Australian Mental Health Outcomes and Classification Network

A Training Framework for the National Outcomes and Casemix Collection

Version 1.0

March 2011
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**Introduction**

The National Outcomes and Casemix Collection (NOCC) has seen the introduction of a suite of standard measures into routine clinical practice (Department of Health and Ageing, 2003). The collection is an evolutionary process that mirrors the Australian mental health reform process as outlined in the 4th National Mental Health Plan (Australian Health Ministers, 2009) and associated information priorities (Department of Health and Ageing, 2005). This paper provides a framework for training in the measures that make up this collection. As the collection is evolutionary so is this document.

The framework has been informed by the National Practice Standards for the Mental Health Workforce (Department of Health and Ageing, 2002) and a process of consultation with the sector and the experience of trainers. Three rounds of consultation have taken place to support the development of this framework. The first was held in November 2008 as part of the 2nd Australasian Mental Health Outcomes Conference: *HeKakano – touching the ground*. A preconference workshop was held which included a review of training requirements for the measures and their implementation. Participants at the preconference workshop provided advice on the content required for initial training, retraining and train the trainer training (see Appendix 2). A second consultation was held in 2009; this occurred online and drew 140 participants from across jurisdictions. The third process of consultation involved discussion with those individuals responsible for NOCC training within each state and territory. These consultations have informed the development of this paper on the requirements for initial,
refresher and further training and this paper is a synthesis of these consultations and the published literature.

Training in the measures that make up NOCC has generally taken one of two forms, either “train the troops” or “train the trainer” (Trauer et al., 2002). Both approaches have demonstrated their ability to develop knowledge and skills in trainees (Coombs et al., 2002). Both approaches have their strengths and weaknesses. It is important to note that training in and of itself will not produce the change in practice required and organizational factors will need to be addressed to support sustainable implementation (Deane et al., 2006).

While there is some evidence to suggest that training is not required for the Health of the Nation Outcomes Scales (HoNOS), the primary clinical measure of the NOCC (Rock and Preston, 2001), training programs have had a positive impact on clinician attitudes towards outcome measurement and its importance in relation to quality improvement in services (Cleary et al., 2002).

Generally, clinicians have not had a positive attitude towards the introduction of routine outcome measurement (Callaly et al., 2006, Walter et al., 1998) with clinicians generally seeing it as a bureaucratic exercise with little clinical utility (Patterson et al., 2006) and prone to bias (Callaly et al., 2003). However, there is evidence to suggest that the use of the consumer self assessment measure may be of benefit to consumers and clinicians alike (Callaly, 1998, Black et al., 2009). The measures may also be useful in developing the cultural competence of the workforce (Coombs and Hirini, 2005). Training materials have been developed that not only have provided an opportunity for retraining in the measures but also the opportunity to explore
the use of the consumer self assessment measure in practice. These training materials were evaluated and found to have improved the attitudes of clinicians towards routine outcome measurement (Willis et al., 2009). Consumers see the benefit of routine outcome measurement and believe that it has the opportunity to improve care, however they have generally been unaware that clinicians have to complete a suite of measures and offer a consumer self assessment measure on a regular basis (Guthrie et al., 2008). For the successful implementation of NOCC, clinicians need to be exposed to a range of training experiences - so that concerns regarding the validity of the information collected can be addressed, to demonstrate that the information collected can be used for the benefit of the consumer and the service and to provide support in interpretation of results and their use in practice (Meehan et al., 2006).

This paper provides guidance on initial training and retraining. Initial training is expected to enable trainees to complete the measures that have been introduced under the NOCC. The focus is on the development of the technical ability to compete the measures, for example, by following the rating rules consistently. The utility of the measures is introduced but elaborated on in later training once the trainee has had some experience with the measures. Follow-up training or retraining, as well as ensuring technical accuracy, is aimed at developing a deeper understanding of the utility of the measures for various purposes within the mental health sector. This includes their use in clinical practice as part of the clinician-consumer interaction, as well as their use for service monitoring and development purposes. This introduction provides the foundation for more targeted training experiences that highlight the clinical and service management utility of the measures.
There have been calls for consumers and carers to be involved in clinicians’ training associated with NOCC (Black et al., 2009). There is some evidence to suggest that the involvement of consumers in training enhances workers skills (Repper and Breeze, 2007). The involvement of consumers and carers has occurred in training and conference presentations (Lewis, 2008). The need to provide specific training and educational opportunities for consumers is considered part of the development process of NOCC implementation.

This paper also provides some guidance on the prerequisites necessary to being a trainer in the NOCC. The competence of clinicians to complete the NOCC can be measured through knowledge tests, observation of behaviour or a combination of these approaches (O’Hearne Rebholz, 2006). This paper outlines the knowledge and skills criteria to establish competence to complete the NOCC measures as part of routine clinical practice.

This paper has been set out with a consistent structure. An introduction to the scope of the training, followed by the knowledge, skills and attitudes that it is hoped will be developed as a result of receiving training. An example training program with content is provided and finally links to, and descriptions of, the available training resources.
Basic Training

At the completion of basic training, trainees should have an understanding of the measures that make up the NOCC. They should also have an understanding of the data collection protocol and how it has been introduced at a local level. The NOCC protocol is the minimum collection required. States and territories, and the service units within them, have modified the protocol to meet their needs. Basic training should include the rationale for the national protocol as well as local variation.

Training should involve the use of material that is relevant, realistic, engaging, challenging and instructional (Kim et al., 2006) and it should provide trainees with the opportunity to reflect on their practice (Williams, 2001).

At the completion of this training trainees should have:

Knowledge

- An understanding of the rating rules of the clinician rated measures, including the HoNOS family of measures.
- An understanding of the rating of the clinician rated measures of functioning – the Life Skills Profile -16 (LSP-16) and Children’s Global Assessment Scale (CGAS).
- An understanding of how to rate other clinician measures, including the Focus of Care, the Factors Influencing Health Status (FIHS) and the Resource Utilisation Groups Activities of Daily Living Scale (RUG-ADL).
• An understanding of the purpose of the consumer self assessment measure, temporary contraindications and permanent exclusion criteria.

• An understanding of the data collection protocol, including collection occasions, one episode and service setting rules and how these work within their local area.

**Skills**

• The ability to complete the clinician rated measures in a way that achieves at least 80% concordance with consensus ratings.

• An expressed understanding of the skills necessary to offer the consumer self assessment measure as part of routine clinical practice, including contraindications and general exclusion criteria.

**Attitudes**

• Expressed the belief that offering the consumer self assessment measure in a way that aims to engage the consumer in the processes of care is a positive aspect of care.

• Expressed the belief that clinician and consumer rated measures have value for a range of stakeholders including consumers, carers, service managers and developers of policy.
Sample Basic Training Program

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 minutes</td>
<td>Welcome, introductions and overview.</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Background and rationale for implementation. Policy context and potential uses of measures.</td>
</tr>
<tr>
<td>60 minutes</td>
<td>The data collection protocol.</td>
</tr>
<tr>
<td>60 minutes</td>
<td>Overview of Health of the Nation Outcomes Scales (Family). Focus on specific measure for specific age group.</td>
</tr>
<tr>
<td>45 minutes</td>
<td>Rate complex vignette.</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Overview of the Life Skills Profile 16.</td>
</tr>
<tr>
<td>15 minutes</td>
<td>The Focus of Care.</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Other data items including mental health legal status and diagnosis.</td>
</tr>
<tr>
<td>30 Minutes</td>
<td>The consumer self assessment measure.</td>
</tr>
<tr>
<td></td>
<td>• Temporary contraindications</td>
</tr>
<tr>
<td></td>
<td>• General exclusions</td>
</tr>
<tr>
<td>30 Minutes</td>
<td>Uses of routine outcome measurement in practice.</td>
</tr>
<tr>
<td></td>
<td>• Engagement and assessment</td>
</tr>
<tr>
<td></td>
<td>• Service development</td>
</tr>
</tbody>
</table>
Basic Training Resources

http://amhocn.org/training-service-development/training-resources

http://amhocn.org/training-service-development/online-training

Retraining

It has long been established that, with the introduction of a measure into either a research or routine clinical practice context, there will be “drift” in the accuracy of ratings (Ventura et al., 1993). A system that ensures that clinicians have opportunities to correct any idiosyncrasies in rating behaviour should be established. Consultation indicated that retraining should include reaffirmation of the key messages and opportunities to practice rating the measures.

At the completion of retraining trainees should have:

Knowledge

- An understanding of all the measures that make up the National Outcomes and Casemix Collection.
- An ability to describe how the national protocol has been modified to meet local needs.
- An understanding of how the measures can be used in clinical practice to support engagement and assessment activities and monitor change over time.

Skills

- The ability to complete the clinician rated measures in a way that achieves at least 80% concordance with consensus ratings.
- An expressed understanding of the skills necessary to offer the consumer self assessment measure as part of routine clinical practice, including contraindications and general exclusion criteria.
Attitudes

- Expressed an intention to explore the use of the standard measures as part of their routine clinical practice.
## Sample Retraining Program

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 minutes</td>
<td>Local Data Collection Protocol and special circumstances.</td>
</tr>
<tr>
<td>60 minutes</td>
<td>HoNOS (Family) retraining.</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Other measures that make up the collection.</td>
</tr>
<tr>
<td>45 minutes</td>
<td>Putting the measures into practice.</td>
</tr>
<tr>
<td></td>
<td>Offering the consumer self assessment.</td>
</tr>
<tr>
<td></td>
<td>Comparing Service Units.</td>
</tr>
</tbody>
</table>

### Retraining resources

- [http://amhocn.org/training-service-development/training-resources](http://amhocn.org/training-service-development/training-resources)
- [http://amhocn.org/training-service-development/online-training](http://amhocn.org/training-service-development/online-training)

The resources below can be used for both retraining and clinical practice improvement training.


Clinical Practice Development

The measures that make up the National Outcomes and Casemix Collection can be used for a number of clinical practice improvement activities. Services units around Australia and New Zealand have been exploring the utility of the measures (Coombs et al.). This has included using the measures to support the assessment and engagement process as well as using them in care planning and monitoring change over time.

Much of the clinical practice utility of the measures is based on the observation that it is the accuracy and reliability of the clinician’s assessment that underpins the validity and reliability of the information being collected (Mellsop and Wilson, 2006) and that completion of the measures is the creation of a summary of the clinician’s assessment of the consumer. For example, a rating of 2 or higher on the HoNOS is seen as a clinically significant rating (Burgess et al., 2009), something that warrants monitoring by the clinician and an active treatment or management plan.

The same logic holds true for the other measures but in a slightly different way. The LSP-16, for example, can be used to not only identify deficits but also the consumer’s strengths. Using the measures to identify consumer strengths is made explicit by the Strengths and Difficulties Questionnaire - the Child and Adolescent self and carer report measure. It is necessary to have training materials that make explicit the relationship between the quality of the assessment and the accuracy and validity of the ratings, an issue of concern to clinicians (Meehan et al., 2006).
Training should provide trainees with the opportunity to explore the use of the measures in a variety of different ways.

It is the reliability of the assessment of the clinician that underpins the validity and reliability of the information being collected (Mellsop and Wilson, 2006).

The use of the measures to support the engagement and assessment process must give clinicians an opportunity to determine how the measures can be introduced and used as part of clinical practice (Doss, 2005). They must practice offering the measures and discussing the results with consumers.

The measures have also been used to support discussion within team reviews. Various models have been proposed and adopted across teams. One approach used in New Zealand is called the Three C’s standing for Concordance, Change and Clinical significance. With a focus on the HoNOS, clinicians are encouraged to reflect on the Three C’s as part of case presentation. Others have focused on an individual item of the HoNOS and ensured that this is monitored during admission to determine progress and suitability for discharge (McKay and McDonald, 2008). AMHOCN advocates a more detailed reflection on all the measures as part of the team review process.

Trauer et al (2009) found that giving clinicians an ability to compare their results with reference material was a useful way of engaging clinicians in the use of standard measures. Training that provides clinicians with the opportunity to review the collected information and how this may be used at an individual and organizational level will be one way of overcoming clinicians’ concerns that information is collected but never used (Andrews and Page, 2005).
At the completion of this training trainees should have:

**Knowledge**

- An understanding of how the measures can be used to support engagement with the consumer and the assessment process.
- An understanding of how the measures can be used to monitor change over time.
- An understanding of the results of the collection, interpretation and utilization of these results.

**Skills**

- Undertaken skills rehearsal in offering the consumer self assessment measure and discussing the results of these and the clinician rated measures with the consumer.

**Attitudes**

- A positive attitude towards the use of standard measures as part of routine clinical practice.
- An intention to practice the skills rehearsed in training.
Sample Program

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 minutes</td>
<td>Welcome, introductions and overview.</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Background and rationale to the collection.</td>
</tr>
<tr>
<td>90 minutes</td>
<td>Offering and providing feedback on the consumer self assessment measure and the clinician rated measure.</td>
</tr>
<tr>
<td>90 minutes</td>
<td>Using NOCC as part of team reviews.</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Comparing service units using aggregate data.</td>
</tr>
</tbody>
</table>

These activities can be completed as a suite or separated into modules that can be incorporated into ongoing in-service training.

Clinical practice development resources


Service Management and Development

The gathering and use of information is essential to support quality improvement activities. Raleigh and Foot (2010) have identified a number of uses of information on the quality of services. Information can be used to inform the public and consumers of service performance, it can be used to pay for services or act as an incentive for certain performance, it can be used to support benchmarking activities enabling peers to support quality improvement activities, it can be used for research purposes and finally it can be used to assess performance and support management decision making. The information provided by NOCC can be used for all of these purposes.

There is a significant amount of information being collected in health but, to date, little has been done to develop the capacity within operational management to understand this material or use it for service development (Pelletier and Diers, 2004). Educational opportunities that explore this utility of the measures should be made available to the appropriate team leaders, service manager and clinical directors. There has been work to use the measures to better understand organizational performance and to support transfer and discharge decisions by teams (Prowse and Coombs, 2009). However, others have questioned the utility of some measures to adequately describe the complexity of specialist services (Cheung et al., 2009) and still others have found that a lack of data make it impossible to evaluate the quality of service provision (Kightley et al., 2010). However, where data sets are more complete greater utility has been identified (Prabhu et al., 2008, Andreas et al., 2010).
The need to engage managers in routine outcome measurement has been seen as essential to its successful implementation (Callaly and Hallebone, 2001). Clinician consultation has indicated that specific training for managers would be useful, in particular in the use of data to inform service development activities. Training should include ways in which managers can overcome the barriers to completion of the measures by building the measures into organizational operation (Callaly, 1998).

Training should also give trainees an opportunity to understand the information that is available and what can be done with the material (Diers and Pelletier, 2001). These activities should provide trainees with an opportunity to reflect on the content of reported information and the underlying organizational processes they describe to create anticipatory reflection (Williams, 2001), preparing the trainees for action once they have returned to their services.
At the completion of this training trainees should have:

Knowledge

- An understanding of the measures and how they are rated and may be used to support the clinical governance and service improvement activities.
- An understanding of how others have used the NOCC measures in clinical practice and service development.
- An understanding of the value and limitations of the measures.

Skills

- An ability to ask questions of the information that will support service management and improvement activities.
- An ability to recognize the opportunities that data may provide and a recognition of the limitations.

Attitudes

- A positive attitude towards the use of standard measures for quality improvement and service development.
Sample Program

This sample program is based on workshops held in Queensland and New South Wales. These workshops were held to support AMHOCN in the development of a training resource.

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 minutes</td>
<td>Examples of the ways others have used routinely collected mental health information.</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Ways of investigating information.</td>
</tr>
<tr>
<td>60 minutes</td>
<td>Reviewing mental health information: What does it tell you about a service?</td>
</tr>
<tr>
<td>60 minutes</td>
<td>Small group work - developing a local implementation plan for the use of standard measures.</td>
</tr>
</tbody>
</table>

Service management and development resources

Examples of how others have used the NOCC within services can be found at:

http://amhocn.org/training-service-development/forums-and-workshops

Additional resources in this area are under development; pilot workshops have been undertaken and additional workshops are planned.
Information Systems

An important area of development in the mental health sector is information literacy which can include computer skills, information searching abilities and interpretation of results (Staggers et al., 2002). The attitudes of staff towards information technology can have a significant impact on its uptake (Ward et al., 2008). In mental health, while the attitudes may be generally positive attitudes staff complain of lack of access to equipment and little training (Walter et al., 2000).

All states and territories have developed information systems with reporting capacity. AMHOCN has developed a web based tool, the web Decision Support Tool (wDST), which provides access to the data within the national collection. Local information systems and resources like the wDST should be a feature of training in NOCC. Trainers should provide trainees with the opportunity to information system reporting into training experiences. The use of this type of material demonstrates that there is access to information that is clinically meaningful (Siris, 2009) and exposes clinicians who generally do not use information systems (Mojtabai, 2007) to systems that provide this data. Clinicians need to be able to use computers and use data, information and evidence systems to provide safe and effective care (Fetter, 2009a). Educators need to provide clinicians with the opportunity to use information which can include the use of technical staff to explain the information systems (Fetter, 2009b).
**Future Developments**

There is still the need for future development work and this document is part of an ongoing development process. With the implementation of activity based funding, additional resources and material will be required to ensure that the mental health sector is informed about casemix and risk adjustment. It has been noted that there is little awareness of case-mix within the sector (Bridges et al., 2001).

Understanding and supporting benchmarking within mental health services will be an area requiring the development of specialist resources. Building on the experience of the National Mental Health Benchmarking Project, resources might describe how benchmarking is undertaken and how it can be used to drive quality improvement activities and support evidence based practice (Tomlin et al., 2002).

The implementation of new measures to the sector will require the development and dissemination of targeted training resources that can replace or add value to the existing material. The 4th National Mental Health Plan commitment to the introduction of recovery focused service provision has seen the identification of suitable measures, a necessary first step in the continued development of the collection.
Some clinicians will be identified as trainers. The approach to training has, and will, vary between organizations. Some may undertake group based training, while others will deliver one to one coaching on the job. Trainers will therefore require a wide variety of experience. This should include clinical practice experience as well as experience with the completion of the measures and their use in routine clinical practice. To train in the National Outcomes and Casemix Collection, trainers should have some, if not all, the following skills and experience:

- Be a clinician.

- Have some training in the measures that make up the National Outcomes and Casemix Collection.

- Have completed the measures as part of routine practice or similar.

- Have a demonstrated ability to deliver training to small and large groups; although formal training qualifications would be an advantage, they are not seen as essential.

- Undertake refresher training on a regular basis.
Trainers will have:

**Knowledge**

- Trainers should have a good knowledge of the measures, their rating rules and be able to make clarifications on rating principles for trainees.
- An understanding of the data collection protocol and its rationale and local adaptation.

**Skills**

- A demonstrated ability to complete the measures.
- Demonstrated ability to train others and model behaviour associated with routine outcome measurement.

**Attitudes**

- Positive attitude towards the introduction of routine outcome measurement to services.
- Positive attitude to the use of the measures for a variety of purposes, including:
  - a tool to support consumer engagement and assessment.
  - monitor change over time.
  - support decision making at service unit level.
  - the use of aggregate data for benchmarking and quality improvement activities.
Appendix 1: Glossary

**Knowledge** Includes awareness of standards of practice, competencies and curriculum statements. It also makes the distinction between discipline specific specialist knowledge and knowledge common to all disciplines.

**Skills** Refers to an understanding of how to implement knowledge of or about a particular Practice Standard.

**Attitudes** Refers to the attitude of mental health professionals towards the treatment of consumers and carers and/or family members.
Appendix 2: Framework Consultation

Consultation Round 1

A total of 37 participants completed evaluation forms. Participants were also asked to indicate if the material should be included in initial, refresher or trainer workshops. The table indicates the proportion of respondents who endorsed the content for the particular type of training.

Table 1

<table>
<thead>
<tr>
<th>Training Content</th>
<th>Indicate if the material should be included in:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Proportion (%) of respondents who agreed with statement is reported)</td>
</tr>
<tr>
<td></td>
<td>Initial</td>
</tr>
<tr>
<td>Background and rationale to the introduction of outcome and casemix measurement</td>
<td></td>
</tr>
<tr>
<td>National Agenda</td>
<td>89.19</td>
</tr>
<tr>
<td>State Agenda</td>
<td>75.68</td>
</tr>
<tr>
<td>Local Agenda</td>
<td>89.19</td>
</tr>
<tr>
<td>Other</td>
<td>2.70</td>
</tr>
<tr>
<td>Data collection protocol</td>
<td></td>
</tr>
<tr>
<td>Conceptual underpinning</td>
<td>94.59</td>
</tr>
<tr>
<td>Basic protocol rules</td>
<td>94.59</td>
</tr>
<tr>
<td>Consumer rated measure</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Overview of measure and rating rules</td>
<td>91.89</td>
</tr>
<tr>
<td>Contraindications and general exclusions when offering the measure</td>
<td>91.89</td>
</tr>
<tr>
<td>Approaches to offer the measure as part of clinical practice</td>
<td>97.30</td>
</tr>
<tr>
<td>Approaches to providing feedback on the measure in clinical practice</td>
<td>94.59</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinician rated measures</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of measure and rating rules</td>
<td>89.19</td>
<td>83.78</td>
</tr>
</tbody>
</table>

Practice Rating Measures

| Health of the Nation Outcomes Scales (65+/CA) | 91.89 | 83.78 | 89.19 |
| Life Skills Profile / CGAS | 89.19 | 83.78 | 86.49 |
| Focus of Care / Factors Influencing Health Status | 91.89 | 83.78 | 89.19 |

Receiving Feedback on performance

| Health of the Nation Outcomes Scales (65+/CA) | 89.19 | 91.89 | 83.78 |
| Life Skills Profile / CGAS | 86.49 | 91.89 | 81.08 |
| Focus of Care / Factors Influencing Health Status | 89.19 | 91.89 | 83.78 |

Using NOCC information

<p>| To support assessment and engagement | 83.78 | 78.38 | 86.49 |
| To monitor change over time | 83.78 | 83.78 | 86.49 |</p>
<table>
<thead>
<tr>
<th></th>
<th>Value 1</th>
<th>Value 2</th>
<th>Value 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand the relationship between measures and care planning</td>
<td>86.49</td>
<td>89.19</td>
<td>86.49</td>
</tr>
<tr>
<td>Discussing the clinician and consumer rated measures with consumers and carers</td>
<td>83.78</td>
<td>86.49</td>
<td>86.49</td>
</tr>
<tr>
<td>Discussing change over time with consumers and carers</td>
<td>78.38</td>
<td>86.49</td>
<td>83.78</td>
</tr>
<tr>
<td>Using aggregate information to inform service development</td>
<td>70.27</td>
<td>67.57</td>
<td>78.38</td>
</tr>
<tr>
<td>Using NOCC information for program evaluation</td>
<td>64.86</td>
<td>64.86</td>
<td>81.08</td>
</tr>
<tr>
<td>With special populations, indigenous, culturally diverse</td>
<td>72.97</td>
<td>70.27</td>
<td>83.78</td>
</tr>
</tbody>
</table>
**Table 2**

(Proportion (%) of respondents who agreed with the statement is reported)

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>6 months</th>
<th>1 year</th>
<th>2 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often should clinicians receive retraining?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21.62</td>
<td>67.57</td>
<td>10.81</td>
<td></td>
</tr>
<tr>
<td>How often should trainers receive training?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>27.03</td>
<td>56.76</td>
<td>16.22</td>
<td></td>
</tr>
<tr>
<td>Should managers receive different training to clinicians?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>81.08</td>
<td>18.92</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Consultation Round 2

AMHOCN created an online survey aimed at better understanding what the sector thought should be included in NOCC training, its duration and frequency as well as the skills required by trainers. The following tables are the results of that survey which ran online for one month in May 2009.

We had 141 respondents with a percentage breakdown across jurisdictions as shown below.
Almost 20% of respondents had not had NOCC training.

<table>
<thead>
<tr>
<th>Have you had training in the outcomes and casemix measures?</th>
<th>%</th>
<th>Number respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>19%</td>
<td>27</td>
</tr>
<tr>
<td>Yes</td>
<td>81%</td>
<td>112</td>
</tr>
<tr>
<td>Unanswered</td>
<td>0%</td>
<td>0</td>
</tr>
</tbody>
</table>

127 respondents answered questions related to training needs. Over 70% felt that managers should have training in the use of information. Over 60% felt that respondents required mental health assessment skills training but did not strongly endorse the use of measures to support development of assessment skills.
117 respondents gave an indication of how long they thought initial training should be, with the majority indicating a full or half day. They also indicated how long their initial training was, with over 10% indicating they had less than one hour.
In terms of retraining, the majority of 109 respondents indicated that retraining should be approximately one half day; while 50% of 97 respondents indicated that retraining often lasted only 1 to 2 hours.

Over 60% of 103 respondents indicated that retraining should occur on a yearly basis.
109 respondents gave an indication of the attributes that they believed trainers should have. The majority of respondents endorsed the need for clinical experience, an ability to complete the measures accurately, an ability to link the measures to clinical practice and an understanding of aggregate data and its uses. They less strongly endorsed the need for a recognized training qualification and extensive understanding of the psychometric properties of the measures.

<table>
<thead>
<tr>
<th>Attributes of Trainers</th>
<th>Did not endorse</th>
<th>Neutral</th>
<th>Endorsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant clinical experience</td>
<td>5.5</td>
<td>75.2</td>
<td>19.3</td>
</tr>
<tr>
<td>A recognized training qualification</td>
<td>19.3</td>
<td>47.4</td>
<td>37.6</td>
</tr>
<tr>
<td>An ability to rate the measures accurately</td>
<td>0.9</td>
<td>2.8</td>
<td>92.7</td>
</tr>
<tr>
<td>Extensive knowledge of the measures and their psychometric properties</td>
<td>0.0</td>
<td>0.9</td>
<td>73.4</td>
</tr>
<tr>
<td>An ability to link the measures to clinical practice</td>
<td>0.0</td>
<td>0.9</td>
<td>73.4</td>
</tr>
<tr>
<td>An understanding of aggregate data; its uses and limitations</td>
<td>0.0</td>
<td>0.9</td>
<td>73.4</td>
</tr>
</tbody>
</table>
Over 60% of 110 respondents indicated that staff should have training in the local clinical information system at the same time that they receive NOCC training.

Results of the survey indicate that, generally, respondents felt there was a need for training and retraining in NOCC, that initial training should be a half day to a full day and that retraining should be a half day long. Respondents indicated that retraining should occur annually. They also indicated that training in NOCC should include training in the local clinical information system. Trainers need to be skilled clinicians, with an ability to complete the measures and demonstrate how they can be used in practice. Respondents did not indicate a need for a formal training qualification. The results of this survey however, should be approached with caution, given that almost 20% of respondents indicated that they had not received any NOCC training.
Appendix 3: Framework Review

The following individuals reviewed and provided comment on this framework for training in the National Outcomes and Casemix Collection.
References


