INTRODUCTION
According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the essential feature of a substance use disorder is a “cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.... An important characteristic of substance use disorders is an underlying change in brain circuitry that may persist beyond detoxification, particularly in individuals with severe disorders.”¹ (p.483)

DSM-5, released in May 2013, contains significantly revised diagnostic criteria for substance use disorders. The 2000 Diagnostic and Statistical Manual of Mental Disorders. 4th ed – Text Revision (DSM-IV-TR)² diagnoses of abuse and dependence were replaced by substance use disorder – mild, moderate, or severe, combining the DSM-IV-TR prior two diagnoses (abuse and dependence) into a single disorder (substance use disorder). Each specific substance is addressed as a separate use disorder (e.g., alcohol use disorder, opioid use disorder, etc.), diagnosed based largely on the same overarching criteria. The diagnosis can apply to all 10 categories of substances in the DSM (with the exception of caffeine).

This guideline addresses substance abuse and dependence (jointly referred to as substance use disorders) as defined in the DSM-IV-TR (see Appendix A).² Issues outside these criteria such as past experimentation with illegal substances or current use of illegal substances without meeting DSM-IV-TR criteria for substance abuse or dependence are administrative issues. This document does not address administrative issues.

Active, ongoing substance consumption is incompatible with working in a safety sensitive position. However, the dedicated and highly motivated LEO with a substance use disorder in full remission (see Appendix A) can be capable to safe and effective performance of essential LEO job functions. An active or only partially remitted substance use disorder may place LEOs at risk for significant impairment or sudden incapacitation, thus jeopardizing their ability to perform essential job functions (link Chapter 3).

An individualized clinical evaluation of the LEOs substance use disorder should be performed to determine whether the individual’s condition impedes safe and effective job performance. Such evaluation must include the following key elements, which are discussed in detail below:

- a review of the history of substance use and any periods of abstinence;
- relevant laboratory tests (e.g., MCV, GGT, AST, ALT, and blood borne pathogens);
- risk for substance use relapse;
- complications or comorbidities of substance use disorders; and
- compliance with treatment and relapse prevention programs

OVERVIEW OF MEDICAL EVALUATION
The medical evaluation consists of the following elements:

- Suspicion of substance abuse or dependence
- Impairment due to substance abuse or dependence
- Assessment
- Recommendations regarding duty status and work restrictions

Suspicion of Substance Abuse: The employer may contact the police physician regarding work behavior suspicious for substance use or abuse. Possible signs of substance (including alcohol) abuse include recurrent “Monday” lateness, unscheduled absences, unkempt appearance, involvement in accidents, inappropriately aggressive behavior, worsening performance, unreliability in someone previously
reliable, and the inability to concentrate. By the time substance-related problems are identified in the workplace the individual has a high probability of meeting the criteria for substance dependence. If, after initial consideration, the suspicion for substance abuse is substantiated, the police physician should recommend modified duty until a clinical evaluation determines whether the LEO has met DSM-IV-TR criteria for substance abuse or substance dependence (see Appendix A).

**Acute Impairment Due to Substances:** LEOs whose substance use has been detected at work (e.g., odor of alcoholic beverages, signs suggestive of intoxication, or of withdrawal) will require appropriate work restrictions until a clinical evaluation has been performed to determine whether the LEO has met DSM-IV-TR criteria for substance abuse or substance dependence (see Appendix A).

**Assessment:**

i. LEOs identified as possibly having substance abuse or substance dependence must undergo a substance use disorder evaluation starting with a comprehensive medical history and physical exam. Obtaining collateral information is recommended. This evaluation should include an assessment for evidence of:

1. Polysubstance abuse;
2. Recent impairment due to a substance;
3. Withdrawal;
4. Substance-related medical comorbidity – e.g., liver disease, cardiac conditions, seizures (see Appendix C-4);
5. Substance-related psychiatric comorbidity both as precipitants and consequences – e.g., depression, anxiety, PTSD, suicidal behavior (see Appendix C-4);
6. Current coping skills;
7. Risk of ongoing use before treatment and risk of relapse following treatment (see Appendix C-6);
8. Medications (pre-existing and treatment).

ii. Some departments may utilize substance abuse professionals (SAPs) in return to work evaluations. SAPs are certified health care providers (e.g., MD, DO, psychologist, or social worker) who evaluate persons with substance abuse issues and may also recommend treatment.a

**Recommendations Regarding Duty Status and Work Restrictions:**

i. The treating addiction specialist physicianb or other clinician knowledgeable regarding substance use disorder management should provide a narrative report certifying whether the LEO has or has not met the return-to-work criteria set out below. In this report, the clinician should acknowledge reading the department’s LEO job description, and the LEO chapter on Essential Job Functions.

ii. Different return-to-work criteria exist for the different DSM-IV-TR diagnoses of substance abuse and dependence. Denial may cloud the distinction between the diagnosis of abuse and dependence. This is important because the return-to-work criteria for dependence are more stringent. Denial is common in assessment of substance use disorders. The evaluator should be skilled in detection and handling of such.

**Return-to-Work Criteria for Substance Abuse:** LEOs meeting the DSM-IV-TR diagnostic criteria for substance abuse (see Appendix A) will require appropriate restrictions until all the following return to work criteria have been met:

1. The LEO is under the ongoing care of an addiction specialist physician or other clinician knowledgeable regarding substance use disorders.

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*aSee [https://www.transportation.gov/odapc.sap](https://www.transportation.gov/odapc.sap) for full definition/job responsibilities of a SAP. Accessed May 18, 2018.*

*bAn addiction specialist physician is a physician certified as an addiction specialist physician by the American Board of Addiction Medicine. See [www.abam.net](http://www.abam.net); accessed May 18, 2018.*
2. The LEO meets DSM-5 diagnostic criteria for early remission with regards to substance use disorder.\(^c\)

3. There is documentation provided of abstinence from all abused substances (with exception of tobacco) for 1 to 3 months.\(^d\)

4. The treating clinician provides a written report with a recommendation for unrestricted duty (see Appendices E & G). The treating clinician should have been provided with and read the LEO’s job description and the LEO chapter on Essential Job Functions.

5. The LEO demonstrates compliance with a Relapse Prevention Agreement (see Appendices D & H).

6. If applicable, the LEO participates in agency-mandated alcohol and/or drug testing. The SAP and/or police physician or MRO may be consulted in developing such testing.\(^e\)

7. Multiple classes of medication may be used in the treatment of substance use disorders (e.g., antidepressants, atypical antipsychotics, anticonvulsants, methadone, buprenorphine, acamprosate, disulfiram, naltrexone, varenicline, and others). See the LEO Medications chapter for information regarding duty status while taking these medications.

Return-to-Work Criteria for Substance Dependence: LEOs meeting DSM-IV-TR criteria for substance dependence (see Appendix A) will require appropriate restrictions until all the following return-to-work criteria have been met:

1. The LEO is under the ongoing care of an addiction specialist physician or other clinician knowledgeable regarding substance use disorders.

2. The LEO meets DSM-5 diagnostic criteria for early remission with regards to substance use disorder.\(^f\)

3. There is documentation provided of abstinence from all abused substances (with the exception of tobacco) for 3 months.\(^g\)

4. The treating clinician provides a written report with a recommendation for unrestricted duty (see Appendices E and G). The treating clinician should have been provided with and read the LEO’s job description and the LEO chapter on Essential Job Functions.

5. The LEO demonstrates compliance with a Relapse Prevention Agreement (see Appendices D and H).

\(--------------------------\)

\(c.\) DSM-5 diagnostic criteria for early remission: None of the criteria for substance use disorder have been met for at least 3 months but for less than 12 months, with the exception of craving.

\(d.\) The 1-3 month abstinence period is a group consensus. The LEO Task Force is not aware of specific academic references on LEOs or other safety-sensitive workers recommending documented abstinence for 3 months before affecting a return to safety sensitive work.

\(e.\) Alcohol and/or drug testing mandated in recovery is intended to assist the LEO in maintaining abstinence. At a minimum, it should test the specific substance(s) of abuse, and commonly abused substances of the same class. If an agency has a written post-offer or random workplace alcohol and/or drug testing program, these routine tests are not a substitute for mandated testing in that they may not test for the abused substances.

\(f.\) DSM-5 diagnostic criteria for early remission: None of the criteria for substance use disorder have been met for at least 3 months but for less than 12 months, with the exception of craving.

\(g.\) The 3-month abstinence period is a group consensus. The LEO Task Force is not aware of specific academic references on LEOs or other safety-sensitive workers recommending documented abstinence for three months before affecting a return to safety sensitive work. The 3-month concept is supported by the following sources:

- DSM-5 defines early remission in the context of DSM-5 Alcohol Use Disorder (moderate to severe DSM-IV-TR Alcohol Dependence), for instance, as at least 3 months with none of the clinical criteria of alcohol use disorder being present. Early remission parallels the addiction medicine concept of the patient being “stabilized” where new relapse prevention behaviors are regularly incorporated into lifestyle. This is the goal before a return to safety-sensitive work.
- Approximately a quarter of all people who are going to relapse, relapse within the first 4 weeks, and an additional 15% relapse by the 12-week mark. Ergo, of those individuals who are going to relapse in the year post treatment, 40% have relapsed in the first 3 months suggesting that this is the period of peak vulnerability.\(^5,6,7,8\)
- This 3-month requirement is also in parallel with the Railway Association of Canada’s medical guidelines for returning those with a DSM-IV-TR diagnosis of substance dependence to a safety critical role. In Canada, this guideline is used in the context of federally required reporting of unfitness to work in safety critical railway workers.
6. The LEO has completed an appropriate addiction treatment program. However, consideration should be given to avoiding substance abuse treatment programs with high criminal offender participant rates. It may be advisable to consider an out-of-jurisdiction treatment program.

7. If applicable, the LEO participates in agency mandated substance testing. The SAP and/or police physician or MRO may be consulted in developing such testing.

8. Multiple classes of medication may be used in the treatment of substance use disorders – e.g., antidepressants, atypical antipsychotics, anticonvulsants, methadone, buprenorphine, acamprosate, disulfiram, naltrexone, varenicline. (See LEO chapter on Medications for information regarding duty status while taking these medications.)

On-Going Monitoring Following Return to Full Duty
Monitoring is usually required in return to work planning in safety sensitive positions. Successful programs include random alcohol and drug testing via an ongoing monitoring program. For physicians, these commonly taper in frequency over a period of 5 years. Monitoring components can include regularly scheduled face-to-face visits with a clinician providing support, screening for impending relapse, reviewing compliance with treatment, and testing breath and body fluids to verify abstinence. For most safety-sensitive positions, monitoring typically includes 24 unannounced tests or monitoring sessions over 2 years, based on the substance use disorder and a consulting physician’s input. Monitoring dates should be unpredictable. A certified medical review officer (MRO) should interpret drug testing results (see Appendix C-6 and C-7).

At a minimum, an addiction specialist physician or substance use disorder treatment provider should assess the LEO very soon after discharge from residential treatment. The purpose of that appointment is to review the discharge summary for prognostic indicators and to approve, or revise, the relapse prevention plan/agreement.

Although ideal, continued regular care under an addiction specialist physician or substance use disorder treatment provider may not be possible locally. Safety-critical employees such as LEOs treated for substance use disorder will ideally require treatment by an addiction specialist physician or substance use disorder treatment provider for a minimum of 24 months. The addiction specialist physician or substance use disorder treatment provider should provide an opinion on the frequency of visits. Alternatively, continued care for a substance use disorder may be provided by suitable primary care provider on a monthly basis for at least 6 months. Addiction specialist physician follow-up is then individualized as needed. The addiction specialist physician may recommend a definitive period of follow up based on prognostic factors or treatment adjustments.

Alternatively, the LEO and/or the treating clinician may request an addictionology reassessment based on significant changes in clinical status such as increased substance cravings, increased stressors taxing current coping skills, decreased social support or significantly disrupted sleep. A relapse to recurrent substance use likely requires reassessment by an addiction specialist physician; however, a single self-identified lapse and self-correction by the LEO may not necessarily require reassessment by an addiction specialist physician.

h. Since there is significant safety risk associated with relapse in LEOs and because inpatient treatment may have better outcomes with decreased risk for relapse, inpatient treatment should be strongly considered in treating LEOs with substance dependence. The period in residence may count toward the documented abstinence period.

i. Alcohol and/or drug testing mandated in recovery is intended to assist the LEO in maintaining abstinence. At a minimum, it should test the specific substance(s) of abuse, and commonly abused substances of the same class. If an agency has a written post-offer or random workplace alcohol and/or drug testing program, these routine tests are not a substitute for mandated testing in that they may not test for the abused substances.
APPENDIX A: DSM-IV-TR AND DSM-5 DIAGNOSTIC CRITERIA

DSM-IV-TR CRITERIA FOR SUBSTANCE ABUSE:
A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
   - Recurrent substance use resulting in a failure to fulfill major role obligation at work, school, or home;
   - Recurrent substance use in situations in which it is physically hazardous;
   - Recurrent substance-related legal problems;
   - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
B. The symptoms have never met the criteria for substance dependence for this class of substance.

DSM-IV-TR CRITERIA FOR SUBSTANCE DEPENDENCE:
A maladaptive pattern of substance use, leading to significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1) Tolerance, as defined by either the following:
   a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
   b) Markedly diminished effect with continued use of the same amount of the substance.
2) Withdrawal, as manifested by either of the following:
   a) The characteristic withdrawal syndrome for the substance.
   b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
3) The substance is often taken in larger amounts or over a longer period than was intended.
4) There is persistent desire or unsuccessful efforts to cut down or control substance use.
5) A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects.
6) Important social, occupational or recreational activities are given up or reduced because of substance use.
7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

DSM-IV-TR Substance Dependence or Abuse Specifiers:
The following Remission specifiers can be applied only after no criteria for Dependence or Abuse have been met for at least 1 month:

- **Early Full Remission:** This specifier is used if, for at least 1 month, but for less than 12 months, no criteria for dependence or abuse have been met.
- **Early Partial Remission:** This specifier is used if, for at least 1 month, but for less than 12 months, one or more criteria for dependence or abuse have been met (but the full criteria for dependence has not been met)
<table>
<thead>
<tr>
<th>DSM-5 DIAGNOSTIC CRITERIA: SUBSTANCE [e.g., ALCOHOL] USE DISORDER*</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least 2 of the following, occurring within a 12-month period:</td>
</tr>
<tr>
<td>1. Alcohol is often taken in larger amounts or over a longer period than was intended.</td>
</tr>
<tr>
<td>2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.</td>
</tr>
<tr>
<td>3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.</td>
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<tr>
<td>4. Craving, or a strong desire or urge to use alcohol.</td>
</tr>
<tr>
<td>5. Recurrent alcohol use resulting in failure to fulfill major role obligations at work, school, or home.</td>
</tr>
<tr>
<td>6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.</td>
</tr>
<tr>
<td>7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.</td>
</tr>
<tr>
<td>8. Recurrent alcohol use in situations in which it is physically hazardous.</td>
</tr>
<tr>
<td>9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.</td>
</tr>
<tr>
<td>10. Tolerance, as defined by either of the following:</td>
</tr>
<tr>
<td>a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.</td>
</tr>
<tr>
<td>b. A markedly diminished effect with continued use of the same amount of alcohol.</td>
</tr>
<tr>
<td>11. Withdrawal, as manifested by either of the following:</td>
</tr>
<tr>
<td>a. The characteristic withdrawal syndrome for alcohol.</td>
</tr>
<tr>
<td>b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.</td>
</tr>
</tbody>
</table>

Specify if:

**In early remission:** After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met for at least 3 months but for less than 12 months (with the exception of criterion A4, “Craving, or a strong desire or urge to use alcohol,” may be met.

**In sustained remission:** After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met at any time during a period of 12 months or longer (with the exception of criterion A4, “Craving, or a strong desire or urge to use alcohol,” may be met.

Specify if:

In a controlled environment.

**Code based on current severity:**

- Mild (2-3)
- Moderate (4-5)
- Severe (6+)

**Note:** Specifier for opioid use disorder adds the following:

- On maintenance therapy:
- In a controlled environment

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*Adapted from Diagnostic and Statistical Manual of Mental Disorders - 5. Copyright 2013 American Psychiatric Association. DSM-5 does not have a generic category of “Substance Use Disorder,” but specifies the criteria for each of the 9 classes of substances (i.e., all but caffeine).

**NOTE:** When an individual meets the DSM-5 criteria identifiers for early remission the risk of imminent relapse has likely declined. When an individual has reached sustained remission, the individual is considered likely stable and the long-term prognosis significantly improves.
The American Society of Addiction Medicine defines addiction as follows:

“Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.”

In addiction, there is a significant impairment in executive functioning, which manifests in problems with perception, learning, impulse control, compulsivity, and judgment. In terms of work relatedness, it can be of assistance to consider that addiction impairment can be explained as occurring in three major domains; craving, compulsion and the consequences ignored (the three Cs):

- **Craving.** The perpetual rumination and obsession related to craving a substance will result in distraction from job demands.
- **Compulsions.** Compulsions are the behaviors of either using or seeking out the desired substance, usually surreptitiously, while in the workplace. This results in disruption of performing job demands.
- **Consequences ignored.** The potential workplace consequences of substance dependence such as tardiness, absenteeism or performance concerns are often rationalized, minimized or denied by the individual with substance abuse or dependence when they occur.

The three clinical features of impairment as noted above will commonly eventually lead to a loss of control in terms of substance use, usually resulting in significant disability in meeting work role requirements.
APPENDIX B: DSM-IV-TR VERSUS DSM-5 ISSUES & CONTROVERSIES WITH REGARDS TO SUBSTANCE USE DISORDER DIAGNOSIS

When addressing workplace substance use disorder issues the DSM-IV-TR distinction between abuse and dependence is preferred for work-related administrative purposes including jurisprudence issues relating to treatment disposition. The DSM-IV-TR definitions are clinically useful for disposition regarding amount of time required for abstinence and stability before return to work with weapons and other law enforcement officer (LEO) safety critical job demands. Specifically, The DSM-IV-TR notes that compared to Substance Dependence, “the criteria for substance abuse do not include tolerance, withdrawal, or a pattern of compulsive use and instead only the harmful consequences of repeated use” This distinction may be helpful in assisting the police physician to decide whether or not the individual is more likely to have a degree of control over his substance use as notably the ASAM definition of addiction includes compulsivity. If the assessing addiction specialist physician or other clinician knowledgeable in substance use disorders chooses to provide a DSM-5 diagnosis however, they must also provide DSM-IV-TR diagnosis as return to work disposition decisions of employees will still be based on DSM-IV-TR abuse and dependence criteria.

- Reasons for this include the fact that jurisprudence issues e.g. in the Americans with Disabilities Act (ADA), can be still based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), Fourth Edition, text revised (DSM-IV-TR) criteria. In addition, many clinicians and institutions have not yet adopted the DSM-5.*

Administratively, the medical guides from the U.S. Federal Aviation Administration (last updated in July 2016), the U.S. Coast Guard (April 2016), the Canadian Nuclear Workers, the Veterans Affairs Canada (modified November 2015), the Canadian Council of Motor Transport Administrators Medical Standards for Drivers (2013), and the Railway Association of Canada’s Canadian Railway Medical Rules Handbook (February 2016), still use the terms abuse and dependence. Others, such as U.S. Department of Veteran Affairs, have adopted the DSM-5 criteria.

- Despite the perceived strengths of the DSM-IV-TR diagnostic approach to substance use disorders there is an attempt with the DSM-5 to improve diagnostic shortcomings. For instance, although it is commonly assumed that abuse is a milder disorder than dependence, abuse criteria include severe consequences such as failure to fulfill major responsibilities. There was also an issue labelled “diagnostic orphans.” Here, in the case of an individual meeting only two dependence criteria (3 were needed for a diagnosis) and no abuse criteria, they were technically ineligible for a diagnosis despite two identified clinical concerns.12

In additions, criticism of the DSM-5 “spectrum of disease” approach includes concerns about the validity of diagnostic thresholds (i.e., mild, moderate, severe) and the arbitrariness of diagnostic cut-offs among SUD diagnoses.13

- A diagnosis of a substance use disorder in the DSM-5 has 11 criteria and can vary from mild to severe depending on the number of criteria meet. Notably, 10 of these 11 criteria are consistent with prior DSM-IV-TR abuse and substance dependence diagnostic criteria.
  - The one new DSM-5 criteria is “craving or strong desire or urge to use...[substance].”1
  - The one DSM-IV-TR substance abuse criterion which is not included is “recurrent alcohol-related legal problems – i.e., arrests for alcohol-related disorderly conduct.”2

* A 2014 poll of 6,000 clinicians by Medscape, 1 year after release of DSM-5, shows only 59% of psychiatrists, 60% of psychologists, and 44% of primary care physicians had incorporated DSM-5 into their practice (see www.medscape.com/viewarticle/830099).
Therefore, 10 of the 11 DSM-5 criteria are identical to prior DSM-IV-TR criteria. The majority of Substance Use Disorders cases diagnosed with DSM-5 criteria can use the DSM-5 criteria to create a match for DSM-IV-TR criteria of substance abuse or substance dependence.\(^\text{12}\)

On the uncommon occasion that an employee meets DSM-5 criteria for mild substance use disorder (presence of at least 2 diagnostic criteria) and this does not align with the past DSM-IV-TR criteria for abuse, then both therapeutic and return to work disposition will be evaluated on an individual basis. A comprehensive personalized assessment should take into account any current psychological impairment, risk of relapse and any psychiatric comorbidities.

Following a comprehensive substance use disorder evaluation, either the assessing clinician or the police physician may have a strong clinical suspicion of substance dependence (see Appendix C-3 regarding denial) but only the DSM-IV-TR criteria for substance abuse may have been formally met. Then, they may adjust the treatment to the dependence level and request additional evaluation in the future. With individuals working in law enforcement, as in other safety sensitive positions, if there is doubt with respect to the diagnosis, it may be considered appropriate to err on the side of safety at least during a defined period of further ongoing evaluation. Notably, individuals with substance dependence may not be fully aware of the magnitude of their problem because of denial or alternatively may simply under-report symptoms and substance use-related adverse consequences.
APPENDIX C: COMMENTARY

C-1: Introduction
Individuals who have used illegal drugs in the past, but are not current users, may be covered by the Americans with Disabilities Act (ADA)\(^1\); however, current illicit drug users and those who misuse alcohol in violation of company policy may not be protected by ADA. Current medical guidelines exist for physician evaluation of fitness for duty following a diagnosis of substance use disorders, including commercial driving,\(^{15,16}\) railway work,\(^17\) and commercial aviation.\(^18\) It is common occupational medical practice in evaluation of fitness for duty in safety-sensitive work that the individual be referred for a comprehensive evaluation if diagnostic criteria are met or suspected for substance abuse or dependence.\(^19\)

In law enforcement work, perceived work stress is significantly associated with increased risk of alcohol abuse with an odds ratio of 3.\(^20\) LEOs may consume alcohol in far greater quantities, have high rates of binge drinking (especially those ages 18 to 25) compared to non-LEOs, and 25% of officers reported having consumed alcohol while on duty.\(^21\)

In a sample of police officers, 18% of male officers and 16% of female officers described adverse consequences from alcohol use, with approximately 11% of males and 16% of females had engaged in at-risk levels of alcohol use during the previous week, over one-third of male and female officers reported binge drinking during the previous month and 7.8% of officers likely had met criteria for alcohol abuse or dependence at some time in their lives.\(^22\)

Alcohol and drug use patterns include:
- Use without problems;
- Use with resultant problems or health risk;
- Use with recurrent or serious consequences meeting DSM-IV-TR criteria for abuse;
- Use meeting DSM-IV-TR criteria for dependence.\(^23\)

C-2: Substances
A substance is defined as any drug with psychoactive qualities. Ten categories, as reflected in the DSM-5 include: Alcohol; Caffeine; Cannabis (marijuana); Hallucinogens (with separate categories for phencyclidine [or similarly acting arylcyclohexylamines] and other hallucinogens); Inhalants; Opioids; Sedatives, Hypnotics, and Anxiolytics; Stimulants; Tobacco (Nicotine); and Other (or unknown) substances. Nicotine and caffeine are listed as substances in the DSM-5. Nicotine use can meet DSM-IV-TR criteria for substance dependence, but this condition is not addressed in this fitness-to-work guide as nicotine, despite the long-term adverse consequences of smoking, is not known to generally impair the ability of the LEO to perform essential job tasks. In addition, any symptoms of craving and withdrawal can be reasonably managed with nicotine replacement therapies.

The following describes some commonly used substances and their effects on the user.
- **Alcohol:**
  A standard drink, as defined by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons) and this is approximately equivalent to 12 oz. of beer, 5 oz. of wine, and 1.5 oz. of spirits.\(^24\) The NIAAA maximum daily drinking limit for women is a maximum of 3 drinks on any day, and up to and including 7 drinks per week. For men, it is 4 drinks on any day, and up to and including 14 drinks per week.\(^25\) Above these limits, alcohol use is associated with multiple comorbid conditions including heart disease, hypertension, stroke, cancers, and liver cirrhosis, among other disorders. Alcohol use disorders are associated with concurrent psychiatric conditions including depressive episodes, severe anxiety, insomnia, suicide, and abuse of other substances.
In the U.S. Armed Forces, service members who are heavy drinkers (defined as 5 or more drinks on one occasion at least once per week) are at more risk for work-related lateness, leaving early, decreased performance, and injuries than non- or light drinkers. A blood alcohol level of 50 mg/100 mL or above indicates unfitness for duty in the Armed Forces.

Tracking, visual vigilance, divided attention, postural stability, and cancellation tasks as well as memory, judgment, and other cognitive tasks are affected by alcohol. Alertness, judgment, decision making, divided attention, and motor performance can be impaired even at low blood alcohol levels of 0.02% blood alcohol concentration (equivalent to 1 drink for a person weighing 150 pounds). Degradation in task performance can still be measured 4 to 8 hours after reaching peak blood alcohol levels and “hangover” effects can affect work performance.

- **Marijuana:**
  Cannabis (marijuana) use is associated with impaired cognition during acute intoxication as well as in the unintoxicated state in long-term users, especially in the domains of verbal learning, memory, and attention. A single “joint” of cannabis can generally cause measurable impairment in skills for more than 10 hours. In flight simulator trials, significant errors occur up to 24 hours post-marijuana inhalation with the cognitive impairments lasting well after the awareness of euphoria has disappeared. Moderate continued cannabis use is associated with selective short-term memory deficits that persist following a period of several weeks of abstinence, irrespective of the source (e.g., medicinal, medical, or otherwise) or context (licit or illicit) marijuana is impairing.

- **Stimulants (Cocaine and Amphetamines):**
  These cause a large outflow of stimulating neurotransmitters, e.g., dopamine and epinephrine, in the nervous system and the brain. Epinephrine (a.k.a., adrenaline) is the neurotransmitter associated with the sympathetic nervous system and the “fight or flight” response. Being under the influence of stimulants like cocaine or amphetamines mimics being in an ongoing fight-or-flight response. The body and the mind are substantially “amped” up. Agitation, irritability, impulsivity, and impaired judgment are common. Stimulants are some of the most highly addictive classes of substances known.
  - **Cocaine:**
    Recreational cocaine users can display numerous performance deficits involving executive functioning deficits. Protracted heavy cocaine use can result in depressive symptoms, persistent cognitive impairment in areas such as executive function, visual perception, psychomotor speed, dexterity, attention, and planning persisting for at least four weeks after abstaining. Disturbances in sleep associated with chronic cocaine use are thought to contribute to abstinence-related cognitive dysfunction.
  - **Amphetamines:**
    Complications include ischemic strokes and rhabdomyolysis, among others. As with cocaine, chronic amphetamine abuse is associated with cognitive impairment, which may persist for several months after beginning abstinence.

- **Benzodiazepines:**
  An acute withdrawal syndrome is recognized; however, the existence of a prolonged withdrawal syndrome is debated. Individuals with alcohol dependence are at risk for benzodiazepine abuse.

- **Opioids:**
  Some individuals with opioid dependence may have a degree of cognitive impairment persisting during early abstinence. Opioid analgesics can be improperly used, and widespread use has resulted in a national epidemic of opioid overdose deaths and addictions.

- **Anabolic Androgenic Steroids (AAS):**
  Approximately 80% of athletes reporting anabolic androgenic steroids use self-administered
intramuscular injections.\textsuperscript{33} Adverse effects include multiple endocrine, cardiovascular and neurological side effects and increased risk of physical training injuries, although most effects resolve within 3 months of discontinuation (although as AAS users age potentially long lasting organ damage may have occurred that may accelerate the deterioration that occurs during the normal aging process).\textsuperscript{25(p282)} Prolonged use may result in hypomania and even psychotic symptoms, and withdrawal may precipitate craving for more steroids and symptoms of fatigue, depression, restlessness, insomnia or anorexia, among others.\textsuperscript{25(p284-5)} Some individuals may meet the criteria for dependence,\textsuperscript{34} and therefore are at risk for relapse after discontinuation. LEOs have been reported to take these drugs.\textsuperscript{34} Many anabolic-androgenic steroid users also abuse other accessory drugs including amphetamines, ephedrine, thyroxine, and growth hormone. The potential adverse effects of some accessory drugs may be more serious than those of anabolic androgenic steroids.\textsuperscript{25(p284-5)}

C-3: User Denial of Substance Use Problem

Denial, a psychological defense mechanism, is not specific to substance use disorders. Patients with other chronic medical disorders will under-report unhealthy behaviors to caregivers.\textsuperscript{25(p295)} Research suggests that concealing substance use is common. Both stigma and sanctions may influence self-reporting as substance use or its consequences can be purposely minimized due to desire to avoid unwanted consequences (e.g., work suspension) or unwillingness to accept responsibility for ensuing behavior (e.g., impairment while at work).\textsuperscript{35} Clinical assessors should attempt to detect an individual’s use of substances despite denial and be familiar with interview techniques to facilitate this process.\textsuperscript{36}

Denial is considered a consistent clinical component of alcohol dependence and includes “the pharmacologic effects of alcohol on memory, the influence of euphoric recall on perception and insight, the role of suppression and repression as psychological defense mechanisms, and the impact of social and cultural enabling behavior.”\textsuperscript{37} Denial related to dependence can be due to cerebral dysfunction rather than a psychodynamic defense. Notably, denial in alcoholism is associated with alcohol-related cognitive impairment of executive function, verbal memory, visual inference, and mental speed.\textsuperscript{38}

C-4: Comorbidity

Substance Use Disorder Comorbidity and Chronic Impairment:

Comprehensive substance use disorder evaluation of LEOs must fully consider the possibility of related medical and/or psychiatric comorbidity. The comorbid conditions likely will warrant further evaluation and treatment. Complications of substance use disorders are associated with increased risk for impairment. The comorbid conditions may themselves be contraindications to return to full police duties.

The components of screening for substance use disorder comorbidity include comprehensive screening for other psychiatric disorders, whether DSM-IV-TR or DSM-5 (e.g., major depression, with suicide screening, bipolar mood disorder, anxiety disorders, including panic disorder). Various clinical screening items exist; for major depression, the PHQ-9, for generalized anxiety disorder the GAD-7, and for panic disorder, question “C” of the PHQ-SADS. (The three screening questionnaires are all available at www.phqscreeners.com) The screening questionnaire for post-traumatic stress disorder is the PCL-5 (available at no charge from www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp.)

- Screening for drug and/or alcohol-related conditions such as gastric ulcers, pancreatitis, chronic anemia, hepatitis B and C, cirrhosis, HIV, myopathy, hypertension, seizures, or Wernicke’s encephalopathy with a complete physical examination, including a thorough neurological screening.
- A detailed mental status examination (MSE), including basic neuro-psychological cognitive screening such as the Montreal Cognitive Assessment (MoCA) which is available at www.mocatest.org (this free site requires registration).
Clinical laboratory investigations such as CBC, liver enzymes, or imaging investigations such as CT head for alcohol related cerebral atrophy as appropriate for established comorbid conditions related to use of that substance.

Substance-dependent individuals with central nervous system damage due to chronic substance use such as Wernicke’s encephalopathy or alcohol-related cerebellar dysfunction will likely require permanent restrictions from return to LEO duties.

Select comorbid conditions may be addressed in the relevant sections of this document [e.g., cardiovascular conditions that may be related to excessive alcohol use such as hypertension, atrial fibrillation and cardiomyopathy (see LEO chapter on Cardiovascular Disease)].

Any impairing substance-related comorbidity should be treated and controlled before returning to work. Therefore, clinicians conducting comprehensive substance use disorder evaluations of LEOs must be highly vigilant for the possibility of comorbidity. For example, chronic heavy alcohol consumption can cause peripheral neuropathy, gastrointestinal disorders, abnormal blood cells production, mild anterograde amnesias, other cognitive deficits, and significant sleep problems. In approximately 25% of “lone” atrial fibrillation or flutter cases requiring hospitalization, alcohol or illicit drugs were the precipitating cause.

Alcohol has also been found to induce obstructive sleep apnea (OSA) in healthy, asymptomatic persons as well as persons who chronically snore. Substance use may also worsen existing severe OSA (see LEO Sleep Disorders chapter). In patients with established OSA, consumption of two or more drinks of alcohol per day is associated with a 5-fold increase in fatigue-related motor vehicle collisions.

Alcohol may cause clinically significant hypoglycemia. There are multiple pathophysiological paths of alcohol-induced hypoglycemia (see Incapacitating Events in the LEO Diabetes Mellitus chapter) and alcohol-induced reactive hypoglycemia.

Of those individuals with an alcohol use disorder, up to 37% have a concurrent psychiatric disorder. Post-traumatic stress disorder (PTSD) is a common comorbid condition in military personnel usually requiring more intensive addiction services. The National Comorbidity Survey found that individuals with PTSD were 2 to 4 times more likely to meet criteria for a substance use disorder.

C-5: Treatment

In safety-sensitive work, a diagnosis generally warrants outpatient treatment, although individuals considered at increased risk (multiple alcohol incidents and severe psychosocial problems) could be placed in a more intensive level in treatment. A diagnosis of alcohol dependence warrants intensive outpatient treatment, day treatment or residential treatment. It may also warrant detoxification services prior to admission to and appropriate program. Although research is mixed, some studies point to better outcomes with residential treatment, especially those with more serious employment problems such as performance or attendance concerns. It is notable that 78% of substance use impaired physicians receive residential treatment for 30-90 days. LEOs, like other safety-sensitive workers, do best when offered cohort-specific treatment, which facilitates adequate self-disclosure and the subsequent repair of the damage produced by past substance-related behaviors. LEOs, especially those in undercover drug operations, have easy access to gray and black market drugs. The treatment of such individuals should include management of drug access, drug refusal skills, work environment modification to decrease drug access, and other occupation-specific interventions geared to decrease relapse.

Containing alcohol and other drug use and sequestering the safety sensitive worker away from work may mandate a more intensive level of initial care than with the general public. Treatment of a safety sensitive worker may require Level 3 care (As defined by ASAM, ranging from clinically managed low-
intensity residential services to medically monitored intensive inpatient services). Specialized substance use treatment cohorts are available for police and fire fighters to go through treatment with others who have comparable workplace experiences.32(p1253-63)

C-6: Risk of Substance Use Relapse
All LEOs with a diagnosis of a substance use disorder should be thoroughly assessed for relapse risk before returning to duties. When a substance use disorder has been diagnosed, consideration should be given to clinical monitoring programs (which usually includes random alcohol and drug testing), mandated employee assistance or impaired professional programs.40(p100)

Approximately 40-60% of discharged substance dependent patients remain abstinent 1 year post-treatment. This is comparable to rates of symptom recurrence of other chronic diseases such as type 2 diabetes and asthma.46 However, up to 70% of professional employees successfully return to work with definitive treatment and subsequent monitoring.47 A period of documented abstinence (which includes sobriety from alcohol) is required following treatment and before a return to safety sensitive work as there is a higher risk of relapse in the period immediately following treatment.47

Even one episode of relapse is a poor prognostic indicator. An initial relapse after a diagnosis of substance dependency has a hazard ratio of 1.7 for a subsequent relapse.47 A family history of a substance use disorder, abuse of a major opioid (such as meperidine hydrochloride, morphine, fentanyl, methadone hydrochloride, heroin, or controlled-release oxycodone hydrochloride) and a concurrent psychiatric disorder are all individually significant relapse risk factors. The presence of all three risk factors has a cumulative hazard ratio of 13.25 for relapse.47 Treatment non-completion is a significant risk factor for relapse. One study shows an odds ratio of 6.5 for relapse as compared to those with successful treatment completion.48 At 3 months’ post-treatment, mild to moderate depressed individuals were on average, 2.9 times more likely to eventually relapse to alcohol. Those severely depressed were 4.9 times more likely to relapse.49 Anxiety disorders, especially social anxiety disorder and panic disorder, are also risks for relapse to alcohol.50

Evaluation and treatment for insomnia is an often-overlooked aspect of both substance use disorder treatment and relapse risk evaluation.40(p92) At the 5-month mark of alcohol abstinence, prolonged sleep latency and poor sleep efficiency are predictors of relapse by 1 year. Abstaining individuals who begin to drink alcohol again will experience an increase in total sleep time and reduction in sleep fragmentation. This initial perceived positive effect of nighttime alcohol use likely contributes to relapse even though continued alcohol use will further disrupt sleep.25(p1221-2) Cognitive behavioral approaches such as sleep hygiene instructions and stimulus control should be included in a substance use disorder treatment plan regardless of the use of pharmacotherapy to assist sleep51 (see LEO chapter on Medications for recommendations regarding sedative, hypnotic, anxiolytic medications). Evaluation and treatment regarding coping skills is an essential part of relapse evaluation and prevention as coping style is a significant predictor of relapse.25(p997)

C-7: Clinical Monitoring
Clinical monitoring is described in the American Society of Addiction Medicine’s (ASAM) most recent definitive text as “not only justifiable, but good medicine.”25(p616) As with the treatment of other medical disorders such as asthma or diabetes, clinical monitoring improves clinical outcomes. Due to limitations of self-reporting with substance use disorders, addiction specialist physicians frequently perform clinical drug testing. When used in concert with a history, physical examination and laboratory result, clinical drug testing improves the medical care of an individual.
Substance use relapses are often detected by workplace monitoring. Monitoring is usually required in return to work planning in safety-sensitive positions. Successful programs include random alcohol and drug testing via an ongoing monitoring program. For physicians, these commonly taper in frequency over a period of 5 years. Monitoring components can include regularly scheduled face-to-face visits with a clinician providing support, screening for impending relapse, reviewing compliance with treatment, and testing breath and body fluids in order to verify abstinence. For most safety-sensitive positions, monitoring typically includes 24 unannounced tests/monitoring sessions over 2 years, based on the substance use disorder and a consulting physician’s input. Monitoring dates should be unpredictable. A certified medical review officer (MRO) should interpret drug testing results.

C-8: Chronic Impairment Despite Substance Abstinence

Recovery and continued abstinence usually results in improvement of substance-related impairment. However, with protracted and heavy use of substances, longstanding or even permanent impairment may result (e.g., cognitive impairment). Cortical atrophy can occur in those individuals with alcohol dependence.

Long-term adverse medical effects of cocaine include cardiac ischemia, myocardial infarction, stroke, and cognitive impairment. Cognitive impairment may persist despite several months of abstinence and sobriety. The most affected cognitive attributes are visual-motor performance, attention, inhibitory control, and verbal memory. Several studies have found abnormalities of behavioral regulation and risk-reward decision-making (for cognitive screening test example, see Appendix F). The Montreal Cognitive Assessment (MoCA) may be used in identifying potential cognitive impairment among substance use disorder patients. Using a cut point score of 25 the sensitivity for substance use disorder is 83% and specificity is 73%. Even in situations where the MoCA test is normal, there may exist subtler cognitive impairments, which may translate into capacity impairment or increased risk in LEO duties. Need for more extensive cognitive testing: Neuropsychological testing should be performed in almost every case. Such testing should be done by a qualified (e.g., board certified) Neuropsychologist who can determine how the results of a substance use disorder impact the safety of work.

Following treatment, and a period of abstinence, there may occur a situation where the LEO may present well in an interview with a normal mental status examination and a normal MoCA test result, however there may exist subtler unrecognized cognitive impairments (see section on Suspicion of Substance Abuse). Amongst other types of potential psychological impairments, the individual may not have the sufficient cognitive capacity for adaptation, a psychological attribute comparable to resilience which is critical for performing LEO duties. An impairment in adaptation is defined as “deterioration or decompensation in a complex worklike setting.” They may perform poorly, withdraw from the situation or experience a relapse of the mental disorder, including a substance use disorder.

If the clinician has a high suspicion of cognitive impairment despite reasonable evidence of abstinence for at least a month, further assessment is warranted. This can take place in one of two pathways, assessment of performance while participating high cognitive demand job simulations or neuropsychological evaluation.

Performance testing for high cognitive-demand duties may be a reasonable initial substitution for neuropsychological testing. Ideally this is department-based and includes job-simulation. Example of venues that the LEO could be required to pass include:

- Scenario-based decision-making
- Firearms use testing
- Use of force demonstration
Should the identified LEO not be able to successful pass the high cognitive response scenarios then a neuropsychological evaluation could be considered to distinguish between medical and nonmedical causes such as poor effort. The questions to the neuropsychologist should be ideally framed in a way that assists in the overall (fitness-for-duty assessment). Asking specifically about areas of psychological impairment such as concentration or memory, limitations and restrictions and, in addition providing a comprehensive job description or a cognitive demand analysis may assist with the clarity of the ensuing report. Such testing should be done by an experienced neuropsychologist who can determine how the results of a substance use disorder impact the safety of work.
APPENDIX D: RELAPSE PREVENTION AGREEMENT COMPONENTS

A Relapse Prevention Agreement may include:

- Total abstinence from all abused substances, including alcohol;
- Total abstinence from tobacco may improve other substance-related outcomes;
- Attendance at counseling with a substance use disorder clinician;
- Reporting arrangements to the police physician;
- Regular attendance at support programs such as Alcoholics Anonymous, Narcotics Anonymous, Al-Anon or Rational Recovery;
- Compliance with treatment for medical or psychiatric comorbidity;
- Attendance at regularly scheduled monitoring visits, which may include scheduled face-to-face visits with a clinician to provide support, screening for impending relapse, and reviewing compliance with treatment;
- Participation in agency-mandated substance testing to verify abstinence; and
- Acknowledgement of consequences of non-adherence.

See Appendix G for a sample Relapse Prevention Agreement.

APPENDIX E: CLINICAL COMPONENTS OF WRITTEN REPORT BY THE TREATING PHYSICIAN

- Acknowledgement of prior review of the job description
- Review of medical documentation and/or collateral interviews (e.g., coworkers, supervisors, or family), performance evaluations, disciplinary actions, etc.
- Medical and psychiatric history
- Occupational/military history
- Physical examination
- Mental status examination
- Results of brief cognitive screening tests*
- Referral for more comprehensive cognitive screen, if required. In cases where the MoCA score is normal, i.e., 26 and above, but the clinical impression suggests clinical impairment is present; further neuropsychological testing may be indicated.
- Results of psychiatric screening questionnaires**
- Laboratory investigation
- Diagnostic formulation as per DSM-IV-TR, including any appropriate substance use abuse or dependence remission modifiers
- Coping skills evaluation, family and social supports
- Treatment recommendations including recommendations for continued relapse prevention
- Monitoring recommendations including type, duration and frequency (see Appendix C-7)
- Assessment of comorbidities and long-term adverse conditions (see Appendices C-4 and C-8)
- Prognosis and risk of relapse (see Appendix C-6)

See Appendix G for an evaluation form for the treating physician if this is used in lieu of a written report.

*The Montreal Cognitive Assessment (MoCA) may be used in identifying potential cognitive impairment among substance use disorder patients. (Using a cut point score of less than 26 the sensitivity for substance use disorder is 83% and specificity is 73%.)

**Such as the PHQ-9 (Patient Health Questionnaire) for Major Depressive Disorder and GAD-7 for generalized anxiety disorder, and PCL-5 for screening for post-traumatic stress disorder.
APPENDIX F: SELECTED OTHER AGENCY MEDICAL GUIDELINES

Canadian Railway Medical Rules Handbook:

Federal Motor Carrier Safety Administration (FMCSA)/Department of Transportation (DOT):


“Alcoholism §391.41(b)(13) A person is physically qualified to drive a commercial motor vehicle if that person: Has no current clinical diagnosis of alcoholism. The term 'current clinical diagnosis of' is specifically designed to encompass a current alcoholic illness or those instances where the individual's physical condition has not fully stabilized, regardless of the time element. If an individual shows signs of having an alcohol-use problem, he or she should be referred to a specialist. After counseling and/or treatment, he or she may be considered for certification.”

Federal Aviation Administration:


An applicant with a history of substances of dependence/abuse (drugs or alcohol) must submit the following if consideration for medical certification is desired:

- A current status report from a physician certified in addictive disorders and familiar with aviation standards
- A personal statement attesting to the substance and amount, and date last used
- If attended a rehabilitation clinic/center, provide dates and copies of treatment plan

Note: The applicant may be required to submit additional information before medical disposition can be rendered.
APPENDIX G: EVALUATION FORM FOR THE TREATING PHYSICIAN

Introduction:
The well-educated and well-motivated law enforcement officer (LEO) with a substance use disorder in remission can be capable of safe and effective job performance. An individualized clinical evaluation of the LEO’s substance use disorder should be performed to determine whether the individual’s condition permits safe and effective job performance. Such evaluation must include the following key elements, which are discussed in detail below:

- Acknowledgement of prior review of the job description
- Medical and psychiatric history
- Review of medical documentation and/or collateral interviews (e.g., coworkers, supervisors or family)
- Physical examination
- Mental status examination
- Results of brief cognitive screening tests*
- In cases where the MoCA score is normal, i.e., 26 and above, but the clinical impression suggests clinical impairment is present; further psychological testing may be indicated.
- Results of psychiatric screening questionnaires**
- Laboratory investigation
- Diagnostic formulation as per DSM-IV-TR, including any appropriate substance abuse or dependence remission modifiers
- Coping skills evaluation
- Treatment recommendations including recommendations for continued relapse prevention
- Monitoring recommendations including type, duration and frequency
- Assessment of comorbidities and long-term adverse conditions
- Prognosis and risk of relapse

Any problem with alertness, attention, insight, judgment, orientation, mood and psychomotor function must be reported.

Assessment:
The LEO should be under the ongoing care of an addiction specialist physician or other clinician knowledgeable regarding substance use disorders. Outpatient and inpatient record(s) of the last three years or since the date of the diagnosis (whichever is shorter) should be reviewed by the treating physician and forwarded to the police physician.

My credentials as a physician knowledgeable about substance use disorders are as follows (or attach CV):

*The Montreal Cognitive Assessment (MoCA) may be used in identifying potential cognitive impairment among substance use disorder patients. (Using a cut point score of less than 26 the sensitivity for substance use disorder is 83% and specificity is 73%.)

**Such as the PHQ-9 (Patient Health Questionnaire) for Major Depressive Disorder and GAD-7 for generalized anxiety disorder, and PCL-5 for screening for post-traumatic stress disorder.
LEO Substance Use Disorders

Medical and Psychiatric History

Substances Used/Abused (check all applicable):
- Alcohol
- Caffeine
- Cannabis [Marijuana/THC (medicinal, “prescription,” legal, or illicit)]
- Cocaine
- Hallucinogens (PCP, ketamine, and other hallucinogens)
- Inhalants
- Opioids (either prescription or “street”)
- Sedative-hypnotic/anxiolytics (e.g., benzodiazepines)
- Stimulants, e.g. amphetamines (either prescription or “street,” including crystal methamphetamine, MDMA and other MDA derivatives)
- Tobacco
- Other, e.g., anabolic steroids and androgens
  Specify: _______________________________________________________________

Substance Use History:
- Mode of use (e.g., smoking, snorting, injecting, other – please explain): ____________________________
- Quantity used: ____________________________
- Frequency of use: __________________________
- Pattern of use (include date of last drink or drug used, duration of sobriety, longest abstinence): __________________________________________________________
- Previous substance use disorder treatments: ______________________________________________________
- Number of withdrawal episodes: _______________________________
- Adverse consequences on family, work, social relationships: _________________________________
- Medical consequences (injury or disease due to substance use): ___________________________

Past Medical History:
- Trauma history: ________________________________________________________________
- Surgeries: ________________________________________________________________
- Hospitalizations: __________________________________________________________
- Medical conditions (GI bleed, pancreatitis, anemia, pneumonia, hepatitis B or C, liver cirrhosis, HIV, myopathy, hypertension, sleep apnea, seizures, peripheral neuropathy...):
 _____________________________________________________________________________
- Medications (prescription & non-prescription): _________________________________________
- Medication allergies: ____________________________________________________________

Past psychiatric history:____________________________________________________________

Social History (check all applicable):
- Violence history
- Legal problems (DUI, arrests, legal infractions, incarceration, probation)
- History of having been abused (physical, mental, spousal, or sexual)
- Work problems (e.g., absenteeism, presenteeism, misconduct, poor performance)
- Substance-related behavior (e.g., unkempt appearance, involvement in accidents, inappropriately aggressive behavior)
- Other, please specify: ____________________________________________________________

Mental Status Examination (MSE):
In addition to a general MSE, please review substance use related behaviors such as uncooperativeness, defensiveness, evasiveness, odor of alcoholic beverages, drowsiness, slurred speech, agitation, or tremors.
Cognitive Screening Tests:
Brief cognitive screening tests are recommended. The Montreal Cognitive Assessment (MoCA) may be used in identifying potential cognitive impairment among substance use disorder patients. (Using a cut point score of less than 26 the sensitivity for substance use disorder is 83% and specificity is 73%.) In cases where the MoCA score is normal, i.e., 26 and above, but the clinical impression suggests clinical impairment is present; further psychological testing may be indicated.

Physical Examination:
In addition to a general physical examination, specifically review the following:

- Weight & height:
- Vital signs:
- HEENT:
  - Head: unexplained trauma signs
  - Eyes: dilated or constricted pupils, red conjunctiva, jaundice
  - Nose: perforated septum, fracture
  - Mouth: dental caries, gingivitis, burns on inside lips
- Gastro-intestinal: RUQ tenderness, hepato-splenomegaly, liver stigmata (jaundice, umbilical venous collaterals, ascites, spider angiomas, palmar erythema)
- Neurological:
  - Cranial nerves
  - Motor
  - Sensory
  - Reflexes
- Musculoskeletal: unexplained trauma signs or myopathy, and Dupuytren’s contracture.
- Dermatological: nicotine stains, track marks, bruises, abscesses.

Psychiatric Screening Questionnaires:
Screen for common psychiatric comorbidities with screening questionnaires such as the PHQ-9 (Patient Health Questionnaire) for Major Depressive Disorder and the GAD-7 for Generalized Anxiety Disorder, and the PCL-5 for Post-traumatic Stress Disorder.

Laboratory:
Include results of appropriate laboratory investigations that may include a CBC (with MCV), liver enzymes (with GGT), blood borne pathogen (e.g., hepatitis and HIV) and a drug test (components determined by the agency and/or the SAP).

Review of Medical Documentation and/or Collateral Interviews:
Review relevant collateral information or interviews (e.g., co-workers, supervisors or family)

Diagnostic Formulation As Per DSM-IV-TR:
Does the LEO meet the DSM-IV-TR criteria for a substance use disorder?
☐ NO
☐ YES (If YES, indicate type)
  ☐ Substance abuse?
  ☐ Substance dependence?
  ☐ Other? (Specify) _____________________________

In addition, diagnostic formulation as per DSM-5:
Does the LEO meet the DSM-5 criteria for a substance use disorder?
☐ NO
LEO Substance Use Disorders

☐ YES (If YES, indicate type)
  ☐ Substance use disorder (mild)?
  ☐ Substance use disorder (moderate)?
  ☐ Substance use disorder (severe)?

How long has the LEO been completely abstinent (documented abstinence) from:
  Alcohol ___________________________
  Substances ___________________________

Has early remission been achieved (as per DSM-5 criteria)?
  ☐ NO
  ☐ YES (i.e., no longer meeting DSM-5 criteria for at least 3 months)

Coping Skills Evaluation:
Review current coping mechanism(s) to help prevent relapse:
  ☐ Exercise
  ☐ Sleep
  ☐ Relaxation techniques
  ☐ Social support
  ☐ Avoidance of environmental precipitants and “risky situations”
  ☐ Spiritual factors
  ☐ Hobbies
  ☐ Refusal skills

Treatment Recommendations: Include recommendations to assist with continued relapse prevention.

Monitoring Recommendations: Include type, duration, and frequency.

Comorbidity and Long-Term Adverse Conditions:
  ☐ Are there comorbid psychiatric conditions or suspected conditions? If so, what investigation or treatment is recommended?
  ☐ Are there comorbid medical conditions or suspected conditions? If so, what investigation or treatment is recommended?

Prognosis and Risk of Relapse: Assess the risk of relapse to substance use.

Recommendations for Return to Duties:
Include your opinion as to whether or not the LEO can return to full duty. If not, can the LEO return to restricted duty, and if so, what restrictions are recommended?

Treating Physician Statement:
Provide additional information not included above that may be helpful to the review by the police physician:
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

Signature of Physician ___________________________ Date ___________________________
Printed or Typed Name of Physician ___________________________ Telephone Number ___________________________
APPENDIX H: RELAPSE PREVENTION AGREEMENT (EXAMPLE)

The following after-care contract is between
______________________________ (Employee)
______________________________ (Employer Representative)

Dr. __________________________ (Primary Care Physician)

Dr. __________________________ (Substance Use Disorder Treatment Provider), and
______________________________ (SAP [Substance Abuse Professional])

Recognizing addiction (the diagnosis of substance dependence) is a chronic illness with a significant risk of relapse, this agreement is designed to both to meet the requirements of workplace safety and to maximize the chances of recovery. This agreement may also apply to the diagnosis of substance abuse.

The duration of this contract shall be for a minimum of two years, and will be subject to review. The contract may not necessarily conclude at that time.

1. Attending a minimum of three 12-step (or reasonable alternative) meetings is required on a weekly basis, (for example, NA or AA).
2. Regular visits with your primary care physician are required and the frequency of such visits to be determined between you and your physician.
3. Regular involvement with alcohol and drug counselling is required and the frequency to be determined by the Substance Use Disorder Treatment Provider.
4. Routine visits with the Substance Use Disorder Treatment Provider are required. The frequency of these visits may be adjusted according to the professional judgment of the Substance Use Disorder Treatment Provider. The patient agrees that the Substance Use Disorder Treatment Provider may be required to provide regular and routine reporting to the employer representative regarding his/her adherence.
5. You will report any absences from work to your Substance Use Disorder Treatment Provider within 24 hours to avoid a potential situation of unexplained absenteeism.
6. You will report any legal interactions or disorderly conduct that are related to alcohol or drug use (e.g., arrests, impaired driving charges, etc.) within 24 hours to the Substance Use Disorder Treatment Provider.
7. Urine drug screens, alcohol breath sampling, hair analysis, or any other method for drug use monitoring will be done on a routine and random basis. When requested to provide a random sample, the patient has 4 hours to comply with this request. Failure to comply is equivalent to a refusal and has the same consequences as a positive test.
8. You will remain abstinent from alcohol and abused substances. No prescription medication shall be taken without the prior authorization of the Substance Use Disorder Treatment Provider. No non-prescription preparations shall be taken without the prior authorization of the Substance Use Disorder Treatment Provider. The exceptions to this rule include:
   - Plain aspirin
   - Plain acetaminophen
   - Plain ibuprofen and other over-the-counter non-steroidal anti-inflammatory drugs (NSAIDS)
9. The patient understands failure to adhere to this contract in a substantial way will result in immediate notification of the employer’s representative.

Signed at ________________________________ This _________________ day of ______
Employee Signature ________________________________________________

Employer Representative ______________________________________________

Substance Use Disorder Treatment Provider ________________________________

Primary Care Physician ________________________________________________
REFERENCES:
18. Federal Aviation Administration. Guide for Aviation Medical Examiners. See www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/


