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Subseries:

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Folder Title:
Correspondence - Todd Summers - Incoming - 10/99 [1]

Stack:	Row:	Section:	Shelf:	Position:
S	66	6	2	1

Subj: **MEMO TO WHITE HOUSE AIDS OFFICIAL**
Date: 10/21/99 1:29:40 PM Pacific Daylight Time
From: TASwann
To: Todd_A._Summers@opd.eop.gov
CC: TASwann

THOMAS A. SWANN
39360 Peterson Road Space 100
Rancho Mirage CA 92270-3098
(760) 324-5670
TASwann@aol.com
Www.proud-gay-veteran.com

October 21, 1999

MEMORANDUM FOR TODD SUMMERS,
DEPUTY DIRECTOR WHITE HOUSE NATIONAL AIDS POLICY OFFICE

Dear Todd:

Bless your heart. I hope this letter finds you happy and well. Today I had my exam with the Multi-center AIDS Cohort Study (MACS). They come to Palm Springs twice per year. They said they received full funding for the next 5 years. They thanked me for my efforts on Capitol Hill and I praised you for making this valuable AIDS research funding set through 2004.

As a nationally recognized AIDS activist and leader in several Democratic Party organizations I have put the word out that you could visit our area in February. John Brown, Executive Director of Desert AIDS Project has been so helpful to other clients and me. He wanted you to be in their annual Walk for Life. However, that same weekend just about every Democrat in the area will be in San Jose for the Annual State Democratic Party convention. So we would like to change the dates one-week.

I am an enabler and not a controller. My role is to find out who would like to meet with you, get you a plane ticket, hotel, rental car and make sure you have an enjoyable visit. So based on the inputs I have received, please find this PROPOSED VERY TENTATIVE ITINERARY subject to change by you and the groups listed. Please understand this is the first DRAFT schedule:

Wednesday Feb 16 - Arrive Palm Springs

Thursday Feb 17 - Tour Desert AIDS Project. Meet with Desert Sun editorial board. Do radio shows and other media arranged by Fred Bilodeau and Melinda Tremaglio of Triangle Broadcasting.

Friday Feb 18 - Meet with Dr. Roger Detels, Principal Investigator of MACS at UCLA and other AIDS researchers.

Saturday Feb 19 - Speak to Democrats of the Desert Club at 9:30 a.m. at Cathedral City Library. They expect 100 people and this is predominantly a "straight" club. The topic would be the achievements of the Clinton-Gore administration on the war on AIDS. You would speak for 20-25 minutes and take some questions about the future of the AIDS pandemic (i.e., a cure, vaccine, Third World needs, Congressional funding, etc.).

Saturday Feb 19 - Desert Stonewall Democrats reception to honor you and fundraiser for the club's voter education projects. Fred Bilodeau is in charge of this and is the spokesperson for Stonewall.

Sunday Feb 20 - Fred Bilodeau might have something else for you to attend with local elected officials and/or Native American Casinos.

Todd, I have done my best to find out who in our area is very eager to meet with you. I believe Charlie Sharples of Stonewall and Gay Veterans will help with a hotel room and some transportation. I am also asking good Democrats like Clark McCartney to help if they have some ideas.

Below are the names and phone numbers of the people who wanted to schedule a meeting with you:

Desert Stonewall Democrats
Fred Bilodeau, President
(760) 328-1100

CA. Democratic Party Region 19 Director
Clark McCartney

(760) 568-5741

Democrats of Desert Club
Art Katz, President
(760) 320-0520

Triangle Broadcasting
Melinda Tremaglio
(760) 322-1217

Palm Springs Gay Veterans
Charlie Sharples
(760) 324-1350

Desert AIDS Project
Mr. John Brown, Executive Director
(760) 323-2118

Multi-center AIDS Cohort Study
LA Men's Study (310) 825-1073

I have a large framed group picture from the AIDS Watch meeting. It will be delivered to you in person by Mark Repass after Veteran's Day. We are getting a smaller picture more suitable for scanning.

Respectfully,

Tom Swann

Managing Health Care

Patients, Activists and Health Care Providers Offer Differing Views of HMO Reform Measures

by Russell A. Jackson

To some, the health care reform bills signed into law by Gov. Gray Davis in October represent the kind of compromise-driven "tinkering" that politicians do best. Unless, that is, you're one of the people directly affected by the measures. Then, as one AIDS activist told *Frontiers*, the new laws can truly represent the difference between life and death.

The HMO reform package signed by Davis is "going to save lives," says Tom Swann, a retired member of the U.S. Navy and an AIDS activist, who blames his HMO's reluctance to approve a visit to a CMV specialist for the progression of retinitis that has left him essentially blind. "If your HMO makes a mistake, you'll have the right to sue them in a jury trial, and most jurors will be very, very compassionate when they find out that you're blind or you've lost a leg because your HMO delayed treatment," Swann says.

The 21 HMO reform bills signed by Davis were less comprehensive than the 70 health care bills Davis put on hold in July when he informed legislators that he would only sign a smaller, more consolidated package. The bills included in the package he signed Sept. 27 were chosen as a result of consultations with lawmakers, industry representatives and consumer advocates.

Dr. R. Scott Hitt, the founding chairman of the Presidential Advisory Council on HIV/AIDS and an HIV specialist in the Beverly Hills office of Pacific Oaks Medical Group, called the HMO bills signed by Davis "a good first attempt" that falls short of fully meeting the health care needs of California residents.

"For HIV patients it's pretty simple," says Hitt. "They just need to have access to a true HIV specialist for their care and they need to be able to have the tests and medications they require." Because the new bills don't fully accomplish that basic need, he says, "they really represent tinkering around the edges."

The package includes measures to:

- Require independent review of HMO decisions by requiring health care service plans to provide patients with written responses to grievances, and to establishing an independent medical review system to take effect by the beginning of 2001.
- Establish a state Department of Managed Care to license and regulate health-service plans, as well as an Office of the Patient Advocate to assist health plan enrollees with complaints, provide educational guides, issue annual reports and make recommendations on consumer issues.
- Provide an array of consumer protections, including the guarantee of a second opinion, expanded privacy rights and the implementation of strictly defined procedures and timelines for handling treatment requests by physicians.
- Require HMOs to offer particular treatments or services, including hospice care, contraceptives, cancer screening, diagnosis and treatment of severe mental illness.

The package also includes a bill making California one of three states to allow lawsuits against HMOs for compensatory and punitive damages. The law only

Continued on page 62

Retired Navy seaman Tom Swann, shown here at a 1993 protest at the Vietnam Memorial, blames his blindness on an HMO's refusal to allow him to see a CMV specialist. He says the health care reform measures are "going to save lives."

Dr. Scott Hitt, an HIV specialist in the Beverly Hills office of Pacific Oaks Medical Group and found-

Two Out of Three

Davis Signs Needle-Exchange and Back-to-Work Bills, but Vetoes HIV Tracking Measure

by Tracy Sypert

When AIDS activists discovered on Columbus Day that Gov. Gray Davis had vetoed AB 103, a bill to establish a "unique identifier" system to track HIV infection in the state, some may have sought comfort in a line from an old Meatloaf song—"two out of three ain't bad."

That's certainly the take Stonewall Democratic Club President Eric Bauman, a special assistant to Davis, was putting on it as he noted Davis' approval of two other top legislative priorities—AB 136, a bill to allow cities to legally operate clean-needle exchange programs that Davis signed on Oct. 9, and AB 155, a bill to allow persons with AIDS and other disabilities to maintain Medi-Cal coverage when they return to work that Davis signed on Oct. 10.

> "The governor obviously believes it's good public policy to be reporting and tracking HIV infection through a confidential non-names based reporting system," Bauman said, "but if we implement a program like this he wants to make sure we do it properly."
>
> —*Stonewall Democratic Club President Eric Bauman*

effectively combat the epidemic. AB 103, a bill by Assemblywoman Carole Migden, D-San Francisco, would have required health officials to use confidential, unique codes—instead of names—to report and track HIV cases.

AB 103 was supported by the California HIV Surveillance Coalition, a statewide coalition of more than 100 public health advocacy organizations. It was opposed by the California Academy of Preventive Medicine, which cited a CDC evaluation that concluded names-based reporting is the best way to achieve public health goals of reducing HIV infection. Most AIDS activists, however, say a names-based system will subject people to the possibility of discrimination.

Prior to Davis' veto, Fred Dillon, state policy director for the San Francisco AIDS Foundation (SFAF), told *Frontiers* that tracking HIV using unique identifiers "will give the people doing planning a tremendous amount of information on the epidemic that they don't now have and it will provide that information through a mechanism that doesn't drive people away."

Indeed, Dillon knew of one patient who moved to California specifically to get away from her home state's mandatory names reporting system. "She didn't want to get her health care in a state with that kind of reporting," he said. "This kind of HIV reporting will make people feel more confident and secure that none of their information will get out

Managing Health Care

Continued from page 53

applies to medical services requested or provided after Jan. 1, 2001, and even then, plan members must first go through the independent review process and then, if they are dissatisfied with the results, show that they suffered "substantial" harm, such as loss of life, disability, disfigurement or considerable financial expense.

The new rights also apply to members of plans offered by self-insured employers—a group that includes most of the nation's largest multi-state companies. Those members are still covered by the federal Employee Retirement Income Security Act (ERISA), which pre-empts state laws governing health benefits. Under it, plans are only liable for the cost of services denied, although a measure currently pending in Congress would allow patients covered by ERISA to sue as well.

Until the federal law is changed, however, one AIDS Project Los Angeles (APLA) executive, could offer only tempered enthusiasm for the California measures. "Certainly some progress has been made," says APLA benefits programs manager Jacques Chambers, "but I have a certain amount of cynicism about the measures in that I don't know of anything in them that pre-empts ERISA. That causes me and my clients more grief than anything."

Hitt adds that simply allowing patients access to specialists won't work if they don't know whom to see. "Too many AIDS patients are being told they can see an infectious diseases specialist but not all ID specialists are HIV specialists," he says. "They may be a little bit better trained in that area than the average physician, but they are by no means HIV specialists."

And while the threat of lawsuits will help some, HMOs will find ways around the legal threat. "Health plans will argue that there's no definition of an 'HIV specialist,'" Hitt says. "They'll say it's not a board-certified specialty. They'll come up with all sorts of reasons to deny access."

Chambers notes that California litigation reform will become more significant if a pending federal Patients' Bill of Rights, which includes a right to sue under ERISA, becomes law. (For more on that bill, which passed the House in early October, see story on page 34.)

The right to independent review, meanwhile "is definitely going to help my clients," Chambers says. "Some of them have problems with getting coverage for human growth hormones, which is a very expensive treatment. The HMOs are slow to approve them. We were really looking for some help there."

Specifically, he adds, "we have two clients who've had real trouble getting the hormone. One finally got the treatment, but one is still pushing. And those delays defeat the purpose of the drug. It's to prevent wasting, and every week the HMO delays, those patients are wasting further."

That's why Chambers remains worried about the specifics of the review process, which won't be in put in place until Jan. 1, 2001. "How long will it take to go through that process?" he asks. "They're just setting up the system."

Carole Migden, one of two open lesbians in the state Assembly, sponsored a central piece of the reform package, AB 55, which requires the establishment of the independent review system. Alan Lofaso, Migden's chief of staff, says the health care bills signed by Davis "don't represent a sea change but they do represent another step forward."

"These are important bills that deal with the health of the gay and lesbian community," Lofaso says. "If we use the term 'civil rights' in its broadest sense—that is, the maintenance and extension of those things that keep people free—it surely includes the ability to make a decent income and get treatment for illness."

Lofaso is certainly getting no argument from Swann, the retired U.S. Navy member who now lives in Rancho Mirage. "I'm blind from CMV retinitis," Swann explains. "It's preventable, but my HMO, Blue Cross' CaliforniaCare, made me wait three months for treatment and then sent me to a glaucoma specialist. He refused to shake my hand because I wore an earring—and I'd told him I had AIDS."

Glaucoma, Swann says, "is very, very different from retinitis. Only people with diminished immune systems get the kind I have. It's really too late for me. My left eye is basically gone and my right eye is way past legally blind."

At the time it happened, Swann notes, he could only sue his doctors, not his health plan. "On the stand, they admitted they didn't have any training in this and didn't know what to do. The problem was I couldn't sue the real culprit."

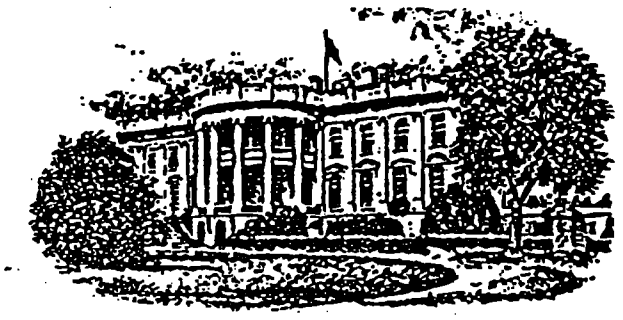
With bills requiring HMOs to provide second opinions, make quick decisions on specialists, and face the legal consequences of such decisions, the California reform package "forces the HMO to refer AIDS patients to doctors for whom AIDS is their main field of medicine," Swann said. "If you're like me and you have CMV retinitis, you get to go to a retinal specialist who'll be able to detect the lesions on your retina in time to treat them. If you have Kaposi's, you can go to someone who knows something about it.

"Remember the man who committed suicide on the freeway?" asks Swann, referring to Daniel V. Jones, an HIV-positive man who, after an alleged dispute with his HMO, fatally shot himself on a Los Angeles overpass in April 1998. "I can understand his frustration. You have to fight them tooth and nail. With this, we're not going to have any more people commit suicide out of frustration."

Todd Summer

5 pages follow

202-456-2438



THE WHITE HOUSE

WASHINGTON

FACSIMILE / MEMO FROM

OFFICE OF PRESIDENTIAL LETTERS AND MESSAGES

OLD EXECUTIVE OFFICE BUILDING, ROOM 97

VOICE: (202) 456-5511 FAX: (202) 456-5426

To: Todd Summers

Date: 10/27/99

Fax #: x 62438

Pages: 2 (including this cover sheet)

From: Susana, PLM

Subject: Need clearance for Osborn letter

Comments:

My director has asked me to clear this A.S.A.P.

C. Dixon Osburn, Co-Executive Director
Michelle M. Benecke, Co-Executive Director
Servicemembers Legal Defense Network
P.O. Box 65301
Washington, D.C. 20035

Thank you for your recommendations. I know you feel strongly about this, and I want you to know that I am committed to continue working on it.

The brave men and women who serve to protect our nation and rise to the highest standards of military conduct, regardless of sexual orientation, have the right to do so. The U.S. will not tolerate misconduct on any level by military service members. As a nation, we have fought hatred and dehumanization abroad, such as in the ethnic cleansing of Kosovo, but we must also work to conquer these challenges at home. The situation that we are faced with is about respect for humanity and individual rights. Since I have been President, I have sought to eliminate the barriers that divide us and to encourage others to recognize our common humanity.

Recently, we announced new guidelines that will require troops in the military to receive anti-harassment training at every level of service throughout their careers. These guidelines also require that inquiries into the sexual orientation of soldiers be handled at senior levels of the military justice system by well-trained investigators. Also, we recently made some overdue changes to the Manual for Courts-Martial.

As we continue our work on this important issue, I appreciate your involvement.

Servicemembers Legal Defense Network

★★★★★

'99 JUL 26 PM 8:08

FAX COVER SHEET

TO: **Richard Socarides**
Sean Maloney
John Podesta
Karen Tramantano

At: **The Whitehouse**

FAX: **456-6682**
456-2215
456-1907
456-2030

FROM: Michelle Benecke

To report any problems with this transmission, please call Josie at 202.328.3244.

DATE: July 26, 1999

PAGES (including cover): 3

COMMENTS:

C.I.D

☑ **Faxed** 7/26
Initial and Date

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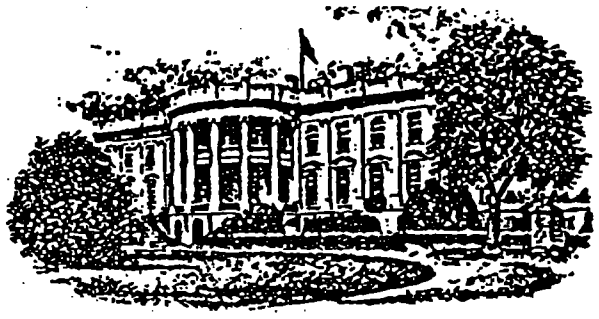
P.O. Box 65301 ★ Washington, D.C. 20035-5301 ★ 202.328.3244 ★ 202.797.1635 fax ★ sldn@sldn.org ★ http://www.sldn.org/



THE WHITE HOUSE

WASHINGTON

FACSIMILE / MEMO FROM

OFFICE OF PRESIDENTIAL LETTERS AND MESSAGES

OLD EXECUTIVE OFFICE BUILDING, ROOM 97

VOICE: (202) 456-5511 FAX: (202) 456-5426

TO: Todd Summers

FAX #: X 62438

FROM: Susana, PLM

SUBJECT: Osburn letter

DATE: 10/27/99

PAGES: 2 (INCLUDING THIS COVER SHEET)

COMMENTS:

This is the incoming letter in regards to the outgoing letter I sent before. Please clear.

Thanx.

MICHELLE BENECKE

Servicemembers Legal Defense Network

★ ★ ★ ★ ★

DAN — 10/26 DID THIS GET A POTUS RESPONSE?

July 26, 1999

President William Jefferson Clinton
The White House
1600 Pennsylvania Ave., NW
Washington, D.C.

SVA

CC: Julian Potter FYI

Dear President Clinton:

Six years ago, on July 19, 1993, you announced the "Don't Ask, Don't Tell, Don't Pursue" policy. You promised to end anti-gay harassment, asking and pursuits, and to respect service members' privacy. These promises have not been fulfilled. We write to request your personal intervention to fulfill them now.

Lesbian, gay and bisexual service members across the military endure a pervasive anti-gay climate every day. The incidence of anti-gay harassment in the military is alarming. In March 1999, we published *Conduct Unbecoming: The Fifth Annual Report on 'Don't Ask, Don't Tell, Don't Pursue.*" We documented a 120% increase in reports of anti-gay harassment. These reports included verbal gay-bashing and death threats.

Recently, PFC Barry Winchell, a twenty-one-year-old soldier at Fort Campbell, Kentucky, was allegedly bludgeoned to death with a baseball bat by other soldiers in his barracks. Serious concerns have been raised that this alleged murder may have been an anti-gay hate crime, and these concerns deserve a proper and fair investigation. Regardless of whether this is ultimately determined to be a hate crime, it has greatly exacerbated the existing fear among soldiers at Ft. Campbell and elsewhere that they might be the next victims of an attack

Service members have no real recourse when harassed. Service members cannot safely report harassment to their commanders without triggering speculation and possible investigations into their private lives. Service members cannot even seek help from their best friends, psychologists or parents because the military is kicking out service members who confide their orientation in these private settings, contrary to the intent of this policy.

As early as SLDN's first annual report on "Don't Ask, Don't Tell, Don't Pursue," published in February 1995, we warned, "It is reasonably foreseeable that if the Department of Defense does not take corrective actions now, deaths of actual and perceived homosexual service members, like slain sailor Allen Schindler, will occur."

SLDN has attempted to obtain guidance against anti-gay harassment and hate crimes from your Administration for nearly six years.

In March 1997, then Undersecretary of Defense for Personnel and Readiness Edwin Dorn issued a policy called *Guidance For Investigating Threats Against Service Members Based on Alleged Homosexuality.* According to the guidance itself, it was intended to permit "service members [to] report crimes free from fear of harm, reprisal, or inappropriate or inadequate governmental response." The services, however, never distributed the guidance to the field, as SLDN documented in two subsequent annual reports. This fact was acknowledged by the Pentagon

P.O. Box 65301, Washington, DC 20035 • 202.328.3244 • 202.797.1635 fax • sldn@sldn.org • http://www.sldn.org

in its April 1998 *Review of the Effectiveness of the Application and Enforcement of the Department's Policy on Homosexual Conduct in the Military*. To this day, the Pentagon has failed to distribute the guidance on anti-gay harassment to the field, despite repeated assurances to SLDN as recently as January and March 1999 that it would be forthcoming within weeks.

In May 1997, the Joint Services Committee on Military Justice proposed that the *Manual for Courts-Martial* be amended to allow sentence enhancement in anti-gay hate crimes. SLDN submitted public comments urging the swift adoption of the proposed amendment. The Department of Defense submitted the proposal to the White House as a proposed Executive Order. The proposed Executive Order has yet to be signed.

In November 1997, SLDN raised the issue of anti-gay harassment and hate crimes in the military to Attorney General Janet Reno at the White House Conference on Hate Crimes, and subsequently raised the same concern in a letter to you in December 1997.

We have repeatedly expressed concern -- to you, Pentagon officials and others -- that service members cannot safely report anti-gay hate crimes and harassment.

Likewise, we have repeatedly expressed concern that commanders in the field do not know the limits to investigations generally, nor have they been told the intent of this policy to respect service members' privacy. We have even gone so far as to extract the general limits to investigations from the lengthy – more than 100 pages – Department of Defense directives and organize them into a two-page memorandum that could easily be distributed to the field. Yet, each year, military leaders have refused to send such guidance to their subordinates. Meanwhile, in each of the last five years, SLDN has documented significant increases in command violations of "Don't Ask" and "Don't Pursue." No one has been held accountable for these violations.

It is time for your Administration to take action. We ask that you:

- ensure that the guidance on anti-gay harassment is sent to the field and that proper training is done to stem the increasing tide of anti-gay harassment in the military;
- sign the Executive Order amending the *Manual For Courts-Martial* to provide for sentence enhancement in anti-gay hate crimes;
- inform all service members of the limits to investigations and the intent of this policy to respect service members' privacy; and
- protect the privacy of conversations with health care providers – these should not be a basis for discharge under "Don't Ask, Don't Tell, Don't Pursue."

Finally, Mr. President, we ask that you personally inform Secretary Cohen and the Joint Chiefs that you will not tolerate violence or harassment against any service member for any reason.

Sincerely,

C. Dixon Osburn
Co-Executive Director

Michelle M. Benecke
Co-Executive Director

Office of the Vice President

TIPPER GORE'S OFFICE

Old Executive Office Building
Washington, DC 20501
(202) ~~456-6640~~ 6-5585

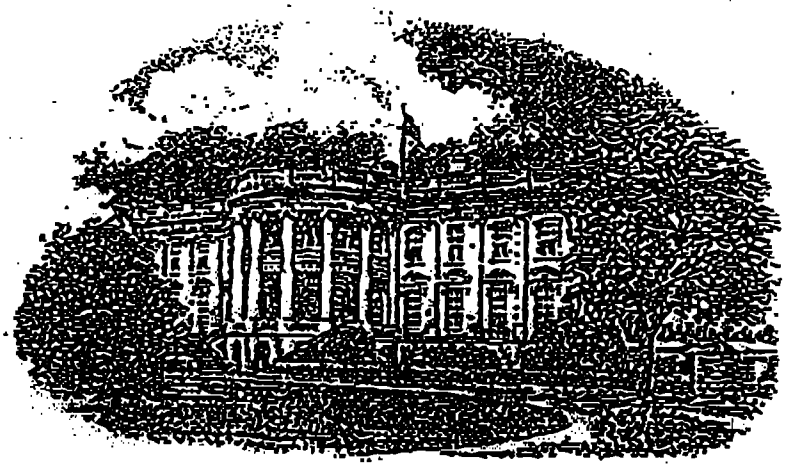
TO: Todd Summers 6-2438

FROM: Sarah Bianchi / Elizabeth

DATE: 10-05-99

number of pages: 6

COMMENTS: Thanks for your help!



SCHEDULING ROUTING SLIP 0 2 L Q

David Slade Routed on: 10/4 **Return to Room 283** by CoB: ASAP

☐ Eli Attie, 566	☐ Philip Dufour, 200	☐ Jim Kohlenberger, 284	☐ Trooper Sanders, 205
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		☐ Tom Rosshirt, 298	

SCHEDULING REQUEST:
Inviting Organization and Event: Kids AIDS Project

Date: 12/1/99 Location: New York, NY

Please weigh this request against the following information provided by scheduling:

Based on these facts, scheduling recommends:
If we do not receive conflicting opinions from routing, that action will be taken.

Please make your recommendation below:

☐ **The Vice President should attend this event or meet with this person or group.**
Priority: ☐A ☐B ☐C
Reasons for supporting request:

☐ **The Vice President should not attend this event or meet with this person or group.**
- ☐ Please send a standard regret letter from Lisa Berg
- ☐ Please send a regret letter from the Vice President
- ☐ In addition to standard regret, please send to correspondence for a VP letter to be read at the event.
- ☐ Please regret his attendance and send to communications for video considerations
- ☐ Our office will regret due to relationship with inviting organization

☐ **The Vice President should not attend this event or meet with this person or group, but someone from our office will.**
Please regret and refer the inviting organization to _____ at ext. _____

☐ **No Opinion**

Todd

THE KIDS AIDS PROJECT

In Collaboration with Alianza Dominicana Inc.
C/o Julia Mejia 676 Riverside Dr. Suite 3AA, New York, New York 10031
Phone/Fax (212) 283-6237 E-mail Jmejia333@aol.com

Fax Memo:

To: David Salde

From: Julia Mejia & Stefany Pena

Date: October 1, 1999

Re: The KIDS AIDS PROJECT

Memo:

David, we really hope that Vice President Al Gore can find some time in his schedule to make an appearance at this event.

Thanks!

THE KIDS AIDS PROJECT

In Collaboration with Alianza Dominicana Inc.
C/o Julia Mejia 676 Riverside Dr. Suite 3AA, New York, New York 10031
Phone/Fax (212) 283-6237 E-mail Jmejia333@AoL.com

Dear Vice President Al Gore,

It's been a while since we last heard from you and your office. But I hope that you have not forgotten me. Stefany Pena, The sixteen year old girl from New York who is working on the KIDS AIDS PROJECT, or in your words "Stefany you are a remarkable young woman and your determination to help others and ability to articulate the issues involved will have a lasting impact". I hope that I did indeed have a lasting impact on you. Because I hope that you are truly determined to help me in the fight against AIDS.

We are writing a play about AIDS and the different issues that put teenagers at risk for World AIDS day. After the play we are having a benefit for our project and I hope you can make it. The time and details really depend on if you can make it. However, the Director of the project says we could have it at Joe's Pub, a really nice place in downtown. Our guest list is very diverse, we have professionals, lawyers, artist and even politicians and I know that if you were the keynote speaker we can raise more money for my project.

People probably wonder why is this teenager so concerned about her work around AIDS. I am going to explain to you why. Imagine yourself (God forbid) having AIDS. Waking up every morning knowing that you may soon die in one of the most horrible ways in the world. Picture yourself losing 100 pounds in one week and gaining 200 pounds the next. Picture your loved ones seeing you go through this. Imagine being a minority having AIDS and knowing that people with money have survived this disease and you not having enough to buy the medication. Picture yourself looking at your children and wife knowing that they will be living without you soon. Who is going to take care of them?

I know that you are a very busy man. But you did say that you were going to help me with this project. The media, our community, as well as the KIDS AIDS PROJECT will love to see you there. I really would love to know when and how you are going to help me. If not I would like to know in order to have someone who will in fact help me make a change. Together we can make a change!!!!!!!!! We have to let the world see that you really care about children affected by AIDS. That's why I am reaching out to you again. I hope that you will host the World AIDS day benefit for the KIDS AIDS PROJECT on Wednesday December 1, 1999.

I was featured in the July issue of Redbook Magazine, highlighted in a PBS documentary, I have a feature article coming out in December in Latin Girl, and the Daily News asked me to be the youth editor for their World AIDS day layout. I was also on UPN 9 for a focus group that the Director facilitates about issues teens face and on Univision, the major Latino network about my efforts to raise money and awareness for children affected by AIDS. I mentioned how you are helping me raise awareness.

Please contact Julia Mejia, the Project Director at (212) 283-6237. I really hope that you can at least come if only for an hour or even 20 minutes. We hope to hear from you soon.

Sincerely,
Stefany Peña ♡
Stefany Pena

OFFICE OF THE VICE PRESIDENT
WASHINGTON

July 7, 1998

Stefany Pena (C/O Jennifer Havens)
Babies Hospital, Columbia Presbyterian
Room 619 N
622 West 168 Street
New York, NY 10032

Dear Stefany:

We are deeply moved by your wonderful presentation at the Family Re-Union Conference. Your courage and desire to help others in your situation are an inspiration.

As you know, we announced at the conference that Tipper will help lead a new initiative focusing attention on the needs of children who are affected by serious illness in their families. We are especially concerned about children and families who are living with AIDS, cancer, depression and multiple sclerosis.

We are very supportive of your plan for a "Kids AIDS Walk", and would like to help make it a reality. Please keep us posted as your plans progress. Although it is impossible to predict our schedules at this early date, we would like to be able to attend the walk.

Stefany, you are a remarkable young woman and your determination to help others and ability to articulate the issues involved will have a lasting impact. We are so proud to know you.

With admiration and affection,

Al Gore

Tipper Gore

Tipper Gore, Stefany Penn, Vice President Al Gore

6/21/99

amfAR
AIDS RESEARCH

American Foundation for AIDS Research
public policy office
1828 L Street, N.W., Suite 802
Washington, D.C. 20036
ph: 202 331-8600
fax: 202 331-8606

FACSIMILE COVER SHEET

DATE: 10/7

TO: Todd

FROM: Jane Silver

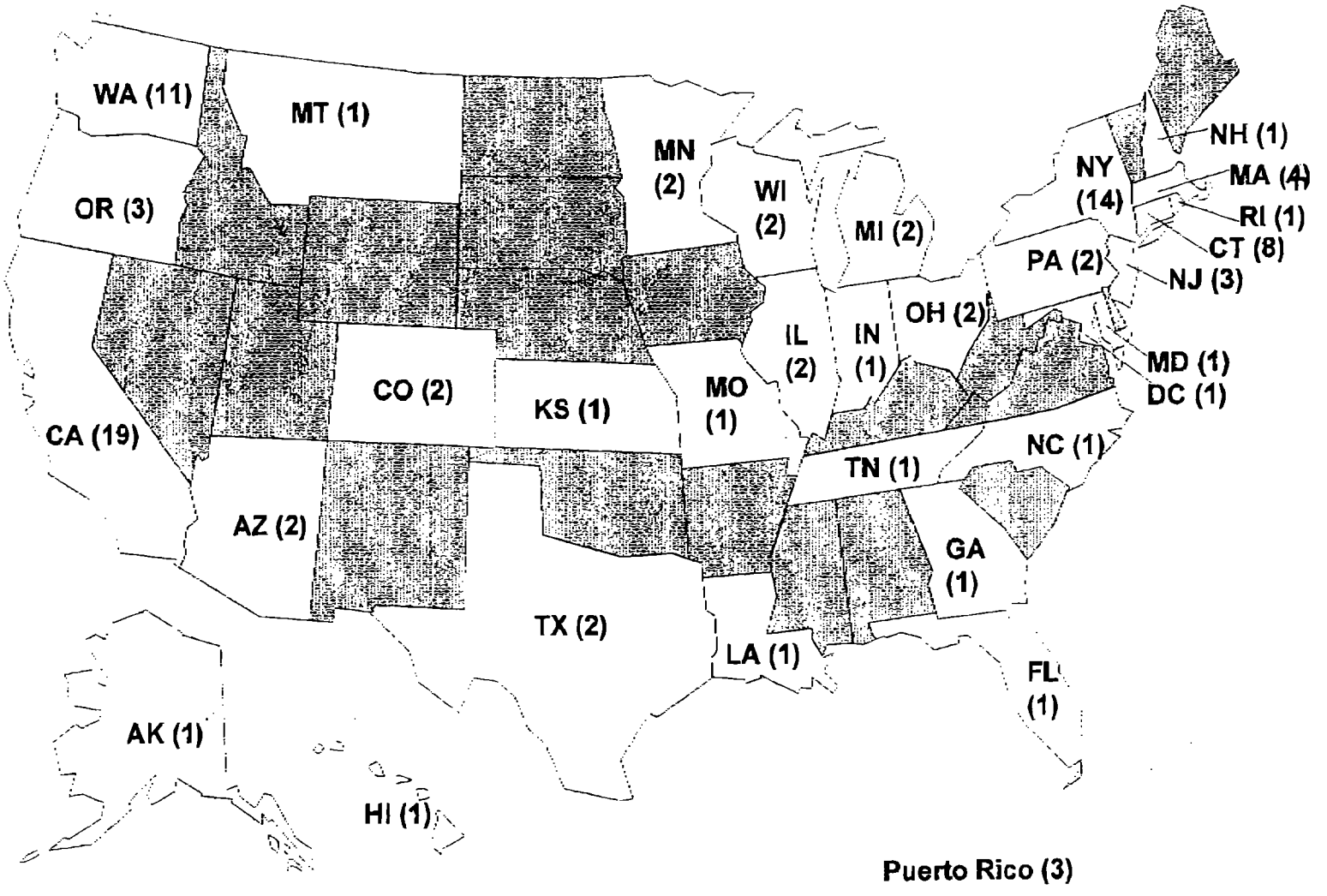
Total # of Pages:
(Includes Cover) 1

Message:

HARRY SIMPSON (313) 872-2424 Michigan
Community Health Awareness Group

Robert Greenwald (617) 437-6200
AIDS Action Committee Boston

Update: Syringe Exchange Programs - United States 1997



SOURCE: Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, August 14, 1998; Represents Syringe Exchange Programs Participating in Beth Israel Medical Center Survey.

Needle Exchange Programs in Wisconsin, Michigan and Illinois

Wisconsin

There are currently three needle exchange programs in Milwaukee, Racine and Madison. They would like to add on Green Bay and Beloit this year. The programs began in March 1994 and are operated by the AIDS Resource Center. Needles and syringes are excluded in the paraphernalia law.

Funding: about $268,000
$50,000 Milwaukee funding (don't purchase needles only wrap around services) plus private funds and Wisconsin AIDS Walk and Milwaukee AIDS Foundation

AIDS Resource Center has a lot of federal dollars
At the county level, the city council voted against by one vote - the county executive had the money in the budget

Michigan - Lifepoint

Funding: $87,000 Michigan AIDS Fund
20,000 Tides
Program has Title I funding for transportation and a jail advocacy program

CHAG has $1,150,000 budget, only $150,000 private (about $650,000 Ryan White funds and about $320,000 state CDC cooperative agreement funds).

Community Health Awareness Group, the largest minority AIDS service organization in Michigan, operates Lifepoint. The program is within an AIDS service organization and provides street outreach, counseling and testing services (orasure tests about 1600 people/year), case management.

The needle exchange program was started on December 1, 1996 through the city health department. They received an exemption from the city paraphernalia ordinance. There are about 1,000 registered participants (participant has to be registered with a unique identification number similar to Baltimore program). The program is a one for one exchange and has exchanged about 160,000 syringes. 85% of participants are African American, 20% referrals for drug treatment, 21% counseling and testing services.

Illinois

Needle exchange programs operate legally through a loophole in the hypodermic syringe act which prohibits except in a variety of situations including research. The programs are linked to a research institution and the participants are given an ID card. The police have been informed that participants are part of a research project – haven't had community problems.

Funding:
Chicago Recovery Alliance and Rockford Illinois - - both receive a combination of state, local, private and county money. The state doesn't pay for purchase of needles, but supports a lot of wrap around services (ie. CRA state funds counselors for referrals to drug treatment)

Massachusetts
Four programs: Boston, Cambridge, North Hampton and Provincetown

There is a state law authorizing up to ten needles statewide that was passed in 1993. There is currently a bill in the state legislature on syringe deregulation (House bill 4358). All receive some public funding.

LEADING U.S. ORGANIZATIONS SPEAK OUT IN FAVOR OF INCREASED ACCESS TO CLEAN NEEDLES AND SYRINGES TO PREVENT BLOOD-BORNE DISEASES

The following organizations have all made affirmative statements through official positions, statements, reports, or correspondence in support of increasing legal access to sterile needles and syringes to prevent transmission of blood-borne diseases. The text of each organization's position is attached.

- American Medical Association
- American Academy of Pediatrics
- American Bar Association
- American Foundation for AIDS Research
- American Nurses Association
- American Pharmaceutical Association
- American Public Health Association
- Association of State and Territorial Health Officials
- Council of State and Territorial Epidemiologists
- National Alliance of State and Territorial AIDS Directors
- National Association of County & City Health Officials
- National Black Caucus of State Legislators
- National Black Police Association

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AIDS RESEARCH

THE DO'S AND DON'TS OF NEEDLE EXCHANGE PROGRAMS

Needle Exchange Programs:

➢DO Reduce HIV and Other Blood-borne Infections and DON'T Increase Drug Use

Scientific studies show that needle exchange programs lower the rate of new HIV infections among injection drug users by as much as two-thirds and don't increase drug use. At the request of Congress, the U.S. Secretary of Health and Human Services reviewed the research on needle exchange programs and determined that there is conclusive scientific evidence that needle exchange programs are effective in preventing the spread of HIV and do not encourage use of illegal drugs.

➢DO Help Drug Users Access Drug Treatment

A recent national survey found that more than 90% of needle exchange programs refer clients for substance abuse treatment. Participation in needle exchange programs makes injection drug users more likely to enter a drug treatment program. In fact, research shows rates of entry into drug treatment two and three times higher for needle exchange participants.

➢DO Help Prevent Transmission of HIV to Newborns

Needle exchange programs help prevent the spread of HIV among injection drug users who are also a bridge to other individuals, including their sexual partners and newborn children. In fact, over 50% of all AIDS cases in children are the result of injection drug use by one or both parents.

➢DON'T Lead to Increased Crime

A new study released this spring reviewed crime rates in the areas surrounding needle exchange sites and found that changes in overall crime levels were no different in needle exchange areas compared to other areas in the city. The study found no significant increases in the number of overall arrests in needle exchange areas and a decrease in break-ins and burglaries.

➢DON'T Encourage Adolescent Drug Use

Scientific evidence dispels the myth that needle exchange programs pull young people into drug use. To the contrary, research has shown an increase in the mean age of injection drug users in a community with needle exchange programs. A new study examining the attitudes of young people found the greatest impact on their drug-using behavior was the actions of their peers and parents. The youth reported that seeing a person at a needle exchange program would have significantly less impact on drug-using behavior.

DO LET THE SCIENCE DECIDE

PLACE PUBLIC HEALTH OVER POLITICS

NATIONAL ORGANIZATIONS RESPONDING TO AIDS

SAVING LIVES THROUGH SYRINGE AVAILABILITY

An estimated 1 to 2 million Americans inject illegal drugs and the sharing of needles among injecting-drug users (IDUs) is a leading cause of HIV transmission. Through June 1996, approximately one-third of all reported adult AIDS cases were directly or indirectly related to injecting-drug use. In addition, more than half of all children with AIDS contracted the disease from mothers who were IDUs or the sexual partners of IDUs.

The scarcity of clean syringes is the result of federal, state and local laws restricting the sale, distribution and possession of syringes. Lowering the rate of injection-related HIV infections requires increasing the availability of drug treatment and increasing access to clean needles through changes in federal, state, and local laws and broad implementation of needle exchange programs.

Barriers to Clean Syringes

STATE AND LOCAL LAWS

Most paraphernalia and prescription laws, adopted to combat illicit drug use, were mostly enacted prior to the HIV/AIDS epidemic. Forty-seven states and two territories have laws that criminalize the sale or distribution of needles and syringes used to inject controlled substances. Eight states and the District of Columbia require a prescription for the purchase of a syringe. Research suggests that legal impediments to syringe possession encourage high-risk behavior while doing little to reduce drug use.

THE FEDERAL FUNDING BAN

Since 1988, Congress has enacted bans on the federal funding of needle exchange programs. The most recent federal ban is included in the FY 1998 Appropriations Act. The ban prohibited the use of federal funds for needle exchange programs until March 31, 1998. After that date, needle exchange programs may be funded if (1) the Secretary of Health and Human Services determines that exchange programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs and (2) the programs are operated in accordance with criteria established by the Secretary.

On April 20, 1998, Secretary Shalala determined that there is conclusive scientific evidence that needle exchange programs are effective in preventing the spread of HIV and do not encourage use of illegal drugs. However, the Administration continues to prohibit the use of federal funds for needle exchange programs.

The significance of the federal ban extends beyond prohibiting direct expenditure of federal funds. State public health officials and needle exchange program administrators claim that the ban has had a chilling effect on state government funding, making states less inclined to fund these programs.

Needle Exchange Programs in the U.S.

Needle exchange programs exchange sterile needles or syringes for used ones to prevent the sharing of injection equipment and the accompanying risk of transmission of HIV or other blood-borne diseases. The programs dispose safely of the used needles and offer a variety of related services to participants, including referrals to drug treatment and HIV counseling and testing.

More than 100 exchange programs operate in more than 40 U.S. cities in 28 states. In 1994, approximately 8 million needles/ syringes were exchanged through these programs. Programs operate under a variety of legal and tolerated mechanisms, including exceptions to state statutes, such as health department waivers or local states of emergency.

Needle Exchanges:

➤REDUCE HIV INFECTIONS
Several major scientific studies have shown that needle exchange programs lower the rate of new HIV infections among injection drug users. One recent study showed a two-thirds decrease in HIV infections among participants in five New York City needle exchanges. In addition, exchanges have shown to reduce significantly the rates of hepatitis B and C among participants.

➤DO NOT LEAD TO MORE DRUG USE
There is no evidence that needle exchange programs lead to increased drug use by exchange clients or in the wider community. In fact, exchanges have been effective links to drug treatment programs.

➤ARE COST EFFECTIVE
One model estimates that over five years, needle exchange programs could prevent HIV infections among clients and their sexual partners and children at a cost of about $9,400 per infection prevented. That compares to the more than $100,000 lifetime cost of treating a person with AIDS.

➤SAYS WHO?
Numerous respected organizations have reviewed the research on needle exchange programs and come to the conclusion that needle exchanges are effective. Organizations that have reviewed the science include the:

- ➤Congressional Office of Technology Assessment
- ➤National Academy of Sciences
- ➤National Commission on AIDS
- ➤National Institutes of Health
- ➤University of California, San Francisco in a study for the U.S. Centers for Disease Control and Prevention
- ➤U.S. General Accounting Office

The Tragic Cost of Not Acting

According to a June 1996 study, the number of HIV infections that could have been prevented between 1987 and 1995 in the U.S. had needle exchange programs been established is between 4,400 and 9,700. In addition, up to half a billion dollars in health care expenditures could have been avoided. The study also found that an additional 11,300 cases among IDUs, their sexual partners and children could be prevented by access to needle exchange programs through the year 2000.

Success in Connecticut

The Connecticut state legislature partially repealed the state's prescription and paraphernalia requirements in 1992. Prior to enactment, 74 percent of injecting-drug users obtained syringes on the street; following enactment, 78 percent obtained syringes through pharmacies. According to the Connecticut Department of Public Health, needle sharing among IDUs fell from 52 to 32 percent following the 1992 repeal.

Americans Support Needle Exchange

In December 1997, the Kaiser Survey on Americans and AIDS/HIV found that a majority of Americans, 61% of respondents, "think current law should be changed to allow state and local governments to decide for themselves whether federal funds should be used for needle exchange."

After reviewing the facts, numerous leading professional organizations have voiced their support for needle exchange as an important HIV prevention strategy. They include the:

- ➤American Academy of Pediatrics
- ➤American Medical Association
- ➤American Nurses Association
- ➤American Public Health Association
- ➤Association of State and Territorial Health Officials
- ➤National Black Caucus of State Legislators.

Talking Points in Opposition to Legislation that permanently bans the direct and indirect federal funding for needle exchange programs:

- The Federal Centers for Disease Control and Prevention reports that there has been no measurable decrease in the rate in new HIV infections, over half of which are directly or indirectly related to intravenous drug use.

- In April,1998, Secretary Shalala and nine top federal scientists, including the Surgeon General and the Directors of the NIH, NIH, CDC and SAMHSA announced that there is unequivocal support from the scientific literature that needle exchange programs reduce HIV infection and do not contribute to illegal drug use.

- Six additional government reports have reviewed the research and determined needle exchange programs are effective, including the National Commission on AIDS, the U.S. General Accounting Office, the Office of Technology Assessment, the University of California San Francisco/Centers for Disease Control and Prevention, the National Institutes of Health, and the National Academy of Sciences.

- After reviewing the facts, numerous respected and leading professional organizations have voiced their support for needle exchange including the American Medical Association, the American Nurses Association, the American Academy of Pediatrics, the American Public Health Association, the Association of State and Territorial Health Officials and the National Association of County Health Officials.

- Legislation to permanently ban federal funding for needle exchange programs is unnecessary and redundant given the existing, clear prohibition on federal funding in the Labor/Health and Human Services Appropriation bill.

← IF SECOND DEGREE SAYS PERMANENT

- The proposed legislation ~~(S5, S227, S899 and HR 982)~~ threatens high quality, local programs that are connected to comprehensive care, and could have a devastating impact on state and local communities working to create comprehensive prevention programs which might include needle exchange. Although President Clinton did not lift the federal funding ban last year, he agreed that states and local communities must be allowed to implement needle exchange programs if they so choose.

← ADDRESSES DIRECT & INDIRECT

- Last year, Congress imposed legislation on the District of Columbia which prohibits the District from funding needle exchange programs and prohibts all federal funding for any organization that operates a needle exchange program. This has had a dramatic impact on the District's needle exchange program and its ability to prevent HIV transmission.

- Additional federal legislation prohibiting state and local communities from funding needle exchange programs would only serve to further politicize an issue that should appropriately be addressed by scientists and state and local public health officials.

- Legislation banning federal funding for needle exchange programs does nothing to respond to the AIDS epidemic which continues to disproportionately strike young people, woman and communities of color.

- Instead of legislating a ban on federal funding for needle exchange programs - already prohibited by the Clinton Administration and Congress - Congress should be taking affirmative and bold actions to reduce the numbers of new HIV infections. These actions should include increasing HIV prevention funding, substance abuse prevention and treatment funding, and expanding the options communities have to address their growing infection rates.

- Political pandering about HIV prevention policy in the face of the epidemic that has directly affected the lives of over one million Americans is offensive.

- Regardless of your individual beliefs about the appropriateness of federal funding for needle exchange, we encourage you to resist affirming a vote that has everything to do with politics and nothing to do with public health.

- Oppose all efforts to permanently ban the direct or indirect use of federal funds to support needle exchange programs and support placing this issue in the purview of the nation's public health officials.

- A no vote on these bills does NOT mean the federal government would fund needle exchange programs. It would still take an act of Congress to eliminate the current ban in the Labor/HHS appropriations bill.

CDC National Prevention Information Network

A Service of the National Center for HIV, STD, and TB Prevention

Operators of the CDC National AIDS Clearinghouse

P.O. Box 6003

Rockville, Maryland 20849-6003

Phone: (800) 458-5231 TTY: (800) 243-7012 Fax: (888) 282-7681 International: (301) 562-1050

CDC Broadcast Fax Cover Page

Date: 10/19/99

To: TODD SUMMERS

Fax Number: 2024562438

Subject: Satellite Broadcast

Pages: 3 (Including Cover)

Organization: WHITEHOUSE OFFICE OF NATL AIDS POLICY

Phone Number: 202 4562437

MAY CONTAIN TIME SENSITIVE INFORMATION

Please deliver to the intended recipient immediately! This fax may contain time sensitive information.

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

HIV Prevention With Faith Communities and Communities of Color

Public Health Training Network

~A Public Health Training Network Satellite Broadcast~
November 18, 1999, 1:00–3:00 PM ET

This broadcast presents a public health update on activities and resources for HIV prevention with faith communities and communities of color. Viewers will hear from government and non-government spokespersons from throughout the country. Programs in action will also be featured through interviews and tours with staff, clients, and activities. Viewers are invited to fax questions and comments in before and during the broadcast.

Please distribute this fact sheet as soon as possible to colleagues and network partners. Encourage them to begin setting up viewing sites and promoting attendance now.

Objectives

At the completion of the broadcast, participants will be able to

- Describe the impact of the epidemic on faith communities and communities of color.
- Demonstrate how local communities are responding.
- Identify partnerships and resources available to communities.

Target Audience

This broadcast is designed for organizations and individuals interested in conducting HIV prevention with faith communities and communities of color. This audience includes national and local faith-based institutions and organizations; community-based organizations; health departments; national and regional minority organizations; and HIV Prevention Community Planning Groups.

Broadcast Sponsors

CDC's National Center for HIV, STD, and TB Prevention in partnership with CDC's Public Health Practice Program Office and the Public Health Training Network.

Local Viewing Info May Be Added Below:

Welcome

- Reverend Edwin Sanders, Executive Director, First Response Center, Nashville and Member, CDC Advisory Committee on HIV and STD Prevention

Invited Panelists Include

- Qairo Ali, Coordinator, HIV Prevention Faith Initiative, Division of HIV/AIDS Prevention, CDC
- Reverend Yvette Flunder, MDiv, Senior Pastor, The City of Refuge and Executive Director, The Ark of Refuge, Inc., San Francisco
- JoAnn Kauffman, MPH, Public Policy Representative, National Native American AIDS Prevention Center, Oakland
- John Manzon-Santos, Executive Director, Asian and Pacific Islander Wellness Center, San Francisco
- Reverend Altagracia Perez, STM, Rector, Episcopal Church of St. Philip the Evangelist, Los Angeles, and Co-chair, Racial and Ethnic Populations Subcommittee, Presidential Advisory Council on HIV/AIDS
- Steven Walker, HIV Prevention Program Manager, Bureau of HIV-STD Prevention, Houston Department of Health and Human Services, Texas
- George Roberts, PhD, Special Assistant for Communities of Color, Division of HIV/AIDS Prevention, CDC

Materials Available after August 18

Broadcast Web Site:

http://www.cdcnpin.org/broadcast

Includes this fact sheet, on-line registration for persons coordinating viewing sites and a list of viewing sites updated daily beginning September 1 as sites register.

CDC Fax Information System: Call toll-free 888-CDC-FAXX or TDD 877-232-1010..

Enter a document number and return fax number.

Document 130031 - This Fact Sheet

Document 130030 - Registering a Viewing Site

Closed-Captioning

This broadcast is closed-captioned for the hearing-impaired. You may order a closed-caption video of the broadcast by contacting the National Prevention Information Network (NPIN) at 800-458-5231 or TTY at 800-243-7012.

Instructions for Viewers

Viewers do not need to register with CDC but are encouraged to contact a registered viewing site between ***September 1 and November 4*** to request seating. ***Beginning September 1,*** a list of registered viewing sites open to guests will be updated daily on the web site. Viewers without Internet access may call 800-458-5231 ***after September 1*** to identify a viewing site. After September 1, viewers seeking a viewing location are encouraged to periodically check the web site to determine if more sites have registered in their area; viewers without Internet access may call NPIN at 800-458-5231.

Setting Up A Viewing Site

Organizations are asked to set up their own viewing sites ***as soon as possible***. To do this, identify and reserve a viewing site with a steerable antenna that receives either C- or Ku-band satellites. Examples of such sites include schools, hospitals, community colleges, universities, county extension offices, and local chapters of the American Red Cross. A fax machine near the viewing room allows viewers to fax questions in.

To register a viewing site, **after August 18,** please visit the Broadcast Web Site or Fax Information System (Document Number 130031) or call 800-458-5231. Please register your site ***soon after August 18 and by November 4*** to be listed as a viewing site and to receive any handouts.

Encouraging Attendance

Once they reserve a viewing site, organizations are encouraged to invite colleagues from various local organizations to view this broadcast (see "Target Audience" on page 1).

Questions/Comments for Speakers

- Before November 18, fax to 404-639-0944
- During the broadcast, information will be provided on how to fax questions/comments for the panelists. We plan to take only faxes and no live calls during this broadcast.
- In the event we are unable to answer a question during the program, you may E-mail or fax your question or comment:
  - E-mail to hivmail@cdc.gov
  - Fax to 404-639-0944, Attn: Satellite Broadcast

Intermission During Broadcast

A 10-minute intermission is planned at approximately the midpoint of this broadcast.

Continuing Education Credit

Continuing Education Credits will not be offered for this broadcast.

Videotapes

Viewing sites are encouraged to record this broadcast as it airs and to share the videotape with colleagues; or you may obtain videotapes of CDC's satellite broadcasts on HIV prevention by calling toll-free 800-458-5231.

Satellite Technical Specifications

After November 1, we plan to add the satellite coordinates to the Broadcast Web Site and Fax Information System (Document 130031). We are often unable to obtain coordinates earlier than 20-30 days before broadcasts. Thank you for your patience.

Satellite Signal Tests

Same technical specifications as the broadcast.

- Wednesday, November 17 (12:30 - 1:30 p.m. ET)
- Thursday, November 18 (12:30 - 12:55 p.m. ET)

Technical Assistance

Technical assistance regarding the satellite transmission will be available ***only on November 17 and 18*** and by calling 800-728-8232 (or from Canada, 404-639-1289). Those telephone numbers also provide a recorded list of the C- and Ku-band coordinates about 20-30 days before the broadcast.

Questions About the Broadcast. . .

After August 18, please call toll-free 800- 458-5231 or TTY 800-243-7012.

Demand Housing
for Homeless People
Living with AIDS & HIV

Dear Todd.

All this happen as a part of Ron's Watch as the aids Policy coordinator He was part of the group that made the discussion to suppress the original NDRI report. There is a limit to what we allow to happen as we hold positions of responsibility We have to talk!—

Thanks
Keith

By the Ron's office opposed Local Law 49 and never supported it.
Their is a public Record of these things—
Please don't be fooled
KC

Housing Works, Inc.
594 Broadway
Suite 700
New York, NY 10012

Phone 212 966-0466
Fax 212 966-0869
www.housingworks.org
hworks@dti.net

JLB

National Development and Research Institutes Inc.

Report to H.O.P.W.A.
Post Graduate Center for Mental Health

Ethnographic Evaluation of SRO Harm Reduction Outreach of the Center for AIDS Outreach and Prevention

1997

Allen Feldman Ph D
Center for AIDS Outreach and Prevention

Ethnographic Evaluation
of SRO Harm Reduction Outreach
of the Center for AIDS Outreach and Prevention,
National Development and Research Institutes

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National Development and Research Institutes Inc.

Center for AIDS Outreach and Prevention

Ethnographic Evaluation of SRO Harm Reduction Outreach

Allen Feldman Ph.D.[1]
Project Ethnographer
National Development and Research Institutes Inc.

EXECUTIVE SUMMARY

A. Demonstration of Project Efficacy

Program Mission

In March 1996 the Center for AIDS Outreach and Prevention, National Development and Research Institutes, Inc. was awarded an HOPWA contract through the Post-Graduate Center for Mental Health to conduct a one year demonstration ethnographic evaluation/harm reduction intervention project with the mission to document (1) the factors preventing SRO residents from seeking alternative housing or drug treatment resources (2) why SROs are not used as transitional housing by DAS clients and (3) the efficacy of our harm reduction intervention in four SRO hotels populated in the main by DAS residents. (The Center ended up servicing five hotels.) The Center's experience with harm reduction outreach to SRO's hotels dates back to 1993; between 1993 and the present the Center has delivered harm reduction services to five SRO hotels

[1] With the assistance of Center Director, Bruce Stepherson MPH, the CIS team: Luis Del Rosario, Elleen Gil de la Madrid, Ariel Clavell, Montserrat Cabrerra, and Administrative Assistant Carol Tarzian.

under an OASAS contract prior to receiving the HOPWA demonstration grant. Thus the Center's street outreach teams and the Center's CIS[2] team specializing in SROs are currently servicing 10 SRO hotels in New York City.

The Center's strategy for SRO residents is grounded in harm reduction theory and practice. We define harm reduction as providing the program client with the materials, knowledge, tools, skills and motivation necessary to protect himself or herself against HIV infection, transmission and reinfection and against other harmful health conditions that result from substance misuse, high risk sexual practices and clandestine life styles. The most effective way of getting people to minimize the harmful effects of their high risk activity is to provide user-friendly services which attract substance misusers, sex workers and other "at-risk" populations and empower them to change their behavior towards realizable intermediate objectives. This means services that are accessible, confidential, informal, and client driven.

From May 1996 to the present the Center for AIDS Outreach and Prevention has mounted an SRO outreach program after conducting reconnaissance of eligible hotels, staff recruitment and training in the preceding two months. The outreach deploys five field workers (Community Intervention Specialist staff or CIS staff) and an ethnographer (medical anthropologist) to conduct and evaluate a low threshold intervention for active substance misusers, persons in recovery, persons-living-with-HIV/AIDS, persons with relapse issues and persons with no history of substance misuse. This intervention took place in the BZB and Carver

[2] Community Intervention Specialist (coined to distinguish this team from street outreach

hotels in the Bronx, the California Suites, Hayden and Kent Hotels in Manhattan. The CIS team combined scheduled room visiting and hallway walks within the hotels, and also conducted street outreach in key locations frequented by hotel residents in the immediate vicinity of their SROs.

Interventions).

FINDINGS

A: The Need for Harm Reduction Intervention and Harm Reduction Efficacy

(1) The SRO hotels worked by the demonstration project harbor an extremely active substance abusing population many of whom are not in-treatment; many of those who are in treatment are in violation of drug treatment abstinence and are thus in need of harm reduction interventions, materials and education as indicated by:

- The numbers of syringe cleaning (bleach) kits distributed;
- the number of drug treatment referrals provided between May 1996 and March 1997;
- ethnographic descriptions of drug and syringe markets operating inside hotels and descriptions of the existence of drug taking networks between hotel residents and surrounding communities;
- The self disclosure of substance abusing behavior by hotel residents, (see drug of preference statistics in hotel profile narratives).

(2) The SRO hotel population is highly sexually active and has developed commercial and non-commercial sexual networks with surrounding communities. Considering the HIV status of hotel residents, this situation requires intensive and ongoing harm reduction interventions as supported by:

- the number of condoms and dental dams distributed;
- ethnographic descriptions of extensive sex-work being conducted out of the hotels;

- the ethnographic description of the use of sex as a stress reduction method by hotel residents;
- the reservation of rooms dedicated to sex work by some hotel managers

(3) Harm reduction and resident advocacy interventions are required in SRO hotels because the informal economy (drug dealing, sex work and loan-sharking) in these hotels combines with the substance mis-use histories of many residents to create structural dependency which subverts the hotels' official function as transitional housing.

- Room regimes (manipulative and arbitrary room closing policies) inhibit SRO residents from seeking long-term drug and medical treatment and alternative housing;
- Debt dependency (loan sharking), and drug and commercial sex markets are interlocking forces that severely inhibit DAS clientele from seeking alternative housing.
- Structural dependency or hotel-addiction occurs when the administrative manipulation of room tenancy, the pervasive debtor economy (through loan sharking), drug markets and chemical dependency interlock into a system of behavioral/financial controls over the SRO tenant. Ethnographic research shows that these interlocking behavioral and financial controls serve to increase the health risk factors of SRO residents and also inhibit the resident from seeking long term drug and medical treatment assistance or alternative housing placement.

(4) Significant numbers of SRO residents do not maintain primary medical care relationships and thus require harm reduction intervention to broker their relationship with primary care service providers as indicated by:

- the number of referrals to primary medical care services;
- the number of contacts without M11 Q forms or with out of date M11 Q forms: out of 422 new contacts made between May 1996 and March 1997, 162 clients did not have M11Qs; 49 clients had out-of date M11Qs; 85 clients physically held up to date M11Qs; while 126 new contacts did not provide information about their M11Qs, due to the brevity of their contact with the CIS team, because of transfer out of the hotel, arrest, illness and death: at a minimum 211 contacts, 50% of all new contacts (and probably many more), did not have the documentation needed to consistently access primary medical care or alternative housing services.[3]

(5) Harm Reduction interventions, education and material met with a positive response from SRO residents; this positive reception was sustainable over time and leads to referrals to services as indicated by:

- The ratio of first resident contacts to room capacity of the impacted hotels;
- Repeated resident contact as measured in units of service delivered

[3] See pp. 95-96 for cases documenting the obstacles DAS clients find in obtaining copies of their M11Q forms from DAS and other service providers.

- The dramatic and rapid development of trust and confidence as evidenced by the provision of personal intake information by residents to project staff, the provision of documentation by residents to enable access of referral services, and provision of ethnographically relevant and highly sensitive data about illegal activities to the CIS staff and project ethnographer.
- The statistics of referrals requested, particularly during those months where a rise in the distribution numbers of harm reduction materials coincided with numerical increases in referrals requested.

(6) The harm reduction model of the demonstration project was capable of addressing diverse needs of SRO residents and in meeting unexpected needs uncovered in the course of field contact and ethnographic inquiry as supported by:

- The diversity of delivered workshop topics;
- the diversity of referrals requested;
- the distribution numbers of unscheduled harm reduction materials such as toilet paper and hygiene kits;
- the development of case management and resident advocacy practice;
- Delivery of workshops to SRO residents in required housing application and entitlement documentation and procurement of documents procedures.

(7) Significant numbers of residents exhibit serious nutritional deficits requiring harm reduction intervention and education as indicated by:

- number of food pantry and meal delivery referrals;
- number of nutrition workshops delivered;
- the close numerical ratio between nutrition referrals requested and nutritional services appointments kept by SRO residents.

(8) The introduction of social service and/or medicalized management of SRO hotels does not negate the need of independent harm reduction services as indicated by:

- the harm reduction materials distribution numbers for the BZB hotel between July 1996 and January 1997 while under Health Improvement Resources Enterprises Inc. administration;
- the drug treatment, housing, food pantry and medical referrals issued at the BZB hotel between July 1996 and January 1997.
- The requests by H.I.R.E. drug counselors at the BZB for technical assistance from CIS staff concerning their drug treatment resources.

(9) Harm Reduction Interventions can be a vehicle for guiding hotel residents to alternative housing as indicated by:

- requests for alternative housing by hotel residents
- housing placement effected by demonstration project (the discrepancy between these two figures can be accounted for by the bureaucratic obstacles and documentation problems that produce

long delays in action taken on housing placement by DAS and alternative housing providers).

(10) Ethnographic Evaluation combined with an ethnographically designed harm reduction intervention to residents of SRO hotels has

- proven to be a productive method for obtaining detailed assessments of actual living conditions, management practices and social service delivery in the hotels, and for diagnosing resistance to seeking alternative housing, drug treatment and medical treatment on the part of SRO residents.

(11) Has maintained and elevated program efficacy under changing field conditions as demonstrated by

- in-situ development of case management/ client advocacy components;
- the expansion of materials and services distributed to contacts;
- the continued delivery of needed services even when a social service management team takes over the administration of an SRO hotel.

(12) The following modifications on the existing program design are recommended.

- Expansion of the harm reduction intervention by building on the network of Bronx and Manhattan hotels currently being serviced, to include SRO hotels not currently serviced in Manhattan and the Bronx.

- Continuation of 5 day per week schedule (up from 4 days per week) that was introduced in January 1997. The shift from 80% to 100% time for CIS staff facilitated the expansion of intervention to a fifth hotel and the enhancement of client advocacy, record keeping, research documentation and case management components.
- Expansion of the SRO resident advocacy and escort component to facilitate more effective referrals to service providers.
- Expansion of food provision component.

Maintenance/ and or expansion of existing technological support introduced in response to encountered service delivery obstacles in the hotels. Such technological supports as company vehicle(s) for the transport of staff and supplies, and cellular phone(s) for facilitating rapid referral placement and client advocacy have vastly improved existing harm reduction services and will be required for the expansion of advocacy/escort service, the expansion of food provision services and the expansion of the network of SRO hotels to be serviced.

B. Wider Policy Issues and Recommendations: Creating Safe Space

(1) The structural dependency identified in the hotels is created and promoted by a variety of factors. Though it is true that residents bring into the hotel numerous behavioral deficits from drug and alcohol mis-use to cognitive and physical disabilities, a host of other forces, practices and persons are in place at the hotels ready and willing to exploit, amplify and enlarge these deficits and disabilities including:

- The creation and promotion of informal exploitative economies (loan-sharking, drug dealing and sex-work) by colluding hotel management and or employees and/or on-site HRA workers;
- The penetration of street based informal economies into the hotels which usually occurs with the permission of hotel managements and/or employees.
- The long bureaucratic delays in obtaining alternative housing which lead previously drug-free residents to either take up substance misuse or to relapse;
- Arbitrary and manipulative use of room closing policies and procedures;
- Sexual and gender exploitation through sex work economies and/ or domestic violence;
- Generic high stress levels due to high risk and/or unsanitary conditions in the hotels which cause residents' to negotiate living-in-hotels with self-medicating behavior.

- The lack of on-site, accessible in-house or outreach support systems providing culturally sensitized health, housing, nutritional, life-skills education and services

Based on this list the AOP- SRO Project can offer the following policy recommendations:

(2) From Safe Space to Transitional Housing: To reestablish the SRO hotels as transitional housing requires limiting the forces that produce structural dependency.

- This curtailment of corruption and informal economies would require the SRO's transformation into Safe Space. Safe Space is a harm reduction concept referring to an environment where people affected by HIV/AIDS are enabled to reduce their exposure to harmful activities and practices and empowered to develop customized strategies of health promotion on an individual and group basis. Harm reduction recognizes a spectrum of potential safe spaces ranging from shooting (drug-injecting) galleries (supplied with harm reduction materials) to drug treatment modalities. This report documents efforts by drug-free residents in the Kent Hotel and other hotels to create safe spaces for themselves through the enclosure of floor wings, entire floors, hallway kitchens and/or bathrooms. These attempts indicate the innate risk reduction desire of many hotel residents for a stabile environment in which their exposure to substance misuse, violence, thievery, intimidation, sex-work and unsanitary and substandard environmental conditions is significantly lowered.

- Hotel managements can introduce gradations of safe space characterized by different levels of harm reduction intervention. Just as harm reduction applied to individuals recognizes a range of risk reduction strategies, from syringe cleaning and syringe exchange to methadone maintenance and drug abstinence, hotels can be redesigned to contain a gradation of safe spaces characterized by different levels of risk reduction strategies: (1) selected floors could contain active substance misusers serviced by harm reduction peer educators, like the CIS team, centering on reducing health risks linked to drug ingestion and related high risk activities, and on the offer of treatment referrals; (2) other floors would be drug free spaces, perhaps divided between residents receiving methadone treatment and totally drug-free residents; (3) it would be crucial to avoid any stigmatization of particular floors or the creation of hierarchies between drug-active and drug-free floors or sectors. The different harm reduction sectors of a safe space reflect different life choices-- each with their own specific risk factors. The avoidance of stigma can be assured through the provision of an equitable range of services and service delivery to all sectors of the hotel safe space and through staff training. (4) In-coming and current residents would have choices as to which type of safe space they would live in, and hotel residents would be able to transfer in a structured, and safe manner from high risk to low risk space and back again, if necessary, without incurring any penalties.[4]

[4] In Harm reduction philosophy relapse back into drug use does not preclude the subject from receiving harm reduction services, materials and support appropriate to his/her new risk new

- A related issue is the living conditions of non-ambulatory and semi - ambulatory residents, a significant number of whom reside on the middle and upper floors of hotels which can severely inhibit their ability to access resources outside the hotel due to their limited physical mobility. This group needs to be relocated on the first floors of hotels where their mobility issues would be easier managed. Visiting Nurse and home-care services are now often adverse to visiting this class of resident because of the over-all high risk settings of the hotels. By placing residents with mobility problems and related severe health issues on the first floor, or the most easily accessible floors of the hotel, and in a structured safe space this group would be more readily accessed by visiting home-care and nutrition services.
- The stabilization of sectors of hotel space would also facilitate resident run floors and buddy systems between residents (modeled on AIDS care-giver buddy networks).
- The creation of stabilized safe space of varying degrees and intensities in the hotels would incrementally move residents away from day to day short term survival strategies and gradually shift them into recovery readiness and/or housing readiness postures where they would be empowered to choose drug treatment and/or to plan for alternative housing.
- Safe space policies and practices will require supplementation from independent harm reduction peer educator teams. Harm reduction

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factors. Relapse is not penalized, an action that could estrange the relapsed person from any future harm reduction intervention.

teams must maintain strict confidentiality for their contacts in order to win the trust of residents. Since such autonomous harm reduction teams are not meant to be involved in residential compliance, enforcement policies and related penalties like room closings, they can build a higher degree of confidentiality and trust with residents than hotel management– who will always be associated with enforcement in the minds of residents. Autonomous harm reduction/peer educator teams have a greater flexibility to access and interact with residents, and to lead to services (1) those residents that fall through the cracks of the official array of services offered by the professionally managed hotel or (2) those residents who are resistant to interventions initiated by hotel management.

(3) Hotel Management and Safe Space: It is both easy and convenient to blame the life styles, behavioral deficits and disabilities of DAS clients for the high risk conditions prevailing in many SROs. But this would only be a partial truth. As stated above hotel management and/or individual employees and/or on-site HRA staff operating separately, or in concert, significantly contribute to the unsafe conditions at the hotels and hotel dependency. The conversion of the hotels into Safe Space would require the ethical reform of hotel administrations.

- Creating Safe Space is not in the economic interest of colluding and corrupt managers, hotel staff and colluding on-site HRA staff. All administrative promotion of, or collusion with illegal loan-sharking, sex-work and drug dealing economies needs to be severely curtailed, if not completely eradicated. Ethical reform can only take place through more strenuous and concerted external and internal oversight of

management operations by independent agencies, and/or through the replacement of colluding management administrations and/or colluding staff.

- One obvious solution to corrupt managers and staff is their replacement by social service and medicalized professional hotel management teams subject to external oversight, monitoring and accountability. Such teams are currently being contracted by DAS to manage SROs. And though they can bring the benefits of on-site coordinated services, these teams can also replace one style of mismanagement with another. H.I.R.E.'s (Health Improvement Resource Enterprise Inc.) running of the BZB hotel in the Bronx is one such example that the CIS staff were able to document over time. Their police-like anti-drug policies and room searches did as much to escalate high risk drug ingestion as any management-run drug dealing operation.

- Safe Space is not a space of incarceration or a setting for invasive surveillance; to be effective and to lead to behavioral changes it needs to be experienced as a safe space by the residents, and not only by the management. This involves respect for, and sensitivity to, residents' privacy, civil liberties, and personal autonomy and sense-of-personal-territory. By creating a prison style environment (as H.I.R.E. attempted in the BZB hotel) managers simply import the dependency creating characteristics of penal incarceration into the SRO setting which does not further the use of these sites as <u>transitional</u> housing. Such prison-

style policies (discussed in the report) only served to estrange BZB residents from the new management and drove substance misuse and sex work further underground without making any in-roads towards their eradication. Hotel managers need to install reasonable security measures, hall patrols, the screening of outside visitors and viable mandated visiting hours. However these precautions can be instituted without violating residents' sense of privacy, their control over their personal space, and their reasonable access to outside support networks of friends and family. Security policies can be introduced in such a manner as not to raise the stress levels of residents, this would allow them to appreciate immediate benefits of hotel stabilization like the cessation of room break- ins, hallway violence, and improved of sanitary conditions.

- The introduction of new social service management teams cannot serve as a cast-iron guarantee against future managerial or staff collusion with drug-dealing, loan sharking, sex work economies and other forms of exploitation. Ethical reform of hotel administrations is a matter of creating on-going accountability and not a one-time event. Since existing policies and practices have proven woefully inadequate, new and innovative modes of monitoring are necessary. Since most ethical lapses by hotel managements involve the informal drug, sex-work and loan-shark economies, independent hotel monitors must be in place to access these informal economies in order to assess conditions at a hotel. This can only be done with the trust of hotel residents and with

relationships of full confidentiality. The Center's CIS harm reduction team were able to monitor in detail the harmful activities of both the private management of hotels like the Kent, and the city contracted social service management of the BZB. Such autonomous and ethnographically trained intervention teams not only provide needed health- and housing- related services but can be a crucial data collecting mechanism that can enable consistent oversight of hotel management, of the environmental conditions and of informal economies at the SRO hotel.

(4) Substance Misuse and the Safe Space:. Officially SRO hotels are bound by law to prohibit illegal substance use and drug sales, however the reality is that these practices will always occur in the hotels, given the particular histories of DAS clients, even when a significant number of DAS clients are in treatment.

- Aggressive managerial anti-drug policies of search and seizure can escalate residents' stress levels leading to more frequent drug ingestion, high risk drug ingestion and the expansion of residents' drug ingesting networks as they seek secure drug-taking spaces beyond a hotel management's scrutiny. Such policies also inhibit residents from accepting offers of harm reduction materials such as syringe-cleaning kits and sterile syringes (from needle exchanges) and from exploring drug treatment referral options, since these behaviors would visibly identify the resident as a substance mis-user. Thus, from a harm reduction and HIV prevention perspective, such policies dramatically escalate risk factors among the hotel population and the wider social

networks with whom they interact. Hotel administrators have the choice to drive substance misuse further underground or to render it less risky and perhaps to stabilize it through harm reduction interventions as described below and in the body of this report.

- This report shows that (1) consistent access to harm reduction support materials and relationships; (2) the building of relations of confidentiality by trained peer educators and (3) the increased availability, through harm reduction outreach, of low threshold drug detox and treatment services, can all serve to stabilize the substance misuse of many residents, decrease risky ingestion practices, and may lead users to referrals for drug treatment. Enlightened hotel management may officially condemn substance misuse while promoting the availability of low threshold harm reduction services by sponsoring independent outreach by appropriate outside agencies.
- At the same time, taking our cue from the drug-free minority at the Kent hotel, the new-style management can promote a spectrum of safe spaces within a hotel by creating drug-free wings and floors and offering residents an opportunity to transfer to these "safer" zones within the hotel.
- Perhaps the major impediment for hotel residents seeking drug detoxification and rehabilitation was the managerial and/or HRA practice of abrupt closing of rooms due to absences from the hotel by residents in drug treatment. Most residents select 28 day or shorter treatment programs to avoid having their rooms closed, yet many did have their rooms closed after 15 days. Fear of inappropriate and illegal

room closings caused many residents to interrupt drug treatment, to choose short-term and less effective treatment modalities, or to avoid seeking treatment altogether. In order to encourage residents to enter viable drug treatment programs they must feel that their personal belongings, post-treatment housing and their financial entitlements during and after treatment are secure.

(5) Gender and Safe Space: The issue of safety can be applied to gender relations, particularly to the sex work economy, and sexual and domestic violence in many of the hotels.

- Just as there can be drug-free zones in an hotel there can be gender-segregated floors and even entire hotels that are dedicated to one gender. To a certain degree gender segregation or gender safe spaces could lower the sexual exploitation and physical intimidation of female residents by male residents. Though such exploitative relationship can be replicated among women and men in same-sex situations as prison studies have shown.

- At the same time, couples are not always units of violence and exploitation they can be bonded units that empower the two parties to make positive changes in their lives. Right now live-in couple have an unofficial and illegal status in DAS hotels. The ways in which the constructive and empowering side of these relationships can be reinforced and developed should be explored by service providers.

C: Intervention Philosophy and Strategy

The SRO outreach and intervention program is user-friendly, encouraging self-directed risk reduction management and life-skills building by residents in diverse areas, such as HIV and AIDS, STD prevention, recovery readiness for drug treatment, relapse prevention, time and nutrition management. The SRO intervention is also a bilingual peer-directed harm reduction intervention: the outreach staff reflect the ethnic, cultural and substance abuse backgrounds of the target population (two members of the staff are former residents of SRO hotels). These peer educators deploy their own critical life experiences to promote and enhance risk reduction skills, activities, and willingness among SRO residents to enter drug and or alcohol treatment and relapse prevention programs. They also recruited volunteer in-situ peer educators from the population of each hotel who served as re-distributors of harm reduction materials, techniques and information.

CIS (Community Intervention Specialists) staff bring harm reduction and health education outreach to SRO residents in their everyday, and frequently, clandestine settings. The program practices a non-invasive intervention which gradually builds trust and cooperation with individual residents and the surrounding residential community. This strategy requires acute sensitivity to socio-cultural and personal boundaries and guarantees of full confidentiality and trust-building. CIS staff function as cultural brokers of health promotion messages, practices and strategies. They translate and tailor public health messages to fit indigenous ideas of risk perception and modes of harm infliction at work in the

hotel's drug taking and commercial sex networks, which interact with wider communities adjacent to the hotels and not only confined to the SROs.

D: Units of Service and Description of Service Provision

Through consistent and scheduled hallway walks and room visits in the SROs the Community Intervention Specialists (a.k.a. CIS staff):

- delivered risk reduction educational messages, materials, strategies, and skills building relating to HIV/AIDS, substance misuse, STDs, hepatitis B & C and TB;
- provided regular consistent verbal education-prevention interventions on HIV/AIDS and drug and or alcohol use/misuse using harm reduction philosophy in concert with the provision of risk reduction materials on every occasion in which they visited the hotels.
- provided referrals to a variety of public benefits and social service agencies, drug and alcohol treatment programs, medical, housing and HIV/AIDS related service providers;
- identified and supported resident volunteer peer educators in the SRO hotels and their peer socio-economic networks in order to disseminate harm reduction education messages and materials among substance misusers, sex workers, persons living with HIV/AIDS and other SRO residents.

Harm Reduction Materials> The outreach staff regularly distributed risk reduction materials which assisted DAS residents in lowering their risk for HIV reinfection and transmission to others. These materials originally included:

- kits which facilitate the cleaning of injection equipment;
- condoms (multiple variety) and other latex barrier protections;
- literature on topics which affect residents' everyday life including drug use/misuse; TB, HIV/AIDS, Hepatitis B&C, and treatments and services from other provider agencies.

Referrals> CIS staff developed a customized referral linkage network that enabled them to offer the following referrals services to SRO residents

- alternative housing, including supported residences, scattered site and independent housing;
- drug and alcohol detoxification and drug and alcohol treatment services;
- comprehensive AIDS treatment services;
- primary medical care services;
- food pantries, meal delivery services and soup kitchens;
- relapse prevention services;
- syringe exchange services.

The CIS staff also tracked all referrals requested by SRO residents to ascertain whether the

- the resident kept the appointment;

- the resident did not keep the appointment;
- CIS workers could not confirm whether the appointment was kept because the provider would not release the information to our program;
- CIS workers could not confirm whether the appointment was kept or not because we were unable to do so.

Workshops> The CIS staff conducted workshops with small groups of SRO residents in the following areas:

- safe syringe cleaning and injecting techniques;
- use of preventative latex barrier materials including Dental Dams;
- Life Skills, including time management, hygiene, stress reduction and nutritional planning;
- relapse prevention techniques;
- alternative housing opportunities and procedures for applying and securing alternative housing;
- consistent utilization of primary medical care services;
- updates on AIDS prevention and treatment issues.
- procurement of documentation related to entitlements.

All of the above units of services and staff/resident interactions were subjected to ongoing documentation by the CIS staff using customized contact data sheets that adapted HOPWA intake protocols to SRO field situations and through ethnographic participant-observation.

Supplements to Contracted Service Provision

In addition to the above units of service that had been built into the original design of the harm reduction intervention, other non-mandated services were provided on a consistent basis. The poor hygienic and nutritional conditions found at the hotels by the CIS staff necessitated the development of supplemental intervention techniques and materials that expanded the harm reduction scope of the intervention.

- toilet paper rolls (toilet paper is distributed in limited amounts once a week in some hotels by management and not at all in others);
- hygiene kits (consisting of soap, plastic comb toothpaste, toothbrush);
- intermittent food distribution (this was limited by lack of a vehicle);
- winter clothing distribution (this was limited by lack of a vehicle).

The CIS staff carried these materials on foot and by public transportation using the Center's store front offices in Hunts Point in the Bronx and Central Harlem in Manhattan as their base of operations, until a budget modification authorized the renting of a van in January 1997.

- **Case Management>** SRO residents exhibited multiple housing, health care and substance abuse needs and usually lacked knowledge, skills, appropriate documentation, physical and mental stamina to negotiate the appropriate bureaucracies and service providers whose assistance they needed. A case management approach was necessary to address the following conditions and situations:

(1) The CIS staff encountered numerous hotel residents who either lacked documentation, or lacked up-to- date documentation such as MIIQ forms and Medicaid cards, a deficit that hindered their capacity to access entitlements from primary medical care to alternative housing. The staff thus engaged in (1) educating hotel residents to their documentation needs, (2) in teaching procedures for acquiring such documentation, and (3) obtained such documentation on behalf of residents. This type of intervention, focusing on the management of appointments and documentation, requires sustained long term contact with residents and substantial office and telephone support work outside the hotel fieldsite by the CIS staff. A cellular phone was added to the outreach enabling CIS staff to do on-the-spot referrals to service providers and to facilitate on-the-spot intake interviews to ascertain resident eligibility and resident advocacy.

(2 DAS residents seeking alternative permanent housing face over-long delays in securing placement. CIS staff had to advocate for the resident with DAS, and real estate services. Such advocacy relationships needed to be sustained over a period of 2- 6 months due to delays in the housing placement system.

(3) Related to residents' lack of M11Q forms or updated M11Q forms was the under utilization of primary medical care and specialized AIDS treatment services by SRO hotel residents. The CIS staff monitored residents' medical and nutritional deficits, and in many instances had to perform crisis intervention to secure residents emergency medical

services. In selected cases CIS staff escorted endangered residents to appropriate medical care and drug treatment facilities.

- **Client advocacy>** CIS staff had to advocate with service providers for residents on the following issues and obstacles:

  (1) numerous SRO residents were unable to obtain copies of the M11Q forms from DAS workers, and/or methadone clinics in which they were enrolled. In order to obtain this documentation CIS staff had to advocate for SRO residents with these organizations.

  (2) SRO residents faced major bureaucratic impediments in having action taken on their housing applications by DAS or by agencies providing alternative housing, a situation which required advocacy intervention by the CIS staff;

  (3) the CIS staff developed a limited escort service for SRO residents taking them to their initial medical appointments and drug treatment appointments and brokered relationships between SRO residents and the referral agency;

  (4) CIS staff successfully advocated for a Manhattan food pantry to change its access hours and method of food distribution to SRO residents with referral slips from the CIS staff.

  (5) CIS staff brokered and accelerated intake procedures for SRO residents with God's Love We Deliver food services and convinced that organization to deliver food directly to the doors of residents in the Carver hotel to prevent the food theft that took place previously when they delivered resident's meals to the hotel manager's office.

(6) CIS staff arranged for ambulette pickups or medication delivery for non ambulatory SRO residents who are in methadone treatment but because of health reasons could not travel to pick up their dosage.

(7) CIS staff arranged Visiting Nurse services for non-ambulatory hotel residents.

(8) CIS staff facilitated hotel residents in negotiating DAS and SSI bureaucracies when their checks were delivered to the wrong address or not issued at all.

E: Criteria for Target Intervention Sites

Based on April reconnaissance the Program Ethnographer determined salient ideal characteristics for hotels selected for the project:

- Stable core residential populations with a significant level of active and former substance abusers;
- The presence of drug taking and sexual networks between hotel residents and surrounding outside community;
- Residents that are accessible to staff within N.D.R.I.'s mandated working hours;
- Ability to access the SRO with permission of hotel management;
- Proximity to hotel of outside congregation sites frequented by hotel residents, i.e. parks, drug selling markets, sex worker strolls, methadone programs, fast food vendors, Laundromats, and related social service sites such as soup kitchens and food pantries.

F: Hotel Ethnographic Profiles: Residential Patterns and Illegal Economies

Kent /Hayden Complex

This report will treat the Kent Hotel, a 60 room building on west 83rd street and the Hayden Hotel a 108 room building on west 79th street as two interrelated but divergent operations. These two hotels exhibit the full range of high risk SRO behaviors and practices on the part of residents and managers; these patterns are also found in varying degrees in the other hotels serviced by this project. Officially, the two hotels are owned and operated by the same management organization, but these two hotels are differently administrated as regards to **room regimes, debt dependency** and the **drug trade**, all of which are directly or indirectly under the oversight of the hotels' managerial apparatus. This report proposes that management styles, practice and policies have an enormous organizing influence over both the high risk behaviors of residents, and the general disorder that can be identified in many SRO hotels.

The terms used above should be defined for they describe not only the managerial and economic structures of the Kent/Hayden complex but can also be applied to the other hotels under consideration in this report, the Carver, the BZB and the California Suites.

- By **room regimes** I mean the strategic way that either hotel managers and/or HRA staff use their capacity to close rooms or keep them open as techniques for administrating a hotel, for concentrating personalized power within an

hotel, for manipulating the behavior of residents, and for earning illegal room fees either from the resident or from misdirected DAS payments.

- **Debt dependency** or loan-sharking in the SRO system is a more complex form of loan-sharking than found in street contexts: it is a vehicle by which hotel management organizations, or individual managers (acting autonomously) or HRA workers earn illegal surplus income in a hotel, and it is also a mechanism for constructing financial/psychological dependency that enlarges the personal power of hotel managers or HRA workers over those residents who are their financial clientele.

- The same can be said for the management run **drug trade.** In the Carver, BZB and California Suites hotels the drug markets are not management run, but operated by a diverse cadre of petty dealers based both inside and outside the hotels. However, in the Hayden/Kent complex, **drug production** and **drug marketing** are run by the management and internally based within the hotels– though external operators are permitted to operate in the Kent from time to time by the Hayden/Kent management. Further there is a structural and formal financial linkage between the drug and loan sharking economies within the Hayden/Kent complex.

This report will propose that (1) room regimes (2) debt dependency; (3) drug economies are crucial and interlocking practices that subvert the hotels' ostensible function as transitory housing and severely inhibit DAS clientele from seeking alternative housing through the creation of structural dependency.

Structural dependency or hotel-addiction occurs when the managerial manipulation of room tenancy, a credit/debt economy and chemical dependency (particularly when credit is advanced in the form of drugs and not only as currency) are combined as behavioral/financial controls over the SRO tenant.

Therefore because the three systems are officially locked together by managerial oversight in the Kent/Hayden complex it would be useful to examine how these systems work there and then to analyze their variations within the other hotels. In the Carver and California Suites, hotel management is involved in varying degrees with the informal economy and these hotels also exhibit a convergence of substance mis-use, debt economies and illicit room regimes which exert a decided influence on the high risk behaviors, and residential patterns of DAS and non DAS residents in these hotels.

The Hayden Hotel

The Hayden and Kent hotels are positioned by their joint management in a front space / back space relationship. By **front space** I mean the formal and public presentation of an acceptable image by hotel management; **by back space** I mean the actual and covert behavioral practices occurring in the hotels which do not contribute to an acceptable public image. The Hayden is located behind the Museum of Natural History on a block characterized by luxury housing and up-scale hotels. The frontage of the Hayden is maintained with a cleanliness that is on a par with its neighbors on the block. And to a lesser extent this impression of antiquated luxury continues within the hallway reception area where the hotel

management maintains its office– though the rooms for DAS residents are as in poor condition as those found in the other hotels surveyed. The upscale image of the Hayden is further reinforced by the type of clientele who can be seen entering or leaving the hotel. DAS clients now account for only 23 out of 108 rooms in the hotel. When we began outreach to the Hayden in May 1996 there were 33 DAS clients residing in the hotel. The majority of rooms are currently rented to foreign students and to upscale sex-workers who rent rooms long-term or by the hour at the Hayden. Further the management tends to cluster DAS clientele on the second and third floors reserving the other rooms for the foreign students and well dressed sex workers. This policy furthers the stigmatization of DAS residents by emphasizing and enforcing their difference in respect to the hotel's other clientele. This type of ghettoization is markedly different than the gradations in safe space advocated above. For in the Hayden the clustering of DAS clients on two floors is accompanied and colored by other stigmatzing factors including the overall lack of services, and the poor condition of the rooms and room furnishings. Residential segregation here implies a gross value distinction between people-with-AIDS and those who appear to be AIDS-free. Further, though the manager has no objection to DAS clients receiving harm reduction services by the CIS team, she has warned the team not to approach the more well dressed non-DAS sexworkers who use the hotel.

The visual appearance of the Hayden changes once one enters into its small elevators and walks through the badly lit, large empty hallways. Here communal and ill-kept toilets are visible and residents can be seen living in rooms as small a broom closets. The rooms and hallways are paneled by old dirty wood and the

floors are worn linoleum. Here the atmosphere of abandonment and decrepitude is in sharp contrast to the upkeep of the hotel's frontage and reception area.

Many of the Hayden DAS clients have been residing in the hotel for a number of years and in turn have an extensive prior history as DAS clients in other hotels. Such is the case of Dee a hit doctor who runs a mini-shooting gallery from her Hayden room. Because of her injecting skills which situated her in a position of trust with the heroin injectors residing at the hotel we recruited her as peer educator to give out bleach kits to residents.

Case History: Hotel career of peer educator at the Hayden

Dee[5] Is an African American women and heroin injector in her mid forties. She was diagnosed as HIV positive in 1985 in one of the first CDC studies. In 1987 she left her apartment in Brooklyn after an incident of domestic violence and entered the SRO system. Since then she has been living in SROs, with the exception of a six month period where she attempted to maintain an apartment which failed due to the cost of her heroin habit. Dee has been a resident at the Hayden since 1993, prior to that she lived at the Marion for a year, and for shorter periods at the Bristol and the Skyway, in Queens. She also lived in Manhattan at the Cambrian, the Riverside, Cavalier ("Where the rooms are so small that when you get into bed the doorknob to the front door gets in bed with you."), at the Allerton, at the Allerton Annex, and at the Barbour. Dee explains this history due to these hotels moving her to another SRO hotel prior to the 28 day limit after which she would receive "residency status." At no time during this period was she encouraged to seek alternative housing outside the hotel system, and indeed the instability of being moved from a hotel every 28 days would interfere with a consistent search for alternative housing. She has also been active in HIV advocacy organizations including the GMHC, Momentum Project, Housing Works, and the Minority Task Force on AIDS. Dee is very cynical about what government agencies can do for her, and offers as evidence a list of 13 recoupments filed against her by DAS, many of which she had overturned in Fair Hearing decisions that have not been acted upon by DAS. Dee also displays an SSI letter she received identifying her as recently deceased and cutting off her SSI benefits. Dee confirms the active sex work scene at the Hayden by complaining about the frequency of "cockblocking," a practice where other hotel residents (men and women) attempt to steal johns away from the sex worker as she or he brings them up to the room.

[5] All residents names are altered to protect confidentiality with the exception of residents whose identity are in the public domain, or who are deceased.

On the floors where DAS clients are concentrated we find four basic type of room arrangements. (1) the mandated arrangement of a single DAS client allocated to a room: (2) A couples room in which two DAS clients registered at the Hayden have formed a sexual/emotional bond and more or less share one of their allocated rooms leaving the other relatively unused; (3) Rooms where the couple are both DAS clients but in which one partner is officially registered at another SRO as was the case with R.M., (female African- American, IDU) in 210, whose male partner was registered at the Marion but lived with her at the Hayden until his death in December); (4) rooms that appear uninhabited but are in fact being held by the management for a DAS clients who has been incarcerated. For example there was G in room 313.

Case History: Tenancy Manipulation at the Hayden

G. (room # 313) is a highly skilled booster i.e. he shoplifts and steals and usually sells his contraband to the Hayden hotel management. G. runs a small heroin injecting gallery for his "get high" network, a tight group of male injectors in 313, and functions as a hit doctor, injecting those clients whose veins have collapsed or scarred over and have difficulties injecting themselves. G. charges for his injecting services and also for making his room available to these injectors many of whom are not residents of the hotel. G. also sells pills and was arrested for this and sent to Rikers Island prison for more than 60 days in late May. However, his room was not closed but kept open for him by the management in direct contravention of DAS regulations about extended absences. G. returned to 313 in August, at that time he informed CIS staff that he paid the hotel manager $500 to keep his room open while he was incarcerated. The hotel management also signed and cashed his SSI and DAS checks for him while he was in prison (the logistics of how this was done will be discussed below in the section on loan sharking). G. was arrested again in September and returned to the hotel in November. During this period the on-site HRA worker attempted to close his room but apparently was prevented from doing so by the hotel manager for G. resumed his residence in 313. He indicated to the outreach staff that he gave the hotel manager "Another little gift."

The cases of G. and the case of R.M. discussed below confirm the extent to which the threat of room closing (1) discourages DAS clients at the hotel from

seeking long term medical care requiring extended leaves from the hotel; (2) inhibits DAS clients from seeking 28 day or longer drug treatment care; (3) encourages under the table payments to those who have the power to close rooms; (4) facilitates illegal disbursement of DAS and SSI checks: and (5) is used as a technique of coercion over DAS clients.

Case History: Room Closing at the Hayden

R.M. in room 210 is a 55 year old African- American female DAS client who is loosing her eye sight. She would not leave her room for days on end and was clearly very ill from malnutrition and related complications. In the words of the CIS worker who initially came into contact with her "she is actually laying there dying" R.M. also received a high dosage of methadone, 90 mm, maintained a pill habit, and used cocaine. CIS staff placed her in Beth Israel for detoxification and primary medical care. Beth Israel kept her there for several weeks when they found she had an abscess in one of her breasts which required an operation. The doctors wanted her to stay longer after her operation because she was running fevers. At the end of three weeks, she was extremely fidgety and told the doctors "I want to leave because R.(the on-site HRA worker) is going to close my room." The Beth Israel Social worker assigned to her case spoke to the CIS worker who had set up the placement in order to verify that HRA would close down her room for being hospitalized longer than three weeks. When told it was a good possibility in the words of the outreach worker "She(Beth Israel social worker) went ballistic, it is illegal, if he (HRA worker) doesn't comply I'll go higher." At this time the CIS team heard from the hotel manager herself that the HRA worker was saying he was going to close R.M.'s room. He told the hotel manager that he was tired of CIS outreach taking his clients out of their rooms without letting him know first, and it if it happens again he would close the client's room.[6] (In other words he was objecting to CIS staff providing confidential treatment referrals to hotel residents) The hotel manager told the HRA staff person that R.M. had been hospitalized on an emergency basis and that she was aware of this situation. The HRA worker persisted in threatening to close the room-- word of which had reached R.M. in Beth Israel through friends from the hotel. The HRA worker may have been unaware of R.M.'s hospitalization but more importantly he previously did nothing about her rapidly degenerating health situation which precipitated the CIS referral to Beth Israel. R.M.'s anxiety about her room being closed has its objective origins in the fact that many DAS residents who go for 28 day drug detoxification have had their rooms closed by either the management or by the HRA worker after 15 days. The same HRA worker had arbitrarily canceled deliveries by Gods Love we Deliver to certain clients in July and August.

[6] For reasons of confidentiality SRO project staff do not disclose to HRA staff what referrals they give to hotel residents unless receiving permission from the client.

The Hayden has an on-site HRA worker who maintains an office within the hotel on the third floor. This worker is supposed to be servicing both the residents of the Hayden and Kent. However the HRA staff person never visits the Kent hotel and none of the residents there know his name or face or are aware that they can access social service, housing and nutritional resources from his office in the Hayden. He has openly stated to outreach staff that he never goes to the Kent and is afraid of the residents housed there.

The HRA staff person is frequently absent from the Hayden hotel, for several days in a row, though these absences are covered by the hotel management who take messages for him and will not reveal his whereabouts. Residents report that he has frequent altercations with other Hayden residents and then disappears from the hotel for hours or days for fear of being physically confronted by these DAS residents.

DAS clients at the Hayden have reported to SRO staff that the HRA staff person has frequently violated their confidentiality by leaking information about them to other DAS residents at the hotel with whom he maintains a special relationship (see discussion of food distribution below).

Case History: HRA Staff Interrupts Drug Treatment of Hayden Resident

J.V. was a 32 year old Hispanic male resident at the Hayden Hotel for nine months in 1996 When the CIS team first met he wanted to go to a detox for alcohol and crack use. CIS staff placed him in an up-state residential detox and rehab facility, Turning Point for 28 days. J.V. informed the on-site HRA worker at the Hayden about his placement for detox for 28 days. Two CIS staff escorted him to the train to Turning Point. One week later this CIS staff received a call from Turning Point stating that J.V. requested to leave detox early because the Hayden HRA worker was closing out his room

by 10/11/96, due to his whereabouts being unknown. The manager of the Hayden verified his room closing. J.V. returned to the Hayden without completing his detox and relapsed one week later. CIS staff found a day treatment program called "Enter" where he could attend support groups. He is still attending this program at the present time and has avoided subsequent relapses.

The HRA staff person does distribute food from his office but hotel residents claim he does so on a preferential basis to residents who are "his favorites." SRO Project staff have witnessed this selective distribution of food to favored residents. The HRA Staff person does not conduct ongoing assessments of the health conditions and nutritional needs of the hotel residents who are DAS clients. He was of no assistance to the CIS staff in seeking appropriate placement for a violence-prone female MICA resident at the Kent who urgently needed psychiatric intervention combined with drug treatment. He was well aware of this client's situation. This DAS client was eventually incarcerated. He has been complicit in, or did nothing to prevent room closings of residents who were away from the hotel on 28 day drug detox treatment programs, a practice that inhibits residents from seeking such treatment options and/ or which forces them to drop out of treatment in order to secure the tenure of their room.

Many of the same high risk conditions and illicit activities present in the more infamous Kent can also be found at the Hayden, the only difference being that management at the Hayden attempt to keep such illicit activities more covert because the surrounding neighborhood requires higher levels of discretion.

Case History: Drug Dealing Wars at the Hayden

T. in room 208 of the Hayden is a male African American DAS client and active heroin injector who worked as an enforcer for the drug operation run by Hayden management, until he set up in an autonomous operation. He was threatened and harassed by other enforcers working for the management and gave up his heroin selling because he is in fear of his life. He is severely depressed and frequently will not open his door when CIS staff knock. When we have entered his room it is littered with uncapped syringes. At his request we have made several appointment for detoxification and primary medical care at Beth Israel comprehensive AIDS treatment center, which he never kept. After a year of such attempts T. was successfully placed in Turning Point, a 28 day drug treatment program, by the CIS team.

Case History: Resident Neglect at the Hayden

Outreach staff developed a relationship with a non DAS elderly white male, living in a first floor room in the back, who had been a private resident in the hotel for 17 years. He was a diabetic confined to a wheel chair. He was twice found by CIS staff on the floor of his room lying in his urine and feces, apparently for hours, if not days on end. Once he managed to get into the bathtub and couldn't get out. This was reported to the management desk who replied that they were aware of his situation and that this was his normal state and it would eventually be corrected, This was doubtful since the cleaning staff of the hotel refused to go into his room and would deliver take-out food to him by leaving it at the front door. On prior occasions he had been released by hospital social workers to the care of the hotel management, a task they took lightly. He informed outreach workers that he was paying the hotel management extra money to take care of his needs. He eventually died in hospital.

The Kent Hotel

In contrast to the Hayden the Kent is a smaller tenement building on a mixed Anglo/Hispanic middle and working class block. The frontage of the Kent is a small stoop on which people affiliated with the hotel hang out and socialize. From there the visitor moves into a small cubicle where one can be buzzed in by the management from 9-6 or let in by a resident when the management are not on premises, (which is frequent). There is no reception area, just the closed door of the management office which is not open at night. Halls and stairwells are as

dingy as those at the Hayden but characterized by an overwhelming chemical odor. In contrast to the Hayden, the hallways and stairways at the Kent are crowded and noisy with people moving up and down the stairs and numerous others who occupy stationary positions on the stairs and in the hallways, doing business and/or socializing while smoking crack or holding crack paraphernalia. There is no HRA office on-site in this hotel, the Hayden HRA worker never visits the Kent, and though he is a notorious figure in the Hayden he is unknown to the vast majority of Kent residents who are not aware that there is an HRA office in the Hayden.

Case History: Hospital Release to the Kent

Sam. A white DAS client at the BZB was beaten up by drug dealers at the hotel and was hospitalized. Upon his release, an ambulance delivered him to the door step of the Kent. He was left on the front step wearing only a hospital shift and slippers. The management office had closed early at 5 p.m. that day because it was Friday though it is officially meant to close at 6 p.m. The ambulance went to the Hayden to pick up the keys to the Kent's front door. The ambulance driver took the wheel chair that Sam had been resting in before going to the Hayden, and left Sam, who could barely stand, leaning against the wall, during which time Sam urinated against the wall in full public view. Such unstructured and risky hospital releases are common with many hotel residents. People who cannot walk, are released to rooms on upper stories of the hotel, while others who cannot take care of their hygiene needs or feed themselves are ostensibly released into the custody of hotel managers or HRA staff who then ignore these residents and their special needs, and are never made accountable by hospital social workers responsible for post-release patients.

The Kent has the reputation of a wide open hotel, particularly at night and on weekends, when the managerial office is closed. During our first visit to the Kent the project field manager and myself were warned not to come to the Kent after 6 p.m. when the management office closed, because it was too dangerous and we were also were advised, by other residents, to visit the hotel after 6 p.m.

as the best opportunity for contact with residents and when high-risk behaviors such as drug ingestion and sex-work were most visible.

After seven months of consistent field work in the hotel it is apparent that, despite the greater disorder at the Kent, Hayden residents are only marginally better off than Kent residents. Violence, and deaths under suspicious circumstance can occur at both hotels, the residents of both hotels exhibit serious deficits in their nutritional status, they are equally estranged from primary care medical systems and mutually immersed in dependency-structures created by the loan sharking and drug markets present in both hotels. For example a DAS client living at the Hayden, who was addicted to crack/cocaine, committed suicide by jumping out of a back window in March 1996. In neither hotel is there adequate oversight exercised in relation to the primary medical, nutritional and safety needs of the residents by the hotel staff or the assigned HRA worker.

Case History: Ella and Eddie at the Kent

Ella and Eddie, in their mid thirties lived at the Kent Hotel, Ella is a Hispanic female and DAS client not registered at the Kent, who also used heroin and alcohol. Eddie is a 38 year Hispanic old male DAS client registered at the Kent who also used heroin and alcohol. The CIS staff trained them in the use of bleach kits to clean their needles. CIS staff also made a real estate agency housing referral for the couple and they eventually moved to their own apartment, At present they are attending AA meetings and receiving medical care which they did not seek while at the Kent Ella stated before she moved that the CIS staff "are angels" and credited our intervention in changing their living situation. Eddie stated he felt he would have died without the intervention of CIS staff.

The original mandate and program mission of this demonstration project was to provide harm reduction and alternative housing services to the DAS clients residing in SRO hotels. The Kent/Hayden complex was chosen as an intervention

site because of the proximity of the two hotels and because the small size of the Kent, 33 rooms, and its reputation as a very active drug and sex work scene made it a highly eligible research site. However with our first day of outreach to Kent habitués, our image of the population we were to serve radically shifted. It was apparent in the Kent that along side the official DAS residents and deeply entangled with the latter's life style was a significant number of people who were neither DAS certified, nor registered paying tenants at the Kent.

Residential Patterns at the Kent

Between May 1996 and December 1996 the outreach staff conducted intake interviews and delivered harm reduction materials and services to, and regularly interacted with 77 persons found at the Kent. Of this number 62 contacts were both DAS clients and official residents of the Kent and 14 were not DAS and not official residents of the hotel, (1 elderly man was an official resident of the hotel but not a DAS client). The number 14 does not fully represent the non- DAS persons frequenting or living at the Kent. Precisely because of their illegal and unofficial status at the hotel this grouping tended to shy away from interacting with, or requesting services from, the outreach staff-- or they requested services through the intermediary of the official registrant of the hotel with whom they had a relationship. For example, in the basement of the Kent cots had been set up by management for approximately 18 illegal Mexican immigrants from the town of Puebla, who slept at the hotel at night and were away for most of the daylight hours when we were able to service the hotel's population. Thus we only interacted with a small number of these Mexican migrants.

The outreach staff rapidly found that there were a diversity of residential and congregating patterns at the Kent which are all structured by the covert drug and sex-work economy that is pervasive throughout the hotel. These multiple illegal residential patterns can be found to the same or lesser degree in the other SRO hotels serviced by the project and are therefore worth reviewing here.

DAS couples/ Subletters I *(In all hotels)*: Where two registered residents and DAS clients would partner up in a single room leaving the room of one partner under-used or empty. The tendency was to sublet this room to outsiders who are neither DAS nor registered at the hotel. In one case of this we were informed by the DAS couple that the on-site manager at the Kent demanded a kick-back payment for allowing this type of sublet.

Subletters II *(In the Kent, BZB[7], Carver and California Suites):* Single residents will also sublet or share a room with someone for either money or a certain amount of crack and/or heroin. Thus there is the case of B. an African American male who does collect SSI, but is not HIV+ nor a DAS client who sublets room 41 at the Kent. Another case is that of a former drug trade enforcer who was rumored to be working for the Hayden management drug operation and was residing in room 42 of the Kent until he was arrested. When he was released from jail six months later he and his girlfriend moved into room 35 which they share with the official resident. The room is filled with boxes belonging to the couple and it is

[7] All assessments of room patterns of BZB concern conditions prior to July-August 1996 before its take over by the H.I.R.E. management.

unclear whether the official resident is receiving payment or being coerced into this arrangement.

Subletters are usually involved in the drug trade based at the hotel since it makes a more secure operational base than dealing on the street– not to mention the almost captive clientele. Subletters will also use the rooms for sex work to which they bring clientele. In this instance the sex worker may not actually live in the room but only use it for trade during certain hours of the day and night. These sex workers focus on clientele from outside the hotel that are picked up on the streets and the underground parking garages adjacent to the Kent.

Dummy Residency *(In Hayden, Kent, California Suites, BZB and Carver)*: are versions of sublets where the DAS client maintains a room in the hotel but actually lives elsewhere and usually shows up at the hotel to pick up entitlement checks and/or sublet fees. Currently in the Kent there is one such room belonging to an African- American male, P., age 36, who is drug free and attending AA meetings. P. has a job and lives with his girl friend in Brooklyn. In June, P. submitted a housing application to DAS for an apartment in Brooklyn to be near his girl friend, but he keeps the room to maintain his benefits. He deliberately avoids the hotel for fear that he will relapse by being sucked into the social/economic life of the Kent.

Squatters *(In Kent, BZB, California Suites)*: These are usually males who take over an empty room or intimidate an official resident to leave their assigned room. The

current resident of room 48 at the Kent simply intimidated/convinced the on-site hotel manager into letting him squat in this room and in return he does odd jobs around the hotel. A Haitian DAS client residing in #31 who spoke no English was intimidated out of his room by a male associated with the hotel drug trade and the Haitian now resides on a cot in the basement with the illegal Mexican immigrants.

Floaters *(In the Kent, California Suites):* These are primarily women who exchange sex for drugs and go where the money is in the hotel, so they will be transitory guests in a number of rooms. Floaters will also use empty rooms, storage rooms and bathrooms to sleep in or from which to conduct sex-work. C. An Hispanic female in her mid-thirties and former public school teacher, on leave of absence because of her crack habit, began visiting the Kent to take care of her boyfriend who is a DAS client and officially resides at the hotel. Eventually her boyfriend moved to an apartment, but C. continued frequenting the Kent and became more and more entangled in the drug and sex-work scene there. This deepening involvement was measured in outreach staff's observations of her gradual decline in appearance and personal hygiene. Once careful about her clothes, the deeper C. sunk into the hotel scene the dirtier and more scraggly her clothes and appearance became. C. lives at the hotel but is not associated with any particular room.

Roomless *(Kent)*: A more desperate form of floater, both male and female who tend to sleep in the fourth floor hallways, and bathrooms and on the stair cases and stair wells on the fourth floor, which are exposed to less traffic.

Day users and/or Hallway Floaters *(Kent, California Suites)*: Usually men or women who end up as squatters or floaters. W. an African American male at the Kent is a day-time floater who usually hangs out on the second floor and buys drugs or runs other errands for people, such as buying food and coffee for the hotel cleaning ladies who tip him with crack-cocaine that they sell on behalf of the management. This day-time population participates in the room-based drug and sex trade. As non residents they are more geographically mobile (less psychologically tied to the hotel) and specialize in bringing resources into the hotel from the outside.

Subterraneans *(Kent)*: Then there are the illegal Mexican immigrants who live in the basement as paying guests of the building superintendent. The superintendent has his own room with twin beds on the first floor and sublets the basement to the Mexican immigrants in the basement. The Mexican are also clients of the female sex workers.

The multiple and illicit room use, the sleeping in hallways and bathrooms, the use of bathrooms for drug ingestion and commercial sex, and the dedicated use of certain rooms for sex-work and drug taking all point to the fact that the multiple forms of residence in the Kent are largely the function of the informal economy of drugs and sex and of managerial complicity in that economy. It should be noted

that the Hayden, operated by the same managerial organizations, does not exhibit such a wide variation in residence patterns and room mis-use.

Floor and Bathroom Enclosures

There are DAS tenants at the Kent and other hotels who resist the penetration of the informal economy and its adjuncts– drug use, sex work and squatting– by enclosing entire floors and locking the hallway bathrooms on a floor. These practices indicate that not all the hotel residents share the same tolerance of high risk, substandard, and anarchic living conditions. Further, the extent to which individual tenants attempt to create safe spaces through their capacity to use force– the existence of floor or bathroom vigilantes-- reveals the lack of any effective managerial oversight of these hotel spaces.

Case History: Creating Safe Space at the Kent

No one deals drugs on the fifth floor west wing (with six rooms one shower and one bathroom): dealers are kept off the floor by "Bat," an African- American male, who not only watches the floor but monitors and prevents illegal occupancy of rooms on that floor. Black intimidates intruders with a bat saying he "doesn't want any bullshit. no drug use. no dealing, no prostitution." He patrols the floor "with an exercise bar and an attitude" as one resident put it, trying to create a drug free safe space. Bat explained to CIS staff how drug users broke into a vacant fifth floor room for use as a crack den, He threw them out by force, "They are a bunch of pigs that leave the bathrooms dirty." He put a lock on the bathroom and gave the other permanent residents on the floor a key. When a new resident comes on the floor, he asks the newcomer about their drug use and socially freezes the new resident if he/she is active. Bat has lived in the Kent for two years and is attending a methadone program.

Case History: Creating Safe Space

A, an Hispanic male invited his daughter over to his room on the third floor at the Kent for Christmas, but he saw his neighbor M. a male sex worker "shoving a dildo up his ass with his door open." A and a friend beat up M. who is a MICA. M. subsequently went after A. with a knife. and A. had to get a court order of protection. A. cut off L. his best friend, because he relapsed. A., who was recently released from prison, states that he is a Muslim, and claims he would set a room on fire if it became a site for drug activity.

Case History: Creating Safe Space

Non-residents from within and outside the Kent tended to use the first floor bathroom to inject heroin or cocaine and to smoke crack because of its easy accessibility from the entrance of the hotel. They can buy drugs from the pushers stationed on the stair case between the first and second floors and move to the bathroom in the rear of the hotel's first floor to ingest the product.

Eddie, is an Hispanic male, aged 28 lived on the first floor of the Kent (room # 1) and patrolled his section of the floor particularly the bathrooms. He is a DAS client, a methadonian, who lives with Ella, a DAS client who is not registered at the Kent: they recently got an apartment from a CIS team referral to a real estate dealer. They were helped by E2., an Hispanic Male and his girlfriend C. who were both DAS clients, also living on the first floor (room #4). The two couples attempted to control who accessed the first floor bathroom. They started by throwing people out of the bathroom who were found injecting and/or sleeping there and then eventually put a lock on the door for which only the floor residents had a key. After Eddie and Ella relocated to an apartment the lock was removed from the bathroom and the drug use in this space resumed.

Room Regimes at the Kent

Room regimes at the Kent are different from that of the Hayden– there is less organized control over tenancy as indicated in the above section but there is also a precise and selective use of room closing that in many ways is responsive to the tides of the local drug market. In the Kent DAS clients' rooms are closed

when they are arrested and away for more than a month or when they disappear from the hotel for a month or more. These rooms remains unoccupied for some time and or until they are taken over by squatters. In March, 1997, CIS staff noted that many rooms that had gone vacant in the preceding two months had not received replacement tenants.

Room closing at the Kent and Hayden also occur if a tenant sets up a drug dealing operation that threatens the management run drug market. The Hayden/Kent management tolerate no competitive drug dealing in the Hayden but do so in the Kent, perhaps as a camouflage for their own operations. However when independent dealing grows to large the management closes it down through intimidation, room tossing and eventually room closing. The latter occurs when management feel that their product is not selling fast enough because the independent dealers in the hotel are cutting in on their trade.

Case History: "How they got rid of S3. "

S3 is a white male and IDU in his mid thirties living on the 4th floor of the Kent as a DAS client, though he had non-DAS female room-mates. S3 was holding drugs for independent dealers at the Kent, however enforcers from the management operation broke into his room destroyed his belongings and room furniture and scattered glass shards on the floor and his bed. So S3 moved to a room upstairs belonging to David (now deceased), who was extremely ill, thin, and who rarely opened his door, except to some young boys who appeared to be his lovers. After S3 moved into David's room the enforcers broke into that room. Then after a three weeks S3 was busted by the police-- and the word was put out that the management had alerted the police to S3's drug cache.

The dynamics of room closing at the Kent is also unconventional since residents, functioning as "trustees" for the management will oversee the process. S2, an

African American female, age 33 was not a DAS client and not officially a resident in the hotel. She sells drugs for the hotel management and is a room floater. T1, was a Kent tenant and DAS client who sold drugs for the management. He was arrested and jailed, and the management subsequently closed his room. His belongings was packed and the room closed out by S2. S2 stored his belongings in her current squat. She is helped by E2, another squatter who cleans the Kent's bathrooms and is given an unnumbered room in exchange for this labor. S2 also cleans bathrooms for the management, and directs the sex-work traffic in the hotel. One resident whose room was closed told us he was glad that S2 cleaned out his room because he knew his belongings would be safe under her care. Another told us that S2 was the only dependable person working for the hotel management.

> "If you ask J. (the on-site manager) you get 'I don't know.' If you ask S2 you get either yes or no."

The use of tenant or squatter labor in the daily upkeep in the hotel is, in part, due to the fact that the official sanitation staff devote significant amount of their work day offering and selling drugs on credit to the residents.

Drug Dealing at the Kent and Hayden

At the Kent CIS staff interacted regularly with 11 residents who identified as injectors and 54 residents who identified as crack-cocaine smokers, though there is substantial poly-drug use taking place. At the Hayden Hotel CIS staff consistently interacted with 12 injectors and 7 crack cocaine smokers. As stated above it is common knowledge of the tenants of both hotels that the hotel management

runs a heroin and crack-cocaine selling operation. In the Hayden drug sales are monopolized by the hotel management and tenants will buy drugs at the managerial office or they go to room # 10. They also buy drugs outside of the hotel but the management's enforcers discourage any independent dealing in drugs by outside operators within the Hayden. The case is different in the Kent, independent drug dealing in the hotel is tolerated to a point by the management, most likely as a way of camouflaging the management's own drug dealing operation.

There is a Mexican male who collects dirty sheets and towels from the Kent bringing them to the Hayden for washing. During these trips he transports drugs to the Kent under the guise of delivering clean linen. He delivers the drugs to the Kent cleaning staff. There are two cleaning women in the Kent who ostensibly clean and mop the hallways and bathrooms. They each carry mopping pails with them, one contains soapy water and the other as witnessed by outreach staff, contains glassine envelopes of heroin and vials of crack placed in plastic bags to protect the product when the drugs are immersed in the water of the second pail. The cleaning women do their rounds in the hotel knocking on the doors and displaying their wares. If a tenant does not have any money on-hand the cleaning women leave the drugs with the tenant and charge an extra 50-100% interest on the drugs to be paid later– usually during check week. A $10 bag of heroin sold on credit is marked up to $15, while a $5 vial of crack-cocaine is marked up to $10. When the DAS, SSI and other entitlements checks arrive by mail the manager, who cashes many of these checks, deducts the drug-debt

fees from the total. Many DAS clients have the manager as their designated co-payee on their checks She also uses residents as drug mules and drug sellers and will go bond for them if they are arrested.

A Dominican restaurant across from the Kent hotel is instrumental in the organization and distribution of crack production and sales in this hotel. Residents have been seen leaving the hotel with bulges under their clothes carrying bags of crack vials and taking them into the restaurant. On the restaurant side of the street there is a male hang-out where drug overseers congregate and supervise the drug trade.

A suspected employee of the Dominican restaurant drug-selling operation is an Jamaican male who regularly visits a little room on the 4th floor of the Kent – once occupied by a resident. He never speaks to the outreach staff nor is he seen socializing with any of the residents. Outreach staff and residents report crack cooking smells emanating from this room and suspect packaging also goes on there. Outreach staff have noted that the use of cleaning detergents and disinfectants by the cleaning staff are intensified on this floor perhaps to cover the smell of crack cooking on the room's hot plate. The fact that this room has remained dedicated to crack cooking for an extended period of time points to managerial complicity and cooperation with the Dominican restaurant drug operation.

We have been informed that the Hayden manager's son-in law mules in the drugs to the Hayden using the cover of a family owned cab company consisting of 9-10 cars. These cars deliver and pick up packages to and from the Hayden. Two or three rooms in the Hayden are reserved for business operations and for the personal use of local policemen and for the up scale sex-workers. Many residents at the Hayden and Kent maintain there is fiscal connection between drugs dealing and prostitution at the Kent/ Hayden complex and the California Suites on 111th street.

There is another component of the drug market at the Hayden/Kent complex that concerns the sale of prescription drugs or "meds" that DAS and Medicaid clients cash in on in order to finance their crack, cocaine and heroin habit. This market ranges from the selling of barbiturates and muscle relaxants to the selling of protease inhibitors and AZT.

Case History: "Selling Meds"

DL, is an African- American poly drug user in her mid forties, she has been a DAS client since 1986 and resides in the Hayden Hotel. "Once on Medicaid I would see 7 doctors a day, 7 days a week collecting scripts and selling meds. I start out at 8 o'clock in the morning. You didn't have to leave the pharmacist, half the time to sell your pills he would buy them back after he gave them to you. I sold Zantax, Keflex, Flexiril, Feldene: 30 of each of these several times a day. You can sell a bottle for $5 at the pharmacy and for $10 uptown, or 30 cents a pill, 50 cents or even a dollar a piece, according to what color they were. You know I'm going for yellows or blues-- and then you buy a couple of dime ($10) bags of crack, 9 rocks in a dime bag, 1 rock for every 30 Zantax, one rock for 30 Valiums."

Residents of the Hayden, Kent and California Suites also sell AZT and protease inhibitors. HIV/AIDS affected persons come to New York from other states to buy these drugs cheaply, particularly people who don't have Medicaid. The primary "meds" markets are located at 155th St. and Broadway and at Pope Park in Kingsbridge, in the Bronx. At these sites the clientele mostly come from New Jersey many of whom keep their immune system status hidden from their families and their physicians

124th street and 5th avenues is also a Meds market site used by residents from California Suites. C. a male Hispanic sex worker from California Suites would sell and buy protease inhibitors there depending on his needs and take these pills without medical supervision. S., an African- American female sex worker, living at the BZB, showed CIS staff a large white bottle of protease inhibitors that she recently bought off the street. M. an Hispanic male IDU at the Carver, who appears to have AIDS wasting syndrome, has an ADAP card and sells his medication.

The existence of a black market in AZT and protease inhibitors means that that most of the clientele of these markets are self medicating without proper medical supervision and thus may be contributing to the evolution of resistant strains of HIV. In turn the substance misusers who only follow incomplete and fragmented medication regimens, because they divert their prescribed AIDS medication to the black market, may also risk developing treatment resistant strains of HIV.

LOAN SHARKING

The monthly receipt of benefits or "check day," on the first and third of every month, is the most important event in the loan sharking and residential calendar. During this period the loan sharks in all the hotels we serviced deploy a variety of collection techniques which we first witnessed in the Kent/Hayden complex. A day or two before check day is one of high activity for the drug-dealers/loan sharks at the Kent/Hayden complex; on that that day they escalate their offers of drugs-on-credit to the residents, the payments for which will be collected in the following two or three days. On check day the manager of the Hayden/Kent complex will often pay personal visits on those who owe her money, this service is afforded to clients who have their government checks sent directly to them. However, there are significant number of residents who have their checks sent to the hotel management and who even list the manager as a co-payee, (ostensibly to facilitate the cashing of checks for those with no bank account); the management can cash these checks, directly deducting what is owed to her in principle and interest. The third technique of collecting debt is the escort service where residents are accompanied to either banks or designated check cashing store by the manager, or her representatives, who then collect on the debt when the check is cashed. Quite frequently the check cashing store is in collusion with the management and is the place where the management cashes the checks of absent or immobilized DAS clients, and thus without the presence of the designated payee. Management will cash the checks of absent residents who are missing from the hotel, or who were arrested, or who had their rooms closed, though benefit checks are still being sent to this non longer current address. Forgery is the prime technique for cashing the checks of absent, or immobile

residents. The Hayden/Kent manager pays, with money or drugs, a select group of residents to forge the signatures of checks of absent DAS clients, who were once registered at the Kent or Hayden. In this she is in collusion with a designated check cashing store. This practice is also resorted to by those residents who expect to be immanently incarcerated: they are supplied with a surrogate, by the management, to cash checks for them in their absence. The management will hold a sum of money for these incarcerated hotel residents for a fee.

On check days CIS staff have often witnessed the Hayden/Kent manager in her a mini-van with several hotel residents and enforcers inside. The residents are either debtors who are being escorted to cash checking places, or surrogates/forgers for absent residents who sign these checks for cashing.

A favorite technique of the management is to close out a room mid month and take in a new resident for that same room in the same month. This means that (1) the management gets paid twice for the same month's rental of that room and (2) because of the time lag between room closing, governmental accounting, and check mailing the management can cash the check of the absent resident whose room was closed. Such practices and the potential profit earned from a room closing makes this event the most anxiety ridden one for residents and it is a major disincentive against residents seeking extended drug treatment or medical services that would take them away from the hotel for extended periods of time.

Structural Dependency or Hotel Addiction at the Kent

In part this report was meant to answer the question-- why SRO residents, living in cramped rooms, with limited or nonexistent services addressing their hygiene, nutrition and health needs, do not seek alternative housing? Or to rephrase: why are the SRO hotels incapable of functioning as transitory housing and are used by the majority of DAS clients as permanent residences. This report answers these question by proposing that the conjuncture of manipulative management room regimes, the informal economy of drug dependency and sex work, and the creation of debt dependency through aggressive loan sharking (which advances drugs or money), have combined to create structural dependency in many SRO hotels-- what I term hotel addiction. I can think of no case more illustrative of this syndrome then the shooting of "Heavy" at the Kent in October 1996 and the subsequent reactions of the residents to that incident. At first glance hotel management does not seem to be implicated in this tale, however they not only tolerated Heavy's presence (he was a non-resident) and the behaviors that led to his murder, but indulged in related practices that essentially legitimized Heavy's conduct in the Kent. In the story of Heavy and his killer Jesus all the pathologies that contribute to the creation of a high risk, violent, yet captive and/ or dependency-creating environment in the SRO's are at play. In turn these factors speak eloquently to why the SRO 's are not treated as transitional housing by their tenants.

The CIS team first encountered Heavy in the late summer of 1996 mistakenly identifying him as part of a "new set of dealers dealing with any disorder in the hotel as regards anybody who is using." (CIS staff description). And as another

CIS worker described Heavy. " When he walks the whole building shakes. He looks like a Samoan wearing a T shirt with a cartoon on it." Heavy would hang around the stairs of the Kent, he was not a resident there, nor was he seen selling drugs, through he would often be witnessed by CIS staff entering and leaving a wide variety of rooms at the hotel. Then we heard of the case of a hotel resident coming into the Kent with groceries and how Heavy took the bag of food away from him. The other residents mostly on the first floor, told us how he used to intimidate them demanding money, drugs and food, when they first took up residence in the hotel. One CIS client, no longer a resident in the Kent, M3, told us

"It was a accepted thing you gave him a few dollars when he asked for it."

Heavy was not an enforcer for the Hayden Kent drug operation in the summer and fall of 1996, but he was generally an intimidator and bully, who extorted money, food alcohol and drugs from vulnerable residents with threats of violence. Heavy, in fact, maintained a peaceful coexistence with the management's drug operation enforcer, they had a lot in common-- they were both non- resident outsiders and Heavy once occupied the same position until he went to jail 6 months previously. This is why the CIS team had not encountered Heavy previous to the late summer. Heavy went to jail before the CIS intervention and then returned. As one client informed us

> "He was dealing before he went to jail, but this time out he was bullying. He protected S. (a female drug dealer working for the management)."

Heavy was deliberately tolerated by the hotel management, he could have easily been ejected in the same manner as the management ejects drug selling competitors. Yet even though Heavy was notorious throughout the

neighborhood, and the police had keys to the hotel and the rooms, and knew he was there, they never removed him from the hotel.

Heavy bullied and extorted money from one particular resident, an elderly Hispanic male retiree, who was not a DAS client, and who lived on the first floor. He had resided at the hotel for more than a decade prior to the influx of the DAS clients. CIS staff described him as follows.

> "There is an old man, Jesus, at the Kent, he doesn't do any drugs he's been there for about 15 years. Jesus lives on the first floor, he is a senior citizen, his two legs have been amputated because of diabetes. For that reason he lives on the first floor, it is the same floor where the management office is. He does take condoms from us, he told us at night when the hotel management leaves, there's nothing but prostitution and fights in the hotel and he can never get any sleep. His stress levels were high. He was a resident long before DAS got there. He said the hotel was fine and the up-keep was fine until they put 'these people in the building.' Since then the place had deteriorated. 'I can't go out of my room at night. Anything is liable to happen to you in the hotel.'
>
> His beer drinking has increased and lately when we visit him, his room smells, he no longer bothers cleaning it. We had to step away from the odor. The management leaves at 6 o'clock and occasionally the electricity cuts off, there is no light on the entire first floor. Jesus has to come out in the dark, out of his room, knock on the door that leads to the basement, to try to get somebody who lives there (illegal Mexican immigrants) to come and try to fix the electricity, because they know how

to hot wire the boxes in the basement. But these people may or may not be there. Otherwise he will spent the rest of the night in the dark. There is no structure for any assistance in case of emergency. It is a matter of luck if the Mexican's are there. He spends 15- 20 minutes banging on the door till someone comes up and fixes the electricity.

There is also the fear he has about his next door neighbors they are having constant fights, throwing bottles at each other. They are using drugs, using everyday. Jesus is also using a lot of sex, as a stress release. He says that sex is a release for him-- something he has in common with other residents. Jesus, like many hotel residents do not see alcohol as a drug, when they feel bad, all of them will say I got to get me a drink, and we notice that almost all of them are walking around the hall ways with a beer in their hand.[8]

Jesus reacted to all the people at the hotel with DAS and SSI because he worked all his life. And now they had ruined his living conditions, messing up the bathroom, the noise, the traffic on his floor, the fights at night, the bottle throwing and the cursing. He used to live on the fourth floor, but being afraid to leave his room at night he then moved to the first floor. He left the fourth floor room because he had to take his clothes off in the hallway and then enter the room from the hall, it was that small. And this became risky when the people began acting out in the hallways. I was

[8] An issue that requires more exploration is the relationship between chronic beer drinking and the nutritional needs of the residents. Beer has been used as a food substitute in Ireland and Biafra.

asking Jesus how many beers he was buying he told me he was drinking an average of 48 cans of beer a day."

Another CIS worker recounted

"Jesus wanted to get out of there, he wanted a housing placement but because of his alcohol abuse and because he wasn't DAS we had nowhere to refer him expect a shelter. He went to an agency we referred him to, seeking a housing placement but he went drunk and the agency refused to place him. Jesus had his own dependencies beside alcohol such as using the females there for sex."

Jesus' increased alcohol intake corresponded to an all around rise in drug and alcohol use in the hotel as the summer turned into the autumn and residents hunkered down for the impending cold weather and enforced hibernation within the hotel. The CIS staff saw all this increased alcohol and drug consumption as a sign of rising stress levels in the hotel once the summer drew to a close. A week after they had identified a marked increase in stress and stress related behavior at the Kent, the following events occurred.

One evening, as Jesus hobbled up the stairs, on crutches, carrying a bag of groceries, he was confronted by Heavy, who was hanging out on the front stoop. He asked Jesus for "his" money and stated that Jesus "better have that money." None of the other residents who witnessed this encounter noticed anything unusual, as one resident later told us

"But they took it for granted this robbery thing is part of the lifestyle. Its not worth killing a man over it because it happens all the time."

For Jesus had gone to his room as if to get the money, but retrieved a pistol and returned to the stoop to confront Heavy.

"Heavy laughed when he saw Jesus with the gun."

And Jesus shot him two times in the back of the head once in the neck and once in the chest. His intent was to kill Heavy and he succeeded. When the CIS team arrived the next morning

> "The reporters were running around the block and the hotel sticking microphones into residents faces, stressing people out. One of the reporters verbally attacked E. (Female. Hispanic, IDU) saying. I've heard you know everything that went on." And she got very defensive and angry. He invaded her space. G. was crying she was one of the actual witnesses. E2
>
> (another female IDU) wanted to go to detox right away.

Another CIS team member adds

> "They were stressed out because their lives were centralized around a certain place and certain routines and these routines can't go on because something is going on at that center, so everybody was running around and running away, they didn't want to be seen or be asked. Once we (the CIS team) left, a lot of them left with us. And they were not just leaving out of the hotel, they were leaving the neighborhood, getting on trains going to Brooklyn, to their families in other boroughs, E. went to her family in the Bronx, because reporters were coming from everywhere."

A CIS worker described the post shooting scene

"The police in the precinct were applauding the death of Heavy and they threatened to arrest certain residents if they didn't tell what they knew about Heavy. They were all paranoid, taking more bleach kits from us and everybody we passed were visibly drinking, and some one walked up to me and asked me where they could cop (buy drugs), right in front of the police, I was shocked! They were going back to the neighborhoods where they lived because they could cop there and they knew they couldn't get high at the hotel. 'Lets go cross town, lets go uptown, lets go Brooklyn.' They were all asking us for carfare."

Even the HRA worker, stationed at the Hayden, but also responsible for the Kent DAS clients, made a rare appearance at the Kent. The CIS team described the encounter

"The only time they (Kent residents) saw R. (the HRA staff person) was the day of the shooting. We approached him saying that we had been looking for him in reference to a client at the Hayden one J. V. R. said he would be right back and never returned."

Another CIS worker recounted

"After the shooting of Heavy his family threatened the residents that any body who was in the hotel when they arrived were going to get shot. This threat is taken seriously, people were avoiding being at the hotel as much as possible, we ran into them wandering the streets. They were afraid. Most of the people we interacted with regularly where gone two days after the shooting.

> The day after the shooting a drug dealer signaled hotel residents not to say anything about Jesus and Heavy to the reporters. He's the one who hangs around the third floor. He is there the first ten days of the month. M., (an African- American male resident) shut completely down on us after the shooting, he went completely paranoid in the aftermath of the shooting, He was quoted in the paper about Heavy and Heavy's relatives threatened to get even with him."

One resident M2 declared to the CIS staff

> "If anything happens to me here, my brother and my family know where I am.'

A grand jury subsequently indicted Jesus for first degree murder. Many of the Kent residents had gone to the grand jury, and were now scared to return to the hotel. The reaction of the residents to the killing was surprisingly mixed, a minority of residents saw the killing as justified but many more denounced Jesus and praised Heavy much to the perplexity of the CIS team

> "Basically I spoke to E. (a female IDU and squatter at the Kent) she was for Heavy– 'The old man was wrong he had no right to shoot him, everyone knew what Heavy was doing.' Heavy probably gave her some money for drugs and a couple of dollars when she needed it. He was an independent preying on them, taking them off. But because of his size he could take from anybody he wanted and give to the people he liked. And E. was someone he liked. He bought her a couple of beers from time to time or gave her drugs, so she couldn't see him do anything wrong because he helped her out. E. was enabled by Heavy who got her drugs

so she couldn't see him doing anything wrong. She called him her 'big brother' and said 'the old man was wrong.'

From another interview taken by a CIS worker after the shooting:

"G. (a DAS client and sex worker) was sitting with Heavy on the stoop when he got shot. Her attitude is that he was a nice guy; but that is only because he protected her in her crime. She takes tricks off all the time. She uses cons, she 's a small lady, that is why she liked having Heavy around. She'd bring tricks to the hotel, give them crack and sex and steal their wallets."

We can draw a dense profile of the hotel as a dependency creating and addictive environment from the story of Heavy's killing alone. Understanding the positive attitudes about Heavy held by many hotel residents requires a comprehension of the economic psychology of the hotel scene. First and foremost is the judgment embodied in the presence and practices of both institutionalized and informal predators who choose to live off the hotel residents-- selecting and cultivating them as a captive prey, exploiting both their chemical and other dependencies and their monthly receipt of benefit checks. Heavy once participated in this predatory scene as a sanctioned drug dealer of the Hayden/Kent management, but returned to continue his predation after the disruption of his enforcer career due to being incarcerated. He had to return: in the hotel residents he had a captive pool of victims that could supply him with ready resources-- government money, drugs and food. In short, the behavior of Heavy and his drug dealing colleagues signified the extent to which the hotel

residents were a convenient turnstile, a pass-through point, a sieve between government money and the informal economy of drugs, sex work, and stolen goods. In order to insure this flow of resources Heavy and others like him cultivated a drug and credit dependency environment subtended by fear and intimidation. Heavy, like the drug dealers and the loan sharks, collected his own government entitlements in an ad hoc fashion from the residents, using them as human ATM machines. However, in contrast to the drug dealers-loan sharks, Heavy collected his money first and then dispensed charity afterwards, but with the same results: nurturing dependency on his control of surplus resources and toleration for his predation.

Due to the institutional predation of the Hayden/Kent management, Heavy's extortion activities were normalized, customary and easily integrated into the course of everyday life by most of the resident in the hotel; in their view Heavy's activities were not even worth mentioning, and certainly not worth killing someone for. Jesus was the abnormal one, in the eyes of many residents he over reacted: he didn't know what it meant to live in the hotel, he hadn't adjusted his behavior.

But the support for Heavy was not simply based on the normalization of violence, intimidation and predation in the hotel ecology. Heavy, despite his parasitic relation to the residents, was also an economic resource himself, a "big brother" as one sex worker at the hotel put it. Just as much as Heavy cultivated a regular network of victims like Jesus, he also cultivated a regular network of clients or

dependents, female sex workers to whom he provided protection, or residents, male or female, to whom he would periodically dole out money drugs and food towards the middle and end of each month when such resources were scarce. In turn he would collect on check day at the start of the next month through subtle and not so subtle intimidation. Heavy was what anthropologists call a Big Man Redistributor, he used his command of force to obtain economic resources from the residents, extracting these goods, currency and services as a form of tribute. And at the same time Heavy selectively and strategically re-distributed these resources in times of need thus creating a reliance on his largesse. His activities gave him status in the eyes of many residents. In this Heavy was following the precedent set by the loan sharking/drug dealing of the Hayden/Kent management. They too supplied needs and met immediate demand while insuring their own profit margin. Thus many residents have positive feelings for the Hayden/Kent manager, in the same way they liked Heavy, because she too has built a patron/client network through her loans and other little favors from which she ultimately makes her profit. What more marked sign of structural dependency can there be when the victim-held hostage maintains a positive identification with their victimizer-- and when those who attempt to halt the victimizer/victim cycle are deemed aberrant?

An auxiliary sign of this structural dependency was the residents' flight away from the Kent, and the dispersal of many of those who fled to their former support networks in outer boroughs. During the course of outreach work in the hotels, most residents complain of lack of carfare for making appointments for

alternative housing, documentation procurement, medical and drug treatment- - they present themselves to the CIS staff as an immobilized population. But after the shooting the Kent residents rapidly acquired a mobility that astounded the CIS staff. They did so because the drug selling, drug sharing and drug consumption networks that bound them to the hotel ecology were severely disrupted under the intense scrutiny of the police and the media. In the aftermath of the killing the hotel was no longer a viable place in which to buy, hustle or consume drugs. Similarly the resident sex workers who usually patrolled the adjacent underground car garages on the street could no longer ply their trade and no longer had a secure covert place to take their clients back to.

The scattering of the residents after the killing was like a movie reel winding in reverse. The accessible drugs, which once magnetized the relation of DAS and non DAS substance abusers to the hotel, were now withdrawn and the hotel was demagnetized. This repelled the users back to old neighborhoods and contacts. The shooting, the communal paranoia about the threatened revenge of Heavy's family (which never occurred), and the police and media exposure effected an instant detoxification from the hotel. The Kent was revealed for what it had been all along– a fragile and transitory edifice, founded solely on the sands of governmental neglect, popular indifference and ignorance and managerial collusion, all of which supported its seductive addictive routines, debt cycles. check days, hustles, everyday betrayals and violence.

BZB Hotel

The BZB, is a 70 room hotel in the Hunt's Point section of the Bronx. Since May 1996 to the present the CIS staff interacted with 124 contacts at the BZB, 118 were DAS clients 6 were not. In the BZB we consistently interacted with 34 residents who identified themselves as injectors and 38 residents who identified themselves as crack-cocaine smokers. Many of these substance misusers are poly-drug users. Hunt's Point is one of the larger drug markets in the city and its factory district boasts an extensive street level sex work trade. The majority of residents at the BZB are fully integrated into the drug trade and /or sex work scene of the area. Prior to July-August 1996, many rooms in the hotel were used as shooting galleries or crack smoking dens. Female and male residents conducted sex work from their rooms in the hotel, bringing clients solicited on the street back to their rooms. Because of the intensity of the drug trade in the vicinity of the BZB, (which is in sharp contrast to the neighborhood surrounding the Hayden/Kent complex) there was little evidence of involvement by the former management of the hotel in the drug trade. Many of the illicit residential room arrangements found at the Kent were also present at the BZB. Including the pairing of a DAS resident and a non DAS sex partner, room subletting and squatting in empty rooms. Sleeping on stairs and stairwells, bathrooms or on upper floor hallways were not evident in the hotel.

In August 1996 H.I.R.E. (Health Improvement Resources Enterprises Inc.), a specialized social service management operation took over the day to day running of the BZB under a contract with DAS. This organization brought in a "professional" intervention team with the mission to move BZB residents from the

hotel to appropriate alternative housing or residential drug treatment facilities within a 90 day period. This team included social workers, who were meant to be specialists in housing placement, and drug counselors meant to place residents in drug treatment facilities. They were supplemented by an on-site nurse and an occasional doctor. The management introduced major structural changes into the hotel that attempted to regulate residents' behaviors. Residents had to leave their keys at the desk every time they left the hotel. The management banned any outside visitors to the hotel including the immediate family of residents. Management banned all drug use in the hotel and backed up this ban with regular surprise room searches in which management forcibly entered residents' rooms in their absence and without their permission. The management banned refrigerators and hot plates from the rooms and forbade all storage and eating of food in the rooms. H.I.R.E. introduced a food service that provided residents with three meals a day. In turn the residents were subjected to a cut in their food stamp allotment because of the meal service, all of which the residents resented for the food stamp cut and the poor quality of the meals.

The attempt by management to actively ban drug use in the BZB, to restrict residents to meals provided by the management, to halt all eating and storage of food in the room dramatically increased stress levels among residents in this hotel. This was expressed in several ways: loss or weight, visible depression, increased conflict with hotel management, relapse into substance abuse by residents who had been abstaining, increase in drug consumption as evidenced by higher demands for bleach kits, the expansion of drug taking networks as residents moved from drug ingestion inside the hotel to outside the BZB, and the

relaxation of drug taking harm reduction precautions as drug consumption moved rapidly from structured settings (hotel) to unstructured settings (street). The Hunts Point area offers a multiplicity of illicit injecting sites beyond the hotel. Adjacent to the BZB is a rooming house with some DAS residents, and a number of BZB residents would repair there to inject or to smoke drugs. The official ban on drug ingestion supported by the room searches merely drove substance misuse further underground and pushed heroin/cocaine users towards higher risk injection practices. Initially after the entry of HIRE, many residents were afraid to request bleach kits from the CIS staff on hotel premises. The CIS staff increased distribution of harm reduction materials to hotel residents off premises in response to these fears.

The SRO project outreach team had been servicing the BZB three months prior to H.I.R.E.'s take-over of the hotel and continued servicing the residents during and after the take-over process: thus they were in a special position to monitor the effect of the new rules and regulations on the residents. The maintenance and increase of the levels of harm reduction materials distribution, and workshop and referral provision to residents at the BZB by CIS staff, months after the HIRE take-over, is indicative that the new administration left many needs of residents unmet which were addressed by the CIS outreach effort. (See discussion of outreach consistency and confidentiality below.) Further, the continued request for harm reduction services by BZB residents indicates that professionalization and medicalization of SRO hotel administrations, even when enhanced by social service and drug counseling staff, does not do away with the need for a harm reduction intervention.

The association of SRO social service and medical staff with various forms of compliance and administrative penalties will always structurally limit the development of client confidentiality particularly as it pertains to substance misuse. Whereas a harm reduction approach not associated with compliance or enforcement mechanisms can build open-ended client confidentiality and reduce risk factors for SRO residents.

BZB residents, facing surprise room searches for drugs, took their drug ingesting activities outside the hotel into environments where risk reduction would be harder to maintain and where access to risk reduction materials and education is more uncertain. By moving outside the hotel in search of secure spaces in which to inject, the BZB IDU enlarged his/her drug injecting network, therefore increasing risk factors for self and others. However the CIS staff were well positioned to provide the BZB injectors with bleach-kits and with personal support for the maintenance of safe injecting practices off the hotel site once they discovered where these new injecting sites were located.

In the BZB people shied away from investigating alternative housing referrals because the H.I.R.E. social workers instituted a policy of providing alternative housing referrals only to those residents who they identified as "drug free." One resident was denied public housing by a social worker because she claimed he "smoked marijuana." Since the hotel is located in Hunts Point, a notorious drug infested area, keeping substance abusing residents in this neighborhood did not contribute to their abstention from drugs or their chance for recovery. This policy has instituted a high threshold obstacle to the resident's accessing housing

outside the hotel. It was inevitable that such policies at first inhibited residents willingness to approach our outreach staff for such referrals under the mistaken assumption that we followed the same policy. Due to the drug ban and other new regulations instituted by the new management, between August and September 1996 many residents, instead of looking to long term alternative housing solutions, talked about hospitalization or checking into hospital emergency rooms. Between August 1996 and January 1997, based on field interviews with BZB residents, the majority of residents transferred from the hotel during or at the terminus of the 90 stay period, were moved to other SRO hotels and not to alternative housing.

Case History: Larry D., BZB.

Larry D. is a 42 year African- American living, and former IDU user, who was currently using crack when the CIS team met him. Larry's T-cells count were down to 3. When he was released from jail in April 1996, he was very thin, depressed and physically weak. Larry's room was on the fifth floor and it was difficult for Larry to walk up and down the stairs. The CIS team spoke with the management and Larry was moved down to the second floor. There were many times Larry was unable to access food, and the CIS team would buy him a sandwich and juice. Larry was very ill. He needed to be placed in a congregate care facility.

The Visiting Nurse Service was contacted. There was nothing they could do for Larry because he did not have medical insurance. Two members of the CIS team escorted Larry down to the Waverly DAS office, where Larry received his Medicaid card and the appointment was made for visiting Nurse Service to come to the BZB hotel to do a pre-screening. VNS did the pre-screening and removed Larry from the BZB. Hotel, and placed him at Bronx Lebanon Hospital. Larry was then placed at Casa Promesa until he passed away on December 12, 1996.

No AIDS related nutritional standards are observed by management in the food menus they serve. The food is fatty, over-cooked and served cold since it is cooked elsewhere and delivered to the SRO. The person who serves and prepares the food does not wear sanitary food preparation gloves. Powdered eggs are served every morning and cold cuts are served for every lunch.

Dinner, consisting always of boiled chicken and boiled vegetables, is served at 6:30pm. The meals are served in a back room of the hotel that lacks any ventilation. It is approximately 12 feet by 9 feet and 30 to 40 people are crammed into this space during meal times in a room that could only comfortably fit 10 people. The management spends approximately $5 per diem per resident for their 3 meals. The food is prepared by food service outside of the hotel and frequently delivered luke warm to cold to the hotel. At lunch-time residents are served meat sandwiches that have been previously frozen and that are hastily and incompletely defrosted before lunch. Due to the ban on food inside rooms, residents who cannot easily, for health reasons, move in or out of the hotel do not have any access to food between 6:30 p.m. and the following morning. This situation can pose a particular problem since many residents have nocturnal living and eating patterns, and their health conditions require more frequent and numerous eating regimens. Under the new rules they are unable to store food in their rooms to alleviate having to go out. Since the management now appropriates the residents' food stamps as part of the payment for the meals being served, residents have reduced financial resources for obtaining additional or alternative nutrition. Residents are very aware of these deficits and are not eating the food offered by the management or they are eating it inconsistently, thus the residents are loosing weight and the physical consequence is discernible in the appearance and behavior of many of our clients at this hotel. The ban on taking food back to rooms and on eating in rooms also places major obstacles for those residents who are not fully ambulatory and who were originally in the habit of having neighbors pick up food trays for them before management forbade all eating in hotel rooms. The CIS staff found no

systematic assessment of the mobility of room residents by the H.I.R.E. staff to determine who could not leave their rooms at meal times.

In October 1996 a resident at the BZB died from a cocaine overdose and his body was left in his room for two days before the death was discovered despite complaints from neighbors concerning odors emanating from the room. The management requires residents to turn in keys whenever they leave the hotel and has residents signing for meals three times a day. Hotel staff also perform periodic room searches whether residents are in their rooms or not. Despite these procedures, none of the hotel staff noticed that this deceased resident had not taken meals, nor left his room, nor turned in his key in almost three days. This event indicates that the new management has not improved the overall safety of hotel residents despite their attempt to prohibit drug use at the hotel. They have simply rendered drug use more covert, and more risky, but not less prevalent.

Case History: Violation of Client Confidentiality

The HIRE social worker Blanca at the BZB asked a CIS worker and the project ethnographer into her office, ostensibly to provide her with referral resources on drug treatment programs. She was in the process of handling a housing placement for a African American women with knife scars on her face. The client was asking for scattered site housing and the social worker was insisting that the women needed a treatment facility, that she could not live on her own. The client insisted that she wanted to be reunited with her children and thus wanted scattered site housing. Suddenly the social worker stood up and began screaming at the client calling her mentally ill and incapable of taking care of herself. "She's not right for housing because she doesn't take her medications regularly" she told us. We immediately withdrew from the room considering both the social worker's behavior and our presence to be professionally inappropriate. Blanca had deliberately used our presence in the room to reinforce her authority over the resident which is a back handed tribute to the level of credibility CIS staff have built with BZB residents. However such violations of client confidentiality can rapidly erode that credibility. From that time onward we maintained as much distance from HIRE staff as possible in order to continue working in the hotel with the residents' trust.

Our outreach staff have witnessed the social workers and case managers of the new administration belittling, and screaming at residents; this further raises stress patterns which can reduce residents receptivity to any alternative outside advice or education. Residents complained of having referrals forced upon them as one resident said of the local social worker discussed above: "This woman thinks she's Hitler ordering me around without asking first." One resident was thrown out of the hotel because he solicited a referral from the Center's street outreach team that works in the Hunts Point area. When we followed up on this case the H.I.R.E. social workers insisted that they be informed by us of any referrals we make with BZB residents which would be a violation of our confidentiality agreement with those in receipt of CIS or AOP referrals.

Case Histories: Room Closing and Drug Treatment.

J., a white male IDU living in Room 209 at the BZB asked for a referral to Turning Point from AOP street outreach workers.[9] He informed Dr. Pena, the on-site primary care physician at the BZB that he was going to Turning Point but didn't inform La Porte the on-site manager. HIRE claimed that hotel management wasn't officially informed, so while he was away at Turning Point at the end of two weeks absence they closed his room and moved his belongings into the basement. They essentially evicted him in the middle of the month with only 14 days absence.

A. W. From BZB was enrolled at Turning Point upstate. His case worker from Turning Point told A.W. that his insurance would not pay the amount required for the full treatment time. A.W. had to return to the BZB He was gone for about two weeks to three weeks. Turning Point attempted to procure an extension on his coverage for him but he wouldn't take it because he feared loosing his BZB room since the extension would take him beyond the time he was permitted to be absent from the hotel. However H.I.R.E. still closed his room after three weeks absence and dumped his belongings on the side walk in front of the hotel.

[9] The Center of AIDS Outreach and Prevention (AOP) operates street outreach teams in the Hunts Point area under a different grant in addition to the SRO CIS team which works mainly in the hotel and their environs..

The professionalism of the H.I.R.E. staff is called into question by the fact that their drug counselors requested extensive information on drug treatment placement from CIS staff because they lacked their own resource directories. In addition the H.I.R.E staff made repeated attempts to get CIS workers to violate the confidentiality of CIS clients and disclose personal information to them about clients on their case load. Another form of inappropriate behavior on the part of H.I.R.E. employees, occurred when Mr. La Porte the manager of the site approached one of our CIS workers about having him refer BZB residents for counseling to social worker colleagues of Mr. La Porte, who offered to supply the CIS worker with a list of designated counselors all of whom maintain offices outside of the hotel.

California Suites

California Suites is a 100 room SRO in the Columbia University area. Like the Hayden the up-keep of its frontage disguises the multiple illicit activities based in the hotel practiced by management and residents-- not to speak of the serious environmental health hazards in the hallways and rooms. Between May 1996 and January 1997 we interacted consistently with 112 individuals of which 103 were DAS clients and 9 were not DAS clients but were residing in the hotel. California Suites is a center for heroin and crack trade– 61 CIS contacts identify themselves as injectors and 39 as crack-cocaine smokers.

Case History: G G. California Suites

"G. G. is a 37 year old, African American male IDU, residing at the California Suites. G.G. needed clean needles when the CIS team first met him. The CIS. team gave him bleach kits and the address of a needle exchange program. G.G. was not sure that he wanted to stop using drugs. He had tried before and failed. We established a rapport, and he said he would think about detox. G.G. continued to take bleach kits, condoms, food pantry referrals and hygiene kits from the CIS team.

G.G.'s mother became ill. He visited her, and when he returned to the hotel he wanted to go into detox. He was ready to go into Bronx Lebanon Hospital detox, but was refused because he had chosen an HMO that Bronx Lebanon Hospital did not accept. G.G. did not give up. CIS team found one detox at Metropolitan Hospital' that accepted him. Presently G.G. is seeking primary medical care. He needs updated paperwork to seek supportive housing. He is trying very hard to keep from using. G.G. has stated that it is hard to stay clean in the hotel because there is plenty of drugs."-- CIS worker

There is a thriving sex work industry comprised of female and male sex workers. The female sex workers pick up customers among the shops on Broadway and the male sex workers use a parking lot in nearby Riverside park to meet customers in their cars. Synthetic heroin has been sold in the hotel since September 1996 and has resulted in a number of overdoses and one heart attack among residents (one OD was witnessed by Dan Tietz, HOPWA Coordinator, during a site visit to the hotel in October). The hotel is also an active market for the sale of both new sterile and used dirty syringes. The high degree of drug activity combined with the need to keep this activity low key in terms of the perceptions of the surrounding middle class neighborhood, means that residents prey on each other. Room robberies are common place in the hotel and it is usual to come across rooms with busted doors and locks that have been abandoned by their residents.

Case History: Room Robbery

M.G. is a 36 Hispanic male, as a CIS staff person described him. "I first met M.G. on January 23, 1997 at the California Suites. M. G. was crying and telling me that he had just came from the hospital and his room had been broken into. M. G.s was very broken and deeply hurt, he stated that he found crack vials on the floor, candy wrappings, cigarette butts and burn marks on his rug. "I give up" he shouted, "fuck it, I don't give a fuck anymore."

"We told M. G. that we were his tools and that he could utilize us to his advantage. Then M.G. calmed down stopped crying and told us he needed a wheel chair to get around, we made a phone call and his counselor said he sent M. G. his wheel chair on Tuesday. On Monday we told M.G. the good news and he seemed very motivated and high spirited."

The frequency of robberies combined with the frequent visits of the warrant squad render residents initially reluctant to open their doors to strangers such as the CIS team. In the California Suites we encountered a new form of theft– kitchen robberies. Food left cooking on a stove unattended will be taken, a practice that limits use of the kitchen and contributes to the degeneration of nutrition standards among the residents. Many of the hotel's hallway kitchens have cat and other animal droppings scattered about which rendered them unsanitary and unsafe for use.

The women residing in the hotel are on constant guard against sexual assault and intimidation. Most of the women will only use the showers or bathrooms when accompanied by a female friend who will wait inside the bath room and keep watch. Women residents have been propositioned and sexually assaulted inside the bathroom by other residents and hotel staff. They have a particular fear of using the bathroom and shower facilities at night. Jars of urine kept in the rooms of female residents are common and CIS staff view this as evidence of female residents' fear about using hallway toilets.

Perhaps the most noticeable environmental health hazard observed in the hotel are the filthy hallways which is the condition that most depresses and demoralizes residents. Cats openly run around the hotel urinating and defecating on hallway carpets. The hallway carpets retain all the odors and are infested with insects that can be seen flying from out of and around the shag. "There are times when we talk to residents and we have to hold our breath" said one CIS worker. CIS staff, conditioned to marginal hygienic conditions in other hotels, single out the

California Suites– complaining that they leave the hotel with odors on their clothes and outreach bags particularly if those bags have rested on the floor. CIS staff have observed garbage thrown in the hallways and the animal odors have progressively worsened during the course of the project. Cleaning staff have been observed dipping their mops in the communal hallway toilets in order to mop the floor. Thus it is not surprising that on certain wings the bathrooms and the have had locks put on them by the residents in an attempt to keep these spaces sanitary. Between December 1996 and January 1997 living conditions and odors in California Suites degenerated at an accelerated rate to the extent that CIS staff are not able to enter one of the wings of the 2nd floor because of the hallway odors. Recently, rodents have been seen by CIS staff in the kitchens of this hotel.

Case History: C.T.

"When we first worked the California Suites C.T., an African-American male in his thirties, he wouldn't open the door and didn't mingle with other residents. He did not use drugs but in the time that we were there he began injecting heroin. During this period we arranged a housing placement with Gabriel House, but there were delays in his transfer. One day CIS staff encountered him going to buy heroin because he was depressed with the delays in his housing placement, but meeting the CIS team made him decide not to cop. " Man if I wouldn't have seen you guys I would've gone and copped." He talked about the smells, the basic hygiene conditions and stated "in order to live here you have to medicate yourself." CIS staff person

Residents capacity for self regard and self esteem is severely damaged by the conditions of many hotel rooms and hallways. CIS staff have seen rooms that are not cleaned at all, in which the linen is rarely changed and even rooms without beds. Residents do not have a basic living environment upon which to base the cultivation of life skills. Showers have been removed from individual rooms which

further lowers residents' sense of control over their environment and their lives which impacts on many other areas of their behavior requiring self esteem.

Case History

"R.C. is a 32 years old, black, female. crack smoker living at the California Suites. She was initially reluctant to talk with the CIS. team at first. Her attitude was that she did not need any help. she would take the harm reduction supplies, and quickly disappear back into her room. She started asking questions and established a rapport with us shortly thereafter. R.C. was on probation and was not reporting regularly to her appointments. She needed someone to intervene with her probation officer. Her probation officer wanted R.C. to get medical care. He was happy that R.C. was talking to the CIS team.

CIS staff made an appointment at St. Luke's clinic for R.C. She never kept the appointments. She had many excuses, but staff kept visiting her and showing her that they cared. When R.C. knew the CIS team was in the hotel, she would come looking for the team. R.C. confided to one staff member that she was pregnant and that she did not want to lose this baby to the system like her other children. We talked, and staff told her to walk in at Mt. Sinai's prenatal clinic as soon as possible and there she could get immediate help. She followed-up, and now she is getting the necessary care she needs. Her probation office, the caseworker at Mt. Sinai and CIS staff stay in touch. I still see R.C. whenever the CIS team visits the California Suites. 'Some days are better than others' she tells me. She has many problems with her health, but she wants her baby. The caseworker at Mt. Sinai says she will be able to enter detox after her medical work."-- CIS worker

As in the Kent and Hayden, the California Suites management are complicitous in varying degrees, with the illegal drug and sex work economies and with the degenerating health conditions of the residents. For instance there is an active prostitute stroll on the first floor behind the reception office. Sex workers, most of whom are based on the third and fourth floors, meet their clients there who come in off the street after making an appointment by phone. They need to escort their clients though the hallway lest the john is stolen by other sex workers congregating there. Outside visitors to the hotel have to check in with the reception desk before visiting residents. The sex worker's clients never do so, these non-residents simply walk in straight to the hallway alcove behind the

reception desk office and are never stopped or questioned by the managers– leading to the conclusion that the management profits from the sex trade there. Similarly on the first floor, only yards away from the management office there is an active shooting gallery with a resident hit doctor who specializes in injecting clients who can't find accessible veins.

Case History: Selling dirty syringes

C.O. is a 35 year old (gay Hispanic) in room 405 who uses heroin and crack, and S, an African-American, age 47 who uses alcohol and heroin. They both separately told CIS that due to the cut backs in SSI money for people in methadone and alcohol treatment, people are intentionally buying dirty needles to inject themselves in order to get DAS eligibility. C.O. works a gay stroll with clients who come from other parts of the city, and are willing to pay $10 to $15 dollars for a dirty needle from someone with HIV, such as the IDUs who work the stroll. Most of this dirty needle selling activity is occurring at California Suites, which is serviced by a needle exchange.

K., who is not DAS, or officially registered at the California Suites used to smoke and deal crack sporadically. He lived with a woman who was DAS and registered at the hotel. She went to jail and he stayed in her room till it was closed. He then moved into the room of a white resident who was shooting heroin. And shortly afterward he started shooting too. He told us he was deliberately sharing needles with his HIV positive roommate, because he said this was the best way to insure that he would get a room in California Suites. He wanted a DAS type room. He's been sharing needles with his roommate for 6 months now.

Residents have reported that management charges them supplementary additional rent of about $60 per week on top of what the hotel receives from DAS. Management is known to run a loan-sharking operation in the hotel. Residents pawn possessions like radios and television sets at the manager's office in exchange for loans. Residents also report that those who redeem their possessions subsequently have their rooms broken into and the formerly pawned article is stolen. Residents feel that management may thus be complicit in some,

though not all, of the room break-ins that occur at this hotel. As in the Hayden and Kent hotels, the California Suites management will, for a fee, keep a room open for those residents who are incarcerated. Management will cash DAS and SSI checks at special check cashing spots taking up to 1/3 of the check as part of their repayment for moneys lent to residents.

Recently, the manager at the California Suites attempted to prevent CIS staff from delivering toilet paper to residents and expressed his willingness to distribute the toilet paper himself. He was refused. CIS staff suspects that he wanted to use the SRO toilet paper for the hotel 's bathrooms thereby relieving himself of the burden of supplying these facilities. Toilet paper is in great demand by residents because management infrequently distributes these supplies and the bathrooms are usually the first place in the hotel to be vandalized.

The management at the California Suites advertised a buffet Christmas dinner for residents to be served at 3 PM the day before Christmas. Residents reported they repeatedly checked the lobby, coming down from their rooms for the dinner, but it was never served.

Carver Hotel

The Carver Hotel on Prospect Avenue in the Bronx is a 70 room SRO adjacent to the Hunt's Point area and thus its residents, like BZB residents, are economically linked to the drug and sex trade of that area. CIS staff have regularly interacted with 84 residents at this hotel: 78 DAS clients and 6 non DAS clients residing at the

hotel; we interacted consistently with 38 residents who identified themselves as injectors and 36 residents who identified as crack smokers. While the other hotels described here have been worked since May 1996 the CIS staff finally managed to negotiate access to the Carver in October 1996. There is an highly active heroin injection scene at the Carver hotel, 33 residents identify themselves as heroin injectors and 28 identify as crack-cocaine smokers.

Case History

D. U. is a white male in his mid forties currently enrolled in a methadone program but still an active substance misuser. He uses pills, crack and cocaine and prior to that had been injecting heroin for 20 years. He was repeatedly hospitalized for PCP but was unaware that he could be preventing this to some extent by observing a regimen using Bactrin every other day. The CIS team apprised D.U. about the importance and techniques of using Bactrin. D.U. claims he still use drugs to deal with the boredom and the stress of living at the Carver. He identifies with his methadone program which affords him a social life that he does not pursue at the Carver where he remains aloof from the other residents. D.U. now waits for the CIS team to arrive on scheduled days, either in his room or in the hotel hallway.

A significant number of the Carver's female residents, like their counterparts in the BZB, are sex workers that stroll the Hunt's Point factory district, bringing their johns back to their rooms in the Carver. However rooms 124 and 131 are reserved by hotel management for a higher priced sex trade conducted by non-resident sex-workers and other rooms are rented on an hourly basis to outside couples. These rooms are usually let only on the weekends. CIS staff have been warned by management not to knock on these doors. These rooms are differently furnished than the rooms of DAS clients. Once when we knocked on the rooms an attractive woman answered " I don't want to talk to anybody I work here." The management does not seem to be involved in the drug trade

and CIS staff have identified two drug buying spots frequented by hotel residents within a block of the hotel indicating the easy access there is to heroin and crack.

Carver Case History

F. Is and African-American in her mid thirties. She is a DAS client living at the Carver hotel in room 633 and who operates as a sex worker in the Hunts Point factory stroll. She makes $250-$300 per night all of which is used for the purchase of crack-cocaine. The CIS team first met her at the BZB which transferred her out to the Carver, a even more high risk drug taking environment than that of the BZB. She accepts condoms and food pantry referrals from the CIS staff and has confided that management allows her to bring back tricks to her room at the hotel. Her neighbors complain about fights and doors slamming shut at night.

Management maintains a loan-sharking business, charging a 100 percent interest on the principle amount loaned. The hotel manager has "a personal posse" that serves as loan collectors. In order to get a loan the resident has to hand over photo ID cards, used for check cashing, Medicaid cards and food stamps as security for a loan. On check day the loan posse accompanies the resident to a check cashing place to secure repayment. The loan posse is not the only resident labor the management uses-- residents can be seen performing maintenance tasks, such as cleaning and painting of hallways. One such painter was the wife of a DAS client; she lives with her husband at the hotel but is not a DAS client herself. The residents who are drafted into these work crews are, more likely than not, people in debt to the management working off their loans. The use of staff in these "trustee" position resulted in food theft of God's Love we Deliver Meals. In response the CIS team arranged for God's Love We Deliver to deliver food directly to the doors of residents registered with the service. Further the CIS team pursued an aggressive campaign of registering Carver residents with God's Love, a process that was greatly facilitated by the mobile phone that

permitted the food service to conduct on-the-spot intake interviews as CIS staff recruited residents.

Case History

Celia was an African American ex IDU in her mid forties. CIS staff encountered her in the hallways of the Carver where she was begging residents for food and for carfare in order to get to her methadone program. She was a tall emaciated women with white froth on the corners of her mouth she told us that she hadn't eaten in several days and had no money for food and carfare and thus had not picked up her methadone dosage for several weeks-- meaning that she probably had relapsed back into heroin usage. Using the cellular phone and scanty information provided by Celia the CIS team contacted her methadone program, managed to locate a her case worker and arranged for an ambulette pick-up to take Celia to the program. Many SRO residents registered in methadone programs are unaware that there are services such as this one that can compensate for any mobility problems they have. Celia died two months later after this encounter.

Though the Carver does not exhibit the dire environmental conditions of the California Suites, many of its room doors are damaged and look broken into. A DAS client who was originally on the 5th floor was repeatedly robbed so management moved him to successive floors. The robbers followed this resident from room to room resulting in management finally moving him to the first floor where they could supposedly keep an eye on his room to prevent further robberies.

An HRA worker maintains an on- site office in the hotel but rarely comes into contact with the residents because the office is frequently closed during day time hours. Residents confirm that her office is frequently closed and when she is present the office door is always kept shut. CIS staff learned that many residents are unaware that there is an HRA office in the lobby of the hotel.

We have left harm reduction materials with the HRA worker to distribute to residents when we are not there and residents report to us that the office is never opened long enough for them to access these materials during times and days when the CIS staff are not present.

God's Love We Deliver provided hot meal service for a small number of residents at the hotel when the CIS team began working there. In the past two months CIS staff have registered many additional residents for this food service. This response indicates that the HRA staff person does not conduct ongoing nutritional needs assessment of the hotel residents.

Case History Carver Hotel Room 215

CIS worker testimony: "When I first met Mr. M., age 38, an Hispanic Male at the Carver Hotel he was on a methadone program and living in a small unsanitary room where Mr. M. was at risk of becoming very ill because of the foul conditions. Mr. M. had broken his leg in the hotel. Mr. M.'s broken leg became a handicap as far as traveling to his methadone program, and for getting meals on time. The team managed to help Mr. M. by getting him a ambulance to pick him up and taking him to the program and we also got Mr. M. God's Love We Deliver. Mr. M. has two opportunistic infections."

A DAS client and hotel resident (Mr. M.) slipped on the hotel floor damaged his leg and was unable to leave his room (216) for two weeks last month. When CIS staff encountered him he hadn't eaten for three days, CIS staff immediately connected him to the food service, noting his comment that he was never visited by the HRA worker even though his injury was common knowledge to hotel management.

The HRA worker at the Carver maintains a system of favoritism selectively distributing food to residents. Cases of food are visibly displayed in her office, When CIS staff once sent residents down to get this food they returned with empty bags, telling staff that the food had already been distributed and that they were told to come back another day. However when CIS staff went downstairs to the HRA office, that same day to verify these reports, there was another line of residents waiting to receive the same food observed earlier by CIS staff. Many clients who are checked into the hotel on Fridays and weekends spend the weekend without any food for lack of financial resources. and information about nearby food pantries and soup kitchens.

G: Intervention Chronicle

Dynamics of Harm Reduction in the Hotels

Within the first two week of conducting outreach to the hotel the CIS staff quickly learned the critical outreach attributes that became the ground of any future efficacy. Consistency, confidentiality and continuity of care are all necessary components to facilitate and establish the credibility and trust of the outreach staff for the hotel residents.

During June 1996 CIS staff began to receive reports from hotel residents expressing surprise that we maintained a consistent visiting schedule with hotels. Many contacts related the view that we were the first program that visited the hotels and then made return visits. Most programs visited once and never came back. At some hotels we found residents waiting for us on the front stoop, in anticipation of our scheduled visits.

Consistency> Consistency was also important to program efficacy because of the arbitrary and unsystematic application of DAS regulations by DAS workers and because of manipulative room regimes by hotel managements or on-site HRA staff. The CIS team offered an alternative model of service delivery to DAS clients in relation to what they had become accustomed to and estranged from. SRO hotel residents have poor and intermittent relationships with social service bureaucracies. Most SRO residents live in a world where they cannot count on predictable support relationships from neighbors (who will betray them for drug-related needs), from their families from whom many are estranged or

geographically removed (since most DAS clients are placed in hotels at some distance from their home neighborhoods), and from indifferent to hostile and unreliable public service providers.

CIS staff became a predictable event in SRO residents lives by maintaining regular room visiting schedules and hallway walks. This level of accessibility and reliability is in marked contrast to some service providers and the social relationships outlined earlier. Another important aspect of the CIS field practice was that staff never unduly raised expectations among their clientele. CIS workers never made promises they could not keep and followed through on those services they did offer or refer to.

Case History PJ

PJ was client we worked with from the BZB annex. He went to jail and was subsequently released to the BZB proper. He was then transferred to the Kent because he continually accumulated debt they he never paid off. He had damaged his leg and while at the Kent a resident was urging him to contact the CIS team as we came onto his floor doing outreach The staff witnessed PJ stiffening and reacting to this suggestion. To the Kent resident who made the suggestion he declaimed proudly "I knew these people before I ever got to the Kent, you don't have to tell me about them!"

One important result of consistent room visiting combined with a non-judgmental approach to hotel residents is the momentary suspension, if not removal, of social stigma associated with being an SRO resident. SRO residents are quite conscious of the social bias and low status that applies to people living with AIDS, substance abusers, and the visibly ill. Residents are also extremely sensitive to the impoverished and frequently sub-standard environments in which they live and their own often unkempt personal

appearance. The consistent room visits by CIS staff, as well as their holding of open-ended needs assessment conversations, impressed hotel residents. In addition outreach staff were not visibly put off by the un-hygienic conditions of hotels, the rooms, or the residents. Staff did not exhibit any bias or fear towards hotel residents because of their sero status or other medical conditions. This willingness on the part of CIS workers to repeatedly engage hotel residents on the latter's terms and in the residents' living conditions won great credibility in settings where few people trust others or show them any respect or civility.

In August the on-site manager at the Kent hotel remarked to the CIS staff that many residents appeared to abstain from drug ingestion and took greater care of their personal appearance and cleanliness on those days that CIS staff visited the hotel. Consistently maintained scheduled visits imported a temporal structure into the hotel, introducing a bit of predictability and order two to three times a week, that was welcomed and affected the presentation of self by the residents.

The CIS team was in constant pursuit of conversation and personal contact with substance mis-users in the hotels. But sustained contact is not easy to achieve. The distribution of free harm reduction materials is merely the means for establishing connections that may lead to attitude change and altered risk perception by hotel residents. And every outreach worker knows that it is the manner with which these materials are given that mediates their acceptance and use.

The selling, buying, injecting and enjoyment of drugs mixes three activities: business, illness and temporary mental/physical cure. This potent combination is characterized by a highly compressed and urgent time structure. The faster one can sell, buy, make money, and ingest, the more business can be done and the swifter the symptoms of illness can be held in abeyance. The clandestine and illegal nature of these activities imposes a further temporal urgency on these acts. The temporal compression of transactions in the drug market is expressed by the state of being *'on-a-mission'* which is a frame of mind, an attitude towards the world, a visible body posture, in addition to being a specific drug-related task. Purchasing, selling and ingesting drugs are goal-directed, monolithic and purpose filled activities. "The mission" allows little room for anything that does not directly contribute to its successful completion. Thus, in order to have the type of conversations through which they can convey health messages, propagandize harm reduction and/or make a referral, the CIS team had to find ways to either infiltrate, or work around, the closed structure of "the mission."

The case histories in this report, the intimate biographical and ethnographic details bear witness to the most important achievement of the CIS team: the carving out of an alternative and provisional safe space from the closed geography and time compression of drug-related practices and the demoralizing ambiance of the hotels. Within the busy to-and-fro of drug markets, loan sharking, sex work, hotel-based shooting galleries, and users on-a-mission moving with method and motive from place to place, the CIS team have been able to fabricate micro-niches for a type of interpersonal contact that is rare in the social and economic settings of substance misuse.

The CIS staff conducted health education, life-skills workshops and case management in 'unstructured' indoor and occasionally outdoor settings. They used their personal knowledge of certain life styles and clandestine behavior, their own social credit built up over time, and sheer persistence, to make and maintain contact with individuals who deploy invisibility and evasion in the conduct of their affairs. The biographical information and ethnographic detail about clandestine activities in the hotels in this report is not only a portrait of harm reduction contact with a particular resident, but of those alternative zones and moments of interpersonal contact which the CIS team literally forges from thin air within the generally anarchic hotel environments. Unlike most social workers, the CIS team have no office, no schedule of enforceable appointments with persons officially designated as clients, and wear no badges of authority. In a process of exchange, the CIS team convinces potential clients to donate some of their time to the team so that in the future they could make claims on the time of the CIS workers. The ethnographic detail in this report documents this reciprocity. In environments characterized by generic insecurity, debt-based obligations, and intimidation this type of reciprocity is rare.

Confidentiality> Quite early in the field intervention hotel residents impressed upon staff the importance of confidentiality to winning their trust. Residents at the Hayden complained vociferously about the tendency of the on-site HRA worker to disclose personal information about residents who were in his disfavor to his network of favored residents to whom he afforded special treatment. In the BZB after its management had been taken over by Health

Improvement Resource Enterprises Inc., instances occurred where the social service staff publicly violated residents confidentiality in front of the CIS staff.

The impact of our consistent visits and maintenance of strict confidentiality was apparent by July– after two months into our intervention. 40 referrals were written for residents to services during June, a month that had 16 working field days. The high number of referrals for this duration of time and during the start-up phase of the project was indicative of the qualitative interactions between the CIS workers and the hotel residents. At the same time CIS staff were able to complete on the-spot data collection with newly designed forms. These, modified HOPWA intake forms, are designed to record personal history and financial information from new contacts made in the hotel, and could be completed, under fieldwork condition, only with the trust of the hotel resident and the resident's faith that the information collected would remain strictly confidential. CIS staff would not have dared asked some of the HOPWA information questions of newly met hotel contacts at the beginning of fieldwork because of the personal nature of many of the questions. By July CIS workers were able to go back to residents met during the first two months of the intervention to complete the data collection process for "new" outreach contacts. Staff were able to do this because the reputation of the CIS staff had spread through the hotels and enabled the gathering of this information.

Continuity of Care> Continuity of Care which in part was based on consistent site visits, also entailed the capacity of the CIS staff to link together different

components of their fieldwork intervention to enlarge the scope of harm reduction interventions. For example in the first weeks of room visiting in the hotels it became apparent that one cause of the un-hygienic conditions in rooms and bathrooms was the time lag between changes of linen, and the provision of amenities like toilet paper, towels and soap to the rooms by management. SRO residents told us that toilet paper was given out once a week at a specified time and was not available at any other time. Some hotels never gave out toilet paper. The CIS staff quickly added toilet paper rolls and hygiene kits to the harm reduction materials disseminated to the residents. Originally it had been intended that qualitative contact with SRO residents would be made primarily through the offer of condoms, bleach kits, AIDS literature and referrals services. These materials were crucial engagement vehicles, yet they were surpassed by toilet paper and hygiene kit distribution as media for initiating conversations with residents. And certainly, unlike the bleach kits and condoms, toilet paper and hygiene kits addressed the needs of residents who were not heroin or cocaine injectors and who did not engage in sex.

Nutrition is also a major continuity of care issue. The nutrition needs of hotel residents was apparent to anyone who visits the hotels and CIS staff realized that food provision was a necessary service and contact incentive. However since the initial program design did not envision food provision or a company vehicle, the SRO project did not have the resources to provide consistent bulk deliveries of food for residents. (Though many individual CIS worker brought residents food on their own.) Intervention workers took steps with an already

established referral linkage, a food pantry on 86th street, to agree to supply emergency food to hotel residents holding our referral slips on days and during hours outside their regular distribution schedule. This pantry serviced our clients from the Hayden, Kent and California Suites hotels.

In order to be able to negotiate referrals to food services (as well as drug treatment and primary medical care services) CIS workers needed to spend extensive time in the field on pay phones which are frequently not available or easily accessed-- a process that reduces CIS contact time with residents. In the early months of the project staff regularly had to borrow the use of the hotels' front desk's office phone. Locating and using the phones in this manner removes CIS workers from interactions with residents for significant periods of time and is not efficient. The acquisition of a cellular phone for use in the field increased our capacity to make rapid referrals without taking CIS staff off the hotel floor and away from conversations with residents. Given the inability of most hotel residents to tolerate long delays in service delivery this cellular phone was a crucial technological support. Having the cellular phones particularly facilitated intake interviews with God's Love We Deliver. Their intake process requires such interviews before deciding on the eligibility of hotel residents to receive food deliveries from them. In October we can document a sharp increase in the use of the cellular phone for arranging referrals, client advocacy and service provision. (CIS staff arranged for door to door meal delivery for Carver hotel residents because workers observed hotel staff stealing food from God's Love food trays that was meant for

residents. This occurred when the food trays were left by God's Love in the meeting room adjacent to the manager's office.)

H: From Harm Reduction to Case Management and Client Advocacy

Three factors encountered in the SRO hotels compelled important alterations in the content and scope of program field interventions:

- At least 50% of DAS residents the CIS team met did not have M11Q forms or up to date M11Q forms which affected their capacity to access alternative housing, primary care and more specialized health related services. Further DAS clients found it almost impossible to obtain copies of their M11Q forms from DAS workers who refused their request. When staff investigated these claims with DAS workers they verified the refusal but justified their action by saying that SRO residents sell M11Qs. The same is true for residents making requests for M11Qs from methadone clinics in which many residents were enrolled.

Case Histories: M11Q denials

1. Michael _____, is a resident of the SRO hotel at California Suites, on West 111 St. in Manhattan, his DAS office is located on 14th street and 5th Avenue. Michael's M11Q forms were smudged and he needed a new copy for alternative housing application referral provided by our staff to Gabriel house, which will not process such applications without an up-to-date M11Q. Michael went to pick up a copy at this DAS office. A Ms. Hill refused to provide him with a Xerox copy of his MIIQ upon his request. Michael then produced a referral form and business card given to him by our outreach staff. Ms. Hill then called our Bronx office to verify that the referral was bona fide and to find out about our organization. Only after speaking to our outreach workers did she agree to give Michael a copy of his M11Q form.

2. Fraser _____ who is resident at the Kent hotel on West 83rd street. went his DAS office and requested his M11Q in order to follow through on an alternative housing referral we

provided him. Fraser told us that his DAS case worker refused to give him the papers rhetorically asking "Why do you need it? Fraser went back to this DAS caseworker with a written note from our outreach staff stating why the copy of the M11Q was being requested. The case worker called our Manhattan office and asked if we were a recognized DAS vendor. When informed that we were not a DAS vender she refused to give Fraser the form.

3. Steve _____ is a resident of the BZB hotel on West Farms Road in Hunts Point. He possessed an M11Q form that was three years old, and needed a more recent form in order to acquire an alternative housing placement. He was refused papers several times by the 14th street and 5th avenue DAS office. Our SRO outreach staff made contact with his DAS worker Sheldon Ford who agreed to give him the M11Q upon our request. He told our staff that he had previously refused to give Steve the "because there was no alternative housing available" so he did not consider a housing referral as a valid reason for giving a DAS client a M11Q form. Two days after obtaining this form Steve, upon his own initiative, located housing in Brooklyn, because of a previous contact he had made with a placement service.

4. Rosa _____ is a resident of California Suites. She is seeking alternative housing placement and a new primary care physician outside of her methadone clinic, Beth Israel on 110 th street and Broadway. She has severe asthma and a heart condition, and feels, she is not getting comprehensive and specialize care at the methadone clinic. She wanted to receive primary care at St. Luke's hospital on 113 th street and Amsterdam near her hotel. Beth Israel refused to provide her with a copy of the form, stating that people were selling M11Q forms.

5 Miguel _____ is a resident in California Suites. He is enrolled at Beth Israel on 125th. street and Park avenue. He wanted a new primary care physician, he is also in the process of loosing his sight, and needed specialist care that he was not receiving from his methadone clinic. Beth Israel has refused to give him a copy of his M11Q form. Miguel does not want use the medical services of Beth Israel on 18th street and First Avenue because they know he is a methadone client and he feels they discriminate against him because of this.

6. Mike _____ is a resident of California Suites. He requested as M11Q from his methadone clinic, Ithaca on 110th street and Madison Avenue because he had requested an alternative housing referral and placement from our staff. The methadone clinic told Mike he had to wait and get re-tested again to ascertain his current T cell count. And that he would have to wait for a month before he could be tested and his housing placement would have to wait till then.

In those cases where an up to date M11 Q was available it was obvious to CIS workers that the examining physician's prescriptions and recommendations for the resident were not being followed mainly because most residents did not have a consistent relationship with a

primary care physician. Not unexpectedly most SRO residents without M11Qs or an updated M11Q did not have ongoing relationships with a primary care physician. Another factor in the absence of primary medical care was that the majority of these SRO residents are located at great distances from their home neighborhoods and from the medical sites where their M11Q forms were originally issued. This is a major obstacle for DAS residents to negotiate in order for them to maintain continuity of their medical care, and in up-dating and/or locating their M11Q forms. Because of drug expenditures, many of these residents lack the necessary carfare, or, because of their health status, lack the physical strength, to travel distances. Due to this disparity between the locale of medical assessment and current hotel location many recommendations for DAS clients listed on M11Q forms issued by the examining physician are not implemented or followed appropriately at the current residential site.

- HIV + residents recently released from prison are not being provided with copies of M11Q forms by prison Doctors. HIV+ individuals are released from incarceration with a medical assessment form which DAS accepts instead of the M11Q. But the NYC Housing Authority does not accept the prison documentation for Section 8 housing– only the M11Q. Thus parolees and ex-inmates have to obtain MllQ forms after their release. This delay in getting proper documentation prolongs their stay in the assigned SRO and inhibits referrals to more permanent housing. Since many ex-inmates arrive from prison drug-free, living in

drug active settings for protracted periods creates a risk for relapse into drug use. Therefore, access and availability to M11Qs would facilitate getting these ex-inmates out of SROs and into alternative housing more quickly. Further, reentry into the chronic drug use, that is part of the SRO, culture, diminishes the capacity of the released inmate to find alternative housing, thus creating a viscous circle.

- One other factor severely inhibits residents from seeking and maintaining primary medical care or from entering residential drug detoxification and long term treatment programs. Those residents who are patients in a hospital for two weeks or longer or for those residents who've left the hotels for 28 day treatment programs have found their rooms arbitrarily closed by either hotel managers or on site HRA staff. DAS residents have been told by various hotel managers that if they are absent from the hotels for 30 consecutive days their rooms will be closed. In actual fact, many residents away on 28 day drug detoxification programs have reported their rooms closed after only 15 days. This managerial practice has caused some referred residents to leave drug or medical treatment early in order to secure their rooms and to consequently relapse. As a result many more SRO residents avoid long term hospitalization and/or drug treatment for fear of loosing their rooms. In some cases DAS residents at the BZB, who had been through 28 day drug treatment programs had their room closed by the H.I.R.E. organization and were transferred to the Carver Hotel. Once in

the Carver they quickly relapsed, due to exposure to the active heroin injection and crack-cocaine smoking scene taking place.

- DAS residents from the Hayden and Carver hotels respectively have expressed their mistrust and suspicion of resident HRA workers. They do not want to request application forms or documentation from these workers and have come to the SRO staff for alternative solutions. We refer such requests to central DAS (Waverly) offices. One resident at the Carver felt he would be charged for documents he requested from the on-site HRA worker.

As a result of this and related gaps in service delivery by official service providers, CIS staff increasingly engaged in case management relationships, dynamics and situations which the initial program proposal did not envision accommodating. The conditions at the hotels compelled the CIS staff to develop a hybrid intervention that mixed harm reduction with case management in unstructured environments. CIS staff spent long hours on the phone attempting to acquire copies of M11Q forms or setting up medical appointments for residents to obtain updated M11Qs from physicians. CIS staff revised their use of the SRO specific confidentiality release forms signed by contacts. This form was originally designed to enable staff to track referrals to services. Now, it is also used by CIS staff to facilitate release of documents by providers that had denied SRO resident's previous requests for access to their documents. By the end of October CIS staff accumulated substantial quantities of client-related paper-work resulting from tracking the prolonged housing placement process and the effort to reconstruct appropriate certification and entitlement documentation

for SRO residents. During November, two weeks were needed to step back from field work in order to organize a secured record keeping process and more comprehensive client tracking system– all of which had not been envisioned as necessary to the original program design and proposal. This explains the temporary drop in distribution levels in November, which was characterized by below average hours in the field, when time was taken to organize a case management record keeping system. Distribution levels and field hours were immediately restored in December. Taking this time to organize an expanded client tracking system formalized the growing case management component and systematized advocacy on behalf of residents to services. Extensive contact records, tracking vehicles and copies of residents documents were stored in secured locked files in the Bronx storefront office.

From May 1996 to September 1996 other forms of client advocacy were also added to the original harm reduction scope of the intervention. This frequently involved deploying CIS staff as service brokers between DAS residents and service providers. This task went well beyond the simple issuing of a referral slip to the SRO resident requesting services. Because of physical, mental and financial situations many SRO residents need escorts/ advocates when they seek to attend referral appointments. The provision of such escort/services is an incentive for the SRO resident to show up for such appointments in the first place. The current contract does not support sufficient staff for us to maintain fieldwork and to simultaneously perform this much needed on-the-spot escort/advocacy service except in limited crisis situations. An important component of brokering relationships between residents and service provider was the development of a

formalized referral linkage with Beth Israel's Comprehensive HIV/AIDS Clinic on 14th street. Two of the CIS staff escorted a female resident M., from the Hayden hotel, to the clinic for medical services and introduced her to peer educators working at the clinic. After this visit the Hayden resident gave extremely positive feedback to her fellow DAS residents, after which several other Hayden residents were referred to Beth Israel from the Hayden. Given these successes CIS staff on a limited basis expanded the escort service to the Kent and California Suites hotels. Thus we currently escort residents to services in order to facilitate the referral for our most needy contacts and to foster the reputation of the service provider among the hotel residents. When necessary DAS residents were supplied with mass transit tokens to enable them to keep medical and drug treatment appointments.

CIS staff also provided life skills workshops to hotel residents on time management-appointment keeping and document management in order to build their capacity to access service providers outside the hotel. Because of residents' drug related life styles, medical as well as mental conditions, many SRO residents do not exhibit the memory capacities that would allow them to maintain and follow through on a protracted series of medical and/or other types of appointments particularly the protracted and bureaucratically complex process of housing placement. Many hotel residents are in dire need of basic life skills training that would allow them to manage their medical appointments, their nutritional needs and their prescribed medication. The absence of such basic life skills should be seen as a critical continuity of care and health promotion issue.

Since we had limited capacity to escort SRO residents to medical care facilities we also attempted to bring medical services into the hotels. In the Carver hotel we identified at least 3 residents on each floor who needed visiting nurse and home-care services to the on-site DAS worker. VNS requires a letter from a doctor or from the on-site HRA worker in order to authorize nurse visits. The CIS team informed the Carver's HRA worker about which residents needed such letters to VNS. Two weeks passed and the Carver's HRA worker had not taken any action on this matter. CIS staff reported that they pleaded with her to speak to residents who had been identified as needing visiting nurse service– but to no avail. Frustrated staff described her to me in a staff meeting by saying "she only watches TV or talks on the phone." In one instance SRO staff asked her to call 911 for an ambulance for a resident and she responded by saying " I know he's ill." She made no effort to call an ambulance. Eventually CIS workers independently arranged for VNS services for non-ambulatory hotel residents, all of whom are in need of some level of medical oversight.

Further Expansions of the Scope of Harm Reduction Interventions

As summer came to an end stress factors increased in the hotels. This was evidenced in increases of self medicating behaviors, increases in relapse behaviors, increases in sexual harassment and domestic violence incidents and in increases in interpersonal violence. These stress behaviors originate in frustration over not finding alternative housing and over the various forms of everyday victimization including robbery, extortion, loan sharking and sexual harassment.

Many residents can only tolerate conditions in the hotel during the summer months when they can be out of their rooms and on the streets for the greater part of the day. The advent of cold weather and winter is not looked forward to by residents because it means confinement to hotel spaces. This was evident to us in the increase in referral requests for alternative housing at this time.

With the advent of colder weather hotel and because of the impact of the cold on their overall health residents are more home-bound; they are usually depressed and/or stressed by being restricted to their rooms and by their degenerating health. Thus CIS staff encountered more residents in each hotel and in turn these residents requested more harm reduction materials as their substance misuse activity and sexual activity increased.

As CIS workers moved deeper into resident social networks during the fall/winter months, the staff noticed more cases of domestic violence and physical abuse between male and female partners residing in the hotels. Ethnographic assessment of the situation has identified that female victims of physical abuse are severely blocked by fear and terror from making any qualitative changes in their living and health situations. The abusing partners are overtly hostile to any intervention that would remove their female partners beyond their influence and violence. Therefore the battered resident is more unlikely than other categories of hotel residents to request services from SRO staff-- particularly alternative housing or residential treatment services outside the hotel which would place them beyond the reach and control of the abusing partner. Attempts to leave the hotel may meet with additional violence. Many male abusers frequently

isolate their female partners in their rooms and attempt to prevent any sustained contact between their female partners and CIS staff. As a result many battered women will often not open room doors to CIS staff. Staff make covert hallway contact with victims of abusing partners whenever possible.

To this pattern of physical abuse must be added other male/female patterns (1) the economic dependency of males on women engaged in sex work and/or receiving DAS checks; (2) the residential dependency of male partners, who are not DAS residents and not officially registered at a hotel, on their female partner who is a DAS resident and officially registered at the hotel. These factors may be contributing to patterns of physical abuse in specific cases. Because of the increasing frequency of such domestic and sexual violence incidents, CIS staff have recently undergone specialized trainings on how to handle contacts who are victims of physical and emotional abuse. They have developed specialized referral resources for the victims of domestic and sexual violence we engage in these hotels

I: Units of Service: Statistical Charts and Narrative

New and Return Outreach Contacts

The October upsurge in material distribution and request for services in all hotel this month is reflected in the doubling of new SRO contacts. The upsurge can also be attributed to the addition of the Carver Hotel as a field intervention site. In general the higher return contact numbers reflect the winter confinement of residents to the hotels, The November dip is accounted for by lower than normal field hours as emphasis was placed on the development and/or reorganization of client tracking and field research instruments and records.

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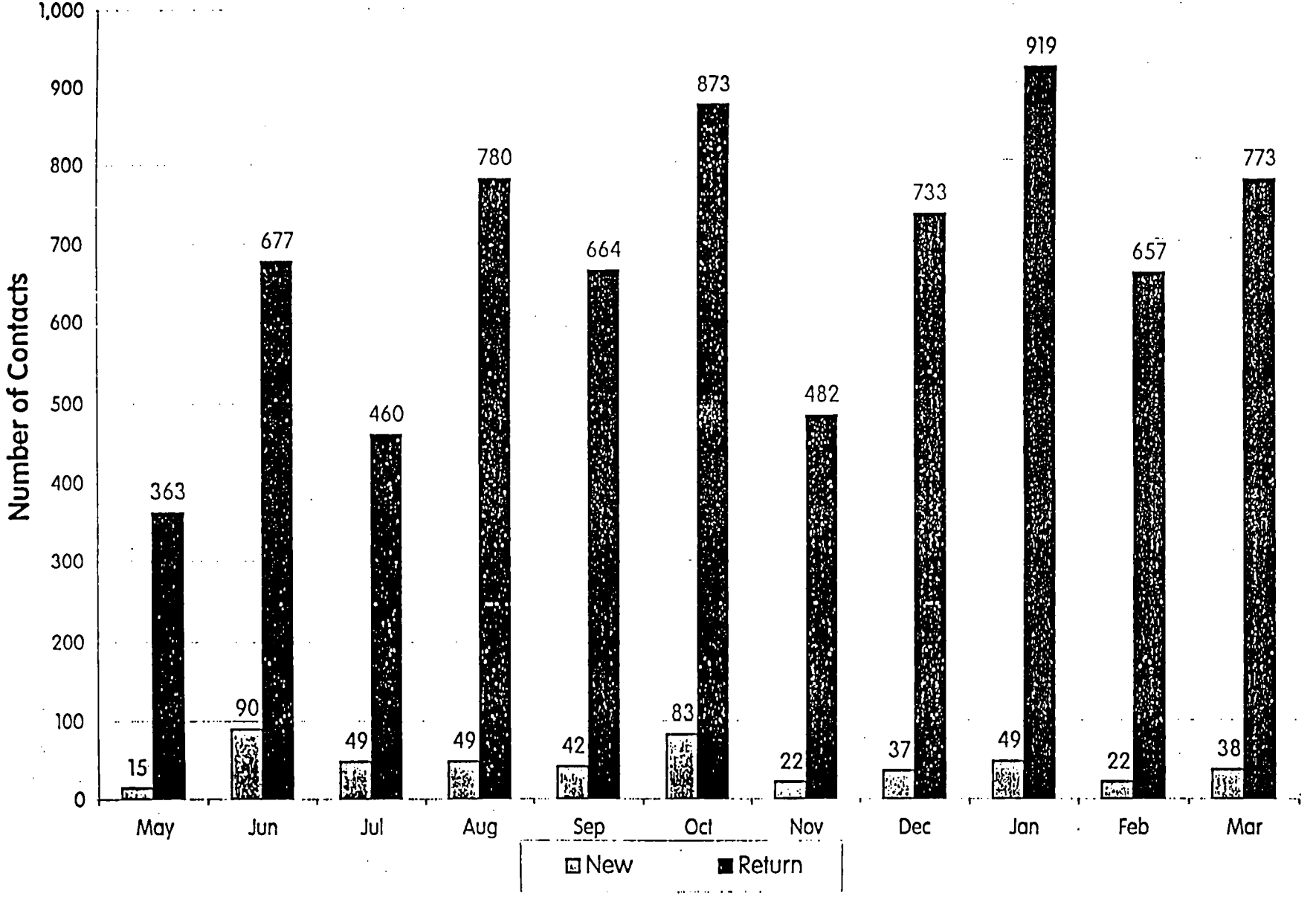
Outreach Contacts 5/96-3/97



Bleach Kit Distribution

- The July drop in bleach kit distribution in part reflects the introduction of the drug ban and room searches by the H.I.R.E. organization in the BZB. The new anti-drug regime forced resident IDU's out of the hotel into dispersed injecting sites in the extremely active Hunt's Point drug selling and drug ingestion scene where many fell out of contact with CIS staff. Based on field observation and interviews overall injecting episodes decreased in the BZB hotel but overall injecting rates of BZB injectors actually increased in street settings. This is reflected in the increased bleach kit distribution of August when contact had been reestablished by the CIS staff through street outreach and the discovery of a shooting gallery adjacent to the BZB used by BZB injectors.
- Marked increase in Bleach Kit distribution in October can be attributed to two factors (1) the addition of the Carver Hotel as an intervention site. This hotel possesses an active IDU scene; (2) the influx of residents from their street habitats back into the hotels with the end of summer and the advent of colder weather. Stress factors in all hotels were uniformly raised in October in anticipation of winter confinement to the hotel milieu, and there was a corresponding increase in stress reducing self-medicating and sexual activity.

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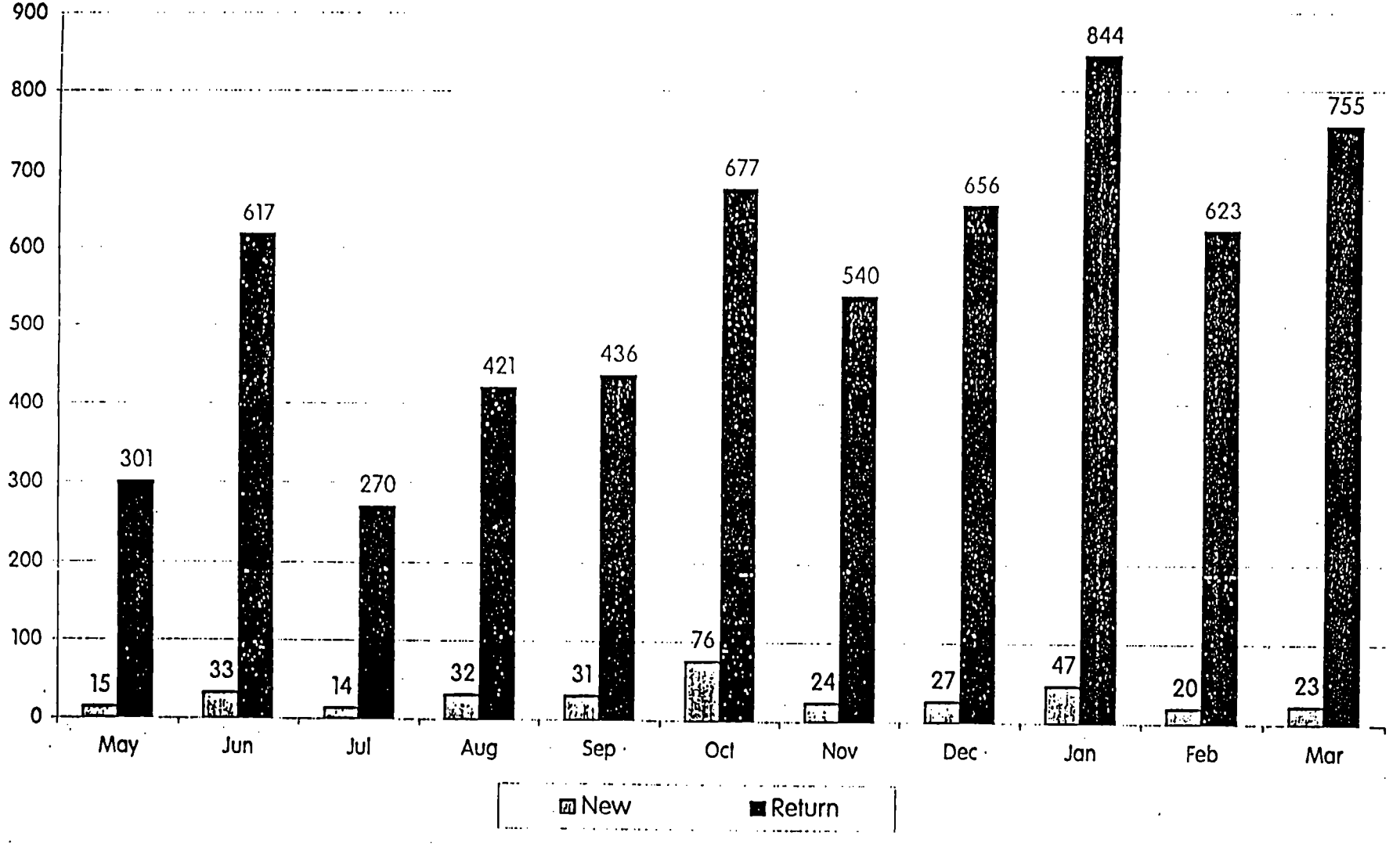
BLEACH KIT DISTRIBUTION 5/96-3/97



Primary Medical Care Referrals and Appointments Kept

- Discrepancies between requests for medical services and "appointments kept" are accountable for by a number of factors that are ethnographically illuminating about hotel conditions and the mentality of many SRO residents. Based on field interviews the disparity between requests for services and appointments kept can be attributed to (1) the lack of a M11Q form or of an updated M11Q form or Medicaid card or number; (2) inability to procure a copy of an existing M11 Q form from DAS or a service provider such as methadone clinics; (3) lack of transportation money; (4) Lack of physical and mental stamina to endure expected prolonged waits in clinics-- on many occasions residents will arrive early in the morning, wait all day and not receive treatment and then told to make another appointment; (4) fear of stigmatization by medical service providers due to residents' HIV condition, drug history, or general appearance; (5) fear of prolonged hospitalization (two weeks or more) resulting in loss of SRO room and DAS benefits; (6) Poor time management due to substance misuse, medically related memory deficits, anomie-depression, and the nocturnal orientation of the hotel culture. Many of these issues could be mediated by the introduction of a client escort/advocacy service where harm reduction staff would broker relations and timely services between SRO residents and medical service providers.
- Upsurge in request for medical care services in October generally parallels the overall increase in requests for material and services as cold weather and anxieties about the impending winter drove SRO residents from the streets back to the hotels with the anticipation of cold weather confinement in the

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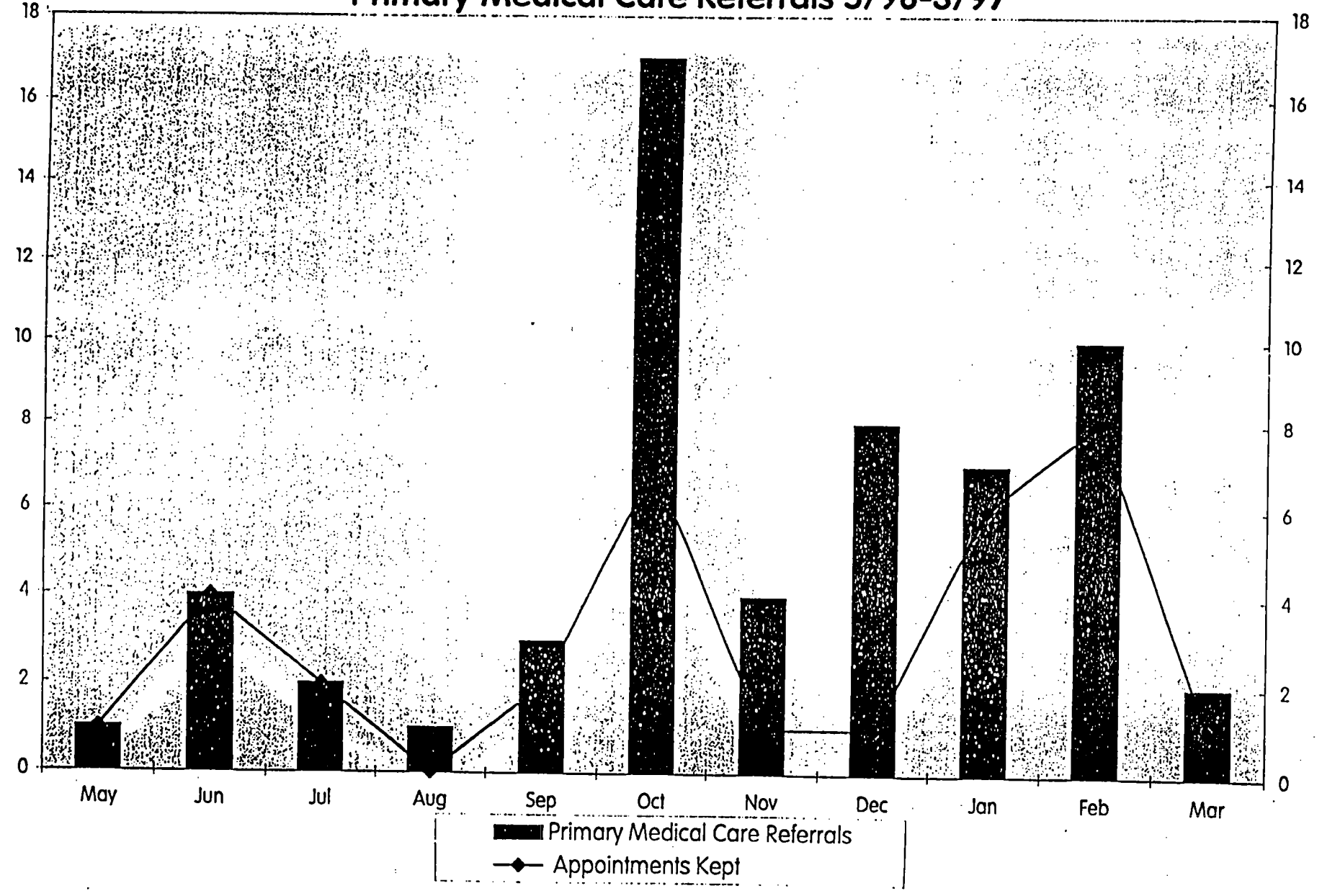
Primary Medical Care Referrals 5/96-3/97



Total Primary Medical Care Referrals = 50

SRO. The addition of the Carver hotel as an intervention site added to this increase. Overall the medical appointments kept were among the highest in October but in ratio to request for medical services there was greater disparity than in other months. In part this may be due to projective anxieties of residents concerning the impending winter and the need the latter expressed of wanting to get out of a hotel which was rarely acted upon. The holiday season between November and December continued the downward trend which may reflect that increasing self medication and apathy of SRO residents during the holiday season and as winter progresses.

Alcohol and Drug Treatment Referrals

- The major obstacles to getting residents into any form of residential treatment revolve around room closing issues. Most residents fear that any prolonged stay away from the hotel – two weeks or more-- will precipitate the closing of their rooms. And CIS staff can confirm that many of their residents entering into 28 day drug treatment programs had their rooms closed after 15 days absence from the hotel. It should be noted that the ratio between requests for drug treatment services and actual appointments kept in the months of June. September, October and December are well above average for most outreach programs.

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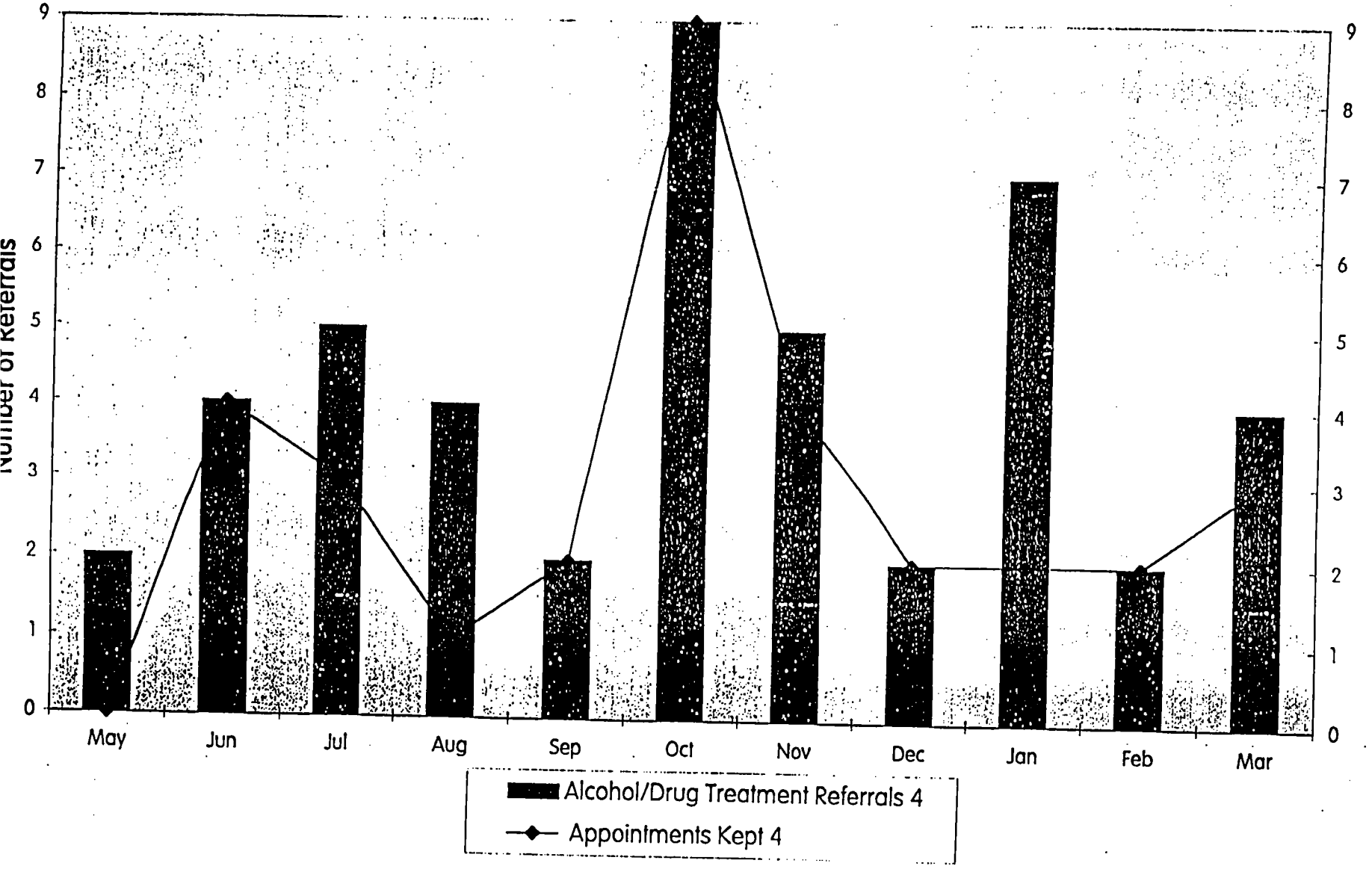
Alcohol/Drug Treatment Referrals 5/96-3/97



Total Alcohol/Drug Treatment Referrals = 46

Condom and Dental Dam Distribution

- Both graphs show the October cold weather upsurge found in other distribution statistics. However the dental dam figures are significant. While contacts exposed to sustained harm reduction outreach will automatically request condoms from outreach staff, they will not for the most part, automatically request dental dams or accept dental dams when they are offered unless a good deal of sex education and HIV education work has been performed with the population concerning oral forms of HIV and STD transmission. Thus the very high distribution numbers for dental dams reflect the efficacy of the harm reduction/sex education workshops conducted by CIS staff in the hotels. The decrease in September distribution reflect supply ordering problems that caused a shortage of dental dams.

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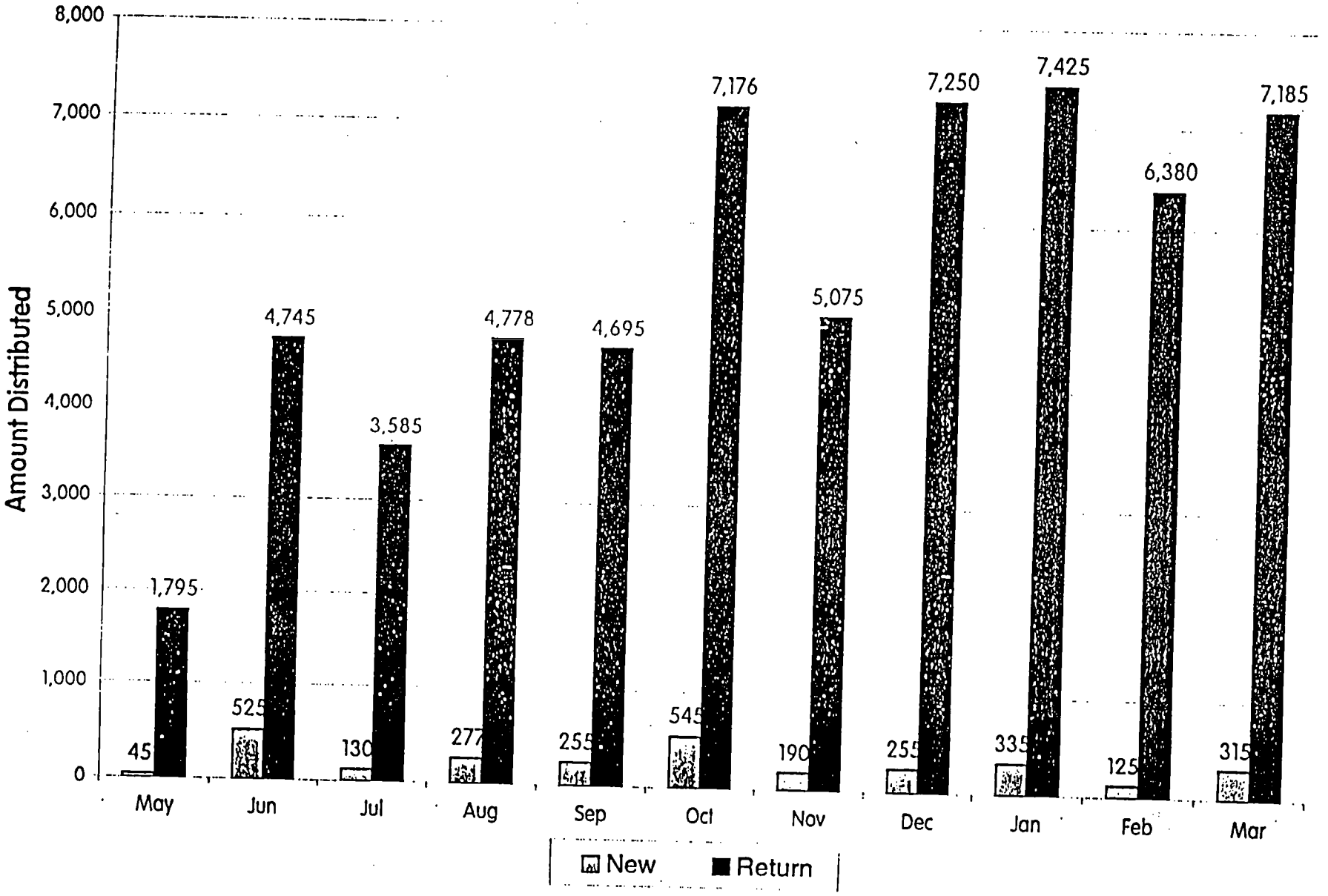
CONDOM DISTRIBUTION 5/96-3/97



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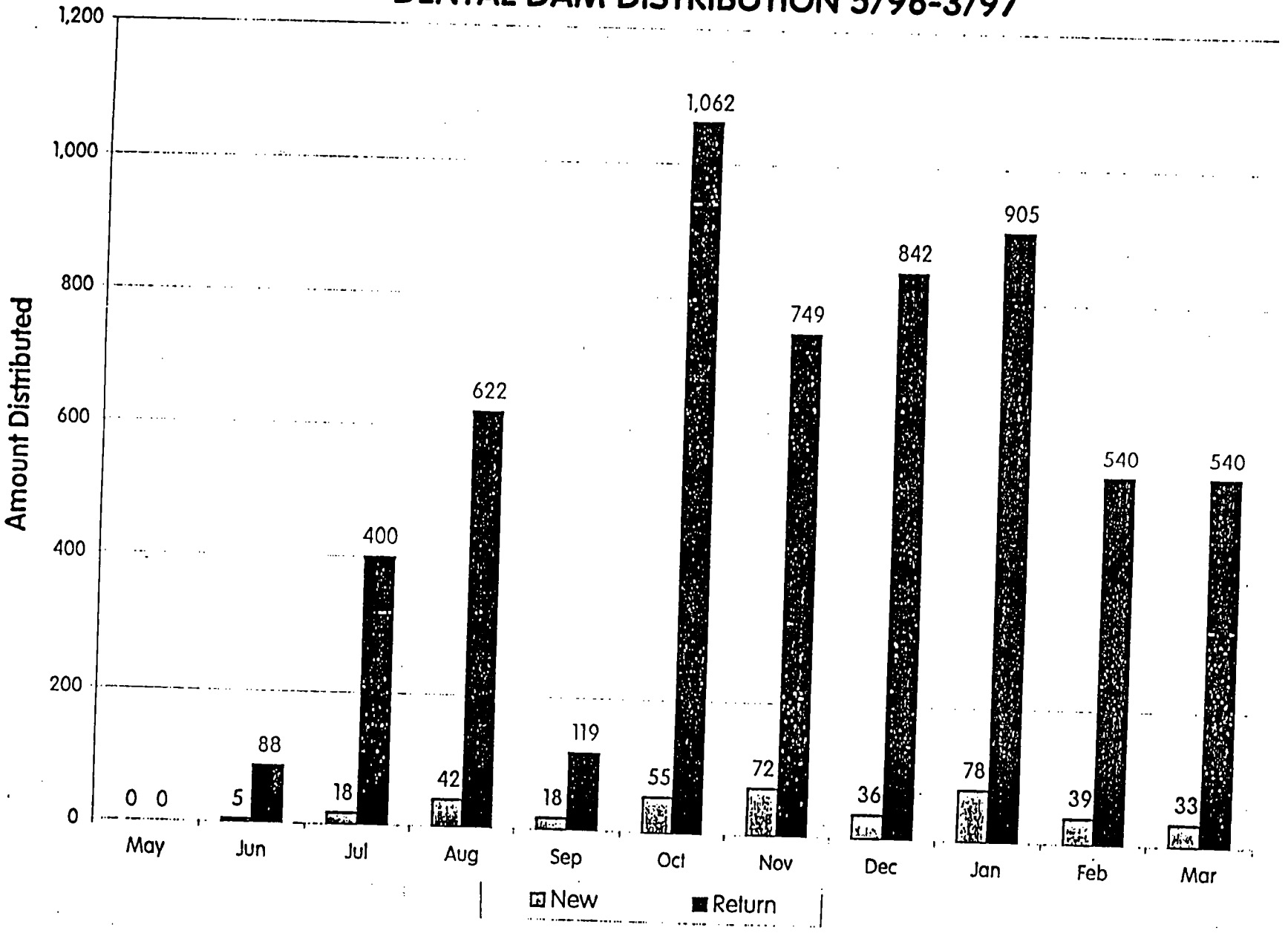
DENTAL DAM DISTRIBUTION 5/96-3/97



Hygiene Kit and Toilet Paper Distribution

- Hygiene kits had been built into the original intervention design, but toilet paper was added to the distribution materials after two weeks of field work in the hotels. The popularity of both items confirms the poor service delivery of hotel managements in reference to soap and toilet paper, and the financial distress of many of the residents. Further the popularity of the hygiene kits demonstrated that resident do have a degrees of self-regard and care for the presentation of self that is frequently undermined by the environmental conditions of the hotels.
- It should be noted that toilet paper distribution figures are affected by the limited capacity of staff to carry large amounts of toilet paper on foot and by mass transit without benefit of a vehicle. A vehicle was added to the outreach in mid January and that month shows a rise in toilet paper distribution possibly due to the increase in toilet paper available for distribution.

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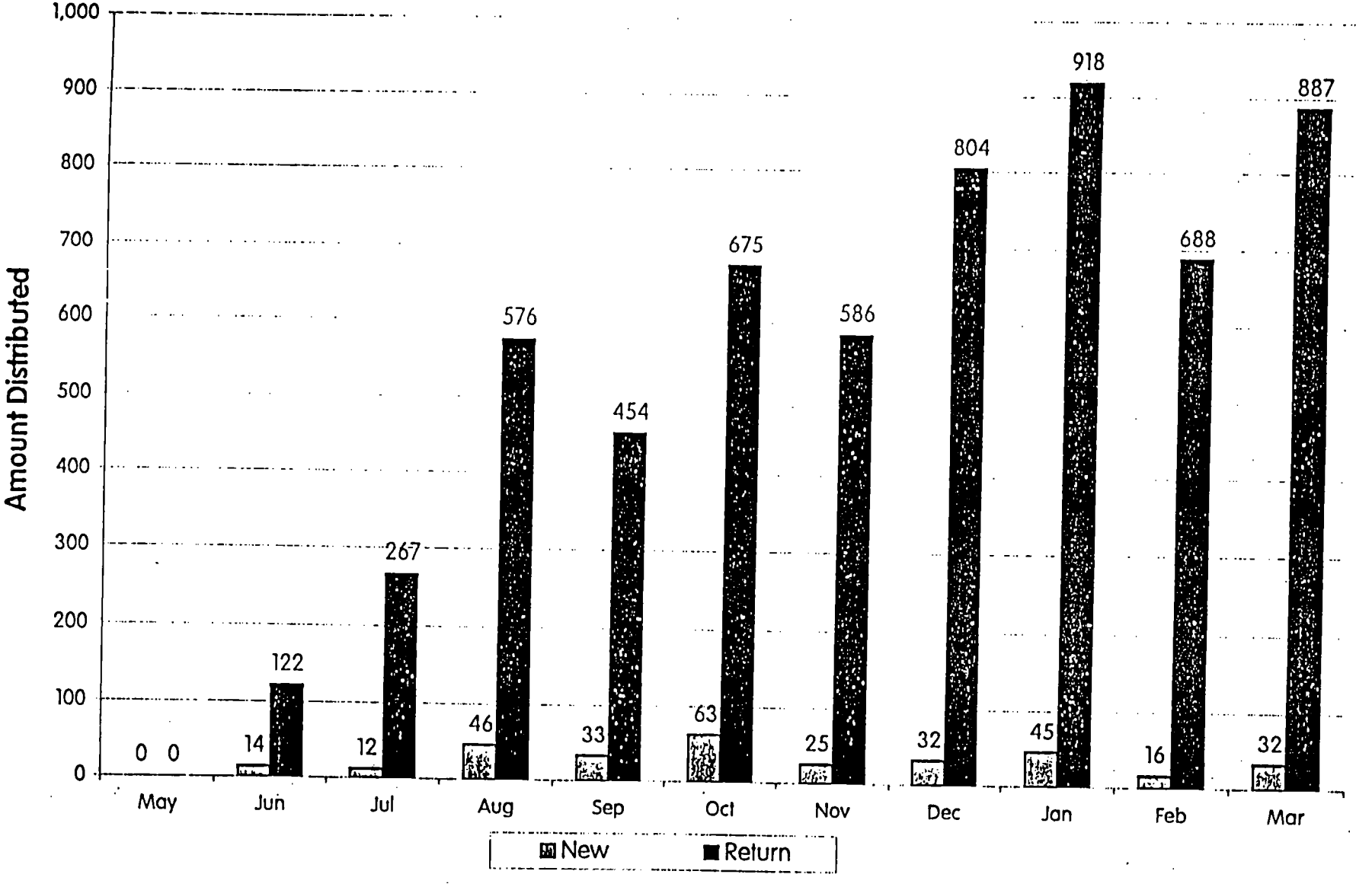
TOILET PAPER DISTRIBUTION 5/96-3/97



Housing Referrals and Placements

This chart documents the disparity between the desire for alternative housing by SRO residents versus the reality of achieving a completed housing placement.

- This report proposes that, among other factors, (1) room regimes (2) debt dependency and (3) drug economies are crucial and interlocking practices that subvert the hotels' ostensible function as transitory housing and severely inhibit DAS clientele from seeking alternative housing through the creation of structural dependencies.
- Numerous SRO residents were unable to obtain copies of the M11Q forms from DAS workers, and/or methadone clinics in which they were enrolled. In order to obtain this documentation CIS staff had to advocate for SRO residents with these organizations.
- SRO residents faced major bureaucratic impediments in having action taken on their housing applications by DAS or by agencies providing alternative housing.
- Due to the inordinate delays in obtaining housing forms and housing placement, and due to the structural dependency which inhibits DAS clients from seeking alternative housing, it is proposed that alternative housing opportunities cannot begin to be viable for DAS clients until the hotels are transformed into safe spaces. Some hotels, once transformed into safe space, can function as alternative supportive-housing opportunities for DAS clients.

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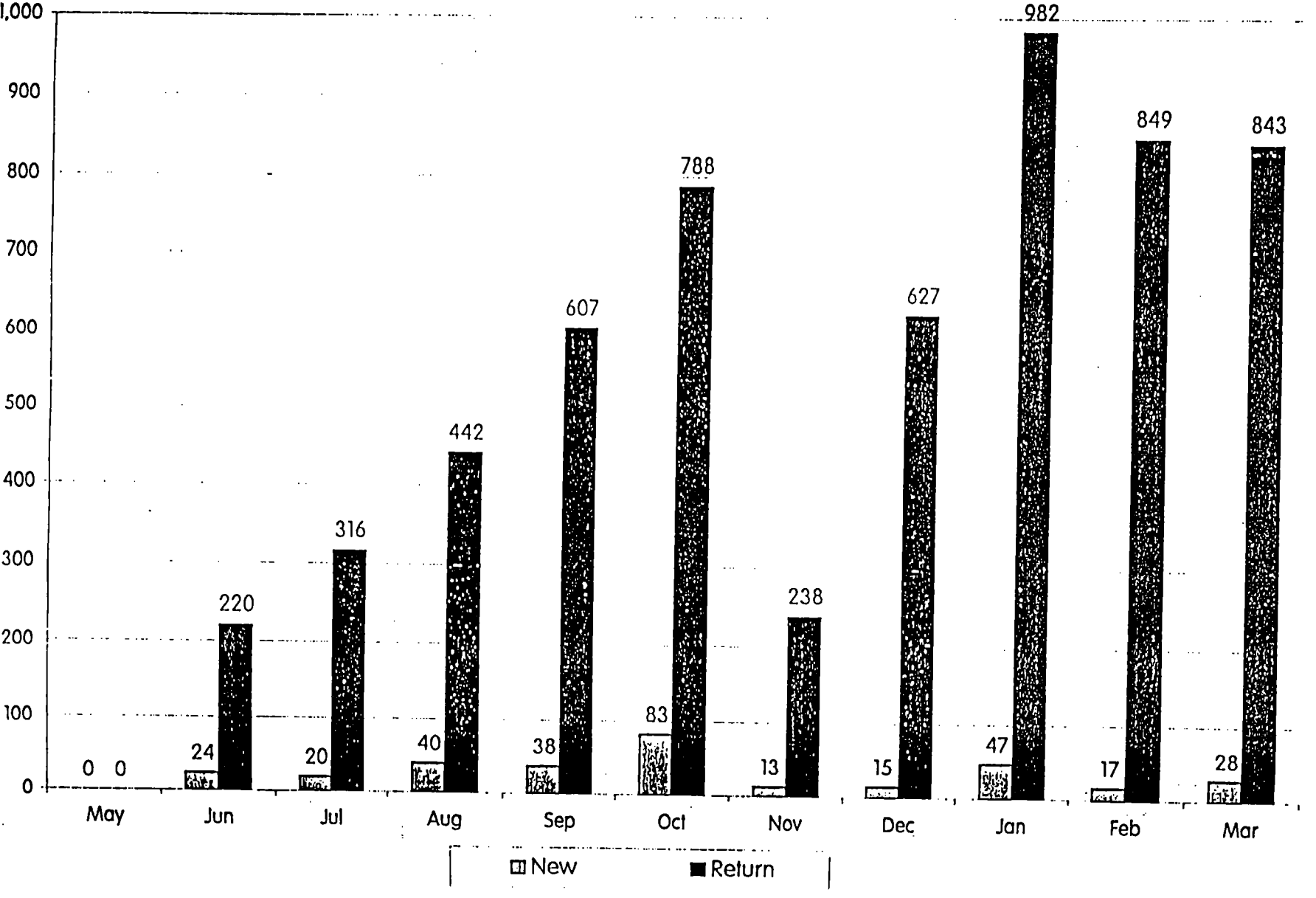
HYGIENE KIT DISTRIBUTION 5/96-3/97



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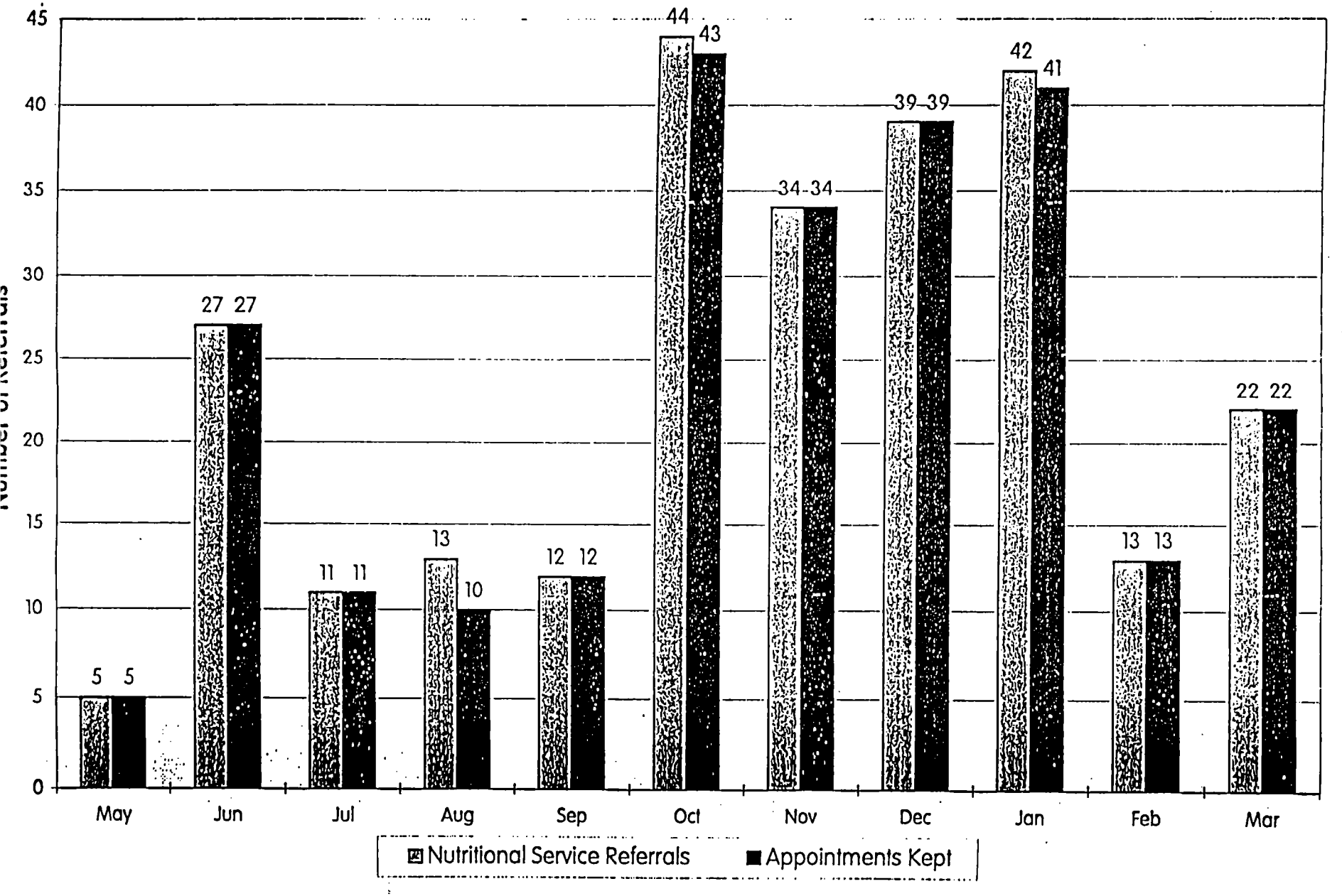
Nutritional Service Referrals 5/96-3/97



Total Nutritional Service Referrals = 262

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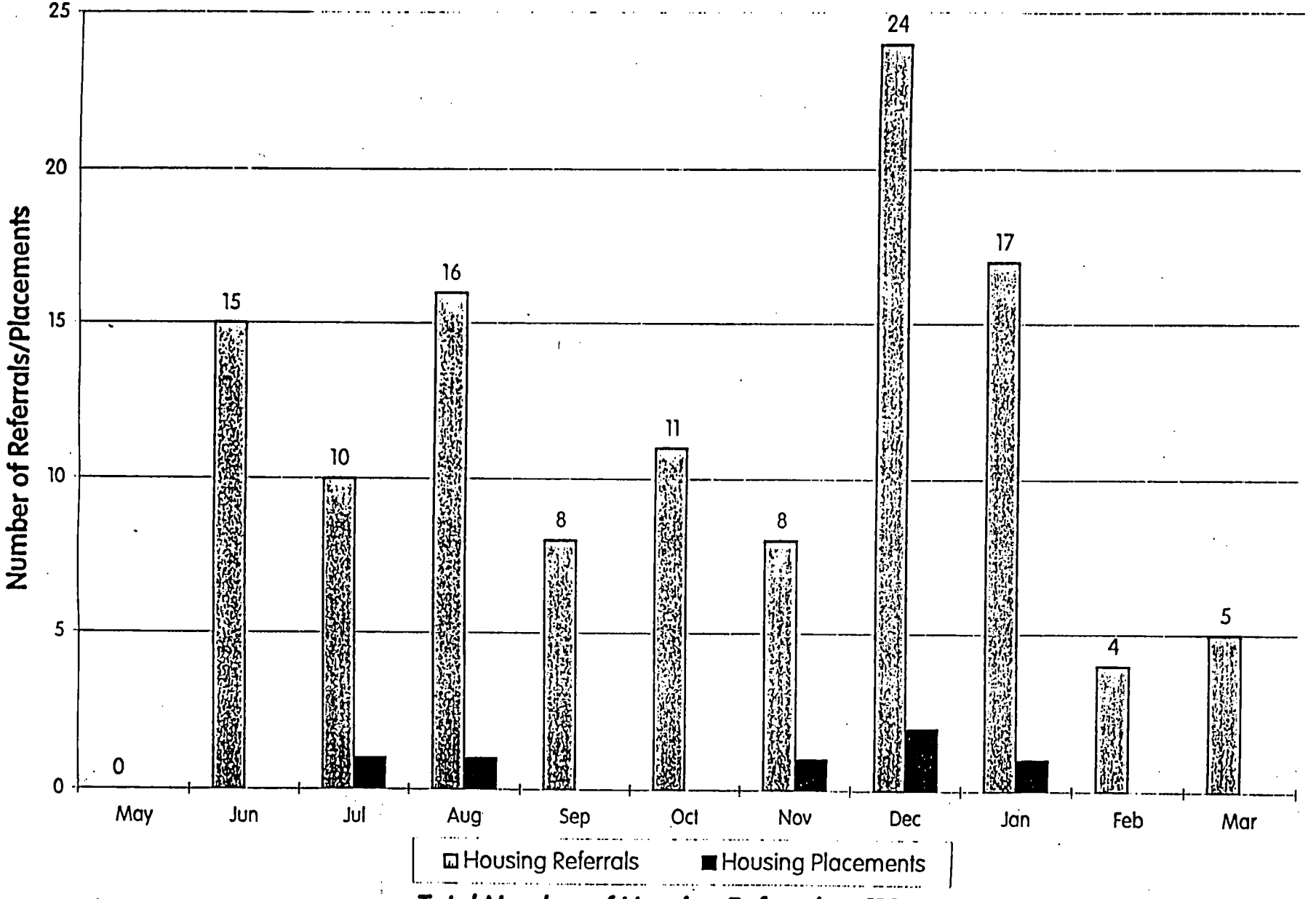
Housing Referrals and Placements 5/96-3/97



Total Number of Housing Referrals = 118

HOUSING WORKS

Demand Housing
for Homeless People
Living with AIDS & HIV

PRESS RELEASE

For Immediate Release: September 29, 1999

For More Information, Contact: Charles King (212) 966-0466 x 269
Terri Smith Caronia (212) 966-0466 x 296

HOUSING WORKS ISSUES REPORT AND ANNOUNCES LITIGATION ON CONDITIONS IN AIDS SROs AT RALLY ON CITY HALL STEPS

New York, New York (September 29, 1999) Housing Works held a press conference and rally on the steps of City Hall to issue a report detailing the squalid conditions of commercial single room occupancy hotels (SROs) where the Giuliani Administration is illegally warehousing homeless people with AIDS. At the press conference, Housing Works also announced the filing of a class action lawsuit, Wright vs. Giuliani, on behalf of persons with AIDS who have been placed in these deplorable conditions in violation of New York City Local Law 49 of 1997 as well as other State and Federal law.

Housing Works' report details the results of a survey of over 200 persons who have been placed in these facilities by the NYC Human Resources Administration's Division of AIDS Services and Income Support over the past year. Of those served, an overwhelming majority indicated that they had experienced appallingly filthy and unsanitary conditions, including vermin, unclean linens, filthy and unsanitary bathrooms and lack of working refrigerators. A shocking number reported illegal activity, including drug dealing, prostitution, and loan sharking, in many instances carried out by SRO staff.

Housing Works' survey was performed in follow-up to two separate studies performed over the last two years that detailed the horrid conditions found in the commercial SROs. The first study, prepared by the National Development and Research Institutes, Inc. under contract with the NYC Mayor's Office, detailed conditions in a number of hotels where NDRI was performing outreach services under contract with the City. The Mayor's Office suppressed this study for nearly a year. Housing Works obtained a leaked copy of the report and issued it to the press in March 1998. At that time, the Mayor's Office announced that the report had been referred to the Department of Investigation. (In response to a recent FOIL request, DOI has indicated that its investigation has not been concluded.) Meanwhile, HRA officials advised the NYC City Council that DASIS had stopped using any SROs that had not corrected deficiencies.

The NYC Comptroller's Office issued a subsequent report in October 1998. The Comptroller's Report found widespread "hazardous" conditions in the SROs utilized by DASIS, stating that the conditions in the SROs "jeopardize[] the life, health, and safety of DASIS' clients." The report further charged that HRA was violating the City Charter by not contracting with the SROs so as to provide meaningful oversight. In a written response published with the report, DASIS again asserted that the issues raised in the report had been rectified.

Based on anecdotal evidence that problems in the SROs had not been meaningfully addressed, Housing Works initiated its own survey of SRO

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residents last spring. According to Housing Works Co-Executive Director, Keith D. Cylar, "Housing Works' survey clearly demonstrates DASIS has made no meaningful progress whatsoever in addressing the systemic and life threatening conditions in which it is placing homeless people with AIDS and HIV."

Of the SRO residents surveyed by Housing Works, 61% reported the presence of vermin in their rooms. Another 18% did not have locking doors, and 17% reported broken windows. A deplorable 55% of residents reported filthy bathrooms, including 45% who reported vermin in the bathrooms. Many reported being required to clean the public bathrooms and supply their own toilet paper. Despite clear legal requirements, a third of residents had no refrigeration for storing medications or food. Despite regulations to the contrary, 88% of those surveyed reported that they had never received a visit by DASIS staff in their hotel.

The survey revealed the SROs to be terrifying, dangerous and often brutal places to reside. Participants in the survey reported widespread illegal activity, including violence and sexual assault. One third of the residents surveyed reported non-residents engaging in illegal activities in the SROs. Even more shocking, a significant number of persons surveyed reported knowledge of hotel staff engaging in illegal activities. Illegal activities by hotel staff included drug dealing, loan sharking, prostitution, sexual assault, burglary and robbery.

Housing Works' lawsuit, filed in Federal Court in the Southern District of New York this morning, asserts causes of action under both the Americans With Disabilities Act and New York City Local Law 49 of 1997. Plaintiffs in the lawsuit seek a number of remedies including regular monthly inspections of the hotels by DASIS, pre-inspection of rooms before any DASIS client is placed, and a grievance process that allows residents to report unsavory conditions and be relocated without fear of repercussions.

Armen Merjian, Housing Works' Senior Staff Attorney, was particularly vociferous in voicing his outrage that the Administration had not addressed the conditions in the SROs despite two prior reports. Said Merjian, "Just this week the mayor has show how swiftly and forcefully he can respond when he is moved by images that he finds offense. Yet to date he has evidenced no response to the horrible reality his administration has tolerated for years for homeless people living with AIDS."

Housing Works is the nation's largest provider of housing and services for homeless people living with AIDS and HIV and the nation's largest minority-controlled AIDS service organization. Organized in 1990 out of the Housing Committee of ACT Up New York, Housing Works has obtained housing for over 5,000 homeless people living with AIDS and HIV. In addition to housing and housing placement, Housing Works offers a comprehensive array of services including health care, job training and employment, case management and harm reduction services. Despite repeated attacks by the Giuliani Administration, Housing Works has maintained a commitment to aggressive advocacy on behalf of homeless and formerly homeless men, women and children who are living with AIDS and HIV.

Housing Works gained access to the steps of City Hall by up to 75 participants for today's press conference and rally through its on-going litigation against the Giuliani Administration's prohibition on use of the City Hall steps by the public. Represented by the New York Civil Liberties Union, Housing Works is continuing to fight arbitrary restrictions on the public's access to the steps to air grievances with the City Administration.

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