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Expanding Access to Evidence-Based Children's Behavioral Health Treatments:

Role of a Train-The-Trainer Approach

Approximately one-third of youth will develop a behavioral health condition prior to age 18.[1] While behavioral health treatment is modestly effective overall, a rapidly increasing number of evidence-based treatments (EBTs), which have been rigorously tested through research studies, have been developed. EBTs improve the effectiveness of treatment for all children, and recent research from Connecticut shows they may reduce disparities in treatment outcomes for children of color.[2] **While EBTs are considered best practice, making them widely available for children and families in community and clinical settings has proven challenging[3] and most children still do not receive EBTs.[4] Increased use of a Train-the-Trainer (TTT) model is a promising strategy for improving dissemination so that more children and families can access EBTs.**

Challenges with the Traditional Training Approach

Ensuring that EBTs developed in research settings are available in the community requires overcoming a number of challenges. Two of the most commonly cited are the additional implementation and service delivery costs, particularly in the absence of enhanced reimbursement for EBTs, and limited expert training capacity. The traditional approach to bringing EBTs into communities has relied on EBT developers or their national trainers to provide clinical training and often time-limited telephone consultation to a group of clinicians. Sometimes, more comprehensive implementation strategies such as learning collaboratives are used. Regardless of the implementation approach, high rates of staff turnover require ongoing training and consultation for new staff even after initial implementation.[5] Training and consultation costs for national trainers can be quite high, particularly if travel is required. In addition to these costs, there are simply not enough national trainers to meet the increasing demands for training and clinical consultation in EBTs nationally[6], resulting in long waits for training or scheduling restrictions for providers who may have to choose from a very limited number of options for training when it is available. In addition, most EBT developers and

many national trainers are based in academic institutions rather than local community mental health agencies where the treatments are ultimately delivered; these developers and trainers are predominantly Caucasian and EBT trainings and materials are nearly always developed in English, resulting in a significant need to tailor EBTs to local communities and populations.

A Train the Trainer Model Can Improve Dissemination of EBTs and Reduce Costs

The Train-the-Trainer (TTT) model is a promising approach to improve the dissemination of EBTs and is compatible with learning collaboratives and other implementation strategies. A TTT model is typically led by the EBT developer or national trainer to train a cohort of local or state trainers. These local or state trainers must demonstrate expertise in the intervention, as well as the ability to provide training and consultation to others within their network and/or community setting. The TTT model has several advantages:

- It builds the capacity of local trainers to tailor and share real-world application of EBT solutions with their local community, given their knowledge of local context and state behavioral health policies.
- Local trainers generally have relationships with the colleagues they train, offering better and longer-term access to model expertise and ongoing consultation for clinicians in the community.
- Local trainers are often less costly and eliminate the need for out of state travel.[7]
- Local trainers generally provide more flexible training options that can be time and cost effective, such as smaller groups, more frequent trainings, in-person clinical consultation, and a training schedule that can be delivered in smaller increments over several days or weeks.

Growing evidence suggests TTT models can be effective at increasing knowledge, improving clinical skills, and producing better client outcomes.[4] A recent study comparing a TTT model with expert training found comparable results for adherence to the EBT (the degree to which a treatment is being delivered as originally developed) and found that the TTT model resulted in superior EBT competency (the skill with which a treatment is delivered)[8]. Given the potential of TTTs to train more therapists over time at lower cost, the TTT model may facilitate widespread dissemination of EBTs[8] and thus increase the number of children receiving EBTs. However, use of a TTT model requires support from the model developer(s) to create and oversee a TTT program. Common concerns from developers include: limited capacity to develop a TTT program, concerns that trainers will experience model drift and that the developers themselves will be too far removed from the training, and reduced revenue from training and consultation if done by local trainers rather than the model developers.

Connecticut has Successfully Used a TTT Model for Several EBTs

CHDI, in partnership with the Connecticut Department of Children and Families (DCF), has been disseminating EBTs since 2008. CHDI and DCF recognized that sustaining these EBTs by bringing in national trainers was challenging due to limited capacity of the national trainers, costs, and a reliance on outside experts for the various EBTs. **CHDI has worked with several EBT developers to develop in-state trainer expertise through TTT initiatives, and to date has trained 30 local or state trainers across four EBTs, who have in turn trained more than 440 clinicians in Connecticut.** While TTT programs vary, typically clinicians already trained and experienced in the EBT are identified and invited by a national trainer for the TTT program based on their knowledge and experience delivering the EBT model and their potential for being an effective and engaging trainer. Participants work closely with the national trainer for guidance on training content, delivery mechanisms, and learning techniques. Several steps are taken to ensure competency and high-quality training which may include live training observation,

trainer consultation, training preparedness, and learning engagement strategies. In some models, a competency exam is required to achieve certified trainer status.

A preliminary CHDI analysis comparing local trainers with national trainers for two EBTs suggests that both approaches result in comparable outcomes for the number of children served per clinician and clinical outcomes of children receiving the EBT.

Recommendations to Expand Training for Evidence-Based Behavioral Health Treatments

A TTT approach for disseminating EBTs has promise for improving access to EBTs, building local expertise and capacity for more flexible training, and reducing dissemination costs. **The following recommendations are made for Connecticut to improve children's behavioral health services by expanding the use of the TTT model:**

1. Collaborate with national trainers/model developers to increase local and in-state trainers in order to develop local EBT expertise and to support sustainability of EBTs.
2. CHDI, the state, and researchers should evaluate how the TTT approach affects dissemination costs and child outcomes to better understand how to effectively and efficiently implement and sustain EBTs.
3. EBT developers and researchers should study different approaches to TTT initiatives to learn how to make them more efficient, effective, and equitable, and to ensure that trainers understand and reflect the communities in which they are training.
4. States, providers, schools, and others considering implementing an EBT should consider prioritizing EBTs that have a TTT model for improving sustainability.

This issue brief was prepared by Tiffany Franceschetti and Jason Lang. For more information visit www.chdi.org or contact Jason Lang (jalang@uchc.edu).

REFERENCES

1. Merikangas KR, Nakamura EF, Kessler RC. Epidemiology of mental disorders in children and adolescents. Dialogues Clin Neurosci. 2009; 11(1):7-20. doi: 10.31887/DCNS.2009.11.1/krmerikangas. PMID: 19432384; PMCID: PMC2807642.
2. Lang, J. M., Lee, P., Connell, C. M., Marshall, T., & Vanderploeg, J. J. (2021). Outcomes, evidence-based treatments, and disparities in a statewide outpatient children's behavioral health system. Children and Youth Services Review, 120.
3. Ray ML, Wilson MM, Wandersman A, Meyers DC, Katz J. Using a training-of-trainers approach and proactive technical assistance to bring evidence based programs to scale: an operationalization of the interactive systems framework's support system. Am J Community Psychol. 2012 Dec; 50(3-4):415-27. doi: 10.1007/s10464-012-9526-6. PMID: 22711269.
4. Triplett, N.S., Sedlar, G., Berliner, L. et al. Evaluating a Train-the-Trainer Approach for Increasing EBP Training Capacity in Community Mental Health. J Behav Health Serv Res 47, 189–200 (2020)
5. Woltmann, E. M., Whitley, R., McHugo, G. J., Brunette, M., Torrey, W. C., Coots, L., . . . Drake, R. E. (2008). The role of staff turnover in the implementation of evidence-based practices in mental health care. Psychiatr Serv, 59(7), 732-737. doi:10.1176/ps.2008.59.7.732
6. Franklin C. Teaching Evidence-Based Practices: Strategies for Implementation: A Response to Mullen et al. and Proctor. Research on Social Work Practice. 2007; 17(5):592-602.doi:10.1177/1049731507301525
7. Yarber, L., Brownson, C.A., Jacob, R.R. et al. Evaluating a train-the-trainer approach for improving capacity for evidence-based decision making in public health. BMC Health Serv Res 15, 547 (2015).
8. Wilfley DE, Agras WS, Fitzsimmons-Craft EE, et al. Training models for implementing evidence-based psychological treatment: a cluster-randomized trial in college counseling centers JAMA Psychiatry (2019)