Bureau of Justice Assistance (BJA)

Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP)

Trauma and the Opioid Crisis: Perceived Impacts on First Responders

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Abstract

This analysis of in-depth interviews with key informants captures perceptions of mid- to high-level staff members of first responder agencies working on the front lines of the opioid and other drug crises in some of the nation's hardest-hit communities. The purpose of the interviews was to gain insights about the experiences, impacts, and needs of the first responder workforce and to inform the Bureau of Justice Assistance (BJA) about the perceptions of first responder agency leadership of the impact of staff members' exposures to potentially traumatic stressors. This article summarizes information gathered from interviews with supervisors of nine local law enforcement agencies, two fire departments, and two emergency medical services (EMS) agencies involved in overdose prevention, mitigation, and response efforts. It describes how overdose response duties affect individuals and organizations, the measures agencies take to minimize any negative consequences, and suggestions on ways to better prepare and support the field to manage the associated stressors. Command staff members of law enforcement agencies, in particular, discussed how frontline staff members react to new approaches that differ from their traditional response to people who use drugs. The lessons and recommendations gleaned from these interviews offer a wealth of valuable information about current and ongoing needs of professionals working on the front lines of this crisis in communities across the nation.

This report is dedicated to Niki Miller (1957–2022), a respected friend, colleague, leader, and advocate for people who use drugs and the research that can improve how we respond to and help individuals in need of support.

Introduction

The sustained impact of the opioid and other drug crises has presented unprecedented challenges to the agencies that respond to overdose emergencies.

COSSUP Comprehensive Opioid, Stimulant, and Substance Use Program

AHP Advocates for Human Potential, Inc.

CHJ Center for Health & Justice at TASC

This article analyzes key informant interviews with staff members from 13 first responder agencies about the impact of overdose response work on frontline staff members. It offers insights into the new partnerships that these agencies have forged across public health, treatment, and recovery continua of care and the lessons learned from responding to relentlessly increasing levels of high-risk drug use in communities across the nation.

Exponential increases in overdose deaths have prompted the rapid development and implementation of new approaches. Many hard-hit communities now primarily rely on a workforce trained to enforce drug laws to intervene with people involved in illicit drug use. Saving lives, diverting people from arrest, and linking them to services exposes public safety professionals to qualitatively different facets of the traumatic stressors that communities contend with as a result of the nation's persistent and burgeoning crisis.

In 2017, the Police Executive Research Forum deemed the opioid crisis the most "vexing and painful" issue facing police.[1] After more than a decade of firsthand experience, many law enforcement professionals have realized that arrest and incarceration seldom deter people from opioid and other drug use and related criminal activity. Many jurisdictions consistently report that up to half of their jail population has an opioid use disorder, and these jurisdictions typically struggle to manage large numbers of individuals experiencing acute opioid withdrawal in custody.[2] There is a growing consensus among public safety professionals that it is impossible to arrest their way out of this pervasive and protracted crisis.

Although first responders tend to have higher rates of trauma-related behavioral health issues than the general population, agency leaders acknowledge that frontline staff members are routinely exposed to far more dangerous, potentially traumatic situations than the typical overdose emergency response call.[3] Yet, paradoxically, working with individuals and families struggling with severe addictive disorders is considered one of the more stressful job assignments.

Frontline overdose emergency responders experience a wide range of emotions—from the pinnacle of satisfaction at saving a life to the depths of futility upon repeatedly reviving the same individual. They may be confronted with the unthinkable grief of a parent who has just lost a child or the desperation of a family trying to get a loved one into treatment.

Because the crisis has prompted agencies to forge new partnerships with other disciplines, there is growing recognition that first responders are uniquely situated to intervene with individuals at high risk for overdose fatality and link them to care. However, there is also a need to learn more about how these expanded roles affect first responders at individual and organizational levels.

The Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP)

In 2016, the federal government passed the Comprehensive Addiction and Recovery Act (CARA) in response to the rise in drug-related deaths. CARA appropriated funds to various government agencies to implement its mandates.[4] BJA was tasked with creating a discretionary grant program to fund collaborative justice system projects to respond to the impact of the opioid crisis on local communities through initiatives aimed at reducing overdose fatalities and mitigating harm to crime victims.[5]

In 2017, the first cohort of Comprehensive Opioid Abuse Program (COAP) grantees received 3-year awards of funding and technical assistance (TA) for

project planning and implementation. In 2019, BJA expanded the scope of these projects to include stimulant and polysubstance use. Hence, BJA renamed this discretionary funding opportunity the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP). (COSSAP will be referred to as COSSUP for the remainder of this article; see "About COSSUP" at the end of this article for further explanation.) Since its inception, COSSUP has supported more than 500 grantee projects involving collaboration between public safety and public and behavioral health systems of care in communities across the nation.[6]

A Catalyst for Public Safety Innovation

By 2016, public safety and justice system leaders were acutely aware of the toll that nearly two decades of unprecedented opioid use was taking on local law enforcement agencies, other first responder agencies, county and municipal jails, the courts, state prisons, probation offices, and other alternatives to incarceration programs. As overdose fatalities rose to unimaginable heights, law enforcement became an increasingly critical component of the overdose emergency response workforce and often the first line of defense against loss of life in rural and underserved communities.

COSSUP was initiated to support the justice and public safety response to the opioid crisis through the development and integration of community programs. This funding opportunity has acted as an incubator for innovation and has helped precipitate a public safety paradigm shift from enforcement-based approaches to alternatives such as deflection, post-overdose outreach, and pre-arrest diversion.*

Alternatives for people engaged in harmful substance use are common throughout the courts, but deflection and pre-arrest diversion are a new "no wrong door" pathway to treatment and recovery at the earliest points of justice system contact. Unlike formalized prosecutorial, court, or jail diversion programs that mandate treatment, deflection employs supportive, proactive outreach that offers individuals a pathway to appropriate care prior to or in lieu of arrest.

The expanded role of first responders in community-based overdose prevention has served as a durable, collaborative bridge across local public safety, public health, and substance use disorder treatment systems of care. A 2020 national survey of first responder deflection programs found that the impetus for initiating most of them has been overwhelming numbers of overdose emergencies and the need to expand community-level capacities to effectively respond.

*In differentiating deflection from pre-arrest diversion, the following definitions apply:

Deflection: the practice by which law enforcement officers or other first responders connect individuals to community-based services when arrest would not have been necessary, in lieu of taking no action, when issues of addiction, mental health, and/or other needs are present. Deflection is utilized absent the threat of arrest if the individual does not "accept the deflection."

Pre-arrest diversion: the practice by which law enforcement officers connect individuals who otherwise would have been eligible for criminal charges to community-based services in lieu of arrest, thereby diverting them from justice system involvement.

Purpose

The main purpose of these key informant interviews was to gain insight into the impact of added duties at the front lines of the opioid crisis on first responders, including potential workplace exposure to traumatic stressors. BJA tasked the COSSUP TA team with capturing observations from the perspectives of all levels of agency leadership. This analysis of the information gathered is aimed at increasing understanding of the nature and intensity of the effects and the measures currently in place to support staff members. Ultimately, these findings may help inform the development of resources to support the first responder workforce.

This article introduces findings to a broader audience and explores these issues within the larger context of first responder exposures to traumatic stressors. Although all interviews were conducted prior to the COVID-19 national public health emergency, the following offers insight into how additional demands can compound already high levels of job-related stress. Understanding how each layer of added demands affects first responders at individual and organizational levels is now more critical than ever and essential to developing workplace supports to safeguard first responders' mental and physical health and wellness.

Method

In fall 2019, a TA team consisting of subject-matter experts in opioid overdose risk reduction, deflection and pre-arrest diversion, alternatives to incarceration, trauma-informed approaches, and qualitative research developed a set of questions that pertained to four key areas of inquiry:

- Impact of the opioid crisis on local communities.
- Impact of added first responder duties at individual and agency levels.
- Steps that agencies are taking to support frontline staff.
- Suggestions for resources and tools to bolster such efforts.

Team members who had direct contact with first responder deflection projects prepared a list of potential interview subjects composed of mid- to high-level leadership staff members of fully operational, mature programs. The list of candidates represented a diversity of approaches employed by first responder agencies from different parts of the country. Lead agencies for COSSUP projects interviewed included law enforcement (9), EMS (2), and fire departments (2). Law enforcement-led initiatives appear overrepresented; however, a recent survey of opioid first responder programs found a significantly greater number of law enforcement-led programs.[10]

Participant Characteristics

Between October 2019 and January 2020, the team completed interviews with three chiefs, one assistant chief, and two majors from police departments; a county sheriff and a deputy sheriff; an assistant fire chief and a captain of a fire department; and EMS coordinators of projects underway in rural and urban settings across nine different states. Nearly all reported that their communities had been disproportionately impacted by the opioid crisis and had consistently higher overdose fatality rates than the nation as a whole.

In order to report and classify the unique characteristics of participating key informants and their respective projects, demographics such as location, lead agency, and key informant rank or

position are listed in table 1, along with the target population, pathway, and program approach. Since the classification of emerging collaborative models of community-based overdose response initiatives is relatively new, the following definitions are provided.

For purposes of this article, "**pathway**" refers to how the target population comes into contact with law enforcement or other first responder deflection programs, as categorized by the Police, Treatment, and Community Collaborative (PTACC).[11] The team's selection of programs used one or more of the three deflection models described below.

1. The **Naloxone Plus Pathway** was used alone or in combination with other pathways by 10 out of 13 programs to conduct outreach to individuals after they experienced an overdose emergency. This model uses multidisciplinary teams, often including peer recovery support specialists, to initiate in-person contact soon after the overdose event with the goal of linking people to treatment and services.
2. The **Self-referral Pathway** was used alone or in combination with other pathways by five projects. This model relies upon self-initiated help seeking from a first responder agency designated as a "safe" place to ask for help with an opioid or other drug problem. It is understood that this pathway affords protection from legal repercussions for small amounts of illicit substances or paraphernalia. Program staff members work to link individuals to treatment and services.
3. The **Officer Intervention Pathway** was used alone or in combination with other pathways by two projects. With this model, law enforcement officers may divert eligible individuals directly to treatment services or issue noncriminal citations in lieu of arrests. In some cases, charges may be held in abeyance until treatment plans are completed.

Table 1. Characteristics of Participating Projects and Key Informants

State	Agency	Key Informant Position	Pathway
AZ	Large Metro Police Department	Assistant Chief	All pathways
AZ	Small Metro Police Department	Chief	Naloxone Plus
IL	Small Metro Police Department	Chief	Self-referral
KY	Small Metro Police Department	Major	Self-referral
MA	Metro Police Department	Project Coordinator	Naloxone Plus, Self-referral
NC	Rural Community Paramedic/EMS	Community Paramedic, Response Team Coordinator	Naloxone Plus
NM	Large Metro Fire Department	Captain	Naloxone Plus, Officer Intervention
OH	Metro Police Department	Major	Naloxone Plus
OH	Metro Department of Fire and EMS	Assistant Fire Chief	Naloxone Plus, Self-referral
OH	Small Metro Police Department	Chief	Naloxone Plus, Officer Intervention
OH	Metro County Sheriff's Office	Sheriff	Naloxone Plus
SC	Rural County Sheriff's Office	Deputy Sheriff	Officer Intervention
WV	Metro EMS	Registered Nurse, Response Team Coordinator	Naloxone Plus

Response Themes

Findings reported in this section are based on analyses of 15 hours of interview recordings; post-interview debriefings; and the analysis of nearly 100 pages of interview summaries. Post-interview summaries of key informant responses were prepared based on notes and recordings. Response details were logged, organized by question, and tagged with key informant identifiers. An iterative joint coding process was used to categorize aggregate response data. Common and unique themes were quantified in tables and compiled into a summary report to BJA with recommendations based on analyses of the findings. The following interview questions with corresponding tables quantify common response themes articulated by three or more key informants. Each table is followed by a brief commentary.

Q1: How is the opioid crisis affecting your community?

Families have been devastated across generations.	62%
The issue is not confined to marginalized groups; it impacts every demographic.	54%
The traumatic landscape has affected first responders and the community.	46%
The community has been impacted by drug-related crime, public overdoses, and growing methamphetamine use.	38%
First responders have lost family and friends; some struggle with substance misuse.	38%
There is a growing need to find alternatives to traditional criminal justice response to drug use.	38%
Businesses and jobs have left the area (because of theft, workers unable to pass drug tests).	31%
There has been an increase in homelessness and suicide crisis calls and a decline in overall community health.	31%
There are not enough treatment resources to meet the need, which adds to first responder stress.	31%
Fiscal impacts—the crisis is draining public safety, health care, and social service resources.	23%
The crisis has contributed to first responder suicides, officers slain during drug raids, firefighter deaths, etc.	23%

One of the most common themes was the toll on first responders from regular contact with families in deep despair who felt they had nowhere else to turn, including families coping with the loss of multiple members and the intergenerational impacts. For example, grandparents who lost adult children to drug overdoses often raised their surviving grandchildren, only to watch them initiate opioid use upon reaching adolescence. It was also common for first responders to have lost family members, friends and, in some cases, co-workers. Additional themes focused on the "chronically traumatic landscape" of communities facing ongoing increases in drug-related crime, widespread homelessness, economic decline, and long-term damage to their overall health and well-being.

Q2: What trends are you seeing?

An influx of fentanyl used to adulterate other illicit drugs (cocaine, pills, etc.)	69%
Poly-drug use, illicit opioids used with stimulants, and big increases in methamphetamine use	62%
A decrease in fatal and nonfatal overdose rates since programs have been operating	54%
Decreased fatalities due to the availability of naloxone to first responders and lay people	46%
More people reaching out for help before a crisis or overdose occurs	31%
Nonresident overdose victims coming into the area to buy or use drugs	31%
Initial decreases in fatal and nonfatal overdoses, followed by a recent uptick	31%
An increase in fatal and nonfatal overdoses despite initiating response programs	23%

Interview subjects were selected because of their involvement with mature projects that had been operating long enough to refine protocols, collect preliminary performance data, and monitor related trends. A total of 10 out of 13 participating projects reported decreases in fatal and nonfatal overdoses since the programs began; however, of those 10 programs, only 7 managed to sustain those decreases

in the face of recent influxes of illicitly manufactured fentanyl, illicit psychostimulant use, and overdose emergencies involving multiple substances. Three key informants reported that fatal and nonfatal overdoses continued to increase despite project efforts.

Q3: In what ways is the situation affecting your personnel, department, or broader community?

Frustration occurs when offers of help are met with distrust or people are revived repeatedly.	100%
Hopelessness occurs when staff members perceive that their efforts perpetually fail to make a difference.	62%
More contact with family members has created a need to have more to offer them.	38%
Ensuring that staff members hear about the positive impacts of the program boosts morale.	31%
Fatigue arises from piecing together a crisis intervention response to a chronic condition.	31%
Law enforcement is more connected to the community and more familiar with services.	31%
There is widespread motivation to work with key partners on finding better solutions.	31%
Increased contact with survivors increases the effect on staff members when those survivors die.	23%

Nearly every key informant discussed how discouraged staff members are when they repeatedly revive certain individuals. Because their duties afford them very little contact with individuals in recovery or regular access to data on overdose fatality rates, negative perceptions about the value of their efforts are very common. Unless leadership takes steps to dispel them, they can have a deeply demoralizing effect on frontline staff members.

Resource availability was often cited as a challenge including the investment of time required to attend to stress management and wellness activities and the costs of sending staff members to offsite trainings. Several key informants indicated that insufficient treatment resources were one of the greatest stressors but also mentioned the positive effects of increased collaboration with community partners.

Q4: In what ways do you see your staff experiencing stress/secondary trauma/ compassion fatigue?

Staff members are fatigued by the duration, scope, and irreparable damage wrought by the crisis.	77%
Citizen complaints about pejorative attitudes toward people who use opioids create stress.	77%
A qualitatively different toll is taken by a drastic shift in response to illicit drug use.	38%
Increased absenteeism, tardiness, and changes in on-the-job behavior are warning signs.	38%
Extreme levels of stress take a toll on personal lives, family, and relationships.	31%
Defenses such as anger, compartmentalizing, shutting down, and numbness build.	31%
When staff members feel that they are making a difference, it positively impacts morale.	23%
Compassion fatigue develops from years of cumulative exposures to traumatic stressors.	23%
Increased alcohol/substance use, sleep problems, and nightmares are prevalent among frontline staff members.	23%

Most of the interview subjects pointed out that stress, compassion fatigue, and secondary trauma are cumulative and often compounded by, but not exclusive to, the protracted, pervasive impact of the opioid crisis. While most of the interview subjects indicated that it is difficult to isolate the effects of increased stressors specific to opioid crisis response work, several were able to articulate examples of their unique manifestations. For example, misdirected anger, blowups, or callous attitudes toward people who use opioids are signs of stress levels that demand the attention of leadership.

Q6: What is underway to help deal with the impact/stress of responding to the situation?

Monthly paid training days on addiction, trauma-informed crisis response, etc.	100%
Peer-to-peer programs: assigning a peer to check in with staff, more informal supports	46%
Critical incident debriefings and tracking staff exposures and injuries	46%
Trauma specialist/police psychologist assistance with training, debriefing, and support	38%
A paid half hour for relaxation, fitness activity, and recreational activities	31%
Resilience training, seminars offered by the state or by fraternal organizations	31%
Investing in quality and employee assistance program services	31%
Specific initiatives, such as Nadine Burke Harris Adverse Childhood Experiences (ACE) Study videos and Handle With Care	31%
Speakers from collaborating agencies presenting on relevant topics	23%
Rotating frontline staff positions or duties (to training or administrative duty)	23%

The overall consensus was that there is an immediate need for additional information and tools to address these issues. Some respondents have begun implementing department-wide initiatives, while others pointed to a variety of measures in the planning stages; however, the opioid crisis may not have been the sole impetus for them all. Examples included debriefing protocols, trainings on addiction and trauma, the addition of embedded trauma or mental health experts, and mandatory mental wellness check-ins. Generally, universal, department-wide initiatives and informal supports such as peer counseling were viewed as less stigmatizing and better utilized than referrals to a mental health professional.

Early intervention was also a consistent theme, not only making support available at the first signs of stress but also introducing stress management as essential to career longevity and job satisfaction during pre-service training. The value of training in trauma-informed approaches was singled out by dint of the dual purpose it serves—increasing understanding of how to deal with individuals impacted by trauma and contributing to staff members' awareness of their own potential responses to traumatic stressors.

Q7: What types of help does the field need?

A guide to implementing peer-to-peer support programs and debriefing protocols	31%
Information and resources for first responders on dealing with affected families	31%
Online training, videos, or onsite training followed by exercises to encourage reflection	31%
Hearing about what other jurisdictions have in place to deal with these issues	23%
Confidential access to online help that does not require going through a supervisor	23%
Short pamphlets, fact sheets, or tip sheets from trusted sources with a few key points	23%
Reinforcement at the national level of local efforts to bring these issues to the forefront	23%
Harm reduction training to orient law enforcement to this new approach	23%

Suggestions included highlighting successful efforts to manage these issues from first responder agencies across the country. There was a clear consensus that videos and online trainings are helpful but only if accompanied by follow-up discussions or activities that encourage critical thinking. Information on peer-to-peer first responder programs and tips for supervisors about broaching taboo subjects were also mentioned. Key informants preferred content that first responders can relate to on a personal level and cautioned against overwhelming staff members with too much information.

Specific suggestions included online supports that staff members can access confidentially, brief fact or tip sheets, and podcasts of stories from first responders who received effective help with traumatic stress. Respondents also preferred resources that broadly address the cumulative nature of secondary trauma, rather than opioid-specific issues exclusively. Several emphasized the need to fully integrate these topics into pre-service and in-service training requirements.

Discussion

Key informants described the ways in which their programs benefited the community as a whole as well as people who use drugs. For example, those who use drugs are more likely to call for help for an overdose emergency when contact with law enforcement and crisis response services does not necessarily result in arrest. People who experience an overdose benefit from immediate follow-up contact, linkage to treatment, and recovery support services from partners that work closely with law enforcement and other first responder-led initiatives. Ultimately, more people have opportunities to receive treatment in the community as opposed to trying to initiate recovery in custody or while facing criminal charges.

Fire and EMS personnel appear to have found the cycle of respond-transport to hospital-release to street as frustrating as law enforcement finds the cycle of arrest-transport to jail-release to street. One of the benefits that agencies derive is empowering overdose emergency responders with options such as a warm handoff to teams that specialize in post-overdose outreach, engagement, and linkage to care. This not only improves opioid and other drug emergency responder morale, it also targets individuals at high risk of subsequent overdose and potentially prevents fatalities.

Defining a Response Continuum

Categorizing responses based on clinical criteria is problematic, especially considering that one need not meet diagnostic criteria for a trauma-related disorder to experience profound and lasting effects. Moreover, clinical criteria fall short when describing the effects of traumatic stressors on communities and organizations. A great variety of terminology is used to describe the effects of workplace exposures to potentially traumatic stressors. After a review of the findings, three nonclinical terms were selected to mark different points along a continuum that aligned with the perceptions of the key informants.

Workplace stress is defined by the World Health Organization as physical, cognitive, behavioral, or emotional alterations that occur when there is a conflict between workplace demands on employees and how much control they have over meeting these demands.[12] Interview themes underscored this conflict. Examples include reports of frustration at insufficient community treatment capacities and the perceived futility of battling a chronic condition with short-term crisis response tools.

According to the British Psychological Society, compassion fatigue is a condition of emotional and physical exhaustion that often results from sustained demands placed on helping professionals that can lead to a diminished ability to empathize with others.[13] Manifestations of diminished empathy were frequently cited as serious signs of compassion fatigue that demanded attention from agency leadership.

The Centers for Disease Control and Prevention (CDC) defines secondary trauma as stress reactions resulting from exposures to traumatic events that other individuals experience, rather than personal direct exposures.[14] Although, first responders are vulnerable to secondary trauma, interview subjects suggested

that it was not a common reaction to overdose response duties. Nevertheless, some key informants described instances of secondary trauma among staff members, often associated with encountering children at the scene of an overdose emergency.

There was a broad consensus among the key informants that serious manifestations of traumatic stress and instances of diagnosed trauma-related disorders are usually the result of cumulative exposures over the course of a first responder's career. Parsing out the impact of overdose response work from other workplace exposures to traumatic stressors was often impossible.

Nonetheless, the interviews yielded valuable information about early indicators of increasing stress levels and identified patterns of behavior that should not go unaddressed. Typically, by the time staff members seek help of their own volition, they are already deeply in crisis. Overcoming the stigma attached to seeking help in a culture of extreme self-sufficiency was also one of the biggest challenges mentioned. When leadership prioritizes monitoring and responding to "yellow flags" that are early signs of compassion fatigue, it is easier to mitigate its negative impact.

Finally, there was not a broad consensus on suggested resources and tools that might support resilience and individual and organizational health. When compiling the information in table 2, the TA team included diverse suggestions, recommendations, and lessons from the field that all had merit.

Table 2. Lessons and Recommendations Based on Findings

Recommendation	Audience(s)
Information that spotlights how first agencies support resilience among opioid crisis first responders	• Agency leadership • Overdose response project coordinators
Introductory training modules for pre-service academies on trauma exposures, resilience, and self-care	• Agency leadership • Training divisions
Initial steps for starting an initiative for frontline staff on the impacts of trauma exposure	• High- to mid-level supervisors • Overdose response project coordinators
Identifying and monitoring yellow flags that are early indicators of compassion fatigue and burnout	• High- to mid-level supervisors • Team leaders
Materials on how addiction affects families, traumatic grief, and children impacted by parental drug use	• Frontline staff • Team leaders
First-person accounts of first responders who sought help because of job-related stress and lessons learned	• Frontline staff • Mid-level supervisors • Team leaders
Steps to creating an effective peer support program for first responders by first responders	• High- to mid-level supervisors • Overdose response project coordinators
Why, who, and how: leveraging the resources of community partners to support first responder resilience	• Overdose response project coordinators • Agency leadership
How leadership can reduce "hidden barriers" to staff access to formal and informal supports	• Agency leadership • High- to mid-level supervisors
Question-and-answer or fact sheets on how addiction impacts brain functions, relapse, and the recovery process	• Frontline staff • Mid-level supervisors • Team leaders
A guide to using data to monitor and reduce stress levels among first responders and evaluate supports	• Agency leadership • Research partners
Integrating suicide prevention materials into trainings to equip staff to respond to and reduce staff suicide risks	• High- to mid-level supervisors • Training divisions
Information on the influence of gender, culture, race, and early childhood on trauma and vulnerability to addiction.	• High- to mid-level supervisors • Training divisions

Although there are many reliable resources available on first responder mental wellness in general, as well as a growing number specific to opioid crisis response, it is probable that many agencies are unaware of what is at their disposal. Increased dissemination efforts may help ensure that these resources are more widely utilized.

Finally, inquiries were subject to several limitations. In recognition of the additional demands placed on first responder agencies, interviews were limited to about one hour. Key informant availability ultimately determined the makeup of the sample; hence, it is not likely to represent activities underway in all regions. The coding process was conducted by a single team member; however, results were reviewed and discussed by the entire team. Because a limited number of EMS and fire department staff members were interviewed, it was not possible to make valid comparisons of the impacts of frontline opioid response work across the three types of first responder agencies involved; however, this may be an avenue for future research.

Conclusions

This article seeks to understand the impact of opioid and other drug overdose emergency response-related stressors, including manifestations of compassion fatigue and secondary trauma, from the perspectives of first responder agency staff members. It represents an organized, focused attempt to collect and analyze current information from practitioners piloting innovative program models in the field. It is not intended as an empirical study; however, findings may serve as a useful point of reference for future research.

Reactions to exposure to traumatic stressors differ based on individual risk and protective factors; event characteristics; and conditions before, during and after exposures, as well as intersecting factors such as gender, culture, and exposure to historical trauma. But the intensity and duration of exposures over the course of a first responder's career elevates risk, as does the emergence of new threats.

The lessons and recommendations gleaned from these key informant interviews offer a wealth of valuable information about the current, ongoing, and emerging needs of professionals on the front lines of a crisis that continues to morph in ways unable to predict. The opioid and other drug crisis is far from over. Unfortunately, the CDC reported provisional data that reflected the highest number of overdose deaths ever recorded in a 12-month period.[15, 16] There is no doubt of an ongoing need for research and additional resources to support the efforts of first responders as they serve communities across the nation.

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Visit the Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) Resource Center at **www.cossup.org**.

About COSSUP

COSSUP has transitioned from the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP). This change in title for the program is indicative of efforts to reduce the stigma related to substance use and to support impacted people in their recovery journey.

About BJA

BJA provides leadership and services in grant administration and criminal justice policy development to support local, state, and tribal law enforcement in achieving safer communities. To learn more about BJA, visit www.bja.gov and follow us on Facebook (www.facebook.com/DOJBJA) and X (formerly known as Twitter) (@DOJBJA). BJA is part of the U.S. Department of Justice's Office of Justice Programs.

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