LITERATURE REVIEW
ON
ALCOHOL SCREENING AND BRIEF INTERVENTION
AND
STUDENT ASSISTANCE TEAMS
FOR
PARTNERSHIP FOR CHANGE COALITION

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Purpose

This report is a literature review of peer reviewed articles on Alcohol Screening and Brief Intervention and Student Assistance Teams. The purpose of the report is to identify best practices that can be applied to the Partnership for Change Coalition’s Strategic Prevention Framework State Incentive Grant’s (SPF-SIG) goal of establishing or supporting school pre-assessment teams in the Coalition’s partner schools.

Part 1: A Literature Review of Alcohol Screening and Brief Intervention

Introduction

This literature review used ten “peer reviewed” articles and five additional articles on the subject of Alcohol Screening and Brief Intervention (ASBI). The peer reviewed articles ranged from August 2011 to May 2000. In the course of the literature review it was discovered that the subject of ASBI also includes other forms of alcohol/drug screening and intervention models including Brief Intervention (BI), Screening and Brief Intervention (SBI) and Screening, Brief Intervention and Referral to Treatment (SBIRT). This review will include evidence found in the studies of all forms of screening and brief intervention, the process of screening and brief intervention, as well as the positive outcomes and some of the limitations discovered. This review will not cover all of the negative outcomes for ASBI or all of the research methodologies used in the studies in the articles reviewed.

The current trend for Alcohol Screening and Brief Intervention utilizes a combination of screening methods and intervention strategies. This review will discuss the research reviewed on the models of screening and brief intervention in a variety of settings. While ASBI is primarily done in primary health care settings with adult populations, there is growing evidence that this model can be used effectively in a variety of settings, including schools and among the adolescent population.

It is important that this topic be reviewed and applied to adolescents because of the growing body of proof that substance abuse, particularly alcohol abuse, is a problem for youth today. The 2009 Youth Risk Behavior Survey (YRBS) identified that 72.5% of high school
students have had at least one drink and 24.2% have engaged in binge drinking 30 days prior to the survey administration. By eighth grade, 39% of students have tried alcohol. In addition, the YRBS showed that adolescents who use alcohol are at risk for related negative consequences including impaired learning, lifetime alcohol abuse or dependence, early pregnancy, and being a victim of violence or engaging in violent or illegal behavior.

Background

The articles reviewed covered studies that were conducted across a large spectrum of settings and populations in which ASBI, BI, SBI or SBIRT was implemented. In addition, the studies included the United States, as well as other countries. Three of the articles related directly to adolescents, one to college students, and the rest to diverse adult populations. The articles were primarily separated into the categories of background of the study, measures used, and outcomes or findings. While most of the studies strictly involved alcohol use, three of the studies also addressed other drug use along with alcohol use.

Throughout all the articles that this literature review is based on, one predominant theme was apparent regarding the purpose of screening and brief intervention whether the study was for ASBI, BI, SBI or SBIRT. This can be stated as the definition given by the World Health Organization (WHO) as “practices that aim to identify a real or potential alcohol (or substance abuse) problem and motivate an individual to do something about it.” The Substance Abuse and Mental Health Administration (SAMHSA) stated it this way, “What if you could stop drinking and substance abuse problems before they became serious enough to destroy people’s lives?”

Generally speaking, Alcohol Screening and Brief Intervention involves screening individuals to assess their level of alcohol and/or substance use and providing brief intervention or a short counseling technique that targets individuals who are not dependent but who engage in risky, harmful and hazardous drinking. Both screening and brief intervention are structured processes that vary depending on where it is being implemented.
Settings and Participants in the Studies in the Peer Reviewed Articles

The settings and participants of the studies outlined in the peer reviewed articles involving adults and adolescents include the following:

1. A randomized controlled trial with adolescents age 12-18 conducted in a school setting by trained counselors through a Student Assistance Program. Participants were 315 students from an urban public school system who were identified by school officials. This geographic location was not disclosed.

2. Seven randomized control trials evaluating risky drinking interventions among adolescent patients in ER departments of Level 1 trauma centers across the country.

3. Primary care settings from eight programs and nine countries with adult participants.

4. In Flint, Michigan a study that involved 3338 adolescents patients between the ages of 14 and 18 who are addressing violence and alcohol use in an urban Emergency Department (ED). This took place between 12 p.m. and 11 p.m. 7 days a week. 43.5% were male and 55.9 were African American.

5. Sixteen randomized control trials that included 6,839 patients who received screening and brief intervention in primary care settings in 2009 across the country (extracted from 8 systemic reviews and electronic database searches).

6. A primary care provider in a large public southeastern university student health center used a sample of college students (age 18>) who screened positive for high-risk drinking. 8,753 students were screened for high-risk drinking and 2,484 (28%) screened positive.

7. A wide variety of medical settings across six states/sites with diverse populations. The six sites ranged from hospital ER’s, trauma centers, medical clinics, community health clinics, school clinics and primary care clinics. The communities included large urban communities, a broad rural area and a modest sized metropolitan area. 459,599 patients were screened; 22.7% screened positive for the spectrum of risky/problematic use or abuse/addiction.

8. Health care settings and health systems in 8 countries. The studies were done in 14 random assignment studies with 20,000 drinkers.
Process of Screening for Alcohol and Other Drugs

The screening processes in all of the studies reviewed were widely varied, utilized different screening tools and as noted above were implemented in many different settings. Most of the studies used control or experimental groups and various “intervention groups”. The length of the studies varied, but all measured use at intake and at follow-up intervals. These intervals were mostly at three months and six months, although one study also conducted follow-up at nine and twelve months.

As mentioned above the settings varied with the majority in health care settings. What all had in common was that the screenings were conducted following negative consequences of alcohol use and some with other drug use. According to Selway (2006), the ideal teachable moment is when the individual has experienced harmful consequences.

Screening tools varied widely and a list of tools used in the articles reviewed are included in the Appendix of this report. Some of the screenings were very comprehensive and involved more than one screening tool or questionnaire. Some of the screenings were done by practitioners or counselors, some were computerized and some used a combination of the two.

The screening tools utilized could be done in a very brief period of time. Two of the studies used the “5/4 gender specific question” which asked how many drinks were used per occasion. The identification of those individuals that needed further intervention were males that use 5+ drinks and females that use 4+ drinks per occasion. In the college study, students were categorized (Presley and Pimental, 2006) as 1) “non-heavy” drinkers, 2) “heavy” drinkers (5+ drinks in last 2 weeks) and 3) “heavy and frequent” drinkers (5+ at least once in past 2 weeks and drinking 3 or more days per week). The frequency of drinking was a part of all of the screening that was done in these studies.

The AUDIT was another screening tool that was mentioned in several studies. The AUDIT (Alcohol Use Disorders Identification Test) was developed by the World Health Organization and consists of 10 items. There is another version of this tool called the AUDIT –C (Alcohol Use Disorders Identification Test-Consumption) which was used in one of the studies reviewed.
The CAGE was also used in two of the studies and consists of 4 questions (Cut down, Annoyed, Guilty, Eye-Opener). An adapted version of this is the CAGE-AID (Cut down, Annoyed, Guilty, Eye-Opener – Adapted to Include Drugs); this screening tool was used in one of the studies of ASBI that included screening for other drug use.

While there are many tools used in ASBI screening, it can be said that screening is the process of identifying drinkers whose use presents harm to themselves or others and those who are beginning to experience problems and signs of alcohol dependence. In other words, the main goal of screening is to identify those individuals who are engaging in risky drinking/substance use, those who display a pattern of regular excessive or occasional high intensity drinking and/or substance abuse and those who could be identified as dependent and needing further treatment.

Process of Brief Intervention

The Brief Intervention strategies used in the studies presented in this literature review varied widely across many different settings but showed similar results which will be discussed further in the “Findings/Outcomes” section.

Screening is just the start of the ASBI process; it is the brief intervention that is the key to behavior change and/or referral for additional services if necessary. The process of Brief Intervention consistently involves an approach that utilizes Motivational Interviewing (MI) that is done in short periods of time and delivered by trained professionals. Some of the brief interventions were conducted by trained therapists, counselors or health practitioners. In one study by Walton, Chemack, Bingham, Zimmerman, Blow, and Cunningham (2010), one of the Brief Intervention strategies used a computer intervention program as a stand-alone interactive session using touch screens and headphones to ensure privacy.

One of the studies reviewed by Madras, Compton, Avula, Stegbauer, Stein, and Clark (2009), consisted of two models for Brief Intervention:

- FRAMES (Feedback, Responsibility, Advice, Menu of Options, Empathy and Self- Efficacy
• Motivational interviewing to raise awareness of risks of substance use, increase motivation to change, and helping individuals commit to self-management skills for changing use behaviors.

This study also included a strategy called “Brief Treatment” that included:

• One session of enhanced Brief Intervention and motivational interviewing, one assessment session, and four sessions based on the cognitive behavioral treatment (CBT) model.

The FRAMES Brief Intervention model was also used in other studies. Selway (2006) more clearly defines these six elements:

1. feedback about the individual’s drinking pattern
2. accepting responsibility for behavior
3. advice on how to quit or cut down risky use
4. giving a menu of change options in which the individual is responsible for the change
5. showing empathy
6. encourage self-efficacy.

Brief Interventions are for those individuals who engage in risky drinking and are characterized by their low intensity and short duration. These sessions of counseling education are short in duration (5 to 60 minutes) with 3 – 5 sessions. The intent is to provide early intervention before or soon after the onset of alcohol related consequences. These sessions are instructional and motivational, address the specific behavior of problem drinking and/or substance abuse, health education, skill building and practical advice, specifically, the sessions educated individuals on what healthy drinking looked like, gave skills for behavior change, and encouraged a self-assessment of the need for behavior change.

All models of Brief Intervention include a component for referral to treatment for those individuals that are determined to be alcohol/substance dependent. Educational materials were also disseminated in several of the studies reviewed.
Studies Involving Adolescents

The purpose of this literature review on ASBI is for use in implementing pre-assessment teams in schools, therefore it is important to make special note of the studies reviewed involving adolescents.

The first study reviewed by Winters, Fahnhort, Botzert, Lee and Lalone (2012), was conducted in a school setting by trained counselors through a Student Assistance Program. It was a randomized controlled trial that evaluated the used of two brief intervention (BI) techniques for adolescents ages 12-18. One was a two-session adolescent only (BI-A) and one was a two-session adolescent and additional parent session (BI-AP). These were also compared to an assessment-only control group. The assessments took place at intake with a six month follow-up.

The 315 students from an urban public school system were identified by school officials either under the influence of alcohol and/or other drugs at school, in possession of alcohol and/or other drugs at school or identified by teachers due to concerns that the student was using alcohol and/or other drugs. The student population was composed of 52% male, 68% white, 9.6% prior treatment and mean age of 16.3.

Each BI consisted of 60 minute individual sessions – the student at school and the parent(s) at home. In BI-A and BI-AP the first session focused on assessment and the second on skills associated with coping skills and triggers of drug use. In BI-AP, the third session focused on parenting practices.

Outcomes were measured on the number of alcohol use days, number of drug use days, symptoms of alcohol and/or drug abuse/dependence and consequences of use. Both of the Brief Intervention groups had better outcomes than the assessment only group. Both of these groups showed a reduction in drug use (there was less reduction in alcohol use) and an increase in problem solving skills. The intervention group that involved the additional session with parents had the best results possibly due to the fact that it promoted additional help seeking. Also noted was the fact that the younger the adolescent the more likely that their behavior may be impacted by parental monitoring.
The next article involving adolescents was reviewed by Uma-Guerrero, Velasquez, von Sternberg, Maxson and Garcia in 2012. This article reviewed 7 randomized control trials evaluating risky drinking interventions among adolescent patients in ER departments of Level 1 trauma centers. All of the studies used motivational interviewing as the foundation for the intervention.

Four of the seven trials showed significant intervention effects, however no one intervention reduced both alcohol use and related consequences. Six of the studies showed positive results for consumption of alcohol and/or consequences of use. The intervention was better when a therapist/practitioner was used rather than a computerized intervention. The conclusion was that it remains unclear whether brief intervention is effective with adolescent risky alcohol use in acute care. It was determined that further research is needed around intervention and implementation.

The third study involving adolescents and ASBI was reviewed by Walton, Chemack, Bingham, Zimmerman, Blow and Cunningham in 2010. This study’s purpose was to determine the effectiveness of brief interventions for adolescents who are addressing violence and alcohol use in an urban Emergency Department (ED). The study involved 3,338 patients between the ages of 14 and 18; 43.5% were male and 55.9 were African American.

All underwent a computerized baseline assessment survey. Control groups received a brochure, a computer brief intervention or a 35 minute brief intervention delivered by a therapist with follow-up assessments at 3 and 6 months. Self-report measures included asking about peer aggression and violence consequences, alcohol use, binge drinking and alcohol consequences.

The intervention group in this study used the AUDIT-C for assessment, along with the 17 scale Problem Oriented Instrument for Teenagers (POSIT). The therapist intervention group involved motivational interviewing and skills training. The brief intervention for violence and alcohol use included: 1) a review of the goals, 2) personalized feedback for alcohol, violence and weapon carriage, 3) an exercise weighing the potential benefit of staying away from drinking and fighting, 4) five role plays involving anger management, conflict resolution, alcohol refusals, not drinking and driving and 5) referrals for treatment as necessary.
Participants in the therapist intervention were less likely at three months to report any severe peer aggression, experience of peer violence and violence consequences. 25% of patients had positive results for both violence and alcohol. At six months, participants in the therapist interventions showed self-reported reductions in alcohol consequences compared with the control group. Participants in computer intervention also showed self-reported reductions in alcohol consequences.

The final results showed that “among adolescents identified in the Emergency Departments with self-reported alcohol use and aggression, a brief intervention resulted in a decrease in the prevalence of self-reported aggression and alcohol consequences” (Walton, et al.).

It can be surmised from these studies outlined above that there is evidence that ASBI among adolescents has been proven to be effective in both school and health care settings. The main differences between these studies and those with adults was the type of screening tools used and the fact that when parents were involved with adolescents there was a greater likelihood that additional services would be sought. The screenings for the adolescent studies were more comprehensive and consisted of several different instruments. The results showed that ASBI, SBI, BI or SBIRT can be effective for adolescents, more so with drugs than with alcohol. However, it is evident that ASBI has only recently been studied among adolescents and more research could be needed.

Findings/Outcomes

A good summary of the outcomes of the majority of the studies can be summarized as described by Winters, Fahnhort, Botzert, Lee, and Lalone, (2012). Screening and Brief Intervention outcomes measure the number of alcohol use days, the number of drug use days, symptoms of alcohol and/or drug abuse/dependence and consequences of use. Other key points are:

- Motivational interviewing techniques are a cornerstone to Brief Intervention.
- There appears to be less reduction in alcohol use as compared to other drugs.
Components for positive outcomes include: one-to-one sessions, fidelity to intervention components, motivation to change, problem solving ability, parenting practices (for adolescents) and additional services received.

Brief Intervention groups have better outcomes than assessment only, although assessment can build empathy and provide incentives for behavior change.

Brief Intervention shows improvements in problem solving skills and reduction in alcohol/drug use behavior.

According to Barbor and Higgins-Biddle (2000), to effectively implement ASBI, a consistent screening tool must be selected, protocols developed, channels of communication established to sequence the different elements of the process, practitioners trained in intervention skills and records must be maintained and stored.

According to Sanchez (2010) ASBI has been proven to be effective in primary care settings with individuals with unhealthy alcohol use, but not with those who are alcohol dependent. The process does identify those individuals with a range of unhealthy alcohol use, from risky use without consequences through dependence and need for further referral. The goal of ASBI could be to reduce drinking and/or alcohol consequences or to provide a referral to additional care.

In the study reviewed by Williams and Lapham, et al., the “Consolidated Framework for Implementation Research” was used. This is the only study reviewed that used this framework. It used five domains as part of the review:

- **Characteristics of the intervention** (in this case ASBI)
- **Outer setting** (environment surrounding the organization undertaking the implementation).
- **Inner Setting** (the degree to which the implementing organization structures, communication mechanisms, resources, leadership and culture fits the ASBI and the organization’s needs and circumstances).
- **Characteristics of the individuals conducting the intervention** (what they believe about the intervention and how enthusiastic they are to implement it).
• *Process of Implementation* (the extent and quality of the implementation effort, the degree to which relevant staff are engaged, the efficiency involved in carrying out the intervention, the extent to which progress being appropriately monitored).

This study showed that the most important domains were found to be *Inner Setting, Outer Setting* and *Process of Implementation*. Yet, there appears to be no single answer to what is needed to successfully implement ASBI. In different settings and circumstances, different strategies are needed to be effective.

All of the studies discussed in the peer reviewed articles emphasized the fact that education and training of the staff providing ASBI, BI, SBI or SBIRT is essential to the process. Some studies suggested that the screenings could be done by anyone who is trained in the process, while others showed that it should be done by professional staff such as health practitioners, counselors or therapists. All of the studies did emphasize that the best results for Screening and Brief Intervention were those that were conducted by trained therapists or counselors versus those using self-reporting through a computerized program.

Relationship building is the key to all forms of Brief Intervention. In all of the studies using the various forms of ASBI, improvements were made in the level of alcohol/other drug use, related consequences and improvement in overall health. It can also be said that the research shows that ASBI is an effective way to reduce alcohol abuse and save money.
Part 2: A Literature Review of Student Assistance Teams

Introduction

This literature review used nine “peer reviewed” articles and two additional articles on the subject of Student Assistance Teams. The peer reviewed articles ranged from 2011 to 2000. In the course of the literature review it was discovered that the subject of Student Assistance Teams (SAT) was intertwined with prevention counseling and Student Assistance Programs (SAP). Four of the articles reviewed were specific to just Student Assistance Teams and 7 to Student Assistance Programs that also included core teams or Student Assistance Teams. This review will include evidence found in all the articles and studies but will primarily focus on Student Assistance Teams or the team process that is part of Student Assistance Programs. This review will not cover all of the various research methodologies used in the studies in the articles reviewed.

The research indicates that the current trend is to use a team approach to refer students who have barriers to their educational success. This review will discuss the research reviewed on the various approaches to provide students intervention strategies through a variety of strategies in various schools across the country.

Background

A student assistance program is generally described as a school-based prevention and intervention program for primary and secondary school students that attempts to interrupt "behaviors of concerns" that appear to be interfering with academic success and influence change in a positive direction. The behaviors of concern could include frequent absences, withdrawal from contact with peers and educators, changes in peer group, attendance issues, discipline issues, substance abuse, mental health issues, family issues and many other behaviors.

Many of the articles reviewed discussed the history of the team process, such as those in Student Assistance Programs and Student Assistance Teams, as part of an approach that lies in a history of school psychology and guidance counseling. Its primary concept is tied to youth development orientation in school settings (Albee, 1995; Conyne, 1997; Keys, 2000; Kleist &
White, 1997; Newnes, 1990; Wagner, 1994). Historically, SAP’s and SAT’s were introduced into school systems as a way to support students affected by issues related to their own or their parents’ use of alcohol and other drugs. SAP’s have been used for about 50 years but have been improved and refined to include a systemic approach for addressing student behavior issues that interfere with academic success. Many of the articles reviewed cite a series of steps that are essential to the effective functioning of Student Assistance Teams.

**Settings and Participants in the Studies and/or Types of Peer Reviewed Articles**

The settings and participants of the studies outlined in the peer reviewed articles include the following:

1. In New York State a total of 407 records from 12 school sites were reviewed. They included three private schools and three public high schools in a metropolitan area, and six additional schools in rural, suburban and small cities. The cases reviewed were randomly selected. Student age range was from 12 to 18 with a mean age of 15.5 years. 64% of the students were female and all but four were high school students. While 25% of the cases did not contain race information, the remaining cases consisted of 74% white, 9% black, 4% Asian or Pacific Islander and 13% other.

2. A literature review commissioned by New York State Office of Substance Abuse Services where the authors reviewed eight scholarly databases, 15 journals and Student Assistant Programs in New York.

3. A study of two Student Assistance Programs in a Connecticut school district that used a model developed by Connecticut's Governor's Prevention Partnership.

4. A peer reviewed resource manual written as a guide for implementing Response To Intervention which includes Student Assistance Teams by the New Mexico Public Education Department.

5. A peer reviewed article detailed an interview with Ellen Morehouse, LCSW, CASAC, CPP, who is the Executive Director for Student Assistance Services in Tarrytown, NY. She is the creator of three national model alcohol and drug abuse prevention and early
intervention programs. In this interview the Westchester Student Assistance Program was reviewed.

6. A study that was the basis for a dissertation the purpose of which was to examine a sample of students who participated in a Student Assistance Program in Southwest Virginia. In the selected sample, which encompasses 2,533 Southwest Virginia students, a little more than one-half of the participants were male. The mean age of students within the sample was 14.57, with over one-half of the students between the ages of 14 to 19. The majority of the students were Caucasian. The records reviewed were from the 2001-2004 school years. Only two chapters of this dissertation specific to Student Assistance Programs will be part of this review.

7. A peer reviewed article presents information on a study conducted in Pittsburgh, PA and is based on conversations with school superintendents, board members, principals, teachers, counselors, and nurses about their students’ social and emotional health and how they are working to help students confront these issues.

8. An evaluation of the Pennsylvania Student Assistance Program. The data collection strategies included statewide surveys of SAP members and county administrators, focus groups, site visits, and the Pennsylvania Department of Education database. A total of 1,204 team members from 154 school buildings completed the SAP survey; 53 county administrators completed their survey; focus groups were comprised of SAP coordinators, school board members and community agency staff. Site visits were conducted at five schools. Participants were approximately two-thirds female and two thirds had graduate level degrees.

9. An article based on a survey sample of principals in a Midwest state about how Student Assistance Programs function in their schools.

**Process of Student Assistance Programs**

This literature review identified that for many of the studies, Student Assistance Programs are considered to be part of Prevention Counseling programs. Loneck, Corrigan, Videka, Newman, Reed and Moonan (2010), found in the research that substance abuse
prevention counseling are found in two settings – school counseling and Student Assistance Programs. In the settings where it is part of school counseling, curricula is used along with targeted counseling with students and their families.

Lonect, et al. also found that Student Assistance Programs are the main approach used in the substance abuse prevention field. This study found that there are two main models for SAP’s. One uses the core team model (or Student Assistance Team) comprised of school personnel. The core team’s primary purpose is to identify and assess problems and refer and provide follow-up services to students who are involved in or at risk of involvement in substance abuse.

In the counselor model, schools contract with an outside substance abuse agency for placement of a Student Assistance Counselor within the school. The primary functions within the counselor model are to identify and assess problems, intervene or refer for services, and provide follow-up services. This study out of New York found that because the core team model typically excludes interventions, it is not as effective. However, other studies disagree with this point and find that when Student Assistance Programs that include core teams or Student Assistance Teams whose membership is school based and systemic in its approach to intervention are the most effective.

The most widely used model is the school team-based Student Assistance Program, also known as the core team or Student Assistance Team model. This team is interdisciplinary and made up of teachers, counselors, administrators and other specialists. These teams most commonly meet weekly with one person acting as a coordinator, who is responsible for the operation, planning, and evaluation of the program. The team is generally under the supervision of an administrator. The rest of the information that will be presented is based on this model of Student Assistance Programs.

In the literature reviewed, Student Assistance Programs are designed to assess the social, academic, emotional, substance abuse and mental health problems of elementary, middle/junior high school and high school students that may be interfering with academic achievement. Some of the literature reviewed includes students with presenting needs that are strictly academic, while others focus on needs that are behavioral, substance abuse, mental health
and family issues, as well as other life needs. All of the literature reviewed points to a Student Assistance Team or core team being the foundation of a Student Assistance Program.

Most Student Assistance Programs use a strengths-based, developmental asset building and resiliency approach. All of these programs/models are science based and build on the findings of other successful prevention programs by using interventions that are effective in reducing risk factors and improving protective factors. The programs are based on documented prevention principles that delay the onset of substance abuse and reduce use in adolescents. According to Morehouse, 2006, they have the following goals in common:

- increasing perception of risk of harm
- changing adolescents’ norms about substance abuse
- building and enhancing social and resistance skills
- changing community values and norms regarding substance abuse
- fostering resiliency and protective factors in high risk youth.

A common theme in many of the articles reviewed was that an effective Student Assistance Program has a four-phase process that can provide support for schools, communities, families and students to work together to overcome students’ barriers to learning. Fertman and Tarasevich (2004) describe the four phases as: referral, team planning, intervention and recommendations, and support and follow-up. The goal is to link students and their families to appropriate programs both in school and in the community that address the presenting concerns. Below is a brief outline of the processes for each of the four phases.

1. Referral:
   - Identify problem behaviors
   - Referral to the SAP
   - Initial fact finding
   - Parent contact and participation

   Common warning signs that warrant a referral include poor attendance, lowered academic performance, discipline issues, alcohol and/or other drug use, and mental health
concerns. A standardized referral form should be used to collect data about the presenting concern. Teachers are the main referral source.

A key part of the process is contact, consent and participation of the parent(s). Their observations of the student are crucial in gathering information for the best possible intervention planning.

2. Team Action Planning:
   - Information gathering
   - Student conference
   - Parent conference
   - Action Planning

   A consistent student information form is circulated to all staff that may have information on the student that would help in deciding on appropriate recommendations. The student and parent conferences help to get their insight into the problems. A plan is then developed that include specific strategies and recommendations to link the student/family to programs that will address the presenting problem(s).

3. Intervention and Recommendation:
   - Intervention in school and/or community-based
   - Recommendations for educational, behavioral and other community services as needed
   - Behavioral health assessment

   School services could include individual counseling, participation in counselor led groups specific to the presenting problem, mentoring, academic assistance, and/or substance abuse assessment (if qualified professional is present in the school). Community services for mental health or substance abuse assessments may also be necessary. Recommendations need to be supported by the parents, especially in the case of community referrals.

4. Support and Follow-Up:
   - Support services for students, parents and faculty
   - Follow—up including monitoring, mentoring and motivating for academic success.
Good communication with teaching staff is necessary to provide them with strategies to help the student succeed academically. The plan may also need to be adjusted if the interventions prove unsuccessful or if there continues to be a decline in the presenting problem.

Other models in the articles reviewed also include basic components including staff training in identification of behaviors of concern, intensive training for SAP members, community collaboration and informing all building staff members of the role of the SAP/SAT and its process during the beginning of the year staff meetings.

The “Student Assistance Program Guidebook” prepared by the Illinois State Board of Education and the Illinois Department of Human Services, though not peer reviewed, had some relevant information that warrants consideration.

The guidebook identifies that effective Student Assistance Program planning is grounded in a systematic continuous improvement process, the end goal of which is to foster the healthy development of students in the school building by implementing universal, selective and indicated strategies. They describe a Four-Step Planning Process which was not discussed in other articles:

1. Identify critical needs and existing system resources in the school setting.
2. Create and implement a plan that includes identified outcomes through utilizing Universal, Selective and Indicated Strategies. This is similar to the three-tiered process of Response To Intervention (RTI) that will be discussed in the next section; however this system is not based on what the authors call “a failure to meet expectations tier movement system”.
   • Universal strategies are provided to all students and include policies, procedures, and prevention programming that focus on building positive social-emotional skills, promoting wellness and/or delaying the onset of problem behaviors (100% of students).
   • Selected strategies target students who are at greater risk of developing behavior and/or substance abuse problems due to factors present in their lives (10-15% of students).
• Indicated strategies focus on the student who is displaying early signs of problems that could or have led to problems such as substance abuse, mental health/behavior issues, violence and others that may lead to school failure or dropping out (5 to 8% of students).

3. Implementing evidence-based and evidence-informed interventions which include using a variety of intervention strategies specific to the presenting problem, including referral to community agencies as needed.

4. Conduct programmatic evaluation. The two types are formative or process evaluation and summative or outcome evaluation.

The articles reviewed use a number of different models or combination of models that provide prevention and/or intervention services, but the consistent theme is the use of a Student Assistance Team or core team as part of the process.

Process of Student Assistance Teams

In the articles specific to Student Assistance Teams, there are many common themes. As stated previously a Student Assistance Team is comprised of a multi-disciplinary team that includes teachers, administrators, counselors, and other specialists including the school nurse, a social worker and sometimes a community agency representative as needed.

Torres-Rodrigues and Goldstein (2010) describes the role of the Student Assistance Team in the larger framework of a Student Assistance Program as:

• Coordinating all SAP elements
• Supporting classroom teachers
• Providing building level support for students
• Developing and using a working agreement and ground rules
• Using team roles effectively
• Using team processes effectively
• Attending SAP training
In their study the six elements identified by team members as critical to their success were “human resources of the team (defined broadly to include caring), administrative participation and support, multidisciplinary team membership, working agreements and ground rules, effective use of the team process, and teacher support for implementing the strategies that are identified by the team”.

The study also reinforced the importance of the teacher in the Student Assistance Team process; without a teacher referral, the SAT process cannot be carried out. And, following a referral, unless the teacher is willing to implement the strategies developed by the team, the student’s needs will go unmet.

Another peer reviewed manual, “The Student Assistance Team (SAT) and the Three-Tiered Model of Student Intervention” written by the New Mexico Public Education Department (2009) was written as a guide for implementing Response to Intervention (RTI). A large component of the manual was devoted to functioning of Student Assistance Teams as a key element in RTI programs. RTI is a continuum of school-wide support that incorporates three levels of intervention. Tier 1 consists of universal screening, appropriate core instruction in classrooms with universal interventions for all students in the school. Tier 2 is the Student Assistance Team process for identified students that consist of supplemental, targeted interventions prescribed by Student Assistance Team members. Tier 3 is Special Education or Gifted Education. For the purposes of this literature review, only the findings for Tier 2 or Student Assistance Teams will be discussed.

This particular manual seems to suggest operating on an as needed basis by bringing students to the team on an individual basis and including the parents as part of the team. There are eight steps that were outlined for conducting the SAT meetings:

- **Step 1: Referral to the SAT (using a form).** The teacher, staff member or parent refers the student to the SAT. There is a SAT Chairperson who reviews and determines if the referral is appropriate, and then schedules the student’s SAT meeting. He or she contacts the parents and staff who need to be involved in this student’s case to arrange a compatible meeting time.
- **Step 2: Gathering Data and Information/SAT Chairperson Certification**
Prior to the initial meeting, the SAT Chairperson collects all relevant information about the student. This is all done using recommended forms.

- **Step 3: Introductions and Agenda**
  At the beginning of the meeting, the team decides who will serve as Facilitator and Recorder. After introductions, the Facilitator announces a target time for the meeting and a brief agenda. The amount of time for the SAT meeting is determined on a case-by-case basis.

- **Step 4: Summary Statement of the Referring Teacher and Parent**
  The referring teacher describes the student and summarizes the student’s strengths. The teacher also describes the circumstances and identifies the concerns that led to the SAT referral.

- **Step 5: Sort and Sift of Records and Relevant Information**
  This step is when the SAT members analyze the available data. The team reviews and discusses any existing information about the student that may be relevant. This may include academic records, results of general screenings, work samples, medical history, discipline records, etc.

- **Step 6: SAT Summary, Synthesis of Information**
  This is the pivotal step for the SAT. In a specific process the SAT members examine and attempt to fit together the information until patterns and some kind of picture about the student needs begin to emerge.

- **Step 7: SAT Summary, Next Steps**
  The team, which includes the parent, makes the most appropriate of the following three decisions:
  1. The student appears to need no intervention at this time. No action or plan is necessary.
  2. The student’s challenges suggest that a SAT Intervention Plan or Behavior Intervention Plan (BIP) is warranted.
  3. Existing data is insufficient for a complete determination. More information is needed. In this case the SAT will recommend further screening or assessment either in the school setting or through an outside agency referral.

- **Step 8: The SAT Intervention Plan**
Targeted individual interventions that are provided by school counselors or other professionals can include individual counseling sessions or small group sessions in the specific area of need. In the case of a student demonstrating behavioral problems, the plan will take the form of a Behavioral Intervention Plan (BIP). The intervention plan may also include an outside agency referral if warranted for either substance abuse or mental health issues.

One of the peer reviewed articles by Conway, Christensen, and Russell was based on a study that consisted of a survey with a sample of principals from a “Midwest state”. This study reinforced what has been discussed but is important in that it was unique and was conducted with secondary school principals. This survey only asked questions about the Student Assistance Team process itself. These principals reinforced that the start of the SAT process began with a referral from a teacher regarding a student who is having learning or behavior difficulties. The SAT then meets with the teacher to discuss the situation and identify student goals and objectives. As in other studies, the team includes teachers, administrators, counselors and other specialists.

In the area that this survey took place, the SAT membership is determined by the district or building administrator. Some also included a Special Education teacher, which is surprising since SAT is a regular education process. Half indicated that membership was on a volunteer basis, while others were assigned to the team. Meetings were generally conducted either on a weekly or as needed basis. 85% of the principals indicated that parents were notified of their student's referral to the SAT. About one-third have the parent(s) on the SAT.

As a group the principals who responded to the survey valued the function and operation of the Student Assistance Teams. They also agreed that the SAT meets the needs of students, teachers, administrators and parents. The majority of principals believed that the SAT process reduces the number of discipline referrals for students.

Concerns of the principals surveyed included the lack of time during the school day for the SAT meetings and for adequate consultation to gather information on the referred student. Also, a substantial number of principals felt that teachers do not implement the recommended interventions.
In summary, a Student Assistance Team is a multidisciplinary school team which includes specific school staff, in some cases the parent and when appropriate the student in a positive problem solving, intervention process. An important part of the process is schools and community agencies working together to support the students so that their school lives will be successful. In some cases there are community representatives on the SAT.

The students are referred by a classroom teacher or other school staff, parent or sometimes the student themselves when it is felt that the student’s learning is being affected by behavior, substance abuse or emotional needs. The main purpose of the SAT is to explore interventions that will best meet the educational and behavioral needs of the students referred, as well as supporting teachers and parents.

Findings/Outcomes

Student Assistance Programs originated as a substance abuse prevention and intervention model that has been used for almost 50 years. Through time the model has changed to provide prevention, early intervention and support services for academic and non-academic issues including mental health, family and other relationship issues, bullying and other school violence issues, and basic life needs, while remaining the primary resource for dealing with substance abuse prevention and early intervention concerns.

The background, history and process of Student Assistance Programs is somewhat varied depending on the particular study reviewed. In many of the schools that were part of the studies reviewed, prevention or Student Assistance Counselors were hired by the school district to coordinate the prevention and intervention programs.

There was one study that was conducted in Southwest Virginia by Hardwicke (2006) and was used for her dissertation that showed negative results for Student Assistance Program outcomes. Specifically, it was noted that students who participated in a SAP showed decreased academic performance, increased days absent, increased discipline referrals but improvement in the presenting problem. This author did note that there was significant data missing on which to base the results and the author did not produce any other plausible reason for these results. This
study contradicts the evidence that has been shown to be true in all of the other research articles where there were improvements for students who participate in SAP’s.

In most cases, students who are dealing with nonacademic barriers to learning are the primary target population for SAP/SAT services. These barriers include school adjustment and attendance problems, dropouts, depression or suicidal issues, self-injury behavior, stress and anxiety related issues, physical and sexual abuse, substance abuse, family issues, behavior issues in school, legal issues involving the juvenile justice system, violence and more.

Intervention services that are recommended as part of the Student Assistance Team process include counseling sessions with guidance counselors or other student support professionals in the school, counseling groups specific to the presenting problems, referral for further assessment for substance abuse or mental health issues, referrals for family counseling, and academic support. In addition, it has been shown consistently that the relationship between the student and the counselor is a critical factor to the results of the interventions.

The systemic operation of the Student Assistance Team in the school building is essential in the effective identification and intervention planning for students who are referred. It has been found that there needs to be: 1) a defined, well communicated referral process, 2) staff knowing how to access the team, 3) consistent communication with parents, 4) training for team members, and 5) team recommendations for a variety of in-school and community services as needed such as providing mental health and substance abuse assessments. In addition, working agreements and ground rules result in a clear understanding among team members of how the team should function and what each member’s responsibilities are. The effective use of the team process results in members coming together to carry out their tasks as specified and in a timely manner.

The research shows that the efforts to address the needs of students in schools often begin with, and depend on, their teachers, whose empowerment should be a goal in any SAP/SAT process. As stated previously, without a teacher referral, the SAP/SAT process cannot be carried out. And, following a referral, unless the teacher is willing to implement the strategies developed by the team, the student's academic needs will go unmet.
In addition, it is crucial to have a member of the team assigned to act as case manager or coordinator to not only support the student in the implementation of the intervention plan, but also to support and communicate with the parent(s).

The peer reviewed New Mexico Public Education Department manual on Student Assistance Teams made some points worth noting. Since most often students are referred to SAT for behavioral and/or mental health issues, special information should be provided on these issues. It was noted that the goal with referred students is early identification and intervention. It needs to be determined if these issues interfere with the student’s learning and safety or the learning and safety of others. In order to do this it was noted that the SAT members need to have a general understanding of the signs and symptoms of the following issues:

- Trauma and Post-Traumatic Stress Disorder (PTSD)
- Attachment Disorder
- Disruptive Behavior (caused by AD/HD, Conduct Disorder)
- Eating Disorders (Anorexia, Bulimia)
- Anxiety Disorders (Separation, Generalized, School Phobia)
- Adjustment Disorders
- Substance Abuse
- Conduct Disorder
- Oppositional Defiant Disorder
- Suicide
- Depression

There is no one method or process for operationalizing the school’s Student Assistance Team and conducting the meetings. However, the following points were emphasized as critically important throughout this review:

- The success of the SAT often hinges on the level of involvement of the parents and student. Always invite parents to participate and contribute, and treat them as equal team members. If possible and appropriate, include the student as well.
• One person from the core team should serve as the SAT Supervisor or Chairperson and directs the activities of the team. This person could be an administrator or someone the administrator designates, such as school counselor. After a decision is made, the SAT Supervisor or Chairperson is also responsible for ensuring that the resulting SAT intervention plan is implemented, properly documented and that the pertinent data collection is maintained and timely follow-up occurs.

• At the meeting, one person is appointed as the Facilitator. This person is not the “leader” of the group in the sense of dominating it, but rather takes the responsibility for the flow and tone of the meeting.

• Have one person serve as Recorder. This person documents the discussion and completes all relevant paperwork.

• Document everything using consistent forms for SAT communications, meetings, decisions, plans, and follow-up. The SAT must keep documentation of all of its decisions and efforts on behalf of the student.

• SAT records, like any other student record, must be kept confidential as required by the federal law known as FERPA.

• The SAT may want to create a resource list of available school, district, or community-based resources, and establish a small library of interventions resources. Interventions should be individualized.

• For purposes of continuous improvement, the SAT should conduct its own Self-Assessment on an annual basis.

Many of the studies did acknowledge the need for improvement in the area of program awareness for parents, students and school staff. Students, staff and parents must be fully aware of the Student Assistance Team process, so they are able to identify the needs that call for multidisciplinary expertise and assistance. This can be done in a number of ways including staff meetings, websites, newsletters, brochures, and classroom and parent presentations.

Student Assistance Programs all include core teams or Student Assistance Teams. According to the Illinois Student Assistance Program Guidebook, it has been proven that:
- Student Assistance Teams have historically been an effective vehicle in schools to address non-academic barriers to learning.
- Student Assistance Teams have been shown to improve academics and behavior, reduce truancy and keep students in school.
- Student Assistance Teams are a framework that allows the school to address student behavioral health concerns through a systematic approach.
- Students whose needs are beyond the scope of the school are connected to community services and take advantage of those services at higher rates than reported nationally through the Student Assistance Team process.
- A self and friend referral system for personal issues is a feature unique to Student Assistance Programs and is essential to services for non-academic barriers to learning.
- Student Assistance Programs use multiple levels of service, utilizes problems solving teams, uses progress monitoring and adapts interventions as needed.
Part 3: Conclusion and Recommendations Based on Literature Review of Alcohol Screening and Brief Intervention and Student Assistance Teams

This report, as stated at the beginning, is a literature review of peer reviewed articles on Alcohol Screening and Brief Intervention and Student Assistance Teams with the purpose of establishing and supporting School Pre-assessment Teams in the Partnership for Change Coalition’s partner schools.

It must first be remembered that the purpose of the school is to teach a child, not to teach a subject. Student behavior needs arising from home situations, relationship issues, mental health and substance abuse issues must be addressed as part of the whole child. To focus on the child as a learner without addressing these needs reduces the positive outcomes for academic achievement and the child as a whole. As the needs of young people in our schools grow and change, we will continue to be challenged to meet the needs that interfere with academic success.

What has been presented through this literature report suggests that, adapting the strategies presented through the studies of ASBI, BI, SBI and/or SBIRT and Student Assistance Teams, could provide a model for School Pre-assessment Teams when a student is referred for alcohol or other drug abuse issues.

It is this author’s recommendation that the next step in the process of implementing School Pre-assessment Teams in Partnership for Change Coalition’s partner schools is to develop a model based on the research presented here. This model would include the strategic operation of a school pre-assessment team, a specific and consistently used screening process and tool followed by the implementation of brief intervention strategies. These could be used by school professionals for students presenting with alcohol and/or substance abuse school or community violations or concerns from school staff, parents or students themselves.

Research supports that School Pre-assessment Teams could help address the barriers to learning that substance abuse and mental health issues create in the lives of children and adolescents.
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Note: * indicates those articles that are “peer reviewed”.
APPENDIX

Screening Tools Used As Presented In Alcohol Screening and Brief Intervention Articles

- Alcohol Use Disorders Identification Test (AUDIT) – 10 items, developed by WHO.
- Problem Oriented Screening Instrument for Teenagers (POSTT)
- Adolescent Drinking Inventory (ADI)
- RUFT-CUT
- CAGE
- Alcohol Use Disorders Identification Test-Consumption (AUDIT-C)
- CRAFFT - Car, Relax, Alone, Forget, Family, Friend or Trouble instrument
  C: Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
  R: Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
  A: Do you ever use alcohol or drugs while you are by yourself, ALONE?
  F: Do you ever FORGET things you did while using alcohol or drugs?
  F: Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
  T: Have you ever gotten into TROUBLE while you were using alcohol or drugs?
- Michigan Alcohol Screening Test (MAST) – 10 items
- Self-Administered Alcohol Screening Test (SAAST) – 35 items
- CAGE – 4 questions (Cut down, Annoyed, Guilty, Eye-Opener)
- CAGE-AID (Cut down, Annoyed, Guilty, Eye-Opener – Adapted to Include Drugs).
- Adolescent Diagnostic Interview –measures criteria of abuse and dependence
- Timeline follow-back – prior 90 days at intake and 6 month follow-up
- Personal Consequence Scale – negative consequences of use
- Stages of Change Readiness and Treatment Eagerness Scale
- Problem Solving Questionnaire – measures problem solving goals
- Alabama Parenting Questionnaire – measures positive and negative parenting styles related to parenting practices of parental monitoring, inconsistent discipline and positive parenting
- Treatment Services Review – records adolescent’s participation in drug treatment or related mental health services; conducted at 6 month follow-up.
- ASI – Addiction Severity Index
- Drug Abuse Screening Test (DAST)
- Single Substance Use Question (SSUQ) – When was the last time you had more than X drinks in one day (X=4 drinks for women and 5 drinks for men)
- Health Lifeways Questionnaire
- Depression Identification and Treatment Protocol.

- Healthy Lifestyle Questionnaire.

The Healthy Lifestyle Questionnaire is a 280-question, Web-based survey related to healthy behaviors, which the students completed in a range of 20 to 40 minutes. Fifty-five of the items related to alcohol-consumption behaviors, alcohol-related harms, and protective factors related to drinking. Other items included demographic data, alcohol expectancies, tobacco and drug use, and readiness-to-change behaviors. The entire tool was administered at baseline and at 12 months. A shortened version of the tool (120 items) was administered at the 3-, 6-, and 9-month follow-up periods; this version excluded the items related to expectancies and drug use.

- Rutgers Alcohol Problem Index (RAPI)

The 23-item RAPI (White and Labouvie, 1989) was imbedded into the Healthy Lifestyle Questionnaire to measure frequency of alcohol-related harms. At baseline and at 12 months, participants were asked to report the frequency of harms in the past year. At 3, 6, and 9 months, participants were asked to report the frequency of harms in the previous 3 months. Counts were grouped into five categories: (0) 0 times, (1) 1-2 times, (2) 3-5 times, (3) 6-10 times, and (4) more than 10 times. Internal consistency was adequate at baseline and follow-
A RAPI sum score was computed by adding the score for each of the 23 items.

- **Other harms**

Eight items from the Drinker Inventory of Consequences-2L (DrInC-2L; Miller et al., 1995) were imbedded into the Healthy Lifestyle Questionnaire. These items included driving under the influence of alcohol, riding with someone under the influence, risk taking, regrets, legal consequences, and physical injury. At baseline and at 12 months, frequencies from the past 12 months were reported. At 3, 6, and 9 months, participants reported frequencies for the prior 3-month period.

- **Readiness-to-change**

Readiness-to-change was assessed by the 12-item Readiness to Change Questionnaire (Rollnick et al., 1992). Based on responses, subjects were classified into one of three categories: precontemplation, contemplation, or action. Students also rated their readiness-to-change on a scale of 0 (not ready) to 10 (ready); this was called the readiness-to-change ruler.

- **Timeline Follow-back drinking measure**

Alcohol-consumption behaviors for the previous 30 days were recorded using the TLFB procedure. Participants recorded their drinking on an electronic calendar with self-identified historical reference points to enhance recall. The TLFB is a well-established tool that provides reliable self-reported drinking data (Sobell and Sobell, 1992). Typical and peak BACs were calculated from the TLFB data, which included gender and weight (Turner et al., 2004).