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## ST. FRANCIS, A MODEL FOR ASSISTING THE CHRONICALLY MENTALLY ILL

MARGARET ANN RAFFERTY

The following article gives an in-depth analysis of the St. Francis Residences in New York City. Run by the St. Francis Friends of the Poor, Inc., these Residences primarily house mental health patients who, in many cases, have been homeless at some time in their past. All of the information in this article, unless otherwise indicated, stems from the author's own knowledge and experience as a nurse working within the Residences. *The Human Rights Annual* is pleased to include this article as a concrete example of one solution to the problem of homelessness.

The crisis of the homeless mentally ill, the search for cost effective treatment for the chronically mentally ill, and the conservative backlash recommending institutionalization all mitigate a closer look at effective means of assisting the chronically mentally ill. One model of interest is the St. Francis Residences in New York City.

The St. Francis Friends of the Poor, Inc. is a not-for-profit organization that purchases and renovates single room occupancy hotels for the purpose of providing safe, permanent and dignified housing to individuals with severe psychiatric disabilities. Although started by two Franciscan priests, this not-for-profit corporation has no legal connections to the church. The first hotel, called the St. Francis Residence, was purchased in 1980 and renovated with money raised primarily through small donations. Because of its success, the project was replicated in 1982 with the purchase and renovation of a 115 room hotel called the St. Francis II. The Franciscans purchased another building in 1985 and are currently renovating the site with an expected opening in early 1987.

Once the initial purchase and renovation costs are paid off in full, the Residences are largely financially self-sufficient. All ordinary maintenance costs are covered by the rent payments of

the tenants. The rent structure is based on tenants' ability to pay. Monthly rents range from \$140 to \$220 per room, depending on the size of the room and the amount of rent that tenants can afford (usually from their federal disability entitlement or welfare housing allotment).

The resources to fund and staff the St. Francis include the St. Francis of Assisi Church, Crisis Intervention Services of the Human Resources Administration, New York University Medical Center-Bellevue Hospital Center, The New York State Office of Mental Health, the Visiting Nurse Service of New York, the Hudson Guild Counseling Center, and St. Vincent's Hospital and Medical Center.

On-site services are critical to the success of the project. The project is directed by three Franciscan priests who divide their time between the Residences. The full-time staff at each site consists of a psychiatric nurse team leader, two activities therapists, and a social worker. A home economist works part-time. There are seven psychiatrists who work 2-7 hours per week between the two sites. Both Bellevue Hospital and the New York State Office of Mental Health provide a part-time social worker. An attending physician visits each site 3 hours a week to provide on-site primary medical care. These on-site health care services are essential since few of the tenants are able to effectively use traditional services.

A yearly cost per tenant of \$5,500 to provide residential care and on-site supportive services provides a compelling economic argument for the St. Francis. This is half the cost of the New York City Municipal Shelter System, one-tenth the cost of a year in a state hospital, and one-third the cost of a state-run community residence. Quality of life measures are more difficult to quantify, but by all accounts, the Franciscans have achieved one of the most pleasant, homelike atmospheres available in chronic care.

The philosophy of the St. Francis Residences is to provide a caring environment with enough structure so that persons with severe mental disabilities can live a "quality" life in the community. One goal of the project is to accept those persons most in need who would not be able to live elsewhere. The St. Francis I houses 101 persons, 50 percent of whom had at least one episode of homelessness. Similarly, the St. Francis II houses 115 persons,

of whom 80 percent were homeless. The majority of tenants are diagnosed as schizophrenics. For the vast majority of these tenants, rehabilitation toward an independent life is not a realistic aim, because most require continuous treatment and support services. The goal, instead, is to prevent hospitalization and assist the patient by providing a network of social support, thereby maintaining the tenant in the community. The program accepts people as they are, harboring no false illusions about their future. There are few rules and a high tolerance for bizarre behavior. People are free to come and go, with the staff intervening only if the behavior becomes dangerous to either the tenant or another member of the community.

Good candidates for admission are those persons with severe and long-standing mental illness who are willing and able to tolerate the structure of the program. Moreover, they must be over 21, have a primary psychiatric diagnosis and live in one of the five boroughs of New York City. The Residences do not take people directly from "the street". This approach was abandoned when it became clear through trial and error that the homeless mentally ill need a transitional step to permanent housing. Generally, referrals come from outreach teams or inpatient psychiatric hospitals. Acceptance to the Residence also hinges on acceptance of psychotropic medication when necessary. This requirement eliminates those potential tenants who adamantly oppose medication. The Residences do not accept persons with a primary diagnosis of alcohol or substance abuse, because these patients have a potential for destructive action that can place a more vulnerable schizophrenic tenant in jeopardy. Occasionally, a dual-diagnosis patient (one with alcohol or substance abuse and a primary psychiatric disorder) is admitted, but only if he has stopped using alcohol or drugs. Persons with a history of violent behavior are screened out because 24-hour clinical staff are not available to deal with their special problems.

Schizophrenics are highly responsive to their social environment. Research has established that schizophrenic episodes are triggered by hostility, criticism, stress, and over emotionalism. Developing the optimal environment has presented a challenge to the psychiatric community with today's trend toward deinstitutionalization.

The St. Francis model is unique from traditional and non-

traditional outpatient clinics because it does not employ the standard "therapy" approach. Activities are the backbone of the program. The primary reason for the focus on activities rather than individual and group psychotherapy is that there is evidence that patients who are chronically mentally ill respond better to programs that emphasize activities. Some researchers have found that the indiscriminate use of more traditional milieu therapies can have an anti-therapeutic effect on the chronic patient.

Tenants are free to attend the many day programs and outpatient programs available in New York City, but few can tolerate the demands of these programs for punctual attendance and appropriate behavior. The emphasis at the St. Francis is to build a community that creates a strong social network for the chronic patient. As a result of their illness, the tenants are profoundly socially isolated. They slowly develop relationships with the staff and their neighbors and eventually provide a strong base of support for each other, twenty-four hours a day.

The key element of the St. Francis is the "open office". The main office of the St. Francis is a communal space shared by the staff and the tenants. Tenants come to the office to socialize, as well as for medications, money, and assistance with various entitlements. No appointments are necessary. Tenants go in and out of the office all day. Some stay for five minutes, and some sit in the office all day. This approach is useful in several respects. A major symptom of schizophrenia, for instance, is the inability to manage such tasks as paying the rent, shopping, personal hygiene and grooming. With the open office system, everything is taken care of for the tenants. Their money is budgeted to a daily allotment and if something goes awry with an entitlement (as is often the case), they are given credit. Breakfast and lunch can be automatically deducted from one's account. The office arranges for rooms to be cleaned, and supplies phones, stamps, and stationery for the needy tenant. This type of support allows the schizophrenic to function as fully as possible. The open office is very informal, with a "kitchen-type" atmosphere. Tenants can go there to chat, play games like scrabble, do crossword puzzles, and tell jokes.

The second way in which the open office is effective is for social skills training. The interaction among staff members in-

volves communication necessary for the ongoing functioning of the program and interpersonal communication as well. This serves as a role model of socialization for tenants and is especially necessary and beneficial for a population in dire need of learning precisely those skills.

Another major symptom of schizophrenia is a tendency toward social isolation, a self-inflicted ostracism from the mainstream community. This inclination lessens as tenants become more familiar and comfortable in the St. Francis community. Tenants have the opportunity to broaden their experiences through voluntary participation in tenant's council and the various planned and unplanned activities. The patients also control the amount of contact they have with the staff. This differs from traditional therapy where the patient schedules appointments with a therapist to talk for a set period of time.

In addition to the open office, St Francis offers a wide variety of activities, including poetry, painting, writing, music and art appreciation, baking, laundry, parties, movies and outings. All of these opportunities significantly improve the quality of life for the residents, as well as lessen the tendency toward isolation.

Work is an integral part of the St. Francis, and all individuals are encouraged to help out in any way they can. Tenants receive a small stipend for running errands, working in the kitchen, or assisting with other tasks.

Medication is another important variable in the improvement of tenants' lives. Numerous studies point to the efficacy of psychotropic drugs in preventing relapses in schizophrenia. Failure to properly administer or take medication is the most common reason for hospital readmissions among chronic schizophrenics. Such failure by the patient often stems from his prior experiences with drug side effects, but can also be due to the patient's forgetfulness or inability to comprehend the complexity of his drug regimen. Psychiatric nurses package and dispense medication seven days a week for about half of the tenants at the Residence. Side effects are diagnosed and treated immediately by the on-site psychiatric staff.

On-site psychiatric staff ensure that patients get adequate treatment. Constant access is especially important for those tenants who tend to avoid physicians. The psychiatrist can often

visit the patient in his room, or stop by the community room. In addition, the withdrawn or isolated person is seen at least once a day for dispersement of medications and/or money, so the psychiatrist can assess his progress by consulting with the staff. More information is obtainable from reports by maintenance staff, daily logs kept by 24-hour desk clerks who note unusual behavior, and informal talks with other patients. Information from these other sources is invaluable in dealing with psychotic persons whose judgement and insight may be very impaired.

Primary health care is provided by an attending physician from St. Vincent's Hospital Department of Community Medicine. Psychiatric patients have a much higher morbidity and mortality rate than the average population so medical supervision is essential. The physician serves as a liason between the Medical Center and the patient. Follow-up is often done by the staff who will ensure that the tenant is escorted to the hospital for diagnostic work and complies with the medical regimen. Despite the best efforts of any program, periodic rehospitalization is the rule for chronic psychiatric patients, although short-term hospitalization is usually as effective as long-term hospitalization in treating relapses. The St. Francis program has a cooperative relationship with Bellevue Hospital Center which accepts tenants when hospitalization is necessary. Tenants may be hospitalized involuntarily when they meet the legal requirements of dangerousness to self or others.

The vast number of homeless mentally ill persons attests to the failures of the mental health system. Lack of affordable housing has been a key factor in creating the crisis of homelessness. Many chronically mentally ill patients were able to etch out an existence in cheap single room occupancy hotels until the virtual elimination of this type of housing resource. While outsiders were often left aghast by the incredible squalor of the single room occupancy hotels, an objective look found that the system worked, albeit at a marginal level. Patients consistently reported that they preferred single room occupancy living to life in the "back wards" of hospitals. The large number of units available in past years ensured that people could either "stay put" if they liked stability, or move around if that became necessary. Single room occupancy living provided a largely deviant social network for chronic patients. Disreputable landlords acted

as money managers for tenants but often kept much of the tenants' money for themselves. Deviance, poor hygiene and bizarre behavior were tolerated and medical care was accepted by these tenants only in dire emergency.

The St. Francis model essentially builds on the more positive aspects of single room occupancy living such as development of an independent life in a community and the establishment of a supportive social network. By taking the profit motive out of housing, the St. Francis has created a more organized, cleaner and happier version of its single room occupancy hotel predecessor. Limiting on-site staff to a minimum provides necessary support while keeping the costs down. The success of this model calls for a reexamination of the key variables that are effective in achieving community tenure for chronic patients.

