

Juvenile Intervention Assessment (JIA)

Inventory of Scientific Findings

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Introduction

Over the past decade, we have witnessed dramatic changes in health care systems, particularly in mental health, chemical dependency, and counseling. There is renewed emphasis upon objective and accurate problem identification, appropriate referral, and documented outcome. Decisions regarding the type of intervention needed, changes in inpatient-outpatient status, continuation or completion of treatment and effectiveness of treatment are, now, subject to review. Provider accountability, utilization review, and substantiation of decision making have been widely adopted and implemented. The Juvenile Intervention Assessment (JIA) was developed to help meet these needs.

This document is a cumulative research record of the evolution of the Juvenile Intervention Assessment (JIA), into a state-of-the-art, clinical assessment instrument. Juvenile Intervention Assessment research is presented, categorically and chronologically. Categories include an overview of the extensive research conducted on the Stress Management Scale, followed by Treatment Intervention Inventory-Juvenile (TII-Juvenile) and, finally, Juvenile Intervention Assessment (JIA) findings. Within each category, the findings are presented chronologically. More recent studies (toward the end of this document) are most representative of current JIA statistics.

- The JIA began as an adult treatment outcome test; the Treatment Intervention Inventory (TII) was, then, modified into the TII-Juvenile.
- The TII-Juvenile was designed for juvenile and troubled youth. The TII-Juvenile retained the nine, adult version scales (measures); however, the reading level was lowered and a few items had to be juvenile oriented.
- The JIA evolved from the TII-Juvenile. The JIA retained the same items, which comprise the same nine scales; however, two of the scales (Stress Management; Family Dynamics) have been renamed to reflect current, clinical language and practice.

The JIA is a brief, easily administered, and automated (computer scored) risk/needs assessment that is designed for clinical use. It includes true/false and multiple choice items, and can be completed in 30 to 35 minutes. The JIA contains nine empirically-based scales: Truthfulness, Self-esteem, Stress Management, Anxiety, Depression, Alcohol, Drug, Distress, and Family Dynamics -- these scales will be described in greater detail below.

The JIA was designed for use at intake (pre-treatment) and post-treatment intervals. It enables comparison of client status prior to, during, and upon treatment completion. The JIA can be re-administered to the same client at 30-day intervals, or at important, decision making points in the treatment program (e.g., intake, referral and continuation, or completion of treatment). The proprietary, JIA database ensures continued research and development.

The JIA report explains clients' attained scores and makes specific, intervention and treatment recommendations. It also presents Truth-Corrected scores, significant items, a concise "structured interview," and much more. The JIA is designed to measure the severity of problems in clinical settings, and has demonstrated reliability, validity, and accuracy. The JIA is to be used

in conjunction with a review of available records and respondent interview. No decision or diagnosis should be based solely on JIA results. Client assessment is not to be taken lightly, as the decisions made can be vitally important, as they affect lives.

Juvenile Intervention Assessment (JIA) Scales

The JIA measures nine domains empirically linked to juvenile treatment outcomes. The nine domains are described below:

1. Truthfulness Scale: Measures the truthfulness of the client while they were completing the JIA. This scale identifies self-protective, defensive, or guarded people who minimize, or even fake answers. This type of scale is considered necessary, if not essential, in any, objective assessment instrument. In most referral and treatment settings, clients are cooperative and positively responsive to assessment procedures. However, it would be very naïve to believe that all clients answer all assessment questions truthfully. All interview and self-report, test information is subject to the dangers of untrue answers, due to defensiveness, guardedness, or deliberate falsification. The Truthfulness Scale also identifies clients who are reading impaired.

2. Self-Esteem Scale: Reflects a client's explicit valuing and appraisal of self. Self-esteem incorporates an attitude of acceptance-approval versus rejection-disapproval. Self-esteem refers to a person's perception of self.

3. Stress Management Scale: Establishes how well the client copes with stress. The National Institute for Occupational Safety and Health (NIOSH) evaluated the health records of 22,000 workers in 130 organizations. **Their conclusion: Stress affects workers in all types of job levels; unskilled laborers are equally susceptible, as are top-line executives.** Stress exacerbates symptoms of emotional and mental health problems.

The Stress Management Scale is much more than just a measure of stress. It is a measure of how well the client copes with stress. Two people can be in the same stressful situation, however, one person is overwhelmed and the other person handles it well. The Stress Management Scale can account for these different reactions to stress.

4. Anxiety Scale: Anxiety is an unpleasant, emotional experience characterized by non-directed fear. Most definitions of anxiety include a sympathetically-induced feeling associated with a sense of threat. General symptoms, such as nervousness, apprehension, and tenseness are included in this definition, as are panic, terror, and, somatic correlates of anxiety.

The Anxiety Scale provides a quantitative score that varies directly with the client's self-reported symptoms. The presence, severity, and magnitude of these symptoms is measured by client's multiple-choice answers, i.e., "rare or never," "sometimes," "often," or "very often."

Two symptom clusters -- anxiety and depression -- are clinically significant, and consistently

related in clinical literature. Anxiety and depression represent the most, commonly reported symptoms of distress, in clinical and counseling settings. **The interaction or blending of these symptom clusters is evident in the definition of dysphoria, i.e., a generalized feeling of anxiety, restlessness, and depression.**

Perceived distress, whether by self or others, represents the major reason people seek help, or are referred for counseling and assistance. Estimates of the prevalence of anxiety and depression in general medical practice are very high. The American Academy of Family Physicians (Business Week, 2-2-86) is quoted as estimating that at least half of all office visits to family doctors are prompted by psychological problems, such as stress, anxiety, and depression.

5. Depression Scale: Depression is a dejected or self-depreciating emotional state that varies from normal to pathological proportions. General symptoms such as melancholy and dysphoric mood are included in this definition, as are impaired social-vocational functioning, and loss of interest in usual activities. In addition, thoughts of suicide and other cognitive as well as somatic correlates of depression are included.

The Depression Scale provides a quantitative score that varies directly with the client's self-reported symptoms and concerns. The Depression Scale identifies depression and establishes its magnitude, or severity via multiple-choice answers, i.e., "rare or never," "sometimes," "often," or "very often."

Anxiety and depression are not mutually exclusive, as any given case may represent both symptom clusters. For these reasons, separate scales are included in the JIA for anxiety and depression. A person's perceived distress level is related to emotional, institutional, family, or marital concerns, and work, as well as their overall adjustment. It is important to assess both anxiety and depression, due to their prominence in treatment, counseling, intervention, and outcome.

6. Alcohol Scale: The Alcohol Scale measures the client's alcohol proneness and alcohol-related problems. This scale was developed with the assistance of experienced, chemical dependency program staff. Item selection was based on relevance and comprehensiveness, employing a rational, consensual agreement procedure. Final item selection is based on each item's statistical properties.

7. Drug Scale: The burgeoning awareness of the impact of illicit drugs emphasizes the need for any clinical assessment to differentiate between licit and illicit drugs. The Drug Scale is an **independent** measure of the client's drug-related problems. Without this type of scale, many drug abusers would remain undetected. Thus, the Juvenile Intervention Assessment (JIA) differentiates between "alcohol" and "drug" abuse, or licit versus illicit drugs. Increased public awareness of drug (marijuana, cocaine, crack, heroin, etc.) abuse emphasizes the importance of a drug scale.

8. Distress Scale: Measures sorrow, misery, pain, and suffering. Distress incorporates pain (physical and mental), physical and mental abuse, agony, and anguish. Distress involves both mental and physical, pain and strain. This Distress Scale was adopted from other clinical tests in which it is used.

9. Family Dynamics Scale: Measures family problems, concerns, and stability. Clients rate their own family and relationship stability, versus problems.

Research Review

The following studies summarize research conducted on a variety of clients, e.g., substance abuse inpatients/outpatients, people applying for jobs, college students, municipal court diversion defendants, etc.

Juvenile Intervention Assessment research is presented categorically and chronologically. Categories include an overview of the extensive research conducted on the Stress Management Scale, followed by Treatment Intervention Index-Juvenile (TII-Juvenile) and, finally, Juvenile Intervention Assessment findings. Within each category, the findings are presented chronologically. Chronological presentation enables the reader to follow the evolution of the JIA into a state-of-the-art, automated (computerized) screening instrument. More recent studies (toward the end of this document) are most representative of current JIA statistics.

Stress Quotient (Stress Management) Research

The Stress Quotient (SQ) or Stress Coping Abilities Scale is based upon the following mathematical equation:

$$SQ = CS/S \times k$$

The Stress Quotient (SQ) scale is a numerical value representing a person's ability to handle or cope with stress, relative to their amount of experienced stress. CS (Coping Skill) refers to a person's ability to cope with stress. S (Stress) refers to experienced stress. k (Constant) represents a constant value in the SQ equation, to establish SQ score ranges. The SQ includes measures of both stress and coping skills, in the derivation of the Stress Quotient (SQ) score. The better an individual's coping skills, compared to the amount of experienced stress, the higher the SQ score.

The Stress Quotient (SQ) scale equation represents empirically-verifiable relationships. The SQ scale (and its individual components) lends itself to research. Nine studies were conducted to investigate the validity and reliability of the Stress Quotient or Stress Coping Abilities Scale.

Validation Study 1: This study was conducted (1980) to compare SQ scores between High Stress and Low Stress groups. The High Stress group (N=10) was comprised of 5 males and 5 females. Their average age was 39. Subjects for the High Stress group were, randomly, selected

from outpatients seeking treatment for stress. The Low Stress group (N=10) was comprised of 5 males and 5 females, (average age 38.7) randomly selected from persons not involved in treatment for stress. High Stress group SQ scores ranged from 32 to 97, with a mean of 64.2. Low Stress group SQ scores ranged from 82 to 156, with a mean of 115.7. The t-test statistical analysis, of the difference between the means of the two groups, indicated that the High Stress group had, significantly, higher SQ scores than the Low Stress group ($t = 4.9, p < .001$). This study shows that the SQ or Stress Coping Abilities Scale is a valid measure of stress coping. The Stress Coping Abilities Scale significantly, discriminates between high stress individuals and low stress individuals.

Validation Study 2: This study (1980) evaluated the relationship between the SQ scale and two criterion measures: Taylor Manifest Anxiety Scale and Cornell Index. These two measures have been shown to be valid measures of anxiety and neuroticism, respectively. If the SQ or Stress Coping Abilities Scale is correlated with these measures, it would indicate that the SQ or Stress Coping Abilities Scale is a valid measure. In the Taylor Manifest Anxiety Scale, high scores indicate a high level of anxiety. Similarly, in the Cornell Index, high scores indicate neuroticism. Negative, correlation coefficients between the two measures and the SQ were expected, because high SQ scores indicate good, stress coping abilities. The three tests were administered to forty-three (43) subjects, selected from the general population. There were 21 males and 22 females, ranging in age from 15 to 64 years. Utilizing a product-moment correlation, SQ scores correlated $-.70$ with the Taylor Manifest Anxiety Scale, and $-.75$ with the Cornell Index. Both correlations were significant, in the predicted direction, at the $p < .01$ level. These results support the finding that the Stress Coping Abilities Scale is a valid measure of stress coping abilities. The reliability of the SQ was investigated in ten subjects, (5 male and 5 female) randomly chosen from this study. A split-half correlation analysis was conducted on the SQ items. The product-moment correlation coefficient (r) was $.85$, significant at the $p < .01$ level. This correlation indicates that the SQ or Stress Coping Abilities Scale is a reliable measure. These results support the Stress Coping Abilities Scale, as a reliable and valid measure.

Validation Study 3: In this study (1981), the relationship between the SQ Scale and the Holmes-Rahe Social Readjustment Rating Scale (SRRS) was investigated. The SRRS, which is comprised of a self-rating of stressful life events, has been shown to be a valid measure of stress. Three correlation analyses were done. SRRS scores were correlated with SQ scores and separately, with two components of the SQ scale: Coping Skill (CS) scores and Stress (S) scores. It was hypothesized that the SQ and SRRS correlation would be negative, since subjects with lower SQ scores would be more likely to either encounter less stressful life events, or experience less stress in their lives. It was also predicted that subjects with a higher CS would be less likely to encounter stressful life events, hence a negative correlation was hypothesized. A positive correlation was predicted between S and SRRS, since subjects experiencing more, frequent stressful life events would reflect more experienced stress. The participants in this study consisted of 30 outpatient psychotherapy patients. There were 14 males and 16 females. The average age was 35. The SQ and the SRRS were administered in counterbalanced order. The results showed there was a significant, positive correlation (product-moment correlation coefficient) between SQ and SRRS ($r = .4006, p < .01$). The correlation results between CS and

SRRS was not significant ($r = .1355$, n.s.). There was a significant, positive correlation between S and SRRS ($r = .6183$, $p < .001$). The correlations were in predicted directions. The significant correlations between SQ and SRRS, as well as S and SRRS, support the construct validity of the SQ or Stress Coping Abilities Scale.

Validation Study 4: This validation study (1982) evaluated the relationship between factor C (Ego Strength) in the 16 PF Test as a criterion measure, and the SQ, in a sample of juveniles. High scores on factor C indicate high ego strength and emotional stability, whereas high SQ scores reflect good coping skills. A positive correlation was predicted, because emotional stability and coping skills reflect similar attributes. The participants were 34 adjudicated delinquent adolescents. They ranged in age from 15 to 18 years, with an average age of 16.2. There were 30 males and 4 females. The Cattell 16 PF Test and the SQ scale were administered in counterbalanced order. All subjects had at least a 6.0 grade equivalent reading level. The correlation (product-moment correlation coefficient) results indicated that Factor C scores were, significantly, correlated with SQ scores ($r = .695$, $p < .01$). Results were significant and in the predicted direction. These results support the SQ or Stress Coping Abilities Scale, as a valid measure of stress coping abilities in juvenile offenders. 6th?

In a subsequent study, the relationship between factor Q4 (Free Floating Anxiety) on the 16 PF Test and S (Stress) on the SQ scale was investigated. High Q4 scores reflect free floating anxiety and tension, whereas high S scores measure experienced stress. A high, positive correlation between Q4 and S was predicted. There were 22 of the original 34 subjects included in this analysis, since the remainder of the original files was unavailable. All 22 subjects were male. The results indicated that Factor Q4 scores were, significantly, correlated (product-moment correlation coefficient) with S scores ($r = .584$, $p < .05$). Results were significant and in predicted directions. The significant correlations between factor C and SQ scores, as well as factor Q4 and S scores, support the construct validity of the SQ scale.

Validation Study 5: Psychotherapy outpatient clients were used in this validation study (1982) that evaluated the relationship between selected Wiggin's MMPI (Minnesota Multiphasic Personality Inventory), supplementary content scales (ES & MAS) as criterion measures, and the SQ scale. ES measures ego strength and MAS measures manifest anxiety. It was predicted that the ES and SC correlation would be positive, since people with high ego strength would be more likely to possess good coping skills. Similarly, it was predicted that MAS and S correlations would be positive, since people experiencing high levels of manifest anxiety would also, likely experience high levels of stress. The subjects were 51 psychotherapy outpatients, ranging in age from 22 to 56 years, with an average age of 34. There were 23 males and 28 females. The MMPI and the SQ were administered in counterbalanced order. The correlation (product-moment correlation coefficient) results indicated that ES and CS were positively, significantly correlated ($r = .29$, $p < .001$). MAS and S comparisons resulted in an r of $.54$, significant at the $p < .001$ level. All results were significant and in predicted directions.

In a related study (1982), utilizing the same population data ($N=51$), the relationship between the Psychasthenia (Pt) scale, in the MMPI, and the S component of the SQ scale was evaluated. The

Pt scale in the MMPI reflects neurotic anxiety, whereas the S component of the SQ scale measures stress. Positive Pt and S correlations were predicted. The correlation (product-moment correlation coefficient) results indicated that the Pt scale and the S component of the SQ scale were, significantly, correlated ($r = .58, p < .001$). Results were significant and in the predicted direction. The significant correlations between MMPI scales (ES, MAS, Pt) and the SQ scale components (CS, S) support the construct validity of the SQ or Stress Coping Abilities Scale.

Reliability Study 6: The reliability of the Stress Quotient (SQ) or Stress Coping Abilities Scale was investigated (1984) in a population of outpatient psychotherapy patients. There were 100 participants, 41 males and 59 females. The average age was 37. The SQ was administered soon after intake. The most, common procedure for reporting inter-item (within test) reliability is with Coefficient Alpha. The reliability analysis indicated that the Coefficient Alpha of 0.81 was highly significant ($F = 46.74, p < .001$). Highly significant, inter-item scale consistency was demonstrated.

Reliability Study 7: (1985) The reliability of the Stress Quotient (SQ) or Stress Coping Abilities Scale was investigated in a sample of 189 job applicants. There were 120 males and 69 females, with an average age of 31. The SQ was administered at the time of pre-employment screening. The reliability analysis indicated that the Coefficient Alpha of 0.73 was highly significant ($F = 195.86, p < .001$). Highly significant, Cronbach Coefficient Alpha reveals that all, SQ scale items are significantly ($p < .001$) related, and measure one factor or trait.

Validation Study 8: Chemical dependency inpatients were used in a validation study (1985) to determine the relation between MMPI scales as criterion measures, and the Stress Quotient (SQ) Scale or Stress Coping Abilities Scale. The SQ is inversely related to other MMPI scales, consequently, negative correlations were predicted. The participants were 100 chemical dependency inpatients. There were 62 males and 38 females, with an average age of 41. The SQ and the MMPI were administered in counterbalanced order. The reliability analysis results indicated that the Coefficient Alpha of 0.84 was highly significant ($F = 16.20, p < .001$). Highly significant, inter-item scale consistency was demonstrated.

The correlation (product-moment correlation coefficient) results between the Stress Quotient (SQ) and selected MMPI scales were significant at the $p < .001$ level and in predicted directions. The SQ correlation results were as follows: Psychopathic Deviate (-0.59), Psychasthenia (-0.068), Social Maladjustment (-0.54), Authority Conflict (-0.46), Taylor Manifest Anxiety Scale (-0.78), Authority Problems (-0.22), and Social Alienation (-0.67). The most, significant SQ correlation was with the Taylor Manifest Anxiety Scale. As discussed earlier, stress exacerbates symptoms of impaired adjustment, as well as emotional and attitudinal problems. These results support the Stress Quotient or Stress Coping Abilities Scale, as a valid measure of stress coping abilities.

Validation Study 9: In a replication of earlier research, a study (1986) was conducted to further evaluate the reliability and validity of the Stress Quotient (SQ). The participants were 212

inpatients in chemical dependency programs. There were 122 males and 90 females, with an average age of 44. The SQ and MMPI were administered in counterbalanced order. Reliability analysis of the SQ scale resulted in a Coefficient Alpha of 0.986 ($F = 27.77, p < .001$). Highly significant, inter-item scale consistency was, again, demonstrated. Rounded off, the **Coefficient Alpha for the SQ was 0.99**.

In the same study (1986, inpatients), product-moment correlations were calculated between the Stress Quotient (SQ) and selected MMPI scales. The SQ correlated significantly (.001 level) with the following MMPI scales: Psychopathic Deviate (Pd), Psychasthenia (Pt), Anxiety (A), Manifest Anxiety (MAS), Ego Strength (ES), Social Responsibility (RE), Social Alienation (PD4A), Social Alienation (SC1A), Social Maladjustment (SOC), Authority Conflict (AUT), Manifest Hostility (HOS), Suspiciousness/Mistrust (TSC-II), Resentment/Aggression (TSC-V), and Tension/Worry (TSC-VII). **All SQ correlations with selected MMPI scales were significant (at the .001 level of significance) and in predicted directions.** These results support the SQ scale or Stress Coping Abilities Scale, as a valid measure of stress coping abilities.

The studies cited above demonstrate empirical relationships between the SQ scale (Stress Coping Abilities Scale) and other, established measures of stress, anxiety, and coping skills. This research demonstrates that the Stress Quotient (SQ) or Stress Coping Abilities Scale is a reliable and valid measure of stress coping abilities. The SQ has high, inter-item scale reliability. The SQ also has high, concurrent (criterion-related) validity with other, recognized and accepted tests. The SQ scale permits objective (rather than subjective) analysis of the interaction of these important variables. In the research that follows, the **Stress Quotient** or **SQ** is also referred to as the **Stress Coping Abilities Scale/Stress Management Scale**.

TII – Juvenile Research

10. Reliability Study of the TII-Juvenile in a Sample of Juveniles (1997)

In early 1997, the Treatment Intervention Inventory (TII) was modified for juveniles (12 to 17 years of age). The present study was conducted to test the reliability of the TII-Juvenile. This juvenile client sample was taken from different, offender assessment programs, from different areas in the country.

Participants

The TII-Juvenile was administered to 153 juvenile clients. There were 117 males (76%) and 36 females (24%). The demographic composition of this group is as follows: Age: 12 & under (7.2%); 13 (13%); 14 (15%); 15 (22%); 16 (22%); 17 (16%); 18 & Over (6%). Ethnicity: Caucasian (72%); Black (5%); Hispanic (11%); American Indian (11%); and Other (2%). Education: 6th grade or less (10%); 7th grade (14%); 8th grade (17%); 9th grade (24%); 10th grade (13%); 11th grade (16%); 12th grade (3%); and some college (4%).

Reliability coefficient alphas, for the TII-Juvenile sample, is presented in Table 1.

Table 1. Reliability coefficient alphas. Juvenile clients (1997, Total N=153)

<u>TII-J Scale</u>	<u>Coefficient Alphas</u>
Truthfulness Scale	.80
Alcohol Scale	.82
Drug Scale	.83
Anxiety Scale	.83
Depression Scale	.87
Distress Scale	.82
Family Issues Scale	.80
Self-Esteem Scale	.90
Stress Coping Abilities	.91

These results strongly support the reliability of the TII-Juvenile. This sample consisted of youths who were evaluated as part of normal, counseling program assessment procedures. The TII-Juvenile has impressive reliability (internal consistency). The TII-Juvenile now offers an alternative for troubled youth assessment. The TII is appropriate for adult assessment, and the TII-Juvenile is an appropriate assessment instrument for juvenile clients.

11. TII-Juvenile Reliability Confirmation Using Large Sample (2013)

A subsequent, confirmation analysis was conducted in 2013 to examine reliability, using a larger sample of juvenile offender. Data were retrieved from the Behavior Data Systems (BDS) proprietary database, and represent offender data from across the United States. The TII-Juvenile was administered to 1,415 juvenile clients.

Reliability coefficient alphas, for the TII-Juvenile sample, is presented in Table 2.

Table 2. Reliability (2013, N=1, 415)

Scales	Coefficients
Truthfulness	.80
Alcohol	.77
Drug	.84
Anxiety	.84
Depression	.87
Distress	.76
Family Issues	.71
Self-Esteem	.90
Stress Coping Abilities	.90

Test reliability refers to a scale's consistency of measurement. Cronbach's Alpha, a measure of reliability, measured the internal consistency of each scale of the TII-Juvenile. Perfect reliability is 1.00, and the professionally accepted standard of reliability for this type of instruments is .70 - .80 (Murphy & Davidshofer, 2001).

For this large sample of offenders, TII-Juvenile, item reliability analyses were below the .80 threshold on the Alcohol Scale, Distress Scale, and Family Issues Scale. These findings were inconsistent with previous research conducted on the TII-Juvenile and, surprising, given the large dataset. These results were the likely a function of fewer items per scale, on these particular scales and, perhaps, the item content. It may be appropriate to examine the underlying construct of each item. In addition, the results could be related to the degree of variation in the sampling process. The data were submitted from across the United States, and the reason for the test administration is not known to BDS researchers. The intended purpose, of the test administration and the clients who completed the assessment, may create a high degree of variance in the responses -- reflected in low coefficients.

Juvenile Intervention Assessment (JIA) Research

12. Reliability Study of the JIA in a Sample of Juveniles (2014)

This study was conducted with a small sample of juvenile clients who completed the Juvenile Intervention Assessment. No substantial changes were made to the items within the assessment,

so reliability coefficients at .80 or higher are expected.

Participants:

Gender: 84% were male, 16% were female. Race/Ethnicity: 59% were Caucasian; 7% were African-American; 32% were Hispanic; 2% reported Other. Education: 6th grade or less 5%; 7th grade, 12%; 8th grade 15%; 9th grade 26%; 10th grade 13%; 11th grade 16%; 12th grade 2%; and less than 1% completed any college. Age: 15.5 was the average age; range was 11 – 21.

As noted above, test reliability refers to a scale’s consistency of measurement. Cronbach’s Alpha, a measure of reliability, measured the internal consistency of each scale of the TII-Juvenile. Perfect reliability is 1.00, and the professionally accepted standard of reliability for this type of instruments is .70 - .80 (Murphy & Davidshofer, 2001). Table 3 presents reliability scores for the 124 juvenile clients.

Table 3. Reliability (2014, N=124)

Scale	Coefficients
Truthfulness	.81
Alcohol	.76
Drug	.85
Anxiety	.87
Depression	.90
Distress	.80
Family Dynamics	.72
Self-Esteem	.88
Stress Management	.90

Juvenile Intervention Assessment (JIA), item reliability analyses were below the .80 threshold on the Alcohol Scale and Family Issues Scale. These findings were consistent with research conducted on the TII-Juvenile in 2013. While within professionally accepted standards, it is believed that the lower reliability coefficient for the Family Dynamic Scale is related to the number of items in the scale -- it has the fewest items of all the scales. As noted earlier, the results could also be related to the degree of variation in the sampling process -- juveniles from a clinical setting may not answer items the same way a detention center offender would answer. This inconsistency may explain the lower Alcohol Scale scores.

Summary

In conclusion, this document is not intended as an exhaustive compilation of Juvenile Intervention Assessment (JIA) research. Yet, it does summarize many studies and statistics that support the reliability and validity of assessment. The JIA offers a sound, empirical foundation for responsible decision making and measure of treatment outcomes.

The JIA is much more than just another assessment test. The JIA is designed specifically for juvenile screening, to evaluate emotional/mental health problems, as well as alcohol and drug problems, and referral to appropriate treatment services.

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