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Training During a Pandemic: Successes, Challenges, and Practical Guidance From a Virtual Facilitated Learning Collaborative Training Program for Written Exposure Therapy

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In response to COVID-19, continued workforce training is essential to ensure that evidence-based treatments are available on the frontline to meet communities' ongoing and emerging mental health needs. However, training during a pandemic imposes many new challenges. This paper describes a multisite training and implementation pilot program, facets of which allowed for continued training despite the onset of the COVID-19 pandemic and subsequent social distancing guidelines. This virtual facilitated learning collaborative in Written Exposure Therapy, an evidence-based treatment for posttraumatic stress disorder, included virtual workshop training, phone-based clinical consultation, implementation-focused video calls for program leadership, and program evaluation. Data are presented about program enrollees and patient impact following the onset of COVID-19–related social distancing restrictions. Challenges, successes, and practical guidance are discussed to inform the field regarding training strategies likely to be durable in an uncertain, dynamic healthcare landscape.

A key task of the mental health field is the dissemination and implementation of effective interventions. Numerous factors contribute to the gap between research and practice, including the broad sociopolitical context; organizational factors, such as leadership support and availability of resources; provider motivation, attitudes, and skills; and characteristics of the interventions themselves (Chen et al., 2017; Stirman et al., 2016). Research suggests that training alone is insufficient to fully implement and sustain effective interventions over the longer term (Godley et al., 2011; Herschell et al., 2010) and that factors at the system, organizational, and individual levels need to be addressed simultaneously to facilitate successful implementation (Beidas et al., 2010; Stirman et al., 2010).

Implementation programs bridge the gap between research and practice by addressing barriers to implementation and leveraging strengths to ensure that evidence-based treatments extend from the lab to the clinic (e.g., Karlin & Cross, 2014; McHugh & Barlow, 2010). At a time when frontline providers must manage the consequences of the COVID-19 pandemic, there is a need to help clinicians learn and deploy interventions for trauma- and stressor-related disorders, including posttraumatic stress disorder (PTSD). The present paper describes a unique program combining training and implementation support that began before and continued during the COVID-19 pandemic. We highlight the training and implementation strategies used and describe how obstacles were addressed, which we hope may be used to guide the development of future virtual training programs that are durable across dynamic, challenging contexts.

One necessary component of implementing a new psychotherapy is training clinicians so they have the skills they need to deliver the new treatment. Traditional training models have involved individual clinicians either attending a workshop only or attending a workshop, often conducted in person, then participating in a period of clinical consultation that includes

support on training cases (LoSavio et al., 2019). Best practices for competency-based training involve didactic training and consultation based on a review of work samples (Hepner et al., 2018).

Yet clinician training alone is often insufficient to change practices in the long term, and assistance is needed to translate new treatments into a particular practice setting (Bauer et al., 2015; Nadeem et al., 2013; Stirman et al., 2017). Organizational barriers, such as insufficient resources and support or a treatment-inconsistent organizational culture, may limit clinicians' success in implementing a new intervention (Karlin & Cross, 2014), whereas organizational supports can facilitate treatment use (Rosen et al., 2016). A variety of implementation strategies have been used to help clinic teams build their capacity for therapy delivery, integrate the new practice into their clinical context, and foster sustainability (Nadeem et al., 2013). Two commonly used approaches are external facilitation (Harvey et al., 2002; Powell et al., 2015; Stetler et al., 2006) and learning collaboratives (e.g., Hanson et al., 2019; LoSavio et al., 2019). In external facilitation, an outside coach supports and advises a local site champion, who works with their clinic team to develop and enact implementation plans that are tailored to their particular circumstance (Ritchie et al., 2017; Stetler et al., 2006). Learning collaboratives help different sites mutually assist each other in implementing a new practice by sharing tools, strategies, and lessons learned (Helseth et al., 2020; McLean & Foa, 2013; Monson et al., 2018).

The present pilot program was based on the ACCESS Model for training and consultation (Stirman et al., 2010). This model, which has previously been used in community-based implementation programs (Creed et al., 2016), is intended to provide competency-based training and consultation while facilitating implementation and sustainment. The ACCESS model comprises the following components: (a) assess and adapt within the organizational context, (b) convey the basics through clinician training, (c) consult to build competency, (d) evaluate work samples, (e) study outcomes, and (f) foster sustainability.

Informed by the ACCESS model, this virtual facilitated learning collaborative integrated several components of competency-based training and learning collaboratives, including team-based didactic training; group consultation, which included the evaluation of psychotherapy work products (i.e., trauma narratives) and fidelity checklists; preparation of program leaders to participate in the learning collaborative and facilitation of cross-site implementation calls with program leaders to support implementation and sustainability; and program evaluation monitoring of outcomes to inform ongoing refinement. Table 1 summarizes how components of the virtual learning collaborative addressed the different domains of the ACCESS model.

Another important feature of this facilitated learning collaborative was that it was fully virtual. Initiatives to train clinicians in evidence-based treatments (e.g., Karlin & Cross, 2014) have often relied on in-person training, which can limit participation due to travel, cost, and timing. Some organizations have shifted to training virtually, but few fully virtual training initiatives include both clinical consultation and implementation support. To enable programs to be scaled up without travel costs, this facilitated learning collaborative was designed from the outset to be fully virtual, combining a distance workshop, group telephone consultation, and group facilitation and learning collaborative calls. This virtual format proved sufficiently flexible and durable to enable the successful continuation of training during the COVID-19 pandemic.

In the next sections, we first describe the virtual facilitated learning collaborative as originally designed and how this collaborative evolved to respond to the challenges of training clinicians and delivering care during the COVID-19 pandemic. We then discuss the initial outcomes from the training during the pandemic and the implications and practical lessons learned.

Written Exposure Therapy Virtual Facilitated Learning Collaborative Program Participants

Training participants included 41 clinicians across 12 sites within the U.S. Department of Veterans Affairs (VA) Healthcare System. Each of the 10 participating team-based sites was led by a program manager who was in a position of leadership within the site (i.e., able to make clinic-level decisions and allocate program resources). Eight of the program leaders also participated as clinicians. Two clinicians elected to enroll under an individual training option, and the program managers at their sites were not involved in the project after the approval of applications. All training participants are included in the information presented herein. Participants were licensed psychologists and social workers who were actively involved in delivering PTSD treatment. Most participants were embedded within outpatient PTSD specialty clinics, with some also providing care in satellite clinics (i.e., community-based outpatient clinics), a residential PTSD program, and a substance use disorder clinic. All clinicians had prior experience delivering evidence-based PTSD treatment such as cognitive processing therapy (Resick et al., 2016) or prolonged exposure therapy (Foa et al., 2007).

Intervention

Written Exposure Therapy (WET; Sloan & Marx, 2019) is a brief evidence-based, trauma-focused treatment for PTSD that is recommended in clinical practice guidelines (VA/Department of Defense [DoD], 2017). This treatment is a five-session, exposure-based protocol that begins with psychoeducation about PTSD symptoms and treatment rationale and moves on to 30 min of writing about the traumatic event in each of the five sessions. Writing prompts direct patients to describe the traumatic event in detail and, in later sessions, to describe the impact of the traumatic experience on their lives. In both

Table 1

Components of the Virtual Facilitated Learning Collaborative Training Model

ACCESS model domain	Program Components		Program evaluation
	Competency-based training	Facilitated learning collaborative	
Assess and adapt within organizational context		• Developed site-specific implementation plans[a] • Monthly group calls with external facilitators	
Convey basics through training	• Live interactive virtual workshop • Updates to the field for telehealth[a]	• Review information • Discuss transition to telehealth with fidelity[a]	
Consult to build competency	• Group consultation on two cases • Group consultation for telehealth delivery[a]		
Evaluation of psychotherapy work products	• Trauma narratives reviewed in consultation, PROM reviewed, • Discussion of feedback for the next session		
Evaluation of outcomes	• Review PROM data within calls	• Review reach and penetration data • Discuss trainee attitudes • Examine PROM data and patient satisfaction as available	• Assess trainee attitudes, patient outcomes, and posttraining use
Fostering sustainability		• Cross-site sharing of materials, lessons learned[a]	• Monitor treatment penetration

Note. PROM = patient-reported outcome measures.
[a] Area was revisited due to COVID-19.

civilian and veteran samples, WET has been shown to be effective (Sloan et al., 2012, 2013, 2018), with outcomes noninferior to cognitive processing therapy (Resick et al., 2017; Sloan et al., 2018). Before the present training program, WET had yet to be formally disseminated.

Training and Implementation Support Procedures

Competency-Based Training

Participating clinicians attended a live, interactive, virtual workshop that was delivered in 6 hr across 2 days. The workshop included an overview of how WET was developed, research findings supporting the efficacy of the treatment, and training on how to deliver the treatment (i.e., session-by-session instructions, description of common issues that arise, and case examples). Immediately following the workshop, clinicians began seeing training cases while participating in 4 months of weekly cross-site, small group consultation calls. The purpose of the consultation is to provide expert guidance in the delivery of the treatment model while clinicians see training cases, with opportunities for vicarious learning from fellow trainees' cases. To successfully complete the competency-based training program, clinicians are required to complete at least two WET cases, which must be discussed during the consultation and approved by their consultant as being delivered with fidelity to the protocol, and to attend at least 75% of the consultation calls. Regarding work samples, consultants assessed clinicians based on their patients' narratives (i.e., the clinician's ability to determine patient adherence to the instructions, devise patient feedback, and detect avoidance), patient-reported outcome measures (PROM), and their discussion of the WET framework within consultations. Clinicians were also asked to complete fidelity measures for each session conducted and document variations in an online data portal.

Facilitated Learning Collaborative

Program managers participated in monthly leadership calls focused on implementation. Beginning the month before the clinician workshop training, the program manager call focused on reviewing site-level implementation plans, which were updated and reviewed at subsequent calls. Implementation plans were adapted from work by Ritchie et al. (2017) and used for external (i.e., WET program staff to program leaders) and internal facilitation (i.e., program leaders to clinicians). Monthly calls also included cross-site sharing of implementation barriers, challenges, and successes, as well as a review of past-month implementation data (i.e., treatment penetration at the site). Program leaders were asked to act as internal facilitators by sharing materials from the program calls with clinicians at their sites either in team meetings or electronically. Both clinicians and program managers submitted program evaluation data throughout the course of training via an online data entry portal. Program leaders were asked to adapt their implementation plans with input from their team through-

out their participation, with a focus on sustainability in their clinics.

Adaptations During COVID-19

Treatment Delivery Challenges During COVID-19

The onset of COVID-19–related impacts occurred approximately halfway through the 4-month training program. The primary adaptation during training was clinicians' transition of care from face-to-face sessions to telehealth. In the WET training workshop, practical considerations regarding telehealth delivery of WET were discussed, although most clinicians were not planning to use telehealth to deliver WET. Some clinicians in the two previous training cohorts had successfully delivered WET via telehealth for patients who elected this modality, and some clinicians in the current cohort were providing WET via telehealth. However, most clinicians were delivering WET face-to-face before the onset of COVID-19 restrictions. Fortunately, video delivery of evidence-based psychotherapies for PTSD has been shown to be as effective as in-person care (e.g., Morland et al., 2017). Nonetheless, new challenges emerged at multiple levels as sites in our virtual facilitated learning collaborative received guidance from their facilities to convert all patients to virtual care modalities. In addition, several sites were tasked with converting clinicians partially or entirely to telework. Of note, most patients had not initially elected to pursue telehealth treatment, but changes in healthcare policy in response to the pandemic encouraged replacing in-person visits with telehealth whenever possible.

One of the advantages of being embedded in a large healthcare system was the support provided at a national level for the conversion to telehealth. For example, a telehealth delivery platform, VA Video Connect, was in place, and all clinicians were granted access. In addition, when challenges arose regarding network capacity, alternative approved platforms were explored for privacy and security and disseminated to the field by the organization. However, universal access does not solve all implementation challenges at the clinic, clinician, or patient levels. We continued using the ACCESS model (Creed et al., 2016) and found that additional work was needed to teach the basics of telehealth delivery and build clinician skill and self-efficacy. We approached this through our existing communication channels by sending supplementary materials directly to the field, engaging program leaders as internal facilitators and experts, and continuing to directly communicate in our weekly consultation calls. We addressed the challenge of remotely sharing written materials used in WET (e.g., giving patients written instructions for each session, reviewing patients' trauma narratives immediately after they wrote them, and collecting clinical assessments) with clinicians directly, as specific challenges emerged in consultation. We review here how we adapted our facilitated learning collaborative program to help clinicians and clinical programs address these challenges during the pandemic.

Adapting the Virtual Learning Collaborative to a Pandemic

Because our facilitated learning collaborative was designed to be virtual, the format or modality of our training and implementation efforts did not need to change during the pandemic. However, in line with the adaptation principle of ACCESS, the content and focus of those efforts were shaped to address the additional challenges posed by COVID-19. These adaptations were introduced through the provision of new didactic material, the consultation process, and group implementation calls.

The didactic workshop training had already been completed before the pandemic onset. However, as most clinicians and team leaders transitioned largely to telework, we supplemented the workshop content with a guide on transitioning from in-person to telehealth-delivered WET, which was reviewed across the learning collaborative calls and in the competency-based consultation calls. We emphasized the elements we considered essential for treatment fidelity, including encouraging the delivery treatment using video telehealth (Rosen et al., 2020), remaining in the virtual room while patients completed their writing, collecting the written narrative, and obtaining program evaluation data. When COVID-19–related factors arose, we facilitated discussion and problem-solving and encouraged peer-to-peer sharing during program leader calls as well as group consultation calls. Participants shared tips and suggestions with each other on how to overcome barriers to care, such as using screen capture capabilities to collect narratives and using the PTSD Coach mobile application (Hoffman et al., 2011) to collect PROM. Additionally, the consultation calls were extended by 3 weeks to allow clinicians extra time to complete cases that were interrupted or support the completion of new cases to replace any training cases that dropped out.

Impacts of COVID-19 on Training Outcomes

Clinician Retention and Training Completion

Despite the onset of COVID-19 and its related challenges, all program leaders remained enrolled and engaged in the training program, with most continuing to consistently submit site-level data and participate in implementation calls. Because of COVID-related impacts, 56.1% ($n = 23$) completed all competency-based training requirements by the original consultation end date. However, a 3-week extension was provided to allow participants access to ongoing consultation, which enabled another 24.4% ($n = 10$) to complete all training requirements (i.e., 80.5% total completion rate) by the extended deadline. An additional 7.3% of clinicians ($n = 3$) partially completed the requirements and continued in an adapted, independent training model. This allowed them to continue with cases or, most often, complete a second case outside of the consultation model. The dropout rate for clinicians was 12.2% ($n = 5$).

Some of the noted reasons for dropout included therapist factors and recruitment difficulty related to COVID-19. Some sites had difficulty with referrals and recruitment following the move to telehealth, and some clinicians elected to discontinue their participation due to a lack of possible cases for WET. Our residential site moved to reduce occupancy (e.g., discharging patients, restricting new admissions), which limited the number of available patients for these clinicians. Some clinicians were personally impacted by illness or caregiving responsibility, including caring for minor children after schools were closed. This led to extended absences that impacted patient care, consultation attendance, and, in some cases, clinician dropout.

The pandemic also impacted clinician adherence to weekly treatment session delivery, as participants sometimes reported having more than a week between WET protocol sessions. In some cases, this was related to the clinician-level factors described earlier (i.e., the clinician was directly impacted by COVID-19, had fellow staff impacted, had a loved one impacted, or were absent due to childcare), whereas in other cases, it was related to the clinician being converted to telework. Ongoing challenges for patients also impacted weekly adherence due to direct or indirect effects of the virus, such as childcare, increased demand at work, lack of privacy at home, or lack of access to adequate technology. As noted earlier, our residential program was impacted, as operations were scaled back; for example, residential patients were discharged early as a protective measure, which resulted in limited options for treatment cases.

Several clinicians commented that having the continuity of the consultation calls provided structure and stability in a time that was both professionally and personally challenging. Feedback from program leaders and clinicians reflected overall positive attitudes about delivering this intervention during the COVID-19 pandemic. The team-based approach may have made it possible for clinicians to continue in consultation, as they received support from the organization (i.e., internal facilitator). One program lead reported that she and her team found WET easier to deliver via telehealth than other evidence-based treatments for PTSD. Group consultation calls also reflected this attitude, although challenges with obtaining measures and narratives were acknowledged.

Patient Retention and Treatment Characteristics

Research studies have shown a low dropout rate for WET, typically reported as less than 10% (Sloan & Marx 2019). Across the first two cohorts of the WET implementation pilot, both of which were completed before COVID-19, the patient dropout rate was 20.8%. Consultation for this third cohort began February 22, 2020, and data were available for 115 cases at the time of this writing. Some cases were completed before the onset of COVID-19–related restrictions and 55 were completed after the onset of COVID-19–related changes in the enrolled clinics, for a total of 84 completed cases during the time reported. Among the 115 patients enrolled, 31 patients dropped out during this time, resulting in a dropout rate of 27.0% during COVID-19. Of note, 12 reported dropout reasons related to telehealth (e.g., technical inability to transition to telehealth, lack

of privacy at home to conduct sessions, preferring to wait for in-person care) or challenges due to COVID-19 (e.g., increased stress due to COVID-19; less time to devote to therapy due to the need to attend to other matters, such as childcare). Patients who cited COVID-19 or telehealth as a reason for discontinuing therapy most often dropped out at Session 1 ($n = 5$) or Session 2 ($n = 4$), and all of these patients dropped out by Session 4. Given that these patients had not planned to enter into telehealth treatment and some had substantial technical limitations, it is striking that the dropout rate was only around 7% higher than we observed in prior training cohorts and below the 31% dropout rate found for veterans receiving trauma-focused therapies in regular VA care (Hale et al., 2019).

To assess if cases and/or individual sessions were impacted by COVID-19, three questions were added to the data collection portal for clinicians. Participants were asked, "Did COVID-19 come up in the session you are reporting on?" If clinicians reported "yes," they were asked to indicate, "Was the content PRACTICAL? (e.g., childcare, figuring out how to do telehealth, availability of groceries, etc.)" and "Was the content EMOTIONAL? (e.g., anxiety, isolation, problems sleeping, etc.)." Clinicians could answer that the content was practical, emotional, or both. At the time these questions were added, most enrolled teams had recently converted patients to virtual care, and several clinicians were also teleworking. Of the sessions that occurred since the onset of COVID-19, clinicians noted that COVID-19 came up in fewer than half of the 244 sessions for which there are data (41.4%; $n = 101$). Of these 101 sessions, the content was considered practical in 61.4% of sessions ($n = 62$). Practical content was commonly noted to include COVID-19–related challenges with engaging in telehealth and impacts of the pandemic on living, schooling, or social interactions. The content was noted to be emotional in 67.3% of sessions ($n = 68$). Emotional content was commonly explained as COVID-19–related anxiety or worries, frustration, and isolation. In consultation, therapists were encouraged to address these challenges in session while maintaining fidelity to the protocol. Discussion of COVID-19 impacts was most frequently addressed during the check-in or at the end of the session when scheduling for the next session. Therapists also reported the need to address these barriers and challenges outside of WET sessions when patients canceled or did not show up for their appointments. We encouraged therapists to be responsive but cautious about the amount of time dedicated to COVID-19 in sessions, maintaining fidelity to the trauma-focused protocol. If therapists were unable to maintain fidelity or found that COVID-19–related challenges became the focus of the session, they were encouraged to document this as an adaptation in the portal.

Clinicians reported that COVID-19 came up during a session for 50 patients (79.4%) during the time studied. As noted earlier, clinicians were encouraged to discuss these concerns while maintaining fidelity to the WET framework. Of the 12 patients that dropped out for reasons related to COVID-19 or telehealth, COVID-19 was documented as impacting a session for only one of these patients (8.3%) before dropout. Thus, it is interesting to note that patients who brought up COVID-19 during sessions were unlikely to drop out due to COVID-19–related reasons, and patients who did drop out due to COVID-19–related reasons did not typically raise the concern in session before dropping out. This might suggest that during times of uncertainty and change in treatment and training, clinicians should consider asking patients about barriers to continuing treatment and problem-solving as needed at each session, even if patients do not spontaneously bring this up as an issue.

Although some patients dropped out due to COVID-19, most clinicians were able to enroll new participants during the COVID-19 pandemic. An additional 41 patients began the WET protocol after the COVID-19–related changes occurred in our enrolled clinics. This suggests that although some patients were unable or unwilling to transition to telehealth, many effectively transitioned and others were open to beginning a new intervention using telehealth.

Discussion

This virtual, facilitated learning collaborative, which began before and continued during the COVID-19 pandemic, was able to be adapted during the COVID-19 pandemic so that most clinicians and clinics were able to successfully complete competency-based training even during a challenging transition. The ACCESS model, which allowed for adaptations to the training model in the face of external challenges, helped maintain continuity of training and may contribute to future sustainability. This scaffolding helped clinicians adapt WET for delivery during the pandemic. Even patients who raised concerns related to COVID-19 during their sessions most often continued in treatment and completed the protocol. Clinicians who address patient concerns within the context of an evidence-based protocol may increase rapport and help with problem-solving across both the practical and emotional issues that arise. It is notable that frequently, patients whose dropout was documented by the clinician as being related to COVID-19 did not indicate that COVID-19 impacted sessions before dropout, indicating that extra attention may be needed to decrease the likelihood patients will drop out during this stressful time, even if patients do not raise the concern during their sessions. However, most patients were successfully retained, and many new patients were willing to begin treatment despite the ongoing pandemic. Additionally, our findings indicate that clinicians and program leaders can persist in and successfully complete training when appropriately supported. The fact that providers were able to continue to administer a structured, evidence-based protocol even when attending to complex external stressors and shifting health care policies reflects the resilience and resourcefulness of our frontline providers.

The data reported herein are informative but should be considered in light of the strengths and weaknesses of this program evaluation data. Strengths of the current design include the fact

that data reflect the experiences of training team members, program leaders, clinicians, and patients from clinics across diverse geographical regions of the United States. This is a particular strength given that the focus of these data is on the consequences of COVID-19, which has differentially affected communities. Despite this strength, we had a small percentage of missing and incomplete data, partially due to some of the providers still treating patients in the program. Additionally, the impact of COVID-19 did not occur simultaneously or evenly across sites, and sites varied regarding the exact dates that in-person care was halted and telehealth began. However, discussions with program leaders indicate that these events occurred close in time (i.e., within 2 weeks) across sites. However, it is likely that in a multisite implementation program, sites will be differently impacted, and the adaptability of training supports must respond accordingly.

This virtual facilitated learning collaborative implemented evidence-based psychotherapy in mental health clinics using a combination of competency-based training and facilitated implementation support. Although the COVID-19 pandemic could not have been anticipated, using the ACCESS model to build and adapt this virtual facilitated learning collaborative may have contributed to the sustainment of the training despite external stressors. This provides an example for future training initiatives so they can ensure the durability of the training approach in challenging and unexpected circumstances.

First, the utilization of a virtual training approach was a strength when weathering a global crisis that limited in-person contact. Strategies were already in place to communicate with participants electronically, including conducting videoconferences and electronically sharing training materials and program evaluation data. Thus, training infrastructure did not have to be changed dramatically in response to the new obstacles created by the pandemic. Our team was able to provide supports across sites and leverage internal facilitators (i.e., program leaders) to disseminate information and encourage continued delivery with fidelity.

Second, the competency-based training strategy, which included weekly consultation and review of work products, was used to support clinicians' delivery of the intervention. Within the ACCESS model, this included consulting to facilitate skill-building and evaluating work samples. Consultation may have helped clinicians successfully address patients' emergent COVID-19–related issues within the framework of WET rather than having them go off-protocol or abandon WET for another treatment. This may be why patients who raised COVID-19–related issues during treatment were no more likely than others to drop out.

The third factor was the learning collaborative framework, which included the involvement of program leaders receiving implementation support. This addressed two aspects of the ACCESS model for implementation—assessing and planning for implementation and supporting sustainability. Including program leaders and implementation facilitation allows training teams to address barriers that interfere with successful implementation (Nadeem et al., 2013). Furthermore, having monthly calls with program managers on implementation challenges allowed for shared problem-solving across sites in response to the crisis, easy dissemination of expert guidance in how to adjust to telehealth delivery, and internal facilitation (i.e., information dissemination from program leaders to their clinical teams). It is noted that sites also provided materials that could be rapidly shared outside these meetings via e-mail or as discussed on consultation calls. Therefore, the training team was able to leverage these meetings to support teams as they rapidly adapted their implementation strategy to telehealth-based care. Team-based facilitation may have also helped to increase buy-in to sustaining this intervention. Team-based training also meant that participants at each site worked together to strategize how to support the completion of training through a difficult transition. This is in contrast to traditional individual clinician–based training models, which could face more challenges sustaining training efforts if the clinician is not supported by their organization in how to continue with training and treatment implementation (Rosen et al., 2016).

Based on the successes and obstacles overcome in this training program, several recommendations are made for the field for future training that is durable in the face of unanticipated challenges, including the uncertain future for training during the anticipated ongoing COVID-19 pandemic. In addition to the existing literature highlighting the many benefits of team-based training (e.g., Brown et al., 2014; Nadeem et al., 2013), our experiences during COVID-19 highlight the strength and flexibility of this approach. Therefore, individuals initiating new training programs are encouraged to consider the virtual facilitated learning collaborative model and the ACCESS framework. The inclusion of program leaders and a specific track of program leader activities is recommended, including ongoing implementation planning, review of site-level data, and problem-solving implementation barriers. Leveraging technology to offer virtual training allows for increased access when in-person travel is not feasible. Finally, it is recommended that training programs include training in telehealth-based delivery of evidence-based treatment, including strategies to overcome common challenges, such as transmitting symptom measures and therapy materials.

Although the primary challenge that we worked to overcome with this training program was COVID-19, the relevance of the discussed training elements likely extends to other challenges that may arise for future training initiatives. At the most basic level, training approaches need to be adaptable to meet the larger national and international needs. As the world becomes more connected online and with social media, there is increased demand for training across long distances, and virtual training is essential to adequately meet that demand. Similarly, when a diverse range of clinicians and sites are being trained, they are likely to have differing levels of experience with the specific intervention or implementation of evidence-based practices more generally. This strengthens the need for involvement of program leaders and cross-site implementation support to increase

the likelihood that the intervention is integrated into the new practice. Additionally, these training approaches are likely to be useful for other types of challenging or dynamic situations. In addition to the possibility of other future global health crises, these approaches can be useful in response to a variety of barriers, such as natural disasters or community violence.

Our training program continues to investigate new training methods that may increase the reach of evidence-based treatments while maintaining high-quality training standards for ensuring mastery and fidelity to the treatment. In future efforts, our team will be investigating independent study models and blended learning training models that incorporate independent and facilitated learning approaches. For example, we will evaluate whether training is as effective and patient outcomes are as strong if providers attend a prerecorded workshop and/or participate in as-needed consultation. These strategies may provide even more flexibility to complete training in an uncertain mental health landscape as well as accommodate the busy work schedules of mental health providers. Furthermore, we plan to conduct a more extensive evaluation of key patient-level and implementation outcomes, including fidelity, reach, acceptability and provider perceptions, and sustainability. An examination of these additional training components will further add to our understanding of the effectiveness of this training approach. Additional research will also be needed to examine other training approaches and training in other evidence-based treatments during periods of social distancing that necessitate the use of telehealth platforms.

The ongoing pandemic has further increased the clinical need for evidence-based psychological interventions for traumatic stress. To continue to build workforce capacity, training programs must be robust in the face of uncertain and evolving circumstances. Fortunately, training strategies can be adapted to withstand new challenges, facilitating clinical mastery and treatment sustainability. By carefully selecting training strategies that maximize flexibility, we can continue to ensure the availability of evidence-based treatments.

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