



## Brief articles

## Phone-delivered brief motivational interventions for mandated college students delivered during the summer months

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## ABSTRACT

**Objective:** Across the United States, tens of thousands of college students are mandated to receive an alcohol intervention following an alcohol policy violation. Telephone interventions may be an efficient method to provide mandated students with an intervention, especially when they are away from campus during summer vacation. However, little is known about the utility of telephone-delivered brief motivational interventions. **Method:** Participants in the study ( $N = 57$ ) were college students mandated to attend an alcohol program following a campus-based alcohol citation. Participants were randomized to a brief motivational phone intervention (pBMI) ( $n = 36$ ) or assessment only ( $n = 21$ ). Ten participants (27.8%) randomized to the pBMI did not complete the intervention. Follow-up assessments were conducted 3, 6, and 9 months post-intervention. **Results:** Results indicated the pBMI significantly reduced the number of alcohol-related problems compared to the assessment-only group. Participants who did not complete the pBMI appeared to be lighter drinkers at baseline and randomization, suggesting the presence of alternate influences on alcohol-related problems. **Conclusion:** Phone BMIs may be an efficient and cost-effective method to reduce harms associated with alcohol use by heavy-drinking mandated students during the summer months.

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### 1. Introduction

Tens of thousands of college students receive alcohol violations for violating campus policy for diverse offenses, include possession of alcohol, being in the presence of alcohol, behavioral problems while intoxicated, and alcohol-related medical complications (see Barnett et al., 2008). Students who are found to violate the campus's alcohol policy are regularly mandated to complete either public service or an alcohol intervention (Wechsler et al., 2002). Brief Motivational Interventions (BMIs) are currently the standard individual intervention supported by empirical research (Cronce & Larimer, 2011). BMIs are commonly delivered in 1 to 2 individual meetings (one-on-one), are approximately 50 minutes long (Carey, Scott-Sheldon, Carey, & DeMartini, 2007), and use a motivational interviewing approach (e.g., Miller & Rollnick, 2012) to reduce heavy drinking.

Although BMIs delivered on campus can effectively reduce drinking (e.g., Carey, Henson, Carey, & Maisto, 2009) and alcohol-related problems (e.g., Borsari & Carey, 2005) in mandated college students, summer months pose a specific challenge to continuity of care as most students leave campus for 3 to 5 months. However, surprisingly little research has been conducted regarding drinking during the summer months, and there is little information regarding how these mandated cases are handled at the end of the school year. Motivational interventions delivered via the telephone have been used to address substance use and other risky behaviors in a variety of populations (Walker, Roffman, Picciano, & Stephens, 2007). Furthermore, telephone interventions have been demonstrated to reduce drinking in adults as a "step down" treatment following intervention (e.g., McKay, Lynch, Shepard, & Pettinati, 2005) or as a component of stepped care (e.g., Bischof et al., 2008). Of course, Web interventions that incorporate personalized feedback and harm reduction strategies have shown some promise with mandated college students (Doumas, Workman, Smith, & Navarro, 2011), and could also be of utility during the summer months. That said, interventions incorporating some degree of therapist contact (whether face-to-face or via telephone) have been linked to larger

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and more sustained reductions in drug and alcohol abuse than computerized or Web-based treatments (Newman, Szkodny, Llera, & Przeworski, 2011). A recent meta-analysis demonstrated a similar pattern with college students; namely, that in-person BMIs were superior to Web- or computer-delivered interventions in facilitating long-term reductions in alcohol use (Carey, Carey, Maisto, & Henson, 2006). Therefore, telephone interventions may represent an ideal blend of convenience and personal communication. To our knowledge, no study has implemented a telephone-administered BMI with college students reporting heavy drinking and alcohol-related consequences.

This study examined a subset of data from a larger trial implementing stepped care with mandated college students (Borsari et al., 2012). The occurrence of alcohol violations occurring late in the school year provided the opportunity to evaluate the efficacy of a phone BMI (pBMI) delivered during the summer months. All participants had received a brief advice session addressing their alcohol use before departing campus, yet continued to report risky drinking 6 weeks after this session. We hypothesized that individuals receiving the pBMI during the summer would reduce their drinking and alcohol-related problems significantly more than individuals receiving assessment only.

## 2. Materials and Methods

### 2.1. Design

The data used in this study was from a larger trial implementing stepped care with mandated college students at a 4-year, private liberal arts university in the northeast US (see Borsari et al., 2012 for description). There were two steps of intervention. First, following completion of the baseline assessment, all participants initially received a 15-minute brief advice (BA) session (step 1). Six weeks following this session, participants completed an assessment via the Internet. Participants who reported continued risky alcohol use (defined as 4 or more heavy drinking episodes and/or reporting 5 or more alcohol-related problems in the past month) during the 6-week assessment were randomized to (a) step 2 intervention, a 60-minute or less pBMI or (b) an assessment only control condition (AO). Urn randomization (Stout, Wirtz, Carbonari, & Del Boca, 1994), using gender and race as blocking variables, was used to randomly assign participants to condition. Participants completed 3-, 6- and 9-month follow-ups via Web assessment.

### 2.2. Participants

Participants ( $N = 57$ ) were undergraduate students age 18 years and older who violated campus alcohol policy within 6 weeks of the end of the spring semester. As a result of the timing of their offense, they received a BA session but completed their 6 week assessment during the summer and therefore were not able to receive an in-person BMI in step 2. This situation provided us with an opportunity to evaluate the efficacy of a phone BMI in this subgroup of participants. Participants provided informed consent and the university institutional review board of Brown University and the study site approved all procedures.

#### 2.2.1. Recruitment

Recruitment took place from April to May throughout the duration of the parent trial (2005–2009). Because the follow-up assessments were completed using Web-based surveys, all potential participants were provided detailed information regarding procedures implemented to protect the security of their responses. Students who declined to participate in the project received treatment as usual from the OHW; this treatment consisted of a 15–30 minute individual discussion of their referral incident and alcohol use. Students were also informed that they might be asked to receive a second

intervention addressing alcohol use and problems over the summer months. Students were told that they would receive \$15 for the baseline assessment, \$40 for the 6-week assessment, and \$25, \$35 and \$60 for the 3-, 6- and 9-month assessments, respectively.

### 2.3. Measures

Participants provided demographic information regarding their gender, age, weight, year in school, and race/ethnicity. Alcohol use outcome variables were obtained using the Alcohol and Drug Use Measure (Borsari & Carey, 2005). Frequency of heavy episodic drinking (HED) was obtained using a gender-specific question that asked participants to report the number of times they consumed 5 or more drinks for males (4+ for females) in one sitting in the past month. This measure also recorded the number of drinks consumed during a typical and peak episode (i.e., the maximum number of drinks), as well as the amount of time spent drinking for each of those episodes to calculate the students' estimated typical and peak blood alcohol concentration (pBAC). Alcohol-related consequences were assessed using the Brief-YAACQ (B-YAACQ; Kahler, Strong, & Read, 2005). The B-YAACQ was used as an outcome variable as this measure has been found to be reliable and sensitive to changes in alcohol use over time (Kahler, Hustad, Barnett, Strong, & Borsari, 2008). The B-YAACQ demonstrated high internal consistency in this sample ( $\alpha = .89$ ). Regarding recidivism, participants were asked how many times they had been mandated for another alcohol violation since the last assessment.

### 2.4. Interventions

#### 2.4.1. Brief Advice

The manualized brief advice was administered by peer counselors (fellow undergraduate students). The counselor training focused on becoming familiar with the didactic information and basic MI strategies (e.g., asking open-ended questions, avoiding confrontation and labeling students). All brief advice sessions were audio recorded and reviewed by one of the first four authors. Peer counselors received on-going, individual feedback on their intervention delivery skills to ensure adherence. Peer counselors facilitated discussion of the events leading to the referral incident and any changes the student had made to his or her drinking as a result. The participant was then provided with a 12-page educational booklet that addressed definitions of risky drinking, common alcohol-related problems, and ways to reduce or stop drinking (adapted from Cunningham, Wild, Bondy, & Lin, 2001). The average time to complete the brief advice was 15.23 minutes ( $SD = 4.06$ ).

#### 2.4.2. Phone Brief Motivational Intervention (pBMI)

This pBMI contained the same content and feedback as the in-person BMI sessions that have significantly reduced alcohol use and problems with mandated and non-mandated students in other trials (Borsari & Carey, 2000, 2005; Borsari, O'Leary Tevyaw, Barnett, Kahler, & Monti, 2007; Carey, Carey, Henson, Maisto, & DeMartini, 2012; Carey et al., 2006; Carey et al., 2009; Hustad et al., in press). The only difference between the BMI delivered in the parent trial and the pBMI was the mode of delivery. The pBMIs were delivered by three master's-level and doctoral-level professional clinicians. For the pBMI, a password protected personalized feedback report was emailed to the participant the day of the scheduled pBMI session. The participants were required to have access to the feedback form during the call, as well as take the call in a private, quiet, and safe location (e.g., not while driving). During the call, the interventionists used motivational interviewing skills while reviewing topics of the feedback form, including normative quantity/frequency of drinking, BAC and tolerance, alcohol-related consequences, influence of setting on drinking, and alcohol expectancies. The pBMI lasted between 35–45 minutes. The pBMI sessions were not audio-recorded.

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