Chapter 43
Rural Mental Health Workforce Development in Hawai'i and the US-Affiliated Pacific Islands

Christopher W. S. Hill
University of Hawaii, USA

Kelley Withy
University of Hawaii, USA

ABSTRACT

Working in Hawai'i and the U.S.-Affiliated Pacific Islands presents unique challenges and opportunities for mental health workforce development. This chapter presents previous, current, and future efforts aimed at not only increasing the size of the workforce but also developing a better trained workforce for existing professionals. The authors draw from their experiences at the Hawaii/Pacific Basin Area Health Education Centers (AHEC), one of the only organizations performing medical, public health, and mental health workforce development across the Pacific Region, to explore culturally appropriate initiatives and interventions. Programs targeting a range of audiences from youth to adults, students to professionals, and patients/clients to caregivers are discussed. The chapter emphasizes health career pathway programs for youth and young adults wishing to enter the health workforce and a variety of educational development and continuing education opportunities for professionals. Specific mental health workforce initiatives are described.

INTRODUCTION

E Hō Mai

E hō mai

Ka `ike mai luna mai ē

`O nā mea huna no`eau

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O nā mele ē
E hō mai
E hō mai
E hō mai
Grant us knowledge
From above
The things of knowledge
Hidden in the chants
Grant us these things

Hawaiian chant for bringing insight, clarity, and collaboration (to be sung three times, each time raising the vocal pitch one-half step) by Edith Kanaka`ole via Papa Ola Lōkahi.

Within the U.S., international and national initiatives exist aimed at improving the mental health workforce. The vast majority of regulation and impact, however, is derived from the individual states, not the federal government. Each state is responsible for the licensing and categorization of mental health providers eligible to practice in that state, and licensure requirements vary widely between the states (emphasizing the necessity of state-level coordinated workforce development efforts). The use of mental health services in the U.S. is generally driven by three inter-related concepts, which are the *quality*, *access*, and *cost* of mental health care. Furthermore, multiple dimensions influence these concepts on a workforce-level. Examples of these dimensions are licensure requirements, scopes of practice, quantity of workforce members, wages, and provider types (Heisler & Bagalman, 2015). The purpose of this chapter is to inform the reader on the types of mental health care practitioners in Hawai'i, the policies that regulate a professional's ability to practice mental health care, the psychological and behavioral health disparities of the U.S.-Affiliated Pacific Islands, and what is being done to address workforce shortages in this field. Through examining current and past programs, initiatives, and activities, recommendations are provided for workforce professionals.

BACKGROUND

Mental Health Workforce in the U.S.

The mental health workforce in the U.S. is generally divided into two main categories: providers who can prescribe medication and providers who can't, with the administration/interpretation of psychological tests falling in the scope of work for clinical psychologists almost exclusively (Heisler & Bagalman, 2015). Beyond this, unfortunately, there is no consensus on the exact provider-types that constitute the mental health workforce. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2013) identifies a broad characterization of the mental health workforce, including psychiatry, clinical psychology, clinical social work, advanced practice (psychiatric) nursing, marriage and family therapy, substance abuse counseling, and counseling. The Institute of Medicine (IOM, 2012) identifies the mental health workforce as including all of the fields presented by SAMHSA and adds primary care physicians,