Arizona Department of Juvenile Corrections Youth Treatment Programming Evaluation
30-Month Follow-Up Report

The October 2021 Arizona Department of Juvenile Corrections (Department)—Youth Treatment Programming Evaluation performance audit was the second of 3 audit reports of the Department we issued as part of the Department's sunset review. The first performance audit determined whether the Department's use of temporary stabilization units for delinquent youth committed to its care is consistent with Department policies and best practices for rehabilitating delinquent youth and the third audit provided responses to the statutory sunset factors. Our initial followup on the first audit determined that the Department had implemented all of the recommendations, and we will issue a separate follow-up report for the third audit.

Our October 2021 performance audit on the Department's youth treatment programming evaluation found that the Department has not assessed fidelity for some treatment intervention components, implemented some treatment programming recommended improvements, and tracked a comprehensive set of outcome measures for its treatment programming, potentially impacting its ability to ensure its treatment programming's effectiveness. We made 7 recommendations to the Department, and its status in implementing the recommendations is as follows:

Status of 7 recommendations

Implemented	4
In process	3

We will conduct a 42-month followup with the Department on the status of the recommendations from the October 2021 performance audit that have not yet been implemented.

Finding 1: Department has not assessed some treatment intervention components to help ensure interventions are delivered as designed, increasing the risk of providing youth less-effective treatment interventions

1. The Department should ensure it delivers its treatment interventions with fidelity, that any identified fidelity deficiencies are corrected, and that corrective actions are documented by:

   a. Developing and implementing policies and procedures and/or revising and implementing existing policies and procedures to establish ongoing monitoring of fidelity with its policy requirements for the frequency and duration of group treatment sessions, the content that should be covered in each session, and the order in which content should be delivered, including procedures for correcting any identified deficiencies.

      Implemented at 30 months—The Department has developed and implemented revised policies and procedures for the ongoing monitoring of fidelity with its treatment programming's policy requirements. For example, the Department's clinical staff hold weekly meetings, which include an agenda item to identify youth who missed group treatment sessions and determine whether they have or need to make-up the missed treatment session. Additionally, the Department has developed electronic and physical fidelity checklists for its treatment programs that Department behavioral health services staff are required to complete when conducting treatment session fidelity assessments. The checklists are designed to alert treatment program facilitators and their supervisors if a treatment session needs to be repeated because it had low or moderate fidelity or was shorter than required and/or if the facilitator did not appropriately manage youth behavior. Our review of a sample of fidelity checklists Department staff completed between June 2022 and January 2023 found that Department staff completed the checklists as required and

the Department followed its policy for correcting deficiencies. For example, for 1 checklist we reviewed, Department behavioral health services staff determined a treatment session had moderate fidelity, and during the monthly treatment fidelity administrators meeting, it was determined that the youth who attended the group did not need to make up the treatment session, but the staff conducting the treatment session should receive refresher training.

b. Developing and implementing policies and procedures outlining staff responsibility for overseeing the results of its fidelity-monitoring efforts, including identifying the staff responsible for overseeing fidelity-monitoring efforts and ensuring identified deficiencies are corrected, and outlining time frames and procedures for doing so.

Implemented at 30 months—The Department has developed and implemented policies and procedures that outline its clinical director's responsibility for overseeing the results of the Department's fidelity-monitoring efforts. For example, consistent with the policies and procedures, the Department's clinical director has participated in weekly meetings with clinical staff that include agenda items such as whether fidelity monitoring efforts have occurred, whether there have been any identified fidelity deficiencies, and whether any youth have missed a group treatment session that they need to make up. Additionally, the Department's clinical director meets with clinical staff who are responsible for identifying and correcting fidelity deficiencies monthly to discuss corrective action plans and ensure deficiencies are corrected.

Finding 2: Department evaluations have recommended treatment programming improvements, but it has not ensured some recommendations were implemented, which could impact its effectiveness in reducing youth recidivism

2. The Department should implement its revised CPC evaluation policy and procedures to help ensure it addresses all actionable CPC evaluation report recommendations.

Implementation in process—In December 2022, the Department completed its first Correctional Program Checklist (CPC) evaluation report since revising its CPC evaluation policy and procedures. The CPC evaluation report found low adherence to evidence-based practices for treatment programming provided to youth at the Department's secure care facility and made 34 recommendations to improve the treatment programming's alignment with evidence-based practices that are associated with reduced youth recidivism. Consistent with its policy and procedures, the Department has developed corrective action plans (CAPs) that address all recommendations and assign priority levels and time frames for their implementation.

As of June 2024, the Department reported it had completed CAPs addressing 10 of 34 report recommendations, was in the process of addressing CAPs for 14 recommendations, and had yet to begin addressing CAPs for the remaining 10 recommendations. Department policy and procedures require that CAPs be monitored until completion of all actionable items or until the next scheduled CPC evaluation. Additionally, the Department's next CPC evaluation is scheduled to begin in the fall of 2025, and the Department reported that because it will not be able to address all report recommendations prior to the next CPC evaluation, the next CPC evaluation will include evaluating areas associated with these recommendations to determine whether any of the recommendations are still needed to address identified deficiencies. Further, consistent with its policy, Department staff will be required to develop new CAPs for the recommendations from the next CPC evaluation report with assigned priority levels and implementation time frames. We will continue to assess the Department's implementation of its CPC evaluation process for addressing actionable CPC evaluation report recommendations during our 42-month followup.

3. The Department should further revise and implement its CPC evaluation policy and procedures for addressing CPC evaluation report recommendations to include:

- Requirements for addressing areas needing improvement that Department staff determine to be nonactionable.
- Requirements for staff to retain documentation demonstrating progress toward completing CAP action items.

- How CIB staff should monitor, assess, and document their review of reported progress toward completing CAP action items during the 12-month monitoring period, such as reviewing documentation or taking other steps to verify reported progress.

Implementation in process—As reported in our initial followup, the Department revised its CPC evaluation policy and procedures to include requirements for addressing areas needing improvement that Department staff determine to be nonactionable; requirements for staff to retain documentation demonstrating progress toward completing CAP action items; and guidance for how CIB staff should monitor, assess, and document progress toward completing CAP action items. Additionally, as discussed in Recommendation 2, the Department completed a CPC evaluation report in December 2022, and as of June 2024, it reported completing CAPs addressing 10 of 34 report recommendations, was in the process of addressing CAPs for 14 recommendations, and had yet to begin addressing CAPs for the remaining 10 recommendations. Department staff have submitted required quarterly memos to the Department director outlining staff progress toward completing CAP action items/report recommendations. We will further assess the Department's implementation of its revised CPC evaluation policy and procedures, including Department procedures for retaining documentation demonstrating progress toward completing CAP action items and guidance for monitoring, assessing, and documenting reviews of staff's reported progress toward completing CAP action items, during our 42-month followup.

Finding 3: Department has not tracked comprehensive set of treatment programming outcomes or conducted outcome evaluations, limiting its ability to demonstrate and improve its treatment programming's effectiveness in rehabilitating youth population who received treatment

4. The Department should develop and implement a plan to identify opportunities, methods, external assistance, and resources for developing additional outcome measures and conducting outcome evaluations related to its treatment programming. The plan should include goals, action items, completion time frames/deadlines, and the individual(s) assigned to complete each action item.

Implemented at 30 months—As reported in our initial followup, the Department developed a plan to identify opportunities, methods, external assistance, and resources for conducting outcome evaluations related to its treatment programming, which includes goals, action items, completion time frames/deadlines, and the individual(s) assigned to complete each action item. Since our initial followup, the Department has continued to implement the plan. For example, as of August 2023, the Department had completed a pilot review of its DBT treatment program to ensure the program is delivered as designed before conducting a full outcome evaluation of the program. Further, the Department reported it evaluated the pilot's results, resolved issues with and made changes to program delivery identified during the pilot, and trained additional staff to deliver the program. As of March 2024, the Department reported it is in the process of conducting another pilot review of the changes made to its DBT treatment program as a result of the first pilot. The Department estimated it will initiate a full outcome evaluation of its DBT treatment program by the end of calendar year 2024.

5. The Department should, based on the implementation of Recommendation 4, and as applicable:

a. Establish and track additional outcome measures related to its treatment programming's goals to address criminogenic risk factors, including outcome measures related to youths' treatment programming progress while in the Facility.

Implemented at 6 months

b. Prioritize and conduct outcome evaluations it identifies through its planning process.

Implementation in process—As discussed in Recommendation 4, the Department estimated it will initiate an outcome evaluation of its DBT treatment program by the end of calendar year 2024. We will further assess the Department's implementation of this recommendation during our 42-month followup.