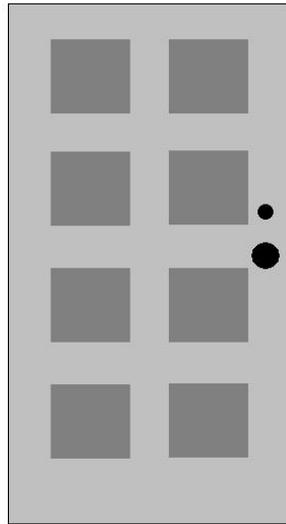


A PLACE TO CALL HOME:

For Some of Tulsa's Most Vulnerable Citizens



The University of Oklahoma Graduate College

**A Place to Call Home:
For Some of Tulsa's Most Vulnerable Citizens**

A Professional Project
Submitted to the Graduate Faculty
in partial fulfillment of the requirements
for the degree of
Master of Science in Architectural Urban Studies

By

Paula Thomas, MHR
Glenpool, Oklahoma
2010

A Professional Project approved for the
College of Architecture
Urban Design Studio

By

Shawn Michael Schaefer, Chair
Showa Omabegho, Ph.D.
Marjorie Callahan



© Copyright by *Paula Thomas* 2010
All Rights Reserved.

TABLE OF CONTENTS

Acknowledgements	4
Introduction	5
Methodology	6
Overview of Mental Health in America	7
Overview of Deinstitutionalization	9
Overview of Mental Health in Oklahoma	14
Overview of Mental Health in Tulsa	23
Literature Review	26
Findings	29
Outcomes	31
Conclusion	35
References	36
Appendix 1	42
- The Harvest Ranch Foundation Capitol Budget	
Appendix 2	43
- The Harvest Ranch Foundation Mission Statement and Bylaws	



ACKNOWLEDGEMENTS

I would like to thank the following individuals for their guidance throughout this project:

Shawn Michael Schaefer, Director, OU -Tulsa Urban Design Studio

Showa Omabegho, Ph.D., OU College of Architecture

Marjorie Callahan , Associate Dean, OU College of Architecture

Andrew Cherry, Jr., DSW, ACSW, OU -Tulsa School of Social Work

Nicole Washington, DO, -Director, OU IMPACT

Mark Davis, MSW , Tulsa Mental Health Association

Connally Perry, Tulsa Mental Health Association

Rose Weller, NAMI-Tulsa

My Family, without whose continual encouragement and support, this project would have not been possible.

This project is dedicated to the many people in the Tulsa area who live with serious mental illness, and to David.



INTRODUCTION

This project arose out of a critical need to find long-term supported housing for a life-long Tulsa citizen with serious mental illness (SMI). Unfortunately, a review of available resources in Tulsa indicates that adequate (safe, clean, affordable) housing for Tulsa citizens with SMI is incongruent with community efforts aimed at integrating this group into mainstream society. The primary purpose of this research is to understand what could be done to facilitate more long-term housing options for this underserved group of some of Tulsa's most vulnerable citizens. It is expected this research will reveal an overburdened mental health system in Tulsa that is currently plagued by budget cuts, and without adequate resources to address the long-term housing needs of Tulsans with an SMI. It is further expected this research will reveal that if our community were better able to match the need for stable, affordable housing with high quality services, such as those provided by Programs of Assertive Community Treatment (PACT) teams, we would increase the likelihood of better outcomes for individuals with SMI, as well as, promote more efficient and effective use of current resources.

The project is grouped into four main segments:

1. An overview of mental illness in America, the process of deinstitutionalization, and the impact of this process on our country, our communities, and our citizens with SMI and their families.
2. An overview of mental illness in Oklahoma, and in particular, Tulsa, including information on where Tulsa citizens with SMI live now, available supportive housing for individuals with SMI, group homes, and impending budget cuts to the mental health care delivery system in Oklahoma.
3. A descriptive literature review structured to accentuate the trends in areas of the evidenced - based model of supportive housing and the PACT team model.
4. The project concludes by proposing an applicable, client-centered solution for two Tulsa citizens with SMI.

With the knowledge that even one pilot starts the process it is the researchers' hope that the proposed alternative to current models could be applicable for others who live with SMI as well.



METHODOLOGY

This project utilizes the general inductive approach within the category of qualitative research. This method was chosen for the purpose of condensing extensive and varied text data into a brief, summary format. In addition, this method was employed in an effort to expand the knowledge and understanding of what could be done to facilitate more affordable supportive housing options for people with SMI. Further, the inductive analysis provides the opportunity to establish clear links between the research objectives and the findings derived from the data. Finally, relationships were established with community mental health partners, the National Alliance on Mental Illness(Tulsa) and the Mental Health Association(Tulsa), to facilitate a current understanding of available housing and service resources in Tulsa. These organizations provided information on available housing for Tulsa citizens with SMI, as well as, service providers equipped to accommodate citizens with SMI who are housed independently. Throughout this project the work of reputable national and local organizations related to mental health including information from Mental Health Association(Tulsa), Mental Health America, National Alliance on Mental Health(Tulsa), National Alliance on Mental Health, Treatment Advocacy Center, Oklahoma Department of Mental Health and Substance Abuse, Mental Health Commission, as well as, the use of information from scholarly publications. Throughout this project references are designated with an endnote and images are designated with a letter, both of which correspond to a list at the end of the work. The table below outlines the schedule for this project and the different color blocks represent the various phases.

Project Schedule	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10
Develop Project Plan										
Identify Community Partners										
Review Available Resources										
Conduct Preliminary Research										
1 st Jury			10/17/09							
Literature Review										
Analyze Data										
Develop Action Plan										
2 nd Jury					12/05/09					
Design/Implementation										POSTER
3 rd Jury								03/06/10		
Production										
Final Jury										05/01/10

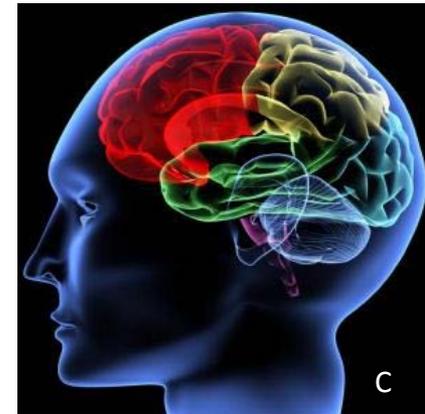


MENTAL HEALTH IN AMERICA

An estimated 26 % of Americans ages 18 and older suffer from a diagnosable mental disorder in a given year.² When applied to the 2010 U.S. Census estimate this 26 % translates to over 77 million people in America ages 18 and older who suffer from a diagnosable mental disorder in a given year. Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion — about 6 %, or 1 in 17 — who suffer from a serious mental illness (SMI).¹ Based on the same 2010 population estimates this translates to 18 million people in America living with a SMI.

NAMI identifies serious mental illnesses (SMI) as:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder
- Major depressive disorder
- Obsessive-compulsive disorder
- Panic and other severe anxiety disorders
- Borderline personality disorder
- Post-traumatic stress disorder (PTSD)
- Autism and pervasive developmental disorders
- Attention deficit/hyperactivity disorder¹



According to NAMI these disorders represent the major mental disorders that current scientific data and consensus conclude are identifiable, disabling medical illnesses, with significant biological underpinnings, and requiring treatment.¹

DEINSTITUTIONALIZATION

Prior to 1965, the public psychiatric care system in our country was almost completely run by the states, often in partnership with local counties or cities.⁴ From roughly 1850 to 1965, people with SMI in America were warehoused in psychiatric institutions, away from mainstream society, as they were deemed to be incurable.⁴ The prevailing attitude was one of “out of sight, out of mind,” and people with SMI were left in these institutions, in many cases, for their entire lives.⁴ In 1955 there were 340 public psychiatric beds available per 100,000 people in the United States.⁵

When changes in civil rights legislation related to adequate levels of care, converged with the widespread introduction of the first effective antipsychotic medication Thorazine, the stage was set for moving patients out of institutional settings.⁴ In 1965, the federal government specifically excluded Medicaid payments for patients in state psychiatric hospitals and other institutions for the treatment of serious mental illnesses, to accomplish two goals:

1) to foster deinstitutionalization; 2) to shift the costs back to the states which were viewed by the federal government as traditionally responsible for such care.⁴ While in state hospitals, patients were the fiscal responsibility of the states, but by discharging them once funds were available outside of state hospitals, the states effectively shifted the majority of that responsibility to the federal government.⁴ States proceeded to transfer massive numbers of patients from state hospitals to nursing homes and the community where Medicaid reimbursement was available.⁴ Deinstitutionalization dropped the population of the nation’s mental hospitals from 560,000 in 1955 to 100,000 in 1996.⁶ In 2005 there were 17 public psychiatric beds available per 100,000 people.⁵ As a result of the deinstitutionalization process, 95 percent of the beds available in the United States in 1955 were no longer available in 2005.⁵



DEINSTITUTIONALIZATION

Surveys of public psychiatric facilities were carried out in 2004 and 2005 by the Center for Mental Health Services, part of the U.S. Department of Health and Human Services, and by the NASMHPD Research Institute, an affiliate of the National Association of State Mental Health Program Directors (NASMHPD).⁵ Since similar data are also available from a survey done in 1955, it is possible to compare the availability of public psychiatric beds over a fifty-year period, prior to and after deinstitutionalization.⁵ In 1955 there were 558,239 public (state and county) psychiatric beds available for mentally ill individuals.⁵ In 2005 there were 52,539 public (state and county) psychiatric beds available for mentally ill individuals.⁵ To determine a minimum number of beds needed, a consensus of experts involved in the study looked at specific criteria such as number of individuals who need hospitalization, length of hospital stay, and current state and federal financing structures.⁵ They also were asked to assume that effective community based services and assisted outpatient treatment programs are available in all 50 states.⁵ Using these criteria, the panel concluded that 50 public psychiatric beds per 100,000 individuals is the absolute minimum number required to meet current needs.⁵ Using 50 public psychiatric beds per 100,000 population as a minimum, it is possible to compare the present bed capacity in each state with the minimum needed.⁵ According to the Treatment Advocacy Center the states can be categorized as follows below and on the next page:

Meets Minimal Standard

(50 or more beds per 100,000 population)

Mississippi - 49.7

Marginal Bed Shortage

(35–49 beds per 100,000 population)

South Dakota - 40.3



DEINSTITUTIONALZATION

Unfortunately, the Treatment Advocacy Center's study of public psychiatric facilities in the United States revealed that 42 of the 50 states have less than half the minimum number of beds considered to be reasonable by knowledgeable experts.⁵ In 32 of the states, the shortage of public psychiatric beds is classified as critical or severe.⁵

Serious Bed Shortage

(20-34 beds per 100,000 population)

Louisiana - 20.2
Nebraska - 20.7
Montana - 20.9
Missouri - 21.5
Maryland - 21.6
Kansas - 21.7
Alabama - 22.1
Virginia - 22.2
New Mexico - 22.3
Wyoming - 24.1
Connecticut - 25.4
North Dakota - 25.9
Minnesota - 26.8
New York - 27.4
New Jersey - 32.4
Delaware - 33.8

Severe Bed Shortage

(12-19 beds per 100,000 population)

Florida - 12.1
Texas - 12.1
Rhode Island - 12.5
Maine - 12.6
Wisconsin - 13.0
Hawaii - 13.5
Utah - 13.8
West Virginia - 14.2
Illinois - 14.3
Kentucky - 15.6
Massachusetts - 15.8
Colorado - 16.9
North Carolina - 17.1
New Hampshire - 17.2
California - 17.5
Tennessee - 18.1
Georgia - 18.5
Pennsylvania - 18.9
Washington - 18.9
Oregon - 19.2
Indiana - 19.3

Critical Bed Storage

(less than 12 beds per 100,000 population)

Nevada - 5.1
Arizona - 5.9
Arkansas - 6.7
Iowa - 8.1
Vermont - 8.9
Michigan - 9.9
Ohio - 10.6
South Carolina - 10.6
Oklahoma - 11.0
Idaho - 11.3
Alaska - 11.3



DEINSTITUTIONALIZATION

The consequences of this radical reduction in psychiatric hospital beds are many. The researcher maintains there was inadequate infrastructure in place in terms of where to house people with SMI who were released from state hospitals. As a result, many people with SMI are forced to live with their families, in substandard housing, nursing homes, group homes, shelters or on the streets with little or no support. One consequences of deinstitutionalization has been a marked increase of severely mentally ill individuals who are homeless.⁴ A report by the National Alliance to End Homelessness, *"The Decennial Census and Homelessness"* (2010), states that in 1930 there were 55,045 homeless individuals in the United States.⁷ In 2000 there were 283,898 people counted as homeless in 14,817 locations.⁷ The Treatment Advocacy Center maintains that people with untreated psychiatric illnesses constitute one-third, or between 150,000 and 200,000 people, of the estimated 744,000 homeless population.⁸ Another consequences is reflected in numbers obtained through the Freedom of Information Act and prepared for The Associated Press by the Centers for Medicare and Medicaid Services which show that nearly 125,000 young and middle-age adults with serious mental illness lived in U.S. nursing homes in 2008.⁹ The AP further reports that these numbers reflect a 41 percent increase from 2002.⁹ Younger, stronger residents with schizophrenia, depression or bipolar disorder are living beside frail senior citizens, and sometimes taking their rage out on them.⁹

"Sadly, we're seeing the tragic results of the failure of federal and state governments to provide appropriate treatment and housing for those with serious mental illnesses and to provide a safe environment for the frail elderly," said Janet Wells, director of public policy for the National Citizens' Coalition for Nursing Home Reform.⁹

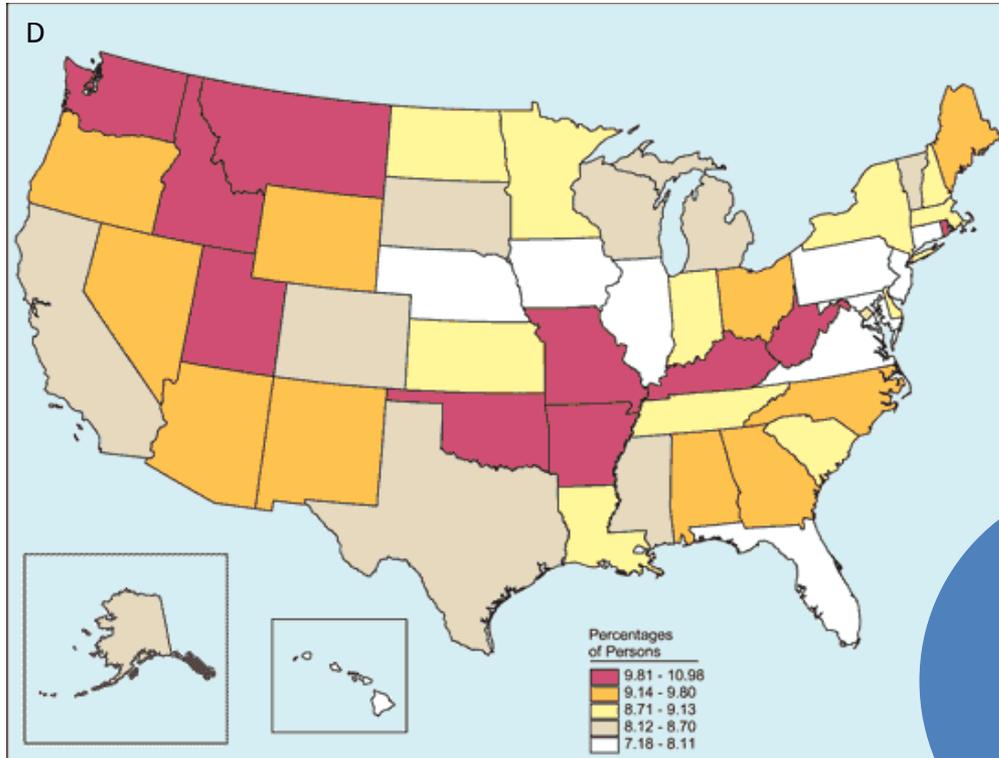


DEINSTITUTIONALIZATION

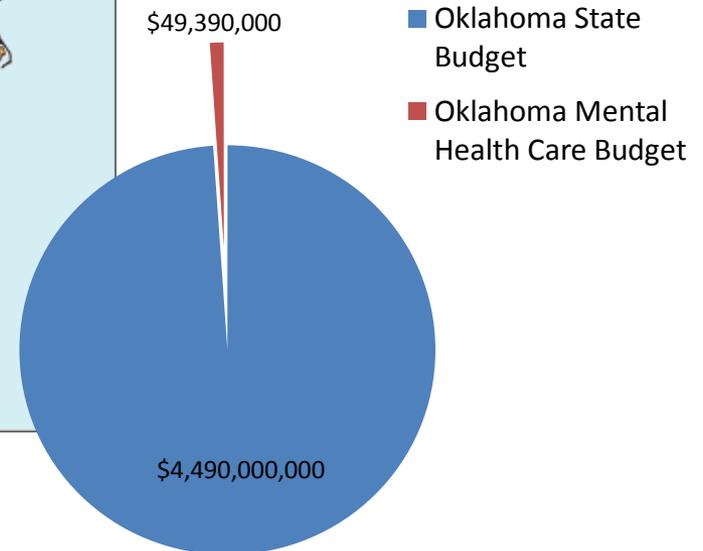
In 2003, the presidential New Freedom Commission on Mental Health found that the service system responsible for helping those with mental illnesses was “fragmented and in shambles.”¹⁰ According to Michael J. Fitzpatrick, director of NAMI, “In America today, the people who must rely on this system are actually being oppressed by it, and many years of bad policy decisions have left families, emergency rooms, and the criminal justice system to shoulder the burden of responding to people in crisis.”¹¹ Fewer than 55,000 Americans currently receive treatment in psychiatric hospitals, meanwhile, almost 10 times that number -- nearly 500,000 -- mentally ill men and women are serving time in U.S. jails and prisons.¹² Yet another consequence of deinstitutionalization, the Treatment Advocacy Center maintains, “We have been unable to identify a single county in the nation where homeless shelters or the county psychiatric inpatient facility is holding as many mentally ill individuals as the county jail.”¹² The number of the mentally ill in American jails and prisons supports the thesis of progressive trans-institutionalism.¹³ Palermo, Smith, & Liska (1991), maintain that the statistical evidence derived from the national census data corroborates their clinical observation that jails have become a repository of pseudo-offenders -- the mentally ill, and are of the opinion that their results probably reflect the state of most U. S. jails.¹³ Observations by psychiatrists and by corrections officials also support a causal relationship between deinstitutionalization and the increasing number of former patients in jails and prisons.¹⁴ As a result of misguided policies, the Los Angeles County Jail now tops the list of psychiatric hospitals in the U.S.⁸ In his letter from the director, NAMI Grading the States 2009, Fitzpatrick states, “Simply put, treatment works, if you can get it. But in America today, it is clear that many people living with SMI are not provided with the essential treatment or supports they need.”¹¹

MENTAL HEALTH IN OKLAHOMA

A 2003 report by the U.S. Department of Health and Human Services, shows Oklahoma in comparison with other States (illustrated in the image below), as having one of the highest rate of serious mental illness among adults (18 years and older).¹⁵ A national study conducted by NAMI shows Oklahoma ranked 44th among the 50 states in the percentage of its total state budget spent on mental health care — about 1.1 percent (illustrated in the chart below).¹⁶



Based on Oklahoma's current population from U.S. Census Bureau, Population Division, and applying NAMI's 6% figure of the population with SMI, the researcher estimates the **Oklahoma SMI population** to be approximately **221,223**.



MENTAL HEALTH IN OKLAHOMA

According to NAMI's Grading the States 2006 report Oklahoma's overall score was a D, (illustrated to the left, below).¹⁷ Over the next three years Oklahoma increased the amount it spent on mental health care and NAMI noted the improvement in it's 2009 Grading the States Report Card, (illustrated to the right, below).¹⁸

 Grading the States 2006 <small>A Report on America's Health Care System for Serious Mental Illness</small>	
Report Card	
Overall Grade:	D
Category Grades:	
Infrastructure:	D-
Information Access:	F
Services:	C
Recovery Supports:	C
	E

Grading the States 2009 Report Card: Oklahoma



“Three years later, the grade is a B, reflecting remarkable improvement and significant opportunities.”

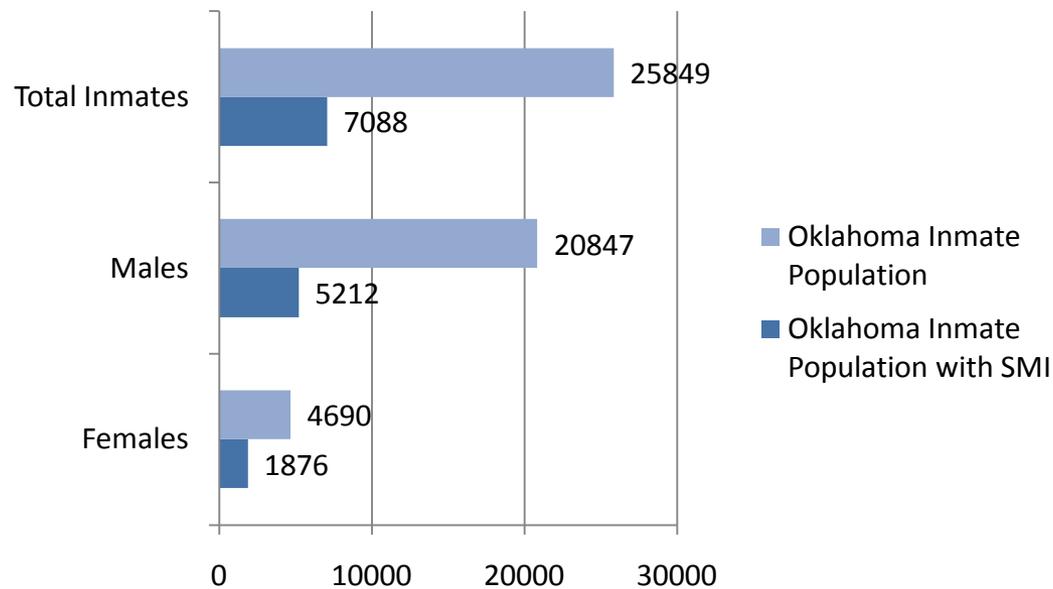
- Health Promotion and Measurement: B** (25% of Total Grade)
Basic measures, such as the number of programs delivering evidence-based practices, emergency room wait-times, and the quantity of psychiatric beds by setting.
- Financing & Core Treatment/Recovery Services: C** (45% of Total Grade)
A variety of financing measures, such as whether Medicaid reimburses providers for all, or part of evidence-based practices; and more.
- Consumer & Family Empowerment: C** (15% of Total Grade)
Includes measures such as consumer and family access to essential information from the state, promotion of consumer-run programs, and family and peer education and support.
- Community Integration and Social Inclusion: C** (15% of Total Grade)
Includes activities that require collaboration among state mental health agencies and other state agencies and systems.

F



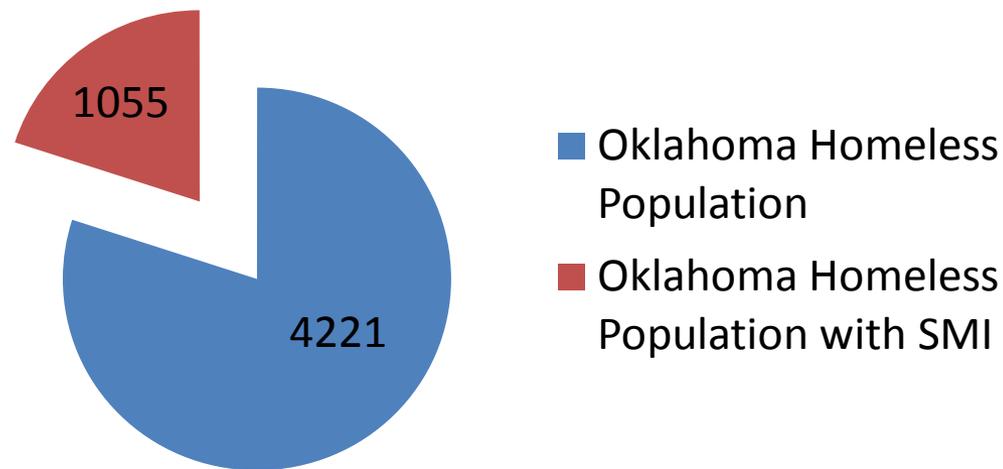
MENTAL HEALTH IN OKLAHOMA

With a population of over 3.6 million in Oklahoma, we have 25,849 people behind bars, according to the Oklahoma Department of Corrections(ODOC).²¹ Further, the ODOC estimates that 25% of males and 40% of females suffer from some type of serious mental illness(illustrated below).²² Governor hopeful, Attorney General Drew Edmondson maintains, “Ninety percent of Oklahoma inmates have an underlying mental health, alcohol or other substance abuse problem”.²³ The ODOC further maintains that data indicates the number of offenders with a history of, or current symptoms of mental illness has risen from 5,780 to over 11,900 in just three years, an increase of 101% compared to a 11% increase in general population during that same time period.²³



MENTAL HEALTH IN OKLAHOMA

Homelessness is a chronic condition sustained primarily by limited access to permanent housing, mental health care and substance abuse treatment specifically designed to meet the needs of chronically homeless adults.²⁴ According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health Information Center, 50% of homeless individuals report some form of mental health problem, and 25 % meet criteria for serious mental illnesses.²⁴ The National Alliance to End Homelessness - State by State Data reports there are 4221 homeless individuals in Oklahoma.²⁵ SAMHSA further maintains that untreated mental illness can cause individuals to become paranoid, anxious, or depressed, making it difficult or impossible to maintain employment, pay bills, or keep supportive social relationships.²⁴ Individuals with co-occurring mental health and substance use disorders are among the most difficult groups to put in stable housing and treat, due to the limited availability of integrated mental health and substance abuse treatment in most locations.²⁴



MENTAL HEALTH IN OKLAHOMA

In the same three year time frame that Oklahoma increased it's funding to mental health care (2006 to 2009), Oklahoma Residential Care Facilities were investigated for at least two dozen cases of abuse and neglect and received more than 2,500 violations of care standards, according to a joint investigation by the Tulsa World and The Oklahoman.¹⁹ Reporters for the Tulsa World and The Oklahoman spent six months reviewing more than 40,000 records from federal, state and local agencies on residential care homes and Intermediate Care Facilities for the Mentally Retarded.¹⁹

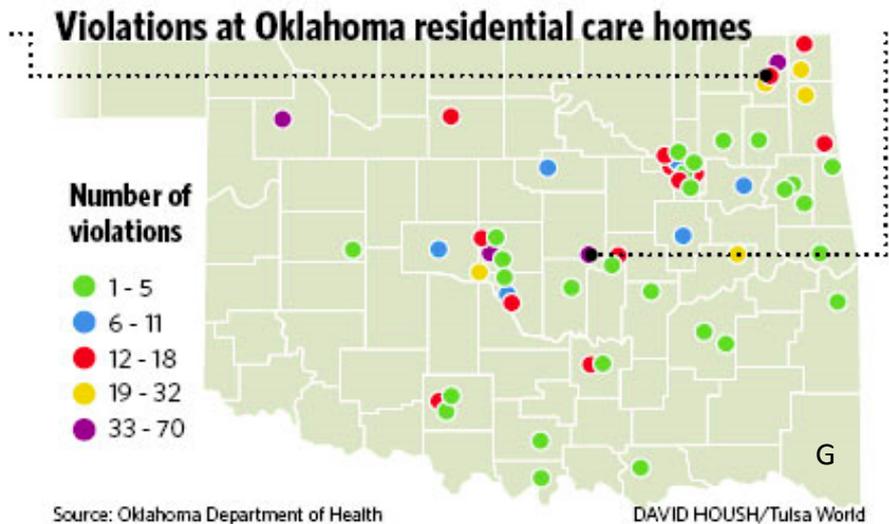
Most the information came from records provided by the Oklahoma State Department of Health spanning from 2006 to 2009, and included thousands of inspection surveys, investigatory reports, letters between home representatives and state officials, and details on how the homes planned to fix problems the state discovered.¹⁹ Because the records were provided as copies of the original forms, reporters looked at each document and created a database to determine tallies of violations by each home.¹⁹

From 2006 to 2009, inspectors documented residents who were...
covered in feces
stolen from
threatened with knives
left to sleep on dirty mattresses
supervised by felons
lived in buildings infested with ants, cockroaches and mice
two alleged rapes¹⁹



MENTAL HEALTH IN OKLAHOMA

According to the same report by the Tulsa World and The Oklahoman, additional violations include 30 cases of inappropriate medical care and 24 cases of client abuse or neglect, four involving the death of a resident.¹⁹ In 2009 an 82-year-old man prone to hallucinations climbed out of his window at Early Autumn's Residential Care Facility in Stillwater before falling off a cliff and dying face-down in a nearby creek.¹⁹ In April 2008, 19-year-old William Eugene Hurst, a resident of the now-closed Green Country Residential in Fairland, was hit by a truck and died after he wandered from the facility.¹⁹ Hurst was mentally ill and had previously walked away from the home seven times in 37 days.¹⁹ In May 2008 a 54-year-old schizophrenic resident wandered away from Edna Lee's Residential Care in Vinita, and was found seven days later dead from dehydration.¹⁹ A male resident died in 2007 after officials at North Fork Residential Care in Checotah failed to treat his infection.¹⁹ Images below are from the Tulsa World article.¹⁹



Most Significant Number of Violations

- Medications: 93
- Food service: 60
- Staff qualifications: 47
- Housekeeping: 45
- Building elements: 32
- Rights — appropriate medical care: 30
- Administration of medications: 29
- General criteria construction: 27
- Rights — abuse and neglect, seclusion and restraints: 25
- Medication storage and maintenance: 23



MENTAL HEALTH IN OKLAHOMA

As Oklahoma grapples with a projected \$1.2 billion shortfall in its budget for the upcoming fiscal year, mental health experts worry that great strides made in recent years to improve treatment for mental illness in Oklahoma will be rolled back as policy makers are forced to ax state programs.¹⁶ Oklahoma Department of Mental Health and Substance Abuse Services addressed a 7.2 percent cut in its 2009-10 budget.¹⁶ The agency's state budget, already cut about \$10 million to start the fiscal year, has been slashed by another \$15 million so far this year as state revenues plummeted amid a sluggish economy and low energy prices.¹⁶ Oklahoma isn't alone. With nearly every state suffering budget shortfalls, mental health programs are hurting across the nation, said Mike Fitzpatrick, executive director of the National Alliance on Mental Illness.¹⁶ "What you're seeing is a gradual weakening of the mental health system — fewer case workers, cutbacks in patient beds, longer waiting lines," Fitzpatrick said. "In Oklahoma, we're concerned they're going to be thrown back significantly because of challenges with their budget. You're beginning to see the last three years progress really eroded, and there's no real light at the end of the tunnel," Fitzpatrick said.¹⁶

About \$17 million has been cut from mental health and substance abuse budgets, so far.²⁰

A huge question looms for Susan Boehrer, and she figures she has particular insight since mental illness plunged her daughter into more than 400 days of hospitalization and her son's violent conduct disorder made him a ward of the juvenile justice system.²⁰

"Do you really want to be driving down the road, looking at the car next to you, wondering if that's one of the folks who, because of the cuts to mental health, aren't receiving the services they need?" Boehrer asked.²⁰

It's a question that she said more people likely will be asking as budget cuts — about \$17 million and counting — deplete the state Mental Health and Substance Abuse Services.²⁰



MENTAL HEALTH IN OKLAHOMA

What's being cut...

Along with serving 70,000 Oklahomans, the Oklahoma Department of mental Health and Substance Abuse Services provides residential treatment for about 300 adults and 100 adolescents at 24 state-run and contracted facilities across Oklahoma.²⁰

The reductions resulting from the department's \$17 million budget cut:²⁰

- Cut 30 of 150 inpatient beds at Griffin memorial Hospital in Norman, which always operated beyond capacity.
- Cut 24 beds for patients with both mental health and substance abuse at the Tulsa Center for Behavioral Health.
- Cut all 26 beds at the Enhanced residential Services program at Central Oklahoma Community Mental Health Center.
- Cut all 65 adult substance abuse treatment beds at the Norman Alcohol and Drug Treatment Center.
- Cut about 30 children's mental health beds at the Children's Recovery Center of Oklahoma in Norman.
- Closed all 20 men's residential substance abuse treatment beds at Bill Willis Community Mental Health Center in Tahlequah.
- Reduced provider contracts for mental health and substance abuse services at contract facilities around the state. The impact of which remains to be seen.



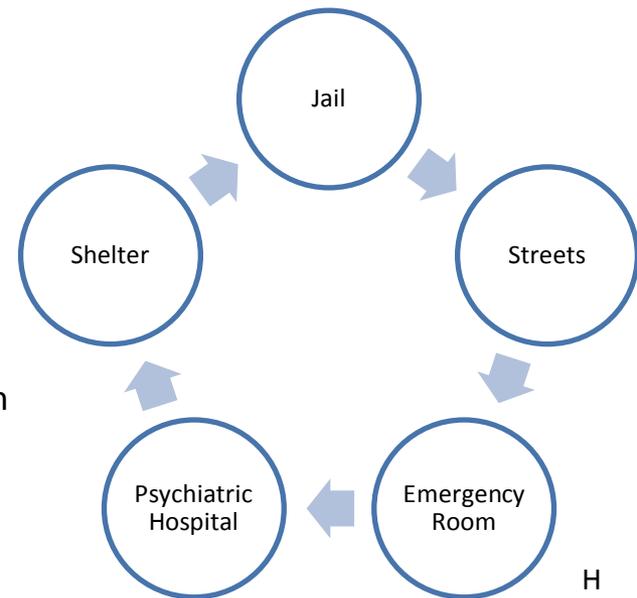
MENTAL HEALTH IN OKLAHOMA

Collateral damage awaits cuts to mental health funding²⁰

Hospitals and their emergency rooms will be asked to pick up the slack for now-missing services.²⁰ The **Oklahoma Hospital Association** ran information on mental health and substance abuse center closure issues in a recent newsletter, **Executive Director Rick Snyder** said.²⁰ "We expect it to have a negative impact on Oklahoma's hospitals, starting probably in the emergency room, which in many communities may be the only other place those patients can go for help. It's unfortunately about the most expensive place to go for help," Snyder said.²⁰

Flooding jails... **Stacey Puckett, executive director of the Oklahoma Association of Chiefs of Police**, said cutbacks are far-reaching and maintains, "There is an immediate need for addressing this issue on a state basis.²⁰ Because what's happening is our county jails are being filled with mental health clients," Puckett said, "And that certainly is not the intent for those to be mental health detention centers."²⁰

According to Hopper, et al. (1997), high utilization of crisis services is often part of a larger "institutional circuit" (illustrated to the right).²⁶ Hopper, et, al (1997) further maintain that the institutional circuit pattern indicates three main points: 1. complex, co-occurring social, health and behavioral health problems, 2. failure of mainstream systems of care to adequately address needs 3. demands more comprehensive intervention encompassing housing, intensive case management, and access to responsive health care.²⁶



MENTAL HEALTH IN TULSA

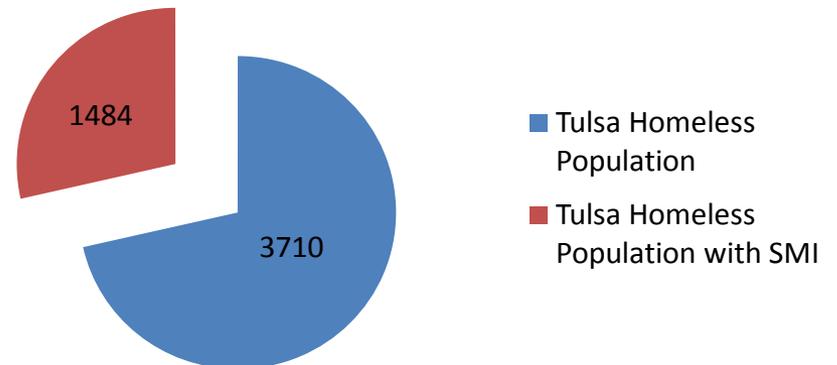
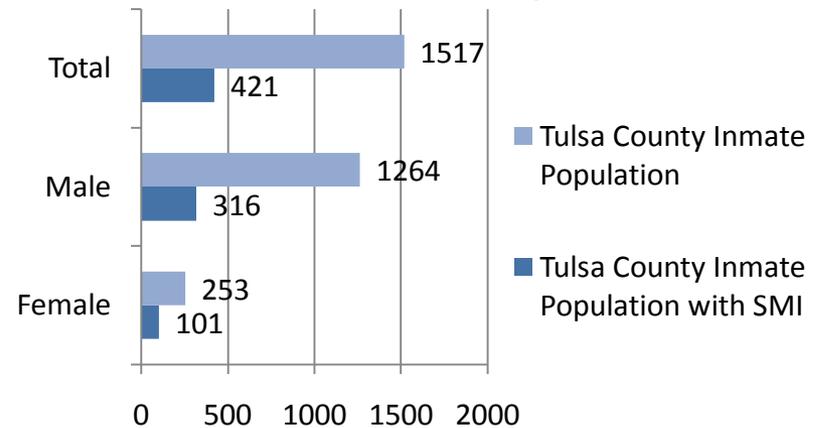
With a population in the Tulsa Metropolitan Service Area (TMSA) of 905,755²⁷, again using NAMI's 6% of the population with SMI figure, the researcher estimates that there are 54,345 individuals in the TSMA who live with SMI. With no county facility for long term in-patient care for citizens with SMI in Tulsa, this population estimate raises the question, "How many of these 54,345 Tulsa citizens are homeless or in the county jail?". To ascertain an answer to that question this research applies state and national estimates to the Tulsa County jail and homeless populations.

Using previously mentioned Oklahoma

Department of Corrections estimates that 25% of males and 40% of females in county facilities suffer from a SMI this research concluded that approximately **421** Tulsa citizens with SMI are housed in David L. Moss (illustrated in the upper right diagram).²²

During its inaugural year (2005), 3,710 unduplicated homeless were registered into the Homeless Management Information System in Tulsa, at 9 different emergency shelters, mental health treatment and substance abuse treatment providers.²⁹ The National Alliance to End Homelessness estimates that 40% of homeless individuals live with SMI (**1484** -Tulsa) (illustrated in the lower right diagram).⁷

David L. Moss Inmate Population



MENTAL HEALTH IN TULSA

The Mental Health Association – Tulsa (MHAT) is working to eliminate and prevent homelessness of people with mental illnesses throughout Tulsa County.³⁰ The Association operates many specialty housing programs designed to meet the unique needs of Tulsa's adults with SMI.³⁰ The programs provide these individuals with safe and affordable housing along with access to support groups, advocacy, treatment and legal counseling.³⁰ In 2008, MHAT reported **245** people served by the agency's rental subsidies and other housing support services.³⁰ Seventy-six units will be added with \$2 million appropriation for a total housing capacity in Tulsa of **283**.³⁰ Only thirty-eight of these new units at the Yale Avenue Apartments will be available to homeless individuals with SMI, while the remaining 38 units are available, at market-rate, to the general population.³⁰ These units are deemed affordable, however, by MHAT's own definition, as well as the federal governments, affordable is defined as paying 30% of an individual's income for housing.³⁰ The most a disability check can be in Oklahoma is \$674/month of which a \$202.20 rent payment would be considered affordable.³⁰ Residents at the new Yale Avenue Apartments will pay between **\$300 – 350 a month** in rent for an efficiency apartment.³⁰ To reiterate, an individual with SMI must be homeless to access one MHAT's 283 apartments.³⁰

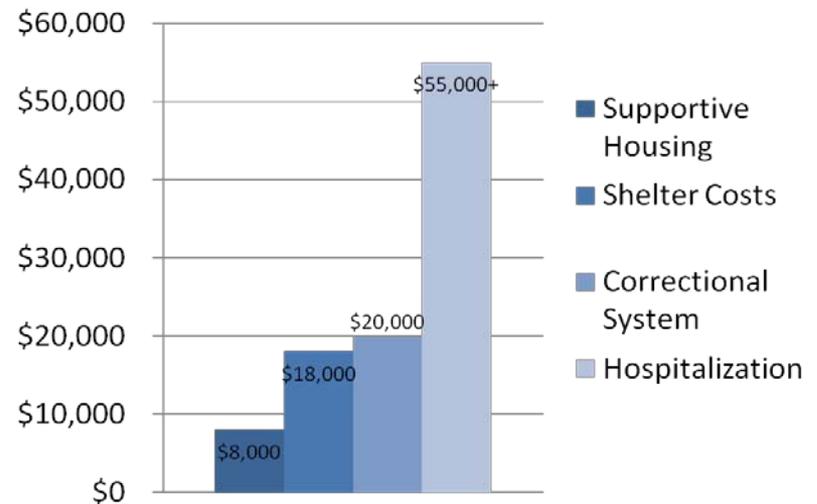
MHAT offers apartment and efficiency units for permanent independent living to adults who are **successfully** recovering from severe mental illness. Assertive community advocacy is available to residents through the Association's other programs and through partnerships with community service providers.³⁰



MENTAL HEALTH IN TULSA

A review of the numbers so far reveals an estimated 2,188 Tulsa citizens with SMI either housed by MHAT, in custody of the county jail, or homeless. That number subtracted from the deduced estimate of 54,345 leaves roughly 52,157 Tulsa citizens with SMI unaccounted for in respects to their housing situation. The very nature of this subject matter makes it difficult to ascertain specific figures because the vulnerability of this population calls for the utmost discretion. However, the researcher concedes, base on national estimates, there is a small percentage of these citizens who live in nursing homes or group homes. The author stipulates, however, that this research indicates it is a very small percent, estimated on the high end at 10% (5215), but in reality is probably closer to 5% (2675) of Tulsa citizens who live either in nursing homes, group homes, or assisted living facilities. Deducting even the high estimate of 5215 still leaves over 45,000+ Tulsa citizens with SMI and their families, to “fend for themselves” and navigate a system MHAT’s own director stated was “archaic and out-of-date”.¹⁹

This research indicates that without more supportive housing, many Tulsa citizens with SMI will end up in (and often overwhelm) much higher-cost and less appropriate settings like jails, hospitals, nursing homes, mental health facilities, and homeless shelters. Using data from MHAT¹⁹ the chart (right) reveals the annual cost to house Tulsa citizens with SMI in four different settings.



LITERATURE REVIEW

In exploring the model of supported housing this research examined six studies, each of which indicate that supported housing works to achieve more positive outcomes for individuals with SMI. According to the Corporation for Supportive Housing, when an individual with SMI becomes homeless, it's a personal catastrophe that eventually affects us all.³¹ He or she embarks on a seemingly endless succession of terrifying nights in shelters and on unsafe streets, punctuated by emergency hospitalizations and encounters with the criminal justice system.³¹ We pay the price twice over, both in a diminished quality of life in our cities and in the high cost of providing repeated emergency interventions.³¹ This researcher maintains that the majority of people with SMI have limited incomes and need access to decent and affordable housing, if meaningful integration into mainstream society is to become a reality.

According to Rogers, et al (2009) “Many individuals with SMI need “supportive housing,” which combines affordable housing with support services such as job training, life skills training, alcohol and drug abuse programs, and case management.³² As reported by Tsemberis & Eisenberg(2000) research indicates the combination of housing and support works well for people with serious mental illnesses, whose housing is at risk and who have very low incomes, to live stable and independent lives.³³ The ever-increasing momentum of government, corporate and philanthropic investment in supportive housing has been bolstered by extensive research documenting its effectiveness.³³ Burt and Anderson (2005) maintain their research has shown that supportive housing has positive effects on housing stability, health, and employment; improves the mental health of residents; and reduces active substance use.³⁴ Tanzman (1993), maintains that numerous supportive housing evaluations show retention rates of 75 to 85 percent, even among individuals with SMI and chronic substance use disorders.³⁵



LITERATURE REVIEW

Houghton (2001) reports supportive housing is an especially critical support for stability, recovery, and independence for individuals with SMI, who live in the community.³⁶ The Institute for Policy Studies (IPS) at Johns Hopkins University (2010) contend that the housing needs of the SMI population can be divided into two parts: the need for decent, affordable housing; and the need for supportive assistance.³⁷ Based on our current state of knowledge, there is nothing to suggest that either severe mental illness or homelessness requires unique physical structures or dwellings, or unique approaches to make housing affordable.³⁷ The IPS (2010) further maintains that new or unique housing policies are not required to address the first part of this population's housing need.³⁷ The IPS (2010) goes on to say that by contrast, the need for supportive assistance is so compelling that it is likely to require new approaches to housing policy and based this conclusion on three factors: (a) the manifestations of severe mental illness--symptoms, behaviors, and functional impairments--do not disappear when a severely mentally ill homeless individual moves into a housing setting; (b) the variations in the manifestations of mental illness and the unpredictability of episodes of decompensation or movement into the active phase of illness; and (c) the consensus among those who have developed and managed housing for SMI individuals that the availability and continuity of appropriate services is key to successful housing experiences.³⁷ Finally IPS (2010) contends that a fundamental housing policy issue is ensuring that the service needs of residents are met.³⁷ This research indicates many of these service needs could be met utilizing the Assertive Community Treatment (ACT) model. In exploring the ACT and Program of Assertive Community Treatment (PACT) Team models, this research examined three studies and one book that suggest the ACT/PACT team approach further helps to insure that our citizens with SMI, who live in the community, do not fall through gaps in delivery of services.

LITERATURE REVIEW

The Assertive Community Treatment (ACT) model was first developed and evaluated by Stein and Test (1980) in Madison, Wisconsin, where it was called the Training in Community Living (TCL) program.³⁸ The TCL model, which was subsequently replicated in Australia, Michigan, and London, has been modified and adapted for different settings, however, the guiding principals remain constant.³⁸ Mowbray et al, (1997) reports that ACT is now recognized as the model proven to be most successful in working with clients with SMI.³⁹ Mowbray et al, (1997) further maintains the ACT model has now received worldwide recognition as an effective community-based program for persons with SMI, and that ACT has been disseminated, replicated, and modified extensively; programs labeled ACT can be found in many U.S. states and other countries.³⁹ According to Rosenheck & Neale (1998), the Veterans Affairs health care system initiated the largest multisite experimental study of assertive community treatment yet undertaken, in which more than 800 veterans volunteered to participate in the evaluation, including a two-year follow-up period.⁴⁰ At the time we were neither experts in nor advocates for assertive community treatment, but we had been asked by VA administrators to conduct a field trial to test its potential value in our health care system.⁴⁰ Rosenheck & Neale (1998) report their study showed reduced hospital use, cost savings, greater consumer satisfaction, and, in the long term, less severe symptoms and better community functioning.⁴⁰ Stein & Santos (1998) report that now, a quarter of a century after its introduction, the world has finally approved ACT as "a service delivery vehicle or system designed to furnish the latest, most effective and efficient treatments, rehabilitation and support services conveniently as an integrated package".⁴¹ Stein & Santos (1998) note that there is a "fragmented non-system of public mental health care in the United States" in which services are "uncoordinated and non-collaborative; this is where the ACT model is breaking new ground."⁴¹



FINDINGS

- The combination of housing and support works well for people with SMI, whose housing is at risk and who have very low incomes, to live stable and independent lives.
- Supportive housing has positive effects on housing stability, health, and employment; improves the mental health of residents; and reduces active substance use.
- Without supportive housing, many will end up in much higher-cost and less appropriate settings like jails, hospitals, nursing homes, mental health facilities, and homeless shelters.
- More supportive housing is necessary if comprehensive community services are to become a reality.
- The housing needs of the SMI population can be divided into two parts: the need for decent, affordable housing; and the need for supportive assistance.
- New or unique housing policies are not required to address the first part of this population's housing need.
- The need for supportive assistance is so compelling that it is likely to require new approaches to housing policy.
- A fundamental housing policy issue is ensuring that the service needs of residents are met.

FINDINGS

- ACT/PACT teams provide highly individualized services directly to consumers.
- ACT/PACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community.
- The ACT/PACT team provides these necessary services 24 hours a day, seven days a week, 365 days a year.
- ACT/PACT services are delivered in a continuous rather than a time-limited framework.
- The ACT/PACT model reduces hospital stays and improves housing stability while being more satisfactory to participants and their families than standard care.
- The ACT/PACT model is endorsed by the “Evidence Based Practice Project” sponsored by the Robert Wood Johnson Foundation, Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Alliance for the Mentally Ill (NAMI).
- ACT/PACT clients spend significantly less time in hospitals and more time in independent living situations, have less time unemployed, earn more income from competitive employment, experience more positive social relationships, express greater satisfaction with life, and are less symptomatic.



OUTCOMES

The researcher maintains that if our community were better able to match the need for stable housing with high quality services, such as those provided by ACT/PACT teams, we would increase the likelihood of better outcomes for individuals with SMI, as well as, promote more efficient and effective use of our resources. This research indicates that with support, persons with serious mental illness can become stable in the community, maximize their abilities, and achieve a higher level of functioning and a better quality of life. The researcher further maintains that this is an issue that demands our attention as it affects the health, safety, and economic well-being of Tulsa and all our citizens. To that end, The Harvest Ranch Foundation (hereafter referred to as “the Foundation”), was established as an umbrella organization for a variety of alternative programs in 2009, and is awaiting designation as a 501c(3) non-profit corporation. One of the Foundation’s programs seeks to assist Tulsa citizens with SMI to achieve a permanent, affordable, supportive home through a pilot initiative called “*A Place to Call Home*”. The mission of “*A Place to Call Home*” initiative is to empower people with serious mental illness to achieve their maximum potential for successful family and community living in a home of their own. “*A Place to Call Home*” is committed to the philosophy that everyone can direct their own care regardless of their level of disability and that all people have the basic right to decide how services and supports will be delivered, who will deliver them and the goals that will be achieved as a result.



OUTCOMES

The primary goals of the “*A Place to Call Home*” initiative are:

- Provide safe affordable housing
- Offer a permanent residential option
- Help residents meet the obligations of tenancy
- Increase residential stability
- Maximize tenants’ self-determination
- Increase residents’ daily living skills
- Promote appropriate use of community-based services
- Decrease use of crisis/emergency services
- Decrease criminal justice system involvement

The Foundation currently serves two clients with SMI who are in dire need of a place to call home. Both of the Foundations’ clients have aging parents who have been searching for a solution to the long term housing needs of their grown children with SMI. The Foundation will assist the Dickenson and Bales families in locating suitable properties, negotiating the purchase, and structure rehabilitation issues. The homes will then be gifted the Foundation with the caveat that their family members with SMI will occupy the homes for as long as they are able to live independently, with the support of the foundation and/or a ACT/PACT team. While the foundation will assist with maintenance and upkeep of the homes in the pilot initiative, the residents will be involved in all aspects of home ownership, to the extent they are able, and will have the same responsibilities as any other homeowner.

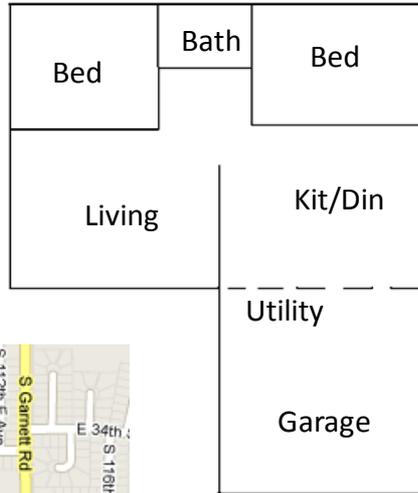


OUTCOMES



Bales House

3445 S 110th E Ave
Tulsa, OK 74146



Preliminary Budget Estimate	
Roof-24 sq. @\$180.per	\$4,320.00
Windows-4@\$400.each	\$1,600.00
Interior Paint-2490sq.ft@\$1.per	\$2,490.00
Flooring	
750sq.ft carpet@\$6.60per	\$4,875.00
230sq.ft.vinyl tile@\$2.89per	\$665.00
Kitchen Update	
countertops/sink/disposal	\$1,000.00
Bath Update	
toilet/vanity/sink	\$600.00
Budget Estimate	\$16,000.00
Contingencies (10%ofBudget)	\$1,600.00
Total Budget Estimate	\$17,600.00

Purchase Price: \$36,900.

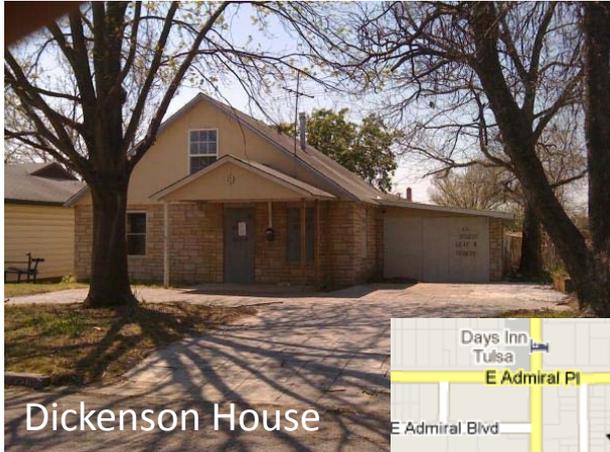
Rehab Budget: \$17,600.

Total Cost: \$54,500.

980 Sq. Ft. - \$55.61 per sq. ft.

The Harvest Ranch Foundation is currently in negotiations with HomeVestors, the owner of the homes, for a reduced price on the purchase of both properties. The client who would live in this home is a 47 year old male who lives with Obsessive Compulsive Disorder(OCD). He receives \$674. per month in Social Security(SSI) and Disability(SSDI) income, as well as, \$320. per month from part-time employment at a sheltered work environment, for a total monthly income of \$994.00 per month. With a structured budget, it is reasonable to assume this client would have the means to pay utilities and insurance.

OUTCOMES

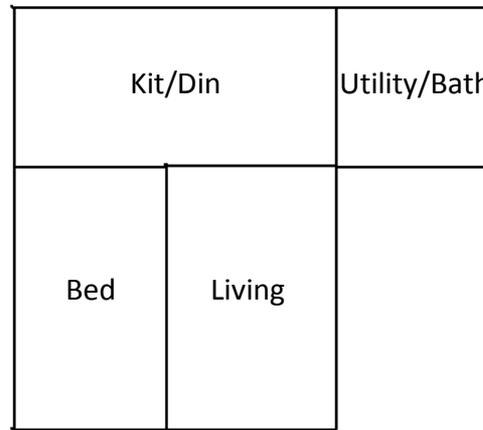


Dickenson House

**226 S. 67th E. Ave
Tulsa, OK 74112**



Purchase Price: \$25,900.
Rehab Budget: \$11,805.
Total Cost: \$37,705.
 896 Sq. Ft. - \$42.08 per sq. ft.



Preliminary Budget Estimate	
Roof-21 sq. @\$180.per	\$3,780.00
Windows-2@\$400.each	\$800.00
Interior Paint-1980sq.ft@\$1.per	\$1,980.00
Flooring	
896sq.ft.vinyl tile@\$2.89per	\$2,572.00
Kitchen Update	
countertops/sink/disposal	\$1,000.00
Bath Update	
toilet/vanity/sink	\$600.00
Budget Estimate	\$10,732.00
Contingencies (10%ofBudget)	\$1,073.00
Total Budget Estimate	\$11,805.00

The client who would live in this home is a 54 year old male who lives with Schizophrenia. He also receives \$674. per month in Social Security(SSI) and Disability(SSDI) income, as well as, \$420. per month from part-time employment at a sheltered work environment, for a total monthly income of \$1094.00 per month. With a structured budget, it is reasonable to assume this client would have the means to pay utilities and insurance.



CONCLUSION

The author maintains that more supportive housing is needed and should be seen as an integral part of the mental healthcare system. The author further maintains that a part of the solution could be the rehabilitation of vacant/abandoned urban structures, especially in areas with existing infrastructure such as transit lines, as well as, the utilization of a community ACT/PACT team. This research suggest that being a part of the community, living within established neighborhoods and when possible working in employment positions alongside individuals without disabilities gives our citizens with SMI a far greater chance of successful integration into mainstream society. Given our current knowledge, there is no single, best model for developing or operating supportive housing for individuals with SMI. The researcher maintains it may be that the main gap is resources, not ideas. However, unless systematic studies of alternative approaches are undertaken, hard evidence to answer this question will never exist.

Based on the direct cost savings, compared with the annual cost of supportive housing, and crisis intervention services, the author contends that community investment in supportive housing would be a sound investment of public resources.

In addition to quality of life benefits and the stability of having a place to call home for our citizens with SMI, the social value of providing greater social protection for individuals with SMI, while difficult to translate into economic terms, constitutes an important additional benefit to our community and to society as a whole.

While the outcome of this research is a work in progress, it is the researchers hope that this project could be used as a foundation for others to build upon.

REFERENCES

1. "NIMH: The numbers count—Mental disorders in America." National Institute of Health. Available at www.nimh.nih.gov/publicat/numbers.cfm.
2. Kessler RC, Chiu WT, Demler O, Walters EE. *Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R)*. *Archives of General Psychiatry*, 2005 Jun;62(6):617-27.
3. National Alliance on Mental Illness. Grading the states 2009. Available at http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009
4. Treatment Advocacy Center - *A Failed History*. Available at http://www.treatmentadvocacycenter.org/index.php?option=com_content&task=view&id=35&Itemid=64
5. Torrey, E., Entsminger, K., Geller, J., Stanley, J., Jaffe, D. *The Shortage of Public Hospital Beds for Mentally Ill Persons; A Report of the Treatment Advocacy Center*, 2007. Available at http://www.treatmentadvocacycenter.org/storage/tac/documents/the_shortage_of_publichospital_beds.pdf
6. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.
7. National Alliance to End Homelessness. *The Decennial Census and Homelessness, (2010)*. Available at <http://www.endhomelessness.org/section/data/factsheets>
8. Treatment Advocacy Center. *Homelessness: One of the Consequences of Failing to Treat Individuals with Severe Mental Illnesses (2008)*. Available at http://www.treatmentadvocacycenter.org/index.php?option=com_content&task=view&id=1379&Itemid=217



REFERENCES

9. Christensen, Pia. Mentally ill patients, elderly mix in nursing homes. Association of Health Care Journalists (2009). Available at <http://www.healthjournalism.org/blog/2009/03/mentally-ill-patients-elderly-mix-in-nursing-homes/>
10. Azrin, Susan, et al, 2003. The Presidents New Freedom Commission on Mental Health, Final Report. This report was prepared by Westat under Task Order No. 280-99-1003, RFP No. 280-02-8073, and submitted to Claire Heffernan, Project Officer. Accessed June 25, 2009 at http://www.mentalhealthcommission.gov/reports/comments_011003.pdf
11. Fitzpatrick, Michael J., Executive Director. National Alliance on Mental Illness. Letter From the Executive Director (2009). Available at <http://www.nami.org/gtsTemplate09.cfm?Section=Overview1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75089>
12. Torrey, E. F., (1997) *Out of the Shadows: Confronting America's Mental Illness Crisis*. New York: John Wiley & Sons.
13. Palermo, G. B., Smith, M. B., & Liska, F. J. (1991). Jails versus mental hospitals: A social dilemma. *International Journal of Offender Therapy and Comparative Criminology*, 35, 97.
14. Torrey, E. F., Stieber, J., Ezekiel, J., Wolfe, S. M., Sharfstein, J., Noble, J. H., " Flynn, L. M. (1992). *Criminalizing the seriously mentally ill*. Washington, DC. National Alliance for the Mentally Ill and Public Citizen Health Research Group, p. 43.
15. Substance Abuse & Mental Health Services Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003. Available at <http://www.oas.samhsa.gov/2k3state/ch6.htm#fig6.1>
16. MURPHY, S. Associated Press Writer, Mentally ill fear impact of Oklahoma's budget cuts (2010). Available at Tulsa World article at http://www.tulsaworld.com/news/article.aspx?subjectid=17&articleid=20100315_11_0_NORMAN966611



REFERENCES

17. National Alliance on Mental Illness. Grading the States 2006. Available at <http://www.nami.org/gtstemplate06>
18. National Alliance on Mental Illness. Grading the States 2009. Available at <http://www.nami.org/gtstemplate09>
19. Tulsa World. Group Homes (2010). Available at http://www.tulsaworld.com/webextra/content/2010/group_homes
20. Colberg, S. Mental health budget cuts may affect schools, jails - About \$17 million has been cut from mental health and substance abuse budgets, so far(2010). NewsOK.com. Available at http://www.tulsaworld.com/news/article.aspx?subjectid=17&articleid=20100215_17_A15_Ahgsu221725
21. Oklahoma Department of Corrections. Quick Overview: Calendar Years. Available at <http://nicic.gov/Features/StateStats/?State=OK>
22. Oklahoma Department of Corrections. NOVEMBER 2008 INSIDE CORRECTIONS . Available at http://www.doc.state.ok.us/newsroom/insidec/11_08/nov08.htm#four
23. Coburn, James (2009). Dem. candidates focus on mental health, substance abuse prevention , The Edmond Sun. Available at <http://www.mhat.org/MHAT/NewsBot.asp?MODE=VIEW&ID=279&SnID=2>
24. The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health Information Center (2003). Homelessness - Provision of Mental Health and Substance Abuse Services. Available at <http://mentalhealth.samhsa.gov/publications/allpubs/homelessness/#why>
25. National Alliance to End Homelessness (2007). State by State Data. Available at <http://www.endhomelessness.org/section/data/homelessmap>
26. Hopper, K., Jost, J., Hay, T., Welber, S. & Haugland, G. (1997). *Homelessness, Severe Mental Illness, and the Institutional Circuit*. Psychiatric Services, 48(5), 659-665.



REFERENCES

27. Tulsa County QuickFacts from the US Census Bureau, 2009. Available at quickfacts.census.gov/qfd/states/40/40143.html
28. David L. Moss Criminal Justice Center, Inmate Population Report, (2010). Available at <http://iic.tulsacounty.org/Reports/ReportViewer.aspx>
29. Lyall, Jim. Homelessness – Homeless Services Network. Associate Director, Community Service Council. Available at <http://www.csctulsa.org/homelessness.htm>
30. Building Tulsa Building Lives (2010). Tulsa Mental Health Association. Available at <http://www.buildingtulsabuildinglives.com/about/newsdetail.asp?nid=15>
31. Corporation for Supportive Housing, Abstract, (2010). University of Pennsylvania New York/New York Cost Study. Available at <http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageID=226>
32. Rogers, Sally, et al., *Systematic Review of Supported Housing Literature 1993-2008, The Center for Psychiatric Rehabilitation, 2009.*
33. Tsemberis, S., Eisenberg, R., (2000). "Pathways to Housing: Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities." *Psychiatric Services* 51:4 (2000): 487;.
34. Burt, M., & Anderson, J. (2005). "AB2034 Program Experiences in Housing Homeless People with Serious Mental Illness." *Corp. for Supportive Housing. (2005).* Available at <http://www.csh.org/index.cfm/?fuseaction=Page.viewPage&pageID=3621>
35. Tanzman, Beth. "An Overview of Surveys of Mental Health Consumers' Preferences for Housing and Support Services." *Hosp. & Community Psychiatry* 44 (1993): 450-55. *National Council on Disability, supra note 6, at 21.*



REFERENCES

36. Houghton, Ted, *The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals*, (May 2001) 6-7. Available at <http://www.csh.org/index.cfm/?fuseaction=Page.viewPage&pageID=3251>.
37. Institute for Policy Studies (2010). THE SEVERELY MENTALLY ILL HOMELESS: HOUSING NEEDS AND HOUSING POLICY Johns Hopkins University. Available at <http://ips.jhu.edu/pub/The-Severely-Mentally-Ill-Homeless-Housing-Needs-and-Housing-Policy>
38. Stein, L.I., and Test, M.A. Alternative mental hospital treatment: I. Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry*, 37:392- 397, 1980. Available at <http://schizophreniabulletin.oxfordjournals.org/cgi/reprint/21/4/657>
39. Mowbray C., Plum, T. & Masterson, T., (1997). HARBINGER II: DEPLOYMENT AND EVOLUTION OF ASSERTIVE COMMUNITY TREATMENT IN MICHIGAN. *Administration and Policy in Mental Health* Vol. 25, No. 2, November 1997. Available at http://deepblue.lib.umich.edu/bitstream/2027.42/44094/1/10488_2004_Article_414562.pdf
40. Rosenheck R., Neale, S. (1998) Cost-effectiveness of intensive psychiatric community care for high users of inpatient services. *Archives of General Psychiatry* 55:459-466, Available at http://archpsyc.ama-assn.org/cgi/content/abstract/55/5/459?ijkey=7242c236350bae6fb8db3da14f648c859836c88c&keytype=tf_ipsecsha
41. Stein, L., Santos, A., (1998). *Assertive Community Treatment of Persons with Severe Mental Illness* Department of Public Mental Health, Division of Neuroscience and Psychological Medicine, Imperial College School of Medicine, Paterson Centre, London W2 1PD New York & London: W. W. Norton & Co. 1998. 274 pp.

IMAGE REFERENCE

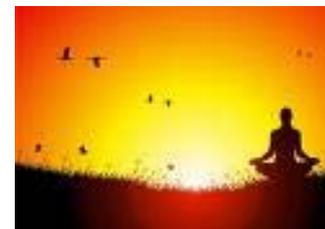
- A. Image of David, a life long Tulsa citizens with SMI. Photo by Paula Thomas,OUUDS.
- B. Image from National Alliance on Mental Illness. Grading the states 2009. Available at http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009
- C. Image from <http://neuronarrative.wordpress.com/2009/03/16/for-the-brain-keeping-it-real-means-keeping-it-relevant/>
- D. Image from Substance Abuse & Mental Health Services Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003. Available at <http://www.oas.samhsa.gov/2k3state/ch6.htm#fig6.1>
- E. Image from National Alliance on Mental Illness. Grading the States 2006. Available at <http://www.nami.org/gtstemplate06>
- F. Image from National Alliance on Mental Illness. Grading the States 2009. Available at <http://www.nami.org/gtstemplate09Jjdfjogjoerj>
- G. Image from Tulsa World. Group Homes (2010). Available at http://www.tulsaworld.com/webextra/content/2010/group_homes
- H. Image adapted from Hopper, K., Jost, J., Hay, T., Welber, S. & Haugland, G. (1997). *Homelessness, Severe Mental Illness, and the Institutional Circuit*. *Psychiatric Services*, 48(5), 659-665.
- I. Image available at http://www.mhat.org/MHAT/Housing_EN.asp?SnID=370485652

Appendix 1

Harvest Ranch Foundation Capitol Budget

Line	Revenue	Program or Project
1	Grants	5,000
2	Contracts	
3	United Way	0
4	Corporate contributions	
5	Memberships	0
6	Individuals	18,000
7	Fees for services	
8	Fundraisers, events, sales	5,000
9	Endowment	0
10	Interest income	0
11	Miscellaneous	
12	Total	\$28,000
13	In-kind	\$3,500
14	Total Revenue	\$31,500
Line	Expenses	Program or Project
15	Staff salaries and wages	18,000
16	Fringe benefits	
17	Occupancy and utilities	3,600
18	Equipment	1,000
19	Supplies and materials	1,000
20	Printing and copying	
21	Telecommunications	1,200
22	Travel and meetings	1,200
23	Marketing and advertising	1,600
24	Staff and volunteer training	
25	Contract services	
26	Miscellaneous	1,500
27	Subtotal	\$29,100
28	General operating (indirect) - 8%	2,248
29	Total	\$31,348
30	In-kind	
31	Artwork	3,500
34	Total In-kind	\$3,500
35	Total Expenses	\$34,848
36	Revenue over Expenses	\$3,348

Appendix 2



The Harvest Ranch Foundation

Harvest Ranch Mission

By creating a network of caring, supportive adults on whom residents can depend, the Harvest Ranch Foundation is committed to providing quality care and a safe environment where physical and emotional needs can be fulfilled through shelter, counseling, and growth-oriented activities. The Harvest Ranch Foundation strives to meet each individual's needs with appropriate services.

Harvest Ranch Vision

The Harvest Ranch will provide independent living opportunities for our clients on their individual journey of personal growth and self exploration that integrates body, mind, and spirit.

It's easy to make a tax deductible contribution to:

THE HARVEST RANCH FOUNDATION

Download and print the [Donation Form](#) and mail the completed form along with your donation to us at:

The Harvest Ranch Foundation
1420 E 35th Place
Tulsa, OK 74105

Other Ways to Make Donations:

Gifts of Securities: A donation of stocks, bonds, mutual funds and IRA's may be given directly or used to fund charitable gift annuities or charitable remainder trusts.

Gifts of Real Estate: These are gifts of land, buildings, homes, business property, etc.

Gifts of Personal Property: These are gifts of art/coin collections, antique cars, artwork, automobiles, etc.

Appendix 2 (continued)

Gifts of Bequests: A specified percentage or dollar amount of an estate to be designated to The Harvest Ranch at the time of death.

Gifts of Trusts: Including charitable remainder trusts, unitrusts, lead trusts, family trusts, annuity trusts, etc.

Gifts of Insurance: This can be an effective means for a donor to fund a charitable giving plan as long as The Harvest Ranch is both the owner and beneficiary.

Gifts that are In-Kind: The donations of goods, services, materials and supplies.

Gifts that are a Capital Purchase: These are the purchase and donation of items for the operation and expansion of The Harvest Ranch ...examples include furniture, computer equipment, appliances, safe rooms, security systems, passenger vans, etc.

Gifts that are Matching: Many companies set aside philanthropic dollars and allocate those funds through matching gift programs. Matching levels vary from one company to another, but regardless of the match percentage, these gifts represent a significant source of funds for The Harvest Ranch.

Memorials and Honorariums: Giving a gift in memory or in honor of someone.



Your support is greatly appreciated!

Fresh Produce – Fresh Flowers – Fresh Honey

Glass Shop - Craft Cottage - Music Room – Wood Shop – Metal Shop – Stables

The Harvest Ranch Foundation is a non-profit charitable organization which is tax exempt and tax deductible under the IRS Code, Section 501 (c) 3 iii. Federal EIN: 73-1146009.