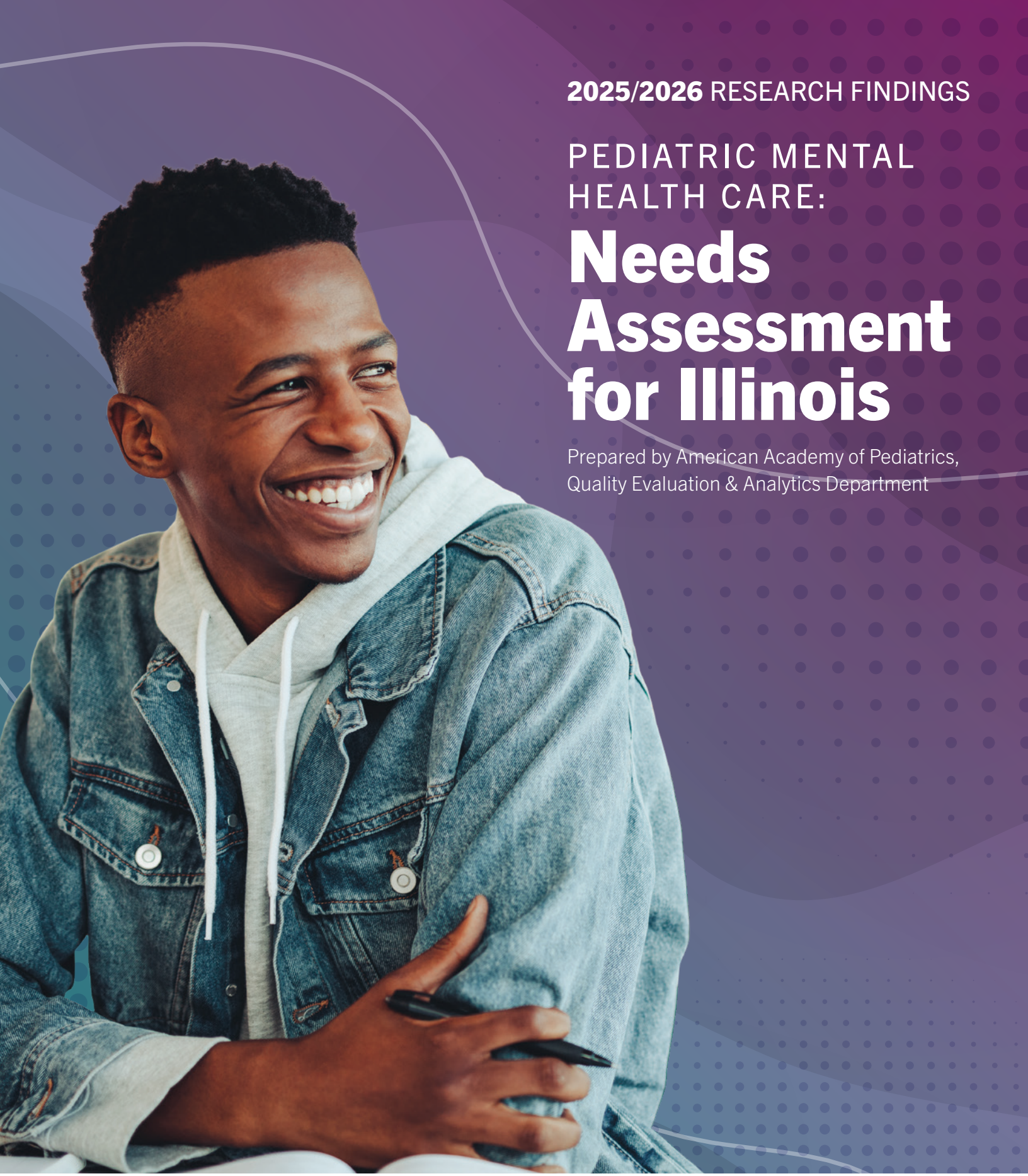

2025/2026 RESEARCH FINDINGS

PEDIATRIC MENTAL HEALTH CARE:

Needs Assessment for Illinois

Prepared by American Academy of Pediatrics, Quality Evaluation & Analytics Department

Partnering to
EXPAND MENTAL HEALTH CARE ACCESS
for *all* kids in Illinois

IDPH Illinois Department of Public Health

ILLINOIS DocAssist

UIC UNIVERSITY OF ILLINOIS CHICAGO

ILLINOIS CHAPTER American Academy of Pediatrics

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Executive Summary

About the T2 Needs Assessment

In 2023, the Illinois Chapter of the American Academy of Pediatrics (ICAAP) administered a baseline needs assessment (T1) to assess pediatric mental health care capacity. Between December 2025 and February 2026, ICAAP conducted a follow-up survey (referred to throughout this report as the T2 survey) to evaluate changes over time. Both targeted the same population: pediatric primary care clinicians and subspecialists practicing in Illinois.

The T2 survey preserved core items from T1 to allow direct comparisons while also adding new content on areas not previously covered (e.g., BEACON as a resource option, standalone questions on Illinois DocAssist) and expanding select T1 items to capture greater detail. Because the surveys were anonymous and independently sampled, individual-level change cannot be assessed; comparisons reflect population-level shifts in the provider community.

176
T1 Respondents (2023 Baseline)

169
T2 Respondents (2025/2026)

2
Years Between Surveys

Summary of T2 Survey Findings

T2 data show progress in several domains between 2023 and 2025/2026. At the same time, structural access barriers remain unchanged, patient mental health burden remains high, and newly documented gaps (in follow-up systems, trauma-informed care implementation, and clinician burnout) were revealed.

- **Confidence increased.** The proportion of clinicians who reported confidence in supporting patients with emotional, behavioral, or mental health needs increased from 65.9% to 81.1% ($p=0.001$), and confidence in recognizing crisis warning signs rose from 84.1% to 95.2% ($p<0.001$).
- **Assessment and education capacity improved across all conditions, but confidence lags for several.** The proportion of clinicians reporting the ability to assess trauma, eating disorders, aggressive behavior, and gender identity and sexuality increased by 26 to 35 percentage points. Gains in the ability to offer education and resources were comparable. However, for several of these conditions, a substantial share of T2 clinicians report capability without confidence, indicating that familiarity with assessment has outpaced mastery.
- **Clinic infrastructure strengthened in areas, with two notable gaps remaining.** Clinic infrastructure strengthened across several dimensions. The proportion of clinics with a CHW or bridge person nearly doubled (31.2% to 60.4%), staff capacity to manage patients in mental health distress increased from 47.2% to 74.6%, collaborative care model utilization rose from 30.1% to 44.6% ($p=0.006$), and on-site mental health provider availability increased from 38.1% to 56.2% ($p<0.001$). However, fewer than half of clinics reported a method for tracking patients needing assertive follow-up (46.4%), and the proportion able to monitor patient cohorts through EHR showed a borderline decline (73.9% to 64.1%, $p=0.050$).
- **Clinics are screening, but systems for what happens next are not keeping pace.** While 94.0% of clinicians report routine mental health screening, only 66.3% report written follow-up policies after a positive screen. The ability to connect patients to community mental health services did not change from T1 to T2 (77.8% to 76.3%, $p=0.739$). Screening is also more variable during the toddler, preschool, and school-age periods than in infancy or adolescence.

- **Burnout is prevalent.** Nearly two-thirds of T2 respondents (63.3%) agreed that staff and clinicians in their clinic experience stress or burnout related to managing mental and behavioral health concerns in their patient population.
- **Illinois DocAssist made clear gains; workflow integration is a remaining barrier.** Awareness rose from 52.3% to 72.2%, utilization increased from 36.9% to 54.1%, and 90.8% of users rated their experience as good or excellent, up from 73.8% at T1. BEACON was added as a resource option for the first time in T2. For both resources, the primary gap among non-users is not unfamiliarity with the resource but uncertainty about how to use it during a patient encounter.
- **Structural barriers are unchanged and remain the most commonly cited challenges.** Long wait times for specialty services (76.7%), insurance or cost barriers (63.5%), limited specialist access (61.6%), limited visit time (59.1%), and family reluctance to engage (55.3%) were reported. Qualitative themes point to care coordination gaps and Medicaid access as the most pressing concerns. Clinicians describe these conditions as structurally inequitable, with disproportionate impact on Medicaid-insured, Spanish-speaking, and rural patient populations.

> *Our patient population is frequently Medicaid-based and most behavioral health services in this area do not accept Medicaid. If they do, the wait list is over two years.*
>
> — T2 Respondent

Engagement & Clinician Practice Patterns

A follow-up analysis examined whether practice patterns and resource use differ between Illinois pediatric clinicians who engaged with ICAAP programming during 2024–2025 and those who did not. Of the 164 clinicians in the analytic sample, 98 reported engaging with at least one ICAAP resource or educational opportunity, with engaged clinicians accessing a median of three resources; 66 reported no ICAAP engagement.

Engaged respondents reported stronger capabilities and broader practice scope across nearly every domain examined. The largest and most consistent differences were:

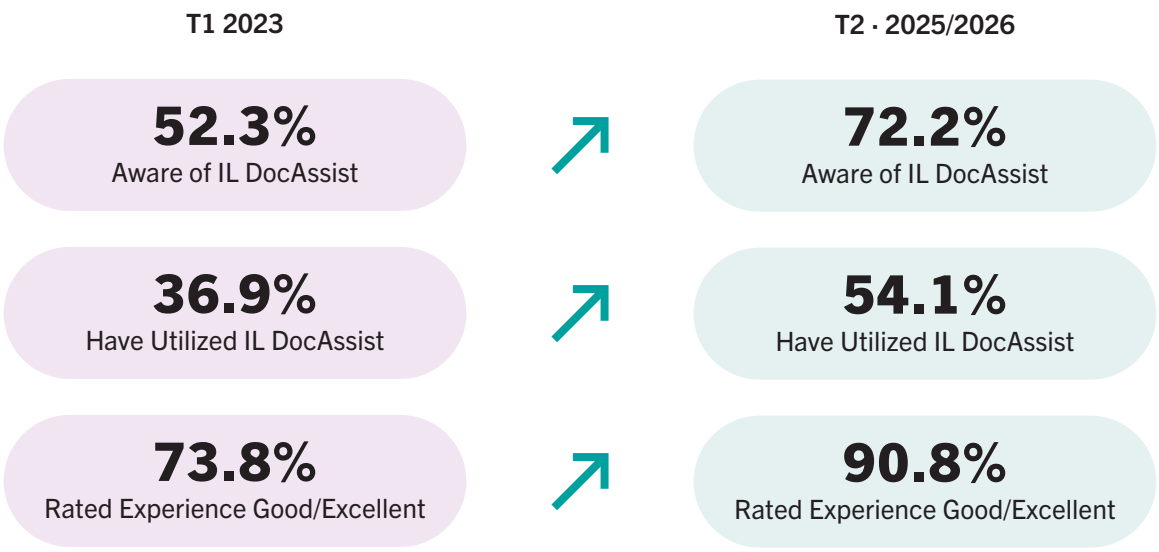
- **Practice readiness:** Engaged clinicians reported significantly higher staff capacity to manage patients with mental health concerns (mean 4.20 vs. 3.41 on a 5-point scale; $p<.001$), more frequent presence of written policies and workflows for mental health care (3.95 vs. 3.33; $p=.004$), and stronger staff training ratings (4.28 vs. 3.69; $p=.001$).
- **Screening practices:** Engaged clinicians screened more comprehensively on 5 of 11 items, with the most prominent differences in adolescent depression (mean 1.85 vs. 1.53 on a 0–2 scale; $p<.001$) and toddler autism (1.61 vs. 1.25; $p=.011$).

- **Treatment in primary care:** Engaged clinicians were more likely to routinely treat — rather than refer — trauma, aggressive behavior, suicidal ideation, eating disorders, and depression within primary care.
- **Medication prescribing:** Engaged clinicians prescribed a broader range of medication classes (mean 2.94 vs. 2.12 classes; p=.006), driven by non-stimulants for ADHD (62.2% vs. 35.4%), mood stabilizers (20.4% vs. 4.6%), and medications for sleep or behavioral regulation.
- **Illinois DocAssist:** Engaged clinicians were substantially more likely to be aware of DocAssist (86.7% vs. 51.5%; p<.001) and to have utilized it (56.1% vs. 13.6%; p<.001). Among those who had used the service, satisfaction was identical across both groups (mean 4.44 on a 1–5 scale), suggesting the gap reflects differential awareness and routing into the service rather than differential experience with it.
- **Awareness of other mental health resources:** Awareness of BEACON (49.5% vs. 19.7%; p<.001) and RAMP at Lurie Children's (33.0% vs. 13.6%; p=.009) was substantially higher among engaged clinicians.

These differences should not be interpreted as caused by ICAAP engagement. Engaged clinicians were more likely to practice in psychiatry or developmental pediatrics (14.6% vs. 4.6%; p=.019) and in independent practice settings (37.1% vs. 18.2%; p=.015) — characteristics associated with higher baseline capability. The correlation may reflect a positive effect of ICAAP programming, self-selection by already-capable clinicians, or both.

The capability gap between engaged and non-engaged clinicians indicates the scale of the opportunity for extending reach. Notably, non-engaged clinicians were more likely to identify referral follow-up and care coordination as an area where they want additional support (52.5% vs. 34.4%; p=.040) — pointing to a concrete starting point for targeted programming aimed at the clinicians ICAAP most wants to reach.

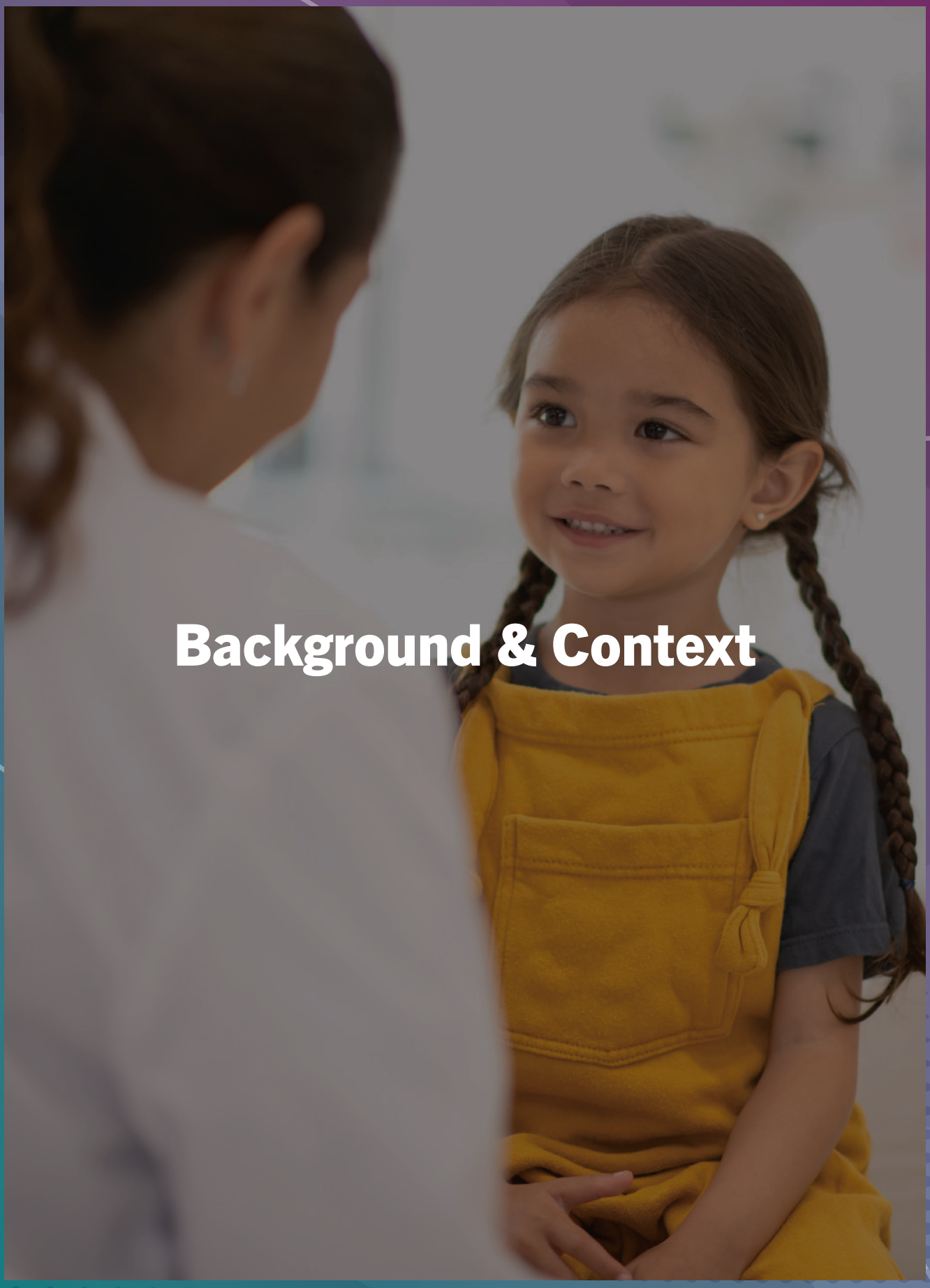
Illinois DocAssist: Progress at a Glance



Proposed Continued Plan of Action

Building on documented progress, ICAAP continues to work toward the following under the Illinois Pediatric Mental Health Care Access Expansion (PMHCA) project:

- Develop case-based Continuing Medical Education (CME) accredited training and education modules on conditions where the gap between self-reported capability and confidence is most pronounced, including trauma, aggressive behavior, eating disorders, gender identity and sexuality, and substance use, incorporating trauma-informed care practices, social determinants of health, and health equity frameworks.
- Create clinical support materials and workflow guides to help pediatric clinicians integrate mental health screening, post-screen follow-up protocols, and care coordination into their clinical practice, including tools to support consistent screening across the toddler, preschool, and school-age developmental periods.
- Create and distribute family-facing outreach and educational materials that help families understand relevant mental health issues, address hesitancy around mental health engagement, and connect them to available support, with attention to culturally responsive communication strategies.
- Advocate for policy and systems changes that address the structural barriers clinicians face, including equitable Medicaid reimbursement rates, reduced prior authorization requirements, child psychiatry and behavioral health workforce development, infrastructure to support expansion of rural telehealth access, and expanded behavioral health services for young children.
- Increase knowledge and understanding of the role of Illinois DocAssist (IDA) and the BEACON platform in supporting delivery of mental health treatment and support to youth in Illinois.



Background & Context

About the Illinois Pediatric Mental Health Care Access Expansion Project

ICAAP and the University of Illinois Chicago's (UIC) DocAssist are the two grantees in a federally funded project with the Illinois Department of Public Health (IDPH), the Department of Healthcare and Family Services (HFS), and the Department of Human Services (DHS). This collaborative effort is known as the Illinois Pediatric Mental Health Care Access Expansion project (PMHCA). The PMHCA is funded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services' (HHS) through two programs authorized by Congress: the American Rescue Plan and the Bipartisan Safer Communities Act.

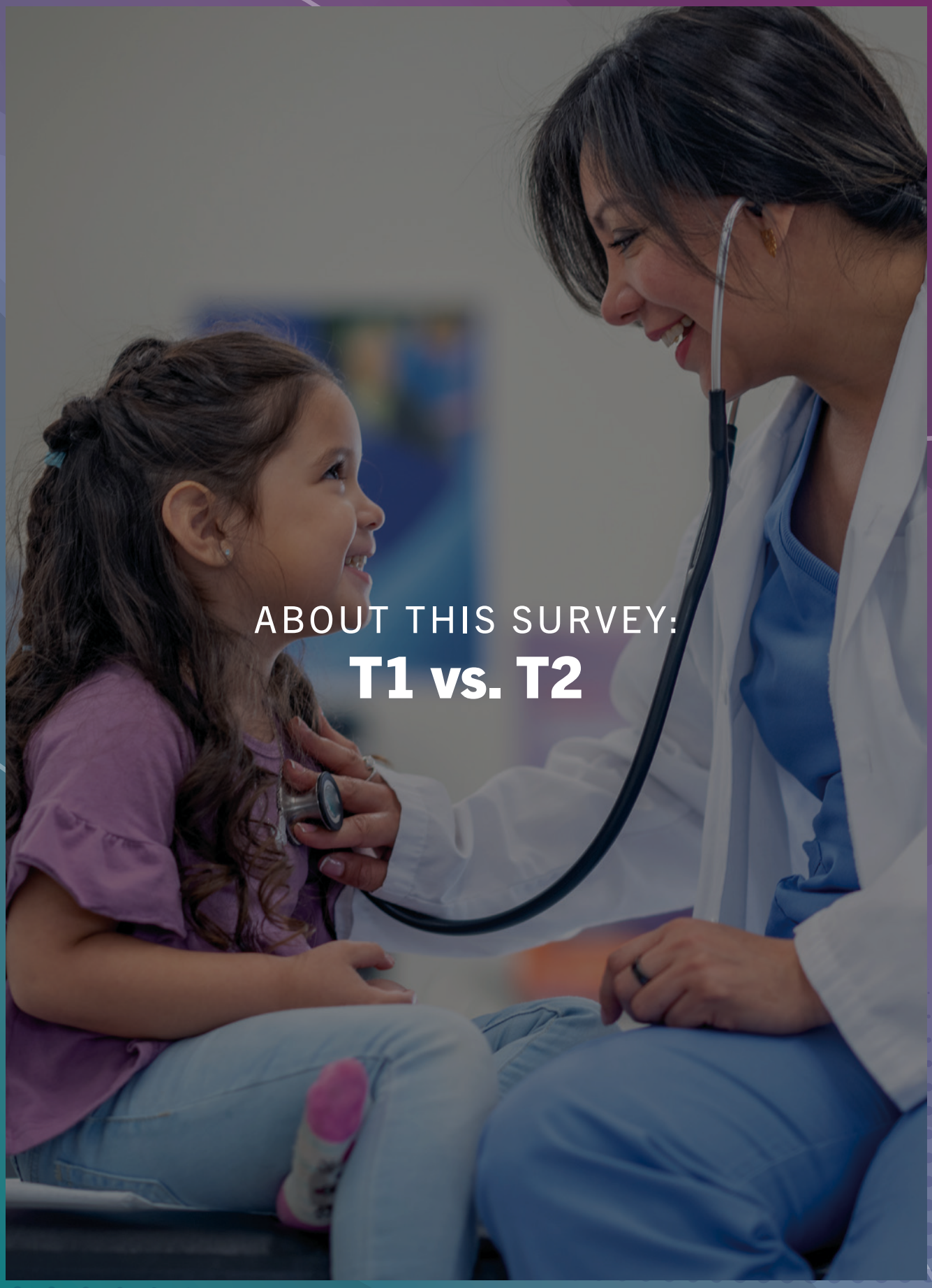
About the Children's Mental Health Crisis in Illinois

Health systems, clinicians and other health care providers, and families in Illinois continue to struggle with children's mental health. Limited resources, inadequate access to specialized care, and high patient volume with insufficient clinician support have defined the landscape since at least 2023, and 2025/26 data show the structural dimensions of this challenge have not resolved.

Pediatric primary care settings remain among the most common first points of contact when parents have concerns about their child's mental health and development. Illinois clinicians are on the front lines of this crisis, conducting screenings and interventions that exceed what most primary care training prepared them for.

About ICAAP

The Illinois Chapter of the American Academy of Pediatrics (ICAAP) is a membership organization of approximately 2,000 pediatricians throughout Illinois. ICAAP is dedicated to improving the health and well-being of infants, children, and adolescents throughout Illinois. ICAAP advocates on behalf of children, families, and health professionals; develops and provides continuing medical education and resources for pediatric professionals; and collaborates with other organizations on programs and projects that improve the health and well-being of children.



ABOUT THIS SURVEY:

T1 vs. T2

About This Survey: T1 vs. T2

This report presents findings from the T2 survey (2025/2026), the second wave of a two-part needs assessment. T1 (June–July 2023) established the baseline; T2 (December 2025–February 2026) measures the landscape roughly two years after ICAAP launched its initial training and resource initiatives.

Both surveys were anonymous, so individual respondents could not be linked across time points. Comparisons between T1 and T2 should be understood as population-level snapshots, reflecting shifts in what Illinois pediatric clinicians and other mental health care providers collectively report, rather than tracking changes in specific individuals.

Feature	T1 2023	T2 2025/2026
Data collection period	June–July 2023	December 2025–February 2026
Sample size (completed)	n = 176	n = 169
Survey platform	Typeform (44 questions)	Qualtrics (48 questions)
Analytic sample note	N/A	169 completers; 22 incompletes + 11 bot entries excluded
Design	Cross-sectional; independent sample	Cross-sectional; independent sample
Qualitative data	6 virtual focus groups (rural, school health, FQHC, private practice, mental health care, advisory)	Open-ended survey questions; no focus groups
New T2 content	N/A	BEACON as resource item; standalone DocAssist questions; expanded SDOH screening; burnout item
Statistical methods	Descriptive only	Mann-Whitney U (ordinal); chi-square / Fisher's exact (binary); phi/Cramér's V effect sizes to compare T1 and T2.

Comparability note: Some items were modified between T1 and T2. Where wording differs meaningfully, this report flags the limitation. In particular, T2's open-text format for the percentage of patients with mental health concerns produces distributional differences from T1's fixed-label format that should not be read as reflecting a true change in patient burden.

T2 SURVEY FINDINGS:

Respondent Demographics

Who Responded

169 pediatric health care professionals completed the T2 survey. The professional profile of respondents is broadly consistent with T1, though practice setting representation shifted noticeably, with substantially greater participation from FQHCs and school-based health centers and a modest reduction in Cook County representation.

Profession (T1 vs. T2)

The majority of T2 respondents were physicians, with strong representation from nurse practitioners and other roles. T1 and T2 used different response formats and profession categories, so direct comparison is not recommended. Both are shown here for reference.

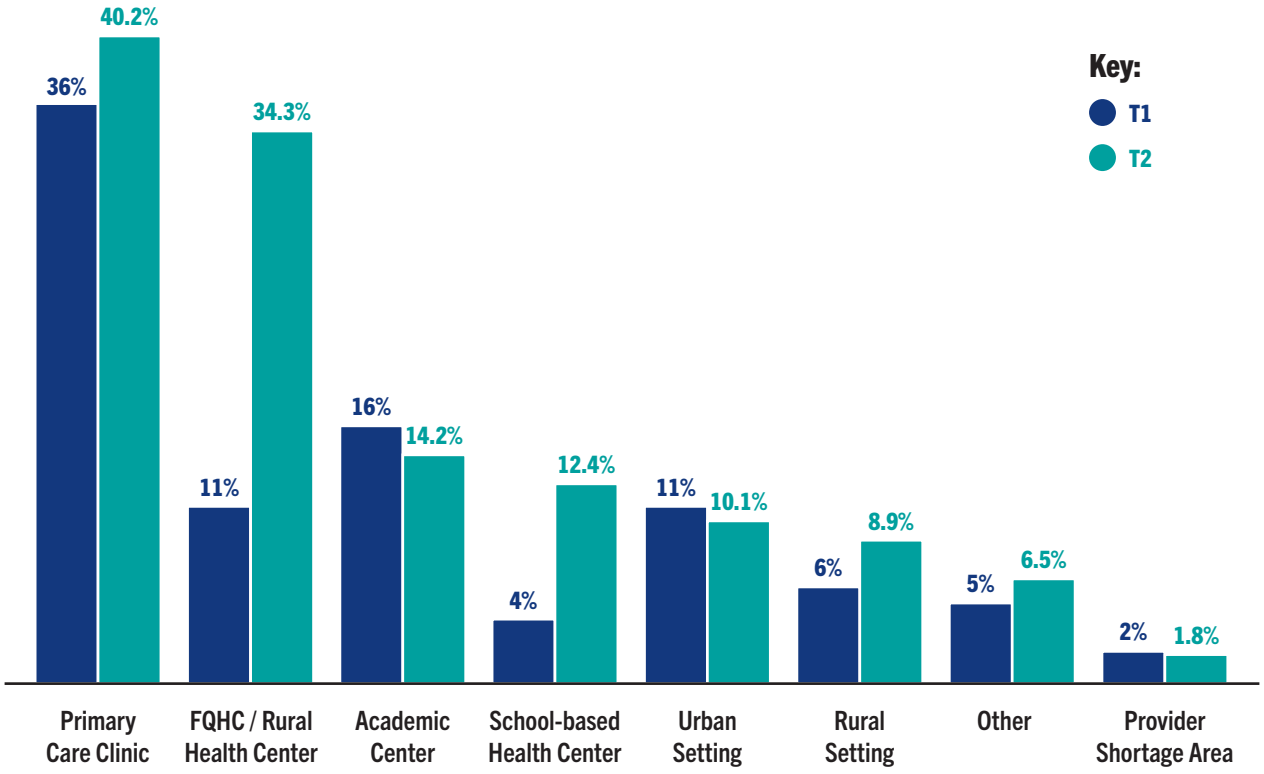
Profession	T1 n	T1 %	T2 n	T2 %
Physician	135	76.7%	104	61.5%
Nurse Practitioner	13	7.4%	31	18.3%
Nurse	18	10.2%	N/A (not a T2 category)	—
Physician Assistant	3	1.7%	5	3.0%
Other (please specify)	—	—	29	17.2%

T2 did not offer 'Nurse' as a standalone category; nurses likely selected 'Other' or 'Nurse Practitioner.' The large 'Other' category at T2 (17.2%) likely captures nurses, social workers, school nurses, and other health professionals. These format changes make profession comparisons unreliable across waves.

Practice Setting

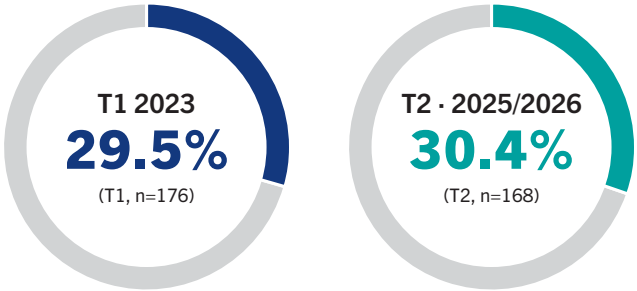
The distribution of practice settings among T2 respondents shows that the largest proportions practice in primary care clinics and FQHCs/rural health centers. Note, practice settings were not mutually exclusive, and percentages reflect proportion of respondents who answered this question (n = 169).

Percentage of Respondents by Practice Setting



FQHC/Rural Health Center participation increased from 11% at T1 to 34.3% at T2, and school-based health center representation grew from 4% to 12.4%. T2 findings may reflect more experiences of clinicians serving higher-need populations compared to T1. Note: T1 practice setting percentages reflect each setting's share of total setting selections across all respondents (274 total selections from 176 respondents; select all that apply), consistent with how figures were reported in the original 2023 T1 publication. T2 percentages reflect the proportion of respondents who selected each setting (n=169 who answered this question). These denominators are not directly comparable; the T1 column is provided for descriptive context only.

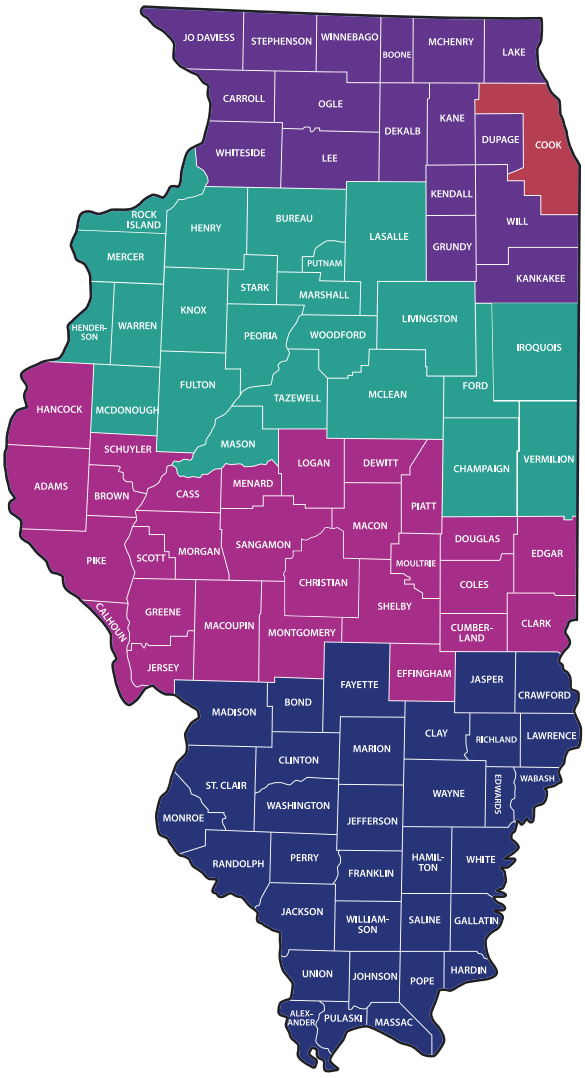
Respondents in Independent Practice Settings



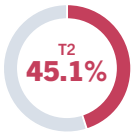
The proportion of respondents in independent practice was virtually unchanged: 29.5% at T1 (n=52 of 176) and 30.4% at T2 (n=51 of 168; 7 respondents skipped this question).

Geographic Distribution by Region

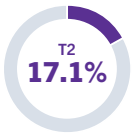
Respondents were most commonly from Cook County, with additional representation across northern and central Illinois and more limited participation from central-southern and southern regions of the state. Regional boundaries follow the IDHS Division of Mental Health map.



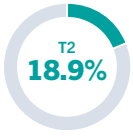
Region 1: Cook County
(including Chicago)



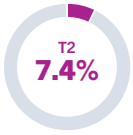
Region 2: Collar & Northern IL
(Boone, Carroll, DeKalb, DuPage, Grundy, Jo Daviess, Kane, Kankakee, Kendall, Lake, Lee, McHenry, Ogle, Stephenson, Whiteside, Will, Winnebago)



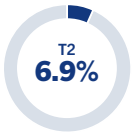
Region 3: Central IL
(Bureau, Champaign, Ford, Fulton, Henderson, Henry, Iroquois, Knox, LaSalle, Livingston, Marshall, Mason, McDonough, McLean, Mercer, Peoria, Putnam, Rock Island, Stark, Tazewell, Vermilion, Warren, Woodford)



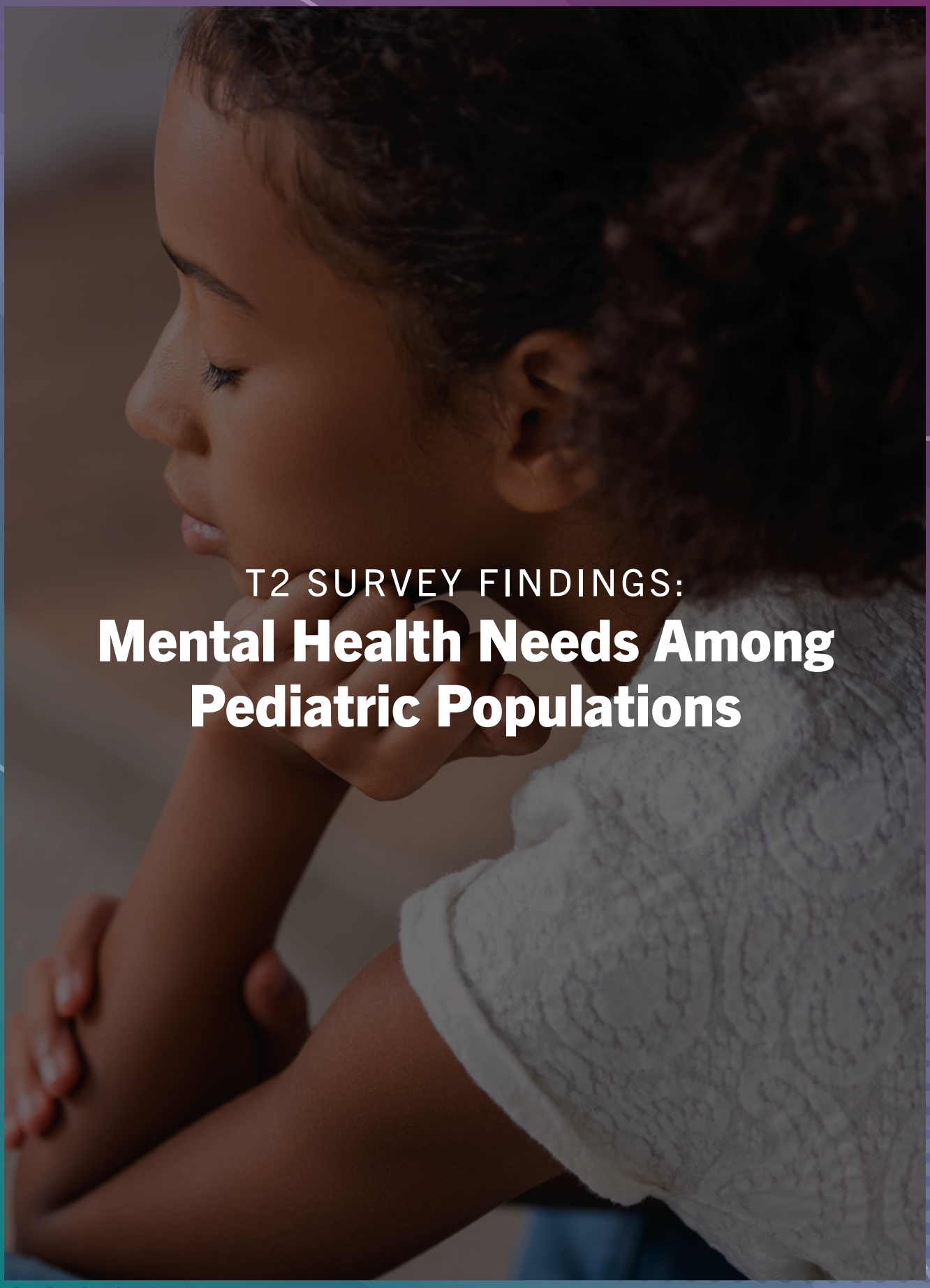
Region 4: Central-South IL
(Adams, Brown, Calhoun, Cass, Christian, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Effingham, Greene, Hancock, Jersey, Logan, Macon, Macoupin, Menard, Montgomery, Morgan, Moultrie, Piatt, Pike, Sangamon, Schuyler, Scott, Shelby)



Region 5: Southern IL
(Alexander, Bond, Clay, Clinton, Crawford, Edwards, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Madison, Marion, Massac, Monroe, Perry, Pope, Pulaski, Randolph, Richland, Saline, St. Clair, Union, Wabash, Washington, Wayne, White, Williamson)



Region 1 (Cook County) representation declined from 53.4% to 45.1%, while Regions 4 and 5, the most rural and historically underrepresented, saw small but meaningful increases.



T2 SURVEY FINDINGS:

Mental Health Needs Among Pediatric Populations

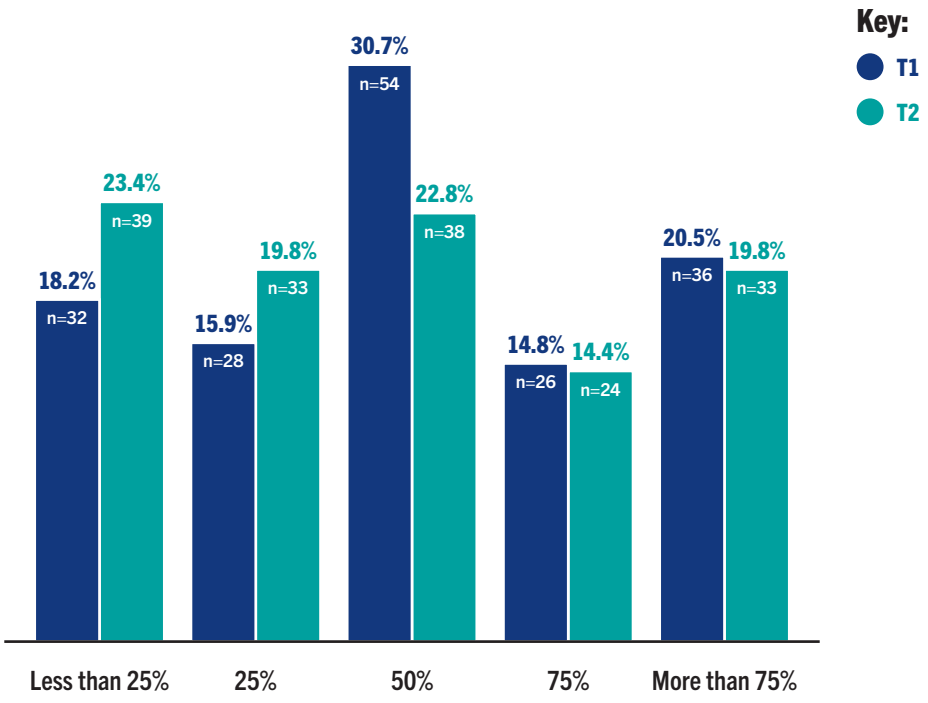
Patient Mental Health Burden

T2 respondents continue to report high mental health concern prevalence in their patient panels. On average, 40.7% of their patients had mental health concern (median 30%, IQR 20-50%). T1 used a fixed ordinal scale, while T2 used an open-text field. As such, T1 and T2 were not directly comparable.

Social Determinants of Health

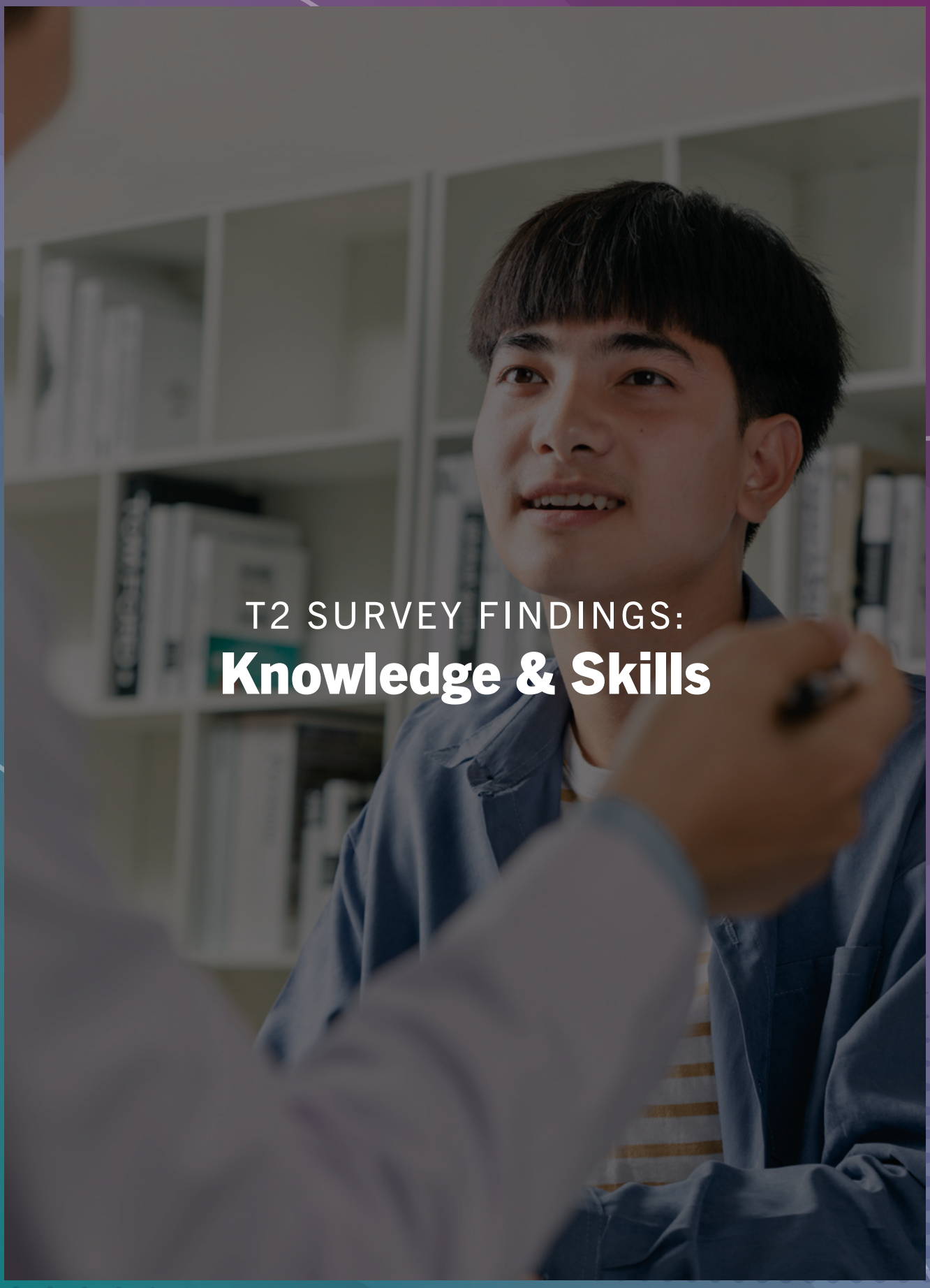
Similar to T1, the majority of clinicians reported that 50% or more of their patients have experienced adverse social determinants of health.

Estimation of Patients Living with Adverse Social Determinants of Health (SDOH)



No statistically significant change was found in the distribution of clinicians' estimates of the proportion of their patients facing adverse social determinants of health (Mann-Whitney U: W=15682, p=0.272, r=0.058). The median response was 50% at both T1 and T2.

> ***These are not 15-minute visits. You have to understand what is going on at home. Often patients see a different doctor at each visit and there is no continuity of care.***
>
> — T2 Respondent, open-ended response



T2 SURVEY FINDINGS:

Knowledge & Skills

Treatment and Management in Primary Care (T2 Only)

T2 asked whether clinicians routinely treat/manage each condition in primary care, sometimes treat with specialist referral for complex cases, or usually refer to a specialist. This question had no T1 equivalent. Respondents report commonly managing general emotional and behavioral concerns, ADHD, depression, and anxiety within primary care, often with referral for more complex cases. Conditions such as suicidal ideation, aggressive behavior, trauma, substance use, and eating disorders are more frequently referred to specialty care.

The findings suggest that primary care practices play a central role in managing more common mental health conditions, while relying on referral networks for more specialized needs.

Percentage of respondents, by condition, who routinely treat in primary care settings:
(n=168)

General emotional/behavioral/MH	50.6%
ADHD	50.0%
Depression	49.4%
Anxiety	44.0%
Suicidal ideation & self-harm	20.8%
Aggressive behavior	18.5%
Eating disorders	11.9%
Trauma	16.1%
Substance use	10.1%

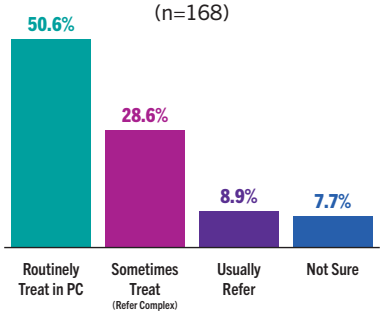
Percentage of respondents, by condition, who usually refer outside of primary care:
(n=168)

General emotional/behavioral/MH	8.9%
ADHD	13.1%
Depression	15.5%
Anxiety	15.5%
Suicidal ideation & self-harm	39.3%
Aggressive behavior	41.7%
Eating disorders	50.0%
Trauma	42.9%
Substance use	59.5%

Treatment and Management in Primary Care by Condition

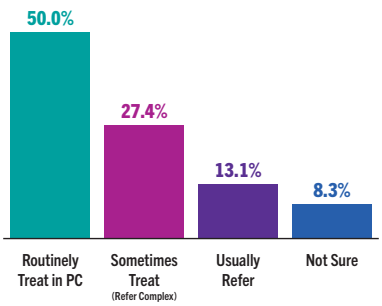
General emotional/ behavioral/MH

(n=168)



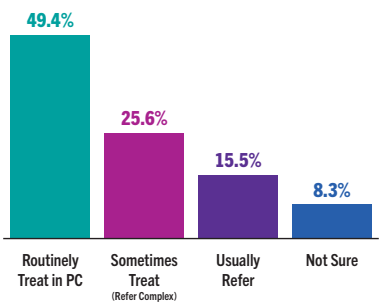
ADHD

(n=168)



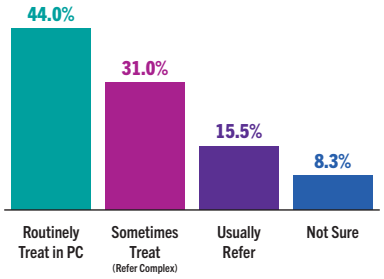
Depression

(n=168)



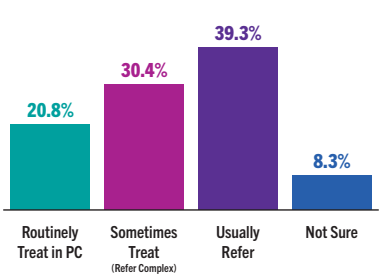
Anxiety

(n=168)



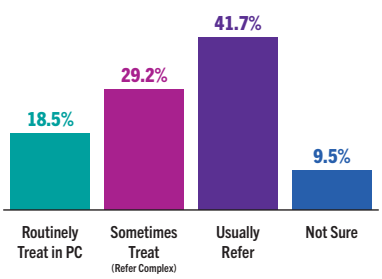
Suicidal ideation & self-harm

(n=168)



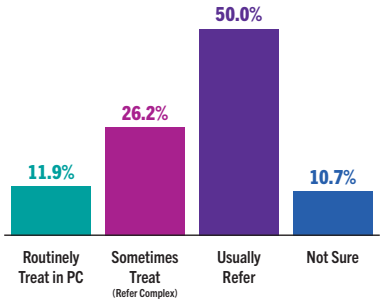
Aggressive behavior

(n=168)



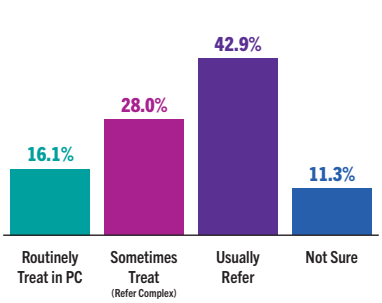
Eating disorders

(n=168)



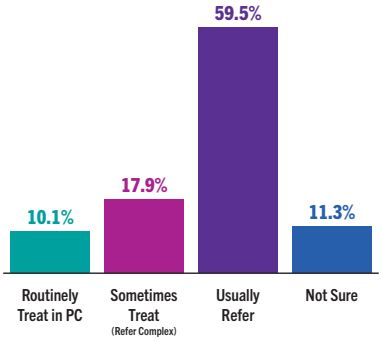
Trauma

(n=168)



Substance use

(n=168)



Substance use shows the highest referral rate (59.5% usually refer to specialist), followed by eating disorders (50.0%) and aggressive behavior (41.7%).

Clinician Confidence Has Increased

At T2 a greater proportion of respondents reported confidence and engagement in key mental health practices, compared with T1, particularly in their ability to support patients with mental health needs and recognize warning signs requiring intervention, two areas that T1 identified as needing the most attention. Routine screening for mental health concerns also appeared more common at T2, though this difference was more modest. In contrast, reported rates of developmental screening were similar across time points.

Percentage of Respondents Who Somewhat or Strongly Agree They are Confident and Engaged in Key Mental Health Practices

Item	T1 % Somewhat or Strongly Agree	T2 % Somewhat or Strongly Agree	p-value	Effect (r)
Can appropriately support patients with emotional/behavioral/MH needs (T1: 176; T2: n=169)	65.9%	**81.1%**	0.001	0.165
Can recognize warning signs that may require crisis intervention (T1: 176; T2: n=168)	84.1%	**95.2%**	<0.001	0.220
Routinely screens patients for mental health concerns (T1: 176; T2: n=169)	84.7%	91.1%	0.068 (trend)	0.087
Routinely screens patients for developmental delays/differences (T1: 176; T2: n=169)	85.8%	85.8%	0.629	0.023

Mann-Whitney U was used because items were on an ordered 1-5 Likert scale. Effect size r = |Z|/sqrt(N): small ~0.10, medium ~0.30. T2 n varies slightly from 169 due to item non-response on the knowledge block.

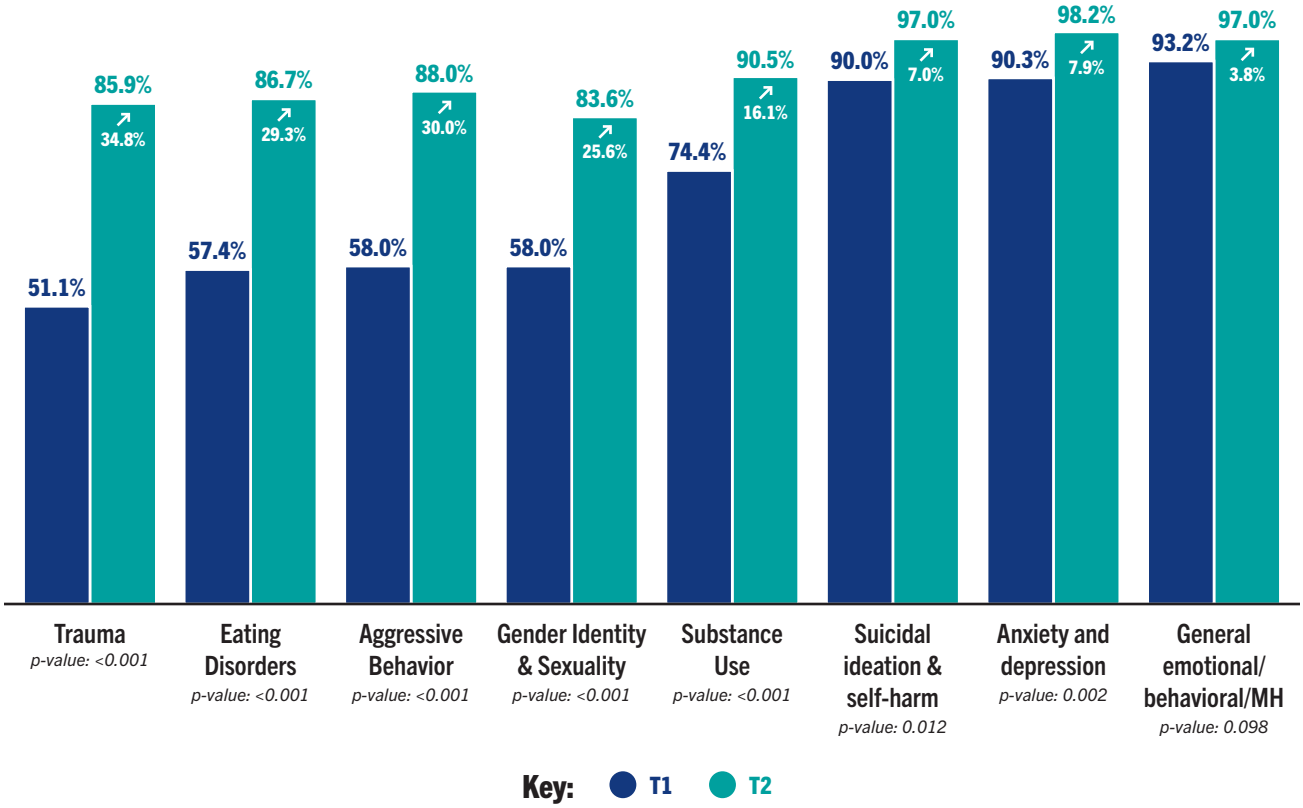
Improvement in Assessment by Condition

The proportion of clinicians reporting that they can appropriately assess mental health conditions increased from T1 to T2, as displayed in the table below. However, T2 adds additional insight by distinguishing between assessments made with confidence versus those made without confidence. For several conditions with the largest increases, a substantial share of T2 respondents indicate they can assess these conditions but do so without confidence. In some cases, responses are nearly split between respondents who feel they can appropriately assess with confidence versus without confidence or skewed toward lack of confidence. For trauma, 37.3% indicated they can appropriately assess with confidence, compared to 45.6% who indicated they can assess, but lack confidence. Aggressive behavior was nearly a split: 43.8% assessing with confidence versus 43.2% without confidence. Eating disorders (28.4% with confidence, 56.8% not confident) and gender identity and sexuality (34.3% with confidence, 47.3% not confident) show similar patterns. In addition, T2 captured that 93.5% of clinicians somewhat or strongly agreed they appropriately assessed ADHD, with only 69.2% reporting that they assessed this condition with confidence.

Because T1 did not capture confidence, these patterns cannot be directly compared over time. However, the results suggest that while more clinicians report that they can appropriately assess mental health conditions, a meaningful portion of this capacity may be tentative. These findings point to an opportunity for future training to focus not only on clinicians' uptake of assessment, but also on strengthening confidence.

Percentage of Respondents Reporting Appropriate Assessment by Condition

(T1 n = 176; T2 n = 169)

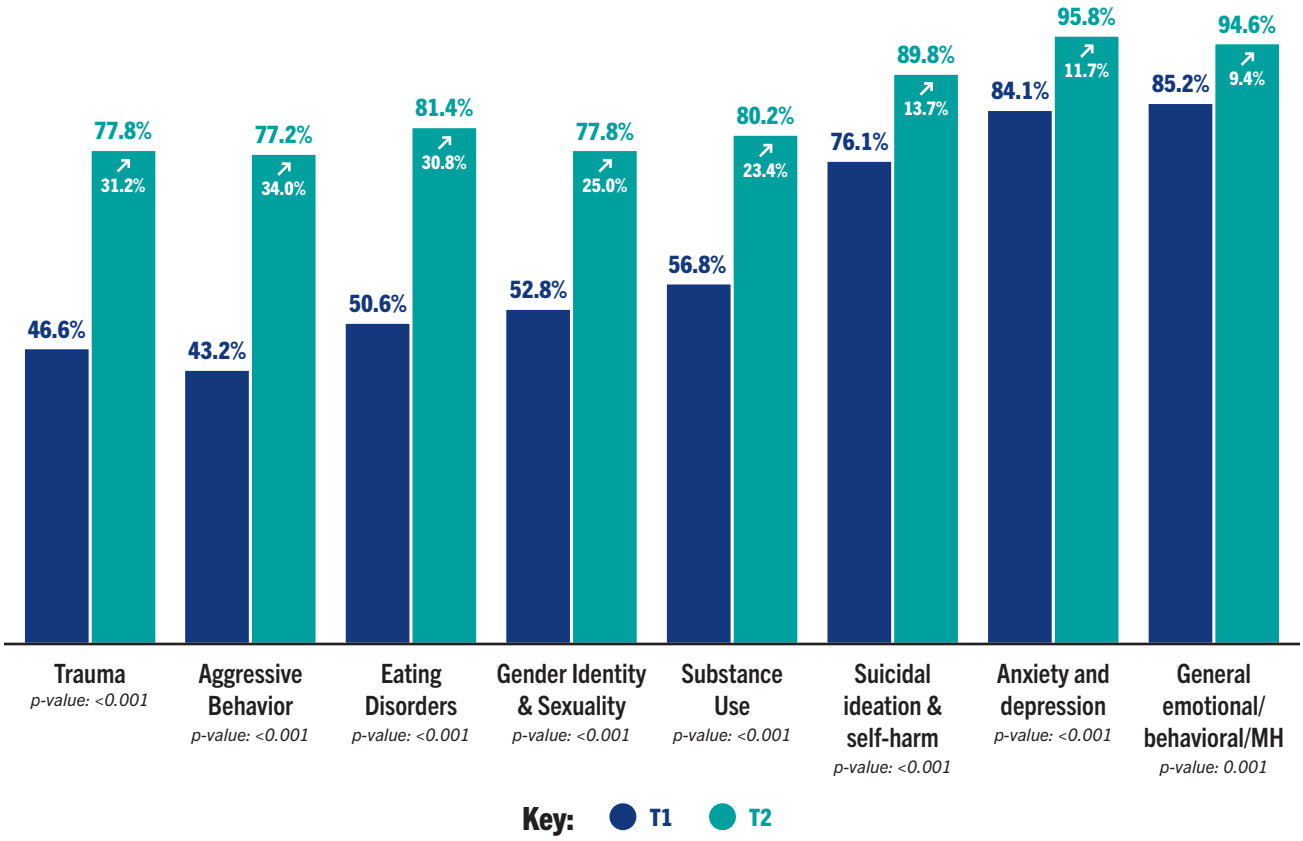


Ability to Provide Education & Resources

Across all conditions, a greater proportion of clinicians at T2 report that they are able to offer education and resources to patients and families, an area of concern at T1. In addition, T2 captured that 94.0% of clinicians somewhat agreed or strongly agreed they can appropriately provide ADHD education and resources, with only 71.2% reporting that they could do so with confidence.

Percentage of Respondents Reporting Ability to Provide Education and Resources by Condition

(T1 n = 176; T2 n = 167)



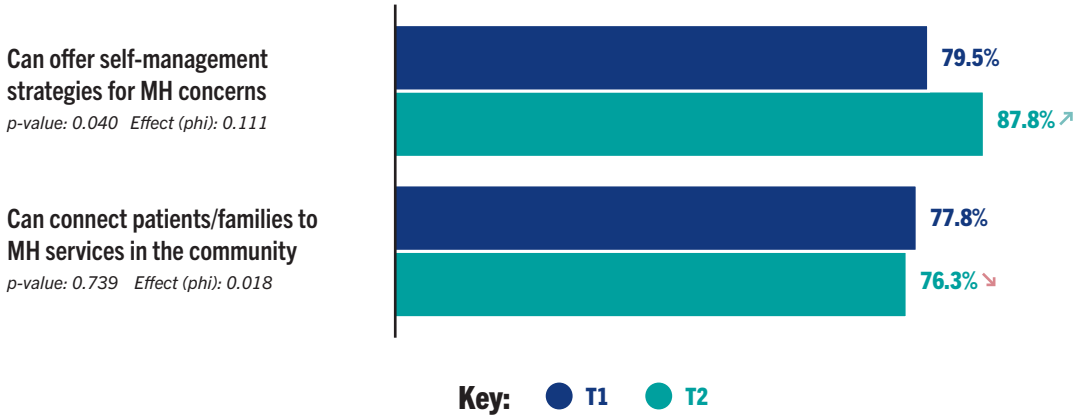
The gap between assessment and resource provision capacity, a defining finding from T1, has narrowed. More clinicians are now reporting capacity to provide education and resources across the board.

Self-Management Strategies vs. Connecting Patients to Services

T2 data reveal that the percentage of clinicians able to offer self-management strategies to patients improved significantly, while the percentage reporting the ability to effectively connect patients to outside mental health services did not change. Notably, among those who reported being able to offer self-management strategies for mental health concerns, only half (51.2%) did so with confidence.

Percentage of Respondents Able to Offer Self-Management Strategies & Connect Patients to Outside Services

(T1 n = 176; T2 n = 169)



Barriers to Connecting Patients to MH Services

(T2 Only, n=40)

Among clinicians who reported difficulty connecting patients and families to mental or behavioral health services, the most commonly cited barriers were limited availability of mental health providers, long wait times for appointments, and insurance or cost-related challenges. The findings highlight structural and access-related challenges that impede successful connection to care.

40 of 169 Respondents Reported Difficulty Connecting Patients to Mental Health Services

Those 40 respondents were surveyed to identify the barriers preventing referral.

Identified Barriers to Connecting Patients with Services

92.5%
Limited availability of mental health providers

87.5%
Long wait times for appointments

82.5%
Insurance coverage or cost barriers

62.5%
Limited care coordination support

57.5%
Lack of familiarity with available MH services

55.0%
Family reluctance to engage with services

52.5%
Lack of clarity on referral pathways

35.0%
Lack of time during visits

27.5%
Language or cultural barriers

7.5%
Other

T2 SURVEY FINDINGS:

Self-Management, Referral, Practice Readiness, & Screening

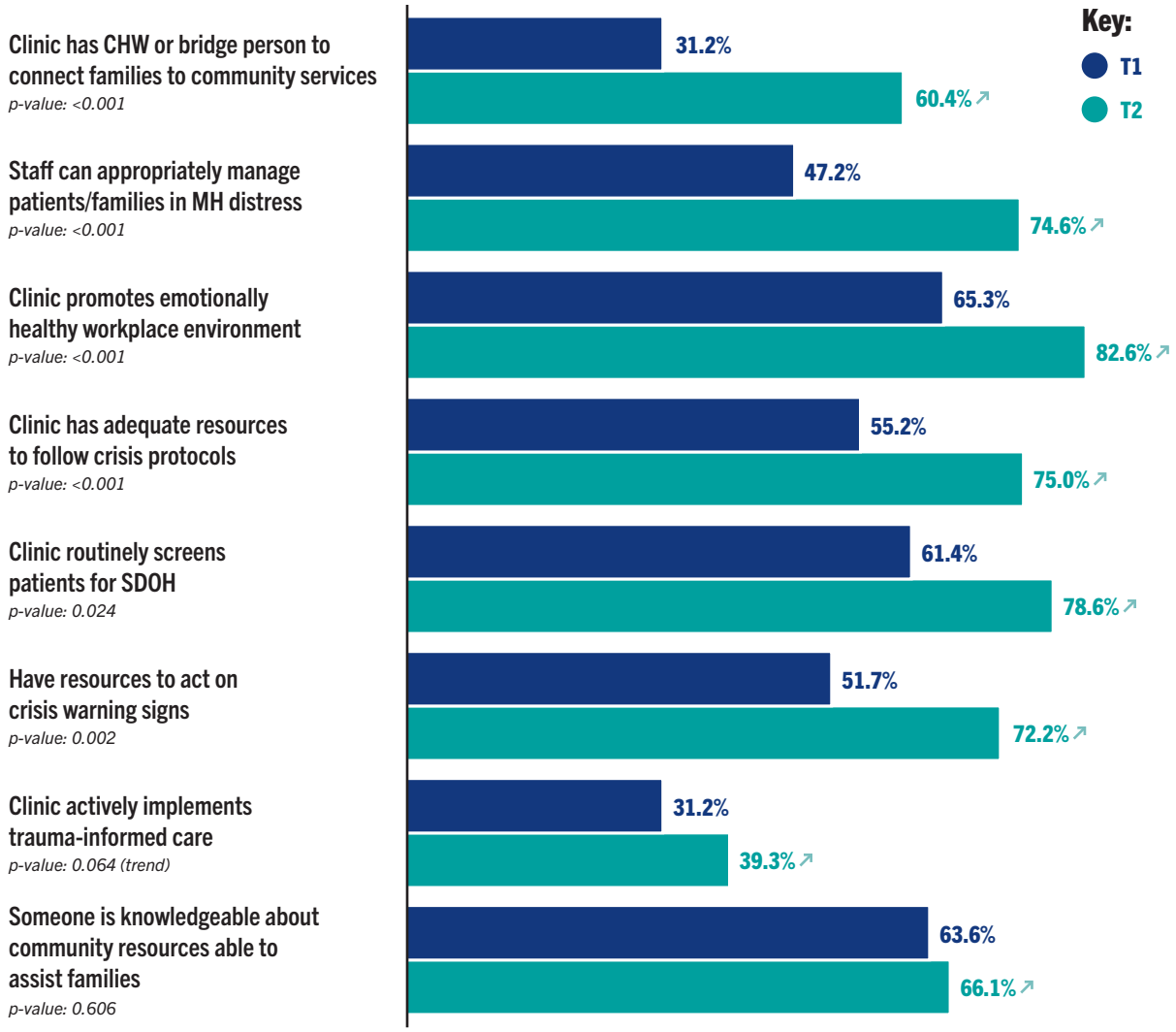
Practice Readiness Infrastructure

Several elements of clinic-level systems and infrastructure for mental health care showed significant improvement since T1. A greater proportion of respondents at T2 indicated that their clinic had capacity to manage mental health concerns, particularly in terms of staff supports and ability to manage crises and mental health distress. Gains were modest or unchanged for trauma-informed care and knowledge of community resources.

Practice Readiness and Capacity: T1 vs. T2 Comparisons

Percentage of Respondents Who Somewhat or Strongly Agree They Have Capacity to Manage Mental Health Concerns

(T1 n = 176; T2 n = 167)



Trauma-informed care implementation remains the most underdeveloped area among practice readiness items: 31.2% agreed at T1 and 39.3% at T2, a trend-level improvement that falls well short of statistical significance (p=0.064). This is consistent with the qualitative finding that clinicians continue to request TIC training and support.

Practice Readiness and Capacity

(T2 Only)

T2 included new items assessing practice readiness and capacity for pediatric mental health care. Written follow-up policies after a positive screen (66.3% agree) lag noticeably behind the very high rate of routine screening (94.0% agree). These results suggest that clinics are identifying patients, but the systems for what happens next are less consistently in place. Additionally, nearly two-thirds of clinicians report that staff experience stress or burnout when managing mental health patients, highlighting ongoing workforce strain.

Percentage of Respondents Who Somewhat or Strongly Agree On Key Indicators of Practice Readiness and Capacity

94.0%

My clinic routinely screens patients for emotional, behavioral, or mental health concerns. *(n=167)*

69.3%

Our practice clinicians are adequately trained in treatment and management approaches for common mental or behavioral health conditions. *(n=169)*

79.8%

Our practice clinicians are adequately trained in diagnostic criteria for common mental health conditions. *(n=168)*

66.3%

My clinic has written policies, protocols, or workflows for follow-up after positive screening for emotional, behavioral, or mental health concerns. *(n=169)*

77.4%

Our practice staff and/or clinicians are adequately trained to administer and score mental health screening tools accurately. *(n=168)*

63.3%

The staff and/or clinicians in my clinic experience stress or burnout related to managing mental and behavioral health concerns in our patient population. *(n=166)*

72.6%

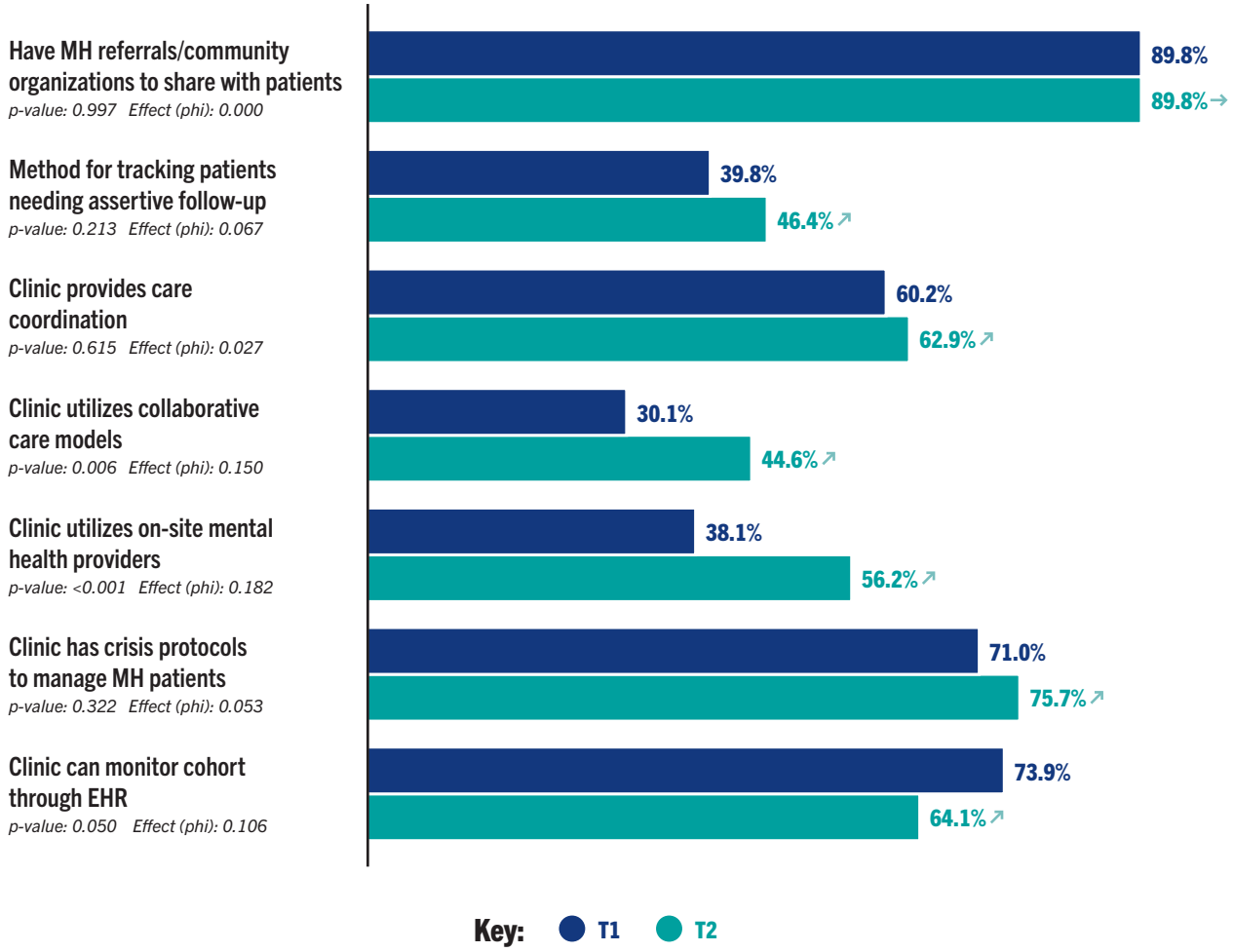
My clinic has written policies, protocols, or workflows for identifying patients with emotional, behavioral, or mental health concerns. *(n=168)*

Practice Infrastructure: Clinic-Level Systems (T1 vs. T2)

Both the T1 and T2 surveys assessed whether specific infrastructure components are present in clinics. Most showed no statistically significant change, with two notable exceptions: collaborative care model utilization increased significantly, and on-site mental health provider availability increased significantly.

Percentage of Respondents Who Answered "Yes" to Having Clinic-Level Infrastructure Components

(T1 n=176; T2 n=168)



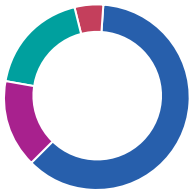
There was an increase in collaborative care model utilization (30.1% to 44.6%, p=0.006) and on-site mental health providers (38.1% to 56.2%, p<0.001). However, patient tracking for assertive follow-up remains low (46.4%), consistent with the qualitative finding about care coordination gaps after referral.

Screening Practices by Developmental Stage: What Clinicians Are Screening For, and When

T2 included a new question asking clinicians to indicate, for each developmental stage, which types of screenings they routinely conduct. This question was not asked at T1, so results are descriptive only. Screening practices are strongest in infancy and adolescence, where the majority of respondents indicate all patients are screened for key concerns such as maternal depression, social-emotional/developmental concerns, depression, and suicide risk. Screening in the toddler, preschool, and school-age periods, as well as substance use screening for adolescents is more variable.

Infancy

Maternal/caregiver depression



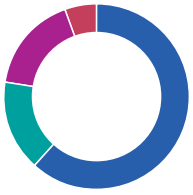
- **61.3%** (n=100) Screen All Patients
- **18.4%** (n=30) Screen Some
- **15.3%** (n=25) Do Not Provide
- **4.9%** (n=8) Not Sure

Social-emotional/developmental

- **60.7%** (n=99) Screen All Patients
- **19.0%** (n=31) Screen Some
- **14.7%** (n=24) Do Not Provide
- **5.5%** (n=9) Not Sure

Toddler

Autism screening



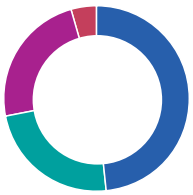
- **61.8%** (n=102) Screen All Patients
- **15.8%** (n=26) Screen Some
- **17.0%** (n=28) Do Not Provide
- **5.5%** (n=9) Not Sure

Social-emotional/behavioral

- **57.6%** (n=95) Screen All Patients
- **14.5%** (n=24) Screen Some
- **21.8%** (n=36) Do Not Provide
- **6.1%** (n=10) Not Sure

Preschool

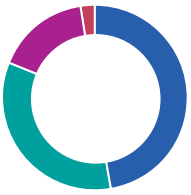
Behavioral/social-emotional



- **48.5%** (n=80) Screen All Patients
- **23.6%** (n=39) Screen Some
- **23.6%** (n=39) Do Not Provide
- **4.2%** (n=7) Not Sure

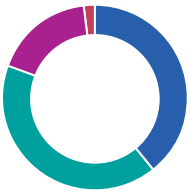
School Age

General mental/behavioral



- **47.3%** (n=78) Screen All Patients
- **33.9%** (n=56) Screen Some
- **16.4%** (n=27) Do Not Provide
- **2.4%** (n=4) Not Sure

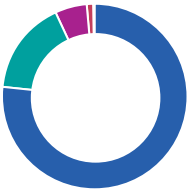
Anxiety screening



- **39.4%** (n=65) Screen All Patients
- **41.2%** (n=68) Screen Some
- **17.6%** (n=29) Do Not Provide
- **1.8%** (n=3) Not Sure

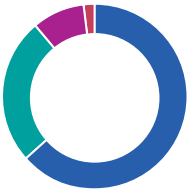
Adolescence

Depression screening



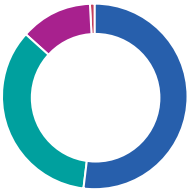
- **77.0%** (n=127) Screen All Patients
- **16.4%** (n=27) Screen Some
- **5.5%** (n=9) Do Not Provide
- **1.2%** (n=2) Not Sure

Suicide risk screening



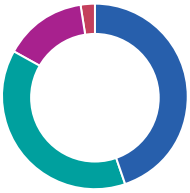
- **63.6%** (n=105) Screen All Patients
- **25.5%** (n=42) Screen Some
- **9.1%** (n=15) Do Not Provide
- **1.8%** (n=3) Not Sure

Anxiety screening



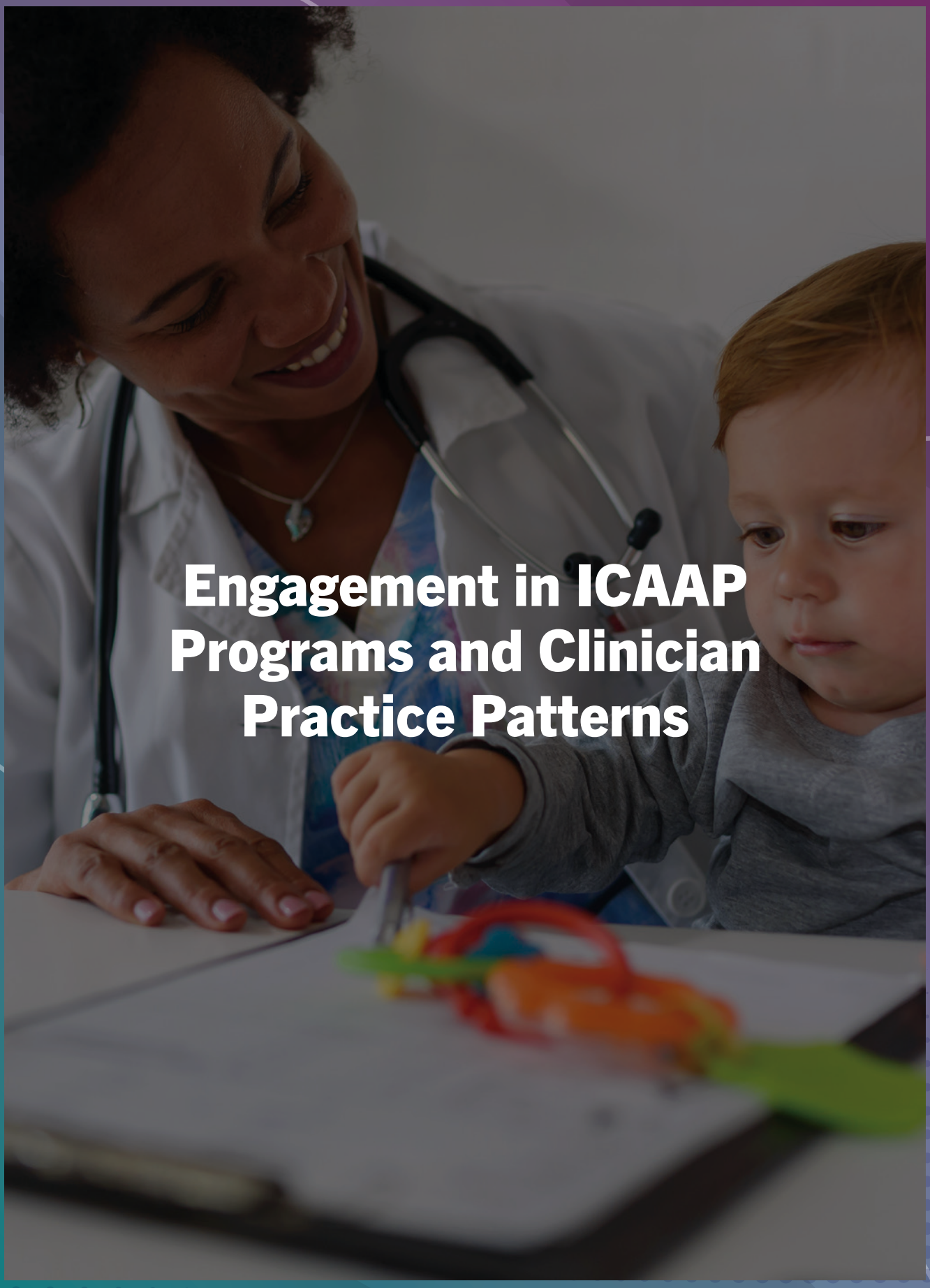
- **52.1%** (n=86) Screen All Patients
- **34.5%** (n=57) Screen Some
- **12.7%** (n=21) Do Not Provide
- **0.6%** (n=1) Not Sure

Substance use screening



- **44.8%** (n=74) Screen All Patients
- **38.2%** (n=63) Screen Some
- **14.5%** (n=24) Do Not Provide
- **2.4%** (n=4) Not Sure

T2 descriptive only; no T1 comparison available. Percentages reflect the proportion of respondents who answered that item and those shown the item due to skip logic.



Engagement in ICAAP Programs and Clinician Practice Patterns

Engagement in ICAAP Programs and Clinician Practice Patterns

T2 included new questions around engagement with ICAAP training, education and resources. These questions allowed for the examination of whether practice patterns and resource use differ between Illinois pediatric clinicians who engaged with ICAAP programming during 2024 to 2025 and those who did not. The analysis compared respondents who reported engaging with at least one ICAAP resource or educational opportunity (n = 98) against those who reported no ICAAP engagement (n = 66; total analytic sample n = 164). Engagement intensity varied within the engaged group, with respondents accessing a median of 3 ICAAP resources (range 1 to 8 of the 8 available options). Comparisons across practice readiness, clinician self-assessment, screening, ability to assess and educate on mental health conditions, treatment in primary care, medication prescribing, practice infrastructure, Illinois DocAssist engagement, and awareness of complementary mental health resources used Mann-Whitney U or chi-square tests at $p<0.05$.

Engaged respondents reported substantively higher capability and broader practice scope across nearly every domain examined. The largest and most consistent differences were:

Practice Readiness

Engaged respondents reported much higher capacity for office staff to appropriately manage patients with mental health concerns (mean 4.20 vs. 3.41 on a 5-point scale; $p<.001$), more presence of written policies and workflows for MH care (3.95 vs. 3.33; $p=.004$), and stronger ratings on staff training (4.28 vs. 3.69; $p=.001$).

Self-Management Offering

Substantially greater capability to offer self-management strategies (mean 1.52 vs. 1.05 on a 0 to 2 scale; $p<.001$), one of the largest single-item effects in the analysis.

Screening Practices

Engaged respondents reported more comprehensive screening on 5 of 11 items, most prominently adolescent depression (mean 1.85 vs. 1.53 on a 0 to 2 scale; $p<.001$) and toddler autism (1.61 vs. 1.25; $p=.011$).

Treatment in Primary Care

Engaged respondents reported routinely treating, rather than referring, trauma, aggressive behavior, suicidal ideation, eating disorders, and depression significantly more often.

Medication Prescribing

Broader prescribing breadth (mean 2.94 vs. 2.12 classes routinely prescribed; p=.006), driven by non-stimulants for ADHD (62.2% vs. 35.4%), mood stabilizers (20.4% vs. 4.6%), and medications for sleep or behavioral regulation.

Patient-Tracking Infrastructure

56.1% of engaged clinicians had a system to track patients in need of follow-up, compared with 30.8% of non-engaged clinicians (p=.003).

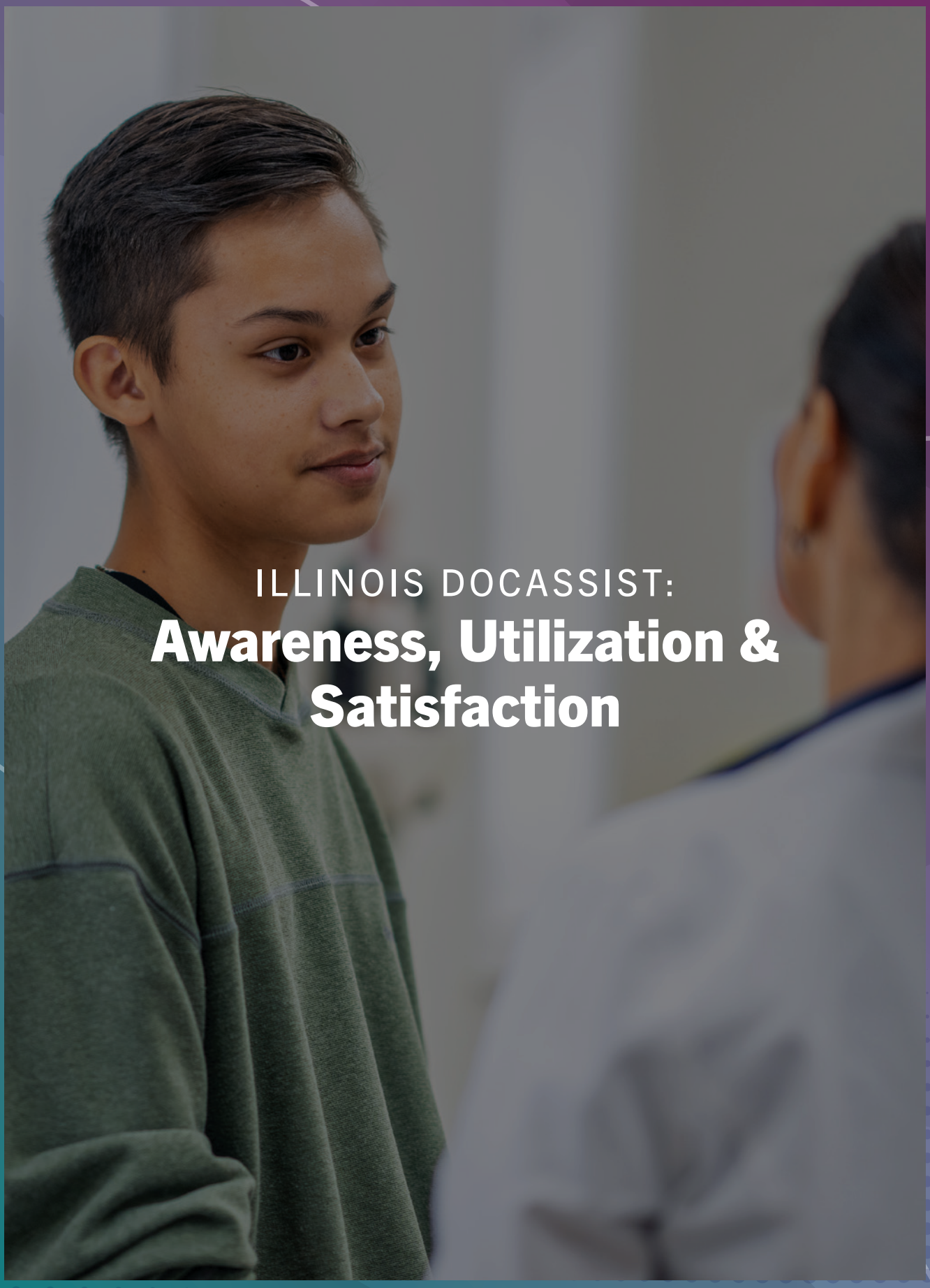
Illinois DocAssist

Engaged respondents were substantially more likely to be aware of DocAssist (86.7% vs. 51.5%; p<.001) and to have utilized it (56.1% vs. 13.6%; p<.001). Among the subset who had utilized DocAssist, experience ratings were essentially identical (mean 4.44 vs. 4.44 on a 1 to 5 scale; p=.97), indicating that the engagement gap reflects differential awareness and routing into the service rather than differential satisfaction with what the service provides.

Awareness of Other Mental Health Resources

Awareness of BEACON (49.5% vs. 19.7%; p<.001) and RAMP at Lurie Children's (33.0% vs. 13.6%; p=.009) was substantially higher among engaged respondents.

These differences should not be interpreted as caused by ICAAP engagement. The two groups differed on baseline characteristics: engaged respondents were more likely to be in psychiatry or developmental pediatrics (14.6% vs. 4.6%; p=.019) and to practice independently (37.1% vs. 18.2%; p=.015). The ICAAP-engaged respondents represent a higher-capability subgroup of Illinois pediatric clinicians whose practice patterns most closely match the integrated, primary-care-based model ICAAP promotes. This correlation could reflect a positive effect of ICAAP programming, self-selection of already-capable clinicians into engagement, or some combination of the two.



ILLINOIS DOCASSIST:

Awareness, Utilization & Satisfaction

Growing Reach, High Satisfaction

Illinois DocAssist showed the clearest positive change of any measured item in T2. Awareness, utilization, and satisfaction all increased significantly.

72.2% ↑
Aware of
IL DocAssist
(up from 52.3% at T1)

54.1% ↑
Have Utilized
IL DocAssist
(up from 36.9% at T1)

90.8% ↑
Rated Experience
Good/Excellent
(up from 73.8% at T1)

Awareness and utilization denominators differ: utilization at T2 was asked only of respondents who indicated awareness (T2 n=122), while awareness was asked of all respondents (T2 n=169). These denominators are not directly comparable to T1, where both items were embedded in a broader resource checklist with all respondents as the denominator (T1 n=176).

Identified Gaps: From Awareness to Practice

Despite the progress, clinicians who have not yet used DocAssist frequently cited not knowing how to incorporate it into their clinical workflow, rather than a lack of awareness that it exists. This distinction matters for how future outreach is designed.

> ***How to incorporate Illinois DocAssist into clinical workflows.***
>
> — T2 Respondent, when asked what training topics would be most useful

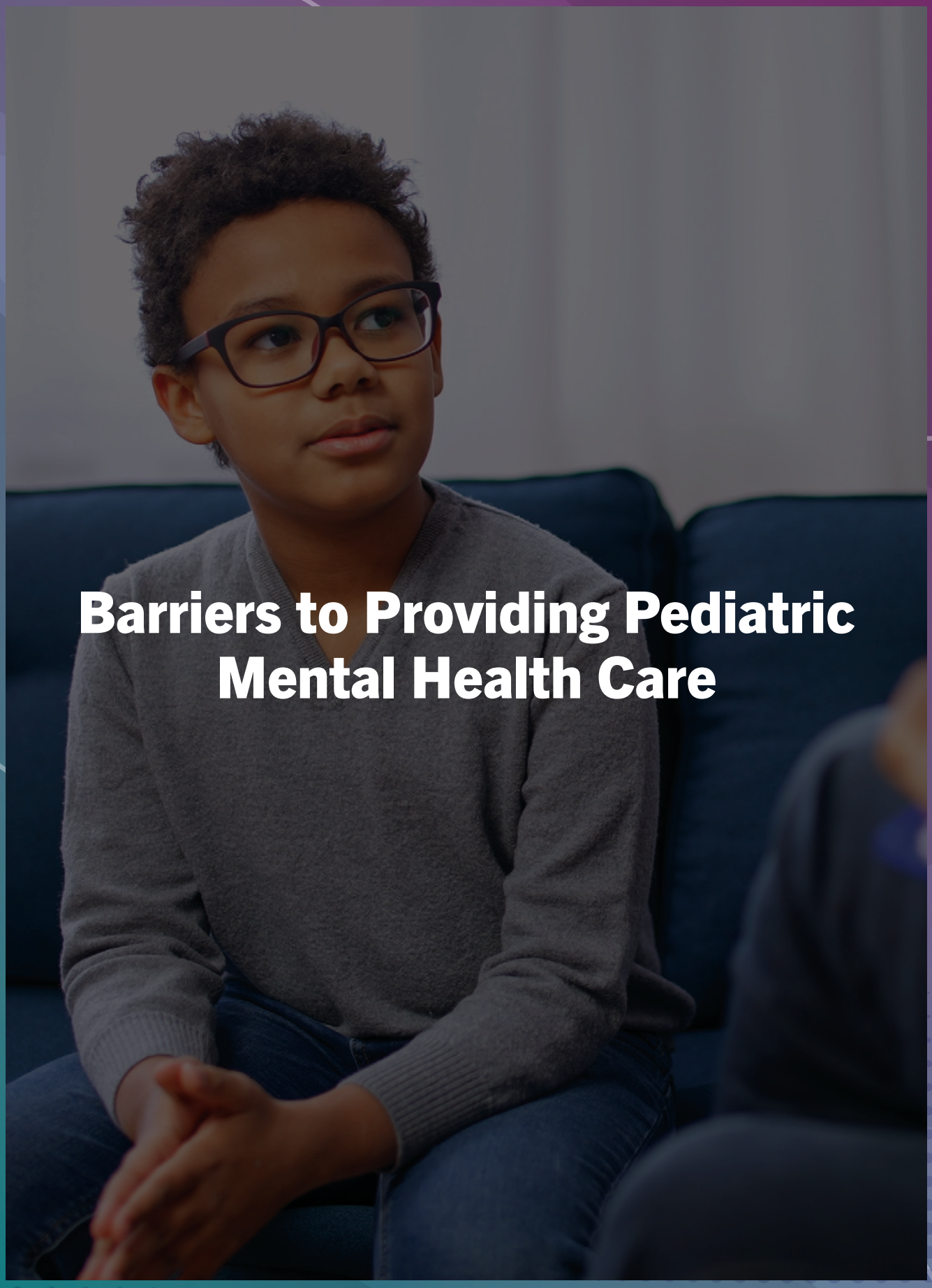
BEACON: Emerging Awareness, Unclear Implementation

BEACON (Behavioral Health Care and Ongoing Navigation) was introduced as a resource option for the first time in T2; therefore, direct comparison to T1 is not possible. Under half (40.7%) of clinicians were aware of BEACON, and 22.2% of clinicians reported they had used it. Qualitative findings reveal a pattern similar to DocAssist: clinicians who encounter BEACON express interest but uncertainty about how to use it in practice.

The most common concern expressed in open-ended responses was not skepticism about the resource but practical confusion about the steps required to access and use it.

BEACON-specific awareness and utilization percentages from T2 are available in the supplemental data document. Because this was a T2-only item, these figures are descriptive only and cannot be compared to T1.

> ***I would love a tutorial on how I as a pediatrician can use it. I understand I need to do something in order to use it but I am not sure what I need to do.***
>
> — T2 Respondent



Barriers to Providing Pediatric Mental Health Care

Structured Barriers Data (T1 and T2)

At T2, respondents indicated the barriers they and their clinic faced in providing care for the majority of emotional behavioral, or mental health concerns. The most commonly indicated barriers included long wait times for specialty mental health services, insurance or cost barriers, and limited access to mental health specialist.

Note, both T1 and T2 asked structured barriers questions, but the item lists were substantially different. Direct comparison is not recommended.

T1 Barriers (n=176)

- **81.2%** Network for referral
- **80.1%** Amount of time
- **51.7%** Office support structures
- **43.2%** Resource materials
- **42.0%** Payment
- **41.5%** Skills and knowledge
- **40.3%** Comfort level/stress tolerance

T2 Barriers (n=159)

Barrier (T2 categories)	T2 n	T2 %
Long wait times for specialty mental health services	122	76.7%
Insurance coverage or cost barriers for patients	101	63.5%
Limited access to MH specialists for consultation or referral	98	61.6%
Limited time during visits to address MH concerns	94	59.1%
Family reluctance to accept or engage with MH care	88	55.3%
Limited knowledge or skills in MH care	73	45.9%
Lack of confidence in diagnosing or managing MH conditions	65	40.9%
Lack of familiarity with community MH resources	59	37.1%
Lack of care coordination support within the clinic	54	34.0%
Lack of standardized workflows or protocols	46	28.9%
Inadequate reimbursement for MH services	42	26.4%
Other (please specify)	7	4.4%

What Clinicians Are Still Up Against

Thematic analysis of T2 open-ended responses identified nine distinct barrier themes, with care coordination gaps and reimbursement/Medicaid access being the most frequently raised.

Care Coordination & Follow-Up Gaps

Clinicians describe giving families referrals and community resources but rarely receiving any follow-up on whether those connections were actually made. Public health systems operate in silos with no shared infrastructure, and psychiatrists are generally not sending feedback to referring primary care clinicians. *(n=8)*

Reimbursement & Medicaid Access

This was the most emotionally charged theme in open-ended responses. Many behavioral health services in providers' areas do not accept Medicaid at all; those that do often have wait lists exceeding two years. Prior authorizations are a consistent frustration. Clinicians described the situation as not just difficult but inequitable, with worse access correlating with income, cognitive ability, and ethnicity. *(n=7)*

Provider Shortage & Long Wait Times

Clinicians reported that particularly in rural areas, the shortage of psychiatrists and licensed counselors is severe enough that children and families may remain in crisis for months. Telehealth helps at the margins but is not a substitute for in-person specialty care, and rural patients face both technology resistance and limited broadband access. *(n=7)*

Specialty Referral Gaps

Neuropsychological testing centers were specifically cited as extremely difficult to access, with particular barriers for Spanish-speaking families and Medicaid patients. Eating disorder and substance use care were also described as harder to access than other referral types. *(n=5)*

Autism-Related Comorbidities

Clinicians described ongoing confusion about clinical responsibility: whether children with mental health issues and autism should be managed by psychiatry or developmental pediatrics, with both specialties frequently deferring to the other. ABA therapy access for Medicaid patients with autism was described as severely limited. *(n=4)*

Time Constraints & Visit Structure

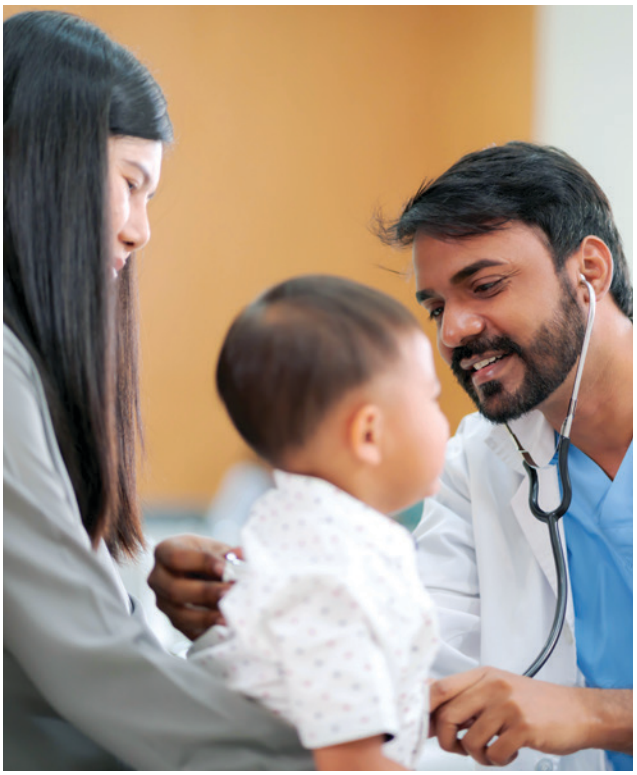
Clinicians acknowledged that thorough mental health care takes time that standard visit structures don't accommodate. High patient volume compounds this, and lack of continuity of care (patients seeing different providers at each visit) makes long-term mental health management especially difficult. *(n=4)*

Age Gaps in Services

Multiple respondents noted that many pediatric behavioral health services only see patients ages 5 and older, leaving families of young children (including 2-year-olds with significant aggression or severe separation anxiety) without options. *(n=2)*

Language & Cultural Access and Family Awareness

Resources in languages other than English are lacking and finding Spanish-speaking clinicians who also accept Medicaid is a particular challenge. Some families also have limited awareness of mental health issues or deprioritize treatment when finances are tight. *(n=1) and (n=1)*



> ***It is obvious to everyone in primary care, involving all ages that mental health care access and support is appalling here. There is no reliable and affordable psychiatry, psychology, social work, therapy, or counseling. Families deserve better. We can only do so much here.***
>
> — T1 Respondent, Family Medicine Physician, Region 3
> (included for context; consistent with T2 themes)

QUALITATIVE THEMES:

Training Needs & Clinician's Feedback

What Clinicians Want to Learn

Thematic analysis of open-ended responses on desired training topics (n=12 valid responses after exclusions) identified the following priority areas. Anxiety and depression remained the top request, though clinicians are increasingly asking for training on more specialized and complex presentations.

Training Topic	n	Representative Response
Anxiety & depression	7	Anxiety, depression, and suicidal ideation. Long-term management of anxiety disorders in autistic children.
Autism & comorbid presentations	4	Aggressive behavior management, particularly in patients with autism. I would love to get trained to do autism diagnosing.
ADHD	1	ADHD and depression.
Eating disorders	1	Autism, anxiety, eating disorders.
Adolescent substance use	1	Adolescent substance abuse.
Complex & refractory cases	1	Complex comorbidities; monitoring and decision-making when using non-FDA-approved treatments due to failure of first-line options.

Resource Integration as a New Training Need

A theme that emerged in T2 without a clear T1 parallel is that clinicians are asking for practical integration support for existing resources, not knowledge training about what the resources are. Both Illinois DocAssist and BEACON show this pattern. Clinicians who are aware of these tools are asking how to use them in their actual clinical practice.

Additional Feedback

Fifteen substantive responses were coded ("Is there anything else you'd like us to know?"). Five themes:

1. **Medicaid & specialist access:** Reinforced barrier themes. Clinicians described the situation as deeply inequitable and difficult to work around.
2. **Efficient workflow integration for training:** Clinicians want training that fits into clinical workflows. A specific request: that ICAAP trainings meet Illinois CME/CE credit requirements with automatic tracking.
3. **Community resource gaps:** Clinicians can identify needs but lack reliable, locally updated resources to refer families to, particularly outside Cook County.
4. **BEACON enthusiasm with practical uncertainty:** One respondent expressed enthusiasm for BEACON but uncertainty about how to use it personally.
5. **Behavioral health service gap for children under 12:** "I do not think I have ever worked in a clinic that offered behavioral health services to children under 12."

Key Insights

What T1 and T2 Together Tell Us

Note on the T2 sample: FQHC and rural health center representation nearly tripled (11% to 34.3%) and school-based health center representation grew from 4% to 12.4% between waves, meaning T2 findings likely better represent clinicians in safety-net and high-need settings than T1 did.

1. The training need has shifted from awareness to clinical confidence

More clinicians are attempting complex assessments than in 2023, but for several conditions (including trauma, eating disorders, aggressive behavior, and gender identity and sexuality) a substantial proportion report doing so without confidence. These findings suggest that building provider confidence in clinical application represents an important complement to efforts that have successfully increased engagement with assessment and education activities.

2. Infrastructure gains were strongest where specific roles or structures were added; systems for tracking and follow-through lagged

Structural additions (CHW capacity, crisis infrastructure, collaborative care model adoption, and on-site mental health providers) showed the clearest gains, suggesting meaningful movement toward integrated care; in contrast, trauma-informed care implementation and community resource knowledge did not improve comparably. Clinics are better equipped to deliver care in the moment than to sustain it: fewer than half reported a method for tracking patients who need assertive follow-up (46.4%), and EHR-based cohort monitoring showed a borderline decline (73.9% to 64.1%, p=0.050).

3. Screening rates are high, but follow-through systems are less consistently in place

Ninety-four percent of clinicians report routine mental health screening, but fewer than two-thirds have written follow-up policies after a positive screen; the ability to connect patients to community services did not improve from T1 to T2; and 63.3% report staff burnout. These findings point to the potential value of follow-up protocol development, clearer referral pathways, and attention to workforce capacity.

4. For DocAssist and BEACON, workflow integration has emerged as a gap

DocAssist awareness increased nearly 20 percentage points and user satisfaction is high, yet open-ended responses from non-users more frequently cite workflow uncertainty than unfamiliarity as a barrier; BEACON shows a similar pattern. These findings suggest that outreach efforts may benefit from shifting emphasis toward practical, encounter-level integration support alongside continued awareness activities.

5. Persistent structural barriers were not measurably affected by training and education interventions between T1 and T2

Long wait times, Medicaid access, specialist shortages, and care coordination fragmentation were among the most commonly cited barriers at both time points, and the distribution of adverse SDOH in clinicians' patient panels did not change significantly. Open-ended responses from providers in rural regions and those serving primarily Medicaid-insured patients describe compounding deficits across multiple dimensions, suggesting that structural and policy-level action may be needed alongside provider-level interventions.

6. Open-ended training requests have shifted toward more specialized clinical presentations

T2 open-ended responses requested training on autism comorbidities, refractory case management, and complex medication decision-making, with fewer requests for introductory mental health content. Though based on a small number of responses (n=12), this pattern is consistent with the assessment confidence data and suggests that training offerings may benefit from content that goes beyond foundational skill-building.

Recommendations

Recommendations

1. Expand DocAssist and BEACON Support to Include Workflow Integration

- Develop step-by-step workflow guides that show clinicians when and how to consult DocAssist during a patient encounter, complementing existing awareness materials.
- Develop a BEACON orientation resource designed for primary care physicians with no prior platform experience; this type of support was requested in T2 open-ended responses.
- Explore EHR integration or brief point-of-care reference tools that clinicians can access during a visit without navigating external systems.

2. Consider Depth Training for Conditions Where Self-Reported Capability Exceeds Confidence

- Consider prioritizing case-based training for trauma, aggressive behavior, eating disorders, gender identity and sexuality, and substance use, the conditions where the gap between self-reported capability and confidence is most pronounced in T2 data.
- Develop training on autism-related comorbidities and behavioral management, which was among the more frequently requested topics in T2 open-ended responses (n=4), though the overall response pool was small (n=12).
- Develop or identify clinical decision-support resources for complex and refractory presentations, including guidance on medication management when first-line options have not been effective.
- Consider incorporating self-management confidence into training design, given that only 51.2% of clinicians who report offering self-management support do so with confidence.
- Where feasible, ensure training offerings meet Illinois CME/CE requirements with credit tracking; several T2 respondents identified the absence of this as a practical barrier to participation.
- Consider incorporating trauma-informed care (TIC) content into existing training offerings; TIC implementation showed only a trend-level change from T1 to T2 (31.2% to 39.3%, p=0.064) and remains the most underdeveloped practice readiness item, consistent with qualitative requests for TIC support.

3. Strengthen Follow-Through Systems After Positive Screening

- Develop written follow-up protocol templates that clinics can adapt to their settings, to help address the gap between near-universal screening rates (94.0%) and the proportion of clinics with formalized post-screen workflows (66.3%).
- Consider providing tools and resources to support more consistent screening during the toddler, preschool, and school-age developmental periods, where universal rates are lower than in infancy and adolescence.

4. Strengthen Care Coordination and Community Resource Infrastructure

- Develop or update region-specific, Medicaid-stratified community mental health resource directories, with attention to providers outside Cook County and those offering Spanish-language services; community resource knowledge did not improve across waves, suggesting this remains a gap.
- Promote collaborative care models to help reduce fragmentation between primary care and behavioral health, including clearer communication pathways between specialists and referring clinicians.
- Consider how to better support access to behavioral health services for children under age 12; this gap was noted in T2 qualitative responses and may affect referral options available to primary care clinicians.
- Consider developing resources to support assertive follow-up tracking within primary care (such as EHR templates, panel management tools, or care coordinator workflows) given that fewer than half of T2 respondents (46.4%) reported having a tracking method in place, and EHR cohort monitoring showed a borderline decline between waves.

5. Develop Resources to Support Family Engagement

- Develop or curate clinical-facing guidance on approaching mental health conversations with families who are hesitant to engage, including culturally responsive communication strategies.
- Develop or identify family-facing educational materials in languages other than English; T2 qualitative responses identified the absence of Spanish-language resources as a barrier.
- Consider incorporating family engagement strategies as a discrete component of training offerings, given that family reluctance was endorsed as a barrier by 55.3% of T2 respondents.

6. Design Training and Delivery with Clinician's Workload in Mind

- Offer training in modular, asynchronous formats where possible, to accommodate the time constraints and workload pressures that clinicians consistently cite.

7. Advocate for Policy and Systems Change

- **Medicaid reimbursement:** Continue advocacy for equitable behavioral health reimbursement rates and reduced prior authorization requirements, which were among the most frequently raised barriers in T2 qualitative responses.
- **Specialist workforce:** Support child psychiatry, psychology, and behavioral health workforce development, with attention to Regions 3-5 where provider shortages were most prominently described.
- **Rural infrastructure:** Advocate for broadband expansion to support telehealth access in rural communities; T2 qualitative data noted that technology and connectivity limitations affect the feasibility of telehealth for some rural patients.
- **Early childhood services:** Advocate for expanded behavioral health access for young children, including EPSDT coverage; the service gap for children under age 5 and under age 12 was raised in qualitative responses.
- **Language and cultural access:** Advocate for expanded availability of Spanish-language behavioral health services and Medicaid-accepting Spanish-speaking clinicians, as identified in T2 qualitative data.

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