HIV/AIDS: STATE POLICE TRAINING PRACTICES AND PERSONNEL POLICIES

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INTRODUCTION

In 1981, the US Center for Disease Control\(^1\) (CDC) noted outbreaks of Kaposi’s Sarcoma and Pneumocystis Carinii Pneumonia (Bigbee, 1993; Jarvis et al., 1991). Although the number infected was less than 400, CDC identified the patterns as “unusual”. By 1984, the outbreaks continued to alarm the CDC and the number of cases was reported as over 5,000. The condition was collectively referred to as Acquired Immune Deficiency Syndrome (AIDS) and the suspected infecting agent subsequently given the term Human Immunodeficiency Virus (HIV).\(^2\) By the end of 1993, CDC reported over 361,000 cases of AIDS and over 220,000 deaths (US Department of Health, 1994). New diagnoses increased 125 percent from 1992 to 1993 (US Department of Health and Human Services, 1994). Repeatedly, leading medical scholars referred to HIV/AIDS as the most serious public health problem in the United States today. In the face of this meteoric rise in HIV/AIDS cases and related fatalities, and given the alarm raised by the medical community, the question becomes “How has the criminal justice system as a whole, and the law enforcement community in particular, responded to HIV/AIDS?”

The 1980s witnessed a relative dearth of research on HIV/AIDS as they relate to the criminal justice community, although a few research studies were generated (Bigbee, 1987; Hammett, 1987a; 1988; Laszlo
and Ayers, 1986). Furthermore, the early criminal justice research agenda almost always focussed on corrections settings (Hammett, 1987a; 1988). The watershed work addressing HIV/AIDS and the law enforcement community was the 1987 study by the National Institute of Justice (Hammett, 1987b). The NIJ report quickly generated a keen interest in, and concern for, the risks encountered by public safety workers in general, and the law enforcement community in particular (e.g. California Department of Health Services, 1988; US Department of Health and Human Services, 1989). The 1987 NIJ report was followed in 1988 by an outline from the CDC for meeting the training needs of public safety workers (US Department of Health and Human Services, 1989). By December 1989, law enforcement’s concerns about HIV/AIDS were addressed when the International Association of Chiefs of Police (IACP) promulgated a model policy entitled “Communicable disease”. With awareness, training and officer safety as the cornerstones, law enforcement entered the 1990s with a keen sense of the issues related to HIV/AIDS.

The 1990s saw the issuance of a plethora of policies and standards regarding the transmission of infectious diseases. Some policies dealt with the HIV/AIDS issue as part of a broad agenda involving infectious diseases and the general population; others addressed specifically the law enforcement’s concerns regarding HIV/AIDS. In June 1990, the IACP model policy from the previous year was followed by a “Concepts and Issues Paper”, which laid to rest any doubt about whether HIV/AIDS posed a threat to the law enforcement community when it declared: “The [IACP Model] policy deals particularly with acquired immunodeficiency syndrome (AIDS)” (IACP, 1990:1).

In December 1991, the Federal government joined those expressing concern for job-related HIV/AIDS issues when the Department of Labor’s Occupational Safety and Health Administration (OSHA) promulgated its final regulations in the Code of Federal Register. OSHA’s “Occupational Exposure to Bloodborne Pathogens” (29 CFR Part 1910.1030) became effective in March 1992, and quite clearly applied to the vast majority of police departments in the United States. This Federal mandate was followed by the adoption of the IACP’s model policy “Prevention of Bloodborne Diseases” in October 1992, and the accompanying “Concepts and Issues” paper, released in May 1993.

This activity relating to the development and implementation of standards and policies on communicable diseases paralleled the opening of a virtual “floodgate” of research addressing specifically the effects,
past and future, of HIV/AIDS on the law enforcement community (Barr and Warshaw, 1994; Benny, 1993; Bigbee, 1991; 1993; Blumberg, 1990; Gates and Lady, 1991; Kennedy et al., 1990; Kime, 1993; Sheridan et al., 1989; Sinkfield and Houser, 1989; Stewart, 1993; Yearwood, 1992). Evidence emerged indicating law enforcement agencies could benefit from HIV/AIDS education programming (Barr and Warshaw, 1994; Yearwood, 1992). It quickly became apparent from these efforts that the law enforcement community needed to become involved in HIV/AIDS issues, given the real likelihood of one or more of the following legal issues arising:

- departmental liability for job-related infection of officers;
- the department’s responsibility for preventing the spread of HIV infection by, and among, prisoners; and
- finally, the potential for criminal charges stemming from intentional or negligent HIV infection (Hammett, 1987b).

Yet, despite the research, preventive efforts, policies and national standards, it was simply a matter of time before the law enforcement community experienced HIV/AIDS work-related exposure, transmission and infection. However, general disagreement existed among researchers as to whether law enforcement had incurred any job-related HIV/AIDS deaths. Although Hammett (1994) reports no deaths, at least one author reported that between 1981 and 1991 seven cases had been documented where police officers had become exposed to, or actually tested positive for, HIV and at least three officers had died from AIDS (Bigbee, 1993). Details and specifics regarding numbers and outcomes aside, given the focus on HIV/AIDS and law enforcement over the past three years, the numerous legal and administrative issues that had arisen and the actual and potential threat being faced by the law enforcement community, the stage was set for research such as this; research exploring the response of the law enforcement community to the HIV/AIDS issues.

By design or default, virtually all previous research involving police organizations focussed on larger, metropolitan or urban police departments. Why, then, assess or evaluate the efforts of state police organizations when policing the traditional “high risk” populations (intravenous drug users, gay men, immigrants, minorities, lower income) is usually associated with larger, metropolitan and urban, police agencies? State police organizations are usually identified with the
delivery of police services to rural locations, populated primarily by the white middle class (Wrobleski and Hess, 1990). Additionally, most police scholars would agree that state police organizations are “conservative” when it comes to adopting new instructional techniques and, historically, have been remiss in addressing cultural or controversial issues such as HIV/AIDS (Edwards, 1993). What, then, is to be gained from this study of state police agencies?

It is precisely because of their inherent “conservatism” and lack of identification with the populations with high rates of infections that the state police organizations lend themselves to this study. By late 1993, the time of this survey, over 13 years had elapsed since the initial recognition of the issues involved with HIV/AIDS and policing. Additionally, over five years had elapsed since the IACP first addressed the issue of communicable disease. Furthermore, several months had transpired since the adoptions of OSHA’s standards and the IACP model policy. Surely by late 1993 responsible law enforcement agencies would have responded to and implemented a variety of training policies to address these concerns. Furthermore, agencies surely would have implemented personnel policies regarding hiring and retention of personnel who were HIV positive or diagnosed as having AIDS. A true test of the efforts by national health and law enforcement agencies to increase awareness of HIV/AIDS issues among law enforcement agencies would be to determine whether state police organizations, often perceived as the “last to change”, had adopted changes in training and/or policies in response to the available information.

Probably the most important reason for assessing state police organizations is that state police organizations, as opposed to most metropolitan agencies, have more control over their recruitment and in-service training processes. The vast majority of state police organizations conduct training in academies they, rather than some state training board, control. Instructors are usually all sworn officers from the state police agency, not “civilians” from “centralized” state training programs. Because of the control and “ownership” of the training facilities, the state police organizations determine both the course content and methodology of the instruction (Edwards, 1993), as opposed to the majority of urban agencies whose training needs are met by state-operated, centrally controlled training councils. Therefore, the presence or absence of instruction relating to HIV/AIDS in a particular state police training program truly reflects the agency’s perceived need, or lack thereof, for instruction on that topic, while the presence or absence of HIV/AIDS
instruction in a training program not controlled by the agency may or may not be reflective of the agency’s needs.

The depth and breadth of these changes by state police organizations would be evidence, and a fairly accurate measure, of how serious the law enforcement community perceived the threat. This research represents an assessment of the depth and breadth of that response.

**METHODS**

Two different survey instruments were employed in this study. The first, sent to the directors of the 49 state police training academies, was a two-page document. The academy directors were asked whether or not their agencies were offering training (either for new recruits or as part of in-service programs) related to HIV/AIDS. If they indicated either type of training was being offered, they were then asked to explain why it was initiated, what problems had been encountered, the methods used, sources, and to provide copies of materials. If either was not offered, they were asked to give reasons. Finally, they were asked whether or not instruction was offered regarding infectious diseases or conditions other than HIV/AIDS.

A second two-page survey was sent to the 49 state police personnel directors. They were asked whether or not their agency had implemented policies addressing:

- officers dealing with, or encountering, persons known to be, or suspected of being, HIV positive or diagnosed with AIDS; and

- the hiring and/or employment of persons testing positive for HIV or diagnosed with AIDS.

If policies existed, agencies were asked to provide a copy; if no policy existed they were asked to explain why such policy had not been implemented.

The surveys, and subsequent clarifying telephone interviews in some cases, resulted in the completion of usable instruments as follows: 42 of the 49 academy directors and 44 of the 49 personnel directors responded to one or more questions (however, not every question was answered by all respondents). For 37 state police organizations, the surveys were completed, to some degree, by both the academy and
personnel director. At least one survey from each of the 49 states with a state police organization was usable. The resulting data set was evaluated and used to generate both quantitative assessments and a more general descriptive account of “the state of the art” relating to HIV/AIDS training and personnel practices.

As an aside, numerous training and personnel policies were provided by the agencies. In fact, the agencies generously provided us with copies of various training manuals, brochures, flyers, course outlines and even video tapes.

**FINDINGS**

*Training*

Forty-two academy directors responded to the question about HIV/AIDS instruction to recruits. A substantial majority ($N = 36, 86\%$) reported they were offering basic training to their recruits. Of the six directors reporting no instruction was being offered, four indicated they were considering such training and two indicated they had no plans to offer such training. Forty-one academy directors responded to the question about HIV/AIDS instruction being offered as part of in-service training. Although the number was smaller ($N = 32, 78\%$), again a substantial majority of the academy directors reported offering in-service training (Table 1).

Thirty-one academy directors indicated instruction was being offered to both recruits and through in-service training. Four directors indicated training was being offered only to recruits and one reported offering training only in-service. Five directors reported they offered no training, either to recruits or as part of in-service, while one academy

| Table 1 |
|------------------------|--------|--------|
| **P REVALENCE OF R ECRUIT/I N-S ERVICE T RAINING R EGARDING HIV I SSUES** |
| Variable (# Responding) | Yes    | No     |
| Instruction Offered: Recruit (42) | 36 (86\%) | 6 (14\%) |
| Instruction Offered: In-Service (41) | 32 (78\%) | 9 (22\%) |
reported offering training to recruits but failed to indicate whether in-service training was being offered.

It is of interest to note 36 agencies reported offering instruction to recruits, while only 32 agencies reported offering in-service instruction to current officers. Furthermore, four agencies offer instruction only to recruits. This training focus on recruits suggests these agencies perceive the risks of HIV infection as less serious than do agencies offering training for all officers. This perspective is further reinforced by the fact that, of the nine agencies not currently offering HIV issues as part of in-service training, only four indicate having given any serious consideration to developing such training. The most common rationale provided for not developing and delivering in-service training is that the anticipated costs (both financial and in terms of manpower) are seen as too great, given the small risk involved.

The academy directors who offered training, either recruit or in-service, were asked to explain why such training was initiated. About the same number of directors responded for both recruit ($N = 23$) and in-service training ($N = 29$). Two primary reasons for initiating HIV/AIDS instruction emerged:

1. to meet legal requirements (recruit, $N = 12$; in-service, $N = 20$); and

2. to address concerns of safety for officers and other agency personnel (recruit, $N = 11$; in-service, $N = 9$).

When queried about problems regarding the delivery of instruction to recruits, academy directors overwhelmingly ($N = 29, 80\%$) reported they had not encountered any significant problems. However, the results are somewhat different with regards to potential problems with the delivery of in-service training. Of the 32 agencies offering in-service training, slightly over one half ($N = 19, 59\%$) report no problems. When problems are encountered, for both recruit and in-service training, they are generally reported to be related to issues of students’ attitudes and resistance to such information. As might be anticipated, veteran officers are expressing their objections more frequently than are the new recruits. This reflects the consequences of both occupational socialization and the fact that the (presumably) younger and better educated recruits have more exposure to HIV/AIDS issues.

A review of the course materials (both recruit and in-service) provided by the agencies suggests that topics, course materials and
instructional methods vary greatly from agency to agency. Generally, the topics offered as part of HIV/AIDS training, whether to recruits or as part of in-service, are the origin and history of HIV/AIDS, decontamination procedures, transmission processes and risks, protocols for prevention of transmission, statistics, medical terms and definitions, officer safety, confidentiality of information and records, supplies/equipment requirements, notification procedures, administrative (paperwork) requirements and evidence handling. Course materials also vary dramatically. One agency utilizes a brief, handwritten outline; others use elaborate training manuals (some over 100 pages), color handouts, and even videos. Frequently, the instruction regarding HIV/AIDS is part of general training on infectious diseases, including Hepatitis-B. Most instruction was based on course outlines or manuals prepared by the agency and supplemented with information, flyers, or handouts from state or federal agencies. Some agencies did have very detailed and professionally produced brochures specifically addressing HIV/AIDS and their agency. A few agencies reported instruction was conducted by medical personnel, most often registered nurses. The effective date on most policies and materials was 1992, with a few dating to 1990. One agency, however, had course materials dating from 1986.

Finally, the academy directors were asked whether or not they were offering instruction on how to deal with infectious diseases other than HIV/AIDS. Thirty-nine academy directors responded, with 35 indicating they were offering other instruction and four indicating no other instruction was being offered.

Analysis also focused on identifying differences in instruction by type of agency (“state police” or “highway patrol”) and by regions of the country. For the purpose of this analysis the classification of agencies recognized by the International Association of Chiefs of Police (IACP) was employed (IACP, 1975). Of the 49 state law enforcement agencies, 23 are classified as “state police” and 26 are classified as “highway patrol”.4 Regional breakdowns follow the model used by the United States Census Bureau. Four regions are identified: East, Midwest, West, and South.5

As Table 2 indicates, there is little difference in whether or not instruction, either recruit or in-service, is being offered based on the type of agency. Furthermore, when the reasons for conducting recruit training are examined by type of agency, there are virtually no differences between state police and highway patrol agencies (Table 3). However, when the reasons for conducting in-service training are reviewed, just
over half of the state police agencies report legal requirements as the reason, while more than three-fourths of the highway patrol agencies reported legal requirements as the reason.

Although virtually no differences in the distribution of reasons for initiating recruit training by type of agency were identified, some differences were discerned in the distribution of reasons for initiating such training when reasons are examined by region of responding agency (Table 4). Furthermore, the reasons for initiating in-service training vary

### Table 2
**Number of State Police/Highway Patrol Agencies Offering HIV/AIDS Training**

<table>
<thead>
<tr>
<th>Type of Training</th>
<th>State Police</th>
<th>Highway Patrol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit</td>
<td>Yes = 17 No = 5</td>
<td>Yes = 19 No = 1</td>
</tr>
<tr>
<td>In-Service</td>
<td>Yes = 16 No = 4</td>
<td>Yes = 16 No = 5</td>
</tr>
</tbody>
</table>

### Table 3
**Reasons for Initiating Recruit and In-Service HIV/AIDS Training**

<table>
<thead>
<tr>
<th>Reason for Initiating Training (N)</th>
<th>State Police</th>
<th>Highway Patrol</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recruit Training</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting Legal Requirements (12)</td>
<td>6 (50%)</td>
<td>6 (50%)</td>
</tr>
<tr>
<td>Concerns of/for Officers (11)</td>
<td>6 (55%)</td>
<td>5 (45%)</td>
</tr>
<tr>
<td><strong>In-Service Training</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting Legal Requirements (20)</td>
<td>8 (40%)</td>
<td>12 (60%)</td>
</tr>
<tr>
<td>Concerns of/for Officers (9)</td>
<td>5 (56%)</td>
<td>4 (44%)</td>
</tr>
</tbody>
</table>

### Table 4
**Number of Agencies, by Region: Reasons for Initiating Recruit and In-Service HIV/AIDS Training**

<table>
<thead>
<tr>
<th>Reason for Implementation</th>
<th>East</th>
<th>Midwest</th>
<th>West</th>
<th>South</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recruit Training (N = 23)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting Legal Requirements (N = 12)</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Concerns of/for Officers (N = 11)</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>In-Service Training (N = 29)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting Legal Requirements (N = 15)</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Concerns of/for Officers (N = 14)</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
somewhat by region. Agencies in the East and Midwest regions reported offering in-service training more due to concerns of/for officers; in the West and South regions, the most frequently offered reason for conducting HIV/AIDS related in-service training is to meet legal requirements.

**Personnel Policies**

In addition to evaluating the instructional activities of state law enforcement agencies, it was also important to examine the development and implementation of policies and standardized procedures regarding interactions with HIV positive individuals across agencies. Forty-one personnel directors responded to the question regarding whether or not their agency had implemented a policy addressing how to deal with persons suspected of being HIV positive or having AIDS. Twenty-nine personnel directors (71%) reported their agency had adopted such a policy. An interesting note is that while 36 agencies reported offering HIV/AIDS instruction either to new recruits or as part of in-service training, only 29 agencies opted to adopt a policy on the topic (Table 5).

Evidently these agencies not adopting policies are assuming the training and instructional recommendations for such encounters are sufficient to ensure adequately the health and safety of officers and the legal protection of HIV positive citizens, rather than through proscriptive or restrictive policies. There are virtually no differences in whether such a policy was adopted by type of agency (Table 6), and only minimal differences were noted when examining the regions (Table 7).

Among those agencies that have developed and implemented policies, more than one-half (55%) report doing so in order to meet legal requirements (usually citing mandates from the Occupational Safety and Health Administration). Other agencies report adopting such policies in

<table>
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<tr>
<th>Table 5</th>
<th>PREVALENCE OF POLICIES REGARDING HIV ISSUES</th>
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</thead>
<tbody>
<tr>
<td>Variable (# Responding)</td>
<td>Yes</td>
</tr>
<tr>
<td>Implement Policy: How to Handle HIV Positive Persons (41)</td>
<td>29 (71%)</td>
</tr>
<tr>
<td>Implement Policy: Employment of HIV Positive Persons (36)</td>
<td>9 (25%)</td>
</tr>
</tbody>
</table>
order to protect their personnel (35%) and to ensure that HIV positive citizens are treated fairly (10%).

When agencies do implement policies regarding interactions with HIV positive individuals, few, if any, problems associated with these policies are reported. Fully 81% of agencies with policies report no problems. This holds true regardless of type of agency (highway patrol: 77%; state police: 86%), or region involved (no problems reported by 75% of East, 66% Midwest and 100% of West and South agencies).

Of the 36 personnel directors who responded to the question asking whether their agency had implemented a policy on the employment of persons with HIV/AIDS, only one-fourth (N = 9) reported having implemented such policies. Only three of the nine agencies provided copies of their employment policies. Interestingly, four agencies not providing copies simply asserted their policy mirrored the non-discriminatory provisions of the Americans With Disabilities Act (ADA). The remaining two agencies offered neither a copy of the policy nor any explanation of what it contained.

For the three policies provided, certain commonalities were readily apparent. Each of the employment policies began with a recitation

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Implemented Policy</th>
<th>No Policy</th>
</tr>
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<tbody>
<tr>
<td>State Police (N = 20)</td>
<td>13 (65%)</td>
<td>7 (35%)</td>
</tr>
<tr>
<td>Highway Patrol (N = 21)</td>
<td>16 (76%)</td>
<td>5 (24%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Implemented Policy</th>
<th>No Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>East (N = 11)</td>
<td>8 (73%)</td>
<td>3 (27%)</td>
</tr>
<tr>
<td>Midwest (N = 11)</td>
<td>9 (82%)</td>
<td>2 (18%)</td>
</tr>
<tr>
<td>West (N = 8)</td>
<td>5 (63%)</td>
<td>3 (37%)</td>
</tr>
<tr>
<td>South (N = 11)</td>
<td>7 (64%)</td>
<td>4 (36%)</td>
</tr>
</tbody>
</table>
that the purpose of the policy was to ensure HIV/AIDS employees, or potential employees, were not discriminated against because of their HIV/AIDS status. The policies all contained provisions relating to confidentiality of medical and personnel records, as well as provisions specifically outlining employee medical and legal rights. Additionally, all three policies contained provisions relating to counseling and benefits. One policy contained elaborate details advising how an employee could advise a supervisor of the condition without jeopardizing employment or fearing retaliation. One policy referred employees to the non-discriminatory provisions of state law.

Agencies reporting not having a policy were asked why no policy had yet been implemented. The most common reason offered was no need for such a policy was perceived. Also offered as explanations was that the Equal Employment Opportunity Commission and/or the ADA prohibits such policies. A number of agencies stated they had no identifiable reason for not having developed such a policy. Furthermore, among those agencies not having policies regarding employment of HIV positive persons, only one in four reported they had even considered the development of such a policy. The results reveal there is no perceived need for such a policy by many state police organizations, although no one reason is being offered for the lack of need.

In the mid-1990s, with estimates suggesting as many as several million persons may be living with HIV (Hammett, 1987b), it would seem both logical, and necessary, to have agency policies regarding the possible employment of persons with HIV disease. However, this does not appear to be the case. The ADA specifically includes HIV/AIDS as being a covered disability. Therefore, at a minimum, it would appear state police agencies would have policies to that effect, given they have adopted policies on gender and racial discrimination based on other federal laws. Virtually every major police department (including the majority of state police agencies) has incorporated the provisions of federal and state non-discrimination statutes relating to gender, race and ethnicity into their policies. Such failure to have an employment policy, even one that simply requires equal treatment, evidences a lack of awareness or sensitivity to the HIV/AIDS issue on the part of the vast majority of state police agencies.

The absence of recognition of a need for policies regarding employment of HIV positive individuals holds consistent across type of agency and region. Of the 36 states responding to this question, an alarming 82 percent of state police agencies and 68 percent of highway
patrol agencies report having no policies regarding the employment of HIV positive individuals. When implementation of employment policy is addressed by region, it is disturbing that no region has more than 30 percent (18% of East, 30% of Midwest, 28% of West and 25% of South) of its state police organizations reporting the implementation of such a policy.

A look at the reasons cited by types of agencies and region further support the idea that rationales for policy development or non-development are consistent across agencies. In both state police and highway patrol agencies the most frequent reason provided for not having implemented policies regarding the employment of HIV positive persons was a lack of perceived need (50% and 43% respectively). Regional analysis shows in the East, Midwest and South the primary cited reason for not having a policy on the employment of HIV positive individuals is a lack of need (50%, 50% and 66% respectively). However, in the West region the only cited reason is a belief the Americans with Disabilities Act and/or Equal Employment Opportunity Commission prohibit such policies. Interestingly, the only other references to these reasons are provided by 38 percent of the East region agencies without such a policy.

**CONCLUSIONS**

Over a decade has passed since the medical and law enforcement communities first became aware of, and concerned about, the implications of HIV/AIDS for police officers. As a result of these concerns, a number of policies and standards have been implemented specifically addressing the training and employment issues relating to what the medical community has labeled the most serious public health threat today. Although a majority of state police organizations have implemented training, fewer agencies have adopted policies informing sworn officers how to deal with persons suspected of, or known to have, HIV/AIDS, even though national standards and model policies have existed for over a year. Even fewer agencies report having policies addressing the employment of HIV/AIDS employees, although no single reason for not having such policies surfaces.

While the clear majority of state police agencies are offering some training to their officers, either in basic or in-service training, the instruction varies widely in terms of both quality and quantity, and a wide variety of source materials currently exist. Course materials range from
simple handwritten outlines to elaborate training manuals over 100 pages in length. Some incorporate superb, professionally produced, video tapes. A handful even offer instruction by personnel from the medical community. Further evaluation of the content of the instruction is not only needed but warranted by the noticeable lack of uniformity. Standardization, by either the national medical or law enforcement community, is essential. While training, and to some degree course content, has been mandated by OSHA and developed by the IACP, little has been done to ensure agencies, state or otherwise, are adhering to the federal mandates or instructing recommended topics.

Many state police organizations have been woefully remiss in implementing policies addressing the employment of HIV/AIDS employees. Furthermore, the dearth of policies cannot be traced to a universal underlying reason founded in either law or practice. Rather, a variety of reasons are offered. Ironically, federal statutes such as the ADA are cited both as a reason for adopting employment policies and as a reason not to adopt such a policy. Agencies without policies appear to be offering excuses, rather than justifications, for their lack of implementation, or it could be argued that these agencies are engaged in collective denial of the simple reality that HIV positive persons will be in their employ. Given the breadth and depth of the HIV/AIDS issue, common sense dictates agencies should be considering the implications of having employees who have HIV disease. Although the risk of a job-related infection for an employee appears to be nearly infinitesimal (certainly significantly less than the risk of contracting Hepatitis-B, for instance), the law enforcement community must acknowledge and address the real likelihood that:

- HIV/AIDS applicants will seek employment; and
- current employees may contract HIV through non-job related transmission processes.

Furthermore, given the current costs of, and efforts to reorganize, health insurance, state (as well as municipal and urban) agencies must seriously consider the HIV/AIDS implications for health insurance.

In conclusion, law enforcement leaders must ask, as virtually every other employer has – how will HIV/AIDS affect my employees and my business? What can I do now to minimize liability and increase employee safety? Are my training practices sufficient to meet the needs of my employees? Are we meeting national standards and adhering to
federal and state training requirements? Are my policies and practices in compliance with current legal mandates? To date, this evaluation of state police efforts seems to suggest that the law enforcement community in general, and many state police organizations in particular, are unable, or unwilling, to address some of these questions.

NOTES

1. Now known as the US Centers for Disease Control and Prevention.

2. It is beyond the scope of this research paper to address the medical background of either HIV or AIDS. Numerous articles and books exist addressing, in great detail, such medical issues as theories regarding origins, methods of transmission, how the human body is affected, which groups are “at risk”, symptoms, testing and research, and incidence. For a superb discussion of the medical issues related to HIV/AIDS, see Blumberg (1990).

3. Hawaii has no police organization equivalent to a true state police agency.


5. West region states are: Alaska, Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Oregon and Washington; Midwest region states are: Indiana, Illinois, Iowa, Kansas, Michigan, Nebraska, North Dakota; Minnesota,
Missouri, Ohio and South Dakota; East region states are: Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New York, New Jersey, Pennsylvania, Rhode Island and Vermont; South region states are: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.

REFERENCES


