

JORDAN, SR., JOSEPH P., Ph.D. An Examination of the Necessary Knowledge and Skills for Juvenile Court Counselors to Intervene with Alcohol and Other Drug Abusing Juvenile Offenders. (2006)  
Directed by Dr. Craig Cashwell. 315 pp.

Juvenile crime and adolescent substance abuse often are co-occurring social problems. Researchers have demonstrated the relationship of one to the other and how continued involvement in substance abuse is positively correlated with continued involvement in the juvenile justice system (Altshuler & Brounstein, 1991; Dembo, Pacheco, Schmeidler, Fisher, & Cooper, 1997; Dembo, Schmeidler, & Williams, 1991; Hawkins, Jensen, & Catalano, 1988). Due to the overwhelming incidence of assigning adjudicated juvenile offenders to probation, the professional person most in contact with juvenile offenders is usually the Juvenile Court Counselor (Snyder & Sickmund, 1999). Therefore, the Juvenile Court Counselor might benefit from specialized education in the area of substance abuse, so as to more efficaciously address this issue, thereby decreasing the incidence of re-offending. Accordingly, this study seeks to identify the knowledge and skills regarding substance abuse most important for Juvenile Court Counselors, with the aim of creating a substance abuse specific educational curriculum for Juvenile Court Counselors.

An on-line survey instrument, the Juvenile Court Counselor Alcohol and Other Drug (AOD) Abuse Training Needs Assessment Questionnaire, will be administered, with potential participants including 403 currently employed Juvenile Court Counselors in the state of North Carolina. Respondent survey results will then be analyzed using descriptive and factor analytic procedures to determine what knowledge and skills are

considered most important for Juvenile Court Counselors and whether a specific factor structure exists that describes the knowledge and skills judged important for Juvenile Court Counselors in North Carolina. Information gathered from survey respondents concerning sex, ethnicity, terminal degree, service area, years of experience, and hours of training in substance abuse since becoming a Juvenile Court Counselor will be examined using inferential and correlational statistics to determine if any of these variables have an effect on the hypothesized factor scales.

It is hoped that the knowledge gathered from this study will help inform possible future training and educational events for Juvenile Court Counselors, as well as providing some baseline information for those who provide instructional training to Juvenile Court Counselors and other mental health professionals. The ultimate goal of the proposed study is to increase the ability of Juvenile Court Counselors and other mental health professionals to respond to the Alcohol and Other Drug Abuse service needs of juvenile offenders, so that both society and juveniles reap the benefits of increased health and decreased dysfunction.

AN EXAMINATION OF THE NECESSARY KNOWLEDGE AND SKILLS FOR  
JUVENILE COURT COUNSELORS TO INTERVENE WITH ALCOHOL  
AND OTHER DRUG ABUSING JUVENILE OFFENDERS

by

Joseph Patrick Jordan, Sr.

A Dissertation Submitted to  
the Faculty of the Graduate School at  
The University of North Carolina at Greensboro  
in Partial Fulfillment  
of the Requirements for the Degree  
Doctor of Philosophy

Greensboro  
2006

Approved by

---

Committee Chair

© 2006 Joseph P. Jordan, Sr.

APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of the Graduate School at the University of North Carolina at Greensboro.

Committee Chair

---

Committee Members

---

---

---

---

Date of Acceptance by Committee

---

Date of Final Oral Examination

## ACKNOWLEDGEMENTS

Although a number of persons have contributed to the completion of this document, I would be remiss if I did not honor the following persons: First, Dr. Craig S. Cashwell and Dr. Gerald Juhnke, both of who served as chair of this dissertation and both of whom contributed in their own way to the completion of this document. Second is my committee, consisting of Dr. Richard Luecht, Dr. Dan Bibeau, and Dr. Kelly Wester. Also, I should mention Dr. Brian Dew, Dr. Bryce Hagedorn, Mr. Jim Scarborough, Mike C., the staff of Youth Unlimited and the Randolph County Day Reporting Center, everyone on the North Carolina Substance Abuse Professional Practice Board, and Mr. Stan Clarkson and the wonderful people at the Department of Juvenile Justice and Delinquency Prevention, without whom this project would have never even got off the ground. Finally, I thank most of all my parents, my wife Laura, and my son Patrick. In the end, it was they who allowed me to accomplish this goal.

## TABLE OF CONTENTS

	Page
LIST OF TABLES .....	ix
LIST OF FIGURES.....	x
CHAPTER	
I. INTRODUCTION.....	1
Juvenile Crime Rates.....	2
AOD Abuse and Juvenile Crime.....	3
Juvenile Justice Professional Training in AOD Abuse.....	4
Juvenile Court Counselor (JCC) Training Requirements.....	6
Statement of the Problem.....	9
Need for the Study.....	11
Research Questions.....	12
Definition of Terms.....	13
Organization of the Study.....	14
II. REVIEW OF RELATED LITERATURE.....	16
Juvenile Crime and Adolescent Alcohol and Other Drug (AOD) Abuse.....	16
Prevalence and Incidence of Juvenile Crime.....	17
The Costs of Juvenile Crime in America.....	20
Short-term Costs.....	20
Long-term Costs.....	22
Societal costs.....	22
Costs for the Juvenile.....	25
The Cost of Juvenile AOD Abuse in America.....	26
Incidence of Juvenile AOD abuse.....	27
Cost to the Juvenile.....	28
Physical Effects on the Juvenile.....	29
Psychological Effects on the Juvenile.....	30
Costs to Society.....	32
Familial Impact.....	32
Short-term Costs.....	33
Long-term Costs.....	34
Co-morbidity with Other Disorders.....	36
The Co-morbidity of Juvenile Crime and Adolescent AOD Abuse.....	38

	Page
Incidence of Co-morbid Juvenile Crime and AOD Abuse.....	39
Effect of AOD treatment on Rates of Re-offending by Juveniles.....	48
Current Court Ordered Interventions for Juvenile Offenders.....	54
Institutional Options.....	55
Community Based Alternatives/Diversion.....	56
Probation.....	57
Juvenile Court Counselor .....	57
Juvenile Court Counselor Responsibilities.....	58
Supervision, Training, and Education of the Juvenile Court Counselor.....	59
Supervision of JCCs.....	59
Training and Educational Requirements for JCCs.....	61
Recommended Juvenile Court Counselor Training for Juvenile Offender AOD Abuse.....	65
Necessary Substance Abuse Skills and Knowledge for Other Professional Groups.....	69
Related Professional Groups with Specialty Credentials.....	70
Social Workers.....	71
Psychologists.....	72
Nationally Certified Counselor.....	73
Nurses.....	73
Certified Substance Abuse Counselor.....	74
Addiction Professionals Working with Criminal Justice Populations.....	75
Previous Research of AOD Abuse Counseling by Professional Counselors.....	78
AOD Abuse Counseling in a Mental Health Settings.....	79
School Counselors and AOD Abuse Counseling.....	81
Conclusion.....	84

### III. METHODOLOGY ..... 85

Research Questions.....	85
Instrumentation.....	86
Survey Construction and Refinement.....	87
Sample Size.....	90
Participant Solicitation and Data Gathering Procedures.....	92
Demographic Variables.....	93
Sample Characteristics.....	93
Pilot Study.....	95
Phase I.....	95
Phase II.....	96

	Page
Phase III.....	101
Limitations of the Proposed Study.....	109
Data Analyses.....	110
Research Matrix.....	111
Chapter Summary.....	111
IV. RESULTS AND DISCUSSION.....	114
Questions and Analysis.....	114
Research Question One.....	115
Research Question Two .....	125
Descriptives for Items on <i>CWAAF</i> .....	125
Descriptives for Items on <i>IA</i> .....	129
Descriptives for Items on <i>DEI</i> .....	131
Important Items Not Loading on Identified Factors.....	133
Research Question Three.....	135
Research Question Four.....	137
Chapter Summary.....	139
V. SUMMARY, IMPLICATIONS, LIMITATIONS, AND RECOMMENDATIONS.....	141
Summary of the Study.....	141
Examination of the Factors.....	141
<i>CWAAF: Clinical Work with AOD Abusers and Families</i> .....	142
<i>IA: Intervention and Assessment</i> .....	144
<i>DEI: Drug Effects and Interactions</i> .....	145
Important Items Not Loading on Identified Factors.....	146
Limitations of the Study.....	149
Response Rate.....	149
Analyses.....	149
Sampling Bias.....	150
Survey.....	151
Implications.....	152
Juvenile Court Counselors in Training.....	152
Counselor Educators.....	155
Recommendations for Future Research.....	158
Substance Abuse Counselors.....	158
Juvenile Court Counselors .....	159
Conclusions.....	160

	Page
REFERENCES.....	162
APPENDIX A. COPY OF EMAIL PROVIDING PERMISSION TO USE RITTER (2001) SURVEY.....	180
APPENDIX B: QUESTIONNAIRE – INITIAL ADAPTATION.....	182
APPENDIX C: PERMISSION TO USE CHART IN FIGURE 1.....	206
APPENDIX D: NOTARIZED AGREEMENT TO CONDUCT RESEARCH .....	208
APPENDIX E: FEEDBACK FROM ADDICTION AND COUNSELING EDUCATORS.....	210
APPENDIX F: EMAIL TO JUVENILE COURT COUNSELORS TO SOLICIT PARTICIPATION.....	225
APPENDIX G: RESPONSES FROM JUVENILE COURT COUNSELORS.....	227
APPENDIX H. PILOT STUDY DESCRIPTIVE STATISTICS.....	230
APPENDIX I. JUVENILE COURT COUNSELOR AOD ABUSE TRAINING NEEDS ASSESSMENT QUESTIONNAIRE.....	235
APPENDIX J. PCA FACTOR ANALYSIS, EIGENVALUE SCREE PLOT, VARIMAX ROTATION.....	270
APPENDIX K. LISTING OF ITEMS ON FACTORS ONE THOROUGH FOUR.....	276
APPENDIX L. GROUP STATISTICS FOR SEX (V1), ETHNICITY (V2), AND DEGREE (V4).....	288
APPENDIX M. PILOT STUDY T TEST OF FACTOR MEAN SCORES FOR SEX (V1), ETHNICITY (V2), AND DEGREE (V4).....	290
APPENDIX N. PILOT STUDY CORRELATIONS FOR YEARS OF JCC EXPERIENCE (V5) AND HOURS OF SUBSTANCE ABUSE TRAINING SINCE BECOMING A JCC (V6).....	294
APPENDIX O. COPY OF SURVEY PARTICIPATION EMAIL SENT TO JCCS BY DEPARTMENT OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION .....	296

APPENDIX P. IMPORTANT ITEMS NOT LOADING ON ANY IDENTIFIED  
FACTOR.....299

## LIST OF TABLES

		Page
TABLE 1	Demographic Information of JCC Respondents .....	94
TABLE 2	Five Survey Questions with Highest Response Mean Score.....	104
TABLE 3	Research Questions/Hypothesis/Data Analysis Matrix .....	113
TABLE 4	Principle Components Factor Analysis.....	116
TABLE 5	Items Loading on <i>CWAAF</i> .....	120
TABLE 6	Items Loading on <i>IA</i> .....	122
TABLE 7	Items Loading on <i>DEI</i> .....	124
TABLE 8	Descriptive Statistics for Items Loading on <i>CWAAF</i> .....	126
TABLE 9	Descriptive Statistics for Items Loading on <i>IA</i> .....	129
TABLE 10	Descriptive Statistics for Items Loading on <i>DEI</i> .....	132
TABLE 11	Important Items Not Loading on Any Identified Factor.....	133
TABLE 12	Multivariate Analysis of Variance for <i>CWAAF</i> , <i>IA</i> , <i>DEI</i> Scale Scores and Sex, Ethnicity, Terminal Degree, and Service Area.....	136
TABLE 13	Intercorrelations between Factor Scale Mean Scores and JCC Variables of Percentage of Successful Cases, Hours of AOD Abuse Training, and Months of Experience.....	138
TABLE 14	Correlations of Factor Sum Scores and Attenuated Correlation of Factor Sum Scores .....	139

## LIST OF FIGURES

	Page
FIGURE 1	Average Cost of Allowing a Juvenile to Leave High School for a Life of Crime and Drugs .....21
FIGURE 2	Probation Supervision Administered by Local Juvenile Courts or by a State Executive Branch Agency.....60
FIGURE 3	Scree Plot.....117
FIGURE 4	Factor Analysis with Varimax Rotation .....119

## CHAPTER I

### INTRODUCTION

Adolescent alcohol and other drug (AOD) abuse is a significant social problem in the United States. Despite years of differing treatment methods, vast research studies, and national anti-drug campaigns such as Nancy Reagan's "Just Say No" movement, there is general consensus among treatment professionals and researchers that adolescent AOD abuse is, and will continue to be, a serious social problem in the U.S. (Daley & Raskin, 1991; Gonet, 1994; Schinke, Botvin, & Orlandi, 1991). Alarming, results from recent surveys indicate that approximately 10.2 % of eighth graders in the United States used an intoxicating substance in the 30 days preceding their survey participation (Monitoring the Future Study, 2003). This percentage increases dramatically for high school seniors, with 25.4 % having used some illicit drug within the 30 days preceding their survey participation (Monitoring the Future Study, 2003). That is, one-fourth of high school seniors reported being under the influence of marijuana or other illegal drugs in the past month. Additionally, approximately half of high school seniors and one-fifth of eighth graders have used alcohol in the last 30 days (Monitoring the Future Study, 2003).

Although these statistics indicate substantial AOD use by youth, they are considered to be significantly lower than the actual level of AOD use among adolescents as under-reporting of use is a common research problem (Substance Abuse Mental Health Services Administration (SAMHSA), 1999). It should be further noted that these

numbers reflect adolescent AOD abuse among only those persons currently attending school. It does not include, however, AOD use in dropouts and chronically truant students, a population thought to be especially prone to AOD abuse (SAMHSA, 1999). Additionally, researchers continue to demonstrate numerous psychological and sociological problems correlated with adolescent AOD abuse, including but certainly not limited to the following: delinquency and involvement with the court system, failing or below ability performance at school, risky sexual behavior resulting in greater risk of Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) or Sexually Transmitted Diseases (STDs), decreased cognitive function, poor relational skills, decreased coping ability, poor family relations, and psychiatric disorders (SAMHSA, 1999).

#### Juvenile Crime Rates

Juvenile crime, defined as unlawful activity by a person not yet recognized as an adult, is another significant social problem. From the late 1980's through the mid 1990's, juvenile arrest for violent crime (i.e., murder, rape, assault, robbery), weapons charges, and drug offenses increased substantially (Snyder & Sigmund, 1999). National statistics indicate that one in five arrests involve a juvenile (Office of Juvenile Justice and Delinquency Prevention (OJJDP), 1999). Furthermore, out of all arrests for the year 1997, juveniles accounted for 37 % of burglary arrests, 30% of robbery arrests, 24% of weapon charges, and 14% of drug arrests (OJJDP, 1999).

Prevalence data also suggest problematic trends in juvenile crime. United States law enforcement agencies made 2.3 million arrests of persons under age 18 in the year

2001 (Snyder, 2003). Unlike property crime rates that remained constant during the 1990s, violent crime rates among juveniles rose by 62% from 1988 to 1994 (OJJDP, 1999). Even more alarming, actual juvenile crime rates may be substantially higher, as many juvenile crimes are either unreported or unsolved (OJJDP, 1999). This is to say that when juveniles commit crimes or are suspected, the victim may choose to contact the juvenile's parents, or the arresting officer may choose not to carry the offense forward to prosecution, all in an attempt to keep the juvenile offender from having a criminal record (Snyder & Sigmund, 1999).

Perhaps the most egregious example of misrepresentation of the juvenile crime landscape involves reporting of multiple offenses by juvenile offenders. When a juvenile is arrested for multiple offenses, only the most serious offense is recorded in the Office of Juvenile Justice and Delinquency Prevention's databases (OJJDP, 1999). For example, if a juvenile offender is arrested at school for simple possession of marijuana (a misdemeanor), public intoxication (a misdemeanor), underage possession of alcohol (a misdemeanor), and carrying a concealed weapon on school grounds (a felony), only the felony charge is reported. Therefore, the reported rates of juvenile crime, while alarmingly high and certainly a cause for concern, are actually skewed toward the reporting of so-called "serious crimes" and do not give a true portrayal of the magnitude of this social issue.

#### AOD Abuse and Juvenile Crime

The two problems of adolescent AOD abuse and juvenile crime are inseparably intertwined (SAMHSA, 1999). Numerous researchers have established a substantial

correlation between substance abuse and juvenile delinquency and have developed an extensive body of literature examining this connection (Altshuler & Brounstein, 1991; Dembo, Pacheco, Schmeidler, Fisher, & Cooper, 1997; Dembo, Schmeidler, & Williams, 1991; Dembo, Williams, & Schmeidler, 1993; Dembo, Williams, & Schmeidler, 1994; Dembo, Williams, Wish, Dertke, Getreau, Wahsburn, & Schmeidler, 1988; Dembo, Williams, Wothke, & Schmeidler, 1992; Elliot, Huizinga, & Ageton, 1985; Elliot, Huizinga, & Menard, 1989; Greenwood, 1992; Hawkins, Jensen, & Catalano, 1988; Inciardi & Pottenger, 1991). Deschenes and Greenwood (1994) reported that rates of substance abuse are five times higher among juvenile offenders than rates of substance abuse among the general population of adolescents. Several researchers have documented the strong association between substance abuse among juvenile offenders and such crimes as selling drugs, serious assault, burglary, and robbery (Altschuler & Brounstein, 1991). Additionally, DeFrancesco (1996) found that 82 % ( $n = 113$ ) of delinquent youths admitted to a state detention facility were daily users of alcohol and other drugs just prior to admission.

#### Juvenile Justice Professional Training in AOD Abuse

Based on the literature review above, it seems logical that a substantial percentage of adolescents involved in the juvenile justice system have either abused AOD in the past or are current AOD abusers. The relationship between juvenile crime and adolescent AOD abuse is such that SAMHSA, a branch of the U.S. Department of Health and Human Services, has issued two Treatment Improvement Protocols (TIPS) that address these two co-occurring social issues: *Combining Alcohol and other Drug Abuse*

*Treatment with Diversion for Juveniles in the Justice System (Tip 21)* and *Continuity of Offender Treatment for Substance Use Disorders from Institution to Community (Tip 30)*. Additionally, SAMHSA released a practice guide, *Strategies for Integrating Substance Abuse Treatment and the Juvenile Justice System: A Practice Guide* in June of 1999.

This practice guide states in a section on recommended training for Juvenile Justice Professionals, “three basic sets of competencies that have been identified are *competencies in alcohol and drug counseling* (emphasis added), in juvenile justice, and in multicultural counseling” (Denver Juvenile Justice Integrated Treatment Network (DJJITN), 2000, p. 93). Additionally, Griffin and Torbet (2002), in their publication *The Desktop Guide for Good Juvenile Probation Practice* emphasized the importance of Juvenile Court Counselor (JCC) proficiency in the area of AOD abuse treatment.

Although JCCs must deal with a vast array of problem behaviors, there is no current evidence that JCCs are given consistent and substantial training or educational opportunities that prepare them to work with juvenile offenders experiencing AOD abuse problems. Although several recognized correctional agencies and national associations, (i.e., American Probation and Parole Association (APPA), American Bar Association, National Center for Juvenile Justice (NCJJ), American Correctional Association, have made recommendations for ideal training standards for JCCs, current research regarding training standards for JCCs show no evidence of a consistent application of these recommendations (Reddington & Kreisel, 2003).

## Juvenile Court Counselor (JCC) Training Requirements

Reddington and Kreisel (2000) recently documented the current trends and patterns of JCC job orientation and training. Utilizing a telephone survey of all 50 states and the District of Columbia, data were gathered concerning the required training prior to beginning job duties of a JCC, as well as required training while a JCC. Results indicated a growing trend toward required JCC certification, as 45% of the surveyed states currently certify their JCCs and two more states are studying the possibility of JCC certification. This leaves 26 states with no required JCC certification. Among those states that currently require certification of their JCCs, there are no standardized requirements. Thus, although there is a movement in the JCC field toward certification, the lack of a national certification leaves room for variability in terms of hours required for state certification, subjects covered during initial training, and experience required to obtain certification (Reddington & Kreisel, 2000).

Reddington and Kreisel (2003) also examined the curriculum content of JCC orientation programs across the United States to determine if there was consistency in course content. Utilizing a curriculum for JCC training developed by the National Center for Juvenile Justice (NCJJ) (Thomas, 1993) as a benchmark, these authors found that only one respondent state trained JCCs in the 14 NCJJ recommended areas, and one more state trained JCCs in all areas except the *Adolescents and Delinquency* content area. Eight was the modal number of content areas covered and six the average number. Of particular importance to the proposed study is that only slightly more than half of respondent states reported teaching the content area of *Special Problems and Appropriate*

*Responses*, which encompasses current research on “timely topics such as substance abuse clients, sex offense clients, and chronic delinquency” (Reddington & Kreisel, 2003, p. 42). Therefore, although there is a movement toward certification for JCCs and the use of standardized curriculum in training JCCs (Reddington & Kreisel, 2003), there is of yet no required or standardized competencies or curriculum in the area of AOD abuse treatment methods or clinical practice for JCCs.

This may be in part because the structure and administration of the Juvenile Justice System varies from state to state. Despite this variance in Juvenile Justice System structure, however, interventions within the juvenile justice system are basically the same across the nation (Siegel & Sienna, 2000). These interventions fall into two main divisions, community-based interventions and non-community based interventions (Siegel & Sienna, 2000). Examples of non-community based interventions are juvenile detention centers, wilderness camps, and pseudo-military “boot camps” (Siegel & Sienna, 2000). Such interventions comprise a small percentage of juvenile justice case referrals. The vast majority of juvenile court cases result in the referral of juvenile offenders to a community-based intervention known as probation (OJJDP, 1999; Snyder & Sickmund, 1999), a time-limited sentence where the offender is kept under observation by a court-appointed official and allowed to carry on activities of daily life within the community (Siegel & Sienna, 2000).

The person appointed by the court to oversee juvenile offender treatment is the juvenile court counselor (Siegel & Sienna, 2000). Although referred to by many titles (e.g., juvenile court counselor, juvenile justice specialist, juvenile community corrections

officer, juvenile or youth services counselors, corrections agents, juvenile service officers, or juvenile justice case managers), persons assigned these titles perform duties related to the administration of the juvenile probation sentence to the juvenile offender (Reddington & Kreisel, 2000). For clarity, the commonly-used title of juvenile court counselor (JCC) will be used throughout this study.

Given that the juvenile court counselor (JCC) is the person most frequently charged with the administration of juvenile offenders' probationary sentence, it seems logical that JCCs be both knowledgeable and skilled in the area of adolescent AOD abuse. With such skills and knowledge, the likelihood for an efficacious and productive probationary sentence for those juvenile offenders with co-occurring substance abuse would be greatly increased. Researchers have found, however, that this may not be the case (Reddington & Kreisel, 2003).

There have been some recent attempts to make the JCC profession aware of a need for competence in the area of AOD abuse treatment. Griffen and Torbet (2002) co-edited an update to Torbet's (1993) original "A Desktop Guide to Good Juvenile Probation Practice." In this updated version, they stated the following:

"Specialized staff should be available to address substance abuse issues among juvenile offenders, as well as specialized staff training should be provided about substance abuse among juvenile offenders. Additionally, there should be regular staff training on available substance abuse treatment and intervention options." (p. 111)

To summarize, despite the fact that the co-occurrence of juvenile crime and adolescent AOD abuse is well-substantiated, JCCs are not required by state or national

standards to have any sort of training, education, or clinical skill sets related to AOD abuse by adolescents. Federal agencies such as SAMHSA and the NCJJ have issued guides for JCC job performance that call for JCC competency in the area of AOD abuse by juvenile offenders. Therefore, this study proposes to investigate the types of knowledge and skills that are needed by entry-level JCCs to prepare them to address the AOD abuse of juvenile offenders.

### Statement of the Problem

Although the intertwining nature of adolescent AOD and juvenile crime seems apparent, there does not appear to be a clear manner by which to address these two co-occurring problems. The OJJDP sponsored research by Huizinger, Thornberry, and Loeber (1995), who found a clear interrelation between substance abuse and involvement in delinquent behavior. That same year, Wanberg (1995) found that longer juvenile offender involvement in AOD abuse treatment resulted in less use of AOD and lower criminal recidivism. Therefore, involving juvenile offenders in AOD abuse treatment appears to be an efficacious way in which to decrease the incidence of both problems. The majority of court-involved juvenile offenders receive probation (OJJDP, 1999; Snyder & Sickmund, 1999). Juvenile Court Counselors (JCC), the persons responsible for overseeing juvenile probationary sentences (Siegel & Sienna, 2000), therefore have far more interaction with juvenile offenders than other juvenile court officials.

Accordingly, previous researchers (DJJITN, 2000; Griffin & Torbet, 2002) and several federally-funded agencies (SAMHSA and NCJJ) have identified a need for JCCs to be skilled and knowledgeable in identifying AOD abuse issues. A lack of AOD abuse

knowledge and skills might lead to missed opportunities for AOD treatment or erroneous judgments about the nature of a juvenile offender's AOD abuse problems, thereby increasing the likelihood of return to juvenile offending and active AOD abuse.

The need for AOD abuse-trained professionals in the juvenile justice field was identified by the Center for Substance Abuse Treatment (CSAT) and OJJDP in 1995. CSAT and OJJDP began collaborating to develop curricula for professionals working in juvenile probation and parole that would help them to more effectively identify and manage substance abusing juvenile offenders (DJJITN, 2000). The resulting curriculum from the APPA includes three training curricula designed to help juvenile justice professionals identify and intervene with AOD abusing juvenile offenders. There is no evidence, however, that this APPA curriculum has been implemented systematically on a national level. Additionally, Reddington and Kreisel (2003) examined fundamental skills training curriculums offered by 49 of 50 states and only one of the 49 offered all the components recommended by the NCJJ for fundamental skills training of juvenile justice professionals. The lack of a national juvenile justice professional certification or licensure indicates a lack of clear standards for juvenile justice professionals in the performance of their job duties, much less in the specific area of treating the AOD abuse of juvenile offenders.

### Need for the Study

Probation, the most commonly used intervention of the Juvenile Justice System, occurs under the oversight and direction of the JCC. Therefore, JCCs are the juvenile

justice persons who have the greatest amount of interaction with juvenile offenders likely to have AOD abuse issues. Also, it appears that JCCs are not consistently required in either pre-employment training or education, or in continuing education standards, to have any particular level of skill or expertise in the treatment of AOD abuse.

Accordingly, a study is warranted to determine the skills and knowledge necessary for training JCCs to adequately address the issue of adolescent AOD abuse. The ultimate goal of this study is to inform an AOD training curriculum for current and future JCCs.

An investigation of JCC demographic variables such as gender, ethnicity, level of education, years of job experience, hours of substance abuse training, recent probationary success with juvenile AOD offenders, and whether the JCC works in a rural or urban service area was conducted to determine if differences in perception of necessary AOD abuse knowledge and skills exist as differentiated by these demographics. If and when such differences are found, then the aforementioned training curriculum would need to be modified or created in such a manner as to address these differences according to those demographic variables for which such differences may be found. For example, if differences exist between the necessary knowledge and skills for rural and urban counselors, then AOD training curriculums might be created according to whether a JCC has an urban or rural service area. This type of targeted education might then be used according to other demographic variables for which differences are found, allowing for more targeted and efficacious JCC training in AOD abuse knowledge and skills.

This study also may add to the general knowledge of counselor education. The International Association of Addictions and Offenders Counselors (IAAOC) is the

division of the American Counseling Association concerned with the topics of AOD abuse counseling and work with criminal offender populations. The very name of this division indicates a long history of the co-occurring nature of these two social issues, and how important it is that counselors and other helping professionals be able to successfully work with offenders who may be experiencing AOD abuse issues. Therefore, this study sought to determine necessary skills and knowledge for successful intervention with juvenile offenders, which could be of value for counselors and other mental health professionals who provide educational opportunities for JCCs.

#### Research Questions

The need for JCCs to assess and address adolescent AOD abuse competently seems apparent. What also seems apparent is the lack of specific requirements for substance abuse competency in pre-employment or continuing education for JCCs. Therefore, it was important to determine what specific skill-sets or knowledge concerning adolescent AOD abuse are needed by entry-level JCCs. To this end, the following research questions were proposed:

1. What is the factor structure of knowledge and skills concerning AOD abuse that characterizes the education and training needs of JCCs, as reported by currently employed JCCs and as measured by the Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire?
2. Given the factor structure from Question One, which specific AOD abuse knowledge and skills within each factor are considered most important for JCCs, as

reported by currently employed JCCs and as measured by the Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire?

3. Given the factor structure from Question One, what linearly related effects do JCC gender, JCC ethnicity, JCC service area (i.e., rural or urban classification) and JCC terminal degree, exhibit upon each of the factor-analysis derived scale scores for the Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire?
4. Given the factor structure from Question One, what are the relationships between percentage of successful cases, hours of JCC AOD abuse training since becoming a JCC, years of experience as a JCC, and the factor analysis derived scale scores for the Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire?

#### Definition of Terms

The following terms are defined as they appear in this study:

*Adolescent* – a person between the age of 12 and 17, per 10A North Carolina

Administrative Code 27G, Section .0103. (North Carolina Administrative Code, 2005).

*Alcohol and Other Drug (AOD) Abuse* – the maladaptive use of alcohol and other mood-altering chemicals such that continued use occurs after adverse consequences occur in a variety of life areas (e.g., physical, psychological, social, occupational, legal), yet continued use occurs (George, 1990; Lewis, Dana, & Blevins, 1988).

*Ethnicity* – for the sake of this study, the term “Ethnicity” will be defined as those groups (e.g., African American, Asian American, Latino, Native American) which are sampled on the U.S. 2000 population census (Greico & Cassidy, 2001).

*Juvenile Court Counselor (JCC)* – the person assigned by the judicial system to supervise the community intervention of probation with a juvenile offender (DJJDP Research and Planning Team, 2000).

*Juvenile Offender*– a person between the age of 13 and 18 who has committed a crime and has been charged with that crime within the Juvenile Justice System, rather than the Adult Justice System. That is, juveniles over the age of 16 who are charged as an adult are not considered juvenile offenders.

*Rural Service Area* –those counties identified as rural by the North Carolina Rural Economic Development Center, Incorporated, based on a population density of less than 200 people per square mile.

*Urban/Metro Service Area* – those counties identified as urban by the North Carolina Rural Economic Development Center, Incorporated, based on a population density of greater than 200 people per square mile.

#### Organization of the Study

This dissertation study is presented in five chapters. The first chapter is an introduction that discusses briefly the co-occurring social problems of adolescent AOD abuse and juvenile crime, the need for AOD abuse knowledge and skills among Juvenile Justice personnel, the primary intervention of the Juvenile Justice System for juvenile crime (probation), how Juvenile Court Counselors (JCCs) are responsible for the administration of probation, and the lack of AOD abuse skills training or knowledge in the orientation and training of JCCs. Additionally, Chapter One proposes the need for a study to determine the necessary knowledge and skills for entry-level JCCs in their work

with substance-abusing juvenile offenders, and details research questions associated with such a study. A definition of terms used in the proposed study is provided.

Chapter II contains a review of literature related to this study. This chapter reviews juvenile crime and corresponding law infraction rates, adolescent AOD abuse, the connection between juvenile crime and adolescent AOD abuse, the role of JCCs, training and educational requirements of JCCs, and previous research concerning JCCs and substance abuse treatment.

Chapter III addresses the design and methodology of this study. Research questions and preliminary hypotheses are stated and the rationale for the use of The Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire is discussed. The evolution of the questionnaire for use with the JCC population is detailed. Data analysis procedures and study limitations also are introduced.

Chapter IV reports the results of this study and Chapter V contains a summary of the research findings and limitations of the study. Implications for JCC training and future research also are provided in Chapter V.

## CHAPTER II

### REVIEW OF RELATED LITERATURE

Divided into two main sections, this chapter provides discussion of previous research relevant to the topic under investigation. The first section reviews selected articles about juvenile crime, adolescent alcohol and other drug (AOD) abuse, the co-morbidity of these two social issues, current court ordered interventions for juvenile offenders, and the training, supervision, and education of persons responsible for the implementation of court-ordered probation with juvenile offenders. The second section describes previous research identifying necessary substance abuse skills and knowledge for counseling professionals, identified training and educational recommendations for professionals who intervene with AOD abusing individuals, and the potential need for Juvenile Court Counselor (JCC) training in substance abuse issues.

#### Juvenile Crime and Adolescent Alcohol and Other Drug (AOD) Abuse

A recent report from the National Center on Addiction and Substance Abuse (CASA) at New York's Columbia University stated the following: “The road to juvenile crime and incarceration is paved with drugs and alcohol” (Califano & Colson, 2005, p. 1). Based on what is likely the most comprehensive analysis ever done of the link between substance abuse and juvenile justice, these researchers make some startling points: (1) 80% of arrested juvenile offenders are under the influence of alcohol or drugs when committing their crime, test positive for drugs, are arrested for a drug or alcohol

offense, admit to having substance abuse or addiction problems, or have some combination of these issues, (2) Drug and alcohol abuse is involved in 70% of violent juvenile crime, 72% of property offenses (burglary, theft, shoplifting), and 80% of other offenses such as vandalism, truancy, or disorderly conduct (fighting), (3) Only 3.6% of the 80% of juvenile offenders with substance abuse or addiction problems ever receive any treatment, (4) 75% of juvenile offenders suffer from a diagnosable mental health disorder, such as depression, anxiety, or schizophrenia, (5) 28% of juveniles arrested meet the diagnostic criteria for addiction, and (6) almost 80% of jailed juvenile offenders have a diagnosable learning disability. Further, these two researchers state, “virtually nothing is being done to stem this disturbing tide” (Califano & Colson, 2005, p. 2). In order to give a complete picture of the enormity of these two social issues, however, each will be separately described in detail. Then the co-morbid nature of juvenile crime and adolescent AOD abuse will be examined to further examine the intertwined nature of these two social problems.

### *Prevalence and Incidence of Juvenile Crime*

One of the most often used measures of juvenile crime is arrest rates for juvenile offenders, yet these arrest rates depict a fragmented and unclear picture and do not address a number of important concerns. For example, not all juvenile crimes are prosecuted. The intervening law enforcement official may decide not to take the juvenile into custody and may instead report the juvenile to their parents or have them engage in a juvenile diversion program (Siegel & Senna, 2000). As juvenile diversion programs do not create a formal record for the identified juvenile offender, there is not a recording of

the juvenile crime or crimes (Siegel & Senna, 2000). Further, many juvenile crimes may go unreported. The National Crime Victimization Survey of 1996 found that victims only reported 43% of violent crimes and 35% of property crimes, perhaps because crime is only likely to be reported if it involves a serious economic loss (Federal Bureau of Investigation (FBI), 1997). As juvenile crime is generally less serious in nature and involves less economic loss than adult crime (Snyder & Sickmund, 1999), it follows that juvenile crime is less likely to be reported. Additionally, a single crime may result in multiple arrests. This is particularly true for juvenile crimes as juveniles are more likely to commit crimes as a group (Snyder & Sickmund, 1999). These multiple arrests for one crime further complicate the overall picture of juvenile crime.

Therefore, to even know the true extent of juvenile crime is extremely difficult. Lack of prosecution of juvenile crime when offenders are juveniles and lack of reporting of juvenile crime due to low economic impact artificially decreases reported rates of juvenile crime. Finally, there is a serious under-reporting of juvenile crime due to Office of Juvenile Justice and Delinquency Prevention (OJJDP) procedure. When a juvenile offender is charged with multiple crimes, only the most serious crime is reported to the OJJDP database (Snyder & Sickmund, 1999). For example, if a juvenile is charged with breaking and entering, possession of stolen property, and forgery, only the most serious of these crimes (i.e., forgery, a felony in most states), is processed into the OJJDP database. Therefore, there are multiple potential sources of misinformation when attempting to ascertain the true extent of juvenile crime in America.

Despite juvenile crime data limitations, there are some statistics that warrant additional discussion. During the year 2003, approximately 16% of all arrests involved a juvenile, and 5% of all arrests for the same year were of persons under age 15 (FBI, 2004). For the same year, individuals under the age of 21 comprised 30.8 % of arrests, meaning that juveniles and young persons below the age of 21 comprised almost a third of all arrests (FBI, 2004). As there were 9,581,423 offenses for 2003, this means that there were approximately 1.5 million juvenile arrests for the year 2003 (FBI, 2004). During the years between 1990 and 2000, law enforcement saw large increases in juvenile arrests for violence (assault, rape, robbery, murder), drugs, weapons, and curfew violations (FBI, 1998). This trend appears to have reversed, though, as there was a 9.3% drop in the rate of violent crime per 100,000 inhabitants from the year 1999 to the year 2003 (FBI, 2004). This would indicate that current interventions might be having the desired effect of decreasing overall crime in the U.S.

Juvenile crime is not going away, however, and certain offenses (such as substance abuse) have increased dramatically (Snyder, 2003). Between 1992 and 2001, juvenile AOD abuse violations increased 121%, and driving while impaired violations for juveniles increased 35% for the same time period (Snyder). Therefore, although overall juvenile crime is at it's lowest since 1994, juvenile arrests for AOD abuse have precipitously increased. It is important to consider potential reasons why juvenile crime arrests for AOD abuse have increased in the same period of time that overall arrests for juvenile crime have decreased. In order to objectively describe the magnitude of juvenile crime costs to society, both short and long-term costs to our society will be detailed.

## The Costs of Juvenile Crime in America

The overall cost of juvenile crime is difficult to quantify due to the myriad of costs associated with prosecuting juvenile offenders, as well as the costs in personnel, court time, investigation, and other activities associated with juvenile crime.

Additionally, there are long-term costs associated with juvenile crime that may not be immediately apparent, such as the costs of housing adult offenders who began as juvenile offenders. Therefore, in order to more specifically focus on the costs of juvenile crime, short and long-term costs will be described in separate sections.

### *Short-term Costs*

The simplest way to quantify the short-term costs of juvenile crime might be to look at the economics of juvenile crime. Money is certainly not the only cost factor of juvenile crime, but it is a telling short-term factor and one that deserves attention. In their recent study on juvenile crime and adolescent substance abuse, CASA at *New York's Columbia University* found that a \$5000 investment in treatment for each of the substance-involved juveniles would break even if only 12 percent of those treated stayed in school and remained drug and crime free (Califano & Colson, 2005). According to the 1999 National Report on Juvenile Offenders and Victims (Snyder & Sickmund, 1999) from OJJDP, the average cost to the American public of allowing one juvenile to leave high school for a life of crime and drug abuse is 1.7 to 2.3 million dollars (See Figure 1). This monetary figure assumes that a juvenile offender will engage in other negative behaviors such as quitting school and/or using Alcohol and other Drugs (AOD). This seems a logical assumption in light of the findings of Califano and Colson (2005).

<b>Invoice</b>	
<b>To: American public</b>	
<b>For: One lost youth</b>	
	Description Cost
<b>Crime:</b>	
Juvenile career (4 years @ 1–4 crimes/year)	
Victim costs	\$62,000–\$250,000
Criminal justice costs	\$21,000–\$84,000
Adult career (6 years @ 10.6 crimes/year)	
Victim costs	\$1,000,000
Criminal justice costs	\$335,000
Offender productivity loss	\$64,000
<b>Total crime cost \$1.5–\$1.8 million</b>	
<b>Present value* \$1.3–\$1.5 million</b>	
<b>Drug abuse:</b>	
Resources devoted to drug market	\$84,000–\$168,000
Reduced productivity loss	\$27,600
Drug treatment costs	\$10,200
Medical treatment of drug-related illnesses	\$11,000
Premature death	\$31,800–\$223,000
Criminal justice costs associated with drug crimes	\$40,500
<b>Total drug abuse cost \$200,000–\$480,000</b>	
<b>Present value* \$150,000–\$360,000</b>	
<b>Costs imposed by high school dropout:</b>	
Lost wage productivity	\$300,000
Fringe benefits	\$75,000
Nonmarket losses	\$95,000–\$375,000
<b>Total dropout cost \$470,000–\$750,000</b>	
<b>Present value* \$243,000–\$388,000</b>	
<b>Total loss \$2.2–\$3 million</b>	
<b>Present value* \$1.7–\$2.3 million</b>	
* Present value is the amount of money that would need to be invested today to cover the future costs of the youth's behavior.	
Source: Authors' adaptation of Cohen's The monetary value of saving a high-risk youth, Journal of Quantitative Criminology, 14(1). Used with permission, see Appendix C	

Figure 1. Average Cost of Allowing a Juvenile to Leave High School for a Life of Crime and Drugs.

Examination of juvenile arrest data versus state expenditure for juvenile justice of one southeastern state, North Carolina, yields some telling facts regarding the short-term monetary cost of juvenile crime. Approximately 130,000,000 dollars were budgeted in North Carolina for juvenile justice efforts for the year 2003. According to published reports, there were approximately 93,000 juveniles served by these funds, an average cost of approximately \$1,400 per served juvenile. Only 30,598 of those juveniles ever actually went through an intake process for juvenile justice services, however, and only 16,606 were referred to court. If one were to look at state expenditure amount versus number of juvenile offenders who actually received intake and subsequent services, whether diversion to community-based services or involvement in approximately \$4300 per juvenile offender. Monetary costs are short-term in nature, however, and are eclipsed by the long-term costs to society and to the juvenile offender in terms of identity development, self-esteem, and lost opportunities for education, socialization, and psychological development. It is these costs that will be discussed next.

#### *Long-term costs*

Juvenile crime has a number of long-term costs, especially to juvenile offenders themselves. Long-term costs may be divided into two main areas, costs for society and costs for the juvenile offender. This will be examined separately in following sections.

*Societal Costs.* Researchers have found that juvenile offenders have an increased chance of committing crimes as adults (Shannon, 1982; Snyder, 1988; Tracy & Kempf-Leonard, 1996; Wolfgang, Thornberry, & Figlio, 1987; Ge, Donnellan, & Wenk, 2001). Further, Califano and Colson (2005) reported that if the United States were to prevent the

criminal behavior and incarceration of just 12 percent of adults with corresponding juvenile records, 18 billion dollars in criminal justice and health care costs would be saved, not counting the 6 million fewer crimes that would be committed or the increased tax revenue as a result of 60,000 additional persons (who would have been inmates at a correctional institution) contributing to the overall tax base of our economy.

The increased chance of re-offending by juvenile offenders has been documented by several different researchers. Clemets, Rosenfield, and Owens (2002) found that for 1000 youth in Vermont for whom a delinquency petition was filed resulting in adjudication, approximately 57.3% of the youths had a new delinquency or criminal charge filed against them in the four years following the initial delinquency petition case. An intriguing aspect of this study was that Clements and his co-researchers followed this same cohort for four years and rates of re-offending dropped each year. For the first year, 46.4% of original participants had a new charge filed. In the second year, 21.5% were charged with a new offense, and in the third year 13.3% received new charges. For the fourth year, 11.2% were charged with a new offense. Although rates of new charges dropped within this sample for each passing year, a substantial number of participants were charged with a new offense between 4.0 and 4.5 years after the original offense ( $n = 64$ ). This indicates that had these authors continued their research, a distinct possibility of a higher rate of re-offending may have been found for the fifth year or beyond (Clement, et.al., 2002).

Additional research about adult re-offending by juvenile offenders was collected by the North Carolina Sentencing and Policy Advisory Committee, who looked at the

rates of recidivism for 2,062 juveniles for whom an initial delinquent petition was filed in 1997. Following a five-year period, the committee found that 32% had a subsequent delinquent petition filed with the court, and 63% were arrested as an adult, including adult charges (Dawes, Ferguson, Ebron, & Katzenelson, 2003).

An investigation by Clarke (2001) provided compelling evidence that juvenile offenders adjudicated to Youth Development Centers are highly likely to commit additional crimes and receive additional sentences within the juvenile justice system. Using a random sample of youths released from Youth Development Centers ( $n = 288$ ) with follow up anywhere from 21 to 47 months, Clarke found that 88.5 % ( $n = 255$ ) were charged with a crime and 58% ( $n = 167$ ) were convicted of a crime. This presents a significant monetary cost in terms of prosecution and court costs, not to mention incarceration, probation, or community based services costs, all for persons who have previously been through the juvenile justice system. Finally, these individuals went through the system at it's most expensive level, that of incarceration, yet one outcome appears to be a high likelihood of re-offending.

These studies further illustrate the simple fact that juvenile offenders present a significant cost to society, both short and long-term. It would be dismissive of the true cost of juvenile crime, however, if the focus was purely on the monetary cost of addressing juvenile crime. The true cost of juvenile crime lies within the juvenile offender, and the identity created through chronic offending. Therefore, the cost of juvenile crime for the offender will now be detailed.

*Costs for the juvenile.* While no single theory of delinquency predominates within the field of juvenile justice (Siegel & Senna, 2000), labeling theory, one of the major theories of delinquency, posits that when juvenile offenders commit their first offense, they are sometimes subsequently labeled by the system as “bad kids” rather than “kids who did something bad”. The resulting response of the juvenile offender is to self-identify as someone who is indeed a “bad kid” (Siegel & Senna, 2000). Therefore, the cost for the juvenile is the development of a self-identity based on criminal activity, which increases the likelihood for re-offending. Additionally, a negative social label such as “juvenile delinquent” or “bad kid” likely will decrease self-esteem and any commitment to social institutions such as school or church, especially when delinquent peers (themselves a product of labeling) further reinforce distrust of these institutions through their own labeling process for school, police, or counselors. This allows for alignment of the deviant peer group together against the source of their negative labels and simultaneously reinforces the juvenile offender’s negative self-image (Kaplan, Johnson, & Bailey, 1987).

Another cost for a juvenile offender is ongoing involvement in the juvenile justice system and the resulting difficulties this may create. When juvenile offenders are released from incarceration, they are almost always assigned to some sort of “aftercare program”, the juvenile corollary of parole for adult offenders (Siegal & Senna, 2000). Often, these juvenile offenders have the following issues with which to contend when they attempt reintegration into society: (a) they are accustomed to a highly regimented environment and have difficulty making independent decisions, (b) incarcerated individuals often

perceive themselves as outsiders or misfits from regular society, and (c) the community itself may view the returning juvenile offender with a great deal of suspicion, thereby unintentionally reinforcing the offender's negative beliefs about self and society (Siegel & Senna, 2000).

Finally, in speaking directly with a currently employed JCC, it was reported that after involvement with the juvenile justice system, most juvenile offenders share the following problems: delayed school achievement, difficulty with reintegration, association with negative peer group, suspicion by school officials, lack of trust by parent and other authority figures, and numerous mental health and substance abuse issues (J. Didona, personal communication, September 13, 2004). While the possibility exists that these problems predicated involvement in the juvenile justice system, these difficulties aptly demonstrate that juvenile offenders have a multitude of problems both during and after their involvement in juvenile justice interventions. The following section will specifically address one significant issue with juvenile offenders, their use of alcohol and other drugs (AOD), as well as exploring the various costs of this social problem.

#### The Cost of Juvenile AOD Abuse in America

Juvenile AOD abuse is possibly one of the largest public health problems in our society. In order to get a comprehensive understanding of this particular issue, it is necessary to know both the extent and ramifications of such a problem, both to the juvenile and to society as a whole. Therefore, both the incidence and the effects of juvenile AOD abuse will be described in the following sections.

### *Incidence of Juvenile AOD Abuse*

One of the largest surveys of juvenile Alcohol and Other Drug (AOD) abuse is the Monitoring the Future Study (Johnston, O'Malley, Bachman, & Schulenberg, 2005), which gathered data about the drug use behavior of 50,000 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> graders across the nation. According to this study, there have been gradual declines in the overall use of AOD by juveniles in these sampled groups. For example, the category of any illicit drug use by respondents in their lifetime reached a peak incidence level of 55% in the year 1999, but has since decreased to a level of 51% for the year 2004. While this marks a decrease in overall use of drugs, over half of the juveniles in our society still engage in illegal drug use before graduating from high school. One particular area of concern is the use of inhalants by juveniles, for unlike other abused drugs such as marijuana and cocaine where there have been slight decreases in use, there has been a statistically significant increase in the use of this class of illicit substances by 8<sup>th</sup> graders (Johnston, et.al, 2005).

Another significant source of information about juvenile AOD abuse is the National Survey on Drug Use and Health (NSDUH), conducted yearly by the Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies, a division of the Department of Health and Human Services. For the year 2003, 3.8% of 12-13 year old, 10.9% of 14-15 year old, and 19.2% of 16-17 year old juveniles reported using some type of illicit drug in the last 30 days (SAMHSA, 2004). What this means is that close to one in five persons aged sixteen or seventeen admitted to using an illegal drug in the last month.

Illegal drug use is only part of the problem. Use of alcohol by juveniles is widespread in our society, with more than three out of every four students reporting that they have consumed alcohol by the end of high school. In fact, nearly half of all students have done so by the end of 8<sup>th</sup> grade. Additionally, while 60% of 12<sup>th</sup> graders report being drunk at least once in their life, 20% of 8<sup>th</sup> graders report this as well (Johnston, et.al, 2005). When data from the 2003 NSDUH is examined, a potentially disturbing trend regarding binge use of alcohol use is apparent. Defined as consuming more than five drinks in one sitting (SAMHSA, 2004), binge drinking rises alarmingly with increasing age among teens. While only 0.9 percent of 12 year olds report binge drinking, this percentage increases to 2.2 percent at age 13, 7.1 percent at age 14, 11.7 percent at age 15, 18.0 percent at age 16, and 24.5 percent at age 17 (SAMHSA, 2004). Also, 17.7 percent of 12-17 year olds report using alcohol in the 30 day time period prior to being sampled for the NSDUH (SAMHSA, 2004).

These statistics verify that adolescent AOD abuse, while decreasing slightly in recent years, continues to be one of our largest public health problems. An examination of various costs associated with juvenile AOD abuse follows, to portray a more comprehensive picture of the scope of this problem.

#### *Cost to the Juvenile*

One of the primary costs of juvenile AOD abuse is a direct negative effect on the development of the juvenile who engages in AOD abuse. Often, the physical costs associated with juvenile AOD abuse are discussed without considering the psychological costs associated with juvenile AOD abuse. While a discussion of physical risks

associated with juvenile AOD abuse is certainly warranted in creating a comprehensive picture of this social problem, a description of unwanted psychological effects is necessary as well, to provide the aforementioned comprehensive description of possible negative consequences for juveniles engaging in AOD abuse.

*Physical effects on the juvenile.* It should be noted that variability in physical development and maturation is the norm rather than the exception with juveniles, so any attempt to describe or quantify the negative effects of AOD abuse on physical development would have to take into account significant variability among juveniles. Additionally, using general statistics that include adults as research participants is useless, as the physical effects of using drugs are markedly different for juveniles than they are for adults (Gonet, 1994). Therefore, the physical effects associated with AOD abuse will be discussed only in light of how juveniles might be affected by such use.

By far the leading cause of death for youth aged 10-24 is motor vehicle crashes (32.3%), which accounts for approximately a third of all deaths among this age group (Center for Disease Control (CDC, 2004). Nearly half of all traffic fatalities are alcohol related, and it is estimated that a total of 2.5 million adolescents drive under the influence of alcohol (CSAT, 1999). The other three leading causes of death for youth age 10-24 are other unintentional injuries (11.7%), homicide (15.2%), and suicide (11.7%). Interestingly, the 2003 Youth Risk Behavior Survey indicated that during the 30 days preceding the survey, numerous respondents had engaged in AOD abuse behaviors that substantially increased their likelihood of inclusion in these four cause of death categories (CDC, 2004).

One main physical risk factor for AOD abusing youth is risky sexual practices. Not only are juveniles at a higher risk of acquiring STDs than adults, juveniles who engage in AOD abuse are more likely than other juveniles to engage in sexual intercourse and sexually risky behaviors (CSAT, 1999), including unprotected sex, sex with multiple partners, and sex without any method of birth control. Also, of sexually active juveniles, one in four reports using drugs and alcohol prior to their last sexual encounter (CDC, 2004).

*Psychological effects on the juvenile.* The psychological effects of juvenile AOD abuse are far-reaching and multi-dimensional in nature. Juvenile AOD abuse can prevent juveniles from completing a myriad of developmental tasks, such as creating close friendships, establishing a career, or having intimate partners (Baumrind & Moselle, 1985; Newcomb & Bentler, 1989), perhaps because a juvenile's use of chemicals may seriously stunt their emotional and social growth (CSAT, 1999). For example, Gonet (1994) described the developmental stunting that occurs with juveniles multi-year use of substances, such as an 18 year-old who giggles inappropriately during a group session, a 16 year-old overly concerned with collections and hobbies (latency age activities), or a 17 year-old who has difficulty with abstract thinking.

When juveniles continue to engage in AOD abuse for a period of time, they may experience psychological problems such as agitation, depression, or paranoia (Nowinski, 1990). These issues may be compounded by the psychosocial problems juvenile AOD abusers sometimes experience such as escapism, egocentrism, externalized locus of control, self-derogation, and alienation and estrangement (Baumrind & Moselle, 1985).

These difficulties may further exacerbate the juvenile's use of chemicals as the cycle of AOD abuse is perpetuated in an attempt to self-medicate the psychological distress initially occasioned by AOD abuse.

Further, there is a delay in cognitive and ethical development associated with juvenile abuse of AOD (Crowe, 1999; Hall & Solowij, 1996), including a lack of transition to abstract thinking and decision-making based on ethics rather than possible consequences. Additionally, an adolescent may develop a superficial and false self-image as a result of increasing identification with the drug culture and drug users, rather than a healthy self-image based on positive life experiences (MacKenzie, 1993).

Another psychosocial effect is a drop in educational performance. Declining grades, increased absenteeism, and dropping out of school are associated with juvenile AOD abuse (Nowinski, 1990). Additionally, a drop in grades often is one of the first indicators of a young person's involvement with drugs, as many drugs impede or otherwise negatively effect a juvenile's learning process (Gonet, 1994). In fact, a drop in academic performance is one of the key indicators of juvenile AOD abuse listed on the following well-known AOD abuse web pages: National Institute on Drug Abuse – <http://www.drugabuse.gov/MarijBroch/parentpg7-8N.html>; Parents. The Anti-Drug – [http://www.theantidrug.com/ei/signs\\_symptoms.asp](http://www.theantidrug.com/ei/signs_symptoms.asp); and American Council of Drug Educators – <http://www.acde.org/common/Symptom.htm>.

These delays in cognitive, psychosocial, and ethical development can be minimized by intervening as early as possible to prevent these short-term effects from becoming long-term in nature (CSAT, 1999). In order to see why early detection and

treatment is such an important goal, it also is important to consider the societal cost associated with juvenile AOD abuse.

### *Costs to Society*

Because juveniles are not of adult age, it falls to society to provide for their care and protection, whether as a parent, care-giver, or publicly-funded program designed to address the problem of juvenile AOD abuse. Therefore, should a juvenile engage in AOD abuse, there is a cost for society in the treatment of that abuse. It is this cost that will be addressed in the following section.

*Familial impact.* While much has been written about the effects of family dynamics as it relates to adolescent AOD use, it is beyond the scope of this section to fully describe these extraordinarily complex interactions and the hypothesized effects these interactions have on juvenile AOD use. Therefore, this section will limit itself to researched effects of juvenile AOD abuse on families. It should be noted, however, that one should always consider systemic interactions between juvenile AOD users and their parents, siblings, and other caregivers when examining juvenile AOD abuse, such as AOD abuse by parents, siblings, or other influential members of the family system.

The families of AOD abusing juveniles suffer some negative effects associated with a juvenile member's use of AOD. Just as the juvenile is likely to become preoccupied with AOD use, so is the family likely to become preoccupied with the juvenile's use of AOD, often to the detriment of the marital relationship and other family sub-systems (Crowe, 1999). Possible effects on the family include experiencing guilt over the juveniles use of AOD (Crowe, 1999), marital discord and withdrawal from

family communication (Seilhamer, 1991), decreased time available for other family members (Nowinski, 1990), lack of trust among family members (Gonet, 1994), enmeshment among family members (Kaufman & Kaufman, 1992), and lack of clear rules and limits on behavior (Reilly, 1992). This is not meant to be an exhaustive list of the effects of juvenile AOD abuse on families, but merely to show how varied the effects may be on a family when a juvenile begins using AOD. Clearly, though, juvenile AOD abuse has a negative effect on the family social unit.

It should be noted that the juvenile AOD users are often influenced by the AOD abuse of their parents or other major care-givers (Secades-Villa, R., Fernandez-Hermida, J. R., & Vallejo-Seco, G., 2005) and research has documented that children with substance-abusing parents are more at risk than their peers for alcohol and drug use, delinquency and depression, as well as poor school performance (Clair & Genest, 1984; Gfroerer & De La Rosa, 1993; Gfroerer, 1987; Gross and McCaul, 1987; Johnson, Leonard, & Jacob, 1989; West & Prinz, 1987; Werner, 1986). Therefore, care should be exercised before blaming juvenile AOD abuse for creating dysfunction within a familial unit.

*Short-term costs.* Further, the economic costs associated with juvenile AOD are extensive. Most persons think of theft as the primary cost associated with juvenile AOD abuse, as juveniles usually begin with stealing liquor or beer from their parents during the early phase of their AOD abuse (Crowe, 1999; Gonet, 1994). This may then progress to theft of household items or money, selling possessions, or dealing drugs, all done to obtain AOD and support their increased use (Fisher & Harrison, 2000). Other costs from

criminal activity related to AOD abuse include provision of correctional facilities, courts, treatment, increased police presence, and other costs associated with the apprehension, prosecution, and punishment of juvenile AOD abusers (Crowe, 1999). In fact, a previous section details the cost of juvenile crime, and in a subsection of Figure 1 (see page 21), 150,000 to 360,000 dollars is projected as the amount of money needed to treat the AOD abuse of one juvenile. Certainly juvenile AOD abuse presents a significant economic burden to our society, even in the short-term. It is the long-term costs of juvenile AOD abuse that will be examined next.

*Long-term costs.* Long-term costs are difficult to measure, due to a general lack of longitudinal research in the area of juvenile AOD abuse. Certainly one area to examine, however, is the psycho-social development of an adult and how it may be affected by juvenile AOD use. Adolescence is a time of identity development, of movement from childhood to adulthood (Gonet, 1994; Perkinson, 2002). Therefore, for those persons who engage in AOD abuse during adolescence, there exists a high probability of a negative effect on their identity development as a result of their increasing reliance on AOD abuse as a means to cope with life stressors (Baurind & Moselle, 1985; Crowe, 1999; CSAT, 1999). Further, it is during the adolescent stage that a more solid sense of self is first formed, a time in which juveniles begin to form ideas about themselves and their place in their family, their community, and the world.

Therefore, the decision to engage in AOD abuse during this period of time can have dramatic long-term consequences in the form of stunted coping skill development, an under-developed sense of self, and inability to handle life stressors. Among recovering

persons, there is a widespread belief that whenever someone begins using AOD, their emotional development stops, meaning that when a person enters recovery, their emotional age may be that of a 13 year-old living in the physically aged body of a much older person (M. Cox, personal communication, May 20, 2004).

Other long-term effects would include effects on the cognitive and physical development of adults who were regular AOD abusers as juveniles. One particularly interesting study of this phenomenon was done with a cohort of Costa Rican men (Fletcher et. al., 1996). A group of heavy cannabis smokers of approximately 45 years of age ( $n = 17$ ) who had been using heavily since age 11, for a total of 34 years of heavy cannabis use, were compared to a group of cannabis users with an approximate age of 28 ( $n = 37$ ) who had been using heavily for 8 years. Both groups were tested on short-term memory, long-term memory, and attentional skills. The long-term cannabis users had significant disruption of short-term memory, working memory, and attentional skills, as compared to the short term users of cannabis.

There is a substantial body of knowledge related to the long-term effects of drugs such as methamphetamine on the cognitive functions of persons no longer using the drug (Ernst, Chang, Leonido-Yee, & Oliver, 2000; Nordahl, Salo, & Leamon, 2000; Obrocki, Buchert, Vaterlein, Thomasius, Beyer, & Schiemann, 1999). In short, use of this chemical has lasting effects on the user's short and long-term memory, as well as their ability to sustain attention to tasks. It is difficult to imagine what effect juvenile use of methamphetamine might have on an adult's ability to function socially, occupationally, or relationally in our society, but it is almost certain to create difficulties.

The preceding research shows that if a juvenile is engaging in AOD abuse, they likely are impairing their developmental, physical, and cognitive development in a negative manner such that the effects may be long-term. The following section examines a specific sub-group within juvenile AOD abuse, those persons who are experiencing both a substance abuse issue and a mental health issue, commonly referred to as a co-occurring disorder.

#### *Co-morbidity with Other Disorders*

Often, juvenile AOD abuse presents with other disorders of mood, thought, or behavior. In fact, co-occurring disorders of juvenile AOD abuse and mental or behavioral disorders are common (Clark, Pollock, Bukstein, Mezzich, Bromberger, & Donovan, 1997) and thus are integrally related, necessitating treatment of both disorders to result in optimal outcome (CSAT, 1995; CSAT, 1999). For example, Latimer, Winters, and Stechfield (1997) found in their research that approximately 80% of adolescents in correctional institutions met the criteria for AOD abuse, while 82% of adolescents receiving inpatient substance abuse treatment met the criteria for an Axis I disorder in the DSM-IV-TR (2000). Other researchers have identified the presence of conduct disorders in juveniles receiving AOD abuse treatment (Grilo, Daniel, Levy, Edell, & McGlashan, 1995) and that approximately 91% of juveniles abusing substances also had a psychiatric disorder (Milin, Halikas, Meller, & Morse, 1991).

There has been considerable discussion in recent years about co-occurring disorders with AOD abuse. Though *dual diagnosis* was a once-widely used term to describe persons suffering from an AOD abuse disorder and a mental health diagnosis,

the most often-used term at present is *co-occurring disorders*. Indeed, this particular issue has received such attention as to warrant the issue of a new Treatment Improvement Protocol (TIP) from the Substance Abuse and Mental Health Service Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) entitled *Substance Abuse Treatment For Persons with Co-Occurring Disorders* (CSAT, 2005) as a follow-up to a previous TIP, *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse* (CSAT, 1994). In order to gain a basic level of understanding of this issue, research specifically regarding juveniles will be examined to illustrate the extent of this problem.

One study of note involved a sample between the ages of 14 and 17 years ( $n = 401$ ) who were already diagnosed with an AOD abuse disorder and were then assessed for the presence of a psychiatric disorder (Kandel et. al., 1999). Utilizing a structured clinical interview assessment, these researchers found that adolescents with AOD abuse disorders were three times more likely to have an anxiety, mood, or disruptive behavior disorder than those adolescents without an AOD abuse disorder. These researchers were not able to determine if the psychiatric disorder was present prior to the development of the AOD abuse disorder, a common problem when examining co-occurring disorders (CSAT, 1994; CSAT, 2005).

Another study of interest sought to determine whether a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) would have any effect on likelihood of relapse to active AOD use among a sample ( $n = 220$ ) of juveniles who completed treatment (Latimer, Ernst, Hennessey, Stinchfield, & Winters, 2004). After controlling for

demographics, pre-treatment conduct-disorder behavior, alcohol use frequency, and treatment factors, they found that those AOD abusing youth with probable ADHD status had a 2.5 times greater risk of post-treatment alcohol relapse than those youth without probable ADHD status. Therefore, it would appear that if a juvenile has a probable diagnosis of ADHD that is not treated or properly addressed during the course of their substance abuse treatment, then that adolescent may be more likely to return to active use of AOD post-treatment. This study highlights the importance of addressing mental health disorders that co-occur with an AOD abuse disorder to make treatment maximally effective.

Some authors have written about the need for treatment specifically constructed to address the needs of juveniles with AOD abuse and co-occurring disorders. For example, Jorgenson and Salwen (2000) describe a day treatment model for dual-diagnosed adolescents. These authors speak at length about the need for a treatment model that addresses both AOD abuse and co-occurring disorders, staffed by competent and caring staff able to appropriately deal with these two issues, as well as the complex needs present in such clients. This research illustrates the connection between juvenile crime and AOD abuse that will be further explored in the following sections, in which the intertwining nature of these two issues will be discussed further.

#### The Co-morbidity of Juvenile Crime and Adolescent AOD Abuse

The preceding sections have detailed both juvenile crime and adolescent AOD abuse. In order to further explore these two social problems, additional information about

the co-occurrence of these two social issues and the effect of treating both issues simultaneously is provided.

*Incidence of Co-morbid Juvenile Crime and AOD Abuse*

One way to consider the co-morbidity of juvenile crime and AOD abuse is to examine juvenile arrests involving AOD abuse. Numerous researchers have established a substantial correlation between AOD abuse and juvenile delinquency and have developed an extensive body of literature examining this connection (Altshuler and Brounstein, 1991; Dembo, Pacheco, Schmeidler, Fisher, & Cooper, 1997; Dembo, Schmeidler, & Williams, 1991; Dembo, Williams, Fagan, & Schmeidler, 1994; Dembo, Willimas, & Schmeidler, 1993; Dembo, Williams, & Schmeidler, 1994; Dembo, Williams, Schmeidler, & Howitt, 1991; Dembo, Williams, Wish, Dertke, Berry, Getreau, Wahsburn, & Schmeidler, 1988; Dembo, Williams, Wothke, & Schmeidler, 1992; Elliot, Huizinga, & Ageton, 1985; Elliot, Huizinga, & Menard, 1989; Greenwood, 1992; Hawkins, Jensen, and Catalano, 1988; Inciardi & Pottenger, 1991). It seems important here to consider specific research that further describes and investigates this relationship.

In one of the larger studies to examine the co-occurrence of juvenile delinquency and AOD abuse, Corwyn and Benda (2002) analyzed a stratified random sample of 3,550 adolescents selected from 55 public school districts in a Midwest state. Their research sought to gather evidence for a delinquency syndrome through the use of cluster analysis. In doing so, they sought to determine the overlap, if any, of criminal behavior, alcohol consumption, and various drug use by adolescents in their sample. Additionally, they sought to determine the amount of overlap between these delinquent behaviors by age,

gender, and ethnicity. A limitation of this study is that the researchers chose to dichotomize ethnicity into two groups, White and non-White. Their findings provided support for a delinquency syndrome, in that a statistically significant relationship was found between the types of delinquent behavior studied (i.e., those juveniles who engage in alcohol use also tend to engage in various drug use and commit crimes). Additionally, utilization of a log-linear procedure identified ethnicity and gender as having significant interactions with these three forms of delinquency. More specifically, a greater percentage of males than females, 50% versus 39%, were involved in all forms of delinquency such as using various drugs and alcohol while committing crimes. This was also the case for the 5% of females who committed three or more crimes while drinking alcohol versus the 9% of males who engaged in the same behavior.

Regarding ethnicity, all percentages for use of various drugs and alcohol while engaged in crime were higher for non-White participants versus White participants. An exception to this was found for non-White participants for whom the drug of choice was alcohol, rather than various other drugs. For this group, White participants engaged in crime at a higher rate while using alcohol than did non-White participants. In short, if alcohol was the drug of choice for a White participant, they were more likely to engage in other delinquent behavior at a rate greater than a non-White participant for whom the drug of choice was alcohol. These authors, however, caution that racial differences should be interpreted with caution due to differences among African-Americans and whites in their exposure to sociological stress. Interestingly, age, while found to be

statistically significant in this analysis, did not account for enough variation between observed and expected values to be included in the best fit model.

A particularly important facet of Corwyn and Benda's (2002) work is the one conclusion they drew from their examination of such a large sample of adolescents: when adolescents use drugs or alcohol, they are more likely to be involved in delinquent behavior and, therefore, more likely to become involved in the juvenile justice system. It should be noted, however, that the authors' use of a school based sampling method would mean the exclusion of those adolescents not attending or expelled from school. Therefore, their findings may actually under-estimate the strength of this relationship. As identified by other researchers, dropping out of school is associated with engaging in delinquent behavior and AOD abuse (Dembo, Williams, Schmeidler, & Howitt, 1991). By failing to sample juveniles no longer attending school, Corwyn and Benda may have excluded an important segment of the population of interest.

White, Tice, Loeber, and Stouthamer-Loeber (2002) sought to examine the proximal effects of alcohol and/or drugs on adolescent crime. Using four years of longitudinal data for 506 adolescent males, these authors found a complex relationship between AOD abuse and adolescent crime. For example, they found no evidence of an interaction between alcohol and drug use with impulsivity or deviant peer involvement in predicting the commission of illegal acts while under the influence. Significant relationships were found, however, between committing an act of crime and being under the influence, committing an aggressive act and being under the influence of alcohol, and committing assault rather than theft when under the influence of drugs or alcohol. In

short, this study found a connection between an adolescent being under the influence of AOD and engaging in criminal behavior. Use of AOD did not, however, significantly predict whether an adolescent would commit a crime.

Prinz and Kerns (2003) provided evidence for the association between AOD abuse and criminal behavior with a unique study that examined the connection between early initiation of drug use and later criminal behaviors. By surveying teens involved in the juvenile justice system (93 males, 96 females; 58% African American, 42% European American), these authors determined that over 79% had used an illegal intoxicating substance by age 13, with an alarming percentage (27%) having used by age 11. These researchers found that for a substantial portion of their sample, 32% of males and 39% of females, early initiation of alcohol or marijuana use turned into frequent early use of alcohol or marijuana. Additional analysis of data utilizing a chi-square analysis found a significant relationship between early use of marijuana, alcohol, or cigarettes and later use of inhalants, hallucinogens, or crack/cocaine ( $\Phi = 4.33, 1.47, 0.80$ , respectively). Interestingly, further analysis using an odds-ratio format indicated that use of any drug before age 12 more than doubled the likelihood that a female would be charged with a status offense or drug offense. Further, if female participants engaged in alcohol use prior to age 10, they were 3.69 times more likely to be charged with a substance related offense. These results indicate that engagement in early childhood substance abuse occurs at a substantial rate for those juveniles who later engage in delinquent behavior and are involved in the juvenile justice system. This further demonstrated that juvenile crime and adolescent AOD abuse are two regularly co-occurring problems. Prinz and Kerns argued

that interventions need to consider both issues, rather than addressing only one or the other.

The multicultural nature of the link between juvenile crime and AOD abuse was addressed by Williams, Ayers, Abbott, Hawkins, and Catalano (1999) in a follow-up study to a longitudinal research project on juvenile delinquency and substance abuse. This follow-up study looked at differences in patterns and paths of risk factors for African American and White youth, utilizing a sub-sample ( $n = 567$ ) of White and African American youth from the original longitudinal research sample ( $n = 808$ ). As part of the initial longitudinal research project, surveys were administered to an ethnically diverse group of 12 to 13 year-olds (46 percent were White (not including Hispanic/Latino), 25 percent were African American, 21 percent were Asian American, and 8.5 percent were classified in other ethnic groups). For the follow-up study, delinquency and substance abuse outcome measures were created from data collected three to four years later from the original research sample ( $n = 808$ ), but only data from White and African American participants ( $n = 567$ ) were examined in the follow-up study. The authors chose these two groups “because of their higher prevalence of delinquency and substance abuse” (Williams, et. al., 1999, p. 244). Because these authors used the term race and racial when referring to ethnic groups, these terms are used here. This analysis of African American and White participants was conducted to determine the existence, if any, of racial differences in identified risk factors that predict delinquent and AOD-using behaviors. An additional analysis was done to investigate the relationship of race among the predictors. In their results section, these authors noted that differences

existed in AOD abuse patterns for African American and White participants. Their use of a structural equation model yielded a path between peer and sibling influence and substance-using behavior that was both significant and of moderate magnitude. No significant path was found, however, for peer and sibling behavior and delinquency. Interestingly, these authors also found that for both African American and White participants, many of the behavioral predictors examined in this study were consistent for both subgroups. In summary, while some variations in AOD abuse and peer involvement in AOD abuse are documented in the literature, it appears that for most adolescents, similar relationships exist between criminal behavior and AOD abuse, as well as for the risk factors for both of these issues.

The connection between juvenile crime and AOD abuse appears not to be unique to the United States. Lowenstein (2001) described the universal nature of intertwined AOD abuse and juvenile crime in the United Kingdom. In his conclusions, he pointed out that much juvenile crime is committed for the reason of obtaining drugs. Additionally, he went on to document that juveniles under the influence of AOD have lowered inhibitions and a decrease in rational thinking, thereby increasing the likelihood of engaging in criminal behavior. Lowenstein (2001) pointed out that criminal behavior might not have been contemplated had the juvenile been functioning with their normal cognitive abilities. Additionally, he pointed out that once the juvenile develops an addiction to AOD, there is often a need to continue a career of crime in order to satisfy the craving for AOD. In other words, the author demonstrated that the connection between juvenile criminal

behavior and AOD abuse is a phenomenon not limited to the United States but also present in the United Kingdom.

In order to more closely examine the burgeoning increase in female juvenile crime and relationships to AOD abuse, Molidor, Nissen, and Watkins (2002) reviewed current literature and research concerning AOD abuse and women, AOD abuse and adolescents, and AOD abuse and juvenile delinquency. Their synthesis of research documents the following: (1) there was a rapid increase in female juvenile crime related to AOD abuse (drug abuse violations rose 117% for females between 1993 and 1997, versus a 78% increase for males), (2) a large percentage of female juvenile offenders have diagnosable AOD abuse and other co-occurring disorders, and (3) there are a lack of trained personnel or research-driven programs to address the treatment needs of AOD abusing female juvenile offenders. In short, female juvenile crime is a rapidly growing problem and intertwined with female AOD abuse, yet there appears to be a shortage of trained personnel and treatment programs to address the particular needs of AOD abusing female juvenile offenders.

Another way to consider the extent of AOD abuse in juvenile offenders is to look at the AOD abuse patterns for juveniles who are incarcerated for their offenses. Dembo, Williams, Fagan, and Schmeidler (1994) conducted such a study. First, these authors analyzed the drug use patterns of 315 youth admitted to a Juvenile Assessment Center in a southern state. A preliminary cluster analysis resulted in a classification of participants into four groups. These groups differed by level of drug use, delinquency, drug screen results, and admission of having a drug problem. Following this initial analysis, the

validity of the proposed typology was established by comparing the participants by using the following five factors: (a) educational experiences, (b) delinquency referral history, (c) neglect, abuse, and family problem history, (d) close friends' problem behavior, and (e) emotional/psychological functioning and mental health and substance abuse treatment history.

Not surprisingly, these researchers (1994) found that the participants “substance use and delinquency/crime are not only related to one another, but to a variety of mental health issues, which need to be considered in understanding them and responding to their needs” (p. 51). This quantitative study sought to develop a classification system for high-risk youth, and preliminary results did show evidence for differing sub-groups of adolescents entering a juvenile incarceration facility. The more salient finding for the current study, however, was the connection these authors found between delinquent behavior, AOD abuse, and co-occurring disorders. This finding offers more evidence of the intertwined nature of juvenile crime and AOD abuse, with the possibility of other mental disorders being present that might increase the intervention complexity.

Coll, Juhnke, Thobro, and Hass (2003) recently considered the connection between AOD abuse, juvenile offenders, and AOD abuse treatment. An examination of available literature led these authors to question whether an existing AOD abuse assessment instrument (the Substance Abuse Subtle Screening Instrument – Adolescent Version: SASSI –A) could be efficacious in identifying AOD abusing juvenile offenders, then serve as an outcome measure for those juvenile offenders who completed treatment. The SASSI-A was administered to 147 adolescent offenders who were being screened for

treatment at a 50-bed residential treatment program for not less than 30 days. Forty of those screened were selected for an intensive six-month treatment episode after their screening revealed AOD abuse or dependence, a low motivation level, and low current insight. At the end of their treatment episode, the participants then re-took the SASSI-A and their scores were compared to their earlier scores. Analysis of pre-treatment and post-treatment SASSI-A scores showed significant reductions on several scales of the SASSI-A, indicating an overall reduction in self-perceived character defects and acting out tendencies for the subjects.

Perhaps an even more interesting result from this research is the significant number of participants that had been admitted to the residential facility who were previously identified as either non-AOD abusing or non-AOD remarkable who, when screened with the SASSI-A, were found AOD dependent or possessing a significant number of concerns related to AOD abuse issues. As the authors state, “most county court system referrals either failed to adequately assess referred adolescent offenders for the presence of AOD risk factors or failed to identify the adolescent offenders as AOD abusing” (Coll, et al., 2003, p. 20). This point, that juvenile justice system professionals may have inadvertently failed to recognize adolescent AOD abuse, will be examined later in this review of the literature.

From this body of literature, there appears to be a connection between juvenile offending and adolescent AOD abuse. Given the apparent comorbidity of juvenile crime and AOD abuse, it would be helpful to determine whether treatment of AOD abuse has any effect on juvenile re-offending. If this is indeed the case, the identification and

treatment of adolescent AOD abuse could possibly lead to decreased levels of re-offending and lower overall rates of juvenile crime, thereby helping both the juvenile and society. Research about the effect of AOD abuse treatment on re-offending will be examined in the following section.

#### *Effect of AOD treatment on Rates of Re-offending by Juveniles*

There have been a number of research studies that indicate that treatment of substance abuse issues can be helpful in reducing re-offending behaviors of juveniles who have been adjudicated delinquent. For example, the Washington State Division of Alcohol and Substance Abuse (1995) conducted a study of court-referred adolescents in publicly funded substance abuse treatment centers and found that 70 percent of those who stayed abstinent reported no arrests in the six months following treatment, while over half of those adolescents who had relapsed had been arrested.

The National Treatment Improvement Evaluation Study (NTIES) of 1996 completed a five-year Congressionally-mandated study of AOD abusers receiving treatment at a variety of institutions supported by public funds. Participants ( $n = 4,411$ ) were surveyed at intake, after treatment, and one year after treatment was completed. From this research, the following treatment effects were reported: decreased use of substances, decreased crime, decreased homelessness, and decrease of engaging in high-risk sexual behavior. There were also the effects of increased employment and improved participant health. Particularly salient were the reported effects on treated offender's criminal behavior: an 82% reduction in shoplifting, a 78% decrease in drug-selling, and a 65% reduction in arrest for any crime (SAMHSA, 1996). For those clients who

supported themselves with illegal activity prior to treatment, 48.3% stopped doing so after completing treatment and for at least a full year after completing treatment.

Interestingly, reductions in AOD abuse by persons receiving treatment were noted regardless of time spent in treatment or type of treatment. It should be noted that this study focused exclusively on particularly vulnerable and difficult to treat populations as all the treatment programs surveyed were serviced by CSAT grants. In light of this, participants surveyed may have been particularly difficult to treat, thereby providing additional evidence for the cost-effectiveness of substance abuse treatment for those involved in the juvenile justice system.

The California Drug and Alcohol Treatment Assessment (CALDATA) provided further evidence for the effectiveness of treatment, especially in the area of reducing criminal activity among those who have received various forms of treatment. Using a sample of individuals ( $n = 1900$ ) who completed different types of AOD abuse treatment (i.e., residential, outpatient, outpatient methadone), Gerstein, Johnson, Harwood, Fountain, Suter, and Maloy (1994) found a significant cost benefit to the state of California for every dollar spent on AOD abuse treatment. Their research found that for \$200,000,000 spent on treatment, over \$1.5 billion was realized in savings, mostly related to reductions in crime. In fact, study participants decreased criminal activity by two-thirds after completing treatment (Gerstein, et al, 1994).

The efficacy of drug courts in reducing recidivism among first time felony drug charge offenders was examined by Deschenes, Turner, Greenwood, and Cheisa (1996). These researchers examined one of the first “drug court” programs in the country, a first

time drug offenders (FTDO) program developed by Maricopa County probation officers, individuals from the RAND corporation, and Alameda county probation officers. This FTDO program randomly assigned subjects ( $n = 630$ ) to one of four cells, one cell being a drug court program ( $n = 176$ ) and the other three cells ( $n = 454$ ) being court-ordered urine drug testing with varying intensity (none, monthly, or bi-weekly). The majority of participants were single males (77%), approximately half were white, one-quarter were Latino, and one-fifth were African American. The FTDO program was designed to last from approximately 6 to 12 months, and incorporated group and educational counseling about substance abuse topics, as well as case management and aftercare services for all participants, regardless of whether they were in the drug court program or the court ordered urine drug screen program.

At the close of this research study, these authors found that drug court participants were more active in treatment than probationers assigned to urine drug screen cells, with 85% of drug court participants attending drug education and outpatient counseling, versus less than 50% of court-ordered urine drug screen participants. They also found, however, that all participants had at least one positive urine drug screen test while in the FTDO program. Rates of re-arrest were not significantly different for control group participants versus experimental group participants. These researches concluded that in this instance a drug court appeared successful at encouraging participation in substance abuse treatment but did not have any effect on rates of re-arrest or use of drugs while in treatment. They did find, however, that court-ordered treatment reduced recidivism, defined as receiving a

second drug charge subsequent to completing substance abuse treatment, at a greater rate than probation alone.

Another research study examined the efficacy of intensive supervision and aftercare in reducing re-arrests by juvenile offenders released from State correctional institutions as compared to probation only (Sontheimer & Goodstein, 1993). These researchers randomly assigned subjects ( $n = 90$ ) to either a control group ( $n = 46$ ) or experimental ( $n = 44$ ) group. Participants were primarily African-American (81 percent) with a mean age of 17.2 years and an average of five prior arrests, 90 percent of which had one prior felony arrest. The average amount of time spent in confinement for participants was 10.8 months. The experimental group was assigned to an Intensive Aftercare Program (IAP), an intensive probationary service in which the assigned probation officer had a limited amount of offenders for whom they were responsible. Additionally, the IAP participants were to receive additional services such as additional contacts during non-business hours (i.e., evenings and weekends), additional interaction with collateral contacts such as parents or school personnel, and an increased amount of regularly scheduled contacts with the participant. The control group received regular probation services for persons released from confinement. Participants received probationary services from 3-17 months, with an average of 11 months of services. At the close of this study, results indicated that IAP participants had a significantly decreased incidence of re-arrests with 1.65 as compared to 2.79 re-arrests for the control group. IAP participants also had a significantly lower incidence of felony arrests than did participants in the control group, 0.41 versus 0.76, respectively.

The authors mentioned an aspect of this study that may be particularly salient for this current study, which is that there was enormous turnover in the probation officers who were providing IAP services, such that there was no original IAP probation officers providing services by the close of the study (Sontheimer & Goodstein, 1993). The authors indicated that this created significant confusion and lack of consistency with providing services for program participants. This may indicate the important role a probation officer has in providing guidance and referral to services for juvenile offenders.

An experimental program of intensive supervision by JCCs in North Carolina was examined by Land, McCall, and Williams (1990). Their examination was an attempt to determine whether assignment to an Intensive Protective Supervision Project (ISP) would decrease rates of recidivism among status juvenile offenders, as opposed to assignment to Regular Protective Supervision (RPS). By definition, status offenders are juveniles less than 16 years old who (a) have run away from home, (b) are unlawfully absent from school, (c) are regularly disobedient to parents and beyond their disciplinary control, or (d) are regularly found in places where it is unlawful for juveniles to be present. It should be noted that legislation passed in 1977 makes it unlawful to send status offenders to state training schools, so juvenile offenders of this type are consistently assigned to probationary services in their community. This research study utilized random assignment of status offenders to either an ISP group ( $n = 90$ ) or an RSP ( $n = 84$ ) group in four selected areas of North Carolina over a two year period. At the end of this two year period, these authors analyzed whether participants had received significantly less

status or delinquent charges while involved in the ISP program than those participants in the RSP program.

Participants in this study were placed in two groups, those with and those without a prior history of a delinquent offense. Three outcome variables were examined among closed cases ( $n = 106$ ) at the end of the two year study period, whether a participant was referred to juvenile court with a new delinquent offense (DELOFF) or status offenses (STATOFF) while involved with the ISP or RSP program, or whether the JCCs assigned to the case considered the participant to have successfully completed their probationary sentence (SUCCESS). Means were computed for the control and experimental groups on these three measures, and a difference of means test was done. For those participants with no prior history of delinquent offenses (IPS  $n = 42$ , RPS  $n = 51$ ), significant differences were found for the DELOFF variable (-15.6 difference of mean, -1.92 t-statistic at  $p < .05$ ) and the SUCCESS variable (22.4 difference of mean, 1.96 t-statistic at  $p < .05$ ), but not for the STATOFF variable (-0.2 difference of mean, -0.02 t-statistic at  $p > .10$ ). For those participants with a history of prior delinquent offenses (IPS  $n = 7$ , RPS  $n = 6$ ), no significant differences were found on any of the three outcome variables. The small number of cases in these two groups, however, would have made any comparisons difficult. In summary, it appears that an IPS program can help to reduce the possibility of additional status offenses for participants while they are involved in the IPS program, but it does not appear to have any effect on participants with a prior history of delinquent offenses.

Some of the non-statistical findings and comments of these researchers are salient for the proposed study. For example, they reported that due to JCC requests, “training in structural family therapy was provided”, (Land, McCall, & Williams, 1990, p. 586), and then went on to report in some detail how JCCs had difficulty in completing behavioral treatment plans and needed to be able to recognize a need for “therapeutic intervention and how to broker it” (Land, McCall, & Williams, 1990, p. 587). One comment, that increased home visits of JCCs for the IPS program resulted in an increased awareness of family dysfunction and the need for intensive and quickly-enacted services, spoke specifically to JCC needs for specialized therapeutic skills.

Based on the previous research, it appears that treatment of AOD abuse treatment can lead to marked reductions in criminal behavior. Additionally, it seems clear that juvenile offending and substance abuse are so intertwined that intervention with a juvenile offender needs to include assessment and intervention of AOD abuse issues. In fact, the Denver Juvenile Justice Integrated Treatment Network (DJJITN) states that “treatment of a juvenile offender without addressing a probable substance abuse issue is impractical” (DJJITN, 2000, p. 8). Logically, one would initiate intervention of juvenile offender AOD abuse when the juvenile offender is under some type of juvenile justice supervision, to provide oversight and guidance. Therefore, a review of current juvenile offender interventions is warranted.

#### Current Court Ordered Interventions for Juvenile Offenders

There are a variety of court-ordered interventions used by the Juvenile Justice System but they may be grouped into three main categories: Probation, Community

Based Alternatives, Probation, and incarceration. In juvenile justice proceedings, the vast majority of juvenile cases result in a referral to probation (OJJDP, 1999; Snyder & Sickmund, 1999) and, of the 1.3 million cases prosecuted in juvenile courts, nearly every one of them had some contact with a Juvenile Court Counselor (JCC) at some point in the processing of the case (Torbet, 1996). Because probation is the most widely used intervention and JCCs are the court officials most likely to interact with juvenile offenders with AOD abuse issues, this review will now focus on the functioning of JCCs and their interaction with juvenile offenders on probation. Community Based Alternatives and incarceration, however, will be discussed briefly to provide information about the other primary interventions of the Juvenile Justice System.

### *Institutional Options*

Incarceration of juvenile offenders has the longest history of the three possible interventions with juvenile offenders. In pre-Revolutionary War America, it was common for juvenile offenders to be locked up with their adult counterparts (Roberts, 1998). Currently there are six main types of institutional options for juvenile offenders: (a) minimum security institutions such as ranches, forestry camps, or farms; (b) short-term shelter care; (c) traditional residential community programs, such as group homes or halfway houses; (d) reception centers for evaluation and diagnosis; (e) pre-adjudicatory detention centers; and (f) youth detention centers (i.e., “training schools”) (Siegel & Senna, 2001). These institutional options range from almost complete freedom for the juvenile offender, such as the minimum-security farm or ranch setting, to secure incarceration facilities where juvenile offenders are kept in locked cells for much of the

day. Placement for juvenile offenders is guided by the principle of *least restrictive alternative*, in that offenders are not placed in a secure facility if a community based program is feasible (Siegel & Senna, 2001). Despite this effort for community placement, there are still nearly 100,000 juvenile offenders in custody of a secure facility on any given day (OJJDP, 2005). Considering that juvenile courts handled more than 1.6 million cases in the year 2000 (OJJDP, 2005), however, institutional options are the least-used intervention of the juvenile justice system. Community based alternative/diversion programs and probation are utilized far more frequently as a way to address juvenile offending.

#### *Community Based Alternatives/Diversion*

Community Based Alternatives (CBA)/Diversion is defined as “any process that is used by components of the criminal justice system (police, prosecutors, courts, corrections) whereby youths avoid formal juvenile court processing and adjudication” (Roberts, 1998, p. 138), the point being that juvenile offenders do not enter the juvenile justice system and instead receive treatment of some type through programs located in the juvenile offender’s community (Siegel & Senna, 2000). Examples of CBA/diversion programs include: group homes, foster homes, family group homes, rural programs (i.e., forestry camps, ranches, farms), and day treatment programs where juvenile offenders receive counseling, education, employment, diagnostic, and casework services from program staff (Siegel & Senna, 2000). While certainly a viable alternative for juvenile offenders, those offenders receiving CBA/diversion represent a small percentage of

juvenile offenders. By far, most juvenile offenders receive probation as a consequence for their unlawful behavior.

### *Probation*

Since 1927 court data was used to publish the 1929 Juvenile Court Statistics, probation has been, by a large margin, the most frequently used intervention in the juvenile justice system (Torbet, 1996). Probation may be defined as when a juvenile offender agrees to comply with certain conditions of behavior in lieu of adjudication (Siegel & Senna, 2000; Tobet, 1996). Juvenile probation covers a broad array of services, from the investigation and supervision of youth involved with the juvenile court, to the initial intake screening of juveniles charged with crimes (National Center for Juvenile Justice, 2000). Probation allows for a juvenile offender to stay in the community, live with primary caregivers, attend school or work, and attempt to change her or his negative behavior patterns, all while under the supervision of a court official commonly called the juvenile probation officer or juvenile court counselor (Siegel & Senna, 2000). Because it is the involvement of the JCC that is being considered in this study, this individual's role deserves further examination.

### Juvenile Court Counselor

There are a large number of persons involved in processing the case of a juvenile offender, including parents, judges, public defenders, police officers, district attorneys, witnesses, and various court personnel. Since the vast majority of juvenile offenders receive probationary sentences that require their interaction with a JCC, by far the person who has the most responsibility for the supervision and administration of court-ordered

and non-court-ordered interventions is the JCC. Whether known as the juvenile probation officer, juvenile court counselor, juvenile justice specialist, juvenile community corrections officer, juvenile or youth services counselors, corrections agents, juvenile service officers, or juvenile justice case managers (Reddington and Kreisel, 2000), this person performs duties related to the administration of the juvenile probation sentence to the juvenile offender. The JCC is “an officer of the court involved in all four stages of the court process- intake, predisposition, post-adjudication, and post-disposition- who assists the court and supervises juveniles placed on probation.” (Siegel & Senna, 2000, p. 371). Because the aim of juvenile offender treatment is to have the greatest number of offenders receive the optimum level of appropriate intervention by juvenile justice personnel, the JCC is the natural choice to initiate, determine, and monitor various interventions. Therefore, an examination of the JCC and supervision, experience, and education level requirements follows.

#### *Juvenile Court Counselor Responsibilities*

The JCC has job duties grouped in the following three areas: intake screening of cases referred to juvenile and family courts, predisposition or pre-sentence investigation of juveniles, and court-ordered supervision of juvenile offenders (Torbet, 1996).

Obviously, the job duties of a JCC vary widely in their focus. Additionally, several authorities within the field have remarked upon the increasing challenges to the work of JCCs (Reddington & Kreisel, 2003; Torbet, 1996). These increased challenges include such issues as their own safety, more personal crime offenders on their caseloads, and overall larger caseloads to supervise (Torbet, 1996). Other challenges include an increase

in violent crime (Reddington & Kreisel, 2003), a more diverse population of offenders with different cultural needs (Thomas, 1993), and changes within the juvenile justice system itself as to what agency serves as the managing government entity (Hurst & Torbet, 1993).

In order to effectively handle their myriad of responsibilities, JCCs would ideally receive appropriate supervision, education, and training. In order to determine whether this is indeed the case, it is necessary to first examine the supervisory structure for juvenile probation and then determine what types of education and training are required and/or mandated for JCC.

#### *Supervision, Training, and Education of the Juvenile Court Counselor*

There is no one particular supervisory structure for JCCs and their respective agencies, nor is there any one training or educational model. As Torbet (1996) discussed, some probation services are administered by the local juvenile court; others are overseen by the State administrative office of courts (See Figure 2).

For other areas where there may be a lack of financial resources or large distances between population centers, probation administration may be a combination of structures such as a juvenile court in urban counties and a State Executive system in rural locations. There are a multitude of methods whereby JCCs are provided programmatic supervision and oversight in the performance of their duties (Hurst & Torbet, 1993).

*Supervision of JCCs.* Supervision of JCCs is most often accomplished by having one person designated as the “Chief Juvenile Probation Officer,” or some analogous designation for a

<u>State Administration</u>		<u>Local Administration</u>	
<u>Judicial Branch</u>	<u>Executive Branch</u>	<u>Judicial Branch</u>	<u>Executive Branch</u>
Connecticut	Alaska	Alabama	<b>California</b>
Hawaii	<b>Arkansas</b>	Arizona	<b>Idaho</b>
Iowa	Delaware	<b>Arkansas</b>	<b>Minnesota</b>
<b>Kentucky</b>	Florida	<b>California</b>	<b>Mississippi</b>
Nebraska	<b>Georgia</b>	Colorado	New York
North Carolina	<b>Idaho</b>	District of Columbia	Oregon
<b>North Dakota</b>	<b>Kentucky</b>	<b>Georgia</b>	<b>Washington</b>
South Dakota	<b>Louisiana</b>	Illinois	<b>Wisconsin</b>
Utah	Maine	Indiana	
<b>West Virginia</b>	Maryland	Kansas	
	<b>Minnesota</b>	<b>Kentucky</b>	
	<b>Mississippi</b>	<b>Louisiana</b>	
	New Hampshire	Massachusetts	
	New Mexico	Michigan	
	<b>North Dakota</b>	<b>Minnesota</b>	
	<b>Oklahoma</b>	Missouri	
	Rhode Island	Montana	
	South Carolina	Nevada	
	<b>Tennessee</b>	New Jersey	
	Vermont	Ohio	
	<b>Virginia</b>	<b>Oklahoma</b>	
	<b>West Virginia</b>	Pennsylvania	
	<b>Wyoming</b>	<b>Tennessee</b>	
		Texas	
		<b>Virginia</b>	
		<b>Washington</b>	
		<b>Wisconsin</b>	
		<b>Wyoming</b>	

Note: Bolded states indicate that probation is provided by a combination of agencies. Often large, urban counties operate local probation departments while the state administers probation in smaller counties.

Source: Hurst, H., IV., & Torbet, P. (1993). *Organization and administration of Juvenile Services: Probation, Aftercare, and State Institutions for Delinquent Youth*. In Snyder, H. & Sickmund, M. (1995). *Juvenile Offenders and Victims: A National Report*. NCG 153569

Figure 2. Probation Supervision Administered by Local Juvenile Courts or by a State Executive Branch Agency

senior JCC, whose primary job duties consist of administrative and logistical support for the JCC under their supervision. That is, supervisors are primarily concerned with

administrative supervision rather than clinical supervision of work with individuals on the JCC's caseload. According to a recent southeastern state survey, the ratio of supervisors to direct line personnel is 1 supervisor for every 20.6 JCCs (System Design Group, 2000). Considering increasing case loads, shrinking resources, and strident public calls for accountability in the juvenile justice system (Corbett, 1999), it seems likely that supervisors are just as over-whelmed as are some JCCs (Corbett, 1999). Although this may be the case, this study seeks only to determine the current supervision, education, and training of JCCs and how this relates to the training needs of JCCs to intervene effectively with juvenile offenders with AOD issues. To this end, the following section details the training and educational requirements of JCCs.

*Training and educational requirements for JCCs.* There is a limited body of expositive and empirical research on the topic of training and educational requirements of JCCs. Two general trends that merit further attention are (a) the training and educational requirements that differ from location to location, and (b) there is not one dominant training paradigm. Reddington and Kreisel (2000) documented the national trends and patterns of JCC training, and highlighted what they described as "little or no information collected about current juvenile probation officer training procedures" (p. 29). Utilizing a telephone survey of all 50 states and the District of Columbia, Reddington and Kreisel gathered data concerning the required training of JCCs both prior to beginning job duties and while a JCC. Using follow-up mailings, faxes, and phone calls, they were able to get an 86 percent return rate on their surveys (43 states and the District of Columbia). Their findings may be summarized as follows:

- (1) Less than half of respondents certify their probation officers (20 states), with three respondents stating that certification procedures were underway.
- (2) Certifying agencies range from Department of Probation and Parole to individual circuits and/or counties.
- (3) Eighty-two percent of respondents mandated training for JCCs, and all certifying states require some sort of training. Respondents varied greatly as to what agency mandated training, however, with the most common response being the Department of Corrections ( $n = 9$ ). Other responses included administrative order, state statutes, court mandates, or agency policy.
- (4) Thirty-one of the respondent states reported monitoring the mandated training. The monitoring agencies varied, however, from Departments of Youth Justice to individual courts. There were a total of at least nine different monitoring agencies, and respondents from three states did not know who was responsible for monitoring training.
- (5) Fourteen states required pre-service training, with the number of hours ranging from 16 to 120. Both the median and mode for pre-service training was 40 hours.
- (6) Respondents from twenty-six states responded that their state had mandatory fundamental orientation training, with amount of hours required ranging from eight to 195. Of those states that required such training, most required it in the first year of employment.

(7) Thirty states required mandatory continuing education, ranging in hours required from eight to 40 hours. Almost half ( $n = 14$ ) of those states that required mandatory continuing education require 40 hours a year.

As seems apparent from these findings, there is a large amount of variance in the amount of on-going training, supervision, and pre-employment training of JCC. It is promising, in particular, that results indicate a growing trend toward required certification for JCCs.

Reddington and Kriesel (2003) followed up on their earlier work by surveying 35 states to determine the nature of basic fundamental skills training curriculum for JCCs to examine whether these curricula were similar in nature. By using the National Center for Juvenile Justice's (NCJJ) recommended Fundamental Skills Training Curriculum for Juvenile Court Counselors (Thomas, 1993) as a categorization tool, 14 separate topic areas for JCC skills training were identified. Only one state offered all the topic areas, with 6 as the average and 8 as the modal number of topics offered. Interestingly, despite the clear relationship between AOD abuse and juvenile crime, only 16 of the 35 states offer the topic area "Special Problems and Appropriate Responses", into which the topic of AOD abuse is subsumed. AOD abuse does not have a primary topic area within the Fundamental Skills Training Curriculum recommended by the NCJJ.

When asked about the possibility of a national certification for juvenile justice professionals, a strong majority (77.1 percent or 27 out of 35) of respondents agreed that national training standards for JCCs are needed (Reddington and Kriesel, 2003), with one respondent asserting that training standards for JCCs have been "neglected" (p. 42). This further underscores the need for a generalized curriculum for the training of JCCs, as

those persons who are providing direct service have realized their lack of proper training and preparation.

Although Torbet (1996) stated that most JCCs are college educated, this does not guarantee that JCCs have received educational instruction in juvenile justice matters. Kreisel, Reddington and Haase (2002) reported that a majority of criminal justice programs across the country offer a juvenile justice course in their criminal justice curricula; however, most criminal justice programs do not require their students to take that course. Therefore, while 86 percent of states minimally require that JCCs have a minimum of a bachelor's degree or some college education (American Correctional Association, 2000), this does not guarantee that a JCC has had the necessary instruction in the unique developmental and psychological needs of adolescents, much less the specific needs of the AOD abusing juvenile offender. Interestingly, a job analysis of JCCs in North Carolina by Systems Design Group (2000) found educational levels virtually identical to those described by Torbet (1996). Also, the analysis by System Design Group (2000) found that 88% of court counselor respondents had a college degree, and 12% had some college. Direct care personnel (i.e., staff of juvenile detention centers, staff of youth development centers [training schools]) of juvenile offenders had much lower levels of formal education, with less than half of respondents having a bachelor's degree, 50% having some college, and 4 % having a high school or GED diploma.

As far as attempting to determine if JCCs across the nation are similar in demographic type, Torbet (1996) found that generally JCCs are "college educated white

males, 30-49 years old, with 5-10 years of experience, typically earning \$20,000-\$39,000 per year” (p. 1). A recent work study analysis in North Carolina, however, found that one-third of direct care personnel are female and two-thirds are African-American, while 47 percent of JCCs are female and 25% are African American (Systems Design Group, 2000). These two reports exemplify the diversity that exists within the Juvenile Justice System among JCCs.

In summary, there appears to be little agreement as to what particular education and training JCCs need to receive prior to beginning their job duties. Most importantly, there does not appear to be systematically mandated training of any type regarding AOD abuse despite compelling evidence that the two social problems of juvenile offending and AOD abuse co-occur to a substantial degree.

As there does not appear to be any consistently mandated training in AOD abuse treatment for JCCs, available sources will be examined to determine what literature exists, if any, concerning JCCs and treating juvenile offender AOD abuse, and whether such training would be effective in helping juvenile offenders with AOD abuse problems.

#### *Recommended Juvenile Court Counselor Training for Juvenile Offender AOD Abuse*

Researchers have investigated the need to integrate AOD abuse treatment into the juvenile justice system. One such study, conducted by the Denver Juvenile Justice Integrated Treatment Network (DJJITN, 2000) and supported by a grant from the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Service Administration (SAMHSA), speaks specifically to the need for juvenile justice professionals to have a competent understanding of treatment services and at least a

“baseline level of information for each area of the system” (p. 87). Additionally, the DJJITN goes on to describe the necessity for “boundary spanners”, a term first used by Steadman (1992), to describe those persons able to recognize when different treatment services are needed to provide comprehensive care for clients. This is similar to the wraparound concept of providing multiple services to individuals and including all of those persons who might be concerned with the outcome of the client treatment (Stevenson, 2003).

As previously mentioned, supervision for JCCs tends to be predominately administrative in nature. Interestingly, the DJJITN (2000) stated that “Clinical supervision is an important aspect of all programs dealing with individuals suffering from addiction, mental illness, or co-occurring disorders, and is critical to ensuring proper and effective patient treatment and care” (p. 91). Therefore, although clinical supervision for those juvenile justice professionals providing AOD abuse treatment is acknowledged as extremely important in the literature, such supervision seems limited, further highlighting the need for JCCs to be trained in AOD issues.

As far as the education and training of juvenile justice professionals in the area of AOD abuse, DJJITN (2000) stated the following:

“In contemporary juvenile justice systems in which substance abuse treatment services are planned or in place, training is of paramount importance. Training relates not only to practice skills, but also to systems change and working across systems as Boundary Spanners who are able to navigate within systems. Experienced professionals in the field of juvenile justice and substance abuse treatment talk extensively about the importance of accessing skills-based training, in addition to networking through conferences, in order to share information, get ideas, and explore new opportunities.” (p. 93)

Therefore, training and educational opportunities have been identified as vitally important in providing quality juvenile justice AOD abuse interventions. In order to know exactly what kind of training and education is most appropriate for this particular subgroup of professionals (JCCs), one must investigate whether core competencies for practice in the area of AOD abuse have been established for JCCs.

DJJITN (2000) stated that in order to identify such core competencies, one would logically identify competencies in the area of AOD counseling competencies and standards, juvenile justice competencies, and multicultural competencies. Echoing these points is the American Probation and Parole Association's (APPA) (1999) guide for juvenile probation and parole professionals working in AOD abuse that discusses the need for a JCC to have the following:

1. A knowledge of the problem of AOD abuse, including properties of various psychoactive substances.
2. Skills for working with AOD abusing youth, including competency in the area of multiculturalism.
3. Strategies to coordinate with other systems to provide the best possible care for juveniles on their caseload, (i.e., wrap-around services).

This guide goes on to state that juvenile justice professionals “must seek training, practice opportunities, and supervision to enhance their knowledge and hone their skills” (APPA, 1999, p. 8). Several authorities in the field of juvenile justice (APPA, DJJITN, CSAT, SAMHSA) emphasize the necessity of training and education for JCCs to be well-prepared intervention agents in the area of juvenile offender AOD abuse.

To this end, CSAT, OJJDP, and APPA worked in partnership to develop training curricula specifically to address the needs of AOD abusing juvenile offenders. One of these curricula, *Working with Substance-abusing Youth: Knowledge and Skills for Juvenile Probation and Parole Professionals*, is a seminar designed to help direct-service juvenile justice personnel develop intervention skills for working with AOD abusing clients (DJJITN, 2000). It is unclear, however, whether this curriculum has been distributed on a large scale, and a search of currently available training programs offered by the partner organizations did not list this seminar.

A related search of this topic area did produce one training offered by the Mid-Atlantic Addiction Technology Transfer Center, a division of CSAT. From a review of the course outline, this curriculum prepares AOD abuse treatment personnel, mental health treatment personnel, and criminal justice personnel to work cooperatively toward addressing the AOD abuse issues of juvenile offenders. There is no indication, however, of desired skills or knowledge JCCs may need in order to be maximally effective with AOD abusing juveniles. Therefore, although a start has been made toward the identification of AOD competencies for JCCs, much remains to be done.

Various other authors and researchers have investigated specific parts of AOD abuse counseling as it relates to juvenile offenders. Examples include: drug testing guidelines and practices for JCC and agencies (APPA, 1992), the role of provider's training in referral to appropriate services (Stiffman, Hadley-Ives, Dore, Polgar, Horvath, & Striley, 2000), behavioral counseling with juvenile offenders (Binder & Binder, 1983), partnering child welfare, juvenile justice, schools, and behavioral health (Luongo, 2000),

effective counseling techniques (Sheppard, 1973), basic counseling skills for juvenile court workers (Fox & Krantz, 1991), probation and parole officers' perception of alcoholism and alcoholics (Berger, 1980), and influence of JCC self and work perception on treatment of juvenile offenders (Anderson & Spanier, 1980). Although all of these studies examine skills and knowledge related to AOD abuse intervention with juvenile offenders, none of them have scientifically examined what particular skills and knowledge a JCC would need in order to successfully treat the AOD abuse difficulties of their clients.

The preceding sections have sought to establish the connection between the two social problems of juvenile crime and adolescent alcohol and other drug (AOD) abuse, the intertwining nature of juvenile offending and adolescent AOD abuse, identification of the person most responsible for interventions with juvenile offenders (JCCs), and the training needs of JCCs to deal with juvenile offender AOD abuse. The apparent lack of JCC training in AOD abuse indicates the need to identify particular skills and knowledge around AOD abuse that might be most important for JCCs. Therefore, the following section details how this has been accomplished with other professional groups.

#### Necessary Substance Abuse Skills and Knowledge for Other Professional Groups

A variety of professional groups have developed specialty certifications or competency recognitions for the treatment of AOD abuse, including psychiatrists, psychologists, registered nurses, nationally certified counselors, and social workers. Another professional group, the Certified Substance Abuse Counselor (CSAC) will be examined as well, as this group includes persons who treat AOD abuse and, like the JCC,

are not required to have a master's degree. The proposed study will identify the knowledge and skills important for JCCs to intervene effectively with AOD abusing juvenile offenders. Therefore, it would be helpful to examine both previous research into identifying necessary AOD abuse skills for professionals, as well as what other related professional groups have determined are necessary AOD abuse knowledge and skills for professionals.

#### *Related Professional Groups with Specialty Credentials*

In order to determine what particular groups should be included in this examination of related professional groups, the International Certification and Reciprocity Consortium /Alcohol and other Drug Abuse (ICRC/AODA), one of the largest credentialing organizations for AOD abuse counselors, was questioned as to which professional groups might have arrived already at a consensus as to what particular knowledge and skills are need to effectively intervene with AOD abusing individuals. Coincidentally, North Carolina, the state where the proposed study is to occur, is the only state in the United States where the state substance abuse credentialing agency, an occupational licensing board and member board of ICRC/AODA, has created an agreement whereby different professions have agreed to honor the master's level or higher specific AOD abuse certifications or specialty credentials of other professional groups (J. Scarborough, personal communication, March 15, 2004). In practice, this means master's level registered nurses, psychologists, national certified counselors, and social workers all may hold the same addiction credential that allows for treatment of AOD abuse disorders. Accordingly, these professional groups will be examined as

models of professional groups that have identified the knowledge and skills necessary to work with AOD abusing individuals.

There are two other professional groups that should be examined as models for determining knowledge and skills necessary to work in the field of AOD abuse. One of these, the *Certified Substance Abuse Counselor*® (CSAC), is the non-master's degree certification offered by the North Carolina Substance Abuse Professional Certification Board (NCSAPCB) in accordance with their credentialing authority, the ICRC/AODA. The other professional group, *Addiction Professionals Working with Criminal Justice Populations*, was examined as part of a role delineation study conducted by the ICRC/AODA in Florida. Both of these professional groups and the requirements identified for their respective credentials will be detailed in subsequent sections.

*Social workers.* Social workers who have achieved competency in knowledge and skills related to AOD abuse treatment may obtain the Certified Clinical Alcohol, Tobacco, and Other Drugs Social Worker (C-CATODSW) credential (NASW, 2004). In order to receive this certification, master's level social workers must document the following: (1) 180 contact hours of alcohol, tobacco, or other drug (ATOD) specific education; (2) two years and 3000 hours of supervised, paid, post-masters experience as a social worker; (3) 3000 hours of paid, supervised, post-masters ATOD-specific counseling experience; (4) evaluation from an approved supervisor, (5) reference from an MSW colleague; (6) current highest state-level clinical social work license; (7) current member of NASW; and (8) agree to adhere to NASW code of ethics and adjudication process. Therefore, it appears that the NASW has identified AOD abuse work experience,

AOD specific education, current licensure, and recommendations from approved supervisors as the necessary components to determine competence to treat AOD abusing individuals.

*Psychologists.* Psychologists obtain a professional certification in AOD abuse treatment proficiency through the College of Professional Psychology. The American Psychological Association (APA) is the parent organization of the College of Professional Psychology, which is a professional certification entity of the APA Practice Organization. Per APA (2004), the certification for licensed psychologists in substance abuse treatment is a vehicle to “identify clearly to third party payers and other consumers of psychological services that they have earned a credential in the treatment of persons for alcohol and other psychoactive-substance use disorders” (APA, 2004, p. 1). The requirements for this certification are as follows: (1) possess a current state licensure to practice independently as a psychologist, (2) have treated alcoholism or other drug dependency disorder for at least 1 year in the last 3 years, (3) provide health services in psychology, and (4) successfully complete the College of Professional Psychology’s examination in the treatment of AOD abuse disorders. Therefore, it appears that APA credentials independent practitioners based on psychology license, experience treating AOD abusing individuals, and demonstrated proficiency through a passing score on a written examination.

*Nationally Certified Counselor.* Nationally Certified Counselors (NCC®) may obtain a Masters Addiction Counselor (MAC) certification from the National Board of Certified Counselors (NBCC®). According to the NBCC website (NBCC, 2004), a NCC

may obtain the MAC if they can do the following: (1) provide documentation of 12 hours of graduate coursework in the field of addictions or 500 CE hours specifically in addictions; (2) three years supervised experience in the addictions field at no less than three hours a week, with two of the years having been completed after the counseling masters degree was conferred; and (3) a passing score on the Examination for Masters Addiction Counselors (EMAC). In order to create this credential, NBCC conducted a study of practicing substance abuse counselors to determine what should be included in the EMAC. According to Ritter (2001), information about the study is proprietary in nature due to its relationship to the construction of the EMAC. Similar to psychologists, Nationally Certified Counselors are able to obtain the MAC through documentation of education, experience, and demonstration of competence through obtaining a passing score on an addiction specific written exam.

*Nurses.* The nursing specific addiction credential is known as a Certified Addictions Registered Nurse – Advanced Practitioner (CARN-AP) (IntSNA, 2004). This certification is obtainable when a registered nurse (RN) with three years experience can document the following: (1) master's degree or higher in nursing or a directly related field; (2) current certification as a Certified Addictions Registered Nurse (CARN) or ability to meet CARN requirements (i.e., 3 years experience as a registered nurse and 4000 hours experience treating addiction patients in the last five years); (3) 500 hours of supervised direct client contact in advanced clinical practice in addictions/psychiatric/mental health nursing; and (4) achieving a passing score on the CARN exam. Again, master's level nurses are able to obtain an AOD abuse practitioner

credential through documentation of experience, education, and a passing score on an AOD abuse specific written examination.

Of these four fields of master's level professional practice, three (Nationally Certified Counselors, psychologists, and registered nurses) require that practitioners achieve a passing score on a written exam. Only social workers do not have to demonstrate competence via a structured written examination process. Interestingly, even medical doctors have a specialty credential for working in the field of AOD abuse treatment, the American Society of Addictive Medicine's Certification in Addictive Medicine (ASAM, 2004). This certification is similar to the previously mentioned certifications in that it requires documentation of current licensure, education in AOD abuse practice, experience in the treatment of AOD abusing individuals, and a passing score on an AOD abuse specific exam (ASAM, 2004).

*Certified Substance Abuse Counselor.* This certification is given to applicants who are citizens of North Carolina and complete the following education, experiential, and examination requirements: (1) minimum of a high school diploma or Graduate Equivalency Diploma (GED); (2) 3 years supervised full-time work experience as a substance abuse counselor; (3) 300 hours of supervised practical training in the 12 Core Functions of Substance Abuse Counseling, with a minimum of 10 hours in each Core Function; (4) 270 hours of continuing education specifically related to the knowledge and skills necessary to perform tasks within the ICRC/AODA performance domains for substance abuse counseling; and (5) passing scores on the ICRC/AODA international written exam for Certified AODA Counselors and the Case Presentation Method (CPM)

oral exam (ICRC/AODA, 2005). These requirements are similar to the previously mentioned requirements for individuals within professional groups to receive specialty AOD abuse credentials, with one exception: CSACs are not required to have a master's Degree. This indicates that within the AOD abuse treatment field, there exists ways in which to credential individuals who do not possess a graduate degree. The following section details how a recent study by the ICRC/AODA examined the knowledge and skills necessary to credential addiction professionals, like the CSAC, who work within the Criminal Justice system.

*Addiction professionals working with criminal justice populations.* A recent study was done by the Certification Board for Addiction Professionals of Florida (CBAPF), in which they conducted a role delineation study for entry level addictions professionals working with criminal justice populations (ICRC/AODA, 2002). Performed as a means of creating a valid exam for addictions professionals who wish to treat criminal justice populations, this study sought to identify the required knowledge and skills to perform the tasks of an addiction professional working in the criminal justice field, then used that information to create an entry level exam for addiction professionals who wish to work in the criminal justice population.

The first part of the CBAPF study consisted of creating a 15-member panel of addiction treatment experts from the criminal justice field who then identified the major content areas, or domains, of addiction counselors working in criminal justice settings. This panel identified the following six major domains: 1 - Dynamics of Addiction and Criminal Behavior; 2 - Legal, Ethical, and Professional Responsibility; 3 - Criminal

Justice System and Processes; 4 - Screening, Intake, and Assessment Procedures; 5 - Case Management, Monitoring, and Client supervision; and 6 - Counseling. After completing this task, the panel delineated the tasks of each domain and generated a list of knowledge and skills required to perform each task competently. Finally, the panel evaluated each performance domain and task, rating each on criticality and importance to the addictions professional and on the frequency with which the activities associated with each domain and task were performed.

The second phase of this study consisted of developing and distributing a 16 page questionnaire to 1,500 addiction professionals, with the purpose of evaluating, validating, and providing feedback on the panel's choices of domains and tasks for addiction professionals in criminal justice settings. Of the 1,500 surveys distributed, 144 were returned for a return rate of approximately 10%. Demographic data returned with the surveys indicated that respondents accurately represented the population under investigation, in that the majority (74%) worked in prisons or jails and most respondents (74%) described their clients as involved in the criminal justice system. Nearly half of the respondents had bachelors degrees (47%), and 37% had their master's degrees, with counseling as the most common field of study (33%), followed by psychology (24%), then criminal justice (19%).

These respondents rated criticality and importance of each domain, as well as frequency of performance for duties in each domain. The three most important domains, in order, were *Dynamics of Addiction and Criminal Behavior*; *Counseling*; and *Legal, Ethical, and Professional Responsibility*. *Screening, Intake, and Assessment* was reported

as the fourth most important domain. *Case Management, Monitoring, and Client Supervision* was rated as fifth most important, and *Criminal Justice System and Processes* was rated as least important of the six domains. For criticality, *Legal, Ethical, and Professional Responsibility* was judged most critical, and *Counseling* judged second most critical. *Screening, Intake, and Assessment* was judged third in criticality, and *Dynamics of Addiction and Criminal Behavior* was fourth. *Case Management, Monitoring, and Client Supervision* was fifth, and *Criminal Justice System and Processes* was judged least critical of these domains.

For frequency of work in these domains, respondents indicated that a majority of their time was spent in the domain of *Counseling*, followed by *Dynamics of Addiction and Criminal Behavior* second, *Case Management, Monitoring, and Client Supervision* third, *Screening, Intake, and Assessment* fourth, *Criminal Justice Systems and Processes* fifth, and *Legal, Ethical, and Professional Responsibility* sixth. This indicates that the least amount of time was spent in the domain of *Legal, Ethical and Professional Responsibility*, despite the fact that this domain was judged most critical. These researchers hypothesized that perhaps survey respondents felt that even though this job duty was not performed with a great deal of frequency, it was still seen as extremely critical to the performance of their work.

All of the domains identified by the expert panel were judged critical by the survey respondents, with each domain achieving a score of 3.62 or higher on the 5 point rating scale, with 3 being *Important*, 4 *Very Important*, and 5 being *Extremely Important*. Similarly, each domain achieved a criticality rating of 3.41 or higher, which means

incorrect performance of the tasks in each domain could result in “moderate to significant harm to a client, the addiction professional, the public, etc.” (ICRC/AODA, 2002, p. 19).

This information was then utilized to develop a certification exam for addictions professionals who wish to work with criminal justice populations. Although Phase One and Two of this study bear some resemblance to the proposed study, there are also some significant differences. The CBAPF examined what addiction professionals working in criminal justice need to know, whereas the proposed study will examine what entry-level juvenile justice professionals working in the area of AOD abuse need to know, specifically as it relates to their performance as a JCC. Additionally, the CBAPF study was not specific to those persons working with juveniles, while the proposed study will focus exclusively on persons working with juvenile offenders between the age of 13-17. As previously mentioned, the adolescent population presents specific challenges that require age-specific theories and intervention, if one is to be successful in treating adolescent AOD abuse (SAMHSA, 1999).

#### *Previous Research of AOD Abuse Counseling by Professional Counselors*

There are two seminal studies, Von Steen’s (1996) study of mental health counselors working in multi-service mental health counseling centers and Ritter’s (2001) examination of necessary AOD abuse skills and knowledge for entry-level school counselors working with AOD abusing students, that examine the work of counselors working with AOD abuse clients in settings other than AOD abuse treatment facilities. As both of these studies research AOD abuse job performance by individuals who do not

uniquely work with AOD abuse clients, examination of them may provide a historical perspective on this issue, as well as providing guidance for the proposed study.

*AOD abuse counseling in mental health settings.* An analysis of work behaviors of mental health counselors providing substance abuse counseling was conducted by Von Steen (1996) as a way to identify the frequency and criticality of certain AOD abuse counseling behaviors, as well as determine what factor structure of work behaviors could be identified. Her finding of a five-factor structure for work behaviors of mental health counselors working with substance abuse clients, as well as measures of criticality and frequency for substance abuse work behaviors, support the concept of specialized training for persons who intervene with AOD abusing individuals.

Von Steen (1996) surveyed the agency administrators or their representatives at 367 multi-service mental health agencies from 14 states in the southern region of the United States. Of the 367 agencies surveyed, 117 representatives responded, for a response rate of 32%. Because of the lack of an existing instrument, Von Steen developed a survey questionnaire for her study, using subject matter experts to help generate a list of work behaviors for mental health service providers providing substance abuse counseling in multiservice mental health agencies. This work resulted in a list of 194 items, each representing a specific work behavior, and each requesting a measure of frequency and criticality associated with that particular work behavior. This study was exploratory in nature, and used both descriptive statistics and factor analysis to address the various research questions. Von Steen's study is similar to the proposed study, as the proposed study will identify needed AOD abuse skills and knowledge for JCCs, while Von Steen's

study identified what AOD abuse counseling behaviors were critical and/or frequently performed by persons working in a multiservice mental health agency.

In her exploratory study, Von Steen (1996) identified five factors of substance abuse counseling work behaviors performed by multi-service agency mental health counselors: (1) Substance-Abuse Specialty Counseling, (2) Assessment and Appraisal, (3) Counseling Process, (4) Professional Practice, and (5) Family Counseling, each with a relatively high factor loading of .40 or higher. Additionally, frequency and criticality means were obtained for each work behavior named in the distributed survey. The first four factors remained the same, whether the responses were based on criticality, frequency, or a combination of both. The fifth factor indicated by criticality was general practice, but for frequency or overall importance the fifth factor remained family counseling.

Von Steen described some of the particular substance abuse counseling work behaviors that loaded on each of the five factors. For example, training in group counseling was recommended for those who treat AOD abuse clients, as work behaviors associated with group counseling loaded on the substance abuse specialty counseling factor. Job search skills, physical abuse, and human sexuality work behaviors also loaded on the substance abuse specialty counseling factor, indicating the myriad of issues with which AOD abuse clients present at mental health agencies. Interestingly, these respondents did not group family counseling as part of substance abuse specialty counseling, which is contrary to most recommendations for intervention and treatment with AOD abusing clients.

Von Steen (1996) made some specific recommendations, based on the results of her investigation into AOD abuse work behaviors. These recommendations were as follows: (a) persons employed at multiservice mental health agencies should receive specialized training in AOD abuse issues, (b) counselor educators should prepare students to work with AOD abusing clients, and (c) The Council on Accreditation of Counseling and Related Educational Program (CACREP) guidelines for community and mental-health programs should include AOD abuse counseling recommendations.

*School counselors and AOD abuse counseling.* Ritter (2001) conducted an investigation of the knowledge and skills necessary for entry level school counselors to work with students affected by alcohol and other drug use. Much like the work of Von Steen (1996), this study utilized a survey format and then an exploratory factor analysis to determine what particular factor structure could be identified from the survey responses.

Similar to Von Steen (1996), Ritter constructed a questionnaire for her study. The questionnaire was constructed using a Delphi panel method to determine what items needed to be included in a survey of education and training needs of beginning level counselors. Because this particular survey was “intended for subsequent use with other counseling specialty areas” (Ritter, 2001, p. 110), a variety of subject matter experts were used in the development of the questionnaire, including five specialists each from the area of school counseling, student development counseling, and community/agency counseling, as well as ten substance abuse counselors. In order to further refine the list of survey items, three addiction educators were asked to determine whether items were

specific to substance abuse counseling or might be learned in more general counseling curriculums. This final review led to a 153 item survey concerning the knowledge and abilities needed to work with AOD abusing individuals.

Ritter distributed 1207 questionnaires through 20 school districts in 13 states and received usable responses from 324 counselors from 16 different school districts in 11 different states. These responses were then analyzed using both descriptive statistics and a factor analytic procedure to identify what constructs organized the respondent's answers. Work setting also was recorded in this study in order to determine if there were differences across work setting (e.g., high school versus elementary school) for what skills and knowledge were considered most important when working with AOD abusing individuals.

Three items (i.e., work behaviors with AOD abusing individuals) were identified as most important, regardless of work setting for school counselors: confidentiality, group dynamics, and personal growth. Ritter made the point that these general counseling items may in fact create the foundation for specialty AOD abuse counseling, which would explain their high importance ranking. Six items were common when compared across work setting, which includes the previous three items and (a) having knowledge of family adaptation to substance abuse, (b) being able to educate clients about self-help groups, and (c) having knowledge of ethical standards applicable to substance abuse counseling. Although the priority of these last three items varied considerably, the six items were consistently judged important across all work settings.

After examining structure, interpretability, amount of total variance accounted for, and proportion of items that load at .40 or higher on at least one factor, Ritter identified the following six factors as the optimal solution for the data from this survey: substance abuse counseling, treatment planning, professionalism, physiological/psychological, and social contextual were common to all analyses. Case management was the sixth factor for those counselors employed in elementary schools, and fundamental addiction knowledge was a seventh factor for middle and high school counselors.

Ritter (2001) offered the following conclusions from her research: (a) currently employed school counselors believe entry-level school counselors should have some preparation to work with AOD abusing individuals, (b) this preparation should include a combination of knowledge and skills that is basic in nature, (c) knowledge of confidentiality requirements is the single most important skill necessary to work with AOD abusing individuals, and (d) possibly the most important area of preparation for school counselors is in the area of professionalism and fundamentals of addiction counseling.

These two previous research efforts are quite similar to the proposed study, in that each looked at the knowledge and skills necessary for intervention with AOD abusing individuals by specific helper groups, mental health counselors and school counselors. Both studies were able to identify specific factors related to the performance of job duties with AOD abusing individuals, which may indicate the existence of factors with other helping professionals. Therefore, the proposed study of JCCs and their work with AOD abusing individuals may draw on this previous research as a guide.

## Conclusion

Juvenile crime and AOD abuse are linked such that any comprehensive intervention with juvenile offenders requires some level of AOD abuse intervention. Juvenile probation is largely the intervention of choice in the juvenile justice system; therefore, to successfully treat the AOD abuse issues of the greatest number of juvenile offenders, JCCs are probably the persons most in need of training and education about AOD abuse intervention. The lack of a national requirement for AOD abuse education or training for JCC has allowed for a variety of training and education recommendations, none of which are backed by national standards for competency or any certifying or credentialing authority.

This study sought to verify the knowledge and skills needed by entry level JCCs to work with those juvenile offenders who may be experiencing AOD abuse issues. It is hoped that by identification of needed AOD abuse knowledge and skills for JCCs, an informed decision may be made as to possible recommendations for training and education, with the ultimate goal of constructing a valid and reliable method of AOD abuse competency assessment for JCCs working with AOD abusing juvenile offenders.

## CHAPTER III

### METHODOLOGY

The preceding chapters discussed the relationship between juvenile crime and adolescent AOD abuse and the need for the primary intervention agent of the juvenile justice system, the Juvenile Court Counselor (JCC), to have knowledge and skills related to juvenile offender AOD abuse. To this end, this study sought to identify the AOD abuse knowledge and skills considered most important for entry-level JCCs as determined by currently employed JCCs. The ultimate goal of this study is to inform the creation of a curriculum of education designed to meet the AOD abuse education needs of current and future JCCs. This chapter contains the research questions addressed, a description of the instrument created for this study, sampling procedures, a description of the pilot study and results, study limitations, data analyses performed, a research question matrix, and conclusions. Because this study is exploratory in nature, no hypotheses were formed.

#### Research Questions

The current study will consider the following research questions:

1. What is the factor structure of knowledge and skills concerning AOD abuse that characterizes the education and training needs of JCCs, as reported by currently employed JCCs and as measured by the Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire?

2. What are the specific AOD abuse treatment knowledge and skills within the identified factors considered most important for JCCs, as reported by currently employed JCCs and as measured by the Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire?
3. Given the factor structure from Question One, what linearly related effects do JCC gender, JCC ethnicity, JCC service area (i.e., rural or urban classification) and JCC terminal degree, exhibit upon each of the factor-analysis derived scale scores for the Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire?
4. Given the factor structure from Question One, what are the relationships between percentage of successful cases, hours of JCC AOD abuse training since becoming a JCC, years of experience as a JCC, and the factor analysis derived scale scores for the Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire?

#### Instrumentation

The Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire is based on The Entry-Level Counselor Substance Use Training Needs Assessment Questionnaire (Ritter, 2001), a 152-item survey that assesses what participants believe are the knowledge and abilities needed for counselors to work with persons affected by AOD abuse. This survey was constructed by Ritter (2001) and used to determine the skills and knowledge entry-level school counselors would need to work with students with AOD abuse issues. Survey participants report their degree of

agreement or disagreement with stem items that begin with “An entry-level counselor should ...” on a five-point likert-type scale. Because of the manner in which this survey was constructed and validated, it may be useful with other populations (Ritter, 2001). Prior to beginning this research, Ritter was contacted via email and permission to use this survey was obtained (See Appendix A). It is important to note that this survey did not examine all of the skills and knowledge necessary for the performance of JCC job duties, but only the knowledge and skills needed to work with AOD abusing juvenile offenders. A copy of the initial version of the Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire is contained in Appendix B.

#### *Survey Construction and Refinement*

In Ritter’s (2001) original construction of the Entry-Level Counselor Substance Use Training Needs Assessment Questionnaire, items for inclusion were gathered from the following sources: Von Steen’s (1996) *Treatment of Substance Abusers in Multi-service Mental Health Agencies Questionnaire*, the survey used by the National Board for Certified Counselors in developing the Master’s Addiction Counselor Examination (1995), and the *Development of Model Professional Standards for Counselor Credentialing* study by Birch and Davis (1984). Ritter (2001) also included items from the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC/AODA) that were the knowledge, skills, attitudes, and competencies for entry-level (ICRC/AODA, 1996) and advanced level (ICRC/AODA, 1997) addiction counselors. The final step of this process was to include items from the Center for Substance Abuse Treatment’s *Addiction Counseling Competencies: The Knowledge,*

*Skills, and Attitudes of Professional Practice* (U.S. Department of Health and Human Services, 1998). During construction of this survey, duplicate items from different sources were excluded, and the result was more than 1200 items in 20 categories. Ritter (2001) described the original categories as: (a) fundamentals of addiction knowledge, (b) fundamentals of treatment knowledge, (c) application to practice, (d) professional readiness, (e) clinical evaluation, (f) assessment, (g) treatment planning, (h) referral, (i) implementing the treatment plan, (j) consulting, (k) counseling, (l) group counseling, (m) counseling for families, couples, and dyads, (n) client, family, and community education, (o) documentation, (p) professional and ethical responsibility, (q) program/agency level tasks, (r) clinical supervision, (s) prevention, and (t) research design, analysis, and utilization.

As this survey was intended for use with other specialty counseling areas (which makes it appropriate for the JCC population), Ritter (2001) formed a Delphi panel of 15 counselors from three specialty areas (five each from school, student development, and community) and ten substance abuse counselors. This panel reviewed the twenty categories of items and eliminated two categories, supervision and research, as inappropriate for the knowledge and skills of entry-level counselors. As Ritter (2001) noted, this is consistent with ICRC/AODA concepts for what is appropriate for advanced level counselors (ICRC/AODA, 1997); these two categories are present in ICRC/AODA requirements for advanced addictions counselors but are not included for entry level addiction counselors (ICRC/AODA, 1996).

After further study by the original Delphi group as to whether items were appropriate for inclusion in a survey of knowledge and skills useful with AOD clients, a total of 650 items were judged as appropriate for inclusion. As it appeared a number of generic counseling items remained, Ritter (2001) formed a second Delphi panel of addiction educators who judged whether the items (a) had a unique application with regard to substance use, or (b) were the same as those skills learned in a general counseling program. After this review, 152 items remained. This survey is applicable to the JCC population in part because the final 152 items on the survey were judged by a Delphi panel of addiction educators, a group qualified to assess what skills and knowledge JCCs might need to intervene with those persons engaging in AOD abuse.

An adaptation of survey items used by Ritter (2001) was distributed to active JCCs in North Carolina. In order to make the survey specific to the population that is being studied, the stem on each item was changed from “An entry-level counselor should” to “A juvenile court counselor should.” Two items were initially altered to aid in comprehension for the sample population, but such alterations were formative in nature and did not change the overall meaning of the item. The items altered included the following:

Item (31) – *An entry-level juvenile court counselor should be able to assist the client in obtaining a temporary sponsor, the addition of in a 12 step program such as Alcoholics Anonymous or Narcotics Anonymous* to the end of the item aided in comprehension of what the term “*temporary sponsor*” means.

Item (64) – *An entry-level juvenile court counselor should have knowledge of the various philosophies and structures of self-help groups and support groups (i.e., AA, Al-Anon, NA),* the addition of the self-help group for family members of addicts, called “*Nar-Anon*”, makes this item more inclusive of the family members of drug-using adolescents.

Additional instrumentation changes that occurred through the pilot study process are detailed later in this chapter.

Using an electronic survey format, each survey skill item was rated on a five-point Likert-type scale as to whether the respondent strongly agrees, somewhat agrees, is neutral, disagrees, or strongly disagrees that a JCC working with AOD abusing juveniles should have that particular skill. Additionally, the demographic questions from Ritter’s survey were eliminated, as they were specific to participants for that study (e.g., at what level school do you work?), and demographic items specific to this study and the research questions under investigation were added. For example, JCCs were asked the county in which they currently perform the function of a JCC, as well as questions concerning their ethnicity, sex, level of education, years on the job as a JCC, percentage of successful cases, and hours of substance abuse education or training since becoming a JCC (See Appendix B).

### Sample Size

Educational research requires informed consent from participants, as well as the option of not participating (Borg, Borg, & Gall, 1999). Therefore, a volunteer sample of JCCs was used in this study. There are approximately 439 JCCs in the southeastern state

that agreed to participate in this study, with 36 JCC supervisors, some of whom carry a caseload and some of whom do not. To avoid any confounding variables such as supervisory position within the Juvenile Justice System, JCC supervisors were not included in the current study, resulting in 403 JCCs who were invited to participate. Assuming a distribution to all current JCC, a return of 202 surveys would sample approximately 50.5% of the populations. Arbitrarily picking 50% as a target return rate is not justified, however, and one should keep in mind that the final determination of sample size should be mitigated by practical considerations (Borg, Borg, & Gall, 1999).

In attempting to determine final sample size, a choice of size of sample “can be based on no single rule but on a combination of indications” (Cattell, 1978, p. 508). One indication discussed by Cattell is that in determining sample size for a good study, 3 times as many participants as variables often has to be accepted, which in this case would necessitate a sample size of 456. In light of the fact that there are only 403 JCCs available for inclusion in this study, this is not a realistic goal. Cattell goes on to state that 200 subjects are acceptable for most purposes, but below 100, stability “can deteriorate rapidly (Cattell, 1978, p. 509).

In light of these guidelines, and after a review of previous research similar to the current study (Ritter, 2001; Von Steen, 1996), a target return rate of 133 surveys was chosen as sufficient for the factor analytic procedures in this study. Additionally, this amount of returned surveys samples approximately a third of JCCs from the total population of JCCs in the southeastern state that participated in this study.

## Participant Solicitation and Data Gathering Procedures

The population examined in this study was JCCs currently employed in one southeastern state of the United States. After meeting with the head of the state Department of Juvenile Justice and Delinquency Prevention (DJJDP) Research Committee and obtaining permission to survey currently employed JCCs throughout the state (for copy of Agreement to Conduct Research, see Appendix D), an invitational email was sent to pilot study participants from one county. This email detailed the study and the purpose of the survey, as well as giving contact information for the primary researcher, confidentiality information and procedures, supporting University Institutional Research Board contact information, and information that results will be reported back to DJJDP without any information identifying individual respondents. This email had a link to the web-based survey used for this study. For the main study, DJJDP sent the survey invitational email to Area Administrators, who then distributed it to all non-supervising JCCs in North Carolina by DJJDP. This email followed the same format as the pilot study email, e.g., explaining the purpose of the study and insuring confidentiality of results.

Data was gathered through the use of a web-based survey, which allowed for both anonymity of respondents and ease of use by JCCs, who commonly use email through their work and are provided email accounts as part of their job (J. DiDona, personal communication, September 14<sup>th</sup>, 2004). Once a participant finished a survey and submitted her or his responses, the data was automatically assigned an identification number and entered into a format for analysis by SPSS 13.0 (SPSS, 2004).

### *Demographic variables*

The demographic variables under investigation were chosen to help inform methods and subject matter for possible future instruction of JCCs. By examining possible differences or relationships among respondent survey responses according to sex, ethnicity, terminal degree, service area, JCC job experience, AOD abuse education hours, or percentage of successful cases, it is possible to construct better informed and specifically targeted educational experiences that address such differences. For example, urban JCCs could experience juvenile offender AOD abuse differently than rural JCCs, and thereby require different educational experiences.

### *Sample Characteristics*

Seven survey questions gathered data about independent variables. JCCs provided information about their sex, ethnicity, service area, terminal degree, length of time employed as a JCC, amount of AOD abuse training hours since becoming a JCC, and percentage of successful cases in the last two years. For this study, successful cases were defined as no re-offending behavior by a juvenile offender while under probationary supervision. For the variable of ethnicity, the categories of white and non-white were used in the main study analyses, due to a lack of respondents who classified themselves as other than Caucasian or African American.

The total number of respondents included in the final sample was 214 ( $\underline{n} = 214$ ). All respondents provided information about their number of months as a JCC, AOD abuse training hours, percentage of successful cases, and ethnicity. One respondent chose not to identify their sex ( $\underline{n} = 213$ ), two chose not to list their terminal degree ( $\underline{n} =$

212), and six respondents did not identify their service area ( $n = 208$ ). There was a fairly even split of male ( $n = 102$ ) and female ( $n = 111$ ) respondents, as well as among urban ( $n = 96$ ) and rural ( $n = 112$ ) respondents. White respondents outnumber all other ethnic group respondents roughly 3:2, and Bachelor degree respondents outnumbered Master degree respondents 6:1. Descriptive statistics for respondents included in the main study are displayed in Table 1.

Table 1  
Demographic Information of JCC Respondents

Variable	N	<u>M</u>	SD
Months as JCC	214	81.56	88.87
AOD Hours	214	7.07	20.51
% Success	214	32.81	32.62
Sex	213		
Female	111		
Male	102		
Ethnicity	214		
African-American	74		
White	128		
Latino	1		
Asian American	0		
Biracial	1		
Native American	7		

Other	3
Total Non-White	86
Service Area	208
Rural	112
Urban	96
Terminal Degree	212
Bachelors	181
Masters or higher	32

---

### Pilot Study

The pilot study process consisted of a three phase process that included two levels of expert review and field testing the instrument.

#### *Phase I*

First, two subject matter experts, one from an urban area and one from a rural area were contacted and an interview was held after each had reviewed the survey for ease of use and applicability to the population under investigation. Both of these experts remarked on the length and readability of the survey, which resulted in the following changes: (1) a change in font size and style (10 point to 11 point, Times New Roman to Arial); (2) the Likert-type scale format was included more frequently to decrease response time; and (3) the stem of the questions (i.e., “An entry-level juvenile court counselor should ...”) was shortened to “An entry-level JCC should.”

## *Phase II*

After incorporating the suggestions from Phase I, the second phase of the process consisted of sending the survey to 8 experts in the field of addiction education and survey research, 6 of whom returned the surveys with feedback on various aspects of the survey. See Appendix E for copies of this feedback in its entirety. A number of comments were of proofreading type, for example, add an “s” to the word issue, add the word “have” between should and knowledge. Also, the average amount of time reported to complete the survey was 17.5 minutes by those respondents who reported how long it took to complete the survey. It should be noted, however, that one respondent reported one hour as the amount of time it took them to complete the survey, due to reading and making changes while reading the survey.

There were enough comments about overall readability to make some vocabulary changes to the questions. None of the questions, however, were changed in such a manner that the overall meaning of the question was affected. A detailed list of the changes to the survey questions includes the following:

- Item 8 was changed from “An entry-level JCC should have knowledge of criteria for assessing substance use disorders and biopsychosocial disorders” to “An entry-level JCC should have knowledge of criteria for assessing substance use disorders and biopsychosocial (affects biology, psychology, and social aspects of the person) disorders.” This was done to explain the word “biopsychosocial”, which may not be familiar to JCCs.

- Item 10 was additionally explained by giving an example of cross addiction, so that instead of reading as “An entry-level JCC should have knowledge of the potential for cross-addiction” it reads “An entry-level JCC should have knowledge of the potential for cross-addiction (for example, addiction to both alcohol and tranquilizers).”
- Item 14 was reworded from “An entry-level JCC should have skill taking client’s family history of addictive disorders” to “An entry-level JCC should have skill in obtaining a client’s family history of addictive disorders.”
- Item 17 was clarified by giving a definition of pharmacokinetics, so that it went from reading as “An entry-level JCC should have knowledge of pharmokinetics” to “An entry-level JCC should have knowledge of pharmokinetics, that is, how long a drug stays in the body.”
- Item 18 was changed from “An entry-level JCC should be able to monitor drug screening test results to “An entry-level JCC should be able to monitor drug screenings and interpret test results.”
- Item 22 was changed from “An entry-level JCC should have knowledge of the relationship between symptoms and responsiveness to varying levels of care” to “An entry-level JCC should have knowledge of the relationship between symptoms and responsiveness to varying levels of care, such as inpatient treatment, outpatient treatment, or residential treatment.”

- Item 25 was changed from “An entry-level JCC should be able to arrange aftercare services” to “An entry-level JCC should be able to arrange aftercare services (that is, continuing care services for clients who complete treatment).”
- Item 26 was changed from “An entry-level JCC should have knowledge of current methods and technologies to present information in a culturally sensitive manner” to “An entry-level JCC should have knowledge of current methods and technologies to present information in a culturally sensitive manner, for example, using language appropriate to the audience.” This was done to give an example of cultural sensitivity.
- Item 31 was changed from “An entry-level JCC should have skill in applying principles of group dynamics in an educational setting” to “An entry-level JCC should have skill in applying principles of group dynamics when leading groups.”
- Item 34 was changed from “An entry-level JCC should have knowledge of relationships between psychoactive substance use and biopsychosocial disorders” to “An entry-level JCC should have knowledge of relationships between psychoactive substance use and biopsychosocial disorders, such as depression or anxiety.”
- Item 42 was changed from “An entry-level JCC should have knowledge of confidentiality laws” to “An entry-level JCC should have knowledge of confidentiality laws specific to substance abuse.”
- Item 47 the word “disorders” was changed to “illnesses.”
- Item 63 was changed to provide a definition of “affective” (that is, “mood”).

- Item 66 was changed from “An entry-level JCC should have knowledge of comprehensive assessment models for substance abuse treatment” to “An entry-level JCC should have knowledge of comprehensive assessment models for the appropriate level of substance abuse treatment.”
- Item 67 was changed from “An entry-level JCC should have skill in explaining and administration procedures of specific substance disorder assessment instruments” to “An entry-level JCC should have skill in the administration and interpretation of specific substance disorder assessment instruments.”
- Item 80 was changed from “An entry-level JCC should have knowledge of changes to client due to client taking/not taking psychotropic medication” to “An entry-level JCC should have knowledge of changes to client functioning due to client taking/not taking psychotropic medication.”
- Item 88 was changed from “An entry-level JCC should have knowledge of how differences among clients (for example, culture, ethnicity, race, gender, sexual orientation) may affect the development of the treatment process” to “An entry-level JCC should have knowledge of how differences among clients (for example, culture, ethnicity, race, gender, sexual orientation) may impact the progression of the treatment process.”
- Item 106 was changed from “An entry-level JCC should have skill in relating self-help group experience to group counseling experience” to “An entry-level JCC should have skill in relating self-help group (for example, AA, NA) experience to group counseling experience.”

- Item 119 was changed from “An entry-level JCC should have skill in conducting a substance abuse client intake” to “An entry-level JCC should have skill in conducting an intake with a substance abuse client.”
- Item 132 was reworded from “An entry-level JCC should be able to understand diverse racial and ethnic cultures and substance use patterns” to “An entry-level JCC should be able to understand the substance use patterns of diverse racial and ethnic cultures.”
- Item 153 was changed from “An entry-level JCC should have knowledge of signs and symptoms of mental and personality disorders as indicated by currently accepted diagnostic criteria and as they relate to substance use, and implications for treatment and referral” to “An entry-level JCC should have knowledge of the signs and symptoms of mental health disorders (as indicated by currently accepted diagnostic criteria) identify how they relate to substance abuse, and recognize the implications of this relationship for treatment and referral.”
- Item 156 was changed from “An entry-level JCC should have knowledge of counselor codependency” to “An entry-level JCC should have knowledge of counselor codependency and other conditions that impair counselor effectiveness.”
- Item 159 was changed from “An entry-level JCC should have knowledge of how the denial process creates manipulation of the health care professional” to “An entry-level JCC should have knowledge of how the client’s denial process can lead to manipulation of health care professionals.”

- The position of one item was changed due to its similarity with the previous item in the survey due to multiple expressed concerns that these two items were measuring the same issue.
- During a post-survey distribution review of survey items for the pilot study, it was discovered that one survey item was identical with the immediately following item (Item 28 and Item 29). This inadvertent duplication during pilot-study survey construction was eliminated in the main survey distribution, resulting in a 152 item survey.

### *Phase III*

Finally, 12 currently employed JCCs in a nearby county were asked, via an email that was sent first to their supervisor and then forwarded to the JCCs (See Appendix F), to take the on-line survey and submit their answers. Because of some initial difficulty with submission of responses by the first survey participant, this process was stopped for a period of time so that technical difficulties could be addressed. In order to make the process easier for pilot study and subsequent participants, the survey was moved from a University web-server to a worldwide web survey company, [www.surveymonkey.com](http://www.surveymonkey.com). This was done after consultations with the Information Technology section of DJJDP and The University of North Carolina of Greensboro Instructional Research and Computing Department. Once the survey was moved, a JCC in the pilot study group was contacted to determine whether submission of results was being allowed by DJJDP computers. It was determined that submission of survey responses were being allowed as a result of moving the survey and the process of survey responses submission was restarted. Feedback from

pilot study participants about the survey process was solicited, both from the participant's supervisor and from participants themselves. Participant comments ranged from praise for the phrasing of questions to complaints about the same question asked several different ways. Several participants remarked on the ease of readability; all were critical of the survey's length. For a complete listing of pilot study respondent comments, see Appendix G.

After all responses from the pilot study participants were collected, a review of participant comments resulted in changes to survey question format. The stem of each question, which previously read "An entry-level JCC should ...." was deleted due to participant comments concerning the repetitive nature of survey questions, as well as a way to decrease overall length of the survey. Instead, the stem "A Juvenile Court Counselor should" was placed at the top of each survey page, and each survey item described the knowledge or skill for the survey participant to judge. For example, survey item 12 reads "... have knowledge of common family patters of adaptation to substance abuse." The term "entry-level" also was deleted from the survey questions, as this term was thought to be both limiting and confusing to the intended survey population, which includes JCC with numerous years of experience as a JCC.

Survey question 85 was changed from "An entry-level JCC should have skill in accessing community resources to support recovery" to ".....have skill in referring clients to appropriate community agencies resources to facilitate recovery" so as to more specifically determine the importance of referring clients to appropriate agencies to assist them in their recovery process.

A demographic question also was changed from “I have worked in the juvenile justice field for the following number of years:” to “What month and year did you begin your job as a Juvenile Court Counselor?” This was done to make it easier for respondents to report amount of experience as a JCC, with the ultimate aim of increasing response rate. A complete listing of all items from the questionnaire including both independent (demographic) variables and survey items is located in Appendix I. Chronbach’s alpha for the questionnaire was calculated at  $\alpha = .99$ , SE = 9.59, 1.3%. This reported  $\alpha$  is identical to the reported alpha for Ritter’s (2001) survey on which this instrument was based.

Albeit with a minimal sample size, the pilot study responses were analyzed in accordance with the previously stated research questions. Each research question is addressed separately. Also, for the main study the research questions were changed so that the factor analysis was done for Research Question One, and Research Question Two identified which particular knowledge and skills are considered most important by currently employed JCC on each factor. This was done after the pilot study process had all ready been completed.

Research Question One was answered by using description statistics to determine those pilot study survey items with the highest mean scores for importance. A complete listing of survey items and their respective descriptive statistics including range, standard deviation, variance, and standard error of the mean is provided in Appendix H. See Table 2 for a listing of the five survey questions with the highest response mean score.

Table 2. Five Survey Questions with Highest Response Mean Score

Item #	Item	Mean Score
24.	An entry-level JCC should have knowledge of trends in street and designer drugs	4.25
18.	An entry-level JCC should be able to monitor drug screenings and interpret test results	4.17
124.	An entry-level JCC should be able to consult with staff of other agencies on their cases involving alcohol or drug-related problems	4.08
42.	An entry-level JCC should have knowledge of confidentiality laws specific to substance abuse	4.00
15.	An entry-level JCC should be able to obtain a substance abuse history.	4.00

Research Question Two attempted to identify the factor structure of knowledge and skills needed by JCC in addressing the AOD abuse needs of juvenile offenders. This question was addressed by using factor analytic procedures to analyze pilot study survey responses. Due to the limited sample size, these results cannot be generalized, but the procedure did offer a blueprint for the main study. The factor analytic procedure consisted of a principle components analysis, which yielded the identification of 11 factors. Upon examination of the amount of variance explained by each factor and a scree plot of the Eigenvalues, an additional factor analysis was computed using a varimax rotation, fixing the number of factors at two, three, or four, with the intention of seeing which extraction would provide the most interpretable pattern. The resulting factor loading matrix showed patterns of loading for each variable, and it appeared that a four factor solution offered the most parsimonious explanation for a factor structure, based on the available data. The complete principle components factor analysis, scree plot of

eigenvalues, factor analysis with varimax rotation of four factors, and factor loadings for each variable is contained in Appendix J.

Examination of the items contained in each factor revealed that the clustering of items was around four concepts, with the most number of items clustered around a factor best termed as *Basic AOD Abuse Knowledge and Skills* (Factor One), with 75 items loading on this factor. Reliability for Factor One was computed using Chronbach's alpha ( $\alpha = .99$ , SE = 5.92, 1.6%). Some of the items from Factor One that exemplify *Basic AOD Abuse Knowledge and Skills* are Item (63) An entry-level JCC should have knowledge of the effects of psychoactive and psychotropic drugs on affective (mood) states, Item (87) An entry-level JCC should have knowledge of the pharmacology of alcohol and other psychoactive drugs and their interaction, and Item (20) An entry-level JCC should have skill in assessing the degree of client's understanding of his/her substance abuse/dependence. A complete listing of the items from Factor One – *Basic AOD Abuse Knowledge and Skills* is contained within Appendix K.

The second factor, *Assessment and Treatment of AOD Abuse*, had 30 survey items that loaded on this factor. Reliability for Factor Two was computed using Chronbach's alpha ( $\alpha = .96$ , SE = 3.49, 2.3%). Some items from this factor are Item (32) An entry-level JCC should have knowledge of emergency procedures associated with overdose, acute withdrawal, and decompensation, Item (135) An entry-level JCC should have knowledge of intoxication, withdrawal and long-term physical effects of substance use disorders, and Item (125) An entry-level JCC should have knowledge of behavior

management of the impaired person. A complete listing of the items that loaded on Factor Two – *Assessment and Treatment of AOD Abuse* is contained within Appendix K.

The third factor, *AOD Abuse Counseling Ethics/Obligations*, had 29 survey items loaded on it. Reliability for Factor Three was computed using Chronbach's alpha ( $\alpha = .94$ , SE = 3.63, 2.4%). It contains survey items such as Item (117) An entry-level JCC should be able to adhere to federal and state laws and agency regulations, regarding alcohol and other drug treatment, Item (49) An entry-level JCC should have knowledge of credentialing and certification requirements, and Item (46) An entry-level JCC should have knowledge of ethical standards which apply to substance use disorder counseling. A complete listing of the items that loaded on Factor Three – *AOD Abuse Counseling Ethics/Obligations* is contained within Appendix K.

The fourth factor, *Knowledge of AOD Abuse Theories*, had a total of 19 items that loaded on this factor. Reliability for Factor One was computed using Chronbach's alpha ( $\alpha = .87$ , SE = 2.61, 3.5%). Some of these were Item (154) An entry-level JCC should have knowledge of the recovery and relapse process, Item (66) An entry-level JCC should have knowledge of comprehensive assessment models related to substance abuse treatment, and Item (60) An entry-level JCC should have knowledge of theories of alcoholism or other drug dependencies. A complete listing of the items that loaded on Factor Four – *Knowledge of AOD Abuse Theories* is contained within Appendix K.

Research Question Three, sought to determine whether differences exist in the factor derived scale mean scores according to the independent variables of JCC sex, JCC ethnicity, JCC service area, or JCC degree, was examined using inferential statistics. The

variables of JCC sex , JCC Ethnicity, and JCC terminal degree were examined using a t-test to determine if significant differences exist between factor scale scores for the groups. Additionally, group statistics were computed for the variables of gender, ethnicity, and terminal degree, which may be viewed in Appendix L. The variable of JCC service area was not computed as there was no variance in this variable; all respondents were from a rural service area.

For the variable of gender, no significant differences were found at the .05 level for factor scale scores of male ( $n = 6$ ) or female ( $n = 6$ ) respondents on any of the factors. For a more complete listing of the  $t$ -test for the variable of gender and the factor scale scores, see Appendix M. The second independent variable, ethnicity, could only be examined to determine if differences in factor scale mean scores existed for African American ( $n = 3$ ) and Caucasian ( $n = 9$ ) respondents, as no other ethnic groups responded to the pilot study survey. No significant difference in factor mean scores existed for these two groups at the .05 level. For a more complete listing of the  $t$ -test for the variable of ethnicity and the factor scale scores, see Appendix M. The third independent variable of service area (i.e., rural or urban county) could not be examined because all of the pilot study participants were from a rural county area, District 19B of the Department of Juvenile Justice and Delinquency Prevention.

The fourth independent variable, degree, was examined by comparing the factor scale mean scores of respondents with a bachelors degree ( $n = 9$ ) or a master's degree or higher ( $n = 2$ ) to if any significant differences existed for these two groups. No significant

differences existed for these two groups at the .05 level. For a more complete listing of the t-test for the variable of Degree and the factor scale scores, see Appendix M.

Research Question Four sought to determine if there was any relationship between the continuous variables of years of JCC employment and hours of JCC substance abuse training with factor scale scores, was examined using correlational methods of data analysis. For the pilot study, a Pearson Product Moment Correlation procedure was utilized.

For the fifth independent variable of years of JCC job experience, no significant correlation was found between years of JCC job experience and factor scales mean scores when using the Pearson Product Moment Correlation procedure. For a complete listing of the correlations for variable of years of JCC job experience and factor scale mean scores, see Appendix N.

For the sixth independent variable, hours of substance abuse training since becoming a JCC, no significant correlations was found between hours of substance abuse training since becoming a JCC and factor scale mean scores. For a complete listing of the correlations for hours of substance abuse training since becoming a JCC and factor scale mean scores, see Appendix N

The seventh independent variable, percentage of successful cases, was not investigated on the pilot study but was included in the main study. This variable was identified for investigation after pilot study procedures had already been completed.

### Limitations of the Proposed Study

This study has limitations that may affect generalization of results and applicability of findings. These limitations, and the extent to which they are controlled or addressed, will be discussed in this section.

The study utilizes an on-line survey to gather information from currently employed JCCs. Because of the voluntary nature of the survey response, it was impossible to determine what the responses of all JCCs might be to the survey, and the possibility existed of a difference between the opinions of respondents and non-respondents. This shortcoming is common with survey research.

An additional concern is that the JCCs surveyed were from only one state. Thus, results may not be generalizable to JCCs from other states. Again, this represents a common threat to the validity of survey research.

Finally, despite the ubiquitous nature of computers and electronic communication, there was the possibility that some JCCs were not familiar with electronic means of communication and the on-line survey might have been misunderstood or intimidating to these persons. This may have resulted in responses from JCCs of a younger age group that may be more familiar with electronic means of data collection or communication, potentially restricting the range of participants' years of experience. In order to address this possible shortcoming, solicited participants were offered the option of receiving and filling out a paper and pencil form of the survey.

## Data Analyses

The objective of this study was to determine what juvenile offender AOD abuse knowledge and skills are considered most important for entry-level JCCs, as identified by currently employed JCCs. To this end, a 152-item survey of AOD abuse knowledge and skills that measures respondent beliefs concerning the importance of particular knowledge or skills was utilized. Factor analyses, descriptive statistics, and mean score comparison techniques such as t-tests, MANOVA, and Pearson Product Moment Correlation were conducted to address the research questions. Pilot study procedures informed changes in research questions and the addition of additional demographic variables, which is detailed below.

Research Question One calls for the identification of factors of knowledge and skills concerning AOD abuse that characterizes the education and training needs of JCCs, as reported by currently employed JCCs and measured by the Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire. This research question was addressed using a principle component analysis and a varimax rotation of JCC survey responses. This allowed for a preliminary factor solution that identified the number and typology of factors derived from the 152 item answers from the Questionnaire.

Research Question Two then sought to determine the most important knowledge and skills on each factor as determined in Research Question One. To this end, descriptive statistics were conducted on those survey responses clustered within the identified factors. These analyses include a determination of mean scores for each survey

item, standard deviations of responses to each survey item, a standard error, range, and variance.

Research Question Three involves determining whether significant differences for the factor scale mean scores exist and whether they are affected by the variables of JCC sex, Ethnicity, service area, i.e., rural or urban, or terminal degree. To this end, an inferential statistical procedure (Multiple Analysis of Variance) was used. Any significant differences found were confirmed through the use of a Post Hoc Analysis procedure, Tukey's Honestly Significant Differences (HSD).

Research Question Four examined whether a relationship exists between factor scale scores and the continuous variables of years of JCC experience, number of hours of substance abuse training since becoming a JCC, and percentage of successful cases. For the purpose of this study, successful cases are defined as those cases in which there is no re-offending behavior while on active probation. Statistical procedures of a correlational nature were used in this analysis (e.g., Pearson Product Moment Correlation).

#### Research Matrix

For a graphic visual representation of the research questions addressed, the variables measured, and the data analyses performed, please see the following Research Matrix in Table 2. Research Questions are in a shortened format due to table constraints. For the full version of the Research Questions under investigation, see previous sections.

#### Chapter Summary

Chapter III has identified the research questions under investigation, an appropriate measurement tool for gathering of information to answer these research

questions, and the methods and means whereby this survey was distributed and results analyzed using accepted statistical procedures. Results of this study will be presented in Chapter IV.

Table 3 – Research Questions/Hypothesis/Data Analysis Matrix

Question	Variables	Data Analysis
1. What is the factor structure of knowledge and skills concerning AOD abuse that characterizes the education and training needs of JCCs?	Likert scale scores on 153 survey items that rank the importance of specific AOD abuse treatment skills or knowledge	PCA Factor Analysis with Varimax Rotation
2. Given the factor structure from Question One, what are the specific AOD abuse treatment knowledge and skills considered most important for JCCs on each factor?	Likert-type scale scores on 153 survey items that rank the importance of specific AOD abuse treatment skills or knowledge	Descriptive Statistics
3. Given the factor structure from Question One, what effects do JCC variables have on the factor-derived scores?	<p><b>Independent variables:</b> JCC sex (male or female), ethnicity (white or non-white), service area (rural or urban), and terminal degree (graduate or undergraduate)</p> <p><b>Dependent variables:</b> Factor scale mean scores</p>	T-Test and ANOVA or MANOVA for final study
4. Given the factor structure from Question One, what relationship exists between JCC variables and factor-derived scores?	<p><b>Independent variables:</b> hours of JCC AOD abuse training since becoming a JCC, percentage of successful cases, and years of JCC job experience.</p> <p><b>Dependent variables:</b> Factor scale mean scores</p>	Pearson Product Moment Correlations

## CHAPTER IV

### RESULTS AND DISCUSSION

In this chapter, the factor analytic procedures used to determine the factor structure of knowledge and skills based on Juvenile Court Counselor (JCC) responses to the Survey of Alcohol and other Drug Abuse Training Needs of Juvenile Court Counselors in North Carolina (hereafter referred to as the Survey) are reported. Further, descriptive statistics of the highest rated knowledge and skills for each factor within the hypothesized factor structure, and whether demographic variables have linear effects or relationships to the factor scale scores for each hypothesized factor are reported.

#### Questions and Analysis

A series of exploratory factor analyses were performed to examine the hypothesized existence of an underlying factor structure to participant Survey responses. A principle components analysis was conducted for Research Question One, and a Varimax rotation of the solution was conducted to identify which items loaded on each factor. Descriptive statistics, including mean score, standard deviation, standard error, range, and variance, were computed for items on each factor. This allowed for the identification of those individual items on each factor considered most important for JCCs working with Alcohol and Other Drug (AOD) abuse issues among juvenile offenders, based on the answers of currently employed JCCs. This analysis addressed Research Question Two. Research Question Three was addressed using a Multiple

Analysis of Variance (MANOVA) technique for factor scale mean scores and the independent variables of sex, ethnicity, terminal degree, and service area. Research Question Four was addressed through the use of a Pearson Product Moment Correlation procedure to identify the relationship, if any, between factor scale mean scores and JCC months of experience, percentage of successful cases, and hours of AOD abuse training since becoming a JCC.

#### *Research Question One*

The factor analysis procedure was a principle components analysis that resulted in the identification of 16 factors, each of which accounted for at least 1% of the variance for a total accounting of 65% of the variance among items. It should be noted, however, that any factor beyond four accounted for less than 2% of the variance among items. Therefore, an additional factor analysis was computed using a Varimax rotation. An initial four factor solution was attempted, based on the amount of variance accounted for by four factors. The resulting component matrix revealed that a number of items were factorially complex and did not have sufficient loading weights to consider their inclusion on any one factor identified in the Varimax rotation. The factorial loading weights were then examined, and those items that did not show preference for a specific factor were excluded from further analysis. This was determined in two ways. Those items with a factor had a loading weight greater than or equal to 0.5 on one factor and less than or equal to 3.5 on any of the other factors in the Varimax rotation were determined to show a clear preference for one factor. These items were then reviewed to determine whether their grouping clustered around a particular concept or idea possibly identified by that

factor. This resulted in the identification of 69 items from the original 152 items. Finally, these items were again analyzed using a Principle Components Analysis with Varimax rotation. This identified three main factors in which the retained items clearly loaded on one of the three factors. The original Principle Components factor analysis is contained in Table 4, the Scree plot of Eigenvalues is shown in Figure 3, and the factor analysis with Varimax rotation of three factors with subsequent factor loadings for each variable is shown in Figure 4. The three identified factors are described in subsequent paragraphs.

Table 4

Principle Components Factor Analysis

---

**Total Variance Explained**

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	61.65	40.56	40.56	61.65	40.56	40.56
2	6.62	4.36	44.91	6.62	4.36	44.91
3	4.94	3.25	48.16	4.94	3.25	48.16

Extraction Method: Principal Component Analysis.

---

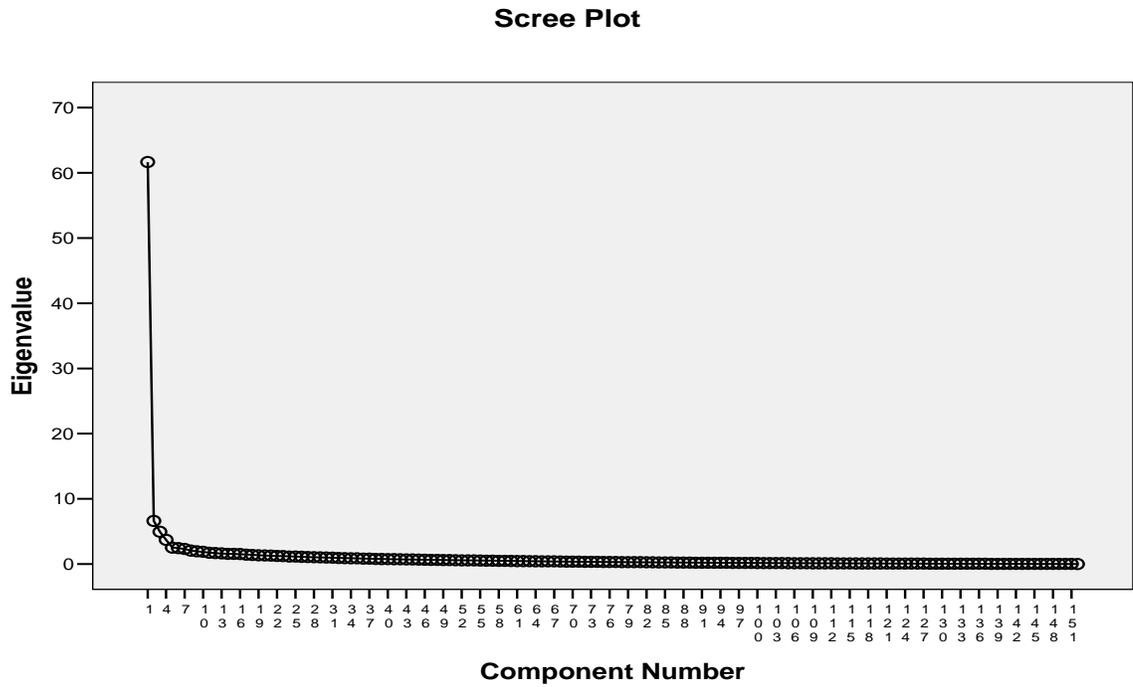


Figure 3. Scree Plot of Eigenvalues

Rotated Component Matrix(a)

	Component		
	1	2	3
V143	<b>0.78</b>	0.23	
V133	<b>0.74</b>	0.27	0.13
V108	<b>0.73</b>	0.20	
V140	<b>0.73</b>	0.25	0.25
V135	<b>0.72</b>	0.21	0.18
V99	<b>0.70</b>	0.19	0.16
V120	<b>0.70</b>	0.22	0.14
V116	<b>0.68</b>	0.23	
V144	<b>0.68</b>	0.32	0.11
V159	<b>0.67</b>	0.26	0.25
V130	<b>0.65</b>	0.21	0.16
V147	<b>0.65</b>	0.31	0.11
V124	<b>0.64</b>		0.18

V107	<b>0.63</b>	0.29	0.18
V142	<b>0.62</b>	0.30	
V110	<b>0.62</b>	0.33	0.13
V121	<b>0.62</b>	0.27	0.22
V112	<b>0.61</b>	0.14	0.16
V151	<b>0.61</b>	0.18	0.12
V85	<b>0.60</b>		0.17
V125	<b>0.60</b>	0.27	0.33
V80	<b>0.60</b>	0.24	0.28
V123	<b>0.59</b>	0.32	0.23
V134	<b>0.59</b>	0.22	0.22
V74	<b>0.59</b>	0.28	0.24
V154	<b>0.59</b>	0.37	0.18
V150	<b>0.58</b>	0.30	0.10
V153	<b>0.58</b>	0.33	0.23
V132	<b>0.57</b>	0.34	0.28
V117	<b>0.57</b>	0.15	0.21
V129	<b>0.56</b>	0.31	0.32
V141	<b>0.51</b>	0.25	
V83	<b>0.51</b>	0.22	0.29
V138	<b>0.51</b>	0.22	0.21
V127	0.20	<b>0.82</b>	0.18
V62	0.16	<b>0.78</b>	0.25
V95	0.15	<b>0.75</b>	
V101	0.28	<b>0.74</b>	
V104	0.27	<b>0.74</b>	
V67	0.17	<b>0.73</b>	0.23
V128	0.32	<b>0.71</b>	0.18
V64	0.31	<b>0.68</b>	0.17
V78	0.27	<b>0.68</b>	0.24
V48	0.25	<b>0.67</b>	0.22
V109	0.34	<b>0.66</b>	
V49	0.22	<b>0.66</b>	0.18
V106	0.39	<b>0.65</b>	
V65	0.34	<b>0.65</b>	0.18
V92	0.35	<b>0.64</b>	
V54	0.26	<b>0.64</b>	0.28
V53	0.28	<b>0.63</b>	0.30
V29	0.16	<b>0.60</b>	0.35
V45	0.16	<b>0.58</b>	0.16
V68	0.39	<b>0.54</b>	0.14
V100	0.26	<b>0.54</b>	0.19
V13	0.21		<b>0.62</b>
V24	0.33	0.12	<b>0.60</b>

V25	0.22	0.12	<b>0.59</b>
V15		0.18	<b>0.58</b>
V19	0.21		<b>0.57</b>
V28		0.18	<b>0.56</b>
V14	0.16	0.27	<b>0.56</b>
V16		0.16	<b>0.55</b>
V11	0.33		<b>0.55</b>
V18	0.20		<b>0.54</b>
V8	0.17	0.20	<b>0.54</b>
V44	0.33	0.22	<b>0.53</b>

Extraction Method: Principal Component Analysis.  
 Rotation Method: Varimax with Kaiser Normalization.  
 a Rotation converged in 6 iterations.

Figure 4. Factor Analysis with Varimax Rotation

---

A total of 35 items clustered around a factor best termed as *Clinical Work with AOD Abusers and Families (CWAAF)*, which included such items as: 143- A Juvenile Court Counselor should have knowledge of the effects of alcohol/drug dependency and recovery on family members and significant others, 140 - A Juvenile Court Counselor should have knowledge of the dynamics of resistance to the treatment and recovery process, and 108 - A Juvenile Court Counselor should have knowledge of how the denial process of client and family affect the family and society of the substance abuser.

Reliability for *CWAAF* was computed using a Chronbach's Alpha ( $\alpha = .97$ , SE = 3.78, 2.26%). All items for *CWAAF*, as well as their factor loading in descending order, are reported in Table 5.

Table 5

Items Loading on CWAAF

Item Number	Item	Item Loadings
143	...have knowledge of the effects of alcoholism/drug dependency and recovery on family members and significant others	0.78
133	...have knowledge of roles of informal support systems on encouraging and/or inhibiting alcohol/drug use	0.74
108	...have knowledge of how the denial processed of client and family affect the family and society of the substance abuser	0.72
135	...have knowledge of intoxication, withdrawal, and long term physical effects of substance use disorders	0.72
140	...have knowledge of the dynamics of resistance to the treatment and recovery process	0.72
120	...have knowledge of cultural lifestyle difference regarding attitudes and values about the use and abuse of alcohol and drugs.	0.70
99	...have knowledge of how external factors (i.e., per influence and the community environment) encourage or discourage substance use, abuse, dependency medication compliance and recovery.	0.69
116	...have knowledge of self-help groups and their programs of recovery	0.68
159	...have knowledge of how the client's denial process can lead to manipulation of the health care professional	0.68
144	...have knowledge of client skills that encourage recovery oriented behavior	0.68
118	...have knowledge of how internal factors (for example, expectation, coping skills, co-existing disorders) influence recovery and relapse processes	0.67
130	...have knowledge of the concepts of prevention, community education, and community outreach regarding substance abuse	0.65
147	...have knowledge of contemporary issues and events relevant to alcoholism/drug dependency (for example, legislative and public policy issues).	0.65
124	...be able to consult with staff of other agencies on their cases involving alcohol or drug-related problems.	0.65
107	...be able to discuss substance use and biopsychosocial disorders with other professional in order to examine the role professional can play in the prevention, treatment, and recovery processes.	0.63

142	...be able to facilitate client exploration about the consequences of substance abuse	0.62
121	...be able to continue to be informed about current trends and developments in alcoholism, drug dependency, the counseling profession, and related fields.	0.62
110	...be able to describe factors that increase the likelihood that an individual, group, or community will be at risk for alcohol or other drug problems.	0.61
112	...have knowledge of withdrawal symptoms	0.61
151	...have knowledge of alcohol and drug abuse withdrawal signs and symptoms.	0.61
85	...have skill in accessing community resources to support recovery.	0.61
80	...have knowledge of changes due to taking/not taking psychotropic medication	0.60
134	...be able to understand the addition professionals obligation to adhere to generally accepted ethical and behavioral standards of conduct in the helping relationship	0.59
123	...have knowledge of issues specific to specific populations (e.g., ethnic minorities, women, youth, elderly, gays, physically impaired).	0.59
125	...have knowledge of the behavioral management of the substance impaired person	0.59
74	...have knowledge of the effects of substance use disorders on a specific community or population.	0.58
154	...have knowledge of the recovery and relapse process.	0.58
150	...have skill in identifying withdrawal effects.	0.58
132	...be able to understand the substance use patterns of diverse racial and ethnic cultures.	0.58
117	...be able to adhere to federal and state laws and agency regulations, regarding alcohol and other drug treatment.	0.57
153	...have knowledge of the signs and symptoms of mental health disorders (as indicated by currently accepted diagnostic criteria) identify how they relate to substance abuse, and recognize the implications of this relationship for treatment and referral.	0.57
129	...have knowledge of incidence and prevalence of HIV/AIDS and sexually transmitted diseases as well as the relationship of these illnesses with substance abuse disorders.	0.56
71	...have knowledge of the various philosophies and structure of self-help groups and support groups (i.e., AA, NA, Al-Anon, Nar-Anon).	0.54
141	...have knowledge of the information needed to complete the intake interview (e.g., use of alcohol and other drugs of abuse, educational background, cultural information, socioeconomic information, lifestyle information, living situation, medical information, treatment history, demographic information, legal status, other relevant data, normal ranges of vital signs).	0.52

83	...have knowledge of drug interactions, including prescription drugs and over the counter drugs	0.51
138	...have knowledge of the physical illness that may be mistaken for symptoms of substance abuse.	0.50

---

The second factor, labeled as *Intervention and Assessment (IA)*, had a total of 21 items to load onto it. *IA* included items such as: 127 – A Juvenile Court Counselor should have skill in developing and writing a recovery plan, 92 – A Juvenile Court Counselor should have be able to organize an intervention by involving family members or significant others affected by alcoholism/drug dependence of clients, and 67 - A Juvenile Court Counselor should have skill in administration and interpretation of specific substance disorder assessment instruments. Reliability for *IA* was computed using a Chronbach’s Alpha ( $\alpha = .96$ , SE = 3.24, 3.1%). All items included on *IA* are listed in Table 6, along with their factor loadings in descending order.

Table 6

Items Loading on *IA*

---

Item #	Item	Item Loadings
127	... have skill in developing and writing a recovery plan	0.82
62	... be able to describe, select, and use strategies from accepted and culturally appropriate models for group counseling with addicted or substance abusing clients.	0.79
95	... be able to design and provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and the recovery process.	0.75

101	... be able to, using current literature and research findings, deliver culturally relevant formal and informal education programs for clients and other significant persons to raise awareness of prevention, treatment, and recovery processes for substance use and biopsychosocial disorders.	0.74
67	... have skill in administration and interpretation of specific substance disorder assessment instruments.	0.74
104	... be able to instruct clients and significant persons through lectures, workshops, and discussions so they understand the influence of substance use and biopsychosocial disorders on families and other relationships.	0.74
128	... be able to understand the established diagnostic criteria for substance dependence and abuse, as well as describe the treatment modalities and placement criteria based on the continuum of care model.	0.71
64	... have knowledge of how to develop an individualized recovery plan that meets the unique needs of the client.	0.68
78	... have skill in assessing and determining the severity of psychoactive substance abuse.	0.68
49	... have knowledge of credentialing and certification requirements.	0.67
48	... be able to organize or facilitate an intervention using case examples.	0.67
109	... have skill in facilitating interventions (for example, with the client's family, employer, or others).	0.66
65	... be able to identify similarities and differences in participation in self-help group meetings and group counseling.	0.65
106	... have skill in relating self-help group (for example, AA, NA) experience to group counseling experience	0.65
54	... have skill in interpreting results of substance abuse disorder assessment instruments and relating the information to clients.	0.65
92	... be able to organize an intervention by involving family members or significant others affected by alcoholism/drug dependence of clients.	0.65
53	... have skill in assessing the client's risk factors for AOD abuse relapse.	0.63
29	... have skill in evaluating the severity of the client's alcoholism and other drug dependency	0.61
45	... be able to make homework assignments that include participation in self-help groups.	0.59
68	... be able to help families, couples, and intimate dyads adopt strategies and behaviors that sustain recovery and maintain healthy relationships.	0.54
100	... have knowledge of diagnostic laboratory results (for example, blood lab, EEG, liver function).	0.54

---

Twelve items loaded onto a third factor, labeled as *Drug Effects and Interactions (DEI)*. It included such items as 25 – A Juvenile Court Counselor should have knowledge of trends in street and designer drugs, 24 – A Juvenile Court Counselor should have knowledge of patterns and methods of misuse and abuse of prescribed and over-the-counter medications, and 18 - A Juvenile Court Counselor should have knowledge of pharmacokinetics, for example, how long it takes a drug to stay in the body. Reliability for *DEI* was computed using a Chronbach’s Alpha ( $\alpha = .85$ , SE = 2.15, 3.6%). All items included on *DEI* are listed in Table 7, along with their factor loadings in descending order.

Table 7

Items Loading on *DEI*

Item #	Item	Item Loadings
13	... have knowledge of common patterns of family adaptation to substance abuse	0.62
25	...have knowledge of trends in street and designer drugs	0.59
15	... have skill in obtaining a client’s family history of addictive disorders	0.59
24	... have knowledge of patterns and methods of misuse and abuse of prescribed and over-the-counter medications	0.58
16	... be able to obtain a substance abuse history.	0.57
19	... be able to monitor drug screenings and interpret test results	0.56
11	... have knowledge of the potential for cross-addiction, that is, addiction to both alcohol and tranquilizers.	0.56
18	... have knowledge of pharmacokinetics, for example, how long it takes	0.56

	a drug to stay in the body	
28	...have knowledge of current professional literature on substance abuse	0.55
8	... be able to describe the behavioral, physical health, and social effects of psychoactive drugs, including alcohol and tobacco, on the consumer and significant others.	0.55
14	... have knowledge of the relationships between psychoactive substance use and other mental health disorders	0.55
44	... have knowledge of adverse effects of combining various types of psychoactive drugs, as well as over the counter medication.	0.53

---

### *Research Question Two*

Research Question Two, which sought to determine those AOD abuse knowledge and skills within each identified factor judged most important by currently employed JCC, was addressed through the use of descriptive statistics. Using the factor structure identified in the previous section, items from each factor were analyzed and the following descriptive statistics were computed for each: mean, standard deviation, standard error, range, and variation. The items and their respective statistics are discussed in subsequent sections according to the particular factor upon which the items load.

*Descriptives for Items on CWAAF.* There were a total of 36 items that loaded on *CWAAF*. Those items loading on *CWAAF* with the highest mean score of importance were: 85 – A Juvenile Court Counselor should have skill in accessing community resources to support recovery, 124 - A Juvenile Court Counselor should be able to consult with staff of other agencies on their cases involving alcohol or drug-related problems, 117 - A Juvenile Court Counselor should be able to adhere to federal and state laws and agency regulations, regarding alcohol and other drug treatment, 112 - A

Juvenile Court Counselor should have knowledge of withdrawal symptoms, 151 - A  
 Juvenile Court Counselor should have knowledge of alcohol and drug abuse withdrawal signs and symptoms. A complete listing of items that loaded on *CWAAF* and their descriptive statistics is provided in Table 8.

Table 8  
Descriptive Statistics for Items Loading on *CWAAF*

Item #	Item	<u>M</u>	SD	SE	Range
85	...have skill in accessing community resources to support recovery.	4.16	0.78	0.05	4
124	...be able to consult with staff of other agencies on their cases involving alcohol or drug-related problems.	3.93	0.81	0.06	4
117	...be able to adhere to federal and state laws and agency regulations, regarding alcohol and other drug treatment.	3.89	0.84	0.06	4
112	...have knowledge of withdrawal symptoms	3.86	0.68	0.05	4
151	...have knowledge of alcohol and drug abuse withdrawal signs and symptoms.	3.82	0.68	0.05	4
99	...have knowledge of how external factors (i.e., per influence and the community environment) encourage or discourage substance use, abuse, dependency medication compliance and recovery.	3.74	0.86	0.06	4
130	...have knowledge of the concepts of prevention, community education, and community outreach regarding substance abuse	3.72	0.84	0.06	4
120	...have knowledge of cultural lifestyle difference regarding attitudes and values about the use and abuse of alcohol and drugs.	3.66	0.89	0.06	4
135	...have knowledge of intoxication, withdrawal, and long term physical effects of substance use disorders	3.65	0.82	0.06	4
116	...have knowledge of self-help groups and their programs of recovery	3.65	0.86	0.06	4

125	...have knowledge of the behavioral management of the substance impaired person	3.62	0.90	0.06	4
150	...have skill in identifying withdrawal effects.	3.61	0.80	0.06	4
143	...have knowledge of the effects of alcoholism/drug dependency and recovery on family members and significant others	3.60	0.80	0.05	4
138	...have knowledge of the physical illness that may be mistaken for symptoms of substance abuse.	3.60	0.84	0.06	4
159	...have knowledge of how the client's denial process can lead to manipulation of the health care professional	3.59	0.89	0.06	4
108	...have knowledge of how the denial processed of client and family affect the family and society of the substance abuser	3.58	0.87	0.06	4
121	...be able to continue to be informed about current trends and developments in alcoholism, drug dependency, the counseling profession, and related fields.	3.58	0.91	0.06	4
74	...have knowledge of the effects of substance use disorders on a specific community or population.	3.57	0.88	0.06	4
133	...have knowledge of roles of informal support systems on encouraging and/or inhibiting alcohol/drug use	3.53	0.87	0.06	4
80	...have knowledge of changes due to taking/not taking psychotropic medication	3.54	0.88	0.06	4
140	...have knowledge of the dynamics of resistance to the treatment and recovery process	3.52	0.88	0.06	4
132	...be able to understand the substance use patterns of diverse racial and ethnic cultures.	3.51	0.84	0.06	4
110	...be able to describe factors that increase the likelihood that an individual, group, or community will be at risk for alcohol or other drug problems.	3.51	0.97	0.07	4
144	...have knowledge of client skills that encourage recovery oriented behavior	3.49	0.86	0.06	4
83	...have knowledge of drug interactions, including prescription drugs and over the counter drugs	3.48	0.89	0.06	4
71	...have knowledge of the various philosophies and structure of self-help groups and support groups (i.e., AA, NA, Al-Anon, Nar-Anon).	3.48	0.97	0.07	4
154	...have knowledge of the recovery and relapse process.	3.46	0.87	0.06	4
134	...be able to understand the addition professionals obligation to adhere to generally accepted ethical and behavioral standards of conduct in the helping	3.42	0.92	0.06	4

	relationship				
123	...have knowledge of issues specific to specific populations (e.g., ethnic minorities, women, youth, elderly, gays, physically impaired).	3.42	0.97	0.07	4
142	...be able to facilitate client exploration about the consequences of substance abuse	3.42	0.99	0.07	4
153	...have knowledge of the signs and symptoms of mental health disorders (as indicated by currently accepted diagnostic criteria) identify how they relate to substance abuse, and recognize the implications of this relationship for treatment and referral.	3.41	0.91	0.06	4
107	...be able to discuss substance use and biopsychosocial disorders with other professional in order to examine the role professional can play in the prevention, treatment, and recovery processes.	3.36	1.05	0.07	4
129	...have knowledge of incidence and prevalence of HIV/AIDS and sexually transmitted diseases as well as the relationship of these illnesses with substance abuse disorders.	3.35	0.97	0.07	4
147	...have knowledge of contemporary issues and events relevant to alcoholism/drug dependency (for example, legislative and public policy issues).	3.34	0.90	0.06	4
141	...have knowledge of the information needed to complete the intake interview (e.g., use of alcohol and other drugs of abuse, educational background, cultural information, socioeconomic information, lifestyle information, living situation, medical information, treatment history, demographic information, legal status, other relevant data, normal ranges of vital signs).	3.34	1.02	0.07	4
118	...have knowledge of how internal factors (for example, expectation, coping skills, co-existing disorders) influence recovery and relapse processes	3.30	0.93	0.06	4
		<u>M</u>	SD	Min	Max
Descriptives for all <i>CWAAF</i> Items		3.58	0.19	3.30	4.16

*Descriptives for Items on IA.* There were a total of 21 items that loaded on *IA*. The five items loading on *IA* with the highest mean score of importance were 68 - A Juvenile Court Counselor should be able to help families, couples, and intimate dyads adopt strategies and behaviors that sustain recovery and maintain healthy relationships, 29- A Juvenile Court Counselor should have skill in evaluating the severity of the client’s alcoholism and other drug dependency, 53 - A Juvenile Court Counselor should have skill in assessing the client’s risk factors for AOD abuse relapse, 54 - A Juvenile Court Counselor should have skill in interpreting results of substance abuse disorder assessment instruments and relating the information to clients, and 92 – A Juvenile Court Counselor should be able to organize an intervention by involving family members or significant others affected by alcoholism/drug dependence of clients . A complete listing of items that loaded on *IA* and their descriptive statistics is provided in Table 9.

Table 9

Descriptive Statistics for Items Loading on IA

Item #	Item	<u>M</u>	SD	SE	Range
68	... be able to help families, couples, and intimate dyads adopt strategies and behaviors that sustain recovery and maintain healthy relationships.	3.13	1.07	0.07	4
29	... have skill in evaluating the severity of the client’s alcoholism and other drug dependency	3.05	1.09	0.07	4
53	... have skill in assessing the client’s risk factors for AOD abuse relapse.	3.01	1.02	0.07	4

54	... have skill in interpreting results of substance abuse disorder assessment instruments and relating the information to clients.	2.99	1.09	0.08	4
92	... be able to organize an intervention by involving family members or significant others affected by alcoholism/drug dependence of clients.	2.94	1.02	0.07	4
109	... have skill in facilitating interventions (for example, with the client's family, employer, or others).	2.93	1.06	0.07	4
65	... be able to identify similarities and differences in participation in self-help group meetings and group counseling.	2.92	0.96	0.07	4
106	... have skill in relating self-help group (for example, AA, NA) experience to group counseling experience	2.90	1.00	0.07	4
48	... be able to organize or facilitate an intervention using case examples.	2.81	1.02	0.07	4
49	... have knowledge of credentialing and certification requirements.	2.76	0.99	0.07	4
64	... have knowledge of how to develop an individualized recovery plan that meets the unique needs of the client.	2.76	1.09	0.08	4
62	... be able to describe, select, and use strategies from accepted and culturally appropriate models for group counseling with addicted or substance abusing clients.	2.75	1.01	0.07	4
78	... have skill in assessing and determining the severity of psychoactive substance abuse.	2.74	1.00	0.07	4
67	... have skill in administration and interpretation of specific substance disorder assessment instruments.	2.74	1.03	0.07	4
100	... have knowledge of diagnostic laboratory results (for example, blood lab, EEG, liver function).	2.74	1.07	0.07	4
128	... be able to understand the established diagnostic criteria for substance dependence and abuse, as well as describe the treatment modalities and placement criteria based on the continuum of care model.	2.67	1.02	0.07	4
45	... be able to make homework assignments that include participation in self-help groups.	2.67	1.06	0.07	4
104	... be able to instruct clients and significant persons through lectures, workshops, and discussions so they understand the influence of substance use and biopsychosocial disorders on	2.66	1.04	0.07	4

	families and other relationships.				
95	... be able to design and provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and the recovery process.	2.65	1.01	0.07	4
101	... be able to, using current literature and research findings, deliver culturally relevant formal and informal education programs for clients and other significant persons to raise awareness of prevention, treatment, and recovery processes for substance use and biopsychosocial disorders.	2.61	0.96	0.07	4
127	... have skill in developing and writing a recovery plan	2.42	0.98	0.07	4
		<u>M</u>	<u>SD</u>	<u>Min</u>	<u>Max</u>
	Descriptives for all <i>IA</i> Items	2.80	0.17	2.42	3.13

---

*Descriptives for Items on DEI.* There were a total of 12 items that loaded on *DEI*. Those five items loading on *DEI* with the highest mean score of importance were 25 – A Juvenile Court Counselor should have knowledge of trends in street and designer drugs, 19 - A Juvenile Court Counselor should be able to monitor drug screenings and interpret test results, 16 – A Juvenile Court Counselor should be able to obtain a substance abuse history, 18 – A Juvenile Court Counselor should have knowledge of pharmacokinetics, for example, how long it takes a drug to stay in the body, 13 – A Juvenile Court Counselor should have knowledge of common patterns of family adaptation to substance abuse. A complete listing of items that loaded on *DEI* and their descriptive statistics is provided in Table 10.

Table 10

Descriptive Statistics for Items Loading on *DEI*

Item #	Item	<u>M</u>	SD	SE	Range
25	...have knowledge of trends in street and designer drugs	4.21	0.58	0.04	4
19	... be able to monitor drug screenings and interpret test results	4.14	0.77	0.05	4
16	... be able to obtain a substance abuse history.	4.05	0.68	0.05	4
18	... have knowledge of pharmacokinetics, for example, how long it takes a drug to stay in the body	4.05	0.63	0.04	4
13	... have knowledge of common patterns of family adaptation to substance abuse	3.93	0.61	0.04	3
8	... be able to describe the behavioral, physical health, and social effects of psychoactive drugs, including alcohol and tobacco, on the consumer and significant others.	3.88	0.88	0.06	4
24	... should have knowledge of patterns and methods of misuse and abuse of prescribed and over-the-counter medications	3.82	0.77	0.05	4
15	... have skill in obtaining a client's family history of addictive disorders	3.80	0.80	0.06	3
14	... have knowledge of the relationships between psychoactive substance use and other mental health disorders	3.72	0.83	0.06	4
44	... should have knowledge adverse effects of combining various types of psychoactive drugs, as well as over the counter medication.	3.69	0.82	0.06	4
11	... have knowledge of the potential for cross-addiction, that is, addiction to both alcohol and tranquilizers.	3.59	0.79	0.05	4
28	...have knowledge of current professional literature on substance abuse	3.57	0.84	0.06	4
		<u>M</u>	SD	Min	Max
Descriptives for all <i>DEI</i> Items		3.87	0.21	3.57	4.21

*Important Items Not Loading on Identified Factors.* Eighty-three items did not have loading weights sufficient to load on any one factor. Descriptive statistics for these items indicate their importance, however, to currently employed JCCs in regards to knowledge and skills about AOD abuse. A listing of items with a mean score of 3.5 or higher is included in Table 11. For a list of descriptive statistics for all items not loading on one of the three factors, see Appendix P.

Table 11

Important Items Not Loading on Any Identified Factor

Item #	Item	<u>M</u>	SD	SE	Range
42	...have knowledge of confidentiality laws specific to substance abuse.	4.05	0.72	0.05	4
58	...have knowledge of federal, state, and local statues relating to the use of alcohol and drugs	4.02	0.81	0.06	4
73	...have knowledge of the importance of family, social networks, and community systems in the treatment and recovery process	3.83	0.74	0.05	4
30	.....be able to involve significant others in aftercare planning	3.79	0.79	0.05	4
55	.....be able to understand terminology, procedures, and the roles of other disciplines related to the treatment of addiction	3.77	0.80	0.06	4
75	...have knowledge of the effects of alcoholism and other drug dependencies on the clients relationship with self, others, and society.	3.77	0.79	0.05	4
27	...have knowledge of current methods and technologies to present information in a culturally sensitive manner, for example, using language appropriate to the audience.	3.76	0.94	0.06	4
41	.....be able to educate clients about self-help groups	3.71	0.76	0.05	4

94	...have knowledge of legal consequences when client rights are violated as specifically related to substance abuse treatment regulations.	3.71	0.94	0.06	4
17	...have skill in determining a client's degree of understanding of alcohol and other drug dependencies	3.69	0.82	0.06	4
158	.....be able to help the client identify the role of substance abuse in his/her current life problems	3.69	0.91	0.06	4
82	...be able to inform significant others about and encourage participation in appropriate self help groups	3.66	0.84	0.06	4
12	...be able to screen for alcohol and other drug toxicity, withdrawal symptoms, aggression, or danger to others, and potential for self-inflicted harm or suicide.	3.63	1.02	0.07	4
76	.....be able to understand the characteristics and dynamics of families, couples, and intimate dyads affected by alcoholism.	3.63	0.81	0.06	4
23	...have knowledge of the relationship between symptoms and responsiveness to varying levels of care, such as inpatient treatment, outpatient treatment, or residential treatment	3.59	0.90	0.06	4
35	...have knowledge of value of periodic self-assessment to personal growth (e.g., career planning).	3.59	0.89	0.06	4
43	...have knowledge of the relationship between psychoactive substance use and values, culture, lifestyle, age, gender, HIV status, sexual orientation, physically challenging conditions, and socioeconomic status.	3.59	0.92	0.06	4
21	...have skill in assessing the degree of client's understanding of his/her substance abuse/dependence.	3.57	0.88	0.06	4
96	...have knowledge of substance use education and prevention models.	3.57	0.91	0.06	4
32	...have knowledge of emergency procedures associated with overdose, acute withdrawal, and decompensation	3.56	1.00	0.07	4
63	...have knowledge of the effects of psychoactive and psychotropic drugs on affective (mood) states.	3.55	0.92	0.06	4
26	...be able to arrange aftercare services, that is, continuing care services for clients that complete treatment	3.54	1.05	0.07	4
20	...have knowledge of relapse prevention theories and techniques	3.53	0.88	0.06	4
90	...have skill in developing linkages to a variety of self-help groups	3.53	0.89	0.06	4
97	...have skill in helping the client evaluate the impact of alcoholism and other drugs	3.53	0.97	0.07	4

46	...have knowledge of ethical standards which apply to substance use disorder counseling.	3.5	0.93	0.06	4
69	...have knowledge of the impact on substance use and specific substance induced mental disorders such as mood, anxiety, personality, and psychotic disorders.	3.5	0.97	0.07	4

---

*Research Question Three*

This question sought to determine whether differences existed in factor-derived scores according to the independent variables of sex, ethnicity, terminal degree, and service area. This was examined through the use of a Multiple Analysis of Variance (MANOVA) Procedure in which the factor-derived scores for each of the identified factors from Research Question One served as dependent variables. Independent variables included respondent sex (female or male), ethnicity (non-white or white), service area (rural or urban), and terminal degree (undergraduate or graduate). The multivariate analyses for factor-derived score variables (sex, ethnicity, service area, and terminal degree) are presented in Table 12. There were no significant main effects for any of the independent variables, nor were there any interaction effects. Because approximately 30 percent of respondents had less than two years experience, an additional multivariate analysis was performed that excluded these cases. This secondary analysis did not reveal any significant main effects for any of the independent variables, nor were there any interaction effects. As a result, no univariate follow-up analyses were run nor are any comparative descriptive statistics shown for these independent variable groups.

Table 12

Multivariate Analysis of Variance for CWAAF, IA, DEI Scale Scores and Sex, Ethnicity, Terminal Degree, and Service Area

Source	Multivariate Analysis	
	Wilkes Lambda	<i>F</i>
Sex (S)	.99	.61
Ethnicity (E)	.98	1.17
Terminal Degree (T)	.97	2.07
Service Area (SA)	.99	.56
S x E	.99	.66
S x T	.97	1.69
S x SA	.99	.63
E x T	1.0	.06
E x SA	.99	.39
T x SA	.98	1.31
S x E x T	.99	.41
S x E x SA	.97	1.84
S x T x SA	.99	.41
E x T x SA	1.0	.34
S x E x T x SA	.98	1.58

#### *Research Question Four*

This question sought to determine whether factor-derived scores have a relationship with the continuous variables of percentage of successful cases in the last two years, hours of AOD abuse training since becoming a JCC, and months of experience as a JCC.

Respondents varied greatly in their reports of success with clients in the past two years, perhaps because success was defined as no re-offending behavior by a juvenile while on a probationary sentence under the supervision of the JCC. The lowest percentage of success reported was 0%, and the highest was 90%. The average response was that 13.27% (SD = 25.4) of cases in the last two years met the criteria for “successful cases”.

Respondents also varied greatly in their reports of hours of AOD abuse training, with the least number of hours of training reported as 0 and the greatest number of hours of training reported as 200. The average respondent indicated 7.07 (SD = 20.51) hours of AOD abuse training. It should be noted, however, that both the median and modal number of AOD abuse hours were reported as 0.

There was a wide range for the variable of Months of Experience as a JCC, with the lowest number of months of experience reported as 1, and the greatest number of months of experience reported as 414. The average experience of respondents was reported as 81.56 months (SD = 88.87).

In order to examine whether a relationship exists between these variables and the factor-derived scores, a Pearson product-moment correlation (PPMC) analysis was

conducted. Although factor scale scores were significantly correlated and there was a correlation between experience and hours of AOD abuse training, there were no significant correlations between factor-derived scores and the variables of percentage of successful cases, hours of AOD abuse training, or experience. This analysis is presented as a Correlation Matrix in Table 13. Again, because approximately 30 percent of respondents reported less than two years of experience as a JCC, these cases were excluded from a secondary correlation procedure identical to the first. No significant correlations were revealed in the second procedure.

Table 13

Intercorrelations between Factor Scale Mean Scores and JCC Variables of Percentage of Successful Cases, Hours of AOD Abuse Training, and Months of Experience.

	Months JCC	SA Hours	Success	<i>CWWAF</i>	<i>IA</i>	<i>DEI</i>
Months JCC	--	.39**	-.05	.07	-.01	-.10
SA Hours		--	-.07	.13	.04	-.03
Success			--	.01	-.02	.06
<i>CWAAF</i>				--	.70**	.58**
<i>IA</i>					--	.52**
<i>DEI</i>						--

\*\* Correlation is significant at the 0.01 level (2 tailed).

It was determined that it might also be useful to calculate attenuated correlations for the factor-derived scores. These correlations are presented in Table 14. This table provides the Pearson product-moment correlations between the observed factor-derived sum scores below the diagonal, the reliability coefficients (Chronbach's  $\alpha$ ) on the diagonal, and the disattenuated [estimated true-score] correlations above the diagonal. The disattenuated correlations indicate the strength of the association between the factor-derived scores, if the sum scores are corrected for unreliability. As Table 14 demonstrates, the disattenuated correlations are moderate, ranging from 0.58 to 0.72, and jointly suggest that the three factors are measuring different traits.

Table 14

Correlations of Factor Sum Scores and Attenuated Correlation of Factor Sum Scores

Factors	<i>CWAAF</i>	<i>IA</i>	<i>DEI</i>
<i>CWAAF</i>	.97	<b>.72</b>	<b>.64</b>
<i>IA</i>	.70	.96	<b>.58</b>
<i>DEI</i>	.58	.52	.85

### Chapter Summary

A total of 264 JCCs participated in this study, which sought to identify the factor structure of knowledge and skills necessary for JCCs to work with AOD abusing juvenile offenders. The responses of 214 of these JCCs were examined through the use of factor analytic procedures, descriptive statistics of items within each identified factor,

comparative, and correlational statistical procedures. This allowed for the identification of three identified factors (*CWAAF – Clinical Work with AOD Abusers and Families*, *IA – Intervention and Assessment*, and *DEI – Drug Effects and Interactions*) within the knowledge and skills necessary for JCCs to work with AOD abusing juveniles. After identification of these factors, descriptive statistics were used to determine the most important skills and knowledge within each of the identified factors. Subsequently, comparative statistical procedures identified whether a difference existed between the identified factor scale mean scores based on the JCC demographic variables of sex, ethnicity, terminal degree, and service area. Finally, correlational statistics procedures determined whether a relationship existed between factor scale mean scores and the JCC variables of percentage of successful cases, hours of AOD abuse training since becoming a JCC, and Months of JCC experience. These results and their ramifications are discussed further in the next chapter.

## CHAPTER V

### SUMMARY, IMPLICATIONS, LIMITATIONS, AND RECOMMENDATIONS

#### Summary of the Study

This study sought to identify the underlying factor structure of Alcohol and Other Drug (AOD) abuse knowledge and skills necessary for Juvenile Court Counselors (JCC) to work with AOD abusing juvenile offenders. An on-line survey with eight demographic questions about JCCs and 152 survey items regarding (AOD) abuse skills and knowledge was used to collect data from currently-employed JCCs as to how important each of the 152 items are for JCCs working with AOD abusing juvenile offenders. Responses were received from 264 JCCs out of 403 eligible JCCs for an initial response rate of 65.5%. Due to incomplete responses, 50 surveys were excluded from the analysis of data. The remaining data were then analyzed to determine if there was an underlying factor structure that characterized the 152 items into separate knowledge or skill areas. Additional analysis of results was done to examine whether demographic characteristics of respondents were associated with significant differences or relationships in identified factor scale mean scores. The following section discusses the implications, limitations, and recommendations that may be drawn from the previously discussed results of the study.

#### Examination of the Factors

There were three factors identified in the main study: CWAAF, labeled *Clinical Work with AOD Abusers and Families*, had a total of 36 items that loaded on it, with a

calculated reliability of  $\alpha = .97$ , SE = 3.78, 2.26%; IA, *Assessment and Intervention*, had a total of 21 items that loaded on it, with a calculated reliability of  $\alpha = .96$ , SE = 3.24, 3.1%; and *DEI, Drug Effects and Interactions*, had a total of 12 items that loaded on it, with a calculated reliability of  $\alpha = .85$ , SE = 2.15, 3.6%. This resulted in a total of 69 items out of 152 with sufficient loading weights on one of the three identified factors. Descriptive statistics for items that did not load on one of the identified factors were calculated and reported in a separate section. Each factor is discussed in more detail in subsequent sections.

*CWAAF: Clinical Work with AOD Abusers and Families*

Items in *CWAAF* were characterized by knowledge and skills related to direct work with AOD abusing juvenile offenders and their families, including knowledge about referral to 12 Step programs, helping family members to see the impact of AOD abuse on themselves and their juvenile, recognizing withdrawal from abused AOD, and a basic understanding of the recovery process for AOD abusing juveniles. Descriptive analyses revealed that the item on *CWAAF* that respondents most strongly agreed was important to clinical work with AOD abusers and their families was having the skill to access community resources to support recovery.

This seeming contradiction, having skill in accessing community resources as the highest rated item among clinical work knowledge and skills aptly demonstrates the multi-faceted nature of JCC work, and is reflected in comments received via email from one JCC respondent, who stated that JCCs tend to “stick to their own area”, e.g., JCCs do not address the issue of AOD abuse, instead tending to focus on the criminal charge that

resulted in the referral to juvenile justice services and preferring to referral AOD abusing juvenile offenders to a community resource. Therefore, skill in identifying recovery resources in the immediate vicinity would be very important to most JCCs, as was reflected in survey responses.

The second most-highly rated item, knowledge of how to consult with staff of other agencies, offers additional evidence of how JCCs see clinical work with AOD abusing juvenile offenders as primarily recognition of AOD abuse issues and the ability to make informed decisions regarding referral of clients to appropriate resources.

There is an additional component to *CWAAF* that bears mentioning. A number of items loading on this factor have to do with understanding specific population or cultural factors as they related to AOD abuse, such as Item 120 – “A Juvenile Court Counselor should have knowledge of cultural lifestyle difference regarding attitudes and values about the use and abuse of alcohol and drugs”, Item 74 – “A Juvenile Court Counselor should have knowledge of the effects of substance use disorders on a specific community or population”, and Item 132 – “A Juvenile Court Counselor should be able to understand the substance use patterns of diverse racial and ethnic cultures”. The inclusion of these items on *CWAAF* indicates that JCC see multicultural competence as a clinical issue and one that is important to their work with AOD abusing juvenile offenders.

An examination of the mean scores for items on *CWAAF* reveals a range from 4.16 to 3.30, with a mean of 3.58 (SD = 0.19) on a five point scale, indicating that skills and knowledge within this factor fell on the “Agree” side of the continuum but were only modestly endorsed by respondents as important.

### *IA: Intervention and Assessment*

The *IA* items were characterized by knowledge and skills associated with intervening on the juvenile offenders AOD abuse and understanding how to appropriately assess the severity of such abuse. Items loading on *IA* include such skills as interpreting results of substance abuse assessments and relaying those results to clients, evaluating the severity of a client's substance abuse issue, assessing a client's risk factors for relapse, understanding diagnostic criteria, organizing or facilitating an intervention with other concerned parties, and developing a recovery plan with juvenile offenders.

Interestingly, two items with strong loadings on *IA*, Item 127 – A Juvenile Court Counselor should have skill in developing and writing a recovery plan and Item 64 – A Juvenile Court Counselor should have knowledge of how to develop an individualized recovery plan that meets the unique needs of the client, have to do with writing a recovery plan. Although these two items load strongly on *IA*, descriptive statistics indicate relatively weak ratings ( $\underline{M} = 2.42$  and  $\underline{M} = 2.76$ , respectively). A possible interpretation is that while respondents see writing a recovery plan as part of the intervention process, they do not see these skills as important for JCCs.

Respondents' scores for whether JCCs should possess these knowledge and skills range from 3.13 to 2.42, with an average of 2.80 (SD = 0.17), indicating that respondents endorsed these items, on average on the *Disagree* side of the continuum. This may explain several issues, such as the inclusion of educational activities on this factor and the loading of assessment and intervention activities on this factor. Often, AOD abuse education activities are carried out by persons with specific training in AOD abuse

prevention (ICRC/AODA, 2000), and assessment often is a complex and difficult task. This difficulty may be further exacerbated by the nature of the juvenile offender population, in that juvenile offenders are almost always ordered to receive assessment and intervention activities and may attempt to hide the nature of their AOD abuse in an attempt to decrease their time under juvenile justice supervision, thereby increasing the difficulty of assessment activities. Taking this into account, it is no wonder that respondents have relatively low scores on whether these intervention and assessment skills should be possessed by JCCs.

*DEI: Drug Effects and Interactions*

The *DEI* factor items described skills and knowledge specific to understanding drugs and their effects on a person and his or her life. These items included knowledge of drug screening protocols, understanding addiction to multiple substances, knowing how long a drug stays in the body, and knowing about trends in street and designer drugs. Item 25 – “A Juvenile Court Counselor should have knowledge of trends in street and designer drugs”, has the highest rating by JCC respondents. This indicates that this item describes a skill or knowledge that more JCC respondents agree a JCC should have than any other skill or knowledge described in the survey, including items that load on one of the three identified factors and those that do not. Respondent scores for whether JCCs should have these skills or knowledge range from 4.21 to 3.57, with an average score of 3.87 (SD = 0.21). This is the highest overall mean score for a factor, indicating that JCCs rate *DEI* items as more important for JCCs than items in the factors of *CWAAF* and *IA*.

This is logical, in that perhaps while respondents believe JCCs should recognize the effects of AOD abuse, both on juvenile offenders and on their support systems, there may be a natural and, perhaps, logical resistance to performing clinical or assessment/intervention activities. The first two factors, *CWAAF* and *IA*, often require specialized education and training in AOD abuse issues, which some JCC respondents may not currently possess, given descriptive information on training in AOD issues.

An additional explanation would be the extreme range in AOD abuse training hours and the effect this may have on respondent ability to feel comfortable with AOD abuse issues. While most persons receive rudimentary education about drugs and their effects while in public school, or even through Public Service Announcements, specialized training regarding clinical work and assessment or intervention with AOD abuse is not generally offered to the average citizen. The range of AOD abuse education hours for JCC respondents was from 0 to 200, which indicates a broad disparity in AOD abuse education among respondents. More telling, however, is the average of 7.07 and mode of 0 hours of AOD abuse education among respondents. This indicates that JCC respondents have received limited education about AOD abuse issues, which may account for the pattern that while respondents agree that JCCs should recognize drug effects and interactions, they are mostly undecided as to whether JCCs should have assessment, intervention or clinical work skills and knowledge to address these issues.

#### *Important Items Not Loading on Identified Factors*

There were 83 items that did not sufficiently load on any of the three main identified factors, yet their descriptive statistics indicate that JCC respondents believe

some items describe knowledge or skills important for JCCs. Also, a number of these items may be considered factorially complex items that load on all three of these factors in such a way that no clear preference is shown for any of the named factors. Given the strength of ratings for some of these items, however, it may be important to consider these knowledge and skill areas in curriculum, training, and specialty credentialing efforts.

The two items with the highest scores among those that did not load on one of the identified factors were Item 42 – “A Juvenile Court Counselor should have knowledge of confidentiality laws specific to substance abuse” and Item 58 - “A Juvenile Court Counselor should have knowledge of federal, state, and local statutes relating to the use of alcohol and drugs”, with agreement scores of 4.05 and 4.02, respectively. These items appear to be more in line with the legalistic side of JCC work and may therefore be particularly important for JCCs who are working within a legal justice system.

Another explanation for these items not loading on any one factor may be the multi-faceted nature of the skill or knowledge described by the item. For example, Item 12 - “A Juvenile Court Counselor should be able to screen for alcohol and other drug toxicity, withdrawal symptoms, aggression, or danger to others, and potential for self-inflicted harm or suicide” describes a skill of being able to recognize drug toxicity, drug withdrawal, danger to others, and potential for self-harm or suicide. The mean agreement score for this item was 3.63, indicating that most JCC respondents agree a JCC should have this knowledge or skill. What is apparent, however, is that this item describes a complex combination of skills and knowledge, in which knowledge and skills from all

three factors would be useful. JCCs with this knowledge and skill would need clinical expertise, assessment and intervention proficiency, and drug effects knowledge.

Therefore, this item and others like it may be factorily complex items.

An additional explanation may be the advanced nature of the knowledge or skills described by items that did not load on a particular factor. For example, Item 47 - “A Juvenile Court Counselor should have knowledge of the correlation between substance use disorders and specific mental disorders such as mood disorders, anxiety disorders, and schizophrenia” and Item 69 - “A Juvenile Court Counselor should have knowledge of the impact on substance use and specific substance induced mental disorders such as mood, anxiety, personality, and psychotic disorders” both describe knowledge of dual diagnosis disorders. The complex interplay of AOD abuse and psychiatric disorders requires specialized education and training to be able to simultaneously treat both issues, and JCC respondents may have recognized that this particular issue is one best addressed by someone who specializes in these types of issues, such as a psychiatrist or mental health professional.

Finally, it may be that items that did not load on any of the three factors were not particularly related to any of the factors, such as Item 35 - “A Juvenile Court Counselor should have knowledge of the value of periodic self-assessment to personal growth (e.g., career planning)”, which describes the process of career self-reflection and does not appear to relate to any of the identified factors.

## Limitations of the Study

This study was exploratory in nature and limitations exist that must be acknowledged and discussed. These limitations are common to exploratory studies such as this one, and should be considered when examining the merits of this study. These limitations also provide a basis upon which to base recommendations for future research.

### *Response Rate*

The very nature of JCC work may have negatively affected the response rate for this study, as JCCs are charged with performing a myriad of job duties and may not have had the time to respond to the solicitation email for this study. A total of 403 solicitation emails were distributed to all currently employed JCC in the southeastern state where this study was conducted. The study was limited to one state because JCC training and educational requirements vary from state to state, but this also limited the amount of possible respondents. A total of 262 online responses were received from currently employed JCCs, and two paper copies were received due to JCC computer problems which prevented survey completion. These two surveys were hand-entered for a total of 264 survey responses from currently employed JCCs. This made for a return rate of 65.5%. Of the returned responses, 50 incomplete surveys were excluded from analysis. Therefore, 214 usable surveys were received from JCCs and used for this study, resulting in a usable return rate of 53.1%.

### *Analyses*

The analyses performed were limited by the total number of usable surveys, which was 214. While there is a commonly accepted recommendation of 5 respondents

for each variable (Cattell, 1978), this was not achievable due to the limited size of the population under investigation. Also, it should be noted that 50 surveys were excluded from analysis because they were incomplete. Some of these submissions were well over 75% complete, and it is possible that this missing data could have better informed this study's analysis of the research questions.

### *Sampling Bias*

Those JCCs who chose to complete this survey may have differed in some way, such as accessibility, cooperation, or interest, from those JCCs who chose not to complete this survey (Issac & Michael, 1995). This was a voluntary study that was completed in cooperation with the North Carolina Department of Juvenile Justice and Delinquency Prevention (NCDJJD). The link to the on-line survey was contained within an email that was sent to all the Area Administrators for the NCDJJD for distribution to area Chief Court Counselors and the JCCs within each of their districts. For a copy of this email, see Appendix O. Therefore, the results of this study may have limited generalizability.

An additional concern of the respondent set is that only JCCs within one state were invited to participate. This was done because JCCs differ according to educational and training requirements from state to state, and to include JCCs from another state would introduce unintended variance in the populations under investigation. This particular point will be further discussed in the section highlighting recommendations for future research

Another consideration is that of the 214 respondents included for analysis, 30% reported their experience level as 24 months or less, which is a telling indicator for the

amount of experience that those JCCs may have with juvenile offenders. That is, almost a third of the respondents were fairly inexperienced in the field of juvenile justice.

### *Survey*

This survey was an on-line survey and was of a self-report type. There was no follow up with respondents to confirm their responses, nor was there any identifying information collected from respondents, both of which were done to assure respondent confidentiality and possibly increase response rate. As noted by Heppner, Kivlinghan, and Wampold (1990), however, self-report measures are vulnerable to distortions by the participant in that respondents may consciously or unconsciously respond in such a way that reflects a response bias rather than the construct being measured. In an attempt to avoid this and other types of “response sets”, participants instructions included a warning to not “fall into a pattern of answering”, as well as an instruction to think carefully about a question prior to answering. Despite these limitations of self-report data, for this type of exploratory study self-report is the only practical choice.

An additional limitation of the survey is that it may not have been sensitive enough to capture the effect of demographic variables on factor scale means scores. This was an exploratory study and the survey used was an adaptation of a survey used with school counselors. Reliability statistics indicated a reliable instrument, but reliability does not equal validity. Therefore, this survey may not have elicited responses which would indicate an effect relationship.

## Implications

The implications section addresses study results and its limitations. These implications focus on juvenile court counselors in training and counselor educators.

### *Juvenile Court Counselors in Training*

Analyses of the factor scale scores and JCC respondent demographics provided results helpful for the training, instruction, and continuing education of future JCCs. The MANOVA results indicated that for this set of respondents, there were no significant differences in respondent's agreement about the knowledge and skills that loaded on the three factors identified in the factor analytic procedure. There are two possible explanations for these results; one, a lack of effect related to demographic variables; and two, the instrument of measure was not sensitive enough to capture the effect. The second explanation was previously discussed in the limitations section. The first explanation means that for currently employed JCCs, sex, ethnicity, service area, and terminal degree have no significant bearing on the importance of the particular knowledge or skills described by the survey items. In addition, hours of AOD abuse education, months of experience as a JCC, or percentage of successful cases also do not appear to have any significant correlation with the factor scale mean scores from the survey, based on the results of the Pearson Product Moment Correlation. This indicates that these experiences do not seem to effect importance ratings in any systemic manner. These results have significant ramifications for how juvenile court counselors are trained and oriented to their position as the primary agent of interaction between juvenile offenders and the juvenile justice system, as well as informing what types of training or

continuing education experiences are offered to new and veteran JCCs already employed as active JCCs. Because of the continuity of opinion regarding the knowledge and skills contained on the three identified factors, it appears that training opportunities can be relatively consistent regardless of demographic characteristics of the JCCs being trained.

For example, while rural areas may have two JCCs to cover a total of four counties and urban JCCs may have over 20 JCCs to cover a single county, the statistical analysis results indicate that these two groups agree as to what particular knowledge or skills are needed to intervene with AOD abusing juvenile offenders, in this case instruction in clinical skills with AOD abusers and their families, learning assessment and intervention skills, and how to recognize drug effects and interactions. Therefore, when training curriculums are created for these groups, service area for the JCCs that are being trained is not a vital consideration.

This is particularly important in regards to the demographic variables of ethnicity and sex, as these two variables also did not appear to differentiate among respondents as to the amount of agreement concerned the importance of these particular AOD abuse knowledge and skills. This finding is in line with the fact that multicultural competency items loaded on IA and had relatively high mean scores of agreement among respondents. These results indicate the perceived importance of multicultural understanding among JCCs, an encouraging outcome from this study.

The statistical analyses from this study give an overall picture of JCCs as persons who believe similarly about knowledge and skills concerning work with AOD abusing juveniles, regardless of sex, ethnicity, service area, terminal degree, amount of AOD

abuse education since becoming a JCC, percentage of success in the last two years, or amount of time as an employed JCC. The highest degree of agreement among JCCs as to what type of knowledge or skills they need to possess for work with AOD abusing juvenile offenders is the ability to recognize common street drugs, their effects on those who abuse such drugs, and the manner and extent to which those drugs affect persons and their environment (*DEI*). The next highest mean score of agreement on a different factor, *CWAAF*, indicates that JCC respondents agree to the necessity of referring to appropriate community agencies to help AOD abusing juvenile offenders and their families successfully address their AOD issues, and that this skill is important for JCCs. The third factor, *IA*, indicates the need for JCCs to have some degree of proficiency in appropriately assessing and intervening with those juvenile offenders who are abusing AOD. The mean scores for items on this scale, however, indicate that respondents have less agreement about JCCs possessing these skills or knowledge than they do about items that loaded on the other two factors.

In light of the above findings, training events for new and currently employed JCCs might be more efficacious if the focus of these trainings was to educate JCCs in the following ways: (1) identification of and familiarity with “street drugs” and their effects, as well as possible interactions between “street drugs” and other abused or prescribed drugs, (2) Development of clinical skills and knowledge that will allow JCCs to identify, collaborate, and work with appropriate referral agencies for AOD abuse treatment of juvenile offenders, and (3) Instruction in basic assessment and primary intervention

techniques that will help JCCs to correctly identify AOD abuse issues present in those juvenile offenders with AOD issues.

Finally, in light of the fact that 30% of JCC respondents had 2 years or less in their current job as a JCC, turnover appears to be a significant issue for JCCs. In addition, the mean number of AOD Abuse training hours for this group was 1.75 hours. Although not a point of inquiry in this study, it is possible that burnout and turnover may be influenced by lack of awareness of AOD abuse issues. This question warrants empirical attention. As previously discussed, Califano and Colson (2005) reported that 80% of arrested juvenile offenders are under the influence of alcohol or drugs when committing their crime, test positive for drugs, are arrested for a drug or alcohol offense, admit to having substance abuse or addiction problems, or have some combination of these issues. Considering that 4 out of every 5 juvenile offenders presents with an AOD abuse issue, the necessity of training new JCCs to recognize, assess, and clinically address AOD abuse issues with juvenile offenders seems supported by the findings of this study, as well as previous research. Accordingly, this task may be best handled by a cooperative partnership between Juvenile Justice Agencies and Counselor Educators. This will be addressed in the next section.

### *Counselor Educators*

The interplay of counseling, counselor education, AOD abuse, and offender treatment has been in evidence for some time. The most apparent example of this is the creation of The International Association of Addictions and Offender Counselors (IAAOC) in 1990. Originally formed as the Public Offender Counselor Association

(POCA) in 1972, POCA was granted Division status in 1974 by the American Personnel and Guidance Association, which evolved into the American Counseling Association (ACA). While the original goal of POCA was to represent the interest and concerns of professional counselors who provided rehabilitation services to public law offenders, the current mission statement describes IAAOC as “an organization of professional counselors and other interested individuals who work in the addictions or forensic/criminal justice fields and advocate for the appropriate treatment for such client populations.” The fact that an entire division of the American Counseling Association is devoted to those who advocate for and treat offender and addicted populations certainly points to the interplay of these two issues and the need for competently trained counselors to deal with these problems.

Considering the history of advocating for and educating professional counselors who work with offender populations, the results of the current study seem to indicate that counselor educators would be a logical choice to help JCCs gain, understand, and develop the knowledge and skills necessary to work with AOD abuse issues. JCCs have similar levels of agreement as to the necessity for particular knowledge and skills in order to effectively work with AOD abusing juvenile offenders, regardless of previously discussed demographic variables. Therefore, counselor educators could help address this need for knowledge and skill development.

The necessity for JCC knowledge of street drugs and their effects was evidenced by this study. Counselor educators have the ability and training to access large amounts of information concerning recent AOD abuse trends among adolescents, e.g., Monitoring

the Future Study, Substance Abuse Mental Health Services Administration, National Survey on Drug Use and Health, as well as the ability to take these large amounts of research-based information and create beneficial and well-informed educational experiences for students. Therefore, counselor educators appear a viable choice for creating the type of educational experience regarding drug effects and interactions that will most benefit JCCs, due to their ability to access large amounts of AOD abuse research and distill it into beneficial educational material.

Another factor identified in this study, *CWAAF*, would require instruction by individuals familiar not only with clinical intervention with AOD abusers, but also how to work with family members of AOD abusing individuals. Both of these areas, addiction counseling and counseling families, are well-known areas of expertise within the counseling profession. Therefore, counselor educators are a logical choice for creating this educational experience as well.

The remaining factor, *AI*, is especially suited for instruction by counselor educators. Assessment competencies are specifically called for in the ACA Counselor Code of Ethics as well as required in those counselor education programs that have achieved accreditation by the Council on Accreditation of Counseling and Related Educational Programs (CACREP) accreditation. Therefore, counselor educators would seem well suited to provide educational opportunities for JCCs seeking instruction and familiarity with assessment procedures or intervention strategies.

Finally, a statistic from the present study may indicate a need for counselor educators that is not directly linked to education about AOD abuse or how to

appropriately counsel AOD abusers. The high degree of turnover for JCCs, as evidenced by the fact that 30% of respondents had 2 years or less in their current employment as a JCC, may be an important issue. Career counseling, long a foundation of the counseling profession, could be instrumental in helping JCCs to examine their career beliefs, values, and ideas, as well as options for experiencing less burnout and potentially increasing longevity among JCC.

#### Recommendations for Future Research

The present study identified a three factor structure for knowledge and skills necessary for JCCs to work effectively with AOD abusing juvenile offenders in one southeastern state. As this was an exploratory study designed to determine whether such a factor structure exists, future research could seek to confirm the identified factor structure in a variety of ways. Additional research could address the results of this study and seek to expound on these results. Two identified populations where possible future research could be conducted are currently employed substance abuse counselors or JCCs. These possibilities are discussed in subsequent sections.

#### *Substance Abuse Counselors*

This study offered information concerning the knowledge and skills necessary for JCCs to work with AOD abusing juvenile offenders. Future studies might involve currently employed AOD abuse counselors, who might be able to offer valuable insight into what types of knowledge and skills could be necessary to work with AOD abusing juvenile offenders. One particular group of interest from North Carolina would be Certified Criminal Justice Professionals (CCJP), who are those persons with a criminal

justice background who have demonstrated proficiency in the area of AOD abuse by documenting supervision, training, and education.

Surveying CCJPs would allow for an examination of knowledge and skills necessary to work with AOD abusing juvenile offenders based on data from persons within the criminal justice system who have already specialized in the area of substance abuse. While CCJPs may not necessarily specialize in adolescent behavior, as JCCs do, they still may be able to offer valuable insights into necessary knowledge and skills for effective work with the substance abusing population as a whole. Demographic questions that determine the make-up of caseload could possibly identify those CCJPs who work primarily with adolescent clients.

AOD abuse counselors for adolescents represent a specific sub-group within counselors who self-identify as substance abuse counselors. Because these individuals have chosen to work primarily with adolescents, it would be most efficacious for future research in the area of necessary knowledge and skills to work with AOD abusing juvenile offender to first survey adolescent substance abuse counselors regarding their opinions in this matter. A comparison of the identified factor structure from the current study with a possible factor structure of AOD abuse knowledge and skills for adolescent AOD abuse counselors could help to inform future trainings, as well as educational offerings valuable to both groups.

#### *Juvenile Court Counselors*

A number of items were excluded from analysis due to complex factor loading patterns, i.e., the item loaded on two or three factors rather than clearly loading on one

main factor. Some of these items also had agreement scores that indicate JJC respondents believe JCCs need to possess the knowledge or skills described by the item. Therefore, these items may need to be investigated in a follow up study where a focus group of currently employed JCCs would review the items and offer feedback as to why and how those particular knowledge and skills are important for JCCs.

A follow-up study with currently employed JCCs in another state also might prove useful. A confirmatory factor analysis could be performed on this data set to further clarify the factor structure.

### Conclusions

The current study utilized a 152-item survey that upon analysis identified a three factor structure knowledge and skills necessary for JCCs to work effectively with AOD abusing juvenile offenders. Additional analyses also determined the amount of agreement among currently employed JCCs as to whether a JCC should possess the knowledge and skills contained within each factor. Further analyses revealed that JCCs were consistent in the amount of agreement they had as to whether JCCs should possess the knowledge or skill described in the survey items, regardless of JCC sex, ethnicity, service area, terminal degree, amount of time as a JCC, hours of AOD abuse education, or percentage of successful cases in the last two years. These last findings paint a positive picture, in that they indicate that JCCs agree about the problem of AOD abuse among juvenile offenders and agree that JCCs need particular skills and knowledge to combat this social issue. It is incumbent upon counselor educators, working in conjunction with Juvenile Justice personnel, to find a way to provide the necessary training and educational experiences,

with the ultimate aim of better addressing the AOD abuse problems of juvenile offenders and perhaps improving our society as a result.

## REFERENCES

- Adapted from Snyder H. (2003). *Juvenile arrests 2001*. [Forthcoming]. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention.
- Altschuler, D., & Brounstein, P. (1991). Patterns of drug use, drug trafficking, and other delinquency among inner city adolescent males in Washington, DC. *Criminology*, 29, 589-622.
- American Corrections Association. (2000). *1998-2000 Probation and parole directory*. Lanham, Maryland: American Correctional Association.
- American Psychological Association. (2004). *The College of Professional Psychology: Certification for Licensed Psychologists in Substance Abuse Treatment*. Retrieved April 12, 2004, from <http://www.apa.org/college/>.
- American Society of Addictive Medicine. (2004). *2004 Certification Application*. Retrieved April 12, 2004, from <http://www.asam.org/>.
- Anderson, E. A., & Spanier, G. B. (1980). Treatment of delinquent youth: The influence of the juvenile probation officer's perception of self and work. *Criminology*, 17, 505-514.
- American Probation and Parole Association. (1999). *Drug testing guidelines and practices for juvenile probation and parole agencies*. Lexington, KY: Author
- Baumrind, D., & Moselle, K. A. (1985). A developmental perspective on adolescent drug use. *Advances in Alcohol and Substance Abuse*, 4, 41-67.

- Berger, E. A. (1980). Probation and parole officers' perceptions of alcoholism and alcoholics. *Dissertation Abstracts International*, 42 (01A), 0415. (UMI No. 8113295)
- Binder, A., & Binder, V. (1983). Counseling psychology in the justice system. *Counseling Psychologist*, 11, 69-77.
- Birch and Davis Corporation. (1984). *Development of model professional standards for counselor credentialing*. Debuque, IA: Kendall/Hunt.
- Califano, J.A., & Colson, C. W. (2005). *Criminal neglect*. Retrieved April 12, 2005, from <http://66.135.34.236/absolutenm/templates/articles.asp?articleid=377&zoneid=29>.
- Cattell, R. B. (1978). *The scientific use of factor analysis in behavioral and life sciences*. New York: Plenum Press.
- Center for Substance Abuse Treatment. *Assessment and treatment of patients with coexisting mental illness and alcohol and other drug abuse*. Treatment Improvement Protocol (TIP) Series 9, DHHS Publication No. (SMA) 95-3061. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994.
- Center for Substance Abuse Treatment. *Combining alcohol and other drug abuse treatment with diversion for juveniles in the justice system*. Treatment Improvement Protocol (TIP) Series 21, DHHS Publication No. (SMA) 00-3464. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995.

Center for Substance Abuse Treatment. (1998). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice*. (Technical Assistance Publication Series 21). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. *Treatment of adolescents with substance use disorders*. Treatment Improvement Protocol (TIP) Series 32, DHHS Publication No. (SMA) 99-3283. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.

Center for Substance Abuse Treatment. *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) Series 42, DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

Clair, D.J., & Genest, M. (1987). Variables associated with the adjustment of offspring of alcoholic fathers. *Journal of Studies on Alcohol*, 48, 343-355.

Clark, D. B., Pollock, N., Bukstein, O. G., Mezzich, A. C., Bromberger, J. T., & Donovan, J. E. (1997). Gender and comorbid psychopathology in adolescents with alcohol dependence. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 1195-1203

Clarke, Stevens H. (May 2001). *Criminal recidivism after incarceration for juvenile delinquency: Report on a study of persons released from North Carolina training schools in 1996*. Chapel Hill, NC: Institute of Government.

[http://www.ncdjdp.org/statistics/reports/legislative/2004\\_Recidivism.pdf](http://www.ncdjdp.org/statistics/reports/legislative/2004_Recidivism.pdf)

- Clements, W. H., Rosenfield, B. & Owen, J. (2002). *Recidivism among delinquency cases in Vermont: Phase II findings*. Montpelier, VT: Vermont Center for Justice Research.
- Coll, K. M., Juhnke, G. A.; Thobro, P., & Haas, R. (2003). A preliminary study using the Substance Abuse Subtle Screening Inventory –Adolescent Form as an outcome measure with adolescent offenders. *Journal of Addictions & Offender Counseling*, 24, 11-23.
- Corwyn, R. F., & Benda, B. B. (2002). The relationship between use of alcohol, other drugs, and crime among adolescents: An argument for a delinquency syndrome. *Alcoholism-Treatment-Quarterly*, 20, 35-49.
- Crowe, A. (1999). *Working with substance abusing youths: Knowledge and skills for juvenile probation and parole professionals*. Lexington, KY: American Probation and Parole Association.
- Daley, D. C., & Raskin, M. S. (Eds.). (1991). *Treating the chemically dependent and their families*. Newbury Park, CA: Sage.
- Dawes, D. M., Ferguson, S., Ebron, R., & Katzenelson, S. (2003) *Juvenile-to-adult comprehensive criminal history project: Recidivism*. North Carolina Sentencing and Policy Advisory Commission Presentation Handout. Presentation for the North Carolina Governor’s Crime Commission. December 5, 2003.
- Dembo, R., Pacheco, K., Schmeidler, J., Fisher, L., & Cooper, S. (1997). Drug use and delinquent behavior among high risk youths. *Journal of Child and Adolescent Substance Abuse*, 6 (2), 1-25.

- Dembo, R., Schmeidler, J., & Williams, L. (1991). Recidivism among high risk youth: Study of a cohort of juvenile detainees. *International Journal of the Addictions*, 26, 121-177.
- Dembo, R., Williams, L., Fagan, J., & Schmeidler, J. (1994). Development and assessment of a classification of high risk youth. *Journal of Drug Issues*, 24, 25-53.
- Dembo, R., Williams, L., & Schmeidler, J. (1993). Addressing the problems of substance abuse in juvenile corrections. In J. Inciardi (Ed.) *Drug treatment and criminal justice* (pp. 97-126). Newbury Park, CA: Sage.
- Dembo, R., Williams, L., & Schmeidler, J. (1994). Psychosocial, alcohol/other drug use, and delinquency differences between urban Black and white male high risk youth. *International Journal of the Addictions*, 29, 461-483.
- Dembo, R., Williams, L., Schmeidler, J., & Howitt, D. (1991). *Tough cases: School outreach for at-risk youth*. Washington, DC: U.S. Department of Education, Office of the Assistant Secretary for Educational Research and Improvement.
- Dembo, R., Williams, L., Wish, E., Dertke, Berry E., Getreau, A., Wahsburn, M., & Schmeidler, J. (1988). The relationship between physical and sexual abuse and illicit drug use: A replication among a new sample of youth entering a juvenile detention center. *The International Journal of the Addictions*, 23, 1101-1123.
- Dembo, R., Williams, L., Wothke, W., & Schmeidler, J. (1992). Examining the structural model of the relationships among alcohol use, marijuana/hashish use, their

effects, and emotional and psychological problems over time in a cohort of high-risk youth. *Deviant Behavior*, 13, 185-215.

Denver Juvenile Justice Integrated Treatment Network. (2000). *Strategies for integrating substance abuse treatment and the juvenile justice system: A practice guide*, June 1999. DHHS Publication No. (SMA) 00-3369.

Department of Juvenile Justice and Delinquency Prevention, (2003). Website address: <http://osp.its.state.nc.us/positiondetail.asp>

Deschenes, E. P., & Greenwood, P. (1994). Treating the juvenile drug offender. In D. MacKenzie & C. Uchida (Eds.), *Drugs and crime: Evaluating public policy initiatives* (pp. 253-280). Thousand Oaks, CA: Sage.

Deschenes, E. P., Turner, S., Greenwood, P. & Chiesa, J. (1996). *An experimental evaluation of drug testing and treatment interventions for probationers in Maricopa County, Arizona*. Santa Monica, California: RAND Corporation.

Federal Bureau of Investigation. (2004). *Crime in the United States 2004: Uniform crime reports*. Washington, DC: U.S. Government Printing Office.

Fisher, G. L., & Harrison, T. C. (2000). *Substance abuse: Information for school counselors, social workers, therapists, and counselors*. Boston: Allyn & Bacon.

Fletcher J. M., Page, J. B., Francis, D. J., Copeland, K., Naus, M. J., Davis, C. M., Morris, R., Krauskopf, D., & Satz, P. (1996). Cognitive correlates of long-term cannabis use in Costa Rican men. *Archives of General Psychiatry*, 53, 1051-1057.

Elliot, D. S., Huizinga, D., & Ageton, S. (1985). *Explaining delinquency and drug use*. Beverly Hills, CA: Sage.

- Elliot, D. S., Huizinga, D., & Menard, S. (1989). *Multiple problem youth: Delinquency, substance use, and mental health problems*. New York: Springer-Verlag.
- Ernst, T., Chang, L., Leonido–Yee, M., & Speck, O. (2000). Evidence for long-term neurotoxicity associated with methamphetamine abuse. *Neurology*, *54*, 1344-1349.
- Fox, R. W., & Krantz, H. M. (1991). Basic counseling skills training program for juvenile court workers. *Journal of Addictions and Offender Counseling*, *11*, 34-42.
- Gall, J. P., Gall, M. D., & Borg, W. R. (1999). *Applying educational research: A practical guide (4<sup>th</sup> ed.)*. New York: Longman.
- Ge, X., Donnellan, M. B., & Wenk, E. (2005). The development of persistent criminal offending in males. *Criminal Justice and Behavior*, *28*, pp. 731-755, retrieved June 1, 2005, from <http://ejournals.ebsco.com/direct.asp?ArticleID=47J95P57XKHBM1QQ5V7K>
- Gerstein, D. R., Johnson, R. A., Harwood, H. J., Fountain, D., Suter, N., & Malloy, K.M. (1994) *Evaluating recovery services: The California Drug and Alcohol Treatment Assessment (CALDATA) : General report submitted to the state of California, Department of Alcohol and Drug Programs, ADP 94-629*, Sacramento, CA: California Department of Alcohol and Drug Programs, Resource Center.
- Gfroerer, J. C. (1987). Correlation between drug use by teenagers and drug use by older family members. *American Journal of Drug and Alcohol Abuse*, *13*, 95-108.
- Gfroerer, J. C., & De La Rosa, M. (1993). Protective and risk factors associated with drug use among Hispanic youth. *Journal of Addictive Diseases*, *12*, 87-107.

- Gonet, M. M (1994). *Counseling the adolescent substance abuser: School based intervention and prevention*. Thousand Oaks, CA: Sage.
- Greico, E. M., & Cassidy, R. C. (2001). *Overview of race and Hispanic origin: Census 2000 brief*. Retrieved August 29, 2005, from <http://www.census.gov/prod/2001pubs/c2kbr01-1.pdf>
- Grilo, C. B., Daniel, W. M., Levy, K., Edell, W., & McGlashan, T. (1995). Psychiatric co-morbidity in adolescent inpatients with substance use disorders. *Journal of American Academy of Child and Adolescent Psychiatry*, 34, 1085-1092.
- Greenwood, P. (1992). Substance abuse problems among high risk youth and potential interventions. *Crime and Delinquency*, 38, 444-458.
- Griffin, P., & Torbet, P. (Eds.). (2002). *Desktop guide to good juvenile probation practice*. Pittsburg, PA: National Center for Juvenile Justice.
- Gross, J., & McCaul, M. E. (1991). A comparison of drug use and adjustment in urban adolescent children of substance abusers. *The International Journal of the Addictions*, 25, 495-511.
- Hall W., & Solowij, N. (1998). The adverse effects of cannabis. *Lancet*, 352, 1611-1616.
- Hawkins, J. Jenson, J., and Cantalano, R. (1988). Delinquency and drug abuse: Implications for social services. *Social Service Review*, 62, 258-284.
- Hepner, P. P. , Kivlighan, D. M., & Wampold, B. E. (1999). *Research design in counseling*, (2<sup>nd</sup>. ed.). Belmont, CA: Wadsworth.
- Inciardi, J., & Pottenger, A. (1991). Kids, crack, and crime. *Journal of Drug Issues*, 21,(2), 257-270.

- International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (1996). *Role delineation study for alcohol and drug abuse counselors*. Research Triangle Park, NC: Columbia Assessment Services.
- International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (1997). *Role delineation study for advanced alcohol and drug abuse counselors*. Research Triangle Park, NC: Columbia Assessment Services.
- International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (2000). *Prevention Specialist Examination Study Guide*. . Research Triangle Park, NC: Columbia Assessment Services.
- International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (2002). *Role delineation study for addiction professionals working in criminal justice settings*. Falls Church, VA: Author.
- International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (2005). Standards for Certified AODA Counselors. Retrieved October 9, 2005, from [http://www.icrcaoda.org/standards\\_counselor.cfm](http://www.icrcaoda.org/standards_counselor.cfm)
- International Nurses Society on Addictions. (2004). *Become a CARN or CARN-AP!!!*. Retrieved April 12, 2004, from <http://www.intsna.org>.
- Issac, S., & Micheal, W. B. (1995). *Handbook in research and evaluation*, (3<sup>rd</sup>. ed.). San Diego: EDITS Publishers.
- Johnson, S., Leonard, K.E., and Jacob, T. (1989). Drinking, drinking styles and drug use in children of alcoholics, depressives and controls. *Journal of Studies on Alcohol*, 50, 427-431.

- Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2005). *Monitoring the Future national results on adolescent drug use: Overview of key findings, 2004*. (NIH Publication No. 05-5726). Bethesda, MD: National Institute on Drug Abuse.
- Jorgenson, E. D., & Salwen, R. (2000) Treatment of dually-diagnosed adolescents: The individual therapeutic alliance within a day treatment model. In J. J. Boren, L. S. Onken, & L. M. Carroll (Eds.), *Approaches to Drug Abuse Counseling* (NIH Publication No. 00-4151, pp. 61-80). Rockville, MD: National Institute on Drug Abuse.
- Kandel, D. B., Johnson, J. G., Bird, H. R., Weissman, M. M., Goodman, S. H., Lahey, B. B., et al. (1999). Psychiatric comorbidity among adolescents with substance use disorders: findings from the MECA study. (Methods for the Epidemiology of Child and Adolescent Mental Disorders). *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 693-700.
- Kaplan, H., Johnson, R., & Bailey, C. (1987). Deviant peers and deviant behavior: Further elaboration of a model. *Social Psychology Quarterly*, 30, 277-284.
- Kaufman, E., & Kaufman, P. (1992). From psychodynamic to structural to integrated family treatment of chemical dependency. In E. Kaufman & P. Kaufman, (Eds.), *Family therapy of drug and alcohol abuse* (pp. 34-45). Boston: Allyn & Bacon.
- Kreisel, B.W., Reddington, F. P., & Haase, J. (2002, April). *Basic Criminal Justice education approach to the topic of juvenile justice: A national examination of*

*juvenile courses in Criminal Justice curriculum*. Paper presented at the Academy of Criminal Justice Meeting, Anaheim, CA.

Land, K. C., McCall, P. L., & Williams, J. R. (1990). Something that works in juvenile justice: An evaluation of the North Carolina counselor's intensive protective supervision randomized experimental project, 1987-89. *Evaluation Review*, 14, 574-606.

Latimer, W. W., Winters, K. C., & Stinchfield, R. D. (1997). Screening for drug abuse among adolescents in clinical and correctional settings using the Problem-Oriented Screening Instrumentation for Teenagers. *American Journal of Drug and Alcohol Abuse*, 23, 79-99.

Latimer, W. W., [Ernst](#), J., Hennessey, J., Stinchfield, R. D., & Winters, K. C. (2004). Relapse among adolescent drug abusers following treatment: The role of probable ADHD. *Journal of Child and Adolescent Substance Abuse*, 13, 1-16.

Lowenstein, L. F. (2001). Recent research into the direct relationship between criminality and AOD abuse. *International Journal of Adolescence and Youth*, 9, 257-272.

Luongo, P. (2000). Partnering child welfare, juvenile justice, and behavioral health with schools. *Professional School Counseling*, 3, 308-314.

MacKenzie, R.G. (1993). Influence of drug use on adolescent sexual activity. *Adolescent Medicine: State of the Art Reviews*, 4, 112-115.

Milin, R., Halikas, J., Meller, J., & Morse, C. (1991). Psychopathology among substance abusing juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30, 4.

- Molidor, C. E., & Nissen, L. B., & Watkins, T. R. (2002). The development of theory and treatment with AOD abusing female juvenile offenders. *Child and Adolescent Social Work Journal, 19*, 209-225.
- National Association for Social Workers. (2004). *Certified Clinical Alcohol, Tobacco, and Other Drugs Social Worker (C-CATODSW)*. Retrieved April 12, 2004, from <http://www.naswdc.org/credentials/specialty/c-catodsw.asp>.
- National Board for Certified Counselors. (1995). *Masters Addiction Counselors Job Analysis Survey*. Greensboro, NC: Author.
- National Center for Juvenile Justice (2000). *National overviews: State juvenile justice profiles*. Pittsburgh, PA: NCJJ. Online. Available: <http://www.ncjj.org/stateprofiles/>.
- Newcomb, M. D., & Bentler, P. M. (1989). Substance use and abuse among children and teenagers. *American Psychologist, 44*, 42-48.
- Nordahl, T. E., Salo, R. & Leamon, M. (2000). Neuropsychological effects of chronic methamphetamine use on neurotransmitters and cognition: A review. *Journal of Neuropsychiatry and Clinical Neuroscience, 15*, 317-325.
- North Carolina Administrative Code. (n.d.). *Subchapter 27G – Rules for mental health, developmental disabilities, and substance abuse facilities and services*. Retrieved October 8, 2005, from [http://ncrules.state.nc.us/ncadministrativ\\_/title10ahealtha\\_/chapter27mental\\_/subchapter27g\\_/default.htm](http://ncrules.state.nc.us/ncadministrativ_/title10ahealtha_/chapter27mental_/subchapter27g_/default.htm)

- Nowinski, J. (1990). *Substance abuse in adolescents and young adults: A guide to treatment*. New York: WW Norton and Company.
- Obrocki, J., Buchert, R., Vaterlein, O., Thomasius, R., Beyer, W., & Schiemann, T. (1999). Ecstasy–long-term effects on the human central nervous system revealed by positron emission tomography. *The British Journal of Psychiatry*, *175*, 186-188.
- Office of Juvenile Justice and Delinquency Prevention. (n.d.) *Custody data 1997-present*. Retrieved April 5, 2005, from <http://ojjdp.ncjrs.org/ojstatbb/corrections/qa08201.asp?qaDate=20021030>
- Office of Juvenile Justice and Delinquency Prevention. (n.d.) *Juvenile Court Cases*. Retrieved April 5, 2005, from <http://ojjdp.ncjrs.org/ojstatbb/court/qa06201.asp?qaDate=20030811>.
- Perkinson, R. R. (2002). *Chemical dependency counseling: A practical guide*. Thousand Oaks, CA: Sage Publications.
- Prinz, R. J., & Kerns, S. E. U. (2003). Early AOD use by juvenile offenders. *Child-Psychiatry-and-Human-Development*, *33*, 263-277.
- Reddington F. P., & Kreisel, B. W. (2000). Training juvenile court counselors: National trends and patterns. *Federal Probation*, *64*, 28-33.
- Reddington, F. P., & Kreisel, B. W. (2003) Basic fundamental skills training for juvenile probation officers: Results of a nationwide survey of curriculum content. *Federal Probation*, *67*, 41-45.

- Reilly, D. M. (1992). Drug abusing families: Intrafamilial dynamics and brief triphasic treatment. In E. Kaufman, & P. Kaufman (Eds.), *Family therapy of drug and alcohol abuse* (pp. 105-119). Boston: Allyn & Bacon.
- Ritter, S. (2001). Working with students affected by alcohol or other drug use: Knowledge and abilities needed by entry level school counselors (Doctoral dissertation, University of North Carolina at Greensboro, 2001). *Dissertation Abstracts International*, 62, 4075.
- Roberts, A. R. (1998). The emergence and proliferation of juvenile diversion programs. In A. R. Roberts (Ed.), *Juvenile justice: Policies, programs, and services* (pp. 138-148). Chicago: Nelson-Hall.
- Roberts, A. R. (1998). *Treating juveniles in institutional and open settings*. In A. R. Roberts (Ed.), *Juvenile justice: Policies, programs, and services* (pp. 138-148). Chicago: Nelson-Hall.
- Schinke, S. P., Botvin, G. J., & Orlandi, M. A. (1991). *Substance abuse in children and adolescents: Evaluation and intervention*. Newbury Park, CA: Sage..
- Secades-Villa, R., Fernandez-Hermida, J. R., Vallejo-Seco, G. (2005). Family risk factors for adolescent drug misuse in Spain. *Journal of Child and Adolescent Substance Abuse*, 14, 1-15.
- Seilhamer, R. A. (1991). Effects of addiction on the family. In D. C. Daley & M. S. Raskin (Eds.), *Treating the chemically dependent and their families* (pp. 172-194). Newbury Park, CA: Sage Publications.

- Shannon, L. W. (1982). *Assessing the relationship of adult criminal careers to juvenile careers*. Washington, D.C.: Grant No. 79-JN-AX-0010. U.S. Dept. of Justice, Office of Juvenile Justice and Delinquency Prevention, National Institute for Juvenile Justice and Delinquency Prevention.
- Sheppard, C. S. (1973). Effective counseling techniques for correctional practitioners. *Canadian Journal of Criminology and Corrections*, 15, 306-315.
- Siegal, L. J., & Senna, J. J. (2000). *Juvenile delinquency: Theory, practice, and law*. Belmont, CA: Wadsworth/Thompson Learning,.
- Slonim, N. (1999). Evaluating the effectiveness of juvenile probation officers: An Israeli study. *Journal of Offender Rehabilitation*, 28, 77-90.
- Sontheimer, H., & Goodstein, L. (1993). Evaluation of juvenile intensive after-care probation: after-care versus system response effects. *Justice Quarterly* 10, 197–227.
- Snyder, H. N. (1988). *Court careers of juvenile offenders*. Washington, D.C.: Grant No. 83-JN-AX-0011. U.S. Dept. of Justice, Office of Juvenile Justice and Delinquency Prevention, National Institute for Juvenile Justice and Delinquency Prevention.
- Snyder, H. N. (2003) Juvenile arrests 2001 [electronic version]. *Juvenile Justice Bulletin*, NCJ 201370. Retrieved February 23, 2004, from <http://www.ncjrs.org/html/ojjdp/201370/contents.html>
- Snyder, H. N., & Sickmund, M. (1999). *Juvenile offenders and victims:*

*1999 national report.* Washington DC: Office of Juvenile Justice and Delinquency Prevention.

Stevenson, R.A. (2003). Wraparound services. *School Administrator*, 60, 24-27.

Steadman, H. (1992). Boundary spanners: A key component for the effective interactions of the justice and mental health systems. *Law and Human Behavior*, 16, 75-87.

Stiffman, A. R., Hadley-Ives, E., Dore, P., Polgar, M., Horvath, V. E., & Striley, C. (2000). Youths' access to mental health services: The role of providers' training, resource connectivity and assessment of need. *Mental Health Services Research*, 2, 141-154.

Substance Abuse and Mental Health Services Administration: Center for Substance Abuse Treatment. (1999). *Treatment of adolescents with substance abuse disorders* (DHHS Publication No. SMA 99-3283). Rockville, MD: National Clearinghouse for Alcohol and Drug Information.

Substance Abuse and Mental Health Services Administration. (1996). *NTIES findings on changes in criminal behavior*. Retrieved January 5<sup>th</sup>, 2005, from <http://ncadi.samhsa.gov/govstudy/f027/crime.aspx>

Substance Abuse and Mental Health Services Administration. (2004). *Results from the 2003 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-25, DHHS Publication No. SMA 04-3964). Rockville, MD.

Sullenger, T. E. (1936). *Social determinants in juvenile delinquency*. New York: Wiley.

- Thomas, D. (1993). *Fundamental skills training curriculum for Juvenile Court Counselors*. Pittsburgh, PA: National Center for Juvenile Justice.
- Torbet, P. (Ed.). (1993). *Desktop guide to good juvenile probation practice*. Pittsburgh, PA: National Center for Juvenile Justice.
- Torbet, P. M. (1996). *Juvenile probation: The workhorse of the juvenile justice system*. U.S. Dept. of Justice Office of Juvenile Justice and Delinquency Prevention. Washington, D.C.: U.S. Government Printing Office.
- Tracy, P. E., & Kempf-Leonard, K. (1996). *Continuity and discontinuity in criminal careers*. New York: Plenum Press.
- Von Steen, P. G., Vacc, N. A., & Strickland, I. M. (2002). The treatment of substance abusers in multiservice mental-health agencies: A practice analysis. *Journal of Addictions and Offender Counseling*, 22, 61-71.
- Wanberg, K. (1995). *Program evaluation services for Denver Juvenile Justice Integrated Treatment Alternatives to Street Crime Project: The research protocol*. Arvada, CO: Center for Addictions Research and Evaluation.
- Washington State Division of Alcohol and Substance Abuse (1995). *Adolescent treatment outcome report: Six-month follow-up of clients referred by the juvenile justice system, those served by schools, as well as those whose parents currently abuse substances*.
- Werner, E. E. (1986). Resilient offspring of alcoholics: A longitudinal study from birth to age 18. *Journal of Studies on Alcohol*, 47, 34-40.

- West, M. O., & Prinz, R. J. (1987). Parental alcoholism and childhood psychopathology. *Psychological Bulletin*, *102*, 204-218.
- White, H. R., Tice, P. C., Loeber, R., & Stouthamer-Loeber, M. (2002). Illegal acts committed by adolescents under the influence of alcohol and drugs. *Journal of Research in Crime and Delinquency*, *39*, 131-152.
- Williams, J. H., Ayers, C. D., Abbott, R. D., Hawkins, J. D., & Catalano, R. F. (1999). Racial differences in risk factors for delinquency and AOD use among adolescents. *Social-Work-Research*. *23*, 241-257.
- Wolfgang, M. E., Thornberry, T. P., & Figlio, R. M. (Eds.). (1987). *From boy to man, from delinquency to crime*. Chicago: University of Chicago Press.

## Appendix A

Copy of Email Providing Permission to use Ritter (2001) Survey

From: Sandy Ritter <shritter@troyst.edu>  
Date: Monday, April 07, 2003 12:30 PM  
To: 'Joe Jordan' [jordans96@triad.rr.com](mailto:jordans96@triad.rr.com)  
Subject: RE: Request

Joe,

I'm honored! Yes, you may use the survey. What is the dissertation on? Maybe we can collaborate on an article when you're finished.

Congratulations on the father-to-be status.

Sandy

-----Original Message-----

**From:** Joe Jordan [mailto:[jordans96@triad.rr.com](mailto:jordans96@triad.rr.com)]  
**Sent:** Monday, April 07, 2003 10:57 AM  
**To:** shritter@troyst.edu  
**Subject:** Request

Dr. Ritter,

Hope you are enjoying your Monday and your position at Troy State. It has been a long time since our work together at Charter Greensboro and at the ACA convention in San Diego. I am writing to request your permission to use the survey you constructed for your dissertation, the *Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire*. I have been searching the literature and find that not only do we share an interest in the treatment of substance abuse, we also share an interest in the determining the competencies of those persons who come in contact with juvenile substance abusers. I assure you that your survey will be used only for gathering data for my topic (knowledge and abilities of juvenile court counselors) and that I will cite you as the author and sole proprietor of the assessment questionnaire. This would be most helpful to me in completing my dissertation, and as I just recently found out I am to be a father in 7.5 months, I am doing everything I can to speed up this process.

Additionally, my stats person (Dr. Luecht) tells me that my data could serve as a confirmatory analysis of your survey, so I believe we would both benefit. I look forward to hearing from you.

Joseph P. Jordan  
MS, CCAS, LPC

“We always grow unto that which we contemplate” – Emmet Fox

## Appendix B

### Questionnaire – Initial Adaptation

Survey of Alcohol and other Drug Abuse Training Needs of  
Juvenile Court Counselors in North Carolina

Thank you in advance for agreeing to participate in this research. Please answer the following questions about yourself by circling the appropriate response or filling in the blank. This portion of the survey is vital to making helpful recommendations about the training of Juvenile Court Counselors.

1. My gender is

- female
- male

2. I identify with the following race/ethnic group:

- African-American
- Biracial
- Caucasian
- Spanish/Hispanic/Latino
- Native American
- Asian American

3. I work in the following county(ies) of North Carolina:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. My educational level is:

- Bachelors Degree
- Masters Degree or higher

5. I have had the following number of hours of training in substance abuse issues:

\_\_\_\_\_

\_\_\_\_\_

6. I have worked in the juvenile justice field for:

---

*You may now go on to the survey.*

Survey of Alcohol and other Drug Abuse Training Needs of  
Juvenile Court Counselors in North Carolina

This survey is designed to help identify the Alcohol and Other Drug Abuse Training Needs of Entry Level Juvenile Court Counselors working in the state of North Carolina.

*Please rate the following statements according to the following scale as to whether you disagree or agree with them*

(1) Strongly Disagree      (2) Disagree      (3) Neutral      (4) Agree      (5) Strongly agree

---

1. An entry-level JCC should be able to describe the behavioral, physical health and social effects of psychoactive drugs, including alcohol and tobacco, on the consumer and significant others.

SD   D   N   A   SA

2. An entry-level JCC should have knowledge of criteria for assessing substance use disorders and biopsychosocial (affects biology, psychology, and social aspects of the person) disorders.

SD   D   N   A   SA

3. An entry-level JCC should be able to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance related problems.

SD   D   N   A   SA

4. An entry-level JCC should have knowledge of the potential for cross-addiction, i.e., addiction to both alcohol and tranquilizers

SD D N A SA

5. An entry-level JCC should be able to screen for alcohol and other drug toxicity, withdrawal symptoms, aggression or danger to others, and potential for self –inflicted harm or suicide.

SD D N A SA

6. An entry-level JCC should have knowledge of common patterns of family adaptation to substance abuse.

SD D N A SA

7. An entry-level JCC should have knowledge of the relationships between psychoactive substance use and other mental health disorders.

SD D N A SA

8. An entry-level JCC should have skill in obtaining a client's family history of addictive disorders.

SD D N A SA

9. An entry-level JCC should be able to obtain a substance abuse history.

SD D N A SA

10. An entry-level JCC should have skill in determining a client's degree of understanding of alcohol and other drug dependencies.

SD D N A SA

SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly

agree

11. An entry-level JCC should have knowledge of pharmokinetics, e.g., how long it takes a drug stays in the body.

SD D N A SA

12. An entry-level JCC should be able to monitor drug screenings and interpret test results.

SD D N A SA

13. An entry-level JCC should have knowledge of relapse prevention theories and techniques.

SD D N A SA

14. An entry-level JCC should have skill in assessing the degree of client's understanding of his/her substance abuse/dependence.

SD D N A SA

15. An entry-level JCC should be able to investigate halfway house alternatives.

SD D N A SA

16. An entry-level JCC should have knowledge of the relationship between symptoms and responsiveness to varying levels of care, such as inpatient treatment, outpatient treatment, or residential treatment.

SD D N A SA

17. An entry-level JCC should have knowledge of patterns and methods of misuse and abuse of prescribed and over-the-counter medications.

SD D N A SA

18. An entry-level JCC should have knowledge of trends in street and designer drugs.

SD D N A SA

19. An entry-level JCC should be able to arrange aftercare services, i.e., continuing care services for clients that complete treatment. SD D N A SA

20. An entry-level JCC should have knowledge of current methods and technologies to present information in a culturally sensitive manner, e.g., using language appropriate to the audience. SD D N A SA

SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly agree

21. An entry-level JCC should have knowledge of current professional literature on substance use. SD D N A SA

22. An entry-level JCC should have skill in evaluating the severity of the client's alcoholism and other drug dependency. SD D N A SA

23. An entry-level JCC should be able to involve significant others in aftercare planning. SD D N A SA

24. An entry-level JCC should have skill in applying principles of group dynamics when leading groups. SD D N A SA

25. An entry-level JCC should have knowledge of emergency procedures associated with overdose, acute withdrawal, and decompensation. SD D N A SA

26. An entry-level JCC should be able to facilitate return to work conferences for clients returning from treatment. SD D N A SA

27. An entry-level JCC should have knowledge of relationships between psychoactive substance use and biopsychosocial disorders, such as depression or anxiety. SD D N A SA

28. An entry-level JCC should have knowledge of the value of periodic self-assessment to personal growth (e.g., career planning). SD D N A SA

29. An entry-level JCC should be able to inform a client about the detoxification process. SD D N A SA

30. An entry-level JCC should have knowledge of the relationship between psychoactive substance use, biopsychosocial disorders, and vocational development. SD D N A SA

SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly

agree

31. An entry-level JCC should be able to assist the client in obtaining a temporary sponsor in a 12-step group such as Alcoholics Anonymous or Narcotics Anonymous. SD D N A SA

32. An entry-level JCC should have knowledge of the interactions between psychoactive substance use, biopsychosocial disorders, and relationships with other concerned persons. SD D N A SA

33. An entry-level JCC should have knowledge of phases of treatment and various client responses (e.g., crisis, impasses, plateaus, resistance). SD D N A SA

34. An entry-level JCC should be able to educate clients about self-help groups. SD D N A SA

35. An entry-level JCC should have knowledge of confidentiality laws specific to substance abuse. SD D N A SA

36. An entry-level JCC should have knowledge of the relationship between psychoactive substance use and such things as individuals' values, culture, lifestyle, age, gender, HIV status, sexual orientation, physically challenging conditions, and socioeconomic status. SD D N A SA

37. An entry-level JCC should have knowledge of adverse effects of combining various types of psychoactive drugs, as well as over the counter medication. SD D N A SA

38. An entry-level JCC should be able to make homework assignments that include participation in self-help groups. SD D N A SA

39. An entry-level JCC should have knowledge of ethical standards which apply to substance abuse counseling. SD D N A SA

40. An entry-level JCC should have knowledge of the correlation between substance use disorders and specific mental illnesses such as mood disorders, anxiety disorders, and schizophrenia. SD D N A SA

SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly

agree

41. An entry-level JCC should be able to organize or facilitate an intervention using case examples.

SD D N A SA

42. An entry-level JCC should have knowledge of credentialing and certification requirements.

SD D N A SA

43. An entry-level JCC should have knowledge of sources to secure information on current trends and developments in alcoholism and related fields (sources include professional associations, related groups, and trade journals).

SD D N A SA

44. An entry-level JCC should have knowledge of legal and regulatory restrictions affecting alcoholism/drug dependency treatment and counseling.

SD D N A SA

45. An entry-level JCC should be able to facilitate the development of basic life skills associated with recovery.

SD D N A SA

46. An entry-level JCC should have skill in assessing the client's risk factors for relapse.

SD D N A SA

47. An entry-level JCC should have skill in interpreting results of substance abuse disorder assessment instruments and relating the information to clients.

SD D N A SA

48. An entry-level JCC should be able to understand terminology, procedures, and the roles of other helping professions related to the treatment of substance abuse. SD D N A SA

49. An entry-level JCC should have knowledge of administration and scoring procedures for substance abuse disorder assessment instruments. SD D N A SA

50. An entry-level JCC should have knowledge of various counseling approaches relevant to assessment and treatment of substance abuse disorders. SD D N A SA

SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly

agree

51. An entry-level JCC should have knowledge of federal, state, and local statutes relating to the use of alcohol and drugs. SD D N A SA

52. An entry-level JCC should be able to provide counseling to individuals who are affected by their past or current association with alcoholic or drug dependent individuals. SD D N A SA

53. An entry-level JCC should have knowledge of the theories of alcoholism or other drug dependencies. SD D N A SA

54. An entry-level JCC should have knowledge of the social, political, economic, and cultural context within which addiction and substance abuse exist, to include the risk and resiliency factors that characterize individuals and their living environments. SD D N A SA

55. An entry-level JCC should be able to describe, select, and use strategies from accepted and culturally appropriate models for group counseling with addicted or substance abusing clients. SD D N A SA

56. An entry-level JCC should have knowledge of the effects of psychoactive and psychotropic drugs on affective (mood) states. SD D N A SA

57. An entry-level JCC should have knowledge of how to develop an individualized recovery plan that meets the unique needs of the client. SD D N A SA

58. An entry-level JCC should be able to identify similarities and differences in participation in self-help group meetings and group counseling. SD D N A SA

59. An entry-level JCC should have knowledge of comprehensive assessment models for the appropriate level of substance abuse treatment. SD D N A SA

60. An entry-level JCC should have skill in administration and interpretation of specific substance disorder assessment instruments. SD D N A SA

SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly

agree

61. An entry-level JCC should be able to help families, couples, and intimate dyads adopt strategies and behaviors that sustain recovery and maintain healthy relationships. SD D N A SA

62. An entry-level JCC should have knowledge of the impact of substance use and specific substance-induced mental disorders such as mood, anxiety, personality, and psychotic disorders.

SD D N A SA

63. An entry-level JCC should have knowledge of the effects of substance use disorders on the functioning of physiological systems (e.g., endocrine, immunity, sexual, skeletal, neurological, muscular, respiratory, circulatory, and digestive).

SD D N A SA

64. An entry-level JCC should have knowledge of the various philosophies and structure of self-help groups and support groups (i.e., AA, NA, Al-Anon, Nar-Anon).

SD D N A SA

65. An entry-level JCC should be able to educate significant others about self-help groups.

SD D N A SA

66. An entry-level JCC should have knowledge of the importance of family, social networks, and community systems in the treatment and recovery process.

SD D N A SA

67. An entry-level JCC should have knowledge of the effects of substance use disorders on a specific community or population.

SD D N A SA

68. An entry-level JCC should have knowledge of the effects of alcoholism and other drug dependencies on the clients relationship with self, others, and society.

SD D N A SA

69. An entry-level JCC should be able to understand the characteristics and dynamics of families, couples, and intimate dyads affected by addiction. SD D N A SA

70. An entry-level JCC should have knowledge of behavior patterns and progressive stages of substance use disorders and biopsychosocial disorders. SD D N A SA

SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly

agree

71. An entry-level JCC should have skill in assessing and determining the severity of psychoactive substance abuse. SD D N A SA

72. An entry-level JCC should be able to counsel significant others concerning substance abuse. SD D N A SA

73. An entry-level JCC should have knowledge of the changes to client functioning due to client taking/not taking psychotropic medication. SD D N A SA

74. An entry-level JCC should have skill in recognizing new treatment needs of clients. SD D N A SA

75. An entry-level JCC should be able to inform significant others about, and encourage participation in, appropriate self help groups. SD D N A SA

76. An entry-level JCC should have knowledge of drug interactions, including prescription drugs and over-the-counter drugs. SD D N A SA

77. An entry-level JCC should have knowledge of the effects of substance abuse and biopsychosocial disorders treatments on the community. SD D N A SA

78. An entry-level JCC should have skill in accessing community resources to support recovery. SD D N A SA

79. An entry-level JCC should be able to help significant others identify and understand their role(s) in the alcoholism/drug dependency system. SD D N A SA

80. An entry-level JCC should have knowledge of the pharmacology of alcohol and other psychoactive drugs and their interaction. SD D N A SA

SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly

agree

81. An entry-level JCC should have knowledge of how differences among clients (e.g., culture, ethnicity, race, gender, sexual orientation) may impact the progression of the treatment process. SD D N A SA

82. An entry-level JCC should be able to assist significant others (e.g., spouses, life-partner, parents, employer) in identifying and understanding their attitudes and behavior in relation to the client's alcoholism/drug dependency. SD D N A SA

83. An entry-level JCC should have skill in developing linkages to a SD D N A SA

variety of self-help groups.

84. An entry-level JCC should have knowledge of the pharmacology of addiction and cross addiction to alcohol and other drugs.

SD D N A SA

85. An entry-level JCC should be able to organize an intervention by involving family members or significant others affected by the alcoholism/drug dependence of clients.

SD D N A SA

86. An entry-level JCC should have knowledge of the effect of psychoactive substances on nutrition.

SD D N A SA

87. An entry-level JCC should have knowledge of legal consequences when client rights are violated as specifically related to substance abuse treatment regulations.

SD D N A SA

88. An entry-level JCC should be able to design and provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and the recovery process.

SD D N A SA

89. An entry-level JCC should have knowledge of substance use education and prevention models.

SD D N A SA

90. An entry-level JCC should have skill in helping the client evaluate the impact of alcoholism and other drugs.

SD D N A SA

agree

91. An entry-level JCC should be able to educate clients and significant/concerned others using appropriate methods and technology regarding the relationship between lifestyle choices and substance use in order that they understand the alternatives that are available. SD D N A SA

92. An entry-level JCC should have knowledge of how external factors (i.e., peer influence and the community environment) encourage or discourage substance use, abuse, dependency, medication compliance, and recovery. SD D N A SA

93. An entry-level JCC should have knowledge of diagnostic laboratory results (e.g., blood lab, EEG, liver function). SD D N A SA

94. An entry-level JCC should be able to, using current literature and research findings, deliver culturally relevant formal and informal education programs for clients and other significant persons to raise awareness of prevention, treatment, and recovery processes for substance use and biopsychosocial disorders. SD D N A SA

95. An entry-level JCC should have knowledge of nutritional and recreational needs of the recovering person. SD D N A SA

96. An entry-level JCC should have skill in guiding the client through the developmental stages of recovery. SD D N A SA

97. An entry-level JCC should be able to instruct clients and significant persons, through lectures, workshops, and discussions, so they SD D N A SA

understand the influence of substance use and biopsychosocial disorders on families and other relationships.

98. An entry-level JCC should have knowledge of the affect of psychoactive drugs on cognitive states. SD D N A SA

99. An entry-level JCC should have skill in relating clients' self-help group (i.e., AA, NA) experience to group counseling experience. SD D N A SA

100. An entry-level JCC should be able to discuss substance use and biopsychosocial disorders with other professionals in order to examine the role professionals can play in the prevention, treatment, and recovery processes. SD D N A SA

agree SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly

101. An entry-level JCC should have knowledge of how the denial processes of client and family affect the family and society of the substance abuser. SD D N A SA

102. An entry-level JCC should have skill in facilitating interventions (e.g., with the client's family, employer, or others). SD D N A SA

103. An entry-level JCC should be able to describe factors that increase the likelihood that an individual, group, or community will be at risk for alcohol and other drug problems. SD D N A SA

104. An entry-level JCC should have knowledge of stages of recovery from alcohol and other drug dependences. SD D N A SA

105. An entry-level JCC should have knowledge of withdrawal symptoms.

SD D N A SA

106. An entry-level JCC should be able to sensitize others to such issues as cultural identity, ethnic background, age, and gender role or identity in the prevention, treatment, and recovery processes.

SD D N A SA

107. An entry-level JCC should have knowledge of the relationship between psychoactive substance use, biopsychosocial disorders, and social behavior and functioning.

SD D N A SA

108. An entry-level JCC should have knowledge of the value of an interdisciplinary approach to addiction treatment.

SD D N A SA

109. An entry-level JCC should have knowledge of self-help groups and their programs of recovery.

SD D N A SA

110. An entry-level JCC should be able to adhere to federal and state laws and agency regulations, regarding alcohol and other drug treatment.

SD D N A SA

SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly

agree

111. An entry-level JCC should have knowledge of how internal factors (e.g., expectation, coping skills, co-existing disorders) influence recovery and relapse processes.

SD D N A SA

112. An entry-level JCC should have skill in conducting an intake with a substance abuse client. SD D N A SA

113. An entry-level JCC should have knowledge of cultural/lifestyle differences regarding attitudes and values about the use and abuse of alcohol/drugs. SD D N A SA

114. An entry-level JCC should be continually informed of the current trends and developments in alcoholism, drug dependency, the counseling profession, and other related fields. SD D N A SA

115. An entry-level JCC should have knowledge of how to "contract" as well as the therapeutic value of contracting, with a client. SD D N A SA

116. An entry-level JCC should have knowledge of issues pertinent to specific populations (e.g., ethnic minorities, women, youth, elderly, gay/lesbian/bisexual/transgender, physically impaired, etc.). SD D N A SA

117. An entry-level JCC should be able to consult with staff of other agencies on their cases involving alcohol or drug-related problems. SD D N A SA

118. An entry-level JCC should have knowledge of behavioral management of the substance-impaired person. SD D N A SA

119. An entry-level JCC should be able to understand the importance of research and outcome data related to substance use disorder treatment, as well as the application of this data to clinical practice. SD D N A SA

120. An entry-level JCC should have skill in developing and writing a recovery plan. SD D N A SA

agree SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly

121. An entry-level JCC should be able to understand the established diagnostic criteria for substance dependence and abuse, as well as describe the treatment modalities and placement criteria based upon continuum of care model. SD D N A SA

122. An entry-level JCC should have knowledge of both the incidence and prevalence of HIV/AIDS and sexually transmitted diseases as well as the relationship of these illnesses with substance abuse disorders. SD D N A SA

123. An entry-level JCC should have knowledge of concepts of prevention, community education, and community outreach regarding substance abuse. SD D N A SA

124. An entry-level JCC should be able to be familiar with medical and pharmaceutical resources in the treatment of addictive disease and other substance related disorders. SD D N A SA

125. An entry-level JCC should be able to understand the substance use patterns of diverse racial and ethnic cultures. SD D N A SA

126. An entry-level JCC should have knowledge of roles of informal support systems on encouraging and/or inhibiting alcohol/drug use. SD D N A SA

127. An entry-level JCC should be able to understand the addiction professional's obligation to adhere to generally accepted ethical and behavioral standards of conduct in the helping relationship. SD D N A SA

128. An entry-level JCC should have knowledge of intoxication, withdrawal and long-term physical effects of substance use disorders. SD D N A SA

129. An entry-level JCC should have knowledge of the relationship of Alcoholics Anonymous 12 Steps and 12 Traditions and the recovery processes. SD D N A SA

130. An entry-level JCC should be able to understand the obligation of the addiction professional to engage in prevention as well as treatment. SD D N A SA

SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly

agree

131. An entry-level JCC should have knowledge of the physical illness that may be mistaken for symptoms of substance use. SD D N A SA

132. An entry-level JCC should have knowledge of the dynamics of resistance to the treatment and recovery processes. SD D N A SA

133. An entry-level JCC should have knowledge of the nature and extent of alcoholism/drug dependency among the target population. SD D N A SA

134. An entry-level JCC should have knowledge of the information needed to complete the intake interview (e.g., use of alcohol and other drugs of abuse, educational background, cultural information, socioeconomic information, lifestyle information, living situation, medical information, treatment history, demographic information, legal status, other relevant data, normal ranges of vital signs, etc.).

SD D N A SA

135. An entry-level JCC should be able to facilitate client exploration about the consequences of substance abuse.

SD D N A SA

136. An entry-level JCC should have knowledge of the effects of alcoholism/drug dependency and recovery on family members/significant others.

SD D N A SA

137. An entry-level JCC should have knowledge of client skills that encourage recovery-oriented behavior.

SD D N A SA

138. An entry-level JCC should be able to facilitate the client's engagement in the treatment/recovery process.

SD D N A SA

139. An entry-level JCC should be able to interpret and apply information from current counseling and alcohol and other drug research literature in order to improve client care and enhance professional growth.

SD D N A SA

140. An entry-level JCC should have knowledge of contemporary issues and events relevant to alcoholism/drug dependency (e.g., legislative and public policy issues).

SD D N A 5

agree

141. An entry-level JCC should have knowledge in substance use disorder assessment instruments, to include their limitations and strengths.

SD	D	N	A	SA
<input type="checkbox"/>				

142. An entry-level JCC should have knowledge in the dynamics of relapse.

SD	D	N	A	SA
<input type="checkbox"/>				

143. An entry-level JCC should have skill in identifying withdrawal effects.

SD	D	N	A	SA
<input type="checkbox"/>				

144. An entry-level JCC should have knowledge of alcohol and drug abuse withdrawal signs and symptoms.

SD	D	N	A	SA
<input type="checkbox"/>				

145. An entry-level JCC should have knowledge of the continuum of care for alcoholism/drug dependency treatment.

SD	D	N	A	SA
<input type="checkbox"/>				

146. An entry-level JCC should have knowledge of the signs and symptoms of mental health disorders (as indicated by currently accepted diagnostic criteria) identify how they relate to substance abuse, and recognize the implications of this relationship for treatment and referral.

SD	D	N	A	SA
<input type="checkbox"/>				

147. An entry-level JCC should have knowledge of the recovery and relapse process.

SD	D	N	A	SA
<input type="checkbox"/>				

148. An entry-level JCC should have knowledge of assessment techniques and instruments related to substance use.

SD D N A SA

149. An entry-level JCC should have knowledge of counselor codependency and other conditions that impair counselor effectiveness.

SD D N A SA

150. An entry-level JCC should have skill in assessing the client's willingness to participate in, and prior history with, self-help groups.

SD D N A SA

151. An entry-level JCC should be able to help the client identify the role of substance abuse in his/her current life problems.

SD D N A SA

152. An entry-level JCC should have knowledge of how the client's denial process can lead to manipulation of health care professionals.

SD D N A SA

## Appendix C

Permission to Use Chart in Figure 1

Dear Mr. Jordan,

Thank you for contacting the National Criminal Justice Reference Service (NCJRS).

We received your request for information regarding copyright permission.

The National Criminal Justice Reference Service is the information clearinghouse for the five agencies of the Office of Justice Programs, U.S. Department of Justice. In this capacity, we distribute documents and information from the National Institute of Justice, the Bureau of Justice Statistics, the Bureau of Justice Assistance, the Office for Victims of Crime and the Office of Juvenile Justice and Delinquency Prevention, as well as the Office for National Drug Control Policy.

In this capacity, we provide documents or information on a wide variety of criminal, substance abuse or juvenile justice issues.

The following statement regarding our copyright policy should be of assistance and can be found on the NCJRS Web site at <http://www.ncjrs.org/privacy.html>:

"The United States Government retains a non-exclusive, irrevocable, and royalty-free license to publish or reproduce these documents for U.S. Government purposes, or to allow others to do so.

These documents may be freely distributed and used for non-commercial, scientific and educational purposes. Commercial use of the documents available from this server may be protected under U.S. and foreign copyright laws. If you wish to publish or reproduce these documents for commercial purposes, please e-mail [askogc@usdoj.gov](mailto:askogc@usdoj.gov) with your request.

Individual documents on this server may have different copyright conditions, and that fact will be noted with those documents."

If you have further questions, please contact us again and thank you for using NCJRS services.

Sincerely,

Maanami  
Customer Service Specialist  
NCJRS  
<http://www.ncjrs.org>

## Appendix D

### Notarized Agreement to Conduct Research

# AGREEMENT TO CONDUCT RESEARCH

**Project Title: An Examination of Substance Abuse Skills and Knowledge for Juvenile Court Counselors**

**Investigator(s): Joseph P. Jordan, MS, CCAS, LPC, CCS**

**Approved Site(s): Varies, on-line survey sent to JCC throughout state**

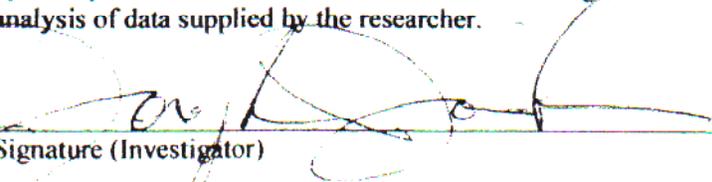
## Pledge of Confidentiality and Ethical Behavior

I, Investigator for this project, pledge that any subject files will be used solely for research purposes. I understand that I have a legal responsibility to protect the right of privacy of all subjects involved in this research project. Therefore, I will adhere to the following:

1. Research reporting or auditing will not directly or indirectly disclose the identity of any subject or family;
2. The data will be used only for the research project listed above;
3. Any data that is identifiable to individuals will be subject to reasonable caution in its storage and use to prevent unauthorized disclosure to, or use by, others and will be destroyed or stripped of its identifiers upon termination of project; and,
4. No DJJDP records will be removed from the premises. The facility Director must authorize photocopying of records in writing.

I am aware that there are specific exceptions, which require violation of confidentiality. If a subject informs me that (s) he is thinking of hurting her/himself, hurting someone else, or planning to breach security, I will quickly pass this information on to an appropriate staff person. I am aware of the sensitive nature of my position. I will not permit any research activity to interfere with the responsibilities of care for the subject. If there is a conflict of interest, I agree that clinical care or custody matters will have precedence over research concerns. I understand that DJJDP reserves the right to interrupt, suspend, or terminate any study that may violate state or federal laws, compromise the security of sensitive information obtained, harm any subject, or significantly disrupt the functioning of the Office and/or its programs.

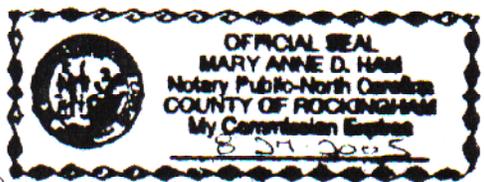
I further pledge to present a final draft of this project to the DJJDP Research Committee to allow opportunity to respond prior to publication or presentation of the data. I will provide raw data upon request. I understand that DJJDP retains the right to use and publish, at its discretion, any analysis of data supplied by the researcher.

  
Signature (Investigator) 6/10/05  
Date

### Notary Public Section:

I, Mary Anne D. Ham, witnessed the signing of this document before me this 10<sup>th</sup> day of June, 2005.  
(Month) (Year)

Include Embossed Seal.



My Commission expires: 8/27/05

## Appendix E

### Feedback from Addiction and Counseling Educators

Hey Joe. Good to hear from you. I have reviewed your survey instrument and have the following feedback for you.

1. It took me about 15-16 minutes to go through the survey.
2. I had some comments about the following questions:
  - a) #6 in demographics - add an "s" to the end of the word issue
  - b) #13 in survey - should this not be relapse "prevention" theories and techniques?
  - c) #17 add the word "have" between should and knowledge
  - d) #36 I thought this question was confusing because there were too many options listed. I was unsure how to respond since I agreed with some and not others.
    - e) #125 the way it is worded was funny for me. Instead of knowledge of racial/ethnic cultures and substance abuse patterns how about something like "the substance using patterns of diverse racial and ethnic cultural groups."
3. The instructions seemed fine to me.

I hope this helps Joe. Good luck with your study!

Joshua C. Watson, Ph.D., NCC, LPC  
Assistant Professor of Counselor Education Meridian Campus Mississippi State  
University  
601-484-0188 (office)  
601-484-0279(facsimile)

Hi Joe,

It took me an hour to go through some of the items on your survey. Below are some comments that I have.

# 4 on Demographic – I would put three categories, instead of two, because someone with a master's degree would respond differently, than a person with more than a master's degree (but what is more than a master's degree?). For future research, you could compare the differences between the responses based on educational level (master's v.s Ph.D).

In terms of the survey I would increase the font of items in the parenthesis ( i.e., D=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly agree) to 11 point font.

Below are the questions that I had questions about.

#8 the wording

An entry-level JCC should have **skill taking** client's family history of addictive disorders.

OR

An entry-level JCC should have skills **an obtaining the client's** family history of addictive disorders.

#13 and #147 appear to asking the same question (or similar)

#134 "An entry-level JCC should **have** knowledge of the information need to complete the intake interview (e.g., use of alcohol and other drugs of abuse, educational background, cultural information, socioeconomic information, lifestyle information, living situation, medical information, treatment history, demographic information, legal status, other relevant data, normal ranges of vital signs).

OR

An entry-level JCC should **be knowledgeable** of the information **needed** to complete the intake interview (e.g., use of alcohol and other drugs of abuse, educational background, cultural information, socioeconomic information, lifestyle information, living situation, medical information, treatment history, demographic information, legal status, other relevant data, normal ranges of vital signs).

#96 and 146 are loaded questions

#123 An entry-level JCC should have knowledge of **concepts** of prevention, community education, and community outreach regarding substance abuse.

OR

An entry-level JCC should have knowledge of prevention, community education, and community outreach **resources available regarding** substance abuse.

This is an extremely long survey are you going to do a factor analysis and discard some of the items?

P.S.

Due to time constraints, I was not able to go through the survey in great detailed. If you need me to take another look at your survey I would be more than happy.

Take care!

Tammy T. Webb Ph.D, M.S.W, LSW  
Assistant Professor  
North Carolina A&T State University  
Department of Human Development and Services  
212 Hodgin Hall  
Greensboro, NC 27411  
(336) 334-7916  
Fax (336) 334-7280  
E-Mail: [ttwebb@ncat.edu](mailto:ttwebb@ncat.edu)

Joe:

You want it; you got it!!

I'm pretty sensitive to wording/semantics in surveys so forgive my "pickiness".

First, I would venture to say that "Euro American" is used more in academic settings, I believe, than the rest of the world so I wonder if you want to list "Caucasian" beside it.

Look at when you've chosen to use "substance use" versus "substance abuse". I think at times you could have used "use" but chose "abuse" and that may pull your reader to answer it in a different way than you intended.

You use "psychoactive substances" at times and "drugs/alcohol" at times. Any reason for the different references?

#1 - Why not add in psychological or emotional to the list.

#4 - Explain cross addiction (give examples)

#5 - why capitalize alcohol and drug

#11 - Explain pharmacokinetics - again, these folks don't dabble as much in the substance abuse world as you do so some of these terms may force them to respond just to respond versus a true answer.

#12 - "Monitor" drug screening test results or "monitor" the use of substances or "interpret" the drugs screens.

#15 - "investigate" or "be knowledgeable about" - anyone should investigate--but shouldn't they stay current on the alternatives.

#16 - a level of care doesn't have symptoms. Are you saying what symptoms would necessitate a specific level of care + average success/failure rate of levels of care. May be 2 different questions.

#17 - a "have" is missing in the question. Is "over the counter" usually with hyphens?

#18 - A WONDERFUL QUESTION!!

#19 - Explain aftercare services. Do JCC's actually participate in aftercare planning? Or do they usually support it as it relates to substance abuse treatment.

#20. What do you mean technologies related to present culturally sensitive material. Is that like programs that present material in different languages? I'm not sure what this means.

#24 - Sounds like a question from my survey but not sure it applies here in the way it is written. I would throw out the educational setting and just say they should have skills in applying principles of group dynamics if working with groups.

#27 - Give examples of biopsychosocial disorders.

#28. Should have knowledge of THE values of periodic self-assessment OF THEIR OWN personal growth.

#35 - I would say specific to substance abuse treatment since they can differ from mental health.

#37 - there is an OF missing.

#41 - I'm not sure what you mean by "using case examples" - do you mean demonstrate they have knowledge of the intervention process by using case examples.

#45 - is it suppose to read "basic life skills"?

#56. Affective versus mood--may resonate more with the average population of JCCs.

#57. An individualized recovery plan is just that--unique to the individual. Therefore, drop unique.

#58. Is just identifying similarities and differences enough, or is identifying the costs and benefits the real jewel.

#59. What do you mean "assessment models" for treatment - how to assess what form of treatment is the appropriate level of care?

#60. Switch order -- "the procedures for administering and interpreting the results of specific substance disorder assessment instruments".

#61 - GREAT QUESTION.

#62 - GREAT QUESTION because you gave examples - may want to incorporate same format in other places (like #2 when you state biopsychosocial disorders)

#67 - "community or population"

#77 - people effect others, not treatments

#84 - seems to be missing something. Why not just say "have knowledge of the pharmacology of addiction and cross addiction."

#85 - would leave out "of clients".

#87 What is the difference in #85, this question and there is one other about interventions in the survey? If you are going to have similar questions worded similarly then 85 & 87 need to be spread out more.

#94 - seems to be missing something - "be able to use current literature and research findings to DESIGN AND DELIVER culturally relevant...."

#97 - seems to need rewording.

#99 - Huh? I really don't know what you are asking.

#101 - I would reorder it to put family first and society second - start with the most meaningful group to the "client" and then the larger context in which they use substances.

#103 - again- build from small to large - individual, group or community

#110 - capitals??

#112 - an intake with a substance abuse client.

#118 - substance impaired (I don't think you've used this anywhere else in your survey - again, be consistent in your description of your population)

#134 - NEEDED

#139 - spell out AOD and how does this differ from #140?

#146 - "clinical and personality disorders" (include the official titles for Axis I & II here) (wouldn't most consider personality disorders a type of mental disorder).

#147 - Could be broader to include counselor behaviors that impair objectivity or effectiveness - codependency being only 1.

#152 - just the health care professional (sounds very hospital-like) or all mental health professionals/providers.

Hope this helps--just another person's opinion/perspective. Let me know if you have any questions.

Hope the family is doing well.

Peace,

Patty Von Steen

Hi Joe-

What a spectacular survey! Joe, it looks great. Clearly, you have worked your tail off.

I did not actually complete the survey, but read the questions, as I've not been a JCC. It took me approximately 18 minutes to complete. A couple of thought, please take these in the spirit given.

First, you may wish to consider breaking question three into two separate questions or identify the "main" question and re-write to address that. As is, it is the first "hard hitting question" and it is a little too encumbering for the reviewer to get her "arms around quickly" and may turn the responder from completing the remainder of the questions.

Second, you might wish to review question 20 and place an (e.g.) with an example. The politically correct answers on everything are "culturally sensitive," "multiculturalism" and "diversity"-- my guess is that you will have a "floor effect" here as most anyone will agree with a doing nearly everything in a "culturally sensitive manner". Thus, so many of your respondents will likely SA this response that it will be of little true or meaningful value. For me, it seems that two potential options make sense. Either include examples of what methods and technologies could be suggested via an "e.g." or attempt to re-write the question in a manner that will potentially provide more refined or differentiated responses.

Fourth, questions 121 and 145 ask about continuum of care regarding treatment. These are excellent questions, Joe. I guess I wonder if it might not be helpful to directly ask about The Substance Abuse Continuum related to diagnosis? As I re-review these questions, Joe, question 121 relates back to treatment modalities and placement criteria within the continuum of care, but I wonder if you would not want to add an additional question (I guess I wouldn't related to the currently length of the instrument), maybe you may

wish to re-write a question related to the diagnosis based on the substance abuse continuum (attachment) as I would suspect many court ref juveniles are going to present with dx less than dependence, but clearly moving towards it. The Substance Abuse Continuum allows more freedom of the JCC related to dx and then she can match with the continuum of care as you have asked.

Overall, Joe, this is a GREAT dissertation. CONGRATULATIONS on doing an outstanding job that WILL CLEARLY CONTRIBUTE to our society. I trust my feedback is taken in the spirit that it is meant, Joe. Clearly, you know so much more regarding addictions treatment than me, my suggestions are merely intended to provide helpful feedback that will allow you to gather THE most useful information for you and for JCC's.

Best Wishes My Friend...

Jerry

Gerald A. Juhnke  
Professor/Doctoral Program Director  
Department of Counseling, Educational Psychology,  
& Adult and Higher Education  
The University of Texas at San Antonio  
501 West Durango Boulevard  
San Antonio, TX 78207  
<http://educ3.utsa.edu/gerald.juhnke/>  
(210) 458-2594  
FAX (210)458-2605

Strap yourself in Joe – See my answers in Blue below:

**Joe Jordan <jordans96@triad.rr.com>** wrote:

Hello friends,

Yes, it is that time of year when Doctoral students send emails to their friends asking for the favor of feedback on their dissertation survey. I have designed a survey to use with Juvenile Court Counselors, and would like your comments on the design, user-friendliness, etc. I have uploaded it to the UNCG server, and you may access it at:

<http://www.uncg.edu/ced/courses/jpJordan/survey2005.html>

Once you have taken the survey, please respond to these questions:

1. How long did it take you to complete? 10:19-well, quite a long time since I made so many suggestions. Had I not made these, I suppose it would have taken me between 15 and 20 minutes.
2. Were there any questions you had difficulty understanding? If so, which ones? (See below)
3. Were the instructions on the survey clear and easy to understand? If not, what would you change?

I would add some additional instructions at the beginning (i.e. what this is for, who will benefit, who will see the results, etc.), but I assume that this will be found in your informed consent form.

I would keep the same order of disagree-agree throughout your instructions. Also, doesn't "agree" come before "disagree" in terms of how you want folks to respond? This would change the order of your answers though...See below:

Please rate these statements according to the following scale (SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly agree) as to whether you disagree or agree with them. Please read each statement carefully, then click on the button that best represents your level of agreement or disagreement with the statement. Also, please answer all the questions.

4. Any other feedback you could give would be greatly appreciated.

Should you tease out (on #6 of demographic form) the number of SA hours that folks have had before AND during their careers as Juvy counselors? Maybe they took these hours before getting their jobs?

#2 - will most JCC's know what you mean by "biopsychosocial disorders" and know the difference between them and SA disorders? #27 too. #30 too

#6 - will most JCC's know what you mean by "family adaptation"

Use similar language throughout the survey - you go back and forth between "substance abuse disorders", "psychoactive substance use," "drug dependency," "addiction" and "addictive disorder." Unless you define these in your instructions as being similar, you may confuse folks.

#11 - define "pharmokinetics"

#17 - insert "have" between "should knowledge"

#20 - unclear as to what you're asking

Given that the survey is as long as it is, I would suggest using some way to break it up for the eyes - background color differences, using a grid, titles for different sections, etc. That way it won't seem so long.

#25 - insert "JCC" between "level should"

#26 - what are "return to work conferences"?

#28 - insert "the" between "of" and "value"...also, are you taking personal growth of the JCC or the client?

#32 - use a different word than one of the "relationship"s in the question as it is used twice and each has a different meaning.

#33 - insert "the" between "of" and "phases"...also, does the common survey taker know about these phases (crisis, impasses, plateaus,(add a space) resistance)?

#36 - add something like what I have in blue:

36. An entry-level JCC should have knowledge of the relationship between psychoactive substance use and **such things as individuals'** values, culture, lifestyle, age, gender, HIV status, sexual orientation, physically challenging conditions, and socioeconomic status.

37. An entry-level JCC should have knowledge **of the** adverse effects of combining various types of psychoactive drugs, **to include the blending of** over the counter medications.

#39 - choose another way to say: "substance use disorder counseling"

40. An entry-level JCC should have knowledge of the correlation between substance use disorders and specific mental **illnesses** such as mood disorders, anxiety disorders, and schizophrenia.

43. An entry-level JCC should have knowledge of **the** sources **of** information **regarding** current trends and developments in alcoholism and related fields (sources include professional associations, related groups,and trade journals).

45. An entry-level JCC should be able to facilitate the development of basic **(basic what?)** and life skills associated with recovery.

48. An entry-level JCC should be able to understand **the** terminology, procedures, and roles of other **helping professions** related to the treatment of addiction.

49. An entry-level JCC should have knowledge of **the** administration and scoring procedures for substance abuse disorder assessment instruments.

53. An entry-level JCC should have knowledge of **the** theories of alcoholism or other drug dependencies.

**From here on, I am not going to insert "the" anymore – but I would HIGHLY suggest that you read each question out loud and add "the" where it is needed.**

54. An entry-level JCC should have knowledge of the social, political, economic, and cultural contexts **within** which addiction and substance abuse exist, **to include the** risk and resiliency factors that characterize individuals and their living environments.

60. An entry-level JCC should have skill in explaining and administration procedures of specific substance disorder assessment instruments. **Confusing question – explaining what?**

62. An entry-level JCC should have knowledge of the impact on substance use and specific substance induced mental **illnesses** such as mood, anxiety, personality, and psychotic disorders.

Confusing question – are you asking for the impact of SA disorders on other mental illnesses, or visa versa?

63. An entry-level JCC should have knowledge of the effects of substance use disorders on the functioning of physiological systems (e.g., endocrine, immunity, sexual, skeletal, neurological, muscular, respiratory, circulatory, and digestive).

64. An entry-level JCC should have knowledge of the various philosophies and structure of self-help support groups (i.e., AA, NA, Al-Anon, Nar-Anon).

#67 & 68 – is it “effects” or “affects”? More such distinctions need to be made throughout

73. An entry-level JCC should have knowledge of changes (changes to what?) due to client taking/not taking psychotropic medication.

75. An entry-level JCC should be able to inform significant others about, and encourage participation in, appropriate self help groups.

79. An entry-level JCC should be able to help significant others identify and understand their role(s) in the substance abuse treatment system.

81. An entry-level JCC should have knowledge of how differences among clients (e.g., culture, ethnicity, race, gender, sexual orientation) may impact the progression of the treatment process.

82. An entry-level JCC should be able to assist significant others (e.g., spouses, life-partners, parents, employers) in identifying and understanding their attitudes and behaviors in relation to the clients' alcoholism/drug dependency.

85. An entry-level JCC should be able to organize an intervention by involving family members and/or significant others who have been affected by the alcoholism/drug dependency of clients.

#87 says the same thing as #85 – if you are doing this intentionally, I would suggest separating them a little more.

88. An entry-level JCC should be able to design and provide culturally relevant formal and informal education programs that raise awareness, increase substance abuse prevention, and support the recovery process.

#89 is very similar to #88

91. Through the use of appropriate methods and technology, an entry-level JCC should be able to educate clients and significant/concerned others regarding the relationship between lifestyle choices and substance use disorders to demonstrate the available alternatives.

91 is similar to 94

94. An entry-level JCC should be able to use the current research literature to deliver formal and informal education programs that are culturally relevant for clients and other significant persons in order to raise awareness of prevention, treatment, and recovery processes for substance use and biopsychosocial disorders.

98. An entry-level JCC should have knowledge of the effect of psychoactive drugs on cognitive states. is it “effect” or “affect”?

99. An entry-level JCC should have skill in relating clients' self-help group experiences to group counseling experiences.
100. An entry-level JCC should be able to discuss substance use and biopsychosocial disorders with other professionals in order to examine the role professionals can play in the prevention, treatment, and recovery processes.
101. An entry-level JCC should have knowledge of how the denial processes of both clients and family members affect society and the family of the substance abuser. Underlined part is confusing
105. An entry-level JCC should have knowledge of withdrawal effects (do you mean "symptoms"?).
106. An entry-level JCC should be able to sensitize others to such issues as cultural identity, ethnic background, age, and gender role/identity in the prevention, treatment, and recovery processes.
110. An entry-level JCC should be able to adhere to federal and state laws and agency regulations, regarding Alcohol and Other Drug treatment. – don't introduce "AOD" for the first time here
111. An entry-level JCC should have knowledge of how internal factors (e.g., expectations, coping skills, co-existing disorders, etc.) influence the recovery and relapse processes.
112. An entry-level JCC should have skill in conducting a substance abuse intake session.
113. An entry-level JCC should have knowledge of clients' cultural/lifestyle differences regarding attitudes and values about the use and abuse of alcohol/drugs.
114. An entry-level JCC should be continually informed of the current trends and developments in alcoholism, drug dependency, the counseling profession, and other related fields.
115. An entry-level JCC should have knowledge of how to "contract," as well as the therapeutic value of contracting, with a client.
116. An entry-level JCC should have knowledge of issues pertinent to specific populations (e.g., ethnic minorities, women, youth, elderly, gay/lesbian/bisexual/transgender, physically impaired, etc.).
119. An entry-level JCC should be able to understand the importance of research and outcome data related to substance use disorder treatment, as well as the application of this data to clinical practice.
121. An entry-level JCC should be able to understand the established diagnostic criteria for substance dependence and abuse, as well as describe the treatment modalities and placement criteria based upon the continuum of care model (?).
122. An entry-level JCC should have knowledge of both the incidence and prevalence of HIV/AIDS and sexually transmitted diseases as well as relationship of these illnesses with substance use disorders.
129. An entry-level JCC should have knowledge of the relationship between Alcoholics Anonymous' 12 Steps and 12 Traditions and the recovery process.

132. An entry-level JCC should have knowledge of the dynamics of resistance to [the](#) treatment and the recovery processes.

133. An entry-level JCC should have knowledge of the nature and extent of alcoholism/drug dependency among the target population. ([what target population?](#))

134. An entry-level JCC should have knowledge of the information needed to complete the intake interview (e.g., use of alcohol and other drugs of abuse, educational background, cultural information, socioeconomic information, lifestyle information, living situation, medical information, treatment history, demographic information, legal status, other relevant data, normal ranges of vital signs, [etc.](#)).

141. An entry-level JCC should have knowledge in substance use disorder assessment instruments, [to include](#) their limitations and strengths.

143. An entry-level JCC should have skill in identifying withdrawal effects. – [this is the exact same question as #105](#)

146. An entry-level JCC should have knowledge of [the](#) signs and symptoms of mental and personality disorders ([as indicated by currently accepted diagnostic criteria](#)) [identify how](#) they relate to substance use, and [recognize the](#) implications [of this relationship](#) for treatment and referral.

147. An entry-level JCC should have knowledge of the recovery and relapse processes. – [this too is a duplicate question – I'm sure there are others – is this intentional?](#)

150. An entry-level JCC should have skill in assessing the client's willingness to participate in, and prior history with, self-help groups.

152. An entry-level JCC should have knowledge of how the [client's](#) denial process [can lead to the](#) manipulation of health care professionals.

WHEW, had enough yet?

Peace

Joe:

I am teaching so I didn't get completely finished. It is readable, understandable and clear. It is very long and that may cut your return rate. It also reads as if a JCC should also be a certified substance abuse counselor in order to do the job well. I happen to agree with that position but I am not sure how that will play out with many JCC's. Good luck with it and keep us informed on the results.

Glenn E. Rohrer, Ph.D., LCSW, CCAS, CCS  
Professor and Coordinator Graduate Social Work Program  
School of Social Work  
336-RW Rivers  
East Carolina University  
Greenville, NC 27858  
252-328-4224  
rohrerg@mail.ecu.edu

## Appendix F

Email to Juvenile Court Counselors to Solicit Participation

Dear Juvenile Court Counselor,

I am a doctoral candidate in the Department of Counseling and Educational Development at the University of North Carolina at Greensboro. As part of my degree, I am conducting research, the purpose of which is to investigate knowledge and skills helpful for Juvenile Court Counselors to intervene with those juvenile offenders who may have Alcohol or Other Drug (AOD) abuse issues.

I previously contacted the Department of Juvenile Justice and Delinquency Prevention (DJJDP) and received their permission to send you this email with a link to my survey. It should only take you approximately 20-25 minutes to complete, and let me assure you, all of your answers to the survey will be kept confidential and submitted directly to a database, with no identifying information attached to your answers. Additionally, all results will be kept in a secure manner and destroyed three years after the completion of this research. There are no risks or benefits to subjects due to the anonymous nature of this project and you are entirely free to withdraw your consent to participate and discontinue in the study at any time without any consequence.

If you have further questions regarding this study, please feel free to contact me at (336) 854-1045 or [jordans96@triad.rr.com](mailto:jordans96@triad.rr.com) or my faculty advisor, Dr. Craig Cashwell at (336) 334-3427 or [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu). Questions regarding the rights of research participants may be directed to the UNCG Institutional Review Board at (336) 334-5878, or if you wish to ask someone directly about the rights of research participants, you may contact Dr. Beverly Maddox-Britt of the University of North Carolina at Greensboro Institutional Review Board at 336-334-5878.

By clicking on the following link you will go directly to the survey, or you may cut and paste the link onto your Internet browser. By doing so, this will indicate your having read this email and understanding your rights as they have been explained to you. Also, please keep a copy of this email for your records. I greatly appreciate your assistance in this matter.

<http://www.surveymonkey.com/s.asp?u=146811289546>

Appreciatively,

Joseph P. Jordan, MS, LPC, CCAS

Doctoral Student, Department of Counseling and Educational Development

The University of North Carolina at Greensboro

Cell: 336-509-5720

Business: 336-272-1200

Fax: 336-272-1182

## Appendix G

### Responses from Juvenile Court Counselors

Heather Ritter [Heather.Ritter@ncmail.net]

Joe,

The survey was a bit long and it appeared to me that some of the questions seemed to repeat themselves towards the end of the survey, or maybe that was just my own ADHD. In my opinion, some of the questions, I felt, were things that should be addressed with a juvenile's therapist. However, I did feel that some of the things would be good for court counselor's to know, maybe just not at the level that I felt some of the questions were asking. Court Counselors could use the base knowledge so to speak, to use as tool.  
Heather

Adrian Deaton [Adrian.Deaton@ncmail.net]

In response to your request to know what feelings were about the recent survey we completed for you, I thought it was a bit length and redundant. I found myself taking breaks to stay focused. I had to keep in mind constantly that you were referring to an entry level court counselor. I am sure the survey will be beneficial as an end result in some way or another. I was glad to do it if it helped you. Keep in mind that we were told you would be contacting us all to take us to Out Back for a steak dinner on you with no cost barred. You know that I am just kidding. We all appreciate the work you do.

Have a great day.

Adrian Deaton

Wilbert Davis [Wilbert.Davis@ncmail.net]

Hello,

This is a response to your survey. It was too long, rhythmic, and too in-depth about substance abuse issues. We (court counselors) do not go into such detail concerning substance abuse. We usually directed the parent and juvenile to a substance abuse counselor to determine their short or long term needs.

Best of Luck,  
Wil

Emily Coltrane [emily.coltrane@ncmail.net]

Joe:

Hello! I hope this find you doing well. I wanted to respond to your survey. The survey seemed too long and very repetitive. It seemed too detailed regarding substance abuse which is not our specialty but we are somewhat knowledgeable. We leave the expertise to substance abuse counselors. I think if this survey was sent statewide, you would here some complaints about the length of time it took to complete it and how the questions seemed very repetitive. Best of Luck!

Emily Coltrane

Kim Giusto [kim.giusto@ncmail.net]

On the positive side, the questions were very well phrased and easy to understand. On the negative side the survey was about 50 questions too long. The asking the same question in a different manner 4 or 5 times was very annoying.

I hope the survey was useful.  
Kim

## Appendix H

### Pilot Study Descriptive Statistics

Descriptive Statistics, Descending Mean

Variable Variance	N	Range	Min	Max	Mean	Std. Error	Std. Dev.	
V24	12	2	3	5	4.25	.179	.622	.386
V18	12	3	2	5	4.17	.241	.835	.697
V124	12	2	3	5	4.08	.149	.515	.265
V42	12	2	3	5	4.00	.213	.739	.545
V15	12	3	2	5	4.00	.275	.953	.909
V158	12	2	3	5	4.00	.123	.426	.182
V58	12	3	2	5	3.83	.271	.937	.879
V130	12	1	3	4	3.83	.112	.389	.152
V129	12	3	2	5	3.75	.218	.754	.568
V110	12	3	2	5	3.75	.250	.866	.750
V73	12	2	2	4	3.75	.179	.622	.386
V123	12	1	3	4	3.75	.131	.452	.205
V116	12	1	3	4	3.75	.131	.452	.205
V108	12	4	1	5	3.67	.284	.985	.970
V85	12	3	2	5	3.67	.256	.888	.788
V75	12	3	2	5	3.67	.256	.888	.788
V121	12	3	2	5	3.67	.256	.888	.788
V159	12	5	0	5	3.58	.398	1.379	1.902
V154	12	2	2	4	3.58	.193	.669	.447
V151	12	4	1	5	3.58	.313	1.084	1.174
V144	12	2	2	4	3.58	.193	.669	.447
V20	12	3	1	4	3.58	.260	.900	.811
V152	12	3	1	4	3.58	.260	.900	.811
V140	12	2	2	4	3.58	.229	.793	.629
V117	12	3	2	5	3.58	.260	.900	.811
V55	12	3	2	5	3.58	.260	.900	.811
V46	12	3	2	5	3.58	.260	.900	.811
V120	12	2	2	4	3.58	.229	.793	.629
V82	12	3	1	4	3.50	.289	1.000	1.000
V16	12	4	1	5	3.50	.359	1.243	1.545
V157	12	2	2	4	3.50	.195	.674	.455
V138	12	3	1	4	3.50	.289	1.000	1.000
V32	12	4	1	5	3.50	.314	1.087	1.182
V7	12	4	1	5	3.50	.399	1.382	1.909
V143	12	2	2	4	3.42	.193	.669	.447
V142	12	2	2	4	3.42	.193	.669	.447
V137	12	2	2	4	3.42	.260	.900	.811
V112	12	4	1	5	3.42	.336	1.165	1.356
V99	12	4	1	5	3.42	.336	1.165	1.356
V27	12	2	2	4	3.42	.193	.669	.447
V122	12	3	2	5	3.42	.260	.900	.811
V80	12	4	1	5	3.42	.336	1.165	1.356

V41	12	2	2	4	3.42	.229	.793	.629
V23	12	2	2	4	3.42	.229	.793	.629
V156	12	2	2	4	3.33	.225	.778	.606
V97	12	4	1	5	3.33	.333	1.155	1.333
V89	12	2	2	4	3.33	.225	.778	.606
V88	12	2	2	4	3.33	.256	.888	.788
V76	12	2	2	4	3.33	.225	.778	.606
V74	12	2	2	4	3.33	.284	.985	.970
V69	12	3	1	4	3.33	.310	1.073	1.152
V153	12	2	2	4	3.33	.256	.888	.788
V125	12	2	2	4	3.25	.279	.965	.932
V72	12	2	2	4	3.25	.279	.965	.932
V25	12	3	1	4	3.25	.305	1.055	1.114
V19	12	4	1	5	3.25	.329	1.138	1.295
V14	12	4	1	5	3.25	.372	1.288	1.659
V147	12	2	2	4	3.25	.218	.754	.568
V90	12	2	2	4	3.25	.279	.965	.932
V17	12	5	0	5	3.25	.524	1.815	3.295
V145	12	3	2	5	3.17	.345	1.193	1.424
V86	12	2	2	4	3.17	.241	.835	.697
V40	12	2	2	4	3.17	.271	.937	.879
V12	12	3	2	5	3.17	.345	1.193	1.424
V11	12	4	1	5	3.17	.386	1.337	1.788
V150	12	4	0	4	3.17	.405	1.403	1.970
V135	12	4	0	4	3.17	.405	1.403	1.970
V109	12	3	1	4	3.17	.297	1.030	1.061
V94	12	4	1	5	3.17	.405	1.403	1.970
V81	12	3	1	4	3.17	.297	1.030	1.061
V71	12	2	2	4	3.17	.271	.937	.879
V63	12	3	1	4	3.17	.345	1.193	1.424
V35	12	3	1	4	3.17	.297	1.030	1.061
V26	12	5	0	5	3.17	.423	1.467	2.152
V133	12	4	0	4	3.08	.358	1.240	1.538
V132	12	2	2	4	3.08	.260	.900	.811
V96	12	3	1	4	3.08	.313	1.084	1.174
V77	12	3	1	4	3.08	.313	1.084	1.174
V53	12	4	1	5	3.08	.379	1.311	1.720
V51	12	3	2	5	3.08	.313	1.084	1.174
V34	12	3	1	4	3.08	.358	1.240	1.538
V30	12	4	0	4	3.08	.379	1.311	1.720
V13	12	3	1	4	3.08	.358	1.240	1.538
V118	12	3	1	4	3.08	.288	.996	.992
V139	12	2	2	4	3.00	.275	.953	.909
V131	12	2	2	4	3.00	.246	.853	.727
V126	12	2	2	4	3.00	.246	.853	.727
V155	12	2	2	4	3.00	.302	1.044	1.091

V149	12	2	2	4	3.00	.275	.953	.909
V134	12	5	0	5	3.00	.426	1.477	2.182
V98	12	3	1	4	3.00	.302	1.044	1.091
V61	12	4	0	4	3.00	.369	1.279	1.636
V44	12	3	1	4	3.00	.326	1.128	1.273
V43	12	4	0	4	3.00	.408	1.414	2.000
V22	12	3	1	4	3.00	.302	1.044	1.091
V115	12	3	1	4	3.00	.302	1.044	1.091
V54	12	3	1	4	3.00	.348	1.206	1.455
V141	12	3	1	4	2.92	.288	.996	.992
V59	12	3	1	4	2.92	.260	.900	.811
V113	12	3	1	4	2.92	.260	.900	.811
V107	12	3	1	4	2.92	.336	1.165	1.356
V105	12	4	1	5	2.92	.358	1.240	1.538
V100	12	3	2	5	2.92	.288	.996	.992
V84	12	3	1	4	2.92	.358	1.240	1.538
V57	12	3	1	4	2.92	.313	1.084	1.174
V52	12	3	1	4	2.92	.288	.996	.992
V39	12	3	1	4	2.92	.358	1.240	1.538
V21	12	3	1	4	2.83	.345	1.193	1.424
V10	12	3	1	4	2.83	.366	1.267	1.606
V136	12	4	0	4	2.83	.366	1.267	1.606
V50	12	2	2	4	2.83	.207	.718	.515
V47	12	3	1	4	2.83	.366	1.267	1.606
V148	12	3	1	4	2.75	.305	1.055	1.114
V146	12	2	2	4	2.75	.250	.866	.750
V114	12	3	1	4	2.75	.329	1.138	1.295
V111	12	3	1	4	2.75	.305	1.055	1.114
V49	12	2	2	4	2.75	.250	.866	.750
V29	12	3	1	4	2.75	.351	1.215	1.477
V8	12	4	1	5	2.75	.411	1.422	2.023
V68	12	3	1	4	2.75	.329	1.138	1.295
V36	12	3	1	4	2.75	.279	.965	.932
V70	12	3	1	4	2.67	.396	1.371	1.879
V119	12	2	2	4	2.67	.225	.778	.606
V91	12	3	1	4	2.67	.310	1.073	1.152
V60	12	3	1	4	2.67	.284	.985	.970
V33	12	3	1	4	2.67	.284	.985	.970
V83	12	4	0	4	2.67	.396	1.371	1.879
V79	12	3	1	4	2.58	.260	.900	.811
V92	12	3	1	4	2.58	.260	.900	.811
V102	12	3	1	4	2.50	.261	.905	.818
V93	12	3	1	4	2.50	.261	.905	.818
V87	12	3	1	4	2.50	.289	1.000	1.000
V48	12	3	1	4	2.50	.261	.905	.818
V37	12	4	0	4	2.50	.399	1.382	1.909

V9	12	3	1	4	2.50	.359	1.243	1.545
V106	12	3	1	4	2.42	.260	.900	.811
V65	12	3	1	4	2.42	.288	.996	.992
V28	12	4	0	4	2.42	.398	1.379	1.902
V45	12	3	1	4	2.42	.288	.996	.992
V103	12	3	1	4	2.33	.284	.985	.970
V78	12	3	1	4	2.33	.310	1.073	1.152
V56	12	3	1	4	2.33	.284	.985	.970
V38	12	3	1	4	2.33	.310	1.073	1.152
V31	12	3	1	4	2.33	.225	.778	.606
V104	12	2	1	3	2.17	.167	.577	.333
V95	12	2	1	3	2.17	.167	.577	.333
V128	12	4	0	4	2.17	.366	1.267	1.606
V127	12	2	1	3	2.08	.149	.515	.265
V67	12	3	1	4	2.08	.260	.900	.811
V101	12	2	1	3	2.00	.174	.603	.364
V66	12	4	0	4	2.00	.302	1.044	1.091
V64	12	2	1	3	2.00	.174	.603	.364
V62	12	2	1	3	1.92	.149	.515	.265

## Appendix I

### Juvenile Court Counselor AOD Abuse Training Needs Assessment Questionnaire

# Juvenile Court Counselor AOD Abuse Training Needs Assessment

## 1. Demographic Information

Please provide the following information about yourself, which will be kept strictly confidential.

**1. My gender is:**

gender  female  male

**2. I identify with the following ethnic group:**

Ethnicity  African-American  Caucasian  Spanish/Hispanic/Latino  Asian American  Bi-Racial  Native American  Other

**3. I work in the following county(ies) of North Carolina:**

**4. My educational level is:**

Educational Level  Bachelors  Masters Degree or Higher

**5. What month and year did you begin your job as a Juvenile Court Counselor?: (example - 10/04)**

**6. I have had the following number of hours of training in substance abuse issues since becoming a Juvenile Court Counselor (JCC):**

**7. For the purpose of this study, "success" is defined as no re-offending behavior while on active probation.**

**In the past two years, estimate what percentage of your caseload has been successful?"**

**Note: for newly employed JCCs without two years experience, please put "N/A".**

## Juvenile Court Counselor AOD Abuse Training Needs Assessment

### 2. Survey Page 1

Please rate these statements according to the following scale (SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly agree) as to whether you agree or disagree with them.

Please read each statement carefully, then click on the button that best represents your level of agreement or disagreement with the statement. Also, please answer all the questions.

The beginning of each question is:

"A Juvenile Court Counselor should ...."

Note: Your answers should vary on the 1-5 scale. If you find that your answers be the same, please slow down and read the questions more carefully.

"A Juvenile Court Counselor should....."

**8. ... be able to describe the behavioral, physical health and social effects of psychoactive drugs, including alcohol and tobacco, on the consumer and significant others.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**9. ....have knowledge of criteria for assessing substance use disorders and biopsychosocial (affects biology, psychology, and social aspects of the person) disorders.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**10. ....be able to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance related problems.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**11. ....have knowledge of the potential for cross-addiction, that is, addiction to both**

**alcohol and tranquilizers.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**12. ....should be able to screen for alcohol and other drug toxicity, withdrawal symptoms, aggression or danger to others, and potential for self –inflicted harm or suicide.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**13. .... have knowledge of common patterns of family adaptation to substance abuse.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**14. .... have knowledge of the relationships between psychoactive substance use and other mental health disorders.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**15. ....have skill in obtaining a client’s family history of addictive disorders.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**16. ....be able to obtain a substance abuse history.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**17. ....have skill in determining a client's degree of understanding of alcohol and other drug dependencies.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[<< Prev](#)

[Next >>](#)

## Juvenile Court Counselor AOD Abuse Training Needs Assessment

### 3. 2nd page

A Juvenile Court Counselor should....

**18. ....have knowledge of pharmacokinetics, for example, how long it takes a drug stays in the body.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**19. ....be able to monitor drug screenings and interpret test results.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**20. ....have knowledge of relapse prevention theories and techniques.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**21. ....have skill in assessing the degree of client's understanding of his/her substance abuse/dependence.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**22. ....be able to investigate halfway house alternatives.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**23. ....have knowledge of the relationship between symptoms and responsiveness to varying levels of care, such as inpatient treatment, outpatient treatment, or residential treatment.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
--	-------------------	----------	---------------------------	-------	----------------

Disagree                      disagree                      Agree  
 Answer                                                                                           

**24. ....have knowledge of patterns and methods of misuse and abuse of prescribed and over-the-counter medications.**

Strongly Disagree    Disagree                      Neither agree or disagree                      Agree                      Strongly Agree  
 Answer                                                                                           

**25. .... have knowledge of trends in street and designer drugs.**

Strongly Disagree    Disagree                      Neither agree or disagree                      Agree                      Strongly Agree  
 Answer                                                                                           

**26. .... be able to arrange aftercare services, that is, continuing care services for clients that complete treatment.**

Strongly Disagree    Disagree                      Neither agree or disagree                      Agree                      Strongly Agree  
 Answer                                                                                           

**27. .... have knowledge of current methods and technologies to present information in a culturally sensitive manner, for example, using language appropriate to the audience.**

Strongly Disagree    Disagree                      Neither agree or disagree                      Agree                      Strongly Agree  
 Answer                                                                                           

[<< Prev](#)                      [Next >>](#)

## Juvenile Court Counselor AOD Abuse Training Needs Assessment

### 4. 3rd Page

A Juvenile Court Counselor should....

**28. .... have knowledge of current professional literature on substance use.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**29. .... have skill in evaluating the severity of the client's alcoholism and other drug dependency.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**30. .... be able to involve significant others in aftercare planning.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**31. .... have skill in applying principles of group dynamics when leading groups.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**32. .... have knowledge of emergency procedures associated with overdose, acute withdrawal, and decompensation.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**33. .... be able to facilitate return to work conferences for clients returning from substance abuse treatment.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
--	-------------------	----------	---------------------------	-------	----------------

Answer

**34. .... have knowledge of relationships between psychoactive substance use and biopsychosocial disorders, such as depression or anxiety.**

Strongly Disagree    Disagree    Neither agree or disagree    Agree    Strongly Agree

Answer

**35. .... have knowledge of the value of periodic self-assessment to personal growth (for example, career planning).**

Strongly Disagree    Disagree    Neither agree or disagree    Agree    Strongly Agree

Answer

**36. .... be able to inform a client about the detoxification process.**

Strongly Disagree    Disagree    Neither agree or disagree    Agree    Strongly Agree

Answer

**37. .... have knowledge of the relationship between psychoactive substance use, biopsychosocial disorders, and vocational development.**

Strongly Disagree    Disagree    Neither agree or disagree    Agree    Strongly Agree

Answer

[<< Prev](#)    [Next >>](#)

## Juvenile Court Counselor AOD Abuse Training Needs Assessment

### 5. Page Four

A Juvenile Court Counselor should....

**38. .... be able to assist the client in obtaining a temporary sponsor in a 12-step group such as Alcoholics Anonymous or Narcotics Anonymous.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**39. .... have knowledge of the interactions between psychoactive substance use, biopsychosocial disorders, and relationships with other concerned persons.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**40. .... have knowledge of phases of treatment and various client responses (for example, crisis, impasses, plateaus, resistance).**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**41. .... be able to educate clients about self-help groups.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**42. .... have knowledge of confidentiality laws specific to substance abuse.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**43. .... have knowledge of the relationship between psychoactive substance use and such things as individuals' values, culture, lifestyle, age, gender, HIV status, sexual orientation, physically challenging conditions, and socioeconomic status.**

Neither

	Strongly Disagree	Disagree	agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>				

**44. .... have knowledge of adverse effects of combining various types of psychoactive drugs, as well as over the counter medication.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**45. .... be able to make homework assignments that include participation in self-help groups.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**46. .... have knowledge of ethical standards which apply to substance abuse counseling.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**47. .... have knowledge of the correlation between substance use disorders and specific mental illnesses such as mood disorders, anxiety disorders, and schizophrenia.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[<< Prev](#)      [Next >>](#)

# Juvenile Court Counselor AOD Abuse Training Needs Assessment

## 6. Page Five

A Juvenile Court Counselor should....

**48. .... be able to organize or facilitate an intervention using case examples.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**49. .... have knowledge of credentialing and certification requirements.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**50. .... have knowledge of sources to secure information on current trends and developments in alcoholism and related fields (sources include professional associations, related groups, and trade journals).**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**51. .... have knowledge of legal and regulatory restrictions affecting alcoholism/drug dependency treatment and counseling.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**52. .... be able to facilitate the development of basic life skills associated with recovery.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**53. .... have skill in assessing the client's risk factors for AOD abuse relapse.**

Strongly	Disagree	Neither agree or	Agree	Strongly
<input type="radio"/>				

Disagree                      disagree                      Agree  
 Answer                                                                                           

**54. .... have skill in interpreting results of substance abuse disorder assessment instruments and relating the information to clients.**

Strongly Disagree    Disagree                      Neither agree or disagree                      Agree                      Strongly Agree  
 Answer                                                                                           

**55. .... be able to understand terminology, procedures, and the roles of other helping professions related to the treatment of substance abuse.**

Strongly Disagree    Disagree                      Neither agree or disagree                      Agree                      Strongly Agree  
 Answer                                                                                           

**56. .... have knowledge of administration and scoring procedures for substance abuse disorder assessment instruments.**

Strongly Disagree    Disagree                      Neither agree or disagree                      Agree                      Strongly Agree  
 Answer                                                                                           

**57. .... have knowledge of various counseling approaches relevant to assessment and treatment of substance abuse disorders.**

Strongly Disagree    Disagree                      Neither agree or disagree                      Agree                      Strongly Agree  
 Answer                                                                                           

[<< Prev](#)                      [Next >>](#)

## Juvenile Court Counselor AOD Abuse Training Needs Assessment

### 7. Page Six

A Juvenile Court Counselor should.....

(YOU ARE A THIRD DONE!!!!)

**58. .... have knowledge of federal, state, and local statutes relating to the use of alcohol and drugs.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**59. .... be able to provide counseling to individuals who are affected by their past or current association with alcoholic or drug dependent individuals.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**60. .... have knowledge of the theories of alcoholism or other drug dependencies.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**61. .... have knowledge of the social, political, economic, and cultural context within which addiction and substance abuse exist, to include the risk and resiliency factors that characterize individuals and their living environments.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**62. .... be able to describe, select, and use strategies from accepted and culturally appropriate models for group counseling with addicted or substance abusing clients.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**63. .... have knowledge of the effects of psychoactive and psychotropic drugs on affective (mood) states.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**64. .... have knowledge of how to develop an individualized recovery plan that meets the unique needs of the client.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**65. .... be able to identify similarities and differences in participation in self-help group meetings and group counseling.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**66. .... have knowledge of comprehensive assessment models for the appropriate level of substance abuse treatment.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**67. .... have skill in administration and interpretation of specific substance disorder assessment instruments.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[<< Prev](#)      [Next >>](#)

# Juvenile Court Counselor AOD Abuse Training Needs Assessment

## 8. Page Seven

A Juvenile Court Counselor should....

**68. .... be able to help families, couples, and intimate dyads adopt strategies and behaviors that sustain recovery and maintain healthy relationships.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**69. .... have knowledge of the impact of substance use and specific substance-induced mental disorders such as mood, anxiety, personality, and psychotic disorders.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**70. .... have knowledge of the effects of substance use disorders on the functioning of physiological systems (for example, endocrine, immunity, sexual, skeletal, neurological, muscular, respiratory, circulatory, and digestive).**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**71. .... should have knowledge of the various philosophies and structure of self-help groups and support groups (that is, AA, NA, Al-Anon, Nar-Anon).**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**72. .... be able to educate significant others about self-help groups.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**73. .... have knowledge of the importance of family, social networks, and**

**community systems in the treatment and recovery process.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**74. .... have knowledge of the effects of substance use disorders on a specific community or population.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**75. .... have knowledge of the effects of alcoholism and other drug dependencies on the clients relationship with self, others, and society.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**76. .... be able to understand the characteristics and dynamics of families, couples, and intimate dyads affected by addiction.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**77. .... have knowledge of behavior patterns and progressive stages of substance use disorders and biopsychosocial disorders.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[<< Prev](#)      [Next >>](#)

# Juvenile Court Counselor AOD Abuse Training Needs Assessment

## 9. Page Eight

A Juvenile Court Counselor should....

**78. .... have skill in assessing and determining the severity of psychoactive substance abuse.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**79. .... be able to counsel significant others (for example, family members) concerning substance abuse.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**80. .... have knowledge of the changes to client functioning due to client taking/not taking psychotropic medication.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**81. .... should have skill in recognizing new treatment needs of clients.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**82. .... be able to inform significant others about, and encourage participation in, appropriate self help groups.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**83. .... have knowledge of drug interactions, including prescription drugs and over-the-counter drugs.**

Neither

	Strongly Disagree	Disagree	agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>				

**84. .... have knowledge of the effects of substance abuse and biopsychosocial disorders treatments on the community.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**85. .... have skill in referring clients to appropriate community agencies resources to facilitate recovery.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**86. .... be able to help significant others identify and understand their role(s) in the alcoholism/drug dependency system.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**87. .... have knowledge of the pharmacology of alcohol and other psychoactive drugs and their interaction.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[<< Prev](#)      [Next >>](#)

# Juvenile Court Counselor AOD Abuse Training Needs Assessment

## 10. Page Nine

A Juvenile Court Counselor should....

**88. .... have knowledge of how differences among clients (for example, culture, ethnicity, race, gender, sexual orientation) may impact the progression of the treatment process.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**89. .... be able to assist significant others (for example, spouses, life-partner, parents, employer) in identifying and understanding their attitudes and behavior in relation to the client's alcoholism/drug dependency.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**90. .... have skill in developing linkages to a variety of self-help groups.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**91. .... have knowledge of the pharmacology of addiction and cross addiction to alcohol and other drugs.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**92. .... be able to organize an intervention by involving family members or significant others affected by the alcoholism/drug dependence of clients.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**93. .... have knowledge of the effect of psychoactive substances on nutrition.** 254

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**94. .... have knowledge of legal consequences when client rights are violated as specifically related to substance abuse treatment regulations.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**95. .... be able to design and provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and the recovery process.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**96. .... have knowledge of substance use education and prevention models.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**97. .... have skill in helping the client evaluate the impact of alcoholism and other drugs.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[<< Prev](#)      [Next >>](#)

# Juvenile Court Counselor AOD Abuse Training Needs Assessment

## 11. Page Ten

A Juvenile Court Counselor should....

**98. .... be able to educate clients and significant/concerned others using appropriate methods and technology regarding the relationship between lifestyle choices and substance use in order that they understand the alternatives that are available.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**99. .... have knowledge of how external factors (i.e., peer influence and the community environment) encourage or discourage substance use, abuse, dependency, medication compliance, and recovery.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**100. .... have knowledge of diagnostic laboratory results (for example, blood lab, EEG, liver function).**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**101. .... be able to, using current literature and research findings, deliver culturally relevant formal and informal education programs for clients and other significant persons to raise awareness of prevention, treatment, and recovery processes for substance use and biopsychosocial disorders.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**102. .... have knowledge of nutritional and recreational needs of the recovering person.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



**103. .... have skill in guiding the client through the developmental stages of recovery.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**104. .... be able to instruct clients and significant persons, through lectures, workshops, and discussions, so they understand the influence of substance use and biopsychosocial disorders on families and other relationships.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**105. .... have knowledge of the affect of psychoactive drugs on cognitive states.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**106. .... have skill in relating clients' self-help group (e.g., AA, NA) experience to group counseling experience.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**107. .... be able to discuss substance use and biopsychosocial disorders with other professionals in order to examine the role professionals can play in the prevention, treatment, and recovery processes.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[<< Prev](#)      [Next >>](#)

## Juvenile Court Counselor AOD Abuse Training Needs Assessment

### 12. Page Eleven

A Juvenile Court Counselor should....

(Two-thirds done now!!!)

**108. .... have knowledge of how the denial processes of client and family affect the family and society of the substance abuser.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**109. .... have skill in facilitating interventions (for example, with the client's family, employer, or others).**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**110. .... be able to describe factors that increase the likelihood that an individual, group, or community will be at risk for alcohol and other drug problems.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**111. .... have knowledge of stages of recovery from alcohol and other drug dependences.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**112. .... have knowledge of withdrawal symptoms.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**113. .... be able to sensitize others to such issues as cultural identity, ethnic**

**background, age, and gender role or identity in the prevention, treatment, and recovery processes.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**114. .... should have knowledge of the relationship between psychoactive substance use, biopsychosocial disorders, and social behavior and functioning.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**115. .... have knowledge of the value of an interdisciplinary approach to addiction treatment.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**116. .... have knowledge of self-help groups and their programs of recovery.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**117. .... be able to adhere to federal and state laws and agency regulations, regarding alcohol and other drug treatment.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[<< Prev](#)      [Next >>](#)

## Juvenile Court Counselor AOD Abuse Training Needs Assessment

### 13. Page Twelve

A Juvenile Court Counselor should....

**118. .... have knowledge of how internal factors (for example, expectation, coping skills, co-existing disorders) influence recovery and relapse processes.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**119. .... have skill in conducting an intake with a substance abuse client.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**120. .... have knowledge of cultural/lifestyle differences regarding attitudes and values about the use and abuse of alcohol/drugs.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**121. .... be continually informed of the current trends and developments in alcoholism, drug dependency, the counseling profession, and other related fields.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**122. .... have knowledge of how to "contract" as well as the therapeutic value of contracting, with a client.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**123. .... have knowledge of issues pertinent to specific populations (for example, ethnic minorities, women, youth, elderly, gay/lesbian/bisexual/transgender, physically impaired, etc.).**

260

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**124. .... be able to consult with staff of other agencies on their cases involving alcohol or drug-related problems.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**125. .... have knowledge of behavioral management of the substance-impaired person.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**126. .... be able to understand the importance of research and outcome data related to substance use disorder treatment, as well as the application of this data to clinical practice.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**127. .... have skill in developing and writing a recovery plan.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[<< Prev](#)      [Next >>](#)

## Juvenile Court Counselor AOD Abuse Training Needs Assessment

### 14. Page Thirteen

A Juvenile Court Counselor should....

(Just a couple of more pages)

**128. .... be able to understand the established diagnostic criteria for substance dependence and abuse, as well as describe the treatment modalities and placement criteria based upon continuum of care model.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**129. .... have knowledge of both the incidence and prevalence of HIV/AIDS and sexually transmitted diseases as well as the relationship of these illnesses with substance abuse disorders.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**130. .... have knowledge of concepts of prevention, community education, and community outreach regarding substance abuse.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**131. .... be able to be familiar with medical and pharmaceutical resources in the treatment of addictive disease and other substance related disorders.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**132. .... be able to understand the substance use patterns of diverse racial and ethnic cultures.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**133. .... have knowledge of roles of informal support systems on encouraging and/or inhibiting alcohol/drug use.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**134. .... be able to understand the addiction professional's obligation to adhere to generally accepted ethical and behavioral standards of conduct in the helping relationship.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**135. .... have knowledge of intoxication, withdrawal and long-term physical effects of substance use disorders.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**136. .... have knowledge of the relationship of Alcoholics Anonymous 12 Steps and 12 Traditions and the recovery processes.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**137. .... be able to understand the obligation of the addiction professional to engage in prevention as well as treatment.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[<< Prev](#)      [Next >>](#)

## Juvenile Court Counselor AOD Abuse Training Needs Assessment

### 15. Page Fourteen

A Juvenile Court Counselor should....

**138. .... have knowledge of any physical illness that may be mistaken for symptoms of substance use.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**139. .... have knowledge of the dynamics of resistance to the treatment and recovery processes.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**140. .... have knowledge of the nature and extent of alcoholism/drug dependency among the target population.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**141. .... have knowledge of the information needed to complete the intake interview (for example, use of alcohol and other drugs of abuse, educational background, cultural information, socioeconomic information, lifestyle information, living situation, medical information, treatment history, demographic information, legal status, other relevant data, normal ranges of vital signs).**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**142. .... be able to facilitate client exploration about the consequences of substance abuse.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**143. .... have knowledge of the effects of alcoholism/drug dependency and recovery on family members/significant others.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**144. .... have knowledge of client skills that encourage recovery-oriented behavior.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**145. .... be able to facilitate the client's engagement in the treatment/recovery process.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**146. .... be able to interpret and apply information from current counseling and alcohol and other drug research literature in order to improve client care and enhance professional growth.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**147. .... have knowledge of contemporary issues and events relevant to alcoholism/drug dependency (for example, legislative and public policy issues).**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[<< Prev](#)      [Next >>](#)

## Juvenile Court Counselor AOD Abuse Training Needs Assessment

### 16. Page Fifteen

A Juvenile Court Counselor should....

THIS IS IT!!!!!!!!!!!! LAST PAGE!!!!!!!!!!

**148. .... have knowledge in substance use disorder assessment instruments, to include their limitations and strengths.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**149. .... have knowledge in the dynamics of relapse.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**150. .... have skill in identifying withdrawal effects.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**151. .... have knowledge of alcohol and drug abuse withdrawal signs and symptoms.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**152. .... have knowledge of the continuum of care for alcoholism/drug dependency treatment.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**153. .... have knowledge of the signs and symptoms of mental health disorders (as indicated by currently accepted diagnostic criteria) identify how they relate to** 266

**substance abuse, and recognize the implications of this relationship for treatment and referral.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**154. .... have knowledge of the recovery and relapse process.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**155. .... have knowledge of assessment techniques and instruments related to substance use.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**156. .... have knowledge of counselor codependency and other conditions that impair counselor effectiveness.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**157. .... have skill in assessing the client's willingness to participate in, and prior history with, self-help groups.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**158. .... be able to help the client identify the role of substance abuse in his/her current life problems.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**159. .... have knowledge of how the client's denial process can lead to**

267

**manipulation of health care professionals.**

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Answer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[<< Prev](#)

[Next >>](#)

## Juvenile Court Counselor AOD Abuse Training Needs Assessment

### 17. You are done!!!!!!!!!!

I would like to thank you for your participation in my survey. If you have any c  
Joseph Jordan, at 336-509-5720, or my dissertation chair, Dr. Craig Cashwell c  
Development Department, School of Education, University of North Carolina at  
Our respective emails are [jjordan@uncg.edu](mailto:jjordan@uncg.edu) and [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu) , if you  
either one of us. Again, thank you for your willingness to participate in this pro

[<< Prev](#)      [Done >>](#)

## Appendix J

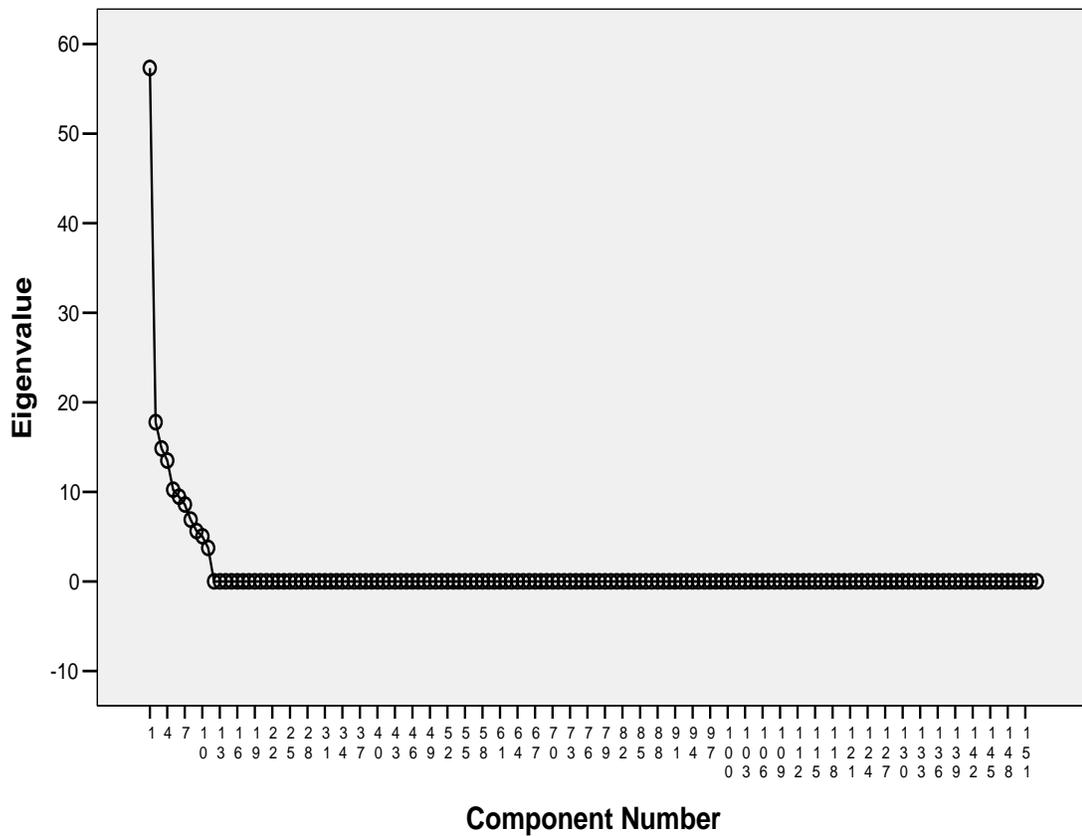
PCA Factor Analysis, Eigenvalue Scree Plot, Varimax Rotation

### PCA Factor Analysis - Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	54.38	35.54	35.54	54.38	35.54	35.54	43.97	28.74	28.74
2	17.74	11.60	47.13	17.74	11.59	47.13	23.71	15.50	44.24
3	14.76	9.65	56.78	14.76	9.65	56.78	17.98	11.75	55.99
4	13.04	8.52	65.31	13.04	8.52	65.31	14.26	9.32	65.31

Extraction Method: Principal Component Analysis.

### Scree Plot



**Rotated Component Matrix(a)**

	Component			
	1	2	3	4
V63	<b>.922</b>			
V7	<b>.916</b>		-.245	
V54	<b>.902</b>			
V16	<b>.889</b>			
V62	<b>.856</b>			
V13	<b>.853</b>		-.348	
V35	<b>.851</b>			
V87	<b>.838</b>	.346		.349
V64	<b>.838</b>			
V84	<b>.838</b>			
V14	<b>.838</b>		.269	
V105	<b>.828</b>			.211
V21	<b>.812</b>			
V65	<b>.810</b>		.487	
V10	<b>.809</b>			
V39	<b>.799</b>	.333	-.328	.342
V47	<b>.799</b>	.322		.375
V29	<b>.798</b>	.335		.328
V114	<b>.787</b>	.303	-.219	.267
V80	<b>.787</b>		.309	
V101	<b>.787</b>			-.306
V77	<b>.785</b>	.392	-.347	
V110	<b>.776</b>			
V20	<b>.775</b>	.367		-.396
V103	<b>.774</b>	.381	.276	.286
V11	<b>.773</b>	.338		.228
V53	<b>.763</b>	.368		.240
V97	<b>.757</b>		.363	
V108	<b>.753</b>	.443		-.305
V38	<b>.738</b>	.308	.390	.254
V94	<b>.735</b>			.233
V69	<b>.730</b>	.452	-.261	
V68	<b>.721</b>			-.210
V25	<b>.719</b>	.267		-.205
V34	<b>.719</b>	.407	-.218	.262
V19	<b>.710</b>	.370		
V111	<b>.708</b>	.554		.289
V78	<b>.705</b>	.478		.473
V44	<b>.702</b>	.469	-.311	.206

V70	<b>.693</b>	.367	-.299	.398
V112	<b>.691</b>	.407		
V18	<b>.690</b>	.337		-.415
V115	<b>.689</b>	.420		
V37	<b>.676</b>	.286	.332	.372
V85	<b>.667</b>	.311	.478	
V67	<b>.665</b>	.437	.314	.369
V98	<b>.663</b>		.212	
V48	<b>.663</b>	.550		.240
V81	<b>.662</b>			.225
V109	<b>.661</b>			
V93	<b>.660</b>			.593
V24	<b>.653</b>	.362		-.221
V12	<b>.648</b>	.378		.426
V8	<b>.646</b>			
V56	<b>.641</b>	.416	.238	.275
V159	<b>.639</b>	.582		
V126	<b>-.636</b>	.353		.229
V91	<b>.627</b>	.494		
V107	<b>.626</b>			
V59	<b>.613</b>	-.546		
V15	<b>.613</b>		.465	
V158	<b>.612</b>		.257	.424
V9	<b>.609</b>	.277	-.292	.358
V55	<b>.606</b>		.284	.355
V52	<b>.592</b>	.349	.453	-.258
V95	<b>.572</b>	-.266		.340
V17	<b>.523</b>			
V28	<b>.517</b>	.228		.215
V106	<b>.513</b>			
V143	<b>.512</b>	.457		-.251
V23	<b>.499</b>	.468		
V99	<b>.477</b>	-.332	.333	.395
V82	<b>.452</b>	-.442		.390
V83	<b>.376</b>	.370		
V133	<b>-.352</b>		.287	.214
V32	.389	<b>.870</b>		
V132		<b>.865</b>		
V125		<b>.846</b>		.249
V139		<b>.802</b>	.319	
V150		<b>.802</b>	-.285	
V138	.382	<b>.768</b>		
V131		<b>.760</b>		

V149		<b>.736</b>		.330
V151	.393	<b>.710</b>		
V128		<b>.708</b>		.552
V36	.456	<b>.693</b>		
V22	.580	<b>.690</b>		.238
V43	.335	<b>.688</b>		.260
V74		<b>.679</b>	.353	
V148		<b>.674</b>	.254	
V152	.468	<b>.667</b>		-.466
V102	.432	<b>.666</b>	.342	
V57	.475	<b>.660</b>	-.356	
V153	.478	<b>.640</b>	-.378	.362
V127		<b>.632</b>		-.470
V119	.314	<b>.622</b>	.352	.293
V155		<b>.577</b>	.266	
V88	.439	<b>.553</b>	.338	
V113	.503	<b>.534</b>	.363	
V33	.494	<b>.506</b>	.452	
V31	.325	<b>.504</b>	.401	-.255
V118	.455	<b>.491</b>	.348	-.298
V130	-.211	<b>.429</b>		.410
V135		<b>.352</b>	.255	-.229
V136		<b>.304</b>		
V117			<b>.831</b>	
V90	.398	-.262	<b>.767</b>	
V58		-.211	<b>.755</b>	
V122	.275		<b>.755</b>	
V120			<b>.753</b>	
V147			<b>.735</b>	
V100		.369	<b>.716</b>	
V134		.345	<b>.716</b>	
V46			<b>.709</b>	.370
V123			<b>.706</b>	
V73			<b>.671</b>	
V121			<b>.669</b>	
V142		-.238	<b>.662</b>	
V51	.325	.284	<b>.633</b>	
V75		.371	<b>.613</b>	
V49	.324	.311	<b>.566</b>	
V76	.519	.368	<b>.564</b>	
V156			<b>.557</b>	.308
V92		-.331	<b>.547</b>	.528
V116	-.244		<b>.543</b>	-.225

V140		.374	<b>.525</b>	.357
V72	.379	-.484	<b>.513</b>	.320
V42	.446		<b>.478</b>	.274
V157		-.372	<b>.474</b>	
V30		.348	<b>.472</b>	
V141	.424	.393	<b>.456</b>	-.291
V146	-.321		<b>.455</b>	.427
V45	.228	.270	<b>.383</b>	
V137	-.284	.343	<b>.367</b>	.352
V96			-.338	<b>.864</b>
V79		-.383		<b>.777</b>
V154		.296	-.210	<b>.688</b>
V104		.328		<b>-.677</b>
V86				<b>.643</b>
V144			-.235	<b>.637</b>
V27			-.420	<b>.594</b>
V89		.223	.201	<b>.589</b>
V124		.533	.331	<b>.563</b>
V60	.438			<b>.555</b>
V41		.242	.358	<b>.548</b>
V40	.507		-.291	<b>.543</b>
V71			.483	<b>.538</b>
V61	.475	-.350		<b>.494</b>
V129		.413	.245	<b>.488</b>
V50		.339		<b>.420</b>
V145			.308	<b>.376</b>
V66	.219		-.318	<b>.328</b>
V26				<b>-.301</b>

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

(a) Rotation converged in 6 iterations.

## Appendix K

### Listing of Items on Factors One Through Four

Factor One - *Basic AOD Abuse Knowledge and Skills* with Factor Loadings

63. An entry-level JCC should have knowledge of the effects of psychoactive and psychotropic drugs on affective (mood) states.	.922
7. An entry-level JCC should be able to describe the behavioral, physical health and social effects of psychoactive drugs, including alcohol and tobacco, on the consumer and significant others	.916
54. An entry-level JCC should have skill in interpreting results of substance abuse disorder assessment instruments and relating the information to clients.	.902
16. An entry-level JCC should have skill in determining a client's degree of understanding of alcohol and other drug dependencies	.889
62. An entry-level JCC should be able to describe, select, and use strategies from accepted and culturally appropriate models for group counseling with addicted or substance abusing clients.	.856
13. An entry-level JCC should have knowledge of the relationships between psychoactive substance use and other mental health disorders	.853
35. An entry-level JCC should have knowledge of value of periodic self-assessment to personal growth (e.g., career planning).	.851
87. An entry-level JCC should have knowledge of the pharmacology of alcohol and other psychoactive drugs and their interaction.	.838
64. An entry-level JCC should have knowledge of how to develop an individualized recovery plan that meets the unique needs of the client.	.838
84. An entry-level JCC should have knowledge of the effects of substance abuse and biopsychosocial disorder treatments in the community.	.838
14. An entry-level JCC should have skill in obtaining a client's family history of addictive disorders	.838
105. An entry-level JCC should have knowledge of the effect of psychoactive drugs on cognitive states.	.828
21. An entry-level JCC should be able to investigate halfway house alternatives.	.812
65. An entry-level JCC should be able to identify similarities and differences in participation in self-help group meetings and group counseling.	.810
10. An entry-level JCC should have knowledge of the potential for cross addiction i.e., addiction to both alcohol and tranquilizers.	.809
39. An entry-level JCC should have knowledge of phases of treatment and various client responses (for example, crisis, impasses, plateaus, resistance).	.799
47. An entry-level JCC should have knowledge of the correlation between substance use disorders and specific mental disorders such as mood disorders, anxiety disorders, and schizophrenia.	.799
29. An entry-level JCC should have skill in evaluating the severity of the client's alcoholism and other drug dependency	.798
114. An entry-level JCC should have knowledge of the value of an	.787

interdisciplinary approach to addiction treatment.	
80. An entry-level JCC should have knowledge of changes due to taking/not taking psychotropic medication.	.787
101. An entry-level JCC should be able to use current literature and research findings, deliver culturally relevant formal and informal education programs for clients and other significant persons to raise awareness of prevention, treatment, and recovery processes for substance use and biopsychosocial disorders.	.787
77. An entry-level JCC should have knowledge of behavior patterns and progressive stages of substance use disorders and biopsychosocial disorders	.785
110. An entry-level JCC should be able to describe factors that increase the likelihood that an individual, community, or group will be at risk for alcohol and other drug problems.	.776
20. An entry-level JCC should have skill in assessing the degree of client's understanding of his/her substance abuse/dependence	.775
103. An entry-level JCC should have skill in guiding the client through the developmental stages of recovery.	.774
11. An entry level JCC should be able to screen for alcohol and other drug toxicity, withdrawal symptoms, aggression or danger to others, and potential for self –inflicted harm or suicide	.773
53. An entry-level JCC should have skill in assessing the client's risk factors for relapse.	.763
97. An entry-level JCC should have skill in helping the client evaluate the impact of alcoholism and other drugs.	.757
108. An entry-level JCC should have knowledge of how the denial processes of client and family affect society and the family of the substance abuser.	.753
38. An entry-level JCC should be able to assist the client in obtaining a temporary sponsor in a 12-step group such as Alcoholics Anonymous or Narcotics Anonymous	.738
94. An entry-level JCC should have knowledge of legal consequences when client rights are violated as specifically related to substance abuse treatment regulations.	.735
69. An entry-level juvenile court counselor should have knowledge of the impact on substance use and specific substance induced mental disorders such as mood, anxiety, personality, and psychotic disorders.	.730
68. An entry-level JCC should be able to help families, couples, and intimate dyads adopt strategies and behaviors that sustain recovery and maintain healthy relationships.	.721
25. An entry-level JCC should be able to arrange aftercare Services, i.e., continuing care services for clients that complete treatment.	.719
34. An entry-level juvenile court counselor should have knowledge of	.719

relationships between psychoactive substance use and biopsychosocial disorders such as depression or anxiety.	
19. An entry-level JCC should have knowledge of relapse prevention theories and techniques	.710
111. An entry-level JCC should have knowledge of stages of recovery from alcohol and other drug dependences.	.708
78. An entry-level JCC should have skill in assessing and determining the severity of psychoactive substance abuse.	.705
44. An entry-level JCC should have knowledge adverse effects of combining various types of psychoactive drugs, as well as over the counter medication.	.702
70. An entry-level JCC should have knowledge of the effects of substance use disorders on the functioning of physiological systems (endocrine, immunity, sexual, skeletal, neurological, muscular, respiratory, circulatory, digestive).	.693
112. An entry-level JCC should have knowledge of withdrawal symptoms.	.691
18. An entry-level JCC should be able to monitor drug screenings and interpret test results	.690
115. An entry-level JCC should have knowledge of the value of an interdisciplinary approach to addiction treatment.	.689
37. An entry-level JCC should have knowledge of the relationship between psychoactive substance use, biopsychosocial disorders, and vocational development	.676
85. An entry-level JCC should have skill in accessing community resources to support recovery.	.667
67. An entry-level JCC should have skill in administration and interpretation of specific substance disorder assessment instruments.	.665
98. An entry-level JCC should be able to educate clients and significant/concerned others using appropriate methods and technology regarding the relationship between lifestyle choices and substance use in order that they understand the alternatives that are available.	.663
48. An entry-level JCC should be able to organize or facilitate an intervention using case examples.	.663
81. An entry-level JCC should have skill in recognizing new treatment needs of clients.	.662
109. An entry-level JCC should have skill in facilitating interventions (e.g., with the client's family, employer, or others).	.661
93. An entry-level JCC should have knowledge of the effect of psychoactive substances on nutrition	.660
24. An entry-level JCC should have knowledge of trends in street and designer drugs.	.653
12. An entry-level JCC should have knowledge of common patterns of family adaptation to substance abuse.	.648

8. An entry-level JCC should have knowledge of criteria for assessing substance use disorders and biopsychosocial (affects biology, psychology, and social aspects of the person) disorders.	.646
56. An entry-level JCC should have knowledge of administration and scoring procedures for substance abuse disorder instruments	.641
159. An entry-level JCC should have knowledge of how the client's denial process can lead to manipulation of health care professionals.	.639
126. An entry-level JCC should be able to understand the importance of research and outcome data related to substance use disorder treatment, as well as the application of this data to clinical practice	-.636
91. An entry-level juvenile court counselor should have knowledge of the pharmacology of addiction and cross addiction to alcohol and other drugs.	.627
107. An entry-level JCC should be able to discuss substance use and biopsychosocial disorders with other professionals in order to examine the role professionals can play in the prevention, treatment, and recovery process.	.626
59. An entry-level JCC should be able to provide counseling to individuals who are affected by their past or current association with alcoholic or drug dependent individuals.	.613
15. An entry-level JCC should be able to obtain a substance abuse history.	.613
158. An entry-level JCC should be able to help the client identify the role of substance abuse in his/her current life problems.	.612
9. An entry-level JCC should be able to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance related problems.	.609
55. An entry-level JCC should be able to understand terminology, procedures, and the roles of other disciplines related to the treatment of addiction	.606
52. An entry-level JCC should be able to facilitate the development of basic and life skills associated with recovery.	.592
95. An entry-level JCC should be able to design and provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and the recovery process.	.572
17. An entry-level JCC should have knowledge of pharmacokinetics, e.g., how long it takes a drug stays in the body.	.523
28. Have skill in evaluating the severity of a client's alcoholism or other drug dependency	.517
106. An entry-level JCC should have skill in relating self-help group (e.g., AA, NA) experience to group counseling experience	.513
143. An entry-level JCC should have knowledge of the signs and symptoms of mental health disorders (as indicated by currently accepted diagnostic criteria) identify how they relate to substance abuse, and recognize the	.512

implications of this relationship for treatment and referral.	
23. An entry-level JCC should knowledge of patterns and methods of misuse and abuse of prescribed and over the counter medications.	<b>.499</b>
99. An entry-level JCC should have knowledge of how external factors (i.e., peer influence and the community environment) encourage or discourage substance use, abuse, dependency, medication compliance, and recovery.	<b>.477</b>
82. An entry-level JCC should be able to inform significant others about and encourage participation in appropriate self help groups	<b>.452</b>
83. An entry-level JCC should have knowledge of drug interactions, including prescription drugs and over the counter drugs.	<b>.376</b>
133. An entry-level JCC should have knowledge of roles of informal support systems on encouraging and/or inhibiting alcohol/drug use.	<b>-.352</b>
32. An entry-level JCC should have knowledge of emergency procedures associated with overdose, acute withdrawal, and decompensation.	<b>.389</b>

Factor Two – *Assessment and Treatment of AOD Abuse* with Factor Loading

32. An entry-level JCC should have knowledge of emergency procedures associated with overdose, acute withdrawal, and decompensation.	.870
132. An entry-level juvenile court counselor should be able to understand the substance use patterns of diverse racial and ethnic cultures.	.865
125. An entry-level JCC should have knowledge of behavior management of the impaired person	.846
139. An entry-level JCC should have knowledge of the dynamics of resistance to treatment and the recovery process.	.802
150. An entry-level JCC should have skill in identifying withdrawal effects.	.802
138. An entry-level JCC should have knowledge of the physical illness that may be mistaken for symptoms of substance abuse.	.768
131. An entry-level JCC should be able to be familiar with medical and pharmaceutical resources in the treatment of addictive disease and other substance related disorders.	.760
149. An entry-level JCC should have knowledge of the dynamics of relapse.	.736
151. An entry-level JCC should have knowledge of alcohol and drug abuse withdrawal signs and symptoms.	.710
128. An entry-level JCC should be able to understand the established diagnostic criteria for substance dependence and abuse, and describe treatment modalities and placement criteria within the continuum of care.	.708
36. An entry-level JCC should be able to inform a client about the detoxification process	.693
22. An entry-level JCC should have knowledge of the relationship between symptoms and responsiveness to varying levels of care, such as inpatient treatment, outpatient treatment, or residential treatment.	.690
43. An entry-level JCC should have knowledge of the relationship between psychoactive substance use and valued, culture, lifestyle, age, gender, HIV status, sexual orientation, physically challenging conditions, and socioeconomic status.	.688
74. An entry-level JCC should have knowledge of the effects of substance use disorders on a specific community or population	.679
148. An entry-level JCC should have knowledge of substance use disorder instruments and their limitations and strengths.	.674
152. An entry-level JCC should have knowledge of the continuum of care for alcoholism/drug dependency treatment.	.667
102. An entry-level JCC should have knowledge of nutritional and recreational needs of the recovering person.	.666
57. An entry-level JCC should have knowledge of various counseling approaches relevant to assessment and treatment of substance use	.660

disorders.	
153. An entry-level JCC should have knowledge of the signs and symptoms of mental health disorders (as indicated by currently accepted diagnostic criteria) identify how they relate to substance abuse, and recognize the implications of this relationship for treatment and referral.	.640
127. An entry-level JCC should have skill in developing and writing a recovery plan	.632
119. An entry-level JCC should have skill in conducting an intake with a substance abuse client.	.622
155. An entry-level JCC should have knowledge of assessment techniques and instruments related to substance use.	.577
88. An entry-level JCC should have knowledge of how differences among clients (e.g., culture, ethnicity, race, gender, sexual orientation) may impact the progression of the treatment process.	.553
113. An entry-level JCC should be able to sensitize others to issues of cultural identity, ethnic background, age, and gender role or identity in prevention, treatment, and recovery.	.534
33. An entry-level JCC should be able to facilitate return to work conferences for clients returning from treatment.	.506
31. An entry-level JCC should have skill in applying principles of group dynamics when leading groups.	.504
118. An entry-level JCC should have knowledge of how internal factors (e.g., expectation, coping skills, co-existing disorders) influence recovery and relapse	.491
130. An entry-level JCC should be able to understand the established diagnostic criteria for substance dependence and abuse, as well as the treatment modalities and placement criteria based on the continuum of care model.	.429
135. An entry-level JCC should have knowledge of intoxication, withdrawal and long-term physical effects of substance use disorders.	.352
136. An entry-level JCC should have knowledge of the relationship of Alcoholics Anonymous 12 Steps and Traditions to the recovery process.	.304

Factor Three – *AOD Abuse Counseling Ethics/Obligations* with Factor Loadings

117. An entry-level JCC should be able to adhere to federal and state laws and agency regulations, regarding alcohol and other drug treatment.	.831
90. An entry-level JCC should have skill in developing linkages to a variety of self-help groups.	.767
58. An entry-level JCC should have knowledge of federal, state, and local statutes relating to the use of alcohol and drugs.	.755
122. An entry-level JCC should have knowledge of how to “contract”, as well as the therapeutic value of contracting, with a client.	.755
120. An entry-level JCC should have knowledge of cultural and lifestyle differences regarding attitudes and values about the use and abuse of alcohol/drugs.	.753
147. An entry-level JCC should have knowledge of contemporary issues and events relevant to alcoholism/drug dependency (e.g., legislative and public policy issues).	.735
100. An entry-level JCC should have knowledge of diagnostic laboratory results (e.g., blood lab, EEG, liver function).	.716
134. An entry-level JCC should be able to understand the addiction professional’s obligation to adhere to generally accepted ethical and behavioral standards of conduct in the helping relationship	.716
46. An entry-level JCC should have knowledge of ethical standards which apply to substance use disorder counseling.	.709
123. An entry-level JCC should have knowledge of issues specific to specific populations (e.g., ethnic minorities, women, youth, elderly, gays, physically impaired).	.706
73. An entry-level JCC should have knowledge of the importance of family, social networks, and community systems in the treatment and recovery process.	.671
121. An entry-level JCC should be able to continue to be informed about current trends and developments in alcoholism, drug dependency, the counseling profession, and related fields.	.669
142. An entry-level JCC should be able to facilitate client exploration about the consequences of substance abuse.	.662
51. An entry-level JCC should have knowledge of legal and regulatory restrictions affecting alcoholism/drug dependency treatment and counseling.	.633
75. An entry-level JCC should have knowledge of the effects of alcoholism and other drug dependencies on the clients relationship with self, others, and society.	.613
49. An entry-level JCC should have knowledge of credentialing and certification requirements.	.566
76. An entry-level JCC should be able to understand the characteristics	.564

and dynamics of families, couples, and intimate dyads affected by alcoholism.	
156. An entry-level JCC should have knowledge of counselor codependency and other conditions that impair counselor effectiveness.	.557
92. An entry-level JCC should be able to organize an intervention by involving family members or significant others affected by alcoholism/drug dependence of clients.	.547
116. An entry-level JCC should have knowledge of self-help groups and their programs of recovery.	.543
140. An entry-level JCC should have knowledge of the nature and extent of alcoholism/drug dependency among the target population.	.525
72. An entry-level JCC should be able to educate significant others about self-help groups.	.513
42. An entry-level JCC should have knowledge of confidentiality laws specific to substance abuse.	.478
157. An entry-level JCC should have skill in assessing the client's willingness to participate in and prior history with self-help groups.	.474
30. An entry-level JCC should be able to involve significant others in aftercare planning.	.472
141. An entry-level JCC should have knowledge of the information needed to complete the intake interview (e.g., use of alcohol and other drugs of abuse, educational background, cultural information, socioeconomic information, lifestyle information, living situation, medical information, treatment history, demographic information, legal status, other relevant data, normal ranges of vital signs).	.456
146. An entry-level JCC should be able to interpret and apply information from current counseling and alcohol and other drug research literature in order to improve client care and enhance professional growth.	.455
45. An entry-level juvenile court counselor should be able to make homework assignments that include participation in self-help groups.	.383
137. An entry-level JCC should be able to understand the obligation of the addiction professional to engage in prevention as well as treatment.	.367

Factor Four – *Knowledge of AOD Abuse Theories* with Factor Loadings

96. An entry-level JCC should have knowledge of substance use education and prevention models.	.864
79. An entry-level JCC should be able to counsel significant others concerning substance abuse	.777
154. An entry-level JCC should have knowledge of the recovery and relapse process.	.688
104. An entry-level JCC should be able to instruct clients and significant persons through lectures, workshops, and discussions so they understand the influence of substance use and biopsychosocial disorders on families and other relationships.	-.677
86. An entry-level JCC should be able to help significant others identify and understand their role(s) in the alcoholism/drug dependency system.	.643
144. An entry-level JCC should have knowledge of client skills that encourage recovery-oriented behavior.	.637
27. An entry-level JCC should have knowledge of current professional literature on substance use	.594
89. An entry-level JCC should be able to assist significant others (for example, spouses, life-partner, parents, employer) in identifying and understanding their attitudes and behavior in relation to alcoholism/drug dependency.	.589
124. An entry-level JCC should be able to consult with staff of other agencies on their cases involving alcohol or drug-related problems.	.563
60. An entry-level JCC should have knowledge of theories of alcoholism or other drug dependencies	.555
41. An entry-level JCC should be able to educate clients about self-help groups	.548
40.	.543
71. An entry-level JCC should have knowledge of the various philosophies and structure of self-help groups and support groups (i.e., AA, NA, Al-Anon, Nar-Anon).	.538
61. An entry-level JCC should have knowledge of the social, political, economic, and cultural context within which addiction and substance abuse exist, including risk and resiliency factors that characterize individuals and their living environments.	.494
129. An entry-level JCC should have knowledge of incidence and prevalence of HIV/AIDS and sexually transmitted diseases as well as the relationship of these illnesses with substance abuse disorders.	.488
50. An entry-level JCC should have knowledge of sources to secure information on current trends and developments in alcoholism and related fields (sources include professional associations, related groups, and trade journals).	.420

145. An entry-level JCC should be able to facilitate the client's engagement in the treatment/recovery process.	<b>.376</b>
66. An entry-level JCC should have knowledge of comprehensive assessment models related to substance abuse treatment.	<b>.328</b>
26. An entry-level JCC should have knowledge of current methods and technologies to present information in a culturally sensitive manner, e.g., using language appropriate to the audience..	<b>-.301</b>

## Appendix L

Group Statistics for Sex (V1), Ethnicity (V2), and Degree (V4)

Group Statistics: V1 and Factor Mean Scores

	V1	N	Mean	Standard Error	Std. Error Mean
Factor One Mean Scores	1	6	2.8933	.68820	.28096
	2	6	3.0510	.88139	.35983
Factor Two Mean Scores	1	6	3.1935	.51894	.21186
	2	6	3.0699	.91795	.37475
Factor Three Mean Scores	1	6	3.2244	.33743	.13775
	2	6	3.3462	.66795	.27269
Factor Four Mean Scores	1	6	3.0290	.35923	.14666
	2	6	3.3043	.38693	.15796

Group Statistics: V2 and Factor Mean Scores

	V2	N	Mean	Standard Error	Std. Error Mean
Factor One Mean Scores	1	3	3.3888	.52447	.30280
	2	9	2.8332	.79705	.26568
Factor Two Mean Scores	1	3	3.2151	.95384	.55070
	2	9	3.1039	.68539	.22846
Factor Three Mean Scores	1	3	3.4231	.64243	.37091
	2	9	3.2393	.49284	.16428
Factor Four Mean Scores	1	3	3.1739	.64927	.37486
	2	9	3.1643	.31185	.10395

Group Statistics: V4 and Factor Mean Scores

	V4	N	Mean	Standard Error	Std. Error Mean
Factor One Mean Scores	1	9	3.1788	.42926	.14309
	2	2	2.6857	1.62731	1.15068
Factor Two Mean Scores	1	9	3.1685	.54881	.18294
	2	2	2.7258	1.61950	1.14516
Factor Three Mean Scores	1	9	3.2350	.53205	.17735
	2	2	3.6154	.54393	.38462
Factor Four Mean Scores	1	9	3.1256	.37931	.12644
	2	2	3.5435	.15372	.10870

## Appendix M

### Pilot Study

T Test of Factor Mean Scores for Sex (V1), Ethnicity (V2), and Degree (V4)

T Test of Factor Mean Scores by Sex

		F	Sig.	t	df	Sig	Mean	Mean	Lower	Upper
Factor One Mean Score	Equal variances assumed	.299	.597	-.345	10	.737	-.15772	.45652	1.17492	.85948
	Equal variances not assumed			-.345	9.445	.737	-.15772	.45652	1.18309	.86764
Factor Two Mean Scores	Equal variances assumed	1.588	.236	.287	10	.780	.12366	.43049	-.83554	1.08285
	Equal variances not assumed			.287	7.9	.781	.12366	.43049	-.87125	1.11856
Factor Three Mean Scores	Equal variances assumed	2.732	.129	-.399	10	.699	-.12179	.30551	-.80251	.55892
	Equal variances not assumed			-.399	7.396	.701	-.12179	.30551	-.83644	.59285
Factor Four Mean Scores	Equal variances assumed	.143	.713	1.278	10	.230	.27536	.21555	-.75563	.20491
	Equal variances not assumed			1.278	9.945	.230	.27536	.2155	-.75599	.20527

T Test of Factor Mean Scores by Ethnicity

		F	Sig.	t	df	Sig.	Mean	Mean	Lower	Upper
Factor One Mean Score	Equal variances assumed	.648	.439	1.110	10	.293	.55560	.50033	-.55921	1.67041
	Equal variances not assumed			1.379	5.456	.222	.55560	.40284	-.45441	1.56560
Factor Two Mean Scores	Equal variances assumed	.264	.618	.223	10	.828	.11111	.49790	-.99827	1.22049
	Equal variances not assumed			.186	2.727	.865	.11111	.59621	- 1.89819	2.12041
Factor Three Mean Scores	Equal variances assumed	.164	.694	.524	10	.612	.18376	.35078	-.59783	.96535
	Equal variances not assumed			.453	2.834	.683	.18376	.40566	- 1.15098	1.51850
Factor Four Mean Scores	Equal variances assumed	3.879	.077	.036	10	.972	.00966	.26842	-.58841	.60773
	Equal variances not assumed			.025	2.316	.982	.00966	.38900	- 1.46320	1.48253

T Test of Factor Scale Mean Scores by Degree

		F	Sig.	t	df	Sig.	Mean	Mean	Lower	Upper
Factor One Mean Score	Equal variances assumed	24.367	.001	.932	9	.376	.49309	.52906	-.70373	1.68991
	Equal variances not assumed			.425	1.031	.742	.49309	1.15955	-13.22961	14.21579
Factor Two Mean Scores	Equal variances assumed	9.556	.013	.757	9	.468	.44265	.58455	-.87970	1.76500
	Equal variances not assumed			.382	1.052	.765	.44265	1.15968	-12.68897	13.57427
Factor Three Mean Scores	Equal variances assumed	.054	.822	-.912	9	.385	-.38034	.41697	-1.32358	.56290
	Equal variances not assumed			-.898	1.462	.492	-.38034	.42354	-3.02297	2.26228
Factor Four Mean Scores	Equal variances assumed	1.133	.315	-1.480	9	.173	-.41787	.28242	-1.05675	.22100
	Equal variances not assumed			-2.506	4.506	.059	-.41787	.16674	-.86102	.02527

## Appendix N

### Pilot Study

Correlations for Years of JCC Experience (V5) and Hours of

Substance Abuse Training since becoming a JCC (V6)

Correlations: V5 and V6 and Factor Scale Mean Scores

		V5	V6	Factor One	Factor Two	Factor Three	Factor Four
V5	Pearson Correlation	1	-.005	-.158	-.466	-.246	.151
	Sig. (2-tailed)		.987	.625	.126	.442	.639
	N	12	12	12	12	12	12
V6	Pearson Correlation	-.005	1	.378	.259	.184	.505
	Sig. (2-tailed)	.987		.226	.416	.567	.094
	N	12	12	12	12	12	12
Factor One Mean Scores	Pearson Correlation	-.158	.378	1	.607(*)	.374	.443
	Sig. (2-tailed)	.625	.226		.036	.231	.149
	N	12	12	12	12	12	12
Factor Two Mean Scores	Pearson Correlation	-.466	.259	.607(*)	1	.393	.433
	Sig. (2-tailed)	.126	.416	.036		.206	.160
	N	12	12	12	12	12	12
Factor Three Mean Scores	Pearson Correlation	-.246	.184	.374	.393	1	.409
	Sig. (2-tailed)	.442	.567	.231	.206		.186
	N	12	12	12	12	12	12
Factor Four Mean Scores	Pearson Correlation	.151	.505	.443	.433	.409	1
	Sig. (2-tailed)	.639	.094	.149	.160	.186	
	N	12	12	12	12	12	12

\* Correlation is significant at the 0.05 level (2-tailed).

## Appendix O

Copy of Survey Participation Email Sent to JCCs by  
Department of Juvenile Justice and Delinquency Prevention

AAs

This is the Survey that we discussed at the last Program Services Meeting. Please distribute it to your districts and encourage court counselor participation. District results will be tabulated and reported back to districts and administrators.

Thank you!

Judy

---

The Department of Juvenile Justice and Delinquency Prevention has authorized a study regarding the knowledge level and training needs of juvenile court counselors in relation to substance abuse issues/AOD (alcohol and other drugs) issues. Researchers obtained authorization after having their research proposal reviewed and approved by our agency Research Evaluation Committee per Departmental Policy.

( <http://www.juvjus.state.nc.us/about/policy/dept/index.html#research> )

Additionally, this project was reviewed and approved by the UNCG Institutional Review Board. These approvals guarantee the confidentiality of survey respondents' answers.

This study is part of a dissertation research project undertaken by Ph.D. candidate, Joe Jordan. Mr. Jordan has worked in the field of adolescent substance abuse since 1989 (17 years), and is on the certification/licensure board for substance abuse practitioners in North Carolina. Mr. Jordan has consulted and worked with juvenile offender cases in District 19B for last five years. The survey was piloted in District 19B.

In completing the survey, bear in mind the following:

- Your participation is critical to insure that court counselors are represented fully.

No one will know your answers, all results are confidential

- It should take between 25 and 35 minutes to complete the survey
- You can stop if you wish, but you have to return to the survey at the same

computer before the end of the day

- If you want a paper survey to fill out instead of using the Internet, contact the researcher via email or phone (see below)

- Survey results in a locked file for three years by the researcher, then will be destroyed

- Area Administrators and Chief Court Counselors will get a report of number of responses and aggregate results from district, but no identifying information

- The final report will be forwarded to DJJDP to use for internal training in Substance Abuse treatment if they wish
- Click on the Internet link below to go to the survey

You can click on the following link to go directly to the survey, or you can cut and paste it onto your Internet browser. By doing so, this indicates your having read this email and understanding your rights as they have been explained to you. Also, please keep a copy of this email for your records.

<http://www.surveymk.com/s.asp?u=146811289546>

If you have any questions regarding this study, please feel free to contact Mr. Jordan at (336) 854-1045 or [jpjordan@uncg.edu](mailto:jpjordan@uncg.edu) or his faculty advisor, Dr. Craig Cashwell at (336) 334-3427 or [cscashwe@uncg.edu](mailto:cscashwe@uncg.edu). Questions regarding the rights of research participants may be directed to the UNCG Institutional Review Board at (336) 334-5878, or if you wish to ask someone directly about the rights of research participants, you may contact Dr. Beverly Maddox-Britt of the UNCG Institutional Review Board at 336-334-5878. If you have questions regarding DJJDP's authorization of this study or the agency policy on research projects, you may contact Stan Clarkson at 919-733-3388 ext 295 or [stan.clarkson@ncmail.net](mailto:stan.clarkson@ncmail.net).

**SURVEY IS TO BE COMPLETED BY: MARCH 18, 2006**

## Appendix P

### Important Items Not Loading on Any Identified Factor

Item	<u>M</u>	SD	SE	Range
42 ...have knowledge of confidentiality laws specific to substance abuse.	4.05	0.72	0.05	4
58 ...have knowledge of federal, state, and local statues relating to the use of alcohol and drugs	4.02	0.81	0.06	4
73 ...have knowledge of the importance of family, social networks, and community systems in the treatment and recovery process	3.83	0.74	0.05	4
30 .....be able to involve significant others in aftercare planning	3.79	0.79	0.05	4
55 .....be able to understand terminology, procedures, and the roles of other disciplines related to the treatment of addiction	3.77	0.80	0.06	4
75 ...have knowledge of the effects of alcoholism and other drug dependencies on the clients relationship with self, others, and society.	3.77	0.79	0.05	4
27 ...have knowledge of current methods and technologies to present information in a culturally sensitive manner, for example, using language appropriate to the audience.	3.76	0.94	0.06	4
41 .....be able to educate clients about self-help groups	3.71	0.76	0.05	4
94 ...have knowledge of legal consequences when client rights are violated as specifically related to substance abuse treatment regulations.	3.71	0.94	0.06	4
17 ...have skill in determining a client's degree of understanding of alcohol and other drug dependencies	3.69	0.82	0.06	4
158 .....be able to help the client identify the role of substance abuse in his/her current life problems	3.69	0.91	0.06	4
82 ...be able to inform significant others about and encourage participation in appropriate self help groups	3.66	0.84	0.06	4
12 ...be able to screen for alcohol and other drug toxicity, withdrawal symptoms, aggression, or danger to others, and potential for self-inflicted harm or suicide.	3.63	1.02	0.07	4
76 .....be able to understand the characteristics and dynamics of families, couples, and intimate dyads affected by alcoholism.	3.63	0.81	0.06	4
23 ...have knowledge of the relationship between	3.59	0.90	0.06	4

	symptoms and responsiveness to varying levels of care, such as inpatient treatment, outpatient treatment, or residential treatment				
35	...have knowledge of value of periodic self-assessment to personal growth (e.g., career planning).	3.59	0.89	0.06	4
43	...have knowledge of the relationship between psychoactive substance use and values, culture, lifestyle, age, gender, HIV status, sexual orientation, physically challenging conditions, and socioeconomic status.	3.59	0.92	0.06	4
21	...have skill in assessing the degree of client's understanding of his/her substance abuse/dependence.	3.57	0.88	0.06	4
96	...have knowledge of substance use education and prevention models.	3.57	0.91	0.06	4
32	...have knowledge of emergency procedures associated with overdose, acute withdrawal, and decompensation	3.56	1.00	0.07	4
63	...have knowledge of the effects of psychoactive and psychotropic drugs on affective (mood) states.	3.55	0.92	0.06	4
26	...be able to arrange aftercare services, that is, continuing care services for clients that complete treatment	3.54	1.05	0.07	4
20	...have knowledge of relapse prevention theories and techniques	3.53	0.88	0.06	4
90	...have skill in developing linkages to a variety of self-help groups	3.53	0.89	0.06	4
97	...have skill in helping the client evaluate the impact of alcoholism and other drugs	3.53	0.97	0.07	4
46	...have knowledge of ethical standards which apply to substance use disorder counseling.	3.5	0.93	0.06	4
69	...have knowledge of the impact on substance use and specific substance induced mental disorders such as mood, anxiety, personality, and psychotic disorders.	3.5	0.97	0.07	4
88	...have knowledge of how difference among clients (for example, culture, ethnicity, race, gender, sexual orientation) may impact the progression of the treatment process.	3.49	0.94	0.06	4
81	...have skill in recognizing new treatment needs of clients.	3.47	1.04	0.07	4
152	...have knowledge of the continuum of care for alcoholism/drug dependency treatment.	3.47	0.88	0.06	4
47	...have knowledge of the correlation between substance use disorders and specific mental disorders such as mood disorders, anxiety disorders, and	3.45	0.99	0.07	4

	schizophrenia				
139	...have knowledge of the dynamics of resistance to treatment and the recovery process	3.45	0.91	0.06	4
51	...have knowledge of legal and regulatory restrictions affecting alcoholism/drug dependency treatment and counseling.	3.4	0.94	0.06	4
77	...have knowledge of behavior patterns and progressive stages of substance use disorders and biopsychosocial disorders	3.4	0.92	0.06	4
111	...have knowledge of stages of recovery from alcohol and other drug dependences	3.4	0.95	0.07	4
57	...have knowledge of various counseling approaches relevant to assessment and treatment of substance use disorders.	3.38	1.01	0.07	4
72	...be able to educate significant others about self-help groups	3.38	0.90	0.06	4
86	...be able to help significant others identify and understand their role(s) in the alcoholism/drug dependency system.	3.38	1.00	0.07	4
137	...be able to understand the obligation of the addiction professional to engage in prevention as well as treatment.	3.38	0.93	0.06	4
149	...have knowledge of the dynamics of relapse	3.38	0.91	0.06	4
61	...have knowledge of the social, political, economic, and cultural context within which addiction and substance abuse exist, including risk and resiliency factors that characterize individuals and their living environments.	3.36	0.93	0.06	4
157	...have skill in assessing the client's willingness to participate in and prior history with self-help groups	3.34	0.96	0.07	4
34	...have knowledge of relationships between psychoactive substance use and biopsychosocial disorders such as depression or anxiety.	3.33	0.97	0.07	4
50	...have knowledge of sources to secure information on current trends and developments in alcoholism and related fields (sources include professional associations, related groups, and trade journals).	3.32	0.96	0.07	4
156	...have knowledge of counselor codependency and other conditions that impair counselor effectiveness.	3.31	0.97	0.07	4
31	...have skill in applying principles of group dynamics when leading groups	3.29	1.01	0.07	4
84	...have knowledge of the effects of substance abuse and biopsychosocial disorder treatments in the community.	3.29	0.92	0.06	4

136	...have knowledge of the relationship of Alcoholics Anonymous 12 Steps and Traditions to the recovery process.	3.29	0.91	0.06	4
60	...have knowledge of theories of alcoholism or other drug dependencies	3.27	0.98	0.07	4
105	...have knowledge of the effect of psychoactive drugs on cognitive states	3.25	1.01	0.07	4
113	...be able to sensitize others to issues of cultural identity, ethnic background, age, and gender role or identity in prevention, treatment, and recovery.	3.25	0.95	0.07	4
114	...have knowledge of the relationship between psychoactive substance use, biopsychosocial disorders, and social behavior and functioning.	3.25	0.94	0.06	4
145	...be able to facilitate the client's engagement in the treatment/recovery process.	3.25	1.01	0.07	4
9	...have knowledge of criteria for assessing substance use disorders and biopsychosocial (affects biology, psychology, and social aspects of the person) disorders.	3.24	1.08	0.07	4
36	...be able to inform a client about the detoxification process	3.24	1.00	0.07	4
40	...have knowledge of phases of treatment and various client responses (e.g., crisis, impasses, plateaus, resistance).	3.22	1.03	0.07	4
89	...be able to assist significant others (for example, spouses, life-partner, parents, employer) in identifying and understanding their attitudes and behavior in relation to alcoholism/drug dependency.	3.22	0.98	0.07	4
98	...be able to educate clients and significant/concerned others using appropriate methods and technology regarding the relationship between lifestyle choices and substance use in order that they understand the alternatives that are available.	3.21	1.05	0.07	4
115	...have knowledge of the value of an interdisciplinary approach to addiction treatment.	3.21	0.98	0.07	4
37	...have knowledge of the relationship between psychoactive substance use, biopsychosocial disorders, and vocational development	3.19	0.94	0.06	4
119	...have skill in conducting an intake with a substance abuse client.	3.19	1.17	0.08	4
22	...be able to investigate halfway house alternatives.	3.16	0.95	0.07	4
155	...have knowledge of assessment techniques and instruments related to substance use.	3.14	0.99	0.07	4
79	...be able to counsel significant others concerning	3.12	1.11	0.08	4

	substance abuse				
39	...have knowledge of the relationship between psychoactive substance use, biopsychosocial disorders, and relationships with other concerned persons	3.11	0.97	0.07	4
70	...have knowledge of the effects of substance use disorders on the functioning of physiological systems (endocrine, immunity, sexual, skeletal, neurological, muscular, respiratory, circulatory, digestive).	3.1	1.02	0.07	4
131	.....be able to be familiar with medical and pharmaceutical resources in the treatment of addictive disease and other substance related disorders.	3.1	1.02	0.07	4
148	...have knowledge of substance use disorder instruments and their limitations and strengths.	3.09	1.03	0.07	4
10	...be able to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance related problems.	3.08	1.06	0.07	4
146	...be able to interpret and apply information from current counseling and AOD research literature in order to improve client care and enhance professional growth.	3.08	0.99	0.07	4
52	...be able to facilitate the development of basic and life skills associated with recovery	3.07	1.00	0.07	4
59	...be able to provide counseling to individuals who are affected by their past or current association with alcoholic or drug dependent individuals.	3.06	1.13	0.08	4
91	...have knowledge of the pharmacology of addiction and cross addiction to alcohol and other drugs	3.05	1.00	0.07	4
122	...have knowledge of how to “contract”, as well as the therapeutic value of contracting, with a client.	3.04	1.05	0.07	4
87	...have knowledge of the pharmacology of alcohol and other psychoactive drugs and their interaction.	3.03	0.98	0.07	4
93	...have knowledge of the effect of psychoactive substances on nutrition	3.03	0.94	0.07	4
126	...be able to understand the importance of research and outcome data related to substance use disorder treatment, as well as the application of this data to clinical practice	3.02	0.95	0.07	4
102	...have knowledge of nutritional and recreational needs of the recovering person.	3.01	0.95	0.07	4
56	...have knowledge of administration and scoring procedures for substance abuse disorder instruments	2.97	1.07	0.07	4

38	...be able to assist the client in obtaining a temporary sponsor in a 12-step group such as Alcoholics Anonymous or Narcotics Anonymous	2.91	1.07	0.07	4
66	...have knowledge of comprehensive assessment models related to substance abuse treatment	2.88	1.02	0.07	4
103	...have skill in guiding the client through the developmental stages of recovery	2.84	1.03	0.07	4
33	...be able to facilitate return to work conferences for clients returning from treatment.	2.74	0.97	0.07	4