Safe Return: A Community-Based Initiative Between Police Officers and the Alzheimer's Association to Increase the Safety of People With Alzheimer's Disease

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A partnership initiated by an Alzheimer's Association (AA) chapter and police departments in 11 New Jersey counties sought to increase enrollment of people with Alzheimer's disease (AD) in a national registration program and expand community AD outreach efforts by training police officers about potentially dangerous wandering behavior in people with the disease. During the first 4 months of the program, almost 3,000 police officers learned how to reduce dangerous wandering behavior in people with AD, to make referrals to the national registration program, and to conduct Alzheimer outreach programs in their communities. Police-sponsored AD community outreach programs increased dramatically, as did enrollment in the national registration program. The authors provide a rationale for health education partnerships with police officers, describe the role of theory in the design, implementation, and evaluation of the officer training program, discuss the initiative and its impact, and offer recommendations for future programs and related research.

INTRODUCTION

Alzheimer's Disease and Wandering. Alzheimer's Disease (AD) is a growing public health concern. Currently, more than 5 million people in the United States have been diagnosed with AD (Alzheimer's Association, 1998). Incidence of AD increases dramatically with age; 10% of people older than age 65 develop the disease, and more than 47% of those over 85 are affected (Evans et al., 1990). By the middle of the 21st century, it is estimated that over 14 million people in the United States will have the disease (Alzheimer's Association, Public Policy Committee, 1997; U.S. Bureau of Census, 1990).

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The cause of this progressive, degenerative disease is unknown. What is known is that damage occurs to nerve cells in the brain, resulting in the loss of cognitive function, which affects one's ability to think, reason, and remember. To date, no medication can reverse the progression of the disease, and there is no cure. The stages and symptoms of the disease have been well documented (Alzheimer's Association, 1996).

One behavior frequently manifested in people with AD is wandering. Although pacing or aimless movement in itself is not dangerous, people with AD may become disoriented and easily lost, even in their own neighborhoods. In fact, as many as 70% of those with the disease wander and may be unable to find their way home (Flaherty & Raia, 1994). Because wandering occurs so frequently in people who are cognitively impaired, it can become a serious problem. Reducing dangerous wandering behavior is important, because almost 75% of those with AD live at home with family members where constant supervision may not be possible.

When people who are cognitively impaired wander, they often are unable to remember their names or where they live (Flaherty & Raia, 1994). Because long-term memory may remain when short-term memory no longer functions, a person may wander to a former job or childhood home. The remembered destination may be a great distance from his or her current residence (Koester, 1995). In most cases, wandering takes place on foot, but individuals with AD have driven as far as 300 miles from home (Safe Return, 1996). Wandering is dangerous, because people with dementia may lose the cognitive ability to remember to eat, drink, or protect themselves from extreme weather. When an AD person wanders and is not located within 24 hours, that individual has only a 50% chance of surviving exposure, dehydration, or both (Koester, 1995).

To compound the problem, there are few, if any, effective community-based wandering management programs. A national registration program for individuals with AD has been developed to prevent wandering from becoming a life-threatening behavior (Koester, 1995). Although some communities may develop their own local citizen registration programs, Safe Return is the only national registration program specifically designed to help those with AD who wander and become lost (Safe Return, 1996). Further, a local program may be effective only if the individual who wanders remains in the community.

The Safe Return program is a national registry run by the national Alzheimer's Association (AA) and partially funded by the U.S. Department of Justice. It helps identify, locate, and return to safety memory-impaired individuals who become lost. The registry includes the names of memory-impaired individuals, their photographs, identifying characteristics, additional medical diagnoses, related medications, and emergency contact information.

Registration in the Safe Return program has increased the speed with which AD wanderers are found, and the program has curtailed the negative consequences of wandering (Silverstein, Salmons, & Flaherty, 1996). When a program participant is reported missing, Safe Return faxes identifying information and a photograph of the participant to law enforcement officials and local chapter offices of AA throughout the country. The Safe Return program has access to 17,000 law enforcement agencies and more than 206 community-based AA chapters.

Registered individuals can be identified immediately by identification labels or jewelry inscribed with their first name, the statement "memory impaired," and the 24-hour, toll-free Safe Return crisis telephone number. When a wandering Safe Return participant is found, police officers call the crisis number, and the Safe Return program then contacts the caregiver. Safe Return minimizes the potential dangers of exposure, starvation, injury, and anxiety to which wanderers are susceptible. The program also increases the speed with which wanderers are returned to the familiarity of their own homes (Safe Return, 1996).

Safe Return registration for AD individuals can be initiated by a family member, health professional, or police officer by completing the simple registration form and forwarding it, along with a one-time registration fee, to the AA chapter (scholarships waiving the $25.00 fee are available from chapters upon request). Individuals may also register by contacting the national Alzheimer's Association. The national registry provides updated registration information to chapters on a monthly basis.

All chapters are required to provide 24-hour Safe Return on-call access. The national registry notifies local chapters each time the Safe Return program is accessed to help locate or identify a person with Alzheimer's disease. Safe Return applications are routinely included in all outgoing informational packets sent by chapters.

When any person is reported missing, all police departments have access to the National Crime Information Computer System (NCIC) (R. Steinel, personal communication, April 21, 1996); however, the police database does not have preexisting information to identify people who are lost. In addition, NCIC does not provide information on family members, nor is it able to provide identifying information on someone with dementia who has been found. These components of the Safe Return program database are especially important when dealing with cognitively impaired individuals who may not be able to identify themselves, their addresses, or their caregivers.

Although Safe Return can provide a life-saving service, nationally fewer than 2% of those cognitively impaired are registered in the program (Silverstein, Salmons, & Flaherty, 1996). Chapter efforts to educate communities about the value of Safe Return have met with limited success. Health education efforts to expand the use of this service have the potential to increase the safety of people who have AD, provide caregivers with an important support system, and enhance the overall quality of life in the community.

BACKGROUND

Partnering with Police Officers. There are many possibilities for partnerships between health educators and police officers. Both professions share a common goal to improve the well-being of the communities in which they work. By law, police officers are required to maintain order and provide neighborhood-based services 24 hours a day. Adams and Nelson (1995) suggest that police officers play an important role in maintaining the quality of life within a community.

The concept of community policing began in 1950. This new approach encouraged police and community members to form partnerships, not only to prevent crime but also to foster communication and understanding between the police and residents. Community policing sought to improve people-to-people relations (Bradstatter & Radelet, 1968). The role of police officers has more recently been expanded to include partnering in public health initiatives. Police interventions have been effective in reducing teen substance abuse (Englander-Golden, Jackson, Crane, Schwarzkopf, & Lyle, 1994; Mislak & Evans, 1994), increasing children's bicycle helmet use (Cote et al., 1992), encouraging victims of family violence to seek out community resources (Buchanan & Perry, 1985), and empowering elderly people to avoid victimization by criminals (Zevits, Dcrim, & Gurnack, 1991). Alliances that empower citizens and prevent problems are advantageous to both the police and the community (Fox, 1967). Police-community partnerships such as these can contribute to healthier communities by utilizing public health education techniques.

As part of their responsibility to maintain order, law enforcement officers are required to help locate and return people who become lost (Meadows, 1985). Since the inception of community policing, police officers have been encouraged to perform "maintenance of peace and order and the protection of persons and property" (Fox, 1967, p. 369). Recognizing that police officers are involved in finding lost persons, Alzheimer experts have sought their help in encouraging families to register individuals with dementia in the Safe Return program (Mace, Whitehouse, & Smyth, 1993).

Increasing the health education skills of police officers can positively impact the lives of people who have AD. Given their presence and role within the community, police officers are uniquely poised to provide valuable assistance to people with dementia and their caregivers by suggesting techniques for managing difficult behaviors. Police can also provide information about how to make a home more secure by using double-bolt doors or childproof knobs (Flaherty & Raia, 1994). Family members are often willing to follow the suggestions of police officers, particularly when the suggested action can help safeguard a person with AD (Safe Return, 1996).

Training officers are key community contacts for health educators who are interested in building police officer-health education partnerships. Although previous police and public health initiatives have been successful (Englander-Golden et al., 1994; Mislak & Evans, 1994; Cote et al., 1992), it may be difficult for a health educator to establish credibility within the police environment. Based on previous studies, police officers tend to associate almost exclusively with other police officers, and they consider everyone external to the police community as outsiders (Klyver & Reiser, 1980). Effective training in a closed society such as law enforcement requires that groups who are respected by police officers reinforce the training program. A survey of law enforcement personnel (Lurigio & Skogan, 1994) found that police training officers are viewed by other officers as role models.

As their responsibilities expand, police officers receive most new information and learn new skills

TABLE 1
Mailing to 611 New Jersey Law Enforcement Agencies

Materials Sent to Law Enforcement	*Description of Materials*
A letter of support from the attorney general	Recommended in-service training by local Alzheimer chapter representatives or police-training officers
1-hour lesson plan	Developed by Alzheimer's Association local chapters and approved by the attorney general
"Victim, Not Criminal" Alzheimer association booklet	Illustrates problem behaviors exhibited by people with AD and potential police actions for each behavior
"Safe Return" video, 12 minutes	Depicts search and rescue methods and how to use Safe Return to help identify or locate people with dementia
Plastic laminated wallet cards (one included for every police officer in New Jersey)	Lists helpful communication techniques and the toll-free number for Safe Return

through departmental training programs. It is the training officer who has the responsibility to design, identify, implement, and coordinate training programs for fellow police officers. When training officers have an opportunity to link with health educators in developing new training programs, there is an even greater potential for behavior change.

The following sections explore the short-term effects of a police officer/AD education initiative provided by the northern New Jersey chapter of the AA and police departments. The authors describe the context, design, implementation, and impact evaluation of the health education-driven AD training for police officers. To our knowledge, this is the first documented health education/ police officer partnership addressing AD management.

THE STATEWIDE INITIATIVE

In January, 1997, New Jersey's state attorney general announced his plan to mandate AD education as part of training for all new police recruits. However, this education program was not mandated for law officers already on the job (veteran police officers). To address this gap, New Jersey law enforcement officials and the AA joined forces to provide New Jersey police officers with voluntary training about AD and the Safe Return program. The long-term goal of this initiative was to lower the incidence of AD-related injuries and death within New Jersey communities by reducing dangerous wandering incidents among people with dementia.

The state attorney general and the AA held a press conference to announce the statewide initiative to encourage AD training for both veteran police officers and new recruits. That same day, standardized packets of training materials were sent by the attorney general's office to all 611 New Jersey law enforcement agencies (see Table 1). The same materials were also sent to all New Jersey police academies. However, the new recruit training would be done at police academies by certified police instructors in a 2-hour format that included information about people with other disabilities, including physical disabilities, mental retardation, and mental illness.

Although statewide training of veteran police officers at the local level was voluntary, the attorney general underscored the importance of the training program during television and radio coverage of the new policy announcement. These mass media messages emphasized that police officer AD training could reduce injury and death in cognitively impaired individuals by reducing wandering incidents (through Safe Return registration) and by using more effective search-and-rescue procedures.

To promote the training, about 1 month after the attorney general's announcement, New Jersey AA chapters encouraged police department participation in the voluntary training program at a statewide meeting of all New Jersey chiefs of police. Alzheimer chapters informed the chiefs that training officers could provide at least minimal training to all law enforcement personnel by using the 12-minute Safe Return video developed specifically for "roll call training" at the beginning of each shift.

Each of the AA chapters proceeded with implementation of the police training based on their staff avail-

ability. An analysis of the statewide initiative involving the training program for all New Jersey chapters is beyond the scope of this paper. This article focuses on the northern New Jersey chapter's training experience. The northern chapter was the only chapter to involve a health educator in the design, implementation, and evaluation of the police- training program. The first author worked as a health education consultant for the chapter; her primary responsibility was to implement this statewide initiative for the chapter. The statewide AD training program was modified to incorporate basic health education theories and principles.

THE NORTHERN NEW JERSEY TRAINING PROGRAM

The northern New Jersey chapter of the AA (NNJCAA) serves about 83,350 people with AD in the state's 11 northernmost counties (Evans et al., 1990; U.S. Bureau of the Census, 1990). Therefore, veteran police officers in these 11 counties were identified as a priority audience for AD training.

To measure the impact and the long-term injury and death prevention outcomes of the program, NNJCAA added two short-term objectives to the state's goals. These objectives were to increase both police officers' AD community outreach activities and registration in the national Safe Return program by encouraging police officers to recommend Safe Return registration to family members of people with dementia.

The preliminary training initiative ran from February 1 to June 1. One month after the original statewide training packet was mailed by the attorney general's office, the northern New Jersey executive director sent a letter to the police chiefs of the 319 law enforcement agencies in the counties served by NNJCAA. The purpose of the letter was to confirm receipt of the state-supplied materials, to offer on-site AD training by the health educator, and to offer certificates of achievement to all police officers who participated in AD training.

Each partner in this initiative had clear roles and responsibilities. The training officer in each local police department promoted and set up the training, completed the evaluation instruments, and saw that resource materials were appropriately distributed to police officers and dispatchers. The health educator from NNJCAA worked with the chapter to develop and deliver an expanded training program and resource materials, designed process and impact assessment instruments, and provided positive recognition through letters of commendation and certificates of achievement to police officers.

NNJCAA modified the lesson plan by adding role play activities and search-and-rescue exercises. Resource materials using health education procedures and theories to increase the likelihood of program success were also provided. Training program activities and materials were expanded to include (a) public speaking information; (b) a one-page true/false post test; (c) role play as a teaching strategy; (d) a two-sided information sheet describing how to identify a person with dementia and access the Safe Return program; (e) a one-page dispatch sheet (job aid) for police station-based dispatchers to use when "talking" officers on the street through the experience of dealing with elderly persons reported as missing; (f) certificates of achievement to be issued by NNJCAA and signed by the department's police chief for all police officers who participated in AD training; (g) letters of commendation to be sent by NNJCAA to police officers each time they contacted the Safe Return program for help in the identifying or recovering people with AD; and (h) follow-up contact by NNJCAA with family members of wanderers found by police officers to (a) urge Safe Return registration and to (b) encourage family members to express their appreciation to the police officers who located the wanderer.

Both training officers and veteran police officers identified the information and dispatch sheet format as a useful tool during the assessment phase. The AD information and dispatch sheets were then pretested with veteran New Jersey police officers, several local police department training officers, and New Jersey police academy instructors to determine the clarity of the step-by-step instructions and to make certain the guidelines fell within appropriate police protocol. The informational sheets were reviewed by the veteran law enforcement personnel, training officers, and academy instructors and revised accordingly.

During the training, true/false pre- and posttests assessed changes in police officer knowledge about AD. Role play scenarios elicited officers' knowledge and demonstrated their ability to identify persons with AD and to demonstrate the steps involved in contacting the Safe Return program. Training officers were encouraged to forward the names of all police officers who had completed AD training to NNJCAA so certificates of achievement could be issued. This process helped NNJCAA track the number of police officers who were receiving AD training.

Four months after the training materials were sent to police departments by the attorney general's office, a 17-item law enforcement training survey and cover letter was mailed to each of the 319 training officers in the 11-county area. Training officers were asked if they had initiated AD training as a result of the attorney general's initiative. If so, they were asked to provide the number of police officers trained; the effectiveness of the lesson plan, information sheet, and dispatch sheet in increasing police officer knowledge about AD; the use of Safe Return to identify and/or locate a person with AD; and the number of community Alzheimer programs conducted by police officers. If they had not initiated AD training, the training officers were asked if they intended to do so. In addition, training officers were asked if their police departments used an alternative registration and identification system for cognitively impaired individuals.

Theoretical Framework

Constructs of Diffusion of Innovation Theory (Rogers, 1983) and Social Learning Theory (Bandura, 1977) provided the foundation for the design and implementation of the police officer education program. Both theories were used to anticipate possible barriers or resistance to the voluntary training program by veteran officers or local police departments and to suggest effective strategies to overcome these challenges.

Social Learning Theory explains behavior change as the result of behavioral capability (knowledge and skills), self-confidence; and positive outcome expectations. This theory assumes an interdependence among the personal characteristics of the person whose behavior is targeted for change, the attributes of the new behavior itself, and the environment or context in which the new behavior is to take place.

To overcome these anticipated barriers, Social Learning Theory behavior change strategies were integrated in the design and implementation of the program. The interdependence of the person, the behavior and the environment where the behavior was to be performed, behavioral capability, expectations, and self-efficacy were interwoven into the fabric of the training program. Role modeling, observational learning, and reinforcement influenced the design of the objectives, the content of the lesson plan, and the resource materials.

Police training officers, who are seen as role models by veteran police officers (Lurigio & Skogan, 1994), were asked by NNJCAA to help implement the training program. The training focused on knowledge acquisition, skill building, and environment modification. We believed the behavioral capability and self-efficacy of police officers in dealing with AD individuals would increase through skill-building exercises in communication and search and recovery. Role-play situations were utilized to provide an opportunity to model and rehearse effective communication techniques. Role-play situations based on actual police encounters with AD individuals were used to reduce officer uncertainty about how cognitively impaired persons respond when lost or in a stressful situation. Reflecting and paraphrasing statements of an AD individual, a technique used effectively over the years by police to reassure victims (Buchanan & Perry, 1985), was practiced. Search-and-rescue exercises were included to increase police officer self-efficacy in these procedures. Police officers both observed and practiced the special techniques needed to locate wanderers. These exercises emphasized that a person with AD who is lost may not recognize his or her name when called and he or she may withdraw to a remote, inaccessible area rather than respond to the calls of a search team. Throughout the training, officers were encouraged to make every attempt to shorten the length of time a person with AD was lost by using aggressive search-and-recovery techniques that would reduce the incidence of dangerous consequences from wandering (Flaherty & Raia, 1994; Safe Return, 1996). The information about search and recovery supported the belief among police officers that the new strategies would shorten the time a person with AD was lost, thereby reducing the likelihood of injury or death.

The wallet cards, police information sheet, dispatcher sheet, and lesson plan were created to increase police officers' communication skills, their sense of the value of effective communication with persons with dementia, and their sense of self-efficacy about use of the new communication skills with persons with dementia. The information and dispatch sheets provided information about the disease, tips for communicating with a person who has dementia, and step-by-step instructions for using the Safe Return program.

To make the on-the-job environment more conducive to the new behavior, support materials were designed to be portable. The information sheet was specifically formatted to be inserted by the officers into their policy manuals. The wallet card and dispatcher sheets were designed as job aids to be carried by officers and dispatchers, respectively, to reinforce the mes-

sages presented during training and to facilitate the implementation of the new behaviors on the street.

Reinforcement, a key Social Learning Theory concept, was provided during and after training. Every training exercise was followed by immediate feedback. Each officer who completed the training program received a certificate of achievement signed by the local chief of police. Changes in police officer behavior, such as early wanderer identification, quick action on search and rescue, and use of the Safe Return program, resulted in positive reinforcement by police chiefs, the chapter, and family members. Letters of commendation were sent by the NNJCAA to all officers who used Safe Return when identifying or attempting to locate a wanderer who had become lost. Positive reinforcement was intended to further strengthen an officer's newly acquired skills in dealing effectively with individuals who might have dementia. In addition, the multiple sources of reinforcement were designed to enhance the environment in which police officers worked, thus increasing the likelihood of their adopting and implementing the new techniques.

As police officers began to use the new techniques, they were encouraged to provide information about Safe Return to community members. The officers were provided with public-speaking tips and were asked to discuss the dangers of wandering with family members, seniors, and other professionals involved in search and rescue.

At the same time, constructs of Diffusion of Innovation Theory were used to design, implement, and evaluate the program. Specifically, Diffusion of Innovation suggested strategies to identify priority training audiences, successfully promote the program among police training officers, design a program that would be well received by trainees, and interpret the results of the chapter's training initiative (Rogers, 1983).

The adoption rate of a new behavior within a social system is dependent on five factors: the context in which the change occurs, the change agent, the characteristics of the innovation itself, the quantity and quality of communication about the innovation, and the innovativeness of the adopter (Rogers, 1983, 1989). The growing practice of community policing and an increasing elderly population provide a timely opportunity to initiate AD training for veteran police officers. The innovative behavior (effective AD communication, early search-and-rescue action, and use of the Safe Return program) was introduced to veteran officers through highly respected, appropriate channels and change agents, including the state attorney general, chiefs of police, and training officers. Communication about the innovation was provided frequently within the time frame of the initiative, particularly within the first 2 months. Law enforcement participation in innovative activities depends upon the degree of departmental support provided (Rosenbaum, Yeh, & Wilkinson, 1994). Media coverage and mailings followed the attorney general's announcement to each police department. NNJCAA actively promoted the AD training opportunity during the next 4 months. In this intervention, the state attorney general and chiefs of police provided highly visible departmental support. Most people evaluate a new idea through the subjective evaluation of peers who have already adopted the innovation (Rogers, 1983). Police officers who had previous contact with AD individuals served as social models for their peers in the video and print materials and during the actual training sessions, whereby officers were encouraged to share their personal experiences.

In keeping with Diffusion of Innovation (Rogers, 1983) principles, the voluntary training was designed to be positively perceived by training officers and veteran police officers. Police AD training addressed the five categories of perceived attributes (relative advantage, compatibility, complexity, trialability, and observability) identified and described by Rogers. The training program was promoted by offering police officers new and more effective skills and resources. Training strategies were compatible with police officers' culture and experience; modeling and role-play are familiar training strategies within the police culture (Ellis, 1991). Cultural compatibility was accomplished through the action of the attorney general, supervisor of all police departments, who videotaped an introduction to the Safe Return video, and by the use of actual uniformed police officers in the video and training booklet sent in the original mailing. To increase training officers' confidence in the doability of the training, the program was scheduled during roll call at the beginning of shifts. In addition to being convenient for the training officers, any overtime or extra travel concerns of veteran police officers were eliminated. The new skills (communication techniques, search and rescue, and Safe Return access) were presented as simple and straightforward, thus enhancing their perceived doability. Finally, the training promised immediately visible results: faster identification and return of persons with AD to their residences and fewer wandering-related injuries and deaths.

Follow-Up and Results

Veteran police officer AD training was conducted by NNJCAA from February through May 1997. All 319 police training officers in the chapter area were surveyed at the end of May to determine the degree to which AD training was implemented and the frequency of community AD outreach activities by trained police officers. Enrollment in Safe Return during the same time period was also assessed.

Of the 319 police departments, 81 complied with the one-time request to complete the follow-up survey (a response rate of 25.39%). The AD-training implementation rate was 23.51% (80 of 319 police departments). Survey responses indicated that training had been offered by 75 of the 81 departments (92.6%) that responded to the survey. An additional 5 departments (6.2%) indicated police training would be provided by the department in the near future.

Police training officers reported that between February 1 and May 30, 1997, a total of 2,892 (21%) of the 14,000 police officers in 10 of the 11 northern counties were trained about AD and Safe Return. (One county had participated in police officer training in 1996, and training officers did not report any additional training in 1997). Police departments reported training between 1 and 360 veteran officers.

Survey results indicated that within 5 months of the inauguration of the initiative, 11 of 81 police departments (13%) had offered community education programs about AD and promoted community use of the Safe Return program. Responding police departments reported training 325 community members, including senior citizen groups, firefighters, emergency rescue personal, government agencies and safety councils, about AD. A total of 17 departments (21%) reported plans to provide AD-specific community outreach programs in the near future.

Registration of AD individuals in the Safe Return program is recorded on a daily basis by NNJCAA. The chapter maintains a copy of each Safe Return application, and the original document is forwarded to the national registry. Average monthly figures for Safe Return during the training initiative increased over 1996 average registration rates. In December 1996, a total of 839 people from the northern New Jersey chapter area had been registered in Safe Return—1% of the 83,350 people estimated to have AD. The average registration during 1996 was 17 people per month. Within 4 months of training, a total of 94 new registrants throughout the 11 northern counties were enrolled in the Safe Return program. From February through May, monthly registration averaged 23.5 people per month, an increase of 38.2% over previous monthly registration rates.

By the end of the first 4 months of the training initiative, Safe Return registration had been encouraged by 82.4% of the police departments who had offered or planned to offer AD community training. Registration programs for elderly residents with documented medical problems, including AD, were also created by local police departments to ensure timely identification of vulnerable individuals. Sixteen (20%) of the 81 respondents indicated use of registration programs other than Safe Return for people with AD. Of those departments using other methods, 62.5% (10) used a picture registration system (sponsored by the local police department) or their own local volunteer citizen registration programs. Five departments (31%) used a combination of local registration programs and the national law enforcement program, NCIC.

DISCUSSION

The short-term impact results of the first wave of a new AD training program on enrollment in a national AD registration program and community AD outreach activities by police officers are encouraging. Although the initial survey response rate was low, it should be noted that the usual protocol of reminder postcards and follow-up mailings and/or phone calls was not possible because of time and financial constraints. The low response rate for the training officer survey (25.39%) suggests that many police departments may not have initiated police or community training about AD. Results described here were from police departments who had either implemented training or planned to implement training in the near future (only one police department of those responding indicated it was not planning to implement AD training), so success of police AD training may not be generalized to all police departments in the 11-county area.

However, the response rate of 25.39% and the AD-training implementation rate of 23.51%, though limited, may reflect the reactions of the more innovative members of the bell curve of priority audience members as Diffusion of Innovation Theory suggests. Rogers describes an S-shaped diffusion curve that indicates the adoption of an innovation. He proposes that a 10% to 20% adoption rate is the “takeoff” point, with those adopting the new behavior identified as “innovators” (2.5%), “early adopters” (13.5%), and “early majority”

TABLE 2
Survey Results, 81 of 319 Police Departments in 11 Counties

Police Training Officer Responses	*Yes*	*%*	*No*	*%*
Police Training				
Training offered to veteran police officers	75	92.6	6	7.4
Training to be offered to police officers in the near future	5	6.2	1	1.2
Total departments offering or planning to offer officer training	80	98.8		
Total number of police officers trained about AD	2,892	20.7	11,108	79.3
Alzheimer Community Training by Police Officers				
Departments offering AD training to community	11	13.6	70	86.4
Departments planning to offer AD training to community	6	7.4	64	79.0
Total departments offering or planning to offer community training	17	21.0		
Total number of community members trained about AD	325			
Safe Return registration encouraged during community training (only departments that indicated community training included)	14	82.4	3	17.6

(34%) (Backer, Rogers, & Sopory, 1992). When the innovators and early adopters adopt the new behavior, it is likely that the rest of the population will also adopt the new behavior. Continued support for the initiative and further follow-up may trigger and/or uncover more AD training activities in the chapter area.

The study demonstrates the potential contribution such training can have in responding to the challenge of increasing enrollment of people with AD in the Safe Return program. Although the average registration rate did increase during the 4-month period of police training, the fact still remains that less than 1% of AD individuals in the service area are registered in Safe Return. The authors believe that a more extensive study period is necessary to truly assess the impact of the program. It is possible that over time, as more police officers are trained about Safe Return and see its value in helping identify or locate missing individuals, Safe Return registration rates will increase more dramatically. However, studies of outreach efforts to other community institutions, such as religious and civic organizations, are needed to determine the best channels for communicating the benefits of Safe Return to caregivers.

This study demonstrates how theory can be used to support the development, implementation, and evaluation of a police training intervention. Both Social Learning Theory and Diffusion of Innovation Theory drove the development of the training program's format (when, where, and who offered it) and content (objectives, messages, and activities). Social Learning Theory (Bandura, 1977) provided a framework for designing a training program to influence knowledge, behavior and the environment. Diffusion of Innovation Theory triggered the careful choice of credible leaders to provide departmental support and frequent positive communication between departmental support and the priority audiences. The AD training program was designed to be perceived favorably by the police training officers and the volunteer police trainees.

The initial success of the first phase of this social science-based initiative to train police officers about AD, effective search-and-rescue techniques, use of the Safe Return program, and community AD outreach programs may provide a model for health educators in other states concerned about AD wandering. This type of training is particularly important as federal funding for health care decreases (Institute of Medicine, 1989). The tremendous demands for resources placed on both governmental and charitable agencies require a greater collaborative effort to identify and provide services for cognitively impaired individuals within the community.

Finally, this initiative calls attention to the growing market for mandated education and training among professional groups on a variety of important health education issues. For example, in many states, sexual harassment training has been mandated for many government employees, and child abuse training has been

mandated for judges, lawyers and schoolteachers (McAfee & Musso, 1995; NCJRS, 1997). Frequently these policies are passed without specific implementation plans and without recognition that health educators could provide technical assistance. When health education organizations and health education consultants are not consulted in providing these services, policy success may be limited because health education principles and theory may not have been used.

CONCLUSION

As the cost of medical care increases and more demands are placed on families who must care for family members with AD, there will be an even greater need for community-related services. Collaborations between public service groups such as police, local health agencies, and members of the community are necessary to improve and assure the quality of life of that community. The preliminary findings of this initial wave of police training are encouraging. Additional research on the specific contributions of social science theories to these initiatives would be helpful. Safe Return is a program that is capable of reducing death and injury when people with AD wander and become lost, yet the tremendous underuse of the program is disturbing. The results of this study should be shared with other Alzheimer chapters. Follow-up with all local police departments in the state is necessary to determine whether the initial training trends have continued. In addition, further studies of the Safe Return program, its perceived attributes, and how best to promote it are needed.

This endeavor demonstrates the importance of health education principles in implementing police/community initiatives. Health educators have the potential to both increase their visibility and improve the quality of the training services provided if they are alerted to new training policies that may require health education expertise. With their program planning, implementation, and evaluation skills, health educators are in a position to help facilitate and assure the effectiveness of mandated training programs. Health educators can enhance these programs through their understanding of important theoretical underpinnings; by applying those theoretical components to the design and delivery of the program and its products; by setting specific, measurable, assigned, realistic, and time-specific objectives; and by evaluation to determine if those objectives have been met and whether the training program needs to be revised.

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