HHS Public Access

Author manuscript

J Am Geriatr Soc. Author manuscript; available in PMC 2018 August 01.

Published in final edited form as:

J Am Geriatr Soc. 2017 August ; 65(8): 1842–1847. doi:10.1111/jgs.14899.

Good cop, better cop: Evaluation of a geriatrics training program for police

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Abstract

Objectives—To develop, implement, and evaluate a training program in aging-related health for police officers.

Design—Cross-sectional.

Setting—"Crisis Intervention Training" program for police officers in San Francisco.

Participants—143 police officers attending one of five 2-hour trainings.

Intervention—A lecture on aging-related health conditions pertinent to police work followed by three experiential trainings on how it feels to be "old."

Measurements—Participants evaluated the quality of the training and the likelihood that they would apply new knowledge to their work, and rated their knowledge using a retrospective pre-post evaluation. In open-ended responses, participants reported work-related changes they anticipated making in response to the training.

Results—All 143 participants completed the evaluation. Most (84%) reported interacting with older adults at least monthly; 45% reported daily interactions. Participants rated the training quality at 4.6/5 and the likelihood they would apply new knowledge to their work at 4.4/5.

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This manuscript was presented as an oral abstract at the 2016 Annual Scientific Meeting of the American Geriatrics Society, May 19, 2016, Long Beach, California.

Author Contributions:

Drs. Brown and Williams had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Brown, Ahalt, Williams.

Acquisition of data: Brown, Ahalt, Williams.

Statistical analysis: Cenzer.

Analysis and interpretation of data: Brown, Ahalt, Rivera, Cenzer, Wilhelm, Williams.

Drafting of the manuscript: Brown.

Critical revision of the manuscript for important intellectual content: Brown, Ahalt, Rivera, Cenzer, Wilhelm, Williams.

Final approval of manuscript for submission: Brown, Ahalt, Rivera, Cenzer, Wilhelm, Williams.

Retrospective pre-post knowledge scores increased for all domains, including how to identify aging-related health conditions that can affect safety during police interactions (2.9/5 to 4.2/5; p<. 001). In open-ended responses, participants anticipated having more empathy for and awareness of aging-related conditions, and greater ability to provide older adults with appropriate community referrals.

Conclusion—A brief training in aging-related health significantly increased police officers' self-reported knowledge and skills. Clinicians have an important opportunity to help enhance safe and effective community policing for older adults.

Keywords

police; training; evaluation; aged

INTRODUCTION

As the population ages, police increasingly serve as first responders to incidents in which aging-related health or social problems play a central role.[1–3] For example, police are called for disruptive behavior due to cognitive impairment or substance use, to assess victims of elder abuse or neglect, and to perform "welfare checks" for at-risk isolated older adults.[4] These older adults represent an extremely medically vulnerable group. Older arrestees have high burdens of multimorbidity, mental illness, and psychosocial needs,[5–9] and older crime victims are at increased risk for nursing home placement and death.[10–12]

As first responders, police assess and triage these medically vulnerable older adults – oftentimes before they are seen by a clinician. When police lack knowledge about aging-related health, they risk causing unintended harms to older adults, such as using excessive force to respond to disruptive behavior related to dementia.[13–15] Yet previous research shows that police receive little training in aging-related health and have key knowledge gaps that may limit their ability to assess and triage older adults.[4] For example, officers engage with older adults who have sensory, cognitive, and functional impairments, but many report challenges in identifying and responding to these conditions. Similarly, officers perform welfare checks for at-risk isolated older adults, but report lacking knowledge about which community resources are available to help.[4]

In a previous study, police recommended addressing these knowledge gaps by developing an interactive, practical training focused on recognizing and responding to aging-related conditions and improving knowledge of community resources.[4] Nationally, several educational programs aim to improve officers' knowledge and skills in specific aspects of their interactions with older adults, such as responding to elder abuse[16] and identifying unsafe drivers.[17] However, these programs do not address officers' requests to learn basic knowledge about aging-related health that would allow them to more effectively assess and triage older adults. We developed, implemented, and evaluated a brief geriatrics training to address these educational needs.

METHODS

Design overview

We developed, implemented, and evaluated a training in aging-related health for police officers in San Francisco. The institutional review board of the University of California, San Francisco approved the program evaluation.

Training development

The San Francisco Police Department (SFPD) requested that a training in aging-related health be incorporated into their 40-hour "Crisis Intervention Training" (CIT). The CIT program includes lectures about special populations and is mandatory for Patrol Division officers. The Division includes nearly 1000 patrol officers who respond to community calls. Trainings are held quarterly and each includes 25–40 officers. The sample of officers for this study included all attendees of five trainings held between March 2015 and September 2016.

We developed the training in collaboration with SFPD, using an iterative process. We first developed a prototype training based on the results of an extensive needs assessment[4] that ascertained officers' knowledge of aging-related health, challenges encountered with older adults, and recommendations for how to address challenges. The training aimed to address the greatest police-identified knowledge gaps: (1) recognizing and responding to aging-related conditions that can affect older adults' safety during police interactions, and (2) improving knowledge of community resources for older adults. In response to police recommendations for how they would like to learn new material, the training included an interactive 45-minute lecture followed by three 15-minute small-group experiential trainings. The training was delivered at several sessions in 2014 and modified iteratively based on written and oral feedback from trainees. Modifications included increasing audience interaction during the lecture and adding additional discussion following the small-group sessions.

The final lecture focused on aging-related health issues that may put older adults at risk for needing police intervention or affect police interactions, including substance use, cognitive impairment and dementia-related behaviors, sensory and functional impairment, and elder abuse. It also included an overview of community resources for older adults (e.g., local Institute on Aging,[18] senior centers, mental health services, meal programs, homeless shelters, and an older adult "ex-offender" reentry program[19]). Trainees received a 1-page handout describing these resources.

The experiential trainings included three stations simulating the effect of aging-related health changes on older adults' ability to perform basic daily activities (walking, dressing, and managing medications), using an adapted version of the Aging Simulation Sensitivity Training Kit.[20] Adaptations were designed to enhance features relevant to police work. Before completing each station, officers participated in facilitated discussion in which they considered how aging-related impairments might affect older adults' interactions with police, including the ability to follow an officer's instructions, provide a history, or get into a police car. At the mobility station, participants practiced walking with a cane that was too short in order to demonstrate that older adults in the community often lack access to

appropriate adaptive equipment, and bungee cords attached around participants' ankles mimicked both restricted hip mobility and being held in leg restraints during an arrest. At the medication management station, participants learned how easily older adults can take the wrong medication or dosage, and how this could impair judgment or cause confusion.

Training evaluation

After the training, police completed self-administered questionnaires including closed-ended and open-ended questions. The closed-ended questions included 3 domains: participant demographics and professional experience; training content evaluation (5-point Likert scale, 5 excellent, 1 poor); and retrospective pre-post evaluation of participants' knowledge and skills rated on the same scale. Retrospective pre-post evaluations are done at the end of an educational intervention and ask participants to retrospectively compare what they knew before the session to what they know after. This approach has better criterion validity and sensitivity to change than traditional pre-post evaluations.[21,22]

The questionnaire included open-ended items to expand responses to closed-ended items. Participants were asked to identify changes in their attitudes towards older adults following the training ("list something you learned that you will take with you when you return to work") and changes in intended behavior ("list something you plan to do differently in your work as a result of what you learned today"). Previous studies show that attitudes and behavioral intention are highly correlated with subsequent behavior.[23] We also asked participants to identify additional areas in which they wanted further training about older adults.

Statistical analysis

We used descriptive statistics to analyze closed-ended responses to questionnaires, and inductive thematic analysis to analyze open-ended responses.[24] Constant comparative analysis was used to develop a codebook for the open-ended responses, code responses into common categories, and identify overarching themes.[25] Two researchers (RTB, CA) independently coded all transcripts with greater than 80% concordance. As new themes emerged, new codes were developed, and previous responses were recoded to reflect the new coding scheme.

RESULTS

Participant characteristics and professional experience

All 143 attendees completed the evaluation. Participants' mean age was 31 years and 83% were male (Table 1). Overall, 27% had at least 5 years of policing experience. Eighty-four percent interacted professionally with older adults at least monthly; 45% reported daily interactions. Of all professional encounters, participants estimated that approximately one in five (19%) involved older adults. Nearly half (44%) reported receiving enough prior professional training about older adults to prepare them for their work, although only 34% had received prior training in dementia and 62% in elder abuse.

Evaluation of training quality and retrospective pre-post knowledge assessment

Participants rated the overall training quality at 4.6 of 5 (SD, 0.7; Table 2). Ratings for overall educational content and for each small-group learning activity ranged from 4.4 to 4.8 (SD, 0.5–0.8). Eighty-six percent of officers endorsed a "very good" or "excellent" likelihood that they would apply what they had learned to their work.

Retrospective pre-to-post knowledge scores increased significantly for all domains, including identifying aging-related health changes that can affect safety during police interactions (2.9/5 to 4.2/5, p<.001; Table 2) and understanding that dementia can cause changes in behavior and judgment (3.1/5 to 4.3/5, p<.001).

Responses to open-ended questions

Three themes emerged from open-ended responses regarding changes in attitudes and intended behavior. These included (1) having increased empathy and patience for older adults; (2) being more aware of aging-related health conditions and how they might affect police work; and (3) using new knowledge from the training to provide appropriate community referrals (Supplemental Table 1).

Having increased empathy and patience for older adults—Officers noted that participating in the small-group experiential trainings gave them empathy for aging-related challenges. One officer wrote, "I learned how the elderly feel after going through the simulations. Before I hadn't put myself in their shoes." Officers anticipated that empathizing with older adults would improve their communication strategies in several ways. Multiple participants noted that they would be more "patient," "understanding," or "sympathetic" towards older adults. Others intended to improve their communication with older adults by slowing the interaction, speaking more slowly and clearly, or anticipating difficulties an older adult might have responding to commands. Others commented that the simulation training helped them draw on their personal life for empathy, by treating individuals encountered at work "as if they were my parents."

Increased awareness of aging-related conditions and how they affect police work—Officers reported an increased understanding of aging-related "challenges" and "impairments," and anticipated several ways these impairments might affect police interactions. Several participants endorsed increased awareness of how sensory or mobility impairments could impair older adults' ability to respond quickly to officers' requests. Others noted their heightened awareness that "hidden" cognitive impairment can be a communication barrier. As one officer reported, he would "realize that someone's outward appearance does not necessarily mean something in regards to mental capacity." Others reported a new appreciation for how aging-related conditions can increase vulnerability to financial scams and elder abuse.

Using knowledge to provide appropriate community referrals for older adults—In a third theme, officers reported that the training improved their knowledge of "great resources" that they planned to use to mobilize referrals. Officers emphasized that providing such referrals would bring great benefit but would also require practice change and extra

effort. One officer wrote of his intention to "go out of my way if possible to provide more resources," while another planned to do "more triaging and calls to APS [Adult Protective Services] in order to be preventative." Another noted that by offering resources to the elderly, he would "let them know some help exists."

Ideas for additional training—Officers identified several topics for future, more in-depth training. Requests included more detail about referrals and how to interact with other agencies, especially APS; how to best respond to older adults with cognitive impairment and dementia-related behaviors; how to help older adults who wander; how to communicate most effectively with individuals with sensory impairments; how to safely transfer functionally-impaired older adults; and more in-depth information about the signs of elder abuse and how to distinguish these from injuries.

DISCUSSION

We found that a short, targeted training in aging-related health changed police officers' self-reported attitudes, knowledge, and anticipated behavior towards older adults. Police officers reported having increased empathy and patience towards older adults following the training, and new knowledge about aging-related conditions and community resources. Officers were enthusiastic about the training and identified multiple areas for additional training. As police departments across the country seek to improve responses to vulnerable populations, this study identifies a time-efficient, scalable approach to aid in that effort.

The 2015 President's Task Force on 21st Century Policing called on police departments to develop policies and procedures for working with older adults.[26] Nationally, training programs exist that focus on improving officers' knowledge and skills in specific interactions with older adults, such as identifying impairment among aging drivers,[17] responding to wandering in dementia,[27] preventing crimes,[28] and responding to elder abuse.[16] This training provides a critical foundation for such programs by educating police more broadly in the role that aging-related health plays in the safe and effective policing of older adults, and in approaches to mobilizing local resources.[4]

Participants highly valued the small group experiential sessions simulating aging-related health challenges.[20] Prior research shows that experiential learning can engender empathy[29] – a central theme that emerged in evaluations. Indeed, officers noted that the experience of empathizing with older adults reinforced their understanding of aging-related health problems and their commitment to changing their behavior in future interactions.

These findings have important policy implications. Police departments nationwide are seeking to improve responses in crisis situations. A leading approach is through "community policing," which uses community partnerships to achieve shared problem solving.[30] An educational model at the forefront of community policing reform is the Crisis Intervention Team (CIT), which promotes more effective interactions between law enforcement and individuals with mental illness.[31] Although these programs have defined mental illness narrowly (as Axis I disorders such as depression and schizophrenia), aging-related health problems may present with symptoms similar to mental illness, or may compound crises

involving individuals with mental illness. For example, dementia-related agitation could be mistaken for psychosis, and an older adult with mental illness may have impairments (e.g., hearing loss) that could compromise safety during police interactions. Familiarity with these aging-related conditions is critical for police to minimize the risk of unintended harm.[13–15]

CIT programs are now becoming a mandatory component of police training nationwide. Police departments have an important opportunity to incorporate training in aging-related health into their CIT programs, to build the educational capacity needed to enhance safety for older adults. The SFPD is among the very first jurisdictions, if not only, to incorporate training in general aging-related health into their CIT program, and could serve as a model for replication in other communities.

Several limitations should be considered when interpreting these results. Knowledge was self-assessed, because instruments to assess knowledge about aging-related health exist for clinicians but not police.[32] As a result, participants may have overestimated their baseline knowledge. However, the retrospective pre-post evaluation is designed to minimize this risk: by assessing baseline knowledge after the training, participants are more likely to recognize limitations in their knowledge before the training.[21] This study was cross-sectional, and did not assess the training's long-term impact on police practice. However, many educational interventions use this approach because studies show that attitudes and behavioral intention are highly correlated with subsequent behavior.[23] Moreover, though not included in the formal program evaluation, several additional sources of feedback point to the training's impact on practice. During small group discussion, many officers discussed specific ways that they would apply new knowledge to their work. Additionally, because officers highly rated the training's practical value, our session received a 2-hour time slot rather than the standard 1-hour. Finally, although the training was completed in a single urban police department, this study describes a blueprint for police training in aging-related health that can be adapted to meet the needs of other communities.

Adverse police interactions with community members have been scrutinized in recent years. We found that a brief, practical training in aging-related health changed police officers' attitudes, knowledge, and anticipated behavior towards older adults. The ongoing training has also enabled the geriatrician-police partnership to grow; next steps include evaluating local policies to improve police interactions with older adults. The rapidly aging U.S. population requires new workforce skills in aging-related health.[33] This training represents a time-efficient, scalable approach to enhancing safe and effective community policing.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

Conflict of interest:

I affirm that I have listed everyone who has contributed significantly to the authorship of the paper, and obtained written consent from all contributors who are named in the Acknowledgment section.

Elements of Financial/Personal Conflicts	RTB		CA		JR		ISC		AW		BW	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Employment or Affiliation		X		X		X		X		X		X
Grants/Funds		X		X		X		X		X		X
Honoraria		X		X		X		X		X		X
Speaker Forum		X		X		X		X		X		X
Consultant		X		X		X		X		X		X
Stocks		X		X		X		X		X		X
Royalties		X		X		X		X		X		X
Expert Testimony		X		X		X		X		X		X
Board Member		X		X		X		X		X		X
Patents		X		X		X		X		X		X
Personal Relationship		X		X		X		X		X		X

Sponsor's Role:

The funding sources had no role in the design or conduct of the study; in the collection, analysis, or interpretation of the data; in the preparation, review, or approval of the manuscript; or in the decision to submit the manuscript for publication.

Funding sources and related paper presentations:

This work was supported by grant KL2TR000143 from the National Center for Advancing Translational Sciences, National Institutes of Health, through UCSF-Clinical and Translational Sciences Institute (Dr. Brown), by grant K23AG045290 from the National Institute on Aging at the National Institutes of Health (Dr. Brown), by grant P30AG044281 from the National Institute on Aging at the National Institutes of Health (Dr. Brown), by Tideswell at UCSF (Drs. Brown and Williams), by the Jacob and Valeria Langeloth Foundation (Dr. Williams), by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under the Geriatrics Workforce Enhancement Program, Grant Number U1QHP28727 (Dr. Williams), and by the UCSF Department of Medicine (Dr. Williams). These funding sources had no role in the preparation, review, or approval of the manuscript. Drs. Brown and Williams are employees of the San Francisco VA Medical Center. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, the Department of Veterans Affairs, or the U.S. Government.

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Table 1

Previous Experience and Aging-Related Health Training of Police Officers (n=76)

Characteristics	All police officers (n=143)
Age, mean years (SD)	31 (1)[a]
Male, No. (%)	118 (83)
Professional experience, years, No. (%)	
<1	68 (49)
1–4	34 (24)
5–20	30 (22)
>20	7 (5)
Frequency of encounters with older adults, No. (%)[b]	
Never	19 (16)
Monthly or a few times per month	23 (19)
Weekly or a few times per week	24 (20)
Daily	53 (45)
Of all professional encounters, estimated percentage involving older adults, mean percentage (SD)	18 (19)
Received enough prior professional training about older adults to prepare for work, No. (%)	61 (44)
Received prior professional training in geriatrics, No. (%)	
Dementia	48 (34)
Falls	38 (27)
Hearing and vision impairment	48 (34)
Elder abuse	89 (62)
Aging-related health problems	40 (28)

SD, standard deviation.

[a] Age data were not available for the 25 participants attending the September 2016 training.

[b] Total n is less than 143 as the training sessions included 24 new police recruits who did not have prior professional experience.

Table 2

Evaluation of Aging-Related Health Training Program by Police Officers (n=76)

Evaluation of individual training components[a]			
Rating of training session, mean score (SD)	5-point Likert scale (5 excellent, 1 poor)		
Educational content	4.4 (0.7)		
Information and resources shared	4.4 (0.7)		
Opportunities for questions and discussion	4.5 (0.8)		
Hands-on learning activity: mobility impairment	4.8 (0.5)		
Hands-on learning activity: dexterity	4.7 (0.5)		
Hands-on learning activity: medication management	4.7 (0.6)		
Likelihood will apply what you learned to your work	4.4 (0.7)		
Overall quality of the session	4.6 (0.7)		
Retrospective pre-post evaluation[b]			
Rating of knowledge and skills before versus after training, mean (SD)	**Retrospective pre**	**Post**	**P value**
Apply principles of geriatrics and aging to your work	2.5 (0.9)	4.0 (0.6)	<.001
Explain that the general population and criminal justice population are aging	2.4 (1.1)	4.1 (0.8)	<.001
Recognize that the health of older adults varies widely	3.1 (1.0)	4.3 (0.6)	<.001
Identify common age-related changes that can affect safety in the criminal justice system (e.g., changes in memory, vision, hearing, skin)	2.9 (1.0)	4.2 (0.7)	<.001
Be familiar with conditions that are common in aging such as vulnerability to heat and cold	3.0 (1.1)	4.2 (0.7)	<.001
Understand that dementia can cause changes in behavior and judgment	3.1 (1.2)	4.3 (0.7)	<.001
Knowledge that memory impairment and dementia can place an older adult at risk for elder abuse	3.3 (1.1)	4.3 (0.7)	<.001
Knowledge that elder abuse is common and underreported	3.3 (1.1)	4.3 (0.7)	<.001
Ability to identify signs of elder abuse	3.1 (1.1)	4.2 (0.8)	<.001
Knowledge of changes in alcohol tolerance in older adults	2.6 (1.2)	4.3 (0.7)	<.001

SD, standard deviation.

[a] Evaluation of training components conducted on a 5-point Likert scale (5 excellent, 1 poor).

[b] Retrospective pre-post assessments conducted on a 5-point Likert scale (5 excellent, 1 poor).