Mitigating the Risk of Heart Disease in Law Enforcement Officers

Voiceover

00:00

Welcome to *The Beat*—a podcast series from the COPS Office at the Department of Justice. Featuring interviews with experts from a varied field of disciplines, *The Beat* provides law enforcement with the latest developments and trending topics in community policing.

Gilbert Moore

00:16

Hello, and welcome to *The Beat*. I'm Gilbert Moore and today we'll be discussing the prevalence of heart disease among law enforcement officers, elements of the profession that place officers at greater risk for heart attack, and a few measures that you can take to mitigate these risks.

Our guest today is someone who is well qualified to lead us through a discussion on these issues. I'll introduce him first as Dr. Jon Sheinberg. A board-certified cardiologist who has expertise in coronary disease detection and prevention before blockages of the heart become apparent. Dr. Sheinberg also wears several other hats. In addition to being a cardiologist, he is also a Lieutenant with the Cedar Park Police Department in Texas. He's a reserve trooper with the Texas Department of Public Safety. He serves as a medical director for the Central Texas Regional SWAT team and he is a member of the Department of Justice Office of Safety and Wellness Working Group. Lieutenant Sheinberg, welcome to *The Beat*.

Lt. Dr. Jon Sheinberg

01:18

Thanks for having me, Gil. Happy to be here.

Moore

01:21

No worries. And I should tell everybody that we're recording this remotely. Dr. Sheinberg is in the field in Texas and I am in Washington, D.C., so keep that in mind as you're listening. And, to get started, Dr. Sheinberg, I just want to ask you one clarifying question. Tell us a little bit about your background and, specifically, how does one end up wearing scrubs and a law enforcement uniform at the same time?

Sheinberg

01:46

I don't wear them at the actual same time [laughs] so I'll give you the background. So, my first career was as a cop. In 1989, I was a patrol officer up in Massachusetts. And after doing that for about a year or so, I decided, you know, I want to give myself a shot at med school, went to medical school, spent 15 years in the military afterwards, and then when I got out and set up a practice in Austin, Texas, or I should say joined a practice in Austin, Texas, I missed the service. I missed giving back and I missed the

camaraderie so I decided to go back into policing. I ended up going back to the Police Academy, becoming a sworn officer again, and joined the local department, and over the last several years, worked my way up the chain and now I've had the rank of lieutenant. So I split my time. I work as a physician most of the time and I work as a law enforcement officer part time.

Moore

02:40

Given that you have two very unique experiences, do I call you Dr. Sheinberg or Lieutenant Sheinberg, which one?

Sheinberg

02:46

Jon is fine.

Moore

02:47

Well, yeah, and that leads into the next question. Tell me, kind of having experience in two very unique professions, the medical profession and law enforcement, are there perspectives that you bring to your job, on the law enforcement side that are informed by the work that you've done on the medical side of the house?

Sheinberg

03:05

You know, Gil, that's a great question and I'll actually flip it the other direction. There are things that I bring from my police training into my medical training. And I can give you a very specific example because I've thought about this quite a bit, but interestingly, you're the first person who's ever asked about it. Physicians tend to have egos and a lot of times, when you have an ego, it's difficult to ask for help. And, for example, I work in a cath lab and there are a lot of physicians who are in the operating room, who are in the catheterization laboratory, and they're doing procedures and they get into a situation in which they need help, they're over their head, they need some assistance. And a lot of times, ego will prevent those doctors from asking for help. In my experience as a cop, I've learned to know when I'm in need of assistance, in need of backup, in need of help.

So my take home from this merger of two professions is I know when to ask for help and I've learned to know where my limits are. And it sounds somewhat bizarre to say it, but that type of mentality has been incredibly helpful and insightful for me as a physician. You know, you have a situation in which there's a lot of similarities between the two groups even though the jobs are completely different. You end up seeing people who are at their most vulnerable. There's a situation in which people look to you for an answer. You have maintain your poise and calm in situations that are catastrophic or rapidly spiraling out of control. So there's a lot of overlap in terms of some of the, you know, not actually work, of course, but in terms of the experiences those individuals go through. It's emotionally, physically exhausting and rewarding at the same time. So I have been able to utilize skill sets I learned in both professions to complement the other one.

Moore

04:54

One thing that I would imagine is unique to law enforcement and that's what I said at the beginning of the discussion and that is that law enforcement has one of the poorest cardiovascular disease health profiles of any occupation. I would imagine that's different for doctors and people in the medical profession. Why is it that law enforcement officers are at such an increased risk for cardiovascular disease?

Sheinberg

05:18

So let me first answer your question by sort of defining what that risk is. Law enforcement officers have lower life expectancies in general than the general population. We know police officers currently live on average 22 years less than their civilian counterparts. We also know that heart disease is much more prevalent in the law enforcement world. We see between the ages of 55 and 59, if you're a civilian, your chance of dying from a cardiac event, heart attack during that time is about 1.5 percent. But if you're a cop, the chance of dying from a heart attack is about 56 percent, so a tremendously increased risk. We see heart attacks younger in law enforcement. So the average age of a cop with a heart attack is 49. The average age of a civilian with a heart attack is 65. And about 40 percent of heart attacks occur at the age of 45 in the law enforcement world whereas in civilians it's only 7 percent. So we see heart attacks more frequently in that younger ages.

Of course, the question is why? And the bottom line answer is we don't really know. It's likely a perfect storm. It's a combination of several different things. When this data is initially presented to a group of people, the first thing that comes to their minds, oh, it's stress, police officers under more stress. And I'll tell you it's not necessarily the stress amount. Everybody is under stress. I see patients every day who are having marital problems or financial problems. Everyone's kids are into things they shouldn't be. Stress patterns are universal.

But law enforcement has a very unique stress pattern. It's a pattern which is what we call… it's 98, 97 percent boredom and in 2–3 percent of sheer terror. So you have a situation in which the stress patterns are rapidly changing and you add that to a population that experiences shift work, a population that is sedentary, a population that eats a diet of convenience. And although it's never been defined, my speculation is there's also an increased genetic risk in this population because we know heart disease has a significant genetic component associated with it and there's got to be something in law enforcement that drives a certain group of people into it that also carry a risk of a coronary disease. So it's a combination of all these things, but irrespective of what causes it, at the end of the day, we're left with cops that die younger and have more frequent heart attacks than their civilian counterparts.

Moore
07:45
You used a couple of terms and I just want to make sure that we're clear because personally, I don't necessarily know the differences of some of the terms. You talk about coronary disease and I think I might've mentioned cardiovascular disease and then we talk about a heart attack. In a layman's terms, what are they, what are the differences, or is there a catch-all that we can use so we can focus our discussion?

Sheinberg
08:08
So I use those terms interchangeably, so coronary disease, heart attack, cardiovascular disease, cardiovascular event, we're all talking about the abrupt blockage of blood flow in the artery and basically a heart attack.

Moore
08:19
So when the arteries get blocked, a heart attack is the end result. Is that the takeaway?

Sheinberg
08:25
Essentially. The pathophysiology behind it is a little bit more complex and how the artery blocks, but basically a heart attack, no matter what term you use to define it, is an artery of the heart that is clogged, therefore, not getting the heart muscle enough blood.

Moore
08:40
So if I'm let's say in the middle of my career recognizing that the world is not going to change simply because I'm on the job and, you know, I'm starting to kind of gain some weight, starting to become a little bit more sedentary with age, what signs should I be looking for in terms of making sure that I don't become one of those statistics that you talked about?

Sheinberg
09:02
So, that's a great question and so the question was what can we do to prevent this?

So the problems is we don't know and we have the technology and we have the knowledge to identify blockages in the arteries years before those blockages cause a problem, years before someone feels chest pain or years before someone ends up in the emergency room having a heart attack or needing a stent or bypass surgery. If we wait until you know, we waited too long. So this is not one of those things in we use the analogy of you don't want to wait until you have a toothache before you go to the dentist.

So there has to be a proactive measure or involvement from multiple levels to prevent this from happening and I would go and say—because the data that we have is so compelling—that the executive leadership really has a moral and ethical obligation to keep this prevalence of disease lower because our job on the executive staff is to make sure our cops get home at the end of the day. So in the same way we make sure our officers wear body armor or make sure they wear reflective vests when they do traffic stops, we have the same obligation to make sure our officers don't die of heart disease.

If you look at the data from the Officer Down Memorial Page, heart attack comes in as the number two or number three line of duty death every time it's calculated. However, that page does not count people who have heart attacks after they take off their uniform for the day and it doesn't count all the heart attacks that don't kill people. Only 3–4 percent of heart attacks are fatal so we're talking about thousands of heart attacks that occur that don't meet the ODMP data points.

So we have the ability to pick this up like I said early. So what we have to do is basically educate our executive leadership, the unions and the individual officers, and say here's the testing that can be done rather easily, rather inexpensively to identify the people who are at risk for blockage formation. And once we identify that risk, we can implement a strategy and mitigate it.

Moore

11:01

Okay, so there are a couple of things there. Number one, the testing. I think that's critically important for us to talk about and, really, why we're here today. But also this concept of executive leadership, right. So for years, there have been policy directives that require officers to wear seat belts, right. And so if you look at the Law Enforcement Memorial Fund's website, I think the number one cause of officer fatalities is car accidents, and I would imagine the significant amount is because people or officers are not in fact wearing seat belts. So if we kind of take that dynamic and we apply it to cardiovascular health: What kinds of things can an agency or executive leadership do to ensure that officers are eating properly, sleeping more consistently, or maybe getting the necessary exercise, or doing those things that are going to help offset or eliminate the presence of heart disease?

Sheinberg

11:53

The presence of heart disease is a component of a larger wellness issue, and wellness is really becoming the tip of the spear throughout the conversation in policing at the moment. It's really taken a forefront, we're finally now going to grasp what the concept… like we said, heart attacks that were prevalent, we're coming to grasp the idea that police officers have depression, higher divorce rates. We see officers are two or three times more likely to kill themselves than to be killed in the line of duty. We see substance abuse rates. So the concept is this overlying wellness program, which is what has to be adopted by executive leadership and command staff.

And no matter what agency or no matter what governing body looks at a wellness program, it always comes down to five different components, and they go by different names and different agencies title them differently, but ultimately, there's five components which make the national conversation for

wellness. One is mental health. One is fitness. The next is obesity and nutrition. And I separate those two because we do see people who are fit and overweight, and we do see people who are of normal weight who are not fit. So even though fitness and nutrition overlap, they're not necessarily identical topics. They do carry some of the same components, but they're not identical. We also see cardiac screening as one of those components. And, of course, the development of a tactical combat casualty care and individual first aid kit deployment is the fifth component. So basically, it's first aid or combat casualty care, cardiac screening, fitness, nutrition, and mental and emotional health. Those are the components, and there are several different ways to handle each one of these components.

To answer your question a little bit more specifically, the executive leadership needs to focus on nutrition and weight loss, fitness, and cardiac screening. So, if I may, I'm going to discuss each one of these issues because the concept overlaps, but when you identify it… there's three different items, it's a little bit easier to get our arms around. So in terms of nutrition we have data that shows that law enforcement is one of the most obese professions. The data will tell us that nationally, about 45 plus percent of cops are clinically obese. However, I can tell you, we collected data on 3,500 law enforcement officers here in the state of Texas, the obesity rate is over 80 percent. And with the obesity rate comes hypertension, diabetes, musculoskeletal problems. So the obesity is a definitive medical issue.

Then, we have the fitness issue and we have officers who are not fit. And officers who are not fit, there's no question that they're, number one, not as effective at their job and, number two, they place themselves, their agency and their municipalities or city or state at increased liability. There's a lot of case law out there that shows that officers who are not fit are more likely to resort to use of deadly force when they have the potential opportunity to use less-lethal means or to go hands on. There's a lot of case law that shows that officers are being held liable if they're not able to meet the fitness standard.

And then the third component is cardiac screening and there are certain tests, which we'll talk about here in a moment that an officer can do, which can identify the early stages of blockage. So in terms of nutrition and weight loss, there's a lot of different ways of doing it. They all have benefits and they all have downsides.

When you serve in the military, as I know you and I have, we have weight standards. We have a uniform policy that has weight restriction and you have to either use body fat measurement or waist circumference measurements to determine whether or not you meet that standard. So when it comes to obesity, there are several markers that can be used to determine whether an officer is at the best possible weight that he or she should be.

And I'll give you a specific example. In Texas, the DPS, the Department of Public Safety, just launched what they call a command presence profile and the command presence says that if you are a male officer, you will have an abdominal waist circumference less than 40 inches and if you're a female officer, you'll have an abdominal waist circumference less than 35 inches, hugely controversial. There's

actually a lawsuit now between the union and the Department of Public Safety because the unions will say you can't tell me a police officer can't be a police officer if their abdominal circumference is 41 inches, but…

Moore

16:00

Really quick, sorry to interrupt you. You said 49 inches was the standard that was implemented by the Texas Department of Public Safety?

Sheinberg

16:07

No, 40 inches for a male. But we have medical literature to support that there is an increased risk of cardiac disease, increased risk of mortality or dying for people who have abdominal obesity so it meets medical standards. So there is, from a nutritional weight loss standpoint, we know people who are overweight have an increased risk of heart disease, diabetes, hypertension, and all the complications that are associated with it. But how do you enforce that? That's the first problem.

The second issue is fitness. How do we define fitness? So, we know that police officers who are fit live longer than police officers who are not fit. There's a lot of data to support the more fit someone is, the more reduction they have in dying. If you exercise more than 2,000 calories per week, the mortality of that group is 18 per 10,000 people. But if you are under that, the mortality in that group is 64 per 10,000 people per year. So the reality is we know people who exercise typically live longer than people who don't. We know people who exercise in the law enforcement world are more effective at performing their job.

How do you test for that? How do you encourage that? Well, in a training environment, it's very easy. You line everybody up at 6:00 a.m. and you go for a run. However, in all practicality, that's not something that can be done in a department level on a regular basis. So what we do is we set fitness standards. We say okay, we have a fitness standard. It's either going to be an old fashioned military physical fitness test, which includes a run, pushups, sit ups or chin ups. It can be an agility course. In Texas, we've adopted the Concept2 rower, which is a stationary rower as a marker of fitness and if you meet a standard, then you are considered fit. If you establish a standard like this, it has to be a standard that either has a benefit or a reward if you make it and/or a punishment or a consequence if you don't, stick-and-carrot approach.

So a lot of agencies here are using both of these. If you make the fitness standard, you get a medal. You know, as cops, we love shiny things and we get to wear a medal on our uniform that says we meet our fitness standard. Some of the departments also will pay their individual officers. So there's several departments here in Central Texas that when their officers make the fitness standard, they will give them extra hundred bucks a month in fitness pay, which is a nice little bonus to have.

However, if you don't make the fitness standard, there's a consequence. There is remediation. Is this something that is going to prevent that individual from working? So there's so many different ways of incentivizing and potentially pushing people to noncritical duty assignment or a suspension or even dismissal if they're unable to make the physical fitness standards.

And again, this is a tremendously cumbersome and difficult topic to discuss because it carries with it all the right to work legislation and the union complains about it, but these are the things that agencies are doing to keep their officers healthy and on the job.

Moore

18:56

I was just going to ask you if I could step in really quick just to keep this in the realm of practical. What does 2,000 calories of exercise look like? Is that three 30-minute workouts per week? Is it one per week? What is 2,000 calories?

Sheinberg

19:08

It's basically five 30- to 40-minute exercise sessions per week, aerobic exercise sessions per week.

Moore

19:19

Aerobic, got it. So lifting weights is not necessarily it. I got to get my heart rate up and, generally speaking, I have to generate a sweat.

Sheinberg

19:24

Exactly. Now that can be done with resistance training, with weight training, but it has to be brisk. It has to be circuit. It has to be CrossFit-type work. Just going and getting on a bench press and then walking over to the leg machine and then walking over and doing some curls, that doesn't really manifest that. But the CrossFit's a tremendous exercise program. Running, elliptical biking. Quite frankly, what we recommend is our individuals rotate. They do some resistance with strength training. They do biking. They do rowing. They get on the elliptical machine. They get on the treadmill or they go for a run because the more you vary the exercise, the more successful you are completing the actual 2,000 calories.

Moore

20:00

I can see right now that there are a lot of officers who are listening that are going to say, "I'd love to be more active and to work out more, but the reality is with the shift that I'm on, with the personal family responsibilities I have, the only way I'm going to be able to work out more if it becomes a part of my job that I'm compensated for," which is not a common thing. Are you aware of law enforcement agencies that are in fact covering or paying officers for time that they spend working out in the gym?

Sheinberg

20:27

Yeah, absolutely. I'm actually happy to say that there are a lot of different departments here in Central Texas that will give their officers several hours a week of on-duty time to work out. It's very difficult to set a fitness standard and require participation in a standard if you don't let the officers have the opportunity to train to meet that standard. So there's some departments that don't, but if you're going to penalize officers and potentially reward them for meeting a standard, you have to be able to provide them the time to do it.

But unfortunately, as you know, a lot of our departments were understaffed, were undermanned, and we just don't have the ability to give the officers the time to do it. There's a big disparity between the line officers who are the patrol officers and the detectives or command staff who have more flexible schedules and may not work the full 12-hour or 10-hour shift. But you're right, it is another controversial topic, but it's very relevant. And it is my personal belief that if a department is going to establish a fitness standard and hold officers accountable, that they really need to be able to provide the officers the time and the facility to train to meet that standard.

Moore

21:32

We are talking with Dr. Jon Sheinberg who is a board-certified cardiologist and also, he is a police lieutenant with the Cedar Park Police Department in Texas. You were talking about five specific aspects of officer wellness. Nutrition and weight loss, fitness, which we just covered, and then next would be cardiac screening. Previously, you said that if we get to the point that individuals that were looking for a sign or a symptom of cardiovascular disease, we're too late. If in fact that's the case, how am I going to know when I'm supposed to go get screening?

Sheinberg

22:08

Another great question and here is what we recommend. So the screening modalities, I'm going to try to describe what they look like and what they mean and how it works. What we have the ability to do and what we want our officers to do is to be able to undergo the test that will identify blockage in their very early stages before those blockages become symptomatic, in other words, before people feel anything. And, in order to understand what happens, they've got to kind of deal with a little bit of science background here. When blockages form, they form inside the blood vessel walls.

So people have an erroneous concept of blockages forming in the blood vessel like scale in a pipe. It doesn't work that way. Blockages, when they occur inside the arteries of the heart, actually occur inside the wall of the artery. The artery wall becomes filled with plaque and the artery walls expand and the artery narrows and then, when someone has a heart attack, it's not an artery that just gradually narrows, in other words goes from a blockage of 10 percent, 20 percent, 40 percent, 90, 99, 100 percent, then a heart attack. That's not what happens.

When someone has a heart attack, there's some plaque in the artery, there's some blockage in that blood vessel wall. The blockage becomes highly inflamed. It takes decades. And eventually that blockage bursts, it ruptures. All the plaque, all the junk in the blood vessel wall, spills out into the opening of the blood vessel and that activates a clotting system and a clot forms. The clot is what abruptly blocks the blood vessel. So in essence, when someone has a heart attack, they're going from an artery that's not obstructed, abruptly to an artery that's 100-percent obstructed. That's a heart attack.

So the questions really are how can we pick up that early plaque in the artery before it were to rupture? There's two things we look for. When plaque forms in the arteries of the heart, that artery can become calcified where little flecks of calcium will occur inside that blood vessel wall. Those flecks of calcium can be picked up on a low-cost, low-radiation CT scan, which is called a coronary calcium score.

It's a very inexpensive test. Matter of fact, most hospitals will offer this test even without a physician's prescription. It's a test in which the individual lies down on a CT scanner with his or her clothes on. The scan occurs over about a 45 second to a minute. The individual gets up and leaves. And the scan looks at these little flecks of calcium in the arteries of the heart. The scan is marketed under several different names. One is HeartSaver CT scan, otherwise known as coronary calcium score, but this scan typically, I can tell you locally in Austin, those scans sell for about $75 so they're rather inexpensive. And if the scan is done and any calcifications are seen within the artery, we know that individual's in the early stages of blockage formation. It's brilliant. So that's the first way of detecting.

Most insurance plans do not cover this type of prevention. It's usually $75 cash. It varies from region to region. I've seen it upwards of $199. I've also seen it down in some places selling it for $50 during February, which is heart month then it tends to be less expensive at that time, but I can tell you in the Central Texas region, we're paying $75 on average.

Moore

25:12

And this is available at those hospitals so I can't go to my doctor. I would have to go to a hospital to take advantage of that type of scan.

Sheinberg

25:19

It usually has to be. Very few physicians have their own CT scanners and then those who do may not have the coronary calcium software loaded on it. So the physicians could certainly point their patients into the right place to get it done or it can be done by scouring the web for it, but these are called coronary calcium scores. And again, there's HeartSaver CT scans and they're located in just about every major medical facility.

Moore

25:43

Great, great. So you were saying?

Sheinberg

25:45

So that's the first component. The second component is to try to identify the inflammation that occurs before someone has a heart attack. And there are several markers that can be detected in a blood test. But the most accurate and effective marker is a marker which is called phospholipase A2 or it's abbreviated the letter L, the letter P as in papa, LP-PLA2, papa, lima, alpha, 2. And it is a blood test that will rise in the blood if that inflammation in the arteries is present.

So what we recommend is that individuals undergo both of these tests. A simple blood test, LP-PLA2 and the calcium score because what we found by looking at 3,500 police officers is we see either an elevation of this calcification or an elevation of that inflammatory marker with very little overlap. In other words, when someone is forming blockages, they will either form blockages, which are calcified or blockages, which are inflamed. And if we're able to pick up either one of those, we can initiate a treatment plan and we can stop it from progressing.

Moore

26:53

Jon, hate to interrupt you. I just want to make this crystal clear for your brothers and sisters in law enforcement. You're suggesting that if people want to guard against, ensure, or know where they stand or potentially identify whether or not they're at risk for heart disease, they would want to do two things. One is get a coronary calcium scan, or figure out what their coronary calcium score is through receiving the scan. And the other is the LP-PLAT2 blood test. Is that right?

Sheinberg

27:23

LP-PLA2.

Moore

27:25

Okay.

Sheinberg

27:26

It used to have a name. We used to call it the "PLAC test," and that was actually spelled P-L-A-C test. However, the company that started that PLAC test, that test has already gone generic. It's no longer a branded test so just about every major lab will offer this type of testing. LP-PLA2 or otherwise known as phospholipase A2 and that test is a test which looks at, like I said, the inflammatory changes, which occur inside the arteries of the heart.

Moore

27:54

So that's three of the five aspects. What are the other two?

Sheinberg

27:57

The other two aspects of the wellness initiative?

Moore

28:00

Yes.

Sheinberg

28:00

So the other two are tactical combat casualty care and the Bureau of Justice Assistance and the COPS Office have done a tremendous job of making individual police officers and agencies aware of the need for Stop the Bleed Kits. Just about every police officer out there is equipped with a belt-mounted tourniquet system and an individual first aid kit, which likely includes a QuikClot gauze. So we have really made incredible strides in this regard.

Combat casualty care is still something that some small departments are struggling with. Interestingly, if you go to these small departments, the officers identify the need for this type of equipment and they have oftentimes cobbled together their own equipment. However, if it's not standardized, it's not as effective.

I'll give you an example. We are trained to use our tourniquets on ourselves. So if I come across a fellow officer who's injured, I want to use his or her tourniquet on that individual. The problem is in a situation where I'm going to need to put a tourniquet on, it's typically a low-light situation, my hands are going to be wet either with blood or sweat, I'm going to have lost fine motor control because my adrenaline is pumping. If I can't find that individual's tourniquet, in other words, if it's not in the standard place and if I do find it and if it's a tourniquet that I'm not familiar with, I have not trained on, my ability to successfully place that tourniquet on properly is substantially diminished.

So just the same way we all carry the same duty weapon when we can throw magazines to each other if we need to, we're able to carry the same type of first aid equipment and use each other's equipment if we need to. So we have a standardized equipment with a standardized carry and a standardized training. So we've eliminated the fact of me coming up to another officer, not knowing where his or her equipment is and if I do know where it is, not being able to apply it properly. We've made tremendous strides in this.

I'll give you a quick anecdote. You know, I was asked to speak in England at the West Midland's Police Department regarding these wellness programs and in England, they are actually undergoing a stabbing pandemic. There's a lack of firearms, but officers are getting stabbed. In fact, the vests that they wear are not bullet-resistant vests, they're stab-resistant vests. And when I explained our wellness initiatives, they couldn't believe that our officers carried tourniquets and first aid kits. And that was a sort of a light bulb and they had to have officers who in the past had gotten stabbed or cut and they'd had to go

wander and knock on doors to try to find bandages until their armed response team or an EMS unit to get there. So, not as well thought out in some of the other countries, but here, most of our officers, at least in Texas, are carrying standardized first aid kits.

And the fifth component is a mental health component. And like I said, there's no question that we do see an increased risk of mental health problems in law enforcement. You know, we have systems set up a lot of times that deal with the critical incidents. We have help available for the mass shootings, for the Walmart shooting, for the Pulse nightclub shooting, but a lot of times what we don't have available to our officers are preventative psychological help to handle all the micro traumas.

We know, as officers, we see domestic violence regularly. We see collisions, which cost family members' lives. We see dogs lit on fire, horrible things, child abuse. I mean these things, even though they may not meet the definition of a critical incident, still take their toll on officers. And there has to be a peer support group or a mental health component that's available to the officers that is open, not punitive, and not frowned upon so our officers can get the help that they need because without it, we're stuck with a higher divorce rate, suicide problems, substance abuse, and PTSD. So we have options. That's another field. I know one of my colleagues is doing a podcast on some of the mental health issues, but it's a real problem that requires real solutions as well.

Moore

31:53

You've unpacked a lot and particularly for law enforcement executives. What are we missing, Jon? Is there anything else that is a critical part of making sure officers are in the best possible position to carry out their mission?

Sheinberg

32:06

I think we covered a lot of it, but if I may just kind of put it in a little bit of a unique framework that's how I see this. So when an officer graduates the academy and becomes a newly-minted police officer, we have now this individual who's probably in the best physical shape of their life. They've also undergone psychological testing so we know at least to the best of our abilities that this individual is also psychologically sound. So we have this phenomenal law material. We have an individual who is at the peak of their physical and mental health.

And now, we're going to take this person and we're going to expose them to this profession and tell them, "Okay, 25 years, you're going to have more heart attacks. You're going to have a higher risk of becoming obese and therefore have a higher risk of high blood pressure, high cholesterol, diabetes and musculoskeletal so hip, knee, shoulder injuries. You're going to have a 75 percent chance of getting divorced. You're more likely to kill yourself. You're more likely to suffer from PTSD and you're more likely to have a substance abuse problem." So we take this phenomenal law product and over the course of 20 years, we destroy it.

So it is our obligation to take our ability to have these selfless men and women who not only put their lives on the line every day, but also are potentially having shorter life expectancy with more medical problems, it is our moral and ethical responsibility to keep these officers healthy. So not only can they go home to their families at night, but they can enjoy their retirement for all the work that they've done.

And it's through programs like the COPS Office and the Bureau of Justice Assistance and through the IACP that we're really organizing behind this and I think this is a tremendously exciting time for us because we've identified the problems and we are the tip of the spear right now. We are now realizing that a healthy, fit police force is a more effective, happy, and longer-living force. So I think we're doing a great job.

The problems that we have are not defining the issue. The problems that we have are taking this information and distilling it down and putting it in the hands of the individual officers. And that's why I'm so happy and so grateful that you're taking the time and the COPS Office is spearheading the ability to get this information out to the men and women who need it most because if it doesn't get distributed down to the line officers, the information's useless. So, Gil, I'm so grateful for you and for your office for putting all this together.

Moore

34:31

As a matter of fact, we truly appreciate you joining us today on *The Beat*.

Sheinberg

34:36

Thank you, Gil

Moore

34:37

Before we go, is there any resource or information that you would like to point our listeners towards so that they can learn a little bit more about the various topics we've discussed today?

Sheinberg

34:37

There is a nonprofit that was mentioned earlier, the Public Safety Cardiac Foundation. That website is www.publicsafetyheart.org. That website will have on it a host of information both on PowerPoint, audio, and video presentations regarding the risk of heart disease in law enforcement and recapping the steps that individuals can take to reduce their risk. That website is a 501(c)(3) nonprofit entity and is a completely independent entity.

Also I would recommend that individuals simply look up, there is a bunch of podcasts and videocasts that have been done through the COPS Office that talk about some of these issues as well, the *What's New in Blue* series, which is available on YouTube, which has answered a lot of these questions as well.

They're available for download as well. Yeah, you've all done a tremendous job of getting this information out and the key is to make sure we direct as many people to look at this great work, because it's incredibly helpful.

Moore

35:44

Thank you Lieutenant Sheinberg, we really do appreciate it. In fact, the COPS Office is honored to be a supporter of the men and women of law enforcement. We have been speaking with Jon Sheinberg, a Board-Certified Cardiologist and Lieutenant with the Cedar Park Police Department in Texas and you've been listening to *The Beat*. Take care.

Voiceover: *The Beat* Exit

36:02

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Voiceover: Disclaimer

37:00

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