

DFP Committee Retreat August 1, 2019

Minutes

Present: Stephen DeLisi, Ph.D. Naomi Leavitt, Ph.D., Lauren Miller, Ph.D., Paul Noroian, M.D., Ira Packer, Ph.D., Helene Presskreischer, Psy.D., Nancy Connolly, Psy.D.

I. Review of mid-training CR report (Candidate P)

II. Proposals for changes to remediation process:

A. We proposed that the Assistant Commissioner appoint an ad-hoc committee to look at the entire CQI process. We identified a number of issues for this committee to consider.

B. For court clinics:

1. Random audit of reports (by a single individual? More than one? Steve and Mary's names came up). Although there were some concerns about having just one person do it, the response was that this person's role would be limited to referring to the CQI committee, so no action could be taken unless that committee determined there was a problem and a need to refer to the DFP committee. Agreed that there was no need to blind the initial reviewer to the identity of the DFP since that is only the first cut, and for future cuts the author's identity will be redacted
2. If the initial audit identified a problem, the auditor(s) would pick a couple (2?) more for review. If (one?) or (both?) is/are problematic, refer to CQI. The ad hoc committee will make recommendations to the Assistant Commissioner on the details of this process.
3. Once referred to CQI – follow existing CQI/DFP procedures (no need for changes to those).
4. If a report is identified outside of this process (e.g., referral by an attorney, judge, or colleague), the problematic report will be referred to the CQI committee, which will then follow existing procedures.

C. For inpatient forensic reports:

1. In principle, we don't necessarily want to keep closely reviewing people who consistently do good work, but we do need a way to identify those

whose work needs improvement. We want to streamline the process as much as possible, while still making it rewarding for the participants.

2. Inpatient facilities already do an internal peer review, but there are differences across facilities. One recommendation was for the Assistant Commissioner to include the following requirements that all inpatient facilities (BSH, WRCH, Fuller, and this includes all consultants) follow:
3. Each year, the peer review process should include at least one CST and one CR.
4. The reports to be reviewed should be chosen randomly, not by the evaluator being reviewed.
5. NOTE: each of the facilities use their own rating forms. We need to gather the forms and perhaps develop one standard form.
6. If reports are considered problematic, then they are referred to DMH Forensic.
7. DMH Forensic will identify a person (or persons – given that there is no inpatient CQI, one suggestion was to have more than one person delegated to this task) to review the identified report(s). If problematic, refer to the DFP Committee, which will follow existing policies/procedures.
8. Alternatively, can have a parallel model with court clinics – that is, a designated person (again, the proposal is to have more than one person, since there is no inpatient CQI committee) randomly review reports from each evaluator. If problematic report identified, refer directly to DFP Committee.
9. Another suggestion was to have reports reviewed across facilities (so wherever possible, no one in a facility will review anyone in that facility's reports)
10. In deciding between models/procedures - consider that there are about 35 individuals who conduct inpatient forensic evaluations (between staff and consultants).

11. One comment made was that the person or committee should be independent of the vendors. [This was not discussed, but also consider whether a non-state employee should review state employee reports.]

D. Process once DFP Committee decides remediation is needed:

1. Should vendors be responsible for providing remediation to their own staff (and similarly state employee for state employee evaluator)? Potential bias and conflict of interest issues need to be taken into account.
2. There was not agreement on this issue – some thought yes, others thought this should be the responsibility of DMH to provide remediation. This is an issue that needs discussion by adhoc committee, and recommendation to Nancy for final decision.
3. Follow up: there was complete agreement that there needs to be follow up after completion of the remediation process. We have had instances of individuals undergoing remediation, and then subsequently being identified again as producing problematic work. The adhoc committee should recommend a process for follow-up following completion of remediation.

E. Additional Notes:

1. Perhaps DMH can pay fee-for-service people \$100.00 to participate in the process. (One way or another, everyone conducting s. 15b evaluations must participate in peer review one way or another).
2. Ira and Mio have been in the habit of giving reviewers feedback on their feedback. That is a good practice to continue for several reasons (e.g., so we get some standardization of thresholds, so people aren't overly harsh, so feedback has a constructive tone and isn't too nit-picky).
3. There are about 35-40 people currently conducting 15b evaluations.
4. We estimate that it would take 1-2 hours to review each report.

III. Standards for opining on need for care and treatment in 15(a) reports.

- A. There is lack of clarity about the current expectations. Several ideas were discussed, that will require further follow-up from the DFP Committee over the course of this coming year.

1. For 15(a) screening: if the evaluatee appears to be incompetent, the evaluator should make an argument for why the evaluatee either need to be in a hospital for further evaluation, or why evaluation can be continued on an outpatient basis (or no further evaluation is needed). This section can be brief but should clearly convey the rationale for the decision.
2. 15(a) extended - similar issues. However, given that it is an extended report, may need to flesh out a bit more than 15(a) screening. The committee will review the two reports from Candidate O (July, 2019), since those reports highlighted some of these issues.

IV. Care and Treatment in Inpatient 15(b) reports

- A. We briefly touched on this issue, and the following items were identified for further discussion:
- B. How should the evaluator convey information/opinion when there is a discrepancy between the treatment team and the evaluator about need for inpatient hospitalization?
- C. Does it matter who is testifying (in some facilities, the forensic evaluator testifies at 16(b) hearings, while at others it is the treating psychiatrist.
- D. For substantive consideration: the DFP Committee has noted that sometimes the data on behavioral stability and medication adherence in the hospital is given undue weight relative to what is expected for the individual in the community. This may be something for the DFP Committee to address.