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

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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. Eighty-nine percent of officers reported interacting with older adults at least monthly. Although 84% of police reported prior training in working with older adults, only 32% rated themselves as 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 handoffs. 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, because they assume 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. **J Am Geriatr Soc 62:2191–2198, 2014.**

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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, or a substance use disorder. In situations such as these, criminal justice and health concerns intersect, and police serve as the primary link between older adults with acute healthcare needs and clinicians in a variety of settings, including emergency departments and county jails. However, 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 users of acute care services. For example, older victims of crimes (including elder abuse) are at greater risk of institutionalization and death.[3–5] Older arrestees have disproportionate rates of 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. Although some emerging programs encourage collaboration between public safety and health professionals in important areas such as elder abuse[12] and unsafe driving,[13] overall police knowledge of geriatric health problems affecting older adults has not

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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 the ability to identify opportunities for collaboration between health and law enforcement professionals to optimize police responses to high-risk, community-dwelling older adults.[14]

This mixed-methods study assessed police knowledge of aging-related health, identified challenges police experience in encounters with older adults, and elicited recommendations for how to bridge their knowledge gaps to address those challenges. A better understanding of the roles police assume in responding to older adults and the knowledge and services they need to perform those roles would help medical and law enforcement professionals develop joint strategies to improve outcomes for medically vulnerable older adults in the community who interact with police.

METHODS

Design Overview

This mixed-methods study of police officers was conducted in San Francisco using self-administered questionnaires and semistructured qualitative interviews between October 2011 and April 2013. The institutional review board of the University of California at San Francisco approved the study.

Setting and Participants

Police officers were recruited from a quarterly Crisis Intervention Training that is mandatory for all officers in the Patrol Division of the San Francisco Police Department. The Patrol Division comprises approximately 1,000 officers who respond to calls from the community and patrol the city. Each training session includes 30 to 40 officers.

The mandatory training program includes a weeklong series of lectures about special populations, including one lecture about aging-related health. The lecture on aging-related health was not itself part of the study but served as a forum for recruiting police into the study. Before hearing this lecture, police officers were asked to complete self-administered questionnaires that included closed- and open-ended questions designed to determine self-assessed geriatrics knowledge gaps for police officers and their recommendations for how to best fill those gaps. The questionnaires incorporated self-assessments to maximally engage police in identifying their knowledge gaps and need for further training in aging-related health.[15] 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

To determine the extent of police officers' interactions with older adults and their previous professional training, officers completed self-administered questionnaires including closed-ended questions in five domains: demographic characteristics, professional experience, attitudes toward older adults, self-reported knowledge of aging-related health, and prior training in working with older adults (aged ≥55, consistent with the definition that the Bureau of Justice Statistics uses to define older adults involved with the criminal justice system).[16] Attitudes toward older adults were assessed using the 14-item Geriatrics Attitudes Scale, which measures compassion toward older adults, perceived social value of older adults, professional satisfaction working with older adults, and beliefs about distribution of resources for older adults.[17] The Geriatrics Attitudes Scale has been previously used with medical[17,18] and nonmedical professionals.[19] Each item was rated on a five-level scale (1–5) and an overall mean score was calculated by dividing the total score by 14; a mean score greater than 3 out of five indicated a positive attitude toward older adults.[17]

Knowledge of aging and aging-related health was measured using a five-item self-assessment. Content for knowledge items was chosen based on the study authors' experience in geriatric health care (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 five-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 five-level scale (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 three-level scale (not important, moderately important, very important).

Open-Ended Questionnaire Responses and Qualitative Interviews

Open-ended items were included in the questionnaire to contextualize and expand participant responses to the closed-ended questions. In these items, participants were asked to identify areas related to aging and health in which they wanted further training and to describe the most-significant obstacles they encountered 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 faced 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 closed-ended responses to self-administered questionnaires, and

standard principles of grounded theory were used to analyze open-ended questionnaire responses and interviews.[20] Interviews were recorded and transcribed. Constant comparative analysis was used to develop a codebook, to code responses into common categories, and to identify overarching themes.[20] Two researchers (RTB, CA) independently coded all transcripts with greater than 80% concordance. As new themes emerged, new codes were developed, and previous transcripts were recoded to reflect the new coding scheme. Interviews were coded in groups of three to four transcripts at a time. When no new themes emerged from a subsequent group of 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, 93% were younger than 55, 75% were male (75%), and 73% had at least 5 years of experience as police officers (Table 1). Eighty-nine percent reported interacting with older adults in a professional capacity at least monthly. The subset of participants that completed qualitative interviews was similar to the larger group that completed questionnaires; 91%

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

Characteristics	Value
Age, n (%)	
<30	22 (16)
30–54	109 (77)
55–64	7 (5)
≥65	3 (2)
Female, n (%)	35 (25)
Race and ethnicity, n (%)	
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, n (%)	
1–4	38 (27)
5–19	86 (61)
≥20	17 (12)
Frequency of encounters with older adults, n (%)	
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 score	
Mean ± SD[a]	3.7 ± 0.4
>3, n (%)	136 (96)
Self-rated knowledge about working with older adults, n (%)	
No specific knowledge	16 (12)
Some or average knowledge	78 (56)
Knowledgeable	32 (23)
Very knowledgeable	13 (9)
Self-reported knowledge of geriatrics, n (%)[b]	
Can describe how depression, delirium, and dementia each affect older adults, n (%)	89 (63)
Can identify and assess barriers to communication such as hearing and vision impairment, speech difficulties, aphasia, limited health literacy, and cognitive disorders, n (%)	103 (74)
Can describe the various types of surrogate decision-makers, including public guardians and appointed power of attorneys, n (%)	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 they have identified the risk, n (%)	125 (89)
Can describe three organizations in San Francisco that provide social services specifically for older adults, n (%)	59 (42)
Received prior training in working with older adults in current profession, n (%)	117 (84)
Self-rated importance of further training in working with older adults, n (%)	
Not important	7 (5)
Moderately important	70 (50)
Very important	63 (45)

[a] Measured using the 14-item Geriatrics Attitudes Scale (range 1–5).[15]

[b] A response of moderately can do, probably can do, or very certain can do the listed skills.

were younger than 55, 64% were male, and 73% had at least 5 years of professional experience. Ninety-six percent of participants demonstrated a positive attitude toward 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), although many rated themselves as knowledgeable about specific aging-related health matters. 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, although they felt confident identifying specific health problems in older adults, they lacked the knowledge needed to contextualize, address, or resolve those problems. 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 encountered older adults at least weekly and 19% daily. In questionnaires and interviews, police described acting as first responders to three types of incidents involving older adults: medical emergencies, reports of suspected criminal activity, and "welfare checks" to assess those that concerned neighbors or relatives identified. Police reported that all three types of incidents frequently involved older

Table 2. Challenges Police Encounter When Responding to Older Adults

Challenge	Domain	Quotation
Identifying and responding to aging-related health needs	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 that repeat	"They'd go out for walks, and they'd get lost, 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 handoffs	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."

adults with complex social and medical needs, including social isolation, addiction disorders, mental health problems, and medical illness. Participants reported that medical emergencies often required police to perform cardiopulmonary resuscitation or call an ambulance, whereas responses to potential criminal activity required determining whether an underlying health problem contributed to the incident or whether to bring an older arrestee to an emergency department before 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," but officers emphasized that, despite performing these rudimentary geriatric assessments, their primary task as first responders is to identify appropriate medical and social service handoffs 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 Officers Encounter in Responding to Older Adults

Participants reported several challenges when interacting with older adults: identifying and responding to aging-related health needs, assessing the need for and ensuring appropriate medical and social service handoffs, and effectively communicating with clinicians (Table 2).

Identifying and Responding to Aging-Related Health Needs

In questionnaires and interviews, officers reported a need for more knowledge of aging-related health issues. Although 84% of officers 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 problems such as cognitive impairment and mental illness. Participants also noted the challenge of responding to specific aging-related conditions. Although traditional police work typically requires officers to assess and triage a series of emergencies rapidly, encounters with older adults often require "slowing down" to assess and respond to hearing impairment, mobility impairment, cognitive impairment, or medical illness (Table 2). Participants stated that,

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 needs	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 problems in 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."

because they often have insufficient time and resources to respond effectively to these problems, 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 Handoffs

Although officers emphasized that their primary task as first responders is to identify appropriate handoffs 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; only 42% could describe three 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 2). Third, officers stated that appropriate resources to address the problems that they encounter with older adults sometimes simply do not exist, especially for socially isolated older adults without involved family members. One officer noted, "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 handoffs are most effective when there is a sense of a shared mission to care for older adults but noted that medical professionals often fail to engage police effectively or to make time to communicate with them clearly about an individual'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 developing practical trainings to help police recognize and respond to aging-related health needs, improving police knowledge of and access to community resources, and enhancing communication and collaboration between police and the healthcare system (Table 3).

Developing Practical Trainings to Help Police Recognize and Respond to Aging-Related Needs

Officers called for more training on 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 individuals 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 assess and address such behaviors quickly, 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 handoffs 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., paratransit 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 better community services and systems of care for older adults who interact frequently with 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 problems and to ensure appropriate medical and social service handoffs.

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 patterns of interaction different from those of younger adults.[2] For example, older adults have been found to encounter police less frequently as suspects but more frequently as victims,[2,21] witnesses, or recipients of medical or social assistance.[22,23] This study's findings that police have concerns about the medical and social complexity of the older adults they encounter underscore the importance of overcoming operational silos in the medical and law enforcement systems to develop a collaborative approach to community services for older adults. The interactions between health and law enforcement professions often are limited to when police bring individuals to jails or emergency departments for medical evaluation. Many of the officers made recommendations to optimize outcomes for older adults that would require close collaboration between police and healthcare leaders, educators, and providers. 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 for older adults who would like access to such services or for older adults who are not competent to make that choice for themselves would require input from experts in social services for older adults, such as geriatric social workers.

Few programs have been developed to prepare police to work with older adults,[24] although several 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 in older adults with dementia, educate community members about strategies to reduce wandering, and refer individuals who wander to a national registration program.[25] 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;[25] these results are consistent with the finding that police desire practical strategies to address recurrent geriatric health problems. 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 were more satisfied and expressed more-positive attitudes toward police than those who interacted with other officers.[26] One Maine county developed a Friendly Caller program during the winter for socially isolated older adults who live alone; older adults who do not call in daily receive a call to ensure their safety. This proactive strategy provides social support while identifying potential medical emergencies,[27] but the potential for better care of older adults through 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 trends in the criminal justice population and health problems common in older adults in jail and prison. Although it is possible that the lecture had some influence on the qualitative interviews, none of the themes that emerged in the interviews were included in the lecture material. Furthermore, the interview findings echoed those of the questionnaire, which participants completed before the lecture. The questionnaire used a self-assessment of geriatrics knowledge rather than an independent knowledge assessment. Although in some instances, independent assessment of knowledge can be more accurate than self-assessment,[28] established tools for testing geriatrics knowledge have been developed for healthcare professionals[29] and are unlikely to capture the knowledge that police need in their professional careers. Furthermore, the goal was to determine police officers' self-assessed knowledge gaps because professional training programs that build upon self-assessed need for knowledge and training are more likely to lead to change in practice.[15] Although the Geriatrics Attitudes Scale has not previously been used with police officers, it has been used with medical[17,18] and nonmedical professionals,[19] and the mean scores and standard deviations for the scale in this study were similar to those identified in previous work.[17–19] Because this study was conducted in officers in one urban police department, its findings may not be generalizable to police serving other communities, although 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. This study focused on identifying police attitudes toward aging and the geriatrics training needs that would help their professional performance. An important next study will be to develop and evaluate a geriatrics training program based on these results.

As the U.S. population ages, nonmedical professionals including police are increasingly interacting with older adults with complex medical and social needs in the community. 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.[30] The current study identifies some of the important challenges that police encounter in these interactions. In doing so, it constitutes a critical first step toward fulfilling geriatricians' professional responsibility to teach the principles of aging-related health to a group of community professionals who are fundamentally engaged in providing services to many at-risk older adults.[31] 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 the community that could inform the work of clinicians, policy-makers, and departments of public health. The findings further suggest significant opportunities for geriatricians to inform local, state, and national policy and to partner directly with law enforcement professionals to ensure that knowledge about aging and principles of geriatric care are widely shared to help identify and improve quality of care for medically and socially vulnerable older adults.

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