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Police on the Front Line of Community Geriatric Healthcare: Challenges and Opportunities

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ABSTRACT

As the population ages, police increasingly serve as first responders to incidents involving older adults in which aging-related health plays a critical role. The goals of this study were to assess police officers' knowledge of aging-related health; to identify challenges police experience in their encounters with older adults; and to describe their recommendations for how to address those challenges. This was a mixed methods study of 141 San Francisco police officers recruited from mandatory police trainings between 2011 and 2013. Descriptive statistics were used to analyze 141 self-administered questionnaires and principles of grounded theory were used to analyze open-ended questionnaire responses and 11 additional qualitative interviews. Nearly all officers (89%) reported interacting with older adults at least monthly. Although 84% of police reported prior training in working with older adults, only 32% rated themselves knowledgeable about aging-related health. Participants described themselves as first-responders to medical and social emergencies involving older adults and identified several challenges including identifying and responding to aging-related conditions and ensuring appropriate medical and social service hand-offs. To address these challenges, officers recommended developing trainings focused on recognizing and responding to aging-related conditions and improving police knowledge of community resources for older adults. They also called for enhanced communication and collaboration between police and clinicians. These findings suggest that despite playing a front-line role in responding to older adults with complex medical and social needs, many police may benefit from additional knowledge about aging-related health and community resources. Collaboration between police and healthcare providers presents

an important opportunity to develop geriatrics training and interprofessional systems of care to support police work with a rapidly aging population.

INTRODUCTION

As the U.S. population ages, police increasingly serve as first responders to incidents involving older adults in which aging-related health plays a critical role.[1,2] For example, police may be called to assess an older adult who is a victim of elder abuse or neglect, perform a “welfare check” for an at-risk older adult, or respond to a complaint of criminal activity involving an older adult with cognitive impairment, mental illness, and/or a substance use disorder. In situations like these, criminal justice and health concerns intersect and police serve as the primary link between an older adult with acute health care needs and clinicians in a variety of settings including emergency departments and county jails. Yet little is known about police knowledge of, and experience with, aging-related health problems common in older adults who interact with the criminal justice system as victims, alleged offenders, and at-risk community members.

Police often encounter older adults who are in poor health, have complex social and behavioral risk factors for poor health outcomes, and are high utilizers of acute care services. For example, older victims of crimes (including elder abuse) are at increased risk for institutionalization and death.[3-5] Older arrestees have disproportionate rates of health problems, including early-onset multimorbidity, untreated mental illness, and unmet psychosocial needs.[6-11] As first responders, police may be well-positioned to disrupt the costly cycles of frequent acute care use and repeat incarceration for these medically complex older adults. Though some emerging programs encourage collaboration between public safety and health professionals in important areas like elder abuse[12] and unsafe driving,[13] overall police knowledge of the geriatric health issues affecting older adults has not been described. As a result, clinicians may be

unaware of how police can help to identify and refer at-risk older adults to medical and social services. This lack of knowledge limits our ability to identify opportunities for collaboration between health and law enforcement professionals to optimize police responses to high risk, community-dwelling older adults.[14]

Therefore, this mixed methods study assessed police knowledge of aging-related health, identified challenges police experience in encounters with older adults, and elicited recommendations about how to address those challenges. A better understanding of the roles police play in responding to older adults and the knowledge and services they need to carry out those roles would help medical and law enforcement professionals develop joint strategies to improve outcomes for medically vulnerable older adults in our communities who interact with police.

METHODS

Design overview

This mixed methods study of police officers was conducted in San Francisco using self-administered questionnaires and semi-structured qualitative interviews between October 2011 and April 2013. The Institutional Review Board of the University of California, San Francisco approved the study.

Setting and participants

Police officers were recruited from a quarterly “Crisis Intervention Training” which is mandatory for all officers in the Patrol Division of the San Francisco Police Department. The Patrol Division comprises approximately 1000 officers who respond to calls from the community and patrol the city. Each training session includes 30-40 officers.

Before receiving a lecture about aging-related health, police officers were asked to complete self-administered questionnaires that included both close-ended and open-ended items. After completing the questionnaires, participants were invited to participate in an in-depth qualitative interview, and 45-minute interviews were scheduled with interested individuals.

Measures

Questionnaires

Self-administered questionnaires included close-ended items in 5 domains: demographic characteristics, professional experience, attitudes towards older adults,

self-reported knowledge of aging-related health, and prior training in working with older adults. Attitudes towards older adults were assessed using the 14-item Geriatrics Attitudes Scale, which measures compassion towards older adults, the perceived social value of older adults, professional satisfaction working with older adults, and beliefs about the distribution of resources for older adults.[15] Each item was rated on a 5-level scale, with scores of 3 or higher indicating positive attitudes towards older adults.

Knowledge of aging and aging-related health was measured using a 5-item self-assessment. Content for knowledge items was chosen based on the study authors' experience in geriatric healthcare (BW, RTB) and included self-assessed ability to recognize and respond to older adults with cognitive impairment, delirium, or depression; identify barriers to communication, such as sensory impairment; describe types of surrogate decision-makers; identify older adults at high safety risk; and describe local organizations that provide social services to older adults. Each item was rated on a 5-level scale ranging from "cannot do at all" to "very certain can do." Participants also rated their overall knowledge about working with older adults on a 5-level scale (range, no specific knowledge to very knowledgeable).

To assess the need for training in aging-related health, participants were asked to report whether they had received prior professional training in working with older adults and to rate the importance of receiving further training on a 3-level scale (not important, moderately, or very important).

Open-ended questionnaire responses and qualitative interviews

Open-ended items were included in the questionnaire in order to contextualize

and expand participants' responses to the close-ended questions. In these items, participants were asked to identify areas related to aging and health in which they want further training, and to describe the most significant obstacles they encounter when interacting with older adults.

The qualitative interview guide included open-ended questions about participants' work with older adults, including probes related to participants' perceived role in the healthcare system, challenges they face when interacting with older adults, and recommendations for how to optimize police responses to incidents involving older adults. The guide was modified iteratively as additional interviews were completed to explore emerging themes.

Data analysis

Descriptive statistics were used to analyze close-ended responses to self-administered questionnaires and standard principles of grounded theory were used to analyze open-ended questionnaire responses and interviews. Interviews were recorded and transcribed, and constant comparative analysis was used to review data iteratively to identify new themes. Two researchers (RTB, CA) coded all transcripts with >80% concordance. As new themes emerged, new codes were developed and previous transcripts were recoded to reflect the new coding scheme. When no new themes emerged from subsequent transcripts, thematic saturation was reached, and no further interviews were conducted.

RESULTS

Characteristics of participants and professional experience

Of 174 eligible police officers, 141 completed questionnaires (81% response rate) and thematic saturation was reached after completing qualitative interviews with 11 participants. Of the 141 participants, most were under age 55 (93%), men (75%), and had at least 5 years of experience as police officers (73%; Table 1). The majority (89%) reported interacting with older adults in a professional capacity at least monthly. The subset of participants who completed qualitative interviews was similar to the larger group who completed questionnaires; 91% were under age 55, 64% were men, and 73% had at least 5 years of professional experience. Nearly all participants (96%) demonstrated a positive attitude towards older adults (Geriatrics Attitudes Scale score ≥3; Table 1).

Self-reported knowledge of aging-related health

Although 89% of police reported interacting with older adults at least monthly, only 32% considered themselves knowledgeable or very knowledgeable about aging-related health (Table 1). However, many participants rated themselves knowledgeable about specific aging-related health issues. For example, 89% reported that they could identify older persons at high safety risk, and 74% felt that they could identify and assess barriers to communication, such as hearing impairment.

In in-depth interviews, officers explained this apparent conflict between their self-reported general and specific knowledge, noting that while they feel confident identifying specific health issues among older adults, they lack the knowledge needed to

contextualize, address or resolve those issues. As one officer explained: “I know when someone is gravely disabled and unable to take care of themselves...but I wouldn't say I'm skilled in the sense of, ‘Okay, this organization is going to be good for you,’ or anything more than [that].’”

Roles police play in responding to older adults

Of the 89% of officers who reported interacting with older adults at least monthly, 41% reported that they encounter older adults at least weekly and 19% daily. In questionnaires and interviews, police described acting as first-responders to 3 types of incidents involving older adults: medical emergencies, reports of suspected criminal activity, and “welfare checks” to assess those identified by concerned neighbors or relatives. Police reported that all 3 types of incidents frequently involved older adults with complex social and medical issues, including social isolation, addiction disorders, mental health problems, and medical illness. Participants reported that medical emergencies often require police to perform CPR or call an ambulance, while responses to potential criminal activity require determining whether an underlying health problem contributed to the incident or whether to bring an older arrestee to an emergency department prior to jail. Similarly, welfare checks require police to perform more complex assessments to determine an older adult’s safety and self-care abilities. As one officer explained: “Let’s say you responded to somebody’s house to interview them. I wouldn’t want to leave there thinking this person can’t care for themselves, this person is in danger.”

To assess older adults’ safety, mental status, and need for medical referral, police

described relying on ad hoc methods. For example, one officer described his approach to welfare checks: “You have to make sure their living conditions are up to par, that they have food, that they’re able to answer what day of the week it is…just some general questions that [show] they are functioning and they know what’s going on.” However, officers emphasized that despite performing these rudimentary geriatric assessments, their primary task as first-responders is to identify appropriate medical and social service hand-offs for older adults rather than to provide direct services. As one officer noted: “We are police officers. We are not doctors. We are not psychologists. We are recognizing the basic need and responsible for getting that person to this person or that person, and that is really the extent of it.”

Challenges police encounter in responding to older adults

Participants reported several challenges when interacting with older adults. These included: (1) identifying and responding to aging-related health issues; (2) assessing the need for and ensuring appropriate medical and social service hand-offs; and (3) effectively communicating with clinicians (Table 3).

Identifying and responding to aging-related health issues

In both questionnaires and interviews, officers reported a need for more knowledge of aging-related health issues. Although 84% of police reported having received prior training in working with older adults, 95% felt that further training was important to address remaining knowledge gaps (Table 1). Specifically, officers described the challenge of distinguishing criminal activity from medical or psychiatric

issues, such as cognitive impairment or mental illness. Participants also noted the challenge of responding to specific aging-related conditions. While traditional police work typically requires officers to rapidly assess and triage a series of emergencies, encounters with older adults often require “slowing down” to assess and respond to hearing impairment, mobility impairment, cognitive impairment, or medical illness (Table 3). Participants stated that because they often have insufficient time and resources to respond effectively to these issues, incidents involving older adults tend to recur, as in the case of older adults with dementia who wander.

Assessing the need for and ensuring appropriate medical and social service hand-offs

Although officers emphasized that their primary task as first-responders is to identify appropriate hand-offs for those in need of referral, they described several barriers to doing so. First, officers reported that they lack knowledge about organizations that provide social services to older adults; overall only 42% could describe 3 such organizations (Table 1). Second, participants noted that even when they are aware of an appropriate service provider, services are often unavailable or understaffed after business hours when many police calls take place (Table 3). Third, officers stated that sometimes appropriate resources to address the issues they encounter with older adults simply do not exist. One officer noted that “There’s no one to look after them, and *we* get charged with looking after them.”

Communicating with clinicians

Many police reported that communication with healthcare providers in the

emergency department is often strained, particularly regarding older adults who are "frequent flyers" and those needing medical clearance before being brought to jail. Police reported that medical hand-offs are most effective when there is a sense of a shared mission to care for an older adult, but noted that medical professionals often fail to engage police effectively or to make time to clearly communicate with them about a patient's condition. One officer reported that when he brings "frequent flyers" to the emergency department, "The hospital will say, 'why are you bringing them here?' It's a push back and forth." Another officer stated: "The doctors will always have a way of being too busy. They're the most important people in the world and they're saving the world and they're too busy for this and too busy for that…And when they hand you some sort of medical record you can't even read it."

Police recommendations to improve their ability to respond to older adults

To address the challenges they face in their interactions with older adults, police recommended (1) developing practical trainings to help police recognize and respond to aging-related health issues; (2) improving police knowledge of and access to community resources; and (3) enhancing communication and collaboration between police and the healthcare system (Table 4).

Developing practical trainings to help police recognize and respond to aging-related issues

Officers called for more training about how to recognize cognitive impairment and other aging-related conditions, but cautioned that such training must be applicable to

real world situations. Specifically, several participants recommended developing case-based trainings to familiarize police with symptoms and behaviors typical of patients with dementia – such as paranoia, agitation, and aggression – that may be mistaken for, or contribute to, criminal activity. Others recommended training in communication with older adults with hearing or cognitive impairment and transportation for older adults with mobility impairment. Officers indicated that such trainings should include practical strategies to quickly assess and address such behaviors, given the limited time police have when responding to calls.

Improving police knowledge of and access to community resources for older adults

To help police identify appropriate medical and social service hand-offs for older adults, participants recommended developing trainings to improve police knowledge of and access to community resources. To improve knowledge of resources, participants recommended creating easily-accessible, portable reference materials (e.g., pocket guides). To improve access to services, participants recommended training a dedicated Patrol Division “aging expert” who could serve as a central resource for other officers. Officers also recommended ways to improve critical services including increasing the capacity of services available 24 hours a day, such as Adult Protective Services and mobile response teams; increasing funding for community services that address aging-related impairments (e.g., para-transit for individuals with impaired mobility) and for outreach programs that augment or replace police services (e.g., home visits by trained social workers); and revising police protocols to include procedures for responding to recurrent problems in vulnerable older adults, such as wandering in those with

dementia.

Enhancing communication and collaboration between police and clinicians

To improve communication and collaboration between police and clinicians, participants recommended educating clinicians about the role police play in the healthcare system, for example by developing brief educational videos depicting police work. Others recommended that police collaborate directly with clinicians and policy makers to develop improved community services and systems of care for older adults who interact frequently with both police and the healthcare system.

DISCUSSION

This mixed methods study found that police report interacting frequently with medically complex older adults in the community and having some knowledge of aging-related health issues, but also found that many police express that more training in aging-related health is important to their work. Participants emphasized that many police experiences with older adults focus on their need for medical and social services. Police further noted that they experience unique challenges during encounters with older adults, including the need to identify and address aging-related health issues and to ensure appropriate medical and social service hand-offs.

Although few studies have examined police interactions with older adults, this study's findings are consistent with others showing that older adults interact frequently with police and have unique patterns of interaction compared to younger adults.[2] For example, older adults have been found to encounter police less frequently as suspects, but more frequently as victims,[2,16] witnesses, or recipients of medical or social assistance.[17,18] This study's findings that police report concerns about the medical and social complexity of the older adults they encounter underscore the importance of overcoming operational silos between the medical and law enforcement systems to develop a collaborative approach to community services for older adults. Currently, the interactions between health and law enforcement professions often are limited to when police bring individuals to jails or emergency departments for medical evaluation. However, many of the officers in this study made recommendations to optimize outcomes for older adults that would require close collaboration between police and healthcare leaders, educators, and clinicians. For example, developing practical and

relevant trainings to help police distinguish between symptoms and signs of dementia, mental illness, and medical conditions would require collaboration between police and medical experts. Similarly, improving police access to, and knowledge of, community resources would require input from experts in social services for older adults, such as geriatric social workers.

Relatively few programs have been developed to prepare police to work with older adults.[19] However, at least 2 existing programs could serve as models for how to address the challenges that police encounter. The Safe Return program, a collaboration between New Jersey police departments and the Alzheimer's Association, includes a curriculum to teach police how to reduce wandering among older adults with dementia; educate community members about strategies to reduce wandering; and refer individuals who wander to a national registration program.[20] After the program was established, the number of police-sponsored community education programs increased substantially, as did the number of police referrals of wandering individuals to the registration program;[21] these results are consistent with the finding that police desire practical strategies to address recurrent geriatric health issues. Another program trained a specialized "Gray Squad" of police officers in communicating with and being sensitive to the concerns of older adults; older adults who interacted with these officers compared to other officers were more satisfied and expressed more positive attitudes towards police.[21] However, the potential for improved care of older adults via collaboration between police departments and healthcare professionals described in this study remains largely unmet.

This study has several limitations. Interviews took place after officers attended a

lecture describing aging-related health among older adults. While it is possible that the lecture influenced the content of the subsequent qualitative interviews, the themes identified in the interviews were not included in the lecture material. Furthermore, the interview findings echoed those of the questionnaire, which participants completed before the lecture. Because this study was conducted among officers in one urban police department, its findings may not be generalizable to police serving other communities. However, San Francisco police serve a large, racially and ethnically diverse population, and the challenges these officers encountered are likely to have generalizable lessons for many communities.

As the U.S. population ages, non-medical professionals including police are increasingly interacting with older adults with complex medical and social needs in our communities. In 2008, the Institute of Medicine's *Retooling for an Aging America* report found that healthcare and service providers from many professions are underprepared to care for older adults.[22] This study identifies some of the important challenges that police encounter in these interactions. In doing so, this study constitutes a critical first step towards fulfilling geriatricians' professional responsibility to teach the principles of aging-related health care issues to a group of community professionals who are fundamentally engaged in providing services to many at-risk older adults.[22] Developing practical geriatrics training for police and improving police access to social services for older adults have the potential to improve outcomes for vulnerable older adults. Moreover, police have unique insights into the needs of the most vulnerable older adults in our communities that could inform the work of clinicians, policy makers and departments of public health. Increased communication and collaboration between

health and law enforcement professionals holds substantial promise for improving the well-being of the many older adults who come into contact with law enforcement professionals.

Key words: Geriatrics, Police, Public Health Policy

REFERENCES

1. Aday RH, Krabill JJ. Older and geriatric offenders: Critical issues for the 21st century. In: Gideon L, ed. Special Needs Offenders in Correctional Institutions. 1st ed. Thousand Oaks, CA: SAGE Publications, 2013, pp 203-233. www.knowledge.sagepub.com/view/special-needs-offenders-in-correctional-institutions/n7.xml. Accessed January 27, 2014.

2. Lachs M, Bachman R, Williams C et al. Older adults as crime victims, perpetrators, witnesses, and complainants: A population-based study of police interactions. J Elder Abuse Neglect 2004;16(4):25-40.

3. Lachs MS, Williams CS, O'Brien S et al. The mortality of elder mistreatment. JAMA 1998;280(5):428-432.

4. Lachs MS, Williams CS, O'Brien S et al. Adult protective service use and nursing home placement. Gerontologist 2002;42(6):734-739.

5. Lachs M, Bachman R, Williams CS et al. Violent crime victimization increases the risk of nursing home placement in older adults. Gerontologist 2006;46(5):583-589.

6. Kushel MB, Hahn JA, Evans JL et al. Revolving doors: Imprisonment among the homeless and marginally housed population. Am J Public Health 2005;95(10):1747-1752.

7. Baillargeon J, Binswanger IA, Penn JV et al. Psychiatric disorders and repeat incarcerations: The revolving prison door. Am J Psychiatry 2009;166(1):103-109.

8. Fazel S, Baillargeon J. The health of prisoners. Lancet 2011;377(9769):956-965.

9. Dumont DM, Brockmann B, Dickman S et al. Public health and the epidemic of incarceration. Annu Rev Public Health 2012;33:325-339.

10. Williams BA, Goodwin JS, Baillargeon J et al. Addressing the aging crisis in US criminal justice health care. J Am Geriatr Soc 2012;60(6):1150-1156.

11. Williams BA, Stern MF, Mellow J et al. Aging in correctional custody: Setting a policy agenda for older prisoner health care. Am J Public Health 2012;102(8):1475-1481.

12. Geriatrics program creates elder abuse resource for police. News & Events 2013. UC Irvine Health (online). Available at: http://www.ucirvinehealth.org/news/2013/01/geriatrics-program-creates-elder-abuse-resource-for-police/. Accessed February 6, 2014.

13. Hill L, Rybar J, Farrow J. Two-hour Training and a Screening Tool to Help Law Enforcement Identify and Manage Older Unsafe Drivers. The Police Chief 2013 (online). Available at: www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display_arch&article_id=3179&issue_id=112013. Accessed February 6, 2014.

14. U.S. Department of Justice, Federal Bureau of Investigators, Crime in the United States, Table 38. Volume 2010. Washington, DC: Department of Justice, 2008.

15. Reuben DB, Lee M, Davis JW,Jr, et al. Development and validation of a geriatrics attitudes scale for primary care residents. J Am Geriatr Soc 1998;46(11):1425-1430.

16. Lachs M, Bove C, Wearing MH et al. Clinical epidemiology of crime victimization in older adults: A multidisciplinary pilot study. Journal of Elder Abuse and Neglect 2001;13:79-90.

17. Liederbach J, Stelle CD. Policing a graying population: A study of police contacts with older adults. Journal of Crime and Justice 2010;33(1):37-68.

18. Sykes RE, Fox JC, Clark JP. A socio-legal theory of police discretion. In: Niederhoffer A, Blumberg AS, eds. The Ambivalent Force: Perspectives on the Police. 2nd ed. Hinsdale, IL: Dryden Press; 1976, pp 171-183.

19. Frommer P, Papouchado K. Police as contributors to healthy communities: Aiken, South Carolina. Public Health Rep 2000;115(2-3):249-252.

20. Lachenmayr S, Goldman KD, Brand FS. Safe return: A community-based initiative between police officers and the Alzheimer's Association to increase the safety of people with Alzheimer's disease. Health Promotion Practic 2000;1(3):268-278.

21. Zevitz RG, Gurnack AM. Factors related to elderly crime victims' satisfaction with police service: The impact of Milwaukee's "Gray Squad." Gerontologist 1991;31(1):92-101.

22. Institute of Medicine for the National Academies. (2008). Retooling for an aging America: Building the healthcare workforce. Washington, DC: The National Academies Press. Available from: http://www.iom.edu/CMS/3809/40113/53452.aspx. Accessed February 17, 2014.

23. Geriatrics End-of-Training Entrustable Professional Activities (EPAs). Academic Resources. Association of Directors of Geriatric Academic Programs (online). Available at: http://adgap.americangeriatrics.org/academic-resources/competencies/entrustable-professional-activities/. Accessed February 12, 2014.

Table 1. Characteristics, Attitudes and Knowledge of 141 Police Officers

Characteristics	All police officers (n=141)
Age, years, No. (%)	
<30	22 (16)
30-54	109 (77)
55-65	7 (5)
>65	3 (2)
Female, No. (%)	35 (25)
Race/ethnicity, No. (%)	
White	65 (46)
Black	7 (5)
Latino	23 (16)
Asian or Pacific Islander	31 (22)
Other or more than one race	15 (11)
Professional experience, years, No. (%)	
1-4	38 (27)
5-20	86 (61)
>20	17 (12)
Frequency of encounters with older adults, No. (%)	
Less than monthly	16 (11)
Monthly or a few times per month	50 (35)
Weekly or a few times each week	51 (36)
Daily	24 (17)
Geriatrics Attitudes Scale, mean (SD)	3.7 (0.4)
Score ≥3	136 (96)
Self-rated knowledge about working with older adults, No. (%)	
No specific knowledge	16 (12)
Some or average knowledge	78 (56)

Knowledgeable	32 (23)
Very knowledgeable	13 (9)
Self-reported knowledge in geriatrics, No. (%)[a]	
Can describe how depression, delirium, and dementia each affect older adults	89 (63)
Can identify and assess barriers to communication such as hearing and/or vision impairments, speech difficulties, aphasia, limited health literacy, and cognitive disorders	103 (74)
Can describe the various types of surrogate decision makers, including public guardians or appointed power of attorneys	66 (47)
Can identify older persons at high safety risk, including for unsafe driving or elder abuse or neglect, and know what to do once you've identified the risk	125 (89)
Can describe 3 organizations in San Francisco that provide social services specifically for older adults	59 (42)
Received prior training in working with older adults in current profession, No. (%)	117 (84)
Self-rated importance of further training in working with older adults, No. (%)	
Not important	7 (5)
Moderately important	70 (50)
Very important	63 (45)

[a]Defined as a response of "moderately can do," "probably can do," or "very certain can do" the listed skills

Table 2. Challenges Police Encounter When Responding to Older Adults

Challenge	Domain	Quotation
Identifying and responding to aging-related health issues	Distinguish criminal complaints from cognitive impairment, mental illness, or medical illness	“She would say that the caregiver was trying to poison her and she would lock them out of the house if they went to take out the garbage…We can't even judge the validity of what she is saying.”
		“Initially I’m thinking I’m dealing with a fraud situation and it ends up it wasn’t that…in talking with her it shifted to the depression was giving her suicidal thoughts.”
	Requires extra time and resources	“When dealing with older people the most important thing for a police officer is just to slow everything down. Slow down the interview, slow down the talking. You can’t expect them to get up and move if you ask them to.”
	Hearing impairment	“They can’t hear you and you have to go slow and loud enough.”
	Mobility impairment	“We call a para-transport service [to transport them] and it takes forever before they get to us.”
	Medical conditions	“Usually people who are older [and are going to be arrested] have different medical problems…so they have to go to the hospital and get medically cleared and that will tie up a unit for at least a couple hours.”
	Chronic issues	“They’d go out for walks and they’d get lost

	that repeat	and it happened multiple times and it was a huge drain on police resources. The helicopter is called out – like literally." • "We end up going back to the same elderly person for the same kind of issues…it's kind of like a revolving door."
Assessing the need for and ensuring appropriate medical and social service hand-offs	Lack of knowledge	• "This is information, resources that are available to seniors that we know nothing about here at the station level."
	Lack of access: Services not available during off-hours	• "Obviously we work 24/7 and our crises do not happen Monday through Friday 8:00 to 5:00. Two a.m. Sunday morning…something could happen and there is nobody."
	Services don't exist	• "The remedies that are available to us in the moment are kind of limited. A lot of the time it is people can go to the hospital or they can go to jail."
Communicating with clinicians	Effective when shared mission	• "The healthcare providers for the most part want to do the right thing and they do allow us to give them what our professional opinions are….To me that is a doable situation because then we are all on the same page."
	Not effective when negative attitudes from clinicians	• "Usually when [an encounter with a clinician] is not positive it is around a suspect and they think maybe we are being a little too firm with them."

Table 3. Police Recommendations to Improve their Ability to Respond to Older Adults

Recommendations	Domain	Quotation
Developing practical trainings to help police recognize and respond to aging-related health issues	General aging-related health	“[Officers need] a basic education on what are the issues that [older adults] have at that particular phase of their life.”
	Distinguish criminal complaints from aging-related conditions	“We could use some more training as far as… trying to narrow down what is the actual problem, like what causes them to call the police.”
	Address impairments	“Something that would be helpful is training in how to transport them or how to be understanding of physical limitation.”
	Address recurrent issues among older adults	“Police teach people to burglar-proof their homes. We could help teach families to keep them from [wandering].”
Improving police knowledge of and access to community resources for older adults	Improve knowledge	“I would like to see…a 1-page thing or card that says, ‘Here are the things that are available and the different services that you can plug an older adult into.”
	Improve access: Increase staffing and hours	“Like maybe someone with a knowledge base [would help]. Let’s just say, for every person on a shift there was one person who would specialize in elderly care…or maybe a social worker per radio channel.”
		“Just having services readily available. ‘Call

		this number and a social worker comes out.'"
	Create resources to fill gaps	• "I think a Mobile Crisis for Elderly People would help." • "We need something that is available during the day or at least until, say, 7:00 or 8:00 p.m. like a drop-in urgent care facility that is just for seniors."
Enhancing communication and collaboration between police and clinicians	Educate clinicians	• "I don't know if they have a way of really explaining what our job entails, really going behind the scenes and seeing…Or actually seeing footage of [our job]: 'Oh, wow. I guess the officer really had no other choice.'"
	Increase collaboration with clinicians	• "I would love to be able to call someone… and say, 'Look, this guy has gone to the hospital 25 times. You need to open up a case on this guy and this needs to be dealt with.' But we don't…we are just on the scene, evaluating."