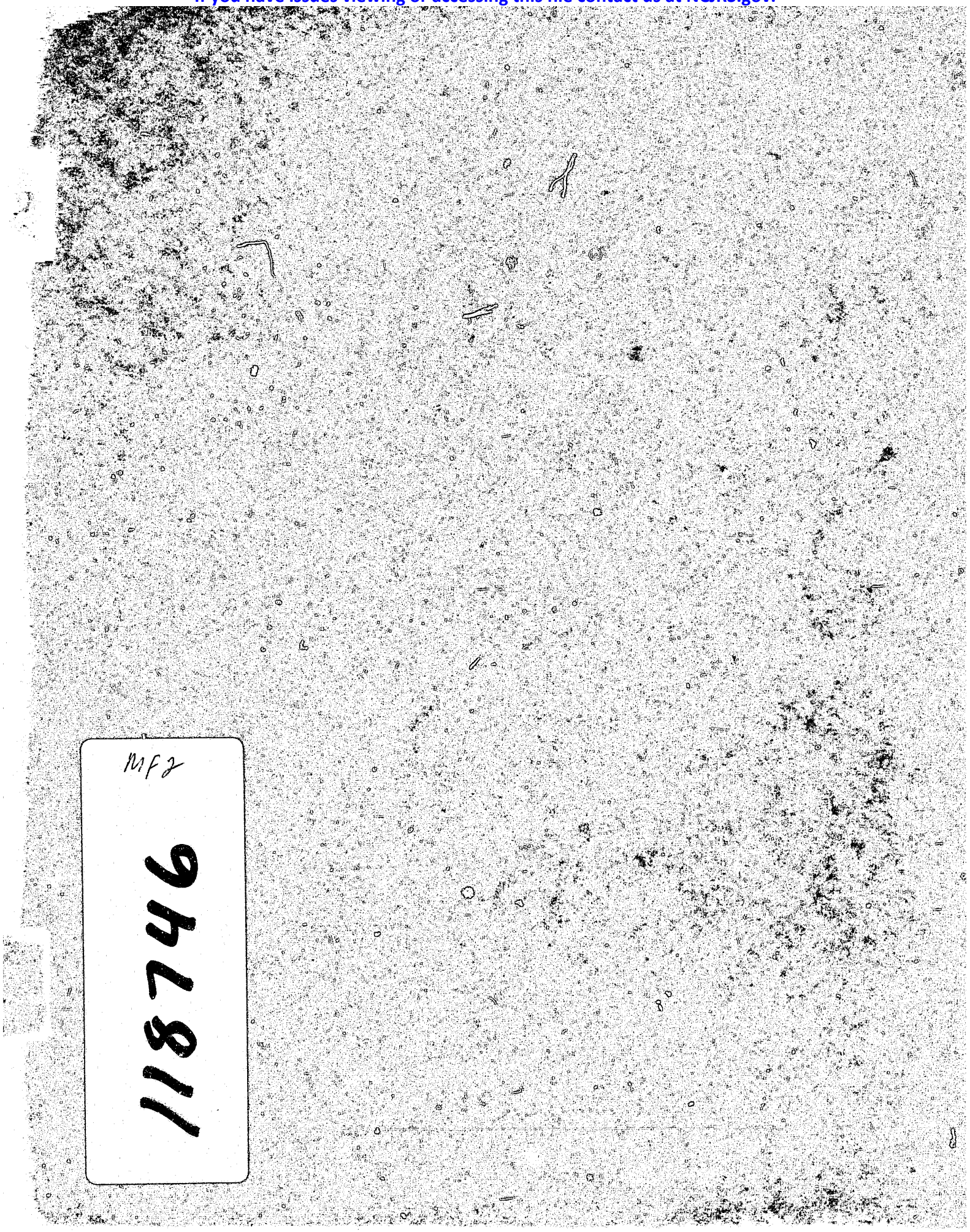

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What Should the Role of Law Enforcement Be in the Societal Response to the AIDS Epidemic by the End of the Twentieth Century?

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Executive Summary

The estimated number of persons infected with the AIDS virus as of the end of 1987, is in the range of 945,000 to 1.4 million. There are known to be more than 46,000 diagnosed cases of AIDS within the United States and more than 24,000 have died of it. At least 60%, and possibly all of those infected with the AIDS Virus, according to current medical estimates, will develop symptoms of AIDS, and/or ARC (AIDS Related Complex). Mortality for diagnosed cases of ARC/AIDS is 100%.

The literature, outside of law enforcement publications, is bare of any reference to a law enforcement role in the response of society to the AIDS epidemic. Law enforcement agencies have restricted themselves, in general, to internal policies and procedures dealing with AIDS-sanitation and evidence handling precautions.

The product of this work is a strategic plan which bridges the gap from the analysis-defined today to the scenario-defined future. That future depicts a large city police department operationally paralyzed by fear of AIDS, and whose leadership and management are ignorant of the facts that would have dissipated that fear. It is a future that can be avoided and steps taken now can assure that it does not come to pass.

The strategic plan and transition management process are directed toward police departments in urban areas serving populations of over 250,000 persons. Agencies of that type and size that are most likely to confront and be affected by the AIDS epidemic, and all that goes with it, on a more than occasional basis.

During the process of policy formulation the planning thrust turned from externally directed responses to the AIDS epidemic to much more internally directed action when it became apparent that fear of AIDS, and the effects of that fear were far more deeply felt than was anticipated. The need felt was not for externally directed action, but the maintenance of services.

Training of their own personnel, development of procedures to make that training effective, continuous monitoring of the environment and updating of procedures to ensure their continued effectiveness, controls to ensure compliance, recognition that employee infections may occur and must be dealt with, and direction to share the knowledge gained with the community served are the major aspects of the plan.

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> "...AIDS is a life threatening disease and a major public health issue. Its impact on our society is and will continue to be devastating..."
>
> *C. Everett Koop, M.D., Sc.D.*
> *Surgeon General of the United States*[1]

Project Background

Introduction

At first thought to be an affliction caused by the homosexual lifestyle and limited to that group, the appearance and spread far beyond any single group or lifestyle of Acquired Immune Deficiency Syndrome (AIDS) has become a factor of American society's everyday life. The numbers of cases have grown to epidemic proportions in Europe and North America, and near catastrophic proportions in sub-Saharan Africa.[2] In fact, AIDS is pandemic, with cases reported in every region of the world. This disease will be a continuing health, political, and social issue well into the Twenty-First Century.[3]

From the beginning of time man has lived with, or died from living with, microparasites and the diseases they cause. The course of human history has been repeatedly altered by contacts

with disease. The Dark Ages of Europe can be attributed as much to the ferocity of the diseases carried by the barbarian tribes that descended on Rome, as to the ferocity of the strangers themselves.[4]

When man first meets a new microparasite, he frequently dies in large numbers. Some, of course, survive and acquire natural immunities to the new virus or bacteria. This survival of a few in the midst of the deaths of many, has precedents over and over again in the history of man, and has even been chronicled in the basis of Judaeo-Christian belief in the biblical description of the Plagues of Egypt.[5] Ancient societies responded to disease with rituals and prayers to ward off its evils and death. That failing, whole peoples fled the plague's current venue and took the plague with them. The entry into Europe of bubonic plague is attributed to the flight of the populace of Messina, Sicily to the Italian mainland when their city became host to a plague delivered by merchant galleys.[6]

The Black Death

The depredations of *pasteurella pestis*, the bubonic plague agent, over the centuries of civilization are well documented. The seven major recurrences of the Black Death between 1348 and 1405 took one-third of Europe to its grave. Profound social change accompanied this grim reaper. The Black Death is given large share of the credit for the freeing of the villein from his landlord as depopulation made labor a seller's market. The plague is also said to have speeded the dominance of English as

Britain's national language due to the decimation of the teachers of French and Latin. The Black Death was likely the beginning of the end of the dominance of the Roman Church over all of Europe.[7] The populace lost a great deal of its faith and confidence in the dominant institution of the day, the Church, as its priests proved powerless to protect the faithful from the curse of the plague.[8] Shaken institutional confidence gave rise to anti-clericalism, spiritual unrest, and religious fundamentalism.[9]

Moral malaise preceded the plague into a 14th Century Europe coming to the end of a long period of growth. Then, as now, one of the by-products of this socio-economic expansion was a societal sense of guilt. Vices of all description were conjured up, pointed out in lurid terms, and condemned according to the prejudices of the particular preacher.[10] The horrors of the Black Death were attributed to divine retribution for man's sins.

Since it is man's nature to blame misfortune on the wickedness of others, persecutions and pogroms were another response of the societies visited by the plague. Jews were accused of a plot to destroy Christendom by poisoning water supplies with the plague; and, some three-hundred-fifty (350) massacres occurred in Europe in the first two years of the Black Death, 1348 and 49. In Spain, Arabs were suspect and persecuted .[11]

As each "new" and devastating disease washed against the shores of the "civilized" world, the affected peoples improvised,

argued, and fled. Some turned to renewed religious piety; others explored science for answers; still others turned upon themselves in rekindlings of chronic social tensions and class warfare.[12]

Small Pox and Inoculation

Little changed in the way mankind responded to disease until the Age of Enlightenment explosively pushed out the bounds of knowledge in all directions. Typified by inoculation and vaccination for smallpox, the human race began to seek control over the microparasites that had historically limited population, economic growth, and exploration. Made imperative by alliance-destroying smallpox deaths in European royal houses in the early eighteenth century, an Asian folk remedy dating to the 11th Century- inoculation with small amounts of the smallpox agent- gained acceptance and general employment. Settlement of the American Colonies, and particularly their westward expansion, could not have occurred without smallpox immunity. The colonists practiced inoculation and thrived. The uninoculated native populations, which impeded expansion by their very presence, were repeatedly ravaged by "the pox". The way to acceptance and implementation of smallpox inoculation was paved by royal deaths that set off political crises and imperatives.[13]

Origins of Public Health Practices

The rise of professional standing armies in Europe in the eighteenth century gave impetus to the adoption and practice of effective health measures. Governments discovered that soldiers' and sailors' lives were much too valuable to squander needlessly when simple and not overly expensive measures could check the ravages of disease. Regulations governing cleanliness, sanitation, overcrowding, and nutrition made it possible to keep large bodies of men under arms in all climes and seasons.[14]

Once tried and proved in military settings, government administrators began to recognize that number and vigor of their subjects was a fundamental component of state power.[15] Translation of effective sanitation measures to the public at large was more difficult. Property and individual rights were deeply rooted in Britain, and great difficulty was had in overcoming libertarian prejudice against any infringement of these rights while any doubts about the necessity of recommended sanitation measures remained unresolved. British liberals decried quarantine as an irrational restraint on free trade and a form of tyranny. Government need to preserve its population, and in the case of Britain especially- its trade domination- overrode opposition and the fight against disease prevailed.[16]

Cholera

Epidemiology and public health practices came into their own through the fight against cholera. This killer of millions rode the rails and shipping lanes of expanding world commerce to encircle the globe in successive outbreaks between 1817 and 1826.[17] The virulence of the disease, the rapid and horrible death it produced, and the apparently capricious manner in which cholera selected its victims, caused frantic and far-reaching reactions.

Parliament, in 1848, authorized a Central Board of Health to carry out programs of public sanitation. Knowledge of the causes of cholera led to the installation of water and sewer systems all over England.[18] Fear of cholera led to the establishment in 1866 in New York City of the first of America's health boards. Although ineffective in result, the world's first international medical congress, in 1851, was convened to study the disease. The 1883 return of cholera to Egypt revolutionized preventive medicine when it attracted teams of European doctors, bringing with them the new resources of bacteriology. Identification of the bacillus was made; its susceptibility to heat and disinfectants learned; and, anti-contagion safeguards developed. Discovery of an effective vaccine in 1893 ended the status of the disease as a scourge. Quarantine and inoculation regulations eliminated the disfigurement of the Moslem Haj by cholera and smallpox.[19] Rapid progress against other diseases marked the 19th century.

Typhoid fever, diphtheria, and milk-borne diseases succumbed to the new techniques of the bacteriologists.[20]

Yellow Fever

The defeat of yellow fever owes as much to political imperative as to science. At the end of the 19th century the United States was flexing new-found muscle and seeking to expand its influence in Central America. Panama, the nation, was born of an exercise in Rooseveltian *realpolitik* when Columbia refused to deal "fairly" over rights to what became the Panama Canal. An American-engineered revolution then neatly severed the disputed realty from its obstinate owner. Once the property was in "safe" hands the work of digging ran afoul of one of the most deadly mosquito coasts in the world. Malaria and yellow fever had ground down an earlier French attempt to pierce the isthmus of Panama with a canal. America, and its "Manifest Destiny", would not be denied by a mere mosquito. Unparalleled resources were placed at the disposal of medical officers in the Canal Zone. This political will to succeed vanquished yellow fever and made possible the building of the Panama Canal.[21]

Spanish Influenza

The least remembered but most deadly epidemic of modern times was the Spanish influenza of 1918. In less than a year it killed as many 40 ***million*** people worldwide. No less than 550,000 in the United States died.[22] If this pandemic had killed one or more of the really famous figures of the nation or

the world it would have been remembered. But the flu didn't knock off Woodrow Wilson or anyone near his stature because our society is so constituted that individuals rarely become really powerful and famous until after the age of forty. Spanish influenza characteristically killed young adults and therefore rarely men in position of great authority.[23] Perhaps because of the national preoccupation with "beating the Boche" the nation was ill-prepared for the first wave of the influenza in autumn, 1918; but, in the war time spirit of national unity citizens complied with alacrity to public health measures once the virus struck. The reaction to the first portends of the second wave of influenza in early December, 1918, particularly in California, is puzzling. The State Health Department decreed that the numbers of new cases reported, which had risen in San Francisco from 57 to 1,517 in two weeks, were statistically insignificant and held no promise of a new wave of influenza. Civil libertarians and Christian Scientists, who had gone along with the public health measures in October now dug in their heels on personal liberty and constitutional rights grounds. Merchants, anticipating a good Christmas shopping season, objected. The Mayor of San Francisco asked for the re-institution of October health measures on December 7. The Board of Supervisors stalled and then defeated the measure on December 16. With mounting numbers of cases, including one of their own members, the Supervisors took up the matter again and passed it on January, 10. Although new influenza cases immediately began to drop in number; hundreds of arrests were made for masking

violations. The public will was not there for a second effort and 16,000 more cases resulted in 1,453 more deaths.[24]

Acquired Immune Deficiency Syndrome

The year 1979 saw the first outbreaks of what would be called AIDS within homosexual groups in New York City, and the counties of Orange, Los Angeles, and San Francisco in California.[25] Physicians were mystified by cases of strange infections in patients whose immune systems were inexplicably depressed. In June, 1981 the pieces of the puzzle started to come together as cases multiplied beyond the point of being mere medical curiosities and reports of them began to be noticed. The patients seen all had immune systems wrecked by an unknown agent or organism, were young, were male, and were homosexual.[26] The disease was then known only by the secondary infections it enabled.[27]

While the cases multiplied, public health officials and treating physicians groped for the cause of this mysterious devastator of human immune systems. False leads and blind alleys reduced the effectiveness of the medical response. Time and money were wasted trying to prove a connection between these immune disorders and stimulant inhalants popular in homosexual communities.[28] Confusion reigning over just who was susceptible found the disease dubbed Gay-Related Immune Deficiency (GRID) and attributed to "overtaxing" of the immune system by the myriad infections then running through gay communities.[29] The mode of transmission was strongly suspected to be sexual.

GRID became meaningless as a name when new reports identifying immune deficiencies in Haitian heterosexuals, Hemophilia A patients, recipients of Hepatitis B vaccines, and heterosexual intravenous drug users destroyed the gay-limitation concept. The issue was forced when the statistical significance of the heterosexual IV drug users, pediatric blood transfusion recipients, and hemophiliacs using clotting factors of whole blood, became apparent.[30] The new, and lasting name for the disease, Acquired Immune Deficiency Syndrome (AIDS), became official and entered the medical lexicon in September, 1982.[31]

AIDS (Acquired Immune Deficiency Syndrome) is a disease that undermines the body's immune system, making individuals susceptible to infections and diseases not generally life-threatening to persons with normal immune systems. AIDS also causes disorders of the central nervous system.[32]

AIDS is caused by a blood-borne virus identified as the Human Immunodeficiency Virus (HIV) which acts by infecting and destroying white blood cells which make up the body's defenses to infection. HIV has also been found to directly attack the central nervous system and brain tissue.[33]

This virus has been isolated in blood, cell-free plasma, lymph nodes, bone marrow cells, lung tissue, cerebrospinal fluid, semen, cervical and vaginal secretions, saliva,and tears.[34] However, saliva and tears have not been demonstrated to be effective carriers of HIV.[35]

The modes of transmission of the virus are primarily: intimate sexual contacts (particularly vaginal and anal intercourse) and needle-sharing with persons already infected. Other modes of transmission, though occurring with less frequency, are: blood transfusion with HIV-contaminated whole blood; use of contaminated blood products (i.e.; plasma, clotting fractions); birth to an infected mother (although whether infection of the newborn occurs prior to, at, or immediately after birth is undetermined); accidental needle sticks with injection of contaminated body fluids; and drenching contacts by broken skin or tissues with contaminated blood.[36]

AIDS Risk Groups: The two groups at "high risk" to HIV infection and AIDS, homosexual males and intravenous drug users,have been historical targets of public antipathy.

Homosexual males have been, almost as a tenet of Judaeo-Christian belief, condemned and suppressed by the societies in which they lived. Classical Athens stands alone among "civilized" western cultures in accepting homosexuality, but even there limits were placed on what conduct was tolerable.

Christianity provided no relief or toleration of homosexuals. Harassment or circumscription of homosexual activity tends to be greater in countries in which governments are strongly influenced politically by Roman Catholicism (*e.g.*, Spain, Austria), in which *machismo* is pervasive (*e.g.*, Mexico), and in which a somewhat puritanical communism is entrenched (*e.g.*, the Soviet Union).[37]

Toleration is more apparent in the Scandinavian countries, in Britain, and in the United States. Laws prohibiting homosexual acts between consenting adults have been repealed in several states (California's in 1975).[38] Despite the apparent public tolerance of homosexuality in a number of large cities in California, strong wells of sometimes violent homophobia remain.[39]

Law Enforcement as an institution tends to reflect the opinions and perceptions of the public it directly serves; but, adopts shifts in those opinions and perceptions with a 2-5 year time lag. Externally and internally perceived as the guardians of public order and safety, police officers tend to exhibit a much more clearly defined sense of "rightness" and hold to a significantly more conservative value set in regards to both what is criminal conduct, and punishment for those crimes.[40] Frequently local governments publicly proclaim acceptance and tolerance of homosexuals while continuing to support, at least tacitly, enforcement policies that are the antithesis of the public proclamations. The resulting friction leaves the police officer somewhat bruised and resentful toward both politicians and gay communities.

AIDS and the fear of AIDS may reveal just how tenuous is the tolerance and acceptance of homosexuals by the general public. In writing about AIDS, some have invoked explanations entailing divine retribution. There have also been calls for the incarceration of homosexuals and for eliminating future tax

dollars for AIDS research. Though such recommendations remain extreme, there is still considerable institutionalized discrimination against homosexuals.[41]

The antipathy and hostility directed toward homosexuals has resulted in a sense of self-identification, unity and community among both "gay" males and lesbians. Political cohesion has been an outgrowth of isolation from larger communities in which they lived and found a name in the Gay Liberation Movement. Feeling, with ample cause, that the public at large was unsympathetic, gay political organizations since 1969 have succeeded in obtaining statutory guarantees of rights on a parallel with those obtaining to racial minorities and women.

Once the disease was recognized, social values and politics intervened. Nearly every band of the socio-political spectrum interposed opinions and positions. Battle lines were drawn on every ground imaginable. Underlying were inherent suspicions of government and newer suspicions of the media and medical profession.

Gay political groups, supported by the left, staunchly fought firm public health measures, declaring any who advocated them "Nazis". The San Francisco Coordinating Committee of Gay and Lesbian Services issued a policy paper asserting that blood donor screening was similar to the rounding up of Japanese-Americans during World War II.[42] When closing bath houses that were a major venue for disease-spreading sex acts was mooted, the proponents were branded "sexual Carrie Nations". Attempts

to save lives through the common sense move of closing bathhouses catering to what amounted to sexual Russian-roulette, were branded a violation of civil rights. The closures that did occur are still mourned as "...small but important defeat[s] for gay civil rights, with little or no off-setting benefit in the fight against AIDS."[43]

Intravenous (IV) drug users are the second major component of those at "high risk" to HIV infection and AIDS.[44] Public abhorrence of IV drug users is based on fear of the crimes which the public closely associates with the use of the illegal drugs to which most IV drug users are addicted. That association is a valid one and empirical data to support it is increasing as recent studies show that up to 92% of robbery arrestees in Manhattan tested positive for cocaine in post-arrest drug testing. California prison and jail inmates who were addicted to heroin reported committing 15 times as many robberies, 20 times as many burglaries, and 10 times as many thefts as non-drug users.[45] Fear of both the criminals and the crimes they commit is a real and controlling factor in the daily lives of the urban public.[46]

A shift toward a disease perception of drug abuse and drug users has gained ground in some public institutions through the inclusion of addiction to drugs in rehabilitation legislation such as the Rehabilitation Act of 1973.[47] Specific anti-discrimination provisions were codified in the Drug Abuse Office and Treatment Act of 1972.[48] It must also be remembered that

addiction, in and of itself, is not a crime.[49] However, despite such statutory protections, widespread public discrimination against drug users continues in almost all areas (*e.g.*, housing, employment, access to medical care).[50]

The public is looked upon by the drug user as a source of money and property that will enable him to continue his habit. In other words, a sheep to be sheared when needed. Drug users will become violent toward members of the public when in need of drugs and frustrated or delayed by some crime victim or innocent passerby. Drug users tend to become so wrapped up in own their addictions that their entire world becomes only the drug and the struggle to obtain it. It is only after that need is fulfilled that family, work, or anything else can be thought of. Although violent death surrounds them, recent research indicates that the prospect of slow, painful death by AIDS is beginning to alter drug users perceptions of their addiction, and the actions needed to reduce their chances of becoming infected by HIV.[51]

Society's Response to AIDS: Information was withheld, facts were buried, and news stories not written because of concerns over political impacts. The battering taken by public health officials, and the lack of support for them demonstrated by the politicians they work under, is apparent in the language of even the best reports and studies. A type of "AIDSpeak" can be found in piece after piece of literature on, or concerning, AIDS. Semen becomes "bodily fluids"; promiscuous becomes "sexually active", infected becomes "exposed."[52] Such meaningless

statements as: "The usefulness of traditional public health infection control measures to be taken by public health authorities is uncertain."; and, "Since there is no generally accepted means of preventing the spread of AIDS other than education, the usefulness of reporting identifying information to public health authorities would be unlikely to outweigh the adverse social consequences of such identification." are found within the pages of otherwise comprehensive, and clear thinking works on AIDS.[53] Social consequences were placed before preserving and protecting life.

Blood Wars: Effective blood donor screening measures were delayed more than two years by blood-industry opposition.[54] Rather than use a test recommended to them in January of 1983 by the Centers for Diseaes Control, (CDC), the blood bankers called for more studies.[55] The Department of Health and Human Services in March, 1983, ignoring its own staff at CDC, recommended to the blood industry a program of "voluntary deferral" of donors who were at "high risk" for AIDS.[56] Meanwhile France banned imports of American blood products, and Britain considered such a ban. Stanford University Hospital, alone, launched its own blood screening program in late May, 1983.[57] One year later Irwin Memorial Blood Bank started to test its blood supplies in May, 1984.[58] It was only in April of 1985 that testing of donated blood throughout the country became a reality.[59]

Labratory Wars: Concurrent with the battle over blood, a war between the laboratories erupted. Once the causative agent was

firmly identified as a virus, new battles raged over identification of that virus. Competitive, rather than cooperative research wasted more time and money. Charges and counter-charges were laid across oceans. Both the Pasteur Institute of Paris and the U.S. National Cancer Institute laid claim to discovery of the virus. The French called it LAV (Lymphadenopathy-associated Virus). The NCI called it HTLV-III (Human T-cell Leukemia Virus, Type III). For a time the virus was known as HTLV-III/LAV in order to prevent a shooting war between researchers. Law suits were filed to effect distribution of royalties earned. Shuttle diplomacy, by none other than Dr. Jonas Salk, resulted in compromise and joint share of the credit for HIV's discovery.[60]

Government Infighting: The researchers weren't the only arm of government suffering internecine strife. The Congressional Record contains more than one entry reflecting the Secretary of Health and Human Services graciously declining offers of more funds while a few lines later a staffer from CDC is citing the need for greatly expanded funding of research and education.[61]

Skirmishes in the Schools: Due to the very nature of the disease, prevention education requires sex and drug education, and involves "dirty words." All three areas provoke strong reactions whenever they approach the classroom. The youth of the nation, emerging into the sphere of sexual activity and becoming potential customers in the illicit drug trade, appear to be woefully misinformed about AIDS, how it is transmitted,

and how transmission can be prevented. Yet, sex education in the schools is often stymied by political opposition and bureaucratic intransigence.[62] Even when sex education is not the central issue, the record of education has been marked by denials of admittance to children with AIDS or suspected of being seropositive. Local school boards and parent groups have sought to deny admission of children cleared for attendance by health officials. In each case the children were granted admission by courts reviewing the administrative acts of the school boards.[63]

AIDS in the Workplace: Just as it has in the classroom, AIDS in the workplace has been the basis of litigation. Several employment discrimination and wrongful termination cases have resulted in the application of state and federal handicapped-protective statutes to persons with AIDS, and persons who are seropositive for HIV.[64] The business sector has become concerned that their "bottom line" may suffer as health care and insurance costs are pushed upward by rising numbers of AIDS cases. Business is also concerned that rising treatment and hospital costs as the AIDS epidemic peaks will force taxes higher. Those companies that have taken the time to investigate the facts of AIDS, and communicate those facts to their work forces, experience fewer AIDS-in-the-workplace problems. Programs in those businesses stress that AIDS patients will receive the same benefits and be treated with the same compassions as employees afflicted with any other life-threatening disease, including being allowed to work as long as

possible.[65] Guides to business in dealing with AIDS in the workplace are available.[66]

Organized Religion: Organized religion's responses have fairly well covered the spectrum. The 1980's retribution of the deity was AIDS. The reverend Mr. Falwell proclaimed on national television that those who shook their fist in God's face by "violate[ing] moral...laws,..." would "...reap the whirlwind."[67] The Catholic Church, while pattering about suffering of AIDS victims, used the opportunity to fog the message with moralisms about homosexuality. Black ministers have been criticized for failing to deliver the word of prevention to their congregations because to do so would require them to speak of drug abuse, homosexuality, and commercial sex among their flocks. Church activism, or at least active compassion for AIDS victims has been carried out at the local level from the start of the epidemic- often in the face of opposition from church hierarchies. Local churches and episcopates have also had to come to grips with the problems of priests and ministers with AIDS.

Medical and Emergency Services: Treating physicians, health care workers, and emergency services personnel have reacted to the threats posed to them by AIDS in varied ways. Early in the epidemic, refusals to treat AIDS patients without the taking of extraordinary precautions, led to labor grievances, transfers and demotions.[68] The CDC propounded precautionary recommendations for health care workers that compared AIDS

transmission routes, in the clinical setting, with those of Hepatitis B.[69] Subsequent, and more job-specific guidelines, have been published for the range of emergency services.[70] The report of three cases of sero-conversion in health care workers, not attributable to parenteral injection of contaminated blood, resulted in the further refinement of existing guidelines and were promulgated.[71]

The quality of emergency services rendered in the face of the AIDS epidemic appears to vary geographically. In areas with few AIDS cases, service refusals and extraordinary protective measures (including release of prisoners without charges upon a claim of HIV infection by the prisoner) frequently occur. Where AIDS is more common, and contact with "high risk" group members is an everyday occurrence, complaints of service refusals or untoward acts towards those with AIDS are rare. This improved quality of service is attributed both to the frequency of regular-business contacts, and to training and clear policy guidelines.[72] In fact, only 7% of law enforcement agencies within California surveyed by one researcher had any form of AIDS policy or procedures.[73] California law enforcement has just seen its first job-incurred AIDS infection, in the report of attribution of an AIDS diagnosis to a seven-year old needle stick in a Sonoma County Deputy Sheriff.[74] Agencies with significant correctional responsibilities have assumed a role in educating their inmates as to what AIDS is, how it is transmitted, and how that transmission can be prevented. The National Sheriff's Association has been seeking to promote such

educational efforts among its members and has produced training materials under grants from the National Institute of Corrections.[75]

In order to avoid the doom of repeating the mistakes of history, where lessons might be drawn, and to preserve the effective delivery of police services in the shadow of this epidemic: the past, the present, and the future are examined in this work. The lessons, and signposts found will be used to form a guide for law enforcement policy makers as they face the challenges presented by this twentieth century plague.

Objective One

Statement

In order to get to the future "there" from the present "here" issues raised in exploring the background of the AIDS Epidemic will be examined for their past, present, and future importance to the central issue: "What should the role of Law Enforcement be in the societal response to the AIDS epidemic in the closing years of the Twentieth Century?" Futures research methodologies will be employed to clarify and explore the issue of law enforcement's role in the containment of the AIDS epidemic. Three futures scenarios will emerge from this exploration.

Issues

Past

Three related issues that emerge from the past and are of assistance in framing the general issue are:

What have societal responses to major historic health crises been? Are there historical experiences instructive to the fight against AIDS? Will American society be doomed to repeat the mistakes of history? Are their parallels to be drawn? Societies faced with large numbers of deaths from disease have fled, fought with each other, blamed the most convenient scapegoat group, turned away from established religions and toward fundamentalist beliefs. The parallels between the

history of plagues and the AIDS epidemic today are apparent. Public fears, the laying of blame and search for the guilty, the retreat to fundamentalism, the societal sense of guilt in the wake of economic growth, the slow start to mobilization of resources and the debate over utilization of those resources are consistent threads in the tapestry of history.

How have political reactions impacted on historic health crises? How has the mix of public health and politics borne of the fight against disease? History has also shown that effective, organized response to a health crisis depends as much on who gets ill as on how many get ill. National political interests can also be more of an impetus to action than national death tolls. It appears that whenever the need to stop a disease reaches a high enough level of political concern, the needed resources are found and bent to the task. Until that critical mass is reached, disease control measures tend to remain half-hearted, partially effective, strapped for resources, and decidedly unpopular. Unless that critical mass of public and institutional will is maintained, the measures and controls fall quickly away to impotence.

How have the public, "high risk groups", and law enforcement perceived each other? Given the groups most directly involved in the war against AIDS, are their group perceptions that must be accounted for? The historical frictions between the public, its guardians in law enforcement, its gay minority, and that class defined by the form of its addiction create an uncharted

minefield of attitudes, prejudices, miscommunications, misperceived motivations, and outright distrust, in which a unified fight against a killer disease must be conducted.

Present

Issues presently emerging define the parameters of the general issue, due to their high relativity to it. They are:

How are major sectors of society reacting to the AIDS epidemic? We have seen a number of turns and twists in the reaction of religion, education, medicine, government, and public health as they have attempted to come to grips with AIDS. Present responses to AIDS are the product of the history of the epidemic. What occurred early on in the AIDS epidemic has colored and shaped the subsequent efforts made to stop the spread of the disease, and reduced the effectiveness of infection control measures. The fact that AIDS' first and most numerous victims were homosexual, has certainly impacted efforts to contain the disease.[76] The responses of the various sectors of society have been deeply colored with the shade of politics that each brought to the AIDS epidemic; and, each sector's performance has been helped or hindered by that political baggage.

Do these sectors perceive a role for law enforcement? Although the behaviors that place great numbers of persons at risk to AIDS frequently are the subject of law enforcement action,

little is said about what law enforcement can do to prevent further HIV infections. Physicians contacted generally did not ascribe a mission to law enforcement in combatting AIDS. Another view holds that nearly every seropositive individual should be locked up, but who should do the locking-up is not spelled out.[77] The other side of the political spectrum is represented by calls to end criminal sanctions against commercial sex and license it instead.[78]

What is law enforcement's current self-perceived role? Law enforcement, as an institution, is not monolithic in any meaningful respect. Agencies with significant custodial/correctional responsibilities are assuming a role in educating their inmates as to what AIDS is, how it is transmitted, and how that transmission can be prevented. The other forms of law enforcement agencies have restricted themselves, in general, to internal policies and procedures dealing with AIDS-sanitation and evidence handling precautions. While needed and obviously beneficial to the fulfillment of missions- these responses are internal in nature and effect. It does not appear from the literature that much consideration has been given to the preservation of their own work forces by law enforcement executives through behavioral risk reduction training applicable to officers' on duty and off duty lives.

Future

The following three issues are seen as likely to emerge by the end of this century. They bear a relationship to the central

issue and have a strong potential for impact on futures scenarios. The future issues are:

Could public outcry force changes in AIDS prevention strategies? To repeat a phrase from an earlier passage- it is man's nature to blame misfortune on the wickedness of others.[79] While it appears unlikely that AIDS-hysteria will cause riots and other civil disorders on a large scale, violence against members of those groups at high risk to AIDS still are frequently the victims of violence.[80] The "thunder on the right" for more effective means of control of HIV, *as it is now transmitted*, has not been stilled.[81] Should HIV mutate, the likelihood of changes in public health strategies, at the gun point of public demand, takes little imagination to foresee. Other pressures placed upon prevention strategies could come from the public as taxpayers should current policies be seen as not having enough impact for their costs.

Could changes in "risk group" demographics alter public health strategies? AIDS is slowly spreading beyond it original groups of victims. With but minor exceptions, the victims heretofore have been of the same age and stature as those who fell to the Spanish influenza epidemic of 1918-19. Were the 20th Century variants of the 18th Century royal small pox victims to begin falling to HIV, change in public health strategies is a near surety. Even the infection of a significant number of law enforcement officers, health care workers, or the like, would bring about change. There is an old adage of cutback

government, that appears applicable to AIDS: "You can close libraries, but you can't take away their cops and firemen."

How can law enforcement most effectively involve itself in the societal response to the AIDS epidemic? Guides to what areas law enforcement might undertake involvement in the societal response to the AIDS epidemic are present in both the literature and in current practices. With education the sole acceptable means at hand to control the spread of HIV infections, law enforcement may have exceptional abilities and unique opportunities to educate the public and reduce the prevalence of "high risk" behaviors by individuals. A role for law enforcement can be carved out, inferentially, from within calls for special efforts to educate the population of intravenous drug users and their sexual partners.[82] As stated above, further efforts can be made in education of the law enforcement work force to cut employee losses, both on and off of the job. Should public health policies change, roles will be thrust upon law enforcement that were unimagined by most.

Definitions

AIDS (Acquired Immunodeficiency Syndrome): a virus induced destruction of the natural immune system of an infected person and also causes neurological damage; transmitted through exchange of blood or bodily fluids that are infected with HIV.

ARC (Aids-Related Complex): a group of symptomologies associated with infection with HIV but not definable as AIDS. Symptomologies include, but are not limited to, chronic fatigue, weight loss, persistent generalized lymphadneopathy, intractable diarrhea, persistent fevers, cachexia, neurologic disorders including dementia.

HIV: Human Immunodeficiency Virus (formerly known as HTLV-III, ARV and LAV) the blood-borne viral agent causative of AIDS

which attacks lymph cells and destroys normal immune processes.

High Risk Groups to AIDS: groups of persons identified by social, medical, and psychological conditions, cultures and customs whose group-associated behaviors or needs place them at a higher than normal risk of infection by HIV. The two most frequently discussed "high risk groups" being homosexual males, and intra-venous drug users. Other such groups have been, or are: whole blood, plasma, or blood fraction recipients who received such sera obtained from stocks created prior to April, 1985; infants born of seropositive, or AIDS/ARC diagnosed mothers; and, persons born in, or having recently resided in Haiti, or Central Africa.

Opportunistic Infections: Viral, bacterial, and protozoal infections, of no moment to persons with normal immune systems, that proliferate in persons after infection by HIV. Kaposi's sarcoma is a usually rare skin cancer that in a person with AIDS can become a generalized cancerous invasion of the body and is frequently seen in AIDS patients.

Seroconversion: Conversion, after serial tests of a person's blood for the presence of particular anti-bodies, from sero-negative to seropositive. That is, from a state of being where none of the anti-bodies sought by the test are present to a state where their presence is detected.

Seropositive: The state of possessing antibodies to a viral agent. In this context, showing the presence of known anti-bodies to HIV and indicating infection by that virus.

Methods: Identification

The methods and techniques employed in the first objective are:

Scanning

Personal Reflection

Group Discussion

Nominal Group Technique

a. Trend forecasting

b. Event forecasting

c. Cross-impact analysis

Futures Scenarios

a. Exploratory

b. Normative

c. Hypothetical

Methods: Implementation

In January of 1988, invitations were sent to a group of twenty-five persons from the educational, medical, public health, political, and law enforcement sectors. The invitees were asked to participate in a structured group workshop wherein examination of the future course of society's response to the AIDS epidemic would be conducted. Eight respondents convened on February 10, 1988 to explore the future state of society's response to the AIDS epidemic at the close of this century. The respondents were from medicine, education, community-based organizations, community mental health services, the gay community, narcotics law enforcement, law enforcement psychiatric liaison, and law enforcement community services.

Personal Reflection

The group began its work with a period of personal reflection on the question of: "What will society's response to the AIDS epidemic be at the close of the Twentieth Century?". Participants were asked to record their ideas, in writing, so that they could have them immediately at hand in later phases of the workshop. A general, and brainstorming, discussion followed

which allowed the group members to center their thoughts on the both the central issue, and related sub-issues.

Nominal Group Technique

Trend Selection: The next activity centered on the generation of candidate trends that bore on the central issue, in order to form a map of the group's thinking. Instruction was given on the definition of a trend; and, that ideas would be recorded in a "round-robin" fashion without debate of discussion at that point. Some forty-nine (49) candidate trends were offered (a full listing of these trends appears at Appendix 1). The group next examined each candidate trend; and terms and concepts were clarified and agreed upon. The next step required group members to individually rate each trend on its importance to the general issue. Voting was conducted anonymously through the use of index cards on which each group member entered their evaluation of each trend. A rendering of the instrument used follows as Figure 1.

FIGURE 1: TREND SCREENING FORM

CANDIDATE TREND	For purposes of top-level strategic planning, how valuable would it be to have a really good long-range forecast of the trend?				
	PRICELESS	VERY HELPFUL	HELPFUL	NOT VERY HELPFUL	WORTHLESS

The first round of anonymous voting reduced the number of candidate trends to twenty. The group was then asked to apply the same standards of evaluation to the remaining trends, but to select only the ten that each judged either "priceless" or "very helpful". Consensus proved difficult and the number of candidates remained at ten. A further issue-clarifying discussion of the remaining trends was held. Those trends are listed below in Table 1.

TABLE 1: INTERMEDIATE CANDIDATE TRENDS

Levels of Expressed Political Concern	Reporting Rates of Sexually Transmitted Diseases
Average Cost of Treatment Per AIDS Patient	Immigration Restrictions
Percentage of Gov't General Funds Spent On AIDS Activities	Number of Restrictions Imposed on Civil Liberties
Overall Cost of Medical Care	New "AIDS Industries"
Cost of Medical Insurance	Number of Medico/Legal Conflicts

A third round of voting was held in which the group was instructed to re-evaluate only the five most helpful trends. Again voting was done anonymously, but with the instruction that the raters were to rank their choices in order of importance to the central issue.

The results of this polling did produce a candidate list of five trends, based on the consensus ranking of their importance. The trends selected were:

1. Percentages of General Funds Spent on AIDS Activities.
2. Expressed Political Concerns.
3. Total Health Care Costs.

4. Restrictions Imposed on Civil Liberties.

5. Cost of Treatment Per AIDS Patient.

Each of the five trends were then quantitatively evaluated by each rater. Each trend was assigned a current level of 100. This signified its level today. The raters were instructed to estimate the level of the trend five years past. They were then instructed to estimate what the level of the trend would be in 1998 if nothing occurred to change its course. Finally, the raters were asked to make a qualitative personal judgment as to what level they each believed the trend should be at in 1998.

Figure 2, below, illustrates the form the raters used in evaluating the trends and bears, as data, the entries made by one of the raters.

FIGURE 2: TREND EVALUATION FORM

TREND STATEMENT	LEVEL OF THE TREND (Ratio: Today = 100)			
	5 Years Ago	Today	"Will be" in 1998	"Should be" in 1998
% of General Funds for AIDS	10	100	200	300
Political Concerns	50	100	350	400
Total Health Care Costs	50	100	1000	800
Restr. on Civil Liberties	0	100	500	200
Cost per AIDS Patient	150	100	80	60

After rating of all trends, the high, median, and low values were selected and plotted on graphs. Table 2 depicts those values ascribed to each trend.

Table 2: Low, Median & High Trend Ratings

	Low	Median	High
Trend 1: Percentage of General Funds for AIDS			
Was	0	20	50
Will Be	150	200	300
Should Be	100	300	500
Trend 2: Expressed Political Concerns			
Was	10	10	50
Will Be	120	150	350
Should Be	15	200	400
Trend 3: Total Health Costs			
Was	2	45	50
Will Be	200	300	1000
Should Be	100	300	800
Trend 4: Restrictions on Civil Liberties			
Was	0	0	50
Will Be	50	200	500
Should Be	20	50	200
Trend 5: Cost of Treatment per AIDS Patient			
Was	130	200	300
Will Be	50	50	200
Should Be	10	50	175

The graphic representations of each trend's values follow as Figures 3 through 7 inclusive.

FIGURE 3: PLOTTED VALUES OF TREND 1
PERCENTAGE OF GENERAL FUNDS FOR AIDS ACTIVITIES

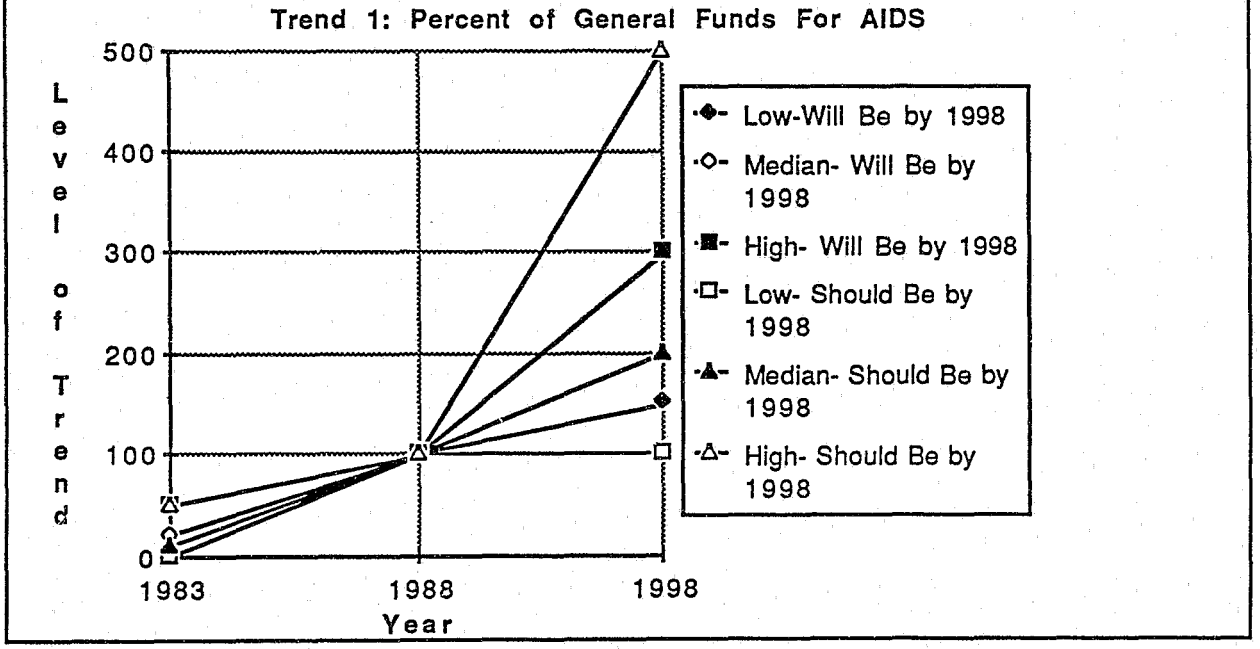


FIGURE 4: PLOTTED VALUES OF TREND 2
EXPRESSED POLITICAL CONCERNS

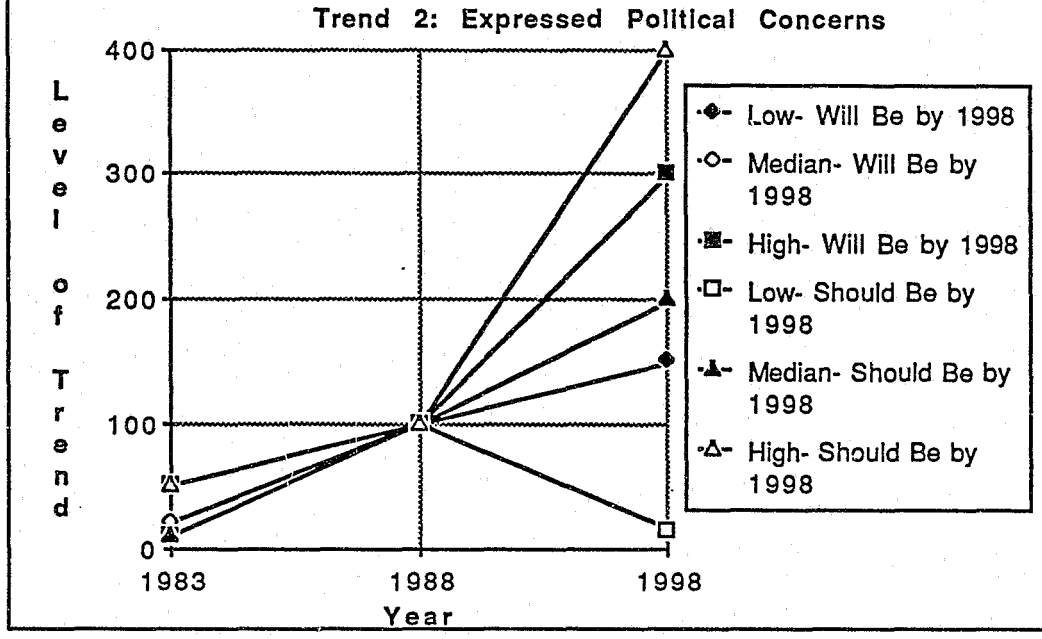


FIGURE 5: PLOTTED VALUES OF TREND 3
TOTAL HEALTH CARE COSTS

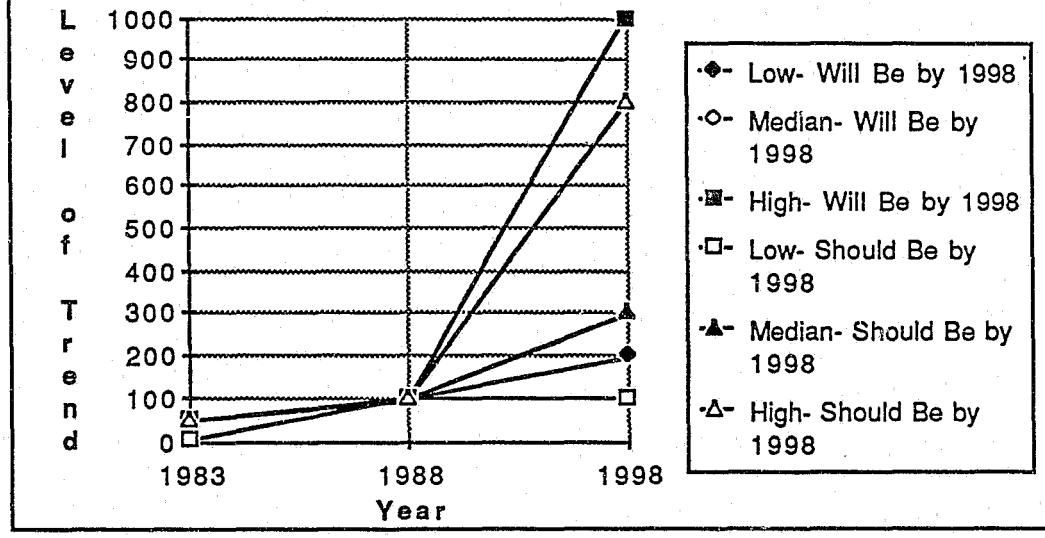


FIGURE 6: PLOTTED VALUES OF TREND 4
RESTRICTIONS ON CIVIL LIBERTIES

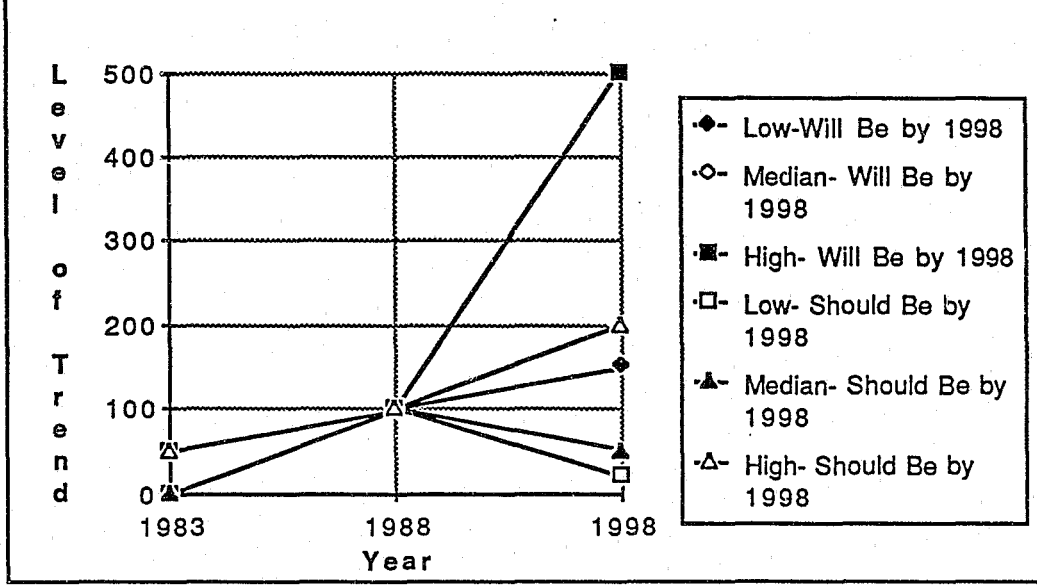
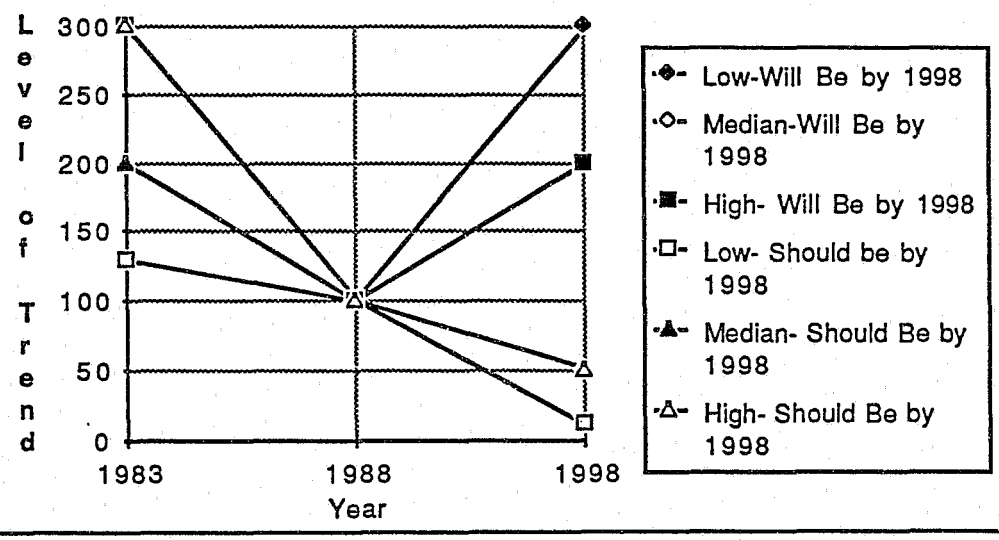


FIGURE 7: PLOTTED VALUES OF TREND 5
COST OF TREATMENT PER AIDS PATIENT



Event Selection: Once charting of the trends was complete, the group was asked to consider discrete occurrences, (i.e., events) that could impact the course of these trends. The process used to identify these events was similar to that used for the

trends. Discussion was followed by personal reflection, recording of ideas, and then round-robin contribution of candidate events. Thirty (30) events were identified (a full listing may be found at Appendix 2). The raters were then instructed to reflect and to select ten events (plus or minus two) that each felt would bear significant impact on one or more of the trends. Surprisingly, consensus was reached on twelve events. The raters were then put to work on deciding, for each event, in which year the probability of that event's occurrence would first exceed zero. They then were to value its probability in the years 1993 and 1998. Finally, they were to assess each event's impact on both the general issue of society's response to AIDS, and on law enforcement. The median of the values given by all the raters was determined and is represented in Table 3, which is also a representation of the instrument used by the raters.

TABLE 3: EVENT EVALUATIONS FOR PROBABILITY AND IMPACT

EVENT STATEMENT	Probability			Net Impact on the Issue Area (+-10)	Net Impact On Law Enforcement (+-10)
	Year that Probability First Exceeds Zero	By 1993 (0-100)	By 1998 (0-100)		
Quarantine Imposed	1994	00	60	-9	-8
HIV Mutates	1990	50	70	-10	-4
Better Anti-Viral Drug Discovered	1990	60	75	+4	+2
Sensational AIDS-related Crime Occurs	1989	55	50	-6	+3
Major Incident of Civil Unrest	1991	50	50	-3	+3
Funding Cut Off for AIDS Research	2000+	00	00	-10	-2
Cure for AIDS Discovered	2000+	00	00	+10	+2
Vaccine for HIV Discovered	1995	00	75	+3	+5
Employment Restrictions Imposed on HIV Infectees and AIDS Patients	1992	50	90	-7	-3
Municipal Bankruptcy Occurs in Major California City	1992	10	20	-8	-7
General Mandatory Testing for HIV Imposed	1990	50	75	-5	-1
More Common Mode of Transmission of HIV Discovered	1990	50	50	-7	-8

Cross-impact Analysis: Five of these twelve events were culled and combined with three of the five trends. The trends were selected for their higher potential value in forming a picture of society's responses to the AIDS epidemic ten years hence. The five events were selected both on their rated impact on the trends, and for their respective levels of probability. That is, some events were chosen because they were relatively certain

while bearing impact. Other were selected because of their great impact, despite their lower probability.

The trends, and opposing events selected are as shown in Table 4:

TABLE 4: SELECTED TRENDS AND EVENTS

Trends	Events
1.Total Health Care Costs	1.Quarantine Imposed
2.% of General Funds for AIDS	2.General Mandatory HIV Testing Imposed
3.Restrictions on Civil Liberties	3.Employment Restrictions Imposed
	4.Vaccine Discovered
	5.HIV Mutates

The trends of history, and change-producing events have rarely if ever occurred in a vacuum, without effect or impact from other occurrences contemporary with them. Events have a propensity to build on one another, each gaining, or losing probability or impact due other forces- some other quite unforeseen. The final step in analysis of the these trends and events is to assess their impacts upon each other. That is, should one of the events actually occur; what effect would its occurrence have on the probabilities of the other events, and the course of the trends. That cross-impact analysis is displayed below as Table 5.

TABLE 5: CROSS-IMPACT ANALYSIS MATRIX

CROSS IMPACT EVALUATION FORM

(Probability of occurrence within next 10 years)

Suppose that this event actually occurred with this probability.....How would the probability of the events shown below be affected?

		E1 Testing	E2 Quarantine	E3 Emp Restr	E4 Vaccine	E5 HIV Mutates	TRENDS T1	T2	T3
E1	75%	X	Increases to 80%	Increases to 90%	No Effect	No Effect	+35%	+40%	+75%
E2	60%	Increases to 85%	X	Increases to 95%	No Effect	No Effect	+40%	+45%	+25%
E3	90%	Increases to 85%	Increases to 75%	X	No Effect	No Effect	+20%	+35%	+100%
E4	75%	Decreases to 40%	Decreases to 20%	Decreases to 30%	X	No Effect	-10%	+10%	-20%
E5	70%	Increases to 99%	Increases to 95%	Increases to 95%	Decreases to 35%	X	+50%	+60%	+100%

Trend 1: Total Health Care Costs
Trend 2: Percent of General Funds for AIDS Activities
Trend 3: Restrictions on Civil Liberties

This cross impact matrix and analysis points out clearly that some events are drivers in that they push both the other events and the trends before them. Others tend to be reactive to other

occurrences.The effects of events upon events is readily apparent from the cross-impact matrix. It is upon the features of trend and event interaction that the scenarios to follow are based.

Scenarios: All that has gone before, the background, the trend and event identification, and the analysis of their cross impacts, will form the basis for the three scenarios that follow.

Scenario 1:

NBC Nightly News Script for May 2, 1998

Once slowed by the imposition of mandatory vaccination against HIV the steady climb of new AIDS patients still continued as pre-vaccine exposures develop into diagnosed cases, and a resistant strain of the virus still has immunologists baffled.

Major metropolitan governments are groaning under the burden of trying to maintain normal services while attempting to comply with the host of mandated public health measures.

Public Health is increasingly relying on law enforcement agencies to perform the "dirty work" of the quarantine, employment restriction, and mandatory HIV testing legislation enacted by federal, state, and local legislatures. Police Officers are finding themselves executing quarantine warrants, rounding up unvaccinated persons, and bearing the brunt of public criticism when force is required to accomplish these new

missions. Civil divisions of sheriff's departments are so busy serving writs on "illegal employees" that their more traditional functions suffered. That may have be a mixed blessing as the number of unexecuted evictions have been inflated by hundreds that are "AIDS-related."

The 1997 law which granted epidemiologists (the so-called "disease detectives") peace officer status and the power to command assistance from other law enforcement agencies in their mission of finding and eliminating suspected "high risk behaviors" reported to them has had some unusual side effects. The "protect" in "Protect and Serve" is acquiring new meanings as police officers find themselves running undercover operations to locate unvaccinated lotharios in singles bars.

Scenario 2:

Atlanta Register

Atlanta, Georgia May 2, 1998

The 1997 Summary Surveillance Report was issued by the Centers for Disease Control in Atlanta today. The 1997 numbers provide no relief from past year, dreary recitations of the steadily increasing diagnoses of new AIDS cases, and deaths of thousands of previously diagnosed victims of the disease.

The trend, which began in the 80's, of the disease moving away from gay communities and into the mainstream, has continued its steady climb. It seems that the wells of infection left over from the eighties are still trapping the unwary and unwise. The

one benefit derived thus far from the 1996 mandatory testing law has been a somewhat clearer demographic picture of HIV infections. The results are not as useful as some imagined since HIV won't tell the testers how long it has been in someone's blood, or where it really came from.

The bright hope of 1993, the discovery of what appeared to be an effective vaccine, has been dimmed by the large number of reactions to the serum and government wrangling over the costs of both running the program and insuring it. The liability issues raised as a result of the 1976 Swine Flu program immunization have not yet been resolved.[83]

State and local governments, already reeling under the fiscal impact of caring for the AIDS patients in their jurisdictions without significant federal help, were dealt another stunning blow by the recent enactment of federally imposed employment restriction directed at those persons infected by HIV. The legislation failed to account for the added welfare costs of the thousands of newly indigent seropositive people. No funding was provided for by Congress for that new burden. The positive of the employment law is that is put aside even more expensive legislation requiring quarantine at the local level of all persons diagnosed with either AIDS or ARC. In fact, the employment restriction law was a compromise fashioned for the sole purpose of getting the quarantine tabled.

Said one City Manager of a large West Coast city, "We're down to health, fire, and police- nothing else. We've got no more

parks, no libraries, no street cleaning, no zoo. We sold our water system three years ago so that the cops and firefighters wouldn't have to walk to their calls- that is those few that still work for us. Public health in general, not just AIDS, is becoming our only business. We're spending ten times what we were spending on health care ten years ago. Now Congress just added 3% to the unemployment rate over night with this employment restriction act. They seem to have forgotten that without jobs there are no tax dollars. Something has got to give."

Scenario 3:

Associated Press:
Des Angles, California- 2 May 1988

A class action civil rights suit was filed today by residents of the Minnesota Flats Housing Project in Des Angles, California over the alleged failure of the City of Des Angles to provide essential services because of a high incidence of AIDS cases within the project.

The class action is based on claims that the City of Des Angles failed to adequately train, equip, and supervise its police employees, failed to take reasonable actions to safeguard the health and welfare of the largely minority residents of the project, and failed to take other measures that had been tried and proved effective in other similar jurisdictions to control

the spread of AIDS among public housing project dwellers who were intra-venous drug users.

Residents allege that D.A.P.D. police officers stopped answering calls to the projects when one officer supposedly contracted AIDS after breaking up a bloody fight between two known drug users who lived in the project. This officer was one of the first victims of a mutated strain of the AIDS-virus that can penetrate unbroken skin that comes in contact with infected blood. The suit claims that because officers were inadequately trained in AIDS risk-avoidance they refused police services to the class members. Incidents of officers seizing condoms and bleach bottles as indicia of commercial sex and drug activities, even when no arrests were made, were highlighted in the resident's complaint as indicative of the complete lack of AIDS-awareness among officers working the Minnesota Flats beat. Protective equipment, readily available on the market, was not provided to officers because of reported budget problems in D.A. Several high-ranking police and city officials are named in the suit as having known of the rank-and-file refusal to respond to the housing development, to have condoned that refusal, and having failed to take any steps to train and protect officers so that normal police services could be maintained.

The next major element of the lawsuit is a claim that D.A. public health and police officials jointly failed or refused to provide basic non-emergency services to the project that were provided to other areas of the city, solely because of the

number of AIDS victims and persons infected with the AIDS-virus who lived there. Likening their situation to that of Belle Glade, Florida in the mid-80's when that small town had 62 AIDS patients out of a population of 7,900, they claim that D.A. did nothing about their situation while devoting educational, drug counseling and rehabilitation resources to other areas of the city.[84] They cite as an example the West Ravine area of D.A. where coordinated anti-drug use activities involving combined health and police teams cut the incidence of both drug use and new AIDS cases in half in a six-month period. Although successful, that program was cancelled and the personnel assigned transferred to quarantine duties when Congress passed the so-called "AIDS Protection Act of 1994." The residents also allege that they were denied the benefits of that act and point, in their suit, to some 250 unserved quarantine warrants for residents of Minnesota Flats.

The class action's final claim states that although Des Angles knew of programs and strategies that had proved successful in similar housing projects, with similar drug and AIDS problems in other cities equivalent to D.A., that nothing was even tried. The example of the joint health-police program from West Ravine is one of twelve drug use/AIDS prevention programs listed but not used by D.A in the Minnesota Flats Project, which is owned by the city. Among those listed were: inmate education programs used by the D.A. County Sheriff for the last decade (the City runs a large jail of its own); consolidated police/public health sub-stations used in Nueva Orleans; and, special visiting

teams of health care workers and police officers tasked with confiscating used hypodermic needles that have been in operation a few miles away in Santa Mordic for the last two years. Anticipating a response from D.A. officials that the city's budget had no room for such programs, the residents attorneys included charts of comparative health care costs in seven major cities. The charts, if accurate, depict a strong case for reduction of health care costs through the employment of concerted, pro-active, health education, risk prevention, and home care strategies. D.A., which has never promoted hospice, and other non-hospital and home-care treatment programs for AIDS and other long-term illnesses, tops the list in per-patient costs, and is also first in administrative overhead costs for the delivery of health services.

The D.A Chief of Police was contacted and agreed to be interviewed. Chief Harry Rockkopff, in response to the allegations in the suit stated for the record that his "...job is to enforce the law and put drug users and other criminals in jail. All this talk about viruses, and bleach, and those 'rubber things' doesn't have a damn thing to do with stopping crime. My officers have the best leather gloves the city can afford, and that's all they need. They know the only way to catch that AIDS is those unnatural acts and shooting drugs. None of my people are inclined to do either of those things. That one officer that got sick...well, we're still looking into that case. Those people in Minnesota Flats have been complaining about our service since that place was built. First

we paid it too much attention and they sued us. Now they say we don't come there at all. How can you win. I'm not a hard guy. I feel very sorry for the families of those people who got AIDS. But those drug people up there were asking for what they got." When asked if his officers at Minnesota Flats shared his views; the Chief stated "Well, I'm sure they're behind me all the way. I care about those officers. In fact, to help make up for all the misfi s that quit out there, I'm drafting replacements from my other divisions to bring them back up to strength." Asked how many officers he was sending; the Chief said" about 65." According to the 1997 D.A.P.D. Annual Report, the division in which Minnesota Flats is located has an authorized strength of 110. The Des Angles City Attorney had no comment on either the law suit or the Chief's remarks.

Summary

The foregoing scenarios, current fiction though they may be, are based upon the background of the central issue and the forecasts of trend and events produced by the members of the Nominal Group. Taking along these scenarios as snapshots of the future, the next objective is to create a plan to either meet or head off the profiles portrayed.

Objective Two

Statement

The second objective is the development of a strategic management process to include:

a. Strategic decision making;

b. Strategic planning; and,

c. Policy considerations.

Strategic management is not linear and its elements are interactive in the process.

The outcome of this objective is a strategic plan which bridges the gap from the analysis-defined today to the scenario-defined future. The future seen in Scenario 3 is the target for the strategic plan. It is a future to be avoided and steps taken now can assure that it does not come to pass.

The strategic plan and transition management process to follow, are directed toward police departments in urban areas serving populations of over 250,000 persons. It is agencies of that type and size that are most likely to confront and be affected by the AIDS epidemic, and all that goes with it, on a more than occasional basis.

Methods: Identification

Environmental Analysis

Stakeholder Identification and Analysis

Strategic Assumption Surfacing Technique (SAST)

Modified Policy Delphi

Planning Model: SMEAC

Definitions:

Stakeholder: Any person, group, organization, or institution with an interest or concern in the area a plan or policy deals with.

Methods: Implementation

Evironmental Analysis: Taking as a starting point the nature and scope of the epidemic today, the environment in which planning will occur is marked by a number of cold facts.

External Environment

An estimated 1,000,000 of our population has been infected with HIV. The Centers for Disease Control (CDC) of the United States Public Health Service, Department of Health and Human Services, estimates that underreporting and underrecognition of AIDS cases may be as high as 20%.[85] With this underreporting factored in, the estimated number of persons infected with the AIDS virus as of the end of 1987, is in the range of 945,000 to 1.4 million.[86] Table 6 illustrates the current rates of infections within all

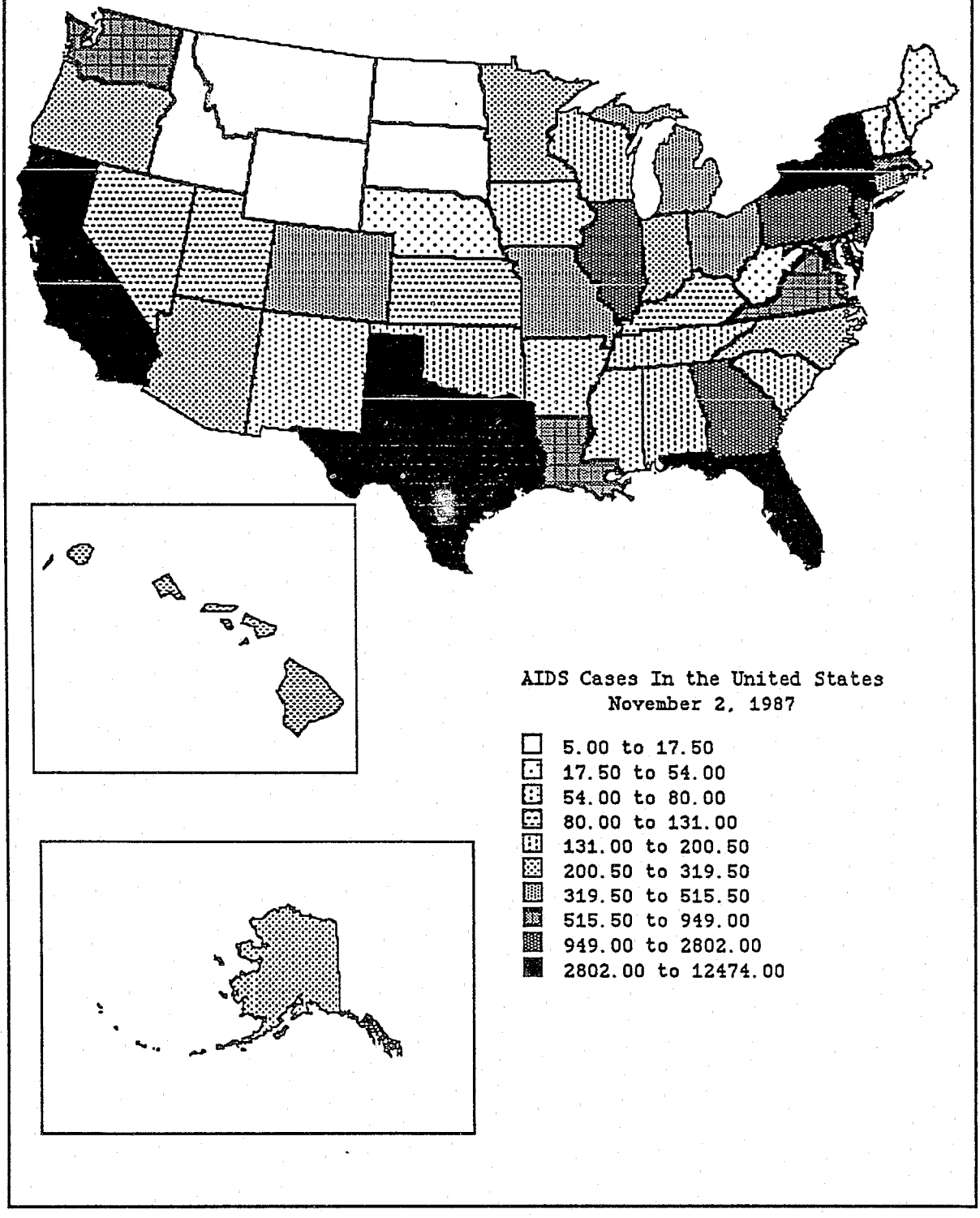
population groups, and estimates total numbers of those infected within each group.

TABLE 6. REEVALUATED PUBLIC HEALTH SERVICE ESTIMATE OF HIV PREVALANCE IN THE UNITED STATES, BY POPULATION GROUP, 1987

POPULATION	ESTIMATED SIZE	APPROXIMATE SEROPREVALENCE	TOTAL INFECTED
Exclusively homosexual throughout life	2,500,000	20-25%	500,000-625,000
Other homosexual contact	2,500,000-7,500,000	5%	125,000-375,000
Regular IV drug use	900,000	25&	225,000
Occasional IV drug use	200,000	5%	10,000
Persons with hemophilia A	12,400	70%	8,700
Persons with hemophilia B	3,100	35%	1,100
Heterosexuals without specific identified risks	142,000,000	0.02%	30,000
Subtotal			900,000-1,270,000
Other groups additional 5-10% of total infections[87]		45,000-1,270,000[88]	
Total			945,000-1,400,000

There are known to be more than 46,000 diagnosed cases of AIDS within the United States and more than 24,000 have died of it.[89] No state is without reported AIDS cases. Figure 10, below, is a representation of the distribution of AIDS cases throughout the 50 states.

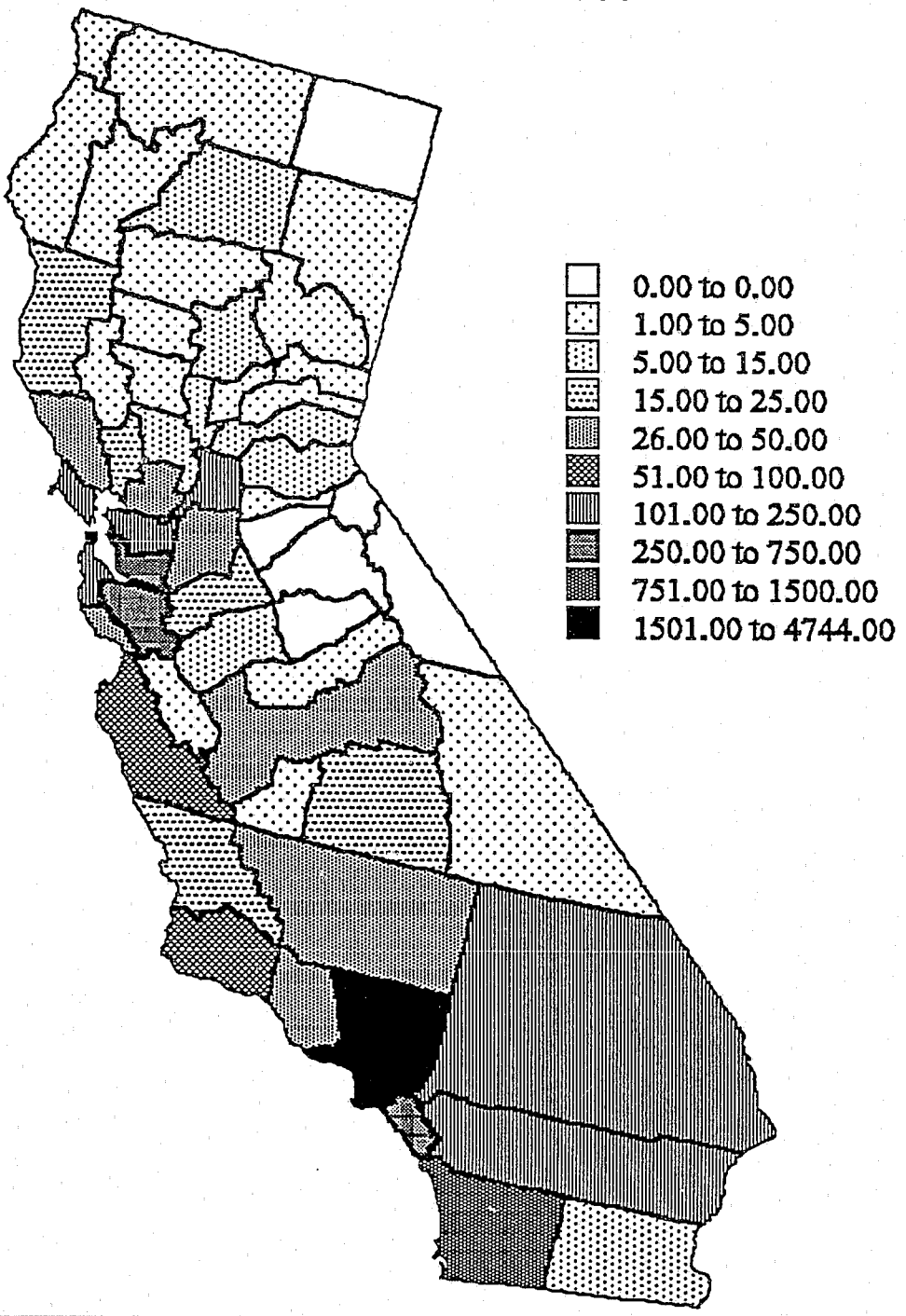
FIGURE 8: DISTRIBUTION OF AIDS CASES IN THE FIFTY STATES[90]



AIDS in California has left few counties untouched by its scythe. As of March 31, 1988, only Alpine, Calaveras, Mariposa, Modoc, Mono, and Tuolomne counties have reported no AIDS cases.[91]

The remaining fifty-two have all experienced, in numbers totalling 12,785, the devastation of this disease as in Figure 9.[92]

FIGURE 9: DISTRIBUTION OF AIDS CASES IN CALIFORNIA AS OF 31 MARCH 1988



There is no cure for AIDS, no means to kill or eliminate the virus from those infected with it. No "silver bullet" cure is likely be developed in this century. Some drugs are now in limited use that reduce, or retard the damage done by opportunistic infections, and the AIDS virus. There is no treatment for the direct damage to the brain and central nervous system done by HIV itself. There is no vaccine for HIV. Even if an effective vaccine were to appear it would do nothing to reduce the staggering numbers of persons already infected with the virus.

The best that medicine and science can currently offer are prevention strategies for the uninfected, and some forms of life-extending treatment for those whose infections have progressed to disease. The prognosis for those infected is poor, at best. At least 60%, and possibly all of those infected, according to current medical estimates[93], will develop symptoms of AIDS, and/or ARC (AIDS Related Complex).[94] Mortality for diagnosed cases of ARC/AIDS is 100%.[95]

It has been hypothesized that by the late 1990's nearly half of all existing hospital beds will be occupied by AIDS patients in acute stages of the disease. Outpatient care, hospice care, and home care will further tax, and cause profound change in both the delivery and availability of medical services. A person with AIDS will require $50,000- $150,000 in medical services in the course of their care and treatment. The vast majority of these costs will be borne by the taxpayers, as most AIDS

patients will have lost their employment, and medical insurance coverage long before they lose their lives. IV drug users are not likely to have either jobs or medical insurance.[96] The Public Health service estimates that the cost of caring for AIDS patients in the year 1991 alone will be between $8 billion and $16 billion.[97]

Against this background should be viewed the current demographics of AIDS. Those first identified as being particularly "at risk" to AIDS are, in the main, still more likely to become infected by HIV. Newly diagnosed cases and discovered infections are still found within the same population groups; but, their proportional representations are changing. Male blacks, male hispanics, and black and hispanic women are the population groups showing the largest percentage gain in newly reported infections and cases. This trend appears to indicate a shift of the disease toward IV drug users and their sexual partners and away from male homosexuals.[98] Infection rates among IV drug users varies according to geographic area. In the Northeast infection rates are at 50% or above. In Chicago and San Francisco the rate is approximately 10%. Yet in the cities of Los Angeles and New Orleans the rate of infection falls to less than 5%. The difference appears to be the result of variations in needle-sharing behaviors.[99]

New infections of HIV are still occurring. Between April, 1985 (when donor blood was first screened on a uniform and universal basis) and May, 1987, 40,000 of 788,105 first-time voluntary

male blood donors were seropositive for HIV anti-bodies. Seropositive female blood donors numbered nearly 15,000 of 726,264.[100] Because the typical time between infection with HIV and the development of clinical AIDS is four or more years, most of the persons who will develop AIDS between now and 1991 are already infected. New AIDS cases in men and women acquired through heterosexual contact will increase from 1,100 in 1986 to almost 7,000 in 1991. By the end of 1991 there will have been a cumulative total of more than 179,000 deaths from AIDS in the United States, 54,000 occurring in 1991 alone.[101] These projections are based on stability of infection rates within risk groups, and stability of risk group population within the general population. Such stabilities are, themselves, uncertain.[102]

The "simple" and "direct" means of disease control used in historical epidemics (i.e.; quarantine, isolation, universal and mandatory control measures), are not soon likely to be employed for a variety of social, legal, and medical reasons.[103] The undertaking of a massive media, educational, and public health campaign to curb the spread of HIV, and, the commencement of substantial, long-term, and comprehensive programs of research in the bio-medical and social sciences intended to prevent HIV infection and treat the diseases caused by it, are believed to be the best and only means at society's disposal to confront the epidemic of HIV infection and AIDS.[104]

The literature, outside of law enforcement publications, is bare of any reference to a law enforcement role in the response of society to the AIDS epidemic. Except for criminal legislation called for by some,[105] law enforcement participation in reducing the prevalence of high risk activity has not been sought.

Internal Environment

Law enforcement agencies have restricted themselves, in general, to internal policies and procedures dealing with AIDS-sanitation and evidence handling precautions. The International Association of Chiefs of Police has published a model policy which centers on such operational concerns.[106] Law Enforcement may be faced with the choice of assuming an active role, or hanging back to compete for funding left-overs as Federal, state, and local budgets will not long sustain six-figure patient loads at $50,000- $150,000 per patient, without cutting other services. Despite historical distrust by groups at high risk to AIDS infection, law enforcement retains high levels of credibility with the general public.

Not much thought been given to the taking of active roles in educating "client" populations. The efforts of the National Institute of Corrections and its constituent agencies in attempting to educate inmates of their facilities are an exception to the internal thrust of most law enforcement activity in regards to AIDS. Law Enforcement has done some work on educating its employees and in providing safety equipment.

Mission Identification:

On March 3, 1988 a group of ten persons was assembled in the offices of the Police Foundation in Washington, D.C. The group was comprised of law enforcement executives, program managers from major law enforcement organizations, law enforcement labor organization officers, researchers from law enforcement foundations, and a representative of the primary federal law enforcement advisory and research agency. This group was tasked with conducting a stakeholder analysis for law enforcement planning in the area of the AIDS epidemic. The group was also to formulate strategic assumptions about these stakeholders and develop candidate policies to meet the question of the general issue of the preferred role of law enforcement in the AIDS epidemic.

Mission of law enforcement within the AIDS epidemic: A general discussion of the issue, as framed by Scenario 1, was followed by a period of personal refection by the group members. The discussion of the central issue was continued at the urging of a majority of the group. In the exchange of views that followed it became apparent that budget shares were not of major concern or interest. The group, almost as one, subscribed to the belief that funding for emergency services would, at worst, remain at current levels. Individual experiences were recounted by members, and the consensus view was reached as to the "macro-mission" of law enforcement in the societal response to the AIDS epidemic. Despite challenges made to this view, the group

firmly held that the primary thrust of law enforcement planning and involvement in the AIDS epidemic should be to preserve its work force, and its own effectiveness in delivering primary law enforcement services to the public. Before involvement in the slowing of the spread of AIDS in the external environment, law enforcement must ensure that AIDS does not spread, at all, within its internal environment. The group believed that without adopting protection of its work force as a primary strategy, the future of law enforcement may more closely resemble the future depicted in Scenario 3, with all the implications that it carries.

The general mission of law enforcement remains the protection of life and property and the detection of crime and arrest of perpetrators of crime.

The issue-mission of law enforcement as a part of a society confronting the AIDS epidemic is to provide un-interrupted quality police services to the public while ensuring the safety of its service-delivering officers from infection.

Stakeholder identification and analysis: A brainstorming session then produced a list of stakeholders who would exhibit interest or influence in any of AIDS-related policies a large police agency might attempt to implement. After its assembly, discussion was held to clarify terms used and eliminate duplicative stakeholder identifications. The resulting list is as portrayed as Table 7, with stakeholders numbered for identification purposes only.

TABLE 7: IDENTIFIED STAKEHOLDERS FOR LAW ENFORCEMENT AIDS PLANNING		
1-City Council	13-City Attorney	25-Local Public Health Agencies
2-Rank and File	14-Police Supervisors	26-Jail Staff
3-Recruits	15-Prosecutors	27-Prisoner Rights Groups
4-NAACP	16-ACLU	28-Police Unions
5-Gay Rights Groups	17-Police Managers	29-Drug Rehab. Providers
6-Social Workers	18-Probation Departments	30-State Peace Officer Commissions
7-Medical Staffs	19-Court Staff	31-Judges
8-Other Emergency Services	20-Emergency Service Unions	32-OSHA
9-Workers' Compensation Agencies	21-City Purchasers	33-Patient's Rights Groups
10-Local Hospitals	22-Mental Health Services	34-Equipment Vendors
11-Media (press, radio, TV)	23-Police Executives	35-General Public
12-Clergy	24-Mayor	36-City Manager

Further discussion was had to refine and reduce the stakeholder list. After two further rounds of polling, in which the purpose and scope of this work were emphasized, the stakeholder list was reduced to ten.

The group was asked to consider and nominate three "snail darters". The term refers to a small, but over-looked fish that stopped an entire reclamation project because it was endangered by the construction. The essence of a "snail darter" is that it has no power of its own, but concern for it by others can have profound impact on any course of action taken. These human, or

organizational "snail darters" were, after some discussion, determined to be: police spouses (and significant others); crime victims; and, the Environmental Protection Agency. This list of three was winnowed down to one by the same methods employed with the major stakeholders. The surviving "snail darter" was-police spouses.

Strategic Assumption Surfacing Technique: These ten stakeholders, plus the "snail darter" were then discussed at length. From that discussion the basis was formed for arriving at assumptions regarding each stakeholder's likely actions and reactions towards the implementation of the selected policies. An assumption was constructed for each, which follows the display of the final stakeholder list at Table 8.

TABLE 8: FINAL STAKEHOLDER GROUP- BASED ON PERCEIVED ABILITY TO INFLUENCE POLICY

1. City Manager/Mayor	2. Police Unions	3. Rank and File
4. Police Executives	5. Local Legislatures	6. State Peace Officer Commissions
7. Gay rights groups	8. Police Managers	9. Local Public Health Agencies
10. Police Supervisors	Snail Darter: Police Spouses	

Construction of assumption sets was combined with data and warrant arguments to allow for testing of the assumption. Assumptions constructed for each stakeholder and their anticipated responses to the initiation and implementation of policies selected are:

1. City Manager/Mayor (stakeholders combined): As the chief executive of any large city where a strategic plan encompassing preservation of police personnel resources would be implemented, this office holder would likely have veto power over such a plan. Cost effectiveness, and political feasibility would be the primary concerns of this stakeholder. They will want justification.

2. Police Unions: Concerns of labor organizations were assumed to be: protection of their membership from both AIDS, and any AIDS-related labor practice they believed to be unfair to their membership. They would be highly sensitive to any policy that increased risks for their members, or made their members' jobs more difficult or onerous. Their key question will be: does this policy improve or degrade working conditions? They will want involvement in the process.

3. Rank and File: While large-city police officers face grave risks on a daily basis, those risks are usually self-evident, relatively certain, and while often grave, the officer facing them retains some element of choice in their acceptance. AIDS-infection risks meet almost none of these criteria in an emergency service setting. Apparency is deceptive. Certainty is lacking. Choice, if full service is to be maintained, is missing. Generally, police officers are motivated and wish to perform the work they are assigned. If they are to assume a risk, they will want to know as much about it as possible, and be assured that as far as possible the consequences will be mitigated. They will want clear explanation of the "why's and how's" and the true state of the risks.

4. Police Executives: Their jobs are to lead, and to obtain mission fulfillment from the led. Although

differing leadership styles make generalizations difficult, executives will be concerned with efficiency of service delivery, political impacts, and costs and consequences of any policy course. They will seek assurances that the policy chosen is the most "correct" both internally, and externally. They will demand that it be effective in costs, operations, and improved morale.

5. Local legislatures: Perhaps the most sensitive to the political impacts of a policy, especially given the highly charged nature of the AIDS epidemic in metropolitan areas, local legislators have the ability to cripple programs (through the budget process) that they perceive as unwise. They can also help ensure public support by contributing their names and votes. A police policy that ensures their constituents continued services, without greatly increased costs and with image-improving aspects should garner their approval. They will support effective, humane policy.

6. State peace officer commissions: Support of such state-level police regulatory agencies will be important. Since they can, depending on their configuration, provide monetary support and other resources for the implementation of the policy. They will seek input and require explanations.

7. Gay rights groups: In many large cities, gay rights groups wield great political power. For a variety of reasons, AIDS has become as much a political issue as it is a health issue. A police AIDS policy, especially any policy that goes beyond mere presentation of information, must necessarily seek and obtain input from the local rights groups. Police motives will be automatically suspect. Care needs be taken to explain clearly the reasoning behind the policy and to demonstrate the methods of its

implementation. As long as honesty is maintained throughout the formulation, implementation and continuation of the policy, resistance can be reduced or eliminated. Gay rights groups will exhibit suspicion and demand detailed explanation.

8. Police managers: This is the level at which many policies fail for lack of endorsement. They must be won over so that implementation will be uniform and effective throughout. Police managers will require convincing that any additional burdens on operations are worth the effort, and are workable.

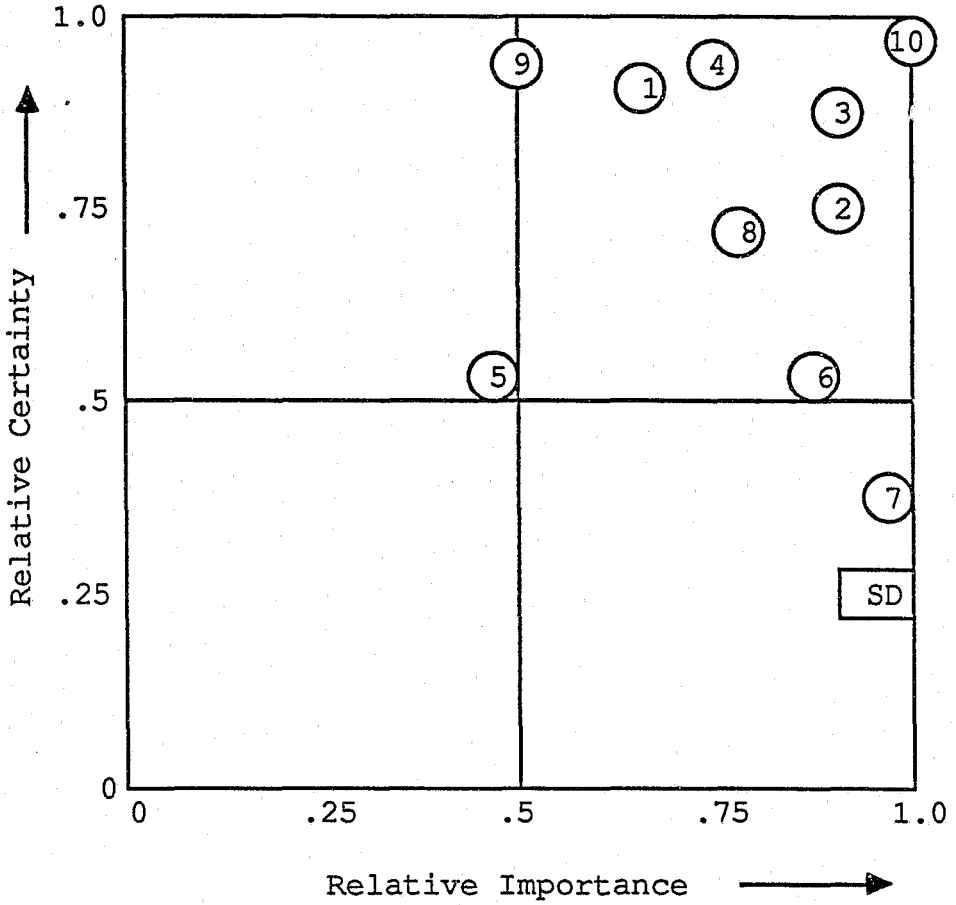
9. Local public health agencies: They are the technical resource for the medical, and epidemiological information that is the foundation of any AIDS education, and risk-reduction policy. Their cooperation is assured as long as their "territory" is not breached. Close and continuing liaison will be required. They will want information that they feel is important to be emphasized and could attempt to take over the policy. They will support a reasonable and effective program to reduce new HIV infections.

10. Police supervisors: The sergeants and corporals are the ultimate quality control agents for any agency policy. They see, directly, how well or poorly any policy or procedure is being implemented. They judge policies. Supervisors can defeat, by allowing non-compliance, any policy they deem to be wrong-headed, useless, or ineffective. Sergeants can also bend policy to conform to operational experience. While this is frequently beneficial, it can ruin policies that depend on strict adherence to procedure for effectiveness. Sergeants will require proof that the policy works in their operational environment.

Snail-darter. Police Spouses (and significant others): Officers facing daily dangers and risks require support systems both on and off the job. Policy subversion can be produced by these support systems as easily as policy support. Although without direct power over the adoption and implementation of an agency's policy, it would be unwise to ignore spouses in the implementation process. Unlike other dangers and risks faced only by police officers, spouses share almost equally in the risk of infection from the AIDS-virus. Their concerns must be addressed as an integral part of the policy's implementation.

Group members were next instructed to rate the importance and certainty of these assumptions made as to each stakeholder's input, position, advice, or opposition to the implementation of strategies. A rating system using combined values for relative certainty and relative importance explained to and demonstrated for the group. The certainty scale was ordered from 0 to 1.0, as was importance with 0 signifying no certainty or importance, and 1 reflecting great certainty or importance. The values ascribed to each stakeholder by the group members were then averaged and plotted on the graph shown below as Figure 10.

FIGURE 10. GRAPH OF RELATIVE CERTAINTY AND RELATIVE IMPORTANCE OF STAKEHOLDER ASSUMPTIONS



This charting of the certainty and importance of the stakeholder assumptions was then put to use in creating policies statements that form the basis for a strategic plan to meet the general issue, and the defined mission of law enforcement.

Modified Policy Delphi: The group was directed to consider policies that might be relevant to accomplishing the mission. The group was given a period of time to silently reflect on

forms of policies that would contribute to mission fulfillment and asked to write out their ideas, for their own reference.

Next, in a round-robin fashion, each member was asked to offer a policy statement. Fourteen (14) candidate policies were obtained and listed. Clarification of terms and concepts was done. In order to narrow the list for more efficient study of each policy's strategic planning facets and implications, the group members were provided with an instrument (Rating Sheet for Policy Delphi) on which to rate each candidate for the factors of "Desirability" and Feasibility". In making their ratings the group members were instructed to exercise their own subjective judgment within the parameters set forth on the rating sheet. Three policy statement ratings showed a clear preference and were selected for further discussion and analysis (see Appendix 3 for a full listing of candidate policies along with the ratings each obtained). The rating key used is displayed as Figure 13.

FIGURE 11: RATING KEY FOR POLICY DELPHI	
Feasibility:	
Definitely Feasible (DF)	no hindrance to implementation no R&D required no political roadblocks acceptable to the public
Possibly Feasible (PF)	indication that this is implementable some R&D required further considerations to be given to political or public reaction
Possibly Infeasible (PI)	some indication unworkable some significant unanswered questions
Definitely Infeasible (DI)	all indications are negative unworkable cannot be implemented
Desirability:	
Very Desirable (VD)	will have positive effect and little or no negative effect extremely beneficial justifiable on its own merits
Desirable (D)	will have positive effect, negative effects minor beneficial justifiable as a by-product or in conjunction with other items
Undesirable (U)	will have a negative effect harmful may be justified only a a by-product of a very desirable item
Very Undesirable (VU)	will have a major negative effect extremely harmful

Clarification was given, as needed for the ratings values and the their meanings and the votes tallied.

The three policies are displayed with their aggregate scores in Table 9.

TABLE 9: CANDIDATE POLICY RATINGS FOR FEASIBILITY AND DESIRABILITY					
Feasibility	DF (3)	PF (2)	PI (1)	DI (0)	Score=(aggregate for each)
Desirability	VD (3)	D (2)	U (1)	VU (0)	Number of Raters: 10
Alternative 1: Law enforcement will educate only its own personnel regarding job safety and AIDS.					
	Feasibility: 18				
	Desirability: 20				
Alternative 2: Internal education programs covering job safety, high risk behavior, and personal responsibility will be run with involvement from both public health and labor.					
	Feasibility: 18				
	Desirability 22				
Alternative 7: Internal procedures and guidelines will be made explicit as to: HIV testing; protective equipment; decontamination; counseling; prisoner handling; rescues; and, crime scenes.					
	Feasibility: 21				
	Desirability: 23				

Policy Statement

After re-examination of the policies, a discussion of the similarities and differences of these three resulted in a synthesizing of the three policies, with the inclusion of aspects of a fourth (see policy 14 at Appendix 3.); and, the following policy statement was formed:

Law enforcement, in order to fulfill its mission, must educate and train its own personnel in the risks, and the ways to avoid the risks, of infection by the AIDS-virus, and should stand ready to share the knowledge gained with the public it serves.

SMEAC Model-Strategic Plan

From this synthesis comes an overall strategy and a plan. It is intended to ensure that law enforcement retains the capability to fulfill its issue-mission while addressing the needs and concerns of the identified stakeholders. The plan is constructed in the "SMEAC" mode, borrowed from the military and employed throughout law enforcement.

Situation

Acquired Immune Deficiency Syndrome (AIDS) is a rapidly growing epidemic within the community served by this agency. Medicine has no cure nor vaccine for this disease. While much is known AIDS and how it is spread; fear of it has reduced the quality of some services.

Mission

This law enforcement agency, in executing its missions of protection and service during the grave public health crisis now facing our society- the AIDS Epidemic, will ensure that all personnel are fully prepared to render full police services to all of the citizens we serve.

Execution

Recognizing that the only means currently at hand to stop the spread of this deadly disease are education, and the elimination of virus-transmitting conduct, all personnel, within all ranks and positions of this agency, shall be thoroughly trained and indoctrinated in: the reduction of risks of infection by the AIDS virus; and the ways and means to assist persons suspected of such infection in a professional and humane manner. Procedures shall be promulgated setting forth the manner in which materials suspected of contamination by the AIDS virus may be safely handled. Protective equipment, and decontamination agents will be procured and maintained at each unit. Methods by which the principles of infection control can be imparted to members of the public who may be unaware of the dangers of particular forms of conduct they are found to be engaging in will be a component of training. Coordination of all activities under this order will be through the Agency AIDS Committee. Training shall be conducted on a continuous basis and modified forms of it will be provided to members' families. New information shall be actively sought by training managers and immediately imparted to all personnel. Personnel of this agency who suffer exposure, or suspected exposure, to the AIDS virus, whether in the course of their duties shall be afforded full and complete assistance. No member of this agency who has become infected by the AIDS-virus shall be reassigned, or suffer other adverse job-consequences due solely their infection status. Members no longer capable of full duties shall be reasonably accommodated with limited duty assignment. No infected member shall be assigned to limited duty unless such limitations are recommended, and endorsed by a physician.

Administration

Training responsibility shall rest with the agency training manager. The training manager shall be responsible for the immediate dissemination of any new information obtained that bears on agency operations. Each subordinate unit within this agency shall designate an infectious disease control officer who shall be responsible for the maintenance of stocks of protective equipment and decontamination agents.

The personnel officer shall receive reports of suspected exposures of members to AIDS-virus infection, and shall coordinate appropriate follow up actions.

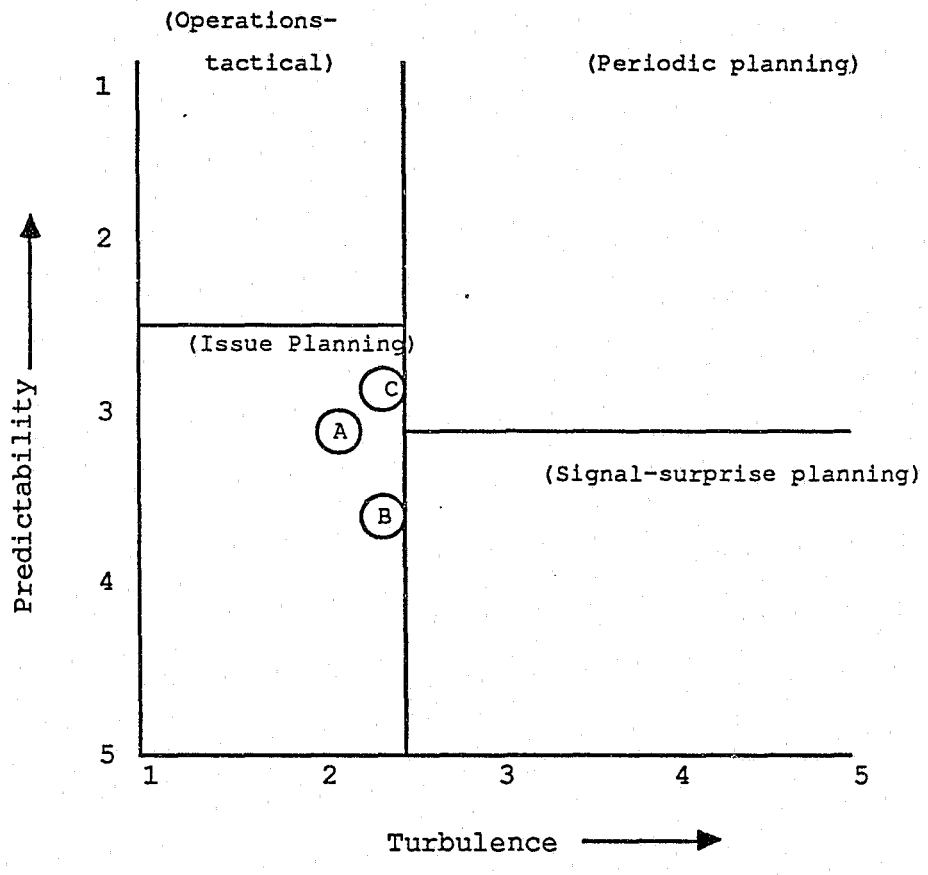
Command, Control, Communications

The personnel officer shall also act as chairperson of the agency AIDS Committee which shall be the liaison with public health agencies, the state peace officer commission, employee organizations, and community organizations and be the reception point for information and inquiries from them.

Planning system design: Planning systems are a function of environmental turbulence and environmental predictability. Law enforcement's general mission is not seen as likely to change drastically by the end of this century. Based on the issue-mission, no significant changes in the law enforcement role within the AIDS epidemic were foreseen. Role changes could come about through changes in the epidemiology of the epidemic, but the likelihood of an overnight shift was discounted. Figure 12 is a representation of a rating chart used to assist in the

determination of the appropriate planning system for a given environment. The scales represent levels of environmental turbulence, and environmental predictability.

FIGURE 12: CHART OF ENVIRONMENTAL TURBULENCE AND PREDICTABILITY



Law enforcement	Turbulence	Predictability
A. Mission	1. No changes	1. Recurring changes
B. Issue Mission	2. A few/occasional changes	2. Forecast by extrapolation
C. AIDS Epidemic	3. Changes on a regular basis	3. Predictable threats & oppotunities
	4. Many changes	4. Partially predictable change- weak signals
	5. Almost continuous change	5. Unpredicatable surprises

Thus the task force form of planning is appropriate to the policy and plan proposed. A task group made up of the major stakeholders, or their representatives should be assembled to tailor the plan to the needs of the agency and the community it serves.

Conflict Management: It is at this point that plans frequently fail due to failure to go back to the stakeholder analysis and seek out the sources of potential conflict. Conflicts can be both, or either, external and internal. The needs of each stakeholder must be identified. Should those needs conflict with policy goals, a means must found to bring the needs and goals into harmony. that means is most often negotiation with the stakeholder to determine what they are really saying, and what their needs really are. The assumptions made about the stakeholders are just that-assumptions. They should be taken only as a guide to probable stances taken by their respective stakeholders. The only means to determine the current position of a stakeholder is to listen and talk with them before conflict-producing actions are commenced. Maslow's theory of the hierarchy of human needs is a good starting point to assess the needs of each stakeholder. Five types of needs are identified. They are: basic physiological needs (food, clothing, shelter); the need for safety and security; the need to belong, and be included; the need for recognition and esteem; and, the need for self-actualization. They are hierarchical. When physiological needs are fulfilled, the remaining needs start to come into play in the order listed. These needs must

be met or addressed. Failure to do so will result in needless conflicts with the overlooked stakeholder.

The way to address those needs is through negotiation. Negotiation requires preparation. Table 14 is a listing of the steps required for negotiations.

TABLE 10: STEPS IN THE NEGOTIATION PROCESS
Determine your goals
Discover the other person's needs
Detail your options
Discover the other person's options
Find the common ground
Build win-win situations
Develop strategy/tactics
Execute the strategy- modify as necessary

The recommended planning system- issue planning through a task force- is ideal for setting up negotiations and keeping them going all the way through to plan implementation. The police agency members of that task group must include persons with sufficient rank-stature to be able to make commitments on behalf of the agency without constantly having to "call time out" to obtain authority from absent executives.

.c2.Summary

The essence of the process of gaining acceptance of the strategic plan described is open, honest communication of the

agency's goals and objectives in istituting the plan. Maintaining the ability to deliver services in a professional manner is an honorable goal. It should not be hidden behind overstated concerns for employee safety, or public opinion. Both employee safety and public opinion are important but the overriding concern should be, and is delivering effective law enforcement services.

Objective Three

Statement:

The third objective is to develop a transition process by which the plan constructed in Objective Two is strategically managed to prevent the future depicted in Scenario 3.

That scenario depicted a large city police department that was operationally paralyzed by fear of AIDS, and whose leadership, and management were ignorant of the facts that would have dissipated that fear. The strategic plan offered is a means to an end, but will remain little more than a piece of paper if it is not supported commitment and a structure to carry it out. That commitment must be built within an organization. It is through creation in the minds of the people that are the organization of a perceived need for change that commitment to it is formed. Once committed to change, the transition from the current state to the changed state must be managed and guided. It does not happen on its own.

Methods Identification:

Value Clarification and Critical Mass Identification

Management Structures

Role Identification

Methods: Implementation:

The transition from business as usual to the recommended path requires the application of processes and skills that seem to be commonsense, but are often overlooked in the rush to get to the result. Change, of any sort or extent, produces discomfort in those undergoing it. That discomfort will lead to resistance, sabotage, and rebellion if the change is not "sold" to its consumers. This selling process involves repeatedly, and at all levels, and in the manner appropriate to that level: opening discussion, dealing with objections, and reaching agreement and obtaining action. At the outset, the underlying reasoning for the change, and the motivations and values guiding it must be firmly fixed.

Value Clarification: This must be conducted at the outset due to the politically sensitive nature of both AIDS prevention measures and education efforts that may be perceived as enforcement actions. Clear consensus on motivations must be arrived at from the start.

The base-line motivation for a strategic plan to preserve the ability of police agencies to deliver the services they are charged to deliver. Preservation of that ability necessitates reducing the risks of infection of the personnel engaged in the actual delivery of services. It is to be accomplished primarily through the education and indoctrination of agency personnel (and their families) and the provision and use of appropriate safety equipment.

The values underlying preservation of organizational ability, and the preservation of the organization's work force are reasonably clear and seemingly not open to misinterpretation. Assuming that others will understand these values and motivations without any explanation can set up early failure and unnecessary opposition. The underlying values must be clearly communicated at the outset, and to every person or group contacted. That includes members within the agency. It is an old "saw" in the military that "someone always fails to get the word." Thus value clarification must begin at home through negotiation with members of the agency's command structure before any outside contacts are made.

A side-effect of proper training of personnel is the imparting of their knowledge to members of the public they contact in the normal course of police business. That is the area of the plan that is most fraught with danger from misinterpretation. The goal of this aspect of the plan must be clearly set from the beginning. That goal is reducing the risks encountered by agency personnel. The goal is not reformation of society. Nor is it "moral regeneration" based on individual, or group beliefs. The purpose is to save lives- the lives of police officers, and by example and information the lives of the public law enforcement serves.

Value clarification must be on-going, requiring restatement and new agreement at most phases in the transition process. Once agreement is reached internally on the motivations of the

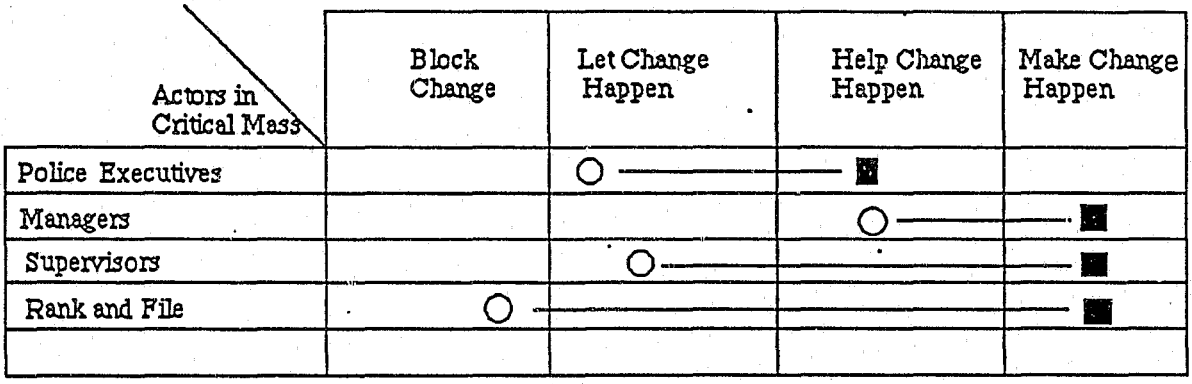
program within the plan, a commitment plan must be formulated to ensure th at implementation can proceed.

Critical Mass Identification: The first step in development of a commitment plan is identification of the "critical mass" necessary to ensure the change to be brought about. Critical mass is defined as: the minimum number of people/groups, who if actively in support of the change, ensure that the change will take place. After those key actors are identified, the level of commitment needed from them, now and in the future, must be identified. Figure 13 represents charting of the critical typical for a large police department, and is useful as a commitment planning guide.

FIGURE 13: CRITICAL MASS GUIDE

■ What is needed from this actor?

○ Where does this actor stand now?



This charting of current position versus needed position reveals where selling of the plan is most needed and saves efforts wasted on "preaching to the choir."

The group of actors seen as most resistant is the rank-and-file. This expected resistance was attributed to fear of the unknown (i.e.; AIDS and what it means to them), and suspicion that the change involved in the plan may be for reasons other than those stated. Rank and file must have the benefits of the training and education, the safety and procedural, and the public contact facets of the plan and strategy clearly demonstrated to them in terms that relate to their daily tasks. This is a prime example of why value clarification is so essential to the process.

The "show me" assumption made about police executives in Objective Two is the basis for their positioning on the chart. Their place in the execution of the plan is to help its implementation by making resources available to those who must carry out its steps. Time must be taken in demonstrating to agency command staff that the plan is a worthwhile investment of resources, and that it will work.

Managers are the upper level of execution. They provide the overall direction in the work units (i.e.: platoons, shifts, watches) that will be, in essence, the plan's consumers. Their buy in to the need, the effectiveness, the practicality, and the reasoning is essential.

The linch-pin of the entire process is the supervisory staff. Supervisors are, by definition, trainers. Their active participation in on-going indoctrination of their subordinates is the only means by which the uniform, consistent, and exacting compliance with risk reduction procedures can be had.

Management structure: The task group form of planning system has been identified as the most appropriate form for the issue-mission. The task group, as stated, should consist of persons from the stakeholder groups, both internal and external. Agency members must have sufficient power to commit the agency to reasonable courses of action without continual reference to higher authorities.

At the agency level a project manager holding rank or position near the top of the agency's organizational chart should be designated and act as executive director. That person's commission from the chief executive should grant clear responsibility for the project development, and commensurate authority to carry out all phases of it.

In putting the change into effect, a diagonal slice of the organization should be used. This involves obtaining representative of the various levels of the agency, as opposed to getting formal representation from groups. There is a need to get continuing input from all levels of the agency during the initial implementation, and on a continuing basis as the procedures and training become an integral part of operations.

Role identification: Time must be taken to thoroughly indoctrinate these representatives. They will, in the course of implementation, be the apostles of the change. An effective means of indoctrination is the team building workshop. At this workshop (which should be held away from the job site) goals can be examined and clarified, roles identified, and responsibilities of individuals assigned. Role identification is used to identify both internal and external "critical masses" so that buy-in and indoctrination of identified leaders can be accomplished.

Roles within the change management structure will differ. The executive manager is a facilitator, an obtainer of resources, and the "big gun" to brought to bear when unreasoning intransigence is encountered. Managers must undergo thorough policy indoctrination to ensure that sidetracking, value degradation, and subversion is minimized. Those in supervisory roles must not only be familiar with policy, but must have a complete understanding of procedure in order to be able to detect flaws in their application and make corrections.

Once overall roles have been identified, the process must be repeated within each organizational unit so that policy and procedure remain consistent throughout the entire agency.

Conclusion

The AIDS epidemic offers law enforcement unique challenges in maintaining its professionalism and its services. The dangers of AIDS must be neither inflated nor minimized. If law enforcement personnel are paralyzed by fear for their own safety, and the safety of their families they will not accept the risks considered "normal" in police work because those those risks now bear heretofore unimagineable consequences.

The outcome of this work is a strategic plan which bridges the gap from the analysis-defined today to the scenario-defined future. The future seen in the third scenario is the target for the strategic plan. That scenario depicted a large city police department that is operationally paralyzed by fear of AIDS, and whose leadership and management remain ignorant of the facts that would dissipate that fear. It is a future to be avoided and steps taken now can assure that it does not come to pass.

A process of policy formulation was employed that resulted in a statement by which to guide the actions required to avoid the consequences of such a future state. The product of that process is the following statement of policy:

> Law enforcement, in order to fulfill its mission, must educate and train its own personnel in the risks, and the ways to avoid the risks, of infection by the AIDS-virus, and should stand ready to share the knowledge gained with the public it serves.

From that statement came a plan of action. Training of its own personnel, development of procedures to make that training effective, continuous monitoring of the environment and updating of procedures to ensure their continued effectiveness, controls to ensure compliance, recognition that employee infections may occur and must be dealt with, and direction to share the knowledge gained with the community served are the major aspects of the plan.

The strategic plan offered is a means to an end, but will remain little more than a piece of paper if it is not supported commitment and a structure to carry it out. That commitment must be built within an organization. Those who can make things happen were identified. Those who can block were also identified and strategies offered to overcome their blocks. A structure for transition management with delineation of roles completed the process of implementation.

Law enforcement is the cutting edge of "...equal protection under the law...", must take a leadership role in educating its own. First, officers must be thoroughly trained and informed of the true nature, and magnitude of the risks of contagion they face, and the precautions they should take to minimize those risks. Then through their innumerable public contacts that education should be passed on to that public. Law enofrcement executives must make plans, and construct supporting procedures, now to confront the problems that will be encountered and created by employees who become infected with the AIDS virus.

Their co-workers' reactions must also be planned for so that the professionalism and effectiveness of the agency is not lost to fear and prejudice.

This work was initially envisioned as means by which law enforcement might preserve its place at the budget table in the face of sharply escalating fiscal requirements of public health as that sector seeks to deal with the AIDS epidemic. The thrust of this work was substantially redirected during the process of policy formulation. It became apparent that fear of AIDS, and the effects of that fear are far more deeply felt outside of San Francisco than was ever imagined. The need perceived is not budget share, but the maintenance of services when the officers responsible for its delivery may be more concerned for their own safety than the public safety. Thus, the issue-mission, and the policy and planning of this work is much more internal in nature than was the original concept.

This should not be taken as a criticism of law enforcement outside of that unique municipality that is San Francisco. Experience with AIDS has been longer, and more complete in that city than in almost any other locale. San Francisco's police department is small enough that information can be rapidly disseminated. The makeup of the San Francisco Police Department is also unique. Openly gay members have been serving in the S.F.P.D. for more than ten years. Several officers have succumbed to AIDS and the rest of the work force has "adjusted", in admittedly varying degrees, to the presence of HIV. Close

cooperation with public health authorities has been continuous, since AIDS first entered the organizational consciousness.

The education, and support, of employees' families must be a prominent feature of any teraining program. This is truly a danger faced not only an officer but by the offer's family in nearly equal measure.

Second to family support is the support of uninfected employees who will, is the institution of law enforcement is refective of society, see some of its members fall to AIDS. Regardless of how the employee became infected- that infection will impact co-workers. Plans should be made, and resources identified and secured now, to maintain the health and effectiveness of the uninfected.

AIDS as an issue will be with society long into the Twenty-First Century. Law enforcement must not remain isolated on the sidelines while the society that depends on it for protection gropes for a means of dealing with this plague.

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Appendix 1: Full Listing of Trends

Full Listing of Trends

1. Cost per AIDS Patient
2. Expressed Political Concerns
3. Level of Uncertainty regarding AIDS
4. Drain on Health Care Facilities
5. Immigration Restrictions
6. Levels of Law Enforcement Activity
7. Sex
8. Insurance Costs
9. Percent of General Funds for AIDS-related Activities
10. AIDS "Industries"
11. Dow-Jones Average for Pharmaceuticals
12. Level of Polarization of Society
13. Urban Demographics (related to movement to and from AIDS treatment facilities)
14. Shifts of AIDS-Educational Responsibilities to Federal Government
15. Federal Attempts at Quarantine Measures
16. No. of Civil Liberties Abandoned
18. Community Philosophy Changes
19. Demands for Risk-free Environments
20. No.'s of Pediatric AIDS Patients
21. Medico/Legal Conflicts
22. No.'s of Medical Refugees
23. Real Estate Prices in Urban areas
24. Disease Doubling Rate
25. Travel Bookings
26. Health Food Sales
27. Treatment Fads
28. No.'s of AIDS Patients
29. Ancillary Service Demands
30. Availability of Ancillary Services
31. Incidents of AIDS-related Civil Unrest
32. Rate of Recreational Drug Use
33. Use of Self-Help Groups
34. Total Health Care Costs
35. Pieces of Restrictive Legislation Passed
36. Pieces of Protective Legislation Passed
37. AIDS Initiative Measures
38. Exhibitions of Major Medical Uncertainty
39. No.'s of People Self-isolating
40. Extent of Patient Confidentiality
41. Teenage Suicide Rates
42. Dollars for Research
43. Marriage and Divorce Rates
44. Birth Rate
45. Sexually Transmitted Disease Rates
46. Migration to Urban Areas
47. Church Attendance
48. Restrictions Imposed on Civil Liberties
49. Rate of Occupational Infections

Appendix 2: Full Listing of Events

1. Significant Military Engagement
2. Testing of Visitors
3. General Mandatory Testing
4. More Common Vector Discovered
5. HIV Mutates
6. Chronic Carrier State Identified
7. New Opportunistic Infection or Tumor Identified
8. New plague
9. Better Anti-viral Drug Discovered
10. Prominent Politician Diagnosed with AIDS
11. Big Political Shift to the Right
12. Bankruptcy of City and County of San Francisco
13. Sensational AIDS-related Crime
14. Cure Discovered
15. Vaccine Marketed
16. Vaccine Discovered
17. Balanced Budget Constitutional Amendment Passed
18. Quarantine Imposed
19. Quarantine Declared Unconstitutional
20. National Education Effort Launched
21. Major Incident of Civil Unrest Related to AIDS Occurs
22. Vaccine Found to Be Unsafe
23. Heterosexual Transmission Level Reaches 10%
24. Major Natural Disaster
25. Fraud Discovered in Handling of AIDS Funds
26. Employment Restrictions Imposed
27. Funding Cut-off for AIDS and HIV Research
28. HIV Restricted to One Generation
29. Large Drop-off in Medical School Applications
30. Socialized Medicine Adopted

Appendix 3: Full Listing of Policies with Feasibility/Desirability Scores

	Policy	Score
1.	Law enforcement will educate only its own personnel re: job safety.....	18/20
2.	Internal programs of education will be run with public health and labor involvement and will regard: safety, high-risk behavior, personal responsibility....	18/22
3.	Accreditation Standards will require comprehensive current and long-term policies and procedures on infectious diseases.	14/20
4.	High-risk behavior in communities will be targeted for enforcement using existing laws.....	11/14
5.	Law enforcement will seek more effective laws to reduce high-risk behavior.....	11/16
6.	Community education programs (DARE, etc.) will includes AIDS prevention aspect and law enforcement should seek a part in other community programs.....	19/18
7.	Internal procedures and guidelines will be made explicit as to: HIV testing, protective equipment, decontamination, counseling, prisoner handling, rescues, and crime scenes.....	21/23
8.	Law enforcement will seek changes in privacy laws for protection of victims and officers.....	9/18
9.	Legislation allowing HIV testing of recruits (and rejection for seroposivity) should be sought.....	13/17
10.	Legislation will be sought to lessen and clarify burden of proof of industrial HIV-infection and provide special benefits for proved claims.....	16/17
11.	Regulations should be sought requiring ID of HIV-positive persons and requiring their registration- beginning with arrestees.....	9/13
12.	Seek AIDS-crime statutes.....	13/17
13.	Make enhanced penalties for prostitution and other sex-related crimes while seropositive.....	12/18
14.	Enforcement and education will be integrated and carried out from arrest through trial to incarceration or probation.....	15/19

Appendix 4: Participants at Nominal Group and Policy Delphi

Nominal Group Technique: San Francisco; 10 February 1988

Mr. Paul Lorch- San Francisco Community College District

Dr. David French, M.D.- SF Dept. of Public Health, San Francisco General Hospital AIDS-Activity, Ward 82

Officer Raymond Benson- SFPD Community Services Div. (Gay Liaison Officer)

Officer Wilbert Battle- SFPD Community Services Div., Director Mid-City Consortium, Chair- AIDS Committee

Diane Wolfe, R.N.- SF Dept. of Public Health, Community Mental Health Services

Officer Lynne Torres- SFPD Psychiatric Liaison Unit

Officer Kevin Jones- SFPD Psychiatric Liaison Unit

Sergeant Barbara Jackson- SFPD, Administrative Narcotics

Modified Policy Delphi & SAST: Washington, DC; 3 March 1988

Inspector Edward Spurlock- Metro DC PD, C.O. Special Operations,
President- Police Management Association

Edwin E. Hamilton- Research Analyst, Police Foundation

Cheri Crawford- AIDS Program Manager,
National Institute of Justice

Donald J. Cahill- Chair. National Legislative Committee,
Fraternal Order of Police

Edward Murphy- Legislative Director,
International Brotherhood of Police Officers

Phyllis P. McDonald- Manager,
National Law Enforcement Policy Center,
International Association of Chiefs of Police

Joseph Brady- Training Director, Police Management Association

John F. O'Brien- Business Agent, F.O.P. Lodge 5, Philadelphia, PA.

Harry C.Cunningham, National Legislative Comm., F.O.P.

Brian Forrest, Research Analyst, Police Foundation