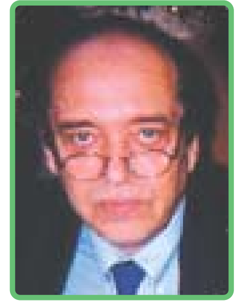
THE POLICE AND SLEEP

by Steven Grenard RRT, RPSGT



In the last issue of FOCUS this column focused on sleep disorders and sleepiness in judges and other parties to judicial proceedings. Now a new study targets law enforcement and the problems with sleep that police officers have. In many large and small towns and cities the policy in scheduling police officers is to constantly rotate their shifts, sometimes as frequently as once a month! This is a policy often decided upon by management and unions in order to make scheduling fair and equitable. But without realizing it, management and unions in deciding on this policy are exposing their officers to even higher levels of stress than many already suffered because of the demands of the job.

Decision-makers consistently fail to consult sleep medical professionals and psychologists or ignored their warnings that placing police officers behind the wheel and arming them while frequently rotating their shifts is a recipe for disaster. And if accidents and unintended or inappropriate shootings did not occur as frequently as expected it was because early retirements with "psychological" disabilities would thankfully often intervene.

Coupled with the frequent need for such officers to appear in day court, even on and in between days they could be working evenings and nights, puts such personnel at risk of a circadian rhythm disorder that defies description other than the catch-all term "shift worker's disorder."

Harvard researchers recently presented the results of a study of nearly 5000 police officers and found that fully 1/3rd had some sort of sleep disorder. They attribute this high incidence of sleep problems to a variety of sleep disorders. Cops had higher than expected percentages of diabetes and heart disease and some 35% of the officers who responded to the study indicated they have sleep apnea which would further exacerbate their difficulty in getting to sleep, staying asleep and awakening well rested and clear headed.

The study, conducted by Dr. Shantha M.W. Rajaratnam of Harvard Medical School, was based on the responses of police officers to a self-report survey that included screening for obstructive sleep apnea (OSA) alone or for OSA and insomnia, restless legs syndrome (RLS), shift work sleep disorder and narcolepsy with cataplexy. The percentage of those who screened positive for any sleep disorder was 38.4 percent, including 35.1 percent for OSA, 6.8 percent for insomnia, 0.7 percent for RLS, two percent for shift work sleep disorder and 0.5 percent for narcolepsy. These individuals were referred to a sleep clinic for a formal evaluation.

"Based on these data, sleep disorders appear to be highly prevalent in the present sample of police officers," said Rajaratnam. Dr. Rajartnam's data was presented at the June 2007 meeting of the APSS and garnered worldwide attention given the nature of the subject.

Although this is the first large scale study of police and sleep, the subject is constantly being debated in police departments and by government agencies with oversight into police issues. And while from a medical point of view there is little to debate regarding frequent shift rotation as a contributor to slow downs in reaction time, poor or clouded judgment, high levels of stress, on the job and off, depression, insomnia and numerous other medical problems and extremely dangerous sleepiness at times when one should be alert and awake. The non-medical players who decide and negotiate police schedules have consistently over, many decades, ignored the medical evidence and input on the dangers of their decisions. When I first met my first police officer patient in our sleep lab some ten years ago I was astounded to hear his description of his work schedule. I could hardly believe it and wanted to sit right down and write an irate letter to the commissioner …. but was told it wouldn't do any good. Not only were there too many issues involved in these schedules, departmental politics and even the unions got in on the act … unions that demanded fair and equitable scheduling with no regard to what would be medically sound scheduling. I considered the scheduling policies of my city's department not only failing. To take into account the welfare of the men and women working in the police but the harm that could and often did come to the people whom these officers were sworn to serve and protect. It was not only not fair to the officers but also to the populace at large.

In 2005 the U.S. Department of Justice solicited research proposals on the effects of shift scheduling in police departments. The name of the RFP was "The Effects of Shift Work Schedules on Police Officer Health, Safety, Performance and Quality of Life." While this was an admirable and probably much needed step in the right direction, the answers to the question of the "Effects of Shift Work Schedules" are already well known and they aren't good. The literature on circadian rhythm disorders includes numerous reviews and studies of shift worker problems. I don't know what the USDOJ hoped to find among the

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research it was soliciting but it is time to put aside all obstacles to creating rational shift work schedules; in other words, stop studying the problem ....and just do something about it.

The action required to deal with this problem occurs on two levels. On the personal level is requires personnel with symptoms of sleep disorders to admit them and seek diagnosis and treatment, especially for conditions such as sleep apnea and PLMS and RLS. On the organizational level is requires rationalization of schedules, not to be fair and equitable, but to be as stress free and healthy as possible given the circumstances. What this may entail is to first to poll all personnel and ask them if they could have a steady shift which would it be? ...and then to give it to them if it one of the least popular shifts. In other words if someone wants to work the unpopular night shift for personal reasons they should be allowed to do so. Some workers, such as sleep techs, have no choice but at least it is a steady shift without the problems caused by frequent rotations.

It is impossible to guess which shift would be least popular, but if one had to guess, it would probably be nights, followed by evenings with daytime being the most popular for a lot of reasons. Obviously a police department is not going to be able to give every officer exactly what he or she requests so after the least popular shifts are populated by volunteers, the balance of the assignments could be based on whatever criteria the department feels meets its needs such as the need for more experienced officers to complement and train newcomers who might draw the unpopular shifts due to lack of seniority. Senior officers have to understand that by drawing a steady but unpopular shift their work pattern would be healthier for them in the long run and they could participate in rotations every six months or annually instead of monthly .... which is the cause of many of the problems mentioned above. And finally police unions have to recognize that being fair and equitable is not in the best interests of their members who will suffer a variety of physical and mental problems by rotating shifts every month or more frequently.

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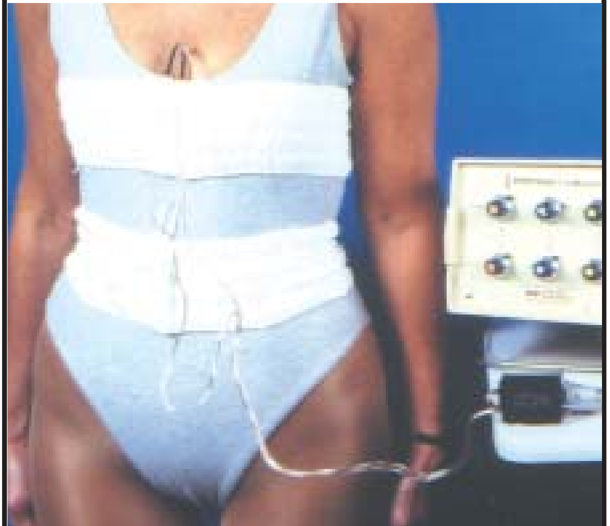
must complete a written ventilator "competency". This document consists of disease based approaches to mechanical ventilation of infants and children. It includes a 140 question written test, and an interactive computer based instruction in pulmonary graphics interpretation. For all three of our intensive care units, this may take as much as 12 to 14 weeks, during which the trainee pairs with a preceptor and they take an assignment suitable for one therapist.

This may sound like a lot of training and orientation. It is. And it is costly. But probably not nearly as costly as the risk to our patients and our organization if we turn new therapists loose without proper training and competency verification. I believe that such a system decreases the likelihood of clinical inconsistency and the resulting poor quality care. I also believe that it reduces the risk of adverse events (errors) caused by inadequate training. Can poor quality care and errors and mishaps still occur in spite of rigorous training? Of course they can because systemically induced procedural errors have multi-factorial causes. But I believe that systematic and rigorous training and orientation are part of the due diligence of all respiratory therapists. Finally, there are some excellent computer based neonatal respiratory therapy training aids. I encourage you to examine the programs developed by Joseph D. Limauro, M.Ed., R.R.T. His software can be found at www.jlenterprise.com.

John Salyer, RRT-NPS is the Director of Respiratory Care at Seattle Children's Hospital. He appears regularly in Focus Journal writing on Neonatal Respiratory Care issues. He can be reached at John.Salyer@seattlechildrens.org



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