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AIDS and the Law Enforcement Officer:

Concerns and Policy Responses

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James K. Stewart
Director

U.S. Department of Justice
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AIDS and the Law Enforcement Officer:

Concerns and Policy Responses

by

Theodore M. Hammett, Ph.D.

June 1987

Issues and Practices in Criminal Justice is a publication of the National Institute of Justice. Designed for the criminal justice professional, each *Issues and Practices* report presents the program options and management issues in a topic area, based on a review of research and evaluation findings, operational experience, and expert opinion in the subject. The intent is to provide criminal justice managers and administrators with the information to make informed choices in planning, implementing and improving programs and practice.

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Foreword

Acquired Immune Deficiency Syndrome — AIDS — has been called the most serious public health problem in the United States and worldwide today. Since it first appeared in 1981, there has been an enormous amount of uncertainty and fear about this fatal disease. Law enforcement officials minister to many people in need of assistance. Because of their emergency responsibilities and other aspects of their jobs, they are in daily contact with intravenous drug users and others at high risk for the disease. Law enforcement officers are justifiably concerned about becoming infected with the AIDS virus during the performance of their duties.

Since there is no vaccination or cure for AIDS, education to prevent transmission is the cornerstone of society's response to this deadly disease. As with any other crisis, rumor and misinformation pose a great threat to public safety. Accurate information can help calm unwarranted fears about the disease and its transmission, thus enabling law enforcement workers to continue their duties.

Since 1985, the National Institute of Justice has worked with the Centers for Disease Control and other public health officials to provide important information about AIDS to criminal justice professionals. This report, *AIDS and the Law Enforcement Officer: Concerns and Policy Responses*, is an example of those efforts. It gives law enforcement professionals the evolving facts about AIDS and applies this information to the day-to-day realities of law enforcement operations. Most important, by drawing on law enforcement experiences with Hepatitis-B and other communicable diseases, it provides guidance and reassurance to law enforcement workers that they can perform their duties as safely as possible in light of this health problem.

The National Institute of Justice is supporting other programs to help criminal justice professionals cope with this crisis. In response to a request from Attorney General Edwin Meese III, I am pleased to announce the creation of the NIJ *AIDS and Criminal Justice Information Clearinghouse*. Criminal justice professionals can call the clearinghouse to obtain current medical information and policy guidance on AIDS. In addition to answering questions, the clearinghouse will collect information on incidents that might involve occupational transmission of the AIDS virus to criminal justice professionals.

President Reagan has said that the AIDS crisis "calls for urgency, not panic, . . . compassion, not blame, . . . understanding, not ignorance." The National Institute of Justice is working to ensure that law enforcement professionals have available accurate information to understand and deal with the occupational risks created by AIDS. The Institute will continue this work because the AIDS crisis affects an ever-widening array of individuals. Until medical science can bring this deadly disease under control, our best defense is a well informed and educated citizenry.

James K. Stewart
Director
National Institute of Justice

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Theodore M. Hammett
June 1987

Table of Contents

List of Figures

Introduction

Acquired Immunodeficiency Syndrome (AIDS) is an increasingly serious public health problem in the United States and worldwide. Moreover, it is an extremely emotional issue that has engendered a great deal of fear and misinformation. AIDS affects the criminal justice system in two important ways. First, AIDS risk groups are probably overrepresented among suspects and offenders with whom the justice system deals every day. As a result, many law enforcement officers and other staff have become concerned that they are at increased risk of acquiring the AIDS virus through contact with suspects and offenders. Such fear and concern may adversely affect the level and quality of service delivered by a law enforcement agency. Second, because law enforcement officers are regularly in contact with intravenous drug users, prostitutes and others who are at high risk of being infected and infecting others, they may serve a vital educational function in the community. If they are armed with accurate information and sound judgment, law enforcement officers may be able to encourage behavioral change that will reduce the transmission of the AIDS virus.

In order to deal effectively with the AIDS issue, law enforcement agencies must address it in a forthright manner, preferably before fear and misinformation have a chance to affect service delivery. Regular education and training that present the facts about AIDS in clear, concise terms are absolutely essential. Obviously, agencies must have the facts about AIDS before they can present them to their staff and to citizens. Accurate medical knowledge is a prerequisite for rational policy decisions.

In an effort to meet agencies' needs for information and evidence, this report summarizes key medical facts, provides documentation from law enforcement agencies' operational policies and training programs, and discusses key legal and labor relations issues. Detailed medical information on AIDS is provided in Appendix A.

This report summarizes the latest medical information on AIDS and presents information from a telephone survey on law enforcement agencies' AIDS-related polices and procedures conducted for this project by the Police Executive Research Forum (PERF). Thirty-five agencies of various sizes, geographic regions, and levels of experience with AIDS were contacted in the survey.*

*The survey sample comprised the two largest departments in each of the five Standard Metropolitan Statistical Areas (SMSA) with the largest numbers of AIDS cases; fifteen departments in jurisdictions with populations in excess of 100,000 and with relatively high incidence of AIDS cases; and ten departments in jurisdictions with populations in excess of 75,000 and with relatively low incidence of AIDS cases.

Chapter One

The Cause, Transmission and Incidence of AIDS

AIDS is a disease that undermines the human body's immune system, rendering the individual susceptible to a range of "opportunistic" infections, malignancies and other diseases which would not generally be life-threatening to persons with normal immune systems. AIDS also causes disorders of the central nervous system. While the overall incidence of AIDS in the American population is still relatively small, the disease nonetheless represents an extremely serious public health problem. This is because of the high mortality rate, the lack of a vaccine or cure for the disease, the potentially very large number of infected (and infectious) individuals, the often prolonged incubation period, and the uncertainty as to whether an infected person will ever develop AIDS-related symptoms or the end-stage disease itself.

The Cause of AIDS

AIDS is caused by a virus known as Human Immunodeficiency Virus (HIV).[1] HIV infects and destroys certain white blood cells, thereby undermining that part of the body's immune system which normally combats infections and malignancies. During the period of infection, these cells are unable to grow normally. One can be infected with HIV for years, even indefinitely, without ever developing symptoms. However, infected persons with or without symptoms may transmit the infection to others.

Prospects for Vaccines and Cures

Today, AIDS is almost always fatal. There have been no reports of prolonged remission of the disease; most patients die within two years of being diagnosed with end-stage AIDS and very few live more than three years.

Scientists have made significant progress in understanding the complex structure and behavior of the AIDS virus in a remarkably short time. However, the goal of developing a vaccine is elusive, and new knowledge about the virus as often frustrates as contributes to progress.

There has also been progress on development of therapeutic drugs for AIDS. Several drugs are now undergoing clinical trials and azidothymidine (AZT) has recently been approved for treatment of certain AIDS patients. However, AZT's potentially serious side effects relative to its therapeutic benefits and its extremely high cost, drastically limit its use.

In general, prospects for a vaccine or cure for AIDS remain less than promising for the immediate future. The National Academy of Sciences concludes that the probability of a vaccine becoming available in the next 5-10 years is "low" and that "development of therapy for HIV infection will most likely be a difficult and long-term process with no presently available guarantees of success."[2]

The unlikelihood that vaccines or cures will be available for the foreseeable future only serves to underline the importance of educational efforts. Education is currently the only available weapon against AIDS. This statement is as true for the law enforcement setting as for society at large. This report will stress that education and training must be the cornerstone of law enforcement agencies' response to AIDS.

The Spectrum of Reactions to HIV Infection

AIDS is not a single disease: rather, there is a spectrum of possible reactions to HIV infection. An infected individual may evidence no symptoms whatsoever for an extended period following infection. The incubation period of AIDS appears to be quite long (3-5 years or more), but the actual range remains unknown at this time. To be diagnosed with AIDS (according to the definition established by the Centers for Disease Control [CDC]), a patient must have one or more "opportunistic infections" or cancers in the absence of all other known underlying causes of immune deficiency. Other symptoms of HIV infection include fever, diarrhea, and persistingly swollen lymph nodes. Patients with such symptoms, but not meeting the CDC definition of AIDS, are generally considered to have "AIDS-related complex" (ARC).

HIV Antibody Test and Safety of the Blood Supply

In early 1985, a commercial test for antibody to HIV was developed to screen the nation's blood supply. The test does not detect the presence of the virus itself—only the presence of antibodies to the virus. (Antibodies are evidence present in the blood that the immune system has attempted to fight off an infection.) A positive result on the test means that the individual

was infected at some time in the past. However, the test cannot pinpoint the date of infection or even determine whether the individual remains infected. However, CDC recommends that persons with positive tests be considered infected and infectious.

The HIV antibody test has been successfully used to protect the blood supply. CDC estimates that only about 100 transfusion-associated infections will occur annually out of a total of 16 million units of blood transfused.[3]

The test is now being used to screen people, and some have advocated broad mandatory screening programs. Substantial controversy surrounds any mandatory use of the test to screen individuals. Primary issues in the debate have been the utility of the test in predicting the future course of the individual's infection, the difficulty of maintaining confidentiality of antibody test results, and the discrimination and other detrimental effects on individuals' lives if test results become known.[4]

Relationship Between HIV Infection and Development of Illness

With the passage of more time to track infected individuals, estimates of the percentage who will develop illness have steadily increased. A recent National Academy of Sciences report estimates that 25-50 percent of infected persons will develop AIDS within 5-10 years of infection. With the long and uncertain incubation period of AIDS, it is likely that the percentage of infected individuals who develop the disease will continue to rise. The National Academy of Sciences report also notes that more than 90 percent of infected individuals show some immune system deficiency within five years of infection.[5]

Transmission of HIV Infection and AIDS

One of the most serious problems surrounding the public response to AIDS has been the large amount of misinformation and rumor about how HIV infection is transmitted. For example, a national survey commissioned by the American Association of Blood Banks discovered that 34 percent of the respondents erroneously believed that one could contract the AIDS virus from *donating* blood.[6] Misinformed fear has been prevalent among law enforcement personnel. This section summarizes the most current medical knowledge on how HIV infection is and is not transmitted.

Known Means of Transmission: Blood, Semen, and Vaginal Secretions

According to CDC, there is extremely reliable information on the means of transmission of HIV infection and AIDS. As with Hepatitis-B, the AIDS

virus is transmitted exclusively through exposure to contaminated blood, semen, or vaginal secretions. This occurs primarily through sexual intercourse and needle-sharing activities. CDC states that HIV is not transmitted through other bodily fluids such as saliva or tears. There is absolutely no evidence of transmission through casual social contact.

As with any sexually transmitted disease, the risk of infection increases as the number of potential exposures increases. Thus, those who are extremely active sexually, with numerous partners and especially with partners not previously well-known to them, may be at higher risk. However, it is possible that infection could result from a single or very small number of exposures. This applies to heterosexuals as well as to homosexuals and bisexuals.

Recent research offers increasing evidence of heterosexual transmission, both male-to-female and female-to-male. However, there continues to be disagreement on the extent of heterosexual transmission. Thus far, only a small percentage of AIDS cases in the United States has been attributed to heterosexual contact. This figure has increased only slightly to about four percent since CDC began compiling surveillance data on the disease. However, the past and current profile of AIDS cases may not accurately predict the future course of the disease. This is primarily because of the large number of carriers now in the population. Although there are probably far more infected men than infected women in the American population at the present time, heterosexual transmission has been demonstrated and must be considered a very serious potential problem in the United States.

Currently, exposure to contaminated blood occurs almost exclusively through needle-sharing by intravenous drug abusers. In the past, there have been cases associated with blood transfusions and hemophiliacs' receipt of blood products. However, as already noted, the nation's supply of blood and blood products is now considered safe, as a result of universal screening of donated blood and heat treatment of blood products regularly given to hemophiliacs.

Finally, there have been cases of transmission to infants by infected mothers. However, it is not yet clear whether the infection is transmitted before, during, or after delivery.

Difficulty of Transmission

HIV infection is difficult to transmit and the virus is quite fragile when outside the human body. It is susceptible to heat, to many common household disinfectants and detergents, and to washing with simple soap and water.

HIV infection is similar to Hepatitis-B infection in that both are transmitted by exposure to contaminated blood and other body fluids,

primarily during sexual activities and intravenous drug use. However, Hepatitis-B is transmitted more efficiently than HIV infection.[7] Therefore, infection control measures (such as blood and body fluid precautions) designed to prevent transmission of Hepatitis-B should be more than sufficient to prevent transmission of HIV. Indeed, CDC recommends that these precautions be used to control transmission of HIV infection and AIDS and states that more extreme measures are unnecessary and inappropriate.

"Casual Contact"

HIV infection is not transmitted through casual contact. CDC emphasizes that AIDS is not spread by sneezing, coughing, breathing, hugging, handshaking, sharing eating and drinking utensils, using the same toilet facilities or any other form of non-sexual contact or activity.

Strong evidence for the conclusion that AIDS is not spread by casual or even intimate non-sexual contact comes from studies of family members of AIDS patients and of health-care workers who cared for AIDS patients, as well as from experience in other settings where close but non-sexual contact or ostensibly risky exposures have occurred. Studies of 437 family members of AIDS patients have identified no HIV seroconversions, despite long-term close contact with the patients including sharing of toilet facilities, food, and eating implements.[8]

Occupational or Social Contact

Except for a very small number of cases in health-care workers attributed to accidental needlesticks (3 of 666 incidents, or 0.5 percent), there continue to be no reports of HIV infection as a result of any occupational contact.[9] There is no evidence of AIDS transmission in schools,[10] offices, churches or other social settings, nor are there any documented cases of police officers, paramedics, or firefighters contracting HIV infection or AIDS in the performance of duty. Finally, a survey conducted for the National Institute of Justice found no cases of correctional staff becoming infected with HIV as a result of contact with an infected inmate.[11]

Incidence of AIDS in the United States

The dimensions of the AIDS problem are alarming. According to CDC figures through May 1987, there have been over 35,000 adult cases of AIDS in the United States. Thus far, over 20,000 persons have died of AIDS in this country.[12]

Over one-half (52 percent) of the total cases have been in New York and California, while New Jersey, Florida and Texas collectively account for another 19 percent. Cases are heavily concentrated in cities and major metropolitan areas.

In addition to confirmed AIDS cases, the National Academy of Sciences estimates that there may be as many as 50,000 to 125,000 cases of AIDS-Related Complex and the Public Health Service estimates that there are 1 to 1.5 million asymptomatic HIV infected individuals. CDC predicts that there will have been 270,000 AIDS cases diagnosed in the United States by the end of 1991.[13]

Over 90 percent of all AIDS cases reported thus far have been in individuals with histories of either homosexual/bisexual activities or intravenous drug abuse. Sixty-six percent have been homosexual/bisexual males, 17 percent IV drug abusers, and 8 percent have both of these characteristics. Figure 1.1 provides a detailed breakdown of AIDS cases by

Figure 1.1

Breakdown of Adult/Adolescent AIDS Cases by Transmission Categories

Transmission Category	% of all cases
Homosexual/bisexual males	66%
Intravenous drug abusers	17
Homosexual male and IV drug abuser	8
Transfusion recipients	2
Hemophiliacs	1
Heterosexuals with a partner in one of the above risk groups	4
Other/unclassified[a]	3
TOTAL	99%[b]

[a]Includes patients with incomplete risk information (due to death, refusal to be interviewed or inability to follow-up on initial information), patients still under investigation, men reported only to have had heterosexual contact with a prostitute, and interviewed patients for whom no specific risk was identified. CDC believes that if full information was available it would be possible to assign these cases to other transmission categories.

[b]Items do not add to 100% due to rounding.

Source: CDC, AIDS Weekly Surveillance Report—U.S., June 1, 1987.

Figure 1.2

Breakdown of Adult/Adolescent AIDS Cases by Demographic Characteristics

A. Racial/Ethnic Group	
White	61%
Black	24
Hispanic	14
Other/Unknown	1
	100%
B. Sex	
Male	93%
Female	7
	100%
C. Age Group	
13-19	0%[a]
20-29	21
30-39	47
40-49	21
Over 49	10
	99%[b]

[a]The figure is actually 0.4%.

[b]Items do not add to 100% due to rounding.

Source: CDC, AIDS Weekly Surveillance Report—U.S., June 1, 1987.

transmission categories. Many public health officials believe that the percentage of cases attributed to IV drug abuse is likely to grow dramatically in the next few years. Moreover, they believe that the greatest threat for significant spread of infection to the heterosexual population is through infection of the sexual partners of IV drug abusers.

Figure 1.2 provides demographic characteristics of AIDS patients. It shows that cases have thus far been overwhelmingly among males between 20 and 49 years of age. However, as heterosexual transmission of HIV

increases, there will of course be growing numbers of cases among women. Blacks and Hispanics (11 percent and 6 percent, respectively, of the population) are also disproportionately represented among AIDS patients. Although not shown in the tables, cases among blacks and Hispanics are much more likely to be associated with IV drug use than are cases among whites.

The latest medical research and epidemiological data together show that AIDS is a very serious problem but that the virus which causes AIDS is transmissible only by intimate sexual relations and direct blood-to-blood contact. In all settings, including law enforcement agencies, the response to AIDS should stress both of these facts and implement education and preventive programs which respond rationally to the real nature and extent of the risk. It is equally dangerous to take a complacent or an alarmist approach to this problem. The following chapter discusses the specific AIDS-related operational issues facing law enforcement agencies.

ENDNOTES

1. The virus was originally called Human T-cell lymphotropic virus Type III (HTLV-III) or lymphadenopathy-associated virus (LAV).
2. Institute of Medicine, National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care, and Research* (Washington, 1986), pp. 219, 229.
3. *Confronting AIDS*, p. 54.
4. See Ronald Bayer, et al., "HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs," *Journal of the American Medical Association* Oct. 3, 1986; 256:1768-1774.
5. *Confronting AIDS*, pp. 44, 91.
6. Press Release, American Association of Blood Banks, Arlington, Virginia, January 9, 1986.
7. This conclusion is based on a comparison of studies of health-care workers exposed to the Hepatitis-B virus and HIV virus through needlesticks and other sharp instrument injuries.

8. G.H. Friedland et al., "Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis," *New England Journal of Medicine* 1986; 314:344-349; Thomas Peterman (CDC), Presentation at 10th National Conference on Correctional Health Care, Washington, October 31, 1986.

9. As this document went to press, the Centers for Disease Control reported three cases of health-care workers with no other known risk factors, who were infected with HIV following exposure of skin or mucous membrane. In two cases, the individuals had abrasions or other skin conditions which may have resulted in blood-to-blood contact. In the other case, the individual had blood splattered into her mouth. CDC notes that the "exact route of transmission in these cases is not known," but concludes that skin or mucous-membrane exposures "may rarely result in transmission of HIV." At the same time, the report emphasizes that all three of the infected health-care workers failed to follow proper infection control guidelines during these incidents. Thus, the message is clear: "These cases emphasize again the need to implement and strictly enforce previously published recommendations for minimizing the risk of exposure to blood and body fluids of all patients in order to prevent transmission of HIV infection in the workplace." *Morbidity and Mortality Weekly Report,* May 22, 1987; 36: 285-288.

10. See, for example, A. Berthier et al., "Transmissibility of HIV in Hemophiliac and Non-Hemophiliac Children Living in a Private School in France," *Lancet* (September 16, 1986), 598-601.

11. Theodore M. Hammett, *AIDS in Correctional Facilities: Issues and Options* (Washington, U.S. Government Printing Office, 1986), 13; Hammett, *Update: AIDS in Correctional Facilities* (Washington, National Institute of Justice, U.S. Department of Justice, 1987).

12. CDC, AIDS Weekly Surveillance Report—U.S., June 1, 1987.

13. CDC, AIDS Weekly Surveillance Report—U.S., June 1, 1987; W.M. Morgan et al., "AIDS: Current and Future Trends," *Public Health Reports* 1986; 101:459-465; *Confronting AIDS*, pp. 69-70.

Chapter Two

Operational Issues

Law enforcement officers have real concerns about AIDS. Many law enforcement activities involve contact with persons who may be infected with the AIDS virus. Common concerns involve searches, assaultive behavior, bites, evidence handling, CPR, and body removal. Nearly all (33 of 35) of the departments surveyed for this study reported that staff had "expressed some concern related to AIDS." Patrol officers—those most likely to have the most direct contact with the public—in almost all (94 percent) of the departments were reported to be concerned. However, other law enforcement personnel, including lockup staff, evidence technicians, laboratory staff and detectives, also have concerns about AIDS.

Our survey found that the level of concern among departments tended to be highest among the smallest departments and those serving jurisdictions with few AIDS cases. This indicates that concern—and especially misinformed fear—about AIDS is inversely related to actual experience with the disease. Knowledge and experience tend to calm unrealistic fears about AIDS.

Despite the concern about AIDS, there have been very few reported incidents in which officers have been exposed to the AIDS virus in the line of duty—or even believed that they may have been exposed. None of these incidents resulted in infection or illness to staff. Indeed, no departments surveyed report any job-related AIDS cases among law enforcement officers or other staff.

Policy Recommendations

Provide Education and Training

Education and training must be the cornerstone of all law enforcement responses to AIDS. Departments should conduct regular training to present the facts about transmission of HIV. Nearly all of the surveyed departments attributed officers' concern about AIDS to media coverage. Accordingly, departments should not leave dissemination of information about AIDS to the mass media. Chapter Three deals with education and training in greater depth.

Provide Specific Policy Guidance Regarding AIDS

Departments can select one of two general policy responses to AIDS: (1) instruct staff to follow existing policies regarding contact with individuals who may have communicable diseases; or (2) adopt specific policies and procedures for AIDS.

Departments' communicable disease policies typically evolved from experience in dealing with individuals infected with the Hepatitis-B virus and other infectious diseases. The procedures typically include basic hygienic measures, prompt medical attention, and reporting of incidents to supervisors. Such policies may be modified to reflect the reality of AIDS or be sufficiently general to cover all such communicable diseases. Several departments believe that developing specific policies for AIDS might in fact increase concern by calling undue attention to the problem.

The District of Columbia Metropolitan Police Department *has* adopted formal policies and procedures regarding AIDS in an effort to eliminate procedural ambiguity and avoid embarassing and needless incidents caused by overreaction and misinformation — such as refusal to handle the body of a person who has died of AIDS. The department believes that when faced with an incident, an officer will not be able to determine with certainty whether an individual is infected with HIV or has AIDS before taking appropriate action. While recognizing that the risk of infection is minimal, the department believes that standard procedures must be followed whenever there is any potential for infection. These procedures closely follow CDC guidelines for preventing HIV transmission in the workplace:

1) thorough handwashing after contact with any individual known to be, or suspected of being, infected with HIV;

2) use of protective gloves if there is a likelihood of contact with blood or body fluids of an individual known to be, or suspected of being, infected with HIV; and

3) prompt clean-up of blood or body fluid spills with 1:9 solution of household bleach.[1]

All policy and procedural responses to AIDS should be commensurate with the level of risk present. Insufficient care and overreaction are both ill-advised and potentially harmful to educational objectives. The remainder of this section discusses specific areas of AIDS-related concern raised by law enforcement personnel and the possible responses to those concerns. Appendix C presents examples of departmental policies on AIDS.

Assaults, Human Bites, and Other Disruptive Behavior: Educate on Low Risks and Recommend Reasonable Precautions

Law enforcement officers express concern about a range of assaultive and disruptive behavior through which they may become infected with the AIDS virus. Behaviors of particular concern are biting, spitting, and throwing urine or feces. Such behaviors may occur in a range of law enforcement situations including arrests, routine interrogations, domestic disputes, and lockup operations.

To address officers' concerns about being bitten by infected individuals, departments should educate staff on the fact that it is almost always the individual doing the biting who comes into contact with the blood of the victim. The victim cannot be infected by the blood of the person committing the bite unless that individual has blood in his or her mouth which comes into contact with the victim's blood.

Precautionary procedures may be implemented for victims of bites, but in conjunction with such procedural measures, staff should be reminded that the danger of infection through bites is extremely remote and that the measures being taken are simply precautions indicated by basic hygienic considerations. The Baltimore City Police Department has instituted procedures for immediate actions to take if an officer is bitten by any individual — whether or not the individual is suspected of being infected with HIV. These actions are:

1) encourage the wound to bleed by applying pressure and "milking the wound";
2) wash the area thoroughly with soap and hot water; and
3) seek medical attention at the nearest hospital.[2]

The HIV virus has been isolated in only very small concentrations in saliva and urine, and not at all in feces. Therefore, education should stress that contact with these bodily substances presents little or no risk of infection with the AIDS virus.

Precautionary measures should always be commensurate with the risk involved. It is certainly advisable for officers to use caution when dealing with persons possibly infected with HIV – to "polish [their] defensive and verbal subject control skills" so as to "minimize physical involvement with any subject."[3]

On the other hand, excessive precautions – such as use of gloves, masks, gowns and plastic "flexcuffs" for all contacts with possibly infected individuals – are unnecessary and may seriously undermine the critical educational message that HIV infection cannot be transmitted by casual contact. If a department states that these items are generally unnecessary and it is only making them available "to alleviate concern" among staff, its actions may have the opposite effect of encouraging the view that there is danger in casual contact. Before instituting any proposed precautionary measures, departments should carefully weigh their possible effects on operations and educational programs.

Police Lockups: Ensure Careful Supervision to Prevent Transmission of HIV

The cornerstone of the response to AIDS in the lockup setting is careful supervision to prevent incidents in which the AIDS virus may be transmitted. Officers working in police lockups tend to be concerned about the same issues as officers on the street – that is, assaultive or disruptive behavior of prisoners. The educational and procedural responses to these risks should be similar.

However, there are additional dimensions in the lockup situation – the risk of infection to other prisoners and the threat of violence or intimidation toward infected individuals. These issues may present real problems for departments because of the physical configuration of lockups, especially the communal nature of many of these facilities. The legal status of detainees may also present problems. Many of them may not have been charged with crimes; some may simply be in protective custody. These considerations suggest that the key to an effective lockup policy ought to be careful supervision. Such measures may present difficult logistical problems, given limitations of time, staff and facilities. However, departments must carefully assess the potential risk involved in not addressing these issues.

While several departments reported isolating prisoners with communicable diseases, our survey did not identify any specific procedures for assessing the HIV infection status of lockup prisoners. For a variety of reasons – including inmate turnover, time constraints and the difficulty of maintaining confidentiality – use of HIV antibody testing does not seem an appropriate measure for screening lockup prisoners.[4]

Searches and Evidence Handling: Counsel Caution, Provide Gloves, and Educate on Low Risks

Law enforcement officers, evidence technicians and laboratory technicians may be concerned about being cut or punctured by sharp instruments such as needles or knives that might be contaminated with the AIDS virus. Cuts or puncture wounds might be sustained by officers while searching suspects and handling evidence in a variety of settings. This problem is particularly evident when officers are searching areas where sharp objects may be hidden from view — such as the pockets of clothing and the areas under car seats. Other contaminated items such as clothing present extremely minimal risk unless there is the likelihood of blood-to-blood contact. Thorough handwashing should be more than sufficient to prevent any infection from such items.

The response of departments to the problem of cuts and needlesticks ought to be threefold:

- Emphasize the importance of using caution when searching pockets, motor vehicles, or any places hidden from view and when handling potentially contaminated evidence. Use mirrors whenever possible before reaching into places hidden from direct view.
- Make protective gloves available for use in searches.
- Educate staff on the results of studies of health-care workers with needlestick injuries which show that the risk of infection even by this means is very low.

Surprisingly few departments have made changes in policies regarding the storage and handling of evidence in response to AIDS concerns. However, consistent with medical recommendations, departments should provide protective gloves for laboratory personnel and evidence technicians. Departments should also provide puncture-proof evidence containers and require special labelling of infectious or potentially infectious evidence.

CPR/First Aid: Educate on Low Risks, Provide Protective Devices, and Follow Infection Control Procedures

Staff may be concerned about exposure to saliva through administration of CPR and exposure to blood through provision of first aid to persons with bleeding injuries. In one surveyed department, several officers refused to participate in CPR training in which a dummy was used, for fear of exposure to the AIDS virus. Departments should respond to these concerns by stressing the studies showing the extreme unlikelihood of HIV transmission through saliva. It is also very important to point out the low incidence (less than 0.5

percent) of infection among people with documented blood-to-blood contact through needlesticks—a type of contact much more serious than typically occurs in first aid situations.

At the same time, departments should make protective masks or airways available to officers for use in administering CPR. Over one-half (63 percent) of the departments surveyed provide these devices to prevent direct contact between the victim and the caregiver. According to our survey, small police departments and those serving jurisdictions which have experienced few AIDS cases are somewhat more likely to provide these protective devices than are departments serving large cities which have had numerous cases of the disease.

Several departments have issued useful information on CPR/first aid issues (see Appendix C). The Los Angeles Police Department instructs officers to keep all open wounds carefully bandaged while at work — thereby creating a "self-help barrier" against infection. Bandages should be changed if they become soiled or wet. Hands should be protected with gloves if contact with blood or other body fluids is likely to occur.[5]

In general, measures already in effect in many departments designed to prevent transmission of Hepatitis-B are more than sufficient to prevent the spread of the AIDS virus. The basic procedures to be followed include handwashing after any contact with blood or body fluids and cleanup of all spills with a 1:9 solution of household bleach.

Body Removal: Adhere to Standard Infection Control Procedures

The primary response to patrol officers' concerns regarding body removal should be that if they comply with the standard crime scene procedure — that is, do not touch anything — then they will have nothing to worry about.[6] For detectives and evidence technicians, and others who may have to touch or remove a body, the response should be the same as for situations requiring CPR or first aid: that is, wear gloves and cover all cuts and abrasions to create a "self-help barrier" against infection and carefully wash all exposed areas after any contact with blood or body fluids. Such procedures should be followed after contact with the blood or body fluids of *anyone*, regardless of whether they are known or suspected to be infected with HIV.

Casual Contact: Provide Education on the Facts and Keep Informed of Research Developments

Despite all evidence to the contrary, fully two-thirds of the law enforcement agencies surveyed report that staff members have expressed concern about contracting HIV infection through casual contact. Issues include possible transmission of HIV during transportation, in court, or in

other settings through forms of casual contact such as having an infected person breathe on you, brush against you, shake hands with you, or share workspace with you.

The proper response to these concerns must and can only be regular education presenting the unequivocal fact that no known cases of AIDS are attributable to casual contact. This is confirmed by studies of families, schools and workplaces. Departments should keep informed of the latest research on the transmission of the AIDS virus. They should not rely on the media for accurate information nor allow the media to become their staff's major source of AIDS information. Departments should develop contacts with local medical experts, establish formal programs to monitor AIDS research, and disseminate key findings as they become available.[7] Having department staff gather, evaluate and disseminate research findings to their colleagues may help to defuse some of the distrust law enforcement officers and others may harbor toward "medical experts' " pronouncements on AIDS.

Coordinate with Other Agencies and Organizations

Obviously, law enforcement agencies do not face the AIDS problem alone. A broad range of public agencies and private organizations are addressing various aspects of the disease and formulating policy responses to it. In the interest of acting on consistent information and developing the most creative and innovative policies, law enforcement agencies should coordinate their AIDS programs with public health departments, hospitals, emergency medical units, fire departments, community-based AIDS action and support groups, and other organizations active on this issue.

Our survey found that about two-thirds of the departments are coordinating their responses with other agencies — most typically with public health departments. Coordination is most prevalent in larger departments and in jurisdictions with relatively larger numbers of AIDS cases. However, very few departments reported coordinating their activities with community-based AIDS action groups or with gay/lesbian groups. This could be beneficial as a means to both maximize agencies' access to current information and preventive strategies and to build closer ties with community groups representing large numbers of high-risk and/or infected people.

ENDNOTES

1. D.C. Metropolitan Police Circular, Series 85, Number 43, "AIDS," August 29, 1985; "Report and Recommendations for Processing Prisoners with AIDS," (n.d.).
2. Baltimore City Police Department, General Order 13-85, "Communicable Disease and Human Bites," October 8, 1985.
3. Such measures are covered in a videotape developed by the Law Enforcement Training and Information Network (L.E. Net) and used by the Houston Police Department. This videotape is "AIDS Symposium," Volume 1, Cassette 8. Available from L.E. Net, 621 South Belt West, Belleville, IL 62220.
4. For a full discussion of HIV testing issues as they affect correctional settings, see Theodore M. Hammett, *AIDS In Correctional Facilities: Issues and Options* (Washington: U.S. Government Printing Office, 1986), pp.33-38.
5. Los Angeles Police Department, "AIDS Fact Sheet."
6. Virginia Wolfe, "Straight Talk about AIDS and Your Job," *Tuebor: Official Voice of the Detroit Police Officers Association* (January 20, 1986), p 23.
7. L.E. Net, Training Guide, Volume 1, Cassette 8, "AIDS Symposium."

Chapter Three

Training and Education

Training and education must be the cornerstone of all law enforcement agencies' response to AIDS. Departments should conduct regular training which clearly presents the facts about AIDS and transmission of the HIV virus. Without training, misinformation may triumph. Departments should not leave dissemination of information on AIDS to the mass media, since the survey done for this study shows that media coverage has precipitated staff concerns in virtually every department. At the same time, almost two-thirds of the surveyed departments expressed a desire for more — and more accurate — information on AIDS. This chapter provides detailed discussion on the key elements of AIDS training for law enforcement officers.

The Need for AIDS Training

AIDS training should be timely (i.e. begun before concerns surface), frequent, sufficiently detailed to cover major issues, and keyed specifically to law enforcement concerns. Two-thirds of the surveyed departments currently provide some training on AIDS and another 11 percent plan to do so in the near future. However, current training tends to be infrequent, superficial, and insufficiently related to the specific concerns of law enforcement officers. Some departments do provide extensive recruit training and periodic in-service sessions focussing specifically on the implications of AIDS for all areas of police work. However, most departments limit their programs to a one-time session on CPR precautions and/or distribution of a general fact sheet on the disease.

Most departments that fail to offer AIDS training or education are small departments. They variously attribute their lack of training to an absence

of expressed concerns among staff, a simple failure to "get around to it," or a belief that it is up to staff to educate themselves. The first two reasons reflect a failure to be proactive in providing staff training and education on AIDS. It is important to anticipate concerns and to provide education and training before misinformation has an opportunity to create irrational fear among staff. The third reason essentially reflects an abdication of responsibility for training and education of law enforcement staff to the mass media, which have often been responsible for spreading misinformation about AIDS.

Almost two-thirds of the surveyed departments that provide training believe that it has helped to allay staff fears. However, only two departments had actually evaluated their training programs. Simple pre- and post-training tests can be used by departments to gauge the effectiveness of the programs in delivering the facts about AIDS to officers and other staff. (A pre- and post-test developed by National Capitol Systems, Inc. for correctional officer training is included in Appendix D).

Key Elements of Training

Staff Participation in Materials Development

Staff and union representatives should assist in the development of training materials and training programs. This can help to counteract staff suspicions that department management is trying to "pull the wool over our eyes."

Like many citizens, law enforcement officers have displayed some suspicion of the medical community's pronouncements on AIDS. Therefore, training which simply presents medical research as fact may not be convincing or effective in allaying irrational fears. Our research on correctional systems' response to AIDS has found that some of the most effective training programs are those developed jointly by management, staff members, unions, medical experts and health professionals. The District of Columbia Metropolitan Police Department, the New York State Department of Correctional Services and the New York City Department of Corrections all surveyed their staff to identify specific questions and concerns regarding AIDS, and shaped their training to address these questions and concerns. The New York City correctional department videotaped a roundtable question-and-answer session between staff members and medical experts and made the tape the basis of its highly successful staff training program on AIDS. Appendix B provides contacts for obtaining these training materials.

Timely and Frequent Training

Ideally, training and education on AIDS should be provided before staff develop irrational fears of the disease. Departments should not wait for staff concern to surface before developing training programs. Training on AIDS should be included in both recruit and regular in-service training. However, in most of the departments surveyed, training is only provided on a one-time basis.*

Regular training takes time and costs money. But the costs are relatively low compared to the problems that may result if staff are left to rely for information on the sometimes inaccurate media coverage of AIDS. There is a real need for regular training and education which presents the emerging facts about AIDS.

The frequency with which information is presented depends on the mode of presentation. Pamphlets and brochures may be distributed or made available almost continuously. In most cases, however, live training programs are only held every few months or as infrequently as every year. Because of the pace of research developments, it is important to present frequent updates and to offer timely and accurate information to counteract unfounded rumors. Experience shows that if training and education programs are allowed to lapse, misinformed fears are quick to resurface.

Live Training by Knowledgeable Trainers

"Live" training on AIDS is the most effective format, because it provides staff members the opportunity to raise their own specific questions and concerns and to receive responses from people who are knowledgeable on the subject. If videotapes or slides are presented, they should be supplemented with live question-and-answer sessions. However, fewer than one-half of the departments surveyed currently present any form of live training. Distribution of printed materials is the most common form of AIDS education for staff in the departments (63%), followed by videotapes (40%), lectures (40%), seminars (14%), and slide shows (11%).

When live training is presented, it is important that trainers be extremely knowledgeable on the epidemiology and means of transmission of HIV infection and AIDS, and able to answer questions clearly and effectively. Agencies can use department staff, public health officials, or other agency staff to present AIDS training.

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*In 29% of the departments, this was provided during recruit training, in 34% as part of in-service training, and in 31% at roll-call.

Training Keyed to Law Enforcement Concerns

Unfortunately, current law enforcement staff training on AIDS tends to be insufficiently focussed on the specific concerns of law enforcement officers. Most departments simply offer generic education on means of transmission and prevention measures. The materials are typically drawn from CDC or Public Health Service pamphlets such as "Facts About AIDS." Fewer than one-half of the departments surveyed provide AIDS training related to any specific law enforcement situations except CPR.

Training and education on AIDS should be related specifically to law enforcement situations and concerns. Appendix C presents examples of departmental bulletins and memoranda on AIDS which address such specific concerns of law enforcement personnel. Figure 3.1 presents a list of key topics to be covered in law enforcement training programs on AIDS. As discussed in Chapter Two, there are certain key educational and action messages that ought to be conveyed in regard to the specific concerns of law enforcement officers. These are summarized in Figure 3.2.

Figure 3.1

Subjects to be Covered in Training and Education Programs on AIDS

- Means of transmission of HIV infection
- Methods of preventing transmission
- CPR/First Aid procedures
- Search procedures
- Arrest procedures
- Transportation of prisoners
- Crime scene processing
- Evidence handling/laboratory procedures
- Disposal of contaminated materials
- Lockup issues
- Body removal procedures
- Legal/liability issues (e.g. obligation to perform duty)
- HIV Antibody testing procedures

Figure 3.2

Appropriate Educational and Action Messages to Address AIDS-Related Concerns of Law Enforcement Staff

Issue/Concern	Educational and Action Messages
Human Bites	Person who bites is typically the one who gets the blood; viral transmission through saliva is highly unlikely. If bitten by anyone, milk wound to make it bleed, wash the area thoroughly and seek medical attention.
Spitting	Viral transmission through saliva is highly unlikely.
Urine/Feces	Virus isolated in only very low concentrations in urine; not at all in feces; no cases of AIDS or HIV infection associated with either urine or feces.
Cuts/puncture wounds	Use caution in handling sharp objects and searching areas hidden from view; needlestick studies show risk of infection is very low.
CPR/first aid	To eliminate the already minimal risk associated with CPR, use masks/airways; avoid blood-to-blood contact by keeping open wounds covered and wearing gloves when in contact with bleeding wounds.
Body removal	Observe crime scene rule: do not touch anything; those who must come into contact with blood or other body fluids should wear gloves.
Casual contact	No cases of AIDS or HIV infection attributed to casual contact.
Any contact with blood	Wash thoroughly with soap and or body fluid water; clean up spills with 1:9 solution of household bleach.

Training materials and programs should stress that the Hepatitis-B virus is more efficiently transmitted through the same body fluids as the HIV virus. Therefore, infection control procedures for Hepatitis-B — use of gloves if contact with blood or body fluids is likely, thorough handwashing after any contact with blood or body fluids, and cleanup of blood and body fluid spills with a 1:9 solution of household bleach — are more than sufficient for HIV. Training and education should also make the point that, in the law enforcement context, there may be more risk in contact with contaminated objects (evidence) — although this risk is also remote — than in contact with infected persons. Therefore, emphasis should be placed on the need for care and caution in searches and evidence handling.

Avoiding Extremes of Alarmism and Complacency

AIDS staff training and education programs must carefully avoid both extremes of alarmism and complacency. An alarmist tone may evoke undue fear, while a complacent tone may fail to encourage the appropriate level of care and caution. The plain facts are that a few well-defined types of exposures and activities must be of concern to everyone and that this concern should affect relationships with everyone. In short, "AIDS is not a disease of high-risk groups but of high-risk behaviors." However, far too many people take the converse — and potentially very dangerous — position that the AIDS virus may be transmitted by many types of contact — including casual contact — but that the only persons to be concerned about are members of "high-risk" groups.

It may be alarmist to require or recommend that staff wear gloves, gowns, and masks for all contact with persons known or suspected to be infected with HIV, or persons who are in AIDS "high-risk" groups. Such precautions are not normally necessary and may tend to encourage the incorrect view that HIV can be transmitted by casual contact. Moreover, to suggest that HIV may be transmitted through all bodily fluids is contradicted by solid research evidence and may spread undue fear.[1]

On the other hand, statements which complacently suggest that risk is limited to certain groups may seriously undermine the critical educational message that everyone must be careful about certain behaviors and exposures. Nonetheless, some police departments continue to suggest that "fear among people who are not in a high-risk group is unwarranted and counterproductive."[2] While unreasoning fear is unwarranted, concern and caution are essential for all.

Finally, consider this statement: AIDS "is not a disease of homosexuals; it appears to be a disease of the sexually promiscuous regardless of their sexual preferences."[3] This message is somewhat misleading. One need not be

promiscuous to contract the HIV virus. Infection may result from one isolated episode. Everyone must be careful about sexual relationships. Law enforcement officers, as well as other citizens, must be careful about blood-to-blood contact with everyone – whether or not they say they have AIDS, appear to be ill, or seem to be in an AIDS risk group. If the tone of AIDS training programs is not properly balanced between caution and reassurance, they may encourage misinformed beliefs which may severely affect the operational effectiveness and service delivery of a law enforcement agency.

Law Enforcement Officers as Educators in the Community

Law enforcement officers represent a potentially very positive educational influence on AIDS in the community. They frequently deal with members of high-risk groups and with individuals who may be carriers of the AIDS virus, such as intravenous drug abusers and prostitutes. Thus, they have perhaps more opportunity to convey to such individuals factual educational messages on HIV infection and AIDS than do any other public officials. Police officers can tell prostitutes and intravenous drug abusers about the risk involved in needle-sharing and in unprotected sexual intercourse. Moreover, they can convey these important messages in clear, frank language understandable to people on the street. Police officers can also refer people to appropriate organizations for voluntary testing, diagnosis, medical care, and support services.

Of course, the effectiveness of law enforcement officers as educators on AIDS depends upon the education and training that they themselves receive. Thus, by providing high-quality training, a law enforcement agency invests not only in the health and job performance of its staff but in the awareness and ultimate health of the community at large.

ENDNOTES

1. A statement that AIDS may be transmitted through all body fluids is contained in San Francisco Police Officers Association Bulletin on AIDS published in 1983. This document was furnished by the department as supplementary material to their survey responses. We are not sure if this material is still distributed to officers.
2. Los Angeles Police Department, "AIDS Fact Sheet."
3. Fairfax County (VA) Police Department, "Memorandum: Advisory Information on AIDS," January 29, 1986.

Chapter Four

Legal and Labor Relations Issues

This chapter deals much more with potential problems than with actual problems. As already noted, there have been very few incidents raising the possibility—or even the perceived possibility—that a law enforcement officer contracted the AIDS virus in the line of duty. A few departments have experienced minor job actions reflecting officers' concerns about AIDS. For example, the union in one city asked that all officers be issued gloves. As far as we know, however, none of these actions or incidents has resulted in any formal legal action against a department. Indeed, we are aware of no pending or disposed cases against law enforcement agencies in any way involving AIDS.

However, over one-half of the departments surveyed for this report consider AIDS a potentially serious legal issue for law enforcement. Of particular concern are the following issues:

- What are the department's responsibilities to report incidents in which HIV transmission may have occurred?
- What policies should the department establish regarding use of the HIV antibody test in response to incidents in which transmission may have occurred?
- What would be the department's liability if an officer contracted HIV infection or AIDS in the line of duty?
- What are the legal and/or labor relations issues involved when an officer refuses to do his or her duty out of fear of contracting AIDS?

- What are the department's responsibilities for protecting the public from infection, through policies for dealing with potential carriers of the virus?
- What are the department's responsibilities to prevent HIV transmission among prisoners in a police lockup?

This chapter presents observations and recommendations for addressing each of these issues.

Establish Procedures for Reporting Incidents in Which HIV Transmission May Have Occurred

Departments should establish formal procedures for reporting incidents in which HIV transmission may have occurred. Incidents should be reported in a timely fashion so that appropriate preventive and medical intervention can be taken. Moreover, departments should carefully document exposures to HIV and track the subsequent condition of potentially exposed individuals, for such information may become critical in the event of subsequent legal action.

About two-thirds of the departments surveyed have established formal procedures for reporting contacts with individuals known or suspected to be infected with the HIV virus. However, in many instances, these are simply extensions of pre-existing policies requiring that contacts with individuals thought to have communicable diseases be reported through channels.

Develop Policies on HIV Antibody Testing

Many complex considerations may affect departmental and individual decisions on HIV antibody testing in response to incidents in which infection may have been transmitted. The HIV antibody test represents the best current means of tracking the infection status of individuals potentially exposed to the HIV virus. The test, when properly confirmed, can show whether an individual has been infected with the virus at some time in the past. (Departments should consult with laboratory staff to ensure that the appropriate confirmatory tests are being used.) Although it cannot determine with certainty whether the individual is still infected, the test remains the best method of discovering whether infection occurred during a particular time period. This is because it takes from 1-3 months for antibodies to appear. If a police officer tests negative immediately following an incident in which infection may have occurred and tests positive three months later, and there is no other known source of infection, this would be strong — although not incontrovertible — evidence that infection occurred as a result of that incident.

Because of potential legal liabilities, departments may wish to require, recommend, or make available testing for officers and other individuals

involved in incidents. Moreover, for health reasons, it is probably to the benefit of the officer and his or her family to know whether infection has occurred. On the other hand, the potential negative effects on individuals' lives in terms of access to insurance, employment, and housing—if positive results were to become known—may weigh heavily against testing.

In several states, including California and Wisconsin, HIV antibody testing without the informed consent of the individual is prohibited by law. In many other jurisdictions there are legal and administrative obstacles to any mandatory testing and to departmental access to test results.

Finally, other legal and labor relations issues, such as the future employment status of HIV-positive individuals, should be considered when developing policies on testing.

Department policies on HIV antibody testing should reflect a careful consideration of all of these issues. Policy statements should specify the rationale for the policy position and the procedures to be used in any testing program. At a minimum, written policies should address the following key questions:

- who is to be tested?
- what is the purpose of the testing?
- is testing voluntary or mandatory (taking into account applicable laws)?
- when and where are tests to be performed?
- what confirmatory tests are to be used?
- who must be notified of the results? and
- what are the requirements for pre- and post-test counselling?

Over 70 percent of the departments surveyed for this study have policies for HIV antibody testing in response to incidents in which infection may have occurred. However, few of these policies are clear and consistent. The policies in the vast majority of these departments (84%) apply only to testing the staff member involved in the incident. Three departments reported policies that cover testing of the staff member and the other individual involved.

The Los Angeles Police Department has established a procedure which addresses many of the key testing issues. The procedure covers incidents between staff and members of AIDS "high-risk" groups. The policy calls for immediate medical assessment of the suspected carrier and the officer, but specifies that "a blood test for the employee is necessary only if the suspected carrier's tests show positive." However, under California law no one may be tested for HIV antibodies without informed consent. The policy provides

for counselling of the employee in the event the other individual refuses to be tested. The employee is to be notified of his or her test results within 48 hours, and employees with initially seronegative results are to be retested at a minimum of five six-month intervals. The Los Angeles testing policy was the most complete identified in our survey. (It is included in Appendix C.) However, it contains a few weaknesses in light of public health recommendations: retesting of initial seronegatives should occur at three-month rather than six-month intervals, and all individuals who are tested should be counselled on the meaning and behavioral implications of the results.

Officers in departments with no testing procedures always have the option to seek testing through their private physicians or CDC-funded alternative test sites that have been established throughout the country. The New York City Department of Corrections has established the following policy for employees involved in incidents: that they have their blood drawn immediately following the incident and again after three months. The department will simply bank the samples and do no testing of them unless and until the individual develops symptoms of illness or there appear to be other diagnostic reasons to obtain antibody test results.

Consider the Department's Potential Liability for Job-Related HIV Infection

Law enforcement officers assume a certain amount of risk when they accept the job. Their department cannot be held liable for damages if, for example, they are killed or wounded by a gunshot from a suspect unless established procedures were violated or the department was negligent. Of course, worker's compensation might well apply to such cases, but this is a separate issue from departmental liability.

The same result would presumably obtain if an officer contracted the AIDS virus from a suspect or other individual in the line of duty and sued the department for damages. Any claim of the department's liability would be further weakened if the officer had been provided accurate, thorough, and regular training on AIDS. For example, if an officer had not been trained to cover open wounds, to wear gloves when contact with blood was likely, and to wash thoroughly after any contact with blood, and developed infection as a result of a contact in which the appropriate precautions had not been taken, then the department could conceivably be held liable. If, on the other hand, the department could document that the officer had received such training, then its position would be much stronger. This suggests not only the importance of the training itself, but also of documenting the training.

Emphasize Officers' Obligation to Perform Duty Involving HIV-Infected Individuals

Law enforcement agencies should establish that fear of AIDS does not free officers from the obligation to perform their duties. Four of the surveyed departments reported incidents in which officers refused to perform duties out of such fear. These incidents involved transportation of prisoners, searches, and handling of evidence. In almost every instance, the departments took swift and strong action, such as suspension without pay against the officers involved. District of Columbia guidelines on AIDS emphasize the evidence against transmission by casual contact and explicitly state that "employees should not be excused from carrying out their duties when no unusual personal risk exists."[1] In another city, a refusal resulted in initiation of a more extensive training and education program on AIDS for officers and other staff.

It would appear that any legal claim supporting officers' refusal to perform duties based on fear of AIDS would be difficult to sustain on two grounds: first, because the research is so clear on the unlikelihood of viral transmission through the types of contacts likely to be experienced by police officers, assuming standard precautions are taken; and second, because the officer assumes certain risks in accepting the job.

Consider the Department's Potential Responsibilities to Prevent Transmission of HIV Infection

It is highly speculative to attempt an assessment of the legal implications of law enforcement agencies' potential responsibilities to protect the public from AIDS through their handling of potential carriers of the virus. These include the questions of whether departments should be trying to incapacitate intravenous drug abusers, prostitutes or others who might spread the HIV virus. In order to sustain any claim against a department on this basis, a plaintiff would first need to establish that law enforcement agencies legitimately bear such responsibilities and can legitimately be expected to carry them out. Moreover, a plaintiff would also need to overcome the problem that his or her infection was contracted as a result of consensual conduct widely known to pose high risks in this regard. Based on these factors, it would appear very difficult to sustain this type of claim against a law enforcement agency.

However, more is involved in such situations than potential legal liability. In the next few years, more and more departments are likely to face the question of how to deal with prostitutes and others in police custody who may be infected with the AIDS virus. Law enforcement agencies, together with public health departments and other government agencies, should

develop clear policies on how to handle such situations so as to prevent continued transmission of the virus by these individuals, while at the same time maintaining protection for their constitutional rights. These policies should be developed as soon as possible so that they are in place if and when an incident occurs.

Consider the Department's Responsibilities to Prevent HIV Transmission Among Prisoners in Police Lockups

Claims of law enforcement agencies' responsibilities to prevent the transmission of the AIDS virus appear to be much more supportable in the event that the conduct resulting in HIV transmission was coerced rather than consensual and occurred in a place under the supervision of the agency. This raises the potential scenario of an individual becoming infected through a rape in a police lockup.

While there are important differences between lockups and other correctional facilities, the experiences of prisons and jails may nevertheless be suggestive with regard to potential legal issues. There have been several suits filed by correctional inmates seeking more protection from AIDS. In three pending Oregon cases[2] and a pending Florida case[3], inmates are seeking mass HIV screening in correctional institutions, while a pending Arkansas case seeks not only mass screening, but also hospitalization of all inmates with AIDS, discharge of any staff who develop AIDS, removal of any seropositive correctional staff from contact with other staff and inmates, and systematic reporting of all AIDS cases to the correctional department and the state health department.[4]

Two pending New Jersey cases allege failure to follow established administrative and medical screening policies and demand systematic identification and segregation of high-risk inmates and those with symptoms of HIV infection, as well as more and better inmate training on AIDS. These suits do not, however, call specifically for mandatory HIV antibody screening.[5]

In New York, a group of healthy inmates sought injunctive relief from the policies of Downstate Correctional Facility which allegedly provided inadequate protection against the spread of AIDS. However, the court held that the segregation policies and precautions followed at the institution were adequate to protect the inmates. Significantly, the court also declared that "In view of the scientific uncertainty concerning...AIDS, and the reluctance of the court to intervene in the day-to-day management of a prison, no procedural regimen regarding the protection of the rights of the AIDS-free inmates shall be judicially mandated."[6]

No cases have been filed as yet by inmates seeking damages for allegedly contracting HIV infection or AIDS while in a correctional facility. Correctional systems (and presumably, by extension, police departments operating lockups) have been required by courts to adhere to a standard of reasonable care in protecting inmates. Breaches of this standard may constitute cruel and unusual punishment.[7] In several cases, correctional systems and their officials have been held liable for damages resulting from homosexual rapes and other inmate-on-inmate assaults on the ground that inadequate supervision had been provided to prevent such incidents.[8]

However, correctional systems have not been held responsible for insuring the *absolute* safety of persons in their custody. In several cases, for example, courts have held that a correctional system could be liable for damages resulting from inmate-on-inmate assault only if its officials knew—or should have known—in advance of the risk to the particular inmate.[9]

This somewhat ambiguous and evolving caselaw may apply to police lockups. Moreover, law enforcement agencies should be aware that they may face more difficulties in protecting prisoners from rape and other incidents in which HIV infection may be transmitted than do correctional systems. This is because of the communal nature of many lockups and the lack of formal prisoner classification. In addition, the rapid turnover of prisoners increases the chances that HIV transmission will occur, but make it more difficult to take action to prevent high-risk behaviors. Although no cases of this nature have yet arisen regarding lockups, the potential for law enforcement agencies to be held liable in such situations appears strong enough to warrant their consideration of preventive measures. As discussed in Chapter Two, departments should certainly take steps to improve their supervision of lockup areas so as to minimize opportunities for high-risk behavior.

In sum, law enforcement agencies perceive AIDS to pose serious potential legal problems. However, there have been no actual cases filed on these issues as yet and, with the exception of the police lockup scenario, there do not appear to be very strong grounds for suits alleging departments' liability for damages associated with HIV infection or AIDS either by officers or by members of the public.

ENDNOTES

1. Government of the District of Columbia, District Personnel Manual Insurance System, DPM Bulletin No. 20B-1, Acquired Immune Deficiency Syndrome, February 10, 1986.
2. *Herring v. Keeney* (U.S.D.C. Oregon, filed September 17, 1985); *Sheppard v. Keeney* (U.S.D.C. Oregon, filed October 7, 1985); *Malport v. Keeney* (U.S.D.C. Oregon, filed October 11, 1985).
3. *Potter v. Wainwright* (U.S.D.C., Middle Dist. Florida, No. 85-1616-CIV-T15).
4. *Knight v. Henderson* (U.S.D.C. Arkansas, No. PB-C-86-16).
5. *Telepo v. Fauver* (U.S.D.C. New Jersey, Civil Action No. 85-1742 [HAA]); *Hook v. Fauver* (U.S.D.C. New Jersey, Civil Action No. 85-5962 [HAA]).
6. *Mtr La Rocca v. Dalsheim*, 120 Misc 2d 697 (NY, 1983).
7. See, e.g., *Doe v. Lally* 457 F. Supp. 1339 (U.S.D.C., Maryland, 1979); *Campbell v. Bergeron* 486 F. Supp. 1246 (U.S.D.C., Middle Dist. Louisiana, 1980), aff'd 654 F. 2d 719 (5th Cir. 1981); *Streeter v. Hopper* 618 F. 2d 1178 (5th Cir. 1980); *Rhodes v. Chapman* 101 S. Ct. 2392 (1981).
8. See, e.g., *Redmond v. Baxley* 475 F. Supp. 1111 (U.S.D.C. E. Dist. Mich. 1979); *Garrett v. United States* 501 F. Supp. 337 (U.S.D.C., N. Dist. Georgia 1980); *Saunders v. Chatham County* 728 F. 2d 1367 (11th Cir. 1982); *Kemp v. Waldron* 479 N.Y.S. 2d 440 (Sup. Ct. 1984); *Thomas v. Booker* 762 F. 2d 654 (8th Cir 1985).
9. See, e.g., *Mosby v. Mabry* 697 F. 2d 213 (8th Cir., 1982); *O'Quinn v. Manuel* 767 F. 2d 174 (5th Cir., 1985).

Chapter Five

Summary of Recommendations

The major recommendations to law enforcement agencies for addressing AIDS-related issues are summarized below.

Operational Issues

Most AIDS-related concerns among law enforcement staff relate to contact with individuals known or suspected to be infected with HIV and with potentially contaminated objects. The following recommendations address these concerns:

- **Provide Education and Training on AIDS for law enforcement officers and other department staff.**
- **Issue Specific AIDS Policies and Procedures, or Revise Existing Communicable Disease Policies to Address AIDS Issues.** Such policies may help to avoid incidents caused by overreaction and fear. On the other hand, promulgating specific AIDS policies may heighten concern by calling attention to the issue. The alternative is simply to apply existing communicable disease policies, based on experience with Hepatitis-B and other infections—i.e., emphasizing basic hygiene and cleanup of body fluid spills.
- **Educate Officers on the Low Risk of HIV Infection Associated with Assaults, Human Bites, and Other Disruptive Behavior by Subjects but Recommend Reasonable Precautions.** To establish low risks, emphasize saliva and needlestick studies. Reasonable precautions include polishing

"defensive skills" to minimize physical contact and practicing good hygiene if contact occurs.

- **Ensure Careful Supervision of Lockup Areas to Prevent Incidents in which HIV Infection May Be Transmitted Among Prisoners.**

- **Counsel Caution and Use of Gloves in Searches and Evidence Handling, but Educate on Low Risk of Infection.** Needlestick studies establish the extremely low risk of infection, but officers should wear gloves and use mirrors when possible to examine places hidden from direct view. Puncture-proof containers should be provided for evidence and potentially infectious materials should be labelled.

- **Use Masks or Airways for CPR, but Educate on Low Risk of Infection.** Saliva studies establish the low risk of infection, but protective devices make sense from the point of view of general hygiene.

- **Follow Infection Control Procedures for First Aid.** When there is likely to be contact with blood, all cuts or open wounds should be covered with clean bandages and gloves worn. There should be careful handwashing after contact and spills should be cleaned up promptly with a household bleach solution.

- **Ensure that No Staff Touch Bodies of Deceased Individuals Unless Authorized or Necessary.** If contact is necessary, infection control procedures should be followed.

- **Provide Clear Education on the Fact that HIV Infection is Not Transmitted by Any Form of Casual Contact.** Departments should keep continuously abreast of research developments in this area and pass all new information on to staff.

- **Coordinate Educational Efforts with Public Health Departments, Hospitals, Emergency Medical Services, Fire Departments, Community-Based AIDS Action Groups and Gay/Lesbian Organizations.** Cooperative ties with the last two organizational categories are currently rare in law enforcement agencies and probably should be expanded.

Key Elements of AIDS Training for Staff

Effective staff training must be the cornerstone of law enforcement agencies' response to AIDS. Key elements of AIDS training are presented in the following recommendations:

- **Involve Staff in the Development of Training Programs and Training Materials.** This lends credibility to the program and allows it to respond to specific issues raised by the staff.
- **Training Should be Timely.** Ideally, it should begin before staff begin to raise serious concerns about AIDS.
- **Training Should Be Presented Frequently.** One-time segments during recruit training are insufficient. Regular in-service training is necessary to present new information promptly and to prevent misinformation from taking hold. Printed materials should be continuously available.
- **Live Training (lectures, seminars, discussions) is the Most Effective Format if Trainers are Highly Knowledgeable.** It is critical that staff have ample opportunity to ask questions and receive answers from experts in the field. Videotapes can be effective but they should be followed by live question-and-answer periods.
- **Training Should be Keyed to Specific Law Enforcement Issues and Situations.** It is not enough to distribute generic informational materials. Training topics should include arrest procedures, searches, CPR, first aid, evidence handling, transportation of prisoners, crime scene processing, disposal of contaminated materials, lockup supervision, and body removal procedures.
- **Training Should Avoid the Extremes of Alarmism and Complacency.** An alarmist tone might foster misinformation and undue fear, while a complacent tone might not provide sufficiently strong recommendations regarding the care and caution appropriate for all staff to practice in all situations.
- **Recognize the Role of Law Enforcement Officers as AIDS Educators in the Community.** Because officers frequently deal with intravenous drug users, prostitutes and others at high risk of being infected with HIV, they may have a unique opportunity to provide frank, practical educational messages on the disease.

Legal and Labor Relations Issues

Law enforcement agencies have expressed concern about a number of AIDS-related legal and labor relations issues. Most of these issues are still hypothetical because few actual cases have arisen as yet. However, the following recommendations address key concerns that have been raised by agencies:

- **Establish Formal Procedures for the Timely Reporting of Incidents in Which Transmission of HIV Infection May Have Occurred.** Such reporting facilitates prompt and appropriate medical intervention.
- **Develop Policies on HIV Antibody Testing.** Departments may wish to require, recommend or make available testing for officers and other individuals involved in incidents in which infection may have been transmitted. Department policies should reflect careful consideration of all of the complex, countervailing issues surrounding HIV antibody testing. Policy statements should specify the rationale for the policy position and the procedures to be used in any testing program.
- **Consider Potential Liability Claims Against the Department (as distinct from worker's compensation claims) Arising from Job-Related HIV Infection.** The probability of such liability being found appears low because of the officer's "assumption of risk" in accepting the job and would be minimized by providing regular training which recommends specific precautions against infection.
- **Emphasize Officers' Obligation to Perform Duties Involving HIV-Infected Individuals.**
- **Consider the Department's Potential Responsibility for Preventing HIV Transmission by its Treatment of Potential Carriers of the Virus.** This might apply to prostitutes and intravenous drug users, but it would seem that departmental liability would be very hard to establish if the conduct resulting in infection was consensual—e.g. shooting drugs or patronizing a prostitute. Nevertheless, departments should develop policies for dealing with prostitutes and others in police custody who may be infected with HIV.
- **Consider the Department's Responsibility to Prevent HIV Transmission Among Prisoners in the Lockup.** This represents a potentially very serious legal problem, particularly if HIV transmission occurs as a result of coerced conduct in the

lockup. Although none of these cases relate specifically to HIV transmission, correctional departments have been held liable for damages arising from homosexual rapes and other inmate-on-inmate assaults where it was established that supervision had been inadequate.

AIDS poses a range of complicated and potentially serious problems for law enforcement agencies. However, timely and rational policy choices, regular staff training keyed to specific law enforcement concerns, and careful consideration of possible legal liabilities can go far toward minimizing the effects of these problems on the delivery of police services to the public.

Appendix A

Medical Information on HIV Infection and AIDS

Chapter One of this report presents basic facts about AIDS. This Appendix is designed to provide more detailed medical and epidemiological information for interested readers.

AIDS was first recognized in the United States in 1981, although it may actually have appeared somewhat earlier. The disease was identified through studies of several groups of previously healthy gay men who developed an unusual form of pneumonia (*Pneumocystis Carinii* pneumonia) and a rare form of cancer (Kaposi's sarcoma). In the absence of other causes, the appearance of these diseases gave evidence of an underlying immunodeficiency in the patients.

In 1983 and 1984, scientists at the Institut Pasteur in Paris and the National Institutes of Health identified and isolated the probable cause of AIDS: a virus previously called Human T-Cell lymphotropic virus Type III (HTLV-III) or lymphadenopathy-associated virus (LAV) and now known in the medical research community as Human Immunodeficiency Virus (HIV). While it is generally believed that HIV is an indispensable requirement for the development of AIDS, it is not fully established that this virus is the sole cause of AIDS; there may well be important "co-factors" that enter into the causal formula.

Definitions

Terms have been given to the degrees of reaction to HIV infection. However, there are variations in the definitions of these terms and, in fact, some researchers and physicians have defined alternative points along the spectrum of illness.[1] However, the following categories are the most important and widely used.

AIDS

AIDS has no independent symptoms. Rather, diagnosis is based on the presence of "opportunistic infections" or unusual cancers. An opportunistic infection is one occurring in individuals whose immune systems are compromised, but not generally seen in individuals with normal immune systems. The CDC "surveillance definition" of AIDS (i.e., the definition used for enumeration and epidemiological analysis of AIDS cases in the United States) is the most widely used.[2] According to this definition, AIDS is

> an illness characterized by: I) one or more opportunistic diseases that are at least moderately indicative of underlying cellular immunodeficiency, and II) absence of all known underlying causes of cellular immunodeficiency (other than HIV infection) and absence of all other causes of reduced resistance. . . .

The CDC definition includes a long list of opportunistic infections, malignancies and other conditions, the two most common of which are probably *Pneumocystis Carinii* pneumonia and Kaposi's sarcoma.

AIDS-Related Complex (ARC)

A diagnosis of ARC is based on presence of a combination of conditions, often quite mild, that together give evidence of infection with the AIDS virus. Individuals with ARC may get better but remain infected. The most commonly used definition of ARC is from the National Institutes of Health: any two from a long list of symptoms including swollen lymph nodes, weight loss, and night sweats and *any* two from a list of laboratory abnormalities, including blood test results showing depressed helper T-cells and depressed helper/suppressor ratio.[3]

HIV Seropositivity

Confirmed seropositivity (i.e., confirmed presence of antibodies to HIV) indicates that the tested individual has been previously infected with the AIDS virus, although the body may have subsequently fought off the infection. The likelihood that HIV seropositivity means current infection with the virus is considered much greater for individuals in identified AIDS risk groups. Nevertheless, seropositive individuals may never develop any symptoms, let alone develop end-stage AIDS. On the other hand, seropositive individuals may be able to transmit the infection to others, even if they never develop symptoms themselves. CDC's recommended criteria for a determination of seropositivity are two positive ELISA tests confirmed by a Western Blot test.

The Relationships among Exposure, Infection, HIV Seropositivity, and Development of ARC or AIDS

Figure A.1 summarizes the meanings of exposure, infection, seropositivity, ARC, and AIDS and the relationships among these stages. However, it is important to note that this is a complex infection and there is no standard rate or pace of progression from stage to stage. Some infected individuals remain asymptomatic for long periods—perhaps indefinitely—while others quickly develop end-stage AIDS and die.[4]

"Exposure" to HIV means that the individual has had contact with the virus in a way that would make it possible for him or her to become infected (e.g., sexual contact or needle-sharing activity). No one knows exactly what fraction of exposed persons will become infected and remain infected. However, research on a cohort of 6,875 sexually active homosexual males in San Francisco reveals very high rates of seroconversion (i.e., becoming

Figure A.1
Relationships Among Exposure, Infection, HIV Seropositivity and Development of ARC or AIDS

Stage	Meaning	Relationship to Previous Stage(s)
Exposure	Individual has contact with HIV in a way that makes transmission possible (e.g., sexual contact or needle-sharing activity)	—
Infection	Individual is infected with HIV. Infection may be permanent or body may successfully combat the virus.	Unknown, although multiple exposures probably increase the risk of infection.
Seropositivity	Individual has antibodies to HIV, meaning that infection has occurred at some time in the past. ELISA test cannot pinpoint date of infection or determine whether individual remains infected.	CDC considers ELISA test a reliable indicator that infection has occurred at some time. Reliability increases with repeat ELISA and Western Blot Test. (See Chapter Three.)
ARC	Presence of a combination of conditions together giving evidence of infection with AIDS virus.	CDC estimates that about 25 percent of seropositive individuals will probably develop ARC. However, this estimate is uncertain due to the lengthy incubation period.
AIDS	Illness characterized by one or more opportunistic infection at least moderately indicative of underlying cellular immunodeficiency.	The Institute of Medicine, National Academy of Sciences estimates that 25-50 percent of seropositives will develop AIDS within 5-10 years of infection and that more than 90 percent show some immune system deficiency within five years of infection.

HIV seropositive over time), indicating that multiple exposure may increase the risk of infection. A representative sample of the cohort was 4 percent seropositive when their blood samples (collected in 1978) were first tested. By 1985, the seropositive rate in the sample had increased to an astounding 73 percent.[5]

HIV seropositivity means that the individual was, in fact, infected at some time in the past, although the ELISA test cannot pinpoint the date of infection or determine with certainty that the individual is still infected. Thus, the view commonly presented in articles regarding AIDS that HIV seropositivity merely indicates possible "exposure" to the virus is considered by many physicians and epidemiologists to be a serious misunderstanding. Indeed, CDC's current position is that, for the purposes of counselling and making public health recommendations, any seropositive person should be considered infected and potentially infectious. The long—possibly indefinite—incubation period of AIDS makes seropositivity a very serious problem because it is never possible for a seropositive individual to know for certain that he or she is free from risk of becoming ill.

It is currently thought that only a minority of seropositive persons will develop ARC or AIDS. Based on data from the San Francisco cohort study, CDC estimates that 25 percent of seropositive individuals will develop AIDS-Related Complex. Such figures may be open to debate because of variations in definitions of ARC and because of the uncertain length of the incubation period. Finally, based on a five-year followup period, 10 percent of HIV seropositives in the San Francisco cohort had developed AIDS.[6]

With the long and uncertain incubation period of AIDS, it is likely that the percentages of individuals in the San Francisco cohort who develop AIDS or ARC will rise. CDC researchers believe that another 3 percent of seropositives may develop AIDS each year. Recent studies of four cohorts of HIV seropositive persons in the United States and Denmark suggest that 8-17 percent will develop AIDS within three years and another recent study of a group of New York City homosexual males suggests that 34 percent of those infected with HIV will develop AIDS within three years.[7]

These research findings are beginning to suggest the quantitative relationships among seropositivity, infection, and the development of illness. However, among the most puzzling questions about AIDS remain the determinants of actual infection among those persons exposed to the virus and the determinants of developing symptoms or becoming ill among those persons who are infected.

There are numerous theories, but no clear answers, regarding the determinants of infection among those persons exposed to the virus. Dr. Charles Rabkin, a New York City Health Department epidemiologist, describes three of the theories as follows:[8]

- "The Russian-roulette theory": development of infection is almost purely a matter of chance. A person who engages in sexual activity during which the infection may be transmitted or shares a potentially contaminated needle has a small chance, each time, of becoming infected; however, the more potential exposures, the greater the cumulative risk of infection.
- "The safe-period theory": development of infection depends on certain specific, but as yet unknown, circumstances which may be present at some times but not at others.
- "The last-straw theory": development of infection becomes more likely with each in a series of exposures, because each exposure progressively weakens the immune system, making it more susceptible to the virus. In addition, drug abuse (whether or not it involves sharing of contaminated needles) or other independent medical conditions may progressively weaken the immune system so that the body is more susceptible to infection.

While these theories refer specifically to the relationship between exposure and infection, similar hypotheses have been advanced regarding the relationship between infection and development of ARC or AIDS. In particular, it has been suggested that continued exposures subsequent to initial infection may increase the chances that symptoms will develop. However, CDC researchers note that it is still unclear whether post-infection behavior plays a role in the development of illness.

Incubation Period of AIDS

As more information is gathered and analyzed by CDC on the natural history of AIDS, the more it appears that the progression from asymptomatic infection to ARC to end-stage AIDS occurs very slowly. The incubation period for AIDS may be two and one-half to five years or more. Indeed, some researchers believe that there may be no real maximum incubation period—that is, an infected person may develop symptoms at any time during his or her life. Because of the painful uncertainties and anxieties involved, this is one of the most troubling aspects of the disease.

The often lengthy incubation period of the disease also poses problems for epidemiological analysis. The patterns of actual disease appearing now reflect the patterns of infection that were occurring several years ago; they do not necessarily reflect what the patterns of the disease will be several years from now.

Heterosexual Transmission of HIV

A study conducted on the incidence of AIDS seropositivity among military recruits found that the ratio of infected men to infected women is 3 to 1. The national average male-to-female ratio had been estimated to be 13 to 1. The authors of the study believe that the ratio among recruits is so small because the AIDS virus is being spread through heterosexual intercourse. This finding is further substantiated by the large number of married couples in which both partners are seropositive. If infection was not transmitted heterosexually, one would expect only one partner to be seropositive.[9] Based on studies of stable monogamous heterosexual couples, CDC researchers believe that 5 to 20 percent of partners of infected individuals will become infected.[10]

HIV seroconversion has recently been documented in Australian women artificially inseminated with semen from an infected male.[11] This research demonstrates heterosexual transmission of the virus.

Heterosexual transmission is also strongly supported by research on Africa. The sex distribution of African AIDS cases is nearly equal and almost all cases are in the sexually-active age range, thus effectively undermining hypotheses regarding non-sexual means of transmission. Studies in Africa also suggest that prostitutes are often carriers of HIV infection, although data vary greatly by country.[12]

The principal evidence against widespread heterosexual transmission of HIV infection in the United States is the relative stability of the percentage of AIDS cases attributed to heterosexual contact. This figure has increased only slightly to about 4 percent since the CDC began compiling data. Some researchers believe that HIV infection will probably continue to be transmitted predominantly through homosexual contact because anal intercourse, which is more likely than vaginal intercourse to result in direct insertion of the virus into the blood stream, is more prevalent among homosexuals than among heterosexuals.[13] However, it should be emphasized that the past and current epidemiological profile of AIDS cases cannot be used as a predictor of the future course of the disease, primarily because of the large number of asymptomatic carriers now in the population. Heterosexual transmission has been demonstrated and must be considered a very serious potential problem.

Evidence Against Transmission By Casual Contact

Altogether, studies of 437 family members and others living in the same household with AIDS patients revealed no cases of AIDS or ARC and only one case of HIV seropositivity. The seropositive individual was a five-year-old child who was probably infected at or before birth. The only known case

of seroçonversion in a family setting was recently reported from Germany, where a 6-year old sibling of an AIDS patient became infected. The cause of this seroconversion is presently unknown.[14]

Family members share dishes, cooking and eating utensils, toothbrushes, razors, toilets, beds, baths, kitchens and many other places and objects with AIDS patients. They also engage in extensive non-sexual physical contact with AIDS patients. However, despite the closeness and frequency of the contact, only one apparent transmission of HIV infection or AIDS has taken place in households occupied by AIDS patients.

Health-Care Workers

There have been cases of AIDS among health-care workers, but almost all of these individuals were themselves in known high-risk groups. There have been a few AIDS cases among health-care workers not known to be in AIDS risk groups. However, none of these individuals had had an occupational exposure to the virus.

Even actual exposure to contaminated blood in a health-care setting has proven to be very low-risk for those not already in known risk groups. CDC has identified 1498 health-care workers with all kinds of direct exposures to the blood and other body fluids of AIDS patients; 666 had actual blood-to-blood contact through needlesticks or other sharp instrument injuries. Of these 666 individuals, 26 (or 4 percent) tested seropositive. However 23 of these 26 seropositives were already in AIDS risk groups. Thus, only three U.S. health-care workers who have been exposed to the AIDS virus through needlesticks or other sharp instrument injuries, and who were not in known risk groups, have tested positive for antibody to HIV (0.5 percent of the 666 persons with needlesticks).

In two of the U.S. cases, it was not even clear that seroconversion occurred as a result of the needlestick, because no prior test results were available to show whether the individuals were positive or negative at the time of the incident. Both of these health-care workers developed lymphadenopathy (prolonged and unexplained enlargement of the lymph nodes), but neither has developed end-stage AIDS. In the third U.S. case, no additional information was available.

One case has also been reported from Great Britain. In this case, a health-care worker seroconverted as a result of a needlestick (a prior negative test was available in this case), but this individual has thus far remained entirely asymptomatic.[15]

Evidence Against Transmission Through Body Fluids Other Than Blood, Semen and Vaginal Secretions

While the AIDS virus has been isolated in saliva, tears and urine, although at much lower concentrations than in blood, semen, and vaginal secretions, CDC notes that there is no evidence of spread of the disease through any bodily fluids other than blood or semen. Recent research strengthens the conclusion that HIV infection is not likely to be transmitted through saliva. Researchers at Massachusetts General Hospital attempted to grow the HIV virus from 83 saliva samples taken from 71 homosexual men, all of whom are HIV seropositive (20 are presently healthy, 32 have ARC and 19 have AIDS). The actual virus could be grown from only one (1 percent) of these 83 saliva specimens. In contemporaneous studies, other researchers are reaching similar conclusions.[16] Moreover, one study which found the HIV virus in saliva has been criticized on the ground that the saliva samples were not drawn directly from the salivary glands, but from fluid already in the mouth which may have been contaminated by blood. AIDS patients often have intraoral bleeding from gums and ulcers.[17]

Physicians and medical researchers emphasize that the studies of family members and health-care workers strongly suggest that the risk of contracting HIV infection through body fluids other than blood or semen is very low. Although CDC notes that biting and kissing which involve exchange of saliva may present some limited risk, there have been no reported cases of AIDS associated with biting and only one case of infection associated with saliva passed through mouth-to-mouth contact. There have been no cases of AIDS or HIV seroconversion attributed to contact with urine or feces.

ENDNOTES

1. See, for example, "Classification System for HTLV-III/LAV Infections," Centers for Disease Control, *Morbidity and Mortality Weekly Report* (hereafter *MMWR*) 1986 May 23; 35:334-339.
2. It has been revised several times since first being issued in 1981, in order to add new opportunistic infections. There is some sentiment for further broadening of the definition due to the appearance of a broad range of syndromes not previously seen in AIDS cases.
3. There is some question as to whether this definition is still officially recognized. It was developed before the advent of the HIV antibody test. There is a new definition under development by NIH.

4. Deborah M. Barnes, "AIDS Research in New Phase," *Science* (July 18, 1986), 282.
5. *MMWR* 1985; 34:573-575. H.W. Jaffe et al., "AIDS in a Cohort of Homosexual Men: A Six-Year Follow-Up Study," *Annals of Internal Medicine 1985; 103: 210-214.*
6. Thomas Peterman, M.D. (CDC), Presentation at 10th National Conference on Correctional Health Care, Washington, D.C., October 31, 1986.
7. Peterman, Presentation at 10th NCCHC; J.J. Goedert, et al., "Three-year Incidence of AIDS in Five Cohorts of HTLV-III-Infected Risk Group Members," *Science* (February 28, 1986), 992-995.
8. Adapted from Janice Hopkins Tanne, "The Last Word on Avoiding AIDS," *New York Magazine*, October 7, 1985.
9. "HTLV-III/LAV Antibody Prevalence in U.S. · Military recruit Applicants," *MMWR* 1986 July 4; 35:421-424; Barnes, "AIDS Research in New Phase," 283.
10. Peterman, Presentation at 10th NCCHC.
11. G.T. Stewart et al., "Transmission of HTLV-III by Artificial Insemination by Donor," *Lancet* 1985; 2:581-584.
12. R.J. Biggar, "The AIDS Problem in Africa," *Lancet* (January 11, 1986), 79-83; Barnes, "AIDS Research in New Phase," 282.
13. Colin Norman, "AIDS Trends: Projections from Limited Data," *Science* 230 (November 29, 1985), p. 1021.
14. G.H. Friedland et al., "Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis," *New England Journal of Medicine* 1986; 314:344-349; Peterman, Presentation at 10th NCCHC; *Lancet*, September 20, 1986, p. 69.
15. *MMWR* 1985; 34: 575-578; *MMWR* 1985; 34: 101-103; S.H. Weiss et al., "HTLV-III Infection Among Health-Care Workers: Association with Needlestick Injuries," *Journal of the American Medical Association* 1985; 254:2089-2093.
16. D.D. Ho et al., "Letter: Infrequency of Isolation of HTLV-III Virus from Saliva in AIDS," *New England Journal of Medicine*, December 19, 1985, p. 1606; Daniel Q. Haney, "Researchers Say AIDS Virus Is Rarely Transmitted in Saliva," *Boston Globe*, December 19, 1985, p. 4.
17. Nicholas Dello Russo, "Inaccuracies about AIDS Lead to Hysteria," Letter to the Editor, *Boston Globe*, November 12, 1986, p. 14.

Appendix B

Resource List

1. **Sources for Current Medical Information**

   - Centers for Disease Control

     AIDS Program
     Center for Infectious Diseases
     Centers for Disease Control
     Atlanta, GA
     (404)329-3651

     Contact: David Collie
     Senior Public Health Advisor

   The AIDS Program issues a weekly Surveillance Report on AIDS cases. CDC produces a weekly publication, *The Morbidity and Mortality Weekly Report*, which contains frequent updates on medical and epidemiological research on AIDS. A bound collection of articles entitled *Reports on AIDS Published in the Morbidity and Mortality Weekly Report* includes all *MMWR* articles relating to AIDS since 1981 and is available from CDC.

2. **Sources of Technical Assistance**

   - National Sheriffs Association
     1450 Duke Street
     Alexandria, VA 22314
     (703)836-7827

     Contact: Anna Laszlo

   - Police Executive Research Forum
     2300 M Street, N.W.
     Suite 910
     Washington, D.C. 20037
     (202)466-7820

     Contact: John Stedman

   - Lt. Jan Dempsey
     Training Manager
     San Francisco Sheriff's Department
     850 Bryant St.
     San Francisco, CA 94103
     (415)558-3127

3. **Printed Information Materials**

This section lists AIDS information resources and cites a number of documents currently available.

- American Federation of State, County and Municipal Employees, AFL-CIO
  1625 L Street N.W.
  Washington, D.C. 20036
  (202)429-1000

  "AIDS Update," "AIDS Fact Sheet"

- HERO (Baltimore Health Education Resource Organization)
  Medical Arts Building, Suite 819
  Cathedral and Read Streets
  Baltimore, MD 21201
  (301)945-AIDS (AIDS Information and Referral Line)

  "Questions and Answers about the HTLV-III Antibody Test," pamphlet developed by HERO and other local agencies, March, 1985.

  "DRUG USERS: Do Not Share Needles," pamphlet.

- Lambda Legal Defense and Education Fund, Inc.
  132 West 43 Street
  New York, New York 10036
  (212)944-9488

  AIDS Legal Guide, A Professional Resource on AIDS-Related Issues and Discrimination, 1984.

- National Gay Task Force
  1-800-221-7044 AIDS Hotline

  Toll-free national hotline provides information and referrals.

- San Francisco AIDS Foundation
  333 Valencia Street, 4th Floor
  San Francisco, CA 94103
  (415)864-4376

  The Foundation has published several dozen pamphlets and bulletins, and has designed 14 advertisements (four examples appear in Appendix D, "General Education Materials").

- U.S. Public Health Service
  1-800-342-AIDS National AIDS Hotline

  Recorded message for general public from 8:30 a.m. to 5:30 p.m.

  and

  U.S. Public Health Service
  Room 721-H
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  (202)245-6867

  Contact: Office of Public Affairs

  Produces AIDS information bulletins and periodic updates on AIDS for general and professional public. Published materials include:

  "Surgeon General's Report on AIDS";
  "What Everyone Should Know About AIDS";
  "Why You Should Be Informed About AIDS";
  "What Gay and Bisexual Men Should Know About AIDS";
  "Lo que TODOS deben saber sobre AIDS" (in Spanish);
  "Facts About AIDS," January 1985.

4. **Audio Visual Materials**

   - American Red Cross

     "Beyond Fear" Part 1: "The Virus"
     Part 2: "The Individual"
     Part 3: "The Community"

     Each part is 20 minutes long. The videotapes are available in 1/2" VHS and 3/4" versions. Order number 8135415763 from:

     Modern Talking Picture Service
     500 Park Street, North
     St. Petersburg, FL 33709

     For further information, contact:

     American Red Cross
     AIDS Public Education Program
     National Headquarters
     Washington, D.C. 20006
     (202) 639-3223

- Law Enforcement Training and Information Network (L.E. Net)

  "AIDS Symposium" (Volume 1, Cassette 8)

  This videotape presents general information on transmission, epidemiology, prevention measures, and recommendations for law enforcement agencies.

  Contact: L.E. Net
  621 South Belt West
  Belleville, IL 62220
  (800)851-5406
  In Illinois: (618)277-0560

- New York City

  The Commissioner of the Department of Corrections in New York City uses two different videotapes on AIDS. The more recent 1985 program is intended for inmates and provides general information about the illness. The other videotape, made in 1982-83, is for staff.

  Contact: Assistant Commissioner for Program Services
  Health Services
  100 Centre Street
  14th Floor
  New York, New York 10013
  (212)374-4541

- Canada

  "AIDS Videotape"

  This videotape for inmates and staff addresses general issues involving AIDS in prisons and work environments. Developed for the Corrections Service Division of Canada by The University of British Columbia's Department of Medicine, the program is also currently being used by the Washington State Department of Corrections.

  Time: approximately 25 minutes

  Contact: Ms. Lee McCarvill
  Biomedical Communications
  Constructional Resources Center
  University of British Columbia
  AV-TV Media Library
  Vancouver, British Columbia
  V6T1W5
  (604)228-3467

- National Audio Visual Center

  "What If the Patient Has AIDS?"

  This videotape was produced in association with the National Institutes of Health and is intended for health care workers.

  "AIDS and Your Job"

  This videotape was produced in association with the Centers for Disease Control and is intended for occupational workers such as policemen and firemen.

  These videotapes are currently being updated and will soon be available for distribution.

  Time: 45 minutes

  Contact: National Audio Visual Center
  (301)763-1896

- Federal Bureau of Prisons

  "AIDS: Key Facts for Correctional Staff"

  This package includes a brochure, poster and leader's guide.

  Time: 35 minutes

  "AIDS: Key Facts for Inmates"

  This also includes a brochure, poster and leader's guide

  Time: 30 minutes

  For the Federal Bureau of Prisons, Capitol Communications Systems developed two videotapes and accompanying literature.

  Contact: Tom Sutty
  Capitol Communications Systems
  19 Chelsea House
  2411 Crofton Lane
  Crofton, MD 21114
  (301)261-6770

Corrections Policymakers and Practitioners

- National Institute of Corrections/Centers for Disease Control

  "AIDS: An Overview with Dr. Harold Jaffe"

  This videotape records the presentation of Dr. Harold Jaffe of CDC at the NIC-sponsored November 6, 1985 meeting of State Directors of Corrections in Atlanta, Georgia. The videotape provides a medical update on AIDS and is available as a training or informational device.

  Time: 35.5 minutes

  Contact: National Institute of Corrections
  Information Center
  1790 30th St.
  Boulder, CO 80301
  (301) 444-1101

- San Francisco Sheriff's Department

  The department has developed training materials and a videotape on AIDS.

  Contact: Lt. Jan Dempsey
  Training Manager
  San Francisco Sheriff's Department
  850 Bryant St.
  San Francisco, CA 94103
  (415) 558-3127

Appendix C

Examples of Departmental AIDS Policies

LOS ANGELES POLICE DEPARTMENT

PERSONNEL AND TRAINING BUREAU

NOTICE May 27, 1986

TO: All Concerned Personnel

FROM: Commanding Officer, Personnel and Training Bureau

SUBJECT: AIDS (ACQUIRED IMMUNE DEFICIENCY SYNDROME) PROTOCOL

The attached information is provided to increase awareness about AIDS and to inform employees of the procedures to be taken when encountering an AIDS victim or suspected carrier. A fact sheet is included to provide knowledge about AIDS and steps to be taken to prevent exposure or decrease the potential risk should exposure occur. A video tape on AIDS will be distributed to supplement tne information presented in this notice.

This information is to be made available to all employees because it could impact their health and welfare, both on and off duty. If additional information is required, it may be obtained from Medical Liaison Section, Personnel Division at 485-4087 or Medical Services Division, Personnel Department at 485-4667, or refer to Personnel and Training Bureau Notice on Disease Risks, September 12, 1985.

PROCEDURE

In the event that an employee sustains an injury such as a puncture wound from a contaminated needle, human bite, blood to blood contact, or blood to mucous membrane contact (eyes and mouth) from a person suspected of having AIDS or identified as "at high risk" for acquiring the disease, the following protocol should be used as a guide.

Transport the suspected carrier to Van Nuys or Parker Center Jail dispensary for medical assessment and evaluation of the wound of the employee and/or suspected carrier. The evaluation may include testing and/or treatment for AIDS, Tetanus, or Hepatitis. A blood test for the employee is necessary only if the suspected carrier's tests show positive.

Medical Services Division will notify the employee by telephone within 48 hours, with the results of the initial tests whether negative or positive. It will take this length of time to receive complete test results prior to notifying the concerned employee (there is no need for quicker action). At the time of notification it will be determined if further testing or treatment will be necessary.

State law requires a signed consent form to test for AIDS. The consent form will be obtained during the initial examination, by the dispensary staff at Van Nuys or Parker Center. In the event the suspected carrier refuses to sign the consent form to have blood drawn for the AIDS test, the employee will be referred to Medical Services Division where the employee will be counseled, informed and if appropriate, blood will be drawn for laboratory testing.

A supervisor from the employee's division of assignment should work closely with the dispensary staff to obtain the necessary information. Should the suspected carrier continue to refuse to cooperate, notify Medical Liaison Section and they will attempt to subpeona medical records through the subpeona process.

A supervisor should also hand carry the Employers' Report of Occupational Injury or Illness (Form 166) to Medical Liaison Section the next business day.

If a suspected carrier's blood test could not be obtained or if the results of a laboratory test for AIDS shows positive and an employee's blood test is negative, the employee must be tested by Medical Services Division every six months, for a minimum of five consecutive six month periods.

Should the employee's test results detect the presence of antibodies to AIDS in the blood, the employee will be referred to a specialist at U.C.L.A. Medical Center or Los Angeles County-University of Southern California Medical Center for appropriate treatment. Even if antibodies to AIDS are detected in the blood, only a very small amount of those who test positive actually contract AIDS.

BERNARD C. PARKS, Commander
Acting Commanding Officer
Personnel and Training Bureau

Attachment

AIDS FACT SHEET

1. AIDS is not easy to catch and is not spread by casual contact. Fear among people who are not in a high risk group is unwarranted and counter-productive.

   The AIDS virus is transmitted in blood cells and semen and must enter the blood stream to survive and multiply. It is a venereal type disease and can be spread by both homosexual and heterosexual contact. Anal sex is considered very risky and oral sex may be risky.

   The AIDS virus is very fragile and does not live long outside the body. When compared to Hepatitis B, which can live up to 20 hours, the AIDS virus dies in approximately 6 minutes.

   Case distribution in Los Angeles County (High Risk Groups):

   a. Homosexual, bisexual males (93% of AIDS cases)

   b. Intravenous drug users (2%)

   c. Hemophiliacs (1%)

   d. Blood Transfusions (2%)

   e. Others (2%)

2. The evidence is overwhelming that AIDS is transmitted primarily by sexual acts between consenting individuals or by sharing drug abuse paraphernalia. However, there is a slight possibility of transmission by:

   a. Receiving blood transfusion (becoming rarer because of blood test to detect AIDS HTLV-III virus).

   b. Infected mother to fetus during pregnancy and/or from an infected mother through nursing her infant.

   c. Accidental needle-stick, cuts, abrasions and mucous membrane (eyes & mouth) exposure to blood or other body fluids of an infected person.

3. For protection it is necessary to build a self help barrier. The skin is the greatest protection against infections and transmissible diseases. Open wounds should be covered while at work. A bandage or dressing should be changed if it becomes wet or soiled. A fresh sore can possibly give the virus a means of entry if exposed to infected blood or body fluid. It is important to protect the hands especially if open cuts or wounds are present. Wear disposable gloves when in contact with body fluids of others.

   If there is a possibility of contact with body fluids, such as at the Coroner's Office during autopsy, eye coverings, masks and gowns are available and should be used.

When accidents occur in the workplace and equipment or vehicles are contaminated with blood or other body fluids from any person, whether infected or not, the area should be disinfected with bleach and water and then cleaned with soap or detergent.
Wash hands or exposed area thoroughly and immediately if accidentally contaminated with any amount of blood or body fluid. Washing hands after contact with any material that could contaminate is advisable.

If blood or body fluid contaminates clothing use a packaged alcohol wipe as soon as possible. Contaminated clothing should be laundered or cleaned by:

a. Washable fabrics should be laundered in a Pinesol solution or bleach solution if the fabric is compatible with bleach.

b. Blood and body fluid stains in fabrics requiring dry cleaning should be diluted in cold water and placed in a plastic bag prior to cleaning.

4. Use extraordinary care while conducting searches of vehicles, suspects/arrestees, homes, etc. Never blindly place hands in areas where there may be sharp objects that could puncture the skin.

   To prevent needle stick injuries do not try to recap or otherwise manipulate a needle or syringe by hand.

5. There is a small risk of transmission if a knife, sharp instrument or other object contaminated with blood is handled and breaks the skin.

6. AIDS Hotline
   213/871-AIDS or toll free 1-800-922-AIDS

SOURCES OF INFORMATION

1. Drug Enforcement Administration

2. San Francisco Sheriff's Department

3. U.S. Department of Health and Human Services/ Public Health Service, Center for Disease Control, Morbidity and Mortality Weekly Reports, November 15, 1985

4. James O. Mason, M.D., Dr. P.H., Acting Assistant Secretary for Health, U.S. Public Health Service. November 14, 1985

5. Shirley Fanin, M.D., Associate Deputy Director of Disease Control Program, Public Health Programs, Los Angeles County Department of Health Services.

6. Lee Hood, M.D., PH.D, Chairman of Biology Division, Caltech. Specialty in Molecular Genetics and Immunology. California Scientist of Year.

7. Jothan Staley, M.D., Medical Director, Medical Services Division, Personnel Department, City of Los Angeles

Police Department

Baltimore, Maryland

General Order 13-85 H-10

8 October 1985

Subject: Communicable Disease and Human Bites

PURPOSE To establish guidelines and procedures to be followed when a member comes into contact with communicable disease or receives a human bite.

DEFINITION Communicable Disease - an infectious disease capable of being passed to another by contact with an infected individual or their body fluids.

PROCEDURE When exposed to a possible communicable disease or the victim of a human bite incident:

Member of the Agency

1. EXERCISE CAUTION and, whenever possible, wear disposable rubber gloves when doing any of the following:

   a. handling items which may contain contaminated blood or body fluid products (hypodermic needles, syringes, etc.)

   b. searching arrestees

   c. packaging and handling these items as evidence

   d. avoid placing fingers in anyone's mouth

   e. cleaning up blood or other secretions which have contaminated floors, seats, equipment, etc.

NOTE The Bureau of Disease Control, Baltimore City Health Department, emphasizes that casual contact (such as touching a person's skin, shaking hands, using the bathroom after a person, touching a doorknob touched by another person, etc.) does not transmit hepatitis B, AIDS, or other disease.

2. Thoroughly wash hands with warm water and soap after removing gloves and thoroughly wash hands, other parts of the body and soiled clothing which may have been contaminated with secretions or excretions.

3. Wear a disposable gown if soiling of clothing by blood, semen or saliva is likely. Masks are only needed if exposure of mouth to blood or saliva is likely.

4. If possible, use a pocket mask when administering CPR.

5. Deposit contaminated items in the specially marked containers.

6. Upon receiving a percutaneous or other exposure to a communicable disease, immediately notify Commanding Officer of the incident and seek immediate medical attention at the nearest hospital.

NOTE Situations which would constitute a percutaneous exposure include being stuck with a hypodermic needle, knife or other sharp object, or being exposed on an open wound or on a mucous membrane (eyes or mouth) to the blood, saliva or semen of a person with hepatitis B, AIDS or infection caused by the AIDS virus.

7. If the victim of a human bite, immediately:

   a. encourage the wound to bleed by applying pressure and "milk" the wound

   b. wash the area thoroughly with soap and hot water

   c. seek immediate medical attention at the nearest hospital

8. Complete a detailed written report concerning any suspected exposures to a communicable disease or human bite incident.

9. Forward written reports via Official Channels to the Chief Police Physician.

10. All personnel shall read and be familiar with "Facts about AIDS," issued by the United States Public Health Service, Annex A.

11. Direct citizen inquiries concerning AIDS to the following agencies:

   a. State AIDS Hotline, operated by HERO (Health Education Resource Organization) for information and referral.

      945-AIDS or 1-800-638-6252

   b. The Baltimore City Health Department AIDS Program.

      396-1927

   c. National Hotline for AIDS.

      1-800-342-AIDS

Commanding Officers

12. Ensure that any arrestee who has bitten a member of this department or suspected carrier of a communicable disease is asked to submit to a blood test.

13. Ensure that the Chief Police Physician is notified weekdays between 0800-1630 hours. During other hours contact the Shift Commander, Communications Division. Be guided by the Chief Police Physician's recommendations.

14. Upon refusal by an arrestee or suspected carrier to submit to a blood test, ensure the Legal Advisor is contacted weekdays between 0800-1630 hours. During other hours contact the Shift Commander, Communications Division.

15. When a person with known communicable disease is released from a detention unit or has been transported in a departmental vehicle:

   a. Ensure the holding cell or vehicle is thoroughly cleaned immediately following the person's release and prior to confining any arrestee in that same holding cell or utilizing the contaminated vehicle. Any areas contaminated by blood, saliva, semen, urine or feces should be similarly cleaned.

   b. Ensure that custodial personnel are notified of the situation and request that the holding cell which housed the person, or the vehicle and other contaminated areas be thoroughly cleaned with the cleaning solution provided by the Property Division. Sterilization is not required.

   c. Whenever the special containers for deposit of contaminated material need disposal, notify the Chief, Property Division.

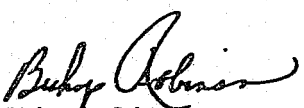
Shift Commander Communications	16.	When requested, contact the Legal Advisor or Chief Police Physician.
Legal Advisor	17.	Take appropriate action to resolve the problem.
Chief Police Physician	18.	Coordinate any necessary medical testing of suspected carriers of a contagious disease and any necessary testing/treatment of members of this department.
Supervisor Custodial Personnel	19.	Use the cleaning solution provided by the Property Division to clean the affected area. Custodial personnel shall wear disposable plastic or rubber gloves when cleaning the affected area and wash their hands thoroughly after cleaning the area.
	20.	Deposit contaminated items in the specially marked containers.
Chief Property Division	21.	Ensure that an adequate supply of disposable gloves, gowns and pocket masks are maintained in all cruising patrols, EVU's, the Laboratory Division and district booking and detention units.
	22.	Ensure that an adequate supply of approved cleaning solution is available for use by custodial personnel.
NOTE		The Baltimore City Health Department suggests that a freshly prepared solution of one part household chlorine bleach (5.25% sodium hypochlorite) and nine parts water be utilized for cleaning contaminated areas.
	23.	Ensure that special containers are provided for the disposal of all contaminated gloves, gowns, masks, etc. These containers shall be clearly marked and properly disposed of whenever necessary.
Handling Contaminated Evidence	24.	All contaminated evidentiary items shall be placed in a plastic envelope and sealed with evidence tape. Plastic envelopes containing contaminated items shall not be stapled.
	25.	The evidence envelope shall be clearly marked "CONTAINS POSSIBLE CONTAMINATED ITEMS."
	26.	When handling items that may be contaminated, members are to wear appropriate disposable gloves or gowns.

RECISION -- Remove from manuals/files and rescind:

Police Commissioner's Memorandum 37-83, "AIDS (Acquired Immune Deficiency Syndrome) Facts and Fiction," dated 25 July 1983.

EFFECTIVE DATE

This Order shall be effective on the date of publication and read at all roll calls for five consecutive days.



Bishop L. Robinson
Commissioner

ANNEXES

A. Facts about AIDS

B. Morbidity and Mortality Weekly Report (Limited Distribution)

Distribution "A"
Plus All Civilian Employees
Plus All Departmental Bulletin Boards

I certify that I have read and fully understand this Order.

_____
Signature

WASHINGTON DC METROPOLITAN POLICE

CIRCULAR

SERIES	NUMBER	EFFECTIVE DATE
85	43	August 29, 1985

SUBJECT

AIDS (Acquired Immune Deficiency Syndrome)

DISTRIBUTION: A

ORIGINATING UNIT: PFC

EXPIRATION DATE: August 1, 1986

There has been a great deal of media attention directed to the subject of AIDS (Acquired Immune Deficiency Syndrome). This has heightened concern and in some cases has resulted in undue anxiety in the community as well as other personnel who have to be in contact with AIDS patients.

The following information is extracted from a draft statement prepared by the Preventive Health Administration, District of Columbia Commission of Public Health, May 28, 1985:

"AIDS is a serious condition caused by a virus called HTLV-III and is characterized by a specific defect in natural immunity against disease. Individuals suffering from AIDS become susceptible to a variety of rare illnesses. The majority of reported cases, however, have been detected in only specific segments of the population. There is no evidence indicating that the disease may be transmitted through routine contact with AIDS patients or persons in high risk groups.

There have been no reported cases in which the disease has been transmitted by casual or even close daily contact with AIDS patients or persons in high risk groups. For instance, family members other than sex partners of the infected persons have not developed AIDS. There have been no reported cases of ambulance drivers, police and firemen who as a result of assisting AIDS patients have contracted the disease. Such is also the case with doctors and health care personnel.

AIDS is spread through intimate sexual contact, blood products and sharing of contaminated needles.

There is no evidence that AIDS is spread through any of the following:

1. Sneezing, coughing or spitting.
2. Handshakes or other non-sexual physical contact.
3. Toilet seats, bathtubs or showers.
4. Various utensils, dishes or linens used by a person with AIDS.
5. Articles handled or worn by person with AIDS.
6. Being around someone with AIDS on a daily basis or over a long period of time.
7. Riding in the same transportation.
8. Eating in the same public places or with an AIDS patient.
9. Working in the same office, shop, etc.

The following procedures are recommended for police personnel and other concerned employees exposed to or having contact with AIDS patients in the performance of their duties:

1. Wash hands thoroughly after contact with the subject or patient. (Careful hand washing is probably your most important and effective method of preventing the spread of various communicable diseases).

2. If you assist a patient in a manner which may cause blood or other body fluids to be on your hands it would be desirable to wear gloves. This does not supercede the value of good hand washing.

3. Clean up blood spills and other body fluids with regular household bleach (clorox) diluted 1 part bleach to 9 parts water. (Wear gloves during this procedure)."

Having had contact with a person suffering from AIDS or any communicable disease, members are reminded that they are to complete a PD Form 251 (Event Report) and a PD Form 318 (Communicable Diseases and Tuberculosis Contact Form)in accordance with General Order 502.3 (Arrest and Transportation of Persons with Communicable and Preventable Diseases). For further procedural information regarding contacts with persons suffering from communicable diseases, members should refer to General Order 1001.1 (Policy and Procedures for Members When Utilizing the Services of the Police and Fire Clinic).

Maurice T. Turner, Jr.
Chief of Police

MTT:JGB:jtw

CIRCULAR

SERIES	NUMBER	EFFECTIVE DATE
86	6	March 11, 19[illegible]

SUBJECT

Information and Guidance on Acquired Immune Deficiency Syndrome in D.C. Government Workplaces

DISTRIBUTION
D

ORIGINATING UNIT
PDD

EXPIRATION DATE
December 31, 1986

Attached for your information is a bulletin issued by the District of Columbi Office of Personnel containing the latest information on Acquired Immune Deficienc Syndrome, as well as official administrative policy concerning employees affecte by this disease.

Each commanding officer shall ensure that all members of his/her command have bee informed of the contents of this bulletin. Each commanding officer shall furthe ensure that all members of his/her command are reminded of their responsibilitie in fulfilling the department's policy of fair and humane treatment of all person in the execution of their police duties.

Circular 84-30 (Acquired Immune Deficiency Syndrome), dated April 12, 1984 is hereby rescinded.

Maurice T. Turner, Jr.
Chief of Police

MTT:MH:jtw

GOVERNMENT OF THE DISTRICT OF COLUMBIA
D.C. Office of Personnel

District Personnel Manual Issuance System

DPM Bulletin No. 20B-1

SUBJECT: Acquired Immune Deficiency Syndrome (AIDS) **Date:** February 10, 1986

Information and Guidance on AIDS
in
D.C. Government Workplaces

Background

AIDS (Acquired Immune Deficiency Syndrome) is a serious disease caused by Human T-Lymphotropic Virus, Type III (HTLV-III). This virus affects the body's immune system and impairs it, thus leaving the body vulnerable to attack from rare cancers and organisms which cause severe infections.

The transmission of AIDS requires the exchange of body fluids, such as occurs in a sexual relationship, or an exposure to blood or blood products from an infected person, e.g., in intravenous drug abusers. Only blood and semen have been implicated in transmission of the virus.

There have been no reported cases in which the disease has been transmitted by casual or even close daily contact with AIDS patients or persons in high-risk groups. For instance, family members other than sex partners of infected persons or infants of infected mothers have not developed AIDS or infection with the virus. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection.

According to recommendations from the Centers for Disease Control, as of November 15, 1985, the kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of the AIDS virus. There have been no reported cases of ambulance drivers, police, firefighters, or health care personnel contracting the disease as a result of assisting an AIDS patient.

Inquiries: On AIDS - Preventive Health Administration; 673-6757
on leave and employee rights--Policy Division, 727-9885

Distribution: Heads of Departments and Agencies, and Personnel Officers

Bulletin Expires: December 31, 1986

O.P. Form 270 (1981)
82-1598-P

AIDS is not transmitted through any of the following methods:

1. Sneezing, coughing, or spitting;

2. Handshakes, hugging, or other nonsexual physical contact;

3. Toilet seats, bathtubs, or showers;

4. Various utensils, dishes, or linens used by persons with AIDS;

5. Articles worn or handled by persons with AIDS, e.g., doorknobs, pens, or cups;

6. Being near someone with AIDS on a daily basis or over a long period of time;

7. Riding the same transportation;

8. Eating in the same public place or with an AIDS patient; or

9. Working in the same office or shop.

The causative virus is quite fragile and will not sufficiently survive on environmental surfaces, on personal articles, or on eating utensils to transmit the disease. Because it is so fragile, there is no reason to exclude AIDS patients or carriers from offices, academic campuses, schools, or social or cultural activities.

Employees with AIDS and Other Workers Sharing the Same Work Environment

The AIDS virus is not transmitted by routine workplace activities. Therefore, any employee with AIDS should be treated in the same manner as any other employee. He or she may continue to work as long as physically able. Moreover, he or she should not be restricted from using telephones, office equipment, toilet, showers, eating facilities and water fountains. Equipment contaminated with blood or other bodily fluids of any worker, regardless of AIDS infection status, should be cleaned with soap and water or a detergent. A disinfectant solution of sodium hypochlorite (a one to ten dilution of household bleach) should be used to wipe the area after cleaning.

Current D.C. Office of Personnel (DCOP) policies and procedures concerning granting leave, employment, rights of employees, hiring and terminations, etc., apply to persons with AIDS in the same fashion as to other employees or applicants.

Education

Educational programs developed by the Commission of Public Health, Preventive Health Services Administration, will be offered to all employees. These programs will be designed to enhance the knowledge and sensitivity of the staff and to reduce any concerns about AIDS at the work site.

Employees who have unfounded fears about working with others whom they believe may have AIDS should take advantage of the educational program. In any event, employees should not be excused from carrying out their duties when no unusual personal risk exists. Existing Center for Disease Control guidelines concerning precautions for health workers who may be exposed to body fluids have been previously distributed, are in the process of being re-issued, and will be applied at the work site. Personal service workers (e.g., barbers and hairdressers) who may come in contact with body fluids from clients should follow the same guidelines for precautions that are recommended for health workers.

There is no evidence that the AIDS virus is transmitted during the preparation or serving of food and beverages. All food service workers (e.g., cooks, servers, and waiters) should follow recommended standards and practices of good personal hygiene and food sanitation. In addition, food service workers should exercise care to avoid injury to hands when preparing food. Should such an injury occur, both aesthetic and sanitary considerations would dictate that food contaminated with blood be discarded.

Confidentiality

An issue of concern is the protection of patient confidentiality. Consequently, any information or records regarding an employee or patient with AIDS is confidential. Access to such information is limited to only those staff who have a legal need to know. Disclosure of any information except as required by law must not be made unless the express written consent of the employee is obtained. District Personnel Manual Chapter 31 should be consulted for guidance on the confidentiality of medical records.

Clinton A. Hilliard
Director of Personnel

Andrew D. McBride, M.D., MPH
Commissioner of Public Health

Appendix D

Pre/Post Test Developed by
National Capitol Systems Inc.

Part I

Directions: Circle the correct response Y = Yes
N = No

1. Only people who are diagnosed as having AIDS can give the AIDS virus to other people. Y N

2. You can get AIDS by drinking from the same cup as someone who has AIDS. Y N

3. The virus that causes AIDS lives in cum (semen) and blood. Y N

4. AIDS can be cured if you get the right treatment. Y N

5. Even though a person's blood test shows that he/she has the AIDS virus, he/she may not develop AIDS. Y N

6. It is impossible for the AIDS virus to be transmitted from women to men during intercourse. Y N

7. The Mid Atlantic states (e.g., Maryland, Delaware, Virginia, etc.) have some of the lowest numbers of AIDS cases in the country. Y N

8. The time from first contact with the AIDS virus to appearance of symptoms of AIDS ranges from 5 months to 5 years. Y N

9. Rubbers (condoms) provide 100% protection from the AIDS virus during sexual intercourse. Y N

10. IV (intravenous) drug users can transmit the AIDS virus by sharing needles. Y N

11. Female homosexuals are considered a high-risk group for receiving and transmitting the AIDS virus. Y N

12. Almost all cases of AIDS among U.S. prostitutes have been attributed to sexual contact. Y N

13. Persons infected with the AIDS virus are considered capable of transmitting the virus to other people even though they have no AIDS symptoms. Y N

14. There have been at least 50 documented AIDS cases in the U.S. among correctional workers who had needle-stick injuries while caring for AIDS patients, shaking down cells, and frisking inmates. Y N

.	The AIDS virus and the herpes virus are similar in that once you are infected with these viruses, you have them for the rest of your life.	Y	N
16.	Individuals who are diagnosed as having ARC (AIDS Related Complex) always develop AIDS.	Y	N
17.	Saliva and tears are considered by public health authorities as body fluids that have great potential for transmitting the AIDS virus.	Y	N
18.	Giving blood at a blood bank puts you at risk for AIDS.	Y	N
19.	Women infected with the AIDS virus can spread the virus to their newborn babies.	Y	N
20.	A positive AIDS antibody test means that an individual may need to modify his or her sexual practices.	Y	N