

Safe House

Using high tolerance to provide housing to those living with HIV/AIDS, mental illness and/or chemical dependency, who are homeless or at risk for homelessness

Safe House is a subsidiary of
Friends Research Institute, Inc.

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INTRODUCTION

What is Safe House?

Safe House is a residential facility whose mission is to offer safe, decent and affordable emergency, transitional, and permanent housing to persons living with HIV/AIDS who also have mental illness and/or chemical dependency, who are homeless or at risk for homelessness. Safe House uses a philosophy of high tolerance to keep its residents housed by drawing its residents closer to existing social, medical and advocacy services especially when symptoms of mental illness and/or chemical dependency become active. Policies that guide most standard housing programs evict multi-diagnosed residents when their mental health or substance abuse problems recur. High tolerance as practiced at Safe House provides the opportunity for medical evaluation followed by intervention while keeping the housing situation stable for its residents as an alternative to eviction. It is our hope that this approach will help reduce the cycle of homelessness common to persons living with HIV/AIDS who also have co-occurring mental illnesses and/or chemical dependencies.



PROGRAM DESCRIPTION – PROGRAM GOALS

Mission Statement

... to provide low income, safe and decent housing to a community of persons who are frequently homeless: those living with HIV/AIDS who also have mental illness and/or chemical dependency. Using a philosophy of high tolerance, Safe House seeks to keep this vulnerable community housed by reducing barriers to care and increasing access to essential services when medical, psychiatric or substance use problems are active.

In 1996, The City of Los Angeles AIDS Coordinator's Office recognized that the greater community of people living with HIV/AIDS enjoyed a relatively vibrant and comprehensive set of medical, social, housing/hospice, legal and advocacy services. Several large AIDS service organizations grew in scope and expertise in meeting the needs of communities of individuals infected with HIV. Moreover, the services were provided either at no cost or at very low cost. Through the hard work of advocates, agencies, and policy officials a legacy remains: Citizens in the County and City of Los Angeles who are infected with HIV/AIDS – even those with few resources – can remedy most needs related to HIV/AIDS with minimal delay.

Still, during this period when the scope of support services for persons living with HIV/AIDS was being formalized, then Los Angeles City AIDS Coordinator, Ferd Eggen and his colleague, Mary Lucey (the current acting City AIDS Coordinator) heard increasing numbers of stories about people living with HIV/AIDS who also had mental illnesses and/or substance dependence who had difficulties finding and remaining in stable housing situations. It seemed that for a variety of reasons, these individuals found it difficult, if not impossible, to access essential services and ended up turning to or returning to the streets. For these individuals, the severe disorganizing effects of their chronic and relapsing psychiatric and/or substance dependence conditions prevented them from being able to effectively negotiate the AIDS service systems to secure necessary services, most notably housing. Many of the individuals displayed extremely disturbed behaviors, sometimes even at the AIDS service agency, which were caused by their co-occurring conditions. Mainstream AIDS service agencies generally had neither the capacity nor the expertise to manage or to control these severe, disruptive behaviors as case managers and others worked to secure some kind of housing services for these clients. Moreover, the amount of time required to work with a few people intensively who are chronic relapsers to

serious mental illnesses (like bipolar conditions or the schizophrenias) or to drug dependence could easily exhaust resources allocated to help the many.

Over time, we've learned that people living with HIV/AIDS who also have co-occurring conditions are generally able to seek care from AIDS service agencies and to comply with program requirements to meet their needs, when their mental illness and/or chemical dependency problems are quiet. People typically use these quiescent periods to make arrangements for housing, medical care, food, and other services by meeting regularly with their case managers and others organized to help address their service needs. But as time passes and the mental illness and/or chemical dependency problems become active, the gains that were made erode quickly. It is during these periods that those suffering with concomitant disorders begin to miss appointments with psychiatrists, case managers, housing specialists, food deliverers, visiting nurses, or any other type of care provider. The accumulated and disruptive consequences of behaviors from these concomitant conditions are swift and severe, often resulting in a return to life on the streets. Gains are lost from the period of quiescence and another phase in the chronic cycle of homelessness often experienced by these individuals begins. Consequently, many of those who are multiply affected withdraw from or are withdrawn from the constellation of services that they need most: mental health, HIV/AIDS and primary medical care, housing, and substance abuse treatment.

Local epidemiological studies indicate that the number of individuals living with HIV/AIDS and comorbid mental illnesses and/or chemical dependency is unknown. What is known is that the extent and severity of the behavioral disturbances caused by the chronic and relapsing conditions of the multidagnosed far outstripped the ability of the existing social service network to manage the needs of this group. It became increasingly clear to the City AIDS Coordinator that for some Los Angeles citizens living with HIV/AIDS, existing systems of care could not effectively meet their needs.

With the leadership of Ferd Eggan and Mary Lucey, the Los Angeles City AIDS Coordinator's office and the Los Angeles Housing Opportunities for Persons with AIDS (HOPWA) program decided to address these chronic problems by sponsoring a program to provide stable housing for the multidagnosed. The two put forward a request for proposals to create a demonstration project designed to provide safe, decent, and affordable permanent, transition, and emergency housing for persons living with HIV and AIDS who are homeless or at risk for homelessness and who also have serious mental illnesses and/or who have chemical dependency. The revolutionary aspect of this request for proposals involved the requirement that the entire program be based on the philosophy of high tolerance.

The Philosophy of High Tolerance at Safe House

The philosophy of high tolerance posits that it is precisely when symptoms indicating active serious mental illness and/or chemical dependency are being expressed that the individual should be woven more tightly into the fabric of existing social services. This simple, key idea of how Safe House works such that when our residents experience symptoms of serious mental illness and/or chemical dependency, they are provided with medical evaluation, mental health assessment, and appropriate referrals to the type of care required. Program staff members also

facilitate residents in accessing the appropriate services at local AIDS service organizations. This aggressive process of evaluation and cross-referral allows leverage of and maximizing of existing resources within the City and County without creating another AIDS service organization. The result of our efforts is that the apartment building at Safe House is much like most others throughout Southern California with the exception that the two staff members based at the site work to connect residents with existing services provided by agencies that partner with us that agree to provide those services.

By contrast, the philosophy and practice of no tolerance followed by eviction effectively withholds housing, mental health, and substance abuse services from those who have the greatest need, transforming a system of care into one of neglect. Safe House represents the recognition of and

proactive efforts by the City of Los Angeles, Friends Research Institute, and the agencies that cross-refer with Safe House to ensure access to services to those most in need – especially when the needs are greatest and when institutional barriers to access are highest. Where other programs might evict or abandon these individuals, Safe House provides shelter and appropriate tailored support from the belief that access to services that treat chronic psychiatric and behavior disorders will reduce the severity and disruptiveness of the individual’s symptoms, with corresponding return of general health. At Safe House, residents are facilitated toward and reinforced for engaging in prosocial and health promoting behaviors like accessing regular HIV health care, seeking emergency medical care, participating in Safe House and greater community events, and using needle exchange. This approach is consistent with a well-developed body of knowledge (i.e., a psychology of learning and behavior) firmly rooted in the idea that positive reinforcement of desired behaviors promotes maintenance of those behaviors.

Translation of the philosophy of high tolerance into practice at Safe House leads to a project goal of maintaining stable housing for individuals while waiting for symptoms of serious mental illness and/or chemical dependency to subside following interventions that connect residents with existing services. To accomplish this goal, Safe House staff members work daily with residents to remain patient while seemingly emergent and critical experiences of residents become less so with medication, intervention, or sometimes, hospitalization. It is our belief that

High Tolerance in Action...

High tolerance at Safe House emphasizes the advantages to long-term physical and mental health, as well as overall quality of life when individuals act in ways that reduce negative health and social consequences associated with mental illnesses and/or substance use. The program philosophy is rooted in the belief that when people are consistently provided with the essentials of existence (food, shelter) they are more likely to choose to engage in behaviors that enhance health and quality of life than when forced out of programs and residences due to disruptive behaviors caused by their disruptive conditions. With each healthier behavior, accumulated harm is reduced and quality of life is increased both for the affected individual and for the greater community. Residents at Safe House are not expected to either change or maintain changes in their behaviors symptomatic of mental illness and/or chemical dependency. Rather, providing consistent essentials of existence allows residents the opportunity to consider and to experiment with behavior changes that reduce harm to themselves and to others. By contrast, removal of stable housing as a response to exacerbations of mental illness and/or chemical dependency would be considered punitive.

providing stable housing to this group of individuals living with HIV/AIDS and other comorbid conditions also serves to help limit the transmission of the HIV to the greater population during periods when residents experience behavioral disruptions due to mental illness and/or chemical dependency.

A beneficial outcome of translation of this philosophy into practice is that the health of the greater community is protected by high tolerance in an important, direct manner. When homeless individuals living with HIV/AIDS who have concomitant illnesses and also experience these active behavioral disruptions, their commission of risk behaviors places them at the “core” of the local HIV epidemic. The “core” concept is an idea from epidemiology to indicate that diseases are most efficiently transmitted within a population (a conceptual term meaning a very large group of people) by a relatively few individuals who have multiple opportunities for exposing others to the agent (the virus or bacteria) that causes disease. During periods when homeless individuals living with HIV/AIDS experience active behavioral disruptions that stem

Benefits to Using a High Tolerance Approach in Providing Housing for Multidiagnosed:

- Addresses those living at the “core” of the epidemic, thereby directly affecting HIV transmission
- Reduces survival behaviors that carry risks to the individual and the greater communities
- Maximizes use of existing services without creating new programs that must be maintained

from concomitant mental illnesses or chemical dependency conditions, they commonly engage in multiple high-risk behaviors, including sharing needles during relapses to drug dependence and engaging in high-risk sexual behaviors that transmit HIV during relapses either to mental illnesses or to drug dependence. We know that when multidagnosed individuals are living on the street, risk behaviors have survival value, yielding desirable and necessary essentials like earning enough money to buy food, finding a safe place to sleep for the night, or escaping from painful symptoms of mental illness. It is our contention that providing support to such individuals, i.e., maintaining stable housing that facilitates immediate referral to existing services that treat the mental illness and/or chemical dependency, ultimately decreases risks to the individuals and the communities

and reduces the size of the “core” of the epidemic in Los Angeles. The common policy of eviction as a response to individuals during such periods only serves to promote resumption of risk behaviors that ultimately increase risks to the individual and the communities. Recognition that current policies applied to the multidagnosed during periods of exacerbation of their comorbid conditions not only fail to coerce behavior change, but also serve to increase risks of HIV and other disease transmission in the general population. We hope that the compelling evidence from this demonstration project serves to convince policy makers generally opposed to high tolerance philosophies to consider formal adoption of harm reduction approaches to those most in need.

Working to keep residents housed during periods of behavioral disruption using a process of referrals and facilitated access to existing services has important philosophical implications for understanding the behavioral disorders that can invoke these behaviors. In short, we use a “medical model,” to understand the behaviors. This model or conceptualization indicates that the behaviors stem from a diagnosable disease (a condition caused by a known disease agent or brain abnormality) or disorder (a cluster of disruptive behaviors with an unknown disease agent or brain abnormality). Although this idea has gained acceptance among those living with serious mental illnesses and patient advocacy groups have worked tirelessly to reduce the stigma attributed to those with these disorders, it is relatively novel to think of addiction as a “brain disease.” Moreover, there are few advocacy groups with political clout that can intervene effectively and represent the concerns of people with chemical dependency problems. An important implication to understanding these disorders from a medical model is the recognition that the behaviors expressed by individuals with these comorbid conditions reflect symptoms of these diseases or disorders rather than poor choices or bad judgment. Our philosophy recognizes that the expression of symptoms of a behavioral disorder indicates the presence of a medical sign of a psychiatric or behavioral disorder and the corresponding need for intervention. We hold to the view that our residents do not choose to engage in disruptive behaviors. Instead, disruptive behaviors are simply the expression of a particular disease or disorder. Increasing access to the social network when these chronic conditions are active instead of eviction represented a way to demonstrate careful application of high-tolerance housing to this high-risk group.

The Practice of High Tolerance at Safe House

Although the philosophy of tolerance at Safe House allows residents many opportunities to seek care for their chronic, behavior disorders, there also exist limits intended to guide residents away from the most egregious behaviors, particularly around on-site substance use and violent behaviors. Delicate balances must be struck among the interests of the program requirements, the safety of the residents and the neighborhood, and the ability for residents to fail while receiving interventions for chronic, relapsing conditions. We have worked hard to arrive at that balance and the limits are communicated to all residents. Safe House program and staff members do not condone illegal drug use. Publicly using illegal drugs at Safe House, peddling drugs at Safe House, or other drug-related behaviors invokes a series of interventions up to, and including eviction. It is unacceptable for anyone at Safe House to publicly engage in drug use and such behavior results in eviction procedures. This understanding is communicated verbally and in writing at the time that new residents move in to Safe House. New residents are informed that anyone detected to be under the influence of drugs or other substances triggers a process of evaluation, referral, and intervention. Violent behavior also is not tolerated at Safe House. It is unacceptable for any resident to harm another individual at Safe House, which includes threatening behaviors, theft, physical altercations, and the like. Finally, it is unacceptable for residents in the permanent housing not to pay rent. As in every apartment building, residents are required to provide some type of monthly payment for rent, although in this building the resident portion is very low in amount. Nonpayment of rent is grounds for eviction. Frequent training and retraining for staff members in our program philosophies is conducted to reinforce use of the medical model that guides understanding of disruptive behaviors (e.g., symptoms) and how we, as staff members, respond (i.e., demonstrating tolerance, evaluating individuals who demonstrate problems, and very rarely, using eviction or removal from the premises).

Residents who experience episodic relapse to mental illnesses and/or chemical dependency present the same or greater challenges to staff members at Safe House as those experienced at general housing programs. Behaviors associated with relapse to these conditions often are disturbing and sometimes are illegal. Retaining the policy of tolerance while residents seek care and concurrently time refraining from engaging in a process that legitimizes such behaviors is a frequent struggle. When it becomes necessary to implement corrective actions on site, we have developed a set of standard operating procedure designed to guide management of these situations:

- **Contain** the situation to ensure the safety of the individual, the community of residents, and the neighborhood.
- **Assess** the resident's need for intervention.
- **Refer** and/or facilitate access to existing services identified as necessary based on the assessment.
- **Defuse** potential or actual threats by removing residents. This involves security measures that include using on-site personnel, calling the police, or beginning eviction procedures (i.e., a 30-day "pay or quit"). This last procedure is implemented only when the situation becomes grave enough to warrant removal of the resident from the community at Safe House.

Unfortunately, there exist few feasible alternative models to high tolerance when providing housing to persons living with HIV/AIDS who have comorbid mental health problems and who are homeless or at risk for homelessness. Policies governing standard housing programs clearly fail to keep this segment of the larger group of those living with HIV/AIDS housed. On the other hand, the costs to society are high for adhering to standard policies. Threats to the individual and to the community are magnified when evicting the multidagnosed individual during relapse, effectively dumping them onto the streets during the height of their need for intervention. Threats and costs are increased when evicting a multidagnosed individual during relapse because this contributes to new cases of HIV infection as members of the greater HIV uninfected community come into contact with multidagnosed individuals experiencing relapse who also provide commercial sex work services or engage in public sex at bathhouses or other sexual venues. Adhering to standard care models also costs society by essentially withdrawing the fabric of care. Withdrawing threads to services and to interventions leads to relapse episodes worsening to the point that individuals often require tertiary care (e.g., emergency rooms, psychiatric hospitals, jails). Existing outpatient services delivered from a basis of stable housing provides sufficient intervention to successfully prevent such relapse episodes from intensifying to the point of requiring such expensive, intensive interventions.

Desired Outcomes from High Tolerance at Safe House

A crucial aspect of Safe House is the “demonstration” nature of the program. As this program moves forward, we’ve built a strong program of evaluation into its architecture to monitor both achievement of program goals and address issues of the program feasibility. It is our intention and our duty to inform the local and national communities of infected persons and of housing providers about our procedures and our outcomes.

Although program reporting requirements mandate quantitative tallies of length of stay in the program, numbers of services delivered, and characteristics of residents, we maintain that the critical criteria that will determine the success of the program involve the qualitative outcomes that focus

on the living situation and overall functioning of residents while at and after Safe House. The rest of the report provides some of the initial information as to the progress of the first year of the project. It is our hope that these initial glances at our residents, our programs, and our procedures provide directions toward optimizing this type of approach in providing stable housing to this vulnerable population.

Desired Outcomes...

- Provide stable housing for those most vulnerable to environmental changes
- Maintain connections between residents and existing service providers
- Increase the health of the individual and greater Los Angeles by encouraging a sense of investment in the self and in the local and larger communities

Another primary desired outcome for Safe House is to fill a unique vacancy in the mix of housing services that are available across the City and County of Los Angeles. Although our program is unique to us, there are (thankfully) pioneers who inform us on ways to implement high tolerance while providing shelter to those who represent some of the most difficult to house. Most notable of these is Molly Lowry from Los Angeles Men’s Place (LAMP), who on a daily basis, demonstrates that services provided with tolerance, respect, and dignity to those who are most severely disturbed can yield dramatic changes and assist better qualities of life for individuals and communities. As well, a similar program of high-tolerance based housing for multiply diagnosed individuals is implemented by a partner agency, Palms Residential Care Facility in the South Los Angeles area (Manchester and Figueroa). Finally, it is the Van Ness Recovery House and its leadership (Kathy Watt and Cathy Reback, Ph.D.) that provide initial and ongoing consultation to us. As these different individuals, communities, and agencies provide experience and leadership in implementing high tolerance to a group of high-risk individuals that generally cannot successfully use standard subsidized housing approaches, information is gained that can guide implementation of this philosophy in a feasible manner. Each day we continue to provide housing services is yet another indication that high tolerance *can* be adapted to meet the needs of an individual, a high-risk group, and several communities.

HIGH TOLERANCE – HARM REDUCTION

Harm Reduction –

A privately funded program of harm reduction and drug hygiene is available to residents. Since all residents at Safe House have HIV and/or AIDS defining conditions, this is seen as essential to protecting the health of residents and of the general community.

High tolerance is the organizing philosophy at Safe House. All aspects of residential and client procedures are adapted to reflect this philosophy. High tolerance emphasizes the advantages to long-term physical and mental health, as well as overall quality of life when individuals act in ways that reduce negative health and social consequences associated with mental illness and/or substance use. There is growing, national recognition that high tolerance is a legitimate helping strategy, especially when helping those with chronic, relapsing problems like substance abuse and homelessness (for more details on this topic, see <http://www.harmreduction.org>). The high tolerance belief holds that when provided with the essentials of existence, the natural path of human development is toward health. At Safe House, there is no expectation or requirement that residents change or maintain changes during periods of active mental illness and/or chemical dependency. Through the provision of these essentials, Safe House affords residents the opportunity to consider and to explore behavior changes that reduce harm to themselves and to others. As indicated, Safe House staff members work diligently to provide residents with the opportunities to fail as they try different treatment or intervention strategies, yet retain contact with the intervention delivery systems.

High tolerance does not imply or advocate legitimization of illegal or unhealthy behaviors. Instead, high tolerance drives creation of processes and procedures that promote the health of the individual and the community. Simultaneously, high tolerance recognizes that those with chronic behavioral disorders like drug dependence will experience challenges in maintaining health-promoting behaviors. Whether high tolerance is practiced as open discussion groups for HIV-infected, gay male methamphetamine users or as formal needle exchange for injecting drug users, the idea remains the same: to provide for the discussion of and guidance toward better health while minimizing harm to the individual and the community. In the case of methamphetamine users, discussion groups based on high tolerance deliver information that meets users “where they’re at” while providing consistent respect and support to members – regardless of drug use. For example, providing information that allows members to learn methods for accurately observing substance use in self and others invokes the first law of behavior change: to observe a behavior fundamentally changes the behavior. Encouraging other

high tolerance-based behaviors, such as reducing negative health impacts due to injection behaviors via needle exchange, greatly enhances the health of the individual and also teaches that substance use does not mean forfeiture of basic human dignity.

The practice of high tolerance at Safe House creates an environment in which residents can begin dialogues about their health concerns and also begin considering strategies to promote their health. For example, many residents who move into Safe House admit to a lack of regular primary and HIV-related medical care.

Rather than require individuals to access HIV medical care, we encourage discussions about whether and when it would be beneficial to start a regimen of HIV medication. Almost all new Safe House residents express feeling a universal, immobilizing fear regarding the consequences of uncontrolled chronic HIV disease, mental illnesses or chemical dependencies. As residents realize that their housing will not be withdrawn (unless they engage in behaviors that pose threats to other residents or to the neighborhood), most residents begin to

disclose their fears in multiple conversations with Safe House staff members and other residents. As residents grow to feel more secure about their housing situation, they gain the confidence in their abilities to consider beginning a regimen of psychiatric care, HIV medication, or substance abuse treatment.

At Safe House, high tolerance is implemented on a program basis and on a day-to-day basis. Safe House is organized to provide as much or more attention to residents when interventions fail as when interventions successfully quiet behavioral symptoms of mental illnesses, chemical dependency or medical symptoms of HIV or other diseases. Safe House

The Human Face of High Tolerance

“I was dying,” said Adam.

Like many who come to Safe House, Adam was HIV-symptomatic and homeless.

He found the challenge of keeping medical appointments and taking his HIV medications too difficult. He was sleeping irregularly, eating sporadically (if he was eating at all), and using more and more drugs and alcohol. Adam was eligible for disability payments, but he was unable to access them without emergency housing.

Adam found transitional housing and more at Safe House. Adam is now assisted with transportation to his medical appointments, which he now attends regularly, and is better at taking his HIV medications. He gets food vouchers that enable him to eat every day and Project Angel Food can deliver prepared meals since he has a stable address for now. Because of this and because of what he has identified as “much less stress,” his health has greatly improved - he is sleeping 7 to 8 hours regularly and he has gained weight. His T-cell count has nearly doubled and his viral load is now undetectable. He is working on getting his driver’s license and has plans for finding employment through re-entry programs that he was introduced to while at Safe House. Another unexpected benefit of living at Safe House for Adam has been the camaraderie and community he shares with other residents.

“I feel safe here,” said Adam. “Safe House is a blessing.”

residents retain a fundamental right to show an inadequate response to treatment without exacting monumental penalties, i.e., forfeiture of their housing. For example, Safe House collaborates with a private, nonprofit agency that conducts a closed program of needle exchange. Staff members also practice high tolerance by attending to or maintaining residents' apartments in the event of necessary absence. Residents who must leave to receive inpatient hospital services for HIV, psychiatric, or substance related care or to receive outpatient treatment for drug dependence can rest assured that they will have a home to return to. The knowledge that they will not lose their housing enables many residents to successfully access and complete the treatment they need to improve their health.

The philosophy of high tolerance is central to the implementation of the Safe House program and requires a multi-faceted evaluation approach. Rather than isolating the effects of individual elements of high tolerance, such as needle exchange, on residents' quality of life, we examine multiple indices of improvement. We expect to demonstrate that high tolerance yields a favorable ratio of number of transfers to stable housing; of numbers of people discharged to police or other controlled environments; and of numbers of people who return to the streets. The beneficial impact of high tolerance can also be documented by how the program of gentle, respectful assistance helps residents to consider and to seek help in addressing chronic, relapsing problems with their physical and/or mental health.

The unique mix of harm reduction-based residential services at Safe House is the first formal implementation of high tolerance-based housing evaluated in the Los Angeles area. The harm reduction-based residential services at Safe House are designed to comply with funding requirements and are not representative of programs that apply these types of procedures more liberally. In truth, many local AIDS housing providers reluctantly follow a "don't ask, don't tell" policy about problems with mental illness and/or chemical dependency when providing services to persons with multiple diagnoses. The "don't ask, don't tell" policy at other agencies can be unreliable, i.e., applied unevenly and unpredictably, depending upon funding, staffing, and program variations. Safe House represents the consistent demonstration of high tolerance-based residential services and as such, implements novel strategies that share few similarities with existing treatment services.

WHO QUALIFIES? – PROGRAM PROCEDURES

Policies Designed for Stable Housing –

- Safe House ensures that those living with mental illness and/or chemical dependency have a real voice in the policies designed to serve them.
- Safe House policies affirm that those living with mental illness and/or chemical dependency are the primary agents of reducing the harms of their drug use
- The realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect people’s vulnerability to and capacity for acting effectively.

... abstracted from Harm Reduction Central

When Safe House opened in February of 2001, we provided residential services to the neediest who appeared on our doorstep. For the first months, we implemented a “first come, first served” admissions policy, which reflected a strongly held belief that those seeking residential services should not have to win a game of “deprivation¹” to claim an apartment. Our initial policy dictated that beds and apartments were available to applicants in the order they appeared to claim the benefit. This policy worked to fill the beds and apartments at Safe House quickly. Within one month of the Safe House opening in March 2001, all apartments and emergency beds were filled. We were forced to start a waiting list of applicants – a list that to this day documents an average of five to ten homeless people living with multiple diagnoses need subsidized housing benefits that as yet are not available.

Our initial experiences showed that we needed to modify our egalitarian admissions policy. It remains that the Los Angeles metropolitan area contains a vast mix of people, a small percentage of whom have tendencies toward violence and/or dangerous behaviors. Upon review of our early operations, it seemed that our policy for admission, though fair, might actually increase the risks to the community of residents living at Safe House. Without some type of screening process during admission, these risks were particularly high for potential residents seeking emergency housing. In fact, in our initial months of operation, we experienced some

¹ Deprivation is a morbid game played by individuals who live in poverty for extended periods. The rules of the game can vary, but the object of the game is to identify the most deprived individual among a group of similar others. Play begins with one individual offering an initial deprivation such as, “I grew up in a cold climate and didn’t have heat in my house.” If others players suffered a similar deprivation they say so and the opening player fails to earn the point. Points are earned only when players disclose deprivations not experienced by others in the game. Round robin play continues with alternating disclosures of deprivations until it is clear from the point total which player is the most deprived or until the group tires of the game.

problems with residents who had trouble controlling their impulsive behaviors and who exhibited violent outbursts. These were resolved quickly, but demonstrated to us the need to revise our admission policy. We responded immediately by adopting a policy that requires referral of potential residents from our partner agencies. Since all residents must document HIV symptoms or AIDS diagnoses, all who are potential residents therefore have prior experience with social and medical AIDS service agencies in Los Angeles. Hence, the threshold for entry into Safe House remains low. But by adopting a policy that accepts applications from people who are referred to Safe House from local agencies, we access knowledge about potential residents that the agencies in the HIV systems of care possess. For example, potential residents known by local agencies to be violent or dangerous are referred to housing programs that have higher levels of intensity in program staffing to manage those behaviors instead of to Safe House, where the low levels of staffing would likely result in involuntary discharge. Thus, Safe House and its practice and philosophy of high tolerance fills a need among service providers for referrals to housing, as well as a need among those who would pose a challenge to traditional housing programs.

Admission Criteria

There are very few criteria that individuals must meet when applying for admission to Safe House. Those that exist are as follows:

- **Proof of a diagnosis of AIDS or of active HIV disease.** This type of proof is generally easy to secure. Most residents of Safe House actively use the AIDS service systems and have documentation easily available. In keeping with the mandate to provide housing to those hardest to serve, potential residents cannot access this program if simply HIV-infected. Residents must show proof that they are symptomatic with HIV disease.
- **Proof of a diagnosis of mental illness and/or chemical dependency.** Although more difficult to arrange than that of an AIDS diagnosis or active HIV disease, most of our residents have extensive involvement in accessing services for serious mental illnesses and chemical dependency problems. Residents must sign privacy release forms to petition mental health or substance abuse treatment agencies in order to provide documentation that verifies concomitant diagnoses. Diagnoses of mental illnesses and/or chemical dependency are not considered verified by signed attendance cards from 12-step meetings or from testimonials from personal contacts.
- **Homeless and/or at risk for homelessness.** This criterion is most frequently verified by the referring agency and is usually verified by conducting a careful housing history during the application process.
- **18 years or over.** At present we require individuals to be aged 18 years or older. Emancipated minors can be considered on a case-by-case basis.
- **Proof of low income designation.** This criterion requires proof that residents yearly income is at or below 80% of the median income for Los Angeles County. This criterion can usually be verified by referring agencies or by copies of the previous year's tax

return. Residents must leave Safe House whenever their yearly income exceeds the threshold of low income.

- **Proof of non-active status regarding tuberculosis.** All potential residents must document that they do not have an active case of tuberculosis. Regardless of their desperate need for shelter, all potential residents must comply with this requirement. Because people with active HIV disease may have such compromised immune functioning that a tuberculin skin test may provide a false negative results (i.e., a result indicating no active case of tuberculosis, when in fact the individual has active tuberculosis infection), we refer all residents to a local agency for a chest X-ray, if they cannot produce a chest X-ray or the results of a chest X-ray taken within the previous six months. In addition to guarding the health of the individual, vigilance against tuberculosis (which can cause severe and sometimes untreatable co-infection with HIV) helps protect the health of the greater community of residents living at Safe House.

Applying for Residence

Applying for an apartment or shelter at Safe House is facilitated by case managers at local agencies who refer their clients to Safe House should the client meet the multi-diagnosis criteria and be at-risk for homelessness. As a unit or a shelter bed becomes available at Safe House, our Housing Assistant contacts agency case managers, who in turn, inform their client(s) of the available benefit. While the client is with the case manager, a “move-in” appointment is arranged with the Safe House Project Director and/or Housing Assistant. Prospective residents are informed that our program is required to document that all residents meet inclusion criteria and are asked to bring copies of HIV/AIDS diagnosis, as well as proof of history with mental illness and/or chemical dependency to this “move-in” appointment. Proof of serious mental illness requires a diagnosis by a licensed care provider and proof of chemical dependency requires records of a formal treatment episode at a substance abuse treatment agency. Records of 12-step group attendance are not sufficient to document chemical dependency. Case managers understand that prospective residents who appear without this documentation will be delayed in accessing the housing benefit and generally are helpful in providing the required documents.

If necessary, transportation services (bus tokens, subway or taxi vouchers) are arranged for prospective residents to visit Safe House. The apartment is located within one block of bus stops and within one-half mile of the North Hollywood subway station. Prospective residents who have special transportation needs (e.g., are unable to walk from the bus stop) receive assistance from our staff members. Upon arrival at the building, prospective residents receive a tour of the apartments and are encouraged to inspect the unit/shelter bed. All prospective residents are encouraged to ask any questions regarding the program. If it is agreed that the prospective resident meets criteria for the benefit and if s/he agrees that Safe House meets her or his needs, s/he is oriented to the rules guiding the Safe House facility. At an initial move-in meeting, Safe House staff members explain the program to new residents, who are informed of the expected rules governing all residents’ behaviors. Those individuals concerned that Safe House is unsuited to their needs are assisted in finding alternate arrangements such as sober living or traditional housing. Otherwise, individuals are asked to complete an intake form including demographic

information, and a brief history of housing, medical care, mental illness and usage of chemical dependency services. Clients then read and sign the appropriate intake documents/leases.

The “move-in” appointment is completed when residents are provided with keys to the property, which includes access to the security gates at the front and rear of the property and to their individual apartment. At move-in, all individuals are supplied with fresh linens (i.e., sheets, towels, pillow cases) and are provided with any toiletries that they may need. Safe House staff members maintain a ready supply of toothpaste, deodorant, shampoo, feminine hygiene products, soaps, grooming products, and cleaning supplies. Residents also receive their first voucher for groceries and are given an application to Project Angel Food.

There often are times, however, when there are no units or shelter beds available. Potential residents who inquire at those times can provide their names and contact information to the waiting list. The waiting list, which consistently contains five to ten individuals waiting for this housing resource, documents the serious shortage of housing designed to meet the unique needs of the multidiagnosed population. When units or beds become available, those on the waiting list are provided first right of refusal to the housing benefit.

Rent. With the exception of the emergency shelter program, all residents are expected to pay some amount toward rent, whether or not they receive subsidies by public assistance programs. The expected monthly rent is \$300, which is the amount billed to those residents who have rental subsidies (Section 8). Basic utilities are understood to be part of this amount (electricity, gas, water, sewer). A minimum of \$120 per month is expected of all residents regardless of financial circumstance. Non-payment of rent, which includes non-payment of the expected portion provided by residents in addition to the subsidies, after 60 days may be a condition for discharge or eviction.

PROGRAM DESCRIPTION

Safe House residential services include Emergency, Transition, and Permanent Housing.

- *Emergency Shelter*: 1, 2-bedroom unit that provides 4 beds for emergency shelter
- *Transition Housing*: 1, 2-bedroom unit and 2, 1-bedroom units that provide 6 beds for transition housing
- *Permanent Housing*: 12, 1-bedroom units that provide 12 beds for permanent housing

Safe House is first and foremost, an apartment building. From the beginning, the “program” at Safe House has reflected this principle. Virtually all residential services delivered through Safe House are leveraged by accessing those that already exist at local AIDS service agencies. To maintain efficiency, only two dedicated, paid staff members assist residents in accessing the existing services. These Safe House staff members, (a Program Director and Housing Assistant), meet with residents regularly and facilitate service utilization at local agencies during periods when residents display symptoms of chronic problems with mental illnesses and/or chemical dependency. The practice of leveraging existing resources minimizes operating costs and maximizes the use of expertise and public resources directed toward people living with HIV and AIDS.

The housing benefits received by residents at Safe House involves subsidies that provide for a stable, decent, and safe environment for those living with HIV/AIDS and co-occurring conditions. This model, which blends provision of the housing subsidy with leveraging of existing social services, is as an efficient, economical way to provide comprehensive coverage to Safe House residents for the multiple services they occasionally need. The model is distinguished from existing social service models in that it mandates all program staff members to be aggressive, community partners within the mix of agencies that provide HIV- and other related services. It is the vital, frequent contact with front line agencies and potential residents that

provides the feedback and access loops to enable use of existing and planned resources by our residents.

The Housing Programs and Facilities

The housing programs available at Safe House involve three options: emergency shelter, transitional housing, and permanent housing. All housing programs are provided at the North Hollywood facility. Units that provide for stays exceeding 30 days are designed so that residents have their own bedrooms (private spaces) that have doors with internal locks. This allows all residents in longer stays at Safe House to control the level of personal security they desire for themselves. The Safe House facility is situated approximately one-half mile from the Metro station in North Hollywood and within one block of bus stops that connect to transportation routes throughout the valley and the city. All residents share amenities at Safe House that include high fences, cinder block walls, and locking gates. There are two entrances to Safe House, one from the front of the property and one at the rear. Both entrances are locked and either require a key for entry or an authorization from a resident. Halogen lights are situated regularly around the perimeter of the property to provide illumination at night. Security guards are employed to manage unforeseen problems that can arise for residents experiencing problems with mental illness and/or chemical dependency during the overnight hours. The facility has a “suds ‘n chat” area, complete with two clothes washing machines, two dryers, a mud sink, a refrigerator, and a public telephone. Outside the area, lawn furniture is provided for residents to gather throughout the day or to lounge on warm evenings. The office for the program is located at the midpoint of the property and provides sufficient space for two office desks, two workstations, a common bathroom, and some small storage areas.

Emergency Shelter

The emergency housing benefit at Safe House offers shelter (food and shelter) for up to 30 days for individuals who qualify for and request the benefit. Emergency shelter is provided using one, two-bedroom apartment. Each bedroom has two twin beds and a separate bathroom (toilet, sink, bathtub/shower). The apartment is spacious (approximately 1600 square feet) and includes a living room/dining area and a full kitchen. The kitchen is equipped with a stove and refrigerator, cookware and dinnerware sufficient for individuals to prepare meals. Filtered, bottled water is supplied to emergency shelter to protect against water borne infections. The nearly 1,600 square foot apartment is carpeted in the living and bedroom areas, with vinyl flooring in the kitchen and bathrooms. Although the unit has a front door that locks to the outside, there are no internal locks on bedroom doors since each bedroom is shared. Climate control is provided by a natural gas heater and an air conditioner, both located in the living room area. Amenities in the emergency shelter include access to toiletries (i.e., dental supplies, soap, deodorant, other personal hygiene products), cleaning supplies (i.e., dishwashing liquid, disinfectant spray), clean linen (i.e., towels, sheets, blankets), and laundry services (i.e., detergent, quarters for machines) from Safe House staff members at any time during weekdays. All shelter residents receive a “welcome kit” upon move-in that includes personal hygiene products and food items.

We have observed that the 30 days of emergency shelter pass quickly. Individuals arrive at the shelter exhausted from a protracted stay on the streets or from lack of a consistent, safe place to sleep. Thus, the first week or so is usually devoted to rest, which prepares shelter residents for the upcoming (and often intensive) processes of arranging stable housing and of addressing emergent medical, legal, mental health, or psychiatric needs. Upon move-in, Safe House staff members provide emergency case management services, as needed. Over the 30 days, staff members work intensively with case managers and social workers to arrange for stable housing situations and to secure necessary intervention for our residents

Although high tolerance emphasizes the role of the individual in the move toward health, Safe House staff members are perhaps most active in providing supervision and direction with those accessing the shelter benefit. Still, the emergency housing shelter is simply a two-bedroom apartment -- the only residential unit at Safe House that “doubles up” residents. The higher density of residents per bedroom for the emergency shelter challenges our staff when providing this benefit using high tolerance, since the physical layout of the program reduces the amount of private space available to each resident. By definition, more of the space in the shelter unit is public than the transition and permanent housing units. Correspondingly, more of the physical area in the shelter is subject to observation by staff members or other Safe House residents. For example, in the emergency shelter program, residents’ bedrooms are defined as public spaces, since each of the two bedrooms are shared by two people, while bedroom areas are considered private spaces in the transitional and permanent housing units. We anticipated that those accessing emergency shelter would also likely experience symptoms of mental illness and/or chemical dependency that might cause disruptive behaviors. Hence, the emergency shelter apartment is situated adjacent to the office for Safe House staff members in order to facilitate easy oversight.

As with residents who access other housing program services, residents who move into the emergency shelter program are informed that the program at Safe House does not condone drug use and that residents observed using drugs are evicted. All shelter residents are informed that all common living areas in the emergency shelter program are subject to entry by Safe House staff and by other residents sharing the shelter space. Because of the accumulated impacts of serious mental illness, chemical dependency, and homelessness, we have learned that the increased level of observation for emergency residents serves a protective function, for the residents and for the program, in that disruptive behaviors can be addressed quickly and efficiently. We have also learned over our first year of operations that the relatively short length of stay (30 days) for individuals seeking shelter care seems to interfere with the development of a sense of “community,” which serves to temper behavioral outbursts from those residents who experience problems due to mental illness and/or chemical dependency who receive housing services with greater lengths of stay. We responded to this observation programmatically by tempering our philosophy of high tolerance philosophy when providing emergency shelter and are very active in providing supervision and guidance to individuals accessing the shelter benefit.

Given the transitory nature of the residents that access emergency shelter, we have observed that some respond to the ending phase of their stay at Safe House with reactance, which involves a devaluing of the emergency shelter benefit at Safe House and a rejection of the

assistance offered to arrange for supportive services and permanent housing. These residents (about 40% of shelter residents total) are discharged from the emergency program to the streets or to unknown housing situations. An equal amount (about 40%) are active in trying to find ways to prolong stays at Safe House, i.e., move to the transitional housing program at the end of the 30 days, while using the housing benefit and assistance in securing supportive services to arrange for permanent housing, either on or off-site. These residents discharge from the emergency housing shelter to stable housing or to situations with friends or family. A minority of residents (about 20%) exhibit violent or illegal behaviors that result in being asked to leave the shelter or in being forcibly removed from the shelter by security or police personnel. Still, the combined effects of the higher density of residents per bedroom, the reduction in available private spaces, and the defined short length of stay at the emergency shelter pose challenges to the provision of the housing benefit using high tolerance. A report evaluating the first year of emergency housing operations is appended with this report.

Transition Housing

The transition housing program at Safe House provides immediate housing to residents for up to four months. Transition housing stays are provided in one, two-bedroom apartment and two, one-bedroom apartments, with a total of six beds for transition housing. All residents in the transition housing program sign a lease agreement that details the guidelines for the program (see below). The two-bedroom unit is situated upstairs from the emergency housing program and provides individual bedrooms for two residents. There are two methods for accessing the transition housing program: directly from referring agencies or from completion of emergency shelter. An important feature of the transition housing program is that each bedroom door is equipped with an internal lock, which provides private space for the resident. In addition, each resident has his/her own bathroom. In the two-bedroom unit, residents share the living, dining, and kitchen areas. Residents in transition housing also have access to the common areas and environmental features shared by all residents at Safe House. Residents in the transition housing program are provided access to all toiletries, cleaning supplies, clean linen, grocery vouchers, meals assistance programs, and other amenities available at Safe House.

Transition housing was originally designed to have a six-month maximum length of stay, which has now been shortened to four months maximum. The maximum was shortened for two reasons: (1) the demand for the transition housing resource is acute and shortening the period allows more individuals to access the benefit; and (2) it seemed that residents in transition housing would avoid arranging more permanent housing solutions until late in their stay. This avoidance often limited the success of the Program Director and Housing Assistant in making arrangements for successful transition into a permanent housing situation. The current four-month maximum appears to assist residents and program staff in remaining task focused when arranging long-term housing solutions for our transition housing residents.

Permanent Housing

Permanent housing at Safe House is consistent with standard independent living situations with the additional benefit that provides for facilitated access to support services, especially during periods of exacerbation of mental illness and/or chemical dependency.

Residents in permanent housing face no limits on their lengths of stay and are required to sign leases, similar to standard housing situations. Permanent housing residents also have access to all services at Safe House and are encouraged to participate in the governance of the residence and in evaluating Safe House client services. A tenant/landlord relationship exists between Permanent Housing residents and Safe House.

Lease and Program Rules

The leases signed by residents at Safe House are similar to those used in most housing situations. There are, however, several important differences in the lease. As described above, all residents in the transitional and permanent housing programs are required to pay some amount each month toward rent. What follows are pertinent agreements shared by tenants at Safe House:

- **Rent Amount.** The rent can be adjusted upward or downward so that the rent due is an amount equal to 30% or less of the tenant's gross monthly income.
- **Quiet Enjoyment.** The tenant agrees to live peacefully and quietly.
- **Limitations on the Unit.** The unit can only be used as the place of residence for the tenant. If a caregiver joins the resident, this must be negotiated with Safe House staff members prior to the caregiver moving to the unit. The caregiver's name can then be added to the lease agreement. No sublets are allowed to this lease. Alterations and improvements are allowed with pre-approval of Safe House staff members.
- **Overnight Guests.** Tenants in transitional and permanent housing are allowed to have guests stay in their apartment. Transition residents are required to have their guests check in at the office. All guests staying longer than seven days must be pre-approved by Safe House staff members. Emergency shelter residents are not allowed overnight guests.
- **Pets.** Tenants are allowed a maximum of one small/medium-sized dog and two cats.
- **Program Rules.** All tenants are required to agree to abide by the following additional program rules:
 - **Remain respectful of others.**
 - **Keep your things neat and orderly.**
 - **Sleep in your bedroom.** Emergency housing residents are required to sleep in their bedroom and can be asked to leave if they do not. Transition and permanent housing residents are allowed to be off premises, with advance approval of staff members.
 - **Policy on drug use.** Drug use is not condoned at Safe House. Anyone detected using or possessing illegal drugs or drug paraphernalia will be given proper referrals to treatment and/or be asked to leave.

OFFICE/ADMINISTRATION

The Basic Idea

Consistent with the idea that Safe House is first, and foremost, an apartment building, there is a minimum level of staffing for the administration of the program. This staffing includes:

- A part time Executive Director
- A full time Program Director
- A full time Housing Assistant
- Part time security
- Part time fiscal administrator

The management plan for Safe House is designed to minimize the costs for supporting infrastructure, yet maintain for the safe operations of housing using a high tolerance approach. The major infrastructure cost for this program is security, particularly for the late night and early morning hours toward the end of the week. Weekdays, Safe House staff double by providing oversight of the facility during work hours. Additional security is provided in the evening hours on some nights.

Safe House program staff members also attend to the needs of residents in providing routine maintenance (a handyman manages minor maintenance issues (e.g., painting), while major problems are provided by contractors (e.g., electrical problems). Residential service activities occur mainly between the hours of 9:00 a.m. and 6:00 p.m., though program staff members are available for emergencies on an immediate basis. A resident manager also supplements oversight of the facility in early evening hours and determines when situations occur that require the attention of the Program Director or other staff members. The on-site resident manager is a position that is paid by providing a reduction in rental fees and is considered to be a position that rotates among the permanent housing residents.

Most of the interaction that occurs between staff members and residents takes place in the Safe House office. The office, located at the center of the property, is a place where residents can access the majority of the services that are available by referral in this collaborative program. Benefits that are available for Safe House residents can be obtained by seeking staff members at

the office. Residents pick up their weekly grocery vouchers at the office. Emergency and transitional residents also visit the office whenever they need fresh linen and/or toiletries. Since the start of the program many residents have used the office to greet staff members, to seek conflict resolution or to socialize with staff.

Given the varied and sometimes extreme needs of residents, the office is a safe and quiet place for residents to meet with the Project Director and/or Housing Assistant to discuss options for mental health and/or substance abuse treatment. The ability to talk frankly with program staff that stems from the high-tolerance policy enables residents to honestly evaluate their needs for services or intervention while retaining the assurance of a stable living environment. It is during these discussions that residents become informed of the referral network that Safe House staff members have established with many mental health and drug treatment facilities.

Confidentiality

Due to the many and difficult problems faced by residents, it is mandated that staff members maintain residents' and community members' confidentiality as a condition of employment. Release forms are used to allow for exchange of information regarding residents among service providers in the network. We comply with mandated disclosure laws when staff members become aware of incidences of child sexual and physical abuse, of child neglect, of elder abuse, of instances involving eminent danger toward self and/or others, and of incidences of reportable health conditions (e.g., TB and STDs). Residents in the permanent housing program receive their mail at a standard mailbox that is outfitted with individual keys. Residents in the transition and emergency program receive mail that can be picked up at the office. Because of the short stays for residents in these programs, we encourage mail to be directed to more stable addresses. Still, in order to protect the identities of residents in the emergency and transition programs, residents' mail remains in a locked cabinet in the Program Director's office until claimed.

Lowering Barriers – Assisted Referral to Essential Services

A critical part of the philosophy of high tolerance at Safe House is the belief that the natural course of human development is toward health when individuals are provided the essentials of existence. Hence, this project is imbued with the belief that it can succeed without replicating existing social service agencies to meet the varied and urgent needs of the residents. Instead, we lowered barriers to service utilization by cultivating extensive collaborations between Safe House and local agencies that provide the many and extensive HIV/AIDS supportive services. This collaborative process serves to leverage existing services provided by specialists, to ensure that Safe House residents receive timely access to services when needed, and to reinforce the primary role of Safe House as a housing facility. In return for providing medical, substance abuse, psychiatric, legal, advocacy, employment and other types of services to Safe House residents – services that already exist due to current contracts – clients at local agencies receive access to the housing benefit at Safe House.

The scope of services provided to Safe House residents via agreement with referring agencies is comprehensive. A listing of the services provided and the community agencies that provide those services is described in Table One.

Table One: Services Provided to Safe House Residents by Collaborating Agencies

Services	Agencies
HIV Medical Care	5P-21/Oliveview Jeffrey Goodman Clinic AIDS HealthCare Foundation North East Valley Community Health
TB Risk	Hollywood Mental Health Center Homeless Health Care LA
Advocacy Services	AIDS Project LA PATH/Access Center Tarzana Treatment Center
Benefits/Legal Assistance	AIDS Project LA Freeman, Freeman & Smiley Pillsbury Madison & Sutro Los Angeles Gay and Lesbian Center
Primary Health Care	AIDS Healthcare Foundation Jeffrey Goodman Clinic/L.A. Gay and Lesbian Center Oliveview Valley Community Clinic
Social Services	AIDS Project Los Angeles Los Angeles Gay and Lesbian Center PATH/Access Center
Spiritual Services	Metropolitan Community Church 12-Step Programs
Substance Abuse Treatment Services	Bear Treatment CRI-Help Tarzana Treatment Center Van Ness Recovery House/Prevention Division
Housing Services	PATH Access LA Family Housing – Sober Living Hollywood Community Housing Tarzana Treatment Center – Sober Living Los Angeles Housing Department – Valley Office
Transportation Services	International Institute of Los Angeles
Meals	AIDS Project LA – Food Bank SOVA – Food Bank

OUTCOMES (as of April 25, 2003)

Since the start, it has been recognized that multidivided people living in Los Angeles are vulnerable to homelessness. Findings from compiling data collected from residents moving to Safe House show that over one-fifth (22%) of residents reported that they spent most nights on the streets in the month prior. Demand for the housing benefit at Safe House remains high. Since opening, the waiting list to enter Safe House is 15-20 individuals per month.

Although data are still being compiled, Safe House residents reflect the diversity of Los Angeles:

- African American – 40%
- Caucasian – 37%
- Latino – 20%
- Other – 4%

One hundred forty one individuals (emergency = 72%, transitional = 18%, permanent = 9%) accessed the housing programs at Safe House since it opened in March 2001. Of these, 13 individuals entered the permanent housing at Safe House. The average length of stay in emergency housing was 22 days, in transitional housing 99 days, and in permanent housing 621 days.

Across the housing programs available at Safe House, 56% of residents moved from Safe House into other forms of stable housing (e.g., standard housing, living with family, permanent housing). Of those who moved from Safe House to other housing programs, 52% of these residents accessed a more stable form of housing than the services accessed at Safe House.

Of the individuals who accessed emergency housing and left the program voluntarily 72% entered stable housing in the community. Of the individuals who accessed transitional housing and left the program voluntarily 88% entered stable housing in the community. All of the individuals who entered permanent housing at Safe House continue to live there except for two residents who passed away.