administer medications as a matter of routine.

Risks of naloxone administration

There are limited risks associated with any of the methods to administer naloxone. The greatest risk in terms of the administration itself is the risk of needle stick injury. Fortunately, options such as the auto-injector and nasal routes either severely limit the possibility of a needle stick injury to the responder or eliminate the risk completely.

Less known, or less discussed, is the risk of an aggressive victim who has their overdose reversed. This risk is elevated when stimulants are used in conjunction with opiates – a fairly common practice among users. The opiates mellow out the intense high of stimulants and when mellowing effects are eliminated, there is a risk of the full effects of the stimulants to take their place. This can result in a violent victim which could then result in greater risk of injury to the first responder and the victim themselves.

Policy considerations for first responders

As the opioid crisis evolves, more jurisdictions are enacting laws to protect those who render aid to an overdose victim. Agencies that have not implemented an education program for first responder safety need to consider the relevant legislation in their jurisdiction. It is important for all first responders to receive education and training about the laws within their jurisdiction.

Additionally, agencies that operate in jurisdictions where laws do not exist, or do not provide adequate protection from liability with respect to Good Samaritan aid, should consider working with other agencies and local government to ensure adequate protection for first responders are in place.

OSHA and relevant legislation. Most jurisdictions require employers to have policies in place to protect staff from identified risks, hazards and threats. Though there may be specific regulations in some states, Occupational Safety and Health Administration (OSHA) and state approved plans contain a General Duty Clause which applies when no specific standard applies. Under the General Duty Clause, if there is an identified

hazard, and the hazard could or has caused injury or death, and the hazard is correctable, employers have an obligation to address the hazard.^{xxviii}

Agencies must employ policies and procedures that align with what is considered best practice based on the CDC and NIOSH guidance.^{xxix} This best practice is aimed at individual agency types and considers the known risks of exposure that each agency might face. It should be noted that this is a tool for guidance for personal protective equipment use based on what the average first responder might come across in their known duties. Agencies that have operations that fall outside of these average activities ought to seek expert opinion based on their unique needs. Experts in the areas of hazardous materials and an industrial or occupational hygienist can provide an expert opinion on personal protective equipment.

Good Samaritan Laws. Good Samaritan Laws in both Canada and the United States provide protection for those who may aid and who are acting in good faith. Because Good Samaritan Laws are complex statutes with provisions that vary considerably by state or province it is important for agencies to be familiar with the statute that governs their jurisdiction. Generally, Good Samaritan Laws protect first responders and citizens from civil liability because of acts or omissions when rendering emergency care in good faith at the scene of an emergency. Many Good Samaritan Laws have an exception for acts or omissions that constitute gross negligence or willful or wanton misconduct.

As of October 24, 2017, approximately 43 states enacted laws that allow non-medical personnel to issue naloxone.^{xxx} Canada enacted Good Samaritan type laws at either the federal or provincial levels to protect those who provide naloxone and are acting in good faith to a suspected overdose victim.

The National Conference of State Legislatures published a paper in June of 2017 outlining the immunity some states are offering individuals for seeking emergency medical assistance. In some states, the Good Samaritan Laws provide immunity from violations such as arrest and prosecution for select controlled substances.

Immunity varies by state with some areas of the United States having a more restricted immunity list. In addition, if an individual does not qualify for immunity, they may still be eligible for a drug rehabilitation treatment program or other diversion program. Nonetheless, states and provinces are increasing their efforts to attend to the opioid epidemic and help save lives. Of note, the National Conference of State Legislatures paper cites that, “Immunity for the covered offenses is not ground for suppression of evidence of other crimes.”^{xxxi}

Liability issues. Liability issues related to agency use and administration are considered low. According to the United States Department of Justice, Bureau of Justice Assistance, helping an overdose victim via treatment of naloxone is considered a ‘good faith effort’. Additionally, “law enforcement officers who act in good faith and within the scope of their training and standard operating procedures, the risk of liability to themselves or their employer is extremely low.”^{xxxii}

Three strikes and you’re out. At least one city has considered a three-strike rule on administering naloxone.^{xxxiii} Under the plan for a person who has been administered naloxone on two previous occasions and has not cooperated with the program or performed community service, the city would not dispatch first responders to a third overdose. The city cited soaring costs of responding to overdoses as the reasoning behind the proposed ordinance. Three-strike rules are problematic for several reasons.

First, the administration aspect of keeping track of the number of overdoses per individual along with tracking their participation in a required rehabilitation or community service program is problematic at best and is open to mistakes being made.

Second, there is an issue of legality and equal protection under the law. Many EMS agencies make repeated calls to patients who suffer from chronic disease such as COPD and diabetes. How is responding to a patient with multiple overdoses different?

Third, poor public perception will likely result from a jurisdiction refusing to provide equal service to all residents and visitors and could result in political pushback from residents.

In one Ohio county, a sheriff's office is not permitting officers to carry naloxone.^{xxxiv} This may be a viable option for law enforcement agencies and fire departments absent a statute requiring them to do so. However, this is not an option for licensed EMS agencies in most jurisdictions where protocols exist for the administration of naloxone.

Public access to naloxone in Canada

Alberta, Canada has experienced a rapid rise in opioid related fatalities in the past several years. This public health crisis has led to unprecedented action. The Alberta government implemented a pragmatic approach to the crisis and followed the evidence with action. This resulted in a 2016 alteration to scope of practice changes to all EMS staff registered to practice in Alberta to have the ability to administer and distribute naloxone.^{xxxv} This was followed almost one year later with the decision to provide the ability for fire departments, law enforcement and peace officers to administer naloxone through an additional ministerial order.

The real success was a large-scale roll out of a take-home naloxone kit program which began in 2015. This was initiated when a small indigenous community in southern Alberta declared a state of emergency due to many overdose deaths in the community. This resulted with a rapid roll-out of the take-home naloxone program at a provincial scale in only a few months.^{xxxvi}

This program is an initiative through addictions teams known as harm reduction. Harm reduction is aimed at reducing the death toll and the compounding effect of addictions.

Agencies should consider partnering with local health agencies and harm reduction groups to learn more on how to combat the opioid crisis. This public health crisis is one that will take a unique approach and require agencies to step outside of their comfort zone to see the benefits in the future. This is not a problem with a quick fix, this is a long-term problem with a long-term solution that requires patience.

Opioid crisis and first responders' mental health

Many first responders are seeing an increase in fatal opioid overdoses each year in their jurisdiction. In the United States, that statistics reveal that nearly 115 people die every day after overdosing on opioids.^{xxxvii}

There are myriad unique stressors related to the jobs first responders perform. They encounter death, exposure to unthinkable cruelty, pain, overdoses and psychological crisis daily. First responders see more death and despair in their first few years on the job than most people would ever see in a lifetime. With the staggering opioid crisis, first responders are now even more vulnerable to invisible injuries. Their mental health wellness must be tended to and agencies must make resources available.

First responders are expected to expand community-based drug prevention efforts, decrease the opioid drug supply through specialized task forces, provide additional safe options for the disposal of drugs and medication and administer naloxone to save the lives of those who have overdosed. Several agencies are doing this by joining forces with public health, federal government and other community-based organizations to combat the opioid crisis. The collaborative effort is adding to the occupational and organizational stressors first responders

must manage, placing them at an even greater risk for developing occupationally derived, trauma-induced, adverse mental health outcomes.^{xxxviii}

Overdose deaths are critical incidents

It is important to recognize and address that first responders are being exposed to an increased number of critical incident exposures because of the opioid crisis. Exposure to traumatic events exerts a psychological toll on an individual, even a first responder. They are not immune to infinite amounts of trauma—they are human too.

These compounded difficulties were recently identified by Delray Beach Police Chief Jeffrey Goldman at a 2017 Police Executive Research Forum event where he stated:

“Keep the mental health of your officers and firefighters in mind. The amount of death officers and firefighters see] is definitely having an effect on them.” In fact, PERF made a plea at the event to keep officers well-protected. Goldman further noted that “the opioid epidemic can be stressful for officers, particularly when children witness overdoses by their parents.”^{xxxix}

Occupational stress

Researchers found that due to the very nature of their job, first responders are at increased risk for post-traumatic stress, burnout, and suicide.^{xl} A study found that the occupational stressors can include gruesome crime scenes and car accidents that involve exposure to critical incidents with injury and death.^{xli}

Research indicates numerous occupational stressors that first responders must learn to manage and cope with, including incidents involving pain, injury and death. The cumulative effects of these incidents can be deleterious mentally and professionally. If first responders are not equipped with resiliency training and new coping skills, serious complications and impairments that may later arise could affect both work performance and personal life.

Excessive stress can induce physiological, psychological and social damage. First responders often find themselves in exceptionally stressful situations that, over time, can increase their risk of stress and burnout.

PTS, STS, CIS and burnout

PTS may be understood as secondary traumatic stress (STS). Ellen Kirschman (2004) defined STS as the emotional responses one has after witnessing a scene of “exceptional physical or mental stress, typically involving death or grave injury.” Whereas Dr. Conn (2018) defined STS as psychological symptoms that mimic PTSD, but do not fully meet the criteria for the diagnosis. Some researchers have alternatively labeled such clusters of symptoms as critical incident stress (CIS).

Stephanie Conn (2018) noted that burnout symptoms are physical, emotional and mental. They can include: chronic fatigue, headaches, backaches, loss of interest in work, aggressiveness, cynicism, slower thinking, cognitive fog, feelings of worthlessness, self-blame and incompetence.

Each of these terms – PTS, STS, CIS and burnout – generally used to describe psychological reactions an individual has post-incident and the cumulative effects of multiple incidents over one’s career.^{xlii}

With the opioid epidemic in full swing, first responders are seeing a sharp rise in the volume of calls related to overdoses. As opioid overdose-type calls for service are increasing, the rates for burnout among first

responders are also rising. This is potentially due to exhaustion from compounded collaborative efforts with community-based programs, providing repeated treatment and care to addicts, their own core beliefs, and the perception of treatment as failing. Passionate work can eventually exert a toll and lead to agitation and frustration.^{xliii}

According to a former medic in California, burnout is a given. He stated:

“We were called to an overdose scene at least one time per night, every night. Some are easier rescues than others and sometimes the rescues just get old. They all start to feel the same and we get little accolades from management or the public, rather we get criticism despite all the hard work. At the end of shift I would feel so drained, I just want to disconnect and make light of the situation. Eventually, you just get so tired of helping everyone, you can’t even help yourself anymore. We often rescue and care for everyone besides ourselves. These kind of calls [overdose calls for service] and the job in general can burn you out.”

When PTS and burnout run their course without treatment, the most adverse consequence can be suicide. Some first responders will try to quickly problem solve on their own, just as they do in the field. However, when failed attempts occur, maladaptive coping starts, and symptoms increase.

Maladaptive coping can include abuse of alcohol and other substances and extramarital affairs, to name a few. Eventually, when these coping mechanisms don’t work, individuals will begin to think and feel as if there are no other solutions. When substance abuse problems occur, families begin to suffer, and the individual suffers from ongoing PTS and burnout symptoms, which can lead to believing that taking one’s own life is the only solution.

Further research needs to address the correlation between the burnout and PTS of first responders and the opioid epidemic—specifically documenting cases of burnout and PTS that are a direct as well as indirect result of this public health crisis. Future investigation needs to review prevention, intervention and recovery strategies for this specific occupational stressor (opioid crisis/overdose calls).

Recommendations for care

There are several actions that agencies and first responders can implement to safeguard mental health.

1. Provide ongoing resiliency training, beginning in the academy through one’s career.
2. Implement quarterly psycho-educational briefings on stress management and compassion fatigue.
3. Offer regular Family Resiliency Training.
4. Conduct preventative annual check-ups for first responders based on the same concept as annual physicals.^{xliv}
5. Offer variety-rotation of positions every few months to a year to avoid complacency (as feasible).^{xlv}
6. Provide briefings and in-service trainings on how to utilize counseling through department resources, private providers and Employee Assistance Programs (EAP) and peer support teams.
7. Maintain early childhood and high-school friends and non-work-related hobbies^{xlvi}

Include all employees in an agency in the above recommendations. For example, 911 telecommunicators are often overlooked due to the technicality of not being on-scene. We argue that dispatchers experience similar on-the-job challenges, including PTS and burnout, which can come from taking the initial phone call for emergency service – such as a child crying and calling 911 because his/her parent is not conscious from an overdose.

Because the opioid epidemic does not appear to be slowing down, it is important that first responders have up-to-date guidance. The importance of department-wide education and training about the opioid crisis and the risks involved in this new era cannot be stressed enough. First responders and their agencies need to have plans that provide this education and protection based on the environment that their agency operates in.

Questions and feedback

Questions and feedback about the *International Public Safety Association InfoBrief: How the Opioid Crisis is Impacting First Responders* can be sent to info@joinipsa.org.

References

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