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The Process of Delivering Peer-Based Alcohol Intervention Programs in College Settings

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Alcohol is routinely cited as the most pervasively misused substance on college campuses (Dawson, Grant, Stinson, & Chou, 2004). To meet the objectives set forth by the U.S. Department of Health and Human Services to reduce binge drinking among college students to 20% by 2010, empirically based selective prevention and intervention programs targeting students who are already drinking are essential.

Individually based motivational interventions have been shown to be able to reduce alcohol use among heavy drinking college students (Borsari & Carey, 2000). To reach more students, peer counselors have been substituted for trained professionals to implement these interventions (Larimer & Cronce, 2007; Salovey & D'Andrea, 1984). Benefits of this approach are supported by Astin (1993) who noted peers influence a variety of topics (social issues, substance use) where changes tend to shift toward the dominant view of the peer group. Ender and Newton (2000) identified peer providers as having the capacity to be as effective, or more effective, than professionals at delivering some services.

Training, supervision, and evaluation serve as key components of successfully implemented peer counseling interventions (Hatcher, 1995; Salovey & D'Andrea, 1984). Studies have shown significant reductions in drinking-related outcomes when examining peer based programs in a controlled research environment where rigorous methods are used to train, assess competence, supervise, and evaluate (Larimer et al., 2001). These steps ensure standardization and fidelity of implementation and delivery of the intervention. Despite these documented essential preparation components, no known studies have examined alcohol peer counseling program implementation used in practice on university campuses. The focus of this study is to examine the level of similarity between the controlled research-based peer counseling intervention approaches and interventions conducted in practice on college campuses. The following questions guide the research:

1. What are the training methods?
2. What are the peer competency methods?
3. How are peers supervised?
4. How are program outcomes evaluated?

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TABLE 1.

Survey Questions

Question	Responses
Training	
What is the model being used for the alcohol intervention?	BASICS; CHOICES; Harm-Reduction Model; Stages of Change Model
How many hours of training do peer counselors complete?	Open
What types of training methods are used to train peer counselors?	Role plays; Rolling w/ resistance; Practicing open ended questions; Reflective listening
Competency	
Does your institution use a threshold of competency for peer counselors before allowing them to see clients?	Yes; No; Unsure
What is the instrument/evaluation used to gauge this level of competency?	MITI; MISC; Subjective evaluation
What determines if a peer counselor is ready to conduct an intervention?	Open
Supervision	
What types of supervision are used in training?	Audiotape; Videotape; Counselor self-reports
What types of counseling skills feedback are provided to peer counselors?	Written; Verbal; Individual while watching/ listening to tapes; Group
On average how long is each supervision session?	Open (minutes)
Evaluation	
In what ways is the program evaluated?	Tracking participants' drinking; Participants' satisfaction survey

METHODS

Participants

An email invitation was sent to 878 individuals at *Network* member institutions (*The Network*, 2006), and 252 surveys were completed of which 44 respondents (17%) reported using peer alcohol counseling services. The mean student body at the respondents' institutions was 7,577 (*SD* = 8,073). The majority were 4-year public institutions (54%), followed by private 4-year schools with no religious affiliation (27%), and 4-year religious institutions (14%). Of these 44 institutions, 90% identified using a peer-delivered version of BASICS (BASICS is a skill based curriculum aimed at reducing harmful alcohol consumption and negative consequences for students who drink alcohol; Dimeff, Baer, Kivlahan, & Marlatt, 1999).

Measures

The questionnaire, focusing on assessments of training (intervention model being used and training methods), competency (qualifications to conduct interventions), supervision (types/

time of supervision), and program evaluation (alcohol assessments), is provided in Table 1.

RESULTS

Peer Counselor Training

The reported modal training time for peer counselors was 10 hours which is similar to the 8–12 hours of didactic training peer counselors received in research protocols (Larimer et al., 2001). The range identified was 3 to 100 hours, showing large differences in training time. Over 60% of programs reported conducting training in several sessions over a few weeks, and one third conducted trainings over one weekend.

Specific skill training included practice using open-ended questions (77.3%), reflective listening exercises (75%), and role plays (72.7%). Almost all programs incorporated alcohol content and other drug information (86.4%). Many programs included motivational interviewing skills (47.7%) and stages of change models in training (40.9%).

Competency

Peer counselors were required to meet a threshold level of competency before meeting with clients in 29% of the programs; of these, 52.3% used peer counselor reports, live supervision (43.2%), or review of audio tapes (5%) to gauge adherence to intervention protocol. In contrast, 27.3% reported completion of the training program was sufficient to meet with clients.

Supervision

Supervision of peer counselors was being implemented in just over half of programs (56.8%); of these, 40.9% were conducted weekly, 11.3% monthly, and 11.3% semester/quarterly. The mean time spent per supervision meeting was 45 minutes (SD = 22). The most common approach involved peer counselors providing self-reports of their session to their supervisor (34.1%) followed by review of audio or visual tapes with their supervisor (11%).

Evaluation

Program effectiveness was evaluated most commonly by use of pre/post alcohol knowledge tests of clients (22.7%), followed by tracking participants' alcohol use (15.9%). Approximately 84% of programs did not examine client drinking behaviors post intervention.

DISCUSSION

These current peer counselor implementation practices are in stark contrast to documented effective peer training methods used in past efficacy studies. This study, similar to findings in other published literature, identified a variety of methods to train peer counselors (Hatcher, 1995; Yaccarino, 1995). Although different training methods are being used (e.g., weekend trainings, counseling skill training), no known research has examined the impact this has on the outcomes of intervention fidelity and drinking outcomes. With limited time for student affairs administrators to prepare peer counselors, it seems important to closely mirror implementation approaches that previous empirical studies have found to be efficacious as opposed to using methods that have no such evidence.

Current findings showed little support for measured competency evaluation to determine if their peer counselors are indeed capable of conducting an alcohol peer counseling session with fidelity. In contrast, empirical studies have evaluated peer counselors' competency levels through various evaluation instruments (Larimer et al., 2001). This leaves questions related to the fidelity of the interventions being conducted on campuses and intervention efficacy. The use of supervised role plays to establish intervention fidelity and subsequent

connections to program efficacy is important to understanding the usefulness of training components as well as the effectiveness of peer-delivered alcohol interventions.

Interestingly, only half of respondents identified a supervision component for their programs. Individual meetings between trainers and peer counselors have proven effective in honing individual skills related to intervention fidelity through feedback of counseling skills and alcohol content information (Conant Sloane & Zimmer, 1993; Hatcher, 1995; Larimer et al., 2001). This is an important area of follow-up in which the use and implementation of supervision needs to be more clearly examined, as no known studies have examined this as a variable related to effective program implementation.

According to survey results, most programs use nothing more than client satisfaction surveys to determine if program objectives are being met, with 84% of programs using no post-intervention alcohol use follow-up. Ender and Winston (1984) commented that the lack of evaluations may help explain why little is known about effectiveness of peer counselors, as they found, similar to current findings, over half of paraprofessional programs did not evaluate program impact on students. As budget constraints and cuts continue to be issues at most colleges and universities, student affairs programs would benefit from focusing on programs that demonstrate evidence of positive outcome results (i.e., decrease in college student drinking). University campuses are prime locations to conduct evaluations through collaboration with faculty and graduate students in research programs (e.g., Prevention Research Centers and Counselor Education, Counseling, and Psychology Departments). Thus, it is recommended that student affairs administrators consider implementing more specific evaluative efforts (Fennell, 1993). Lastly, although peer counselors aim to produce positive behavior change, research has shown when substance use interventions are conducted incorrectly, increased substance use may occur resulting in iatrogenic effects (Miller & Rollnick, 2002). Therefore, it cannot be underscored enough how important it is for student affairs administrators to track behavioral outcome effects of peer-delivered interventions.

CONCLUSION

Based on the low cost and availability of peers and the needs of universities to find effective methods to reduce alcohol abuse, a growth in the field of alcohol peer counseling can be expected. Therefore, to best serve the populations of the future, there is a call to narrow the gap between the evidence-based approaches and the current practices. The present study has identified discrepancies in training, counselor competency, supervision practices, and program evaluation that need to be addressed. The end result will be more effective prevention and intervention programs at U.S. universities and reductions of negative outcomes.

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