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## Police reports of accidental fentanyl overdose in the field: Correcting a culture-bound syndrome that harms us all

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In August 2021, San Diego County Sheriff Bill Gore released a dramatic video allegedly depicting a deputy overdosing on fentanyl following incidental exposure during an investigation in the field. The film asserts the deputy only survived thanks to the swift action of his colleagues, who administered four doses of intranasal naloxone, first two within seconds of his collapse, then again minutes later. Blowback from experts came swiftly: toxicologists have found it is impossible to inhale or transdermally absorb enough fentanyl to quickly overdose (Moss et al., 2018). The deputy's symptoms were inconsistent with an opioid overdose, and the video's narration contained inaccuracies about overdose identification and response. Misinformation about the risks of incidental exposure to fentanyl has proven to be persistent among U.S. law enforcement (Attaway et al., 2021; Beletsky et al., 2020). It is critical to correct these misconceptions and ensure appropriate response.

In 2016, the U.S. Drug Enforcement Administration (DEA) released an advisory and training video that warned:

[J]ust touching fentanyl or accidentally inhaling the substance... can result in absorption through the skin and that is one of the biggest dangers with fentanyl. The onset of adverse health effects, such as disorientation, coughing, sedation,

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respiratory distress or cardiac arrest is very rapid and profound, usually occurring within minutes of exposure (DEA, 2016).

This statement, along with photos of tiny, allegedly lethal doses of the drug, set against a penny for scale, conveyed the idea that minor, incidental exposure could quickly turn fatal. At the time, illicitly-manufactured fentanyl had begun to dominate the illicit opioid market, and first responders were ill-informed about its properties. The narrative seemed plausible (Persaud & Jennings, 2020). This false message was echoed nearly verbatim by many other authorities that officers consider credible, including the Department of Justice, and the National Police Foundation (NPF, 2016; USDOJ, 2017). In response, the American College of Medical Toxicology and the American Academy of Clinical Toxicology released a joint statement clarifying that fentanyl toxicity from incidental exposure was so unlikely as to be nearly impossible (Moss et al., 2018). Such evidence from expert bodies led law enforcement agencies in Canada and the United Kingdom to temper their own warnings about the risks of exposure in the field (Tunney, 2019). In contrast, many American law enforcement professionals clung to this narrative of extreme risk—with Sheriff Gore’s recent video but one example of their years long, enduring belief in it.

This misinformation presents serious obstacles to addressing the overdose crisis. It falsely transforms overdose emergencies, which require rapid response to prevent death, into perceived life-and-death situations for first responders as well. It perpetuates the stigma that people who use illicit opioids are inherently dangerous to encounter, that their bodies and belongings are poisonous. No less important, perpetuating the falsehood that officers could die from contact with a substance they routinely encounter in the field is profoundly stressful to officers. Alleged “overdoses” have been cited as examples of the “nocebo effect,” where inaccurate beliefs about a drug generate negative somatic effects upon exposure. Yet these false “overdoses” are more complex. Fentanyl has well-known sedative effects. Law enforcement officers are generally aware of them. Yet the false belief that one has received a substantial dose, can produce very real, distressing symptoms—panic, hyperventilation, vertigo, a racing heart—that are misrecognized as evidence of fentanyl’s known effects (Persaud & Jennings, 2020). Misrecognized symptoms appear to confirm misinformation, and no one’s wellbeing is served.

These incidents should be taken seriously as distressing and underexplained medical events. Vasovagal syncope, or panic attacks induced by context-driven anxiety, are a highly plausible explanation (Herman et al., 2020). Yet, the sequelae of many other biomedical conditions (ranging from dehydration to ischemic strokes) may be indistinguishable from a panic attack to the untrained observer—especially if that observer is already primed by misinformation to perceive an overdose and is part of an occupational culture that characterizes fear and panic as unacceptable weaknesses. In the case of genuine health emergencies, these events could turn harmful or fatal from misdiagnoses and inappropriate treatment. We hear reports of first responders hesitant to deliver naloxone during genuine overdose emergencies due to fear of fentanyl. The myth, itself, could be deadly.

Simply asserting the incidents have been misdiagnosed does not allow us to constructively assert what actually happened. A named condition with a basis in evidence would benefit

both the patient and the public, correcting misinformation while taking the patient's bodily experience seriously. It may be helpful to recognize false officer "overdose" as a culture-bound syndrome (a well-established diagnostic concept that conforms to ICD-10 classifications) originating from incidental encounters with fentanyl in the context of pervasive misinformation about the risks it poses. Creating such a classification would enable a standardized approach to assessing personal, physiological, and environmental factors associated with these events and allow a more accurate estimation of prevalence. It would require being mindful of the potentially stigmatizing effects of diagnostic labels, but doing so would empower medical and law enforcement professionals to properly situate and respond to these events when they occur, and more importantly to prevent them by training officers about their origin and their basis in misinformation. It would provide patients influenced by pervasive stigma against psychological distress in public safety professions the means to reject a panic attack diagnosis with a valid and meaningful framework for articulating their experiences. Treatment could shift from reversing the effects of fentanyl to the mental health and wellness issues that underlie an officer's perceived overdose.

First responders who experience these false overdose events may also benefit from a standard of care for these incidents. That approach should presume fentanyl overdose to be highly unlikely though the distressing somatic event is real—and potentially indicative of another underlying concern. Such an approach would promote more cautious and accurate diagnoses. In the context of careful diagnosis, toxicology screens may offer much needed clarity while allowing clinicians to take the patient's report seriously.

Stigma against people who use drugs commonly manifests as disbelief about the statements they make, often resulting in life-saving care delayed or denied. In this case, law enforcement officers experience the opposite prejudice: their demonstrably false claims are accepted as truth by media and professional peers without question, even though they are well-contradicted in scientific literature and, ironically, by the extensive experience of people who package, distribute and use illicitly-manufactured fentanyl. In follow up reporting, Sheriff Gore conceded that he produced his video based on his own diagnosis, without consulting with physicians or other experts. Gore subsequently removed the video from his department's social media accounts. Within weeks, the DEA finally and belatedly removed its 2016 press release and video from its own archives. This content nevertheless remains widely available online, reproduced by numerous accounts across several platforms, easily discoverable by those seeking reliable information about fentanyl from an authoritative source. The effort to remove this content should be suitably comprehensive.

First responders work in the midst of an epidemic that claimed over 94,000 lives last year. So long as law enforcement remain key first responders across the United States, they will continue to encounter fentanyl, and evidence suggests training may help correct these misconceptions (Winograd et al., 2020). Mitigating the psychological harms that false beliefs about fentanyl exposure bring to first responders requires a deliberate approach—and clearer answers to the unanswered questions at the heart of these events. Doing so will better protect officers' mental health and reduce the potentially deadly risks this misinformation poses to overdose victims in need of effective emergency response.

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