Opioid Use Disorders Among Police and Public Safety Personnel: What Law Enforcement Leaders Need to Know

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It is well-established that opioid use disorders represent a current health crisis. In October 2017, Acting U.S. Health and Human Services Secretary Hargan declared the opioid crisis a public health emergency.[1] Data supporting this declaration included more than 52,000 people in the United States dying from drug overdoses in 2015, including more than 32,000 overdose deaths due to prescription pain relievers and heroin use.[2] However, the only connections between opioids and police officers typically reported by the news media outlets concern accidental exposure to fentanyl or the deployment of naloxone (sold under the brand names Narcan and Evzio) in cases of opioid overdose. So, while police officers work on the front lines of the opioid crisis, little, if any, attention is paid to the potential for police officers to develop an opioid use disorder.

Police officers are susceptible to developing an opioid use disorder, perhaps more so than the average person, due to several risk factors specific to law enforcement personnel. First, police work is physically demanding, and officers can get injured on the job. In addition, an officer may develop chronic pain due to wearing a heavy gun belt or driving around in a patrol car for hours at a time. In either of these situations (injury or chronic pain), an officer may be prescribed a prescription opioid painkiller by a well-meaning physician.

Beyond issues related to physical injury lies job-related stress; police work is inherently unpredictable, with long periods of boredom interspersed and punctuated by periods of very stressful, dangerous, and potentially life-threatening activity. Moreover, police officers are almost guaranteed to be exposed to events that can be physically or psychologically traumatizing. Given their chronic and repeated exposure to stressful events and that there remains a culture within law enforcement where seeking help is often seen as a sign of weakness, some officers will turn to substances as a means of self-medication. Heretofore, alcohol has been the prevalent substance of choice among police officers, primarily due to alcohol being legal, easily available, and socially acceptable; however, in the authors' experience, the prevalence of opioid use among officers has increased in recent years.

How, then, does a police chief know if an officer has an opioid use disorder? First, police officers are trained to be inquisitive and are usually among the first to know when something is "off" with one of their brothers or sisters, so it is important to foster an agency culture of care and concern with regard to officer wellness. When someone is using opioids, the following symptoms may be present: sedation, respiratory depression, constipation, euphoria, small pupils, and cough suppression. In addition, officers struggling with opioid addiction might demonstrate one or more problems: (1) tardiness, (2) poor work attendance, (3) diminished productivity at work, (4) social isolation, and (5) unexplained financial problems. As physical injury is a common pathway for police officers to opioid use, it is important to know about any injuries (on or off duty) that might have led an officer to use opioid prescription medication.

Police executives are consummate risk managers. As such, they must ensure that their officers are properly trained and equipped to handle a countless number of possible situations. The police chief must also recognize and mitigate or eliminate the risk associated with an officer using opioids. Hence, in the interest of community and officer safety, it is important for the department to have a policy on medication use for police officers. With such a mechanism in place, a chief might come to learn that an officer is being prescribed an opioid for pain relief or buprenorphine and naloxone (a combination drug sold under the brand name Suboxone). Suboxone is a partial opioid agonist used for replacement therapy in cases of opioid addiction.

Moreover, Suboxone falls in the "restricted" category according to the American College of Occupational and Environmental Medicine's Guidance for the Medical Evaluation of Law Enforcement Officers; this means that the medication is "known to have an effect that will very likely adversely impact safety or performance of job functions," and the officer should not be at full duty while taking Suboxone.[3]

When a department has concerns about one of its officers, it is best to consult with a police psychologist or police physician. Consulting with doctors can help a police chief understand if a fitness-for-duty evaluation is warranted; a properly trained police psychologist or physician will be aware of the threshold for referring an officer for a fitness-for-duty evaluation (FFDE). Specifically, the *Psychological Fitness-for-Duty Guidelines* published by the International Association of Chiefs of Police states:

> *4.1: Referring an employee for an FFDE is indicated whenever there is an objective and reasonable basis for believing that the employee may be unable to safely and/or effectively perform his or her duties due to a psychological condition or impairment. An objective basis is one that is not merely speculative but derives from direct observation, credible third-party report, or other reliable evidence.*[4]

If the threshold has been met, and if the state has a prescription drug monitoring program (PDMP), then it would also be helpful for the police physician to access the PDMP to determine what medications have been prescribed to the officer in question. In cases of prescription drug abuse, it is common for people to seek prescriptions from multiple providers; however, sometimes people resort to obtaining prescription medications illegally. Most PDMPs will indicate whether the medication was paid for by an insurance carrier or independently by the patient. Given that collective bargaining has often resulted in good medical and prescription drug insurance plans for police officers, the avoidance of insurance plan submittals for prescription pain medications is a potential indicator of an opioid use disorder.

Once it has been established that an officer has an opioid use disorder, the focus should be on ensuring that the officer receives the necessary treatment. Treatment for opioid addiction can take several months, especially if it involves Suboxone replacement therapy; hence, departments are encouraged to be patient and supportive with their officers experiencing opioid use disorders. In addition, ideally, the department will have an established relationship with a facility that has expertise

in treating first responders. Following the completion of treatment, there are typically aftercare recommendations including abstinence from using opioid medications (officers may also be recommended to avoid using potentially addictive or intoxicating medications like benzodiazepines and muscle relaxants), as well as attending outpatient therapy and 12-step meetings. Agencies should also consider subjecting the officer to a period of random drug testing to ensure that the officer has not relapsed.

Progressive law enforcement executives should recognize that opioid use disorders have become the "new normal" in the United States. Moreover, although police officers are often recognized as stalwarts of society, police chiefs must realize that their officers are human beings who can succumb to the disorders plaguing other members of the very communities they serve. It is important for law enforcement leaders to understand that their officers often don't choose to develop a disorder; rather, opioid use disorders typically emerge following an injury or from an effort to deal with job stress. Almost all police officers who develop an opioid use disorder are redeemable; thus, police chiefs should seek to rehabilitate those dedicated, highly trained, and highly skilled officers in whom the agency has made a significant investment of time, money, energy, and training. Making the decision to rehabilitate a formerly sound officer will send an unspoken message to the rank and file that the administration cares about the officers in the department.

That being said, it is important to note that the aforementioned recommendation to rehabilitate an officer is based on the assumption that the officer developed an opioid use disorder based on typical issues (e.g., physical injury) and not as a result of recreational use of prescription medications or the purchase or use of illicit substances. Recreational use of licit drugs or any use of illicit drugs should be addressed through the disciplinary process, up to and including dismissal. In addition, the decision to rehabilitate an officer is predicated on the assumption that the officer has not engaged in criminal conduct that would warrant termination.

The culture of a police organization is evident in the ways the administration manages its employees, the officers perform their duties, and the department interacts with the community it serves. The authors believe that every police executive has the opportunity—and the responsibility—to develop, sustain, and improve an agency's culture. The stereotypical police culture of the past, where the

personal challenges of individual officers were concealed by the offending officer and shrouded by the "blue wall" of their fellow officers, must evolve to address the issues of the present. Police in today's society are challenged with striking a balance between the warrior mentality and the guardian or caretaker mentality. The innovative police chief can use that balance to foster a guardian or caretaker culture within the organization, where coworkers look for signs of distress in fellow officers and where troubled cops can seek assistance without the fear of undue discipline or "career suicide." A chief who advocates for peer support initiatives, employee assistance programs, and professional mental health treatment options will be utilizing their leadership to help remove the stigma of police officers seeking help.

In sum, opioid use disorders represent a current and serious threat to the health and well-being of police officers. Police leaders need to be aware of the signs and symptoms of opioid use and abuse, as well as understand the common origins of opioid use and abuse. Moreover, chiefs should have a plan in place for how to help officers who develop an opioid use disorder. Finally, police chiefs have the power to help reduce the stigma of help seeking among the officers in their department.

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Dr. Schlosser is a member of the International Association of Chiefs of Police, Police Psychological Services Section. He currently serves on the Executive Board of the Police Psychological Services Section as the education chair. Dr. Schlosser is also an affiliate member of the New Jersey State Association of Chiefs of Police and the Bergen County Police Chief's Association.

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Chief McAleer is the president of the Chiefs of County Detectives/Investigators Association of New Jersey and a member of the Middlesex County Association of Chiefs of Police, the New Jersey State Association of Chiefs of Police, and the International Association of Chiefs of Police.

Notes:

[1] U.S. Health and Human Services, "HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis," news release, October 26, 2017.

[2] American Society of Addiction Medicine, *Opioid Addition 2016 Facts & Figures*.

[3] American College of Occupational and Environmental Medicine, *Guidance for the Medical Evaluation of Law Enforcement Officers*.

[4] IACP Police Psychological Services Section, *Psychological Fitness-for-Duty Evaluation Guidelines* (2013).

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