YEAR 3 REPORT | 2023

External Evaluation of the Texas Child Mental Health Care Consortium

September 1, 2022 – August 31, 2023

Lara S. Savas, PhD, Program Evaluation Lead Co-PI
Melissa F. Peskin, PhD, Program Evaluation Lead Co-PI
Belinda Hernandez, PhD, Implementation Science
Robert Addy, PhD, Statistical Analysis
Erica Frost, MPH, Program Manager
Andrea Siceluff, Research Coordinator
Chelsey Kanipe, MPH, Graduate Research Assistant
Center for Health Promotion & Prevention Research, University of Texas Health Science Center at Houston (UTHealth) School of Public Health

Cynthia Castaldo-Walsh, PhD
Chelsea Whiting
Simone Jackson
Maria Osorio
Jillian Helmick
Decision Information Resources, Inc.

UTHealth | School of Public Health
The University of Texas Health Science Center at Houston

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EXECUTIVE SUMMARY

The External Evaluation was funded in September 2020 to evaluate the Texas Child Psychiatry Access Network (CPAN), Texas Child Access Through Telemedicine (TCHATT), and the Child Psychiatry Workforce Expansion (CPWE) programs. The 86th Texas Legislature created and funded these initiatives as part of the Texas Child Mental Health Care Consortium (TCMHCC) to increase access to mental health services for Texas youth through the coordinated efforts of 12 higher education health-related institutions (HRIs). These initiatives are designed to promote statewide coordination and extension of mental health care services through the provision of telehealth-based consultation and training to primary care providers and in-school telemedicine services for at-risk youth. This Year 3 External Evaluation Report highlights findings from fiscal year 2023 (September 1, 2022 – August 31, 2023) external evaluation activities, including surveys and in-depth interviews conducted with key program stakeholders, and provides recommendations to inform decision-making and improve program implementation. Assessing participant experiences, particularly as they relate to the strengths, challenges, and impacts of the programs, can provide valuable information to the TCMHCC and program directors about what can be done to further support their goals of improving mental health care for children and adolescents in Texas.

This Executive Summary describes key findings from the CPAN, TCHATT, and CPWE Year 3 data collection activities and associated recommendations.

CPAN Provider Survey

Purpose and Sample

The purpose of the CPAN provider survey was to examine barriers and facilitators to CPAN implementation at clinic sites, including program fidelity, and providers' perceived impact of the program. Year 3 CPAN implementation surveys were obtained from a diverse cross-sectional sample of providers who used CPAN services in the past year (n=118). Both close-ended (quantitative) and open-ended (qualitative) questions were included.

Key Findings from CPAN Survey

Half of the providers were pediatricians and 13% were family physicians. The majority of providers were from clinics that accept Medicaid; on average, providers reported that nearly half of their patients are covered by Medicaid. Of surveyed providers, 36% report calling CPAN regularly and 63% report calling CPAN occasionally. Pediatricians and providers who had been practicing longer (i.e., for 10 years or more) were more likely to report being regular CPAN users, while family physicians and providers practicing for less than 10 years were more likely to report being occasional CPAN users.

There was high buy-in for CPAN services among users, with almost all providers (>95%) reporting an intention to use CPAN again in the next six months and agreeing that they would recommend CPAN to other providers.

Reasons for CPAN Use

Similar to results obtained in the Year 2 External Evaluation Report[1], the most commonly reported reason for calling CPAN was for medication management (20%) followed by referral assistance (19%).

[1] The University of Texas Health Science Center at Houston (UTHealth) School of Public Health. *External Evaluation of the Texas Child Mental Health Care Consortium Year 2 Report.*

Benefits to Users

More than 70% of providers that utilized CPAN reported that their knowledge, skills, and confidence to provide mental health care increased moderately or very much due to CPAN. Regular CPAN callers were more likely to report higher knowledge, skills, and confidence than occasional callers.

Training and Continuing Medical Education (CME)-related Feedback

The majority of surveyed providers reported receiving instructions on how to call into CPAN (92%) and information about CPAN services (85%) during enrollment; however, less than half (42%) reported receiving instructions on how to text CPAN. Only 18% of providers reported that either they or other clinic staff attended a CPAN training. However, among those providers who did report attending a CPAN training, 80% felt that the training was very or extremely helpful. While only 17% of respondents reported that they knew how to bill for a CPAN consult, almost half of respondents ranked their perceived importance of billing for a CPAN consult to be "high" or "very high". Nearly 70% of providers reported receiving education from the CPAN HRI on identifying and treating mental health conditions, and 43% reported participating in CME activities offered through CPAN.

Perceived Benefits and Barriers Related to CPAN Utilization and Areas for Improvement

A content analysis of open-ended survey responses provided insight into providers' perceived benefits and barriers related to CPAN utilization, as well as areas for improvement. By far, the greatest benefit of the CPAN program identified by respondents was accessibility of consultation services, information, and resources to help address the pediatric mental health needs of their patients. Some providers found that this access enhanced their confidence in treating their patients with immediate mental health needs until they were able to be seen by a psychiatrist. Further, the education and training opportunities offered by CPAN, especially related to CME, was seen as advantageous. The greatest barriers to utilization included time constraints, the program not fully meeting the needs of physicians and their patients (e.g., lack of resources and referrals for uninsured patients), and lack of awareness among and buy-in from others. Areas of improvement included improving connections to resources and referrals in the community and conducting outreach and building awareness among other health providers and clinics.

Figure 1 provides a visualization of the content discussed across open-ended questions in the survey, with the size of words depicting the frequency in which they were mentioned (highest frequency words larger; lower frequency words smaller).

Figure 1. Visual Depiction of all CPAN Open-ended Responses

Recommendations from CPAN Survey Findings

1) **Increase outreach and awareness of CPAN in the larger community.** This could help improve buy-in and support at clinics, enroll more providers across the state, and better inform other institutions about the role CPAN is playing in mental health care.

2) **Improve connections to community resources and referrals through CPAN** by:
    a. Updating referral lists
    b. Offering more affordable and viable resources for patients, particularly for uninsured and underinsured patients
    c. Ensuring that community resources are accessible (e.g., offer telehealth options for underserved patients who cannot travel far during work hours) and relevant to patients' needs

3) **Provide more frequent trainings and increase access to training resources**, including:
    a. Training providers on how to text CPAN and bill for CPAN consults
    b. Training providers on the services and resources available to them through CPAN
    c. Improving communication to providers about CPAN program trainings (to guide use of the program) and mental health education opportunities (e.g., CMEs)
    d. Increasing access to CPAN trainings and CMEs by providing different delivery methods, e.g., in-person, virtual, video recording for later viewing, and guides for providers to reference in clinics
    e. Targeting training to younger providers, family physicians, and advanced practice providers (i.e., PAs and NPs), who have lower rates of program utilization

CPAN Survey Limitations

There are some limitations of the Year 2 CPAN provider survey. First, there was a low response rate, even after multiple outreach attempts. Due to the voluntary nature of participation, providers who agreed to complete the survey may be more likely to provide more favorable responses. Additionally, the sample was drawn from a list of providers covered by a signed agreement as of August 2023, so it may not represent providers enrolled in CPAN after this time. These factors limit the conclusions that can be drawn from the results. Care should be taken when generalizing to groups that are substantially different from the respondents.

TCHATT School Survey

Purpose and Sample

The purpose of the TCHATT implementation survey was to examine barriers and facilitators to TCHATT implementation, program fidelity, and the impact of the program as perceived by school staff. Year 3 TCHATT implementation surveys were obtained from a diverse cross-sectional sample of school staff involved in the implementation of TCHATT (n=224). Both close-ended (quantitative) and open-ended (qualitative) questions were included.

Key Findings from TCHATT Survey

The majority of survey respondents were counselors (84%); two-thirds reported being very involved in the implementation, and 32% reported being somewhat involved in the implementation of TCHATT. Most survey respondents (83%) reported implementing TCHATT for at least 6 months. **There was high satisfaction with the TCHATT program, with almost 90% reporting that they would recommend TCHATT to other schools, and 93% reporting that their school intends to continue using TCHATT in the next 6 months.**

Perceived Student Outcomes

Perceptions of TCHATT's effect on student outcomes are favorable among school staff; 63% of respondents indicated that, because of TCHATT, students had decreased behavioral incidents, and 50% indicated that students had better attendance and grades at school. Over 70% of campuses actively implementing TCHATT reported that at least half of parents/guardians had consented to obtain TCHATT services for their child when TCHATT services were offered.

Implementation Evaluation

We conducted exploratory analyses to examine level of TCHATT implementation (inconsistent vs. full and systematic implementation) by campus characteristics. Compared to campuses implementing TCHATT fully and systematically, campuses implementing TCHATT inconsistently were more likely to report:

- A higher percentage of students with non-educational support needs;
- Spending more time addressing non-educational needs;
- A higher percentage of student with needs for counseling or behavioral therapy;
- Spending more time addressing behavioral problems.

Parental consent (as reported by respondents) and the existence of another school/district MOU (besides TCHATT) to provide mental health services to students did not differ by TCHATT level of implementation, suggesting that these do not serve as a barrier to full and systematic TCHATT implementation.

Campus Characteristics and Parental Consent

We also compared campus characteristics among school staff who reported high ($\geq$50%) parental consent for TCHATT services for their child and school staff who reported low (<50%) parental consent for TCHATT services for their child (when child was referred to TCHATT).

Lower (<50%) perceived parental consent for TCHATT services was reported among school staff from:

- Large districts (>15,000 students);
- Campuses located in metro and suburban areas;
- Campuses with a higher percentage of economically disadvantaged students;
- Campuses with a higher percentage of students with needs for counseling or behavioral therapy.

Training and Implementation Support

While most respondents (84%) reported that their school received material about TCHATT, including how to refer students, only 68% reported receiving ongoing information from the HRI to support implementation of TCHATT. This is a decrease from last year, when 80% of school staff reported often or sometimes receiving ongoing information from the HRI. This year, 29% of respondents reported that their school provided training to school staff (e.g., to support staff making student referrals to TCHATT), which is also a decrease from what was reported by school staff last year (38%).

Perceived Benefits of TCHATT and Areas for Improvement

Similar to the Year 2 findings, respondents indicated that the biggest benefits of the program included accessibility of care for underserved students in need and mental health support that extends beyond the capacity of school counselors. Areas of improvement also echoed last year's findings including the desire for a more efficient implementation process (i.e., referrals, intakes, scheduling), better communication and follow-up about student care, engaging more TCHATT providers in the program, and increasing the number of sessions for students.

Figure 2 provides a visualization of the content discussed across open-ended questions in the survey, with the size of words depicting the frequency in which they were mentioned (highest frequency words larger; lower frequency words smaller).

Figure 2. Visual Depiction of all TCHATT Open-ended Responses

Recommendations from TCHATT Survey Findings

1) **Simplify the implementation process**, including:
    a. Simpler referral process (e.g., a more efficient and streamlined paperwork system as well as an online option)
    b. Easier consent and intake process for parent engagement
    c. Improved scheduling process (e.g., using an online scheduling system that allows one to choose an appointment time and send a confirmation with a calendar invite)

2) **Consider ways to improve communication and follow-up while students are involved in the TCHATT program**, including:

a. A system to track the status of students referred and receive updates on those currently receiving services

b. Better communication, including the plan for follow-up care, after all TCHATT sessions have been completed

3) **Improve staffing support** in order to reduce wait times, especially for rural districts with limited resources

4) **Develop implementation support strategies**, particularly for schools that lack other mental health services and have a greater need for TCHATT

TCHATT Survey Limitations

There are some limitations of the Year 3 school staff survey. Due to the voluntary nature of participation, school staff who agreed to complete the survey may be more likely to provide more favorable responses. Further, the sample was drawn from the list of enrolled campuses as of March 31, 2023 and, therefore, may not represent school staff from campuses that enrolled after this time. These factors limit the conclusions that can be drawn from the results. Care should be taken when generalizing to groups that are substantially different from the respondents.

In addition, these findings are descriptive in nature and, therefore, causality cannot be inferred. Several variables (e.g., parental consent and participant outcomes) are from the perception of school staff and unable to be measured objectively.

CPWE Qualitative Interviews

Purpose and Sample

The Year 3 evaluation of the CPWE program focused on exploring trainees' (1) experiences in community mental health (CMH) prior to CPWE training, (2) experiences in the CPWE training program, (3) preparation for culturally responsive care and capacity to serve diverse patient populations, (4) perceived impacts of the program, (5) perceived strengths and challenges of the program, and (6) satisfaction and recommendations for improvement. Through in-depth interviews conducted with 11 trainees of the program across participating HRIs, there continues to be evidence that the CPWE initiative is preparing participants to serve the diverse needs of patients of the public mental health system in the long term while building the capacity of CMH clinics to serve medically underserved youth in the short term.

Like last year, we found that implementation of the CPWE program continues to vary widely across HRIs and clinics. This variation makes it difficult to generalize the experiences across all sites and trainees; however, important insights could help program directors understand strengths, challenges, and areas for improvement.

Key Findings from CPWE Qualitative Interviews

The key findings from the in-depth interviews support CPWE findings from Year 1 and Year 2 External

Evaluation Reports[1,2] – the CPWE program is **building the capacity of trainees to serve diverse patient populations** in public mental health settings and is **contributing positively to their overall training in psychiatry**. The program itself is **expanding participants' thinking about community mental health as a career option**.

While much feedback was site specific, the greatest strength of the CPWE program continues to be training experience based on working with diverse patients and clinic settings. **Exposure to diverse patients and community-based clinical settings** was found to build the capacity of participants to provide individualized and culturally responsive patient care and navigate resource challenges. It helped them understand the barriers faced by their patients and offer **flexibility in care**.

> *"I developed my skill set in a different way. For example, how to talk to teenagers, how to talk to children and their parents, coming up with plans, understanding limitations. Things like that for sure it helped me become a better psychiatrist. Also, it helped me understand what kind of services were available. It was the ground reality of what it's like. I had more exposure than ever before." –Fellow*

While supervision was not identified as a key strength this year, most trainees reported satisfaction with the level of supervision they received. Interestingly, the vast majority of **fellows reported positive, direct engagement with other TCMHCC initiatives such as CPAN and TCHATT,** and about half of residents knew of the programs but did not directly engage with them. They shared that these experiences enhanced their learning and understanding of TCMHCC's goal of increasing access to mental health care for Texas children.

CPWE trainees did not identify as many challenges with the program and areas for improvement this year as they did in prior years. The **complexity in treating patients and coordinating complementary resource support** continues to be the biggest challenge, especially as it relates to addressing child needs beyond mental health care with limited access to resources.

> *"I think one of the most challenging aspects was the complexity of paired access to resources. I think that was one of the most challenging things on a day-to-day basis because you are left feeling a little bit frustrated or helpless. One of the biggest challenges was knowing what is going on with patients, what they need, but not knowing how to get that for them." –Fellow*

Some trainees would like **more education regarding resource support and working in community healthcare**, though they also indicated that there is a larger systemic issue to addressing access than the CPWE program can likely provide.

> *"Briefing, maybe some lectures specifically on community healthcare. It doesn't have to be every week or every month, but maybe a few times a year for residents in the program. For example, providing a reminder on what the goals are and what to look out for, what to keep in mind for these populations, and what to really emphasize. A lot has been learning on my own." –PGY3*

[2] The University of Texas Health Science Center at Houston (UTHealth) School of Public Health. *External Evaluation of the Texas Child Mental Health Care Consortium Year 1 Report.*

Other challenges and areas for improvement were more site specific than general. For example, some trainees would like to see **improvements to administrative support and efficiencies to workflow** at certain clinics. Unlike last year, almost all residents and fellows conducted a combination of in-person and telemedicine visits. One of the challenges identified by residents last year was the lack of opportunity for meeting with patients in person, which did not come up as a challenge this year. Similarly, fellows did not bring up time constraints in each rotation as they did last year, which may indicate some progress in this area.

Recommendations from CPWE Qualitative Interviews

1) **Offer a formal orientation to CPWE** and its goals so that trainees understand their learning objectives and what they are contributing to through their participation (e.g., increasing access to care for underserved children in under-resourced communities). By doing so, it can create a sense of ownership and commitment to the cause, perhaps sparking a longer-term interest in CMH.

2) **Provide additional learning opportunities** related to CMH, working with children and adolescents, identifying community resources, navigating challenges related to patient access, providing trauma-informed and culturally responsive care, as well as other relevant topics throughout the training period. This will enhance trainees' experiential learning, build their confidence, and provide more tools for effective patient care.

3) **Conduct internal evaluations of administrative and resource support** at training sites to ensure trainees have what they need to learn and be successful in their training. Identify pain points and gaps that can be addressed and corrected. Work with trainees to identify the resources they need to do their work effectively and efficiently.

4) **Continue to build on strengths of the program** such as exposure to diverse patients and settings, as well as providing strong supervision and opportunities to inter-professional collaboration.

Limitations of CPWE Interviews

There is much more to learn about the longer-term impacts of the CPWE initiative. Documentation of CPWE implementation across sites, and how uniform or varied it is across HRIs, was limited. Like in Year 2, we did randomly select trainees from each HRI. However, while we based recruitment on a random sample of CWPE trainings, our sample may be affected by self-selection bias. Many trainees (particularly, resident trainees) did not respond to our outreach attempts, and, in some cases, HRIs only had a handful of residents to choose from. Limitations of this method include the potential for non-response bias. Triangulating trainee interview data with other data sources such as surveys or interviews with other key stakeholders (e.g., HRI staff responsible for implementation) will be advantageous to evaluating the CPWE program. This is the goal for the external evaluation Year 4 interviews with CPWE medical directors. It will be important to continue embarking on a learning and discovery journey to better understand the CPWE initiative from the selection and onboarding processes to the ways HRIs are structuring and implementing the residencies.

CPAN PROVIDER SURVEY

Introduction

The UTHealth Houston External Evaluation team distributed and analyzed a CPAN provider survey as part of the Year 3 external evaluation of TCMHCC. Understanding providers' perceptions of the CPAN program and factors that influence their engagement with the program can help guide quality improvement and decision making for future program planning and implementation. **The survey purpose was to assess: (1) provider-related factors influencing use of CPAN services, (2) organizational factors and processes affecting program adoption and implementation, and (3) perceived outcomes from clinic stakeholder perspectives.** The survey included closed-ended and open-ended questions.

This report augments the learnings from the Year 1 and Year 2 evaluation reports.[2,1] In the sections that follow, we discuss the methods used, highlight key findings, and offer recommendations as they pertain to program implementation and the evaluation.

Methods

Sample

For Year 3, our goal was to survey 200 providers enrolled in CPAN. We identified a diverse sample of "recent users" (i.e., those who used CPAN services in the past year) across all 12 HRIs based on the following factors: (1) childhood opportunity index (COI) (a social vulnerability composite measure for children) and (2) population density. The resultant sample included 432 providers (36 per HRI). We conducted outreach (by phone) for 32 (of 432) providers with missing email addresses, and we were able to obtain a valid email address for five of the providers. For the remaining providers with missing email addresses (n=27), we used our sampling frame to identify a replacement provider from that HRI. We were unable to replace four providers from one HRI (UTMB) due to a smaller pool of eligible providers (i.e., enrolled providers who used CPAN services in the past year) and missing email addresses leaving a total 428 providers to who the survey was distributed.

In August 2023, we invited the 428 providers to complete the electronic *Year 3 CPAN Provider Survey*. We continued data collection through late-September 2023. After multiple outreach attempts, 124 providers completed the survey (29.0% response rate). Providers who reported not calling into CPAN in the past 12 months (n=5) and who did not complete the eligibility section (n=1) were excluded from analyses and will be the focus of the Year 4 CPAN Survey. Therefore, the final sample size for the results presented below was 118 providers (Figure 3).

Figure 3. CPAN Provider Survey Completion

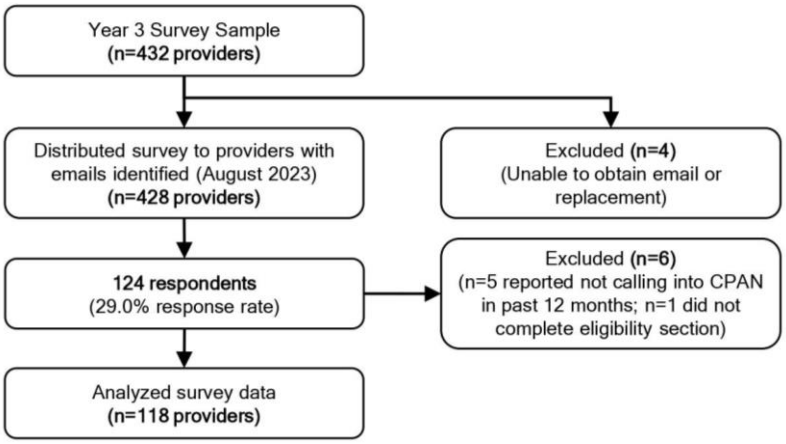
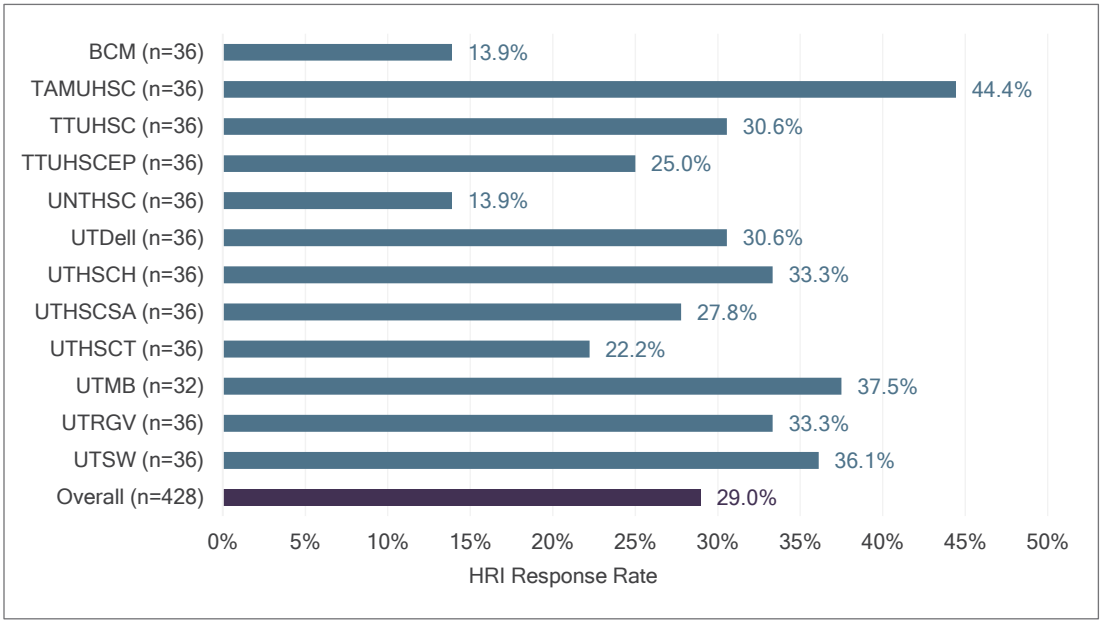


Figure 4 presents the individual HRIs' participant survey response rates. For example, 13.9% of individuals sampled at BCM campuses participated in the survey. Survey response rates varied by HRI, ranging from 13.9% (among sampled BCM and UNTHSC providers) to 44.4% (among sampled TAMUHSC providers).

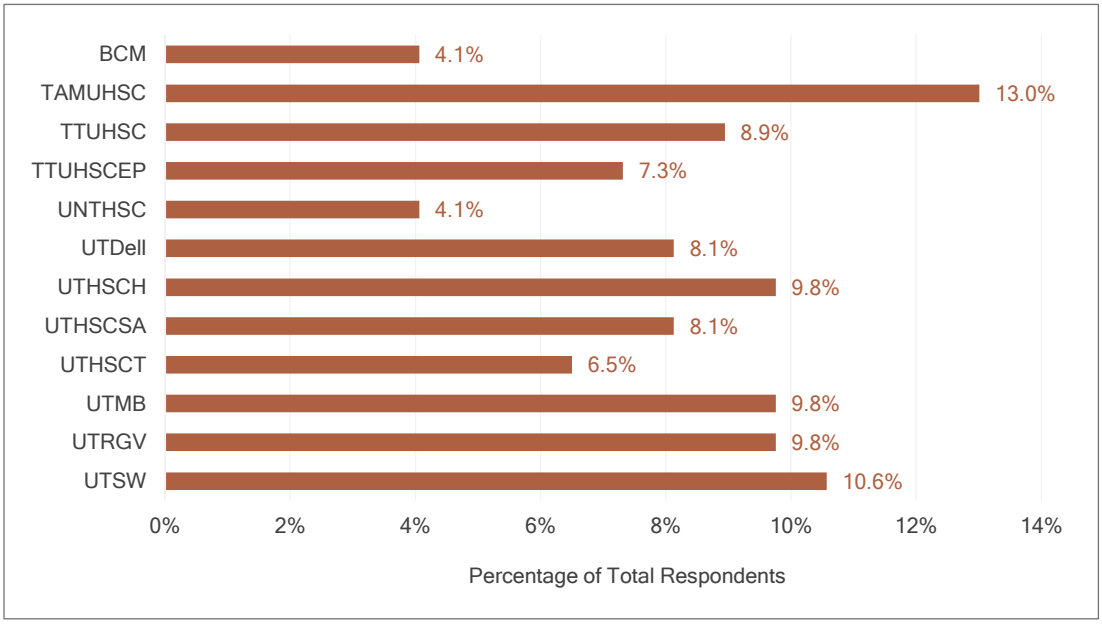
Figure 5 presents the percent of participants from each HRI that comprised the total survey respondents. For example, 4.1% of all survey respondents were BCM providers.

Figure 4. Participant Survey Response Rate Within HRIs[a]



(a) Data Source: 2023 External Evaluation CPAN Provider Survey.

Figure 5. Percent of Participants from each HRI among Total Survey Respondents[a] (n=124)



(a) Data Source: 2023 External Evaluation CPAN Provider Survey.

Survey & Data Collection

Development of CPAN provider survey was guided by the external evaluation logic models (updated at the beginning of Year 2), measures table, and Year 1 process mapping findings. In Year 3, we adapted the survey based on our internal review as well as feedback from UT System leadership and the Centralized Operations Support Hub (COSH).

Quantitative Results

Descriptive Characteristics of Surveyed Providers

Table 1 presents descriptive characteristics of providers who completed the survey and reported calling CPAN in the past 12 months. As described in the methods section above, we sampled "recent users" (i.e., those who used CPAN services in the past year) only. The majority of providers (76%) were female. A little more than half (57%) identified as non-Hispanic White and approximately 17% Hispanic (data not shown). More than half of the sample reported working as a provider for 14 years or less and a third reported working as a provider for 20 years or more. On average, respondents reported working at their current clinic for 8.5 years. Physicians comprised more than three-fourths of the sample; 50% reported their primary role as pediatrician. In the sample, 36% of respondents reported calling CPAN regularly and 63% reported calling CPAN on occasion. Less than 2% of respondents reported calling CPAN in the past but stating that they do not intend to call again in the future.

Table 1. Characteristics of Surveyed Providers

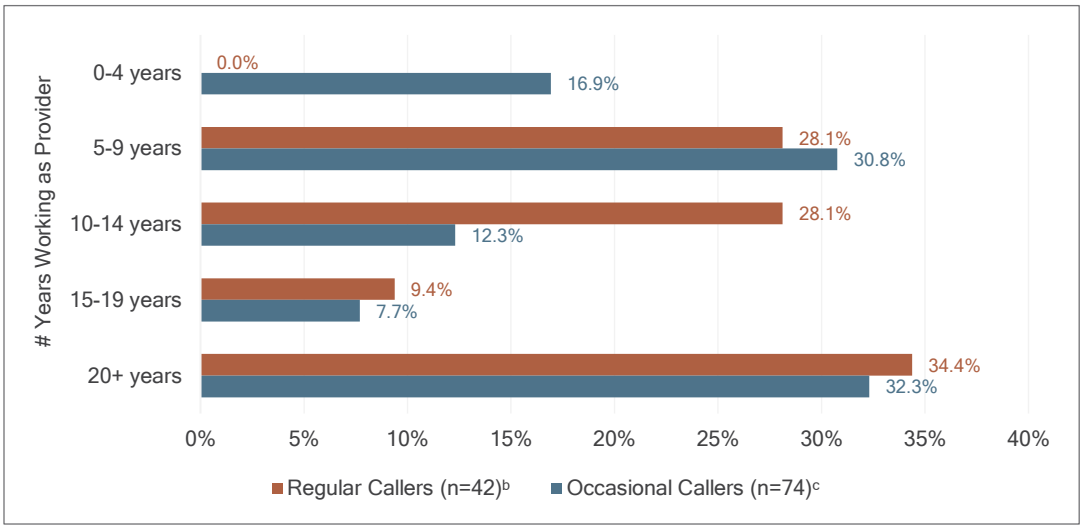
	Total Providers[a] (n=118) n (%)
Years Working as a Provider	
Less than 5 years	11 (11.2%)
5-9 years	29 (29.6%)
10-14 years	17 (17.4%)
15-19 years	8 (8.2%)
20 years or more	33 (33.7%)
Provider Role[b]	
Physician Assistant	1 (0.9%)
Nurse Practitioner	23 (19.7%)
Pediatrician	59 (50.4%)
Family Physician	15 (12.8%)
Other Physician besides Pediatrician or Family Physician	1 (0.9%)
Medical Director	7 (6.0%)
Resident	2 (1.7%)
Other	9 (7.7%)
Years Worked at Clinic	
Mean [Min, Max]	8.5 [0,32]
Hours per Week Worked at Clinic	
Mean [Min, Max]	35.7 [6,65]
CPAN Utilization Over the Past 12 Months	
Call CPAN regularly	42 (35.6%)
Call CPAN on occasion	74 (62.7%)
Have called CPAN but do not intend to in the future	2 (1.7%)

(a) Data source: 2023 External Evaluation CPAN Survey. Includes individuals who reported calling CPAN in the past 12 months. (b) Respondents could choose more than one role; therefore, responses are not mutually exclusive.

Figure 6 and Figure 7 present provider characteristics (i.e., number of years working as a provider and specialty type) by CPAN use (i.e., providers who reported calling into CPAN regularly versus

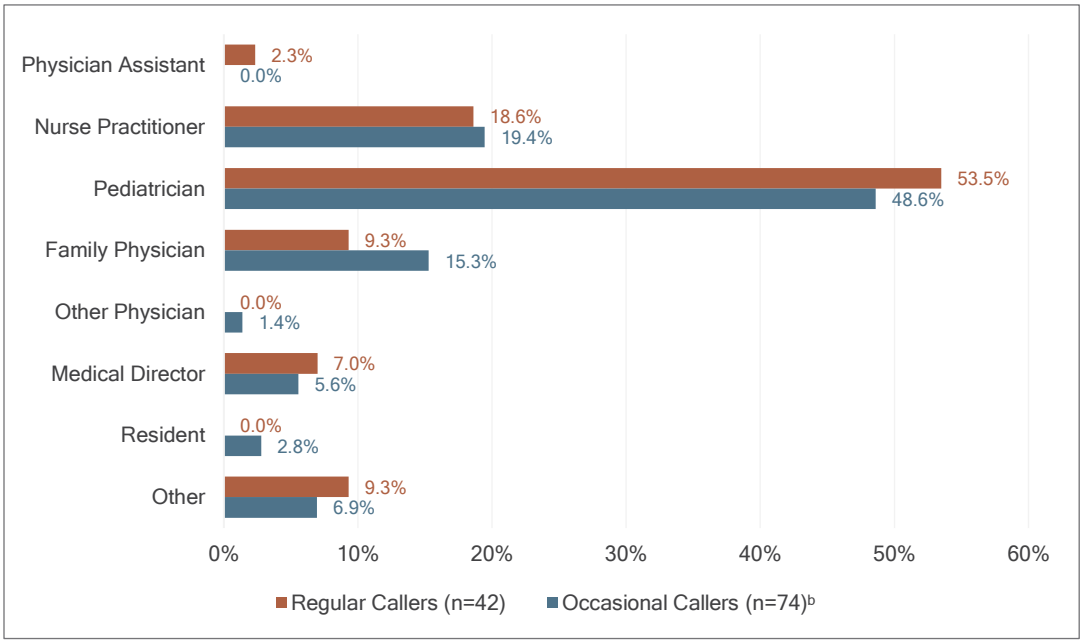
on occasion over the past 12 months). Overall, results show that regular utilization of CPAN was more common among providers who had been practicing longer (i.e., for 10 years or more) compared to providers who had been practicing for less than 10 years (Figure 6). In addition, pediatricians were more likely to be regular CPAN callers, while family physicians were more likely to be occasional CPAN callers (Figure 7).

Figure 6. CPAN Utilization by Number of Years Working as a Provider[a]



(a) Data source: 2023 External Evaluation CPAN Survey. Includes individuals who reported calling CPAN regularly or on occasion in the past 12 months only. (b) Number of years working as a provider missing for 10 regular callers. Number of years working as a provider missing for 9 occasional callers.

Figure 7. CPAN Utilization by Provider Role[a]



(a) Data source: 2023 External Evaluation CPAN Survey. Includes individuals who reported calling CPAN regularly or on occasion in the past 12 months only. Respondents could choose more than one option; thus, responses are not mutually exclusive. (b) Provider role missing for 2 occasional callers.

Descriptive Characteristics of Clinics

Table 2 compares geographic and population-level vulnerability indicators for clinics enrolled in Trayt (through 8/31/23) and clinics that completed the survey. The following measures are used as indicators of geographic and population-level vulnerability:

Rural-Urban Commuting Area Codes (RUCA). RUCA is a census tract-based classification developed by U.S. Department of Agriculture that uses standard census measures of population density, urbanization, and daily commuting to characterize all U.S. census tracts with respect to their rural/urban status and commuting relationships to other census tracts.

Child Opportunity Index 2.0 (COI 2.0). The COI is a validated tool that quantifies neighborhood conditions in the United States for children, ranking them from lowest to highest opportunity. This index includes 29 indicators in three domains: (1) education, (2) health and environment and (3) social and economic.

With respect to RUCA codes, the geographic distribution was similar between clinics enrolled in Trayt (as of 8/31/23) and clinics that completed the survey. With respect to COI, overall, childhood opportunity levels were similar between enrolled and surveyed clinics, although clinics in “low opportunity” areas were slightly under-represented in the survey sample.

Table 2. Comparison of Clinics Enrolled in CPAN and Surveyed Clinics by Geographic and Population-Level Vulnerability Indicators

	Total Enrolled Clinics[a] (n=2,459) n (%)	Surveyed Clinics[b] (n=123) n (%)
Rural-Urban Commuting Area Code[c]		
Urban	2050 (83.6%)	100 (82.0%)
Large Rural City/Town	225 (9.2%)	12 (9.8%)
Small Rural Town	176 (7.2%)	10 (8.2%)
COI Level[d]		
Very Low	563 (23.0%)	28 (22.8%)
Low	446 (18.2%)	15 (12.2%)
Moderate	465 (19.0%)	26 (21.1%)
High	491 (20.0%)	24 (19.5%)
Very High	485 (19.8%)	29 (23.6%)

(a) Data source: Trayt CPAN Clinic Staff Directory; enrolled refers to clinics with a signed agreement as of 8/31/23. (b) Data source: 2023 External Evaluation CPAN Survey. (c) Data Source: 2010 Rural-Urban Commuting Area Codes (RUCA), USDA Economic Research Service, U.S. Department of Agriculture. Secondary RUCA codes were aggregated as follows: Urban: 1.0, 1.1, 2.0, 2.1, 3.0, 4.1, 5.1, 7.1, 8.1, and 10.1; Large Rural City/Town: 4.0, 4.2, 5.0, 5.2, 6.0, and 6.1; Small and Isolated Small Rural Town: 7.0, 7.2, 7.3, 7.4, 8.0, 8.2, 8.3, 8.4, 9.0, 9.1, 9.2, 10.0, 10.2, 10.3, 10.4, 10.5, and 10.6. RUCA classification missing for 8 enrolled clinics. (d) Data source: 2022 Child Opportunity Index 2.0 database (https://www.diversitydatakids.org/). COI classification missing for 9 enrolled clinics.

Table 3 presents clinic characteristics of surveyed providers, including type of clinic practice, clinic region, clinic size, and percentage of economically disadvantaged patients. The majority of surveyed providers were employed at private practices (53%), followed by hospital-based clinics (23%) and federally-qualified health centers (FQHCs) (21%). Forty-four percent of surveyed providers were from suburban regions and a little more than half (55%) were employed at small clinics of two to five providers. The majority (80%) of surveyed providers were from clinics that accept Medicaid; on average, surveyed providers reported that nearly half (47%) of their patients are covered by Medicaid. Almost all of the surveyed providers (95%) reported having an EHR installed and in all (>90%) areas of their clinic.

Table 3. Clinic Characteristics of Surveyed Providers

	Surveyed Providers[a] (n=118) n (%)
Type of Clinic Practice	
Private practice	57 (52.8%)
FQHC	23 (21.3%)
Hospital-based clinic	25 (23.2)
Military clinic	2 (1.9%)
Other	1 (0.9%)
Clinic Region	
Urban	31 (28.7%)
Suburban	48 (44.4%)
Rural	29 (26.9%)
Clinic Size	
Solo (1 provider)	11 (11.2%)
Small (2-5 providers)	54 (55.1%)
Medium (6-20 providers	30 (30.6%)
Large (20+ providers)	2 (2.0%)
Years Clinic in Operation	
Less than 10 years	27 (27.3%)
10-19 years	27 (27.3%)
20-29 years	24 (24.2%)
30 years or more	21 (21.2%)
Patients Scheduled per Hour for Respondent	
Mean [Min, Max]	6.2 [1,85]
Clinic Accept Medicaid	
Yes	86 (80.4%)
No	21 (19.6%)
Percentage of Patients Medicaid	
Mean [Min, Max]	46.5 [0,98]
EHR System	
EHR installed and in all (>90%) areas of clinic	103 (95.4%)
EHR installed and in use for some of clinic staff and providers	2 (1.9%)
Do not have an EHR	3 (2.8%)

(a) Data source: 2023 External Evaluation CPAN Survey. Includes individuals who reported calling CPAN in the past 12 months only (n=118); however, sample sizes vary due to missing data.

Implementation Evaluation

Table 4 describes survey respondents' receipt of program materials, instructions, and participation in CPAN enrollment and training activities. The majority of surveyed providers reported receiving instructions on how to call into CPAN (92%) and information about CPAN services (85%) during enrollment; however, only 42% reported receiving instructions on how to text CPAN. More than half of providers (58%) reported receiving a welcome packet from the HRI during enrollment. A third or fewer providers reported receiving other materials, such as posters (33%), pens (25%) and stickers (20%). Slightly less than 20% of providers reported that they did not receive any CPAN materials. The majority of providers reported that either they or other clinic staff did not attend a CPAN training (59%) or that they didn't know if they attended a CPAN training (23%) (Table 4). ***However, among those providers who did report attending a CPAN training (n=21), 80% felt that the training was very or extremely helpful. No providers reported that the training was not at all helpful.***

Table 4. CPAN Enrollment and Training Activities

	Total Providers[a] (n=118) n (%)
Information Provided During CPAN Enrollment[b]	
Instructions on how to call into CPAN	108 (91.5%)
Instructions on how to text CPAN	49 (41.5%)
Information about CPAN services	100 (84.8%)
Other	2 (1.7%)
Did not receive any information about CPAN	1 (0.9%)
CPAN Materials Received[b]	
Welcome Packet	68 (57.6%)
Posters/PDF	39 (33.1%)
Stickers	24 (20.3%)
Pens	30 (25.4%)
Other	17 (14.4%)
Did not receive CPAN materials	22 (18.6%)
Respondent or Other Clinic Staff Attended CPAN Training	
Yes	21 (18.3%)
No	68 (59.1%)
Don't know	26 (22.6%)
Helpfulness of Trainings[c]	
Extremely helpful	5 (25.0%)
Very helpful	11 (55.0%)
Somewhat helpful	4 (20.0%)
Not at all helpful	0 (0.0%)

(a) Data source: 2023 External Evaluation CPAN Survey. Includes individuals who reported calling CPAN in the past 12 months only (n=118); however, sample sizes vary due to missing data. (b) Respondents can choose more than one option; therefore, results are not mutually exclusive. (c) n=21; however, response was missing from 1 respondent.

Participation in CPAN Activities & Implementation Fidelity

Among the 118 survey respondents who reported calling into CPAN in the past 12 months, we queried their participation in various activities that comprise CPAN. These questions were designed to assess implementation fidelity based on the CPAN process maps developed with CPAN stakeholders in Year 1 of the external evaluation. Activities are divided into the following categories: Awareness, Training, Implementation Support, Consultation, and Child Assessment and Ongoing Care (Figure 8).

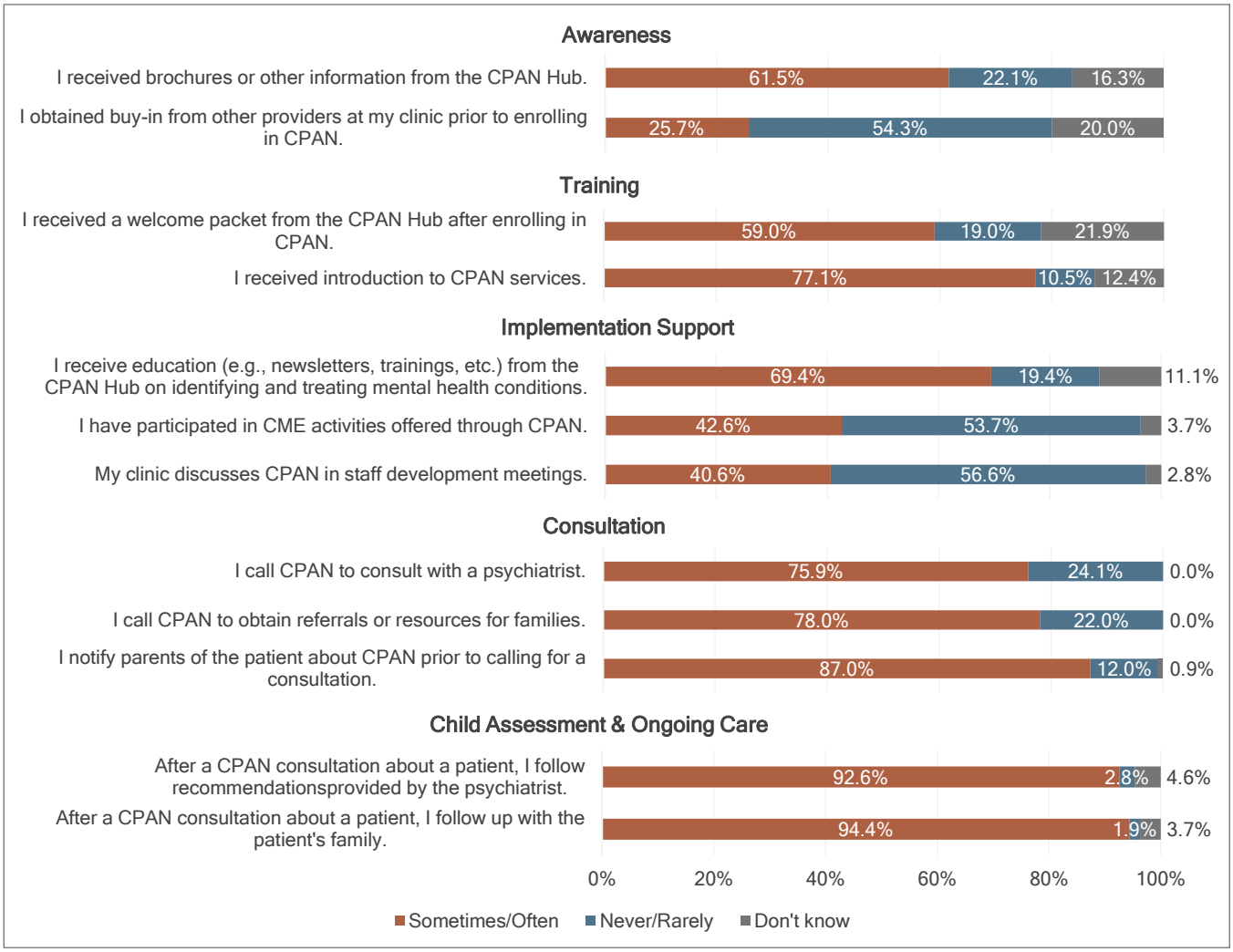
Similar to the Year 2 findings, the majority of respondents (62%) reported receiving brochures or other information from the CPAN HRI, and approximately one-fourth reported obtaining buy-in from other providers at the clinic before enrolling in CPAN. Compared to last year, more providers reported receiving a welcome packet from the HRI after enrolling (59% in Year 3 vs. 52% in Year 2) and receiving an introduction to CPAN services (77.1% in Year 3 vs. 44.3% in Year 2). Nearly 70% reported receiving education from the CPAN HRI on identifying and treating mental health conditions; however less than half reported participating in CME activities offered through CPAN.

Provider Use of CPAN Consultation Services

Compared to Year 2, more providers reported sometimes or often calling CPAN to consult with a psychiatrist (76% in Year 3 vs. 55% in Year 2) and obtain referrals or resources for families (78% in Year 3 vs. 53% in Year 2), although this likely due to our sampling of CPAN users only this year. Fewer providers also reported notifying parents of the patient about CPAN prior to calling for a consultation (87% in Year 3 vs. 71% in Year 2). Finally, the vast majority of surveyed providers reported participating in child assessment and ongoing care activities related to following the psychiatrist's recommendations

(93%) and following up with the patient's family (94%), which is consistent with what was reported by providers in Year 2.

Figure 8. CPAN Activity Checklist[a] (n=116)



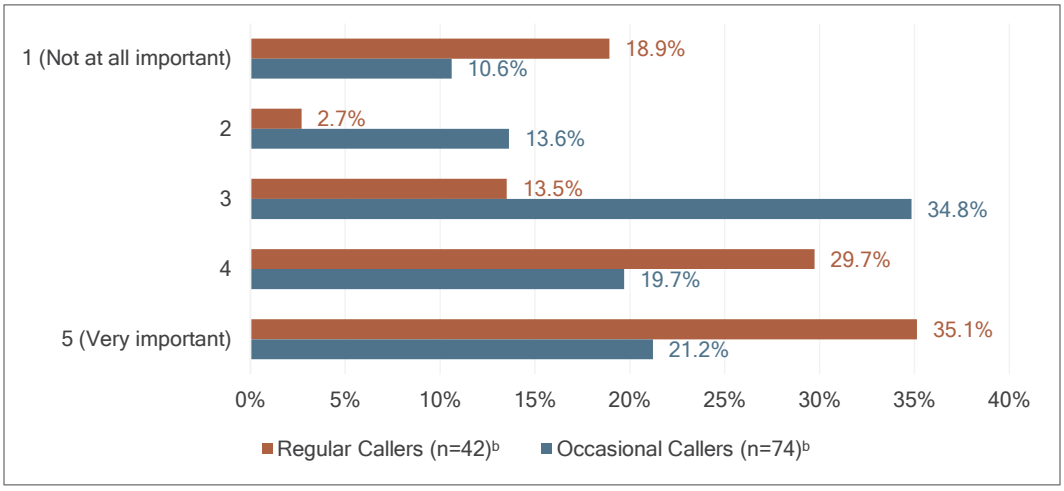
(a) Data source: 2023 External Evaluation CPAN Survey. Includes providers who reported calling CPAN regularly or on occasion (n=116); however, sample sizes vary due to missing data.

Participants' Perceived Importance of **Billing for a CPAN Consult**

Participants responded to questions regarding their knowledge of how to bill for a CPAN consult as well as their perceived importance of being able to bill for a CPAN consult. Only 17% of respondents reported that they knew how to bill for a CPAN consult (data not shown). Respondents were asked to rank their perceived importance of billing for a CPAN consult on a scale of 1 to 5, with 1 being "not at all important" and 5 being "very important". Overall, almost 50% of respondents ranked their perceived importance of billing for a CPAN consult to be high or very high, while 27% ranked it a 3 (data not shown).

Figure 9 presents respondents' perceived importance of billing for a CPAN consult by their level of utilization (regular CPAN callers vs. occasional CPAN callers). Results show that regular CPAN callers were more likely than occasional CPAN callers to report a higher perceived importance of billing for a CPAN consult.

Figure 9. Perceived Importance of Billing for CPAN Consult and CPAN Utilization[a]

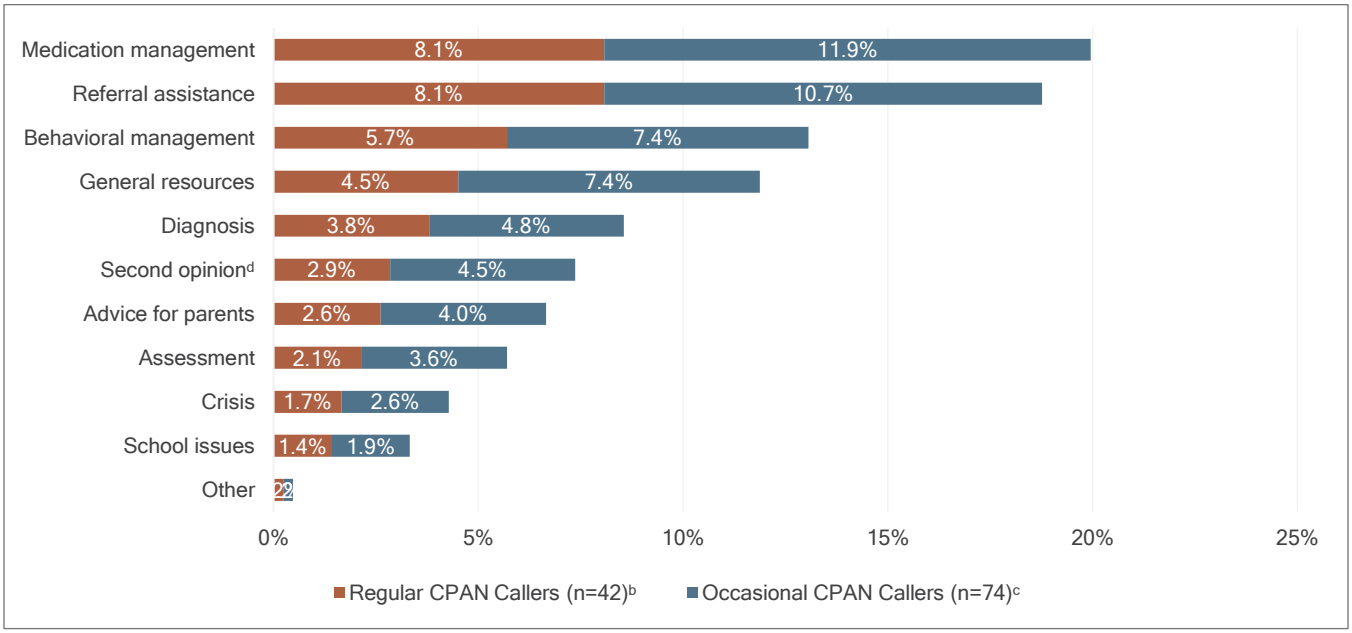


(a) Data source: 2023 External Evaluation CPAN Survey. Includes providers who reported calling CPAN in the past 12 months.
(b) Response missing from 13 respondents (5 regular callers and 8 occasional callers).

Reasons for Calling CPAN

Figure 10 presents the reasons that survey respondents reported for calling CPAN (total and by CPAN use; i.e., providers who reported calling into CPAN regularly versus on occasion over the past 12 months). The most commonly reported reason for calling CPAN, in general, was for medication management followed by referral assistance, behavioral management, and general resources. A little over one-fourth of respondents reported reasons for calling related to each of the following areas: diagnosis, second opinion, advice for parents, and assessment. Note that respondents could choose more than one reason for calling; therefore, results are not mutually exclusive. These top reasons for calling are consistent with those reported in Years 1 and 2. They also did not vary between regular and occasional CPAN users.

Figure 10. Reasons for Calling CPAN[a] (n=116)



(a) Data source: 2023 External Evaluation CPAN Survey. Includes individuals who reported calling into CPAN regularly or occasionally in the past 12 months. Respondents can choose more than one option; therefore, results are not mutually exclusive. (b) Includes individuals who reported calling CPAN regularly in the past 12 months only. (c) Includes individuals who reported calling CPAN occasionally in the past 12 months only. (d) Second opinion refers to questions or concerns about care provided by a community mental health provider.

When asked about the reason for their *first call to CPAN*, over three quarters of respondents reported that it was to obtain a psychiatric consult for a difficult case (Table 5).

Table 5. Reasons for First Call to CPAN

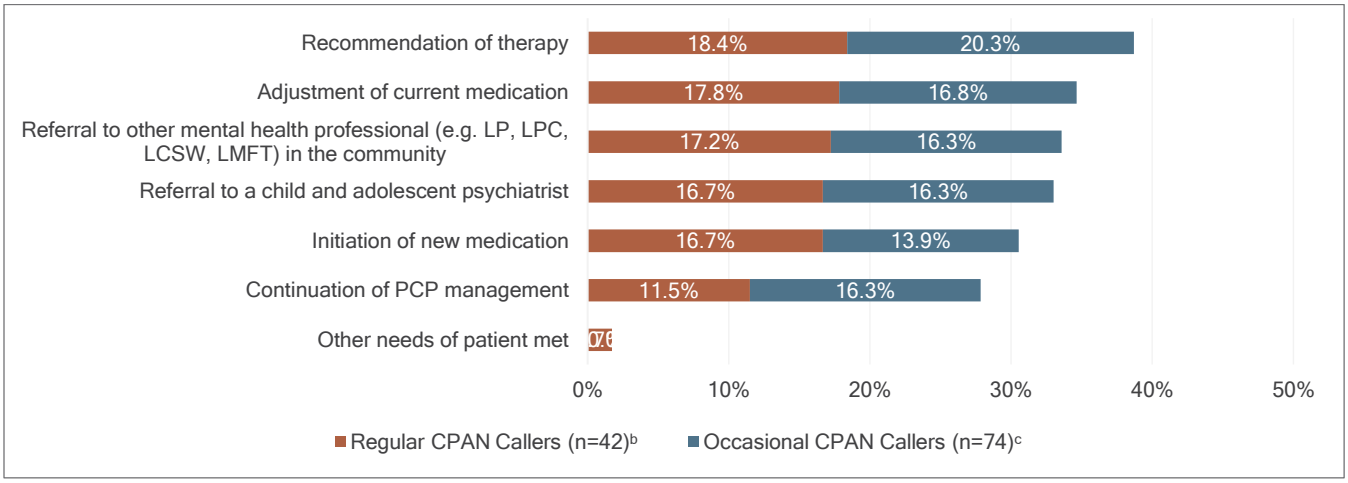
	Total Providers[a] (n=118) n (%)
Reason for First Call[b]	
Difficult case and needed psychiatric consult	90 (76.3%)
Needed to find referrals for patient	50 (42.4%)
Curious	4 (3.4%)
Other[c]	3 (2.5%)

(a) Data source: 2023 External Evaluation CPAN Survey. Includes individuals who reported calling CPAN in the past 12 months only. (b) Respondents can choose more than one option; therefore, results are not mutually exclusive. Reason(s) for first call to CPAN missing for 0 individuals. (c) Other reasons include: new to diagnosing and managing mental health concerns, to provide a useful list of resources and referral for parents and medication management help.

Outcomes of CPAN Calls

Figure 11 presents outcomes that occurred at least once as a result of a CPAN call (total and by CPAN use; i.e., providers who reported calling into CPAN regularly versus on occasion over the past 12 months). The most commonly reported outcome was for recommendation of therapy, followed by adjustment of current medication, referral to a mental health professional in the community (e.g., LP, LPC, LCSW, LMFT), and referral to a child and adolescent psychiatrist. Call outcomes did not vary by CPAN use.

Figure 11. Outcomes that Occurred at Least Once as a Result of a CPAN Call[a] (n=116)

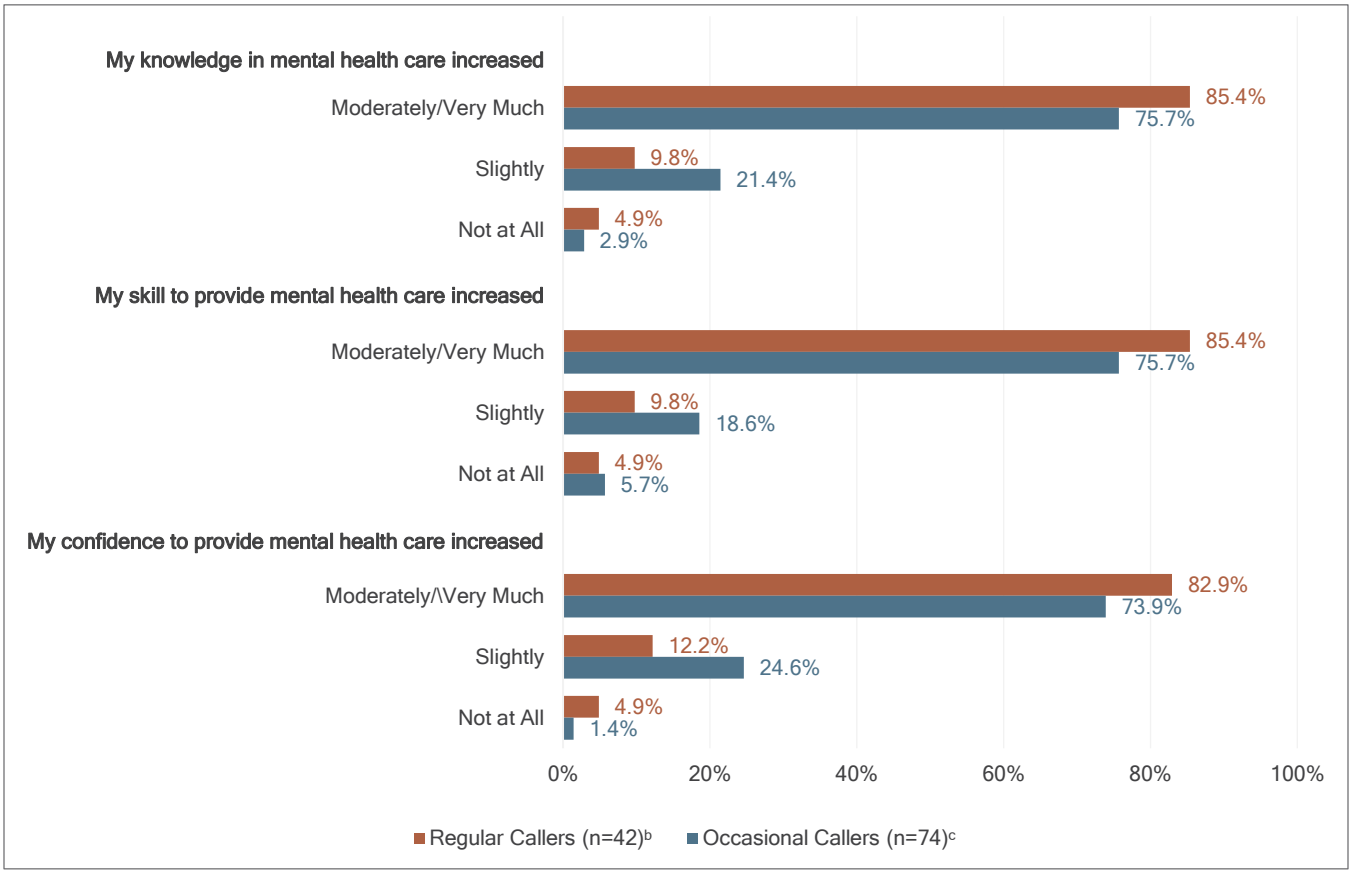


(a) Data source: 2023 External Evaluation CPAN Survey Includes individuals who reported calling into CPAN regularly or occasionally in the past 12 months. Respondents can choose more than one option; therefore, results are not mutually exclusive. (b) Includes individuals who reported calling CPAN regularly in the past 12 months only. (c) Includes individuals who reported calling CPAN occasionally in the past 12 months only.

Participants' Perceived Outcomes and Future Recommendations for CPAN

Provider respondents reported favorable perceived outcomes of CPAN. More than 70% of providers reported that their knowledge, skills, and confidence to provide mental health care increased moderately or very much due to CPAN (Figure 12). Regular CPAN callers were more likely to report higher knowledge, skills, and confidence than occasional callers.

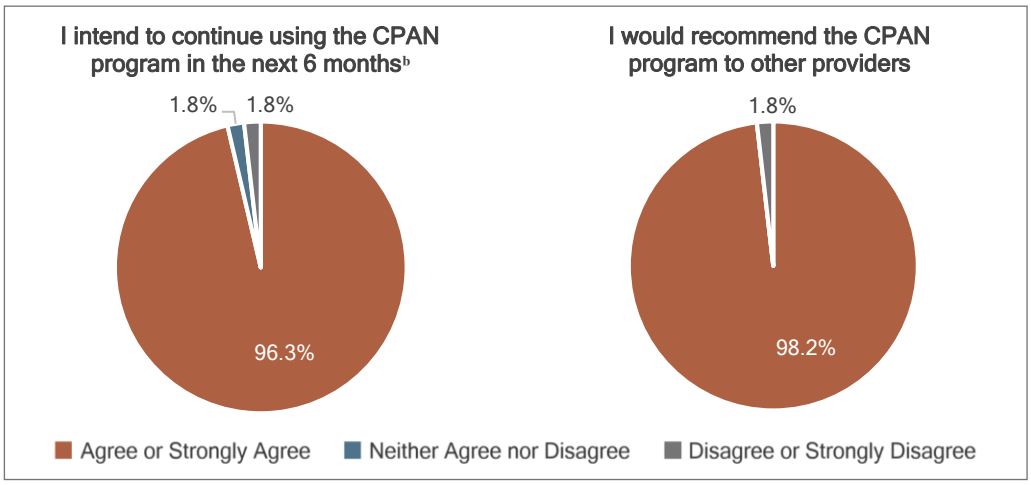
Figure 12. Survey Providers' Perceived Outcomes of CPAN[a] (n=116)



(a) Data source: 2023 External Evaluation CPAN Survey. (b) Includes individuals who reported calling CPAN regularly in the past 12 months only (n=42; however, sample sizes vary due to missing data). (b) Includes individuals who reported calling CPAN on occasion in the past 12 months only (n=74; however, sample sizes vary due to missing data).

Almost all providers reported that they will continue to use CPAN in the next 6 months and that they agree or strongly agree with recommending CPAN to other providers (Figure 13).

Figure 13. Survey Providers' Recommendations and Future Use of CPAN[a] (n=116)



(a) Data source: 2023 External Evaluation CPAN Survey. Includes individuals who reported calling CPAN regularly or on occasion in the past 12 months. (b) Response missing from 9 providers. (c) Response missing from 8 providers.

Qualitative Results: An Analysis of Open-ended Questions

The University of Texas Health Science Center at Houston (UTHealth Houston) External Evaluation team partnered with the Decision Information Resources, Inc (DIR) qualitative analysis team to conduct a content analysis of open-ended survey responses.

The open-ended survey questions included:

- Overall, what do you see as the biggest benefit of the CPAN program?
- How can the CPAN program be improved or what is the biggest barrier to using CPAN?
- What, if anything, surprised you about CPAN?

A content analysis was used to code and categorize open-ended stakeholder responses to each relevant survey question. Coding categories were derived directly from the response data. Open-ended responses were coded under more than one category when necessary. For example, when two or more benefits of a program were identified in the same response. Preliminary categories and subcategories were refined throughout the analysis, with final codes organized into a hierarchical structure separately by survey question.[3] A qualitative analysis of the coded and categorized content was conducted to highlight the experiences of stakeholders as it relates to implementation of the program.

The findings in this section discuss CPAN survey respondents' perceptions of the benefits of the program, barriers to utilization, surprises, and areas for improvement.

Benefits of the CPAN Program

Overall, 99 CPAN participants provided open-ended responses asking about the greatest benefits of the CPAN program. An important benefit-related theme that emerged was **accessibility** of the CPAN program. A small drop from last year's findings,[1] respondents specified that the accessibility of consultation services, information, and resources provided by the CPAN program helped them to better address the pediatric mental health needs of their patients. They reported that immediate access to mental health professionals, particularly psychiatrists, is beneficial to serving patients as wait times for direct mental health care services can be long and resources limited. It helps streamline care for patients. Providers appreciated quick consultations with psychiatrists to get the immediate needs of their patients met, especially in more extreme cases, whether it was advice on medication management or referrals to community resources. Further, the lists of community resources tailored by patient zip code were reported as helpful and reduced burden on physicians.

"It is the greatest resource for mental health information. I love to call and get resources for my patients who are in need of therapy or medication." –Nurse Practitioner

"When kids need mental health care, it shouldn't wait. CPAN allows me to take next steps without having to wait for them to get in to see another provider." –Internal Medicine and Pediatrics Physician

[3]Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res. 2005 Nov;15(9):1277-88. doi: 10.1177/1049732305276687. PMID: 16204405.

"It directly connects primary care providers with psychiatric specialists while simultaneously removing the guess work of coverage for patients. This results in a cost efficient, stream-lined process for our patients." –Registered Nurse

"It is an amazing resource. It is very beneficial to run cases by a psychiatrist. The referrals are great because they take patient insurance and location into consideration. They are non-judgmental, very helpful, and their advice and support make a huge positive impact on patient care." –Pediatrician

Similar to the quantitative results described earlier, another benefit-related theme emerged related to participants' perceptions that CPAN **increased their confidence in treating patients with mental health needs**. The program allowed physicians to care for patients without the need for a referral, or to bridge their care until a psychiatrist could be seen. Specifically, providers indicated that they felt more comfortable prescribing and managing the medication needs of patients with psychiatric conditions through consultations with CPAN psychiatrists. Several mentioned that not only had their confidence increased, but also their knowledge about caring for patients with mental health needs. This is also aligned with the quantitative results described earlier.

"Using CPAN allows me to take better care of my patients with mental health problems and allows me to bridge care until they are able to get into specialists." –Pediatrician/Medical Director

"I have more referral resources for families and with each case I manage with CPAN, my knowledge and confidence increases." –Pediatrician

"I feel more confident treating my patient's because I know that CPAN providers are available whenever I need them." –Nurse Practitioner

Finally, one other theme that emerged was the perception that the **education and training** provided by CPAN was beneficial. Specifically, several participants mentioned that the opportunity to earn Continuing Medical Education (CME) credits through CPAN's presentations and training opportunities was valuable. This is a new finding in Year 3 of the evaluation.

Overall, most respondents agreed that quick and direct access to consultation services with psychiatrists to obtain information and resources to support patient needs was the biggest benefit to enrolling in and using CPAN services. Additionally, CPAN continues to increase primary care providers' confidence in treating patients with mental health needs more efficiently and effectively. This is especially important given the long wait times for patients to be seen by psychiatrists for their mental health needs. Finally, CPAN offers educational opportunities that allow for CME credit, which some respondents found to be beneficial. Only one respondent indicated that they had not seen a benefit of the program so far.[4]

Barriers and Improvements to the CPAN Program

Overall, 93 CPAN providers provided open-ended responses asking about barriers and improvements to the CPAN program. Like last year, the most prominent barrier to utilizing CPAN services that emerged was **time constraints**. As busy care providers, making calls to CPAN can disrupt workflow and requires

[4] The respondent indicated that the referral lists provided for patients were mostly for self-pay or private insurance, not patients on Medicaid.

additional time built into schedules to allow for consultations despite the benefits of the program. They do not always have time to wait for a call back from CPAN about a particular patient, as they have others waiting.

> *"I am ok with it the way it is set up right now. I think for me and my colleagues, the biggest barrier would be time constraints- as in if the clinic is very busy, CPAN consultations will not be a priority even if there may be a patient need for it at the time." –Pediatrician*

> *"Barrier: finding the time to call and wait for a return call." –Nurse Practitioner*

> *"Consults can be helpful but are harder to fit into clinic flow. (can't wait for call back if I am seeing patients)." –Pediatrician*

Other barriers identified most often were the **program not fully meeting their needs** and **lack of awareness and buy-in from colleagues at their clinics**. They shared how the recommendations and referrals provided by CPAN do not always meet their needs, or those of their patients. For example, referral lists do not always cater to uninsured or underinsured patients, have clinics with long wait times, and tend to lack telehealth options for underserved patients that cannot travel far during work hours. Further, other providers at their clinics are unaware of CPAN or do not see the benefit when it is recommended. They suggest that more outreach and education by CPAN staff could be beneficial.

> *"I think it is a fabulous program but cannot always convince my colleagues that it would be worth their time, which is such a meager resource for PCPs." –Nurse Practitioner*

> *"Several times the referrals were not actually covered under the patients' insurance plan." –Family Physician/Medical Director*

> *The most difficult thing is looking for counseling, as many are out of town. If there were more telehealth options to offer patients for counseling or psychiatry, that would be good. Also, I would like more recommendations than sending the patient to the hospital, if possible." –Resident*

CPAN users varied in their responses to areas for program improvement. Common themes that emerged included:

- **improved connections to community resources and referrals**
- **improved outreach and awareness**

To address identified barriers, respondents shared ways CPAN could improve their program. First, they suggest improving processes for putting together referral lists. Ensuring that community resources take uninsured and underinsured patients, are accessible, and relevant to patients' needs would be helpful. If possible, some indicated that it would be helpful for CPAN to make direct referrals for patients (e.g., assist in making their first psychiatry appointment). Having access to more reliable, up-to-date resources could help respondents keep their patients out of the hospital.

"Help make more resources available in our communities, especially for disadvantaged/ Medicaid populations." – Pediatrician

"We have a high uninsured patient base. If there could be more resources for the uninsured, it would be helpful." – Family Physician/Medical Director

Respondents also expressed a need for improved outreach and general awareness of the program. This would help remedy the barrier of buy-in and support at clinics, as well as increase the utilization of CPAN. Outreach and awareness were discussed both in terms of primary care providers' own clinics and community institutions at large. They indicated that providers within their own clinics were not always aware of CPAN services and having more of a presence in clinics could be beneficial to enrollment in the program. It would also help enrolled providers understand the resources available to them better. Similarly, the program could benefit from increasing outreach and awareness in the larger community to enroll more providers and inform other institutions about the role CPAN is playing in mental health care. This latter part is particularly useful when making community referrals.

"Blast the departments and let the CMAs, LVNs know that it is a referral source, and put it as a referral option in the EMR please." –Family Physician

"I think a lot of community providers do not know about CPAN. I learned about it through a coworker. I believe greater community outreach to pediatrician offices in the community would ensure more people know about this program." –Physician Assistant

Other suggestions for improvement were identified by respondents but were less widespread. They include things like offering **alternative ways to consult** with CPAN providers (e.g., videoconferencing), **extending hours** to avoid overlap with busy clinic hours (e.g., after 5 pm), **improving communication about trainings** (e.g., CME), **improving accessibility to trainings** (e.g., video recording for later viewing), and **providing documentation** of calls and follow-up.

In summary, the most common barriers to utilizing CPAN services that emerged included:

- time constraints
- program not always meeting the needs of physicians and patients
- lack of awareness and buy-in among others

The most identified areas of improvement included:

- connections to resources and referrals in the community
- conducting outreach to improve awareness among clinics and providers

In Year 2 interviews, implementation support was an area identified as needing improvement, though it did not come up as often in Year 3. While a few respondents indicated that additional training or consultation to increase understanding regarding how to fully utilize what CPAN has to offer would be helpful, it was not prominently discussed. Respondents last year shared a desire for more communication options such as texting or videoconferencing. Comments in the survey suggest that texting had been added as an option this year, which yielded favorable responses.

Surprises about the CPAN Program

Overall, 78 respondents provided open-ended responses asking whether anything surprised them about the CPAN program. Overwhelmingly, respondents indicated that they were most surprised by how **easy and efficient** it was to use CPAN. While time constraints were identified as a barrier, most respondents indicated that they were pleasantly surprised by response time and how easy it was to receive professional consultation from a psychiatrist when needed.

> *"They were so easy to get in touch with and so nice! I guess I thought since psychiatrists are stretched so thin it would be harder to communicate with the program, but it was so simple." –Internal Medicine & Pediatrics Physician*

> *"I was pleasantly surprised at how easy it was to find such great mental health resources that could actually be used for our patients. No more jumping through hoops or guessing if the providers take the patient's insurance." –Registered Nurse*

> *"Very quick response both by phone and then with resource lists; nothing else related to consultation support happens this quickly and efficiently!" –Pediatrician*

A few other surprises were mentioned to a lesser extent. Respondents indicated that the **CPAN providers were professional** and gave sound advice and that **the resource and referral lists received were tailored** to their patients. Only one respondent provided a negative response, indicating that after calling CPAN several times for consultation, no one got back to them.

TCHATT SCHOOL STAFF SURVEY

Introduction

The UTHealth Houston External Evaluation team distributed and analyzed the TCHATT school staff survey as part of the Year 3 external evaluation of TCMHCC. Understanding school staff perceptions of the TCHATT program and factors that influence their engagement with the program can help guide quality improvement and decision making for future program planning and implementation. **The survey purpose was to assess: (1) factors influencing school staff participation in TCHATT, (2) campus-level factors and processes affecting program adoption and implementation, and (3) perceived outcomes of the program from school stakeholders.** The survey included closed-ended and open-ended questions. The survey included closed-ended and open-ended questions.

This report augments the learnings from the Year 1 and Year 2 evaluation reports.[2,1] In the sections that follow, we discuss the methods used, highlight key findings, and offer recommendations as they pertain to program implementation and the evaluation.

Methods

Sample

The Year 3 survey sampling was split between two stages: first, re-sampling campus respondents who completed the Year 1 and Year 2 survey and were still active; second, selecting a new sample of campuses (i.e., schools) enrolled in TCHATT. Overall, our goal was to survey TCHATT program implementers from 200 campuses. We identified a diverse sample of campuses covered by an MOU across all 12 HRIs based on the following factors: (1) rural/urban/charter classification, (2) economic disadvantage (i.e., percent of students eligible for free or reduced-price meals or other public assistance) and (3) district size. The sample represented 157 campuses that completed the Year 1 survey, 161 campuses that completed the Year 2 survey, and 165 new campuses for a total of 483 campuses represented in the survey results. To identify survey respondents, we reached out to districts to compile a distribution list of TCHATT program implementers at sampled campuses. One main TCHATT program implementer (i.e., the person identified by either the HRI or district as the main TCHATT contact) was identified at 461 of the sampled campuses.

In May 2023, we invited the 461 school staff to complete the *Year 3 TCHATT School Staff Survey*. We continued data collection through mid-June 2023. After multiple outreach attempts, 226 school staff completed the survey (49.0% response rate). School staff who reported that their campus was not currently implementing TCHATT (n=2) were excluded from analyses and will be the focus of the Year 4 TCHATT Survey. Therefore, the final sample size for the results presented below was 224 (Figure 16).

Figure 14. TCHATT School Campus Survey Completion

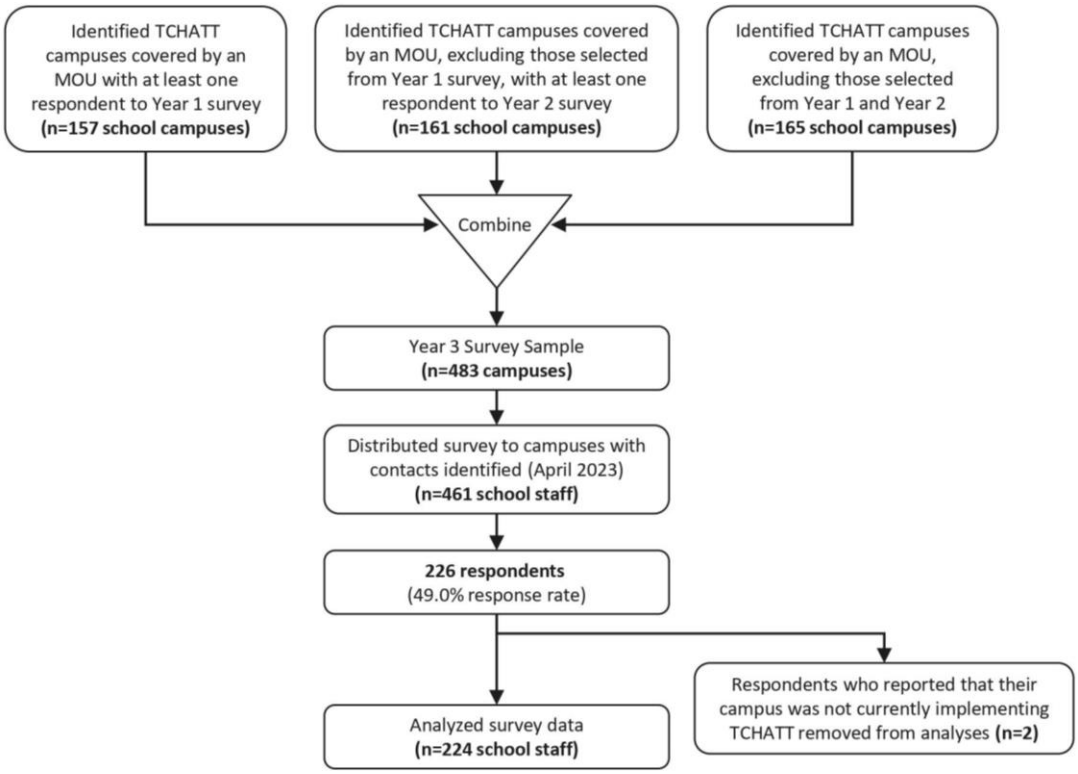
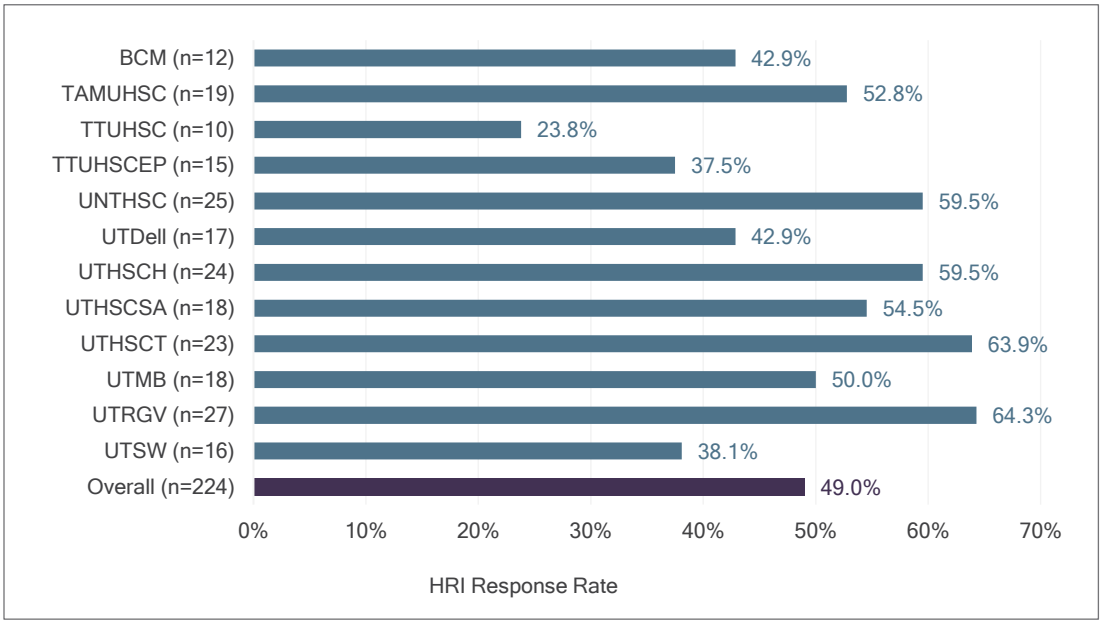


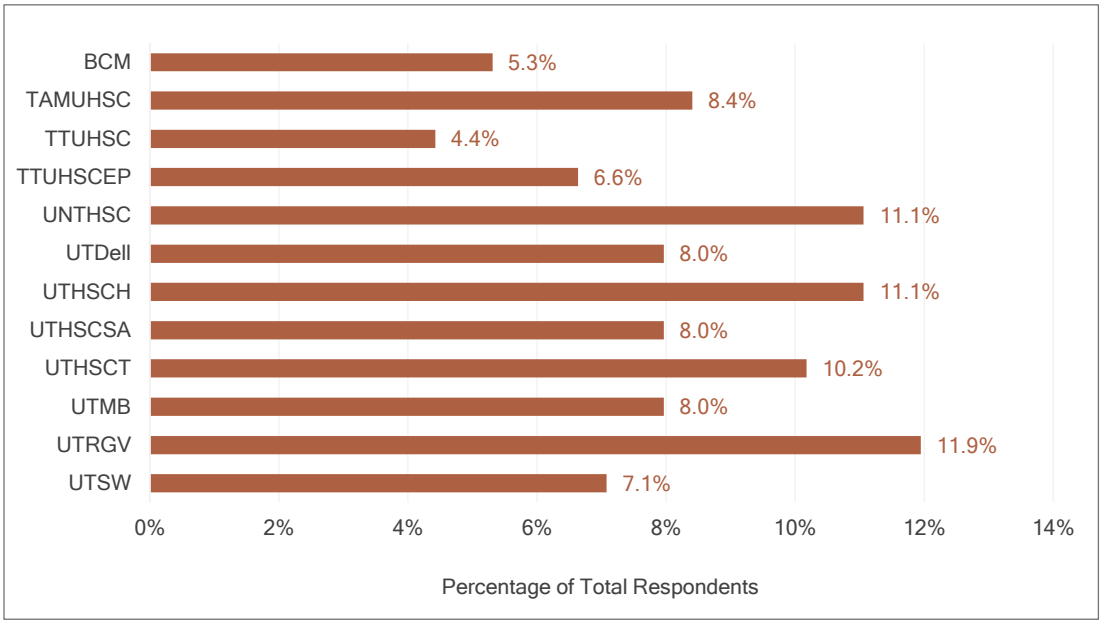
Figure 15 presents the participant survey response rates for individual HRIs. For example, 42.9% of individuals sampled at BCM campuses participated in the survey. Survey response rates varied by HRI, ranging from 23.8% (among sampled TTUHSC campuses) to 64.3% (among sampled UTRGV campuses) (Figure 15). Figure 16 presents the percent of participants from each HRI that comprised the total survey respondents. For example, 5.3% of all survey respondents were from BCM campuses.

Figure 15. Participant Survey Response Rate Within HRIs[a]



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know.

Figure 16. Percent of Participants from each HRI among Total Survey Respondents[a] (n=224)



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know.

Survey & Data Collection

Development of the TCHATT school staff survey was guided by the external evaluation logic models (updated at the beginning of Year 2), measures table, and Year 1 process mapping findings. In Year 3, we adapted the survey based on an internal review as well as feedback from UT System leadership and COSH.

Quantitative Results

Descriptive Characteristics of Surveyed School Staff

Table 6 presents the descriptive characteristics of TCHATT survey respondents. Slightly more than 90% of respondents were female. Sixty percent of respondents were non-Hispanic White, 9% were Black, and almost 30% were Hispanic (data not shown). The majority were counselors (84%) and reported having a master's degree or higher (94%). Eighty-three percent of survey respondents reported that they were the person who coordinates TCHATT at their school.

Table 6. Characteristics of Survey Participants

	Total School Staff[a] n=224 n (%)
Primary Role[d]	
Principal/Assistant Principal/School Administrator	9 (5.3%)
Counselor	144 (84.2%)
Social worker	6 (3.5%)
Other	12 (7.0%)
Highest Education[e]	
Associate's degree	1 (0.6%)
Bachelor of Arts/Bachelor of Science	9 (5.3%)
Master of Arts/Master of Science/other professional degree	93 (55.0%)
Master's degree plus 15 or more additional course hours	60 (35.5%)
EdD/PhD	6 (3.6%)
Are you the person who coordinates TCHATT at your school?[f]	
Yes	181 (83.4%)
No	29 (13.4%)
Don't know	7 (3.2%)

(a) Data source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know. (b) Gender missing for 50 respondents. (c) Race/ethnicity missing for 55 respondents. (d) Role missing for 53 respondents. "Other" includes: CIS Site Coordinator, Case Worker, Coordinator, Crisis and Counseling Services Coordinator, FRC Coordinator, Psychologist, LSSP, Social Emotional Behavior Specialist, Student Family Advocate, and Youth Service Specialist. (e) Highest education missing for 51 respondents. (f) Involvement in the coordination of TCHATT missing for 7 respondents.

TCHATT Implementation among Surveyed School Staff

In response to the survey question asking participants if their school implemented TCHATT during the past 12 months, almost all surveyed school staff (97%) reported that their school implemented TCHATT at some level (early stage, inconsistent implementation, or full and systematic implementation)[5] (data not shown). Among respondents who reported TCHATT implementation at their school, two-thirds reported being very involved in the implementation, and 32% reported being somewhat involved in the implementation of TCHATT (Table 7). Most survey respondents (83%) reported implementing TCHATT for at least 6 months. **Over 75% reported that they or other school personnel attended at least one TCHATT training.**

Table 7. Survey Participant Involvement in TCHATT and TCHATT Trainings

	School Staff[a] n=224[b] n (%)
Involvement with the implementation of TCHATT at school[b]	
Not at all involved	3 (1.3%)
Somewhat involved	71 (31.8%)
Very involved	149 (66.8%)
Months implemented TCHATT[c]	
Less than 6 months	32 (15.2%)
6 - 12 months	114 (54.0%)
More than 12 months	65 (30.8%)
Respondent or other school personnel attended TCHATT training(s)[d]	
Yes	165 (77.5%)
No	25 (11.7%)
Don't know	23 (10.8%)

(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know. (b) 224 school staff completed the survey; however, sample sizes vary due to missing data.

[5] Walker TJ, Risendal B, Kegler MC, et al. Assessing levels and correlates of implementation of evidence-based approaches for colorectal cancer screening: a cross-sectional study with federally qualified health centers. *Health Educ Behav*. 2018;45(6):1008–1015.

Descriptive Characteristics of School Campuses

Table 8 presents a comparison of three groups: all Texas campuses per the Texas Education Agency (TEA), all Texas campuses enrolled in TCHATT as of 8/31/23 per Trayt, and all Year 3 surveyed campuses. The table provides a description of school characteristics across the three groups in regards to indicators of vulnerability, including TEA campus type, National School Lunch Program eligibility (a measure of economic disadvantage), and campus size. Overall, surveyed campuses are comparable to Texas campuses and campuses enrolled in TCHATT with respect to the percentage of students considered economically disadvantaged and campus size. However, urban campuses with the NCES classification of "city" and "suburban" are slightly under-represented among surveyed campuses compared to Texas campuses and campuses enrolled in TCHATT. This discrepancy is likely due to our oversampling of rural campuses to ensure representativeness of this population.

Table 8. Comparison of Texas Campuses, Enrolled TCHATT Campuses, and Surveyed Campuses by Geographic and Population-level Indicators

	Texas Campuses[a] n=9,312 n (Column %)	Enrolled TCHATT Campuses[b] n=4,493 n (Column %)	Year 3 Surveyed Campuses[c] n=224 n (Column %)
Campus Type[d]			
City	3412 (38.2%)	1548 (35.7%)	55 (24.9%)
Suburb	2200 (24.6%)	1160 (26.8%)	51 (23.1%)
Town	1053 (11.8%)	527 (12.2%)	45 (20.4%)
Rural	2262 (25.3%)	1101 (25.4%)	70 (31.7%)
% Students Economically Disadvantaged[a]			
< 70%	4110 (49.1%)	2039 (50.2%)	113 (50.4%)
≥ 70%	4261 (50.9%)	2024 (49.8%)	111 (49.6%)
Campus Census[a]			
<500	4437 (50.0%)	1935 (44.9%)	106 (47.3%)
500-999	3427 (38.6%)	1747 (40.5%)	88 (39.3%)
1000-1499	523 (5.9%)	323 (7.5%)	22 (9.8%)
≥1500	491 (5.5%)	304 (7.1%)	8 (3.6%)

(a) Data Source: Texas Education Agency PEIMS Data 2021-2022. There are 9,312 Texas school campuses, but sample sizes vary due to missing data. (b) Data Source: TCHATT Campus List (through August 31, 2023). There are 4,493 Texas school campuses enrolled in TCHATT, but sample sizes vary due to missing data. (c) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know. (d) Data Source: TEA 2020-2021 Campus Type Data. NCES locale definitions: "City" = Territory inside an urbanized area and inside a principal city; "Suburb" = Territory inside an urbanized area and outside a principal city; "Town" = Territory inside an urban cluster; "Rural" = Census-defined rural territory.

Characteristics of Implementing TCHATT Campuses Surveyed

Table 9 presents characteristics of campuses who reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who reported not knowing if their campus was implementing TCHATT. Characteristics reported by school staff include perceived need for and awareness of campus mental health services (besides TCHATT) and perceived parent/guardian consent for TCHATT services (Table 9). Overall, awareness of school mental health services was low, with almost 40% of respondents reporting that they did not know whether or not there was a school/district MOU for providing mental health services (besides TCHATT). The most commonly reported mental health services available to students (other than TCHATT) included another mental health provider (21%), a local mental health center (19%), and Communities in Schools (17%) (data not shown). At least half of respondents reported that more than 1 in 4 students in their campus population had a need for non-educational support (e.g., meals, clothing) and needs related to counseling or behavioral therapy. Twelve percent of respondents reported that school staff spend more than 30 hours per week addressing non-educational student needs, and nearly 40% of respondents reported that school staff spend more than

30 hours per week addressing counseling or behavioral problems. Finally, over 75% of respondents reported that at least half of parents/guardians had consented to obtain TCHATT services for their child (if the child was referred to TCHATT).

Table 9. Characteristics of School Campuses Implementing TCHATT (as Reported by School Staff): Other Mental Health Services, Perceived Student Needs, and Perceived Parental Consent for TCHATT Services

	School Staff[a] n=224[b] n (%)
Presence of School/District MOU to Provide Mental Health Services to Students (Besides TCHATT)	
Yes	52 (29.4%)
No	56 (31.6%)
Don't know	69 (39.0%)
% student population has need of non-educational supports (e.g., meals, clothing)	
25% or less	78 (47.3%)
Greater than 25%	87 (52.7%)
% student population has need for counseling or behavioral therapy	
25% or less	72 (41.4%)
Greater than 25%	102 (58.6%)
Time school staff spends addressing non-educational needs (e.g., meals, clothing)	
30 hrs/wk or less	145 (87.9%)
More than 30 hrs/wk	20 (12.1%)
Time school staff spends addressing counseling or behavioral problems	
30 hrs/wk or less	107 (60.8%)
More than 30 hrs/wk	69 (39.2%)
% parents/guardians who have consented to obtain TCHATT services for their child (if child was referred to TCHATT)	
50% or less	39 (22.5%)
More than 50%	134 (77.5%)

(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know. (b) 224 school staff completed the survey; however, sample sizes vary due to missing data.

The next set figures present the characteristics of campuses that implemented TCHATT either inconsistently or fully and systematically. School staff who reported that they were at an early stage of implementing TCHATT (n=27) or that they didn't know if their campus was implementing TCHATT (n=4) were not included in the following analyses. Thus, the total sample size for these analyses is **193**.

We examined campus characteristics by level of TCHATT implementation (inconsistent vs. full and systematic implementation) to identify trends in the data, including potential barriers and facilitators to TCHATT implementation.

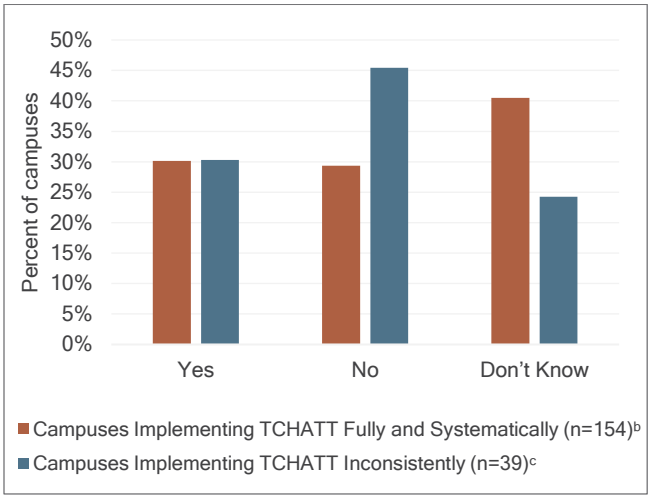
The following figures present exploratory trends when we examined campuses characteristics by level of TCHATT implementation (inconsistent vs. full and systematic implementation):

Presence of School/District MOU to Provide Mental Health Services besides TCHATT. A similar proportion of campuses who implemented TCHATT fully and systematically and campuses who implemented TCHATT inconsistently reported having another school/district MOU (besides TCHATT) to provide mental health services to students (Figure 17). This suggests that having another MOU to provide mental health services to students is not serving as a barrier to full and systematic TCHATT implementation. However, campuses implementing TCHATT inconsistently were more likely to report not having another school/district MOU compared to campuses implementing TCHATT fully and systematically (45% vs. 29%, respectively); while campuses implementing TCHATT fully and systematically were more likely to report not knowing if they have another school/district MOU compared

to campuses implementing TCHATT inconsistently (40% vs. 24%, respectively). Since campuses that lack other mental health services for students may have a greater need for TCHATT, these campuses may benefit from additional supports to enable more systematic TCHATT implementation.

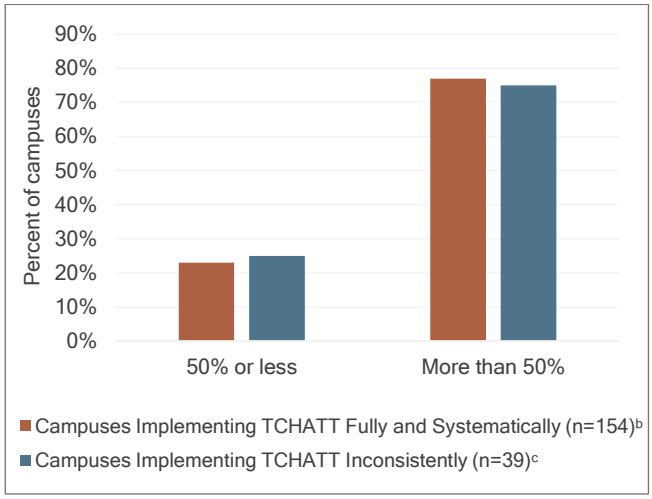
Perceived Parent/Guardian Consent for TCHATT Services. Overall, the perceived percentage of parents/guardians who consented to obtain TCHATT services for their child did not differ between campuses implementing TCHATT fully and systematically and campuses implementing TCHATT inconsistently (Figure 18). This suggests that low parental consent is not a barrier to full and systematic TCHATT implementation.

Figure 17. Presence of School/District MOU to Provide Mental Health Services to Students (Besides TCHATT)[a]



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. (b) Includes individuals who reported implementing TCHATT fully and systematically (n=154; however, response missing for 28 participants). (c) Includes individuals who reported implementing TCHATT inconsistently (n=39; however, response missing for 6 participants).

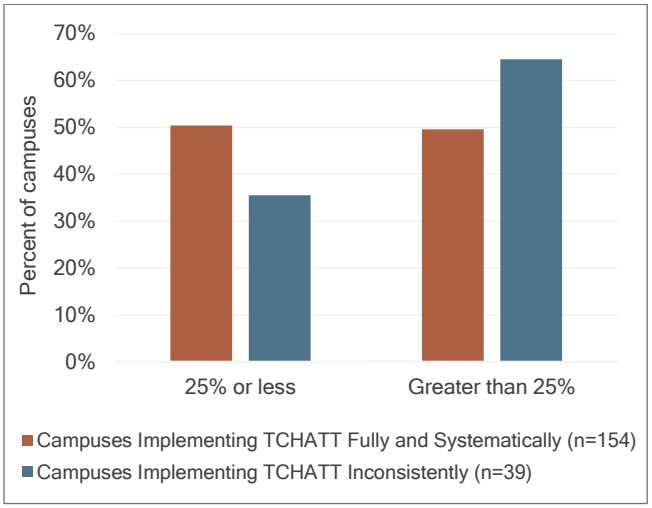
Figure 18. Perceived Percentage of Parents/Guardians Who Consented to Obtain TCHATT Services for their Child[a]



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. (b) Includes individuals who reported implementing TCHATT fully and systematically (n=154; however, response missing for 24 participants). (c) Includes individuals who reported implementing TCHATT inconsistently (n=39; however, response missing for 3 participants).

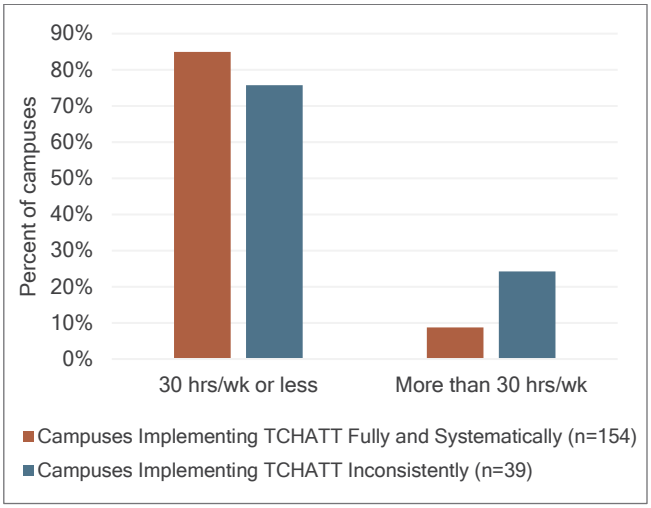
Perceived Student Needs. Overall, campuses implementing TCHATT inconsistently were more likely to report a higher level of student needs for non-educational supports compared to campuses implementing TCHATT fully and systematically (65% vs. 50%, respectively) (Figure 19). Campuses who implemented TCHATT inconsistently were also more likely to report spending over 30 hours per week addressing non-educational needs compared to campuses who implemented TCHATT fully and systematically (24% vs. 9%, respectively) (Figure 20).

Figure 19. Student Population Need of Non-Educational Supports by Level of Implementation[a]



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who reported implementing TCHATT fully and systematically (n=154) or inconsistently (n=39).

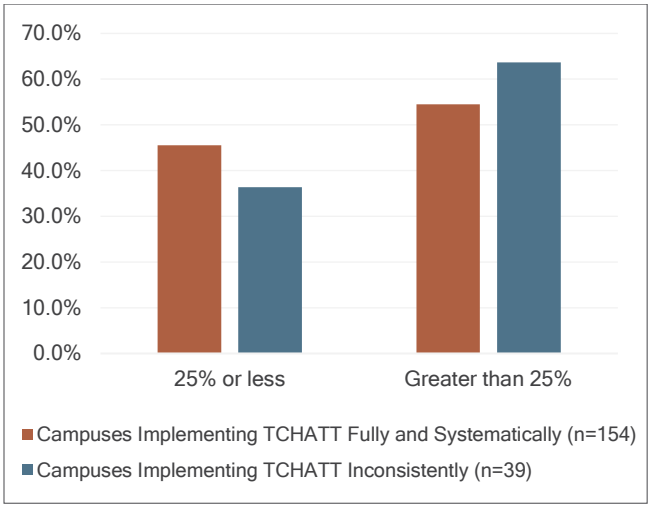
Figure 20. Time School Staff Spends Addressing Non-Educational Needs by Level of Implementation[a]



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who reported implementing TCHATT fully and systematically (n=154) or inconsistently (n=39).

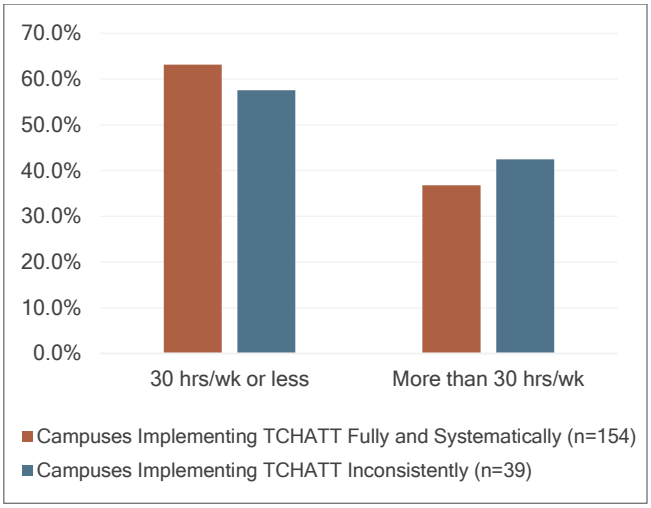
Similarly, campuses implementing TCHATT inconsistently were more likely to report a higher level of student needs for counseling or behavioral therapy compared to campuses implementing TCHATT fully and systematically (64% vs. 55%, respectively) (Figure 21). Campuses implementing TCHATT inconsistently were also more likely to report spending over 30 hours per week addressing behavioral problems compared to campuses implementing TCHATT fully and systematically (42% vs. 37%, respectively) (Figure 22). Once again, this suggests that campuses with a greater need for TCHATT may benefit from additional supports to enable more consistent TCHATT implementation.

Figure 21. Student Population Need for Counseling or Behavioral Therapy by Level of Implementation[a]



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who reported implementing TCHATT fully and systematically (n=154) or inconsistently (n=39).

Figure 22. Time School Staff Spends Addressing Behavioral Problems by Level of Implementation[a]

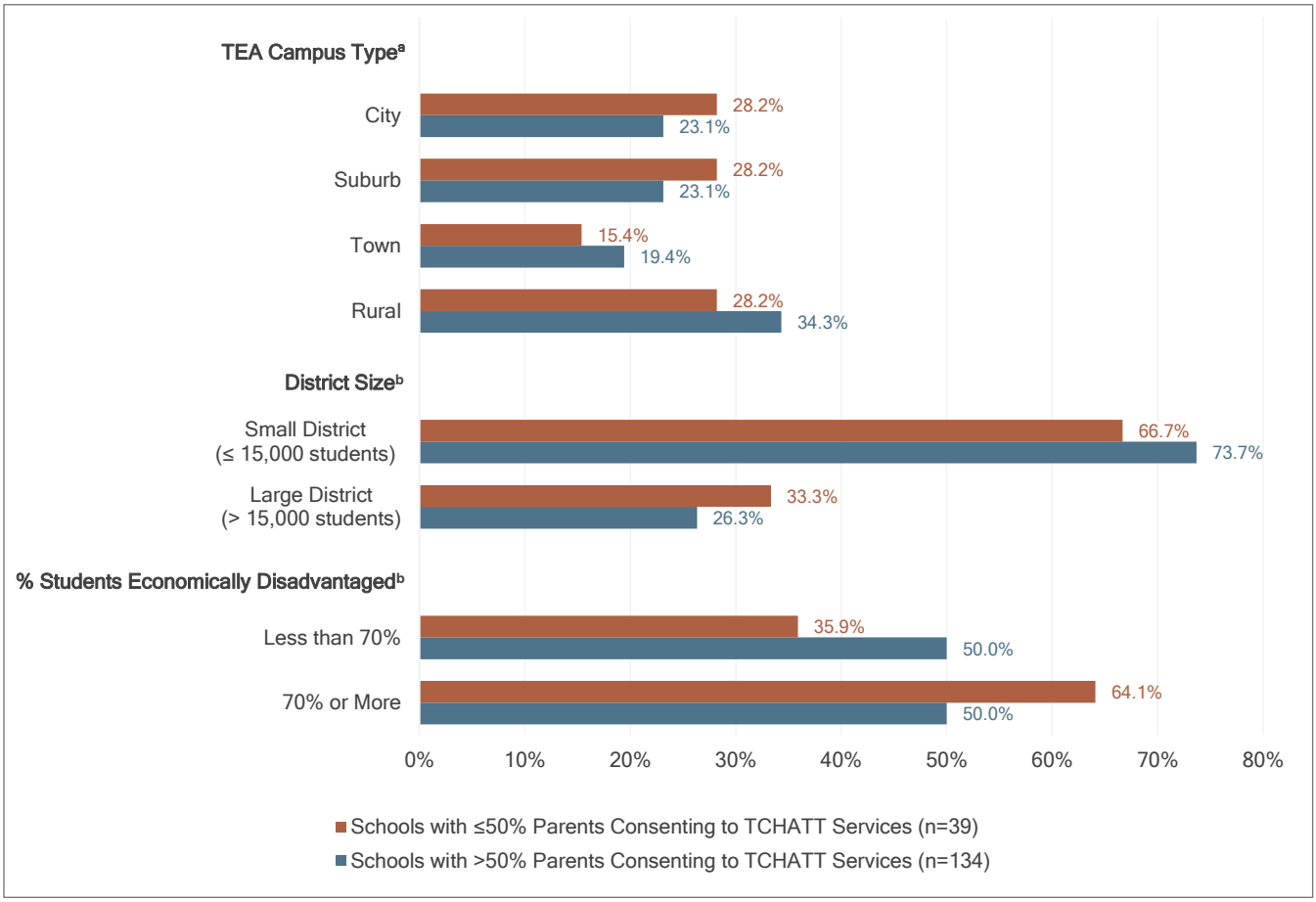


(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who reported implementing TCHATT fully and systematically (n=154) or inconsistently (n=39).

Because parental consent to TCHATT services is an important pre-requisite for TCHATT implementation, we also examined characteristics of campuses by perceived parental consent to TCHATT services (≤50% vs. >50% of parents/guardians consenting to TCHATT services):

District/Campuses Characteristics and Parental Consent. Respondents from larger districts, urban and suburban campuses, and those with a higher percentage of economically disadvantaged students reported lower parental consent to TCHATT services compared to smaller districts, rural campuses, and campuses with fewer economically disadvantaged students (Figure 23).

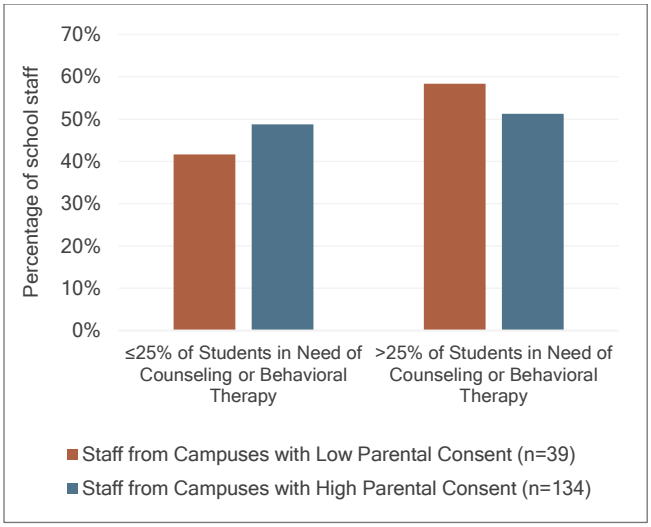
Figure 23. District and Campus Characteristics and Percentage of Parents Consenting to TCHATT Services



(a) Data Source: TEA 2020-2021 Campus Type Data. NCES locale definitions: "City" = Territory inside an urbanized area and inside a principal city; "Suburb" = Territory inside an urbanized area and outside a principal city; "Town" = Territory inside an urban cluster; "Rural" = Census-defined rural territory. (b) Texas Education Agency 2019-2020 District Snapshot. (c) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported that their school was implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or that they didn't know. School staff were asked to provide their best estimate of the proportion of parents/guardians who consent to TCHATT services for their child.

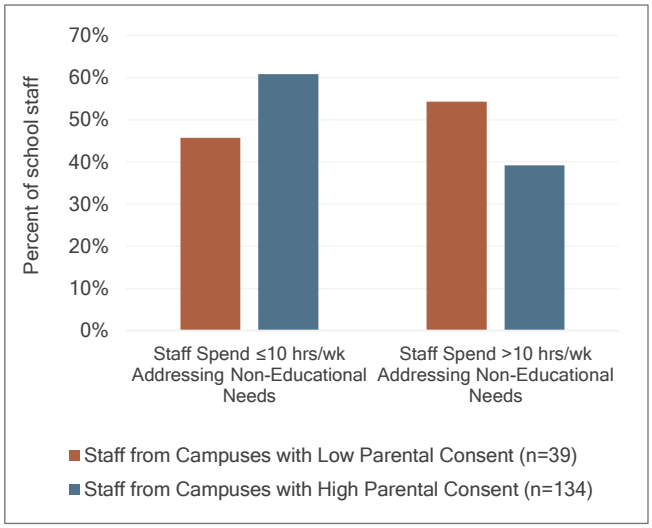
Perceived Student Needs and Parental Consent. School staff from campuses with low parental consent (≤50% of parents/ guardians consenting to TCHATT services) were more likely to report a higher level of student need for non-educational supports (Figure 24) and more school staff time spent addressing non-educational needs compared to school staff from campuses with high parental consent to TCHATT services (>50% of parents/ guardians consenting to TCHATT services) (Figure 25).

Figure 24. Student Population Need of Non-Educational Supports by Parental Consent to TCHATT Services[a]



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or who didn't know. Staff reported their perceived student population with need of non-educational supports (e.g., meals, clothing).

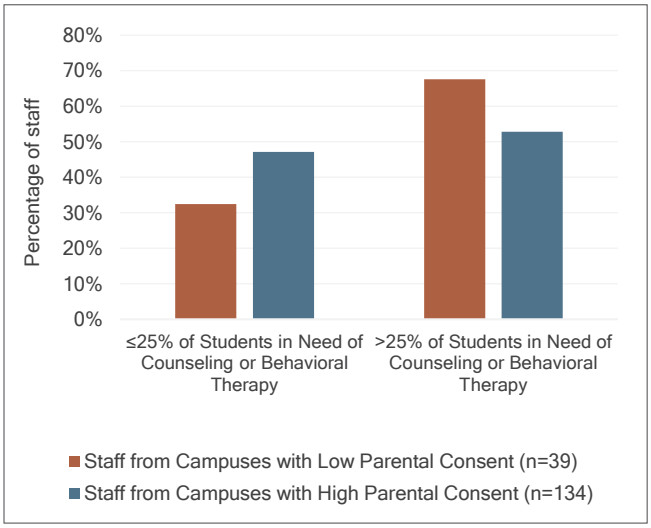
Figure 25. Time School Staff Spends Addressing Non-Educational Needs by Parental Consent to TCHATT Services[a]



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or that they didn't know. Staff reported their perceived time school staff spends addressing non-educational needs (e.g., meals, clothing).

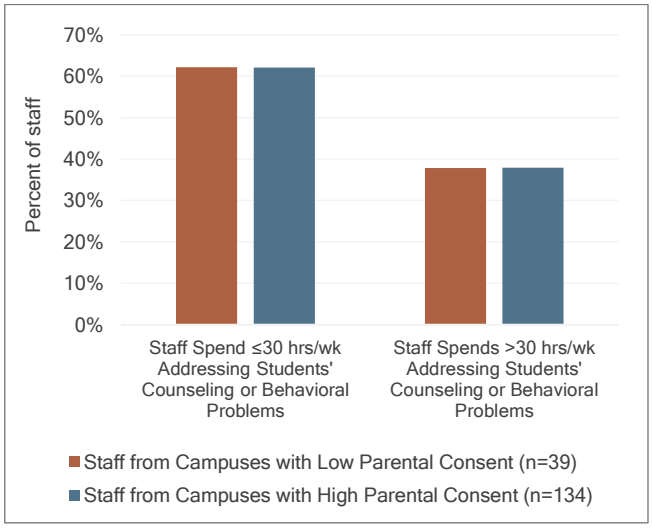
Similarly, among school staff from campuses with low parental consent versus high parent consent (≤50% of parents/ guardians consenting vs. >50% of parents/ guardians consenting to TCHATT services), staff from low consenting school campuses reported a higher level of student need for counseling or behavioral therapy compared to school staff from campuses with high parental consent, (68% vs. 53% respectively) (Figure 26). However, time school staff spends addressing counseling or behavioral problems did not differ between campuses with high vs. low parental consent to TCHATT services (Figure 27).

Figure 26. Student Need for Counseling or Behavioral Therapy by Parental Consent to TCHATT Services[a]



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported that their school was implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or that they didn't know. Staff reported their perceived student population with need for counseling or behavioral therapy.

Figure 27. Time School Staff Spends Addressing Counseling or Behavioral Problems by Parental Consent to TCHATT[a]



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who either reported that their school was implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or that they didn't know. Staff reported their perceived time school staff spends addressing counseling or behavioral problems.

Implementation Evaluation

Among the 224 school staff who reported that their school was either implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or that they didn't know whether their school implemented TCHATT, we queried respondents' participation in various activities that comprise the TCHATT program in schools. These questions were designed to assess implementation fidelity based on the TCHATT process maps developed with TCHATT stakeholders in Year 1 of the external evaluation. Activities were divided into the following categories: Awareness, Training, Implementation Support, Referrals, Service Delivery, and Ongoing Care (Figure 28).

Implementation Fidelity

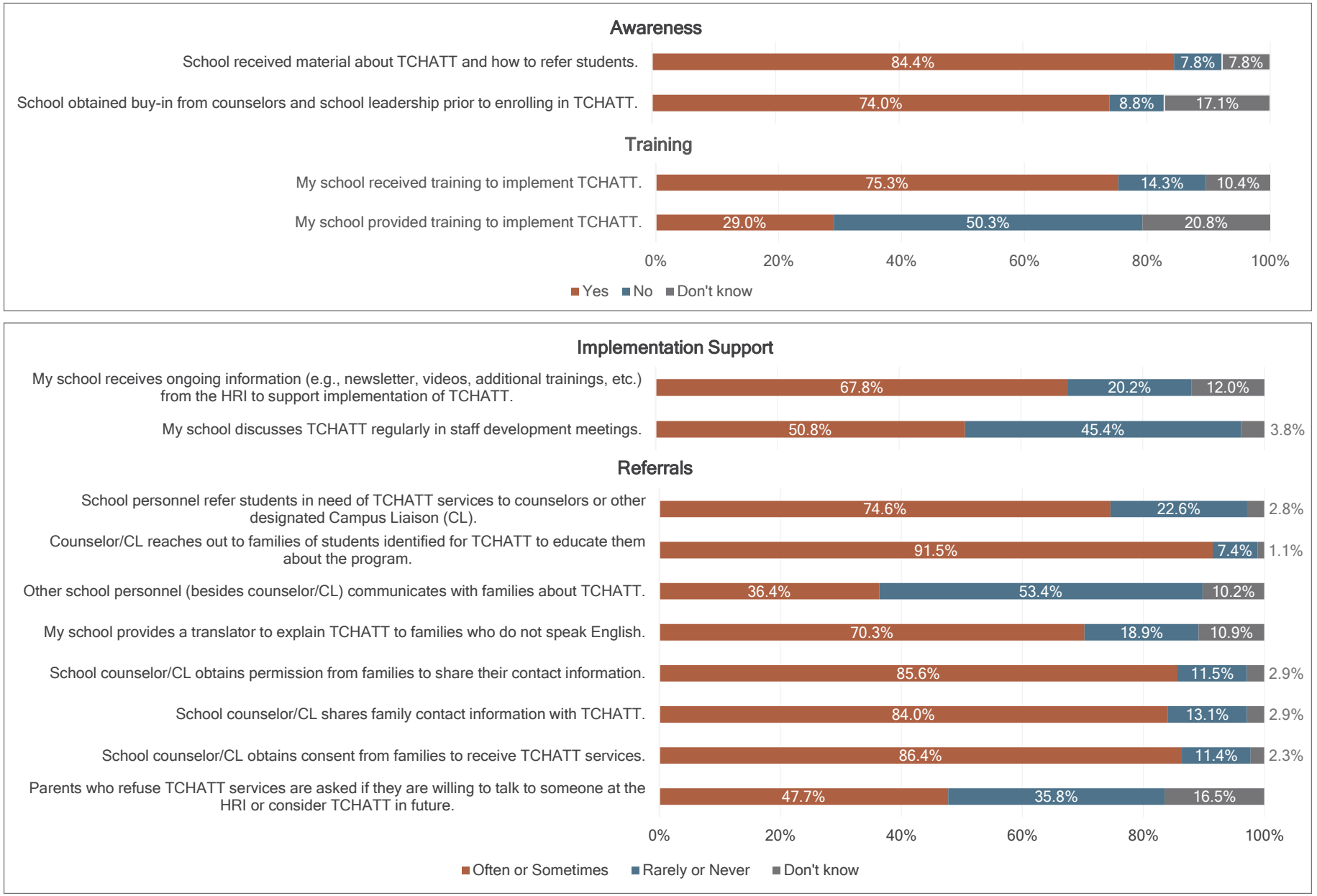
Most respondents (84%) reported that their school received material about TCHATT and how to refer students, while 68% reported that their school often or sometimes receives ongoing information from the HRI to support implementation of TCHATT. This is a decrease from the Year 2 survey,[1] when 80% of school staff reported often or sometimes receiving ongoing information from the HRI. Similar to last year,[1] over 70% of respondents reported that their campus obtained buy-in from school counselors or leadership prior to enrolling in TCHATT, 75% of respondents reported that their school received training to implement TCHATT, and over 50% of respondents reported sometimes or often discussing TCHATT regularly in staff development meetings. **This year, only 29% of respondents reported that their school provided training to school staff (e.g., to support staff making student referrals to TCHATT), which is a decrease from what was reported by school staff last year (38%)**.

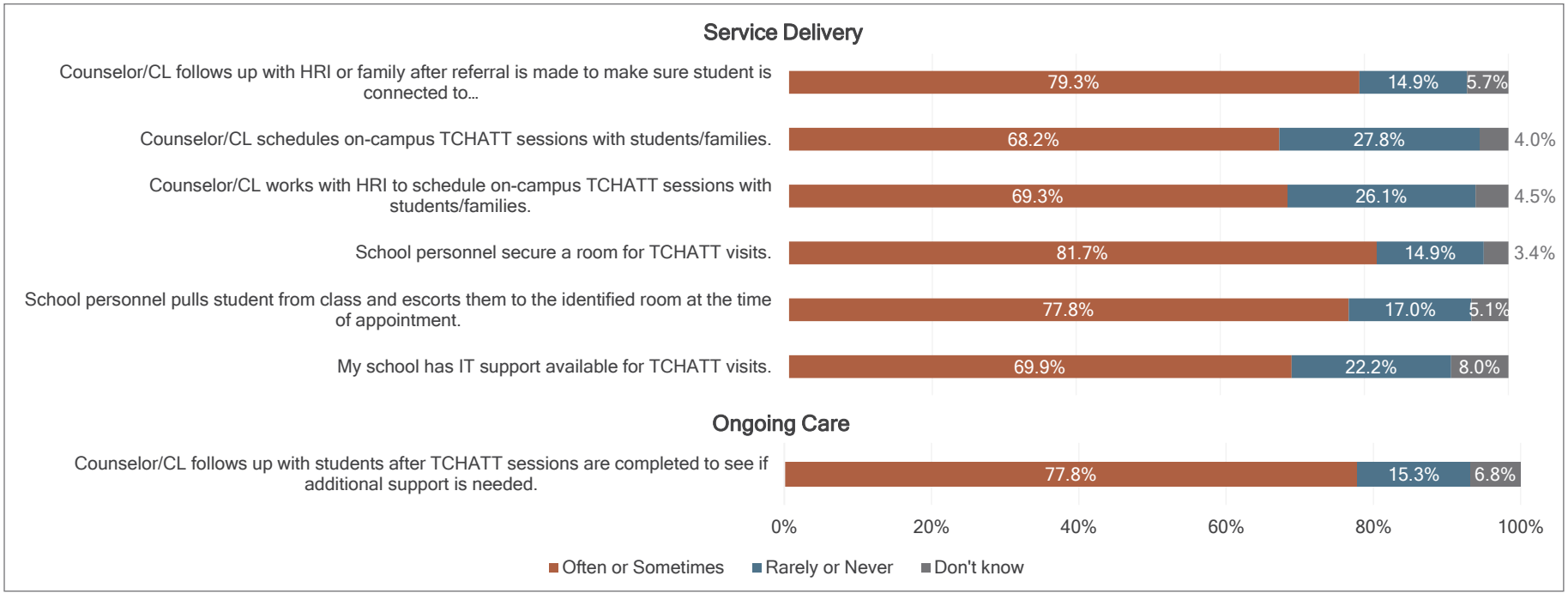
Similar to Year 2 survey findings,[1] 75% of survey respondents reported that school personnel often or sometimes refer students in need to TCHATT, over 90% of respondents reported that the counselor often or sometimes reached out to educate families of students identified for TCHATT, and fewer than 40% of respondents reported that other school personnel often or sometimes communicate with families about TCHATT. When parents refuse TCHATT services, less than 50% of respondents reported that their staff often or sometimes asked parents if they are willing to talk to someone at the HRI or consider TCHATT in the future, which is consistent with what was reported by school staff last year.

Similar to last year, most respondents reported that service delivery activities occur often or sometimes, including post-referral follow-up with HRI or family (79%), scheduling of on-campus TCHATT sessions with students/families (69%), securing a room for TCHATT sessions (82%), IT support for TCHATT sessions (70%), and escorting students to appointments at the scheduled time (78%). Compared to last year, fewer respondents reported working with HRIs to schedule on-campus TCHATT sessions with students/families (69% in Year 3 vs. 77% in Year 2) and following up with students after TCHATT sessions are completed to check on additional support needs (78% in Year 3 vs. 85% in Year 2).

Implementation processes with lower activity rates in the TCHATT Activity Checklist below (Figure 28) may indicate a need for the development, or tailoring, of implementation strategies to meet context-specific barriers to implementation.

Figure 28. TCHATT Activity Checklist (n=224)[a]



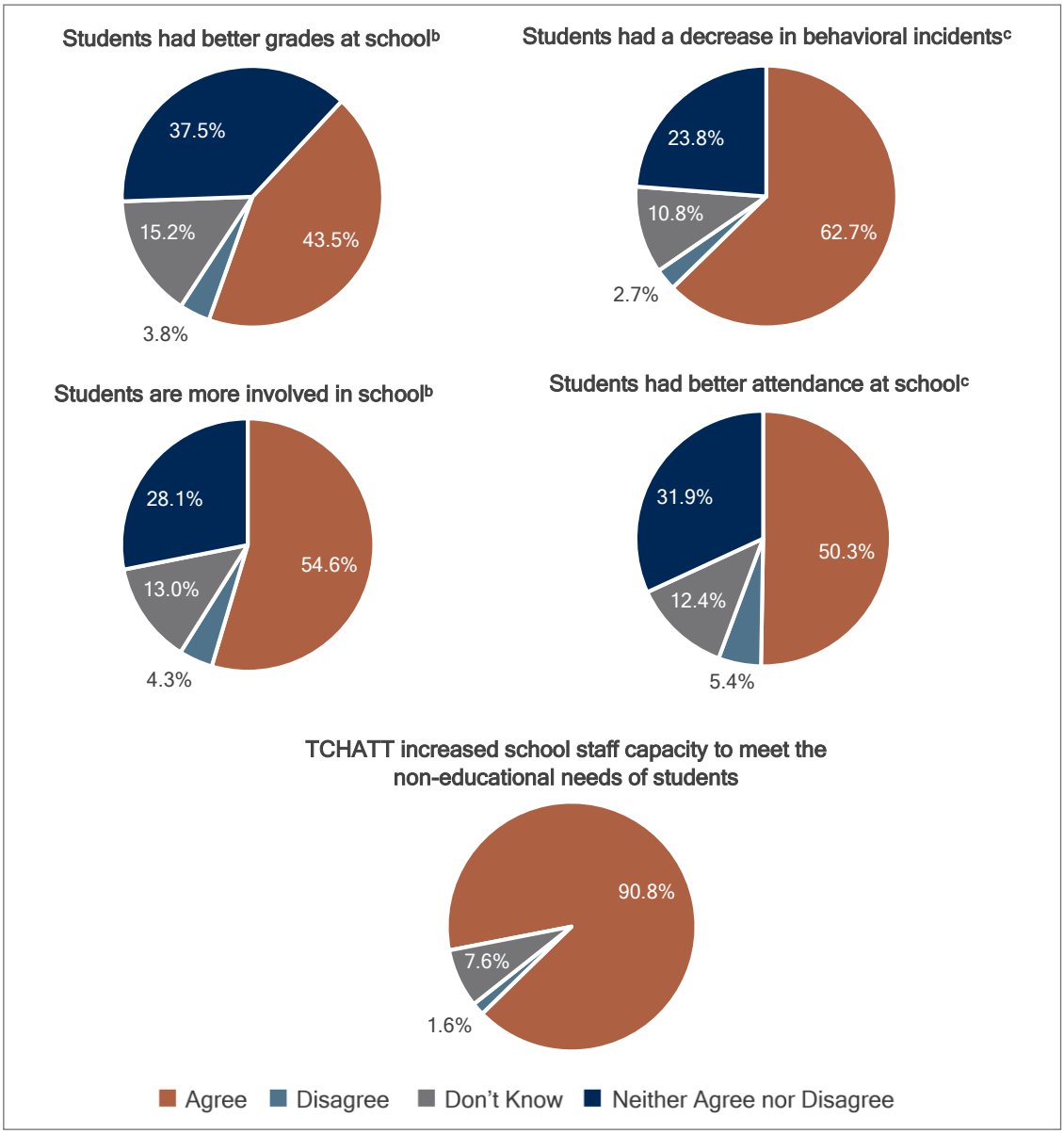


(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who reported that either their school was implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or that they didn't know. Some individuals are excluded due to missing data. "Often" was combined with "sometimes" and "rarely" was combined with "never" for reporting purposes.

Participants' Perceived Outcomes and Future Recommendations for TCHATT

Perceptions of TCHATT effects on student outcomes and staff capacity are favorable among school staff. Between 44-63% of respondents indicated that, because of TCHATT, staff perceived students to have decreased behavioral incidents, better attendance and grades at school, and school involvement (Figure 29). Between 11-15% of respondent reported that they did know whether TCHATT had an impact on behavioral incidents, attendance, grades, and involvement in school. **Finally, over 90% reported that TCHATT increased school staff capacity to meet the non-educational needs of students.** This is an increase in percent agreement compared to last year (91% in Year 3 vs. 79% in Year 2) and also a decrease in percent disagreement compared to last year (2% in Year 3 vs. 19% in Year 2).

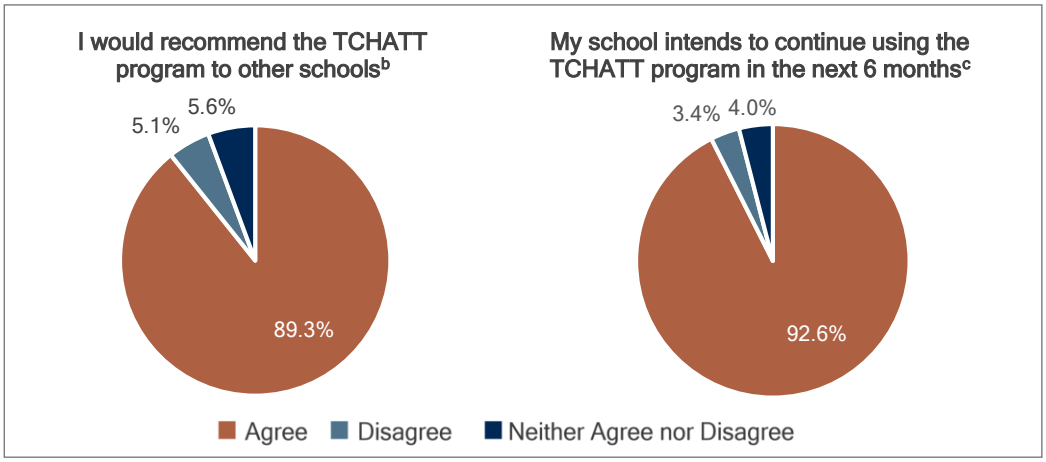
Figure 29. Survey Participants' Perceived Outcomes of TCHATT (n=224)[a]



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who reported that their school was either implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or they didn't know. Strongly agree was combined with agree and strongly disagree was combined with disagree for reporting purposes. (b) Response missing from 40 school staff. (c) Response missing from 39 school staff.

School staff who responded to the survey also reported high satisfaction with the TCHATT program. Almost 90% reported that they would recommend TCHATT to other schools, and 93% reported that their school intends to continue using TCHATT in the next 6 months (Figure 30). These findings are consistent with levels of satisfaction reported by school staff in the Year 2 survey.

Figure 30. Participants' Recommendations and Future Use of TCHATT (n=224)[a]



(a) Data Source: 2023 External Evaluation TCHATT School Staff Survey. Includes individuals who reported that their school was either implementing TCHATT (at an early stage, inconsistently, or fully and systematically) or they didn't know. Strongly agree was combined with agree and strongly disagree was combined with disagree for reporting purposes. (b) Response missing from 47 school staff. (c) Response missing from 49 school staff.

Qualitative Results: An Analysis of Open-ended Questions

The University of Texas Health Science Center at Houston (UTHealth Houston) External Evaluation team partnered with Decision Information Resources, Inc. (DIR) to conduct a content analysis of open-ended survey responses.

The open-ended survey questions included:

- Overall, what do you see as the biggest benefit of having the TCHATT program available in your school?
- How can the TCHATT program be improved?
- Do you have any additional comments related to the activities that you conduct as part of TCHATT?

A content analysis was used to code and categorize open-ended stakeholder responses to each relevant survey question. Coding categories were derived directly from the response data. Open-ended responses were coded under more than one category when necessary. For example, when two or more benefits of a program were identified in the same response. Preliminary categories and subcategories were refined throughout the analysis, with final codes organized into a hierarchical structure separately by survey question.[6] A qualitative analysis of the coded and categorized content was conducted to highlight the experiences of stakeholders as it relates to implementation of the program.

[6]Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res. 2005 Nov;15(9):1277-88. doi: 10.1177/1049732305276687. PMID: 16204405.

The findings in this section discuss TCHATT survey respondents' perceptions of the benefits of the program, barriers to utilization, and areas for improvement.

Benefits of the TCHATT Program

Of the 224 respondents, 142 provided open-ended responses to the question asking about the greatest benefits of having the TCHATT program available in their schools. Important benefit-related themes that emerged were **accessibility** of mental health care services for underserved students in need and **additional mental health support** for youth beyond the school counselor were found to be the greatest benefits of TCHATT.

Many indicated that **accessibility of free mental health care for underserved students in need was the greatest benefit** of the TCHATT program. This was consistent with the findings from last year. Respondents indicated that TCHATT provides immediate and flexible mental health services to underserved children who may not have access to care without the program. The program is seen as a convenient external resource that can support school staff and parents in getting children the mental health care that they need when alternative resources are extremely limited. Respondents indicated that their students tend to come from underserved and underinsured communities, making the cost-free services of TCHATT valuable. Since the visits are virtual and conducted while children are in school, it also removes the barrier of transportation for parents and minimizes time spent away from the classroom for students.

"Families that cannot afford counseling have a way to access help. Many of the outside agencies have a wait list. TCHATT provides services immediately." –Counselor

"Our kiddos are being seen right away. This is so helpful for our families, and so many of them are grateful for the free services they would not have received otherwise." –Counselor

"It is a free referral service. The parents don't have to drive anywhere. They can have the sessions during class time." –Counselor

Respondents stated that TCHATT **provides a level of mental health care that cannot be provided by school counselors alone**. This was also consistent with the findings from last year. Respondents discussed how school counselors may not have the level of expertise some students require and there are confidentiality concerns. TCHATT provides school counselors with additional support to serve their students' mental health needs more effectively and provides students and families with a trusted outside provider that will help address mental health needs directly and through referrals. TCHATT provides feedback to both parents and school counselors as permitted, creating a collaborative environment to help children get their needs met.

Other benefit-related themes included:

- The virtual/telehealth component of TCHATT is beneficial.
- Student improvement is evident because of TCHATT.
- TCHATT provides connections to community resources.

"It was nice to have a student able to meet with a mental health professional who could provide therapy for the student as opposed to me as a school counselor. I love that part very much! Knowing there is someone else invested in you is empowering and I think this benefits the kids so much!" –Counselor

"Students with intense mental issues can get the needed help from qualified professionals other than having the stigma of talking to the school counselor when confidentiality is breached." –Counselor

"We typically choose TCHATT as our next resource if the school counselor/administrator feels like we need more resources other than what we can offer on campus. It is our next go-to service outside of traditional school counselors - like a "Tier III" intervention." –School Administrator

Only one respondent indicated that the program has not yet been fully implemented in their school; therefore, they could not speak to benefits.

Improvements to the TCHATT Program

Overall, n=101 respondents provided open-ended responses to the question asking about improvements to the TCHATT program. TCHATT stakeholders varied in their responses to areas for program improvement. The most frequently mentioned areas for improvement included:

- a **more efficient** implementation process
- **better communication** with school staff
- engage **more TCHATT providers**
- **increase the number of TCHATT sessions** per student

Respondents reported that the TCHATT program could be improved with a **more efficient implementation process.** This includes **making the referral process simpler**, providing an **easier consent and intake process** for parent engagement, and **improving the scheduling process**. Paperwork was described as lengthy, often confusing, and overwhelming. Accessibility of forms, complicated paperwork, and the need for a parent (or school counselor, in some cases) to be present during sessions has been an issue for families. In general, this has been a barrier to care for underserved students. The referral and scheduling processes for school staff can be burdensome, too. For example, scheduling is done via email and spots fill up quickly. Respondents suggest an online scheduling system that allows one to choose an appointment time and send a confirmation with calendar invite.

"Have an online option for referrals sent, not just emails." –FRC Coordinator

"Possibly a scheduling service in Trayt or another application that has a calendar to list all appointments. Sometimes emails, while very helpful, get lost in the shuffle. An application with a reminder feature would be extra nice!" –Counselor

"It can be improved by providing more in-person assistance with parents filling out the paperwork and parent education." –Counselor

"Parent paperwork shortened or an option to fill out paperwork on paper (some parents struggle with having internet at home and/or electronic devices)." –Counselor

Respondents would like **improved communication and follow-up while students are involved in the TCHATT program**. Specifically, respondents indicated that they would like to receive:

- notifications of case status (i.e., whether a student received services or not);
- updates on students receiving services (e.g., outcomes, connections to community resources); and
- information about follow-up care after all sessions are completed.

They expressed a desire to help students and families if they are struggling with the intake process or making connections to resources in the community as part of their treatment plan.

"It would be nice to get updates on students receiving services. It would be helpful to know if they are receiving counseling services and if they get referred to a local provider as their sessions end with TCHATT. The school could help to follow up and ensure that the parent connects with a local provider to continue receiving support....and if not, we could find out what the barrier is and help the parent work through it." –School Administrator

"The TCHATT program can be improved by providing the students that have been accepted, completed sessions, been given referrals to outside resources to continue sessions after the free 5 sessions, and those TCHATT applications that were not accepted and for what reason." –Counselor

Respondents expressed a desire for more TCHATT providers and sessions for students. While respondents were grateful to have access to TCHATT sessions for their students, several expressed a desire for more sessions. Respondents suggested that the number of allowable sessions is not always adequate and providing more can help ensure students are in a stable place before referring them to follow-up care. Sometimes there can be a long wait period for children to receive follow-up care after their TCHATT sessions end, resulting in a gap of care and potential risk to their mental health. Some respondents suggested that increasing the number of available clinicians would help with student reach and wait times, as well as open the possibility for more individual sessions if possible. Four respondents indicated that wait times for student services are longer as demand has grown, so trying to increase support and response time would be beneficial. This is especially true for rural districts with limited resources.

"Sometimes, I do not believe 4 sessions is enough. For some of my students, it takes this long for them to start talking about their real needs, so that strategies and needs can be meet. Students often wished it lasted longer and they feel an unfinishedness to it." –Counselor

"We had students seen quickly but now there is a long wait period. For bigger districts, they have the resources such as licensed counselors, social workers, and school psychologists, while the rural schools do not have any of those resources. The rural schools need to be a priority." –Counselor

"More than four sessions, longer term counseling support. Additional clinicians." –Counselor

"Our school loves TCHATT and has utilized it multiple times throughout the year. My only concern is the back-log/wait time that has come with recommending students to TCHATT." –School Administrator

Other suggestions for improvement were provided by respondents but were less widespread. They include things like **offering in-person** treatment options, providing more **marketing materials** to share with families, providing **more training** for school staff, providing **bilingual support**, providing **equipment** for virtual session, and offering more connections to **community resources**. Nine percent of respondents did not have any recommendations for improvement.

Additional Comments Related to the TCHATT Program

Overall, 49 school staff provided open-ended responses to the question asking for additional comments related to the TCHATT program. Out of those respondents, 31% (n=15) provided **positive remarks regarding the program in terms of support offered to students and school staff**.

While some comments provided to this question addressed benefits and areas for improvement mentioned above, there were noteworthy comments, particularly regarding Spanish-translated materials. Some respondents indicated that **TCHATT is now providing Spanish language materials** for parents of children at their schools.

"This is a great service for our students and their families. I am so thankful that we have this available to them. It has changed some our students' and families lives!" –Counselor

"We have not had to translate materials on our own because we are provided with Spanish materials along with English materials." –Counselor

Other comments were reflective of what was expressed last year, such as school-based implementation challenges on their campus (e.g., not having ample space to conduct the sessions or limited staff with competing demands). A few respondents shared reasons schools had not used TCHATT services, including there were no students to refer, counselor was new to the school and TCHATT program, lack of awareness about implementation on campus, and other supports in place to help students.

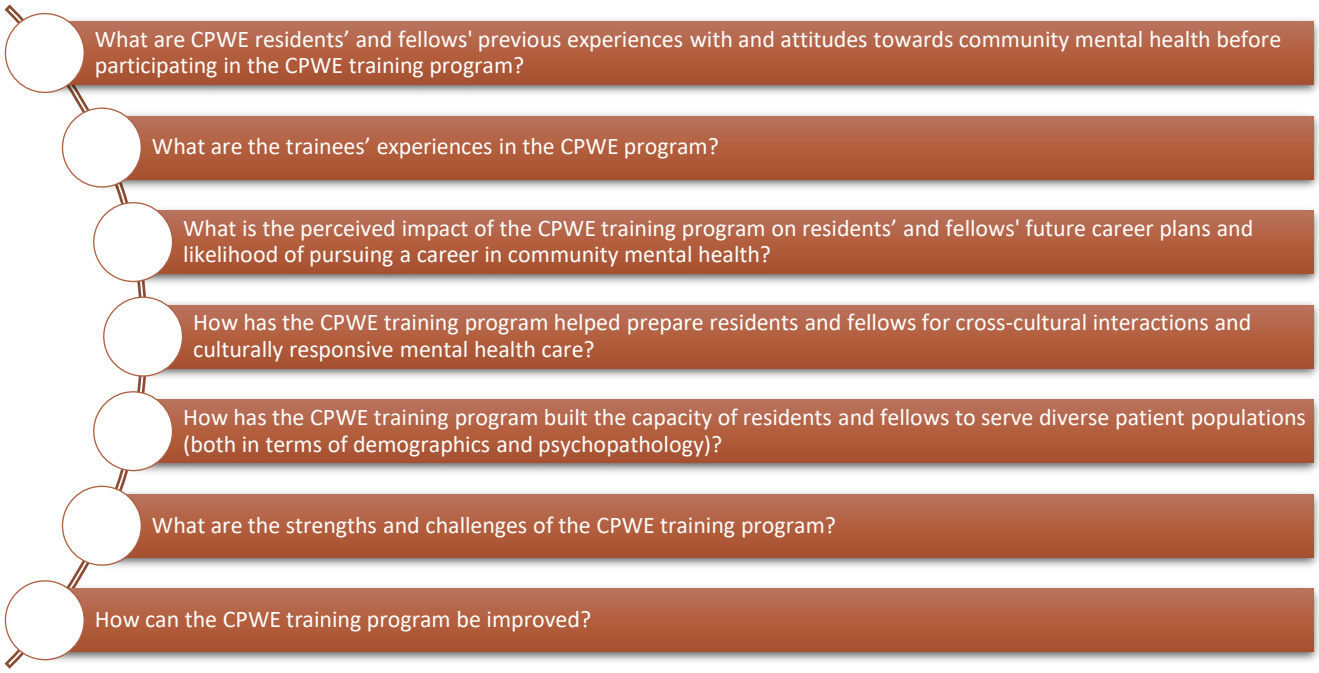
CPWE QUALITATIVE INTERVIEWS

Introduction

The UTHealth Houston External Evaluation team partnered with Decision Information Resources, Inc. (DIR) to conduct and analyze in-depth interviews with residents and fellows of the CPWE program as part of the Year 3 external evaluation of TCMHCC's initiatives. Understanding the impacts of the CPWE program is an important component of determining whether TCHMHCC's goals for this initiative are met. **The goals of the CPWE qualitative program evaluation are to understand trainees' (residents and fellows) (1) experiences in community mental health prior to CPWE training, (2) experiences in the CPWE training program, (5) preparation for culturally responsive care and capacity to serve diverse patient populations, (6) perceived impacts of the program, (5) perceived strengths and challenges of the program, and (6) satisfaction and recommendations for improvement.** Documenting participant experiences, particularly as they relate to the strengths, challenges, and impacts of the CPWE program, can provide valuable information to the TCMHCC and CPWE program directors about what can be done to further support their goals of providing improved mental health care to underserved youth and support the development of future community mental health practitioners.

This report augments the learnings from the Year 1 and Year 2 evaluation reports.[2,1] A summary of the evaluation questions this qualitative program evaluation seeks to answer are provided in Figure 31. In the sections that follow, we discuss the methods used, highlight key findings, and offer recommendations as they pertain to program implementation and the evaluation.

Figure 31. Year 3 CPWE Evaluation Questions



Methods

Sample

We sought to engage a sample of trainees across HRIs, to understand their range of experiences as participants in the CPWE program. We compiled a directory of current CPWE trainees from the CPWE

reporting templates provided by HRIs, and randomly selected a sample of CPWE residents and fellows from the directory. DIR then invited CPWE trainees by email to take part in the interviews. The only eligibility requirement was that residents and fellows participated in the CPWE program during the 2022-2023 fiscal year. To increase response rate, we reached out to CPWE program contacts at each HRI and asked them to notify their residents/fellows about the interviews. In total, 11 CPWE trainees (4 residents and 7 fellows) representing 9 participating HRIs were interviewed as part of this Year 3 evaluation. Two HRIs (TAMUHSC and UT Dell) did not have current or recent residents or fellows in the CPWE program; therefore, they could not be represented in the data collection and analysis. One of the HRIs (TTUHSC Lubbock) did have residents and fellows; however, they did not respond to requests for interviews. Table 10 provides an overview of interview participant characteristics and demographics.

Table 10. Year 3 Interview Participant Characteristics and Demographics[a]

	Total Trainees (n=11) n (%)
Participant Type	
Resident	4 (36.4%)
Fellow	7 (63.6%)
Graduating Class	
2013	1 (9.1%)
2015	1 (9.1%)
2016	1 (9.1%)
2017	2 (18.2%)
2018	1 (9.1%)
2019	2 (18.2%)
2020	2 (18.2%)
2021	1 (9.1%)
Ethnicity	
Hispanic/Latino	2 (18.2%)
Not Hispanic/Latino	7 (63.6%)
Unknown	2 (18.2%)
Race	
Asian	3 (27.3%)
Black/African American	2 (18.2%)
White/Caucasian	2 (18.2%)
Other	1 (9.1%)
Unknown	3 (27.3%)
Gender	
Male	8 (72.7%)
Female	3 (27.3%)

(a) Participants were asked basic open-ended demographic questions ahead of their interviews, without specific response options. The responses shown in the table are self-reported.

In-depth Interviews

A semi-structured interview guide was developed to gain an in-depth understanding of trainees' experiences during their training, perceived impact of the program, satisfaction, and recommendations for the program. In Year 3, we made adaptations to the interview guide based on our internal review as well as feedback from UT System leadership and COSH. Questions were added to learn more about the CPWE program onboarding process (e.g., formal trainings and resources provided) as well as trainees' integration with the rest of the team at their LMHA training site, including supports and resources they were provided with to effectively treat patients. As in Year 2, questions about trainees' experiences prior to participating in the CPWE program were included to gain a better understanding of trainees' experiences with and attitudes towards community mental health prior to participating in CPWE. This provided context and background information for each trainee, which helped further explain trainees' perceptions of the CPWE program.

Each in-depth interview was conducted by a lead interviewer and supported by a note taker. All 11 interviews were conducted via Zoom between July 18 and August 16, 2023. Residents and fellows were informed of their rights as participants in the evaluation, including confidentiality. Verbal consent and a request to audio record was requested of each participant ahead of their interview. Each participant was offered a $50 gift card as a thank you for their time.

Data Analysis

A team of five researchers trained in qualitative methods conducted a thematic analysis[7] to identify patterns and themes within the qualitative data collected. This iterative process included transcribing the audio files from each interview, reading through the transcripts for deeper understanding, and analyzing and interpreting the data using both deductive and inductive coding processes. We developed a qualitative codebook to guide the initial coding process, which was refined as the analysis continued. It included codes, definitions, and examples to ensure uniformity and reliability in applying codes. Inter-rater reliability was conducted to ensure consistency across coders. Second cycle coding was used to refine and categorize the data, as well as identify emerging themes. Data management and coding was conducted in NVivo, a computer-assisted qualitative data analysis software tool.

In the section that follows, we present the key findings that emerged from the Year 3 interviews as they relate to the goals of the qualitative program evaluation.

Results

Experiences with Community Mental Health Prior to CPWE

Trainees varied in their experiences with community mental health care prior to their CPWE training.

Similar to findings from the Year 1 and Year 2 interviews, participants varied in their experiences and understanding of community mental health (CMH) care[8] prior to entering the CPWE training program. Differences could be seen when looking at the number of years of post-graduate (PGY) training across participants. Specifically, **experience and understanding of CMH increased as PGY increased**. This was generally true irrespective of whether a trainee was a resident or fellow. For example, trainees who were three years post-graduate at the time of their CPWE training shared a similar level of experience and knowledge of CMH regardless of whether they identified as a resident or fellow. The further along in their post-graduate training, the more exposure to CMH and child psychiatry they typically had.

Residents generally went into their training optimistically, but with little understanding of CMH and experience working in child psychiatry. The earlier residents were in their training, the more likely they were to describe their CPWE residency as a natural progression of their medical training in psychiatry, not a program they specifically sought out due to interest in CMH or working with children. One resident indicated they had a choice in rotation site during their third year, and the clinic they chose was a new one that opened at the time. They specifically chose that site because they wanted to see

[7] Coding and thematic analysis process was guided by the framework outlined in Saldaña, J. (2016). *The coding manual for qualitative researchers.* SAGE Publications.

[8] "Community mental health" (CMH) care was defined as satisfying at least one of the following criteria: (1) non-profit, (2) part of local government behavioral health authority, and (3) tribal health clinic or health center. CMH clinics are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age.

what the experience would be like, not because it was a clinic focused on CMH or part of the CPWE program.

> *"I had no familiarity with psychiatry, honestly, in general. Then to top that off, my knowledge of community psychiatry was very limited. First and second year of residency, I was familiar with what CMH is, but I wasn't familiar with the services in the local area and what we could offer until recently." –PGY3 Resident*

Prior to CPWE training, residents described working or shadowing in other clinical settings such as acute, inpatient units and sometimes outpatient clinics, often focused on treating adult patients. Some indicated that they worked in other capacities within their LMHAs previously (e.g., community hospital), providing a level of familiarity working in settings serving underserved patient populations. Most often, residents were not aware of the goals of the CPWE training program.

Fellows generally had some exposure to CMH or child psychiatry going into their CPWE training, sparking their interest in a child and adolescent specialized training opportunity, though the level of exposure varied based on how long they were out of medical school. Like residents, fellows described working in a variety of clinical settings throughout their post-graduate training including inpatient and outpatient. While fellows reported that they were at least familiar with CMH as part of their earlier rotations, most did not feel strongly about it as a career option heading into their CPWE training. Yet, they did look forward to working with children and adolescents in a different capacity than they had previously, contributing to favorable attitudes going into their CPWE training.

> *"I was excited and fairly confident coming into this training because I had worked with the child adolescent population on the inpatient side in the hospital setting and consults, and then, within the juvenile justice system and a couple of outpatient clinics." –Fellow*

Compared to last year, fellows did not report receiving information about the goals of the CPWE program as much nor did they report applying specifically because of the desire to work in CMH settings. For example, one fellow indicated that the opportunity was an elective offered through her residency, one shared that they applied to multiple child psychiatry focused fellowships across several states, and another indicated that they were told they would be taking part in this fellowship with little choice.

CPWE Training Experience

CPWE trainees focused on child and adolescent psychiatry in community outpatient clinics, though implementation of the program varied.

When asked how the CPWE training was structured and implemented, there were commonalities and differences in the experiences of participants. Like last year, the biggest commonality was that residents and fellows alike **focused on child and adolescent psychiatry in community mental health settings** as part of their CPWE training. Patient populations were described as diverse, underserved, and underinsured or not insured. Communities were often described as under-resourced and in need of access to mental health providers, particularly rural areas. Trainees discussed receiving **regular supervision** by attending psychiatrists or program directors as part of their training, though fellows expressed having more autonomy in their training than residents. For example, fellows indicated that

they had more freedom to make decisions about patient care than residents who were more likely to take direction from supervisors. Some trainees reported having one supervisor, while others had several.

> *"My supervisor was a child psychiatrist with [HRI], who worked at [community clinic]. She basically supervised everything that I did. Initially, in the first week or two, I was mostly restricted to just writing notes. Then after the first couple of weeks, I started seeing follow-ups and new patients on my own. Then after I'd see the patient, I'd present the patient treatment plan and she'd agree or disagree. Then we'd come back in the room together and wrap things up. When we were doing telepsychiatry, we'd be on a Zoom call together with the patient. She'd close her camera and audio and I'd do most of the interview. Then towards the end of the visit, she'd jump in, and we'd come up with a plan together. That's how most of the rotation went." –PGY2 Resident*

> *"We had a different supervisor every day, sometimes each half day. It's not direct supervision to where they're always over your shoulder, it was more they were immediately available as needed. Then from a patient population standpoint, it was very diverse." –Fellow*

Clinical exposure to complex cases and **education regarding diagnoses, treatment and community resources** were identified as key benefits to trainees' experiences. Unlike last year, residents and fellows equally reported **exposure to in-person and telehealth visits** with patients through their training. In some settings, telehealth was utilized as the primary method for meeting with patients, whereas in others it was offered as an option. This varied from clinic to clinic.

Trainees discussed **differences in the onboarding, schedule, and structure** of their CPWE training. In terms of onboarding, standard practices included getting acquainted with the electronic health record (EHR) system and oriented to the clinics. Residents generally discussed onboarding as straightforward and well-organized, receiving essential items and materials to get started (e.g., laptops, cell phone, office space). Fellows shared mixed feelings about onboarding. Some described the process as simple and others as complicated and inefficient. Inefficiencies were related to the need to follow different onboarding procedures at each of their assigned clinics and not always having access to the tools needed to complete their onboarding training (e.g., no Wi-Fi at an in-person training site). In terms of schedules and program structure, there was wide variation. Often, **residents were placed in clinics for longer durations than fellows** (e.g., 12 months versus 3-6 months), but this was not always the case. Yet, both groups discussed rotating through different sites during their training year. Not all sites fell under CPWE, per se (e.g., one resident reported meeting with kids in a community clinic once per week and seeing adults at other clinics; some fellows participated in elective experiences that fell under other TCMHCC initiatives in addition to CPWE). In this sense, all were exposed to multiple clinical experiences throughout the year that contributed to their overall experience. Finally, trainees **differed in their opportunities to collaborate on interdisciplinary teams**. When trainees had opportunities to work collaboratively with other psychiatrists, case managers, nurses, and therapists, they found it valuable to their learning. For example, collaboration deepened their understanding of psychological or behavioral presentations, treatment plans, medications, referral sources, and other aspects of working with diverse patient populations in community settings. However, these opportunities were not always available in every clinic.

"Throughout those four months, I was at the same clinic Monday through Friday, 8:30 to about 4:30 or 5:00. Every other Wednesday afternoon I went over to [another clinic] focused on kiddos with dual diagnoses, intellectual developmental delays and psychiatric comorbidities. That was my schedule for the four months. With the clinic community, it was made up of one nurse, some medical assistants, front desk person, a security guard, and three or four doctors. It was a great community clinic environment." –Fellow

Lastly, **fellows were more likely to report working under other TCMHCC initiatives** such as the Child Psychiatry Access Network (**CPAN**) and Texas Child Health Access Through Telemedicine (**TCHATT**) during their training year. Many fellows reported direct engagement in one or both. Participation in these programs was not part of CPWE but complemented their overall experience working in child and adolescent psychiatry and contributed to expanding the capacity to serve youth in need. Some residents shared knowledge of the programs but did not directly engage with the programs. However, one resident indicated that youth participants in TCHATT were often referred to her clinic for follow-up care. Exposure to CPAN and TCHATT contributed to trainees' understanding of the goal of TCMHCC programs (i.e., to improve child and adolescent mental health access and care in Texas).

Preparation for Culturally Responsive Mental Health Care

Exposure to diverse patients in community settings has helped prepare trainees to provide culturally responsive care.

Similar to last year, **exposure to diverse patients in community settings** has helped prepare trainees for providing individualized mental health care that is responsive to the needs and beliefs of their patients. Direct exposure to high-needs, demographically diverse patients who present with a variety of symptoms and diagnoses, for example, provides **opportunities to learn** how patients express themselves, cope, and think about mental health care. Both residents and fellows shared how direct exposure helped them **better understand the challenges of their patients** and how they impact treatment plans, how patients' cultural backgrounds and norms can influence treatment options, and how navigating nuances is important to delivering effective care. Further, working with children required trainees to also work closely with families, contributing to their understanding of how socioeconomic barriers and intergenerational trauma impact the mental health of their young patients.

Working in CMH settings allowed participants to see how important **accessibility to mental health services** is to their patients, **contributing to their understanding of the need to reduce disparities in care**. While formal trainings on cultural competency and culturally responsive mental health care did not appear to be part of CPWE training, experiential learning through direct exposure and conversations with care teams were significant parts of participants' preparation for working with diverse patient populations and providing culturally responsive care. It built empathy and required flexibility. Overall, CPWE participants felt they learned how to provide a level of care that meets the needs of patients.

"You realize that a lot of people have been through a lot of trauma and life issues. You try and be supportive the best as you can. The more experiences that you have with different patients, the more you start to understand how these experiences have shaped them. You phrase what you say differently, to be more responsive." –PGY3 Resident

"I think first is the fact that we provide care to patients that have limited access to care. Either financially, or because there's no access to a psychiatrist in their area. We see a very diverse range of patients. For us, the more diverse our population is, the more learning we can have. We're seeing individuals with different problems, different perspectives, different everything. The more exposure we get, the more we learn." –Fellow

Capacity Building

Working with diverse patients in community settings and navigating resource challenges has built the knowledge and capacity of trainees to provide flexible and individualized care.

When discussing how the CPWE program has expanded participants' capacity to serve diverse patient populations (i.e., both in terms of demographics and psychopathologies), participants indicated that **exposure to demographically diverse patients experiencing a variety of mental health conditions** and **learning to navigate resource challenges** experienced by patients have been most impactful. Trainees shared how their exposure to patients experiencing different symptoms, diagnoses, and psychosocial stressors has also exposed them to a **variety of assessment strategies and treatment modalities** that has built their capacity as providers.

"I think the training you get with community psychiatry is the best thing ever. It's like you can go anywhere after that. It makes you use other parts of your training, not just medicine. My capacity to provide care has definitely expanded. You must use different techniques, different medicines such as trying a lot of off-label stuff. It's different, less straightforward than private practice. I feel like you must have a deeper understanding of pharmacology, neuroscience, neurobiology, and psychology. I feel like you must have more background and more tricks in your belt." –PGY3 Resident

Exposure and knowledge (e.g., understanding of patient socioeconomic and resource challenges; wide range of mental health conditions) acquired during the CPWE program has allowed trainees to consider the best and most cost-effective treatment options to meet their patients' needs. Further, almost all trainees indicated that working with disadvantaged and underserved patients has **increased their flexibility in care**. Trainees shared how they had become acutely aware of the socioeconomic barriers their patients face seeking mental health services, whether it is transportation to and from visits, the cost of treatment and medications, long wait times for appointments, or other systemic barriers that create access issues and gaps in care. Just over half of trainees discussed how their knowledge of community resources had increased through their CPWE training, making them more confident in their ability to make patient referrals to services such as counseling and case management.

"It greatly expanded my capacity to serve diverse populations just by seeing so many different families and patients. I could have a whole day of patients with ADHD, but each one could look so different depending on the family dynamic, socioeconomic status, where they live, if there's trauma layered on top, or if there is a family mental health history. Even within one diagnosis, there's so much diversity. I saw everything in terms of ADHD, ODD, DMDD, depression, anxiety, psychosis, OCD, bipolar disorder, eating disorders, autism, and so on." –Fellow

Perceived Impact of the CPWE Training Program

Most trainees are considering community mental health as a future career option.

Most trainees (n=8) indicated **considering community mental health as a future career option**. In some cases, this was influenced by their CPWE experience, and in others their training year reaffirmed what they were already considering previously (i.e., they went into training already considering CMH and working with children as likely career paths). The CPWE training expanded **their understanding of the field of psychiatry and working in community settings.** Trainees discussed how exposure to the challenges of working in community settings with underserved populations, navigating complex cases, and making connections to community resources contributed to their knowledge base. Like previous years, participants generally viewed the CPWE program as **one component of a larger integrated training experience** working across mental health systems and with diverse patient populations to build their skills and knowledge as psychiatrists.

Trainees shared further thoughts about their future careers. Several trainees shared that they would like to work in more than one setting, which would include CMH. Two fellows shared that their immediate career paths have already been determined due to existing contracts in place but would like to make CMH part of their future. Another fellow indicated that the demands of CMH can be a challenge when you are a parent to a young child, so although she enjoys CMH, it does not fully fit into her current lifestyle. Though, she would consider telemedicine options to support communities in need. One resident shared frustration with one particular site but pointed out that it did not sway his commitment to working in underserved communities. Another resident shared that the CPWE program experience had a negative impact on their desire to pursue CMH due to institutional and systemic challenges that make it hard to move the needle for patients. Overall, the CPWE program offered exposure to CMH in a way that **contributed positively** to participants' training in psychiatry and expanded their consideration of CMH as a career option. Though, in most cases trainees were not committed to a particular path.

> *"I would like to spend some time in a community setting. Maybe a hybrid model where I do inpatient part of the day and then go to a community clinic afterwards. That's how I envision myself starting out, at least in the first 10 years after the program is completed." –PGY3 Resident*

> *"I'm open to all the opportunities, but I would like to practice in an underserved area and hopefully in a community setting. I'm open to everything. One of the main reasons I'm doing the fellowship in child and adolescent psychiatry is so I can treat all ages." –Fellow*

Strengths of the CPWE Training Program

Exposure to diverse patients while working in community settings was identified as the greatest strength of the CPWE training program.

Almost all trainees indicated that **exposure to diverse patients and community clinics** was the greatest strength of the CPWE program. They believed that exposure increased their understanding of the complexities of care (i.e., there is a need to address patient needs on multiple levels) and capacity to provide quality care in the future. As discussed previously, exposure has enhanced the awareness, knowledge, and skills necessary to understand the needs of diverse patients and provide treatment in an

individualized and culturally responsive way. Working within CMH settings also opened trainees' eyes to the resource challenges patients face and desire to provide accessible and flexible care.

> *"I learned that medications are not everything. It helps, but it's not everything. It's a tool. It's like a tool in your toolbox." –PGY3 Resident*

> *"I developed my skill set in a different way. For example, how to talk to teenagers, how to talk to children and their parents, coming up with plans, understanding limitations. Things like that for sure it helped me become a better psychiatrist. Also, it helped me understand what kind of services were available. It was the ground reality of what it's like. I had more exposure than ever before." –Fellow*

While supervision did not rise to the top of the list this year in terms of the program's greatest strengths, most trainees indicated that they were **happy with the supervision received**. They expressed that the time, attention, and feedback received from attending physicians, and other mentors was helpful to their growth. Those trainees who were able to engage in **inter-professional collaboration** with case managers, nurses, counselors, and other psychiatrists found that to be a strength of their program.

Challenges of the CPWE Training Program

Challenges varied widely across trainees, though complexity in treating patients rose to the top.

Unlike last year, only one challenge was identified by the majority of the trainees – **complexity in treating patients**. This challenge was discussed in terms of patient **access to care** and working with vulnerable youth and families. Access to care was a challenge when scheduling patients (e.g., transportation barriers for in-person; lack of technology or privacy for virtual), and when referring to other important wrap-around services (e.g., lack of resources; long wait times).

> *"The referrals were harder because you can refer your patients, but who knows if they're going to have an opening. Who knows if they're going to have a car to get to the place. You are working with much less in every aspect, so you're thinking about more things." –PGY3 Resident*

Trainees also shared their experiences working with children who have **needs beyond mental health services**, making treatment challenging. For example, socioeconomic struggles that lead to unstable housing or food insecurity, lack of family involvement in treatment, trauma, or abusive home environments. They spoke of the difficulties treating child patients' mental health when parents were disengaged and did not follow through with treatment plans. At times, trainees felt like they were not able to make the impact they would like on children's lives. Other challenges were discussed, though they were more site specific and not widespread. They included **administrative and logistical challenges** (e.g., EMR, lack of institutional resources and support) and a **high volume of patients**.

> *"I think one of the most challenging aspects was the complexity of paired access to resources. I think that was one of the most challenging things on a day-to-day basis because you are left feeling a little bit frustrated or helpless. One of the biggest challenges was knowing what is going on with patients, what they need, but not knowing how to get that for them." –Fellow*

Satisfaction and Areas of Improvement

Trainees were generally satisfied with their CPWE training.

Overall, trainees were **satisfied** with their CPWE training experience, rating it an average of 8 (range of 4 to 10) on a scale from 1 to 10, with 10 being the highest. When discussing areas of improvement to the CPWE program, trainees primarily reflected on the challenges they experienced in specific training sites. Areas of improvement were few, varied widely, and did not apply across the entire program. For example, specific improvements around **administrative support, creating efficiencies, and workflow** were identified by some trainees who felt they were lacking in certain clinics.

> *"Making sure there is a steady patient population. We had days where we saw very few people and got to go home early. Sometimes that was great, but from an education perspective, it could be optimized. I don't want it to swing too far the other way and become a workhorse because then you don't learn. Need a balance." –Fellow*

A few trainees identified more **learning opportunities** as an area of improvement, especially around community healthcare and community resources. One trainee mentioned that an **orientation and introduction to the CPWE program** would be useful before the placement begins.

> *"Briefing, maybe some lectures specifically on community healthcare. It doesn't have to be every week or every month, but maybe a few times a year for residents in the program. For example, providing a reminder on what the goals are and what to look out for, what to keep in mind for these populations, and what to really emphasize. A lot has been learning on my own." –PGY3 Resident*