

Overdose and Behavioral Emergencies

Continuing Education
July 2018



**NORTHWEST
COMMUNITY
EMERGENCY
MEDICAL
SERVICES
SYSTEM**



Questions/Comments
regarding this CE are welcome,
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Northwest Community EMSS

Continuing Education

Overdose and Behavioral Emergencies

Susan Wood, R.N., EMT-P

National EMS Education standard:

Epidemiology, pathophysiology, psychosocial impact, presentations, prognosis, and management of (complex depth, comprehensive breadth) patients who are involved in a overdose or behavioral emergencies.

Assigned readings:

This handout; NWC EMSS SOPs

Goal: Upon completion of the class, each participant will independently do the following with a degree of accuracy that meets or exceeds the standards established for their scope of practice:

OBJECTIVES:

1. Define the following terms: Substance or drug abuse; substance or drug dependence; tolerance; withdrawal; and addiction
2. Appreciate the incidence, morbidity and mortality of toxic and drug abuse emergencies.
3. Predict the risk factors most predisposing to toxic emergencies.
4. Discuss the anatomy and physiology of the organs and structures related to toxic emergencies.
5. Prioritize the routes of entry of toxic substances into the body.
6. Anticipate the most commonly abused drugs (both by chemical name and by street names).
7. Determine the pathophysiology, assessment findings, need for rapid intervention and transport and management of toxic emergencies.
8. Assess the prevalence of behavior and psychiatric disorders.
9. Predict the factors that may alter the behavior or emotional status of an ill or injured individual.
10. Determine the medical legal considerations for management of emotionally disturbed patients including the use of Petition forms.
11. Appraise the overt behaviors associated with behavioral and psychiatric disorders.
12. Define the following terms: affect, anger, anxiety, confusion, depression, fear, mental status, open-ended question, and posture.
13. Describe the verbal techniques useful in managing the emotionally disturbed patient.
14. Explain appropriate measures to ensure the safety of the patient, paramedic and others.
15. Anticipate the circumstances when bystanders and others should be removed from the scene.
16. Construct techniques that facilitate the systematic gathering of information from the emotionally disturbed patient.
17. Predict interviewing traps that impair effective communication
18. List situations in which the PM is expected to transport a patient forcibly and against his will.
19. List Identify techniques for physical assessment in a patient with behavioral problems.
20. Identify the behaviors that may be seen indicating that patient may be at risk for suicide.

Overdose and Behavioral Emergencies

Introduction:

- A. **Toxicology:** Study of **toxins** (drugs and poisons) and antidotes and their effects on living organisms.
- B. The American Association of Poison Control Centers estimates that there are over 4 million poisonings every year. Poisoning deaths include those resulting from drug overdose, those resulting from other misuse of drugs, and those associated with solid or liquid biologic substances, gases or vapors, or other substances such as pesticides or unspecified chemicals.
- C. Children <6 years account for over 70% of all poisoning cases, but only 5% of deaths. More serious cases in children may involve intentional poisoning by parents or caretakers. A child who has experienced an accidental ingestion has a 2.5% chance of another, similar ingestion within one year
- D. Adults account for most hospitalizations. Most deaths (95%) occur in adults and adolescents. Most are intentional due to illicit drug use, alcohol abuse, attempted suicide and "suicidal gesturing".
- E. Fentanyl overdoses have a growing presence in the illicit drug market and is involved in an increasing proportion of opioid overdose deaths (CDC Weekly, 2017).
- F. Suicide rates in the U.S. continue to increase and in 2016, suicide was the 10th leading cause of death (Hedegaard, Curtin, et al. 2018).
- G. Suicide by suffocation or by firearms is increasing in both the global female population as well as in the male population aged 65 and older.

Today's conversation will focus on the rapidly growing epidemic of opioid overdoses and the role EMS providers have in making the difference

The rate of overdosing, whether intentional or accidental is growing at an alarming rate in the general population. It is a problem that crosses age, race, religion, and socioeconomic factors without precedence. These people become patients for EMS and the first opportunity to address is the need for *safety in EMS*.

There's no such thing as just another OD...

The abuse of drugs, including all opioids and narcotics is killing the US population at an increasing rate resulting in these patients needing intervention from EMS in greater

numbers. Because the way in which people are taking drugs leads to a greater tolerance and subsequent need for higher doses; people's behavior is more and more unpredictable. Additionally, patients frequently need higher doses of the reversal agent (naloxone) to regain appropriate respiratory rates. The repeat dosing of naloxone have the potential for putting EMS at greater risk of exposure if not adequately protecting oneself with appropriate PPE.

Naloxone itself, is safe and effective medication that rapidly reverses the effects of narcotic overdose; however EMS should be careful to only give as indicted as per SOP p. 27, Drug Overdose / poisoning.

A few simple things to protect oneself from exposure is to where appropriate PPE when the presence of narcotic is suspected. Additionally, AVOID actions that may cause power substances to become airborne; thus inhaling a drug. To avoid this situation, a properly fitted respirator and eye protection should be worn. The potential for substance absorption is always possible, therefore every attempt to minimize skin contact when responding to a situation where even small amounts of drugs should be taken.

Safety for EMS

What does this mean? It means that the old adage that one cannot care for another if they themselves have become a patient. Because of the change in potency of drugs and the drugs used, safety is even of greater importance when interacting with overdose patients.

Let's be honest, EMS may be called for one complaint and quickly enter into a situation that is very different than what dispatch was given. As EMS personnel we are all too often called to the scene of a preventable tragedy. We are responsible for treating patients after problems have occurred; overdose is no exception. However, we are responsible as members of the community to help educate the public on how to prevent illness and injury. Equally important, we are responsible for maintaining our own good health and physical conditioning in an effort to ward off preventable disease and injury.

Situational awareness is paramount when responding to known areas where drugs are being used. In our areas, the majority of the time if a hostile environment is suspected, law enforcement is there to secure any potentially dangerous or violent situations before EMS crews enter. One policy that helps to guide practice and includes specific roles and interactions of police and fire/EMS personnel is **Policy P-3: Interaction with Police/Crime Scene Responses.**

Additional specialty teams may be needed such as Haz Mat if a meth lab is suspected. They can be literally anywhere; stationary buildings or mobile such as in the trunk of a car.

The best preparation EMS can have for handling emergency situations such as overdose situations or behavioral emergencies is by understanding the pathophysiology, personal protection, patient handling, and restraint techniques when encountering these patients. The final matter of priority is to understand the importance of proper documentation!

It Can Happen to the Best of Us

For EMS to understand these emergency situations, it's important to appreciate that anyone can succumb to drugs, alcohol, or a behavioral breakdown as a result of life's pressures. It is also imperative to appreciate the need for assessing the origin of the violent patient outburst that called EMS to the scene in the first place.

While medical emergencies can mimic a behavioral crisis, upon thorough evaluation of such, overdose and behavioral emergencies should be treated with as much empathy and compassion for both the patient and the family as EMS has. The magnitude that this is someone's child, parent, or loved one must be appreciated when entering the situation and speaking to all involved. Frequently, EMS has responded to the person previously. This does not mean that they wanted to overdose intentionally.

Why do people take drugs?

Great question; I'm sure one that can be confusing for even the most experienced individual to answer. According to the National Institute on Drug Abuse, "there is a defined science of addiction; a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain—they change its structure and how it works. These brain changes can be long-lasting, and can lead to the harmful behaviors seen in people who abuse drugs" (NIH, 2014).

Addiction is powerful, but not unlike other diseases in that it disrupts the normal, healthy function of the underlying organ; in this case the brain and can have serious harmful consequences. When care is sought, much can be treated; if left untreated, the consequences can last forever.

In reading and researching many stories, many people discuss "innocently" stumbling into drugs. Meaning, many young people, and females in particular, casually use for the first time as a result of a partner introduces them or the intense peer pressure gives way to trying something "just once." Other circumstances occur as a result of an injury in which the person may need pain medication.

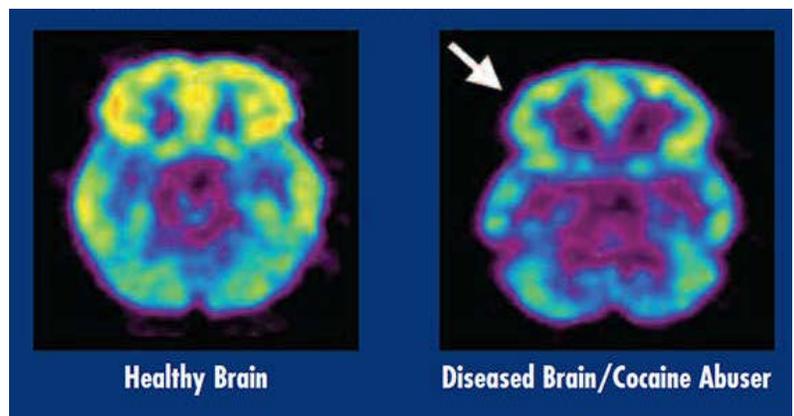
Complications may arise in the treatment process causing additional medications that can lead to tolerance and addiction. Unfortunately the potency and addictive nature of the chemical compounds seen today makes that one time all that is needed for the addiction to occur.

Once encountered, people find the good feeling being craved over and over again. The feeling of "feeling better" is sometimes sought after for those who have anxiety or a great amount of stress from work or school. Additionally the chemical enhancement temporarily helps to "do better" or achieve more as an example in sports which may account for the initial role of experimentation and subsequent abuse of continued use.

The initial experimentation may be under the false pretense that since drugs makes a person feel good / better, why can't they take them? Unfortunately, with continued use, the good feelings become less appealing and the desire to avoid the "dope sick" feeling creates a never-ending cycle of addiction. This feeling creates such a propulsion to do anything to avoid the horrific feeling that people steal from loved ones, lie to them, risk relationships, including their own children. With continued use, tolerance is noted; thus requiring a greater amount of drug to either "get high" or avoid the sick feeling. Habits can financially cost an individual several thousands of dollars a day, each and every day.

Therefore the answer to the question, "why doesn't someone just stop," is really because the continued drug use isn't voluntary at that point. With the initial use being voluntary, the continued abuse is no longer. The physiologic changes impair the person to think rationally about anything; as well as the person's ability to exert self-control is all but lost.

As noted in the CT images, there are physiologic changes that occur to the brain when a person abuses drugs.



DECREASED BRAIN METABOLISM IN PERSON WHO ABUSES DRUGS

Another question asked by loved ones can be what they can do to change their loved one from becoming addicted. As with any other disease, each person is unique and addiction differs from person to person, however, generally speaking, the more risk factors a person has, the greater the chance that taking drugs can lead to addiction. Below is a chart with risk and protective factors for abuse and addiction (NIH, 2014).

Risk and Protective Factors for Drug Abuse and Addiction

Risk Factors	Protective Factors
Aggressive behavior in childhood	Good self-control
Lack of parental supervision	Parental monitoring and support
Poor social skills	Positive relationships
Drug experimentation	Academic Competence
Availability of drugs at school	School anti-drug policies
Community poverty	Neighborhood pride

Opportunities for Education

Before EMS is able to educate the public, they themselves must be knowledgeable about the subject matter. Additionally, one must have empathy for the person in the situation and be able to demonstrate it in a believable manner. That leads to the discussion of bedside manners.

As briefly discussed in the section, "It Could Happen to the Best of Us," there are a variety of ways in which a person can become addicted to drugs and alcohol. The first response to appreciate is that "the why" is not really the business of EMS. Meaning, while we may never know *why* someone does drugs, there is no difference in the way that person should be treated. Keep in mind however most drug abusers are eventually homeless. As discussed previously, the power the addiction has creates a person no longer in control of themselves or their actions. EMS may be the only persons who have shown this person kindness in a very long time. EMS may the only one to demonstrate empathy for their current situation; recognizing that only because of a few different choices we have made in our own lives, caused us to be standing over this person on the EMS cot, rather than the other way around is why one can care for the other.

Once an individual is able to be linked to assistance, one idea to help stop the addiction is to create a contract with the addict. With trust built between two entities and a therapeutic relationship is established, opioid contracts

have proven one way in which to assist in sustaining adherence to opioid therapy (Buchman and Ho, 2017). While this treatment is after cessation of drugs has been reached, the EMS treatment of a person with dignity and respect may just have been the initial contact that created the pathway to adherence.

While education may not occur when the patient has a significant altered mental status, as the professional, one must take the opportunity to keep you in check.

Remember:

1. "Don't take insults or verbal abuse personally." Whatever the substance, its use alters the patient therefore you as the professional need to remember to keep safety as the priority.
2. Make sure the patient's AMS is NOT because of a treatable cause. Check A,E,I,O,U,T,I,P,S.
3. The use of physical restraints is important for the safety of the patient when needed. Utilize them and make sure to maintain protection of the patient's airway at all times and document. Per Procedural standard, EMS must assess for decisional capacity; they must identify at least 3 elements that indicate a behavioral emergency with a possibility of violence requiring restraints such as the patient being combative, shouting, pacing, punching or kicking or apparent anger before direct application of a physical restraint can be applied found in Skills Performance Standard for Restraint, Procedural Manual (Hseih, 2011).

Why are people using heroin and IV drugs in an alarming rate?

Once tolerance is achieved and more drugs are needed to get high, stay high, and not feel "dope sick" the expense quickly adds up. Sadly, heroin is cheap and more potent. The use of heroin increased 63 % in one year in 2013 with the users crossing the spectrum (MMWR, 2015). When they become tolerant to that, there is fentanyl and carfentanil. They are highly addictive but cheaper relatively speaking. This is why the population builds on the stronger drugs.

There is sometimes confusion in the EMS population that the fentanyl used on the street is exactly the same as what is carried in the rigs; this thinking is incorrect. The fentanyl, synthetic opioid and carfentanil is imported from China and is NOT FDA regulated.

One study in Mass. investigated the opioid overdose death from October 2014- March 2015 to find that approximately two thirds of all opioid deaths involved fentanyl (CDC, 2016).

What is being done with the problem?

Drastic times call for drastic measures and we have hit that with the opioid crisis. Traditionally naloxone administration has been given only by advanced life support paramedics or in hospitals, but this is no longer the case. There are programs and grants being given to police and non-medical personnel to obtain and administer this drug in emergent situations.

Additional measures include the DEA cracking down on the prescribers and pharmacists who administer the pain control drugs to the individuals. Because prescription drugs are one way in which a person first encounters the drugs, the prescriptions must be done so with substantial oversight and limitations. People need to be educated as to the risk and benefit of taking any prescription narcotics. In April of 2018, the DEA arrested 28 prescribers and pharmacists and revoked 147 licenses of individuals who handle controlled substances (Brooks, 2018). The unfortunate reality is that there are so many illegal activities compounding the issue of drugs and overdoses.

You will never find what is NOT assessed!

Altered mental status is a common call for EMS and should emphasize that all treatable medical conditions should be properly assessed for and treated before just assuming the patient has a psychological disorder. This will damage EMS credibility every time a diabetic, stroke or cardiac patient it missed. In p. 26 of the SOP's, under altered mental status, there are two pneumonics that are listed for EMS to assess with any patient. Under AMS, AEIOUTIPS helps to consider possible etiologies for causes, some treatable prehospital. HEADHEARTVESSELS are the syncope differentials that should be considered as patient presentations can be similar in description.

AMS: Consider possible etiologies; use appropriate SOPs

- A:** Alcohol and ingested drugs/toxins; ACS/HF, arrhythmias, anticoagulation
- E:** Endocrine/exocrine, particularly thyroid/liver; electrolyte/fluid imbalances; ECG abnormalities: prolonged QT; Brugada syndrome (incomplete RBBB pattern in V1/V2 w/ ST segment elevation)
- I:** Insulin disorders: hypoglycemia; DKA/HHNS
- O:** O₂ deficit (hypoxia), opiates, overdose, occult blood loss (GI/GU)
- U:** Uremia; other renal causes including hypertensive problems
- T:** (recent) Trauma, temperature changes
- I:** Infections, both neurologic and systemic; infarction
- P:** Psychological; massive pulmonary embolism
- S:** Space occupying lesions (epi or subdural, subarachnoid hemorrhage, tumors); stroke, shock, seizures

Because EMS often walks into unknown circumstances, part of the scene size-up (as outlined in SOP) includes:

- Inspect environment for bottles, meds/drugs, letters/notes, sources of toxins suggesting cause
- Ask bystanders/patient about symptoms immediately prior to change in mentation; S&S during event; duration of event, resolution of event (spontaneous, after interventions)

Additionally secondary assessment includes:

- **Affect; Behavior:** consolable or non-consolable agitation
- **Cognitive function** (ability to answer simple questions); hallucinations/delusions
- Memory deficits; speech patterns
- Inspect for Medic alert jewelry, tags, body art
- General appearance; odors on breath; evidence of alcohol/drug abuse; trauma
- **VS:** observe for abnormal respiratory patterns; ↑ or ↓ T; orthostatic changes
- **Skin:** Lesions that may be diagnostic of the etiology
- **Neuro exam:** Pupils/EOMs; visual deficits; motor/sensory exam; ✓ for nuchal rigidity; EMS stroke screen

EMS must never overlook the possibility that a patient may have a seizure, needing intervention. They may also have head trauma requiring advanced airway management, and because of underlying unknown cardiac conditions with many patients, cardiac monitoring is required.

According to SOP:

If possible opiate toxicity w/ AMS & respiratory depression/arrest: **NALOXONE** IVP/IO [ALS] IN/IM [EMR/BLS]

If spontaneously breathing: 0.4 mg; repeat q. 30 sec until ventilations increase up to 4 mg

If apneic: 1 mg. May repeat q. 30 sec until breathing resumes up to 4 mg. All additional doses require OLMC.

- Syncope differential**
- H** Head injury
 - E** Epilepsy
 - A** Aneurysm
 - D** Drugs/psychiatric causes
 - H** Hypoxia or heart disease
 - E** Embolism
 - A** Arrhythmia
 - R** Respiratory (hyperventilation or breath-holding)
 - T** Thoracic outlet syndrome
 - V** Vasovagal
 - E** Ectopic (pregnancy-related hypotension)
 - S** Situational, sepsis
 - S** Sinus sensitivity
 - E** Electrolytes
 - L** Lung (pulmonary embolism)

2017 State of Illinois Comprehensive Opioid Data Report
Drugs involved in fatal opioid overdose

Facts in Illinois

Executive Summary

Illinois is in the midst of an unprecedented opioid epidemic. In 2016, opioid-related overdoses claimed the lives of 1,946 Illinoisans, more than one and half time the number of homicides and nearly twice the number of fatal car accidents. In response, state agencies began meeting to develop a comprehensive plan to address the crisis. On September 6, 2017, the State of Illinois Opioid Action Plan (SOAP) was released pursuant to Executive Order 2017-05.

Since 2013, Illinois has experienced a substantial increase in overdose deaths from all categories of opioids. Most striking has been the tenfold increase in deaths due to synthetic opioids, including fentanyl and fentanyl analogues. Deaths due to natural and semi-synthetic opioids, including prescription pain relievers such as hydrocodone, oxycodone, and oxymorphone, doubled, and deaths due to heroin increased by 73 percent.

1. Opioid overdoses have been increasing in recent years

An 82% increase since 2013 to 2016

2. Synthetic opioids such as fentanyl and its analogues are disproportionately contributing to the rise in both fatal and nonfatal overdoses.

Over the past three years, deaths due to synthetic opioids have increased tenfold

3. Opioid overdoses are an urban, suburban, and rural problem. While the highest absolute number of opioid overdoses are in Cook County and the collar counties, many of the highest per population overdose rates are seen in pockets of rural counties statewide

4. Opioid prescribing activity has been decreasing.

Since 2013, the total number of opioid prescriptions reported to the Illinois Prescription Monitoring Program has decreased by 9.8%. This is consistent with an overall national trend toward reduced opioid prescribing in recent years as compared to peak prescribing in the late 2000s and early 2010s.

Table 3. Substances involved in opioid overdose deaths

Substance	2013	2014	2015	2016
<i>Heroin (T40.1)</i>				
Heroin	583	711	844	1007
<i>Natural and Semi-synthetic (T40.2)</i>				
Any natural/semi-synthetic opioid	184	251	271	370
Buprenorphine	0	0	1	0
Hydrocodone	92	118	129	154
Hydromorphone	5	17	15	38
Morphine	54	74	84	104
Oxycodone	29	49	51	65
Oxymorphone	5	10	8	18
<i>Methadone (T40.3)</i>				
Methadone	92	106	99	121
<i>Synthetic (T40.4)</i>				
Any synthetic opioid	87	127	279	879
3-Methyl Fentanyl	0	0	0	1
4-ANPP	0	0	0	219
Acetyl Fentanyl	0	0	10	35
Acrylfentanyl	0	0	0	6
Carfentanil	0	0	0	3
Fentanyl	58	92	234	606
Furanyl Fentanyl	0	0	0	188
Norfentanyl	0	0	0	8
Tramadol	24	29	31	56
U-47700	0	0	0	8

Conclusion

The data in this report show that no group is unaffected by the opioid crisis in Illinois. Rather, different groups are affected differently when it comes to prescribing, nonfatal overdose, fatal overdose, infectious disease, and other aspects of opioid use. This understanding will help shape future research, interventions, and policies as we target interventions appropriately, culturally competently, and effectively.

Introduction

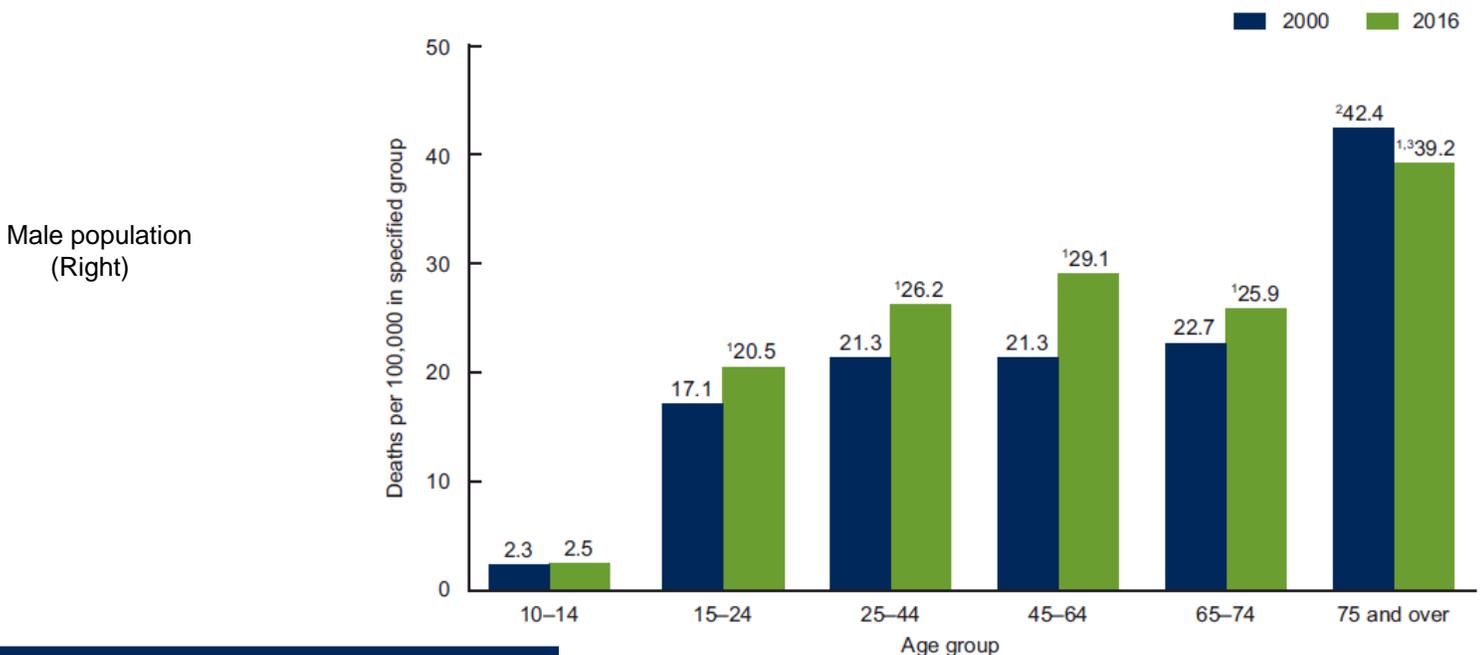
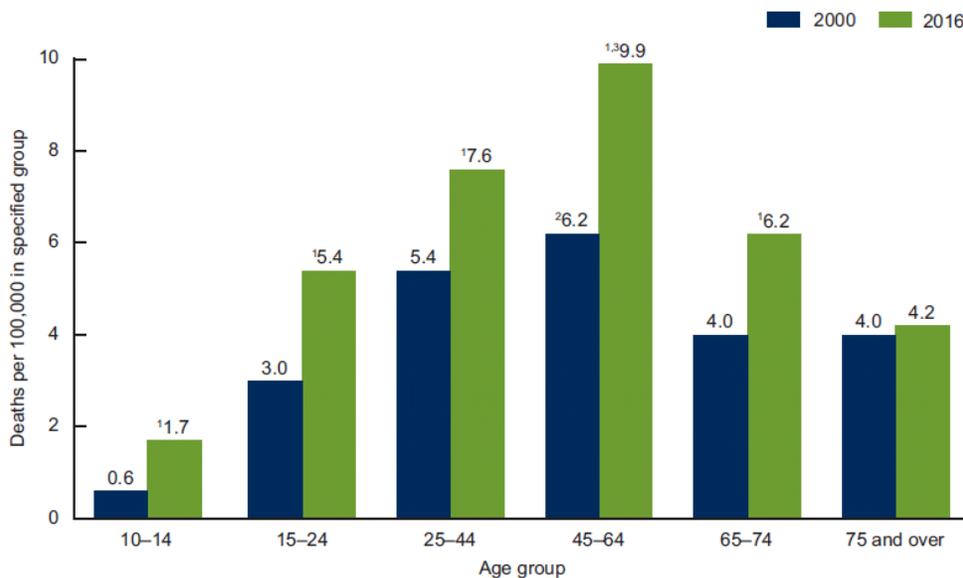
As we discuss this next topic, I am reminded that EMS can see incredible situations that the general public may not be aware of and certainly does not come in contact with on a regular basis. *What pushes your button?* Perhaps the homeless intoxicated person who swears at you, daring you to fight with him, "Be a man," he says. During his vulgar rant, he gets your blood to boil. After all, no one is immune to stressful situations and on top of work, you have a fight with your spouse, the kids are rebelling and working the side job is wearing you thin.

Is it really worth the possibility of the demotion or even worse, losing your job? That is not what you are thinking about in the moment; you just want the patient to shut up...and now! These situations may be difficult to cope with and unfortunately some do not cope at all.

The Greatest Concern

According to the Center for Disease Control (CDC) suicide rates in the US continue to increase. There are a variety of reasons that will be discussed, however the data is showing:

1. In 2016, suicide was the 10th leading cause of death in the US; but 2nd in those aged 10-34.
2. From 2010-16, the suicide rate increased 30%
3. From 2010-16, the rate of suicide increased in males by 21% but for females increased 50%
4. The few commit suicide with both suffocation and poisoning is increasing
5. In 2016, firearms were the most common means of suicide in males over 15 years of age.



What is really telling about the statistics from the CDC is the fact that 54% of people who died by suicide did not have a known mental health condition. We all have a role to play in helping others.

What really is the conversation that is needed to occur is what does one person do for another when the hurting person is not necessarily a patient but a peer, a colleague or even you?

The Provider becomes the person in Need

The introduction started by talking about the stressors of the EMS field and what can occur when those stressors are compounded by other situations in a person's personal life that adds to the stress. The image below shows some of the common stressors a person may face. These situations put an individual at risk for substance use and potential abuse. Once again, the statistics will show that no one is immune to such problems and in fact statistics will also show that EMS may be at an even higher risk.

According to one report, EMS personnel suffer from depression up to 36% of the time. Depression is the start of a spiral effect that can lead to burnout, sleep deprivation (up to 72% of EMS providers are poor sleepers) and substance abuse. If left untreated, there is risk of suicide as well. The belief is that after 9/11, the stress is at an all-time high (Collopy, 2012) siting that during an 18-month period, the Chicago Fire Department experienced 7 suicides.

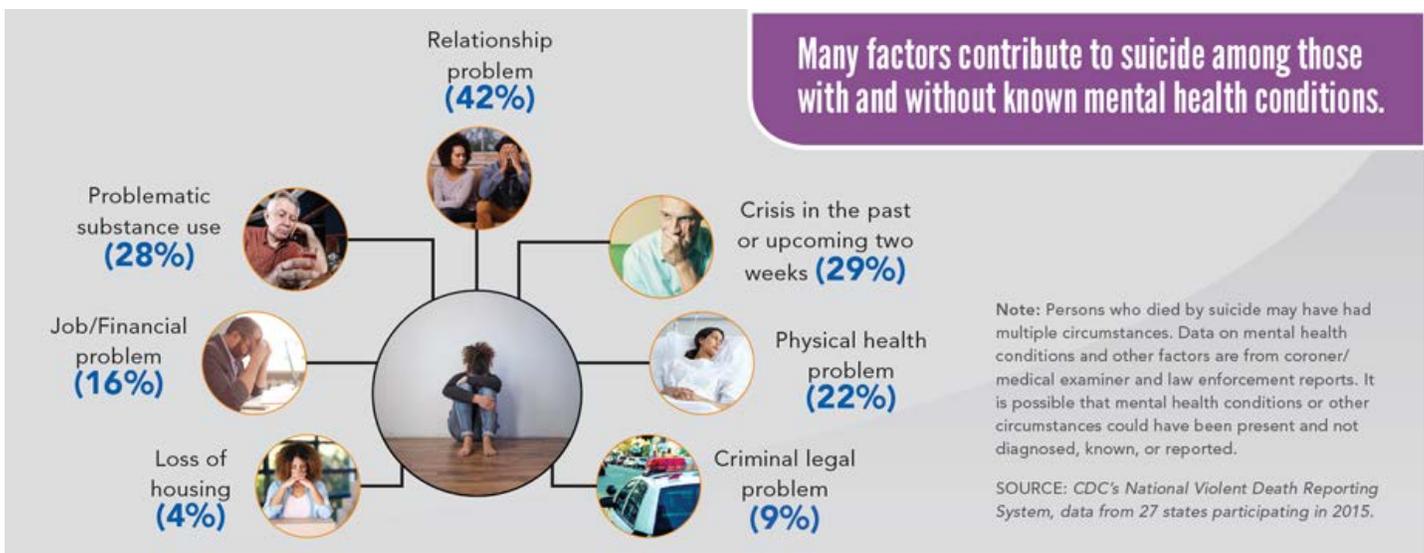
Burnout

Many providers will admit to having some type of "burnout." It is not uncommon; it is essentially the presence of a constant negative attitude toward any aspect of an individual's work" (Collopy, 2012).

There are so many reasons EMS personnel can site for having burnout such as long shifts, inconsistent sleep patterns due to calls, sheer call volume, abuse of the 911 system, and perceived lack of administrative support.

Critical stress is real and most would categorize it as either a single incident that had a significant impact on an individual or the accumulation of stress over a period of time that has a strong impact; regardless of the years of service (Newland, Barber, et al., 2015). This critical stress is one that almost all EMS personnel have most certainly encountered but has an individual effect.

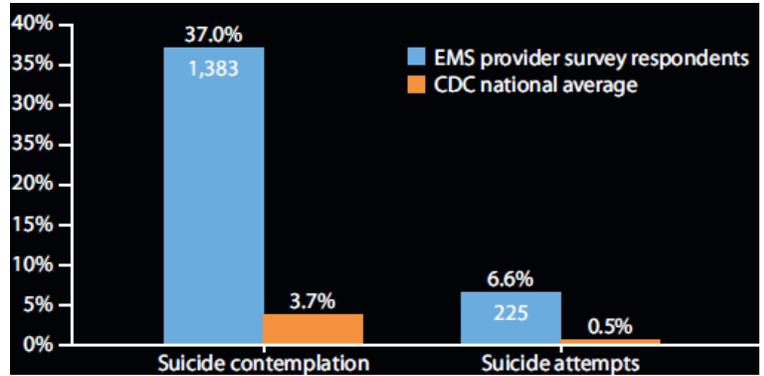
The additional concern is what has or is being done to help personnel through these situations. Some may have CISM and employee assistance programs; however they demonstrate varying degrees of effectiveness. Certainly a peer should be able to go to another peer for understanding in times of struggle? While the answer may be yes, some have perceptions of weakness when attempting to seek out any help of any kind.



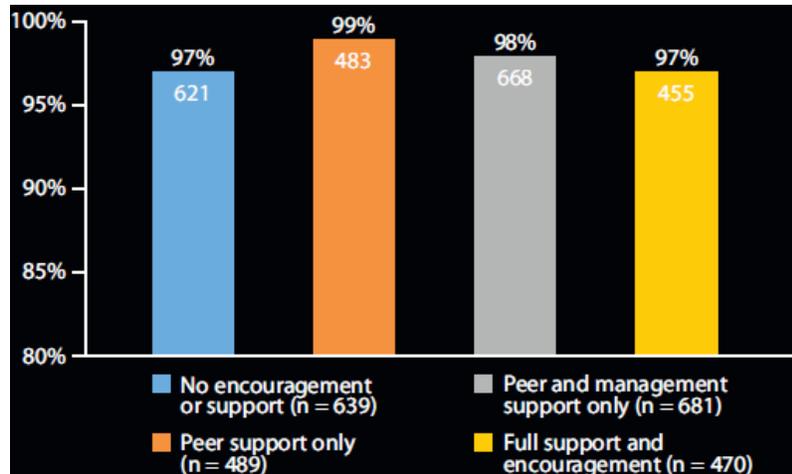
What can each individual do to prepare themselves if they should encounter someone who asks for assistance? According to Fitch, there are six immediate action steps every EMS leader should take to address this critical issue:

1. **Increase your personal knowledge:** get to know people and their needs. Excuses such as "I didn't want to pry," seem very petty when a suicide has occurred.
2. **Review current resources:** Just as EMS should learn their current surroundings; they should also take the time to review the resources available to them before the crisis of needing immediate help arises.
3. **Increase broad awareness:** take the time to look beyond yourself for a variety of reasons. Helping or lending a hand to another person helps you to keep your focus off of your personal situations; especially if you are the one who happens to be feeling down at present.
4. **Train middle managers and supervisors:** because people may not want to take such personal business to their chief, they may feel more comfortable with a direct supervisor or a person other than management.
5. **Ramp up strategies:** reviewing critical stress management, employee assistance, and global issues, it becomes more commonplace and comfortable to discuss openly.
6. **Develop longer-term strategies:** longer-term wellness programs are becoming more common and vital to this EMS profession; seeking out professional resources should be made available to providers on an ongoing basis.

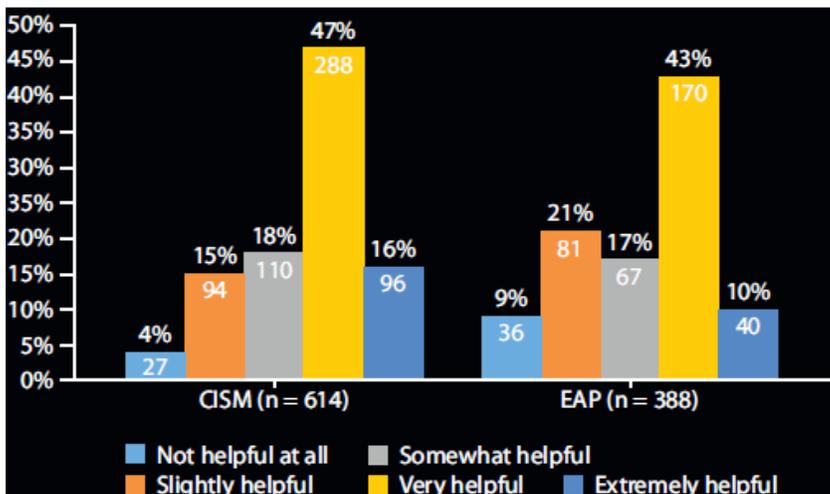
Comparison of suicide contemplation and attempt rates: survey respondents vs. national average (n = 4,022)



EMS cultures and the presence of critical stress



Effectiveness of formal support institutions



Resources

There are many resources for help; individuals only need to ask for assistance. Please know that this is an opportunity to restore health and wellness without need of shame or embarrassment. The first thing to identify is who might be covered under both your insurance provider or through Employee Assistance plans. For veterans, the VA hospitals have many opportunities to find help. A few resources are listed below but are not all inclusive. Please feel free to contact the resource hospital or any associate hospitals for assistance as we are here to help.

Veterans Crisis Line: 1-800-273-8255; press 1 or text 838255

Defense Centers of Excellence for Psychological Health and TBI: 1-866-966-1020;

resources@dcoeoutreach.org

National Suicide Prevention Lifeline: 1-800-273-TALK

Serve and Protect Crisis Line: 1-615-373-8000;

www.serveprotect.org

National Volunteer Fire Council: Fire/EMS Hotline: 1-888-731-3473

NREMT: <https://www.naemt.org/initiatives/ems-mental-health>

SAMHSA Treatment Referral Helpline: 1-877-SAMHSA7 (1-877-726-4727)

Table 1: Coping Strategies as Reported by EMS Providers¹¹

Constructive Coping Strategies	% Providers Using Strategy
• Talking with colleagues	100
• Thinking about positive benefits of work	94.9
• Focusing on outside interests	92.0
• Thinking about own family	92.0
• Looking forward to off-duty time	85.5
• "Black," or dark humor	77.7
• Using available mental health services	55.3
• Talking with spouse/significant other	37.9
Destructive Coping Strategies	% Providers Using Strategy
• Keeping thoughts/feelings to oneself	88.1
• Avoiding conversation about calls	81.2
• Picking and choosing calls	58.0
• Reducing workload to bare minimum required	52.6
• Consuming alcohol	50.7
• Engaging in risky behaviors	37.9

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