Arizona Department of Juvenile Corrections
Youth Treatment Programming Evaluation

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

Performance Audit

October 2021
Report 21-121

A Report to the Arizona Legislature

Lindsey A. Perry
Auditor General

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October 1, 2021

Members of the Arizona Legislature

The Honorable Doug Ducey, Governor

Mr. Jeff Hood, Director
Arizona Department of Juvenile Corrections

Transmitted herewith is the Auditor General's report, *A Performance Audit of the Arizona Department of Juvenile Corrections—Youth Treatment Programming Evaluation*. This report is in response to a September 14, 2016, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting within this report a copy of the Report Highlights to provide a quick summary for your convenience.

As outlined in its response, the Arizona Department of Juvenile Corrections agrees with all but 1 of the findings and plans to implement or implement in a different manner all the recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

Sincerely,

Lindsey A. Perry

Lindsey A. Perry, CPA, CFE
Auditor General

Arizona Department of Juvenile Corrections
Youth Treatment Programming Evaluation

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

Audit purpose

To determine whether the Department's processes for evaluating the treatment programming it provides to youth committed to its care are consistent with recommended practices, including processes for assessing if its evidence-based treatment interventions are implemented as designed and evaluating whether its youth treatment programming follows practices associated with reduced recidivism and is achieving its intended rehabilitative outcomes.

Key findings

The Department:

- Is statutorily responsible for rehabilitating delinquent youth committed to its care, which involves addressing youths' risk of reoffending with the goal of reducing crime and protecting public safety.
- Has established a process to monitor if its group treatment interventions for youth are delivered as designed, also known as fidelity. However, it has not assessed some treatment intervention components necessary to ensure fidelity, such as frequency, duration, and required order of content of group treatment interventions, increasing the risk of providing less-effective treatment interventions.
- Has evaluated whether its youth treatment programming adheres to certain practices associated with reduced recidivism using the Evidence-Based Correctional Program Checklist (CPC) but has not ensured some CPC evaluation report recommendations from its 3 most recently completed evaluations were implemented, potentially impacting its treatment programming's effectiveness in reducing youth recidivism. However, it revised its CPC evaluation policy during the audit to address some issues.
- Has not tracked outcome measures related to its treatment programming's goals in the aggregate, i.e. for the entire youth population receiving treatment programming, or conducted outcome evaluations, and may not have some information to assess and improve the effectiveness of its treatment programming in rehabilitating youth in its care.

Key recommendations

The Department should:

- Ensure it delivers treatment interventions with fidelity and develop and/or revise and implement policies and procedures for monitoring treatment intervention fidelity and correcting identified deficiencies.
- Implement its revised CPC evaluation policy and further revise and implement the policy to include requirements for addressing recommendations that Department staff have determined to be nonactionable.
- Develop and implement a plan for identifying additional outcome measures and conducting outcome evaluations related to its treatment programming, and establish outcome measures and conduct outcome evaluations, as appropriate.

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INTRODUCTION

The Arizona Auditor General has released the second in a series of 3 audit reports of the Arizona Department of Juvenile Corrections (Department) as part of the Department's sunset review. This performance audit determined whether the Department's processes for evaluating the treatment programming it provides to youth committed to its care are consistent with recommended practices, including processes for assessing if its evidence-based treatment interventions are implemented as designed and evaluating whether its youth treatment programming follows practices associated with reduced recidivism and is achieving its intended rehabilitative outcomes. 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 final audit report will provide responses to the statutory sunset factors.[1]

Department is responsible for rehabilitating delinquent youth committed to its care

The Department is statutorily responsible for the supervision, rehabilitation, treatment, and education of delinquent youth committed to its care (see textbox for the Department's mission statement).[2] Pursuant to A.R.S. §§41-2801 and 8-342, youth who are at least 14 years old and under the age of 18 years old, or under the age of 19 years old if subject to extended jurisdiction, and who have been adjudicated or previously adjudicated delinquent for a felony offense may be committed to the Department's care by the Superior Court of Arizona.[3,4] Youth who are at least 14 years old and under the age of 18 years old, or under the age of 19 years old if subject to extended jurisdiction, seriously mentally ill, and adjudicated delinquent for any offense may also be committed to the Department's care.[5] A.R.S. §41-2816(A) requires the Department to operate and maintain or contract for secure care facilities for the custody, treatment, rehabilitation, and education of youth who pose a threat to public safety, who have engaged in a pattern of conduct characterized by persistent and delinquent offenses that, as demonstrated through the use of other alternatives, cannot be controlled in a less secure setting.[6] As of July 2021, the Department operated and maintained 1 secure care facility in the City of Phoenix, the Adobe Mountain School (Facility), where youth

Department mission statement

To rehabilitate the youth in our care by providing evidence-based treatment, prosocial activities, education, and career training that will lead them to become productive, healthy, law-abiding members of society.

Source: The Department's fiscal year 2022 strategic plan.

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1 Arizona Auditor General Report 21-104 *Arizona Department of Juvenile Corrections—Use of Temporary Stabilization Units*.

2 Arizona Revised Statutes (A.R.S.) §41-2802(B).

3 Additionally, pursuant to A.R.S. §13-501(A), youth between the ages of 15 and 17 years old who commit a violent felony offense, such as first- or second-degree murder or armed robbery, or are chronic felony offenders, are prosecuted as adults. Similarly, A.R.S. §13-501(B) authorizes county prosecutors to prosecute youth as adults who are at least 14 years old who commit various felony offenses or are chronic felony offenders. A.R.S. §8-342 prohibits youth who are less than 14 years old from being committed to the Department. A.R.S. §8-341 outlines various commitment options for youth, including those who are less than 14 years old, and have been adjudicated delinquent, such as being committed to the care of the youth's parents, subject to the supervision of a probation department.

4 A.R.S. §8-202(H) requires the court to retain extended jurisdiction over a youth who is at least 17 years old and who has been adjudicated delinquent until the youth reaches 19 years old if the State filed a notice of intent to retain jurisdiction.

5 A.R.S. §§41-2801 and 8-342.

6 A.R.S. §41-2801(5) defines secure care as confinement in a facility that is completely surrounded by a locked and physically secure barrier with entrance and exit restrictions.

under the Department's care reside until released (see page 7 for more information on release from the Facility).[7] A.R.S. §41-2816 also requires the Department to provide an array of services appropriate to each youth's age, needs, and abilities to help support youth rehabilitation, including educational and vocational training, treatment, recreation, and mental health services (see Arizona Auditor General Report 21-104 for more information on the Facility and services the Department provides to youth committed to its care).

Rehabilitation involves addressing youths' risk of reoffending with the goal of reducing crime and protecting public safety

One of the main goals of the juvenile justice system is to protect the public by reducing crime by rehabilitating delinquent youth.[8] Juvenile justice literature indicates that rehabilitation of delinquent youth should target specific factors that may increase youths' risk of committing additional delinquent offenses by helping them develop skills and competencies to reduce these risks (see textbox for information on risk factors for delinquency).[9] For example, youth with aggressive tendencies may benefit from treatment programming designed to help them manage their emotions and practice strategies for reducing anger. Research also indicates that providing youth with treatment programming that targets their specific risk factors reduces their likelihood of reoffending.[10] Because crime reduction is one of the juvenile justice system's main goals, juvenile justice agencies commonly track youth recidivism.[11,12]

Criminogenic risk factors—Factors research has shown increase the risk of delinquent behavior. Sometimes referred to as "criminogenic needs," these factors include, but are not limited to, negative beliefs or attitudes, aggressive tendencies, poor self-control, and substance abuse.

Source: Lipsey, Conly, Chapman, & Bilchik, 2017; CJI, 2004; Seigle, Walsh, & Weber, 2014.

Department assesses youths' recidivism risk and treatment needs to prescribe treatment programming and determine housing unit placement

To help meet its statutory requirement to provide youth in its care with rehabilitative services, the Department has established processes for screening all youth committed to the Facility using the Arizona Youth Assessment

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[7] A.R.S. §41-2818 authorizes the Department to release a youth from the Facility on parole (see page 7 for more information), and A.R.S. §41-2820 requires the Department to discharge youth from its jurisdiction regardless of rehabilitative progress when they reach 18 years old, or 19 years old if the juvenile court retains extended jurisdiction over the youth pursuant to A.R.S. §8-202(H).

[8] Butts, J.A., & Schiraldi, V. (2018). *Recidivism reconsidered: Preserving the community justice mission of community corrections*. Cambridge, MA: Harvard Kennedy School. Retrieved 5/7/20 from https://johnjayrec.nyc/2018/03/15/recidivism-reconsidered/; Harris, P.W., Lockwood, B., & Mengers, L. (2009). *A CJCA white paper: Defining and measuring recidivism*. Braintree, MA: Council of Juvenile Correctional Administrators. Retrieved 5/7/20 from http://cjca.net/wp-content/uploads/2018/02/CJCA-Recidivism-White-Paper.pdf; Lipsey, M.W., Conly, C.H., Chapman, G., & Bilchik, S. (2017). *Juvenile justice system improvement: Implementing an evidence-based decision-making platform*. Washington, DC: Center for Juvenile Justice Reform. Retrieved 4/16/20 from https://www.ojp.gov/pdffiles1/ojjdp/grants/250443.pdf; Lipsey, M.W., Howell, J.C., Kelly, M.R., Chapman, G., & Carver, D. (2010). *Improving the effectiveness of juvenile justice programs: A new perspective on evidence-based practice*. Washington, DC: Center for Juvenile Justice Reform. Retrieved 4/17/20 from https://cjjr.georgetown.edu/resources/publications/; Crime and Justice Institute (CJI). (2004). *Implementing evidence-based practice in community corrections: The principles of effective intervention*. Boston, MA. Retrieved 4/17/20 from https://nicic.gov/implementing-evidence-based-practice-community-corrections-principles-effective-intervention.

[9] Lipsey, Conly, Chapman, & Bilchik, 2017; CJI, 2004; Seigle, E., Walsh, N., & Weber, J. (2014). *Core principles for reducing recidivism and improving other outcomes for youth in the juvenile justice system*. New York, NY: Council of State Governments Justice Center. Retrieved 3/27/20 from https://csgjusticecenter.org/publications/juvenile-justice-white-paper/.

[10] Lipsey, Conly, Chapman, & Bilchik, 2017; Seigle, Walsh, & Weber, 2014.

[11] Butts & Schiraldi, 2018; Council of State Governments Justice Center. (2014). *Measuring and using juvenile recidivism data to inform policy, practice, and resource allocation*. New York, NY. Retrieved 3/2/2020 from https://csgjusticecenter.org/publications/measuring-juvenile-recidivism/; Lipsey, Howell, Kelly, Chapman, & Carver, 2010; CJI, 2004.

[12] Recidivism is defined as a relapse into criminal behavior. For example, see Butts & Schiraldi, 2018; Council of State Governments Justice Center, 2014; Harris, P.W., Lockwood, B., Mengers, L., & Stoodley, B.H. (2011). Measuring recidivism in juvenile corrections. *Office of Juvenile Justice and Delinquency Prevention (OJJDP) Journal of Juvenile Justice*, 1(1), 1-16.

System (AZYAS), a validated risk-and-needs assessment. The AZYAS is designed to assess a youth's overall risk to reoffend, criminogenic risk factors, and barriers to treatment, based on 7 domain areas.[13] Department policy also requires staff to administer additional assessments and screenings to learn more about a youth's treatment needs, including their substance abuse history, suicide risk, mental health status, propensity for aggression/violence, history of trauma, and any sexually aggressive behaviors. Once the Department has completed these assessments and determined a youth's recidivism risk level and treatment needs, Department policy requires staff to identify treatment programming for the youth, such as specific treatment interventions, individual counseling, and psychiatric services, and places the youth in a housing unit based on the youth's specific risks and needs (see textbox, page 4, for an example of a youth's housing unit placement and prescribed treatment interventions based on assessments the Department conducted; see pages 3 to 5 for more information on treatment interventions). For example, the Facility has specialized housing units that house and provide treatment programming for youth with histories of violence, substance abuse, mental health issues, and sexual offenses as well as general population housing units.[14] Additionally, the Facility has 1 housing unit for all female youth.[15]

Once it has placed a youth in a housing unit, the Department is required by its policy to assign a multidisciplinary treatment team (treatment team) to oversee the youth's progress toward achieving rehabilitative and educational goals and to review the youth's behavioral and/or emotional issues, as necessary. Treatment teams consist of various Department staff, including housing unit staff, licensed mental health professionals, education staff, and the youth's parole officer (see page 7 for more information on parole officers). Department policy requires treatment teams to meet at least weekly to discuss the youths they oversee.[16]

Department treatment programming includes specific treatment interventions to support youth rehabilitation

Under the supervision of licensed psychologists, various Department staff provide group and individual treatment interventions to help address youths' specific treatment needs, such as the need to reduce aggression (see Appendix A, page a-1, for information on the Department staff involved in facilitating and overseeing youth treatment interventions). Depending on a youth's recidivism risk and treatment needs, a youth may receive a combination of these group/individual treatment interventions as part of their overall treatment programming, which also includes meeting periodically in individual therapy sessions with licensed clinical staff. Specifically, the Department provides 1 or more of the following 5 treatment interventions to youth:

- **Aggression Replacement Training (ART)—**A treatment intervention for youth with an assessed need to reduce aggressive and violent behavior. ART is divided into 3 components—social skills training, anger control training, and moral reasoning. A research study found that ART improves juveniles' social skills and moral reasoning and reduces other problem behaviors, such as defiance of authority and lack of cooperation with peers.[17] A second study found that ART reduced 18-month felony recidivism rates for juvenile offenders.[18]

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[13] The 7 domain areas include juvenile justice history; family and living arrangements; peers and social support networks; education and employment; prosocial skills; substance abuse, mental health, and personality; and values, beliefs, and attitudes.

[14] According to the Department, youths with multiple specialized treatment needs will receive treatment programming to address those needs, regardless of their housing unit placement. For example, a youth may be placed in a specific housing unit because of their propensity for violence and the Department's need to separate them from the general population. However, that same youth would still receive services to address their other specialized treatment needs, such as to address substance abuse problems, even though they are not placed in a specialized housing unit for youth with substance abuse problems.

[15] Female youth are not placed in separate housing units for specialized treatment needs because of the small population of female youth at the Facility. However, according to Department policy, female youth with specialized treatment needs, such as the need for substance abuse treatment, receive treatment for those needs while residing in the female housing unit.

[16] Youth and their parents/guardians are invited to monthly treatment team meetings, which allows youth the opportunity to provide updates on their treatment and educational progress, their participation in positive activities, and any behavioral issues.

[17] Gundersen, K., & Svartdal, F. (2006). Aggression Replacement Training in Norway: Outcome evaluation of 11 Norwegian student projects. *Scandinavian Journal of Education Research*, 50(1), 63-81.

[18] Washington State Institute for Public Policy. (2004). *Outcome evaluation of Washington state's research-based programs for juvenile offenders*. Olympia, WA. Retrieved 8/27/20 from http://www.wsipp.wa.gov/ReportFile/852.

According to Department policy, ART is intended for youth assessed at a moderate to high risk to recidivate by AZYAS and should be delivered in a group treatment setting 3 times per week over a 10-week period. Additionally, each group session should be held for a minimum of 60 minutes.

Example of a youth risk and needs assessment, resulting treatment programming, and housing unit placement

According to the Department, Youth A was committed to the Department for violating probation but had also previously been adjudicated delinquent for possession of drug paraphernalia. Upon arrival at the Facility, the Department reported it completed the following assessments and reviews to determine Youth A's housing unit placement and prescribed treatment interventions:

- Department staff administered assessments, including AZYAS, and determined that Youth A was medium risk to recidivate and moderate risk for violence and aggression. According to the Department, the assessments suggested a lower-risk housing unit would be most appropriate.[1]
- A licensed mental health professional conducted a clinical interview, file review, and clinical assessments to determine a diagnosis and treatment needs for Youth A.[2] According to the Department, it determined that Youth A had severe cannabis use disorder and moderate alcohol use and opioid use disorder, as well as antisocial personality factors, such as anger and lack of coping skills.

Based on this information, the Department reported it determined that Youth A should be placed in a lower-risk substance use specialty unit and should participate in several treatment interventions intended to address substance abuse, aggression, and antisocial behaviors (see pages 3 through 5 for more information on the treatment interventions the Department provides to help address youths' needs).

[1] According to the Department, most youth in the Facility are considered medium or high risk to recidivate and moderate or high risk for violence and aggression. As a result, youth considered medium risk to recidivate and moderate risk for violence and aggression are generally considered to be the lower-risk youth in the Facility.

[2] The Department's Clinical Director reported that the file review includes reviewing a variety of documents, including the youth's offense history, police reports, and court documents.

Source: Auditor General staff interviews with Department staff.

- **Dialectical Behavior Therapy (DBT)—**A treatment intervention designed to help youth experience emotions in a healthy and effective way and to create and maintain positive relationships. DBT is intended to help youth develop and practice skills in multiple areas, including distress tolerance, emotion regulation, and interpersonal effectiveness, and is used to address multiple unproductive behaviors, including substance use, suicidal and self-harm behaviors, and interpersonal difficulties. Research indicates that DBT reduces self-harm behaviors, suicidal ideation, and depressive symptoms in youth.[19] According to Department policy, all youth in the Facility are required to receive DBT, which is intended to be delivered over the course of 24 weeks and consists of 90-minute group treatment sessions held once per week.

- **Seven Challenges—**A treatment intervention for youth assessed with moderate to severe substance use issues. Seven Challenges is intended to motivate youth to evaluate their lives, consider changes they may wish to make, and then succeed in implementing their desired changes. Research studies indicate that the effects of participating in Seven Challenges include reduced adolescent substance abuse, improved mental health, and decreases in the number of crimes committed by participants.[20] According to Department policy,

[19] McCauley, E., Berk, M., & Asarnow, J. (2018). Efficacy of dialectical behavior therapy for adolescents at high risk for suicide: A randomized clinical trial. *JAMA Psychiatry*, 75(8), 777-785; Mehlum, L., Ramberg, M., Tormoen, A.J., Haga, E., Diep, L.M., et al. (2016). Dialectical behavior therapy compared with enhanced usual care for adolescents with repeated suicidal and self-harming behavior: Outcomes over a 1-year follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry*, 55(4), 295-300.

[20] Korchmaros, J.D. (2018). Examining the effectiveness of the Seven Challenges comprehensive counseling program with adolescents. *Journal of Social Work Practice in the Addictions*, 18(4), 411-431; Smith, D.C., Hall, J.A., Williams, J.K., An, H., & Gotman, N. (2010). Comparative efficacy of family and group treatment for adolescent substance abuse. *The American Journal on Addictions*, 15(1), 131-136; Stevens, S.J., Schwebel, R., & Ruiz, B. (2006). The Seven Challenges: An effective treatment for adolescents with co-occurring substance abuse and mental health problems. *Journal of Social Work Practice in the Addictions*, 7(3), 29-49.

youth prescribed to attend Seven Challenges should participate in group treatment sessions for a minimum of 45 minutes at least once per week to discuss material from the Seven Challenges manual and spend 30 minutes per week individually completing journaling exercises from 9 different Seven Challenges journals.[21]

- **Sex Trafficking Awareness and Recovery (STAR)—**A treatment intervention for female youth who have been or are at risk of being victims of sex trafficking that is intended to help participants avoid sex trafficking. STAR is designed to help participants learn about trauma, boundaries, and healthy relationships and is delivered through group treatment sessions. Although the STAR intervention materials do not identify any research studies demonstrating STAR's effectiveness, according to the Department, STAR incorporates principles of cognitive behavioral therapy (CBT), which research has shown to have positive effects in reducing youth recidivism.[22,23]

- **Stages of Accomplishment—**A treatment intervention for youth who have an adjudicated sexual offense or have been assessed as sexually aggressive. Stages of Accomplishment consists of a series of 4 workbooks that clinical staff use in individual counseling sessions to introduce youth to concepts and skills intended to help reduce and eliminate sexual deviant fantasies and sexually aggressive behaviors. Although the Stages of Accomplishment intervention materials do not identify any research studies demonstrating Stages of Accomplishment's effectiveness, according to the Department, similar to STAR, Stages of Accomplishment incorporates principles of CBT.

See Table 1 for information on the number of youths prescribed each treatment intervention as of May 31, 2021.

Table 1
Number of youths prescribed treatment interventions
As of May 31, 2021[1]
(Unaudited)

Treatment intervention	Number of youths prescribed treatment intervention
ART	**85**
DBT	**136**
Seven Challenges	**77**
STAR	**4**
Stages of Accomplishment	**7**

[1] This table provides the number of youths prescribed each treatment intervention during intake to the Facility for all youth in the Facility as of May 31, 2021. As of May 31, 2021, the Department reported a population of 136 youths in the Facility. According to the Department, the same youth may have been prescribed multiple treatment interventions and, as such, would be counted in more than 1 treatment intervention category.

Source: Auditor General staff review of the Department's May 2021 "*Just the Facts*" document and Department-provided information.

The Department has developed policies and procedures for providing the ART, DBT, and Seven Challenges treatment interventions. The policies and procedures outline requirements for delivering these 3 treatment interventions consistent with the interventions' designs. These include requirements for the frequency and duration of group treatment sessions that should be provided to youth, the content that should be covered in each group treatment session, the order in which new concepts should be introduced, and guidelines for

[21] Youth with a lower substance-abuse risk are not placed in Seven Challenges group treatment sessions with higher-risk youth but may still participate in Seven Challenges as part of their individual therapy sessions.

[22] Lipsey, Conly, Chapman, & Bilchik, 2017; Lipsey, Howell, Kelly, Chapman, & Carver, 2010.

[23] CBT focuses on helping individuals to develop problem-solving skills and to recognize and change distorted or unrealistic thinking, attitudes, and beliefs in order to eliminate problematic behaviors. See American Psychological Association (APA). (2017). *What is Cognitive Behavioral Therapy?* Retrieved 4/1/21 from https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral#; Beck, J.S. (2011). *Cognitive Behavior Therapy: Basics and beyond* (2nd ed.). Guilford Press.

expected youth and facilitator behavior during group treatment sessions (see Finding 1, pages 8 through 12, for more information about the Department's compliance with these requirements). The Department reported that it does not have similar policies and procedures for STAR because the content of STAR sessions can be sensitive, including discussions of sex trafficking and trauma, so Department staff who facilitate STAR sessions are allowed flexibility in how group treatment sessions are conducted. Additionally, Stages of Accomplishment is discussed in a Department policy related to treating youth with sexualized behaviors, but the Department reported it has not developed specific procedures or requirements for Stages of Accomplishment because its sessions are guided by the workbooks that form the basis for this treatment intervention.

Department assesses youths' individual rehabilitative progress and readiness for parole using milestones

The Department assesses committed youths' individual rehabilitative progress during their stay at the Facility using 6 different treatment milestones, which are designed to assess youths' level of understanding and application of concepts learned during their treatment (see textbox for more information). The Department reported that its treatment milestones are based on the Stages of Change Theory, which indicates that rehabilitation is a gradual process during which individuals progressively commit to changing their behavior. Department clinical staff evaluate youth progress at each milestone using standardized criteria that apply to all youth. For example, to demonstrate they have met the "understanding" milestone, youth must discuss with a clinical staff member the reasons behind their past behaviors and demonstrate they understand how their thoughts and emotions led to those behaviors. Once a clinical staff member determines that a youth has met all requirements for a milestone, Department policy requires a Department psychologist to approve the clinical staff member's determination, and a youth must meet the requirements for all 6 milestones to be eligible for consideration for release on parole from the Facility (see page 7 for more information on parole).[24]

Department's rehabilitative milestones

Orientation—During Facility intake, youth must learn about treatment and Facility expectations before being assigned to a housing unit.

Acknowledgement—Youth must demonstrate accountability and awareness by acknowledging negative behaviors and identifying treatment areas to work on.

Understanding—Youth must demonstrate an understanding of the reasons for their past behaviors and acknowledge the need for appropriate solutions, techniques, and skills to address their problems.

Application—Youth must apply the knowledge and skills they have learned during treatment, with feedback from Department staff.

Demonstration—Youth must consistently demonstrate the skills they have learned during treatment, act as role models for other youth, and begin developing a plan for success after release.

Re-entry—Youth must finish developing a plan for success after release. If possible, youth may be temporarily released to the community to provide them an opportunity to demonstrate the skills they have learned during treatment.

Source: Auditor General staff review of Department policy and other milestone documentation provided by the Department.

[24] According to Department policy, the decision to allow youth to progress toward the next milestone is also based on youths' behavior and adherence to Facility rules, whether youth pass their education classes, and whether youth participate in their prescribed treatment interventions.

Department may release youth on parole if it determines they are not likely to be a threat to public safety

A.R.S. §41-2818 authorizes the Department to release a youth from the Facility on parole and to establish release conditions with which the youth must comply if it determines the youth is not likely to be a threat to public safety and the youth's continued treatment, rehabilitation, and education in a less restrictive setting are consistent with protecting the public's safety and interest. Once a youth has met the requirements for the demonstration milestone and begins working toward achieving the re-entry milestone, Department policy requires a Juvenile Community Reentry Board (JCRB) to be scheduled, which is a panel comprising Department staff that meets to review an individual youth's rehabilitative progress and determine if the youth will be released from the Facility to parole.[25] Department policy includes standard release conditions with which youth released on parole must agree to comply, including refraining from using drugs and alcohol, attending school or other educational programs, and refraining from contacting victims. Department policy also allows the Department's community corrections bureau to establish additional release conditions for individual youth. Parole officers from the Department's community corrections bureau regularly meet with youth on parole to determine if the youth are complying with their release conditions.[26] A.R.S. §41-2819 authorizes the Department to revoke parole and return a youth to the Facility for violating release conditions if the youth's return to the Facility is in the public's best interest.

[25] According to Department policy, JCRB panels must include a Facility administrator, the Department's education superintendent or designee, a Department psychologist or other clinical staff member, and the Department's community corrections bureau administrator, deputy parole administrator, or designee.

[26] A.R.S. §41-2818(D) also authorizes the Department to require youth on parole to submit to random drug and alcohol testing at least 2 times per week if they were adjudicated for drug offenses or the purchase, possession, or consumption of alcohol.

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

Evidence-based treatment interventions are more likely to achieve intended outcomes when implemented with fidelity, and literature recommends agencies monitor for and correct fidelity deficiencies

Research indicates that evidence-based treatment interventions are more likely to achieve their intended outcomes when they are implemented as designed—also commonly referred to as implementing with fidelity (see textbox, page 9, for more information on fidelity).[27] For example, 1 review of over 500 studies found that programs implemented with higher levels of fidelity resulted in 2 to 3 times more positive change, on average, than programs implemented with lower fidelity.[28,29] According to juvenile justice literature, implementation of evidence-based programs in practical settings often strays from fidelity because of a lack of resources or other constraints, potentially negatively impacting treatment programming effectiveness.[30] As a result, literature recommends that

[27] Borrelli, B. (2011). The assessment, monitoring, and enhancement of treatment fidelity in public health clinical trials. *Journal of Public Health Dentistry*, 71, S52-S63; James Bell Associates. (2009). *Evaluation brief: Measuring implementation fidelity*. Arlington, VA. Retrieved 4/30/20 from https://www.acf.hhs.gov/cb/resource/measuring-implementation-fidelity; Morris, J.A., Day, S., & Schoenwald, S.K. (eds.). (2010). *Turning knowledge into practice: A manual for human service administrators and practitioners about understanding and implementing evidence-based practices*, (2nd ed.). Boston, MA: The Technical Assistance Collaborative. Retrieved 4/16/20 from http://www.modelsforchange.net/publications/281; Office of Juvenile Justice and Delinquency Prevention (OJJDP). (n.d.). *OJJDP model programs guide glossary*. Washington, DC: U.S. Department of Justice. Retrieved 4/30/20 from https://www.ojjdp.gov/MPG/Resource/Glossary.

[28] Durlak, J.A. & DuPre, E.P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, 41, 327-350; James Bell Associates, 2009.

[29] Although some research indicates that adhering to at least 80 percent of required components of an evidence-based program's design is a sufficient level of fidelity that will likely result in the achievement of intended outcomes, the threshold for sufficient fidelity may differ between evidence-based programs. However, research generally indicates that higher fidelity is more likely to produce intended outcomes than lower fidelity. See Bond, G.R. & Drake, R.E. (2020). Assessing the fidelity of evidence-based practices: History and current status of a standardized measurement methodology. *Administration and Policy in Mental Health and Mental Health Services Research*, 47, 874-884; Borrelli, 2011; Wilczynski, S.M. (2017). Progress Monitoring. In *A practical guide to finding treatments that work for people with autism* (pp. 75-86). Academic Press.

[30] Crime and Justice Institute (CJI). (2004). *Implementing evidence-based practice in community corrections: The principles of effective intervention*. Boston, MA. Retrieved 4/17/20 from https://nicic.gov/implementing-evidence-based-practice-community-corrections-principles-effective-intervention; James Bell Associates, 2009; Lipsey, M.W., Howell, J.C., Kelly, M.R., Chapman, G., & Carver, D. (2010). *Improving the effectiveness of juvenile justice programs: A new perspective on evidence-based practice*. Washington, DC: Center for Juvenile Justice Reform. Retrieved 4/17/20 from https://cjjr.georgetown.edu/resources/publications/; Morris, Day, & Schoenwald, 2010.

agencies conduct ongoing monitoring of their treatment program implementation in order to identify and correct any fidelity deficiencies.[31]

Fidelity—The extent to which an evidence-based program is implemented consistent with key elements of the program's original research design that were shown to be critical to achieving the program's positive results. Some components of fidelity include:

- Delivery of required program content, such as the type and order of concepts/activities covered in treatment sessions.
- Quality of facilitators' treatment session delivery.
- Participants' response to and/or engagement in treatment sessions.
- Participants' exposure to prescribed amount of treatment, such as attendance in treatment sessions at the required frequency and duration.

Source: Borrelli, 2011; James Bell Associates, 2009; Morris, Day, & Schoenwald, 2010; OJJDP, n.d.

Department's fidelity-monitoring process does not assess some treatment intervention components important for ensuring group treatment sessions are implemented with fidelity

The Department has established a fidelity-monitoring process for its ART, DBT, and Seven Challenges group treatment sessions.[32] Specifically, Department clinical staff use standardized checklists to assess whether ART, DBT, and Seven Challenges group treatment sessions include required concepts and activities, the quality of facilitators' delivery, such as whether the facilitator made connections for youth between treatment concepts and their delinquent or antisocial behavior, and youths' engagement in treatment sessions, such as whether each youth practiced a key skill during the session (see Appendix B, pages b-1 through b-3, for more information on items included in the Department's fidelity-assessment checklists). The Department reported that it has a goal for clinical staff to conduct 1 fidelity-assessment observation per month of each Department staff member who facilitates group treatment sessions (see Appendix A, page a-1, for information on group treatment session facilitators).[33]

However, the Department's fidelity-monitoring process does not assess some other components of its treatment programming that are important for ensuring its treatment programming has been implemented with fidelity. In addition, other Department monitoring activities that are not designed to assess treatment programming fidelity have identified potential deficiencies with some treatment intervention components, but these processes did not include determining if these potential deficiencies resulted in fidelity issues and it did not correct some other deficiencies its fidelity assessments have identified. Specifically:

- **Group treatment session content and order of delivery—**Department policy outlines requirements for the specific content that should be covered in each group treatment session and the order in which content should be delivered over the course of the entire treatment intervention (see Appendix C, pages c-1 through

[31] James Bell Associates, 2009; Lipsey, M.W., Conly, C.H., Chapman, G., & Bilchik, S. (2017). *Juvenile justice system improvement: Implementing an evidence-based decision-making platform*. Washington, DC: Center for Juvenile Justice Reform. Retrieved 4/16/20 from https://www.ojp.gov/pdffiles1/ojjdp/grants/250443.pdf; Morris, Day, & Schoenwald, 2010; Pew-MacArthur Results First Initiative. (2014). *Evidence-based policymaking: A guide for effective government*. Washington, DC & Chicago, IL: The Pew Charitable Trusts & The John D. and Catherine T. MacArthur Foundation. Retrieved 9/1/20 from https://www.pewtrusts.org/en/research-and-analysis/reports/2014/11/evidence-based-policymaking-a-guide-for-effective-government.

[32] As discussed in the Introduction (see pages 3 through 5), the Department has developed policies and procedures for providing the ART, DBT, and Seven Challenges treatment interventions that outline requirements for delivering these 3 treatment interventions consistent with the interventions' design. Additionally, although the Department uses manuals outlining the design of the STAR and Stages of Accomplishment treatment interventions, these manuals do not identify any research studies that have demonstrated which components of these treatment interventions' design are critical for achieving the interventions' intended outcomes. As a result, STAR and Stages of Accomplishment are not included in the same fidelity-monitoring process as ART, DBT, and Seven Challenges.

[33] Some facilitators may not receive a fidelity assessment in a given month if they did not facilitate any treatment sessions during the month. Additionally, according to the Department, the staff responsible for conducting fidelity assessments are not always able to complete assessments of all facilitators during a month because of scheduling conflicts, such as a facilitator unexpectedly being away from work.

c-2, for examples of these requirements). However, the Department's fidelity-monitoring process does not assess whether group treatment session facilitators followed these content and delivery order requirements.

In April 2020, Department clinical staff learned that several DBT facilitators did not deliver DBT concepts in the order required by the DBT policy, including repeating some concepts in multiple group treatment sessions and failing to deliver some required concepts during sessions. Specifically, during a youth's individual counseling session, a clinical staff member noticed the youth discussed DBT content that the youth had learned that week but that was not part of the youth's assigned DBT content. Clinical staff further reviewed this issue and determined that several DBT facilitators had not delivered content as required by Department policy. According to Department records, it corrected these deficiencies for the affected youth by requiring them to repeat their DBT group treatment sessions. In addition, according to the Department records and interviews with Department staff, the Department disciplined and/or provided coaching and training for the DBT facilitators involved in these incidents.

- **Group treatment session duration—**Department policy requires youth to attend group treatment sessions for a specific duration of time. For example, Seven Challenges group treatment sessions are required to be held for a minimum of 45 minutes. Although the Department's fidelity-monitoring process assesses whether DBT and Seven Challenges group treatment sessions were held for the required duration, it does not include a similar assessment for ART group treatment sessions. Additionally, its fidelity-monitoring process does not assess if any youth missed any portion of a session and thus did not receive the required duration of treatment.

- **Frequency of group treatment sessions youth attended—**Department policy also requires youth to attend a specific number of group treatment sessions each week but allows youth to miss some treatment sessions and still be considered to have received the treatment with fidelity. For example, a youth can miss up to 3 ART group treatment sessions within a 10-week period and be considered to have received this treatment with fidelity. However, the Department's fidelity-monitoring process does not assess whether any youth were absent from their observed group treatment sessions. Thus, in its assessment of fidelity, the Department does not track whether youth received the required minimum number of group treatment sessions.

Although part of a separate process, Department Quality Assurance (QA) staff conduct weekly compliance inspections to assess whether some youth in each housing unit have attended their assigned ART, DBT, and Seven Challenges group treatment sessions. Our review of the Department's weekly QA inspection reports completed between January through March of 2020 found that 3 of 10 inspected housing units repeatedly failed to provide youth with the frequency and/or duration of group treatment sessions required by Department policies during this 12-week period (see Figure 1 on page 11). For example, 1 housing unit did not provide the required frequency and/or duration of group treatment sessions to between 10 and 80 percent of the youth QA staff reviewed for 7 of the 12 weeks. As of September 2021, the Department reviewed and compiled group treatment session attendance information contained in youths' case plans pertaining to the group treatment sessions that youth did not attend as identified by these QA inspections and determined that none of the missed group treatment sessions resulted in a fidelity deficiency.[34] However, rather than the Department compiling this information as part of an ongoing monitoring process while these group treatment sessions were occurring in January through March 2020, such as through its QA inspections or monthly fidelity assessments, the Department compiled this information more than a year later in response to our questions about whether the youth identified in the QA inspection reports had received their required treatment programming.[35]

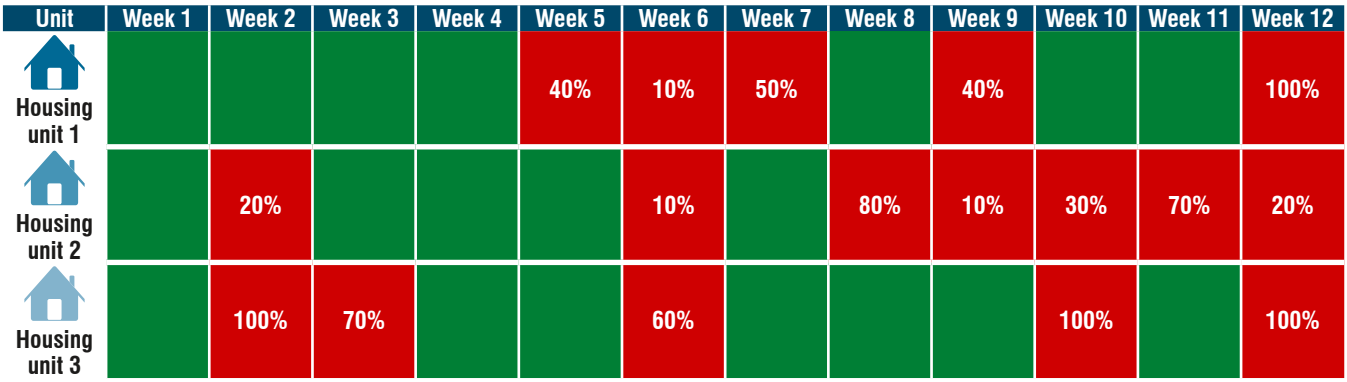
Finally, the Department tracks the percentage of ART, DBT, and Seven Challenges group treatment sessions clinical staff assessed during each month that were delivered with fidelity. The Department considers a group treatment session to be delivered with fidelity if clinical staff observe that the facilitator adhered to at least 80

[34] According to Department-provided information, the missed sessions did not result in fidelity deficiencies either because the youth did not miss the session, the youth made up the session, the youth was not required by policy to make up the session, the youth had an opportunity to make up the missed session at a later date, or the youth was released from the Facility for reasons other than release on parole prior to completing required treatment sessions.

[35] We requested this information in April 2021.

percent of the items on the Department's fidelity-assessment checklist for the intervention. Based on the monthly fidelity assessments clinical staff performed in July through May of fiscal year 2021, the Department reported that 100 percent of the observed sessions were at or above the 80 percent threshold for 2 months. For the remaining 9 months, not all observed group treatment sessions met the 80 percent threshold.[36] The Department reported that it conducts feedback sessions between facilitators and clinical staff after group treatment session observations to correct any identified issues and to mentor, train, and coach group facilitators, and provides other coaching and training to facilitators and clinical staff to help ensure fidelity deficiencies are corrected. However, the Department's fidelity-monitoring process does not include requirements for identifying youth who attended group treatment sessions its fidelity assessments found were not delivered with fidelity and addressing any potential impacts on these youth, such as determining whether youth who attended these group treatment sessions needed to retake these sessions and/or requiring them to do so.

Figure 1
Percent of youth that did not receive required frequency/duration of group treatment sessions as determined by QA inspections[1]
January through March 2020



[1] A green square indicates that all youth reviewed in the inspected housing unit received the required frequency/duration of group treatment sessions during the week.

Source: Auditor General staff review of Department QA inspection reports.

Although the Department reported it has some practices for monitoring treatment intervention fidelity, its policies and procedures inconsistently reflect these practices and lack additional procedures and guidance for monitoring some fidelity components

The Department reported it has practices in place to monitor the frequency and duration of ART, DBT, and Seven Challenges group treatment sessions and whether these group treatment sessions are delivered with the required content and delivery order. The practices the Department cited include monitoring youths' group treatment session attendance and treatment progress during weekly treatment team meetings, reviewing youths' progress toward meeting rehabilitative milestones, and regularly reviewing QA reports to identify potential fidelity issues. However, the Department did not provide documentation demonstrating that these practices constitute ongoing monitoring of youths' group treatment session attendance for the required frequency and duration and that youths receive treatment programming content in the required order. Additionally, the Department's written policies and procedures inconsistently reflect these practices and lack other procedures and guidance for monitoring some fidelity components. Specifically:

- Department policy requires youths' treatment teams to meet weekly. During these weekly meetings, treatment teams are required to review rehabilitative progress for youth who are being considered for promotion to

[36] Approximately 4 percent to 14 percent of the observed group treatment sessions each month were below the 80 percent threshold.

the next rehabilitative milestone, including reviewing whether youth have completed their required treatment programming (see Introduction, page 6, for more information on rehabilitative milestones). However, this policy requires treatment teams to review treatment programming progress during weekly meetings only for youth who are eligible for promotion to the next rehabilitative milestone or who are not progressing as expected toward the next rehabilitative milestone. As a result, the policy does not require weekly monitoring of all youths' attendance of required group treatment sessions.

- Department policy and the written guidelines Department psychology associates (PSAs) and psychologists use to determine if youth have met their rehabilitative milestones require PSAs and psychologists to review if youths fully participated in and successfully completed group treatment sessions to be eligible for milestone promotion (see Appendix A, page a-1 for more information about PSAs and psychologists). However, this policy and written guidelines do not further define participation in or successful completion of treatment programming, such as whether youths attended the required number and duration of group treatment sessions, and in the required order to be considered to have received treatment interventions with fidelity. As a result, the Department's policy for reviewing youths' progress toward meeting rehabilitative milestones does not require ongoing monitoring of whether youth received treatment sessions in the required order, and for the required frequency and duration.

- Department policy requires the Department's clinical director and clinical staff to hold weekly meetings to discuss various quality improvement areas, including discussing QA reports. However, the policy does not include any procedures or other written guidance indicating if or how these discussions should use QA reports to monitor for potential fidelity issues. In addition, based on our review of QA inspection reports, they do not include sufficient details to allow clinical staff to identify fidelity deficiencies without conducting additional research. For example, the QA inspection reports we reviewed that identified youth who did not receive the required frequency or duration of group treatment sessions (see Figure 1, page 11) included only the inspected housing unit name, the name of the treatment intervention, and the number of youths who did not receive the required treatment. The reports did not include youth names or identification numbers, indicate which or how many group treatment sessions each youth missed or specify whether some youth missed part of the group treatment sessions. As a result, clinical staff's ability to monitor for fidelity deficiencies during these meetings and based on their review and discussion of QA inspections reports is limited.

In addition, the Department lacks policies and procedures outlining staff responsibility for overseeing the results of its fidelity-monitoring efforts to help ensure fidelity deficiencies are corrected. This lack of policies and procedures likely contributed to the Department taking several months to report that it determined none of the missed group treatment sessions identified in the QA inspection reports we reviewed resulted in a fidelity deficiency.

Recommendation

The Department should:

1. 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.

    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.

Department response: As outlined in its **response**, the Department disagrees with the finding but will implement the recommendation.

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

Department has established process for evaluating its treatment programming's adherence to practices associated with reduced recidivism, as recommended by literature

In addition to monitoring whether evidence-based treatment programming is implemented with fidelity (see Finding 1, pages 8 through 12, for more information on monitoring fidelity), juvenile justice literature recommends that juvenile justice agencies evaluate whether their overall treatment programming for youth follows practices associated with reduced recidivism using standardized assessment tools.[37,38] Consistent with this recommendation, the Department has established a process, separate from its monthly fidelity assessments conducted by clinical staff and its weekly compliance inspections conducted by QA staff (see Finding 1 for more information on fidelity assessments and compliance inspections), for evaluating the quality of its treatment programming using the Evidence-Based Correctional Program Checklist (CPC). The CPC is a standardized assessment tool designed to evaluate whether correctional intervention programs adhere to certain practices research has shown are correlated with reduced recidivism.[39] The Department's Continuous Improvement Bureau (CIB) staff use the

[37] Lipsey, M.W., Conly, C.H., Chapman, G., & Bilchik, S. (2017). *Juvenile justice system improvement: Implementing an evidence-based decision-making platform*. Washington, DC: Center for Juvenile Justice Reform. Retrieved 4/16/20 from https://www.ojp.gov/pdffiles1/ojjdp/grants/250443.pdf; Lipsey, M.W., Howell, J.C., Kelly, M.R., Chapman, G., & Carver, D. (2010). *Improving the effectiveness of juvenile justice programs: A new perspective on evidence-based practice*. Washington, DC: Center for Juvenile Justice Reform. Retrieved 4/17/20 from https://cjjr.georgetown.edu/resources/publications/; Seigle, E., Walsh, N., & Weber, J. (2014). *Core principles for reducing recidivism and improving other outcomes for youth in the juvenile justice system*. New York, NY: Council of State Governments Justice Center. Retrieved 3/27/20 from https://csgjusticecenter.org/publications/juvenile-justice-white-paper/.

[38] Recidivism is defined as a relapse into criminal behavior. See Butts, J.A., & Schiraldi, V. (2018). *Recidivism reconsidered: Preserving the community justice mission of community corrections*. Cambridge, MA: Harvard Kennedy School. Retrieved 5/7/20 from https://johnjayrec.nyc/2018/03/15/recidivism-reconsidered/; Council of State Governments Justice Center. (2014). *Measuring and using juvenile recidivism data to inform policy, practice, and resource allocation*. New York, NY. Retrieved 3/2/2020 from https://csgjusticecenter.org/publications/measuring-juvenile-recidivism/; Harris, P.W., Lockwood, B., Mengers, L., & Stoodley, B.H. (2011). Measuring recidivism in juvenile corrections. *Office of Juvenile Justice and Delinquency Prevention (OJJDP) Journal of Juvenile Justice*, 1(1), 1-16.

[39] The CPC was developed by the University of Cincinnati Corrections Institute (UCCI) based on studies conducted on both adult and juvenile correctional programs. These studies found that certain practices related to implementing correctional interventions, such as providing treatment programming staff with relevant training and assigning youths' treatment programming based on their assessed recidivism risk and treatment needs, were correlated with reductions in recidivism for program participants. For an overview of the CPC from UCCI, see https://cech.uc.edu/about/centers/ucci/products/evaluations.html.

CPC to periodically evaluate the overall treatment programming provided to youth in each of its individual youth housing units.[40]

Each CPC evaluation results in a report that includes an overall CPC evaluation score indicating how closely the treatment programming in the evaluated housing unit adheres to practices associated with reduced recidivism, as follows: very high adherence, high adherence, moderate adherence, and low adherence. According to the Department's CPC evaluation reports, scores of very high or high adherence indicate that the evaluated program has adhered to practices associated with reductions in offender recidivism. Each CPC evaluation report also outlines recommendations for the evaluated housing unit to improve its adherence to practices associated with reduced recidivism.[41] For example, the Department's 2018 CPC evaluation report for its specialized housing unit for youth with sexually abusive behaviors recommended that new staff should receive more training in the theory and practice of the treatment interventions the housing unit provides.

Finally, the Department's CPC evaluation policy and procedures require the clinical staff assigned to the housing unit, in consultation with CIB staff, to develop a corrective action plan (CAP) within 30 days of completing a CPC evaluation report to address each of the report's recommendations.[42] The policy and procedures also require CIB staff to conduct a follow-up evaluation within 180 days of completing a CPC evaluation report to assess the implementation status of the report recommendations and provide a status report to the Department Director.

Department did not address some CPC evaluation report recommendations in CAPs, complete some CAP action items, or conduct 1 of 3 follow-up evaluations

For the Department's 3 most recent CPC evaluation reports completed as of August 2021, Department staff developed CAPs to address and implement CPC evaluation report recommendations, but the Department did not ensure some recommendations were implemented.[43] Specifically, contrary to Department policy the CAPs developed in response to these evaluation reports and the Department's efforts to address specified action items had the following deficiencies:

- **Did not address some recommendations from the CPC evaluation reports—**For example, the CAP for the 2018 CPC evaluation of the Department's specialized housing unit for youth with sexually abusive behaviors did not address recommendations related to assigning youths to housing units and treatment programming based on their assessed recidivism risk and treatment needs. Additionally, the CAP for the 2018 CPC evaluation of the Department's specialized housing unit for youth who violated parole did not address recommendations related to adjusting treatment programming based on youths' assessed recidivism risk, such as providing more frequent programming for higher-risk youth.

- **Did not complete or document completing some action items specified in the CAPs—**The Department could not demonstrate that it had completed the CAP action items either because Department staff failed to complete them or failed to document completing them. Specifically, as of June 2020:

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[40] As discussed in the Introduction (see pages 2 through 3), the Facility has general population housing units as well as specialized housing units that house and provide treatment programming for youth with histories of violence, substance abuse, mental health issues, and sexual offenses. According to Department policy, CIB staff must conduct CPC evaluations during a housing unit's first year of operation and then upon any significant program modifications within the housing unit or at the direction of the Department Director. The Department reported that CIB staff complete each CPC evaluation over the course of approximately 3 to 4 months, and each evaluation involves various information gathering methods, such as interviews with housing unit staff, observations of group treatment sessions, and a review of relevant treatment programming materials, such as treatment intervention manuals and policies.

[41] An evaluation that results in a high score may still provide recommendations for improvement in specific areas.

[42] Although the CPC methodology recommends that evaluated programs prioritize recommendations for improvement and develop action plans to systemically address them rather than addressing all recommendations at once, the Department's policy does not include guidance for prioritizing implementation of recommendations.

[43] We reviewed CPC evaluation reports of the Department's specialized housing unit for youth with significant mental health needs completed in January 2017; the Department's specialized housing unit for youth with sexually abusive behaviors completed in January 2018; and the Department's specialized housing unit for youth who violated parole completed in August 2018.

- The CAP for the 2017 CPC evaluation of the Department's specialized housing unit for youth with significant mental health needs had no information about the status of the CAP action items, such as whether they were started, in process, or completed (see below for information on a follow-up evaluation CIB staff completed related to this CPC evaluation).

- The CAP for the 2018 CPC evaluation of the Department's specialized housing unit for youth with sexually abusive behaviors had action items in 3 main areas, and although the action items for 2 of these areas were noted as being complete, the CAP indicated that the action items for the third area were 75 percent complete.

- The CAP for the 2018 CPC evaluation of the Department's specialized housing unit for youth who violated parole had action items in 4 main areas. The CAP indicated that nearly 93 percent of the action items were completed.

Additionally, although 2 CAPs generally stated whether action items had been completed, the Department could not provide other documentation or evidence demonstrating how it determined that the action items in these 2 CAPs had been completed.

- **Did not conduct or document conducting 1 of 3 follow-up evaluations or providing status reports for 2 of 3 CPC evaluations—**In June 2017, CIB staff prepared a memo for the Department Director that reported the results of a follow-up evaluation related to the January 2017 CPC evaluation report for the Department's specialized housing unit for youth with significant mental health needs. The memo indicated that the housing unit had made minimal progress in some CAP areas and provided details of the progress and additional items that needed to be completed. Additionally, the documentation the Department provided related to the 2018 CPC evaluation of its specialized housing unit for youth with sexually abusive behaviors indicated that a follow-up evaluation was completed; however, it did not provide documentation indicating a follow-up evaluation had been performed for the 2018 evaluation of its specialized housing unit for youth who violated parole. Further, although the Department developed reports with information on the implementation status of these 2 reports' recommendations and reported that it provided them to the Department Director, it could not provide documentation demonstrating that it did so, as required by its policy.

Department's failure to address some CPC evaluation report recommendations could negatively impact its treatment programming's effectiveness in reducing youth recidivism and its efficient use of resources

By not addressing recommendations made in its CPC evaluation reports, the Department risks negatively impacting the effectiveness of its treatment programming in reducing recidivism. Specifically, none of the 3 CPC evaluations we reviewed received overall scores of very high or high adherence, which would indicate that the evaluated program has adhered to practices associated with reductions in offender recidivism (see Table 2, page 16, for additional information). As a result, these CPC evaluations made recommendations to improve Department housing units' adherence to practices associated with reduced recidivism, such as assigning youths to housing units and treatment programming based on their assessed recidivism risk and treatment needs. However, by not addressing each CPC evaluation report recommendation, the Department has not taken the complete set of actions it deemed necessary to improve its level of adherence with practices associated with reduced recidivism.

In addition, conducting a CPC evaluation requires substantial amounts of time and staff involvement. By not addressing the recommendations from these evaluations, the Department may not be efficiently using the time and resources necessary to conduct CPC evaluations. For example, the Department reported that 2 to 3 staff members spend a significant amount of their working hours over the course of approximately 3 to 4 months to complete each CPC evaluation (see footnote 39, page 14, for more information on the methods CIB staff use to complete a CPC evaluation).

Table 2
Results of Department's most recent CPC evaluations for 3 housing units
As of August 2021

Evaluated housing unit	Year CPC evaluation report produced	Overall adherence score	Is adherence score associated with reduced offender recidivism?
Housing unit for youth who violated parole	2018[1]	Moderate	No
Housing unit for youth with sexually abusive behaviors	2018	Not reported[2]	No
Housing unit for youth with significant mental health needs	2017	Moderate	No

[1] This was the first CPC evaluation conducted for the specialized housing unit for youth who violated parole.

[2] The 2018 CPC evaluation report for the Department's specialized housing unit for youth with sexually abusive behaviors did not provide an overall adherence score. However, this CPC evaluation report outlined various recommendations for the housing unit to improve its adherence to practices associated with reduced recidivism.

Source: Auditor General staff review of Department CPC evaluation reports.

Department lacked procedures and guidance for addressing CPC evaluation report recommendations but revised policy to include additional procedures during audit

Department's CPC evaluation policy and procedures lacked some requirements and expectations for addressing CPC evaluation report recommendations and how Department staff should develop, document, and follow up on CAPs—Although the Department's CPC evaluation policy and procedures required staff to develop CAPs to address CPC evaluation report recommendations and conduct follow-up evaluations related to these CAPs (see page 14), the Department lacked other requirements, procedures, and guidance for staff to follow when doing so. Specifically, the Department's CPC evaluation policy and procedures:

- **Lacked instructions and guidance for how to address certain types of CPC evaluation report recommendations—**Department policy required CAPs to address all CPC evaluation report recommendations. However, the policy lacked specific instructions/guidance for addressing all CPC evaluation report recommendations, especially in instances where different Department staff would need to be responsible for addressing the recommendations. For example, the Department reported that some of the CPC evaluation report recommendations were not included in CAPs because they were outside of the authority of the staff assigned to complete the CAP, such as recommendations related to ensuring housing unit staff who deliver treatment programming had relevant educational backgrounds to provide this programming. Although other Department staff could have potentially addressed these recommendations, the Department's CPC evaluation policy and procedures did not include guidance for identifying and assigning appropriate staff to address all CPC evaluation report recommendations.

- **Did not include requirements and expectations for developing and documenting completion of CAP action items—**Department policy did not include any requirements or guidance for the information that should be included in CAPs, such as time frames/deadlines and staff responsibility for completing action items. Additionally, Department policy did not require Department staff to regularly report on the status of completing action items or maintain documentation demonstrating the completion of action items, which would facilitate CIB staffs' follow-up evaluations.

- **Did not include requirements and expectations for CAP follow-up evaluation activities, including documentation—**Specifically, the Department's policies and procedures:
    - Did not specify if CIB staff should assess/verify the completion of all CAP action items during follow-up evaluations and how they should do so.
    - Did not outline steps CIB staff should take if CAP action items were not completed at the time of the follow-up evaluation, such as conducting additional follow-up evaluations or documenting the reasons why action items were not completed, as necessary.
    - Did not require follow-up evaluations or status updates to the Department Director to be documented.

During the audit, Department revised its CPC evaluation policy and procedures to include additional procedures for addressing CPC evaluation report recommendations but did not include some needed revisions—During the audit, effective March 2021, the Department incorporated the following revisions in its CPC evaluation policy and procedures:

- Requiring designated Department staff to create CAPs within 60 days of completing a CPC evaluation report using a standardized form. The policy requires CAPs to address and prioritize items identified as needing improvement that are actionable or specify the reasons they are nonactionable, identify the person(s) responsible to complete actionable items, and establish time frames for completing each actionable item.
- Requiring CIB staff to monitor progress made on actionable items for a 12-month period, including requiring staff responsible for creating and implementing CAPs to submit an updated CAP every 90 days to CIB staff detailing the progress made on actionable items and barriers related to completion.
- Requiring CIB staff to submit a memorandum to the Department Director at the end of the 12-month period detailing actionable items that were completed and any applicable barriers to completion, and providing action plan reports received during the monitoring period.
- Requiring the Department Director to determine any feasible or fiscally responsible actions necessary to remove barriers for completion and appropriate employee disciplinary action for noncompliance in addressing the actionable item areas needing improvement.
- Requiring CIB staff to retain all documentation related to CPC evaluations in accordance with the Department's records retention policy.

However, the revised policy and procedures should be further revised to include additional requirements and further clarify some of the revisions. Specifically, the revised policy and procedures:

- Do not specify how to address areas needing improvement that Department staff determine to be nonactionable. For example, similar to the procedure for actionable items, the CPC evaluation policy and procedures could require the Department Director or management to determine any feasible or fiscally responsible actions necessary to complete or remove barriers for completing areas needing improvement that have been determined to be nonactionable.
- Lack requirements for staff to retain documentation demonstrating progress toward completing CAP action items.
- Do not outline how CIB staff should monitor, assess, or 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.

Recommendations

The Department should:

2. Implement its revised CPC evaluation policy and procedures to help ensure it addresses all actionable CPC evaluation report recommendations.

3. 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.

Department response: As outlined in its **response**, the Department agrees with the finding and will implement the recommendations.

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

Literature recommends juvenile justice agencies evaluate treatment programming's effectiveness in rehabilitating youth

One of the Department's statutory responsibilities is rehabilitating the youth committed to its care (see Introduction, pages 1 through 2, for more information). In addition to the recommended practices for evaluating its treatment programming discussed in Findings 1 and 2 (see pages 8 through 18), literature recommends that juvenile justice agencies assess their effectiveness in rehabilitating youth by evaluating if youth treatment programming is achieving its intended rehabilitative outcomes, including long-, medium-, and short-term outcomes, in the aggregate—in other words, for the entire youth population receiving treatment programming and/or specific treatment interventions (see textbox on page 20 for more information on different types of outcomes).[44,45] Literature outlines 2 main methods for evaluating treatment programming effectiveness:

- **Tracking outcomes through performance measurement—**Performance measurement consists of collecting and tracking information on short-, medium-, and long-term programming outcomes for the youth

[44] Crime and Justice Institute (CJI). (2004). *Implementing evidence-based practice in community corrections: The principles of effective intervention*. Boston, MA. Retrieved 4/17/20 from https://nicic.gov/implementing-evidence-based-practice-community-corrections-principles-effective-intervention; Fratello, J., Kapur, T.D., & Chasan, A. (2013). *Measuring success: A guide to becoming an evidence-based practice*. Brooklyn, NY: Vera Institute of Justice. Retrieved 4/16/20 from http://www.modelsforchange.net/publications/463; Juvenile Justice Evaluation Center. (JJEC). (2004). *Approaches to assessing juvenile justice program performance*. Washington, DC: Justice Research and Statistics Association. Retrieved 6/7/21 from https://www.jrsa.org/pubs/juv-justice/approaches_assessing.pdf; Morris, J.A., Day, S., & Schoenwald, S.K. (eds.). (2010). *Turning knowledge into practice: A manual for human service administrators and practitioners about understanding and implementing evidence-based practices*, (2nd ed.). Boston, MA: The Technical Assistance Collaborative. Retrieved 4/16/20 from http://www.modelsforchange.net/publications/281; Office of Juvenile Justice and Delinquency Prevention (OJJDP). (n.d.). *OJJDP model programs guide glossary*. Washington, DC: U.S. Department of Justice. Retrieved 4/30/20 from https://www.ojjdp.gov/MPG/Resource/Glossary; Pew-MacArthur Results First Initiative. (2018). *The role of outcome monitoring in evidence-based policymaking: How states can use performance management systems to achieve results*. Washington, DC & Chicago, IL: The Pew Charitable Trusts & The John D. and Catherine T. MacArthur Foundation. Retrieved 9/4/20 from https://www.pewtrusts.org/-/media/assets/2018/08/rf_outcome_monitoring-brief_v4.pdf; Seigle, E., Walsh, N., & Weber, J. (2014). *Core principles for reducing recidivism and improving other outcomes for youth in the juvenile justice system*. New York, NY: Council of State Governments Justice Center. Retrieved 3/27/20 from https://csgjusticecenter.org/publications/juvenile-justice-white-paper/; Walker, S.C., Bumbarger, B.K., & Phillippi Jr., S.W. (2015). Achieving successful evidence-based practice implementation in juvenile justice: The importance of diagnostic and evaluative capacity. *Evaluation and Program Planning*, 52, 189-197.

[45] For example, according to Lipsey, Howell, Kelly, Chapman, & Carver (2010), evidence-based treatment programs are more likely to serve a different population in real-world settings as compared to the population in the research studies. Therefore, evaluating both fidelity and outcomes helps provide assurance that the programs are effective.

population receiving treatment programming.[46] For example, performance measurement in the juvenile justice system could include measuring/tracking the percentage of youth who recidivate, which is a long-term outcome that indicates whether youth have avoided relapsing into criminal behavior. Additionally, performance measurement could include measuring/tracking the percentage of delinquent youth with measurable reductions in their criminogenic risk factors during their time in a secure care facility, which is a short-/medium-term outcome that indicates how well an agency is rehabilitating youth (see Introduction, page 2, for more information on criminogenic risk factors).

Literature considers performance measurement a useful tool for gathering information about whether treatment programming's desired rehabilitative outcomes are being or are likely to be achieved for the population of youth receiving the treatment programming.[47] Specifically, long-term outcomes are often not measurable until well after youth participate in treatment programming and, therefore, literature states that short- and medium-term outcomes can be useful as more immediate and frequent indicators for assessing whether treatment programming is on track to achieve expected long-term outcomes.[48] For example, because certain risk factors are associated with youth delinquency, assessing the percentage of youth who participated in treatment programming and whose risk factors have decreased and/or whose behaviors and attitudes intended to reduce these risk factors have improved can provide information on whether long-term outcomes, such as reduced delinquency or recidivism, are likely to be achieved. However, performance measurement cannot determine if youths' outcomes are directly attributable to participation in treatment programming and not as a result of other factors (see next bullet for more information).[49]

Types of treatment outcomes

Long-term outcome—Outcome most closely related to the overall goal or intent of treatment programming, such as reduced delinquency or substance abuse, that is generally the result of treatment participants' new attitudes, knowledge, or skills. Long-term outcomes may not be fully achieved until after youth are released from the juvenile justice system.

Short/medium-term outcome—Expected result of programming most closely related to and influenced by the programming's subject matter, such as changes in youths' attitudes, knowledge, skills, or behavior from participating in group treatment sessions, and that can indicate whether the intervention is on track to achieve long-term outcomes.

Source: Fratello, Kapur, & Chasan, 2013; JJEC, 2004; OJJDP, n.d.

- **Conducting outcome evaluations—**Outcome evaluations use experimental and/or other statistical methods to determine whether observed outcomes for treatment programming participants resulted directly from their participation in treatment programming and not as the result of other factors.[50] However, outcome evaluations may be difficult to undertake because they require significant time and technical expertise to complete.[51]

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[46] Fratello, Kapur, & Chasan, 2013; JJEC, 2004; Morris, Day, & Schoenwald, 2010; Pew-MacArthur Results First Initiative. (2014). *Evidence-based policymaking: A guide for effective government*. Washington, DC & Chicago, IL: The Pew Charitable Trusts & The John D. and Catherine T. MacArthur Foundation. Retrieved 9/1/20 from https://www.pewtrusts.org/en/research-and-analysis/reports/2014/11/evidence-based-policymaking-a-guide-for-effective-government; Pew-MacArthur Results First Initiative, 2018.

[47] Fratello, Kapur, & Chasan, 2013; JJEC, 2004; Pew-MacArthur Results First Initiative, 2018.

[48] OJJDP, n.d.; Pew-MacArthur Results First Initiative, 2018.

[49] Fratello, Kapur, & Chasan, 2013; JJEC, 2004.

[50] Randomized control trial experiments are generally considered to provide the best causal evidence of a treatment's impact, but other statistical methods may also provide varying levels of evidence of a program's impact on outcomes. See Fratello, Kapur, & Chasan, 2013; OJJDP, n.d.; Lipsey, M.W., Howell, J.C., Kelly, M.R., Chapman, G., & Carver, D. (2010). *Improving the effectiveness of juvenile justice programs: A new perspective on evidence-based practice*. Washington, DC: Center for Juvenile Justice Reform. Retrieved 4/17/20 from https://cjjr.georgetown.edu/resources/publications/.

[51] Fratello, Kapur, & Chasan, 2013; JJEC, 2004; Lipsey, Howell, Kelly, Chapman, & Carver, 2010.

Department's limited set of outcome measures provide insufficient information on the effectiveness of its treatment programming in helping to rehabilitate youth, and it has not conducted treatment programming outcome evaluations

Youth outcomes the Department tracks provide limited information on the effectiveness of its treatment programming in helping to rehabilitate youth, and it lacks other aggregate performance measures related to its treatment programming's goals to assess youths' rehabilitative progress while in the Facility—Although the Department tracks and measures 2 youth outcomes related to its treatment programming's rehabilitative goals (see Introduction, pages 2 through 5, for information on the goals of treatment programming to address criminogenic risk factors), these outcomes do not fully reflect youths' rehabilitative progress and provide only limited information on the Department's effectiveness in rehabilitating youth. Specifically:

- **Department tracks recidivism, but recidivism rates alone do not fully reflect youths' progress toward treatment programming's rehabilitative goals—**Similar to other juvenile justice agencies, the Department tracks youth recidivism rates as a long-term outcome of its efforts to rehabilitate youth (see Introduction, page 2, for more information on juvenile justice agencies' tracking of recidivism).[52] However, juvenile justice literature indicates that rehabilitation is a long-term process of cognitive and social change in which a youth may face setbacks, including possibly committing additional offenses, and thus recidivism rates are not a complete indicator of a youth's rehabilitative progress.[53] Additionally, youth recidivism can be influenced by external factors youth experience after release from the Facility that are beyond the Department's control, such as interactions with family and friends. As a result, recidivism rates provide only limited information on the effectiveness of the Department's treatment programming to help rehabilitate youth.

- **Department's parole completion measure also does not fully reflect youths' progress toward treatment programming's rehabilitative goals—**The Department has established a short-/medium-term outcome and related performance measure that tracks the percentage of youth released from the Facility to parole who complete their conditions of parole without committing a new criminal or delinquent offense (see Introduction, page 7, for more information about parole and release conditions).[54] However, similar to recidivism rates, this parole-completion performance measure also is not a complete indicator of a youth's rehabilitative progress because rehabilitation is a long-term process of cognitive and social change in which a youth may face setbacks, including possibly committing additional offenses that could result in unsuccessful parole completion.

In addition, the Department has not developed, nor does it track, other outcomes related to its treatment programming's goals in the aggregate to assess youths' rehabilitative progress during their time in the Facility up to the time of their release. For example, although the Department assesses individual youths' rehabilitative progress during their stay at the Facility using 6 different treatment milestones, literature indicates that agencies should measure and assess rehabilitative outcomes in the aggregate for youth participating in treatment

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[52] The Department defines recidivism as a subsequent offense or parole violation following a youth's release from a first commitment to the Facility that results in a youth's return to custody with the Department or the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR). The Department monitors whether youths have been returned to the Department's or ADCRR's custody at intervals of 1, 2, and 3 years following youths' release from their first commitment to the Facility.

[53] Butts, J.A., Pelletier, E., & Kazemian, L. (2018). *Positive outcomes: Strategies for assessing the progress of youth involved in the justice system*. New York, NY: Research and Evaluation Center, John Jay College of Criminal Justice, City University of New York. Retrieved 5/7/20 from https://johnjayrec.nyc/2018/02/01/positiveoutcomes2018/; Butts, J.A., & Schiraldi, V. (2018). *Recidivism reconsidered: Preserving the community justice mission of community corrections*. Cambridge, MA: Harvard Kennedy School. Retrieved 5/7/20 from https://johnjayrec.nyc/2018/03/15/recidivism-reconsidered/.

[54] The Department considers both youth who complete the terms of their parole and youth who age out of the juvenile justice system while on parole to have "successfully" completed parole as long as they do not commit a parole violation or subsequent criminal or delinquent offense. Additionally, this performance measure includes information only for youth who are released from the Facility on parole and does not include information on youth who are released from the Facility for other reasons, such as age (see footnote 6, page 2, for more information on youth who are released from the Facility because of age).

programming and not only on an individual youth basis (see Introduction, page 6, for information about the the Department's assessments of individual youths' rehabilitative progress). Additionally, as discussed in the Introduction (see pages 2 through 5), the Department's treatment programming is intended to help reduce youths' specific criminogenic risk factors, such as past substance abuse or a history of antisocial behaviors. However, the Department has not identified short- and medium-term outcomes to assess how well its treatment programming has addressed these risk factors, such as measurable changes in youths' assessed risk to recidivate or improvements in youths' knowledge, skills, and/or attitudes.

Finally, although the Department has measured and tracked some information related to youth education and employment, these are not directly related to its treatment programming's goals. These include measures tracking the percentage of youth who complete educational classes with a passing grade and reporting the number of youths on parole who are employed each month. Although these measures may provide an indication of rehabilitative progress, they are not directly related to the specific criminogenic risk factors the Department's treatment programming is designed to address.

Department has not conducted outcome evaluations—The Department also reported that it has not conducted any outcome evaluations to determine if a causal relationship exists between youth participation in its treatment programming and any rehabilitative outcomes experienced by youth. For example, the Department has not conducted an outcome evaluation to determine if a relationship exists between its youth treatment programming and youth recidivism rates.

Without comprehensive set of outcome measures and conducting targeted outcome evaluations, Department may not have information to assess and improve its treatment programming's effectiveness in rehabilitating youth in its care

Department may not have all the information it needs to assess how effectively its treatment programming is helping to rehabilitate all youth under its care—Without a comprehensive set of performance measures that includes additional outcomes related to its treatment programming's goals, the Department may not have all the information it needs to assess how effectively its treatment programming is helping to rehabilitate youth. For example:

- **Department may not timely identify problems with and trends in its treatment programming's impact—**Literature indicates that tracking short- and medium-term treatment programming outcomes over time can help agencies identify trends in youths' overall rehabilitative progress and potential problems with treatment programming more quickly than tracking long-term outcomes, such as recidivism.[55] For example, as an agency collects data from performance measurement over time, it can organize the data according to specific youth characteristics, such as gender, race/ethnicity, recidivism risk level, or mental health needs, which may reveal whether treatment programming is on track to achieve longer-term outcomes for specific groups of youth but not for others.[56] By developing additional short- and medium-term outcomes and tracking them over time, the Department may be able to more quickly identify potential problems with its treatment programming or trends in the rehabilitation of the population of youth in its care, such as identifying certain groups of youth who are not responding to treatment programming as well as others.

- **Department may not have definitive evidence of the effectiveness of some of its treatment programming—**Literature also recommends that agencies use targeted outcome evaluations to obtain more definitive evidence of treatment programming effectiveness. Instances where targeted outcome evaluations would be helpful include the use of innovative programming where the effects of the programming have not already been established by research, when an agency first implements programming, or when an agency's performance measurement indicates that treatment programming's expected outcomes are not being

[55] Fratello, Kapur, & Chasan, 2013; JJEC, 2004; Pew-MacArthur Results First Initiative, 2014; Pew-MacArthur Results First Initiative, 2018.

[56] JJEC, 2004; Pew-MacArthur Results First Initiative, 2018.

achieved.[57] For example, the Department's STAR and Stages of Accomplishment treatment intervention manuals do not identify any research studies demonstrating which components of these treatment interventions' design are critical for achieving the interventions' intended outcomes (see Introduction, page 5, for additional information on STAR and Stages of Accomplishment). As a result, conducting outcome evaluations could help the Department obtain definitive information on these interventions' effectiveness for the youth in its care who receive these treatment interventions.

- **Department may benefit from additional information to assess the effectiveness of its treatment programming in rehabilitating approximately 39 percent of its youth population—**As previously discussed, statute requires the Department to discharge some youth from the Facility because of age (see footnote 6, page 2) and not because they have been determined to be eligible for parole. Although these youth are reflected in the Department's recidivism measure, because these youth are not released on parole, they are not reflected in the Department's parole completion measure. Further, as mentioned previously, recidivism is a long-term outcome measure that provides limited information on youth rehabilitation, and the Department has not established other aggregate outcome measures related to its treatment programming's goals to assess youths' rehabilitative progress during their time in the Facility up to the time of their release. For example, in fiscal years 2020 and 2021, approximately 39 percent of youth were required to be released from the Facility because of age and not because they had demonstrated sufficient rehabilitative progress to be released on parole. Establishing aggregate outcomes related to these youths' treatment programming progress while in the Facility could help the Department assess and demonstrate its treatment programming's effectiveness in helping rehabilitate these youth, even if some of these youth later recidivate.

Department may miss opportunities to improve its treatment programming—Literature indicates that juvenile justice agencies should use information from performance measurement and outcome evaluations to identify opportunities to improve treatment programming and inform juvenile justice policy decisions.[58] Absent a comprehensive set of treatment programming outcomes and without conducting targeted outcome evaluations, the Department may miss opportunities to make programming implementation adjustments or inform policy decisions. For example, the Washington State Juvenile Rehabilitation Administration contracted for an outcome evaluation of its ART program, which found that male ART participants were significantly more likely to recidivate than similar youth who did not participate in ART.[59] In response to these types of evaluation findings, potential programming implementation adjustments might include modifying treatment intervention procedures, discontinuing and/or replacing ineffective treatment interventions, identifying different treatment interventions for certain youth populations, and/or providing further training and coaching to staff who deliver treatment interventions.[60] Further, if the Department's evaluations indicated that some youth who are released because of age after short stays in the Facility are not generally making rehabilitative progress, policymakers could potentially use this information to inform statutory changes related to providing services to these youth after release.

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[57] JJEC, 2004; Lipsey, Howell, Kelly, Chapman, & Carver, 2010; Pew-MacArthur Results First Initiative, 2014; Pew-MacArthur Results First Initiative, 2018.

[58] Fratello, Kapur, & Chasan, 2013; Morris, Day, & Schoenwald, 2010; Pew-MacArthur Results First Initiative, 2018; Walker, Bumbarger, & Phillippi, 2015.

[59] Knoth, L., Wanner, P., & He, L. (2019). *Washington state's Aggression Replacement Training for juvenile court youth: Outcome evaluation*. Olympia, WA: Washington State Institute for Public Policy. Retrieved 7/12/21 from http://www.wsipp.wa.gov/Publications?reportId=628.

[60] Juvenile justice literature states that evidence-based treatments have core components that should be adhered to with fidelity. However, evidence-based treatments may also have elements that can be adapted for a local context. For example, the Department reported that DBT facilitators are given flexibility in the language and examples they are permitted to use in group treatment sessions to make the DBT content more understandable for some youth. Literature indicates that agencies should assess whether adapted treatment programming still produced desired rehabilitative outcomes. See James Bell Associates. (2009). *Evaluation brief: Measuring implementation fidelity*. Arlington, VA. Retrieved 4/30/20 from https://www.acf.hhs.gov/cb/resource/measuring-implementation-fidelity; Morris, Day, & Schoenwald, 2010; Pew-MacArthur Results First Initiative, 2014.

Department recognizes value of developing outcome measures and conducting outcome evaluations, but indicated doing so is not easily accomplished; other states we reviewed have additional outcome measures and perform outcome evaluations

Although the Department reported that it recognizes the value of developing outcome measures and conducting large-scale outcome evaluations, it indicated that doing so is not easily accomplished. For example, it cited a partnership between the Department and the National Council on Crime and Delinquency from 1996 through 2003 that attempted to develop outcome measures that it reported succeeded only in determining how to measure recidivism. Although the partnership's first annual report issued in 1997 included several recommendations for potential performance-based outcome measures, subsequent partnership reports we reviewed did not comment on any further discussion or approval of performance-based outcome measures.[61] Additionally, the Department reported that designing and conducting outcome evaluations is extremely complex, and requires extensive planning to establish the infrastructure to ensure appropriate data is available to produce information that is valid, meaningful, and actionable.

To help address these obstacles, the Department could review other states' efforts to develop and use outcome measures and/or conduct outcome evaluations and may be able to obtain assistance from external entities to develop outcome measures and conduct outcome evaluations. Specifically, we identified other state juvenile justice agencies that have incorporated youth treatment programming outcomes into their performance measurement systems or have conducted outcome evaluations to help assess the effectiveness of their rehabilitative programs for youth.[62] For example, some states:

- **Track changes in risk scores to assess treatment programming's effectiveness in reducing youths' recidivism risk and other risk factors—**As previously discussed (see page 20), because certain risk factors are associated with youth delinquency, assessing whether treatment programming has reduced youths' risk factors can provide information on whether long-term outcomes, such as reduced delinquency or recidivism, are likely to be achieved. Juvenile justice agencies in Colorado and Idaho track changes in youths' assessed risk to recidivate during their time in secure confinement, including changes in youths' overall assessed risk to recidivate and individual risk factors.[63] Specifically:

    - Colorado tracks and publicly reports the percentage of youth in its care assessed as high, medium, and low risk for recidivating at both entry to secure care and discharge from the juvenile justice system, and the percentage of youth assessed as high risk for individual risk factors such as aggression.[64] In addition, Colorado reports on the percentage of youth whose assessed risk level for recidivating decreased between their entry to secure care and the time of discharge.

    - Idaho tracks and publicly reports the percentage of youth in each fiscal year whose assessed risk to recidivate was reduced prior to being released from a secure care facility.

- **Track successful completion of treatment programming as an indicator of youths' reduced risk—**As previously discussed (see page 20), assessing positive changes in youth behaviors and attitudes intended to reduce youths' delinquency/recidivism risks can also provide information on whether long-term outcomes, such as reduced delinquency or recidivism, are likely to be achieved. Juvenile justice agencies in Idaho and Texas track and publicly report the percentage of youth who successfully complete treatment programming

[61] The Department was able to provide excerpts of the 1997, 1999, 2002, and 2003 annual reports for our review.

[62] Similar to the Department, the state juvenile justice agencies we contacted in Colorado, Idaho, and Texas operate secure care facilities for delinquent youth. However, because of differences between these states and Arizona, including differences in the populations of youth committed to secure care, the performance measures implemented in other states are presented for informational purposes rather than as specific recommendations for the Department to follow.

[63] These states' risk assessments classify youths' risk to recidivate into categories that indicate risk level, such as high, medium, and low.

[64] Colorado reports risk information for a combined group of youth discharged during the 3 most recent fiscal years.

prior to release to show that youth have sufficiently demonstrated the relevant behaviors, skills, and/or knowledge learned through treatment programming that are intended to address specific risk factors.[65]

- **Conduct targeted outcome evaluations as an indicator of treatment programming's effectiveness in rehabilitating youth—**Outcome evaluations can help determine whether observed outcomes resulted directly from participation in treatment programming. For example, as previously discussed, the Washington State Juvenile Rehabilitation Administration contracted for an outcome evaluation of its ART program and found that that female ART participants were significantly less likely to recidivate than similar youth who did not participate in ART, whereas male ART participants were significantly more likely to recidivate than similar youth who did not participate in ART.[66]

Finally, the Department could seek assistance from federal government organizations such as the Office of Juvenile Justice and Delinquency Prevention (OJJDP), State government organizations such as the Arizona Criminal Justice Commission, universities and other academic institutions, or professional organizations such as the Council of Juvenile Justice Administrators.[67,68,69] Literature also notes that some private foundations and government agencies offer research and evaluation grant opportunities that the Department could explore to help fund outcome evaluations.[70]

Recommendations

The Department should:

4. 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.

5. 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.

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

Department response: As outlined in its **response**, the Department agrees with the finding and will implement or implement in different manner the recommendations.

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[65] According to the Texas Juvenile Justice Department, it publicly reports on successful completion for youth in specialized treatment programming, such as treatment programming for sexual behavior and alcohol or other drug use.

[66] Knoth, Wanner, & He, 2019. Washington's 2018 outcome evaluation assessed if its ART program significantly reduced the likelihood of recidivism; if the effects of ART varied between youth of different risk levels, gender, and racial groups; and if the effects of ART depended on other factors, such as the competency levels of treatment session facilitators.

[67] The OJJDP is part of the U.S. Department of Justice, Office of Justice Programs. According to OJJDP's website, its work includes preventing juvenile delinquency, improving the juvenile justice system, and protecting children, which it accomplishes by supporting states and local communities in their efforts to develop and implement effective programs for youth. In addition, OJJDP's website indicates it sponsors research and training initiatives, disseminates information about juvenile justice issues, and awards funds to states to support local programming.

[68] The Arizona Criminal Justice Commission is established by A.R.S. §41-2401 et seq., and its responsibilities include facilitating research among the State's criminal justice agencies, coordinating efforts to improve criminal justice information and data sharing, and overseeing the work of the Arizona statistical analysis center, which provides statistical research and analysis related to the criminal justice system in Arizona.

[69] The Council of Juvenile Justice Administrators is a national nonprofit organization with a mission to improve juvenile justice systems, secure care facilities, services, programs, and long-term youth outcomes, which it achieves through educational activities, research, and technical assistance projects. The Council of Juvenile Justice Administrators has formed a Positive Youth Outcomes Committee to develop guidelines on appropriate and useful methods for collecting and analyzing positive youth outcome data within juvenile correctional agencies.

[70] Fratello, Kapur, & Chasan, 2013.

Auditor General makes 5 recommendations to the Department

The Department should:

1. 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.

    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 (see Finding 1, pages 8 through 12, for more information).

2. Implement its revised CPC evaluation policy and procedures to help ensure it addresses all actionable CPC evaluation report recommendations (see Finding 2, pages 13 through 18, for more information).

3. 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 (see Finding 2, pages 13 through 18, for more information).

4. 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 (see Finding 3, pages 19 through 25, for more information).

5. 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.

    b. Prioritize and conduct outcome evaluations it identifies through its planning process (see Finding 3, pages 19 through 25, for more information).

Staff responsibilities for youth treatment interventions

As discussed in the Introduction (see page 3), various Department staff provide group and individual treatment interventions to help address youths' specific treatment needs. Figure 2 provides information about Department staff who facilitate and oversee youth treatment interventions.

Figure 2
Staff involved in treatment intervention delivery

Housing unit staff	
Youth Program Officer (YPO)	Provides case management for youth and is generally responsible for facilitating group treatment sessions for ART, DBT, and Seven Challenges. YPOs receive training for the group treatment sessions they facilitate.
Youth Corrections Officer (YCO)	Provides direct supervision of youth and manages the day-to-day movement of youth throughout the Facility. YCOs may also request to facilitate group treatment sessions for ART, DBT, and Seven Challenges. YCOs receive training for the group treatment sessions they facilitate.
Clinical staff	
Psychology Associate (PSA)	Observes and assesses the quality of group treatment sessions facilitated by YPOs and YCOs (see Finding 1, pages 9 through 10, for information on these assessments), conducts youths' individual therapy sessions, facilitates STAR group treatment sessions, and facilitates some ART, DBT, and Seven Challenges group treatment sessions. PSAs are mental health professionals licensed by the Arizona Board of Behavioral Health Examiners.[1]
Psychologist	Supervises PSAs and oversees the delivery of all psychological services in the Facility, including the facilitation of group treatment sessions. Psychologists are mental health professionals licensed by the Arizona Board of Psychologist Examiners.[2]

[1] According to the Department, PSAs hold various licenses issued by the Arizona Board of Behavioral Health Examiners, including Associate Counselor, Professional Counselor, Master Social Worker, Clinical Social Worker, and Independent Substance Abuse Counselor.

[2] According to A.R.S. §32-2071, licensed psychologists must have a doctoral degree in clinical or counseling psychology, school or educational psychology, or another subject in applied psychology acceptable to the Arizona Board of Psychologist Examiners.

Source: Auditor General staff review of Department policies, Department-provided information, and interviews with Department staff.

Department fidelity-assessment checklists

Figures 3, 4, and 5 present the items contained within the Department's fidelity checklists for ART, DBT, and Seven Challenges group treatment sessions, respectively.[71]

Figure 3
ART group session fidelity checklist items—Social skills training group sessions

Checklist item	Yes	No
Was a positive climate established through welcoming youths?	☐	☐
Were any issues since the last social skills training session dealt with?	☐	☐
Were group norms reviewed, emphasizing positive participation?	☐	☐
Did most youth complete the Social Skills Practice Sheet?	☐	☐
Were the Social Skills Practice Sheets used to review last week's social skill?	☐	☐
Were homework efforts appropriately and genuinely acknowledged?	☐	☐
Were homework achievements rewarded?	☐	☐
Were the Social Skills Sheet collected or kept in the youths' folders?	☐	☐
Were visual aids used (skill cards distributed and social skill title and steps displayed)?	☐	☐
Was the new social skill correctly introduced, defined, and briefly explained in understandable language?	☐	☐
Was the new social skill perfectly demonstrated by the facilitator and co-facilitator using a relevant adolescent situation?	☐	☐
Did someone point to the social skill steps during the demonstration and practices?	☐	☐
Did each youth express how the social skill could be personally useful?	☐	☐
Did each youth correctly practice the social skill as the main actor?	☐	☐
Did each youth pick their own practice partner?	☐	☐
Did each youth provide performance feedback?	☐	☐
Skill steps read to the class by the assigned youth during performance feedback?	☐	☐
Was the order of performance feedback correct (co-actor, group members, co-facilitator, facilitator, main actor)?	☐	☐
Were new Social Skills Sheets given to each youth requiring the top section filled out?	☐	☐
Was behavior appropriately managed?	☐	☐
Did the session pace keep the youths interested and active?	☐	☐
Did the youths appear to understand the skill being taught in this session?	☐	☐
Does primary facilitator interact with the youth in a positive manner?	☐	☐
Does the co-facilitator interact with the youth in a positive manner?	☐	☐
Does the co-facilitator aid the facilitator in delivering the curriculum?	☐	☐

Source: Department's ART fidelity checklists.

[71] ART is divided into 3 components—social skills training, anger control training, and moral reasoning—and Department staff use a separate fidelity-assessment checklist for each component. We have included the fidelity assessment checklist for the first component, social skills training.

Figure 4
DBT group session fidelity checklist items

Checklist item	Yes	No
Were group rules/norms reviewed?	☐	☐
Was a mindfulness exercise completed?	☐	☐
Did a brief discussion of how the exercise was mindful occur?	☐	☐
Did the mindfulness exercise and the discussion not exceed approximately 10 minutes?	☐	☐
Were homework assignments reviewed for each youth?	☐	☐
Was a brief verbal Behavior Chain Analysis completed for any youth who did not do his/her homework?	☐	☐
If a youth identified being "unsuccessful" in attempting their homework, was this addressed?	☐	☐
Did the primary facilitator teach new material?	☐	☐
Did the new material follow the Adolescent Manual and the DBT Skills Training Group: Table of Contents format?	☐	☐
Did the primary facilitator provide examples, stories, handouts, visual aids, etc. to explain concepts in a manner that the youth could understand?	☐	☐
Did the primary facilitator check for youth understanding of the material?	☐	☐
Was the material connected with criminal, delinquent, or unhealthy behaviors?	☐	☐
Was the material for the entire session covered?	☐	☐
Was homework assigned relating to the new material taught?	☐	☐
Did youth appear engaged in group?	☐	☐
Was the pace of the group appropriate?	☐	☐
Was appropriate behavior and participation acknowledged and praised?	☐	☐
Was a co-facilitator present for the entire duration of group?	☐	☐
Did the co-facilitator appropriately manage behavior?	☐	☐
Were youth redirected to address personal issues in other settings if he or she attempted to process during this group?	☐	☐
Was the number of youth in group at or below 12 to 16 youth?	☐	☐
Was the group held for a minimum of 45 minutes (for 12 or fewer youth)?	☐	☐
Was 5 minutes added for each additional youth (from 13 to 16 youth)?	☐	☐

Source: Department's DBT fidelity checklist.

Figure 5
Seven Challenges group session fidelity checklist items

Checklist item	Yes	No
Did the session start with a Seven Challenges welcoming statement?	☐	☐
Were group rules/norms reviewed?	☐	☐
Were all youth asked to "check-in"?	☐	☐
Did the "check-in" involve rating their emotions/current state in some way?	☐	☐
Was the "check-in" brief?	☐	☐
Was each youth specifically asked, "What do you want to work on today?"	☐	☐
Did all youth have a Seven Challenges book of readings?	☐	☐
If a reading was completed, was it relevant to the group topic?	☐	☐
Was there an appropriate balance of youth-initiated work and counselor-initiated work?	☐	☐
If the group was mostly or all counselor-initiated, was there a valid explanation for this?	☐	☐
For youth who identified work, was it clarified, a session goal established, possibilities considered, resolution achieved, and ended with closure?	☐	☐
Did the youth make frequent connections to the Seven Challenges?	☐	☐
Did the facilitator make frequent connections to the Seven Challenges?	☐	☐
Did the facilitator encourage youth to provide feedback to one another?	☐	☐
Did youth appear engaged in group?	☐	☐
Was the pace of the group appropriate?	☐	☐
Was appropriate behavior and participation acknowledged and praised?	☐	☐
Was behavior appropriately managed?	☐	☐
Was the Seven Challenges poster visible in the room?	☐	☐
Was the Working Sessions poster visible in the room?	☐	☐
Were group rules/norms posted in the room?	☐	☐
Was the number of youth in group at or below 10 youth?	☐	☐
Was the group held for a minimum of 45 minutes?	☐	☐
Does the group only consist of youth with SL1 and/or SL2 classifications?	☐	☐
Is journaling time provided each week? If yes, when?	☐	☐
If facilitator is not a Leader, does a Leader observe their group at least once a quarter?	☐	☐

Source: Department's Seven Challenges fidelity checklist.

Content and content delivery order requirements for ART social skills training group treatment sessions

The Department's ART treatment intervention includes 3 components—social skills training, anger control training, and moral reasoning—and each component should be delivered in a group treatment setting once per week over a 10-week period. The ART treatment intervention manual outlines the required order of group treatment sessions for each component and specific steps for delivering each individual group treatment session within each component. See Table 3 for information on the required order of content for ART group treatment sessions in the social skills training component, and see textbox, page c-2, for an example of required content for 1 social skills training group treatment session.

Table 3
ART social skills training group session weekly content and required delivery order

Week	Content order (1 topic per week)[1]
1	• Making a complaint
2	• Responding to failure • Dealing with an accusation
3	• Dealing with someone else's anger • Dealing with embarrassment
4	• Getting ready for a difficult conversation • Dealing with group pressure • Keeping out of fights
5	• Dealing with group pressure • Apologizing • Avoiding trouble with others • Being a good sport
6	• Deciding what caused a problem • Negotiating • Apologizing • Setting a goal
7	• Dealing with an accusation • Getting ready for a difficult conversation
8	• Responding to failure • Keeping out of fights
9	• Understanding the feelings of others • Dealing with an accusation
10	• Expressing affection/appreciation

[1] ART social skills training group facilitators select 1 of the social skills for weeks with multiple content options.

Source: Auditor General staff review of Department's ART facilitator manual.

Example outline for facilitating ART social skills training group session (week 2)

1. Set the climate by greeting youth and focusing their attention.
2. Review group rules.
3. Review the skill introduced in previous week's session ("making a complaint"), including acknowledging youth who successfully practiced this skill.
4. Introduce this week's skill: either "responding to failure" or "dealing with an accusation."
5. Demonstrate the skill to youth.
6. Discuss the need for this skill with each youth.
7. Practice the skill with the youth, including helping youth choose situations for acting out and practicing that skill and requiring other youth to observe the practice session.
8. Provide feedback to youth after practicing the skill.
9. Repeat steps 7 and 8 for each youth being the main actor in a skill practice session.
10. Remind youth to practice the skill throughout the week.

Source: Auditor General staff review of Department's ART facilitator manual.

Scope and methodology

The Arizona Auditor General has conducted this performance audit of the Department's processes for evaluating its youth treatment programming pursuant to a September 14, 2016, resolution of the Joint Legislative Audit Committee. The audit was conducted as part of the sunset review process prescribed in A.R.S. §41-2951 et seq.

We used various methods to study the issues addressed in this performance audit. These methods included reviewing the Department's statutes, website, policies and procedures, and reports; interviewing Department staff; and reviewing recommended practices for evaluating evidence-based programs. In addition, we used the following specific methods to meet the audit objectives:

- To assess the Department's processes for monitoring and measuring treatment intervention fidelity, we reviewed fidelity assessments and QA inspections the Department conducted of its treatment interventions over a 3-month period. Specifically, we reviewed:
    - Checklists for the 73 fidelity assessments conducted by Department clinical staff from January through March 2020.
    - QA inspection reports for 10 Facility housing units from weekly inspections conducted over the 12-week period from January 1 through March 31, 2020.

  Additionally, we reviewed 3 Department Administrative Incident Reports from April 2020 related to DBT delivery deficiencies and reviewed recommended practices for monitoring and measuring treatment program fidelity.[72]
- To assess the Department's use of the CPC, we reviewed the 3 most recent CPC evaluation reports and related documentation from CPC housing unit evaluations the Department conducted in 2017 and 2018.[73] We also reviewed information from the CPC developer—The University of Cincinnati Corrections Institute—and literature describing the purpose of evaluations such as the CPC.[74,75]

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[72] Bond, G.R. & Drake, R.E. (2020). Assessing the fidelity of evidence-based practices: History and current status of a standardized measurement methodology. *Administration and Policy in Mental Health and Mental Health Services Research*, 47, 874-884; Borrelli, B. (2011). The assessment, monitoring, and enhancement of treatment fidelity in public health clinical trials. *Journal of Public Health Dentistry*, 71, S52-S63; Durlak, J.A. & DuPre, E.P (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, 41, 327-350; James Bell Associates. (2009). *Evaluation brief: Measuring implementation fidelity*. Arlington, VA. Retrieved 4/30/20 from https://www.acf.hhs.gov/cb/resource/measuring-implementation-fidelity; Morris, J.A., Day, S., & Schoenwald, S.K. (eds.). (2010). *Turning knowledge into practice: A manual for human service administrators and practitioners about understanding and implementing evidence-based practices*, (2nd ed.). Boston, MA: The Technical Assistance Collaborative. Retrieved 4/16/20 from http://www.modelsforchange.net/publications/281; Wilczynski, S.M. (2017). Progress Monitoring. In *A practical guide to finding treatments that work for people with autism* (pp. 75-86). Academic Press.

[73] We reviewed the Department's evaluation reports for CPC evaluations of the Department's specialized housing unit for youth with significant mental health needs conducted in 2017, the Department's specialized housing unit for youth with sexually abusive behaviors conducted in 2018, and the Department's specialized housing unit for youth who violated parole conducted in 2018. In addition, we reviewed any documentation the Department could provide related to corrective actions and follow-up evaluations it completed in response to the results of these CPC evaluations.

[74] University of Cincinnati Corrections Institute (UCCI). (n.d.). *CPC: Evidence-based correctional program checklist*. Cincinnati, OH. Retrieved 6/10/20 from https://cech.uc.edu/about/centers/ucci/products/evaluations.html.

[75] Lipsey, M.W., Howell, J.C., Kelly, M.R., Chapman, G., & Carver, D. (2010). *Improving the effectiveness of juvenile justice programs: A new perspective on evidence-based practice*. Washington, DC: Center for Juvenile Justice Reform. Retrieved 4/17/20 from https://cjjr.georgetown.edu/resources/publications/; Seigle, E., Walsh, N., & Weber, J. (2014). *Core principles for reducing recidivism and improving other outcomes for youth in the juvenile justice system*. New York, NY: Council of State Governments Justice Center. Retrieved 3/27/20 from https://csgjusticecenter.org/publications/juvenile-justice-white-paper/.

- To determine whether the Department's evaluation of youth treatment outcomes was consistent with recommended practices, we compared the Department's evaluation practices against recommended practices and other research related to outcome evaluations, performance measurement, and youth rehabilitation.[76,77] Further, we judgmentally selected juvenile justice agencies in 4 western states—Colorado, Idaho, Texas, and Washington—and obtained information on how these agencies use performance measurement and outcome evaluations related to youth treatment programming.[78]

- To obtain information for the Introduction, we reviewed research studies that describe ART, DBT, and Seven Challenges program effectiveness on specific research populations and reviewed program materials related to Stages of Accomplishment and STAR.[79] We also reviewed information on cognitive behavioral therapy, the purpose of juvenile justice systems, and youth recidivism risk factors.[80,81]

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[76] We reviewed the importance of measuring treatment program outcomes in both general circumstances and in juvenile justice settings from the following sources: Fratello, J., Kapur, T.D., & Chasan, A. (2013). *Measuring success: A guide to becoming an evidence-based practice*. Brooklyn, NY: Vera Institute of Justice. Retrieved 4/16/20 from http://www.modelsforchange.net/publications/463; Juvenile Justice Evaluation Center. (JJEC). (2004). *Approaches to assessing juvenile justice program performance*. Washington, DC: Justice Research and Statistics Association. Retrieved 6/7/21 from https://www.jrsa.org/pubs/juv-justice/approaches_assessing.pdf; Lipsey, M.W., Conly, C.H., Chapman, G., & Bilchik, S. (2017). *Juvenile justice system improvement: Implementing an evidence-based decision-making platform*. Washington, DC: Center for Juvenile Justice Reform. Retrieved 4/16/20 from https://www.ojp.gov/pdffiles1/ojjdp/grants/250443.pdf; Morris, Day, & Schoenwald, 2010; Office of Juvenile Justice and Delinquency Prevention (OJJDP). (n.d.). *OJJDP model programs guide glossary*. Washington, DC. U.S. Department of Justice. Retrieved 4/30/20 from https://www.ojjdp.gov/MPG/Resource/Glossary; Pew-MacArthur Results First Initiative. (2014). *Evidence-based policymaking: A guide for effective government*. Washington, DC & Chicago, IL: The Pew Charitable Trusts & The John D. and Catherine T. MacArthur Foundation. Retrieved 9/1/20 from https://www.pewtrusts.org/en/research-and-analysis/reports/2014/11/evidence-based-policymaking-a-guide-for-effective-government; Pew-MacArthur Results First Initiative. (2018). *The role of outcome monitoring in evidence-based policymaking: How states can use performance management systems to achieve results*. Washington, DC & Chicago, IL: The Pew Charitable Trusts & The John D. and Catherine T. MacArthur Foundation. Retrieved 9/4/20 from https://www.pewtrusts.org/-/media/assets/2018/08/rf_outcome_monitoring-brief_v4.pdf; Walker, S.C., Bumbarger, B.K., & Phillippi Jr., S.W. (2015). Achieving successful evidence-based practice implementation in juvenile justice: The importance of diagnostic and evaluative capacity. *Evaluation and Program Planning*, 52, 189-197.

[77] We reviewed the following sources to better understand youth rehabilitation and the limitations of using recidivism as an outcome indicator related to youth rehabilitation: Butts, J.A., Pelletier, E., & Kazemian, L. (2018). *Positive outcomes: Strategies for assessing the progress of youth involved in the justice system*. New York, NY: Research and Evaluation Center, John Jay College of Criminal Justice, City University of New York. Retrieved 5/7/20 from https://johnjayrec.nyc/2018/02/01/positiveoutcomes2018/; Butts, J.A., & Schiraldi, V. (2018). *Recidivism reconsidered: Preserving the community justice mission of community corrections*. Cambridge, MA: Harvard Kennedy School. Retrieved 5/7/20 from https://johnjayrec.nyc/2018/03/15/recidivism-reconsidered/; Harris, P.W., Lockwood, B., Mengers, L., & Stoodley, B.H. (2011). Measuring recidivism in juvenile corrections. *Office of Juvenile Justice and Delinquency Prevention (OJJDP) Journal of Juvenile Justice*, 1(1), 1-16.

[78] To learn more about other states' use of treatment outcomes, we interviewed staff from the Colorado Department of Human Services, Office of Children, Youth and Families, Division of Youth Services; the Idaho Department of Juvenile Corrections; and the Texas Juvenile Justice Department. In addition, we researched the Washington State Juvenile Rehabilitation Administration's use of outcome evaluations. For example, see Knoth, L., Wanner, P., & He, L. (2019). *Washington state's Aggression Replacement Training for juvenile court youth: Outcome evaluation*. Olympia, WA: Washington State Institute for Public Policy. Retrieved 7/12/21 from http://www.wsipp.wa.gov/Publications?reportId=628.

[79] Gundersen, K., & Svartdal, F. (2006). Aggression Replacement Training in Norway: Outcome evaluation of 11 Norwegian student projects. *Scandinavian Journal of Education Research*, 50(1), 63-81; Korchmaros, J.D. (2018). Examining the effectiveness of the Seven Challenges comprehensive counseling program with adolescents. *Journal of Social Work Practice in the Addictions*, 18(4), 411-431; McCauley, E., Berk, M., & Asarnow, J. (2018). Efficacy of dialectical behavior therapy for adolescents at high risk for suicide: A randomized clinical trial. *JAMA Psychiatry*, 75(8), 777-785; Mehlum, L., Ramberg, M., Tormoen, A.J., Haga, E., Diep, L.M., et al. (2016). Dialectical behavior therapy compared with enhanced usual care for adolescents with repeated suicidal and self-harming behavior: Outcomes over a one-year follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry*, 55(4), 295-300; Smith, D.C., Hall, J.A., Williams, J.K., An, H., & Gotman, N. (2010). Comparative efficacy of family and group treatment for adolescent substance abuse. *The American Journal on Addictions*, 15(1), 131-136; Stevens, S.J., Schwebel, R., & Ruiz, B. (2006). The Seven Challenges: An effective treatment for adolescents with co-occurring substance abuse and mental health problems. *Journal of Social Work Practice in the Addictions*, 7(3), 29-49; Washington State Institute for Public Policy. (2004). *Outcome evaluation of Washington state's research-based programs for juvenile offenders*. Olympia, WA. Retrieved 8/27/20 from http://www.wsipp.wa.gov/ReportFile/852.

[80] American Psychological Association (APA). (2017). *What is Cognitive Behavioral Therapy?* Retrieved 4/1/21 from https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral#; Beck, J.S. (2011). *Cognitive Behavior Therapy: Basics and beyond* (2nd ed.). Guilford Press.

[81] Butts & Schiraldi, 2018; Council of State Governments Justice Center. (2014). *Measuring and using juvenile recidivism data to inform policy, practice, and resource allocation*. New York, NY. Retrieved 3/2/2020 from https://csgjusticecenter.org/publications/measuring-juvenile-recidivism/; Harris, P.W., Lockwood, B., & Mengers, L. (2009). *A CJCA white paper: Defining and measuring recidivism*. Braintree, MA: Council of Juvenile Correctional Administrators. Retrieved 5/7/20 from http://cjca.net/wp-content/uploads/2018/02/CJCA-Recidivism-White-Paper.pdf; Lipsey, Conly, Chapman, & Bilchik, 2017; Lipsey, Howell, Kelly, Chapman, & Carver, 2010; Crime and Justice Institute (CJI). (2004). *Implementing evidence-based practice in community corrections: The principles of effective intervention*. Boston, MA. Retrieved 4/17/20 from https://nicic.gov/implementing-evidence-based-practice-community-corrections-principles-effective-intervention.

- Our work on internal controls, including information system controls, involved reviewing the Department's policies and procedures and, where applicable, testing the Department's compliance with these policies and procedures; reviewing the Department's processes for monitoring its performance; and interviewing Department staff about their responsibilities. We reported our conclusions on applicable internal controls in Findings 1, 2, and 3.

We selected our audit samples to provide sufficient evidence to support our findings, conclusions, and recommendations. Unless otherwise noted, the results of our testing using these samples were not intended to be projected to the entire population.

We conducted this performance audit of the Department in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We express our appreciation to the Department Director and staff for their cooperation and assistance throughout the audit.

Auditor General's comments on Department response

We appreciate the Department's response including its agreement with most of the audit findings and its plan to implement or implement in a different manner our recommendations. However, the Department's response includes several statements that necessitate the following comments and clarifications.

1. The Department makes several statements in its response indicating its existing processes are sufficient to address and/or mitigate the deficiencies we identified in our report. In addition, the Department's response suggests that the documentation it provided was sufficient to reflect its existing processes and that we did not review some of its processes.

   We disagree that the Department's existing processes are sufficient to address and/or mitigate the deficiencies we identified in our report and that we did not review some of its processes relevant to our findings and conclusions. Throughout our audit, on multiple occasions we discussed with Department staff the deficiencies we found, the information we had reviewed to come to our conclusions, and our recommendations for correcting the identified problems. We also fully assessed any additional information the Department provided and revised our report accordingly, including reflecting any relevant information about its existing processes in our report.

2. The Department makes the following statement related to its consistent adoption of the latest research (see Department response, page 2):

   "ADJC responded to a recent study mentioned in the report about Washington State Aggression Replacement Therapy by exploring available options and working to replace our program with a more effective one."

   Although we appreciate the Department reviewing the report's example regarding Washington State Juvenile Rehabilitation Administration's outcome evaluation of its ART program, we are concerned the Department is not fully evaluating its own programs before taking action to modify or replace those programs. We included the Washington State Juvenile Rehabilitation Administration's outcome evaluation of its ART program in the report as an example of how another state had assessed and determined the effectiveness of its treatment programming for its youth population rather than to suggest that ART is not an effective program for the Department's youth population. However, the Department's response indicates that it plans to take action and replace its ART program based on Washington State's assessment of the ART program's effectiveness for its population. This reported action illustrates why we recommended that the Department develop and implement a plan for establishing and tracking additional outcome measures and conducting outcome evaluations related to its treatment programming to determine its effectiveness for the Department's youth population.

3. The Department makes the following statement related to treatment programming attendance (see Department response, pages 3 through 4):

   "Fidelity refers to the degree to which the treatment program is being delivered in accordance with the guidance and parameters of the program… However, missing a treatment session is not a breach of fidelity, and youth who miss treatment sessions are provided opportunities to make these sessions up."

   We disagree with the Department's definition of fidelity and that missing treatment sessions are not a breach of fidelity. As discussed in our report (see Finding 1, page 9), literature's definition of fidelity

includes multiple components, including participants' exposure to the prescribed amount of treatment, such as through attendance in treatment sessions at the required frequency and duration. By not attending treatment sessions, youth may not receive treatment at the required frequency and duration and thus may not receive treatment with fidelity. Further, for some of the youth who the Department identified as having missed treatment sessions, the Department stated only that the youth had an opportunity to make up the missed sessions, not that the youth completed missed treatment sessions. Providing youth the opportunity to attend treatment sessions does not ensure youth received treatment at the required frequency and duration and thus is not sufficient to ensure youth received treatment programming with fidelity. Specifically, as noted in our report, between January through March 2020, Department Quality Assurance (QA) inspection reports we reviewed found that 3 of 10 inspected housing units repeatedly failed to provide youth with the frequency and/or duration of group treatment sessions required by Department policies during this 12-week period (see Figure 1, page 11). For example, 1 housing unit did not provide the required frequency and/or duration of group treatment sessions to between 10 and 80 percent of the youth QA staff reviewed for 7 of the 12 weeks.

4. The Department's response asserts that it adheres to "industry standards" for evaluating its treatment programming's effectiveness (see pages 2 and 7).

   Although the Department's response asserts that it follows industry standards, the Department failed to identify these standards during the audit and similarly failed to do so in its response. As noted in our report, we considered recommended practices from multiple sources within the juvenile and criminal justice fields, including the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention, the Council of State Governments Justice Center, the Justice Research and Statistics Association, the Center for Juvenile Justice Reform, the Vera Institute of Justice, and the Crime and Justice Institute.

DEPARTMENT RESPONSE

ARIZONA DEPARTMENT OF JUVENILE CORRECTIONS

DOUGLAS A. DUCEY
Governor

JEFF HOOD
Director

September 29, 2021

Ms. Lindsey A. Perry, Auditor General
Arizona Office of the Auditor General
2910 N. 44th Street, Suite 410
Phoenix, AZ 85018

Re: Youth Treatment Programming Audit

Dear Ms. Perry:

The Arizona Department of Juvenile Corrections (ADJC) appreciates the efforts of the Office of the Auditor General (OAG) in providing a valuable review and constructive analysis of our internal processes for evaluating our treatment programming. ADJC agrees with many of the OAG's recommendations and has already implemented some of them. ADJC appreciates the opportunity to engage with the OAG prior to the publication of this report; however, we would like to summarize some of our remaining concerns with the findings and recommendations and the way they are presented. Additionally, the performance audit report Title Page and Highlights have not been provided and therefore comments on these sections of the report are not included in the following response.

ADJC is committed to providing high-quality treatment to the youth in our care that is both grounded in evidence-based practices and produces desired outcomes. Ultimately, the desired outcome is youth rehabilitation, consistent with our mission to lead youth to become productive, healthy, law-abiding members of society. ADJC takes the effectiveness of our treatment programming very seriously and prioritizes the ongoing adoption of evolving best practices. Through the use of our Readiness for Release "Phases" system, every individual youth is provided with the best possible opportunity to receive the programming and services most likely to help them succeed in the community.

Because ADJC stays abreast of evidence-based practices, we are confident that our evidence-based treatment programs are producing the desired outcomes for youth. While we appreciate the auditors' recommendation that we develop additional measures to demonstrate ADJC's effectiveness in rehabilitating youth, we would like to emphasize that the programs ADJC employs at Adobe Mountain School have been studied and shown by empirical research to have the desired outcomes when delivered according to program design. Conducting outcome evaluations of these programs is more complex than the audit report suggests. Further, although the report suggests ADJC may have insufficient information on effectiveness warranting the need for additional measures and evaluations, ADJC routinely assesses and tracks whether treatment is effectively rehabilitating each individual youth through case plans and progress notes in line with industry standards. We would also like to emphasize that, although the report indicates that educational achievement and employment measures are not outcomes directly related to treatment programming, ADJC, consistent with the recommended best practices, measures, tracks, and attempts to improve youth's performance in these two critical areas and sees success in these areas as directly related to treatment programming effectiveness.

In order to ensure evidence-based treatment programs are delivered as designed, ADJC utilizes robust fidelity, quality assurance, and evaluation processes, consistent with best practices. ADJC employs qualified mental health staff to deliver and oversee treatment programming and stays abreast of the latest developments in proven, effective programs found to successfully rehabilitate youth. In addition to treatment programs, ADJC also maintains an exceptional ratio of one qualified mental health professional to every twelve youth at Adobe Mountain School, which provides greater time for and attention to each youth's individualized needs.

ADJC also incorporates emerging best practices into our programming as evidenced by the numerous advancements made in just the last few years. ADJC trains all clinicians in and began offering Eye Movement Desensitization and Reprocessing therapy (EMDR) to youth, which is a form of psychotherapy used to help clients process and heal from traumatic life events. We are currently implementing neurofeedback therapy and Comprehensive Dialectical Behavioral Therapy (DBT), expanding upon the DBT program already in place. We are also in the beginning stages of building upon our existing trauma-informed care components and expanding our trauma-informed practices. Further exemplifying ADJC's consistent adoption of the latest research, ADJC responded to a recent study mentioned in the report about Washington State Aggression

Replacement Therapy by exploring available options and working to replace our program with a more effective one.

As acknowledged in the report, ADJC's treatment program array is limited to programs that are grounded in evidence-based practice. We have robust processes in place to ensure ADJC's evidence-based programming is delivered as designed in order to yield the desired results. These processes include ongoing internal fidelity checks, continual quality assurance monitoring, routine clinical supervision, regular reviews by the Clinical Director, program evaluation using the Correctional Program Checklist (CPC), and visits from the program designers and consultants who provide onsite training and verification of fidelity, some of which were not reviewed during the course of this audit. ADJC also utilizes the Arizona Management System to measure performance and problem solve using data and trend analysis. Collectively, these mechanisms and tools provide comprehensive information about ADJC's programming to ensure programs are being delivered with fidelity and deficiencies are discovered and corrected.

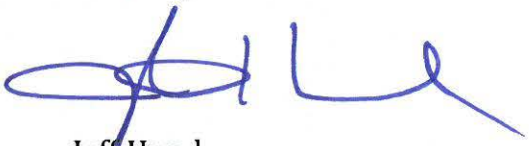
ADJC is concerned that, while the report correctly identifies frequency and duration of group sessions as important measures of fidelity, the report's concern for and attention to youth absences from treatment sessions is mis-placed. Fidelity refers to the degree to which the treatment program is being delivered in accordance with the guidance and parameters of the program. Youth attendance is a separate measure and is monitored in several different ways by each youth's treatment team. Much like school attendance, there are a number of reasons why youth may be absent from a treatment session. While the quality assurance reports the OAG reviewed indicated some youth absences, ADJC demonstrated that all of the youth who were identified as being absent had either received the required treatment programming, had been provided with an opportunity to make up the treatment programming, or had aged out of our jurisdiction shortly after the absence.

Rather than tracking attendance in the aggregate, treatment session facilitators track individual youth attendance, and clinical staff track progress toward program completion in our case management system. Consistent with program fidelity standards, youth may only progress through ADJC's Phase system and complete treatment programming once they have satisfied all of the requirements of the given program, including dosage when required. Advancing a youth or issuing a completion of treatment without satisfying overall program criteria would be a breach of fidelity. However, missing a treatment session is not a breach of fidelity, and youth who miss treatment sessions are provided

opportunities to make these sessions up. Therefore, ADJC's practices are aligned with fidelity standards. The spreadsheet that ADJC staff produced served to verify for the auditors that the processes currently in place to ensure youth attendance, participation, and makeup of missed sessions, are working as designed.

ADJC is grateful for the OAG's observations and recommendations. ADJC's use of evidence-based treatment programming, our regular evaluation of program fidelity, the use of the Correctional Program Checklist, and the various rehabilitative interventions provided to youth, such as educational services and individualized therapy, are all essential to the treatment and successful rehabilitation of Arizona's seriously delinquent youth. As we work to continuously improve our treatment programming and the services we provide, the OAG's observations and recommendations are appreciated.

Sincerely,



Jeff Hood
Director

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

Recommendation 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:

Recommendation 1a: 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.

Department response: The finding of the Auditor General is not agreed to but the recommendation will be implemented.

Response explanation: ADJC disagrees with the finding that it has not assessed all treatment intervention components. ADJC has ensured that program content is delivered in the order specified by the corresponding program manuals, if required. As noted in the report, ADJC identified issues with the order of DBT module delivery in April of 2020. To prevent this issue from recurring, ADJC implemented a facility-wide DBT rotation schedule to further assist staff in monitoring treatment content and order of delivery. Furthermore, ADJC has updated its fidelity form to include a checkbox to verify that the module being delivered during a particular treatment session is, in fact, the module that is scheduled to be delivered. ADJC has created a Behavioral Health Monitoring and Quality Improvement Database to house the fidelity assessment forms. This database will provide immediate notification if an assessed group that has a specified order, such as DBT, is conducted out of order.

The report notes that, while DBT and Seven Challenges fidelity assessment processes include a requirement to assess if the group treatment session was held for the required duration, the ART fidelity assessment process does not have a similar requirement. ADJC's assessment of ART fidelity uses a validated form directly from the ART program materials which does not require an assessment of duration, thereby satisfying the fidelity requirements of the program.

ADJC considers youth missing a portion or all of a group to be an attendance issue rather than a component of fidelity. ADJC delivers treatment groups at the frequency prescribed per each corresponding program manual. Youth attendance, as depicted in Figure 1 of the report, is independent of fidelity and has no bearing on the fidelity of treatment delivery. Although youth attendance and treatment progress are already tracked at an individual level, ADJC is committed to making continual improvements, and will therefore explore options for programming an easily accessible report of youth attendance information and maintaining the information in a centralized location.

Recommendation 1b: 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.

Department response: The finding of the Auditor General is not agreed to but the audit recommendation will be implemented.

Response explanation: ADJC has developed and implemented policies and procedures outlining staff responsibility for overseeing the results of its fidelity monitoring efforts consistent with the recommendation. Additionally, ADJC is automating monthly fidelity assessments and will include documentation of follow-up and corrective action in the Behavioral Health Monitoring and Quality Improvement database system.

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

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

Department response: The finding of the Auditor General is agreed to and the recommendation will be implemented.

Response explanation: ADJC agrees with the finding that it has not completed certain items within corrective action plans to address treatment programming improvements and will implement revised CPC evaluation policies and procedures. ADJC's CPC policy was updated March 29th, 2021, but ADJC will further revise and implement our policy to align it with the CPC manual.

While ADJC agrees that some CPC recommendations were not implemented, we remain concerned about the way the finding is presented. We would like to emphasize that all 3 follow-up evaluations were completed and documented, although 1 follow-up evaluation did not include details indicating the date the follow-up was completed. Additionally, all 3 reports were provided to the ADJC director, consistent with policy, although only 1 of the reports was accompanied by a memo, which was not required by policy. ADJC has since updated the policy to require the report to be accompanied by a memo to better document that the report is actually being provided to the Director.

Recommendation 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.

  Department response: The finding of the Auditor General is agreed to and the recommendation will be implemented.

  Response explanation: ADJC will further revise its current policy and procedures to incorporate the recommendations. During the audit process, ADJC compared the CPC policy to the University of Cincinnati Corrections Institute (UCCI) CPC manual. According to the manual, facilities should *not* attempt to address all recommendations at once, but should prioritize them. The manual also cautions that not all areas of deficiency may have actionable recommendations for improvement. Therefore, further revisions are being made to bring the policy into alignment with the manual. ADJC will also implement a process to review recommendations and prioritize and schedule implementation for those that are feasible and reflect agency priorities. The policy will be updated to require continued monitoring of recommendations that are prioritized for implementation beyond the 12-month CPC follow-up period or that may take longer than 12-months to complete.

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

Recommendation 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.

Department response: The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

Response explanation: Although we already have a number of outcome measures in place, we agree that there are opportunities to track additional outcome measures related to our treatment programming. We would like to emphasize that ADJC is aligned with industry standards and consistently tracks and reports recidivism on an annual basis, which is the primary approach employed by criminal justice agencies to measure outcomes. ADJC has also employed numerous other performance measures appropriate for a juvenile correctional system. For example, ADJC regularly calculates, reports, and tracks length of stay and successful completion of parole. We also calculate and report outcome measures in line with the federal Juvenile Justice Delinquency and Prevention Act (sec. 251 xii). Per the Act, states should measure "positive outcome measures, such as attainment of employment and educational degrees" and use those measures to "evaluate the success of programs aimed at reducing recidivism." ADJC tracks and reports educational progress and degree attainment for youth at Adobe Mountain School and youth attainment of employment or enrollment in school after their release to community supervision.

In response to this finding, we will explore aggregating data from our Phase system to better understand and demonstrate youth outcomes, and we will expand our recidivism measure. While there are no standard outcome measures directly related to treatment programming, we will survey other juvenile justice agencies over the course of the next year to determine whether there are other measures that may be meaningful, and we are committed to implementing additional outcome measures that show potential. ADJC will develop and implement a plan related to outcome measures that includes goals, action items, completion time frames/deadlines, and the individual(s) assigned to complete each action item.

However, conducting outcome evaluations is much more complex than the audit report suggests. Outcome evaluations are large-scale, multi-year studies of programs. ADJC agrees that there are potential benefits to conducting outcome evaluations, but ADJC cannot commit to doing so without first narrowing our focus on what may be realistic to evaluate and what may add value to and inform our programming choices. We are committed to pursuing an outcome evaluation, but we cannot commit to creating a detailed action plan at this time, as those details cannot be determined until we are able to identify what types of studies may be possible.

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

Recommendation 5a: 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.

Department response: The finding of the Auditor General is agreed to and the recommendation will be implemented.

Response explanation: In addition to the outcome measures ADJC already tracks, ADJC plans to aggregate data from our Phase system, which tracks individualized youth progress toward addressing criminogenic risk factors, and expand our recidivism measure. We will also survey other states and adopt outcome measures that appear to be viable measures of rehabilitation.

Recommendation 5b: Prioritize and conduct outcome evaluations it identifies through its planning process.

Department response: The finding of the Auditor General is agreed to and another method of dealing with the finding will be implemented.

Response explanation: ADJC is committed to pursuing outcome evaluations in the future, and will seek out partnerships, if necessary, to conduct such evaluations. Due to the complexity of conducting these types of evaluations, ADJC cannot commit to doing so until we conduct initial research to determine what may be realistic and valuable to inform our agency operations. ADJC will prioritize conducting this research during the next 18 months.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