An Agenda for Quality Improvement in Forensic Mental Health Consultation

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Recent developments in quality assurance in health care have embraced the total quality management approach to industrial quality control. Setting a goal of "continuous quality improvement" for medical care, this approach features special attention to the process and systems of care provision. Applying this approach to the specialty of forensic mental health consultation yields a variety of potential ways of improving care, by articulating common problems in the consultation process that might respond to the total quality management approach. These problems include the setting of appropriate goals for forensic evaluation, and selecting cases for attention on the basis of those goals; determining appropriate standards for thoroughness and validity in the use of evaluation techniques; and establishing clear expectations regarding the provision of mental health services beyond the consultation process itself. Creating interdisciplinary teams at various levels of administration of trial courts and mental health agencies can provide contexts for reviewing cases, with the aim of discovering problems in these areas, educating professionals across boundaries about sources of problems, and developing clearer and more consistent standards of practice to reduce problems and improve quality of service.

Forensic psychiatry and psychology are narrow subspecialty areas of the health care professions that face unusual challenges in the area of quality assurance. As in other areas of health care, quality assurance in forensic mental health needs to establish standards for professional activity in the areas of mental health evaluation and treatment. However, in addition to dealing with ordinary concerns about setting standards for professionals' clinical activity, efforts at quality assurance in forensic mental health need to address a variety of concerns that stem from the complex multiple client relationships in which forensic mental health services are provided. These concerns include understanding conflicts in evaluation and treatment agendas as they may be presented by a number of different (and potentially antagonistic) agents involved in interactions between law and mental health. They include as well some special ethical considerations, and some difficult questions of determining professional responsibility in the context of interactions between the mental health and legal systems.

The literature of forensic mental

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health pays little explicit attention to questions of quality assurance. This article will review some directions in quality assurance generally, and in forensic mental health professionals' attention to quality work. It will suggest some areas in which both forensic mental health and legal professionals might collaborate to develop systems for ensuring good quality forensic mental health service, especially in the area of public sector agencies providing consultation to courts.

Clinical Standards

The traditional approach to quality assurance in health care is to establish standardized approaches to addressing clinical problems, and then to develop some systems for reviewing professional practice to ensure that it conforms to the standard. Most writing in forensic mental health relevant to quality assurance follows this approach implicitly. It focuses especially on the first part, establishing clinical standards for the conducting and reporting of forensic mental health evaluations.

Several kinds of agencies have taken initiatives to set clinical standards. The most official of these is the Joint Commission on the Accreditation of Health Care Organizations.[1] Others include individual practitioners and academics, professional organizations of mental health or legal practitioners, and some individual forensic mental health agencies or courts.

In its Standards for Forensic Institutions,[1] the JCAHCO follows its general pattern of laying out appropriate standards of care for hospitals, in this case for hospitals providing forensic evaluation and treatment services. Its focus is especially on ensuring that all patients receive an appropriate minimum (at least) of clinical attention, that patient rights are respected, and that the institution establish routine arrangements for reviewing care to ensure that it meets the standards.

The American Bar Association standards for mental health evaluation in criminal justice contexts[2] address many detailed issues of legal procedure, focusing for the most part on ensuring that the client-defendant's rights are protected in the process of undergoing forensic mental health evaluation. These standards do not include any specific attention to developing systems of review or enforcement, as they appear to assume that the attorney's active advocacy for the client's interests will be sufficient in the context of the adversarial legal system to ensure that the quality goals of these standards are indeed met.

A few mental health professional organizations have ventured into the area of standard setting for specific areas of forensic mental health evaluation. These may take the form of specific expectations for professional qualification and conduct in responding to certain salient situations involving contact between clinical and legal systems. Examples include recommendations for conducting child custody evaluations offered by the Group for the Advancement of Psychiatry[3] and by the American Psychiatric Association[4]; the report on the role of psychiatry in the criminal sen-

tencing process by the American Psychiatric Association[5]; and the standards for child sexual abuse evaluation offered by the American Academy of Child and Adolescent Psychiatry[6] and by the American Professional Society for the Abuse of Children.[7] Or, organizational standards may take a broader view, describing in general what are thought to be appropriate standards of ethical conduct for professionals involved in this area of practice.[8,9] Such standards provide organizational imprimaturs that are important in setting basic expectations for professionals' clinical activities. Ethical standards are especially important in dealing with the intrinsic ambiguities in professional expectations that exist in interactions between systems as diverse as law and mental health.

Many practitioners and academics have suggested standards for clinical practice in various specific areas of forensic mental health consultation in recent years. Examples of such work are Weithorn's[10] book on child custody consultation and Grisso's[11] detailed review of clinical approaches to evaluating competencies in various legal contexts. These works are important for their careful attention to how clinical data are gathered and interpreted, and to developing appropriate ways to ensure that clinical data and interpretation are indeed relevant to the legal questions at hand.

At a still more practical and concrete level, some local courts and forensic mental health provider organizations have set explicit standards for the work in which they have a specific interest. The San Diego County Juvenile Court, in a partnership with the County Mental Health Department, has established specific local standards for expert qualification and for certain areas of professional practice in the mental health evaluation of child abuse cases.[12] These include setting threshold qualifications for examiners, establishing standard formats for referrals and reports, providing training, and conducting peer review of evaluations. The Massachusetts Division of Forensic Mental Health has established a statewide qualification process for certain forensic examiners that sets out some standards for clinical practice in the conduct of certain forensic evaluations.[13] This program covers all court-ordered evaluations described by the state mental health law, sets threshold qualification standards and some standard report formats, and provides training and supervision for candidates. In a well-documented project involving the development of a new capacity to provide forensic evaluations in community settings,[14] the Virginia Department of Mental Health established basic clinical standards for the conduct of certain mental health evaluations for courts. This project involved training providers of community mental health services in forensic issues, and providing standard reporting formats for certain kinds of reports.

All these initiatives in standard setting have in common a tendency to be fairly narrow in their focus, attending almost exclusively to issues within the boundaries of their professional interest and expertise. The standards of clinicians

and clinical organizations focus on issues of appropriate qualification, procedures for referral and evaluation, and reporting of results, including questions of validity and reliability of findings and limits of expertise. ABA standards include some attention to training requirements and procedures for forensic practitioners, but their major focus is on legal procedures and rights. With the exception of the JCAHCO standards, the San Diego Juvenile Court expert witness program, and the peer review process suggested by the American Psychiatric Association's Council on Psychiatry and Law,[15] these efforts do not address issues of how to review the ongoing work of individual professionals, or of how to enforce standards. For the most part they do not address issues relating to understanding and improving the effective use of forensic mental health consultation and evaluation services as a contributing element of the broader legal dispute resolution system. To oversimplify, standards (especially clinical ones) focus on the *products* of forensic mental health consultation, rather than on its *process.*

Total Quality Management

A newer approach in the field of quality assurance sets its explicit scope more broadly. Based on the industrial quality control approach called Total Quality Management, this approach recognizes that setting standards for clinical practice, and case review of adherence to those standards, may miss many problems which affect the effectiveness of health care delivery.[16] Aiming for "continuous quality improvement,"[17-19] it sets the goal of enlisting the attention of all players in the provider system to discover places where effective provision of care breaks down, and to develop opportunities for improvement.

Berwick[19] likens this quality assurance approach to that in an enlightened factory assembly line. He pictures a shop foreman who encourages criticism of the manufacturing process and creative suggestions for changing it from those most closely involved with it, and contrasts to another foreman who rigidly enforces production procedures established by a distant planner who may not appreciate the real constraints of the shop floor.

Berwick cites Deming and Juran *et al.*[20-23] as the most influential developers of this approach to industrial production management in the United States, but notes that the approach has been adopted most fruitfully by twentieth century Japanese industry. A fundamental principle of the approach is expressed in the following modern proverb: "Every defect is a treasure."[19] Defects are not just to be stamped out, but more importantly are to be explored, and to be seen as potential signs of underlying problems in the design of the production process. The key to this approach toward improving quality is not the setting of standards; this is only preliminary. The more important activity is the continuous monitoring of how well following the standards succeeds in actually creating products and services of increased quality, and exploring failures in quality to learn what needs to be changed.

A fundamental effect of this approach

to quality assurance is establishing a way to identify defects in the production process. Many methods are possible, but they all have the goal of discovering problems worthy of review, and learning from these problems what needs to be changed. In a service industry such as health care, this discovery process usually works by reviewing cases. A permanent or rotating committee involving representatives of each group of practitioners in a system, or a more permanent specialized office of program evaluation and quality improvement, selects and reviews case examples. The job of the committee is to examine selected cases in sufficient detail to discover whether there might be some noteworthy reproducible problem in the case, representing a potentially more significant problem in the service process as a whole.

Forensic Mental Health Consultation

Although the mental health literature includes some attention to applying the principles of total quality management to mental health care,[24,25] it has not extended this attention to forensic mental health consultation. Applying this approach to quality assurance offers considerable promise as an aid to improving the quality of professional activity in a field as dominated by complex and obscure processes as is mental health consultation to courts. A wide variety of players take part in this consultation process, not just among the mental health consultant community, but also within the community of legal professionals who will ultimately be responsible for either using mental heath input, or being frustrated by its inadequacies. This community includes not only judges and probation officers, but also defense and prosecuting attorneys, guardians *ad litem*, mental health and other service professionals who may be involved in a case outside the legal system, and client-consumers with varying types and degrees of mental disorder.

Each of these players may have different goals in the forensic mental health consultation process, and may prefer to set different professional standards in pursuit of those goals. These differences may contribute to problems in the provision of consultation, and make clarification of the nature of these problems especially difficult. The total quality management approach offers the promise of including all these players in a constructive, collaborative process that seeks out problems in forensic mental health practice and uses them as opportunities to improve processes that may not have worked well. This may be in contrast to a more static, "standard product" oriented approach, in which mental health professionals may attend to meeting standards set for the conduct and reporting of evaluations by a mental health agency that may be far from the action of consultation to the legal system, and not responsive to the needs of legal and clinical actors at a local level.

Specific Issues in the Forensic Mental Health Consultation Process

A variety of specific examples of common areas of uncertainty in the process

of forensic mental health consultation illustrate how the continuous quality improvement approach to quality assurance could be applied to forensic mental health. These applications would yield improvements not only in the products of consultants, but also in the actual usefulness of consultation to the legal system and its clients. This exploration follows Keilitz'[26] analysis of phases in the forensic consultation process, and draws examples from each basic phase of the consultation endeavor. These include *delineation* of the consultation problem, *acquisition* of relevant mental health information, and *provision* of reports, testimony, or other service responses to the request for help.

Delineation Phase Two areas in the delineation phase are potentially worthy of attention. The first is case selection, and the second is defining a consultation agenda.

Case Selection Criteria and procedures for selecting cases for forensic mental health attention vary considerably from jurisdiction to jurisdiction. In some settings there may be quite explicit criteria by which cases are included or excluded, while in others there may be complete discretion for referrers.[27] Settings with more discretion encourage greater flexibility and spontaneity in the use of forensic mental health services to help courts address a variety of difficulties. However, discretion may also foster problems with "inappropriate" referrals, that is, requests for forensic mental health help that the forensic mental health professional sees either as outside his or her expertise, or as outside the scope of problems that a program or agency may define as the appropriate target of clinical consultation.

Even in the absence of problems about "appropriateness," high discretion systems are vulnerable to many case selection biases. This problem refers to the tendency to select a case for mental health attention preferentially because of some associated factors, thought to indicate mental disturbance, which in themselves may or may not have anything to do with mental health problems in fact. An example of such bias is Lewis *et al.*'s[28,29] description of the impact of race and gender on selecting adolescents for attention by either the juvenile justice or mental health systems. Somewhat more subtle are combinations of race or socioeconomic status with other elements of a presenting problem. For example, in a large urban court, many prostitutes who are poor and black may pass through the system without mental health evaluation; the unusual white college student prostitute might be selected for special mental attention with the sense that for her, "something must be wrong." Addressing biases such as these requires value clarification about the ultimate purposes of forensic mental health consultation. It also calls for some empirical knowledge about how well factors mitigating for or against selection of cases for referral serve as proxy variables, which signal the presence of conditions that the program has determined are appropriate indications for case selection and referral.

Examples of strict and explicit referral criteria include such legal factors as

being charged with or convicted of a specific offense (often including sexual or violent offenses); being involved in a specific legal process (such as juvenile waiver or transfer hearing[30,31]; or demonstrating specific symptoms or other behavior (such as self-destructiveness). In all these circumstances, legal staff and/or consultants may believe that a case presenting with such legal or clinical features is automatically deserving of further mental health attention. Where such specific referral criteria exist, issues of potential inappropriateness or bias in case selection are less of an issue. However, even in such settings problems may arise of frustration with unavailability of resources in marginal cases, or of misrepresenting features of a case, either to enable mental health evaluation to take place or to avoid it. For example, if a program sets a policy that any case involving a juvenile transfer hearing will receive forensic mental health evaluation, then legal players on the scene, with an interest in exposing delinquents to pre-adjudication mental health evaluations, may press for transfer hearings in delinquency cases where transfer to criminal courts is not a serious possibility, solely to obtain mental health evaluation of the case.

Consultation Agendas Perhaps the most mysterious process difficulties in forensic mental health consultation are those associated with defining the consultation agenda. This includes both establishing clear, consensual questions for consultants to address, and, more broadly, defining the variety of purposes to which forensic mental health services may be put in individual cases. Even in settings where the forensic mental health agenda seems closely defined by clear and explicit legal standards, such as in evaluating a defendant's competency to stand trial or the capacity of a witness to testify, it is quite common for referrers or other interested players to intend the forensic mental health service to have features other than, or in addition to, those legally prescribed.[32] These features most commonly include the hope that the forensic evaluation referral will result in the case becoming involved in an appropriate program of mental health treatment. They may also include such goals as delaying the legal proceeding or harassing parties to the proceeding by involving them in a forensic mental health evaluation. In some such circumstances, the additional agenda is a perfectly reasonable one, which needs only to be explicated to be pursued. In others, it may need to remain hidden, since to explicate it would be to expose its deviance from accepted purposes for forensic mental health activity.

Finding individual cases with problems related to case selection or referral agendas, and exposing those cases to quality improvement review, would improve both forensic mental health service and the quality of justice in the following ways. The major impact would be to establish a broader and clearer consensus within the court and the forensic mental health agency as to the *appropriate purposes* of forensic mental health service. This process would clarify what cases should be exposed to consultation, with what expectations regarding

results. Review would stimulate attention to examining and clarifying what legal and clinical features of a case are true indicators of a need for forensic mental health attention, and what features may be misleading in this regard. Examining questions for example of whether all defendants with a previous history of mental health involvement should be referred for consultation, or whether all cases of childhood sexual abuse should receive clinical attention, would force consumers and providers of forensic consultation to reach some clear consensus regarding where such consultation should be used.

Acquisition Phase In the acquisition phase of the forensic mental health consultation process, potential problems relate to the actual conduct of the forensic mental health evaluation. This is the area that has received the most attention in the academic literature. Many thorough and insightful books and articles have appeared in the last decade setting forth recommendations about what to do in acquiring the necessary data for a forensic mental health evaluation.[3-6,10,11,32,33] This work has attended to such important process areas as confidentiality and the suspension of privilege,[34,35] defining functional measures of legal criteria to be evaluated,[11] and the reliability and validity of various data gathering devices such as interviews and tests.[11] In other important areas, notably drug abuse forensic evaluation and forensic mental health involvement with adolescent status offenses, very little similar work has appeared.

Quality improvement review of problems in the acquisition phase would improve the quality of forensic mental health evaluations for courts by ensuring that the collection of data in the consultation process had been relevant to the consultation question, adequate to provide a basis for a valid response, but not so detailed as to be intrusive or inefficient. For example, review might be useful in a competency to stand trial evaluation of a mentally ill defendant in a shoplifting case, where the consultant had included a detailed and specific exploration of the defendant's history of sexual fantasy and behavior. Such an exploration might well be irrelevant to the forensic question, needlessly intrusive into the privacy of the defendant, and wasteful both of clinical resources and of legal attention. Alternatively, review might be even more important in responding to an evaluation of criminal responsibility in which the consultant had failed to explore changes in the defendant's mental state over the period of time prior to the offense, or had neglected to attend to available sources of information beyond the clinical interview that might have been informative regarding the defendant's condition and behavior at the time of the offense. Review would be appropriate when the consultation appeared to have used standardized assessment techniques inappropriately, such as in predicting parent capacity solely on the basis of projective personality testing[10] or on the basis of standardized but unvalidated structured measures.[11] Problems in the actual process of acquiring data, such as initiating a sexual abuse evaluation of a

child with leading questions, or failing to take sufficient account of communication problems in interviewing across linguistic or cultural boundaries, would also be appropriate areas for exploratory review.

A case review scheme focusing on deviance from standard practice would likely bring some cases to attention in which standards for data acquisition may not have been met, but in which a consultation may nonetheless have been of high quality. In such cases, reviewers would have important opportunities to discover in what individual case circumstances the standards did not seem to set the right program for clinical evaluation. In some cases, individual circumstances might dictate more extensive or detailed data regarding gathering than that prescribed by standards. In others, more superficial or rapid evaluation techniques might be sufficient to the specific task at hand, or might be indicated by other aspects of the case, in spite of giving results that might be less than ideally thorough. Determining under what conditions basic standards of data acquisition might need to be altered would be an important quality improvement task for individual forensic mental health settings to accomplish.

As in other areas of quality improvement review, consensual review and learning from complaints having to do with the actual acquiring of forensic mental health data would offer courts and forensic mental health providers outstanding opportunities for mutual education. Such reviews would be ideal settings for forensic mental health staff to demystify mental health interview and testing procedures, and to educate legal staff about the complex and difficult questions of standardization, validity, and reliability, which are at the core of many concerns about the adequacy and appropriateness of specific data collection methods. Perhaps even more importantly, it would afford forensic mental health professionals outstanding opportunities to learn from legal staff just what kinds of information, developed in what ways, seem useful from the legal professional's point of view, in what kinds of cases.

Such review would undoubtedly lead in some cases to recognition that information the court wants actually may not be meaningful in the ways the court wishes it were, as forensic mental health professionals often lament. For example, it would enable consultants to explain that *post facto* evaluation will not be able to determine whether a specific event actually took place, though legal consultees may wish that it could, as in the evaluation of child sexual abuse. However, it will also lead to the discovery of what kinds of decision making parameters judges and probation staff really use in responding to problems in which mental health issues are involved,[36] and to more efficient development and input of information relevant to these parameters. Creative review might even lead to the development, by consensus between consultant and court, of explicit clinical algorithms by which the processes for developing forensic mental health information in various kinds of routine cases might be described.

Provision Phase In the provision phase of forensic mental health consultation, quality improvement would be helpful in two areas. The simpler of these is the area of improving the quality of written reports and oral testimony. More complex issues would arise in areas related to follow-up care, especially in areas of crisis management, case management, and treatment interventions with cases referred for forensic mental health consultation.

Reporting Improving written reports may simply be a matter of improving technical writing skill. Complaints about reports being unclear or difficult to read often stem just from bad writing, and can be addressed by helping consultants to write with better organization, focus, and clarity. Following a standard format and using electronic word processing equipment can both be helpful in this effort.

More substantive problems with reports may stem from failure to adhere to basic principles of forensic testimony, whether in written or oral form. These principles include such generally accepted recommendations as the following: State the legal context (including issues of voluntariness and expected uses of the evaluation) and the referral question(s) clearly; describe sources of data; report data separately from conclusions, avoiding jargon as much as possible; include clinical data specifically relevant to the explicit legal question at hand; and offer conclusions and opinions that are relevant to the legal questions, with a clear explanation of how they stem from the available data.

In other areas of reporting, including such issues as length of reports, level of detail, degree of attention to clinical rather than legal issues, and the nature of recommendations, there may be less consensus about what constitutes quality work. Different legal consumers will have different preferences and needs in these areas, and it is not possible to set overall standards for forensic mental health consultation that will be appropriate everywhere. Some cases in some courts appear to require great attention to a variety of areas of clinical detail in a report, in order for the court to be able to proceed to address the legal issues in the way it wants to. In such cases the most helpful report will be long, detailed, and include considerable explicit clinical material. Other cases in other courts will call for brief, succinct reports, focussing on narrow issues and not burdening the court with excessive detail on clinical or other issues which do not concern it. Similarly, in some cases in some courts, forensic mental health consultation conclusions and recommendations will be most helpful by being very detailed and clinical, whereas in others it may be most helpful to offer only a brief statement summarizing certain findings relevant to a legal issue. Some courts will need conclusory statements explicitly addressing the ultimate legal issue, while in other courts providing such a statement might be the forensic mental health consultant's most egregious breech of consultative etiquette.

Clarifying local expectations regarding these issues, and establishing thereby local standards that reflect the court's

real practice in using forensic mental health consultation input, would be the major contribution of quality improvement review of forensic mental health reports.

Addressing the provision of information in oral testimony offers some challenges different from those involved in reviewing written reports. These challenges stem in part from a recognition that the issue of personal style is probably even more important in oral presentation than it is in written reports. However, they stem more substantially from the fact that the agenda for oral testimony is set not by the consultant, but by the attorneys performing direct and cross-examination. Unlike the peer review process suggested by the American Psychiatric Association's Council on Psychiatry and Law,[15] a testimony review process informed by the principles of total quality management would include participation by lawyers, judges, and other involved legal personnel, in order to be able to attend specifically to the complex issues of interdisciplinary communication that arise in providing oral testimony. Such review of actual interaction between attorneys and experts on the witness stand might have a very valuable impact on the ability of expert witnesses to conduct themselves in a useful and appropriate manner on the stand, as well as on the court's ability to gain input that will help it to resolve disputes.

Implementation The other major area for quality improvement exploration in the provision phase concerns what mental health or other direct services may be part of the court's expectation of the forensic mental health consultant. These concerns usually relate to questions about how to implement a consultant's mental health service recommendations, and especially to what extent the consultant him or herself should be responsible for implementation.

Implementation services may include the provision of direct crisis intervention or more extended treatment services, referral for treatment elsewhere, follow-up of treatment compliance and response, and other case management services. Courts vary considerably in their tendency to use their own forensic mental health consultants to provide these services, as opposed to using other mental health professionals, other outside service providers, or their own probation staff. The most demoralizing problems in forensic mental health consultation arise when the court and forensic mental health consultants are not clear in setting policy about who should be responsible for implementing court orders based on forensic mental health recommendations for treatment, resulting in no actual service being provided at all.

Quality improvement review of cases in which forensic mental health recommendations have been made would enable the court and its consultants to recognize areas where policy on these matters may not be clear or may not be implemented in practice. In response the court could develop clearer standards for establishing under what conditions, with what kinds of cases, and by whose decision it would determine (1) when a con-

sultant would be responsible for making a treatment referral or for continuing treatment or case management; (2) when a probation officer should be expected to take that responsibility; or (3) when an outside agency worker would be responsible.

The Quality Improvement Process

How the quality improvement process should be structured and who should take part in it are questions whose specific answers will vary widely depending on the organizational features of specific legal and mental health systems, especially of local courts and mental health agencies and practitioners. The ideal system of quality management would involve interdisciplinary activities at various levels of organization of both mental health and legal systems.

At the central administration level of a trial court, at the county or state level, it would include involvement in overall standard setting and data collection regarding forensic mental health consultation, as a first step toward a capacity to recognize problems on a statistical outlier basis. Standards would include legal standards regarding such issues as representation, timeliness, and access,[37] clinical practice standards on such issues as evaluation formats, and standards for clinical-legal interaction in such areas as defining consultation agendas and appropriate provision of evaluation and follow-up care.

More detailed case review would take place at the local level, focusing in most situations on the court as the unit of activity, since it is within the court that forensic mental health consultation has its most salient uses. Quality improvement teams[25] within the court would be made up of court representatives (such as court administrators, judges, attorneys, and probation, intake, and/or case management staff) and staff of whatever clinical agency (or agencies) may be involved with the court. This may be an on-site court clinic, or a local mental health clinic providing services to the court; staff involved from the clinic should include both forensic and nonforensic clinicians, as well as administrative personnel. To the extent that independent forensic mental health practitioners are closely involved with a local court, it would be ideal to include them in the team as well. The ideal team would also include some representatives of the patient population.

Identifying who is the customer is one of the enduring challenges in understanding forensic mental health systems. It is helpful to recognize that each of these team members is an "internal customer" [25] for another; that is, they each rely on one another's work as a basis for the quality of their own. The forensic consultant relies on the quality of the case selection and definition of referral questions provided by various legal professionals, while the legal professionals rely on the quality of the forensic consultation process in order to provide quality in the legal service of dispute resolution.

The identity of external customers depends on how the boundaries of the overall system are defined. An ideal system will be flexible in defining these

boundaries as it responds to different types of problems. It will be generous in according special attention to the roles and perceptions of team members whose responsibilities cross these boundaries, recognizing that the functioning of these "boundary spanners" is often crucial to the success of an overall system.[38]

Fundamental improvements in the quality of interaction between legal and clinical practitioners stem from the close interaction of these team members, exploring cases in attempts to discover what has gone wrong, if anything, in the provision of forensic mental health consultation. This exploration can become a context for professionals educating one another across the usual disciplinary boundaries, for clarifying basic agendas in seeking and providing forensic mental health consultation, and for refining standards and developing specific action plans to prevent the recurrence of problems in the future.

The following vignette illustrates how this process can work in a simple way to improve practice in a forensic mental health setting. The Boston Juvenile Court has generally restricted its involuntary hospital commitments of juveniles to those cases in which a genuine civil commitment standard of mental illness and dangerousness is met. Case management difficulties presented by these cases include questions of appropriate legal prodecure in handling such commitments, qualification to conduct evaluations for this purpose, where the youth should be committed and under what section of the law, how to get what kind of information to the receiving hospital, how to transport the youth to the hospital, and ultimately about how to enable the hospitalization process to be a useful one for the child and to fit into the court's efforts to foster an appropriate broad service plan for the child.

In the context of broad system changes aimed at improving hospital care in recent years, the administrative procedures and requirements for hospitalization changed, and the process of obtaining commitments for court involved youth then became even more confused, as the court struggled to understand how to fit into the new requirements. Despite efforts by the Department of Mental Health and the court clinic to make clear what the new opportunities and procedures were for obtaining inpatient care, there continued to be distress and confusion in the commitment process because of the wide variety of players involved and the lack of consensus about what their various roles were. After one case that had been especially confusing in terms of who was supposed to call whom, and when, with what information, to get a child to a destination that was unclear, the judge on the case directed the court's human services liaison worker to gather everyone involved in the process together and work out a detailed list of procedures to follow. This led to the informal establishment of what was in essence an *ad hoc* interdisciplinary quality improvement team, involving representatives of the bench, the juvenile defense and mental health bars, the probation department, the court clinic, and the case management and hospital communities

within the Department of Mental Health. This group explored the various steps in the civil commitment process, and discovered how complicated this seemingly straightforward process actually proved to be. The team discovered that there was good reason for some of the confusion that had reigned, and that creating and disseminating a very detailed plan of action for this sort of case made a significant difference in speed and clarity, contributed to better relationships with hospitals and the Department of Mental Health, and fostered better coordination of care between the court and the mental health system.

Identifying Cases for Review

Any mechanism for quality assurance that relies on individual case review needs to have some method for selecting cases to examine. Such methods include selecting cases (1) randomly; (2) on the basis of some feature(s) that identifies the case as unusual on one or more parameters of interest ("outlying" cases); (3) on the basis of some general identifying category of interest (e.g., all drug abuse commitments, or all adolescent sex offender evaluations, or all cases seen by Dr. Smith or referred by Judge Jones); or (4) on the basis of complaints.

Each of these methods has advantages and disadvantages. Selecting cases identified by a complaint mechanism involving clients, court and other legal staff, and forensic mental health professionals has the following disadvantages. It would likely be cumbersome to administer. It would risk being too sensitive, encouraging many spurious complaints generating little meaningful information (and potentially considerable discord); or not sensitive enough, in settings where staff might be reluctant to "make waves" by raising concerns. It would almost certainly generate a sample of cases that would be skewed by the perceptions and expectations of the complainers. At worst, this would burden the system with multiple complaints about good quality work from clients or staff who may be unsophisticated or have a personal ax to grind, and reveal nothing about problems in forensic mental health practice of which individuals in a local setting may be unaware.

Advantages of a complaint based selection system on the other hand lie in its potential for sensitivity and creativity. It would enable reviewers to be open minded about what problems might exist in a system, rather than limit reviews to case types that showed features likely to indicate problems already identified, as in the outlying or special case type method. Because it would not identify cases with *a priori* categorizations of problems, it would force reviewers to explore what really seemed to have gone wrong in response to each complaint. This search would potentially enable reviewers to find the treasure in the defect, which might not have been previously discovered. Though as noted, a complaint-based system could potentially generate discord, the converse potential is that it might enlist greater support for the quality improvement process from staff. Everyone would be encouraged to participate, and the ideal result would be improvements in the sense of individ-

ual empowerment. To the extent that the review process involved and encouraged complaints from a variety of different kinds of professionals representing the court, the bar, and other agencies involved with the forensic mental health evaluation process, it would also generate improvements in interdisciplinary cooperation. The peer review process adopted within the certification process of the San Diego Juvenile Court and County Mental Health Department has used a complaint mechanism to generate cases for review, and this process is described as the key to making the entire certification process effective in improving the quality of forensic consultation in this setting.[39]

Review methods targeting outliers or other selected categories of cases offer the advantage of efficiency, in that at least the nature of *apparent* problem or symptom is already defined. Targeting outlying cases has the additional advantage that it might be based on sophisticated methods of statistical profiling.[24] This process involves collecting data on a variety of parameters describing the consultation process, creating profiles of parts of the system defined according to one or more of these parameters, and then selecting cases for review on the basis of their falling outside the usual limits of these profiles. Cases might thus be selected on the basis of having reports that are too long or too short for a particular type of case, or taking too much or too little time, or including too narrow or too broad an array of clinical data, or on any combination of similar bases.

As noted, however, the potential disadvantage of such a statistical approach is that defining the profiles defines the potential problems. As a result, the opportunity for discovering *unrecognized* defects may be lessened in favor of focusing efforts for improving quality on recognized problems. Even with outlier or other "selected case" methods, however, careful exploration of cases can discover a variety of unrecognized process difficulties which may contribute to a final common defect.

Selecting cases at random (or *all* cases) for review has the advantage of open mindedness, like a complaint method. It lacks the complaint method's potential for efficiency in selecting problem cases, but it also lacks that method's potential for distracting and preoccupying reviewers disproportionately with problems that may in fact be unimportant.

Summary

Forensic mental health consultation presents special challenges for developing systems of quality assurance because of the complexity of the systems in which it plays a part. These systems often present multiple and sometimes conflicting demands and expectations regarding goals and standards for consultation. Clients, courts, attorneys, and other human service agencies may all have a plethora of different views about what constitutes good quality work in this area.

Basing quality assurance efforts for forensic mental health on the approach of total quality management offers po-

tential benefits. These include the promise of clarifying and improving consensus among the variety of professionals involved with forensic mental health consultation regarding (1) the goals of consultation; (2) appropriate selection criteria for referring cases; (3) techniques of evaluations; (4) styles and formats for reports and testimony; and (5) defining additional roles and responsibilities for forensic mental health practitioners beyond consultation and evaluation. Establishing local case review mechanisms may enable individual courts and their consultants to discover where there may be problems in these areas, and to work together to develop improved procedures and more consensual goals.

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