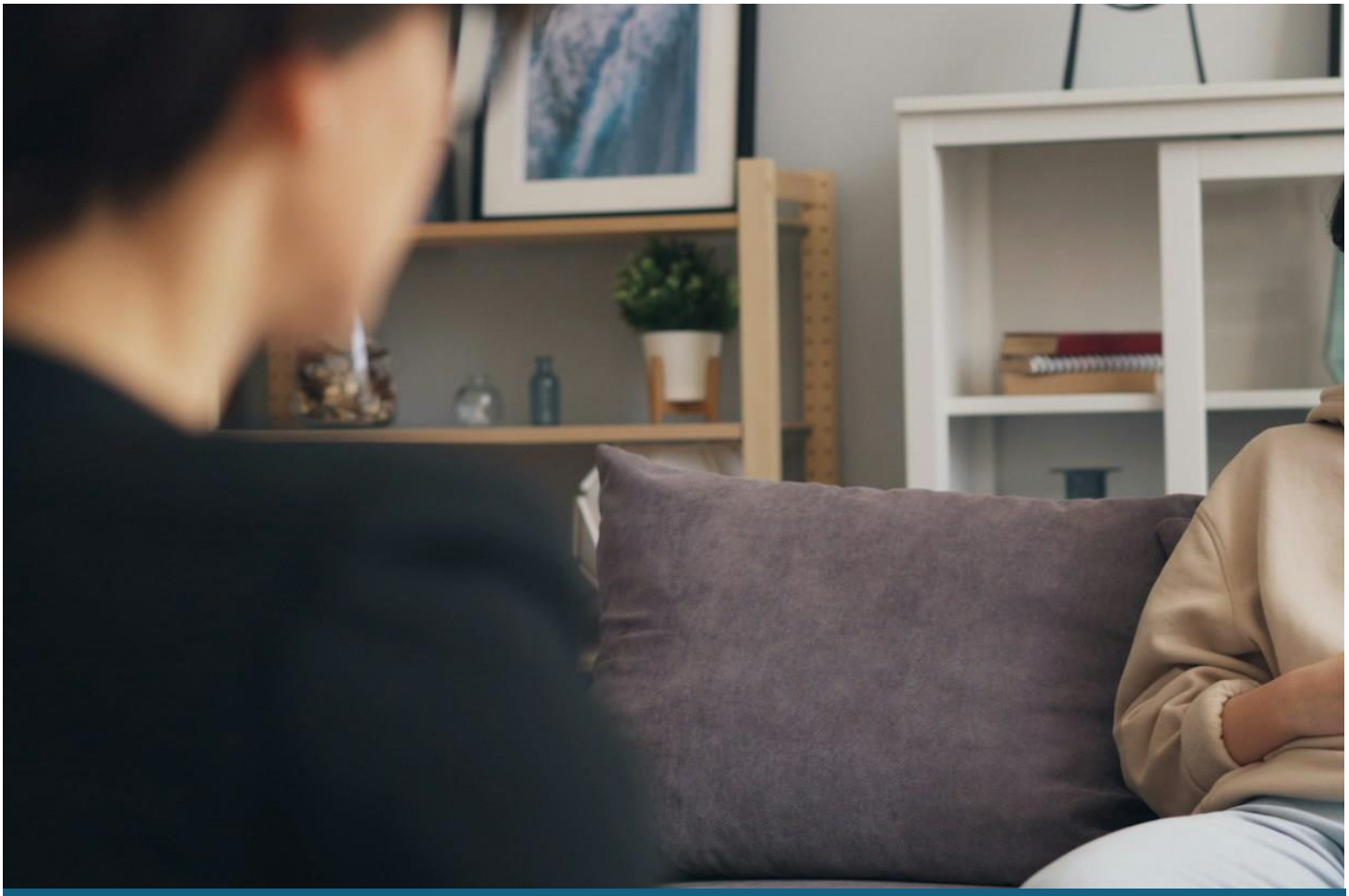

Behavioral Health Care in the Texas Panhandle

An Exploration of Wait Times, Provider Shortages, and Barriers to Mental Health Accessibility

2025

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Executive Summary

Since 2016, the Panhandle Behavioral Health Alliance (PBHA) has led regional efforts to strengthen access to mental and behavioral health care, including addressing persistent provider shortages across the Texas Panhandle. Thus, this case study offers to illuminate provider availability, care-seeking challenges, and opportunities for system improvement. It reflects PBHA's ongoing commitment to improving the availability and quality of behavioral health services across the region. *Behavioral health* refers to the spectrum of mental health and substance use conditions, as well as the behaviors and biological processes that influence psychological well-being and daily functioning.

PBHA conducted exploratory research using a Secret Shopper methodology to evaluate wait times and accessibility to mental health services across its 27-county service area in the Texas Panhandle. In addition, the structured and replicable design is particularly useful for identifying barriers in rural and underserved areas. Across the Texas Panhandle 309 behavioral private practitioners were contacted by phone. These providers represented a range of licensure types, including Licensed Professional Counselors (LPCs, LPC-As, LPC-Ss), Licensed Clinical Social Workers (LCSWs), Licensed Marriage and Family Therapists (LMFTs), Licensed Chemical Dependency Counselors (LCDCs), Psychologists (Ph.D or Psy. D), and Psychiatrists (MD), with the highest representation from LPCs and Social Workers. Key findings included appointments were offered successfully only 16% of the time upon initial contact with the practitioner; providers explicitly stated they were not accepting new patients 11% of the time; and among practitioners only 56% were determined to be accepting new clients. In the area, the cost of a visit for 94% of the practitioners is below $175.

The findings reveal issues of provider non-responsiveness, high follow-up burdens, and limited referrals which all contribute to fragmented access and reinforce existing disparities. Grounded in local data, this report provides both a clear picture of access challenges and a replicable framework for regional analysis. The insights are intended to inform decision-making at every level, empowering care seekers, providers, and policymakers to build a behavioral health system that is more responsive, coordinated, and equitable.

Introductions

Access to mental health care is a critical determinant of individual and community well-being, yet the reality for many seeking these services remains fraught with challenges. Despite the growing recognition of its importance, significant barriers to accessing timely and appropriate care remain. Particularly in rural and frontier regions like the Texas Panhandle, the scarcity of mental health professionals and the concentration of providers in just a few urban centers contribute substantially to the significant gaps in accessing care. Additional factors such as long wait times, limited provider availability, and high out-of-pocket costs can hinder individuals from receiving the support they need. These barriers are multifaceted, encompassing issues related to provider shortages, geographic isolation, economic disparities, and systemic limitations in healthcare infrastructure.

Extensive literature underscores the disproportionate impact of mental health service inaccessibility on rural populations, where higher incidences of untreated mental health conditions are often associated with limited provider availability and long travel distances. Research indicates that individuals in rural areas are less likely to receive timely or continuous mental health care, often facing delays of more than a decade between the onset of symptoms and treatment (Wang et al., 2004). These access gaps are further compounded by social stigma, limited mental health literacy, and siloed systems of care that operate without effective coordination (Coombs et al., 2021; Street et al., 2009). Studies have shown that rural areas frequently experience a scarcity of behavioral health providers, particularly psychiatrists, with more than two-thirds of Texas counties lacking even one licensed psychiatrist (Simpson, 2024). In response to these disparities, the Texas Legislature has directed targeted investments toward improving behavioral health infrastructure in underserved regions, including the Panhandle. Despite these efforts, there remains a critical need for data-driven evaluation of access at the local level to inform targeted interventions and guide system-level improvement.

In this context, the Panhandle Behavioral Health Alliance (PBHA) undertook a comprehensive case study in the fall of 2024, employing a Secret Shopper methodology to objectively evaluate access to behavioral health services in the region. This approach allowed for real-time assessment of provider responsiveness, appointment availability, service modalities, insurance acceptance, and cost structures. For the purposes of the study, PBHA utilized two trained interns, posing as prospective clients, to systematically contact providers and collect standardized data on responsiveness, appointment availability, service modality, and other access-related variables. The data obtained provides valuable insights into the current state of mental health care access in the region.

This report outlines the methodology and key findings of the Secret Shopper case study, offering a focused look at the real-world experiences of individuals attempting to access behavioral health care in the Texas Panhandle. While the study does not aim to generalize beyond its scope, the findings contribute to a deeper understanding of access challenges in rural behavioral health systems. It concludes with observations intended to support care seekers, guide providers and community stakeholders, and inform decision makers working to improve access, reduce disparities, and strengthen the region's behavioral health system. In doing so, the study also provides critical insights for PBHA leadership and stakeholders as they continue efforts to educate the community and develop collaborative solutions that promote health equity and access across the region.

Methodology

To assess the applied accessibility of behavioral health services in the Texas Panhandle, this study employed a secret shopper methodology, a well-established approach frequently used in healthcare and public health research to evaluate service availability, timeliness, and responsiveness (Rankin et al., 2022; CMS, 2024; Rhodes et al., 2009). This method is particularly effective for objectively measuring barriers to care, as it mitigates the risk of providers altering their behavior in response to observation or formal evaluation. By simulating real-world attempts to secure initial mental health services, this approach allowed for an in-depth assessment of provider responsiveness, appointment availability, service modalities, and cost structures.

This methodology was selected for its appropriateness to the research questions and its feasibility within the study's logistical constraints. It enabled research interns to gather ecologically valid data without requiring provider participation or disrupting service delivery. Furthermore, the design allowed trained interns to function as consistent data collectors using standardized protocols via phone and email—replicating the most common contact points used by clients seeking care. This method provided a practical, scalable, and ethically sound approach for evaluating behavioral health access across a geographically dispersed, largely rural region.

Sampling Criteria

Using purposive sampling, this study focused on private behavioral health providers located across 27 counties of the Texas Panhandle. Providers were identified using the two most commonly referenced directories by PBHA stakeholders: the *Panhandle Mental Health Guide (PMHG)* and *Psychology Today*. However, only providers listed in *Psychology Today* who also met the inclusion criteria for the PMHG were selected for the sample.

To qualify for inclusion in the PMHG (www.PanhandleMentalHealthGuide.org)—and therefore this study—providers were required to maintain a physical practice location within PBHA's 27-county service area. Telehealth providers were included only if their place of business was located within this same geographic footprint, ensuring the exclusion of providers based outside the region (e.g., Houston or Dallas) who offer remote services but lack a local presence.

Eligible providers represented a range of specialties, including Licensed Professional Counselors (LPCs, LPC-As, LPC-Ss), Licensed Clinical Social Workers (LCSWs), Licensed Marriage and Family Therapists (LMFTs), Licensed Chemical Dependency Counselors (LCDCs), Psychologists, and Psychiatrists. Associates practicing under supervision were included and recorded with the name of their LPC-S on the data collection form (see Appendix B).

The final sample included 309 providers.

Justification and Limitations of Sample Size

This study aimed to assess behavioral health access across the Texas Panhandle using a purposive sample of providers presumed to be actively practicing based on their inclusion in publicly accessible directories. According to the Texas Health Professions Resource Center (HPRC), there are 830 licensed behavioral health professionals across the 27 counties included in PBHA's service area. However, workforce data from the Texas Behavioral Health Executive Council suggests that only 81% of licensed professionals in Texas are actively providing services, with the remaining 19% citing burnout and transitions into administrative roles as factors limiting clinical availability.[1]

Applying that 81% benchmark yields an estimated active workforce of 672 providers in the region at the time of the study. From this pool, a total of 309 providers were selected for inclusion, representing approximately 47% of the presumed active workforce. This approach aligns with statewide trends and ensures that the findings of this study are insightful, actionable, and highly relevant to addressing challenges to mental health access despite the inherent limitations of non-probability sampling.

While certain provider subsets, when analyzed by licensure type, did not meet conventional thresholds for statistical reliability—typically cited as a minimum of 20 observations per group—these limitations stem directly from the small number of professionals practicing within specific licensure categories. The limited sample size within some licensure categories reflects the reality

[1] This figure is based on licensure data from the Texas Behavioral Health Executive Council, which regulates social workers, professional counselors, marriage and family therapists, and psychologists. Psychiatrists and psychiatric nurse practitioners are licensed separately by the Texas Medical Board and Texas Board of Nursing, respectively, and are not included in this dataset.

of provider distribution in rural and frontier regions, where certain specialties are rare. (A detailed breakdown of licensure types and the respective sample sizes can be found in Appendix C.) Although the small sample sizes reduce the generalizability of licensure-specific findings, they still offer valuable insight into access patterns and systemic gaps.

Rather than indicating sampling error, the lower-than-optimal sample sizes highlight the very workforce limitations this study seeks to illuminate. The overall sample offers a pragmatic and proportionally reflective lens into the current state of behavioral health access in the Texas Panhandle. This design supports the study's intent: to offer a regionally grounded understanding of access dynamics within a constrained rural workforce, rather than to produce generalizable statistical claims.

Data Collection Process

Two trained interns, one in the final semester of a Bachelor's Degree in Psychology and the other pursuing a Master's Degree in Counseling (LPC track), posed as prospective private pay clients. Using standardized scripts, secret shoppers initiated contact with behavioral health providers by phone. When calls went unanswered, voicemails were left. If no response was received within 10 business days, a second phone call was made. If the second attempt at contact also failed to elicit a response, a follow-up email was sent five business days later.

Interactions were first documented using a structured Call Note Template designed to capture the nuances of each inquiry (see Appendix B). These notes were then transferred into a standardized Data Input Sheet, which compiled findings into a format suitable for analysis. This two-tiered approach ensured accuracy, reduced transcription errors, and maintained consistency across interactions.

Reliability Measures

To enhance data reliability, both interns completed a comprehensive three-hour training session led by PBHA staff. The training included role-playing provider conversations, working through potential scenarios and curveballs that might arise during calls, and practicing documentation using the Call Note Template and Data Input Sheet. A standardized call note template (See Appendix B) and a data collection form were used to reduce variability and maintain consistency across interactions.

Throughout the data collection period, PBHA staff conducted weekly Zoom check-ins with the interns to answer questions, provide clarification, and ensure adherence to protocol. These meetings also served as a quality assurance measure, allowing real-time troubleshooting and reinforcing consistency across interactions.

Interns were instructed to use consistent tone, language, and pacing across calls, and to document each interaction promptly. The use of standardized templates, along with structured training, regular supervision, and internal data checks, helped ensure a high degree of reliability in both the collection and transcription of data.

Ethical Considerations

All interactions were conducted anonymously, and care was taken to avoid disrupting provider operations. Secret shoppers used the same gender-neutral pseudonym to standardize interactions and ensure a consistent client persona. The methodology adhered to ethical standards for research, ensuring that the data collection process remained unobtrusive and respectful of provider time and resources. The emphasis on ethical interactions is especially critical in rural regions like the Texas Panhandle, where professional networks are smaller, and providers may be more sensitive to the implications of research. By adopting an anonymous and unobtrusive approach, this study ensured that the data collection process did not compromise provider trust, professional relationships, or the integrity of the behavioral health care community. This commitment to ethical research practices also helped to minimize disruptions to providers' daily operations while maintaining the validity and reliability of the findings.

This structured and standardized approach provides a replicable framework for evaluating barriers to mental health care access, particularly in rural and underserved regions like the Texas Panhandle. The use of a regionally grounded sample, combined with the secret shopper methodology and rigorous data collection protocols, ensures that future analyses can build on these methods to monitor trends, assess interventions, and refine strategies to address provider shortages. While limitations such as small sample sizes reflect the realities of rural mental health care, the methodology remains adaptable and scalable for ongoing evaluation of accessibility challenges and potential solutions.

Key Findings

Provider Responsiveness

Of the 309 providers contacted, an overwhelming majority of first contact attempts, 77.9% (241), did not result in meaningful progress toward accessing care. In some cases, calls were answered by a representative, such as a receptionist, who could assist with scheduling or provide relevant information.[2] Only 68 of the 309 first contact attempts resulted in meaningful progress to access

[2] Both direct conversations with providers and interactions with receptionists were included in the responsiveness rate, provided these interactions resulted in meaningful steps toward initiating care, such as offering appointment options or providing follow-up instructions.

care. When initial contact could not be made, voicemails were left requesting a callback. Voicemails were left for 102 providers. Interns then waited 10 business days for a response before initiating a second contact attempt. Despite this, 94 of those providers still required a second contact due to lack of response, yielding an initial response rate of 7.85%. If no reply was received after the second attempt, a follow-up email was sent as a final effort to reach the provider. A third contact attempt via email was required for 69 providers. Ultimately, more than 1 in 5 (22.3%) of the sampled providers required a third contact attempt through email, and 46 (14.88%) of those providers remained completely unresponsive.

Provider Availability

Across all contact attempts, data revealed persistent barriers to accessing mental health care in the Texas Panhandle. Appointments were successfully offered in only 15.8% of cases upon initial contact. Additionally, 10.68% of providers explicitly stated they were not accepting new patients. Overall, 55.66% of providers were determined to be accepting new clients at the time of the study. The remaining providers had listings that were not current, had changed roles (i.e. shifted to administration, not providing direct services) or offered a wait list option.

Referral Practices

During the research phase, of the 33 providers not accepting new clients, only six (18%) offered referrals to other mental health professionals, underscoring a lack of referral culture among behavioral health providers in the region. Overall, providers gave referrals in just 1.94% of cases, reflecting limited efforts to connect patients with alternative options when care could not be provided directly. The absence of a referral leaves patients at a dead end, and without clear direction for next steps. For individuals in urgent need of care, this can be particularly dangerous. While referrals may not be necessary from providers who are accepting new clients, the failure to offer them when services are unavailable or subject to extended wait times represents a missed opportunity to reduce barriers and support continuity of care.

Accessibility and Service Variability Among Providers

The collected data revealed significant differences in both wait times and response rates across provider specialties. Wait times were only calculated for licensure categories with more than 20 providers to ensure the reliability of the data, while response rates for all specialties are included in Appendix C, regardless of sample size.

Wait Times: Measured from the moment of contact to the date of the provider's first available slot, data revealed a median wait time of 7 business days indicating that most patients can access care relatively quickly. However, variability was high, with responses ranging widely across providers. Wait times ranged from as little as 1 business day to an

astounding 400 business days reflecting a highly skewed distribution. The mean wait time of 16.44 business days demonstrates the significant impact of outliers—providers with exceptionally long wait times—on overall accessibility. This skewed distribution highlights disparities in access and the need for targeted interventions to address bottlenecks, particularly in psychiatry.

When analyzed by provider licensure (limited to categories with more than 20 providers to ensure reliable and representative data), the following differences in wait times and response rate were observed:

Figure 1
LPC and LCSW Wait Times and Response Rates.

LPC
Average Response Rate: 69.1%
Average Wait Time: 11.89 days
Median Wait Time: 7 days

LPC-A
Average Response Rate: 73.9%
Average Wait Time: 5.90 days
Median Wait Time: 3 days

LPC-S
Average Response Rate: 80.0%
Average Wait Time: 7.90 days
Median Wait Time: 8 days

LCSW
Average Response Rate: 63.6%
Average Wait Time: 8.71 days
Median Wait Time: 4.5 days

Service Modalities: The analysis revealed significant differences in service modalities among providers:

- **72.7%** of providers in the sample offered both in-person and telehealth appointment options.
- **18.2%** of providers offered only in-person appointments, with no telehealth services available.
- **9.1%** of providers were telehealth-only.

Financial Accessibility: The study revealed important insights into the financial accessibility of mental health services in the Texas Panhandle:

- **64.7%** of providers offered a sliding scale payment option, which can help reduce financial barriers for patients with limited resources.
- **93.3%** of providers accepted insurance, making services more accessible for those with coverage, though challenges related to insurance reimbursement rates may still limit options for some patients.
- **96.3%** of providers offered appointments with fees ranging from $50 to $175, highlighting significant variability in out-of-pocket costs for individuals without insurance or who do not qualify for sliding scale fees. These findings suggest that while many providers strive to accommodate patients with diverse financial needs, affordability may still be a barrier for some, particularly for uninsured or underinsured individuals.
- The most frequently occurring cost range was **$126-$150**, representing **31.8% of providers**. Nearly **94% of providers** charge below **$175**, indicating that mid-range pricing is the most common.

FIGURE 2

Initial Appointment Costs

Appointment Cost ($)	Number of Providers
$50-$75	18
$76-$100	35
$101-$125	31
$126-$150	50
$151-$175	13
$176-$200	4
$201-$225	1
$226-$250	0
$251-$275	0
$276-$300	2
$301-$325	0
$326-$350	2
$351+	1

Analysis and Discussion

Implications of Limited Provider Response

The issue of non-responsiveness among mental health providers represents a critical barrier to effective healthcare access, particularly in underserved regions. When providers fail to respond after initial contact attempts, individuals seeking mental health care face increased barriers to access. The lack of a response can discourage further attempts, particularly for vulnerable populations who may already be hesitant to seek help due to stigma or logistical challenges including those with acute mental health needs, low socioeconomic status, or limited social support networks. From a theoretical perspective, provider responsiveness is a key determinant of healthcare system efficiency and equity.

This study revealed significant challenges in securing meaningful engagement even after multiple contact attempts. On a systemic level, high non-response rates indicate potential gaps in provider capacity or communication infrastructure. This suggests a systemic failure in communication infrastructure or capacity, leaving individuals without care even when they actively seek it. Addressing this issue requires a multifaceted approach, including improved provider training, accountability measures, and individual investment in patient engagement technologies.

Communication Channels and Accessibility

The findings revealed an unanticipated reliance on email as the most effective communication channel for securing provider responses. While this approach yielded positive results in the study, it presents significant challenges in real-world contexts. For individuals experiencing acute mental health crises or seeking immediate assistance, email may not be intuitively considered as a primary or viable method for contacting providers. As one secret shopper intern noted, “It is entirely possible to call an individual private practitioner, have the call answered, and be offered an appointment all during one initial call. However, the same call, 30 minutes later, might require leaving a voicemail, waiting for a callback, and potentially getting caught up in a ‘phone tag’ situation.” Such variability, often dependent on timing, reflects the inherent challenges in connecting with solo practitioners.

Research on healthcare communication strategies underscores the importance of real-time interaction, particularly in mental health contexts where delays in engagement can exacerbate patient distress and decrease the likelihood of follow-through (Street et al., 2009). The reliance on counterintuitive communication methods for booking appointments, such as email, highlights a potential misalignment between provider preferences and patient expectations.

Addressing this disparity necessitates a dual-pronged approach that enhances provider responsiveness across multiple communication channels while educating patients on effective engagement strategies. Potential interventions include:

Improving Phone Responsiveness: For solo practitioners, limited resources may hinder the ability to staff phone lines adequately. In the data collection phase of this study, the process of contacting providers was often influenced by the structure and resources of individual practices. The most common type of private practice observed was the solo counselor, operating a small business independently. These counselors, while providing vital mental health services to the community, are often responsible for their own administrative tasks, including answering the phone, making callbacks, and replying to emails. This dual role—clinician and administrator — makes initial contact particularly challenging. However, it is essential to address phone inquiries promptly, as many individuals expect real-time responses when seeking care. All providers should prioritize ensuring timely responses to reduce frustration and the risk of patient disengagement.

Patient Education Initiatives: Developing targeted campaigns to inform individuals about the most effective ways to contact providers, emphasizing the potential benefits of email while advocating for improved responsiveness across all channels.

Streamlining Follow-Up Processes: Establishing automated follow-up systems for both phone and email inquiries can improve response consistency and reduce the burden on patients.

By bridging the gap between provider communication practices and patient needs, these strategies can enhance access to mental health care and promote a more patient-centered model of service delivery.

Identified Gaps and Barriers to Access

The findings demonstrate that even when multiple contact attempts are made, securing care often remains difficult due to a combination of factors. It is also important to note that reported wait times reflect the provider's first available appointment and do not account for whether the offered time fits into the schedule of the person seeking services. For individuals with inflexible schedules or urgent mental health needs, this gap between availability and practical accessibility could present a significant barrier to care. The secret shopper study identified several key gaps and barriers to accessing mental health care in the Texas Panhandle:

Limited Provider Availability: The majority of behavioral health providers are concentrated in Potter and Randall counties, leaving rural areas in the remaining 25 counties with limited access to care. While 55.66% of contacted providers were accepting

new clients at the time of the study, this figure still reflects substantial barriers for individuals seeking timely service, particularly in rural and frontier communities where options are already scarce.

One factor influencing access is the modality of care offered. Although not definitive, the data suggests a possible relationship between service modality and appointment availability. Providers offering both in-person and telehealth services appeared to have longer wait times on average than those offering only one format.-This may indicate higher demand among dual-modality providers due to their broader accessibility. However, shorter wait times among single-modality providers do not necessarily signal improved access. Limited modality options can create barriers for care seekers whose circumstances require a specific format. For example, individuals in geographically isolated areas may rely on telehealth, yet still struggle to find local providers offering remote services. Similarly, patients in need of intensive, in-person support may be unable to engage with telehealth-only providers.

These patterns underscore the importance of viewing modality not in isolation, but in relation to patient needs, geographic realities, and provider capacity. Ensuring equitable access will require not only increasing the number of available providers, but also supporting a service infrastructure that reflects the diverse needs of the region's population.

Non-Responsiveness: As noted, nearly 40% of providers did not respond after the first contact attempt, creating significant barriers for individuals seeking care. A significant portion of providers are functionally inaccessible. Some licensure categories had significantly lower response rates, indicating critical gaps in accessibility for those groups. This variation suggests that patients may experience significantly different levels of accessibility based on the provider's licensure. High response rates from certain groups (e.g. LPC-A) contrast with low or non-existent response rates in other groups, highlighting the need for targeted interventions to ensure consistent access across categories. See Appendix (C) for response rate of all licensure types.

High Burden of Follow-Up: The need for second and third contact attempts (and the diminishing response rate, with only 28.2% responding to a second call) places a disproportionate burden on individuals seeking care. This is especially problematic for those already experiencing mental health challenges, as persistence in seeking care may be difficult.

Long Wait Times for Some Licensure: The findings highlight a significant bottleneck in access to psychiatric care, with psychiatrists demonstrating substantially longer wait times

compared to other specialties. This trend, observed even within the small sample of 8 psychiatrists, reflects a critical shortage of psychiatric providers in the Texas Panhandle. While the small sample size precludes detailed statistical analysis, it underscores the urgent need to address the shortage of psychiatric providers in the Texas Panhandle to reduce barriers for patients requiring specialized care. The Texas Department of State Health Services reported that in 2023, there were 2,651 psychiatrists statewide, yet 170 Texas counties had no licensed psychiatrist at all. This shortage translates to an average of 11,758 residents per psychiatrist — exceeding the Health Resources and Services Administration's recommended benchmark of 10,000:1 for adequate coverage, though still well below the federal shortage designation threshold of 30,000:1 (Health Resources and Services Administration, n.d.; Simpson, 2024). This level of disparity highlights the acute provider-to-population imbalance in the Texas Panhandle.

For rural regions like the Panhandle, where access to mental health services is already constrained, this scarcity exacerbates delays in care, leaving individuals with limited or exceptionally long wait times for initial consults for psychiatric treatment. These local findings mirror national trends in behavioral health, where psychiatrist shortages have become a widespread barrier to timely and adequate mental health care. Addressing this gap will require targeted strategies, including expanding telepsychiatry services, increasing training opportunities for psychiatric professionals, and incentivizing practice in underserved areas.

These gaps underscore the urgent need for targeted efforts to improve provider responsiveness, expand availability in rural areas, and reduce financial barriers to care. The pervasive issues of unresponsiveness, high follow-up burdens, and insufficient referrals reveal a fragmented and often inaccessible behavioral health in the Texas Panhandle.

Implications for Rural Communities

Rural communities in the Texas Panhandle face unique challenges in accessing mental health care. With most providers located in Potter and Randall counties, residents of more remote areas often must travel significant distances to receive care. This geographic disparity exacerbates existing barriers such as cost and limited provider availability. The lack of local providers in rural areas increases the burden on already underserved populations, leading to delayed or unfulfilled care. Additionally, stigma around mental health may be more prevalent in rural settings, further discouraging individuals from seeking help.

Economic disparities present profound challenges to mental health care access in rural communities, where lower average household incomes exacerbate the financial burden

associated with seeking care. The high cost of mental health services often acts as a deterrent, compelling individuals to forgo treatment despite unmet needs.

This economic vulnerability is compounded by insufficient insurance coverage, which remains disproportionately common in rural areas. Such gaps in coverage result in further marginalizing already underserved populations. The geographic scarcity of in-network providers intensifies these challenges. Many rural individuals face long travel distances to access care or are left with no feasible options within their networks, further entrenching disparities in service utilization.

The intersection of economic, insurance, and geographic barriers underscores a systemic inequity in mental health care access for rural populations. Addressing these challenges requires a multifaceted approach. Without these targeted interventions, the disparities faced by rural communities are likely to persist, leaving critical gaps in care unaddressed.

PBHA's mission to support rural communities is integral in addressing challenges for improved access to care in the Texas Panhandle. For increased impact, potential strategies include:

Telehealth Expansion: Telehealth has the potential to bridge the gap particularly in rural communities where mental health services are scarce. While telehealth alone cannot fully address the mental health disparities in rural areas, it remains a critical component of a multifaceted approach to improving access to care. Though it may serve as an essential solution, it remains an imperfect one. Despite the expansion in telehealth infrastructure during the COVID-19 pandemic, technology limitations still impede access to mental health services in rural communities. Limited broadband coverage in rural areas may limit rural residents' access to advancements designed to improve telehealth capacity, as rural households have fallen behind urban access to broadband services. (Mack et al) While telehealth alone cannot resolve the disparities faced by rural populations, it represents a critical component of a broader strategy to enhance mental health care access in these communities.

Population level interventions and Local Systems Change: Increasing awareness of available services in rural communities and reducing stigma around mental health through targeted education and outreach programs is vital. Effective engagement and improved mental and behavioral health literacy can help normalize behavioral health care and empower individuals to seek support. PBHA's work in Hutchinson County offers one such example. In response to rising concerns about youth mental health, PBHA partnered with the United Way of Hutchinson County to help form a locally led coalition focused on increasing awareness, stigma reduction, early-intervention, expanding peer support services, and coordinating care. For more than 5 years, PBHA facilitated and provided education on mental health resources and issues to nurture coalition development and

continues to provide technical assistance, facilitation, and consultation services to the community of Hutchinson County. By engaging with the community and applying a strengths-based approach, PBHA was able to connect local leadership with additional resources and help pilot local projects. This community led effort also led to an increase in the number of local behavioral health providers.

Recommendations

Provider-Level Recommendations

At the provider level, implementing best practices in communication and client engagement is essential for improving behavioral health care accessibility. Mental health providers should advocate for the adoption of streamlined communication methods, such as unified scheduling platforms that allow clients to self-book appointments. This approach can minimize the burden on providers and administrative staff while reducing the need for repeated outreach by clients. Telehealth platforms, in particular, could be enhanced by incorporating instant booking options, enabling clients to schedule care efficiently without reliance on direct communication with providers.

To further support improvements, PBHA is offering providers the opportunity to review findings from the evaluation process related to their practices. While data for individual providers will not be publicly released, this feedback mechanism allows providers to reflect on their accessibility and responsiveness, identify potential gaps, and implement meaningful changes. By fostering transparency and collaboration, this initiative aims to empower providers to enhance client communication and improve access to care.

Additionally, targeted outreach and education campaigns could promote provider responsiveness and enhance client communication practices. These initiatives might include training for providers on best practices for timely communication, such as establishing clear response protocols and leveraging technology to optimize client interactions.

Collectively, these strategies can enhance client satisfaction, reduce barriers to access, and ensure more efficient use of provider resources.

Community-Level Recommendations

Community-level efforts to enhance behavioral health care accessibility should focus on three critical areas: promoting telehealth services, advocating for provider recruitment and retention in rural communities, and tailoring resources to underserved populations. Increasing awareness about telehealth as a convenient and effective modality for mental health care is essential,

particularly for geographically isolated residents. In Texas, several state-funded initiatives aim to expand access to virtual care and consultation support. Programs like TCHATT (Texas Child Health Access Through Telemedicine), CPAN (Child Psychiatry Access Network), and PPAN (Perinatal Psychiatry Access Network) offer targeted telehealth and consultative services to address critical gaps in pediatric and perinatal mental health care. While these programs are not direct service providers, they enhance local capacity by connecting primary care and school-based professionals with psychiatric consultation, reinforcing the broader telehealth infrastructure across rural and frontier communities.

Education campaigns should focus on demystifying telehealth platforms, providing clear instructions for use, and addressing potential barriers such as digital literacy and internet access. Advocacy for recruiting and retaining providers in rural communities is equally vital.

Collaborative efforts with local health systems, universities, and policymakers can raise awareness of the behavioral health provider shortage in these regions and encourage innovative strategies to attract and retain professionals willing to serve rural populations. Emphasizing the unique opportunities for community impact and professional fulfillment in underserved areas may also appeal to prospective providers.

Lastly, outreach strategies must address the unique barriers faced by underserved groups, including rural residents, racial and ethnic minorities, and low-income individuals. Tailored approaches, such as offering multilingual resources and culturally responsive materials, can bridge gaps in understanding and access while fostering trust within these communities. To further reduce workforce-related barriers, PBHA also offers stipends to support clinical licensure and reimburses supervision costs, helping expand the pipeline of qualified behavioral health professionals in underserved areas. Together, these initiatives can create a more equitable and accessible behavioral health care system.

Conclusion

This study reveals critical barriers to behavioral health care access in the Texas Panhandle, highlighting challenges such as non-responsiveness, prolonged wait times, provider shortages, and financial obstacles. For many individuals, especially those in rural or underserved areas, these barriers create significant hurdles to accessing timely and effective care. The findings emphasize the urgent need for systemic reform to address disparities and ensure equitable mental health care for all residents.

Yet, alongside these challenges, there is a significant opportunity for meaningful change. The insights gained from this study provide a roadmap for action, offering practical solutions to

improve access and equity. Expanding telehealth services, fostering community outreach, and advocating for targeted recruitment and retention of providers in rural areas represent actionable steps toward creating a more responsive and inclusive system. Equipping providers with tools to streamline communication and educating patients on effective engagement strategies can further bridge gaps and enhance the care-seeking experience. Importantly, improving provider responsiveness could have far-reaching impacts. A landmark study found that while 80.1% of individuals with a lifetime DSM-III-R mental health disorder eventually make treatment contact, delays in initiating that care average more than a decade (Wang et al., 2004). Addressing early points of disengagement, such as unanswered calls, slow follow-up, or lack of referral, has the potential to reduce this delay and mitigate the long-term consequences of untreated mental health conditions.

The efforts of the Panhandle Behavioral Health Alliance and its partners demonstrate that progress is not only possible but already underway. By fostering collaboration among stakeholders, empowering providers, and engaging communities to support the development of locally designed solutions, the Texas Panhandle has the potential to transform its behavioral health care landscape. These efforts, rooted in shared commitment and innovation, offer hope for a future where every individual—regardless of location or circumstance—can access the care they need.

While the challenges are significant, so is the resilience and determination of the communities and stakeholders committed to addressing them. This study not only underscores the barriers but also illuminates a path forward, one built on collaboration, compassion, and a shared vision for a healthier, more equitable future. With sustained efforts, the Texas Panhandle can serve as a model for advancing behavioral health care in rural and frontier regions, inspiring hope for meaningful and lasting change. As PBHA and its partners move forward, this study can serve as both a benchmark and a guide, supporting collective efforts to reduce disparities, align systems, and improve behavioral health outcomes across the region.

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Appendix A: Abbreviations for Mental Health & Behavioral Health Licensure

Professional Counselors	
LPC	Licensed Professional Counselor
LPC-A	Licensed Professional Counselor - Associate
LPC-S	Licensed Professional Counselor - Supervisor
Marriage and Family Therapists	
LMFT	Licensed Marriage and Family Therapist
LMFT-A	Licensed Marriage and Family Therapist - Associate
LMFT-S	Licensed Marriage and Family Therapist - Supervisor
All LMFT	*Refers collectively to all LMFT categories*
Social Workers	
LCSW	Licensed Clinical Social Worker
LCSW-S	Licensed Clinical Social Worker - Supervisor
Specialists	
CYMHS	Child and Youth Mental Health Specialist
LCDC	Licensed Chemical Dependency Counselor
LMHC	Licensed Mental Health Counselor
RPT-S	Registered Play Therapist - Supervisor

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Appendix B: Call Note Template & Instructions

Column Field	Response	Definition/Instructions
Provider Name		Enter Providers First Name and Last Name
Provider Phone		Enter the phone number that the secret shopper used to contact the provider
Specialty Type		Enter the applicable Specialty Type of the practitioner from the list below: Psychiatry, Psychology, LPC, LPC-I LMFT, LCDC
Supervisor Name		If the Provider is an LPC-I please list their supervisor.
Subset Experience		If Provider specializes in a subset of the mental health field note focus area here. Ex: anxiety, depression, addiction, trauma.
Youth Experience		If Provider specializes in or has advertised knowledge working with youth, please specify ages.
Contact 1 Date/Time		Record the date of the first contact attempt, formatted as MM/DD/YYYY.
Contact Type		Record the type of interaction: Receptionist Interaction, Voicemail interaction, online booking redirection.
Contact 1 result		If the first contact attempt resulted in valid data, record the outcome: Left Voicemail, Appointment Offered, Not Accepting New Clients, Waitlist Offered, Referral Given.
Contact 2 Date/Time		If more than one contact attempt was made, record the date of the second contact attempt. If the first contact attempt resulted in valid data, this field does not need to be reported.
Provider Call Back		If initial contact resulted in leaving a voicemail, did the provider call back?
E-mail Date		After 1 voicemail attempt with no response and an unanswered follow up 10 days later send email correspondence. If contact was made mark this field N/A

Accepting New Clients?		Record Yes/No based on provider response.
Date of 1st Available Appointment		If appointment availability information was obtained, record the date of the first available (i.e., soonest) appointment formatted as MM/DD/YYYY.
Format of 1st Available Appointment		If the first available appointment offered is a telehealth appointment, enter "T" in this field. If the first available (i.e., soonest) available appointment offered is an in-person appointment, enter "P" in this field.
Types of Appointments Offered		Record "P" for in-person, "T" for Telehealth, and "H" for Hybrid/Both.
Date of alternative appointment		If a provider offers both in-person and telehealth appointments, and the first available appointment offered is a telehealth appointment, then the secret shopper must obtain appointment availability information for the next available in-person appointment and record the date of the next available in-person appointment in this field.
Time elapsed between call and 1st appointment.		Enter the number of business days (excluding weekends and Federal holidays) between the date of the call that the appointment was set and the date of the first (i.e., soonest) available appointment offered.
Session Cost		Record session cost.
Sliding Scale		Inquire if a sliding scale for payment is available.
Waitlist		Does the provider maintain a waitlist? If yes, what is the procedure for the waitlist? Will the provider's office make contact or is the client required to continue calling back? If the client must follow up on the waitlist how often does the provider recommend calling back?
Referral Given		If the provider is not accepting new clients, was a referral given? Record yes/no. If a referral is given see if the referred provider is already on the list. If they are not on the current list add the new provider and collect data.
Insurance Accepted		Does the provider accept insurance?

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Appendix C: Response Rate & Wait Time by Licensure

Licensure Types	# of Provider Per Type	# Responded	Never Responded	Could Not Be Contacted	Response Rate (%)	Average Wait Time (Business Days)	Median Wait Time (Business Days)
LPC	191	132	38	21	69.1	11.89	7
LPC-A	23	17	5	1	73.9	5.9	3
LPC-S	25	20	4	1	80.0	7.9	8
LCSW	22	14	6	2	63.6	8.7100	4.5
LCSW-S	6	4	0	2	66.6	-	-
LMFT	6	5	1	0	83.3	-	-
LMFT-A	1	1	0	0	100	-	-
LMFT-S	1	1	0	0	100	-	-
Psychiatrist	10	9	1	0	90	-	-
Psychologist	2	1	1	0	50	-	-
CYMHS	1	1	0	0	100	-	-
LCDC	8	6	0	0	75	-	-
LMHC	1	0	1	0	0	-	-
RPT-S	1	1	0	0	100	-	-

NOTE: *The total number of licensures exceeds the total number of providers (n=309) because some providers hold multiple licenses. Wait times for licensure categories with fewer than 20 providers are not shown. Cells for these categories are greyed out.*

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