

# Development and Implementation of a Case Review Conference Model for Juveniles: A Structured Approach to Learning from Unsuccessful Probationers

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**IN THE FIELD OF MEDICINE**, mortality and morbidity reviews (MMRs) are routinely used to enhance medical education and improve patient care through the critical examination of case studies that have experienced an adverse outcome (Aboutamar, Blackledge, Dickson, Heitmiller, Freischlag, & Pronovost, 2007; Travaglia & Debono, 2009). The MMR as a form of peer review has existed in the literature for more than 50 years, and is now widespread among internal medicine, psychiatric, surgical, and pediatric training programs (Deis, Smith, Warren, Throop, Hickson, Joers, & Deshpande, 2008; Nolan, Burkard, Clark, Davidson, & Agan, 2010). In fact, the Accreditation Council for Graduate Medical Education currently mandates MMRs (Deis et al., 2008).

In essence, the MMR conference is a traditional forum that provides clinicians with an opportunity to discuss medical error and adverse events (Deis et al., 2008). Furthermore, previous research on the effectiveness of these reviews has documented benefits related to the identification and engagement of clinicians in system improvements, reductions in patient deaths, increases in accountability and communication, decreases in the costs of patient care and medication, and the creation of a safe forum for the discussion of errors by

removing fear of recrimination (Antonacci, Lam, Lavarias, Homel, & Eavey, 2009; Bechtold, Scott, Dellsperger, Hall, Nelson, & Cox, 2008; Guevart, Noeske, Mouangue, Ekambi, Solle, & Fouda, 2006; Nolan et al., 2010; King & Roberts, 2001; Liu, 2008; Kim, Fetters & Gorenflo, 2006). Denneboom, Dautzenberg, Grol, and De Smet (2008) also found evidence that participants of MMRs experienced an “educational spillover effect,” where lessons learned from discussing clients in MMRs were applied to other clients in different settings. Interestingly, this practice has not been used extensively in the fields of juvenile justice and corrections despite its obvious application to case management with offender populations.

Nolan et al. (2010) underscored the importance of a structured, organized approach in order to maximize the utility of MMRs. It is perhaps also important to note that Travaglia and Debono (2009) recently reviewed the literature on MMRs and concluded that the format of case reviews varies considerably and the goals of the process are often not clearly defined. Taking these lessons learned from the field of medicine, this pilot project was initially conceptualized as an attempt to articulate a theoretical framework for the Case Review Conference (CRC) process in corrections, identify goals, and create a standard format to structure reviews.

## Theoretical Framework

It is evident from the medical literature that case review conferences tend to be the most useful when implemented in a manner consistent with the theoretical framework described in what follows (see Travaglia & Debono, 2009; Deis et al., 2008; Fussell, Farrar, Blaszkak, & Sisterhen, 2009). First, the primary focus of the meetings should be on improving services for offenders and their families. To this end, case reviews should take place in a safe and supportive environment in order to minimize the fear of recrimination and facilitate an open and honest discussion of relevant issues. The CRC process is separate from an investigation in response to a critical incident; in contrast, it represents an effort by the agency to become a learning organization through the systematic examination of its failures on an ongoing basis. The focus is more on the broader, system-level processes and deficiencies, rather than individual-level mistakes. Second, senior staff members should ensure peer input and engagement through support and leadership.

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The involvement of senior staff members is critical, because it encourages the process to be viewed collaboratively within the organization. Third, a structured format should be established for reviewing cases to ensure that the process is more systematic, interactive, and comprehensive. Furthermore, a detailed protocol should be established for feedback and follow-up. Finally, plans should be made to investigate the identified system-wide issues that contribute to adverse outcomes. These plans are opportunities for improvement, which should be linked to the evidence-based literature whenever possible. The CRC process was specifically designed to ensure adherence to this theoretical framework.

## Goals and Objectives

In general, the CRC process can be described as a “decision support system” to promote critical thinking and better decision-making (Nolan et al., 2010). Specifically, the CRC process was intended to accomplish four main objectives (see Orlander, Barber, & Fincke, 2002, for a detailed discussion as it relates to the field of medicine): (1) to facilitate the identification of the key factors that resulted in the adverse outcome for the youth<sup>2</sup>; (2) to create an opportunity for the attendees to engage in an open discussion of the case to acknowledge and address reasons for possible errors; (3) to allow conference participants to use their individual and collective experiences to identify and disseminate information and insights about case management; and (4) to reinforce individual and system-level accountability for providing high-quality interventions to youth and their families.

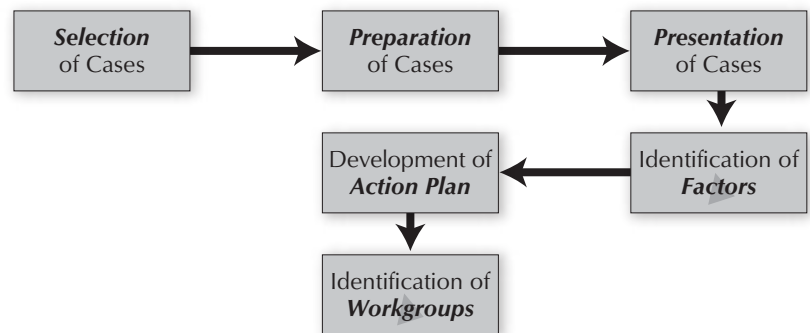
## Overview of the Conference Process

Given the theoretical framework and objectives established in the previous two sections of this report, the CRC process was designed to include six basic steps (see Figure 1).

The first step involves the *selection of cases*. Any member of the team can submit a case to the CRC Coordinator for consideration. The most appropriate nominations are cases that have educational value, have experienced a preventable outcome, and can provide insight into individual practice changes and/or system-based issues to improve the quality of supervision and service. After reviewing all of the referred cases, the CRC Coordinator

**FIGURE 1.**

*Overview of the Case Review Conference*



consults with the appropriate probation officers and/or supervisors if further information is needed. The CRC Coordinator is then responsible for approving and scheduling the case for review.

The second step of the CRC process involves the *preparation of cases*. Ideally, the probation officer and/or supervisor should be responsible for case preparation, given their extensive and intimate knowledge of the youth and his or her family. At a minimum, this should include a review of the client file and solicitation of input from other providers if applicable. The CRC Coordinator then alerts the team of the case to be reviewed and distributes a synopsis of the available background information.

The third step involves the *presentation of cases*. Ideally, the probation officer and/or supervisor present the case in a timeline format. Attendees can ask questions to clarify points of interest. The fourth step involves the *identification of factors related to outcome*. During this phase of the process, conference participants engage in an open discussion under the guidance of an outside facilitator representative in order to identify contributing factors. The fifth step involves the *development of an action plan*. This should include the consideration of practical solutions to individual-level or system-based issues. The final step involves the *assignment of work groups* in order to implement and provide oversight of the action plan. The workgroups should then report back to the group on progress at subsequent meetings.

## Method

This section describes the conference participants and their respective roles in reviewing cases, as well as the specific process and

methodology used during the pilot project. Finally, we present a discussion of the data collected on cases.

### Conference Participants

The juvenile court system selected for this pilot study was located in a Midwestern state. The court system had jurisdiction over a variety of juvenile-related matters, including under-age delinquents charged with crimes, allegations of abuse and neglect, and certain custody, visitation, and child support matters. The system comprises four components: (1) the judges' office, which hosted the clerk's office, probation and administrative offices, and the majority of court hearings; (2) a secure placement facility for youth awaiting adjudication or transfer to other facilities; (3) a residential treatment facility for adjudicated youth; and (4) a work detail to supervise youth performing court-ordered community service.

It is important to include members with different levels of decision-making capabilities in the CRC meetings. This may vary by jurisdiction or setting. The conference participants in this pilot study routinely included the court administrator, executive director of court services, chief magistrate,<sup>3</sup> superintendent of the secure placement facility, chief probation officer, director of special services and placement, deputy chief probation officer, as well as several probation supervisors. All participants were invited to attend the bi-monthly case review conference meetings. The chief probation officer agreed to serve as the CRC coordinator for this pilot project. The CRC coordinator was primarily responsible for providing oversight and coordinating the logistics for the team. He also selected and

<sup>2</sup> Although our development of the CRC was used for juvenile probationers, we believe that this process is applicable to adult offenders as well.

<sup>3</sup> The chief magistrate serves as a judicial officer appointed by the judge.

scheduled all of the cases for review and disseminated relevant client information prior to each meeting.

At least one representative from the University of Cincinnati Corrections Institute (UCCI) also participated in each of the CRC meetings as the outside facilitator. This individual was responsible for engaging attendees in a discussion of the case as well as summarizing the main points at the end of the meeting. The outside facilitator was also responsible for ensuring that the discussion related only to facts of the case and not personal issues.

### Case Selection

Eligible cases included juvenile offenders who had been under the jurisdiction of the probation department and had experienced an adverse outcome. The operational definition of *adverse outcome* included any of the following: commitment to the Department of Youth Services, transfer to Adult Court, recidivism (e.g., technical violation, re-arrest, etc.), placement out of the home, or some other critical incident (e.g., AWOL, psychiatric hospitalization). Although any member of the team could recommend specific cases for the CRC, the youth included in the pilot project were all selected by the CRC coordinator.

### Case Preparation

Prior to each scheduled meeting, background information was distributed to other team members. This information included the Youth Information Sheet (which contained demographic information as well as details regarding criminal history), any available risk/need assessments (such as the Ohio Youth Assessment System (OYAS) assessment, substance abuse assessments, etc.), case plans (including both the probation supervision plan and facility treatment plan), as well as any other relevant documents (such as psychological evaluations and discharge summaries). The CRC coordinator also completed the Case Review Form developed for this project (see Appendix). In essence, this form served to create a timeline for the case and highlighted important points from the client's history and case plan.

### Case Presentation

The first CRC was held on January 24, 2011 and the pilot included a total of 10 cases. The CRC coordinator presented the Case Review Form and briefly elaborated on pertinent details. Conference participants then posed questions relevant to the case for clarification.

In what follows, the CRC process is described in detail, results from the pilot project are summarized, and recommendations for future applications of the model are provided.

### Identification of Factors Related to Adverse Outcome

Attendees considered several possible factors related to adverse outcomes. The identification of the specific factors relevant for a particular case can serve as a process improvement tool for facilitating the identification of future failing points for other offenders. The Case Review Form organizes these factors into six broad categories: (1) the development of the case plan (e.g., incomplete or inaccurate assessments, missing clinical information, disconnection between assessment results and target behaviors); (2) communication (e.g., problems with sharing information between professionals or when transferring cases); (3) coordination of care (e.g., gaps in sending or receiving information from other service providers); (4) volume of activity/workload (e.g., perceptions of workload problems, increased demands on time); (5) escalation of care; and (6) recognition of change in risk or need factors. During the CRC all participants have the opportunity to identify system-based issues and recommend alternative solutions. When issues are identified as potentially problematic, the CRC coordinator can select the key contributing factors to be addressed.

### Development of Action Plans and the Assignment of Work Groups

The fifth and sixth steps of the CRC process, the development of an action plan and identification of work groups, were not addressed as part of this pilot project. Essentially, however, these two steps would require the CRC team to (a) consider and develop a practical solution for each identified issue and (b) assign the appropriate work group members to implement and provide oversight of the action plan. It would also be the responsibility of the work group members to report back to the CRC group on any progress that has been made at subsequent meetings.

## Results

### Attendance

A total of 19 participants attended 10 conferences during the six-month period. The average number of participants per session was 12 and included both juvenile justice officials and UCCI representatives.

### Sample Demographics

A total of 10 cases experiencing adverse outcomes were presented in the CRC series between January 24, 2011, and June 6, 2011. Basic demographic information for cases included in the CRC series indicated that 9 of the juveniles were males, the average age was 16.6, and education ranged from 8<sup>th</sup> to 10<sup>th</sup> grade. The specific adverse events triggering case selection are listed in Table 1.

**TABLE 1**  
*Adverse Events Triggering Case Selection*

Adverse Event	N
DYS Commitment	5
Transfer to Adult Court	5

### Factors Related to Adverse Outcomes

In each of the CRC meetings, attendees identified the leading contributors to adverse outcomes. These factors were categorized and tabulated by the outside facilitator following each review, and the results are summarized in Table 2. Problems associated with the development of case plans were the most common contributing factor, cited in 7 out of 10 of the cases reviewed.

**TABLE 2**  
*Factors Contributing to Adverse Outcome*

Factor	N
Development of Case Plan	7
Communication	4
Coordination of Care	5
Volume of Activity/Workload	0
Escalation of Care	2
Recognition of Change in Risk and/or Need Factors	3

### Development of Case Plan

Several shortcomings were noted in the development of case plans. In approximately four of the cases, the narrative of the client file did not appear to match the scoring of specific items on composite risk assessment. This raised some concerns about the accuracy of the results and the possible need for additional quality assurance measures. Second, the attendees noted a disconnection between the assessment results and the domains as identified on the case plan in at least three of the cases reviewed. Third, many of the case plans did not appear to be individualized and/or did

not contain appropriate, specific target behaviors. Finally, the available treatment options for certain criminogenic need areas appeared to be very limited and resulted in some questionable (or at least not ideal) referrals for services. For example, a drug dealer with no documented substance use problem was referred to a traditional substance abuse treatment program. It is conceivable that this type of intervention may not address the underlying causes related to drug dealing specifically (i.e., antisocial attitudes and values).

### *Communication*

In at least four cases, communication problems were noted when offenders were transferred to another facility or service provider. In these situations, offenders were transferred with incomplete assessment or clinical information that would have been helpful to the receiving agency.

### *Coordination of Care*

Although it is clear that the youth included in the CRC series received a considerable number of services, progress on treatment targets was not systematically shared with the probation officer and integrated into the case plan. These breakdowns in communication led to inaccurate offender assessments, and therefore less informed supervision and case management decisions.

### *Volume of Activity and/or Caseload*

It did not appear that the volume of activity and/or caseload presented a significant problem for the cases reviewed in this pilot project. It should be noted, however, that probation officers were not included in this initial CRC series, and as a result their viewpoint is not represented in this report.

### *Escalation of Care*

In two cases, it appeared that clients were not referred to more intensive services when their current situation warranted because the probation officer did not have the authority to mandate youth and/or their families to participate in treatment.

### *Recognition of Change in Risk and/or Need Factors*

In three cases, youth were successfully terminated from probation when it appeared that some criminogenic need areas were not sufficiently addressed (despite the fact that the youth had passed drug tests). In two of these cases, the adverse outcome occurred shortly after the case had been closed. This

underscores the need for more individualized case plans with meaningful target behaviors and measures to assess client progress.

## **Impact of the Conference**

The purpose of the CRC process is to systematically review failures and draw from this review lessons that can help guide agencies to make changes to improve the delivery of their services. As previously noted, this pilot project represents an ongoing commitment to improve services for juveniles and their families in this jurisdiction. The CRC process used here was useful in identifying at least three important system-based issues that should be addressed in the near future.

First, it was discovered that the jurisdiction did not have an intervention for high-risk youth to target antisocial attitudes and values. Rather, most youth were referred to a theft prevention educational workshop for this purpose. This intervention is not based on an evidence-based approach such as the cognitive-behavioral model and does not offer a sufficient dosage to be effective with a high-risk population. In order to expand the services available to youth, this jurisdiction should consider methods to secure resources for a treatment program that addresses antisocial attitudes and values.

Second, participants consistently reported that the agency experienced difficulties with client motivation. Since the court does not necessarily mandate certain services, the probation officers have limited ability to engage families who are unwilling to participate in services with youth. Unfortunately, this creates some difficulties in establishing and enforcing eligibility criteria for certain services. This agency should explore the use of mandatory treatment with youth identified as at high risk of not following through with service recommendations.

Finally, it was discovered that offender case plans were dishearteningly similar to one another. As a whole, the plans examined did not utilize the unique information found within the risk/needs assessments. Thus, treatment recommendations and supervision strategies were not individualized, but were simply standard. Moving forward, it will be important for this agency to provide its probation officers with some additional training on how to use risk/needs assessment information in the case planning process.

Participants of the CRC process also found it helpful. It was reported on satisfaction surveys that a benefit of the CRC

meetings was increased communication with referral agencies.

## **Recommendations for Future Applications**

The final section offers three recommendations for future CRC meetings in correctional settings and provides some implications for the process in general. First, this pilot project did not include the final two steps of the CRC process (i.e., development of an action plan and assignment of work groups). These are arguably the most important two components of the process. While it was prudent to use the pilot in order to establish the roles and responsibilities of participants, it will be important for departments to move beyond the identification of issues and work to develop and implement solutions to individual service and system-based problems.

Second, the probation supervisors were primarily responsible for the presentation of cases in the CRC meetings. It is important for probation officers to be included in the process in the future to encourage the "educational spillover effect" described by Denneboom et al. (2008).

Finally, the CRC process provides a vehicle for conducting objective, structured sessions to review and discuss cases. This structure is important since it offers a framework for systematically examining all components of case management, including the initial assessment, supervision activities, referrals and treatment, response to violations, and other case-related activities. By adding the outside facilitator, the CRC increases expertise and unbiased views about the cases to be introduced. The structure also ensures that all participants remain focused and directed toward the case under review.

Failures occur daily in corrections. The question is: "How do we learn from these failures so that we can improve our practices in the future?" The CRC process provides a clear structure to review and learn from cases. Although the pilot involved only juvenile offenders in a probation setting, the CRC model has the potential for a much wider application, such as in other correctional settings with both adults and juveniles. The costs associated with adopting the CRC model are also minimal. The model only requires participants' time. However, in exchange the CRCs hold the potential to be very valuable to the field of corrections.

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**Appendix**

**CASE REVIEW FORM**

Date of Case Review: ____/____/____	Presented By:	
Name of Youth:	DOB: ____/____/____	ID:
Probation Officer:	Supervisor:	
Type of Adverse Event: <input type="checkbox"/> DYS commitment <input type="checkbox"/> Transfer to adult court <input type="checkbox"/> Recidivism (re-arrest, technical violation, etc.) <input type="checkbox"/> Placement out of home <input type="checkbox"/> Other critical incident (please describe)	Date of Adverse Event: ____/____/____	

**Instructions:**

*In order to prepare your case for presentation, please answer the following questions:*

1. Please provide a brief description of the current offense. Consider official documents (e.g., police reports, pre-sentence reports, other court documents), victim statements, and self-report information.

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2. Please provide a brief description of past criminal history (e.g., official complaints, institutional intakes/incidents, etc.).

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3. Please provide a brief summary of strengths and/or concerns in each of the following criminogenic need areas. In addition, please append a copy of the most recent OYAS assessment (and/or other measures of risk and need factors, if applicable) that includes the quantitative scores for each item, domain and overall.

Family \_\_\_\_\_

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Education/Employment \_\_\_\_\_

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Peers/Social Support \_\_\_\_\_

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Prosocial Skills \_\_\_\_\_

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Substance Abuse/Personality/Mental Health \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attitudes, Values and Beliefs \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Total Score: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

- 4. Please provide a summary of the case management plan (including referrals, participation in other services, etc.).

\_\_\_\_\_  
\_\_\_\_\_

- 5. Please provide a brief description of the events leading to the adverse outcome.

\_\_\_\_\_  
\_\_\_\_\_

**Note: Please prepare a timeline for your presentation that includes the significant events described in the previous five questions.**

- 6. Please describe the factors contributing to the adverse outcome in each of the following areas:

Development of Case Plan \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Communication \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Coordination of Care \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Volume of Activity and/or Caseload \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Escalation of Care \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recognition of Change in Risk and/or Need Factors \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. In your opinion, was the adverse event preventable? If yes, please explain what might have been done to change the outcome.

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8. Is there clinical evidence to support individual practice change that might have altered the outcome of this case? If yes, please explain.

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9. Are there any system-based changes that might prevent future similar outcomes? If yes, please describe.

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10. List three learning points from this case.

1. 

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3. 

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