



Clinical Perspectives

Training the Collaborative Care Behavioral Health Care Manager and a Child Psychiatrist's Role

J. Nathan Copeland, M.D., M.P.H.¹ , Catherine Cheely, D.N.P.¹ , Gary R. Maslow, M.D., M.P.H.¹ 

¹ Department of Psychiatry & Behavioral Sciences, Duke University Health System

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Objective

The Collaborative Care Model (CoCM) is an evidence-based intervention delivered within the primary care setting for the treatment of common mild-moderate mental illnesses. CoCM introduces a new member to the primary care treatment team, a behavioral health care manager (BHCM), whose role is critical to the delivery of the service. However, while CoCM has been recognized as a way to increase access to mental health services in the primary care setting and improve pediatric mental illness, there is no standardized training for the pediatric BHCM to ensure quality and facilitate adoption. Here, the experiences of a real-world BHCM training program are discussed.

Method

The North Carolina Psychiatry Access Line has trained 20 pediatric BHCMs and supported 7 community pediatric practices in the implementation of pediatric CoCM. The BHCM training involved a combination of publicly available self-paced courses, tailored live virtual didactics, a biweekly learning collaborative, and case-based education by the psychiatric consultant during weekly panel staffing.

Results

Pediatric BHCMs reported feeling well-trained and supported in their role. Additionally, this training demonstrated that core BHCM skills could be taught quickly using publicly available resources, and ongoing BHCM knowledge and skill mastery could be accomplished through CoCM panel staffing and regular group discussions.

Conclusion

The training of the pediatric BHCM is critical to the implementation of pediatric CoCM, and training can be completed through multimodal resources that focus on core BHCM skills with ongoing support. Ensuring thorough and standardized pediatric BHCM training is necessary for pediatric CoCM uptake.

INTRODUCTION

The Collaborative Care Model (CoCM) is an evidence-based intervention delivered within the primary care setting for the treatment of common mild-moderate mental illnesses (eg, depression, anxiety, and attention-deficit/hyperactivity disorder).¹⁻⁴ This model of care introduces a new member to the primary care treatment team, a behavioral health care manager (BHCM), whose role is key to the delivery of the service. In the primary care setting, a BHCM can manage the majority of common mental illnesses through frequent patient follow-ups, measurement-based tools, brief behavioral health interventions, and weekly psychiatric

consultation.⁵ Through this process, along with case management and coordination across the team, the BHCM can increase access to high-quality primary care mental health services.⁶ It is CoCM's ability to increase access and improve mental health treatment that has led many states, such as North Carolina, to encourage addition of this new team member and uptake of this model.⁷

While CoCM was originally developed for adults, it has been adapted for pediatric patients.^{2,3} However, there is no standardized training for pediatric BHCMs to ensure competency and safety. This creates a challenge because a BHCM may come from multiple disciplines, including nursing, social work, counseling, and other related fields. Some



may also be nonlicensed trained team members.⁸ Regardless of discipline, all BHCMS are expected to provide comparable services and achieve similar outcomes. As such, there is a need for comprehensive pediatric BHCM training that addresses necessary skills.

In this Clinical Perspective, real-world pediatric CoCM implementation in North Carolina, a multimodal approach to BHCM training involving child psychiatrists, and future directions are highlighted.

NORTH CAROLINA PSYCHIATRY ACCESS LINE AND COLLABORATIVE CARE MODEL

The North Carolina Psychiatry Access Line (NC-PAL) was launched in 2017 and is a child psychiatry access program.⁹ NC-PAL provides pediatric and perinatal providers in North Carolina telephonic access to behavioral health care coordinators and psychiatrists, and it has expanded to support other pediatric mental health services (www.ncpal.org). In 2022, to support growth of CoCM,¹⁰ the State of North Carolina made multiple efforts to increase CoCM expansion. These efforts included increasing CoCM Medicaid reimbursement and providing practice support and education through the North Carolina Area Health Education Centers and Community Care of North Carolina. Additionally, a CoCM stakeholder consortium was convened to provide subject matter expertise for expansion efforts. Child psychiatrists with NC-PAL participated in the consortium and education efforts.

Within Duke University Health System, which serves as the NC-PAL hub, CoCM has been active since 2016 for adults and 2021 for pediatrics.¹¹ In 2023, CoCM was made available for all primary care clinics in the Duke University Health System network for patients ages 12 years and older with depression and/or anxiety. Duke University Health System's CoCM program utilizes licensed clinical social worker associates, fully qualified licensed clinical social workers, and registered nurses in the BHCM role. NC-PAL team members have led much of the CoCM implementation and training. In North Carolina, a licensed clinical social worker associate needs >2 years of clinical work and >3000 supervised clinical hours within 6 years to become a licensed clinical social worker and practice independently.¹²

Through this work, in addition to reviewing training delivered in pediatric CoCM clinical trials and speaking with clinical trial authors,^{2,3,13} the NC-PAL team developed CoCM expertise. As a result, the State of North Carolina directed NC-PAL to support both the training of pediatric BHCMS and growth of pediatric CoCM among community practices to expand availability.

In 2023, a pilot was created with NC-PAL, in partnership with North Carolina Area Health Education Centers and Community Care of North Carolina, to support up to 9 community pediatric practices in deploying CoCM. In the pilot, NC-PAL was tasked with providing psychiatric consultation, support for clinical implementation, and training of the BHCM. Drawing from previous BHCM training experience, the NC-PAL team developed a curriculum to ensure

BHCMS would be equipped to deliver effective, safe, and evidence-based care.

BEHAVIORAL HEALTH CARE MANAGER TRAINING AND ONGOING SUPPORT

The pediatric BHCM role requires a clear understanding of responsibilities within the CoCM team, foundational knowledge of common pediatric mental illnesses and treatments, and comfort in using mental health screening tools. BHCMS must also be skilled in delivering brief evidence-based interventions, engaging effectively with children and families, conducting safety assessments, and navigating the broader mental health system. The NC-PAL CoCM team developed a BHCM training program with a focus on pediatric depression and anxiety to support the most common mental illnesses. This included a combination of publicly available self-paced online courses, tailored live virtual didactics, and real-time support. BHCM onboarding occurred based on the practice's readiness to launch CoCM and hiring of the BHCM.

Once the BHCM is hired and ready to begin training, the curriculum takes approximately 1 week to complete if done sequentially ([Table 1](#)), but each component that follows may be done separately based on availability of the BHCM or timing of NC-PAL training.

First, all learners were enrolled in University of Washington's Advancing Integrated Mental Health Solutions BHCM 9-hour self-paced curriculum (<https://aims.uw.edu/behavioral-health-care-managers>). Because the BHCM role is different than any other health care position, it was necessary for all trainees to have an introduction to skills needed, patient tracking tools, and experience with interdisciplinary interactions. The Advancing Integrated Mental Health Solutions BHCM curriculum provided this foundational training covering key skills such as patient engagement, effective use of the CoCM registry, coordination of care between primary care providers and psychiatric consultants, and other essential competencies.

Second, BHCMS were enrolled in an online adolescent-specific motivational interviewing (MI) 6-hour self-paced training course that reviewed concepts surrounding adolescent development, confidentiality, common risk-taking behaviors, and how MI can support behavior change. To perform the BHCM role effectively, skills are needed for patient-family engagement and maintaining patient participation in brief behavioral health interventions. MI is an effective framework to achieve these goals. Additionally, while many potential BHCMS might be proficient in MI, others from different educational backgrounds or without recent clinical experience benefit from additional training. Finally, because MI is itself a brief behavioral health intervention,¹⁴ it provides an effective structure for working with children and families that also facilitates symptom improvement.

Third, BHCMS completed depression and anxiety modules from the First Approach Skills Training (FAST) program. These modules, each approximately 2 hours in length, are tailored for the pediatric primary care setting

Table 1. Example of Behavioral Health Care Manager Training Schedule

	Activity	Location/notes
Monday		
9-10 AM	Intro to BHCM training	Virtual with NC-PAL team member
10 AM-5 PM	AIMS BHCM training course	Self-paced online modules
Tuesday		
8 AM-noon	Complete AIMS BHCM training	Self-paced online modules
12:30 PM-1 PM	BHCM training check-in	Virtual with NC-PAL team member
1-5 PM	Adolescent MI training course	Self-paced online modules
Wednesday		
8 AM-noon	Complete MI training course	Self-paced online modules
2-2:30 PM	BHCM check-in	Virtual with NC-PAL team member
2:30-5 PM	FAST-Anxiety	Self-paced online module
Thursday		
9-9:30 AM	BHCM check-in	Virtual with NC-PAL team member
9:30 AM-noon	FAST-Depression	Self-paced online module
1-3 PM	Screening tools, common medications, and BHCM check-in	Virtual with NC-PAL team member
Friday		
8 AM-1 PM	Assessment of youth suicidal thoughts and behaviors + SAFETY-A intervention	Virtual or in-person with NC-PAL team member
1-5 PM	REACH PPP	Virtual with NC-PAL team members
Saturday		
8:30 AM-5 PM	REACH PPP	Virtual with NC-PAL team members
Sunday		
8:30 AM-1 PM	REACH PPP	Virtual with NC-PAL team members

AIMS = Advancing Integrated Mental Health Solutions; BHCM = behavioral health care manager; FAST = First Approach Skills Training; MI = motivational interviewing; NC-PAL = North Carolina Psychiatry Access Line; REACH PPP = REACH Institute Patient-Centered Mental Health in Pediatric Primary Care.

and focus on behavioral activation and exposure therapy skills, respectively. While both behavioral activation and exposure therapy are part of cognitive behavioral therapy, their stand-alone use for the treatment of pediatric depression and anxiety is recent, and their design allows them to be delivered quickly, effectively, and by a range of educational backgrounds.^{15,16} As such, a focus on both behavioral activation and exposure therapy was necessary to ensure brief treatment and that all BHCMs could deliver these interventions. This made FAST resources a useful training addition. Additionally, FAST's publicly available workbooks geared toward children and families are useful for practices that may not have access to other mental health materials, and FAST resources have been utilized in other CoCM programs.⁴ These materials also support psychoeducation, healthy behaviors, problem-solving, and other useful skills such as sleep hygiene. Finally, the approachable structure of the FAST workbooks also supported trainees who were less familiar with brief behavioral interventions and benefited from a structured treatment plan.

After each of these self-paced training courses, though no standardized evaluations of skill were done, an NC-PAL team member would work with the learner to ensure they felt comfortable with the interventions. Enhancing online courses with real-time coaching was thought to be important in developing competencies and ensuring progress of the BHCMs.

Fourth, all trainees completed the REACH Institute Patient-Centered Mental Health in Pediatric Primary Care (PPP) course. This 16.5-hour intensive and interactive 3-day course, offered and taught by NC-PAL, is designed to train pediatric providers in diagnosing and treating mental illnesses commonly seen in the primary care setting. While this training is designed for primary care providers and taught some skills that were beyond what a BHCM would likely be expected to perform, it met important educational objectives. The objectives included utilizing rating scales (eg, PHQ-9, GAD-7, SCARED, and Vanderbilt), knowing common pediatric mental illness interventions, recognizing different presentations of pediatric mental illness, discussing benefits and side effects of common psychiatric medications, and becoming aware of comorbidities and diagnostic overlap of pediatric mental illnesses.

Fifth, all BHCMs were taught risk assessment and safety planning skills through the Safe Alternatives for Teens and Youth-Acute (SAFETY-A) intervention. SAFETY-A is a brief, strengths-based, trauma-informed, family-centered, and developmentally appropriate intervention that improves engagement in mental health services and reduces suicide attempt risk.^{17,18} The NC-PAL led SAFETY-A training takes approximately 5 hours to complete. As pediatric BHCMs work with adolescents experiencing depression or anxiety, they will inevitably encounter patients experiencing self-harming behaviors or suicidal ideation. Consequently,

training in youth-focused risk assessment and safety planning is critical to ensure appropriate and timely intervention. Additionally, SAFETY-A trained BHCMS could serve as resources for their practice by supporting adolescents with safety concerns, whether in CoCM or general pediatric appointments requiring safety planning.

In addition to the previously mentioned trainings, all NC-PAL child psychiatrists who served as psychiatric consultants also used the weekly panel staffing time to reinforce skills, enhance BHCMS' knowledge of pediatric mental health care, and help BHCMS master their role. As such, the panel staffing time was used to develop treatment plans for patients and utilize the expertise of child psychiatrists for case-based teaching opportunities. Because most NC-PAL child and adolescent psychiatric consultants also staffed the NC-PAL phone line and taught REACH PPP courses, supporting pediatric BHCMS was an effective utilization of child psychiatrists accustomed to teaching evidence-based pediatric mental health practices. The NC-PAL team also met weekly to discuss progression of CoCM panels and identify BHCM educational needs.

Finally, a 1-hour biweekly virtual "learning collaborative" was developed for NC-PAL BHCMS to problem-solve, share resources, and deepen skills. In these learning collaboratives, NC-PAL team members and child psychiatrists joined to provide education and CoCM guidance. Because the BHCM is a new health care role, the learning collaborative also serves as a space to support standardization between panels, identify areas of growth for the practice and BHCM, and ultimately foster community among BHCMS to reduce burnout and enhance connection to the work.

FUTURE DIRECTIONS

After training more than 20 BHCMS between Duke University Health System and NC-PAL community practices and supporting the launch of CoCM in 7 community pediatric practices, NC-PAL BHCMS have reported that their training and ongoing support prepared them for the role and enriched their experience.

However, the NC-PAL team also identified additional areas of training opportunity. Because there are no data supporting the management of pediatric trauma within CoCM, NC-PAL child psychiatrists identified that enhanced BHCM education in trauma could ensure more rapid identification of children and families that may need other resources. Currently, the NC-PAL team is exploring different trauma screening tools that could be implemented among a pediatric primary care population while being mindful that some children with trauma may still benefit from CoCM to address co-occurring depression and anxiety while waiting for or participating in evidence-based trauma therapy.¹⁹ Additionally, because the BHCM role and implementation of brief behavioral health interventions require training and practice to develop proficiency, it may be important to supplement training with opportunities to shadow other BHCMS and have educators shadow them to provide real-time feedback. This would further ensure consistency and fidelity between and within panels.

While this training has been effective, NC-PAL recognized that stand-alone training specifically tailored to the unique pediatric BHCM role would be more efficient. This training could be disseminated by national integrated mental health educators such as the AIMS Center or REACH Institute or locally within Area Health Education Centers or child psychiatry access programs. Development of this training would facilitate adoption of CoCM. Also, the NC-PAL team recognizes that the development and implementation of preassessments/postassessments and competency checklists for BHCM training are important to achieve standardization, and efforts to build these are beginning and will be necessary to achieve national standards for pediatric BHCMS.

However, financial support will be necessary to cover educational costs for practices. Nationally, bills such as the Collaborate in an Orderly and Cohesive Manner Act,²⁰ which was introduced in 2021 but not passed, would have provided practice-level funding for CoCM training and implementation, and advocating for similar bills may be required. Locally, North Carolina is supporting program start-up costs through a CoCM Capacity Building Fund of up to \$50,000 for practices adopting CoCM,²¹ and other states could consider how state dollars could drive CoCM growth. Finally, while the real-world training has had high satisfaction among its BHCMS, other ways of educating BHCMS may be more effective, and comparing efficacy of training will be important as this new health care role becomes widespread.

PLAIN LANGUAGE SUMMARY

Collaborative Care Management is a new way for children and their families to access high-quality mental health services in their pediatrician's office for the treatment of conditions such as anxiety and depression. This model of care adds a new member to the team, a Behavioral Health Care Manager, who develops treatment plans in partnership with the PCP and a child psychiatrist, provides brief therapies, and tracks progress. Here, we describe how our team has trained Behavioral Health Care Managers to ensure their services are effective, safe, and high-quality.

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ABOUT THE AUTHORS

J. Nathan Copeland, MD, Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, North Carolina, USA.

Catherine Cheely, DNP, Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, North Carolina, USA.

Gary R. Maslow, MD, Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, North Carolina, USA.

CORRESPONDENCE TO:

J. Nathan Copeland, MD, email:
nathan.copeland@duke.edu, 919-681-0045.

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