Middle Tennessee State University

Drug-Free Schools and Campuses Regulations Biennial Report
2020-2022

Contents

Introduction and Executive Summary

The Drug-Free Schools and Campuses Act ("DFSCA") provided in the Department of Education's General Administration Regulations ("EDGAR"), Part 86, (34 CFR Part 86, Vol. 55, No. 159 (Aug. 16, 1990)), requires all institutions of higher education ("IHE") that receive any form of federal funding to adopt and implement programs that prevent "the unlawful possession, use, or distribution of illicit drugs and alcohol by students and employees." As part of DFSCR, IHEs are required to:

- Provide annual notification to all employees and students, in writing, of standards of conduct; appropriate sanctions for violation of federal, state, and local law and campus policy; a description of health risks associated with alcohol and other drug ("AOD") use; and a description of available treatment programs;
- Develop methodology to distribute annual notification information to all students and staff; and
- Prepare a biennial report on the effectiveness of its AOD prevention and education programs and the consistency of sanction enforcement.

To comply with the DFSCA, as well as to promote an alcohol- and drug-free campus community for the safety and security of all students, faculty, and staff, Middle Tennessee State University ("MTSU" or "University") has developed policies and processes to:

- Ensure engagement and review of AOD programs and policies by a cross-section of University departments and divisions; Develop annual notifications and communications to employees and students regarding MTSU's standards of conduct, drug and alcohol policies, and a description of appropriate sanctions related to University, local, state, and federal violations of drug or alcohol possession, use, or distribution;
- Provide annual information on AOD prevention and treatment programming;
- Regularly provide information on the health risks associated with AOD use;
- Examine and review trends in AOD use on campus to enhance program delivery and treatment and/or support services; and
- Annually review campus AOD programming, and reports on programming effectiveness.

1. Alcohol and Other Drug-Prevention Program Elements

The National College Health Assessment ("NCHA") continue to be used to assess current trends in usage, risk, and behaviors. The Executive Summary of the NCHA report, Spring 2022 is included in Appendix A. The NCHA has been updated (moving from version II to version III) since the last reporting period. As part of the NCHA, it flags that comparisons between prior versions can be inaccurate.

University Policies

Campus AOD policies are designed to limit the availability of alcohol and drugs through environmental management. The University's requirements on maintaining an alcohol-, drug-, and tobacco-free campus are included in several institutional policies:

- 540 – Student Conduct
- 541 – Residential Life and Housing Policy
- 750 – Tobacco-Free Campus
- 755 – Alcoholic Beverages
- 760 – Drug-Free Workplace

The University also coordinates with local law enforcement, as well as the county's AOD prevention coalition, to advocate and enforce AOD policies. Efforts to include parents of students and faculty/staff in AOD prevention programming continue to occur.

Counseling

MTSU offers counseling services that provide brief, personal counseling for currently enrolled students. In addition, Counseling Services seeks to help students plan, and achieve, their educational, personal, and vocational goals. Counseling also refers students to external local, county, and state agencies and medical facilities in cases where additional treatment and/or intervention strategies are needed. Parents attending CUSTOMS for new, incoming students are provided with AOD information to encourage family discussions with their student about MTSU's AOD policies, Counseling services, and prevention programming. Through Counseling and Psychological Services ("CAPS"), a training center for graduate level counseling students, AOD counseling services also are available. Student therapists are trained to offer brief, motivational interviewing as part of a related counseling session.

Health Services and Campus Pharmacy

The University offers Health Services to enrolled students, upon request, and extends such services for up to thirty (30) days after a student's graduation. Students do not pay a fee to be seen by the medical staff at Health Services; however, expenses may be incurred if additional medical testing is required. Campus Pharmacy services also are available to students, as well as faculty and staff.

Staff Professional Development and Training

The University's Health Promotion's staff, as well as members of MTSU's administration, continue to participate in the state-wide prevention coalition known as the Coalition for Healthy and Safe Campus Communities ("CHASCo"), which is funded by the State of Tennessee's Department of Mental Health and Substance Abuse Services. Participation in CHASCo as a member University allows MTSU staff and administrators the opportunity to receive ongoing professional development, education, and strategic tools in AOD prevention. Membership in CHASCo also continues to provide the University with suicide prevention, mental health, stress management, and diversity/inclusion strategies and initiatives.

2. Program and Policy Awareness

AOD Programs and Campaigns

As part of MTSU's efforts to increase awareness of its AOD programs, initiatives, policies, and resources, the following are updates:

- Annual distribution of the Higher Education Opportunity Act ("HEOA") notifications regarding: Title IX; sexual misconduct prohibitions; sex discrimination prohibitions; sexual assault resources; and the contact information for MTSU's Title IX Coordinator, Counseling Services, Health Services, The June Anderson Center for Women, the Sexual Assault Liaison, and University Police.
- Annual distribution of the HEOA notifications regarding the legal sanctions, health risks, and disciplinary sanctions related to drug and alcohol use on campus.
- Annual distributions of the HEOA notifications regarding MTSU's policy on student drug convictions and federal student financial aid.

In addition to the above initiatives, the University continues to require that students and staff acknowledge their awareness of the University's AOD policy and programs. The Biennial Reports for 2016 – 2018 and 2018 – 2020 also are posted on public-facing University webpages to continue to increase student, staff, and public awareness of MTSU's ongoing AOD prevention programs and activities.

AOD University Policies

The MTSU Human Resources (HR) Department provides all employees with information about the University's policy as a drug-free workplace. As part of the HR's department employee benefits orientation, staff members are informed of MTSU's prohibition regarding the possession, use, or distribution of illegal drugs and alcohol on the campus, or on institutionally owned, leased, or University controlled property. The HR webpage additionally provides information on the serious health risks associated with alcohol consumption and heavy drinking, as well as the health risks associated with the use of illegal/illicit drugs. The University's prohibition on the use, possession, and/or distribution of illegal drugs and alcohol on campus also applies to student workers. Additionally, HR provides a brochure to employees regarding MTSU's alcohol and drug prohibitions, sanctions, health risks, and treatment resources.

Distribution of AOD Notices

The Dean of Students sends an electronic notification to all enrolled students each semester regarding the impact of a drug conviction on a student's financial aid eligibility. In addition, a regular notifications are sent to students concerning drug and alcohol use and abuse, and includes information on legal sanctions, health risks, and AOD treatment resources. Examples of these notifications are included in Appendix C.

3. Program Review, Strengths, and Opportunities

The University's AOD programming is reviewed frequently as part of our CHASCo participation. Each year, the University works on a plan covering:

- Policy, Practice, or Procedure Changes
- Providing Information
- Building Skills
- Providing Support
- Increasing Barriers and Reducing Access [to harmful items]
- Reducing Barriers and Increasing Access [to information, training, and treatment]
- Changing Incentives or Consequences
- Changing the Physical Design of the Environment

These plans incorporate changes to programming to help accomplish the University's goals.

Ongoing Program Strengths

- Ongoing collection of data on substance use and related attitudes that has allowed for the continue identification of trends and statistics;
- Ownership and responsibility of prevention programs shared among several departments;
- University participation in the CHASCo state-wide coalition with training opportunities and use of program funding;
- Staff willingness to work cooperatively and comprehensively to improve substance and alcohol abuse prevention efforts.

Ongoing Program Opportunities

- Drug issues continue to be the largest category of violations
- Response to COVID-19 masking potential underlying trends by skewing data for this reporting period

4. Program Statistics for 2020-2022

The following are summary statistics from MTSU's program for 2020-2021 as well as 2021-2022, from the Offices of Student Conduct (formerly Judicial Affairs). Data from the University Police is also included regarding arrests.

Alcohol and Drug Violations, from the Office of Student Conduct

Violation Type	2022-2021	2020-2021	2019-2020	2018-2019
Alcoholic Beverages	30	31	26	25
Drugs	61	37	125	107
Drug Paraphernalia	18	18	55	47
Public Intoxication	9	6	13	27

Noteworthy observations from 2020-2021:

The university made serious adjustments to all operations beginning in March of 2020 due to the COVID pandemic. These adjustments had a direct impact on the Office of Student Conduct and the types of referrals the office received. Housing and Residential Life was at single occupancy for the duration of the time period covered by these statistics which meant less students physically living in housing and less activity, social or otherwise. On-site classes were also limited during this time period. The campus was under mask requirements and social distance protocols. The office handled more "non-conduct" referrals as a result (which are not reflected in these statistics). Staff assisted with outreach to students who were potentially in violation of expectations associated with COVID.

Noteworthy observations from 2021-2022:

There was a significant drop in total number of conduct cases charged during this review period, specifically a reduction of 70 cases from the previous year. Part of this decline is attributed to a substantial drop in cases reported by the Department of Housing and Residential Life. Housing and Residential Life referrals dropped by half. This was partly due to a higher number of single rooms meaning there were less residential students living on campus. The office is partnering with the Department of Housing and Residential Life to assess the decline in cases in relation to the upcoming year.

The office re-evaluated the delivery of the Educational Pathway sanctions and decided to return to a general category of educational sanctioning, thus the educational pathways will not be included in future statistics.

Drug cases continue to be the most common issue handled by the office.

The links to the full statistics from the Office of Student Conduct are available here:

- 2021-2022
- 2020-2021
- 2019-2020
- 2018-2019

Alcohol, Drug, and Weapons Related Arrests for 2018-2021 by University Police

Arrest Type	2021	2020	2019	2018
Liquor Law Violations				
On Campus	4	2	10	4
Non-Campus	0	0	2	0
Public Property	1	0	0	2
Student Residence	2	1	10	1
Drug Violations				
On Campus	17	11	36	32
Non-Campus	1	0	0	0
Public Property	26	26	0	14
Student Residence	0	4	10	11
Weapons Violations				
On Campus	0	0	4	0
Non-Campus	1	0	0	0
Public Property	2	0	0	0
Student Residence	0	0	0	0

5. Recommendations

The student conduct data from 2020-2021 and 2021-2022 show sharp decreases in drug, drug paraphernalia, and public intoxication violations. There is a similar sharp decrease in the arrest information for on campus liquor and drug violations for the same period. As indicated in the 2020-2021, the University's response to COVID-19 (shifting to single occupancy dorm and social distancing, for instance) likely had the single largest impact on these statistics.

As part of our Biennial Review and Reporting Process, MTSU will work towards or continue:

- Offering alcohol use presentations to student groups addressing usage facts, standard drink sizes, abstinence, and harm reduction
- Offering e-CheckUptoGo Marijuana as an educational activity for students
- Continue to participate and attend CHASCo meetings, webinars, events, and conferences
- Continue ongoing training of peer health educators, a group of students who are trained to be peer advocates for alcohol awareness, HIV/STI prevention, and risk reduction among fellow students
- Provide parents with talking points regarding alcohol and marijuana use among college students
- Participating in national prescription drug take back events
- Continue to prioritize regular assessment of University students' health knowledge, attitudes, and behaviors through the use of survey tools such as the National College Health Assessment and the Healthy Minds Study Student Survey

Closing Remarks

The AOD prevention programming and support services of MTSU continues to expand, as administrators, faculty, and staff work together to advocate for the mental health, wellness, and safety of students. The University's continued collaboration among departments and divisions, as well as its work and commitment to AOD prevention will reduce instances of alcohol, drug, tobacco, and prescription-drug abuse.

Appendix A: MTSU American College Health Association National College Health Assessment III, Spring 2022

MIDDLE TENNESSEE STATE UNIVERSITY
Executive Summary
Spring 2022

American College Health Association
National College Health Assessment III

ACHA-NCHA III

The ACHA-NCHA III supports the health of the campus community by fulfilling the academic mission, supporting short- and long-term healthy behaviors, and gaining a current profile of health trends within the campus community.

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ACHA, the nation's principal advocate and leadership organization for college and university health, represents a diverse membership that provides and supports the delivery of health care and prevention and wellness services for the nation's 20 million college students. For more information about the association's programs and services, visit www.acha.org, and www.acha.org/NCHA.

Suggested citation for this document:

American College Health Association. American College Health Association-National College Health Assessment III: Middle Tennessee State University Executive Summary Spring 2022. Silver Spring, MD: American College Health Association; 2022.

Introduction and Notes

The ACHA-National College Health Assessment (ACHA-NCHA) is a national research survey organized by the American College Health Association (ACHA) to assist college health service providers, health educators, counselors, and administrators in collecting data about their students' habits and behaviors on the most prevalent health topics. The ACHA-NCHA now provides the largest known comprehensive data set on the health of college students, providing the college health and higher education fields with a vast spectrum of information on student health.

ACHA initiated the original ACHA-NCHA in 2000 and the instrument was used nationwide through the Spring 2008 data collection period. A revised survey, the ACHA-NCHA-II, was in use from Fall 2008 - Spring 2019 data collection periods. The survey was redesigned again, and data collection with the ACHA-NCHA III began in Fall 2019.

Please note that it is not appropriate to compare trends between versions of the survey. Directly comparing data points between the Original ACHA-NCHA, the ACHA-NCHA II, and the ACHA-NCHA III can lead to an erroneous conclusion and is not recommended.

Notes about this report:

1. Missing values have been excluded from analysis and only valid percents are included in this document, unless otherwise noted.

2. **The ACHA-NCHA III is programmed differently than earlier versions of the survey.** Rather than asking the respondents to answer every question (and offering a "not applicable" option), display logic was used throughout the survey to determine whether, based on their response to an earlier question, the student saw a follow-up question. This makes the valid percents of certain questions impossible to apply to the entire sample, as the denominator used was limited to only the number of students that saw the question. When appropriate, results are also presented using the entire sample as the denominator to show the proportion of the overall sample that experienced a particular issue. These differences in presentation are carefully noted throughout the document and will often explain differences observed between this document and the full data report. Please look carefully at descriptions of the data presented in each table, as well as any footnotes included.

3. **About the use of sex and gender in this report:** Survey results are reported by sex based on the responses to questions 67A, 67B, and 67C. The responses to these questions are used to create a new variable called RSEX. RSEX is used for organizing results in the ACHA-NCHA report documents. Respondents are reported as cis men or cis women only when their responses to 67A, 67B, and 67C are consistent with one another. If gender identity is consistent with sex at birth AND "no" is selected for transgender, then respondents are designated as either cis men or cis women in RSEX. If respondents select "yes" for transgender OR their sex at birth is not consistent with their gender identity, then they are designated as transgender/gender non-conforming in RSEX. A respondent that selects "intersex" for sex at birth, "no" for transgender, and man or woman for gender identity are designated as cis men or cis women in RSEX. A respondent that selects "intersex" for sex at birth, "yes" for transgender, or selects a gender identity other than man or woman are designated as transgender/gender non-conforming in RSEX. A respondent that selects "another identity" on 67C is designated missing in RSEX. A respondent that skips any of the three questions is designated as missing in RSEX. Totals displayed in this report include missing responses. Please see the ACHA-NCHA III survey codebook for more information about how data on sex and gender are coded.

For additional information about the survey's development, design, and methodology, email Mary T Hoban, PhD, MCHES, (mhoban@acha.org), Christine Kukich, MS (ckukich@acha.org), or visit www.acha-ncha.org.

We need to draw your attention to an important change in your ACHA-NCHA Report documents. Beginning in Spring 2021, responses for transgender and gender-nonconforming students are readily available directly in the report documents. This represents an important change in the way we have been reporting ACHA-NCHA results. We've prepared the following information to better explain the specific changes, our reasoning for doing so, and tips for using these redesigned report documents.

I. What we've done to date

- The ACHA-NCHA has asked respondents about their gender identity for 12 years.
- Data on transgender and gender-nonconforming (TGNC) students was available in the data file, but not displayed explicitly in the report documents documents in an effort to protect the privacy of TGNC students, particularly those students in smaller campus environments and at schools that publicly shared their ACHA-NCHA report documents.
- We have been trying to find the right balance between protecting students' privacy and making the results accessible to campus surveyors who may not use the statistical software that would be required to extract this information directly from the data files. Until now, we've erred on the side of protecting student privacy.

II. Why change?

- The number of TGNC students in our samples has been increasing over the years. Between 2008 and 2015, the number of students identifying as TGNC was very small (less than 0.05%). We've learned over the years that gender identity is complex and fluid. To better capture this complexity, we began asking separate questions about sex at birth and gender identity in Fall 2015. Now TGNC students tend to represent 3-4% of the overall sample.
- With greater number of students identifying as TGNC on the ACHA-NCHA in recent years, we have a better opportunity to understand their needs and behaviors than we have in years past.
- A number of health disparities between TGNC students and their cisgender peers have been well documented[1], and schools need readily available access to this data in order to better address the needs of TGNC students.

III. What's different about the way we are reporting?

- First – a note about how we have been reporting ACHA-NCHA results to date. RSEX is a variable we create based on the responses to the questions on sex at birth, whether or not a student identifies as transgender, and their gender identity. The RSEX variable had allowed us to sort respondents into 4 groups for reporting purposes: male, female, non-binary, and missing. (Details about this variable can be found in all report documents.)

- The value labels for RSEX have been revised to better represent gender identity rather than sex. A value of "1" has been changed from "Male" to "Cis Men[2]." A "2" has been changed from "Female" to "Cis Women[3]." The value "3" has been changed from "non-binary" to "Transgender and Gender-Nonconforming" (TGNC), as it's a more accurate and inclusive term. The value "4" on RSEX remains "missing/unknown" and is used for students who do not answer all three questions.
- The "missing/unknown" column in the Data Report document has been replaced with a "Trans/Gender-Nonconforming" column. Because space limitations in the report prevent us from displaying all 4 categories plus a total column in the same document, it's now the "missing/unknown" column that is not displayed. Now when the Total of any given row is higher than the sum of the cis men, cis women, and TGNC respondents, the difference can be attributed to "missing/unknown" respondents that selected the response option presented in that row
- A column for "Trans/Gender-Nonconforming" has been added the Executive Summary Report document.

IV. Important considerations with this new format

- Percentages in the Executive Summary may represent a very small number of TGNC students and can limit the generalizability of a particular finding. To assist with the interpretation of the percentages displayed in the Executive Summary, the total sample size for each group has been added to every page.
- We encourage ACHA-NCHA surveyors to carefully review their report documents, particularly among the student demographic variables, and consider students who may be inadvertently identified in the results based on a unique combination of the demographic characteristics before sharing the documents widely or publicly. This is especially true for very small schools, as well as schools that lack diversity in the student population.
- Think about the implication of working with and documenting very small samples – from the perspective of making meaningful interpretations, as well as the privacy of respondents. This is true of all demographic variables, and not limited to gender identity. You may consider a minimum cell size or another threshold by which you make decisions about making your Institutional Data Report publicly available. It is less of a concern in your Institutional Executive Summary as we only display the percentages with the overall sample size.

[1] Greathouse M, BrckaLorenz A, Hoban M, Huseman R, Rankin S, Stolzenberg EB. (2018). Queer-spectrum and trans-spectrum student experiences in American higher education: The analysis of national survey findings. New Brunswick, NJ: Tyler Clementi Center, Rutgers University.
[2] Cisgender refers to people whose gender identity matches their sex assigned at birth. Cis men is short for "cisgender men" and is a term used to describe persons who identity as men and were assigned male at birth.
[3] Cis women is short for "cisgender women" and is a term used to describe persons who identify as women and were assigned female at birth.

This Executive Summary highlights results of the ACHA-NCHA III Spring 2022 survey for Middle Tennessee State University consisting of 691 respondents.
The response rate was 11.5%.

Findings

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

A. General Health and Campus Climate

- 41.7 % of college students surveyed (46.6 % cis men, 40.7 % cis women, and 28.6 % transgender/gender non-conforming) described their health as ***very good or excellent.***
- 82.0 % of college students surveyed (86.4 % cis men, 82.2 % cis women, and 60.0 % transgender/gender non-conforming) described their health as ***good, very good or excellent***.

Proportion of college students who reported they *agree* or *strongly agree* that: *Percent (%)*	**Cis Men**	**Cis Women**	**Trans/ Gender Non-conforming**	**Total**
I feel that I belong at my college/university	64.2	62.9	56.1	62.4
I feel that students' health and well-being is a priority at my college/university	48.1	53.3	36.6	50.6
At my college/university, I feel that the campus climate encourages free and open discussion of students' health and well-being.	52.9	57.7	36.6	54.8
At my college/university, we are a campus where we look out for each other	39.0	46.5	22.0	42.3

B. Nutrition, BMI, Physical Activity, and Food Security

College students reported: *Percent (%)*	**Cis Men**	**Cis Women**	**Trans/ Gender Non-conforming**	**Total**
Drinking 0 sugar-sweetened beverages (per day), on average, in the last 7 days	30.1	26.8	22.0	27.4
Drinking 1 or more sugar-sweetened beverages (per day), on average, in the last 7 days	69.9	73.2	78.0	72.6
Drinking energy drinks or shots on 0 of the past 30 days	68.1	73.1	65.9	71.1
Drinking energy drinks or shots on 1-4 of the past 30 days	17.6	13.4	14.6	14.9
Drinking energy drinks or shots on 5 or more of the past 30 days	14.3	13.4	19.5	14.0
Eating 3 or more servings of fruits (per day), on average, in the last 7 days	9.7	15.5	17.1	14.3
Eating 3 or more servings of vegetables (per day), on average, in the last 7 days	29.0	31.1	24.4	30.4

Estimated Body Mass Index (BMI): This figure incorporates reported height and weight to form a general indicator of physical health. Categories defined by The World Health Organization (WHO) 2000, reprinted 2004. Obesity: Preventing and Managing the Global Epidemic. WHO Tech Report Series: 894.

BMI *Percent (%)*	**Cis Men**	**Cis Women**	**Trans/ Gender Non-conforming**	**Total**
<18.5 Underweight	4.8	5.0	5.0	4.9
18.5-24.9 Healthy Weight	41.4	42.2	35.0	41.0
25-29.9 Overweight	29.0	22.9	25.0	25.0
30-34.9 Class I Obesity	17.2	15.2	25.0	16.4
35-39.9 Class II Obesity	6.5	7.5	5.0	7.1
≥40 Class III Obesity	1.1	7.3	5.0	5.6

Mean	26.40	27.24	27.98	27.14
Median	25.72	25.63	27.25	25.75
Std Dev	5.61	7.43	7.31	7.00

Students meeting the recommended guidelines for physical activity

Based on: US Dept of Health and Human Services. *Physical Activities Guidelines for Americans* , 2nd edition. Washington, DC: US Dept of Health and Human Services; 2018

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

Definitions:

- Recommendation for **aerobic activity**: 150 minutes or more of moderate-intensity physical activity per week or 75 minutes of vigorous-intensity physical activity or the equivalent combination
- Recommendation for **strength training**: 2 or more days a week of moderate or greater intensity activities that involve all major muscle groups
- ***Active Adults*** meet the recommendation for strength training **AND** aerobic activity
- ***Highly Active Adults*** meet the recommendation for strength training and **TWICE** the recommendation for aerobic activity (300 minutes or more of moderate-intensity physical activity per week or 150 minutes of vigorous-intensity physical activity or the equivalent combination)

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Guidelines met for **aerobic exercise only**	62.8	57.8	57.9	59.0
Guidelines met for **Active Adults**	41.0	31.7	15.8	33.2
Guidelines met for **Highly Active Adults**	32.2	22.5	10.5	24.5

Food Security

Based on responses to the *US Household Food Security Survey Module: Six-Item Short Form (2012)* from the USDA Economic Research Service.

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
High or marginal food security (score 0-1)	54.3	53.4	39.0	52.4
Low food security (score 2-4)	24.2	25.0	26.8	25.6
Very low food security (score 5-6)	21.5	21.6	34.1	22.0
Any food insecurity (low or very low food security)	45.7	46.6	61.0	47.6

C. Health Care Utilization

College students reported: *Percent (%)*	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Receiving psychological or mental health services within the last 12 months	18.7	34.9	68.3	32.7
*The services were provided by:				
My current campus health and/or counseling center	8.6	22.9	14.8	19.5
A mental health provider in the local community near my campus	25.7	34.0	26.9	31.5
A mental health provider in my home town	57.1	51.3	66.7	53.9
A mental health provider not described above	18.2	21.6	14.3	20.1

**Only students who reported receiving care in the last 12 months were asked these questions*

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Visiting a medical provider within the last 12 months	58.8	76.6	82.9	72.1
*The services were provided by:				
My current campus health center	37.5	29.7	35.5	32.6
A medical service provider in the local community near my campus	26.7	32.6	28.1	30.9
A medical service provider in my home town	76.9	72.4	67.6	73.0
A medical service provider not described above	7.6	6.3	4.0	6.4

**Only students who reported receiving care in the last 12 months were asked these questions*

Cis Men n =	188
Cis Women n =	444
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College students reported: *Percent (%)*	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Flu vaccine within the last 12 month	39.8	40.2	46.3	40.2
Not starting the HPV vaccine series	23.7	27.1	17.1	25.4
Starting, but not completing HPV vaccine series	1.6	3.8	7.3	3.5
Completing HPV vaccine series	35.5	41.6	51.2	40.6
Not knowing their HPV vaccine status	39.2	27.4	24.4	30.5
Ever having a GYN visit or exam (females only)		57.9	43.9	
Having a dental exam in the last 12 months	60.1	70.0	61.0	66.6
Being tested for HIV within the last 12 months	8.5	12.8	12.2	11.4
Being tested for HIV more than 12 months ago	11.7	10.8	14.6	11.3
Wearing sunscreen usually or always when outdoors	16.5	36.9	26.8	30.5
Spending time outdoors with the intention of tanning at least once in the last 12 months	29.2	51.9	26.8	44.0

D. Impediments to Academic Performance

Respondents are asked in numerous places throughout the survey about issues that might have negatively impacted their academic performance within the last 12 months. This is defined as negatively impacting their performance in a class or delaying progress towards their degree. Both types of negative impacts are represented in the figures below. Please refer to the corresponding Data Report for specific figures on each type of impact. Figures in the **left** columns use all students in the sample as the denominator. Figures in the **right** columns use only the students that experienced that issue (e.g. students who used cannabis, reported a problem or challenge with finances, or experienced a particular health issue) in the denominator.
(items are listed in the order in which they appear in the survey)

	Negatively impacted academic performance among all students in the sample				Negatively impacted academic performance among only students that experienced the issue			
Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Alcohol use	1.6	1.4	4.9	1.6	2.3	2.0	6.9	2.3
Cannabis/marijuana use	2.7	1.4	4.9	1.9	8.6	5.1	12.5	6.7
Problems or challenges in the last 12 months								
Career	8.5	15.1	14.6	13.2	23.9	40.1	35.3	35.8
Finances	14.9	16.2	29.3	16.6	28.3	30.6	42.9	31.3
Procrastination	46.8	45.5	65.9	46.5	62.0	59.9	71.1	61.3
Faculty	10.1	7.9	14.6	8.7	65.5	61.4	85.7	64.5
Family	8.0	16.0	22.0	14.0	24.6	34.8	39.1	33.0
Intimate Relationships	11.2	9.7	26.8	11.0	28.8	28.9	47.8	30.6
Roommate/housemate	5.3	6.1	9.8	5.9	26.3	26.0	33.3	26.3
Peers	3.7	4.1	7.3	4.2	20.0	20.0	27.3	21.0
Personal appearance	2.1	6.1	7.3	5.1	4.5	9.7	10.3	8.8
Health of someone close to me	9.6	11.9	12.2	11.1	24.3	24.4	21.7	24.3
Death of a family member, friend, or someone close to me	8.0	9.0	17.1	9.3	29.4	30.8	58.3	32.5
Bullying	1.1	0.9	7.3	1.4	20.0	13.3	100.0	22.7
Cyberbullying	0.5	0.9	7.3	1.2	25.0	23.5	60.0	30.8
Hazing	0.0	0.5	2.4	0.4	0.0	33.3	100.0	37.5
Microaggression	2.1	1.6	9.8	2.3	12.5	12.1	25.0	14.7
Sexual Harassment	0.5	2.3	7.3	2.0	20.0	22.2	50.0	24.6
Discrimination	1.1	2.5	7.3	2.5	12.5	30.6	37.5	27.9

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

	Negatively impacted academic performance among all students in the sample				Negatively impacted academic performance among only students that experienced the issue			
Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Acute Diagnoses in the last 12 months								
Bronchitis	1.1	1.8	0.0	1.4	66.7	27.6	0.0	30.3
Chlamydia	0.0	0.2	0.0	0.1	0.0	6.7	0.0	5.6
Chicken Pox (Varicella)	0.0	0.2	0.0	0.1	0.0	25.0	0.0	25.0
Cold/Virus or other respiratory illness	9.0	16.7	9.8	13.9	32.7	37.8	22.2	35.6
Concussion	0.5	1.8	2.4	1.4	100.0	50.0	100.0	55.6
Gonorrhea	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Flu (influenza or flu-like illness)	3.2	3.6	0.0	3.2	31.6	47.1	0.0	38.6
Mumps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mononucleosis (mono)	0.0	0.9	0.0	0.6	0.0	57.1	0.0	50.0
Orthopedic injury	3.2	3.2	4.9	3.2	42.9	29.8	33.3	32.4
Pelvic Inflammatory Disease	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pneumonia	0.0	0.9	0.0	0.6	0.0	57.1	0.0	44.4
Shingles	0.0	0.5	0.0	0.3	0.0	40.0	0.0	40.0
Stomach or GI virus or bug, food poisoning or gastritis	2.1	3.8	12.2	3.8	25.0	32.7	62.5	33.3
Urinary tract infection	0.0	3.8	4.9	2.7	0.0	27.4	33.3	27.1

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Any ongoing or chronic medical conditions diagnosed or treated in the last 12 months	27.7	33.8	65.9	33.6	44.4	41.9	73.0	44.7
Other impediments to academic performance								
Assault (physical)	0.0	0.5	0.0	0.3	0.0	15.4	0.0	11.1
Assault (sexual)	0.5	2.9	4.9	2.3	20.0	38.2	40.0	35.6
Allergies	4.3	1.6	0.0	2.2	13.3	3.8	0.0	5.8
Anxiety	26.1	35.6	56.1	34.0	46.7	51.1	67.6	51.9
ADHD or ADD	6.9	10.8	17.1	10.4	44.8	65.8	63.6	61.5
Concussion or TBI	1.6	2.3	2.4	2.0	50.0	52.6	50.0	51.9
Depression	19.7	27.0	56.1	26.5	46.8	60.3	76.7	58.7
Eating disorder/problem	1.1	4.3	9.8	3.6	20.0	28.4	44.4	28.4
Headaches/migraines	9.0	13.7	17.1	12.6	29.8	31.4	31.8	31.5
Influenza or influenza-like illness (the flu)	3.2	3.6	2.4	3.3	40.0	30.8	50.0	33.3
Injury	2.1	2.9	4.9	2.7	30.8	27.7	28.6	27.9
PMS	0.0	12.8	9.8	8.8	0.0	28.5	44.4	29.0
PTSD	2.1	4.1	17.1	4.3	50.0	43.9	70.0	50.0
Short-term illness	3.2	5.4	14.6	5.2	46.2	35.3	50.0	38.3
Upper respiratory illness	7.4	6.8	4.9	6.8	32.6	22.6	25.0	25.1
Sleep difficulties	23.9	24.3	43.9	24.9	48.9	44.6	72.0	47.4
Stress	29.8	44.1	53.7	40.2	46.3	55.2	68.8	54.0

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

E. Violence, Abusive Relationships, and Personal Safety

Within the last 12 months, college students reported experiencing:

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
A physical fight	4.3	1.8	4.9	2.9
A physical assault (not sexual assault)	1.6	0.9	7.3	1.6
A verbal threat	12.9	9.9	26.8	11.9
Sexual touching without their consent	3.2	5.2	9.8	4.9
Sexual penetration attempt without their consent	0.5	2.3	4.9	1.9
Sexual penetration without their consent	1.1	1.1	2.4	1.3
Being a victim of stalking	1.6	5.0	9.8	4.3
A partner called me names, insulted me, or put me down to make me feel bad	10.8	11.8	20.0	12.0
A partner often insisted on knowing who I was with and where I was or tried to limit my contact with family or friends	5.4	5.4	2.6	5.3
A partner pushed, grabbed, shoved, slapped, kicked, bit, choked or hit me without my consent	2.7	3.2	2.5	3.0
A partner forced me into unwanted sexual contact by holding me down or hurting me in some way	0.5	1.6	2.5	1.5
A partner pressured me into unwanted sexual contact by threatening me, coercing me, or using alcohol or other drugs	1.6	4.8	5.0	3.8

College students reported feeling ***very safe*** :

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
On their campus (daytime)	84.3	75.4	63.4	77.1
On their campus (nighttime)	44.9	14.7	12.2	23.0
In the community surrounding their campus (daytime)	38.4	33.0	34.1	34.9
In the community surrounding their campus (nighttime)	20.0	9.5	7.3	12.4

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

F. Tobacco, Alcohol, and Other Drug Use

	Ever Used				*Used in the last 3 months			
Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Tobacco or nicotine delivery products (cigarettes, e-cigarettes, Juul or other vape products, water pipe or hookah, chewing tobacco, cigars, etc.)	41.4	36.7	34.1	38.1	27.7	25.0	31.7	25.8
Alcoholic beverages (beer, wine, liquor, etc.)	71.5	70.5	75.6	71.3	64.4	62.8	61.0	62.4
Cannabis (marijuana, weed, hash, edibles, vaped cannabis, etc.) ***[Please report nonmedical use only.]***	44.3	36.8	51.2	40.0	26.6	21.2	34.1	23.2
Cocaine (coke, crack, etc.)	7.6	5.7	0.0	5.8	1.6	0.9	0.0	1.0
Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) ***[Please report nonmedical use only.]***	12.4	8.4	7.5	9.3	2.1	1.6	0.0	1.6
Methamphetamine (speed, crystal meth, ice, etc.)	2.2	1.4	0.0	1.5	0.5	0.0	0.0	0.1
Inhalants (poppers, nitrous, glue, gas, paint thinner, etc.)	6.0	1.8	5.0	3.1	2.1	0.0	2.4	0.7
Sedatives or Sleeping Pills (Valium, Ativan, Xanax, Klonopin, Librium, Rohypnol, GHB, etc.) ***[Please report nonmedical use only.]***	8.1	6.3	12.2	7.1	2.1	2.0	2.4	2.0
Hallucinogens (Ecstasy, MDMA, Molly, LSD, acid, mushrooms, PCP, Special K, etc.)	14.6	9.9	14.6	11.3	4.8	2.0	2.4	2.7
Heroin	0.5	0.5	0.0	0.4	0.0	0.0	0.0	0.0
Prescription opioids (morphine, codeine, fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine [Suboxone], etc.) ***[Please report nonmedical use only.]***	9.8	4.7	12.2	6.5	1.6	0.7	2.4	1.0

**These figures use all students in the sample as the denominator, rather than just those students who reported lifetime use.*

Substance Specific Involvement Scores (SSIS) from the ASSIST

	*Moderate risk use of the substance				*High risk use of the substance			
Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Tobacco or nicotine delivery products	18.1	16.7	26.8	17.5	1.6	2.3	4.9	2.2
Alcoholic beverages	10.6	8.6	9.8	9.1	2.1	1.1	4.9	1.6
Cannabis (nonmedical use)	16.0	13.7	24.4	14.9	1.6	0.2	4.9	0.9
Cocaine	1.1	0.9	0.0	0.9	0.0	0.0	0.0	0.0
Prescription stimulants (nonmedical use)	2.1	0.9	2.4	1.3	0.0	0.0	0.0	0.0
Methamphetamine	0.5	0.2	0.0	0.3	0.0	0.0	0.0	0.0
Inhalants	1.6	0.0	2.4	0.6	0.0	0.0	0.0	0.0
Sedatives or Sleeping Pills (nonmedical use)	1.6	2.0	2.4	1.9	0.0	0.0	0.0	0.0
Hallucinogens	1.6	1.1	2.4	1.3	0.0	0.0	0.0	0.0
Heroin	0.0	0.5	0.0	0.3	0.0	0.0	0.0	0.0
Prescription opioids (nonmedical use)	1.1	0.7	2.4	0.9	0.5	0.0	0.0	0.1

**These figures use all students in the sample as the denominator, rather than just those students who reported lifetime use.*

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

Proportion of students (overall sample) who report misusing prescription medications (taking without a prescription, or taking more medication or more often than prescribed) in the past 3 months:

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Prescription stimulants	1.1	1.1	0.0	1.0
Prescription sedatives or sleeping pills	2.1	1.6	2.4	1.7
Prescription opioids	1.6	0.2	2.4	0.7

***Tobacco or nicotine delivery products used in the last 3 months**

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Cigarettes	6.9	5.6	19.5	6.7
E-cigarettes or other vape products (for example: Juul, etc.)	17.6	19.4	24.4	19.0
Water pipe or hookah	0.0	2.7	0.0	1.7
Chewing or smokeless tobacco	6.9	0.0	2.4	2.0
Cigars or little cigars	7.4	1.8	4.9	3.5
Other	2.1	0.0	0.0	0.6

**These figures use all students in the sample as the denominator, rather than just those students who reported tobacco or nicotine delivery product use in the last 3 months.*

Students in Recovery

■ 2.9 % of college students surveyed (2.1 % cis men, 3.0 % cis women, and 6.1 % transgender/gender non-conforming) indicated they were in recovery from alcohol or other drug use.

When, if ever, was the last time you:

	Drank Alcohol				*Used Cannabis/Marijuana			
Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Never	22.5	23.5	19.5	22.8	50.3	59.0	43.9	55.5
Within the last 2 weeks	49.2	42.9	34.1	44.0	17.6	10.4	29.3	13.6
More than 2 weeks ago but within the last 30 days	8.6	8.8	9.8	8.8	3.2	3.4	4.9	3.4
More than 30 days ago but within the last 3 months	6.4	11.3	17.1	10.4	3.7	6.1	0.0	5.2
More than 3 months ago but within the last 12 months	7.0	6.5	9.8	6.8	7.0	7.7	9.8	7.7
More than 12 months ago	6.4	7.0	9.8	7.2	18.2	13.4	12.2	14.7

**Students were instructed to include medical and non-medical use of cannabis.*

Driving under the influence

- 17.8 % of college students reported driving after having ***any alcohol*** in the last 30 days.*
  **Only students who reported driving in the last 30 days and drinking alcohol in the last 30 days were asked this question.*
- 42.1 % of college students reported driving within 6 hours of using cannabis/marijuana in the last 30 days.*
  **Only students who reported driving in the last 30 days and using cannabis in the last 30 days were asked this question.*

Estimated Blood Alcohol Concentration (or eBAC) of college students. Due to the improbability of a student surviving a drinking episode resulting in an extremely high eBAC, all students with an eBAC of 0.50 or higher are also omitted from these eBAC figures. eBAC is an estimated figure based on the reported number of drinks consumed during the last time they drank alcohol in a social setting, their approximate time of consumption, sex, weight, and the average rate of ethanol metabolism. Only students who reported drinking alcohol within the last 3 months answered these questions.

Estimated BAC Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
< .08	86.4	82.3	82.6	83.7
< .10	94.1	88.1	87.0	89.8
Mean	0.03	0.04	0.04	0.04
Median	0.01	0.02	0.01	0.01
Std Dev	0.05	0.06	0.07	0.06

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

***Reported number of drinks consumed the last time students drank alcohol in a social setting.**

Number of drinks *Percent (%)*	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
4 or fewer	71.4	83.5	87.5	80.3
5	6.7	7.6	4.2	7.3
6	7.6	2.9	4.2	4.2
7 or more	14.3	6.1	4.2	8.2
Mean	3.7	2.8	2.4	3.0
Median	2.5	2.0	2.0	2.0
Std Dev	3.1	2.2	2.2	2.5

**Only students who reported drinking alcohol in the last three months were asked this question.*

Reported number of times college students consumed five or more drinks in a sitting within the last two weeks:

	Among all students surveyed				*Among those who reported drinking alcohol within the last two weeks			
Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Did not drink alcohol in the last two weeks (includes non-drinkers)	50.8	57.2	65.9	56.1				
None	26.7	22.4	17.1	23.4	54.3	52.4	50.0	53.4
1-2 times	16.6	16.7	7.3	15.9	33.7	39.2	21.4	36.2
3-5 times	4.3	2.5	4.9	3.1	8.7	5.8	14.3	7.0
6 or more times	1.6	1.1	4.9	1.5	3.3	2.6	14.3	3.4

**Only students who reported drinking alcohol in the last two weeks were asked this question.*

***College students who drank alcohol reported experiencing the following in the last 12 months when drinking alcohol:**

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Did something I later regretted	17.3	14.1	20.7	15.2
Blackout (forgot where I was or what I did for **a large period of time and cannot remember**, even when someone reminds me)	9.0	6.8	24.1	8.4
Brownout (forgot where I was or what I did for **short periods of time, but can remember** once someone reminds me)	15.8	17.6	24.1	17.7
Got in trouble with the police	0.8	0.7	0.0	0.6
Got in trouble with college/university authorities	0.8	0.3	0.0	0.4
Someone had sex with me **without my** consent	0.8	1.0	6.9	1.3
Had sex with someone **without their** consent	0.8	0.0	0.0	0.2
Had unprotected sex	12.0	14.3	27.6	14.5
Physically injured myself	6.0	7.2	13.8	7.2
Physically injured another person	0.0	0.3	3.4	0.4
Seriously considered suicide	6.0	3.9	10.3	4.9
Needed medical help	0.8	0.7	0.0	0.6
Reported two or more of the above	20.6	20.0	31.8	20.6

**Only students who reported drinking alcohol in the last 12 months were asked these questions.*

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

G. Sexual Behavior

When, if ever, was the last time you had:

Oral sex

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Never	33.5	33.7	41.5	34.0
Within the last 2 weeks	30.8	32.6	24.4	31.8
More than 2 weeks ago but within the last 30 days	5.4	7.1	9.8	6.8
More than 30 days ago but within the last 3 months	8.6	7.3	9.8	7.7
More than 3 months ago but within the last 12 months	8.6	8.0	7.3	8.3
More than 12 months ago	13.0	11.4	7.3	11.4

Vaginal intercourse

Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
43.7	36.4	46.3	39.0
30.6	37.8	26.8	35.4
2.2	6.8	7.3	5.5
6.6	4.8	2.4	5.2
7.7	4.6	7.3	5.5
9.3	9.6	9.8	9.4

Anal intercourse

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Never	68.5	80.0	80.0	76.9
Within the last 2 weeks	6.5	1.1	0.0	2.5
More than 2 weeks ago but within the last 30 days	2.2	1.1	0.0	1.5
More than 30 days ago but within the last 3 months	5.4	1.4	5.0	2.7
More than 3 months ago but within the last 12 months	6.0	4.1	5.0	4.6
More than 12 months ago	11.4	12.3	10.0	11.8

***College students who reported having oral sex, or vaginal or anal intercourse within the last 12 months reported having the following number of sexual partners:**

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
None	0.0	0.0	0.0	0.0
1	74.3	75.1	54.5	73.7
2	8.3	12.5	22.7	11.9
3	8.3	4.5	9.1	6.0
4 or more	9.2	7.9	13.6	8.4
Mean	2.2	1.7	2.4	1.9
Median	1.0	1.0	1.0	1.0
Std Dev	4.2	1.9	2.5	2.7

**Only students who reported having oral sex, or vaginal or anal intercourse in the last 12 months were asked this question.*

College students who reported having oral sex, or vaginal or anal intercourse within the last 30 days who reported using a condom or another protective barrier *most of the time* or *always:*

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Oral sex	4.6	3.4	7.1	3.9
Vaginal intercourse	25.4	26.5	21.4	25.9
Anal intercourse	12.5	10.0	0.0	11.1

**Only students who reported having oral sex, or vaginal or anal intercourse in the last 30 days were asked these questions.*

College students who reported having vaginal intercourse (penis in vagina) within the last 12 months were asked if they or their partner used any method to prevent pregnancy the last time they had vaginal intercourse:

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Yes, used a method of contraception	78.8	78.9	77.8	78.9
No, did not want to prevent pregnancy	4.7	3.4	0.0	3.8
No, did not use any method	14.1	17.7	22.2	16.8
Don't know	2.4	0.0	0.0	0.6

**Only students who reported having oral sex, or vaginal or anal intercourse in the last 12 months were asked this question.*

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

***Those students who reported using a contraceptive use the last time they had vaginal intercourse, reported they (or their partner) used the following methods:**

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Birth control pills (monthly or extended cycle)	41.8	44.9	14.3	42.9
Birth control shots	0.0	2.1	0.0	1.5
Birth control implants	7.5	6.4	14.3	7.0
Birth control patch	0.0	1.1	0.0	0.7
The ring	4.5	1.6	7.1	2.6
Emergency contraception ("morning after pill" or "Plan B")	7.5	4.3	7.1	5.1
Intrauterine device	19.4	13.9	14.3	15.4
Male (external) condom	44.8	38.5	50.0	40.7
Female (internal) condom	0.0	0.0	0.0	0.0
Diaphragm or cervical cap	0.0	0.0	0.0	0.0
Contraceptive sponge	0.0	0.0	0.0	0.0
Withdrawal	14.9	27.8	42.9	25.3
Fertility awareness (calendar, mucous, basal body temperature)	1.5	7.5	14.3	6.2
Sterilization (hysterectomy, tubes tied, vasectomy)	3.0	8.0	7.1	6.6
Other method	0.0	2.7	0.0	1.8
Male condom use plus another method	29.9	27.8	35.7	28.6
Any two or more methods (excluding male condoms)	13.4	26.2	21.4	22.7

**Only students who reported they or their partner used a method the last time they had vaginal intercourse were asked these questions.*

College students who reported having vaginal intercourse (penis in vagina) within the last 12 months were asked if they or their partner used emergency contraception ("morning after pill" or "Plan B") in the last 12 months:

Yes (10.5 % cis men, 19.5 % cis women, 22.2 % trans/gender non-conforming)

College students who reported having vaginal intercourse (penis in vagina) within the last 12 months were asked if they experienced an unintentional pregnancy or got someone pregnant within the last 12 months:

Yes (0 % cis men, 2.1 % cis women, 0 % trans/gender non-conforming)

H. Mental Health and Wellbeing

Kessler 6 (K6) Non-Specific Psychological Distress Score (Range is 0-24)

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
No or low psychological distress (0-4)	28.3	19.4	0.0	20.9
Moderate psychological distress (5-12)	54.3	56.0	43.9	54.7
Serious psychological distress (13-24)	17.4	24.5	56.1	24.5
Mean	7.99	9.14	13.83	9.10
Median	7.00	9.00	14.00	9.00
Std Dev	5.37	5.26	4.98	5.42

UCLA Loneliness Scale (ULS3) Score (Range is 3-9)

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Negative for loneliness (3-5)	48.4	49.8	24.4	47.9
Positive for loneliness (6-9)	51.6	50.2	75.6	52.1
Mean	5.63	5.62	6.59	5.67
Median	6.00	6.00	6.00	6.00
Std Dev	2.07	1.98	1.80	2.01

Diener Flourishing Scale – Psychological Well-Being (PWB) Score (Range is 8-56)
(higher scores reflect a higher level of psychological well-being)

	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Mean	42.24	44.92	37.93	43.71
Median	45.00	46.00	40.00	46.00
Std Dev	10.06	8.13	10.75	9.12

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

The Connor-Davison Resilience Scale (CD-RISC2) Score (Range is 0-8)
(higher scores reflect greater resilience)

	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Mean	6.23	6.01	5.05	6.00
Median	6.00	6.00	5.00	6.00
Std Dev	1.65	1.55	1.79	1.62

Self injury

- 12.1 % of college students surveyed (9.1 % cis men, 10.6 % cis women, and 41.5 % trans/gender non-conforming) indicated they had intentionally cut, burned, bruised, or otherwise injured themselves within the last 12 months.

Within the last 12 months, have you had problems or challenges with any of the following:

***Of those reporting this issue, it caused moderate or high distress**

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Academics	47.3	50.1	65.0	50.4	74.7	87.8	92.0	85.0
Career	36.4	37.7	42.5	37.6	71.6	82.5	56.3	78.2
Finances	53.2	53.2	68.3	54.3	76.8	79.9	85.7	79.6
Procrastination	76.3	76.5	95.0	77.6	58.2	69.2	75.7	66.7
Faculty	15.5	12.9	17.5	13.7	55.2	71.9	85.7	67.7
Family	32.8	46.5	57.5	43.7	54.1	76.7	77.3	72.2
Intimate relationships	39.0	33.6	56.1	36.5	53.4	61.7	77.3	61.1
Roommate/housemate	20.3	23.5	30.0	23.0	45.9	61.2	66.7	57.8
Peers	18.8	20.9	27.5	20.8	54.3	49.5	54.5	51.1
Personal appearance	47.1	62.8	72.5	58.9	42.5	60.7	48.3	55.8
Health of someone close to me	39.6	49.1	57.5	46.8	59.5	65.4	52.2	62.8
Death of a family member, friend, or someone close to me	27.3	29.4	29.3	29.0	82.0	73.1	83.3	76.0
Bullying	5.3	6.8	7.5	6.5	60.0	53.3	66.7	56.8
Cyberbullying	2.1	3.8	12.5	3.8	50.0	58.8	80.0	61.5
Hazing	0.5	1.4	2.5	1.2	0.0	50.0	0.0	37.5
Microaggression	17.1	13.1	39.0	16.1	19.4	48.3	62.5	41.7
Sexual Harassment	2.7	10.2	15.0	8.4	20.0	68.9	50.0	63.2
Discrimination	8.6	8.1	20.0	9.0	31.3	61.1	75.0	55.7

**Only students who reported a problem or challenge in the last 12 months were asked about level of distress.*

Students reporting none of the above	5.9	5.9	2.4	5.7
Students reporting only one of the above	8.6	5.6	0.0	6.2
Students reporting 2 of the above	11.8	7.7	2.4	8.5
Students reporting 3 or more of the above	73.8	80.8	95.1	79.6

Suicide Behavior Questionnaire-Revised (SBQR) Screening Score (Range is 3-18)

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Negative suicidal screening (3-6)	65.1	71.0	41.5	67.4
Positive suicidal screening (7-18)	34.9	29.0	58.5	32.6
Mean	5.91	5.53	8.83	5.84
Median	5.00	4.00	9.00	4.00
Std Dev	3.39	3.29	4.29	3.46

Suicide attempt

- 3.6 % of college students surveyed (2.1 % cis men, 3.2 % cis women, and 12.2 % trans/gender non-conforming) indicated they had attempted suicide within the last 12 months.

Within the last 30 days, how would you rate the overall level of stress experienced:

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
No stress	2.7	1.1	0.0	1.5
Low	26.3	15.1	7.3	17.8
Moderate	43.5	45.7	43.9	45.0
High	27.4	38.1	48.8	35.7

I. Acute Conditions

College students reported being diagnosed by a healthcare professional within the last 12 months with:

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Bronchitis	1.6	6.5	2.6	4.9
Chlamydia	1.6	3.4	0.0	2.7
Chicken Pox (Varicella)	0.0	0.9	0.0	0.6
Cold/virus or other respiratory illness (for example: sinus infection, ear infection, strep throat, tonsillitis, pharyngitis, or laryngitis)	28.1	44.8	45.0	40.2
Concussion	1.1	3.6	2.4	2.8
Gonorrhea	1.1	0.7	0.0	0.7
Flu (influenza) or flu-like illness	10.4	7.7	10.3	8.5
Mumps	0.0	0.5	0.0	0.3
Mononucleosis (mono)	0.5	1.6	0.0	1.2
Orthopedic injury (for example: broken bone, fracture, sprain, bursitis, tendinitis, or ligament injury)	7.5	10.8	14.6	10.2
Pelvic Inflammatory Disease	0.0	0.5	0.0	0.3
Pneumonia	0.5	1.6	0.0	1.3
Shingles	0.0	1.1	0.0	0.7
Stomach or GI virus or bug, food poisoning or gastritis	8.6	11.8	20.0	11.5
Urinary tract infection	1.1	14.3	15.0	10.5

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

J. Ongoing or Chronic Conditions

The questions for the *ongoing or chronic conditions* are presented differently in this report than the order they appear in the survey. In the survey, all items appear in a single list, ordered alphabetically. In this report, the conditions are presented in groups to ease burden on the reader. The findings are divided into mental health conditions, STIs and other chronic infections, and other ongoing or chronic conditions in this report.

Mental Health	College students reported ever being diagnosed with the following:				*Of those ever diagnosed, those reporting contact with healthcare or MH professional within last 12 months			
Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
ADD/ADHD - Attention Deficit/Hyperactivity Disorder	10.8	12.5	20.0	12.6	40.0	70.4	75.0	64.3
Alcohol or Other Drug-Related Abuse or Addiction	1.1	1.1	5.1	1.3	50.0	0.0	50.0	22.2
Anxiety (for example: Generalized Anxiety, Social Anxiety, Panic Disorder, Specific Phobia)	23.1	41.7	68.3	38.1	53.5	71.6	85.7	70.3
Autism Spectrum	5.4	1.8	7.5	3.1	50.0	57.1	33.3	50.0
Bipolar and Related Conditions (for example: Bipolar I, II, Hypomanic Episode)	3.8	5.5	23.1	6.2	57.1	83.3	100.0	82.9
Borderline Personality Disorder (BPD), Avoidant Personality, Dependent Personality, or another personality disorder	0.0	0.9	10.0	1.2	0.0	75.0	100.0	87.5
Depression (for example: Major depression, persistent depressive disorder, disruptive mood disorder)	22.2	32.0	70.7	31.5	46.3	71.6	86.2	69.0
Eating Disorders (for example: Anorexia Nervosa, Bulimia Nervosa, Binge-Eating)	0.0	8.4	15.0	6.4	0.0	41.7	100.0	50.0
Gambling Disorder	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Insomnia	8.6	9.5	17.5	9.6	37.5	61.9	66.7	56.3
Obsessive-Compulsive and Related Conditions (for example: OCD, Body Dysmorphia, Hoarding, Trichotillomania and other body-focused repetitive behavior disorders)	3.8	5.9	17.5	6.1	71.4	60.0	100.0	70.0
PTSD (Posttraumatic Stress Disorder), Acute Stress Disorder, Adjustment Disorder, or another trauma- or stressor- related condition	3.8	8.9	26.8	8.4	57.1	48.7	90.9	57.9
Schizophrenia and Other Psychotic Conditions (for example: Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Delusional Disorder)	0.5	0.5	0.0	0.4	100.0	0.0	0.0	33.3
Tourette's or other neurodevelopmental condition not already listed	1.1	0.0	5.0	0.6	100.0	0.0	100.0	100.0
Traumatic brain injury (TBI)	0.5	1.6	5.1	1.5	100.0	57.1	50.0	60.0

**Only students who reported ever being diagnosed were asked about contact with a healthcare or mental health professional within the last 12 months.*

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Students reporting none of the above	61.3	49.2	22.0	51.0
Students reporting only one of the above	14.0	12.9	9.8	13.0
Students reporting both Depression and Anxiety	17.7	28.1	63.4	27.3
Students reporting any two or more of the above (excluding the combination of Depression and Anxiety)	7.0	9.8	4.9	8.7

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

STI's/Other chronic infections

Percent (%)	College students reported ever being diagnosed with the following: Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	*Of those ever diagnosed, had contact with healthcare or MH professional within last 12 months: Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Genital herpes	0.5	1.4	0.0	1.1	0.0	50.0	0.0	42.9
Hepatitis B or C	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
HIV or AIDS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Human papillomavirus (HPV) or genital warts	0.0	3.0	5.0	2.2	0.0	46.2	0.0	40.0

**Only students who reported ever being diagnosed were asked about contact with a healthcare or mental health professional within the last 12 months.*

Other Chronic /Ongoing Medical Conditions

Percent (%)	College students reported ever being diagnosed with the following: Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	*Of those ever diagnosed, had contact with healthcare or MH professional within last 12 months: Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Acne	20.4	27.0	22.5	25.0	18.4	33.9	44.4	30.5
Allergies - food allergy	12.0	14.8	25.0	14.7	36.4	26.6	20.0	28.9
Allergies - animals/pets	11.9	18.3	25.0	17.0	27.3	31.3	10.0	28.3
Allergies - envirounental (for example: pollen, grass, dust, mold)	28.6	34.2	41.0	33.0	19.2	31.5	31.3	28.3
Asthma	17.7	16.6	32.5	18.0	30.3	47.9	15.4	39.5
Cancer	0.5	1.8	0.0	1.3	100.0	25.0	0.0	33.3
Celiac disease	0.0	0.2	4.9	0.4	0.0	100.0	50.0	66.7
Chronic pain (for example: back or joint pain, arthritis, nerve pain)	8.6	9.8	15.0	9.8	56.3	74.4	83.3	69.7
Diabetes or pre-diabetes/insulin resistance	3.8	4.5	5.0	4.3	71.4	75.0	50.0	72.4
Endometriosis	0.0	5.7	2.5	3.9	0.0	64.0	100.0	65.4
Gastroesophageal Reflux Disease (GERD) or acid reflux	5.9	9.1	15.0	8.4	10.0	60.0	66.7	51.8
Heart & vascular disorders (for example: atrial fibrillation or other cardiac arrhythmia, mitral valve prolapse or other valvular heart disease, congenital heart condition)	3.2	3.6	0.0	3.3	33.3	56.3	0.0	50.0
High blood pressure (hypertension)	2.7	7.3	5.0	5.8	80.0	80.6	100.0	81.6
High cholesterol (hyperlipidemia)	1.1	4.6	2.5	3.4	100.0	70.0	100.0	73.9
Irritable bowel syndrome (spastic colon or spastic bowel)	5.9	7.7	19.5	8.0	36.4	61.8	50.0	53.7
Migraine headaches	11.8	18.3	20.0	16.4	33.3	41.3	62.5	41.3
Polycystic Ovarian Syndrome (PCOS)	0.0	6.1	2.6	4.2	0.0	66.7	100.0	67.9
Sleep Apnea	7.0	4.3	2.5	5.1	38.5	73.7	0.0	55.9
Thyroid condition or disorder	1.1	6.9	0.0	4.9	0.0	80.0	0.0	78.1
Urinary system disorder (for example: bladder or kidney disease, urinary reflux, interstitial cystitis)	0.5	2.7	2.6	2.1	100.0	58.3	0.0	57.1

**Only students who reported ever being diagnosed were asked about contact with a healthcare or mental health professional within the last 12 months.*

Cis Men n =	188
Cis Women n =	444
Trans/GNC n =	41

Students who reported being diagnosed with diabetes or pre-diabetes/insulin resistance, indicated they had:

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Type I Diabetes	16.7	0.0	100.0	11.1
Type II Diabetes	33.3	36.8	0.0	34.6
Pre-diabetes or insulin resistance	57.1	75.0	0.0	67.9
Gestational Diabetes	0.0	5.3	0.0	3.8

K. Sleep

Reported amount of time to usually fall asleep at night (sleep onset latency):

Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Less than 15 minutes	44.4	38.1	29.3	39.4
16 to 30 minutes	26.7	29.3	14.6	27.8
31 minutes or more	28.9	32.7	56.1	32.9

Over the last 2 weeks, students reported the following average amount of sleep (excluding naps):

	On weeknights				On weekend nights			
Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
Less than 7 hours	50.3	48.9	63.4	50.2	24.6	28.4	39.0	27.8
7 to 9 hours	48.1	49.1	36.6	48.0	67.9	64.9	58.5	65.5
10 or more hours	1.6	2.0	0.0	1.8	7.5	6.8	2.4	6.8

Students reported the following on 3 or more of the last 7 days:

	Felt tired or sleepy during the day				Got enough sleep so that they felt rested			
Percent (%)	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total	Cis Men	Cis Women	Trans/ Gender Non-conforming	Total
0 days	5.3	2.9	0.0	3.4	18.3	24.6	29.3	23.1
1-2 days	24.1	16.9	14.6	18.6	40.9	40.0	43.9	40.4
3-5 days	43.9	37.2	24.4	38.2	29.6	28.4	17.1	28.1
6-7 days	26.7	43.0	61.0	39.8	11.3	7.0	9.8	8.4

Demographics and Sample Characteristics

Age

18 - 20 years:		39.5 %
21 - 24 years:		31.4 %
25 - 29 years:		11.5 %
30+ years:		17.7 %
Mean age:	24.8 years	
Median age:	21.0 years	

Gender*

Cis Women:	64.3 %
Cis Men:	27.2 %
Transgender/Gender Non-conforming:	5.9 %

** See note on page 2 regarding gender categories*

Student status

1st year undergraduate:	19.8 %
2nd year undergraduate:	13.2 %
3rd year undergraduate:	22.9 %
4th year undergraduate:	16.7 %
5th year or more undergraduate:	8.2 %
Master's (MA, MS, MFA, MBA, etc.):	14.5 %
Doctorate (PhD, EdD, MD, JD, etc.):	3.1 %
Not seeking a degree:	0.9 %
Other:	0.6 %
Full-time student:	83.3 %
Part-time student:	15.9 %
Other student:	0.9 %

Visa to work or study in the US: 6.9 %

Relationship status

Not in a relationship:	44.8 %
In a relationship but not married/partnered:	39.9 %
Married/partnered:	15.3 %

Primary Source of Health Insurance

College/university sponsored SHIP plan:	2.8 %
Parent or guardian's plan:	58.9 %
Employer (mine or my spouse/partners):	16.1 %
Medicaid, Medicare, SCHIP, or VA:	7.7 %
Bought a plan on my own:	5.0 %
Don't have health insurance:	6.8 %
Don't know if I have health insurance:	0.9 %
Have insurance, but don't know source:	1.9 %

Student Veteran: 3.4 %

Parent or primary responsibility for someone else's child/children under 18 years old: 9.4 %

Students describe themselves as

Straight/Heterosexual:	70.3 %
Asexual:	1.9 %
Bisexual:	13.2 %
Gay:	3.1 %
Lesbian:	2.2 %
Pansexual:	3.1 %
Queer:	2.2 %
Questioning:	3.2 %
Identity not listed above:	0.7 %

Housing

Campus or university housing:	16.8 %
Fraternity or sorority residence:	1.3 %
Parent/guardian/other family:	28.8 %
Off-campus:	51.5 %
Temporary or "couch surfing":	0.1 %
Don't have a place to live:	0.0 %
Other:	1.5 %

Students describe themselves as

American Indian or Native Alaskan	1.6 %
Asian or Asian American	7.1 %
Black or African American	10.7 %
Hispanic or Latino/a/x	6.7 %
Middle Eastern/North African (MENA) or Arab Origin:	2.9 %
Native Hawaiian or Other Pacific Islander Native:	0.6 %
White:	73.8 %
Biracial or Multiracial:	4.2 %
Identity not listed above:	0.6 %

If Hispanic or Latino/a/x, are you

Mexican, Mexican American, Chicano:	50.0 %
Puerto Rican:	15.2 %
Cuban:	4.3 %
Another Hispanic, Latino/a/x, or Spanish Origin:	37.0 %

If Asian or Asian American, are you

East Asian:	34.7 %
Southeast Asian:	36.7 %
South Asian:	24.5 %
Other Asian:	4.1 %

■ **First generation students** (Proportion of students for whom no parent/guardian have completed a bachelor's degree)	45.7 %

■ **Do you have any of the following?**	
Attention Deficit/Hyperactivity Disorder (ADD or ADHD):	15.2 %
Autism Spectrum Disorder:	4.1 %
Deaf/Hearing loss:	3.6 %
Learning disability:	2.8 %
Mobility/Dexterity disability:	0.9 %
Blind/low vision:	4.3 %
Speech or language disorder:	0.9 %

■ **Participated in organized college athletics:**	
Varsity:	1.2 %
Club sports:	3.1 %
Intramurals:	3.4 %

■ **Member of a <u>social</u> fraternity or sorority:**	
Greek member:	8.5 %

Appendix B: Drugs and Alcohol Don’t Work at MTSU

Drugs and Alcohol Don't Work at MTSU

Middle Tennessee State University prohibits the possession, use, or distribution of illegal drugs and alcohol on the campus proper or on institutionally-owned, leased, or otherwise controlled property.

Various federal and state statutes make it unlawful to manufacture, distribute, dispense, deliver or sell, or possess with intent to manufacture, distribute, dispense, deliver, or sell controlled substances. The penalty imposed depends upon many factors which include the type and amount of controlled substance involved, the number of prior offenses, if any, and whether any other crimes were committed in connection with the use of the controlled substance. Possible sanctions include incarceration up to and including life imprisonment and imposition of substantial monetary fines.

Tennessee statues provide that it is unlawful for any person under the age of twenty-one (21) to buy, possess, transport (unless in the course of his or her employment), or consume alcoholic beverages, wine, or beer. Any violation of this law results in an offense classified a Class A misdemeanor punishable by imprisonment for not more than 11 months, 29 days, or by a fine of not more than $2,500, or both. The receipt, possession, or transportation of alcoholic beverages without the required revenue stamp is also a misdemeanor punishable by imprisonment of not more than thirty (30) days or a fine of not more than $50, or both.

The use of alcohol can lead to serious health risk:

- loss of muscle control, poor coordination, slurred speech
- fatigue, nausea, headache
- increased likelihood of accidents
- impaired judgment
- possible respiratory paralysis and death
- birth defects/fetal impairment

Heavy drinking can lead to:

- alcoholism
- damage to brain cells
- increased risk of cirrhosis, ulcers, heart disease, heart attack, and cancers of liver, mouth, throat, and stomach
- hallucinations
- personality disorders

Health risks associated with the use of illegal drugs include:

- increased susceptibility to disease due to a less efficient immune system
- increased likelihood of accidents
- personality disorders
- addiction
- death by overdose

- anemia
- poor concentration
- fetal impairment/addiction

Additional information about how the use of drugs and/or alcohol affects your health is available through the Health Promotion office of Student Health Services located in the Health, Wellness, and Recreation Center.

MTSU regular employees with full benefits have available to them the statewide Employee Assistance Program which provides confidential assistance for assessment and short-term counseling. Up to six visits are provided free of charge. Additionally, treatment for chemical dependencies on both an in-patient and out-patient basis are generally covered expenses under the state group health insurance plan. Please refer to your health insurance brochures for specific coverages and limitations. Referral to community treatment facilities may be made by the MTSU Human Resource Services Office if assistance is desired.

Middle Tennessee State University will impose sanctions against individuals who have violated rules prohibiting the use, possession, or distribution of illegal drugs or alcohol.

Sanctions for students using or possessing illegal drugs or alcohol include disciplinary probation, and in appropriate cases, suspension from the University. In addition, residence hall students will be removed from the housing system. Referral for criminal prosecution may be made in all appropriate cases.
Individuals involved in the sale or distribution of illegal drugs or alcohol will be suspended from the University and referred to the appropriate authorities for criminal prosecution.

All employees, including student employees, agree as a condition of employment to abide by this policy. Sanctions against employees for use or possession of illegal drugs or alcohol in the workplace include termination of employment by means of the termination procedures available by contract and/or in policy. Additionally, employees are required to notify the institution of any drug convictions no later than five days after the conviction

In compliance with the Drug-Free Schools and Communities Act and the Drug-Free Workplace Act of 1988, MTSU provides this information as a service to the campus community.

Available at: https://www.mtsu.edu/hrs/benefits/drugs_and_alcohol_brochure.php (last visited: September 29, 2022)

Appendix C: Higher Education Opportunity Act Notifications

Higher Education Opportunity Act Notifications

Higher Education Opportunity Act Notification #1

Even though the Department of Education (ED) has rescinded the student eligibility requirement that indicates federal aid is suspended if a student received a drug conviction that occurred while enrolled and receiving aid, this question is still being required on the 2021-2022 FAFSA application. If you answer 'Yes' to Question 23 on the FAFSA, ED is notifying students that they are not eligible for federal aid. However, if you receive the following information, the MTSU Financial Aid Office will waive this requirement and this rule will no longer prevent you from receiving Title IV aid. This notice is also to inform any students who have not applied for federal aid because of the following information that they are eligible to apply.

Any student who is convicted of any offense under any Federal or State law involving the possession or sale of a controlled substance while enrolled in an institution of higher education and receiving any federal financial aid (such as a grant, loan or work assistance)may lose his/her eligibility for such federal assistance.

The following information is located on the MTSU website at http://mtsu.edu/financial-aid/policies.php:

Drug Convictions

Students convicted of a federal or state offense of selling or possessing illegal drugs may not be eligible for federal student aid (grants, loans, and work-study). Students who answer "Yes" to question 23 on the FAFSA will be required to answer additional questions on the FAFSA to determine if the conviction affects eligibility for aid. Also, if the Financial Aid Office is notified that a student has been convicted of possession or sale of illegal drugs during the academic year, all federal student aid will be suspended immediately.

Convictions only count if they were for an offense that occurred during a period of enrollment for which the student was receiving federal student aid. Also, a conviction that was reversed, set aside, or removed from the student's record does not count.

The chart below illustrates the period of ineligibility for federal student aid funds, depending on whether the conviction was for sale or possession and whether the student had previous offenses. (A conviction for sale of drugs includes convictions for conspiring to sell drugs.)

	Possession of illegal drugs	Sale of illegal drugs
1st offense	1 year from date of conviction	2 years from date of conviction
2nd offense	2 years from date of conviction	Indefinite period
3+ offenses	Indefinite period	

Students regain eligibility the day after the period of ineligibility ends or when they successfully complete a qualified drug rehabilitation program. Further drug convictions will make them ineligible again. Students denied eligibility for an indefinite period can regain it only after successfully completing a rehabilitation program or if a conviction is reversed, set aside, or removed for the student's record so that fewer than two convictions for sale or three convictions for possession remain on the record. In such cases, the nature and dates of the remaining convictions will determine when the student regains eligibility.

It is the student's responsibility to certify to the Financial Aid Office the date of the conviction and if (s)he has completed a drug rehabilitation program.

Higher Education Opportunity Act Notification #2

Information concerning drug and alcohol use and abuse; legal sanctions; health risks; available resources; disciplinary sanctions for violations may be found at:

http://www.mtsu.edu/student-conduct/drug.php

Contact information:

Mr. Rick Chapman, Director, Student Health Services

(615)898-2988, richard.chapman@mtsu.edu

Higher Education Opportunity Act Notification #3

Middle Tennessee State University (MTSU) is committed to ensuring equity in education and eliminating the campus of any and all acts of sex discrimination, which includes sexual harassment and misconduct, as prohibited by Title IX. Title IX of the Education Amendments of 1972 was the first comprehensive federal law to prohibit sex discrimination against students and employees of educational institutions. Examples of prohibited conduct include: sexual harassment, dating violence, domestic violence, sexual assault, and stalking.

MTSU's Policy 29 on sexual misconduct covers certain individuals at locations in the United States where MTSU has substantial control; it defines *sexual harassment* as conduct on the basis of sex that satisfies one or more of the following: 1) an employee conditioning the provision of an aid, benefit, or service of MTSU on an individual's participation in unwelcome sexual conduct; 2) unwelcome conduct determined by a reasonable person to be so severe, pervasive, and objectively offensive that it effectively denies a person equal access to MTSU's education program or activity; or 3) any of the following offenses:

Sexual assault is an offense classified as a forcible or non-forcible sex offense under the uniform crime reporting system of the Federal Bureau of Investigation.

Forcible Sex Offenses are: any sexual act directed against the complainant, without their consent, including instances where the complainant is incapable of giving consent. Forcible sex offenses include: *rape* (excluding statutory rape); *Sodomy,* which is oral or anal sexual intercourse with the complainant, without the consent of the complainant; *Sexual Assault with an object* or instrument to unlawfully penetrate, however slightly, the genital or anal opening of the body of the complainant, without their consent; and *Fondling,* which is touching the private body parts of the complainant for the purpose of sexual gratification, without the consent of the complainant. *Non-forcible sex offenses* include: *Incest*, which is the non-forcible sexual intercourse between persons who are related to each other within the degrees wherein marriage is prohibited by law; and *Statutory Rape*, non-forcible sexual intercourse with a person who is under the statutory age of consent.

Dating Violence is violence committed by a person: 1) who is, or has been, in a social relationship of a romantic or intimate nature with the Complainant; and 2) where the existence of such a relationship shall be determined based on a consideration of the following factors: a) the length of the relationship, b) the type of relationship, c) the frequency of interaction between the persons involved in the relationship.

Domestic Violence is violence committed by a current or former spouse or intimate partner of the complainant, by a person with whom the complainant shares a child in common, by a person who is cohabitating with, or has cohabitated with as a spouse or intimate partner, by a person similarly situated to a spouse of the complainant under the laws of the State of Tennessee, or by any other person against an adult or youth complainant who is protected from that person's acts under the domestic or family violence laws of the State of Tennessee.

Stalking is engaging in a course of conduct directed at a specific person that would cause a reasonable person to: a) fear for his/her safety or the safety of others; or b) suffer substantial emotional distress.

Policy 27 addresses incidents related to sex or gender that are not covered by Policy 29. Disciplinary procedures and potential consequences for violating the institution's policies on sexual misconduct include possible suspension or expulsion of students found in violation. A copy of the MTSU's disciplinary procedures and policies may be found online at: http://www.mtsu.edu/student-conduct/. Additional information about MTSU's sexual violence policy and resources may be found online at: http://www.mtsu.edu/sexual-violence/

Students are encouraged to report incidents of sexual assault or harassment to the appropriate campus official or law enforcement officer. On the MTSU campus, Christy Sigler serves as a point of contact for any student who wishes to discuss a concern, including confidential reporting. Ms. Sigler can be found in the Cope Administration Building, room 116, by phone, 615.898.2185, or email christy.sigler@mtsu.edu. A summary of reported complaints of sexual misconduct may be found online at: https://www.mtsu.edu/iec/docs/TitleIXSummaryReport.pdf

Students who desire assistance, including treatment for injuries, preventative treatment for sexually transmitted diseases, a rape kit, a sexual assault nurse examiner, or victim's advocate have the following local resources available to them:

On Campus

MTSU Counseling Services

Keathley University Center, Room 326-S

615-898-2670

MTSU Student Health Services

Health, Wellness, and Recreation Center 615-898-2988

MTSU June Anderson Center for Women and Non-Traditional Students

Student Union Building, Room 330

615-898-5812

University Police

615-898-2424 (emergency from a cell phone or non-emergency from campus phone or cell phone)

Emergency (from a campus phone): 911

Title IX Coordinator

Cope Administration Building, Room 116

615.898.2185

In Murfreesboro/Rutherford County

Domestic Violence and Sexual Assault Program
1423 Kensington Square Court
24-hour crisis line: 615-494-9262

St. Thomas Rutherford Hospital (SART Program)
1700 Medical Center Parkway
615-396-4100

Murfreesboro Police
1004 North Highland Avenue
615-893-1311
Emergency: 911

Higher Education Opportunity Act Notification #4

Register to Vote!

The 1998 Higher Education Act requires all post-secondary institutions to distribute information to students concerning voter registration. Tennessee residents who wish to register to vote may do so by visiting this website: http://sos.tn.gov/elections

Rutherford County encourages MTSU students to participate in local, county, state and national elections. To vote in elections in the State of Tennessee, one must be registered **at least 30 days** prior to the election date. Upon receiving and approving the voter registration application form, the Rutherford County Election Commission will assign the individual a voting precinct (where the voter will vote on election day based on residence address).

Voter Registration applications are available on campus at the MTSU Student Union Information Desk. Voter Registration applications and other election information may also be obtained by visiting the Rutherford County Election Commission website at https://election.rutherfordcountytn.gov/

Additional information about registering to vote, upcoming elections, and MTSU student voting rates from the American Democracy Project may be found online at: http://www.mtsu.edu/amerdem/index.php

Students with questions about any election process should call the Rutherford County Election Commission at 615-898-7743, or email inquiries to **election@rutherfordcounty.org** . The Election Commission office is located at 1 Public Square South, Room 103, Murfreesboro, TN 37130.

Individuals may register to vote if they:

- **Are a U.S. citizen**
- **Will be 18 years of age on/or before the next election**
- **Are a resident of Tennessee**
- **Have not been convicted of a felony or, if convicted, had voting rights restored by a court order or pardon**

You may find out more information about voter identification requirements by visiting this website: http://sos.tn.gov/products/elections/what-id-required-when-voting

What IDs are acceptable?

Any of the following IDs may be used, even if expired:

- Tennessee driver license with your photo
- United States Passport
- Photo ID issued by the Tennessee Department of Safety and Homeland Security
- Photo ID issued by the federal or Tennessee state government
- United States Military photo ID
- Tennessee handgun carry permit with your photo

What IDs are not acceptable?

The following ID's are NOT acceptable:

- College student IDs
- Photo IDs not issued by the federal or Tennessee state government are NOT acceptable. This includes county or city issued photo IDs, such as library cards, and photo IDs issued by other states.

Higher Education Opportunity Act Notification #5

TCA § 49-7-172 requires each state institution of higher education to provide the suicide prevention plan to students, faculty, and staff at least one (1) time each semester. The MTSU Suicide Prevention Plan for students can be found here: https://mtsu.edu/stuaff/ and the MTSU Suicide Prevention Plan for employees can be found here: https://mtsu.edu/hrs/relations/docs/Suicide_Prevention.pdf

Contact Information for students:

Dr. Mary Kaye Anderson, Director, Counseling Services

(615) 898-2670, marykaye.anderson@mtsu.edu

Contact information for employees:

Kathy Musselman, Assistant Vice President, Human Resource Services,

(615) 898-2929, Kathy.musselman@mtsu.edu

Appendix D: Residential Housing Rules

Residential Life & Housing Rules

Alcohol and Drugs

No alcoholic beverages, illegal drugs, or drug paraphernalia are permitted on the campus of Middle Tennessee State University. Empty alcohol containers (including but not limited to bottles, cans, and kegs) may not be used for display purposes in any residence hall room or apartment. Students found responsible for drug violations WILL be removed from the residence hall.

Prohibited Items

The following items are prohibited in residence hall rooms or single student apartments: personal air conditioners, ice boxes, unauthorized refrigerators, exterior aerials or antennas, heavy electrical appliances, personal stoves, extension cords, halogen lamps, candles, incense, firearms, explosives, fireworks, flammable fluids, slingshots, paint ball guns, "super soakers," dangerous chemical mixtures, pellet guns, B.B. guns, ammunition (which includes but is not limited to bullets, paint balls, pellets, and B.B.s) propelled missiles, alcoholic beverages, and illegal drugs or paraphernalia.

Smoking

Smoking is prohibited in all public areas, (lobbies, hallways, community baths, classrooms, etc.) residence hall rooms, and apartments. Students wishing to consume tobacco products must do so in the privacy of a personal vehicle. Tobacco products can only be stored in the private vehicle.

*These are selected excerpts related to alcohol, drugs, and smoking. The full list of rules is available at: https://www.mtsu.edu/student-conduct/code/housing-policies.php (last visited September 20, 2022).

Appendix E: Rethinking Drinking Presentation

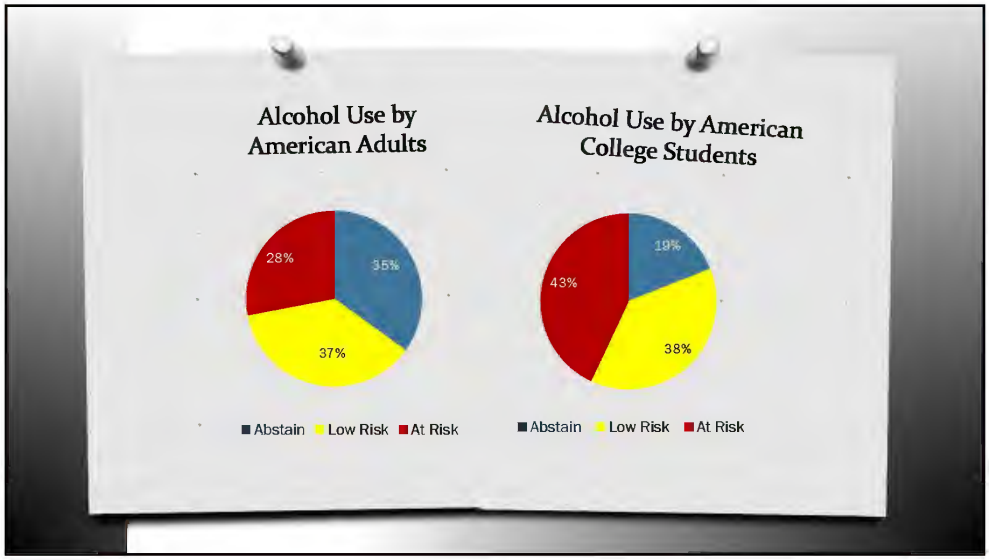
RETHINKING DRINKING

1

OH NO!
ANOTHER ALCOHOL AND DRUG SPEECH

Wait!
This is
different!

2


Alcohol Use by American Adults
28%
35%
37%
Abstain
Low Risk
At Risk
Alcohol Use by American College Students
19%
43%
38%
Abstain
Low Risk
At Risk

3


WHAT COUNTS AS A DRINK?
• "Standard drink" sizing
– 0.6 fl oz of alcohol
• Beer- 12 oz
• Wine- 5 oz
• Liquor- 1.0-1.5 oz

4

IMPAIRMENT IN MALES

Men	Approximate blood alcohol percentage								
	Body weight in pounds								
Drinks	100	120	140	160	180	200	220	240	
0	.00	.00	.00	.00	.00	.00	.00	.00	Only safe driving limit
1	.04	.03	.03	.02	.02	.02	.02	.02	Impairment begins
2	.08	.06	.05	.05	.04	.04	.03	.03	Driving skills significantly affected Possible criminal penalties
3	.11	.09	.08	.07	.06	.06	.05	.05	
4	.15	.12	.11	.09	.08	.08	.07	.06	
5	.19	.16	.13	.12	.11	.09	.09	.08	
6	.23	.19	.16	.14	.13	.11	.10	.09	
7	.26	.22	.19	.16	.15	.13	.12	.11	Legally intoxicated Criminal penalties
8	.30	.25	.21	.19	.17	.15	.14	.13	
9	.34	.28	.24	.21	.19	.17	.15	.14	
10	.38	.31	.27	.23	.21	.19	.17	.16	

5

IMPAIRMENT IN FEMALES

Women	Approximate blood alcohol percentage									
	Body weight in pounds									
Drinks	90	100	120	140	160	180	200	220	240	
0	.00	.00	.00	.00	.00	.00	.00	.00	.00	Only safe driving limit
1	.05	.05	.04	.03	.03	.03	.02	.02	.02	Impairment begins
2	.10	.09	.08	.07	.06	.05	.05	.04	.04	Driving skills significantly affected Possible criminal penalties
3	.15	.14	.11	.10	.09	.08	.07	.06	.06	
4	.20	.18	.15	.13	.11	.10	.09	.08	.08	
5	.25	.23	.19	.16	.14	.13	.11	.10	.09	
6	.30	.27	.23	.19	.17	.15	.14	.12	.11	Legally intoxicated Criminal penalties
7	.35	.32	.27	.23	.20	.18	.16	.14	.13	
8	.40	.36	.30	.26	.23	.20	.18	.17	.15	
9	.45	.41	.34	.29	.26	.23	.20	.19	.17	
10	.51	.45	.38	.32	.28	.25	.23	.21	.19	

6

ABSORPTION & OXIDATION OF ALCOHOL

- Factors affecting Absorption
  - What and how fast you're drinking
  - Effervescence
  - Food in stomach
- Factors affecting Oxidation
  - Only TIME!
  - We oxidize off 0.016% of our blood alcohol content per hour (roughly one drink per hour)

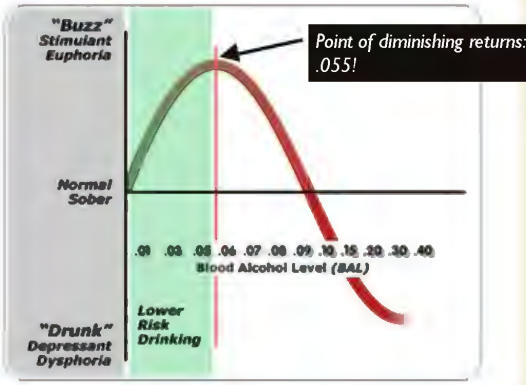
7

WHAT THAT MEANS....

- If you stop drinking at 3:00am with a BAC of .08%
  - .08%.... .064%.... .048%.... .032%.... .016%.... .000%
  - You're not sober until 8:00am
- If you stop drinking at 3:00am with a BAC of .16%
  - .16%.... .144%.... .128%.... .112%.... .096%.... .08%.... .064%.... .048%.... .032%.... .016%.... .000%
  - You're not sober until 1:00pm
- If you stop drinking at 3:00am with a BAC of .24%
  - .24%.... .224%.... .208%.... .192%.... .176%.... .16%.... .144%.... .128%.... .112%.... .096%.... .08%.... .064%.... .048%.... .032%.... .016%.... .000%
  - You're not sober until 6:00pm!

8

ALCOHOL'S TWO PHASES



9

IMPAIRMENT IN MALES

Men	Approximate blood alcohol percentage								
	Body weight in pounds								
Drinks	100	120	140	160	180	200	220	240	
0	.00	.00	.00	.00	.00	.00	.00	.00	Only safe driving limit
1	.04	.03	.03	.02	.02	.02	.02	.02	Impairment begins
2	.08	.06	.05	.05	.04	.04	.03	.03	Driving skills significantly affected Possible criminal penalties
3	.11	.09	.08	.07	.06	.06	.05	.05	
4	.15	.12	.11	.09	.08	.08	.07	.06	
5	.19	.16	.13	.12	.11	.09	.09	.08	
6	.23	.19	.16	.14	.13	.11	.10	.09	
7	.26	.22	.19	.16	.15	.13	.12	.11	Legally intoxicated Criminal penalties
8	.30	.25	.21	.19	.17	.15	.14	.13	
9	.34	.28	.24	.21	.19	.17	.15	.14	
10	.38	.31	.27	.23	.21	.19	.17	.16	

10

IMPAIRMENT IN FEMALES

Women	Approximate blood alcohol percentage									
	Body weight in pounds									
Drinks	90	100	120	140	160	180	200	220	240	
0	.00	.00	.00	.00	.00	.00	.00	.00	.00	Only safe driving limit
1	.05	.05	.04	.03	.03	.03	.02	.02	.02	Impairment begins
2	.10	.09	.08	.07	.06	.05	.05	.04	.04	Driving skills significantly affected
3	.15	.14	.11	.10	.09	.08	.07	.06	.06	
4	.20	.18	.15	.13	.11	.10	.09	.08	.08	Possible criminal penalties
5	.25	.23	.19	.16	.14	.13	.11	.10	.09	
6	.30	.27	.23	.19	.17	.15	.14	.12	.11	
7	.35	.32	.27	.23	.20	.18	.16	.14	.13	Legally intoxicated
8	.40	.36	.30	.26	.23	.20	.18	.17	.15	Criminal penalties
9	.45	.41	.34	.29	.26	.23	.20	.19	.17	
10	.51	.45	.38	.32	.28	.25	.23	.21	.19	

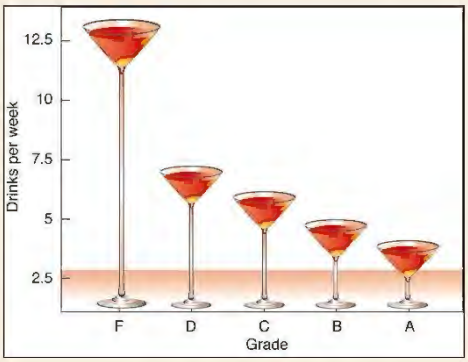
11

TOLERANCE

- Impacts how you feel effects of alcohol
- No impact on actual BAC
- May be more related to environmental factors than physiological factors

12

ALCOHOL USE & ACADEMIC SUCCESS



The more alcoholic drinks consumed per week, the lower your grade point average.

13

Check your learning.

Trivia Time!

On your mobile device, go to:

www.kahoot.it

FOR MORE INFO:

Lisa Schrader, MPH, MCHES

Director of Health Promotion

Middle Tennessee State University

Lisa.Schrader@mtsu.edu

615-494-8704

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Appendix F: Prevention 101


PREVENTION
101:
Things to Know when Prevention was
NOT your Training Background

Table of Contents

Introduction

Congratulations! You've landed a job at an institution of higher education, or maybe you've been working there for a while, and you've been told that part of your job is now going to involve "prevention." But what does that mean? Preventing failing grades? Preventing drop outs?

No…. Your job is about preventing substance misuse, violence, and other negative health and social outcomes. And, yes, that is now mandated by the federal government.

Your training in higher education administration, counseling, student development, social work, or any number of other backgrounds that might lead into working on a college campus probably included very little (one course? one academic assignment?), if any, didactic training on the topic. But now you are the "prevention person" on your campus and are expected to be the resident expert. What's a person supposed to do? Draw on memories of what prevention looked like back when you were in grade school or college?

Take a deep breath. While you may have some positive memories to fall back on, CHASCo is here to help give you a more structured guide. This manual is a crash course in the history, theory, best practices, and guiding documents of the field. We hope you find it helpful as a foundation for your work and that, combined with ongoing professional development from CHASCo, you can chart a new path for prevention at your own unique institution.

CHASCo

COALITION FOR HEALTHY
AND SAFE CAMPUS COMMUNITIES

History of Prevention

"Public health saved your life today. You just don't know it." - Author unknown

Philosopher and author Mokokoma Mokhonoana once wrote, "It is usually impossible to know when you have prevented an accident." Then-president of the American Public Health Association, Dr. Linda Rae Murray, expressed a similar sentiment at a commencement address when she said, "When public health works, we're invisible." It is somewhat of a puzzle of the senses that, in the field of prevention, when everything is working like it should, nothing happens. Nothing happening is exactly our goal.

A side effect of this invisible nature of prevention is that few people outside of those who have studied it truly know what it is or understand the science behind it. But the field of prevention has more than 70 years of research guiding its best practices, the development of theories behind why people do what they do, and how practitioners can intervene to make healthier choices become easier choices.

Here is a sampling of some of the key milestones in the field of wellness and collegiate alcohol and other drug prevention:

Timeline of Prevention [1,2,3,4,5]

1953: Straus and Bacon conduct the first wide scale research study of drinking at 57 institutions of higher education.

1958: The World Health Organization issues a more comprehensive definition of health, defining it as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

1976: The University of Wisconsin-Steven's Point becomes the first institution of higher education to launch a campus wellness program.

1985: 64% of institutions of higher education report having a task force or committee focused on alcohol prevention.

1987: The Fund for the Improvement of Post-Secondary Education (FIPSE) begins providing grants to institutions of higher education to support collegiate alcohol and drug prevention programs. $7,780,000 was awarded in 1987 among 92 schools, and the program continued annually through 1994 when $14,412,719 was awarded among 144 schools. As part of the awards, campuses receive funding to administer the Core Alcohol and Drug Survey (often abbreviated as Core Survey) as a measure of baseline status and of program evaluation. These grants make the Core Institute, based out of Southern Illinois University, the keeper of the nation's largest database of statistics on the use of alcohol and drugs among college students.

1988: The minimum legal drinking age is moved to 21 in all 50 states.

1994: The term "binge drinking" is coined by Henry Wechsler of Harvard University in the publication of results from the College Alcohol Study (CAS) to describe a pattern of drinks in which men consume 5 or more standard drinks in a sitting and women consume 4 or more standard drinks in a sitting. The CAS conducted 4 national surveys involving over 14,000 students at 120 four-year colleges in 40 states in 1993, 1997, 1999, and 2001. The schools and students selected for the study provided a nationally representative sample. In addition, CAS colleges with high levels of heavy alcohol use were resurveyed in 2005.

1995: The Higher Education Center for Alcohol, Drug Abuse, and Violence Prevention (HEC) is founded under the umbrella of the U.S. Department of Education. The mission of the Center is to help college and community leaders develop, implement, and evaluate programs and policies to reduce problems experienced by students related to alcohol and other drug use. Due to federal budget cuts, the Center was closed in 2012. The former co-director of HEC, Dr. John Clapp, came to The Ohio State University in 2013 to open the Higher Education Center for Alcohol and Other Drug Prevention (HECAOD) to meet this still existent national need.

2000: The Department of Health and Human Services launches Healthy People 2010 as a blueprint for improving the nation's health status. That same year, the American College Health Association launches the companion Healthy Campus 2010 document.

2002: The National Institute for Alcohol Abuse and Alcoholism (NIAAA) creates the Task Force on College Drinking and implemented the Rapid Response to College Drinking initiative. Its central report, *A Call to Action: Changing the Culture of Drinking at U.S. Colleges* introduces four "Tiers of Effectiveness" which document the efficacy of various prevention programs through a review of published scientific research.

2015: The College Alcohol Intervention Matrix (College AIM) is released as an update to *A Call to Action* and allows readers to compare effectiveness and cost of multiple individual and environmental level prevention strategies.

Definitions, Theories, and Models of Prevention

Like any professional field, prevention comes with its own language of key terms, acronyms, theories, and models. While not an exhaustive list, this section details some of the most commonly used terms to help bring you up to speed quickly.

Some of the first terms to understand relate to the *"who"* and the *"when"* of prevention. In terms of *audiences* (the "who") that prevention programs will attempt to influence, you will hear of three categories of prevention:

- ***Universal*** prevention- refers to activities targeting the entire population within your sphere of influence; ex., all students at your university
- ***Selective*** prevention- refers to activities targeting groups within your population considered to be "at risk;" ex., fraternity members, residential students, athletes, etc.
- ***Indicated*** prevention- refers to activities targeting individuals who are already experiencing symptoms or consequences; ex., students in recovery, sanctioned students, etc.

Additionally, you will hear of three terms that describe the *timing* (the "when") of a prevention intervention:

- ***Primary*** prevention- refers to measures designed to forestall the onset of illness, injury, or consequences; ex., educational workshops, poster campaigns, etc.
- ***Secondary*** prevention- refers to measures leading to early diagnosis and prompt treatment; ex., depression screenings, Alcohol Screening Day, etc.
- ***Tertiary*** prevention- refers to measures aimed at preventing relapse following illness, injury, or consequences; ex., drug courts, Alcoholics Anonymous, recovery communities, etc.

As you will see in the subsequent section on theories and models, the factors that drive our decision making and our behaviors are varied and complex. Those factors that influence whether or not behavioral change occurs are broken down into three categories:

- ***Predisposing factors***- precede behavior and provide the rationale or motivation for a behavior; ex., knowledge, attitudes, beliefs, personal preferences, existing skills, and self-efficacy beliefs
- ***Enabling factors***- precede behavior and allow for a motivation to be realized; ex., programs, services, resources, training in new skills, environmental factors that affect behavior
- ***Reinforcing factors***- follow a behavior and provide continuing reward or incentive to repeat that behavior; ex., includes social support, peer influence, significant others, material incentives, etc.

Common Acronyms

In addition to the aforementioned definitions, it will also be helpful to familiarize yourself with the alphabet soup of prevention-related acronyms. These include:

- **AOD**- "alcohol and other drug"
- **AODV**- "alcohol, other drug, and violence"
- **CADCA**- "Community Anti-Drug Coalitions of America"-a nonprofit organization that is committed to creating safe, healthy and drug-free communities globally. CADCA is the umbrella organization of most of the county prevention coalitions that operate in Tennessee.
- **EDGAR 86-** "Education Department General Administrative Regulations Part 86"- the specific section of federal law that lays out the requirements for institutions of higher education regarding drug and alcohol abuse prevention; it mandates, among other things, annual notification to all employees and students of the school's AOD policies and a biennial review process to document effectiveness of prevention efforts and consistent enforcement of sanctions.
- **NASPA**- "National Association of Student Personnel Administrators"- the professional association for the advancement, health, and sustainability of the student affairs profession in higher education
- **NIAAA**- "National Institute of Alcohol Abuse and Alcoholism"- one of the 27 institutes and centers that comprise the National Institutes of Health (NIH). NIAAA supports and conducts research on the impact of alcohol use on human health and well-being.
- **SAMHSA**- "Substance Abuse and Mental Health Services Administration"- the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.
- **TDMHSAS**- "Tennessee Department of Mental Health and Substance Abuse Services"- the mental health and substance abuse authority for the State of Tennessee. TDMHSAS is the funding source for most of the administrative and programming dollars provided to and by CHASCo.

Three Prevention Models

Multiple textbooks exist explaining the theories, models, and research behind behavior and the complex reasons that people do what they do when it comes to their personal health. This manual will address three such models that will provide some baseline information on the interplay of these influences and how prevention interventions can target various elements of that interplay to increase the likelihood of successful outcomes.

First up is the ***Health Belief Model***. It is a type of value-expectancy theory. The desire to avoid illness or to get well (value) and the belief that a specific action would prevent or improve illness

(expectation) can help predict what behaviors an individual will engage in. The Health Belief Model was originally formulated by a group of social psychologists in the US Public Health Service in the 1950s, and it helped explain why simply knowing that a behavior was good or bad did little to predict whether or not an individual took part in that behavior.

Figure 1. Health Belief Model [6]

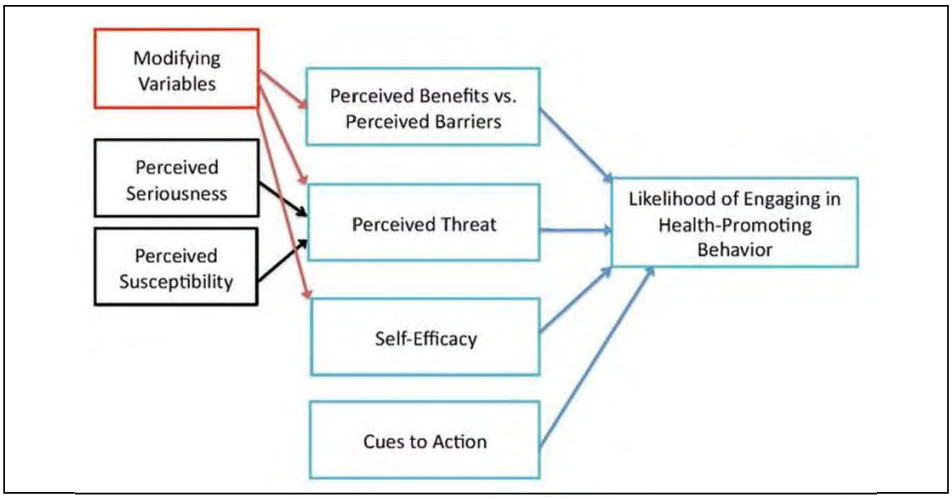


Figure 1 shows the various components of the Health Belief Model and how they interact with each other. These components, listed alphabetically, include:

- Cues to action: strategies to activate one's readiness (i.e., a sign at the local drug store motivates you to consider a flu shot)
- Modifying variables: demographic, sociopsychological, and structural variables that may affect one's perceptions and thus indirectly influence behavior; ex., educational attainment can have an indirect effect on behavior by influencing the perception of susceptibility, severity, benefits, and barriers. Other variables could include age, sex, ethnicity, personality, socioeconomic status, etc. (i.e., females are more likely to engage in preventative health care like flu shots than males)
- Perceived barriers: one's belief about the tangible and psychological costs of the advised action (i.e., you believe going to get a flu shot will take too much time)
- Perceived benefits: one's belief in the efficacy of the advised action to reduce risk or seriousness of impact (i.e., you believe that getting the flu shot last year helped keep you well during the previous winter)

- Perceived seriousness/severity: one's belief of how serious a condition and its associated symptoms/consequences are (i.e, you believe having to miss work due to the flu would be detrimental to your efforts to get a promotion)
- Perceived susceptibility: one's belief regarding the chance of getting a condition (i.e., you believe you will be exposed to the flu in your day-to-day interactions and could contract it)
- Perceived threat: the amount of personal risk one feels based on perceptions of seriousness and susceptibility (i.e., you believe you could catch the flu and become ill, which is undesirable)
- Self-efficacy: one's confidence in one's ability to take action (i.e., you know where to access the flu shot if you want one)

To give an example, if we are considering creating a campus safe rides program to deter drunk driving, we should not assume that simply building the service and telling students it exists will lead to a full schedule for the drivers. Our intervention and marketing campaign would need to consider, from a potential user's perspective, what benefits the service would provide (ex., free, safe transportation) and what barriers it might entail (ex., could take longer to get home, increase in student fees). How seriously do our students view drunk driving, and how susceptible do they personally feel to being caught engaging in drunk driving? Do they have the self-efficacy necessary to schedule a ride pickup? Are there cues in places from which they might need a safe ride in order to help activate their motivation? Do they see people who look like themselves using a safe ride program? The more of these questions an intervention can address, the greater the likelihood of targeted students actually choosing a safe ride program over getting behind the wheel themselves.

For brief video explanations of the Health Belief Model, check out https://www.youtube.com/watch?v=hI5LDiz8Le0 or https://www.youtube.com/watch?v=uXLUBjzZVOM.

Another commonly applied model is the ***Transtheoretical Model***, introduced by Prochaska and DiClemente and also known as "Stages of Change." This model developed in the late 1970s/early 1980s as an effort to integrate processes and principles of change from across various theories, including things like consciousness raising as proposed by Sigmund Freud and contingency management as proposed by B. F. Skinner. Early research into this effort documented that individuals used different strategies depending on where they were in the change process.

Those stages of change included:

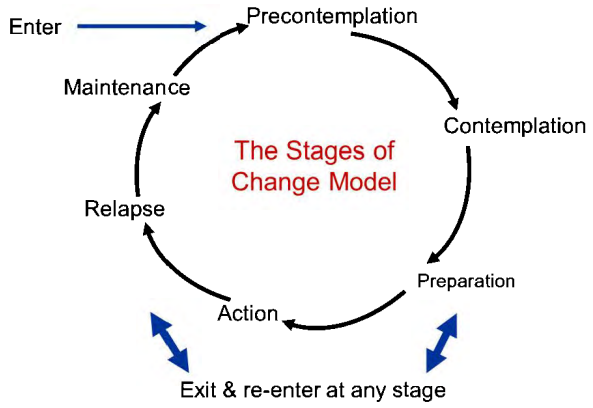
- Precontemplation- having no intention to take action within the next six months
- Contemplation- intending to take action within the next six months
- Preparation- intending to take action within the next 30 days and already taking some behavioral steps in that direction
- Action- has changed behavior for less than six months
- Maintenance- has changed behavior for more than six months

These changes are not linear, and an individual can move back and forth between them as they cycle through the different stages. Figure 2 shows how this model is commonly depicted.

Some of the processes of change that the researchers documented and which were being applied at different stages of change were:

- Consciousness raising- increasing awareness about causes, consequences, and cures for a particular problem behavior
- Contingency management- increasing the rewards for healthy behaviors and decreasing the rewards for unhealthy behaviors
- Counterconditioning- substituting healthier alternative behaviors for the unhealthy behavior
- Dramatic relief- experiencing the negative emotions that go along with unhealthy behavioral risks (ex., fear, anxiety, worry)
- Helping relationships- seeking and using social support for the healthy behavior change
- Self-liberation- making a firm commitment to change
- Self-reevaluation- seeing behavior change as an important part of one's identity
- Stimulus control- removing reminders or cues to engage in the unhealthy behavior and adding cues or reminders to engage in the healthy behavior

Figure 2. The Transtheoretical Model [7]



In early stages, individuals are most likely to apply cognitive and affective strategies like consciousness raising and dramatic relief to get closer to their change goals. In latter stages, they are most likely to apply counterconditioning, contingency management, support, and environmental controls to get closer to maintenance. (See Table 1.)

Although originally tested with people trying to quit smoking, this model can be applied to multiple health behaviors requiring individual change, including alcohol or other drug abuse, treatment of mental

illnesses, diet and/or exercise, cancer screenings, STI/HIV prevention, and more. Prevention practitioners should first assess the current stage of the client(s) and then plan interventions using the appropriate processes of change.

Table 1. Processes of Change that Mediate Progression between the Stages of Change.

	Stages of Change				
	Precontemplation	**Contemplation**	**Preparation**	**Action**	**Maintenance**
Processes	Consciousness raising				
	Dramatic relief				
		Self-reevaluation			
			Self-liberation		
					Counterconditioning
					Helping relationships
					Contingency management
					Stimulus control

To watch a brief video explaining the Transtheoretical Model, check out https://www.youtube.com/watch?v=Twlow2pXsv0.

The final model we will consider in this manual is the ***Social Ecological Model***. The Social Ecological Model was developed in the 1980s but was continually revised by Urie Bronfenbrenner until his death in 2005. It recognizes that human behaviors and decision making do not happen in a vacuum and describes the different levels of influence that can impact behavior. Those levels are diagrammed in Figure 3.

The levels of influence identified by Bronfenbrenner were:

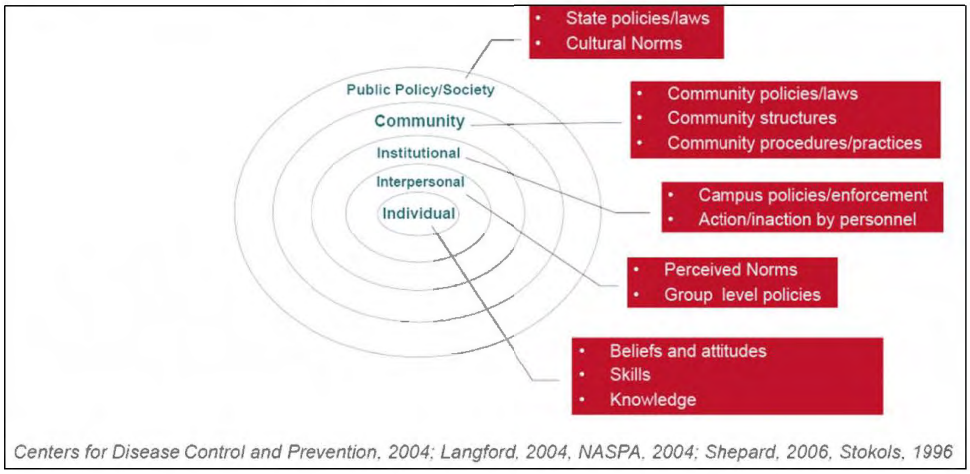
- Individual -- identifies biological and personal history factors that impact behavior, including knowledge, attitudes, behavior, self-efficacy, developmental history, gender, age, religious identity, racial/ethnic identity, sexual orientation, economic status, financial resources, values, goals, expectations, literacy, stigma, and others. Specific approaches at the individual level may include education and life skills training.
- Interpersonal -- examines close relationships, formal and informal, that may influence behavior, including family, friends, peers, co-workers, religious networks, customs or traditions; the interpersonal level not only influences an individual's behavior, but it also contributes to their experience. Prevention strategies at the interpersonal level may include parenting or family-focused prevention programs, mentoring and peer programs, faith-based programs, etc.
- Institutional and Community -- these levels explore the settings (with defined boundaries), such as schools, workplaces, and neighborhoods, in which social relationships occur and seek to identify the characteristics of these settings that are associated with behaviors of interest;

includes the built environment (e.g., parks), village associations, community leaders, businesses, and transportation. Strategies at these levels impact the social and physical environment – for example, by reducing social isolation, improving economic and housing opportunities in neighborhoods, and cultivating positive climates, processes, and policies within school and workplace settings.

- Public Policy/Society -- looks at the broad societal factors without defined boundaries that help create a climate; includes social and cultural norms that support or reject behaviors of interest. Strategies at this most encompassing level include local, state, national and global laws and policies, as well as policies regarding the allocation of resources, or a lack of policies.

A comprehensive prevention program should take into account all of these levels and have elements supporting all of them. For example, a comprehensive violence prevention program could have bystander intervention training, a poster campaign around attitudes towards sexual violence, clearly communicated and easily accessible campus resources for survivors and reporting, coordination with local domestic violence shelters and hospitals, and state or national media campaigns to normalize and promote healthy attitudes.

Figure 3. The Social Ecological Model [8]



To watch a brief video explaining the Social Ecological Model, check out https://www.youtube.com/watch?v=e9UyplfevyQ.

As you can see, one takeaway message for prevention strategies is that **knowledge is necessary, but not sufficient,** to change behavior. While increasing knowledge will likely be an outcome of most prevention programs, we should not expect measurable behavior change if increasing knowledge is our only outcome. How many of us know that eating a fresh from the oven chocolate chip cookie is probably not in our best dietary interest, and yet we still partake at least occasionally in that treat? Or we know that consistently getting eight hours of sleep at night will help us feel and perform our best during the day, and yet we allow ourselves to watch "just one more" episode of whatever we're currently binging on Netflix? The theories and models we have just addressed help us think through what other elements of human decision-making we need to consider and try to influence if we truly want to increase the likelihood of a sustainable behavior change.

11

Best Practices for Prevention

Having now examined different theoretical models that can guide our prevention strategies, this section will introduce some best practices in prevention intervention, including general principles and specific approaches.

Elements of Successful Prevention Programs

Back in 2003, a team of researchers led by Maury Nation conducted a review of successful prevention programs and identified nine elements that were common to all of them.[9] Those elements included:

- ***Comprehensiveness:*** multicomponent programs that address critical domains (ex., family, peers, community) that influence the development and perpetuation of the behaviors to be prevented; these programs could include a combination of interventions in multiple settings
- ***Varied teaching methods:*** programs involve diverse teaching methods that focus on increasing awareness and understanding of the problem behaviors and on acquiring or enhancing skills; programs should be careful not to rely on knowledge, information, or group discussion as the major change mechanism
- ***Sufficient dosage:*** programs provide enough intervention to produce the desired effects and provide follow-up as necessary to maintain effects; effects of most prevention programs decline over time, so booster sessions focusing on prior skills or the development of news ones can be helpful to sustain results
- ***Theory driven:*** programs have a theoretical justification, are based on accurate information, and are supported by empirical research
- ***Positive relationships:*** programs provide exposure to adults and peers in a way that promotes strong relationships and supports positive outcomes
- ***Appropriately timed:*** programs are initiated early enough to have an impact on the development of the problem behavior and are sensitive to the developmental needs of participants
- ***Socioculturally relevant:*** programs are tailored to the community and cultural norms of the participants and make efforts to include the target group in program planning and implementation
- ***Outcome evaluation:*** programs have clear goals and objectives and make an effort to systematically document their results relative to the goals; effectiveness should not be judged primarily on the basis of anecdotal or case study results
- ***Well trained staff:*** program staff support the program and are provided with training regarding the implementation of the intervention; implementation is most effective when staff are sensitive, competent, and well-supervised

A Comprehensive Prevention Process

Programming is really just the tip of the iceberg in terms of effective prevention. A good prevention program is part of a larger, more comprehensive prevention process. EverFi has created a graphic

depicting just that phenomenon, with programming sitting atop a pyramid of prevention components (see Figure 4).

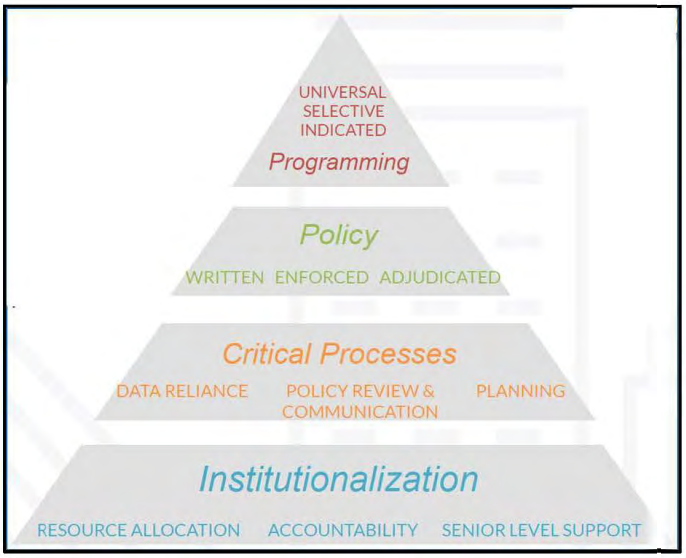
At the base of the pyramid is Institutionalization. In many instances, the staff member tasked with prevention work is buried in the college or university's organizational structure under multiple layers of supervision. In order for prevention efforts to be successful in higher education settings, senior administrators need to buy in to the process and be willing to support the efforts through resource allocation and accountability.

The next level up the pyramid is Critical Processes. This level involves the behind the scenes efforts to ensure that prevention strategies are based on strategic planning and localized data when possible. It is also at this level that processes are put in place for policy review and communication across the campus's affected constituents.

Nearing the top of the pyramid is the Policy level. Effective prevention efforts have well written policies that are enforced and efficiently adjudicated. Policies set the tone for the values and expectations of the campus, and no amount of work by a prevention practitioner will overcome a conflicting policy or a supportive policy that is not enforced.

Lastly, the Programming level sits on top. Remember that programming should involve universal, selective, and indicated target audiences and contain the nine elements previously mentioned as components of effective prevention programs. When all levels of the pyramid are in place, prevention efforts are highly likely to be successful.

Figure 4. The Process of Successful Prevention.[10]



In summary, there are things we know make for good prevention programming and things that are not so good. A prevention program is most likely to be effective when it is rooted in theory and evidence, is comprehensive in scope, is repeatable, is relevant to your community, and is collaborative. In contrast, programs least likely to be effective are single shot, standalone programs that rely primarily on scare tactics or an increase in knowledge alone to change behavior.

A Note on Scare Tactics (Don't Use Them!!)

It is worth mentioning that a default approach to prevention, particularly among individuals with no formal training in the field, is to use fear based messages as a way to "scare" their population into healthy behavior. You have probably witnessed many of these approaches yourself—a presentation showing pictures of diseased genitalia intended to deter sexual activity, a crashed car and/or other staged accident scene intended to discourage drunk driving, testimonials from people who have served jail time for the choices they made around substance use or illegal activity, etc. But as common as they are, scare tactics have never been documented in the literature as effective at changing behavior. In fact, some of them have even been shown to increase the chances of a target audience engaging in the very behavior organizers were trying to prevent!

In spite of the organizers' good intentions, the use of scare tactics can have one or more of the following less than helpful effects on the target audience:

- A behavioral "paralysis" where participants don't know what to do to avoid the described consequence, especially if abstinence from a particular behavior is not seen as a viable option
- A "game" mentality where the participants are determined to continue a negative behavior to "prove" to the organizers that the consequence they described won't happen to them
- A loss of the organizers' credibility as the participants process that behaviors they and their peers have engaged in previously did not lead to the consequences being featured in the intervention

For all of these reasons, CHASCo encourages its member schools to avoid the use of scare tactics in their prevention efforts and to instead consider some or all of the specific strategies that follow and are currently considered best practices in our field.

Environmental Prevention Strategies

Environmental prevention strategies seek to address the underlying conditions in a community that can lead to healthy or unhealthy behaviors. These could include policies, programs, and practices that promote well-being or reduce risk. Environmental prevention could take place in many formats, and ideally, would utilize multiple designs. Here are some general examples, but you can also consider some specific examples compiled by CHASCo of practices used by member schools. Check the CHASCo website for the most current listing.

- **Campus policies**
  College and university policies that restrict the accessibility of alcohol can effectively deter student drinking **when they are well enforced**. Such policies could include bans on alcohol advertisements on campus, dry campus policies, scheduling Friday classes, or party registration policies, to name a few. CHASCo institutions who elect to complete prevention plans will find that the planning process will require consideration of their local policies and if and how they could be improved.

- **Mandated population-level education**
  Requiring all students complete some type of evidenced-based in person or online education curriculum can change the environment and culture around behaviors you wish to prevent. Some schools choose to assign the curriculum as an online pre-matriculation requirement and tie its completion to a student's ability to enroll in classes for the upcoming semester.

  "AlcoholEdu" by EverFi and "eCheck Up To Go (eCHUG)" by San Diego State University probably have the most name recognition in this category, but there are other options available through various vendors. CHASCo has negotiated discounted rates for its member schools to utilize eCHUG, so contact the CHASCo director if you would like more information about that product.

- **Late night social activities**
  The use of school-sponsored social activities during typical peak drinking times is another common tactic universities use to alter the environment of their campuses. The activities would generally be held on Thursday, Friday, or Saturday nights with a 9:00pm or later start time and a midnight or later end time to coincide with time frames that tend to be common drinking periods for students. They could also be held around holidays like Halloween, St. Patrick's Day, or Cinco de Mayo that are associated with alcohol consumption. The activities are never advertised as "alcohol-free alternatives," but that is, in effect, the purpose they serve. San Diego State University has one of the most well-established programs of this sort called Aztec Nights. Additional information about its program can be found at https://as.sdsu.edu/aztecnights/. Many CHASCo member schools use money available from their prevention plans to fund similar late night activities.

- **Universal screenings**
  A newer effort at changing the environment is the use of universal screenings in student health clinics and counseling centers. When implemented, all students seen in one or both of those settings are asked a standard set of questions around their use of alcohol, experience with depression, suicide ideation or other area of interest. The screening allows for the gathering of information that might not have come up in the student's appointment otherwise, and students who screen positive can quickly be referred to the appropriate resource.

- **Community partnerships**
  One last example of how environmental factors can be used as a best practice is community partnerships. All of our campuses exist as part of a larger community, and working with your local partners is key to preventing problems within one sphere bleeding over into the other. To

give a specific example, the Safer California Universities Project was an NIAAA-funded grant that allowed 14 schools in the California State University system to implement a variety of interventions aimed at curbing high risk alcohol use among their students. The schools in the program partnered successfully with local law enforcement to offer well-publicized DUI check points, off campus party patrols, crackdowns on sales of alcohol to minors, and a wide-scale media campaign during the first few weeks of the academic year. You can read more about the project and download a free toolkit if you are interested in trying something in your own community at https://prev.org/SAFER/interventions.html.

Many counties in Tennessee have local prevention coalitions. If you are unsure about your own county, the State of Tennessee has a website that lists community based prevention coalitions at https://www.tn.gov/behavioral-health/substance-abuse-services/prevention/prevention/join-an-anti-drug-coalition0.html. CHASCo encourages its member campuses to partner with their community coalitions when possible.

Social Norms Marketing

Another well-researched best practice is the strategy of social norms marketing. Social norms in general refer to the perceptions we all have of what is typical behavior (descriptive norms) or what is considered acceptable or unacceptable behavior (injunctive norms). Those perceptions commonly guide our behavioral decision making (i.e., "when in Rome, do as the Romans do"). The social norms marketing strategy involves publicizing messaging around the healthy behaviors of the students on your campus that might fly in the face of ingrained stereotypes. If students become aware of the true attitudes and behaviors of their fellow students around substance use and violence prevention, they may feel less pressure to engage in behavior that goes against their values or comfort levels.

Figure 5. Sample Social Norms Marketing image from University of Tennessee Chattanooga.[11]

Social norms marketing can take place as a universal campaign or as a targeted campaign for particular groups of students. In a universal campaign, you are likely to see messages along the lines of "Most University of X students don't drive after drinking" or "88% of University of X students did not use tobacco in the past 30 days." The messages are often accompanied by a campaign branded tag line and always include a source statement for the data being referenced. Targeted campaigns would have similar messaging but use images and specific phrasing to make them relevant to the desired population. For example, a targeted campaign message could look something like "3 out of 4 fraternity men at University of X say they would confront a brother who made a racist comment."

If you choose to use the social norms marketing strategy, be sure to consider the contexts in which your students would most likely see the messages. The traditional social norms marketing campaign relies on posters, fliers, and other print materials to display its messages. However, those formats may not be the best options in today's digital world. Consider things like social media ads, computer lab screen savers, online platforms students use to conduct university business, etc. Even if you go with traditional print materials, think about locations where students are most likely to see them. Things like billboards, cafeteria table tents, and shuttle bus stops might get more looks like a poster stuck on a departmental bulletin board.

Additional information on social norms theory and social norms marketing campaigns can be found through the National Social Norms Center housed at Michigan State University, http://socialnorms.org/.

CHASCo has a long history of providing funding to its member schools for social norms marketing campaigns. The CHASCo website, www.tnchasco.org, has examples of some of those campaigns (see Figure 5), and the CHASCo director and Executive Committee Programming Chairperson are also available to offer technical assistance to any campus working on a campaign.

Motivational Interviewing

A third example of a best practices strategy is motivational interviewing (MI). MI is a technique that has been used in counseling environments for decades but has also established a strong foothold in the realm of AOD prevention work. It involves a meeting or series of meetings with individual students or small groups to uncover each student's personal rationale for substance use and openness to the idea of change. The trained facilitator uses open-ended questions to elicit a student's "hook," that is, a potential motivating factor relevant to the student for moving towards a healthier behavior. For some students, the hook could be a realization that their alcohol use has cost them some friendships or perhaps has negatively impacted their grades. For others, it could be that they don't like the weight they have gained from drinking or that they find they lose motivation and productivity when they are high. Perhaps it's even something as simple as they don't like their clothes smelling of cigarette smoke all the time. Whatever is important to that student becomes the driving force behind the facilitator's follow up questions to assess how motivated the person is to trying to change.

When using MI, the Transtheoretical Model becomes key in determining where a person is regarding their readiness to change. A student who is assigned a motivational interviewing intervention due to a sanction for a policy violation may be in precontemplation with no interest in changing his behavior. On the other hand, a student who has experienced a medical emergency or who has self-selected into your

intervention may very well be in the contemplation, preparation, or even action stages. Depending on the stage, you can expect varying levels of resistance and/or ambivalence to change. Keep in mind that students are the "experts" in their sessions, so roll with whatever resistance they present rather than trying to immediately debate their logic or convince them of a need they don't perceive. If students are pre-contemplative, you can try to increase their risk perception by providing normative feedback on how their drinking behaviors compare with local or national norms. If students are contemplative, help elicit reasons for change or risks of not changing that they identify. In preparation or action stages, help your clients determine their best next steps to change and provide them with positive reinforcement. With any of the stages, asking clients where they would rate themselves on interest in or ability to change and then following up with what it would take for them to rate themselves higher can shine light on their motivations and provide potential hooks for further discussion.

It is important to remember that with motivational interviewing, any step towards positive change is considered a win. You may not get the students to the ideal health behavior during your sessions, but moving them along the motivation and behavior change continuum is a desirable outcome.

Brief Alcohol and Screening Intervention for College Students (BASICS)

One example of a specific intervention based on motivational interviewing is the Brief Alcohol Screening and Intervention for College Students (BASICS). There is no official certification involved in becoming a BASICS facilitator, but trainers are available around the country to provide background, skill building, and technical assistance for campuses. CHASCo has periodically sponsored BASICS trainings over the years, as well. The book "Brief Alcohol Screening and Intervention for College Students: A Harm Reduction Approach" by Linda A. Dimeff, John S. Baer, Daniel R. Kivlahan, and G. Alan Marlatt and available from Guilford Press (www.guilford.com) is an excellent resource with reproducible handouts and assessment instruments for individuals who may be interested in learning more about BASICS.

Bystander Intervention

A final best practice that we will discuss is bystander intervention. This practice is based on the fact that most of the social and personal problems associated with alcohol, drugs, and violence are witnessed by others, the healthy majority. Activating that majority to intervene can thus help prevent many harms. Unfortunately, human nature seems to pull us towards inaction when we are bystanders, assuming that someone else will deal with a situation or that it is none of our business. However, research in the field of social psychology documents that people trained to feel responsible for addressing things they see and armed with skills to act are much more likely to intervene. Bystander intervention has been used successfully in many prevention areas, including both violence prevention and substance abuse prevention.

Multiple curricula exist to train individuals and groups in bystander intervention, but a common element of them is the recognition that there are different strategies through which a person could intervene.

For example, some of the commercially available programs refer to the "3 D's." Those D's of intervention are:

- Direct,
- Distract, and
- Delegate

A Direct intervention involves the direct confrontation of the offender, such as directly taking the keys from an intoxicated person about to drive. A Distraction intervention could be directed at the offender or at other bystanders with a goal of creating a diversion that allows for the potential victim to be removed from the situation or that distracts the offender from completing his plan of action. For example, someone intervening could strike up a conversation with the offender or potential victim (i.e., "Excuse me, but you look really familiar to me. Do we have class together?" or "I'm so sorry, but I think your car may be getting towed!"). A Delegation intervention involves seeking help from other bystanders or from authority figures who may be better equipped to address a situation, like contacting campus security when you smell marijuana from a residence hall room. Individuals may feel more comfortable with one or more of these options than others, but the important thing is that acting in any way is better than not acting at all.

To view specific examples of bystander intervention programs and curricula, consider Green Dot Bystander Intervention, created by Dorothy Edwards (https://alteristic.org/services/green-dot/green-dot-colleges/), Step UP! Be a Leader Make a Difference, created by the University of Arizona (http://stepupprogram.org/), or Response Ability: A Complete Guide to Bystander Intervention, created by Alan Berkowitz (www.alanberkowitz.com).

Implementation Science

While each of the previously described strategies is considered a current best practice, it is important to keep in mind that "best practices" are constantly evolving as additional research is done on existing or new interventions. This evolution also means that the way a best practice was implemented at one or more specific institutions may not translate exactly to how it could look at your school. The relatively new field of Implementation Science aims to help us understand how to take research findings and actually put them into practice with our unique populations. In general, implementation science recognizes that every intervention may need to be tweaked in order to fit unique campus environments and cultures.

Although you don't want to change things so much that you break away from the theoretical underpinnings of the intervention, you do need to consider your organizational context, population characteristics, and local resources to know what is feasible for your campus. Don't be afraid to fail. Culture change is hard, and it takes time. There is a plethora of published research covering successful interventions, but as a field, we have not done as well at explaining in that research exactly how those interventions were implemented, or at publishing our intervention failures from which others could learn. In your own efforts to implement best practices, keep notes of what you tried, and if you fail, revisit your theoretical models and see what could be tweaked to try again.

A Word of Caution

Regardless of the strategies you may ultimately decide to employ, be aware that the most commonly used strategies among colleges and universities are not necessarily the most effective, and vice versa. Administrators at 330 4-year colleges and universities in the United States have been surveyed every three years as a part of the College Alcohol Survey run by George Mason University. Included among the survey questions is for the respondents to rank on a scale of 1 to 5 (with 1 being strongly disagree and 5 being strongly agree) the accuracy of the statement "Our campus utilizes the most effective alcohol abuse prevention strategies based on professional literature, conference workshops, training, etc." The mean score on that item in 2015 was 3.64, which is hardly an improvement over the 3.57 mean score when the question was originally introduced in 2003[12].

A review of results from the 38 schools who participated in EverFi's Sexual Assault Diagnostic Inventory[13] shows that three of the five most commonly reported sexual violence prevention strategies (awareness events, tabling events/health fairs, and invited speakers) are shown by research to be least effective, while four of the five least used sexual violence prevention strategies (social norms marketing, academic course engagement, bystander intervention, and small group social norms) are among the most promising.

These numbers can increase confusion for administrators and other professionals new to the prevention field, as they often look to peer institutions for programming ideas. If you can't always trust that peer institutions are using effective strategies, where can you turn for ideas? This questions leads into our next and final section on research tools and guiding documents.

Guiding Documents and Research You Should Know

Fortunately, there are lots of free tools available in online and print versions to help you plan your prevention efforts and assess their efficacy.

NIAAA Tools

A great starting point for prevention, specifically in higher education environments, is the website www.collegedrinkingprevention.gov, which is maintained by the NIAAA. The website is a repository of information, including fact sheets, reports, and presentations that can be helpful to both the beginner and the more seasoned prevention practitioner. To ground yourself in how the website seeks to categorize interventions, check out the 2002 document, "A Call to Action: Changing the Culture of Drinking at U.S. Colleges," as well as its 2007 update, "What Colleges Need to Know: An Update on College Drinking." "A Call to Action" reviews many of the strategies used at the time of publication to prevent high risk drinking and ranks them into "Tiers of Effectiveness" based on the amount of published research that supports their success rates at reducing substance misuse. "What Colleges Need to Know" provides a follow up on how colleges were utilizing the 2002 report and offers updated recommendations and statistics.

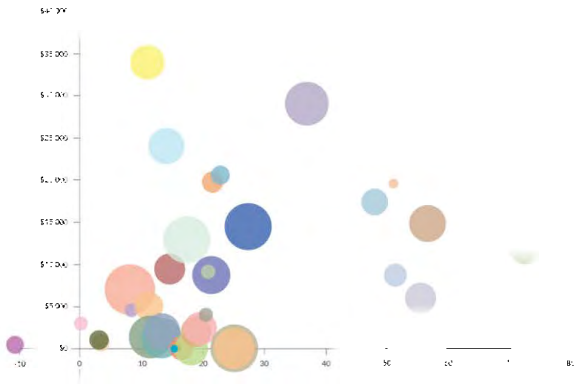
Once you are familiar with the ranking system, you should next familiarize yourself with the "College Alcohol Intervention Matrix (AIM)." This tool was published in 2015 and updated in 2019. It is available as a print copy (see Figure 6) or digital download through the website or as an interactive tool while on the website. The tool is divided into sections, with matrices that review current environmental and individual interventions, and with planning worksheets. If using the interactive version online, the environmental interventions are categorized based on effectiveness and cost at https://www.collegedrinkingprevention.gov/CollegeAIM/EnvironmentalStrategies/default.aspx. Click on any of the bolded strategies to learn more about them, as well as see how much supporting research they have. Similarly, the individual strategies can be viewed at https://www.collegedrinkingprevention.gov/CollegeAIM/IndividualStrategies/default.aspx. A strategy planning worksheet can be downloaded or completed online at https://www.collegedrinkingprevention.gov/CollegeAIM/Resources/Worksheet_for_Choosing_Alcohol_Interventions.pdf and allows a practitioner or task force to think through current strategies and their effectiveness, strategies they may wish to add, and what next steps should be considered to improve the overall efforts on their campuses.

Figure 6. The College AIM Print Edition.[14]

Alcohol Prevention Compass

Another great tool is the Alcohol Prevention Compass, developed by EverFi and available at https://compass.everfi.com/tool/compass/. This visualization depicts 34 different strategies and plots their effectiveness, cost, and scale of impact on a graph. On the website, you can click on a strategy to see where it falls on the graph, learn more about the strategy, and see the available research that led to its placement on the compass. Print versions of the compass can be obtained by contacting an EverFi representative. The website also provides an avenue for campuses to receive a custom compass depicting the strategies currently used by individual institutions, which can be useful for guiding discussions with decision makers and senior administrators at your school. Keep in mind, though, that EverFi is a for-profit company, and while they offer many consultative services for free, their end goal is to sell you their online education products, so expect some frequent sales pitches.

Figure 7. Alcohol Prevention Compass Image.[15]



Evidenced-Based Practice Resource Center

SAMHSA also offers a free tool called the Evidenced-Based Practice Resource Center. This tool is not specific to higher education environments, but it is a database of various interventions, toolkits, resources, and information on a variety of substance use and mental health topics that is easily searchable. From its website, https://www.samhsa.gov/ebp-resource-center, you can search by topic, population, or target audience to review relevant materials and other documents that might be similar to your search terms.

This section in no way provides an exhaustive list of the resources currently available to help with prevention efforts, but it will hopefully give you enough information to get started and to feel more confident that you are selecting proven strategies for your unique campus. Additional resources and supporting documentation are available in the appendix of this manual.

Conclusion

As you are now aware, there is a great deal of science underlying prevention work to help increase the chances of meeting our goal of "nothing" happening. CHASCo is here to help you each step of the way as you begin navigating your new responsibilities and making decisions about the strategies you want to employ at your institution. Keep in mind that culture change will take time, and anticipate having to explain on occasion why you are using the specific strategies you select rather than just providing more educational information or attempting to scare students into positive behaviors. Those of us within CHASCo are in the fight together, and we stand in solidarity with you in your efforts to utilize effective strategies for your students.

In the words of John F. Kennedy during his 1961 inaugural address:

> "All of this will not be finished in the first one hundred days. Nor will it be finished in the first one thousand days, nor in the life of this Administration, nor even perhaps in our lifetime on this planet. ***But let us begin."***

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Appendix- Additional Resources

Textbook Resources

Bensley, R.J. and Brookins-Fisher, J. (2003). Community health education methods: A practical guide. 2nd edition. Jones and Barlett Publishers.

Glanz, K., Rimer, B.K., Lewis, F.M. (2002). Health behavior and health education: Theory, research, and practice. 3rd edition. Jossey-Bass Publishing.

Green, L.W. and Kreuter, M.W. (1999). Health promotion planning: An educational and ecological approach. 3rd edition. Mayfield Publishing Company.

Web-based Resources

Coalition for Healthy and Safe Campus Communities (CHASCo)

This website of the statewide prevention coalition for higher education institutions in Tennessee includes prevention resources, training opportunities, and information about upcoming in person and online business meetings and professional development.

Centers for Disease Control and Prevention (CDC)

The Guide to Community Preventive Services is a resource for evidence-based recommendations from the Community Preventive Services Task Force about what works to improve public health.

Center for the Advancement of Public Health at George Mason University

Creating a Strategic Plan for College Students provides resources around strategic planning, including a "Promising Practices Action Planner" and a "Promising Practices Task Force Planner."
Implementation in the College contains multiple documents, standards, and workbooks about interventions taking place on college campuses. Although some of the information is becoming dated, like the **"Promising Practices: Campus Alcohol Strategies"** from 2001, it is still a useful resource in learning about efforts at a variety of campuses.
Reviewing College Initiatives offers guidance and self-assessment tools for evaluating prevention efforts. This site also offers access to the most recent results of the College Alcohol Survey.

Center for Community Health at the University of Kansas

Community Tool Box offers step by step guides and models related to community building to address social determinants of health, engaging stakeholders, action planning, building leadership, improving cultural competency, evaluation, and sustainability over time. Toolkits are available for 16 areas of planning and program administration.

Higher Education Center for Alcohol and Drug Misuse, Prevention, and Recovery

Prevention 101 is a five-part video series designed for new prevention professionals that explores the foundations of collegiate substance misuse prevention.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

Alcohol Policy Information System provides detailed information on alcohol-related policies in the United States at both state and federal levels. Detailed state-by-state information is available for more than 30 policies.

Safer Campuses and Communities website is based on an NIAAA-funded study that examined a variety of environmental-level strategies that could be implemented on campuses and in their surrounding communities. A free toolkit for implementing the collaborative model is available online.

National Institute on Drug Abuse (NIDA)

NIDA's College-Age and Young Adults page provides the most recent data on substance use among this age group, including patterns of marijuana use, non-medical use of prescription drugs, cocaine, and newer trends like synthetic drugs, e-cigarettes, and hookah use. It also provides other links of interest to educators, residence hall supervisors, counselors, clinicians, and researchers who work with this age group, as well as students and parents.

Substance Abuse and Mental Health Services Administration

Center for the Application of Prevention Technologies is a national substance abuse prevention training and technical assistance site. Resources on the site include:

- Evaluation tools and resources from federal and nonfederal sources
- Strategic Prevention Framework, a five-step planning process that guides the selection, implementation, and evaluation of evidence-based, culturally appropriate, sustainable prevention activities

Report to Congress on the Prevention and Reduction of Underage Drinking (2013) includes policy summaries and state summaries identifying current legislative and other ongoing efforts. This report is compiled by the Interagency Coordinating Committee on the Prevention of Underage Drinking and is available through www.StopAlcoholAbuse.gov and the SAMHSA Store.

U.S. Department of Education

National Center on Safe Supportive Learning Environments offers training, technical assistance activities, and resources to support assessment, capacity building, strategic planning, implementation, and evaluation. Resources on this site include:

- *Using a Public Health and Quality Improvement Approach to Address High-Risk Drinking with 32 Colleges and Universities* (2014)
- *College Alcohol Risk Assessment Guide: Environmental Approaches to Prevention* (2009)

- ***Methods for Assessing College Student Use of Alcohol and Other Drugs*** (2008)

U.S. Department of Justice

Underage Drinking Enforcement Training Center provides federal and non-federal resources, such as:

- College e-kit web section
- *Preventing Binge Drinking on College Campuses: A Guide to Best Practices* (2012)
- Promising Practices: Campus Alcohol Strategies (includes an Alcohol Task Force Action Planner)
- *Party Patrols: Best Practice Guidelines for College Communities* (2010)

Appendix G: Alcohol eCHECKUP TO GO

[Skip to Main Content]

Welcome to the Alcohol eCHECKUP TO GO at Middle Tennessee State University

The Alcohol *eCHECKUP TO GO* will provide you with accurate and personalized feedback about:

- ✔ Your individual drinking pattern
- ✔ Your risk patterns
- ✔ Your aspirations and goals
- ✔ Helpful resources at **Middle Tennessee State University** and in your community

Start a new eCHECKUP TO GO

Review a Previous Entry

This Alcohol *eCHECKUP TO GO* program was purchased for the exclusive use of, and tailored to, the Middle Tennessee State University community. If you are not a member of the Middle Tennessee State University, please do not proceed on this site.

More Info...

The pages produced by the eCHECKUP TO GO program are valid HTML and CSS and are Section 508 compliant.
Javascript is required for the proper operation of this web site.

Appendix H: Cannabis eCHECKUP TO GO

[Skip to Main Content]

Welcome to the Cannabis eCHECKUP TO GO at Middle Tennessee State University

The Cannabis *eCHECKUP TO GO* will provide you with accurate and personalized feedback about:

- ✔ Your individual pattern of cannabis use
- ✔ Your risk patterns
- ✔ Your aspirations and goals
- ✔ Helpful resources at **Middle Tennessee State University** and in your community

play | pause | mute | vol+ | vol- | text

Start a new eCHECKUP TO GO

Review a Previous Entry

This Cannabis *eCHECKUP TO GO* program was purchased for the exclusive use of, and tailored to, the Middle Tennessee State University community. If you are not a member of the Middle Tennessee State University, please do not proceed on this site.

More Info...

The pages produced by the eCHECKUP TO GO program are valid HTML and CSS and are Section 508 compliant.
Javascript is required for the proper operation of this web site.

Appendix I: Request for Exception, Tobacco on MTSU Property

REQUEST FOR EXCEPTION TO ALLOW USE OF TOBACCO ON MTSU PROPERTY

Requesting Individual (name, address, M-number, phone number)	Requesting Department
Detailed description of proposed activity :	
Description of requested location:	
Age and number of expected participants:	
Anticipated safety measures/protection from secondary effects of tobacco use:	

_____ _____
Applicant Date

CONCUR:

_____ _____ _____ _____
Print name: Date Print Name: Date
Campus Planning Environmental Health and Safety Services

APPROVED:

_____ _____
Provost or Vice President, Date
as applicable