

AMHD news

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HAWAII STATE
DEPARTMENT
OF HEALTH

Hale Imua's first BRIDGES graduates



From left: In the back row, graduates Richard V. Schlunt, Jr. and Rudy Camarillo join Windward CMHC's Sunny Medeiros and Dr. Keith Pedro with graduate Patrick Kennedy. Graduates James Dillon and Freddie Mondala pose in the front row.

In January, Hale Imua congratulated its first class of BRIDGES graduates with a luncheon and awards ceremony at the Buffet 100 restaurant in Honolulu.

"The classes were a good help for all of us," said graduate Richard Schlunt. "I feel that when a person looks at it open-heartedly and wants to make progress with it, it can be a real stepping stone in their trip toward wellness."

Schlunt and five other Hale Imua residents received diplomas and gift certificates

for completing the 14-week program.

BRIDGES, "Building Recovery of Individual Dreams and Goals through Education and Support," provides education and support to mental health consumers. Participants learn about their illnesses, how to manage symptoms, how to deal with stigma, and how to access the supports available in the community.

"The classes teach that they can recover," said Sunny Medeiros, BRIDGES facilitator

and Hawai'i certified peer specialist. "BRIDGES gives them hope."

Medeiros works for the Windward Community Mental Health Center, one of many agencies collaborating on the Hale Imua program. Hale Imua helps consumers on conditional release transition back into the community through 24-hour supervised housing and a comprehensive array of treatment and supports such as BRIDGES. ❀

In Brief

MHA, new name same initials

Last year, the National Mental Health Association changed its name to Mental Health America. As one of its 341 affiliates, the Mental Health Association in Hawai'i has also changed its name. It is now known as Mental Health America of Hawai'i.

Sound bites

“The more we educate the population about the realities of mental illness and make more aware that recovery is possible, the sooner we can end the marginalization.”

Bebe Moore Campbell, journalist and bestselling author, died on November 27, 2006 from brain cancer. Noted as one of the most important African-American novelists of this century, Campbell took on topics of racism and mental illness in many of her novels. Her last novel, *72 Hour Hold*, is about a woman facing the challenges of stigma and the healthcare system when her grown daughter becomes mentally ill.

AMHD Collaboration

One of eight AMHD Core Values

We value teamwork and endeavor to build partnerships, consumer and community participation to attain our goals.

Mission:

We provide a comprehensive, integrated mental health system supporting the recovery of adults with severe mental illness.

Vision:

Everyone has access to effective treatment and supports essential for living, working, learning and participating fully in the community.

Technology transfer

Heather Jablonski, MHSRET Program Technical Assistance Group Coordinator

What is the best way to teach someone who isn't from Hawai'i how to make ahi poke? Let's take, for argument's sake, my mother who lives in the Midwest. Her specialties include chicken and noodles, and rhubarb pie. People in her community rave about her wedding cakes. Although she's considered a first-rate cook in Indiana, I have my doubts about her skills in making poke. First, she has never tasted ahi poke. In fact, she will not eat raw fish. Secondly, you won't find ingredients such as shoyu or sesame oil in her pantry. Lastly, my mother is not interested in learning to make ahi poke. What are the odds that sending her recipe or having her attend a training session will get her to make a decent poke?

We are in a similar predicament when we embark on changing the clinical practices within our service system. Yet, more often than not, training becomes the cornerstone for managing the change. The Technology transfer Assistance Group (TAG) with the University of Hawai'i and the AMHD aims to move us away from simply viewing training as the primary means for improving clinical practice. The use of technology transfer principles provides a more comprehensive approach to bringing science to service. For us, the "technology" refers to those services with some proven effectiveness for people with severe and persistent mental illnesses. Often, these are evidence-based practices (EBPs). Consider the table below contrasting training and technology transfer.

Training	Technology Transfer
<ul style="list-style-type: none">• Transfer of the technology through imparting knowledge	<ul style="list-style-type: none">• Transfer of processes and information for the application of the technology• Focuses on having the desired change accepted, incorporated, and reinforced within the organization
<ul style="list-style-type: none">• Targets the direct practitioners' knowledge and skills	<ul style="list-style-type: none">• Targets all levels of the organization, not only the direct practitioners, to implement the desired change
<ul style="list-style-type: none">• Time specific	<ul style="list-style-type: none">• Ongoing process
<ul style="list-style-type: none">• Usually broad and able to be generalized	<ul style="list-style-type: none">• Specific to the context and organization
<ul style="list-style-type: none">• Comparatively inexpensive means to disseminate information, but alone is not effective in generating desired change	<ul style="list-style-type: none">• Comparatively more expensive, but more effective in generating desired change
<ul style="list-style-type: none">• Does not address principles of technology transfer	<ul style="list-style-type: none">• May utilize training as one "tool" in implementing the desired change
<ul style="list-style-type: none">• Communication mainly one-way	<ul style="list-style-type: none">• Two-way interactive process

A technology transfer plan rather than training would have a much greater likelihood of teaching my mother to make ahi poke. The same holds for moving EBPs into the community. We must assess the practitioner's, the organization's, and the system's motivation, readiness, and capacity for change. Training is an effective way to provide education, but technology transfer includes providing support in implementing the practice after the training is over. Often this is referred to as "technical assistance." We must address barriers that arise in the application of the new practice. These often include funding issues, cultural considerations, attitudinal barriers, and resource limitations. In this way, technology transfer encourages bi-directional communication and problem-solving among all parties involved: the consumer, the practitioner, the organization, the state agencies (for example, the AMHD and Department of Human Services), and the experts/researchers of the clinical practice. In upcoming newsletter columns, the TAG staff looks forward to sharing real-world experiences in using technology transfer principles in implementing EBPs. ❀

2006 cultural competency organizational assessment: Results and recommendations

Dr. Kimo Alameda, AMHD Multicultural Services Director

In September 2006, research assistant Dayna Minatodani and I completed a cultural competency organizational assessment of nine community mental health centers (CMHCs) statewide. The goal of this assessment was to obtain baseline data and to determine the cultural competency themes that emerge as a result of the observations, interviews, and focus groups. The second goal was to determine the types of resources and training needed to ensure culturally responsive services.

First, we arrived at each center thirty minutes early to observe the interactions of the staff and the consumers as they entered the center. We looked at the interactions from the perspective of being “warm and welcoming.” Also, we took notes of the waiting area décor looking for diversity in magazines, posters, and in the overall ambiance. We then interviewed the CMHC manager by using a 12-item standardized cultural competency assessment survey (CCAS). The questions reflected the center’s commitment to cultural competency as seen through their policies, procedures, and daily practice. Examples of questions included:

- Does your CMHC collect demographic data identifying the cultural groups being served and underserved?
- Does your CMHC offer training to staff in which cultural competency issues are addressed?
- Does your CMHC have a documented goal to recruit, hire, and retain staff from cultural groups that reflect the population served?
- Are your key forms translated into non-English languages?
- Does your CMHC have a free-standing cultural competency committee that gives input into the planning and implementation of services?

The responses were plotted on a 5-point Likert scale. Following the interview, we conducted a focus group with the staff and asked open-ended questions like “In what ways is cultural competency addressed (or not addressed) at your center?”

There were several themes that emerged from the assessment. All center managers shared the difficulty of obtaining language interpreters. Centers did not have a documented goal to recruit, hire, and retain staff from diverse backgrounds or staff who are bilingual. None of the centers had a committee or designated person addressing cultural competency issues on a regularly basis, and none of the centers provided regularly scheduled training on multicultural issues for their staff. Center managers also indicated that none of their key forms and service descriptions were translated into another language for non-English speaking consumers.

The most interesting aspect of the assessment was the silent observation of consumer and staff interactions. With the exception of a few centers, it appeared that we can improve in the area of greeting consumers as they enter our centers as well as maintaining a friendly and professional relationship during and after their appointments. The physical set-up of the centers may have helped (or hindered) the “warm and welcoming” feeling. For example, the waiting area of some centers was either too small or too old looking with out-dated informational materials, old paint, and

old furniture. Some centers have barriers that force consumers to speak over a counter or in a hole when talking to the receptionist. If conversation did occur between the receptionists and the consumer, it wasn’t always “warm and welcoming.” Although the center’s décor (paintings, artwork) were consistent with the diverse cultures of Hawai’i, the reading materials (magazines, pamphlets, brochures) were mainstream and did not reflect the diversity of Hawai’i. Also, there were few, if any, reading materials in a non-English language and much of the informational brochures were written above a sixth-grade reading level.

Each center can improve by developing a plan that addresses cultural competency in the areas mentioned above. It doesn’t have to be an elaborate or separate plan. The plan for culturally competent services could be integrated with the center’s plan to embrace the recovery model, since these two initiatives go hand in hand. In the meantime, we can improve cultural competency by translating key forms into the most common non-English languages; being more warm and welcoming when interacting with consumers; providing multicultural training on a quarterly basis; starting to dialog on how we can increase engagement efforts with consumer groups who underutilize services; and always considering cultural issues when planning and implementing services. The next cultural competency organizational assessment is scheduled for June of 2007 and is aimed to include purchase of service providers as well. ❀

Dr. Alameda may be contacted by emailing ckalamed@amhd.health.state.hi.us.

Community-based case management

The AMHD is preparing to implement a new community-based case management (CBCM) contract, utilizing a blended model of case management. The goal is to create a single level of case management that responds to the fluctuations and varied needs of each consumer.

This new blended model opens the door for consumers to receive their medication management and case management services from a single provider. Also, the intensity of case management services will be clinically-based and tailored to individual consumer needs and strengths rather than external utilization criteria. For example, consumers will no longer have limits on the number of monthly visits with their case manager.

Rather than relying on a case manager to consumer ratio of 1:20 or 1:40, service providers will create a case management team consisting of a team leader, case managers, a psychiatrist, a certified peer specialist, and a registered nurse (required if the team is serving more than 60 consumers). Provider to consumer ratios will be as follows:

- Psychiatrist, 1:250
- Case manager, 1:30
- Registered nurse, 1:150
- Peer specialist, 1:150

The case management service director and the case management and support services specialist in collaboration with the Office of Consumer Affairs, provider relations director, and the service area administrators in each county will work to ensure that consumers and case management providers are provided adequate information on the CBCM model before the contract starting date, which has yet to be determined.

Consumer discussion sessions and in-services at provider meetings will be offered in each county. For more information, please contact the Office of Consumer Affairs or the provider relations director at (808) 586-4688.

Pre-booking jail diversion collaboration

The Honolulu Police Department's human services unit joined an interagency collaboration on O'ahu dedicated to responding to consumers in crisis. This pre-booking jail diversion project aims to head off needless arrests of consumers and unnecessary stays in hospital emergency departments.

In the past, when encountering people experiencing a mental health crisis, HPD police officers had two options to handle the situation: arrest the person or take them to a hospital emergency department.

Now, with HPD's involvement in the pre-booking jail diversion cooperative, officers are being instructed to call the HPD human services unit to help assess the situation. The HPD human services unit is staffed by three clinical psychologists designated by the Director of Health as mental health emergency workers. If the HPD psychologist determines that the person in crisis appears to be a threat to themselves or others, the psychologist can recommend that the person be taken to either Queen's Medical Center, Castle Medical Center, or Tripler Hospital on an MH-1 (an involuntary psychiatric evaluation). If the person appears to be of no threat, then the HPD psychologist will call AMHD's ACCESS line who will in turn send out the person's case manager (if they are an AMHD consumer) or the crisis mobile outreach team.

Crisis services director Steve Balcom is thankful for the cooperation of the HPD's human service unit, which also provides counseling services to HPD employees, their families, and to victims and witnesses. "It's great for us that we've got this unit at HPD as the first point of contact for our folks in the field," said Balcom. "The HPD human services unit

really has embraced this whole approach with the crisis mobile outreach team."

The crisis mobile outreach team, the Queen's Medical Center, and the AMHD have already worked together for over a year on the project to coordinate their response to consumers in crisis. Despite a number of challenges in the past, the agencies have developed a close working collaboration. And with the addition of the HPD component, the hope is that the cooperative will become even more effective. Since the project launched in December, Queen's Medical Center reported that they are seeing a decrease in the number of people on MH-1s being sent to their emergency department.

The AMHD will collect more data from the HPD, Queen's, and its own crisis services to track the project's progress as it continues. Linda Appel, O'ahu service area administrator, is optimistic and is encouraged by the collaborative process involved. "The beauty of this project is that this is not just an AMHD project," Appel said. "You can see it's reaching all throughout the community. We're in Queen's Medical Center. We're collaborating with HPD, the crisis mobile outreach team providers... and I think the consumers are getting better care as a result of it."

The pre-booking jail diversion project has already been brought to Castle Medical Center in December and plans are in the works to include Tripler Hospital. Further plans for the project include creating a detoxification program for consumers with alcohol and substance abuse issues. This program would add to the current alternative to hospital emergency departments — licensed crisis residential services. The long-term plan is to spread this project to the neighbor islands. ❀

Provider monitoring improved for 2007

In February, the AMHD will kick off the second round of service provider monitoring with a revised process. Revisions were based on feedback from providers and the AMHD monitoring team during last year's round of monitoring.

One of the significant changes is the utilization of Hawai'i certified peer specialists who will join staff from AMHD's Office of Consumer Affairs in interviewing consumers about the services they receive from service providers. The interviews will be held away from provider locations when possible to help consumers feel more at ease in speaking freely.

Another change is the option for providers to schedule the fiscal review at a different time than the general and service review. Helene Jo, quality improvement administrator, explains that the reason for this change was the Deficit Reduction Act, which was passed by the federal government in 2005. The act puts providers receiving Medicaid funds under greater scrutiny with less tolerance for reporting errors. "We want to do a good sample so we can validate how the providers are doing," said Jo, "and be able to encourage them in their own plans of improvement to keep them out of trouble." Because of its own participation in the Medicaid Rehabilitation Option and as an outpatient clinic Medicaid provider, the AMHD will also fall under close scrutiny by the federal government and has already begun the fiscal review process in the community mental health centers.

Jo said that although no one looks forward to being under such scrutiny, providers can make the process more pleasant for them-

selves and AMHD staff by doing the following:

- Assign the responsibility for preparing audit materials to a knowledgeable person
- Organize materials in tabbed binders or files
- Assign staff to be available to retrieve files for the review team

This year's monitoring process is slated to end by August and will focus on providers' progress in enacting plans of improvement since last year's round of monitoring. Service providers who were not visited in 2006 will go through a complete review by the AMHD using all relevant monitoring tools.

As with the first cycle, the AMHD will solicit feedback from providers and will make combined results available to stakeholders with the names of providers removed. ❀

Across the Pacific

The 5th International Conference on Social Work in Health and Mental Health

Last December, Hawai'i State Hospital MISA coordinator Susan Cromer spoke in Hong Kong at the 5th International Conference on Social Work in Health and Mental Health. As one of over 1,300 international attendees, she presented Hawai'i State Hospital's work in treating substance abuse and mental illness.

"It was a privilege to go and to represent Hawai'i State Hospital, said Cromer. "I'm just proud of the programs we have and the evidenced based practice we use."

Micronesia Transformation Conference

Tumon, Guam hosted the Transforming Mental Health Systems in Our Pacific Islands Conference in October. Attendees included representatives from the Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands, Republic of Palau, and Guam. Hawai'i was represented by Ronnie San Nicolas and Steven Onken from the UH Mental Health Services Research, Evaluation, and Training program. San Nicolas gave a keynote address on the history of Guam's mental health system, and led a workshop on family psychosocial education. Onken presented a keynote on moving recovery research and theory into practice, and led workshops on recovery measures and recovery- and evidence-based practice.



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Hawai'i Convention Center



Dr. Thomas Hester,
Adult Mental Health
Division Chief

Over the past few years, we have made significant improvements to the AMHD system in areas of expanding services and accessibility, implementing new evidence-based practices, and promoting a consumer-centered recovery model. As these initiatives and others become established, important questions arise:

- Are these initiatives helping consumers in meaningful ways?
- How can we tell which programs are cost-effective?
- Do consumers have the correct information about the different AMHD programs to choose the AMHD service provider and program correct for them?
- How can we tell when cultural adaptations of evidence-based practices are more effective than the original models?

The answers to these, and similar questions, result from evaluation made possible after systematic collection of information (data). The purpose of evaluation is to assist management, clinicians, and consumers in making decisions. In its simplest form, an evaluation answers the question, "Who received what kind of services with what kind of outcome?" With the AMHD's increasing emphasis on prior-authorization of services and revenue collection from external sources such as Medicaid and the Medicaid Rehabilitation Option, the division has

done an excellent job of documenting the "what kind of services" part of the question above. However, we have been less successful in collecting data that allows the AMHD to answer the "who" and the "outcome" parts of the question. Both these areas require the active support of all AMHD staff and AMHD-funded and -operated service providers.

The AMHD tracks all information on service delivery (the "what") and consumers' demographic (the "who"), functional and clinical status ("who"), changes occurring to functional and clinical status during treatment ("outcome"), and other specifically defined outcome measures (for example, increased employment, decreased homelessness, and information about overall quality of life). The importance of collecting data is to demonstrate past and continuing improvement, particularly in the "who" and "outcome" areas.

Table 1 gives an example of some of the outcome data collected by the AMHD.

It is good to see a general increase in the percent of consumers active in recovery planning, employment, and those reporting satisfaction with the outcomes they have attained (see Table 1). There is a decrease of consumers reporting criminal justice involvement from 14% in 2004 to 11% in 2006. The table also shows some variation, but in general, the trend is one of improvement. The ability to watch these trends over several years is extremely important and will help the AMHD to evaluate the success or lack of success of various programs.

The use of data to answer the "Who received what kind of services with what kind of outcome?" question becomes

especially problematic when it is clear that an insufficient set of data is available from which to draw conclusions. For example, last fall, a report that was developed by Dr. Annette Crisanti and Dr. Keith Claypoole (*Technical Report No. 061028*) looked at outcomes reported by consumers in Fiscal Year (FY) 2005 in various quality of life areas. The AMHD policy is that quality of life interviews (QOLIs) be completed at intake, every six months, and at discharge for consumers in assertive community treatment (ACT) programs as well as for consumers receiving case management services, such as intensive case management, targeted case management, and care coordination.

The records showed that 7,681 consumers were registered with an ACT program or received case management services during FY 2005. However, QOLIs were available for only 3,292 consumers, providing a response rate of 43%. It is worth noting that, despite AMHD policy, data was obtained for less than half of the consumers being served. Nevertheless, some rather remarkable outcomes were observed based on the limited data available. When looking at QOLI scores at admission compared to scores of those receiving services for at least six months, consumers reported the following:

- Percent rating mental health as poor: 33.2% (intake) versus 12.0% (in service)
- Percent rating functional status as poor: 27.0% (intake) versus 11.2% (in service)
- Percent rating physical health as poor: 21.4% (intake) versus 14.8% (in service)
- Percent arrested: 14.1% (intake) versus 4.7% (in service)
- Percent incarcerated: 13.5% (intake) versus 4.0% (in service)
- Percent victimized from a violent crime: 11.7% (intake) versus 3.6% (in service)

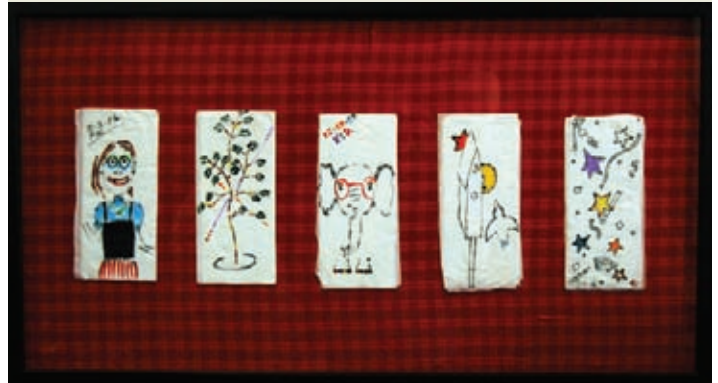
Table 1

Outcome Data Area	FY 2004	FY 2005	FY 2006
Consumers active in recovery planning	68%	79%	79%
Consumers reporting employment	19%	24%	23%
Consumers satisfied with outcomes attained	68%	70%	71%
Consumers reporting criminal justice involvement	14%	10%	11%

Abilities Art

From the Abilities 2006 Art Show

“Table for 5” by Kenny Hegland



17.5" x 34" pens on napkins

“Art is just something I do while sitting in a restaurant having a cup of coffee and listening to music on the jukebox. That’s how these five came to be. It makes me feel good to do it. I’m happy people enjoy my work.”

- Percent victimized from a non-violent crime: 20.4% (intake) versus 9.6% (in service)
- Percent employed: 17.0% (intake) versus 20.2% (in service)

These results are impressive and speak well to those programs and providers comprising the AMHD system. However, because we only are able to report data for 43% of the group served during this time, this information is compromised and open to critical scrutiny by stakeholders and those who fund our services. Again, the focus of discussion is likely to turn to what is not present rather than what is present. The sad thing is that I am confident that a complete data set would confirm that programs and providers are doing outstanding work.

This absence of data is not limited to the “outcome” end of the question. For example, over the past years we have increasingly emphasized culturally competent service delivery, but in our information system we see that more than 25% of consumers do not have basic information on race or ethnicity available. This makes it very hard to review program and consumer progress in programs designed to emphasize cultural appropriateness.

Without reliable data, the years of hard work by all AMHD staff and providers in developing a strong system will not be adequately explained to external stakeholders. This, in turn, will make it difficult to gain support for continued funding of important initiatives. As the AMHD moves forward, data will be the foundation for budget requests, resource allocation and program development. In other words, we must demonstrate to external stakeholders that our services are a good value.

In time, the regular collection of consumer demographic and outcome data will become better integrated into providers information systems’ and it will be easier to collect data electronically from providers on a regular basis. However, for the time being more effort must be expanded by case management programs and agencies to assure that demographic and outcome data be captured at admission, reported to AMHD, and updated with reports to AMHD regularly. Then, and only then, can we provide evidence to our funding sources, our consumers, their families and ourselves that we are supporting meaningful community-based recovery programs, that we are managing our resources well, and most importantly that our services are improving people’s lives. ❀

Request for Proposals/Information

RFI No. HTH 420-2-07, Concerning Community Based Intervention (CBI) Services for persons with severe and persistent mental illness (consumers). CBI is an adjunct support service designed to temporarily assist consumers with remaining in the least restrictive living environment through the provision of direct therapeutic support and supervision for skill building and the enhancement of self-care capability. AMHD plans procurement of a contract to offer short-term, temporary assistance to consumers during times of psychiatric or medical destabilization and support through their progress through the recovery process.

RFI No. HTH 420-3-07, Concerning Assertive Community Treatment (ACT) Services on the islands of O’ahu and Hawai’i. ACT is a team treatment approach designed to provide all-inclusive, comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with severe and persistent mental illness (consumers). AMHD plans procurement of a contract to offer ACT services on the islands of O’ahu and Hawai’i. Consumers served by ACT also have severe functional impairments and have avoided or not responded well to traditional outpatient mental health care and psychiatric rehabilitation services.

AMHD is seeking comments through these RFI’s on the feasibility of approach and the factors that should be considered.

To receive a copy of the RFI by mail or fax, please contact the contracts unit at (808) 586-4688. An RFI for an opioid maintenance outpatient therapy program is scheduled to be released soon.

Any questions relating to RFI’s, RFP’s, contracts, or modifications, should be directed to the contracts unit at (808) 586-4688.

Updates

Clubhouses November 2006	Diamond Head Clubhouse (O'ahu)	Friendship House (Kauai)	Hale O Honolulu (O'ahu)	Hale 'Olua (Hawai'i)	Hale O Lanakila (Maui)	Hui Hana Pono (O'ahu)	The Kona Paradise Club (Hawai'i)	Ko'olau Clubhouse (O'ahu)	Waipahu Aloha Clubhouse (O'ahu)	Total
Transitional (PT) Employment	3	16	6	7	0	N/A	3	6	18	59
Supported Employment	3	10	9	16	4	N/A	5	17	8	72
Independent Employment	7	14	8	17	3	N/A	4	3	4	60
Total Wages Earned	\$9,851	\$23,595	\$10,010	\$15,891	\$2,469	N/A	\$12,212	\$13,486	\$8,168	\$95,682
Average Hourly Wage Earned	\$9.28	\$8.90	\$7.48	\$7.84	\$8.13	N/A	\$9.23	\$7.18	\$7.10	\$8.61
Members in Supported Education	2	2	8	33	0	N/A	0	4	17	66
Active Members	54	70	183	125	52	N/A	41	150	168	843
Average Daily Attendance	20	31	46	38	23	N/A	13	48	78	297
Outreach Contacts	41	215	240	155	255	N/A	29	147	134	1,216
Evening/Weekend/Holiday Hours	12	42	37	53	14	N/A	40	52	30	280
New Member Referrals	7	3	3	3	3	N/A	4	4	2	29

Employment

Supported Employment Program

The Steadfast Supported Employment Program found 8 more jobs for consumers in November, for a total of 1,434 job placements and 1,719 referrals made since January 2001.

Consumer Employment Survey

As of November 1, 2006, 1,477 consumers completed a Quality of Life Interview within the previous seven months at state-operated community mental health centers. Of the 1,378 consumers who responded to the employment questions, 345 (25%) reported being employed (99 full-time and 246 part-time).

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