Connecticut Healthy Campus Initiative

Final Program Evaluation Report

UCONN HEALTH
CENTER FOR PUBLIC HEALTH AND HEALTH POLICY

July 2014

Connecticut Healthy Campus Initiative

Final Program Evaluation Report
July 2014

Principal Investigator/Program Evaluator: Sara Wakai, PhD
Assistant Professor, Department of Medicine
Assistant Director of Public Health Research
Center for Public Health and Health Policy
UConn Health
263 Farmington Ave. MC 6030
Farmington, CT 06030-6030
Office: 860-679-5503
Fax: 860-679-1650
swakai@uchc.edu

Statistician: Elizabeth A. Schilling, PhD
Research Associate, Center for Public Health and Health Policy
UConn Health
263 Farmington Ave. MC 6030
Farmington, CT 06030-6030
860-679-8871
eschilling@uchc.edu

Co-Principal Investigator: Robert H. Aseltine, Jr., PhD
Professor, Division of Behavioral Sciences and Community Health
Director, Institute for Public Health Research
Center for Public Health and Health Policy
UConn Health
263 Farmington Avenue, MC 3910
Farmington, CT 06030-3910
Office: (860) 679-3282
Fax (860) 679-1650
aseltine@uchc.edu

UCONN HEALTH
CENTER FOR PUBLIC HEALTH AND HEALTH POLICY
263 Farmington Avenue, MC 6030
Farmington, Connecticut 06030-6030

Acknowledgement

The principal investigator and co-investigator would like to thank Mary Kate Mason, MSW and Dawn Grodzki-Sideman Project Coordinators of the Connecticut Healthy Campus Initiative (CHCI) at the Connecticut Department of Mental Health and Addiction Services (DMHAS), for the opportunity to conduct this evaluation. We are also very grateful to Wheeler Clinic's Connecticut Center for Prevention, Wellness and Recovery (CCPWR) for their leadership and administrative support: Judith Stonger, Cathy Sisco, Heather Clinger, Corrine King, and Jessica Downes. We would like to acknowledge the contributions of Eric Horan, JD, MPA who reviewed and revised the final report. Connie Cantor impressed us again with her editing and formatting talents. A special thank you goes to the representatives of the sub-recipient campuses and community organizations who, among numerous other responsibilities, coordinated the administration of the Core surveys on their campuses. Thank you to the CHCI members who attended meetings, completed surveys, and contributed their time and knowledge to this evaluation.

The evaluation was funded by DMHAS, with support from Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Education (ED) (Grant number: Q184Z100001).

Table of Contents

Executive Summary

Connecticut Healthy Campus Initiative

The mission of the Connecticut Healthy Campus Initiative (CHCI) is to serve as a catalyst for creating and sustaining healthy college campus and community environments. Members of CHCI include individuals from campus-community coalitions throughout the state. CHCI is funded by the Connecticut Department of Mental Health and Addiction Services (DMHAS), with the support of the Substance Abuse and Mental Health Services Administration (SAMHSA) and U.S. Department of Education (ED). DMHAS contracted with Wheeler Clinic's Connecticut Center for Prevention, Wellness and Recovery to provide administrative support and for the services of the Center for Public Health and Health Policy (CPHHP) at the University of Connecticut Health Center (UCHC) to conduct the program evaluation. In December 2010, CHCI released a request for proposals (RFP) to provide funding to establish or expand evidence-based strategies to reduce the rate of underage drinking on Connecticut college campuses. In January 2011, interested campuses and community organizations submitted proposals and ten entities received $20,000 sub-awards. The funding period for sub-awards was originally from January 2011 to June 2012. The funding period was later extended to June 2014. CHCI also awarded eight additional mini-grants in 2014.

The sub-recipient campuses and community organizations were:

- Connecticut College: New London, Connecticut (2011-2014)
- Fairfield University: Fairfield, Connecticut (2011-2014)
- Manchester Community College/ERASE: Manchester, Connecticut (2011-2014)
- Northwestern Connecticut Community College/McCall Foundation: Winsted, Connecticut (2011-2014)
- Norwalk Community College/Positive Directions: Norwalk, Connecticut (2011-2014)
- Sacred Heart University: Fairfield, Connecticut (2011-2014)
- Southern Connecticut State University: New Haven, Connecticut (2011-2014)
- University of Connecticut, Avery Point: Avery Point, Connecticut (2011-2012)
- University of Connecticut, Storrs/ Mansfield Community Campus Partnership: Storrs, Connecticut (2011-2012)
- University of New Haven: New Haven, Connecticut (2011-2014)

Evaluation Design

The evaluation design for the CHCI used a comprehensive framework detailed in the handbook *Understanding Evaluation: The Way to Better Prevention Programs* which was developed with funding from the U.S. Department of Education (Muraskin, 1993). The model espouses three evaluation components: process, outcome and impact. The evaluation was designed to address the three objectives of the CHCI, which were:

Objective One. Expand and enhance the Connecticut Healthy Campus Coalition, a voluntary group of institutions of higher education, state government officials, and community organizations who have come together to change aspects of the

campus and community environment that contribute to high-risk drinking and other drug use.

Objective Two. Increase the level of cooperation and coordination occurring among members of the CHCI relative to alcohol abuse prevention.

Objective Three. Achieve a quantifiable increase in the number of campuses reporting a reduction in 30-day alcohol use and binge drinking rates.

Process Evaluation

The purpose of the process evaluation was to address Objective One by measuring programmatic activities and collaborative efforts at the State and campus levels related to expanding and enhancing the CHCI.

At the conclusion of the CHCI Leadership Summit, attendees were asked to complete a brief survey. Eighty percent of the respondents found the Leadership Summit to be "Helpful" or "Very Helpful" in assisting them to address underage drinking and binge drinking on college campuses. Over half of the respondents were interested in obtaining more information about the CHCI. The training topics of greatest interests to the respondents were: Internet/social media for underage drinking prevention; Effective student engagement strategies; and Strategies for sustaining effective campus-community coalitions. This information guided the selection of topics offered at the CHCI professional development meetings.

A CHCI Coalition Feedback Survey was administered in the fall of 2010 and again in 2011 to obtain an overview of networks and resources. The results indicated that the respondents felt their areas of professional strength included: having access to technology that facilitates networking (e.g. networking, e-mail listserv, and newsletters), having colleagues from whom they can seek advice, knowing experts in the field, and engaging in high-risk alcohol and other drug (AOD) prevention. The mean scores were fairly stable from 2010 to 2011.

The Coalition offered 29 monthly business or professional development meetings from October 2010 to May 2014 with an average of about 26 members in attendance. The business meetings focused on coalition building program planning and announcements. Professional development meetings were facilitated by guest speakers and satisfaction survey results indicated that respondents were very satisfied with the presentations. The Coalition sponsored four intervention trainings: BASICS training, BASICS Training of Trainers, BASICS Training Symposium, Red Watch Band Training of Trainers and a Campus Enforcement Partnership Event.

The Coalition established and maintained three listservs to address membership needs. CHCI membership has grown considerably with the initiation of the program: from 106 members in 2011 to 168 members in 2014 (an increase of 58 percent).

Outcome Evaluation

The Outcome Evaluation component was designed to measure the level of cooperation and coordination occurring among members of the CHCI relative to alcohol abuse prevention (Objective

Two). To address this objective, individuals applying for the Connecticut Healthy Campus Initiative in 2011 were required to complete the Scanning Exercises of the College Alcohol Risk Assessment Guide developed by the U.S. Department of Education's Higher Education Center (2009). Sub-recipients also completed the Environmental Scan again in 2012.

In response to Scanning Exercise A-1: A Quick Profile of Risks for Alcohol Problems, Campus Life items focused on the visibility and level of opportunities for socializing which may provide positive alternatives to alcohol consumption. A comparison of the 2010 and 2012 Campus Life items indicated an increase in mean scores for each activity except for Health Promotion Activities (e.g., visibility of smoke-outs, AIDS awareness week). Related-Samples Wilcoxon Signed Rank Tests were performed to determine whether the average number of persons in each category differed significantly ($p < 0.05$) by year. A significant increase in mean scores between 2010 and 2012 were found for Nearby Campus-Oriented Commercial Services (e.g. bars, restaurants) ($p = 0.046$) and Athletic Activity (e.g. inter/intramural sports, sports facilities) ($p = 0.034$).

Items included in Alcohol Issues focused on ways a campus may address alcohol problems. The mean scores for all of the items remained the same or increased from 2010 to 2012. Related-Samples Wilcoxon Signed Rank Tests were performed to determine whether the average number of persons in each category differed significantly ($p < 0.05$) by year. Significant increases in mean scores were found for Support for Alcohol Policies ($p = 0.046$), and Enforcement for Alcohol Policies ($p = 0.020$). A significant increase was also found for Visibility of Alcohol Use indicating an increase in drinking in public places on campus, greater acceptance of visible intoxication, party promotions, etc. ($p = 0.020$).

Scanning Exercise A-2: Looking Around Your Campus and Community focuses on the extent alcohol availability and visual messages regarding alcohol use were present on and near campus. Respondents were asked to indicate whether alcohol is sold on campus, ways radio and print media promote alcohol consumption, and types of messages endorsing alcohol consumption in student neighborhoods. Some variations (both increases and decreases) in the responses occurred between 2010 and 2012. Related-Samples Wilcoxon Signed Rank Tests were performed to determine whether there were significant differences by year. The tests indicated no significant differences ($p < 0.05$).

In Scanning Exercise A-3: Having Conversations, respondents were asked to list individuals who were potential allies and sources of information regarding student alcohol use and prevention. Respondents were instructed to talk to some or all of these people to confirm or negate impressions identified in the previous sections of the scanning exercise. On average, respondents reported that they had the greatest number of colleagues in Campus Life and Activities with whom they could have a conversation (mean 2010=7.6, mean 2012=6.4) and had the fewest colleagues in Academics (mean 2010=1.9, mean 2012=2.1). Related-Samples Wilcoxon Signed Rank Tests were performed to test whether the changes differed significantly by year. Results determined that none were significant at the $p < 0.05$ alpha level.

Impact Evaluation

In accordance with Objective Three, the impact evaluation component was designed to measure changes in 30-day alcohol use and binge drinking rates to assess whether the interventions the sub-recipient campuses implemented led to changes in patterns of student alcohol consumption and AOD related problems. A grant requirement was to administer the Core Alcohol and Drug Survey and the Faculty and Staff Environmental Alcohol and Other Drug Survey in the spring of 2011, 2012, and 2014.

Core Student Results

Students received mixed messages about alcohol and drug use on campus. On the one-hand, students reported that their campus has an alcohol and drug policy and that the policy was enforced. In addition, the students felt that their campus was concerned about drug and alcohol prevention, and that the campus offers drug and alcohol prevention programs. However, even with these efforts over one-third of the students were unaware of any prevention programs on campus and over half of the students felt that the social atmosphere on campus promoted alcohol use. Progress was made from 2011 to 2014 with a significant increase in awareness of drug and alcohol prevention programs (X^2=9.007, df=1, $p < .004$), and student involvement in prevention efforts (X^2=25.756, df=1, $p < 0.000$). However, there was a significant decrease in the number of students reporting their campuses was concerned about drug and alcohol prevention (X^2=21.335, df=2, $p < 0.000$).

The data directly related to alcohol use illustrated that not only do college students drink frequently and to excess but their drinking increases once they become of legal drinking age. However, there were significant decreases from 2011 to 2014 in past 30-day alcohol use, average number of drinks per week, and consuming five or more drinks at a sitting.

Students recognize that alcohol and drug use leads to many negative consequences. The most frequently noted consequences were having a hangover, being nauseous or vomiting, doing something later regretted and having memory loss. Difficulties that respondents experienced due to other students' drinking include being interrupted while studying and others making a mess in a common living area.

The data suggest that the primary reasons students drink were related to the perceived increase in sociability, especially initial social interactions. For example, students felt that drinking breaks the ice, enhances social activity, gives people something to do, and something to talk about. Although students report that they drink for social reasons, the severity of the consequences of alcohol consumption indicates that the drinking is excessive and far beyond the general notion of social drinking.

Core Faculty and Staff Results

The faculty and staff at the sub-recipient campuses completed the Faculty and Staff Environmental Alcohol and Other Drug Survey in the spring of 2011 (n=1,082), 2012 (n=609), and 2014 (n=1362). Institutions appeared to have a policy concerning alcohol and other drugs as reported by the vast majority of respondents. However, the effectiveness of the policy may be limited since less than half of the respondents had seen or read the policy and only one-third felt the alcohol and drug

policy was consistently enforced on campus.

Over half of the respondents viewed alcohol and drugs as a problem and a concern for educators. A possible reason why faculty and staff had a negative view of alcohol and drugs may be attributed to their belief that alcohol and drugs have a deleterious effect on students' academic performance and overall quality of student life.

The majority of faculty and staff reported that they knew the signs of problem alcohol and drug use and how to refer students or colleagues who may have alcohol or drug problems. In addition, the respondents were interested in obtaining more information on identifying problem alcohol and drug use among students and would be willing to attend a workshop on prevention. Further professional development on this topic is warranted since the respondents reported that they needed more information on identifying problem alcohol and drug use among students and would be willing to attend a workshop on prevention. Other indicators of professional development needs are that less than one-third of the respondents reported that their campus provided training on alcohol and drug related problems to staff and faculty and few had attended training on this topic on campus.

Connecticut Healthy Campus Initiative
Final Evaluation Report

Introduction

The Connecticut Healthy Campus Initiative (CHCI) was established in 2004 when representatives from approximately 25 institutions of higher education and state partners began meeting to discuss strategies to prevent high-risk alcohol, tobacco and other drug use and to reduce related consequences among college students. The current mission of the CHCI is to serve as a catalyst for creating and sustaining healthy college campus and community environments. Members of the CHCI Coalition include individuals from campus-community coalitions throughout the state. The CHCI is funded by the Connecticut Department of Mental Health and Addiction Services (DMHAS), with the support of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Education (ED) (Grant number: Q184Z100001). DMHAS contracted with Wheeler Clinic's Connecticut Center for Prevention, Wellness and Recovery (CCPWR) to provide administrative support and for the services of the Center for Public Health and Health Policy (CPHHP) at the University of Connecticut Health Center (UCHC) to conduct the program evaluation. In December 2010, the CHCI working group (hereafter referred to as the Coalition) released a request for proposals (RFP) to provide funding to establish or expand evidence-based strategies to reduce the rate of underage drinking on Connecticut college campuses. In January 2011, interested campuses and community organizations submitted proposals and ten entities received $20,000 sub-awards. The original funding period for the sub-recipient campuses was from January 2011 to June 2012. In 2013 and 2014, the sub-recipient campuses were given the opportunity to apply for additional funding. Eight of the original sub-recipients chose to do so and received $10,000 in 2013 and $13,000 in 2014. In addition, CHCI funded eight one-time mini-grants to campuses during FY 2014 for innovative projects to address underage drinking prevention and mental health promotion for students. The various types of grants were used to enhance recovery housing services, foster new on-campus coalitions, increase use of web-based interventions and develop student organizations focusing on alcohol misuse prevention, among other things. A few examples of particular programs funded include: After-hours Cafés to provide alcohol-free activities for students; intervention referral training (BASICS); and curriculum infusion.

The original sub-recipient campuses and community organizations were:

- Connecticut College: New London, Connecticut (2011-2014)
- Fairfield University: Fairfield, Connecticut (2011-2014)
- Manchester Community College/ERASE: Manchester, Connecticut (2011-2014)
- Northwestern Connecticut Community College/McCall Foundation: Winsted, Connecticut (2011-2014)
- Norwalk Community College/Positive Directions: Norwalk, Connecticut (2011-2014)
- Sacred Heart University: Fairfield, Connecticut (2011-2014)
- Southern Connecticut State University: New Haven, Connecticut (2011-2014)
- University of Connecticut, Avery Point: Avery Point, Connecticut (2011-2012)
- University of Connecticut, Storrs/ Mansfield Community Campus Partnership: Storrs, Connecticut (2011-2012)
- University of New Haven: New Haven, Connecticut (2011-2014)

Background and Significance

In 2007 and 2009, reducing underage alcohol use was identified as a top priority by the Connecticut Alcohol and Drug Policy Council (ADPC), a legislatively mandated body comprised of representatives from: the three branches of State government; consumer and advocacy groups; private service providers; individuals in recovery from addictions; and other stakeholders engaged in a coordinated statewide response to alcohol, tobacco, and other drug use and abuse in Connecticut.

In 2009, an examination of substance abuse data by the Connecticut State Epidemiological Outcomes Workshop (CSEOW) showed that alcohol continued to be the drug of choice for young people in Connecticut, and their use rates remained higher than the national average. The data at the college level were even more alarming in Connecticut, where Core Alcohol and Drug Survey data indicated that 72 percent of college students reported current drinking; 46 percent reported drinking five or more alcoholic beverages at one time within the past two weeks; and 30 percent of students said that they had driven a car while under the influence of alcohol or other substances.

Evaluation Design

The evaluation design for the CHCI used a comprehensive framework detailed in the handbook *Understanding Evaluation: The Way to Better Prevention Programs* which was developed with funding from the U.S. Department of Education (Muraskin, 1993). The model espouses three evaluation components: process, outcome and impact. The process evaluation focuses on program plans, activities, materials, etc. while the program is being implemented. This component assesses the appropriateness of the program and allows for feedback and programmatic adjustments. The outcome component examines immediate or direct effects of the program on individuals and/or the environment. The impact component emphasizes long-term program effects.

The evaluation was designed to address the three objectives of CHCI which were:

Objective One. Expand and enhance the CHCI, a voluntary group of institutions of higher education, state government officials, and community organizations who have come together to change aspects of the campus and community environment that contribute to high-risk drinking and other drug use

Objective Two. Increase the level of cooperation and coordination occurring among members of the CHCI relative to alcohol abuse prevention

Objective Three. Achieve a quantifiable increase in the number of campuses reporting a reduction in 30-day alcohol use and binge drinking rates.

Process Evaluation

The purpose of the process evaluation was to address Objective One by measuring programmatic activities and collaborative efforts at the State and campus levels related to expanding and enhancing the CHCI.

Campus-Community Key Leadership Summit. On September 24, 2010, the Coalition hosted a Campus-Community Key Leadership Summit. The Coalition invited 175 guests from institutions of higher education, state agencies, law enforcement, and retailers. Ninety-one guests attended the event. Speakers included key stakeholders representing diverse state sectors from institutions of higher education, community organizations and municipalities including Central Connecticut State University, New Britain Police Department, Connecticut Department of Mental Health and Addiction Services, Connecticut Department of Children and Families, and Connecticut Department of Transportation. In addition, nationally recognized researchers, educators and policy makers presented various topics on alcohol abuse and prevention on college campuses.

At the conclusion of the event, attendees were asked to complete a brief survey (Appendix B). The survey asked respondents to rate the helpfulness of the summit, whether they would like more information about CHCI, and to suggest training topics that CHCI should sponsor to members. Forty-five attendees completed the survey for a response rate of 49 percent (Table 1 and 2). Eighty percent of the respondents found the Leadership Summit to be "Helpful" or "Very Helpful" in assisting them to address underage drinking and binge drinking on college campuses. Over half (58 percent) of the respondents were interested in obtaining more information about CHCI. In response to this finding, the Coalition established two listservs. The training topics of greatest interests to the respondents were: Internet/social media for underage drinking prevention; Effective student engagement strategies; and Strategies for sustaining effective campus-community coalitions. This information guided the selection of topics offered at the CHCI professional development meetings. The final question of the survey allowed for open-ended comments about the summit. Four respondents replied with comments such as needed "more networking time" and there was a "lack of diversity on Panel".

Table 1

CHCI Leadership Summit Survey
(*n*= 45)

	Somewhat Helpful *n* (%)	Helpful *n* (%)	Very Helpful *n* (%)
Question: How helpful was the Campus-Community Key Leadership Summit?	9 (20)	19 (42)	17 (38)
	Yes *n* (%)	**No** *n* (%)	**No answer** *n* (%)
Question: Would you like more information about CHCI?	26 (58)	3 (7)	16 (35)

Table 2

CHCI Leadership Summit Suggestions for Future Training Topics
(*n*= 45)

Training Topics	***n***	**Percent**
Internet/social media for underage drinking prevention	38	84
Effective student engagement strategies	32	71
Strategies for sustaining effective campus-community coalitions	27	60
Evaluation of campus prevention initiatives	22	49
Suicide prevention on college campuses	22	49
Evidence-based environmental prevention	21	47
Federal mandates, DFSCA, Biennial Review	17	38
Implementation of recovery supports on college campuses	15	33
Problem gambling among college students	12	27
Marijuana use	2	4
AOD prevention with non-resident students	1	2
Law enforcement role	1	2
Ways to engage parents of college students	1	2
Sexual tendencies	1	2

CHCI Survey 2013

In June 2013, CCPWR administered a survey to elicit member input for topics for the monthly CHCI professional development meetings during the 2013-2014 academic year. The survey was administered via Survey Monkey and invitations to participate were sent to the 218 e-mails then listed on the CHCI listservs. For 2012-2013 and 2013-2014, the CHCI professional development meetings were conducted in conjunction with the professional development meetings of a closely related intervention, the Connecticut Campus Suicide Prevention Initiative (CCSPI). CCSPI members were also invited to respond to the CHCI Survey 2013, even if they were not otherwise members of the CHCI. The response rate was 24 percent, with 53 CHCI and CCSPI members completing the survey (Table 3 and Table 4).

Table 3

CHCI Survey 2013

n=53

What topics would you like presented at monthly CHCI meetings?		
	n	**Percent**
Onset of mental health disorders in college students	33	66
New Drug Trends	30	60
Peer education programs and mental health promotion	27	54
Alcohol use among underage college students	23	46
Marijuana	23	46
Binge drinking	22	44
Prescription drug abuse	21	42
Effect of substances on the brain	18	38
Evaluation / assessment	19	38
Bystander education	18	36
Curriculum infusion	18	36
Understanding social norms and how to plan a campaign	18	36
Parent engagement	17	34
Violence prevention	16	32
Athletes and substance misuse	15	30
Gambling	14	28
Hazing	9	18
Greek life and substance misuse	8	16
Amnesty policies	8	16

*Responsive open-ended answers include:
Options to support students in recovery; How to implement peer education programs effectively

Table 4

CHCI Survey 2013

n=53

I am interested in the following professional development trainings	*n*	Percent
Motivational Interviewing	19	43.2
AMSR – Assessing and Managing Suicide Risk	11	25.0
Mental Health First Aid	11	25.0
BASICS – Brief Alcohol Screening and Intervention for College Students	15	23.1
ASIST – Applied Suicide Intervention Skills Training	10	22.7
TIPS – Training for Intervention Procedures	10	22.7
QPR Training of Trainers	8	18.2
Red Watch Band	8	18.2
SSN – Student Support Network	7	15.9
Connect Prevention	6	13.6
SAFE TALK – Suicide Awareness for Everyone	6	13.6
Connect Postvention	5	11.4
Not interested in professional development	4	9.1

*Responsive open-ended answers include: Every Choice, Think About It, TIPS.

Roundtable. In June 2013, CCPWR hosted a Roundtable to gather information to better meet the needs of campuses in the final year of the grant. There were 18 attendees at the Roundtable: Wheeler Clinic (3); DMHAS (1); University of Connecticut Health Center (1); institutions of higher education (9); Regional Action Council (2); campus-community coalition (1); and non-profit organization, CT Council on Problem Gambling (1). The objectives of the Roundtable were: 1) To identify issues on campuses that are impacted by high-risk and underage drinking; 2) To identify trends and needs of campuses related to students' substance use and mental health promotion. Results from the discussion, facilitated by Cathy Sisco, indicated that campuses were impacted by alcohol use in several ways including arrests, judicial referrals, medical transports, dependency issues and sexual assaults. Trends related to substance use and mental health included increase in prescription drug abuse, use of alcohol in combination with designer and other drugs, perception that marijuana is a low risk drug, and increased alcohol consumption by women to be on par with men's alcohol consumption. In addition, participants identified what they felt they needed to better address these trends including sustainability of CHCI, more funding to address alcohol, marijuana, prescription drugs, and mental health, greater support from the Board of Regents, training, better relationships with athletic departments and increased collaboration of prevention and recovery efforts.

Technical Assistance. Throughout the funding period, sub-recipients received technical assistance to facilitate progress towards program objectives. In February 2011, CCPWR convened a meeting with sub-recipients to review grant expectations and evaluation requirements. The

DMHAS project coordinator, CCPWR team members, and CPHHP evaluator discussed details on procedures such as reporting timelines, budgets, and survey administration. The CPHHP evaluator created survey administration protocols, templates for cover letters, data sharing agreement letters, timelines, etc. and reviewed those documents with the sub-recipients. In February 2012, the Coalition hosted a Grantee Meeting. The evaluator presented Core results focusing on Connecticut state norms and reviewed the Core and Environmental Scan protocols in preparation for the spring administration. There was time reserved for questions and answers. Cathy Sisco, Program Manager CCPWR, outlined the content of the evaluation and budget reports due at the end of the academic year. The group was given the opportunity to discuss their accomplishments and lessons learned. Heather Clinger conducted site visits with the sub-recipients during the latter part of FY 2013 and throughout FY 2014. In addition, Heather Clinger, the CCPWR coordinator provided technical assistance at the monthly meetings, via individual monthly telephone calls and as needed with in-person discussions, telephone conversations, and e-mail correspondences.

CHCI Membership. CHCI membership grew considerably with the initiation of the program. In 2008, CHCI consisted of 11 associations with active memberships. In June 2011, CHCI membership increased to 106 members representing 40 associations (29 Institutions of Higher Education and 11 community organizations/state agencies). By June 2014, there were 168 CHCI active coalition members representing 62 associations (38 Institutions of Higher Education and 24 community organizations/state agencies) (Table 5).

Active membership was defined as having one or more individuals from the association on the active member listserv, with the intent that the individual would like to attend CHCI monthly coalition meetings. CHCI has three categories of membership to accommodate various levels of need of the stakeholders. These categories were organized into three listservs used for various forms of communication:

- The sub-recipient listserv consisted of individuals from the 10 sub-recipient colleges and community coalitions. The number of members decreased to 8 in 2013 and remained at 8 in 2014.
- The Coalition listserv consisted of individuals from institutions of higher education and surrounding communities that were connected to the mission and were able to attend Coalition meetings even if only on an irregular basis. The Coalition listserv increased from 106 individuals from 40 associations in 2011 to 168 individuals that represent the 62 associations in 2014.
- The informational listserv included individuals who belong to the Coalition listserv and additional individuals who requested on-going information but were unable to commit to the Coalition on a more active level. The size of the informational listserv has increased from 15 (2011) to 228 individuals in 2014.

Table 5

CHCI Listserv Membership

Listserv	2011 *n*	2011 Associations	2012 *n*	2012 Associations	2013 *n*	2013 Associations	2014 *n*	2014 Associations
Sub-recipient	10	10	10	10	8	8	8	8
Coalition	106	40	152	62	165	62	168	62
Informational	152	40	202	62	232	62	228	62

Feedback Survey. The Feedback Survey (Appendix C) was developed specifically for this evaluation. The survey focused on expectations of the CHCI, progress towards CHCI goals, suggestions for programmatic improvement, networking, and professional development opportunities (Table 6). It consisted of 12 closed-ended questions with response options ranging from "Strongly Disagree," (score of one) to "Strongly Agree" (score of five), two open-ended questions, and an option for further comments.

In the original evaluation plan, the Feedback Survey was to be administered at three time points. However, it was decided to reduce the number of administrations to two due to extensive reporting demands placed on the sub-recipients at the end of Year 2. The first administration was in October and November 2010 at the two CHCI Coalition meetings where 30 non-duplicated institutional members were present. The 15 individuals who responded to the survey represent a response rate of 50 percent. The second administration of the Feedback Survey began with the distribution of a paper version at the October 2011 business meeting. To make the survey more accessible, a link to the survey was distributed to the 106 individuals on the Coalition listserv via Survey Monkey. The survey remained open from October 28, 2011 to January 2, 2012 due to school breaks and holiday recess. Twenty-four respondents completed the survey for a response rate of 22.6 percent.

The results from the fall 2010 administration indicated that the respondents felt their areas of professional strength included: having access to technology that facilitates networking (e.g. networking, e-mail listserv, and newsletters) (mean=4.53), having colleagues from whom they can seek advice (mean=4.33), and engaging in high-risk AOD prevention (mean=4.33). In 2011, the respondents reported the areas of professional strength to be: having access to technology that facilitates networking (e.g. networking, e-mail listserv, and newsletters) (mean=4.33), engaging in high-risk AOD prevention (mean=4.33), and knowing experts in the field of AOD prevention from whom I can seek advice (mean=4.25) (Table 6).

The mean scores were fairly stable between 2010 and 2011. The items with the largest mean score gain were: Know effective ways to foster a campus-community culture that reduces high-risk alcohol and other drug use (+.50); Have access to technical assistance for social norms marketing (+.46); Contribute to and receive results from a statewide data collection that monitors student health, gaps in services, etc. (+.35). Analyses to determine statistical significance in mean scores between the two time points were not conducted due to small sample sizes.

In both 2010 and 2011, responses to the open-ended question "What do you need most from

Connecticut Healthy Campus Initiative?" focused primarily on professional development, networking opportunities and technical assistance. In 2011, there was a request for a scheduling change and for a greater focus on non-residential campuses.

In 2010, responses to the open-ended question, "What specific suggestions do you have for improving Connecticut Healthy Campus Initiative?" included professional development opportunities, and suggestions for funding sources. In 2011, the suggestions were more pragmatic such as scheduling CHCI Coalition meetings at various locations around the state and on different days/times to accommodate members' schedules, and to improve the business meetings structure and function.

The following comments represented responses regarding further remarks:

- 2010
  - » So glad we are back! Excellent high level, knowledgeable members
  - » Great program
- 2011
  - » The information/training provided is first class and the members are very accommodating and helpful
  - » Being a part of the Healthy Campus Initiative has been a great education for me personally as we are working toward the same goal with different risk factors. What I have gotten out of the meetings has been invaluable, not to mention the network of people in the College Community that I now have!

Table 6

CHCI Coalition Feedback Survey Fall 2010 and Fall 2011
(2010, *n*=15; 2011, *n*=24)

As an AOD professional working with an institution of higher education I currently . . .	Mean 2010	Standard Deviation 2010	Mean 2011	Standard Deviation 2011	Difference in Mean 2010 to 2011
Know effective ways to foster a campus-community culture that reduces high-risk alcohol and other drug use.	3.50	0.76	4.00	0.72	+0.50
Have access to technical assistance for social norms marketing.	3.29	1.07	3.75	0.90	+0.46
Have access to technology that facilitates networking: website, email listserv, newsletter.	4.53	0.52	4.33	0.70	-0.20
Contribute to and receive results from a statewide data collection that monitors student health, gaps in services, etc.	3.35	0.92	3.70	0.95	+0.35
Know ways to implement science-based AOD prevention and intervention initiatives.	3.80	0.86	4.08	0.83	+0.28
Have access to information sharing and action planning networks for statewide issues related to high risk AOD.	3.79	0.89	3.92	0.78	+0.13
Advocate for state policy change regarding prevention of high-risk AOD use among college students.	3.43	0.94	3.54	0.93	+0.11
Know experts in the field of AOD prevention from whom I can seek advice.	4.20	0.77	4.25	0.74	+0.05
Engage in efforts to prevent high-risk AOD use.	4.33	0.62	4.33	0.56	0
Attend AOD professional development events.	4.20	0.68	4.17	0.92	-0.03
Attend AOD networking events with other campuses and community organizations.	4.00	0.76	3.88	0.90	-0.12
Have colleagues in the field of AOD prevention from whom I can seek advice.	4.33	0.49	4.17	0.87	-0.16

Range: 1 (strongly disagree) to 5 (strongly agree)

Monthly CHCI Meetings. The CHCI steering committee sponsored monthly meetings which initially alternated between business and professional development formats. The business meetings were scheduled for two hour periods and the professional development meetings were scheduled for three hour periods. The business meetings focused on coalition building, subcommittee discussions, informal networking, and announcements. Professional development meetings were facilitated by a guest speaker who provided training on topics identified as important from the results of the Leadership Summit Survey, the Feedback Surveys, the Training Survey and CHCI and, later, CCSPI members. The meetings typically included presentations, group activities, and discussions.

Based on member feedback, the Coalition modified the meeting schedule to limit the number of business meetings to four and increase the number of professional development meetings to five during the 2011-2012 academic year. At the end of the 2011-2012 year, members of the CCSPI joined the CHCI Coalition. Thereafter, for the 2012-2013 and 2013-2014 academic years, the businesses meeting format was eliminated and the monthly CHCI-CCSPI meetings focused on professional development sessions (Table 7 to Table 10).

At the conclusion of each professional development meeting, members were asked to complete a satisfaction survey (Appendix D). The satisfaction survey consisted of ten closed-ended questions with responses on a scale of one (strongly disagree) to five (strongly agree), two open-ended questions, and an opportunity to offer additional comments. The respondents reported that they were very satisfied with the professional development presentations. As noted in Appendix A respondents reported satisfaction or strong satisfaction with all of the presentations.

Table 7

CHCI Business and Professional Development Meetings Attendance

2010-2011	**Meeting Type, Professional Development Presenter and Topic**	***n***
October 2010	Business meeting	25
November 2010	Carla Lapelle, Associate Dean of Student Affairs at Marshall University presented "Working Toward Change" a discussion focused on systematic strategies to reduce underage and binge drinking on college campuses such as using data to identify problem areas, having stakeholders agree on desired outcomes, and implementing environmental changes.	23
December 2010	Business meeting	21
January 2011	Caryn S. Kaufman from Caryn Kaufman Communications, LLC and Greg Williams Co-Director Connecticut Turning to Youth and Families provided information on using social media and social marketing strategies to influence college students' attitudes and behaviors regarding alcohol and other drug use.	27
February 2011	Business meeting	21
March 2011	Lara Hunter, national coordinator for the Red Watch Band program, and Coordinator of Clinical AOD Services at Stony Brook University presented on ways the program provides students with the knowledge, awareness, and skills to prevent toxic drinking and to promote a student culture of responsibility.	21
April 2011	Business meeting	25
May 2011	Robert J. Chapman, PhD, Clinical Associate Professor from Drexel University presented on medical amnesty and Good Samaritan policies related to alcohol and other drug use on college campuses.	23

Table 8

CHCI Business and Professional Development Meetings Attendance

2011-2012	**Meeting Type, Professional Development Presenter and Topic**	***n***
September 2011	Welcome Back event was held for Coalition members for the new academic year, motivational speaker Mark Petruzzi from Success Waypoint, LLC presented on "The Life Aligned: Reducing Stress, Making Better Choices, and Achieving our Goals from the Inside-Out." The presentation focused on stress management, emotions, making choices, and interpersonal communications in the workplace, related to the college environment and students.	30
October 2011	Business meeting	22
November 2011	Beth DeRicco, Ph.D. from DeRicco Consulting presented information about Curriculum Infusion, incorporating underage/high risk alcohol use prevention into the curricula and how to build interest with faculty/staff.	20
December 2011	Business meeting	20
January 2012	Ken Aligata from Connecticut Community for Addiction Recovery (CCAR) and Anne Thompson from Connecticut Turning to Youth and Families presented on integrating Student Recovery Supports on Campus.	19
February 2012	Business meeting	22
March 2012	Ryan M. Travia, M.Ed. from Harvard University Health Services presented "Peer Education: Empowering Student-Leaders to Promote Health and Safety." Ryan spoke about the process of creating Drug and Alcohol Peer Advisor (DAPA) Program, an effective peer education program of a select group of student leaders who have been trained to respond to questions about alcohol and other drug issues at Harvard University.	23
April 2012	Maureen Pasko from the CT VA presented TIPS 50 suicide prevention training and Jack Suchy from the CT Liquor Control Commission presented on Connecticut Liquors Laws and how the laws are related to underage/high-risk alcohol use and college students.	30
May 2012	A Roundtable discussion on How to Increase Administrator Support for Campus Prevention Efforts was offered for the final professional development meeting of 2012. Panel participants included the following college administrators: Robert Baer, Ed.D. Dean of Students at Norwalk Community College; Laura Tordenti, Ph.D., Vice President of Student Affairs at Central Connecticut State University; and Kenneth Bedini, Vice President of Student Affairs at Eastern Connecticut State University.	21

Table 9

CHCI Professional Development Meetings: Presenters, Topics and Attendance

2012-2013	Professional Development Presenter and Topic	*n*
September 2012	In September, the professional development meeting topic was "Addressing Cultural Competence for Collegiate Professionals." Marc Chartier from the Multicultural Leadership Institute (MLI) presented on multiculturalism focusing on the importance of cultural awareness when hosting trainings/ events and while counseling students. After Chartier's presentation, a representative from the Connecticut Council on Problem Gambling informed the Coalition about their poster design contest.	23
November 2012	In November, members of the VA Connecticut Healthcare and the Connecticut Army National Guard (CTARNG) Behavioral Health Team presented on "Active Duty and Veteran College Students' Substance Abuse and Mental Health." Latonya Hart, from the VA, shared information on the VA's suicide prevention programs and Todd Perkins presented on the substance abuse treatment programs offered by the VA Hospital. Major Javier Alvarado, Dr. Lisa Miceli, Susan Tobenkin, Michael Dutko, Specialist Kristy Soucy, and Sergeant First Class Claude Campbell shared information on the substance abuse trends and suicide and substance abuse prevention programs the military has available. All speakers provided Coalition members with materials and resources to assist active duty and veteran students.	31
December 2012	In December, Kimberly Gleason from the American Foundation for Suicide Prevention (AFSP) presented on the foundation's Interactive Screening Program (ISP). Gleason provided an overview of the ISP, demonstrated the tool and shared funding opportunities available through the local AFSP chapter. Dr. Meredith Yuhas from the University of St. Joseph highlighted ways the implementation of the ISP has been successful on her campus. CCPWR led a discussion of the online screening and education programs available for substance abuse prevention. A representative from the Jordan Matthew Porco Memorial Foundation presented on their Fresh Check Day and discussed participation requirements for campuses interested in the program.	28
April 2013	Robin McHaelen, Executive Director of True Colors presented on LGBTQI culture. True Colors is a non-profit organization that works with other social service agencies, schools, organizations, and within communities to ensure that the needs of sexual and gender minority youth are both recognized and competently met. Robin discussed the increased risk for substance abuse and suicide among LGBTQI students. Following Robin's presentation, a panel of campus professionals gave an overview of their LGBTQI programs.	24
May 2013	John MacPhee, Executive Director and Victor Schwartz, MD, Medical Director from the Jed Foundation presented "Developing a Comprehensive Campus Approach to Prevention." The presenters introduced the JedCampus, an online survey to help colleges assess their mental health and suicide prevention programs. Following the presentation, participants implemented a cross-walk activity designed to develop a comprehensive plan to address substance use, mental health and suicide prevention on campus.	53

Table 10

CHCI Professional Development Meetings: Presenters, Topics and Attendance

2013-2014	**Professional Development Presenter and Topic**	***n***
September 2013	Fany DeJesus Hannon, Director of the Puerto Rican / Latin American Cultural Center (PRLACC) at UConn, and Graciela Quinones-Rodriguez, LCSW, from Counseling and Mental Health Services at UConn, delivered a presentation and led a discussion on issues, challenges and successes facing Latino/a students.	41
October 2013	Sara Wakai, Ph.D, Director of Evaluation at the Center for Public Health and Health Policy at UConn Health discussed the importance of program evaluation and provided attendees with basic steps to design and implement small scale evaluations on college campuses and in other settings.	28
November 2013	Raymond (Chip) Tafrate, Ph.D., a member of the Motivational Interviewing Network of Trainers, a psychologist, and professor at Central Connecticut State University, presented on "Motivational Interviewing (MI)." MI fosters behavior change by helping individuals explore and resolve their own indecision. MI emphasizes reasons for change rather than skills or techniques used to bring change about. This approach seeks to make individuals active participants in directing change, values freedom of choice over compliance with external norms, and focuses on the individual's own reasons for change rather than presenting advice from others.	22
December 2013	Barbara Greenberg, Ph.D., a clinical psychologist focusing on the mental health of teens and young adults, discussed signs of emerging mental health disorders among college students. Her presentation included a discussion of eating disorders, depression, suicidality, and violence.	41
February 2014	Raymond (Chip) Tafrate, Ph.D., a member of the Motivational Interviewing Network of Trainers, a psychologist, and professor at Central Connecticut State University, presented a Two-Day Training on Motivational Interviewing. The intensive workshop focused on developing the foundational skills of the motivational interviewing (MI) approach.	35
March 2014	Cheryl Chandler and Elizabeth McCall from the Connecticut Council on Problem Gambling presented on warning signs of high risk gambling and the relationship between gambling and other risky behaviors. Jonathan Pohl, PhD from CCSU's gambling prevention program and Joe Turbessi, author of Into the Muck: How Poker Changed My Life discussed gambling addiction among college students.	24
April 2014	Tracy Desovich, MPH and Elizabeth Pratt, MPH, Technical Assistance Providers from the Massachusetts Technical Assistance Partnership for Prevention (MassTAPP) presented on the theory and practice behind positive social norms marketing, the steps to effectively implement a campaign, how to include students in a campaign, and how to sustain a campaign.	29
May 2014	Recognizing the Achievements of Campuses to Reduce Underage and High-Risk Drinking	31

Intervention Trainings

The Coalition sponsored four additional trainings facilitated by intervention specialists. The trainings were offered at various locations around the state and were half or all day events. CHCI also funded nine scholarships to attend the BASICS Training and Symposium at Columbia University in New York City in June 2013.

BASICS Training. The Coalition sponsored a BASICS (Brief Alcohol Screening and Intervention of College Students: A Harm Reduction Approach) training in November, 2010. The training was administered by Aliza Makuch, Coordinator of Wellness Promotion from Eastern Connecticut State University and a CHCI steering committee member who is a trained BASICS facilitator. Thirteen participants, 11 of whom were CHCI Coalition members, attended the training. The training consisted of an overview of underage and binge drinking on college campuses, college students' motivation to change, applying motivational interviewing, and delivering BASICS. In addition to a PowerPoint presentation, small group discussions, role playing, and questions from participants were incorporated into the training.

At the conclusion of the training, participants were asked to complete a satisfaction survey. As noted in Table 11, nine participants (response rate=69 percent) responded with high levels of satisfaction with the training. Based on the open-ended questions, the information respondents felt was of greatest value included learning about the BASICS protocol, motivational interviewing, and how to use the paperwork. The respondents also noted that they planned to share information with key stakeholders and colleagues on campus.

Table 11

Professional Development Satisfaction Survey Results
BASICS, November 2010 (*n*= 9)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.50	0.51
The content was relevant to my work on underage drinking prevention.	4.82	0.39
This opportunity has helped me connect with other underage drinking prevention professionals.	4.56	0.62
I will share the knowledge that I have learned with others.	4.78	0.43
Was well organized.	4.83	0.38
Used teaching methods that were effective.	4.72	0.75
Used an interactive style to engage participants.	4.78	0.43
Demonstrated mastery of the topic.	4.89	0.32
Respected differences of opinion.	4.89	0.32
Demonstrated cultural sensitivity.	4.67	0.69

Range: 1 (strongly disagree) to 5 (strongly agree)

BASICS Training of Trainers

In June 2011, Aliza Makuch, Coordinator of Wellness Promotion from Eastern Connecticut State University presented a BASICS Training of Trainers. This training qualified 25 college prevention professionals in Connecticut to train other eligible individuals on the BASICS program. As noted in Table 12, eighteen participants (response rate=72 percent) responded with high levels of satisfaction with the training. Based on the open-ended questions, the information respondents felt was of greatest value included learning about the E-Chug tool, motivational interviewing assessment tool, rating readiness for change and how to use the paperwork. The respondents noted that they planned to share information with academic counselors, faculty, administrators, Residential Life directors, and graduate interns. They also planned to initiate or enhance the use of BASICS on their campuses.

Table 12

Professional Development Satisfaction Survey Results
BASICS, Train the Trainer, June 2011 (*n*= 18)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.61	0.50
The content was relevant to my work on underage drinking prevention.	4.39	0.61
This opportunity has helped me connect with other underage drinking prevention professionals.	4.39	0.78
I will share the knowledge that I have learned with others.	4.56	0.51
Was well organized.	4.83	0.38
Used teaching methods that were effective.	4.83	0.38
Used an interactive style to engage participants.	4.78	0.43
Demonstrated mastery of the topic.	4.83	0.38
Respected differences of opinion.	4.72	0.46
Demonstrated cultural sensitivity.	4.50	0.71

Range: 1 (strongly disagree) to 5 (strongly agree)

Campus-Enforcement Partnership Event

The Campus-Enforcement Partnership Event sponsored by CHCI was held in August, 2011 and 31 individuals attended. Presenters were from the Central Connecticut State University (CCSU)/ City of New Britain Partnership and the Wesleyan University Partnership and discussed how they established their partnerships and continue to implement successful prevention strategies. Members of the CCSU/City of New Britain partnership included: Jonathan Pohl Ph.D., Alcohol & Drug Education Coordinator from Central Connecticut State University; Meagen Wentz, Wellness Programs Administrator, from Central Connecticut State University; Sgt. Michael Baden from the City of New Britain Police Department; and Det. Michael Cummiskey from the City of New Britain Police Department. The Wesleyan University Partnership included: Joyce Walter, Director of Student Health Services from Wesleyan University; Tanya Purdy, Health Educator from Wesleyan

University; Lt. Paul Verrillo from Wesleyan University Public Safety (Table 13).

Table 13

Professional Development Satisfaction Survey Results
Campus-Enforcement Partnership Event (*n*= 22)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.50	0.60
The content was relevant to my work on underage drinking prevention.	4.55	0.67
This opportunity has helped me connect with other underage drinking prevention professionals.	4.50	0.60
I will share the knowledge that I have learned with others.	4.59	0.50
Was well organized.	4.68	0.48
Used teaching methods that were effective.	4.45	0.60
Used an interactive style to engage participants.	4.50	0.60
Demonstrated mastery of the topic.	4.64	0.49
Respected differences of opinion.	4.71	0.56
Demonstrated cultural sensitivity.	4.38	1.02

Range: 1 (strongly disagree) to 5 (strongly agree)

Red Watch Band Training of Trainers

The Coalition sponsored a Red Watch Band Training of Trainers in September 2011. Lara Hunter, the national coordinator for the Red Watch Band Program, and Coordinator of Clinical AOD Services from Stony Brook University was invited to follow-up on her professional development presented in March 2011. Twenty-four college prevention professionals were trained to provide a four-hour training session to educate students about underage and high-risk alcohol use, an understanding about how alcohol emergencies are medical emergencies that require professional care as well as learn how to recognize and respond to alcohol emergencies. Another component of the class was CPR certification that was provided by a certified trainer.

At the conclusion of the training, participants were asked to complete a satisfaction survey. As noted in Table 14, nineteen participants (response rate=79 percent) responded with high levels of satisfaction with the training. Based on the open-ended questions, the information respondents felt was of greatest value included learning about dangers of toxic drinking, common myths that students believe about drinking, and specific ways to interact with students to help them understand the severity of binge drinking consequences. What was of greatest value to one respondent was "Increasing kids' awareness as to the level of urgency the situation carries as well as challenging them to do the right thing." The respondents also noted that they planned to share information with administrators, RA's, in their classes, at student orientation and with community colleges.

Table 14

Professional Development Satisfaction Survey Results
Red Watch Band Training of Trainers, September 2011 (*n*= 19)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.37	0.76
The content was relevant to my work on underage drinking prevention.	4.53	0.84
This opportunity has helped me connect with other underage drinking prevention professionals.	4.21	0.79
I will share the knowledge that I have learned with others.	4.84	0.37
Was well organized.	4.61	0.50
Used teaching methods that were effective.	4.37	0.60
Used an interactive style to engage participants.	4.37	0.60
Demonstrated mastery of the topic.	4.74	0.45
Respected differences of opinion.	4.58	0.61
Demonstrated cultural sensitivity.	4.47	0.61

Range: 1 (strongly disagree) to 5 (strongly agree)

BASICS Training and Symposium

In June 2013, the Coalition provided scholarships for nine individuals to attend the BASICS Training and Symposium at Columbia University in New York City. Scholarship opportunities were open to all CHCI Coalition members. Representatives from five campuses and CCPWR attended the training.

Subcommittees

At the December 2010 business meeting, a CHCI steering committee member facilitated a group discussion to aid in the creation of subcommittees. The subcommittees were created to expand and enhance the function of the CHCI by increasing campus and community partnerships, developing members' skills, encouraging members to have an active role in the CHCI, and providing opportunities for members to exchange information. The facilitator asked CHCI Coalition members a series of questions regarding interventions that are currently being implemented, successful strategies and types of support or training needed for improvement. Five cohesive themes emerged from the responses which were used to create distinct subcommittee topics which are described below. The CHCI Coalition members were then asked to join a subcommittee that was: of particular interest to them; addressed a topic that needed to be developed on their campus; or was an area that the CHCI Coalition member had expertise in and could assist other members. Each subcommittee had a CHCI steering committee member as well as a Coalition member appointed in a leadership role. Manageable tasks were delegated to subcommittee members. Each subcommittee member spent approximately six hours per semester during the 2010-2011 academic year on subcommittee related tasks not including CHCI meetings. Between February 2011 and December 2011, the committees communicated through e-mails, phone calls

and meetings to define institutional and Coalition needs. In 2012, the decision was made to re-direct the energy of the Coalition members away from the subcommittee model toward statewide messaging that included recovery and mental health promotion. The following is a description of the subcommittees and the achievements they completed while in operation.

- The Communication subcommittee consisted of five members and was created to expand communication systems among Coalition members, senior administration and the public. The subcommittee helped to identify the self-care professional development topic. They also suggested developing handouts and monthly messages for campuses.
- The Legal subcommittee consisted of six members and focused on clarifying legal guidelines, barriers to enforcement and ways to engage local police. The Legal subcommittee organized a training presentation focused on the positive impact of collaboration between public safety and underage drinking (UAD) prevention professionals to address underage and high-risk drinking prevention held in August 2011.
- The Training subcommittee consisted of six members and was designed to identify training needs and organize in-person and on-line training to students, administration and faculty. During the 2010-2011 academic year the subcommittee created and administered two on-line surveys to obtain Coalition members' training priorities and professional development needs. Findings from the surveys led to the selection of topics and presenters for the professional development meetings offered throughout the school year.
- The Partnership Development and Sustainability subcommittee consisted of four members and concentrated on ways to involve senior administration, faculty, community members, property owners and retailers to prevent underage and binge drinking on college campuses. The subcommittee encouraged several campuses to provide TIPS training to local merchants. The sub-committee decided the messaging and engagement of other stakeholders was better addressed through the full group.
- The Non-Residential Students subcommittee consisted of 10 members and was created to focus on strategies to reduce underage and binge drinking specific to non-residential campuses. This subcommittee found the most beneficial use of their time was to network with one another and continue to meet to discuss issues pertinent to their campuses.

Outcome Evaluation

The Outcome Evaluation component was designed to measure the level of cooperation and coordination among CHCI Coalition members related to alcohol abuse prevention (Objective Two). To address this objective, the sub-recipients completed the Scanning Exercises of the College Alcohol Risk Assessment Guide developed by the U.S. Department of Education's Higher Education Center (2009) (Appendix E). The Scanning Exercises consist of:

- Scanning Exercise A-1: A Quick Profile of Risks for Alcohol Problems
- Scanning Exercise A-2: Looking Around Your Campus and Community
- Scanning Exercise A-3: Having Conversations

The environmental scan was conducted at two time points. First, in December 2010, individuals applying for the Connecticut Healthy Campus Initiative were required to conduct an environmental scan of their campus as part of the application process. The environmental scan functioned as a needs assessment to guide the evaluation of the proposed strategies the applicants planned to implement in their comprehensive under-age and binge drinking prevention efforts. In addition, information gathered from the 2010 environmental scans was used as baseline data for the sub-recipient campuses. The environmental scans were conducted again in June 2012.

All ten of the sub-recipients submitted the Environmental Scan in 2010 and 2012 for a response rate of 100 percent for each year. Analyses were conducted to identify what, if any, changes in the campus environment occurred during the first year of the grant-funded interventions.

In response to Scanning Exercise A-1: A Quick Profile of Risks for Alcohol Problems, respondents were asked to develop a profile of their campus culture, environment, and risk factors that may contribute to alcohol use and adverse consequences. Respondents used a scale of 1 to 4 (low to high) to rate items in this section.

Campus Life items focused on the visibility and level of opportunities for socializing which may provide positive alternatives to alcohol consumption. A comparison of the 2010 and 2012 Campus Life items indicates an increase in mean scores for each activity except for Health Promotion Activities (e.g. visibility of smoke-outs, AIDS awareness week) (Table 15). Related-Samples Wilcoxon Signed Rank Tests were performed to determine whether the average amount of activities in each category differed significantly ($p < 0.05$) by year. A significant increase in mean scores between 2010 and 2012 were found for Nearby Campus-Oriented Commercial Services (e.g. bars, restaurants)($p = 0.046$) and Athletic Activity (e.g. inter/intramural sports, sports facilities) ($p = 0.034$).

Items included in Alcohol Issues focused on ways a campus may address alcohol problems. The means scores for all of the items remained the same or increased from 2010 to 2012 (Table 16). Related-Samples Wilcoxon Signed Rank Tests were performed to determine whether the average ranking in each category differed significantly ($p < 0.05$) by year. Significant increases in mean scores were found for Support for Alcohol Policies ($p = 0.046$), and Enforcement for Alcohol Policies ($p = 0.020$). A significant increase was also found for Visibility of Alcohol Use indicating an increase in drinking in public places on campus, greater acceptance of visible intoxication, party promotions, etc. ($p = 0.020$).

Table 15

Scanning Exercise A-1: A Quick Profile of Risks for Alcohol Problems
Campus Life
(2010 *n*=10; 2012 *n*=10)

Item	Mean 2010	SD 2010	Mean 2012	SD 2012	*p*
On-campus social activities	2.60	0.84	3.00	0.67	0.102
Nearby campus-oriented commercial services	2.10	0.99	2.50	0.71	0.046*
Athletic activity	2.50	1.08	3.10	0.88	0.034*
Special events	2.60	0.84	2.80	0.79	0.480
Greek life	1.88	0.99	2.00	1.07	0.317
Alumni activity	1.50	0.53	1.60	0.52	0.317
Health and counseling services	2.30	0.67	2.60	0.97	0.180
Health promotion activities	2.70	0.82	2.60	0.84	0.705
Alcohol and other drug prevention responsibilities	2.33	1.00	2.90	0.99	0.206

Range: 1 (low) to 4 (high)
Related-Samples Wilcoxon Signed Rank Test
* Indicates a significant difference at p < 0.05

Table 16

Scanning Exercise A-1: A Quick Profile of Risks for Alcohol Problems
Alcohol Issues
(2010 *n*=10; 2012 *n*=10)

Item	Mean 2010	SD 2010	Mean 2012	SD 2012	*p*
Awareness of alcohol policies	2.20	1.03	2.70	1.16	0.059
Support for alcohol policies	2.50	0.71	2.90	0.74	0.046*
Enforcement of alcohol policies	2.40	0.70	3.10	0.74	0.020*
Communicating alcohol polices	2.80	0.92	3.30	0.95	0.157
Influence of alcohol task force	2.20	0.92	2.44	1.13	0.157
Perceptions that alcohol contributes to problems	2.60	0.84	2.60	0.97	1.00
Visibility of alcohol use	1.80	1.03	1.90	1.10	0.020*

Range: 1 (low) to 4 (high)
Related-Samples Wilcoxon Signed Rank Test
* Indicates a significant difference at $p < 0.05$

Scanning Exercise A-2: Looking Around Your Campus and Community focuses on the extent alcohol availability and visual messages regarding alcohol use were present on and near campus. Respondents were asked to indicate whether alcohol is sold on campus, ways radio and print media promote alcohol consumption, and types of messages endorsing alcohol consumption in student neighborhoods. Response options were "yes," "no," or N/A.

The following summarizes responses to Scanning Exercise A-2 by topic:

- Alcohol Availability and Promotion: The majority of respondents reported that there were alcohol outlets near campus, and that people distribute handouts for parties or other social events (Table 17).
- Media Environment: The campus media includes health promotion messages and addresses alcohol use and/or adverse consequences (Table 18).
- What's on the Walls: Posters, banners and flyers decorated walls and ceilings in common areas and doors to student rooms. There were also health promotion posters or banners (Table 19).
- Student Neighborhood Environments: Alcohol outlets were in the neighborhood near campus. There were messages that focus on alcohol and high-risk drinking, advertisements and promotions that targets students (Table 20).
- Drinking Environments: Walls were decorated with alcohol promotional material, servers checked for identification, the ambience appeared to encourage drinking, other activities were available, and servers appeared to monitor drinking rates of patrons (Table 21).
- Neighborhoods Around Campus: Alcohol outlets targeted students with advertisements or flyers (Table 22).
- Parties and Events: Parties and events had non-drinking recreational activities, appetizing food, non-alcoholic beverages, sober monitors and measures to prevent underage drinking (Table 23).
- Campus Bookstores: The campus bookstores carried campus related merchandise. They also sold items that promoted drinking as well as items that promoted health (Table 24).

Some variations (both increases and decreases) in the responses occurred between 2010 and 2012. Related-Samples Wilcoxon Signed Rank Tests were performed to determine whether there were significant differences by year. The tests indicated no significant differences ($p < 0.05$).

Table 17

Scanning Exercise A-2: Looking Around Your Campus and Community
Alcohol Availability and Promotion
(2010 *n*=10; 2012 *n*=10)

		Percent			
Item	**Year**	**Yes**	**No**	**N/A**	***p***
Do bulletin boards sport party notices, banners, or posters advertising or promoting alcohol-related activities?	2010	10	90	0	
	2012	20	80	0	1.00
Are they for on-campus events?	2010	0	30	70	
	2012	60	30	0	---[1]
Off-campus events?	2010	20	10	70	
	2012	20	10	60	---[1]
Are they from commercial alcohol outlets such as bars, taverns, restaurants, liquor stores, or grocery stores?	2010	20	10	70	
	2012	20	10	60	---[1]
Do people distribute handouts for parties or other social events?	2010	60	30	10	
	2012	60	40	0	1.00
If so, do the messages focus on alcohol consumption rather than the event itself?	2010	50	20	30	
	2012	30	40	20	0.50
Are high-risk activities part of the message?	2010	50	20	30	
	2012	20	50	20	0.25
Do most of the postings appear to be alcohol-related?	2010	10	70	20	
	2012	20	80	10	1.00
Is alcohol sold on campus?	2010	40	60	0	
	2012	40	60	0	1.00
If so, do on-campus alcohol outlets promote or advertise alcohol sales?	2010	10	60	30	
	2012	10	40	40	1.00
Are there alcohol outlets near campus or in neighborhood with large concentrations of student residents?	2010	70	30	0	
	2012	70	30	0	1.00
If so, do they target the campus through advertisements and promotions?	2010	40	40	20	
	2012	30	50	20	0.50

[1]unable to compute significance test

Response options: Yes, No, N/A

Related-Samples Wilcoxon Signed Rank Test

Table 18

Scanning Exercise A-2: Looking Around Your Campus and Community
Media Environment
(2010 *n*=10; 2012 *n*=10)

		Percent			
Item	**Year**	**Yes**	**No**	**N/A**	***p***
Do they advertise or promote alcohol-related activities?	2010	30	60	10	
	2012	30	70	0	1.00
If so, are they for on-campus events?	2010	0	40	60	
	2012	0	30	70	1.00
If so, are they for off-campus events?	2010	30	10	60	
	2012	30	0	70	1.00
Do the messages focus on alcohol consumption rather than the event itself?	2010	40	30	30	
	2012	20	60	20	1.00
Are high-risk activities part of the message?	2010	20	50	30	
	2012	0	80	20	0.50
Does the editorial content of the publication address alcohol use and/or adverse consequences?	2010	50	40	10	
	2012	50	40	10	1.00
Are there advertisements for alcoholic beverages or alcohol-related activities on the campus radio station?	2010	0	90	10	
	2012	0	90	10	1.00
Do messages focus on alcohol consumption or high-risk drinking?	2010	0	60	40	
	2012	10	70	20	1.00
Do community radio stations target your campus?	2010	20	70	10	
	2012	20	80	0	1.00
If so, do they advertise alcoholic beverages or alcohol-related activities?	2010	20	20	60	
	2012	20	30	50	1.00
Does the campus media include health promotion messages?	2010	60	40	0	
	2012	90	10	0	0.25

[1]unable to compute significance test

Response options: Yes, No, N/A

Related-Samples Wilcoxon Signed Rank Test

Table 19

Scanning Exercise A-2: Looking Around Your Campus and Community
What's on the Walls?
(2010 *n*=10; 2012 *n*=10)

		Percent			
Item	**Year**	**Yes**	**No**	**N/A**	***p***
Do posters, banners, and flyers decorate the walls and ceilings, including common areas and doors to student rooms?	2010	70	10	20	
	2012	50	10	30	1.00
Are they alcohol-related?	2010	30	40	30	
	2012	20	30	30	1.00
Are there health promotion posters or banners?	2010	70	10	20	
	2012	60	0	30	1.00
Do students decorate their rooms with alcohol-related items?	2010	40	40	20	
	2012	40	20	30	1.00
Do room window shelves sport pyramids of beer cans or beer advertisements?	2010	20	60	20	
	2012	10	50	30	1.00
Are doors to student rooms decorated with beer posters?	2010	10	70	20	
	2012	0	60	30	1.00
Are trash cans filled with beer cans and bottles after the weekend?	2010	30	50	20	
	2012	30	30	30	1.00
Do residence halls appear damaged? (n=9)	2010	20	60	20	
	2012	30	30	30	1.00

Response options: Yes, No, N/A

Table 20

Scanning Exercise A-2: Looking Around Your Campus and Community
Student Neighborhood Environments
(2010 *n*=10; 2012 *n*=10)

		Percent			
Item	**Year**	**Yes**	**No**	**N/A**	***p***
Do beer banners hang from apartments and houses? (*n*=9)	2010	0	89	11	
	2012	0	60	20	1.00
Are there pyramids of beer cans in the windows?	2010	30	60	10	
	2012	10	60	20	0.50
Are notices and posters advertising or promoting alcohol-related activities posted on telephone poles? (*n*=9)	2010	11	89	0	
	2012	10	60	20	1.00
Are there alcohol outlets in the neighborhood?	2010	80	20	0	
	2012	80	0	10	1.00
Do they target students in their advertisements and promotions? (*n*=9)	2010	56	44	0	
	2012	40	30	20	1.00
Do messages focus on alcohol and high-risk drinking?	2010	60	40	0	
	2012	40	30	20	1.00
Are there alcohol billboards or other messages on the paths that approach campus?	2010	10	80	10	
	2012	10	60	20	1.00

Response options: Yes, No, N/A

Table 21

Scanning Exercise A-2: Looking Around Your Campus and Community
Drinking Environments
(2010 *n*=10; 2012 *n*=10)

		Percent			
Item	**Year**	**Yes**	**No**	**N/A**	***p***
Are walls decorated with alcohol promotional material?	2010	90	10	0	
	2012	80	0	10	1.00
Do servers check for identification?	2010	70	30	0	
	2012	70	10	10	1.00
Does the ambience appear to encourage drinking?	2010	90	10	0	
	2012	80	0	10	1.00
Are other activities available?	2010	90	10	0	
	2012	80	0	10	1.00
Do servers appear to monitor drinking rates of patrons?	2010	50	50	0	
	2012	30	50	10	1.00

Response options: Yes, No, N/A

Related-Samples Wilcoxon Signed Rank Test

Table 22

Scanning Exercise A-2: Looking Around Your Campus and Community
Neighborhoods Around Campus
(2010 *n*=10; 2012 *n*=10)

		Percent			
Item	**Year**	**Yes**	**No**	**N/A**	***p***
Is there a wide variety of retailers tailored to the campus?	2010	40	60	0	
	2012	40	60	0	1.00
Are there alcohol outlets?	2010	90	10	0	
	2012	100	0	0	1.00
Do they target students with ads or flyers?	2010	60	40	0	
	2012	60	40	0	1.00
Are there billboards or other types of advertisements for alcohol products?	2010	100	0	0	
	2012	20	80	0	0.50

Response options: Yes, No, N/A

Related-Samples Wilcoxon Signed Rank Test

Table 23

Scanning Exercise A-2: Looking Around Your Campus and Community
Parties and Events
(2010 *n*=10; 2012 *n*=10)

		Percent			
Item	**Year**	**Yes**	**No**	**N/A**	***p***
Is alcohol permitted at events?	2010	30	70	0	
	2012	30	70	0	1.00
Are other activities such as non-drinking games, dancing, or other recreational activities available?	2010	80	20	0	
	2012	100	0	0	0.50
Is appetizing food available?	2010	70	30	0	
	2012	100	0	0	0.25
Are nonalcoholic beverages available?	2010	90	10	0	
	2012	100	0	0	1.00
Is faculty drinking with under-aged students condoned?	2010	10	90	0	
	2012	10	90	0	1.00
Are sober monitors present?	2010	60	30	10	
	2012	60	20	20	1.00
Are measures taken to prevent underage drinking?	2010	90	10	0	
	2012	90	10	0	1.00

Response options: Yes, No, N/A

Related-Samples Wilcoxon Signed Rank Test

Table 24

Scanning Exercise A-2: Looking Around Your Campus and Community
Campus Bookstores
(2010 *n*=10; 2012 *n*=10)

		Percent			
Item	**Year**	**Yes**	**No**	**N/A**	***p***
Does it carry a variety of campus-related merchandise?	2010	100	0	0	
	2012	100	0	0	1.00
Does it carry alcohol-related merchandise?	2010	40	60	0	
	2012	50	50	0	1.00
Does alcohol-related merchandise sport your school's name, crest, or mascot?	2010	50	50	0	
	2012	40	60	0	1.00
Do posters or clothing sport pro-drinking messages?	2010	90	10	0	
	2012	10	90	0	1.00
Do posters or clothing sport health promotion messages?	2010	80	20	0	
	2012	30	70	0	1.00

Response options: Yes, No, N/A

Related-Samples Wilcoxon Signed Rank Test

In Scanning Exercise A-3: In the Having Conversations section, respondents were asked to list individuals who were potential allies and sources of information regarding student alcohol use and prevention. Respondents were instructed to talk to some or all of these individuals to determine their interest in prevention efforts. On average, respondents reported the greatest number of colleagues in Campus Life and Activities with whom they could have a conversation (mean 2010=7.6, mean 2012=6.4) and had the fewest colleagues in Academics (mean 2010=1.9, mean 2012=2.1) (Table 25). Some changes occurred in the average number of individuals identified in each category between 2010 and 2012. Related-Samples Wilcoxon Signed Rank Tests were performed to test whether the changes differed significantly by year. Results determined that none were significant at the $p < 0.05$ alpha level.

Table 25

Scanning Exercise A-3: Having Conversations

Category	Year	*n*	Mean	Range
Campus Life and Activities	2010	7	7.6	3 - 11
	2012	7	6.4	2 - 13
Health Services	2010	8	3.0	2 - 4
	2012	7	2.7	0 - 4
Community Members	2010	7	2.6	1 - 5
	2012	7	1.0	0 - 2
Security and Law Enforcement	2010	8	2.4	1 - 4
	2012	7	0.9	0 - 3
Administration	2010	7	2.1	1 - 4
	2012	7	2.1	0 - 4
Academics	2010	7	1.9	1 - 4
	2012	7	2.1	0 - 5

Impact Evaluation

In accordance with Objective Three, the impact evaluation component was designed to measure changes in 30-day alcohol use and binge drinking rates to assess whether CHCI funded initiatives led to changes in alcohol and other drug use and related problems of college students at sub-recipient campuses. To address this objective, CHCI sub-recipients administered the Core Alcohol and Drug Survey and the Faculty and Staff Environmental Alcohol and Other Drug Survey in the spring of 2011, 2012 and 2014.

IRB

An application for project approval was submitted to UCHC's Human Subjects Protection Office. The Institutional Review Board (IRB) determined the research related to the Core Alcohol and Drug Survey qualified for exempt status (IRB number: 11-138-2). The Faculty and Staff Environmental Alcohol and Other Drug Survey and other components of the evaluation were determined to be not human subjects research.

Instruments

The Core Alcohol and Drug Survey-Long Form (Appendix F) was developed by the Core Institute at the Southern Illinois University Carbondale Student Health Center with funding from the US Department of Education. It is designed to assess students' attitudes, perceptions and consequences of alcohol and other drug use on college campuses. The survey consists of 39 questions and takes about 20 minutes to complete.

The Faculty and Staff Environmental Alcohol and Other Drug Survey (Appendix G) was developed in 1993 by the Core Institute at the Southern Illinois University Carbondale Student Health Center with funding from the US Department of Education. It is designed to assess faculty

and staff perceptions of alcohol and drug use on campus. The survey consists of 42 questions and takes approximately 20 minutes to complete.

Methods

Procedures

The Core Alcohol and Drug Survey and the Faculty and Staff Environmental Alcohol and Other Drug Survey were administered by the sub-recipient campuses. Sub-recipient campuses had the option of administering both surveys in either paper or electronic format.

Core Alcohol and Drug Survey. In the spring of 2011, nine campuses administered the Core Alcohol and Drug Survey-Long Form. One campus administered the Core Alcohol and Drug Survey-Short Form in the fall of 2010. CHCI allowed the campus to submit their data for the evaluation since it was judged to be overly-burdensome to administer the Long Form within the same academic year of administering the Short Form. The Short Form consists of the first 23 questions of the Long Form. Eight campuses administered the survey on-line and two campuses administered the paper version of the survey.

In the spring of 2012, the same nine campuses administered the Core Alcohol and Drug Survey-Long Form. In the fall of 2011, the same campus administered the Core Alcohol and Drug Survey-Short Form as in the fall of 2010. Seven campuses administered the survey on-line, two campuses administered the paper version, and one campus used both formats (Table 26).

In the spring of 2014, seven campuses administered the Core Alcohol and Drug Survey-Long Form online, and one campus administered a paper version of the form.

Table 26

Format of Core Alcohol and Drug Survey Selected by Campuses

Year	On-line	Paper	On-line and Paper
2011	8	2	0
2012	7	2	1
2014	8	0	0

Paper Format. Sub-recipient campuses that administered the paper format were instructed to select designated class days and times to administer the paper version. For example, all classes that met on certain days of the week could be selected for participation. The expectation was that the classes collectively would be fairly representative of the student population and minimized the chance that a student was asked to complete the survey more than once. If a student was enrolled in two selected classes both class times, he/she was asked to complete the survey in the first class and decline taking the survey in the second class. Administration of the survey took about 20 - 30 minutes. Allowing the survey to be administered in class was voluntary and there was not a record of which classes or students completed the survey.

Electronic Format. The Core Institute sent a link to the survey with a five digit access code to sub-recipient campuses that chose to administer the survey on-line. Campuses e-mailed a sample of students an invitation to participate in the survey with the link to the survey

and the five digit access code. Electronic survey responses went directly to a Core Institute database. A campus could not collect surveys electronically and did not have access to individual survey responses. Sub-recipient campuses typically sent a reminder to complete the survey one or two weeks later. The link to the survey was kept active for two to three weeks.

Faculty and Staff Environmental Alcohol and Other Drug Survey. In the spring of 2011, nine sub-recipient campuses administered the Faculty and Staff Environmental Alcohol and Other Drug Survey in electronic format and one campus used a paper format. In the spring of 2012, eight campuses administered the survey on-line and one campus administered the paper format of the survey. In the spring of 2014, all eight campuses administered the survey online (Table 27).

Table 27

Format of Faculty and Staff Environmental Alcohol and Other Drug Survey Selected by Campuses

Year	On-line	Paper
2011	9	1
2012	8	1
2014	8	0

Paper Format. In 2011 and 2012, one campus sent a sample of full-time faculty and staff the Faculty and Staff Environmental Alcohol and Other Drug Survey via campus mail. Completed surveys were returned to that campus's Director of Institutional Research who submitted the surveys to Core. In 2014 none of the surveys were completed with the paper format.

Electronic Format. The Core Institute sent a link to the survey with a 5 digit code to sub-recipient campuses that chose to use the electronic format. Campuses were instructed to e-mail all faculty and staff with a campus e-mail address an invitation to participate with the link to the survey and the 5 digit access code. Electronic survey responses went directly to a Core Institute database. A reminder to complete the survey was sent one to two weeks later. The link to the survey was kept active for two to three weeks. In 2014 100% of surveys were completed electronically.

Sample Size

In 2011, a total of 28,885 Core student surveys were distributed by the 10 sub-recipients and 6,675 surveys were completed for a response rate of 23.1 percent. Based on a grant objective, the focus of the evaluation was 18 to 24 year-olds. As a result, 602 surveys were eliminated from the data set because they did not meet the age criteria. This reduced the number of usable surveys to 6,073 or 21.0 percent of distributed surveys. A total of 4,730 faculty surveys were distributed by the 10 sub-recipients and 1082 were completed for a response rate of 22.9 percent.

In 2012, a total of 31,958 Core student surveys were distributed by the 10 sub-recipients and 6329 surveys were completed for a response rate of 19.8 percent. 660 surveys were eliminated from the data set because they did not meet the 18 to 24 age criterion. This reduced the number of usable surveys to 5669 (17.7 percent). A total of 9,465 faculty surveys were distributed by nine sub-recipients and 609 were completed for a response rate of 6.4 percent (Table 28).

In 2014, a similar number of surveys were distributed to students as in previous years, though the exact number for all of the sub-recipients was unavailable at the time of this report, making a calculation of the response rate impossible. The students returned 4,551 responses, of which 583 had to be eliminated from the data set because they did not meet the 18 to 24 criterion. The final number of valid student responses was 3,968. Faculty and Staff returned 1,362 valid responses in 2014, though, as with the student responses, the response rates was unavailable.

In addition to the data collected from the sub-recipients, the evaluation utilized three additional data sets from the Core Institute. The Connecticut Core Alcohol and Drug Survey data are based on surveys administered from 2010 to 2011 and consist of 6,009 respondents (18 to 24 years old). The national Core Alcohol and Drug Survey data are based on 94,636 respondents collected from 2010 to 2011. The national Core Faculty and Staff Environmental Alcohol and Other Drug Survey data consist of 10,304 respondents from institutions that administered the survey during 2006 to 2011. Summary statistics from these data sets are included in the report for general comparisons but were not used in any of the impact analyses. The response rates for these data sets were unavailable and so their results should be viewed with caution.

Table 28

Sample Size

Surveys	CHCI 2011 *n* (Response Rate)	CHCI 2012 *n* (Response Rate)	CHCI 2014 *n* (Response Rate)	Core Alcohol and Drug Survey Connecticut (2010-2011)	Core Alcohol and Drug Survey U.S. (2010-2011)	Core Faculty and Staff Survey U.S. (2006-2011)
Student Sample Size						
Surveys Distributed	28,885	31,958	NA	NA	NA	--
Surveys Completed	6,675 (23.1%)	6,329 (19.8%)	4,551	6,386	107,442	--
Surveys Met Age Criteria	6,073 (21.0%)	5,669 (17.7%)	3,968	6,009	94,636	--
Number of Schools	10	10	8	NA	NA	--
Average *n* per School	667.5	629.9	496.0	NA	NA	--
Range	55 to 1,876	22 to 1,651	9 to 1,317	NA	NA	--
Faculty Sample Size						
Surveys Distributed	4,730	9465		--	--	NA
Surveys Completed	1,082 (22.9%)	609 (6.4%)	1,362	--	--	10,304
Number of Schools	10	9	8	--	--	NA
Average *n* per School	108	68	170.25	--	--	NA
Range	14 to 189	14 to 158	18 to 326	--	--	NA

NA = Data not available at time of report.

Data Entry and Analysis

Campuses that administered the paper version of the Core Alcohol and Drug Survey and the Faculty and Staff Environmental Alcohol and Other Drug Survey sent completed surveys via certified mail to the Core Institute where the surveys were scanned into a database. Campuses using the electronic version of the Core Alcohol and Drug Survey and the Faculty and Staff Environmental Alcohol and Other Drug Survey had respondents complete the survey on-line and responses went directly to a Core Institute database. The CPHHP statistician conducted the analyses.

Student Results

Demographics. In 2011, there were 6,073 students at the sub-recipient campuses between the ages of 18 to 24 who submitted the Core Alcohol and Drug Survey (Table 29). In 2012 and 2014, there were, respectively, 5,669 and 3,968 students within the designated age range who submitted the survey. The respondents for 2011, 2012 and 2014 were evenly distributed by year in school. The majority of the respondents to each of the three administrations of the survey were full-time, white,

female, and lived on campus. The average ages were 20.05 (2011), 21.33 (2012), and 20.16 (2014), with a grade point average of approximately 3.3 each year. Analyses conducted on demographic variables found significant differences between 2011 and 2014 for year in school, ethnicity, gender, residence, and employment status, indicating differences between the years for these characteristics. Mean age and student status composition (full-time versus part-time) did not differ significantly between years, however.

Table 29

Core Student Data: Demographics

Student Demographics	CHCI 2011 Frequency (%)	CHCI 2012 Frequency (%)	CHCI 2014 Frequency (%)	CT 2010-2011 Frequency (%)	US 2010-2011 Frequency (%)
Year in School					
Freshman	1,671 (27.6)	1,556 (27.6)	1,077 (27.3)	1,673 (27.9)	28,062 (29.7)
Sophomore	1,610 (26.6)	1,496 (26.5)	1,019 (25.9)	1,555 (26.0)	23,216 (24.6)
Junior	1,399 (23.1)	1,330 (23.6)	836 (21.2)	1,366 (22.8)	21,520 (22.8)
Senior	1,301 (21.5)	1,208 (21.4)	937 (23.8)	1,333 (22.3)	19,458 (20.6)
Graduate/ Professional	25 (0.4)	14 (0.2)	42 (1.1)	45 (0.8)	1,731 (1.8)
Not Seeking Degree	12 (0.2)	7 (0.1)	9 (0.2)	3 (0.1)	119 (0.1)
Other	33 (0.5)	35 (0.6)	21 (0.5)	16 (0.3)	344 (0.4)
Ethnicity					
American Indian/Alaskan Native	37 (0.6)	25 (0.5)	24 (0.6)	32 (0.5)	606 (0.6)
Asian/Pacific Islander	336 (5.6)	226 (4.8)	165 (4.3)	314 (5.3)	4,135 (4.4)
Black (non-Hispanic)	331 (5.6)	314 (5.7)	327 (8.5)	281 (4.8)	8,321 (8.9)
Hispanic	405 (6.8)	371 (6.7)	309 (8.0)	335 (5.7)	4,804 (5.1)
White (non-Hispanic)	4,620 (77.6)	4,347 (78.4)	2,893 (75.2)	4,718 (80.1)	72,623 (77.8)
Other	223 (3.7)	220 (4.0)	127 (3.3)	207 (3.5)	2,887 (3.1)
Gender					
Female	3,657 (62.4)	3,498 (64.2)	2,502 (54.9)	3,559 (61.5	57,057 (62.1)
Male	2,203 (37.6)	1,954 (35.8)	1,295 (34.1)	2,226 (38.5)	34,768 (37.9)
Unknown	155	217	171	224	2,811
Residence					
On-Campus	3.781 (66.5)	3,596 (67.9)	2,249 (61.3)	4,114 (73.0)	52,916 (58.8)
Off-Campus	1,904 (33.5)	1,700 (32.1)	1,418 (38.7)	1,525 (27.0)	37,120 (41.2)

Table 29

Core Student Data: Demographics

Student Demographics	CHCI 2011 Frequency (%)	CHCI 2012 Frequency (%)	CHCI 2014 Frequency (%)	CT 2010-2011 Frequency (%)	US 2010-2011 Frequency (%)
Employed					
Full-time	282 (4.7)	273 (4.9)	221 (5.7)	203 (3.4)	4297 (4.6)
Part-time	3,012 (50.2)	2,830 (50.5)	2,034 (52.2)	2,866 (48.3)	44,681 (47.5)
None	2,710 (45.1)	2,503 (44.6)	1,644 (42.2)	2,866 (48.3)	45,061 (47.9)
Student Status					
Full-time	5,761 (95.6)	5385 (95.5)	3,757 (95.4)	5836 (97.7)	91,956 (97.4)
Part time	267 (4.4)	256 (4.5)	182 (4.6)	135 (2.3)	2,429 (2.6)
Age					
18 to 20	3,827 (63.0)	3,578 (63.1)	2,387 (60.2)	3,828 (63.7)	59,460 (62.8)
21 to 24	2,246 (37.0)	2,091 (36.8)	1,581 (39.8)	2,181 (36.3)	35,176 (37.2)
Mean	20.05	20.02	20.16	20.01	20.07
Standard Deviation	1.417	1.389	1.495	1.377	1.502
Grade Point Average					
Mean	3.28	3.31	3.36	3.29	3.26
Standard Deviation	0.579	0.590	0.577	0.572	0.647
Total	**6,073**	**5,669**	**3,968**	**6,009**	**94,636**

Campus Culture and Alcohol Use. The first step in examining student alcohol and drug use is to review the campus culture. It appears that students received messages (Table 30). On the one-hand, in 2011, 2012, and 2014 the vast majority of students reported that their campuses had alcohol and drug policies and that the policies were enforced. In addition, the students felt that their campuses were concerned about drug and alcohol prevention and offered drug and alcohol prevention programs. However, even with these efforts in place over one-third of the students were unaware of any prevention programs on campus, over half of the students felt that the social atmosphere on campus promoted alcohol use and only about 10 percent of the students were actively involved in prevention efforts. It appears that progress was made from 2011 to 2014 with significantly more awareness of drug and alcohol prevention programs (X^2= 9.007, df=1, p < 0.004) and student involvement in prevention efforts (X^2= 25.756, df=1, p < .000). However, fewer students reported that their campuses were concerned about drug and alcohol prevention in 2012 (X^2= 8.554, df=1, p < .003), and fewer still in 2014 (X^2= 21.335, df=2, p < .000 when compared to 2011).

Table 30

Core Student Data: Campus Alcohol and Drug Prevention

Campus Alcohol and Drug Prevention	CHCI 2011 Frequency (%)	CHCI 2012 Frequency (%)	CHCI 2014 Frequency (%)	CT 2010-2011 Frequency (%)	US 2010-2011 Frequency (%)
Campus has alcohol and drug policies					
Yes n (%)	5,482 (91.3)	5,145 (92.0)	3,510 (90.6)	5,619 (94.6)	86,377 (91.9)
No n (%)	37 (0.6)	30 (0.5)	27 (0.7)	34 (0.6)	515 (0.5)
Don't Know n (%)	483 (8.0)	416 (7.4)	336 (8.7)	288 (4.8)	7,055 (7.5)
Policies are enforced					
Yes n (%)	4,288 (71.9)	3,943 (71.1)	2,700 (70.3)	4,381 (72.9)	64,422 (68.9)
No n (%)	557 (9.3)	555 (10.0)	334 (8.7)	644 (10.9)	8,852 (9.5)
Don't Know n (%)	1,121 (18.8)	1,049 (18.9)	806 (21.0)	886 (15.0)	20,208 (21.6)
Campus has drug and alcohol prevention program					
Yes n (%)	3,509 (58.8)	3,405 (61.5)	2,374 (61.8)	3,453 (57.5)	46,644 (49.9)
No n (%)	197 (3.3)	140 (2.5)	103 (2.7)	220 (3.7)	4237 (4.5)
Don't Know n (%)	2,262 (37.9)	1,993 (36.0)	1,362 (35.5)	2,233 (37.8)	42,560 (45.5)
Campus concerned about drug and alcohol prevention					
Yes n (%)	4,727 (79.4)	4,276 (77.1)	2,895 (75.6)	4,715 (78.5)	71,122 (76.2)
No n (%)	546 (9.2)	557 (10.0)	385 (10.1)	574 (9.7)	10,234 (11.0)
Don't Know n (%)	682 (11.5)	711 (12.8)	548 (14.3)	603 (10.2)	12,013 (12.9)
Actively involved in prevention efforts					
Yes n (%)	642 (10.8)	684 (12.3)	542 (14.2)	646 (10.9)	9,508 (10.2)
No n (%)	5,325 (89.2)	4,855 (87.7)	3,278 (85.8)	5,261 (89.1)	83,924 (89.8)
Social atmosphere on campus promotes alcohol use					
Yes n (%)	3,182 (63.2)	2,831 (61.3)	1,377 (52.0)	3,827 (63.7)	49,022 (53.2)
No n (%)	1,851 (36.8)	1,786 (38.7)	1,270 (48.0)	1,999 (33.3)	43,099 (46.8)

Patterns of Alcohol Use. To examine patterns of alcohol use, the evaluation focused on six topics: preference for alcohol and drugs at parties, past 30-day alcohol use, alcohol use in the past year, change in alcohol use in last 12 months, average number of drinks per week, and consuming five or more drinks at a sitting.

To obtain students' views on substance use, respondents were asked whether they preferred to have alcohol or drugs available at parties they attend on or around campus. The data show that the majority of students approved of having alcohol available at parties; however, substantially fewer approved of having drugs at parties (Table 31). Chi-square tests conducted on this item indicate no significant differences between the 2011 and 2014 samples for alcohol, but somewhat more students preferred having drugs available in 2014 than 2011 (X^2=25.331, df=1, $p < .000$).

Table 31

Core Student Data: Preference for Availability of Alcohol and Drugs at Parties

Alcohol or Drugs	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	CT 2010-2011 *n* (%)	US 2010-2011 *n* (%)
Alcohol					
Have Available	4,617 (78.2)	4,269 (77.3)	2,964 (77.3)	4,677 (80.0)	66,325 (71.4)
Not Have Available	1,288 (21.8)	1,254 (22.7)	853 (22.3)	1,169 (20.0)	26,513 (28.6)
Drugs					
Have Available	1,501 (25.6)	1,498 (27.1)	1,154 (30.2)	1,567 (26.9)	17,653 (19.1)
Not Have Available	4,367 (74.4)	4,020 (72.9)	2,661 (69.8)	4,251 (70.7)	75,008 (80.9)

The data directly related to alcohol use (past 30-day alcohol use, alcohol use in past year, change in alcohol use in last 12 months, average number of drinks per week, and consumption of five or more drinks at a sitting) were examined for 3 groups: all students (ages 18-24), (2) students under the legal age to purchase or drink alcohol (18 to 20 years old), and (3) those of legal age to buy and consume alcohol (21 to 24 years old). The data in tables 30 to 34 illustrate a disturbing trend: not only do college students drink frequently and to excess but their drinking increases once they become of legal drinking age.

Over three-quarters of the 18 to 24 year-olds in 2011, 2012, and 2014 reported consuming alcohol at least once in the past 30-days (Table 32). Approximately, two-thirds of the respondents consumed alcohol 1 to 9 days and about one-sixth consumed alcohol 10 to 30-days. To assess difference in reported alcohol use between the years, the ordinal response categories were re-coded to reflect the number of days alcohol was used in the past 30-days (e.g., "0 days" was coded "0," "6 to 9 days" was coded "7.5," etc.) and means were calculated. Results from an ANOVA show significantly less alcohol use from an average of 5.34 days in 2011 to 4.93 in 2012, ($F(1, 11502)=21.422$, $p = 0.001$) to 4.91 in 2014 ($F(1, 9782)=28.1$, $p = 0.001$, when compared with 2011). When examining the data by age group, the findings indicate that 21 to 24 year-olds consume alcohol more frequently than underage students. Over one-quarter of the 18 to 20 year-olds did not use alcohol at all in the past 30-days; however, only about 13 percent of the 21 to 24 year-olds reported abstaining from alcohol use. Similar proportions of students in both age groups reported consuming alcohol 1 to 9 days (about two-thirds for 18 to 20 and 21 to 24 year-olds in 2011, 2012, and 2014). However, approximately twice as many 21 to 24 year-olds consumed alcohol 10 to 30-days as 18 to 20 year-olds. Although older students consume alcohol more frequently, ANOVAs conducted on past 30-day alcohol use show a significant reduction for both age groups. The average number of days 18 to 20 year-olds drank was higher in 2011 (4.48 days) than in 2012 (4.09 days)($F(1, 7262)=16.109$, $p = 0.000$), and 2014 (3.99 days)($F(1, 6049)=30.384$, $p < 0.0001$). The average number of days for 21 to 24 year-olds was also higher in 2011 compared to 2012 (6.80 days and 6.36 days, respectively) ($F(1, 4229)=7.260$, $p < .008$), and compared to 2014 (6.80 and 6.28 days, respectively) ($F(1, 3722)=8.860$, $p < .004$).

A small percent (approximately 13%) of the 18-24 year-olds in 2011, 2012, and 2014 reported abstaining from alcohol in the past year (Table 33). Approximately two-thirds of the respondents consumed alcohol once a year to once a week, and about one-quarter consumed alcohol three times per week to every day. To assess change between the years, the ordinal response categories were re-coded to reflect number of days (i.e., "did not use" was recoded to "0," "once a week" was recoded to "52") and means were calculated. Results from an ANOVA show that students reported significantly less past year alcohol use in 2012, from an average of 63.42 days in 2011 to 59.48 days in 2012, ($F(1, 11563)=12.695$, $p = 0.000$). This increased slightly, however, to 61.18 days in 2014. When examining the data by age group, ANOVAs showed significantly less past year alcohol use for both age groups in 2012 compared to 2011. The average number of days 18 to 20 year-olds drank was higher in 2011(52.45 days) compared to 2012 (48.98 days)($F(1, 7292)=7.619$, $p = 0.006$) and 49.50 in 2014. The average number of days for 21 to 24 year-olds was higher in 2011 (82.08 days) compared to 2012 (77.52 days)($F(1, 4260)=5.316$, $p = 0.021$), but not significantly higher than 2014 at the .05 alpha level (78.84 days)($F(1,3743)=3,175$, $p < 0.08$).

The majority of the 18 to 24 year-olds surveyed in 2011, 2012 and 2014 reported that their alcohol use remained the same in the last year (Table 34). Approximately, 20 percent of the respondents reported an increase in their alcohol use and about 20 percent reported a decrease in each of the three years. A chi-square to examine reported increased vs. reported decrease from 2011 to 2012 and from 2011 to 2014 indicated no significant difference ($X^2=1.524$, df=1, $p = 0.217$) and ($X^2=0.740$, df=1, $p = 0.390$). When examining the data by age group, the relative proportions of 18 to 20 year-olds reporting increased use compared to decreased use was significantly different in 2012 compared to 2011 with fewer 18 to 20 year-olds reporting an increase in their alcohol use in 2012 than in 2011 and more 18 to 20 year-olds reporting a decrease in their use in 2012 compared to 2011 ($X^2=4.621$, df=1, $p = 0.032$). Although the same pattern was observed from 2011 to 2014, it was not significant ($X^2=1.974$, df=1, $p = 0.160$). The trend was reversed for the 21 to 24 year-olds, but a chi-square indicated no significant difference ($X^2=0.951$, df=1, $p = 0.330$) from 2011 to 2012 or from 2011 to 2014 ($X^2=0.597$, df=1, $p = 0.440$).

Table 32

Core Student Data: Alcohol Use Past 30 Days

Number of Days	CHCI 2011[1] *n* (%)	CHCI 2012[1,2] *n* (%)	CHCI 2014[1,3] *n* (%)	CT[1] 2010-2011 *n* (%)	US[1] 2010-2011 *n* (%)
0 Days					
18 to 24 years	1,295 (21.7)	1,257 (22.6)	926 (24.1)	1,207 (20.5)	28,190 (30.2)
18 to 20 years	1,013 (27.0)	1,000 (28.4)	708 (30.7)	946 (25.2)	22,105 (37.7)
21 to 24 years	282 (12.8)	257 (12.6)	218 (14.2)	249 (11.9)	6085 (17.5)
1-2 Days					
18 to 24 years	1,105 (18.5)	1,121 (20.2)	834 (21.7)	1,072 (18.2)	18,835 (20.2)
18 to 20 years	753 (20.0)	727 (20.7)	518 (22.5)	751 (20.0)	11,798 (20.1)
21 to 24 years	352 (16.0)	394 (19.3)	316 (20.6)	309 (14.8)	7,037 (20.3)
3-5 Days					
18 to 24 years	1314 (22.1)	1,238 (22.3)	809 (21.1)	1,345 (22.8)	17,709 (19.0)
18 to 20 years	798 (21.2)	785 (22.3)	472 (20.5)	846 (22.5)	9,973 (17.0)
21 to 24 years	516 (23.4)	453 (22.2)	337 (22.0)	483 (23.2)	7,736 (22.3)
6-9 Days					
18 to 24 years	1,288 (21.6)	1,199 (21.6)	705 (18.4)	1,348 (22.4)	15,557 (16.7)
18 to 20 years	752 (20.0)	682 (19.4)	372 (16.2)	797 (21.2)	8,658 (14.8)
21 to 24 years	536 (24.4)	517 (25.4)	333 (21.7)	453 (26.0)	6,899 (19.9)
10-19 Days					
18 to 24 years	832 (14.0)	648 (11.7)	479 (12.5)	824 (14.0)	10,852 (11.6)
18 to 20 years	398 (10.6)	288 (8.2)	203 (8.8)	387 (10.3)	5,276 (9.0)
21 to 24 years	434 (19.7)	360 (17.7)	276 (18.0)	430 (20.6)	5,576 (16.1)
20-29 Days					
18 to 24 years	100 (1.7)	77 (1.4)	66 (1.7)	87 (1.5)	1,776 (1.9)
18 to 20 years	35 (0.9)	27 (0.8)	20 (0.9)	27 (0.7)	643 (1.1)
21 to 24 years	65 (3.0)	50 (2.5)	46 (3.0)	59 (2.8)	1,133 (3.3)
All 30 Days					
18 to 24 years	24 (0.4)	15 (0.3)	16 (0.4)	19 (0.3)	390 (0.4)
18 to 20 years	8 (0.2)	7 (0.2)	10 (0.4)	6 (0.2)	183 (0.3)
21 to 24 years	16 (0.7)	8 (0.4)	6 (0.4)	13 (0.6)	207 (0.6)

[1] Indicates a significant difference for distribution of drinking frequencies between 18-20 and 21-24 age groups at $p < 0.05$

[2] 2011 and 2012 are significantly different for participants 18-24, 18-20, and 21-24 at $p < 0.05$.

[3] 2011 and 2014 are significantly different for participants 18-24 ($p < 0.05$), 18-20 ($p < 0.08$), and age 21-24 ($p < 0.08$).

Table 33

Core Student Data: Alcohol Use Past Year

Number of Times	CHCI 2011[1] *n* (%)	CHCI 2012[1,2] *n* (%)	CHCI 2014[1,3] *n* (%)	CT[1] 2010-2011 *n* (%)	US[1] 2010-2011 *n* (%)
Did not use					
18 to 24 years	754 (12.6)	732 (13.1)	486 (12.6)	712 (12.0)	16,755 (17.9)
18 to 20 years	583 (15.5)	584 (16.5)	378 (16.2)	552 (14.6)	13,665 (23.2)
21 to 24 years	171 (7.7)	148 (7.2)	108 (7.0)	153 (7.3)	16,755 (17.9)
Once per Year					
18 to 24 years	285 (4.8)	277 (4.9)	221 (5.7)	258 (4.4)	6,192 (6.6)
18 to 20 years	222 (5.9)	224 (6.3)	154 (6.6)	202 (5.4)	4,716 (8.0)
21 to 24 years	63 (2.8)	53 (2.6)	67 (4.3)	51 (2.4)	6,192 (6.6)
6 Times per Year					
18 to 24 years	462 (7.7)	459 (8.2)	363 (9.4)	427 (7.2)	9,413 (10.0)
18 to 20 years	366 (9.7)	328 (9.3)	253 (10.9)	347 (9.2)	6,399 (10.9)
21 to 24 years	96 (4.3)	131 (6.4)	110 (7.1)	77 (3.7)	9,413 (10.0)
Once per Month					
18 to 24 years	367 (6.1)	383 (6.8)	289 (7.5)	344 (5.8)	6,976 (7.4)
18 to 20 years	236 (6.3)	269 (7.6)	194 (8.3)	223 (5.9)	4,453 (7.5)
21 to 24 years	131 (5.9)	114 (5.5)	95 (6.2)	119 (5.7)	6,976 (7.4)
Twice per Month					
18 to 24 years	823 (13.6)	805 (14.4)	496 (12.8)	803 (13.5)	12,820 (13.7)
18 to 20 years	541 (14.4)	529 (14.9)	305 (13.1)	543 (14.4)	7,830 (13.3)
21 to 24 years	282 (12.7)	276 (13.4)	191 (12.4)	252 (12.0)	12,820 (13.7)
Once per Week					
18 to 24 years	1,762 (29.5)	1,647 (29.4)	1,096 (28.3)	1,854 (31.3)	22,072 (23.5)
18 to 20 years	1,084 (28.8)	979 (27.7)	635 (27.3)	1,168 (31.0)	12,333 (20.9)
21 to 24 years	678 (30.6)	668 (32.5)	461 (29.9)	667 (31.7)	22,072 (23.5)
3 Times per Week					
18 to 24 years	1,339 (22.4)	1,146 (20.5)	770 (19.9)	1,365 (23.0)	16,228 (17.3)
18 to 20 years	657 (17.5)	573 (16.2)	357 (15.3)	675 (17.9)	8,232 (14.0)
21 to 24 years	682 (30.8)	573 (27.8)	413 (26.8)	681 (32.4)	16,228 (17.3)
5 Times per Week					

[1] Indicates a significant difference for distribution of drinking frequencies between 18-20 and 21-24 age groups at $p < 0.05$.

[2] 2011 and 2012 are significantly different for participants 18-24, 18-20, and 21-24 at $p < 0.05$

[3] 2011 and 2014 are significantly different for participants 18-24 and 18-20 at $p < 0.05$; Difference between 2011 and 2014 for age 21-24 ($p < 0.08$).

Table 33

Core Student Data: Alcohol Use Past Year

Number of Times	CHCI 2011[1] *n* (%)	CHCI 2012[1,2] *n* (%)	CHCI 2014[1,3] *n* (%)	CT[1] 2010-2011 *n* (%)	US[1] 2010-2011 *n* (%)
18 to 24 years	151 (2.5)	122 (2.2)	122 (3.2)	136 (2.3)	2,673 (2.9)
18 to 20 years	64 (1.7)	45 (1.3)	42 (1.8)	53 (1.4)	1,014 (1.7)
21 to 24 years	87 (3.9)	77 (3.7)	80 (5.2)	80 (3.8)	2,673 (2.9)
Every Day					
18 to 24 years	33 (0.6)	27 (0.5)	28 (0.7)	29 (0.5)	639 (0.7)
18 to 20 years	10 (0.3)	9 (0.3)	12 (0.5)	8 (0.2)	258 (0.4)
21 to 24 years	23 (1.0)	18 (0.9)	16 (1.0)	21 (1.0)	639 (0.7)

[1] Indicates a significant difference for distribution of drinking frequencies between 18-20 and 21-24 age groups at $p < 0.05$.

[2] 2011 and 2012 are significantly different for participants 18-24, 18-20, and 21-24 at $p < 0.05$

[3] 2011 and 2014 are significantly different for participants 18-24 and 18-20 at $p < 0.05$; Difference between 2011 and 2014 for age 21-24 ($p < 0.08$).

Table 34

Core Student Data: Change in Alcohol Use Last 12 Months

Number of Times	CHCI 2011 *n* (%)	CHCI 2012[1] *n* (%)	CHCI 2014[1] *n* (%)	CT[1] 2010-2011 *n* (%)	US[1] 2010-2011 *n* (%)
Increased					
18 to 24 Years	1,227 (24.6)	1,057 (22.9)	620 (23.5)	1,448 (25.1)	19,983 (21.8)
18 to 20 Years	875 (27.3)	712 (24.1)	411 (25.0)	1,030 (28.1)	13,296 (23.1)
21 to 24 Years	352 (19.8)	345 (20.7)	209 (21.1)	418 (20.0)	6,687 (19.6)
About the Same					
18 to 24 Years	1,990 (39.9)	1,927 (41.7)	1,072 (40.7)	2,302 (39.9)	32,427 (35.3)
18 to 20 Years	1,158 (36.1)	1,128 (38.2)	607 (36.9)	1,326 (36.1)	18,151 (31.5)
21 to 24 Years	832 (46.7)	799 (47.8)	465 (47.0)	976 (46.6)	14,267 (41.9)
Decreased					
18 to 24 Years	1,055 (21.1)	980 (21.2)	567 (21.5)	1267 (22.0)	20,992 (22.9)
18 to 20 Years	603 (18.8)	579 (19.6)	322 (19.5)	717 (19.5)	11,410 (19.8)
21 to 24 Years	452 (25.4)	401 (24.0)	245 (24.7)	550 (26.3)	9,582 (28.1)
I Have Not Used Alcohol					
18 to 24 Years	719 (14.4)	661 (14.3)	375 (14.2)	749 (13.0)	18,380 (20.0)
18 to 20 Years	575 (17.9)	536 (18.1)	304 (18.5)	598 (16.3)	14,822 (25.7)
21 to 24 Years	144 (8.1)	125 (7.5)	125 (7.5)	151 (7.2)	3,558 (10.4)

[1] No significant differences between 2011 and 2012 or 2014 at $p < 0.05$

The average number of drinks consumed per week by respondents was significantly lower for 18 to 24 year-olds in 2012 compared to 2011 (6.04 in 2011 and 5.43 in 2012) ($F(1,11,528)=19.911$, $p < .0005$) (Table 35). In 2014, students reported consuming even fewer drinks per week, 5.07, a significant difference ($F(1, 9860)=26.56$, $p = 0.000$). Students of legal drinking age (21 to 24 years old) consumed an average of about two drinks more per week than underage students (18 to 20 years old). The difference between weekly drinks reported by 21 to 24 year-olds and 18 to 20 year-olds narrowed from 2011 to 2014, from 1.83 drinks per week in 2011 to 1.61 drinks per week in 2014. ANOVAs conducted to assess difference in the average number of drinks consumed per week for 2011 compared to 2012 revealed that significantly fewer were consumed in 2012 compared to 2011 in the two age groups: 5.32 drinks in 2011 compared to 4.75 in 2012 among 18 to 20 year-olds ($F(1, 7267)=12.80$, $p < .0005$; and 7.26 in 2011 compared to 6.58 in 2012 among 21 to 24 year-olds ($F(1, 4250)=8.30$, $p <= .0005$). In 2014, 18 to 20 year-olds reported drinking an average of 4.42 drinks per week, significantly less than in 2011 ($F(1, 6093)=23;52$, $p < .0005$) and 21 to 24 year-olds reported drinking an average of 6.03 drinks per week, significantly less than in 2011($F(1, 3756)=8.27$, $p < .005$). It should be noted that moderate alcohol use is considered to be 7 drinks per week for women and 14 drinks per week for men (http://www.cdc.gov/alcohol/faqs.htm#moderateDrinking). However, many drinkers, including college students, do not adhere to a standard drink size (12 ounces of beer, 5 ounces of wine, and 1.5 ounces of 80 proof distilled spirits) when counting the number of drinks consumed. As a result, the number of drinks reported per week by the respondents may be even greater (http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/standard-drink).

Over one-half of the 18-24 year old respondents in 2011, 2012, and 2014 consumed five or more drinks at one time at least once in the last two weeks (Table 36). The ordinal response options were re-coded to reflect the number of drinks (e.g., "none" was recoded to "0," "3 to 5 times was recoded to "4," etc.) to calculate means. ANOVAs conducted to assess the difference in the average number of occurrences show significantly fewer occurrences reported in 2012 and 2014 compared to 2011 for the three age groups: 1.7 times in 2011 compared to 1.5 times in 2012 for 18 to 24 year-olds ($F(1, 11649)=15.854$, $p = 0.000$) and 1.4 times in 2014 ($F(1, 9,930)=30.92$, $p < .0005$); 1.5 in 2011 compared to 1.4 in 2012 for 18 to 20 year-olds ($F(1, 7351)=7.746$, $p < 0.01$) and 1.3 in 2014 ($F(1, 6140)=19.62$, $p < 0.0005$); and 2.0 in 2011 compared to 1.8 in 2012 for 21 to 24 year-olds ($F(1, 4287)=9.226$, $p = 0.002$) and 1.6 in 2014 ($F(1, 3,779)=13.96$, $p < .0005$).

Table 35

Core Student Data: Average Number of Drinks Consumed Per Week

Number of Drinks per Week	CHCI 2011	CHCI 2012	CHCI 2014	CT 2010-2011	US 2010-2011
18 to 24 years of age[1,2]					
N	5958	5581	3913	5916	93606
Mean	6.04	5.43	5.07	6.39	4.81
Standard Deviation	8.609	7.806	8.185	8.600	8.322
18 to 20 years of age[1,2]					
N	3755	3523	2349	3767	58773
Mean	5.32	4.75	4.42	5.54	4.27
Standard Deviation	8.098	7.066	7.359	7.568	7.958
21 to 24 years of age[1,2]					
N	2203	2058	1564	2149	34833
Mean	7.26	6.58	6.03	7.89	5.72
Standard Deviation	9.290	8.813	9.207	9.986	8.827

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)
[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Table 36

Core Student Data: Number of Times Had Five or More Drinks at a Sitting in Last Two Weeks

Number of Times	CHCI 2011 *n* (%)	CHCI 2012 [1,2,3] *n* (%)	CHCI 2014 [1,2,3] *n* (%)	CT 2010-2011 *n* (%)	US 2010-2011 *n* (%)
None					
18 to 24 Years	2523 (41.9)	2551 (45.2)	1870 (47.7)	2391 (40.1)	50717 (53.8)
18 to 20 Years	1746 (46.0)	1762 (49.4)	1218 (51.7)	1681 (44.2)	34206 (57.7)
21 to 24 Years	777 (34.9)	789 (38.0)	652 (41.6)	678 (32.2)	50717 (53.8)
Once					
18 to 24 Years	1093 (18.2)	1007 (17.9)	722 (18.4)	1067 (17.9)	14316 (15.2)
18 to 20 Years	685 (18.0)	609 (17.1)	400 (17.0)	683 (18.0)	8286 (14.0)
21 to 24 Years	408 (18.3)	398 (19.2)	322 (20.6)	377 (17.9)	14316 (15.2)

[1] Difference with 2011 is significant for age 18 to 24 ($p < 0.05$)
[2] Difference with 2011 is significant for age 18 to 24 ($p < 0.05$)
[3] Difference with 2011 is significant for age 18 to 24 ($p < 0.05$)

Table 36

Core Student Data: Number of Times Had Five or More Drinks at a Sitting in Last Two Weeks

Number of Times	CHCI 2011 *n* (%)	CHCI 2012 [1,2,3] *n* (%)	CHCI 2014 [1,2,3] *n* (%)	CT 2010-2011 *n* (%)	US 2010-2011 *n* (%)
Twice					
18 to 24 Years	965 (16.0)	889 (15.9)	599 (15.3)	1005 (16.8)	11537 (12.2)
18 to 20 Years	573 (15.1)	537 (15.1)	341 (14.5)	597 (15.7)	6652 (11.2)
21 to 24 Years	392 (17.6)	352 (17.0)	258 (16.5)	402 (19.1)	11537 (12.2)
3 to 5 Times					
18 to 24 Years	1108 (18.4)	927 (16.4)	560 (14.3)	1189 (19.9)	12892(13.7)
18 to 20 Years	624 (16.4)	518 (14.5)	305 (13.0)	690 (18.1)	7438 (12.6)
21 to 24 Years	484 (21.8)	409 (19.7)	255 (16.3)	488 (23.2)	12892 (13.7)
6 to 9 Times					
18 to 24 Years	245 (4.1)	193 (3.4)	112 (2.9)	242 (4.1)	3465 (3.7)
18 to 20 Years	126 (3.3)	99 (2.8)	58 (2.5)	121 (3.2)	1907 (3.2)
21 to 24 Years	119 (5.4)	94 (4.5)	54 (3.4)	120 (5.7)	3465 (3.7)
10 or more Times					
18 to 24 Years	87 (1.4)	72 (1.3)	57 (1.5)	72 (1.2)	1363 (1.4)
18 to 20 Years	43 (1.1)	40 (1.1)	32 (1.4)	32 (0.8)	757 (1.3)
21 to 24 Years	44 (2.0)	32 (1.5)	25 (1.6)	40 (1.9)	1363 (1.4)

[1] Difference with 2011 is significant for age 18 to 24 ($p < 0.05$)
[2] Difference with 2011 is significant for age 18 to 24 ($p < 0.05$)
[3] Difference with 2011 is significant for age 18 to 24 ($p < 0.05$)

The question arises as to where do students go to drink (Table 37). The data indicate that the typical locations for students to drink are: private parties, residence halls and private residences. An interesting, although not surprising, difference emerges when examining the data by age of student. Students of legal drinking age drink primarily in bars and restaurants (82.6 percent in 2011, 78.5 percent in 2012, and 74.5 percent in 2014). A smaller but still substantial percent of students under the legal drinking age also drink in bars and restaurants (40.6 percent in 2011, 35.8 percent in 2012, and 31.0 percent in 2014). A sizeable number of students (18 to 24 years old) drink at on-campus events (36.9 percent in 2011, 28.7 percent in 2012, and 29.1 percent in 2014). Chi-square tests indicate significantly less alcohol use for all of the age groups at all of the locations in 2012 and 2014 compared to 2011.

Table 37

Core Student Data: Locations of Alcohol Use

Location	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	CT 2010-2011 *n* (%)	US 2010-2011 *n* (%)
Never Used					
18 to 24 years	684 (13.2)	670 (12.1)	465 (12.2)	640 (10.8)	15277 (16.4)
18 to 20 years	546 (16.3)	533 (15.2)	368 (16.0)	515 (13.7)	12628 (21.6)
21 to 24 years	138 (7.5)	137 (6.7)	97 (6.4)	121 (5.8)	2649 (7.6)
On-Campus Events					
18 to 24 years[1,2]	1982 (36.9)	1596 (28.7)	1111 (29.1)	2079 (35.2)	19079 (20.5)
18 to 20 years[1,2]	1110 (32.0)	862 (24.5)	559 (24.3)	1148 (30.4)	9897 (16.9)
21 to 24 years[1,2]	882 (45.5)	734 (36.0)	552 (36.4)	921 (44.1)	9182 (26.5)
Residence Halls					
18 to 24 years[1,2]	3416 (62.0)	3146 (56.6)	1898 (49.8)	3629 (61.4)	36518 (39.2)
18 to 20 years[1,2]	2120 (60.1)	1943 (55.2)	1132 (49.3)	2266 (59.2)	22315 (38.1)
21 to 24 years[1,2]	1296 (65.5)	1203 (59.0)	766 (50.5)	1346 (64.5)	14203 (41.0)
Fraternity/Sorority					
18 to 24 years[1,2]	1404 (26.6)	1293 (23.3)	604 (15.8)	1367 (23.1)	26975 (28.9)
18 to 20 years[1,2]	890 (26.4)	824 (23.4)	351 (15.3)	884 (23.4)	16550 (28.2)
21 to 24 years[1,2]	514 (27.1)	469 (23.0)	253 (16.7)	477 (22.9)	10425 (30.1)
Bar/Restaurant					
18 to 24 years[1,2]	3181 (56.4)	2859 (51.5)	1847 (48.4)	3111 (52.6)	45359 (48.7)
18 to 20 years[1,2]	1431 (40.6)	1260 (35.8)	717 (31.2)	1405 (37.3)	17990 (30.7)
21 to 24 years[1,2]	1750 (82.6)	1599 (78.5)	1130 (74.5)	1665 (79.8)	27369 (79.0)
Private Residence					
18 to 24 years[1,2]	3642 (64.6)	3379 (60.8)	2231 (58.5)	3646 (61.7)	53206 (57.1)
18 to 20 years[1,2]	2011 (56.5)	1861 (52.9)	1132 (49.3)	2035 (54.0)	27348 (46.0)
21 to 24 years[1,2]	1631 (78.4)	1518 (74.5)	1099 (72.4)	1570 (75.2)	25858 (74.7)
Car					
18 to 24 years[1,2]	1226 (20.2)	1048 (18.9)	734 (19.2)	1167 (19.7)	14357 (15.2)
18 to 20 years[1,2]	714 (20.7)	607 (17.3)	402 (17.5)	687 (18.2)	8456 (14.4)
21 to 24 years[1,2]	512 (26.5)	441 (21.6)	332 (21.9)	468 (22.4)	5901 (17.0)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)

[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Table 37

Core Student Data: Locations of Alcohol Use

Location	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	CT 2010-2011 *n* (%)	US 2010-2011 *n* (%)
Private Parties					
18 to 24 years[1,2]	4148 (72.6)	3744 (67.4)	2397 (62.9)	4177 (70.6)	60278 (64.7)
18 to 20 years[1,2]	2512 (69.3)	2247 (63.9)	1375 (59.9)	2552 (67.7)	35091 (59.9)
21 to 24 years[1,2]	1636 (78.4)	1497 (73.5)	1022 (67.4)	1585 (75.9)	25187 (72.7)
Other					
18 to 24 years[1,2]	1182 (22.2)	1014 (18.3)	656 (17.2)	1156 (19.6)	17619 (18.9)
18 to 20 years[1,2]	736 (21.4)	611 (17.4)	375 (16.3)	704 (18.7)	10717 (18.0)
21 to 24 years[1,2]	446 (23.5)	403 (19.8)	281 (18.5)	439 (21.0)	6902 (19.9)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)
[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Consequences of Alcohol Use. Students recognize that alcohol and drug use leads to many negative consequences (Table 38). The most frequently noted consequences that students reported experiencing at least once were having a hangover, being nauseous or vomiting, doing something they later regretted and having memory loss. These are all serious consequences and indicators of heavy alcohol consumption. To determine whether there were any differences in prevalence of consequences between 2011 and 2012 or 2014, ordinal response options were re-coded to reflect number of times consequences were reported to occur in the past year (e.g., "Never" was recoded as "0," 3-5 times was recoded as "4," etc.). ANOVAs found significant differences for several items and indicate that students reported fewer occurrences of consequences in 2012 and 2014 compared to 2011 (Table 38).

In addition to the consequences that students create for themselves, peers who drink have a negative impact on those around them (Table 39). For example, difficulties include being interrupted while studying and others making a mess in a common living area. Chi-square tests on these items found two significant differences between 2011 and 2012 and five between 2011 and 2014. For each significant difference, a lower percentage of students reported interference in their lives due to drinking in 2012 and 2014 compared to 2011, suggesting a lower negative impact of drinking on students in 2012 and 2014.

Table 38

Core Student Data: Percent of Consequences of Alcohol or Drug Use During Past Year

Consequence	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	CT 2010-2011 *n* (%)	US 2010-2011 *n* (%)
Had a hangover[1,2]					
Never	1,737 (29.3)	1,733 (31.1)	1,215 (31.7)	1,676 (28.4)	36,538 (39.1)
Once	750 (12.6)	810 (14.5)	556 (14.5)	727 (12.3)	12,657 (13.6)
Twice	757 (12.8)	720 (12.9)	505 (13.2)	745 (12.6)	10,577 (11.3)
3-5 Times	1,062 (17.9)	925 (16.6)	609 (15.9)	1,078 (18.3)	13,753 (14.7)
6-9 Times	632 (10.6)	528 (9.5)	360 (9.4)	640 (10.9)	7,294 (7.8)
10 or more Times	998 (16.8)	858 (15.4)	592 (15.4)	1,027 (17.4)	12,573 (13.5)
Performed poorly on test or important project					
Never	4,430 (74.6)	4,306 (77.3)	2,880 (75.2)	4,412 (74.9)	74,130 (79.5)
Once	654 (11.0)	611 (11.0)	420 (11.0)	652 (11.1)	8,496 (9.1)
Twice	447 (7.5)	340 (6.1)	263 (6.9)	443 (7.5)	5,294 (5.7)
3-5 Times	297 (5.0)	220 (4.0)	187 (4.9)	296 (5.0)	3,827 (4.1)
6-9 Times	70 (1.2)	56 (1.0)	42 (1.1)	61 (1.0)	861 (0.9)
10 or more Times	40 (0.7)	34 (0.6)	36 (0.9)	29 (0.5)	641 (0.7)
Trouble with police, residence hall or college authorities[1,2]					
Never	4,981 (83.8)	4,796 (86.1)	3,299 (86.2)	4,930 (83.6)	81,578 (87.5)
Once	699 (11.8)	562 (10.1)	380 (9.9)	705 (12.0)	8,571 (9.2)
Twice	173 (2.9)	139 (2.5)	94 (2.5)	174 (2.9)	1,878 (2.1)
3-5 Times	65 (1.1)	55 (1.0)	34 (0.9)	66 (1.1)	869 (0.9)
6-9 Times	12 (0.2)	7 (0.1)	10 (0.3)	10 (0.2)	113 (0.1)
10 or more Times	13 (0.2)	12 (0.2)	10 (0.3)	14 (0.2)	174 (0.2)
Damaged property, pulled fire alarm, etc.					
Never	5,596 (94.3)	5,201 (93.7)	3,606 (94.3)	5,528 (93.9)	88,147 (94.6)
Once	168 (2.8)	212 (3.8)	121 (3.2)	192 (3.3)	2,511 (2.7)
Twice	102 (1.7)	79 (1.4)	50 (1.3)	93 (1.6)	1,195 (1.3)
3-5 Times	37 (0.6)	36 (0.6)	27 (0.7)	39 (0.7)	774 (0.8)
6-9 Times	12 (0.2)	8 (0.1)	7 (0.2)	16 (0.3)	221 (0.2)
10 or more Times	22 (0.4)	15 (0.3)	11 (0.3)	22 (0.4)	330 (0.4)
Got into argument or fight[1,2]					
Never	3,714 (62.7)	3,662 (66.2)	2,583 (67.9)	3,716 (63.2)	65,238 (70.1)
Once	828 (14.0)	774 (14.0)	518 (13.6)	840 (14.3)	11,007 (11.8)
Twice	678 (11.5)	526 (9.5)	331 (8.7)	662 (11.3)	8045 (8.6)
3-5 Times	461 (7.8)	398 (7.2)	243 (6.4)	427 (7.3)	5317 (6.1)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)

[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Table 38

Core Student Data: Percent of Consequences of Alcohol or Drug Use During Past Year

Consequence	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	CT 2010-2011 *n* (%)	US 2010-2011 *n* (%)
6-9 Times	136 (2.3)	89 (1.6)	64 (1.7)	131 (2.2)	1589 (1.7)
10 or more Times	102 (1.7)	79 (1.4)	63 (1.7)	103 (1.8)	1474 (1.6)
Got nauseated or vomited[1,2]					
Never	2,440 (41.2)	2,369 (42.7)	1,717 (45.1)	2,379 (40.5)	44,149 (47.5)
Once	1,272 (21.5)	1,222 (22.0)	761 (20.0)	1,264 (21.5)	18,211 (19.6)
Twice	940 (15.9)	891 (16.1)	585 (15.4)	957 (16.3)	12880 (13.9)
3-5 Times	830 (14.0)	701 (12.6)	493 (12.9)	844 (14.4)	11305 (12.2)
6-9 Times	244 (4.1)	221 (4.0)	145 (3.8)	239 (4.1)	3555 (3.8)
10 or more Times	202 (3.4)	141 (2.5)	106 (2.8)	192 (3.3)	2877 (3.1)
Drove car while under influence[1,2]					
Never	4,758 (80.4)	4,565 (82.1)	3,069 (80.4)	4,827 (82.1)	74,157 (79.7)
Once	465 (7.9)	389 (7.0)	281 (7.4)	428 (7.3)	7159 (7.7)
Twice	241 (4.1)	235 (4.2)	174 (4.6)	230 (3.9)	4010 (4.3)
3-5 Times	225 (3.8)	185 (3.3)	137 (3.6)	201 (3.4)	3807 (4.1)
6-9 Times	97 (1.6)	72 (1.3)	52 (1.4)	74 (1.3)	1435 (1.5)
10 or more Times	133 (2.2)	113 (2.0)	102 (2.7)	116 (2.0)	2493 (2.7)
Missed class[1,2]					
Never	3,894 (65.8)	3,895 (70.3)	2,718 (71.5)	3,817 (65.0)	67,154 (72.2)
Once	595 (10.0)	535 (9.7)	386 (10.2)	602 (10.3)	8,044 (8.7)
Twice	525 (8.9)	432 (7.8)	282 (7.4)	532 (9.1)	6,933 (7.5)
3-5 Times	517 (8.7)	416 (7.5)	257 (6.8)	533 (9.1)	6,483 (7.0)
6-9 Times	206 (3.5)	135 (2.4)	84 (2.2)	200 (3.4)	2,315 (2.5)
10 or more Times	184 (3.1)	127 (2.3)	74 (1.9)	186 (3.2)	2,032 (2.2)
Criticized by someone I know[1]					
Never	3.920 (66.4)	3,820 (69.0)	2,616 (68.8)	3,853 (65.7)	66,022 (71.0)
Once	720 (12.2)	693 (12.5)	470 (12.4)	748 (12.8)	9,987 (10.7)
Twice	579 (9.8)	475 (8.6)	324 (8.5)	571 (9.7)	7,350 (7.9)
3-5 Times	419 (7.1)	326 (5.9)	233 (6.1)	433 (7.4)	5,771 (6.2)
6-9 Times	136 (2.3)	106 (1.9)	74 (1.9)	126 (2.1)	1,556 (1.7)
10 or more Times	132 (2.2)	117 (2.1)	84 (2.2)	133 (2.3)	2,267 (2.4)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)
[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Table 38

Core Student Data: Percent of Consequences of Alcohol or Drug Use During Past Year

Consequence	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	CT 2010-2011 *n* (%)	US 2010-2011 *n* (%)
Thought I might have a drinking or drug problem					
Never	5,320 (89.8)	5,041 (90.7)	3.391 (89.2)	5,272 (89.7)	84,698 (91.0)
Once	278 (4.7)	236 (4.2)	189 (5.0)	272 (4.6)	3,626 (3.9)
Twice	153 (2.6)	108 (1.9)	86 (2.3)	151 (2.6)	1,889 (2.0)
3-5 Times	89 (1.5)	68 (1.2)	61 (1.6)	94 (1.6)	1,367 (1.5)
6-9 Times	28 (0.5)	33 (0.6)	22 (0.6)	31 (0.5)	479 (0.5)
10 or more Times	56 (0.9)	74 (1.3)	52 (1.4)	58 (1.0)	1,053 (1.1)
Had a memory loss[1,2]					
Never	3,445 (58.3)	3,324 (60.0)	2,402 (63.2)	3,322 (56.6)	59,847 (64.4)
Once	835 (14.1)	766 (13.8)	502 (13.2)	860 (14.7)	11,485 (12.4)
Twice	650 (11.0)	575 (10.4)	354 (9.3)	654 (11.1)	8,214 (8.8)
3-5 Times	532 (9.0)	515 (9.3)	284 (7.5)	573 (9.8)	6,995 (7.5)
6-9 Times	201 (3.4)	161 (2.9)	135 (3.6)	205 (3.5)	2,853 (3.1)
10 or more Times	249 (4.2)	200 (3.6)	121 (3.2)	253 (4.3)	3,530 (3.8)
Did something later regretted[1,2]					
Never	3,444 (58.2)	3,396 (61.4)	2,344 (61.9)	3,323 (56.6)	60,502 (65.1)
Once	935 (15.8)	861 (15.6)	561 (14.8)	956 (16.3)	13,027 (14.0)
Twice	694 (11.7)	560 (10.1)	399 (10.5)	704 (12.0)	8,384 (9.0)
3-5 Times	510 (8.6)	440 (8.0)	306 (8.1)	543 (9.2)	6,768 (7.3)
6-9 Times	179 (3.0)	131 (2.4)	78 (2.1)	176 (3.0)	2,036 (2.2)
10 or more Times	159 (2.7)	146 (2.6)	98 (2.6)	170 (2.9)	2,218 (2.4)
Arrested for DWI/DUI					
Never	5,837 (98.7)	5,465 (98.6)	3,735 (98.6)	5,787 (98.6)	91,891 (98.8)
Once	46 (0.8)	45 (0.8)	31 (0.8)	49 (0.8)	593 (0.7)
Twice	9 (0.2)	20 (0.4)	10 (0.3)	10 (0.2)	139 (0.1)
3-5 Times	9 (0.2)	9 (0.2)	7 (0.2)	7 (0.1)	77 (0.1)
6-9 Times	5 (0.1)	1 (0.0)	2 (0.1)	4 (0.1)	49 (0.1)
10 or more Times	10 (0.2)	3 (0.1)	4 (0.1)	11 (0.2)	122 (0.1)
Have been taken advantage of sexually					
Never	5,366 (90.9)	5,050 (91.5)	3,449 (97.9)	5,303 (90.5)	84,839 (91.4)
Once	346 (5.9)	309 (5.6)	214 (1.3)	91 (1.6)	4,932 (5.3)
Twice	124 (2.1)	100 (1.8)	67 (0.3)	32 (0.5)	1,677 (1.8)
3-5 Times	38 (0.6)	38 (0.7)	24 (0.2)	16 (0.3)	739 (0.8)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)

[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Table 38

Core Student Data: Percent of Consequences of Alcohol or Drug Use During Past Year

Consequence	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	CT 2010-2011 *n* (%)	US 2010-2011 *n* (%)
6-9 Times	6 (0.1)	8 (0.1)	9 (0.1)	4 (0.1)	169 (0.2)
10 or more Times	26 (0.4)	15 (0.3)	14 (0.3)	16 (0.3)	473 (0.5)
Took advantage of someone sexually[1]					
Never	5,759 (97.3)	5,407 (97.8)	3,705 (97.9)	5,706 (97.3)	90,840 (97.7)
Once	82 (1.4)	75 (1.4)	50 (1.3)	91 (1.6)	1,098 (1.2)
Twice	41 (0.7)	24 (0.4)	10 (0.3)	32 (0.5)	422 (0.5)
3-5 Times	16 (0.3)	13 (0.2)	9 (0.2)	16 (0.3)	246 (0.3)
6-9 Times	3 (0.1)	5 (0.1)	2 (0.1)	4 (0.1)	74 (0.1)
10 or more Times	20 (0.3)	6 (0.1)	10 (0.3)	16 (0.3)	292 (0.3)
Tried unsuccessfully to stop using					
Never	5,651 (95.5)	5,288 (95.4)	3,588 (95.2)	5,619 (95.8)	89,028 (95.7)
Once	90 (1.5)	96 (1.7)	67 (1.8)	89 (1.5)	1,507 (1.6)
Twice	79 (1.3)	75 (1.4)	46 (1.2)	70 (1.2)	1,105 (1.2)
3-5 Times	48 (0.8)	37 (0.7)	37 (1.0)	46 (0.8)	742 (0.8)
6-9 Times	20 (0.3)	14 (0.3)	10 (0.3)	17 (0.3)	214 (0.2)
10 or more Times	29 (0.5)	32 (0.6)	19 (0.5)	24 (0.4)	414 (0.4)
Seriously thought about suicide[2]					
Never	5,642 (95.5)	5,268 (95.4)	3,682 (94.2)	5,609 (95.8)	89,295 (96.1)
Once	126 (2.1)	120 (2.2)	50 (2.3)	120 (2.0)	1607 (1.7)
Twice	71 (1.2)	59 (1.1)	17 (1.1)	64 (11.1)	818 (0.9)
3-5 Times	32 (0.5)	29 (0.5)	12 (1.2)	29 (0.5)	553 (0.6)
6-9 Times	9 (0.2)	12 (0.2)	2 (0.6)	6 (0.1)	199 (0.2)
10 or more Times	28 (0.5)	32 (0.6)	6 (0.6)	27 (0.5)	425 (0.5)
Seriously tried to commit suicide					
Never	5,834 (98.5)	5,443 (98.4)	3,682 (97.7)	5,799 (98.8)	92,132 (98.9)
Once	47 (0.8)	47 (0.8)	50 (1.3)	37 (0.6)	585 (0.6)
Twice	15 (0.3)	19 (0.3)	17 (0.5)	14 (0.2)	182 (0.2)
3-5 Times	13 (0.2)	14 (0.3)	12 (0.3)	8 (0.1)	97 (0.1)
6-9 Times	5 (0.1)	5 (0.1)	2 (0.1)	4 (0.1)	42 (0.0)
10 or more Times	6 (0.1)	5 (0.1)	6 (0.2)	8 (0.1)	130 (0.1)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)
[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Table 38

Core Student Data: Percent of Consequences of Alcohol or Drug Use During Past Year

Consequence	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	CT 2010-2011 *n* (%)	US 2010-2011 *n* (%)
Hurt or injured					
Never	4,845 (81.9)	4,573 (82.8)	3,138 (83.6)	4,765 (81.2)	78,449 (84.2)
Once	534 (9.0)	480 (8.7)	290 (7.7)	565 (9.6)	7220 (7.7)
Twice	304 (5.1)	266 (4.8)	195 (5.2)	315 (5.4)	4088 (4.4)
3-5 Times	169 (2.9)	142 (2.6)	78 (2.1)	155 (2.6)	2262 (2.4)
6-9 Times	33 (0.6)	31 (0.6)	21 (0.6)	36 (0.6)	552 (0.6)
10 or more Times	34 (0.6)	34 (0.6)	32 (0.9)	35 (0.6)	653 (0.7)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)
[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Table 39

Core Student Data: Difficulties with Other Students' Drinking

Difficulties	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	CT 2010-2011 *n* (%)	US 2010-2011 *n* (%)
Interrupts Studying[2]	1,896 (38.6)	1,687 (37.3)	795 (30.9)	2,221 (39.2)	28,318 (31.4)
Feel Unsafe[1,2]	815 (16.6)	607 (13.5)	295 (11.6)	909 (16.1)	13,713 (15.2)
Mess in Living Space[2]	1,836 (37.5)	1,713 (38.1)	815 (31.9)	2,188 (38.8)	26,265 (29.2)
Involvement in Athletic Team or Organized Group	525 (10.8)	441 (9.8)	257 (10.1)	591 (10.5)	9,108 (10.1)
Prevents Enjoyment of Event[2]	913 (18.7)	770 (17.2)	404 (15.9)	1,021 (18.1)	7,466 (17.0)
Other Ways[1,2]	1,433 (29.4)	1,228 (27.4)	559 (22.1)	1,670 (29.7)	24,482 (27.3)
No Interference	2,371 (49.3)	2,143 (48.6)	1,232 (50.0)	2,664 (48.0)	45,706 (51.5)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)
[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

With all of the acknowledged negative consequences of alcohol, why do students drink? The data suggest that the primary reasons students drink are related to the perceived increase in sociability, especially to facilitate initial social interactions (Table 40). For example, students feel that drinking breaks the ice, enhances social activity, gives people something to do, and something to talk about. Although students reported that alcohol makes it easier to deal with stress and makes food taste better, these aspects are not as striking as the perceived social enhancement of alcohol. Students reported that they drink for social reasons, however, the frequency and quantity of alcohol consumption and the severity of the consequences noted above indicate that much of the alcohol use is excessive and far beyond the general notion of social drinking. Chi-square tests found two

significant differences between 2011 and 2012 and seven significant differences between 2011 and 2014. Compared to 2011, in 2012 fewer students reported (1) that alcohol allows people to have more fun (X^2=4.071, df=1, $p < .044$) and (2) that alcohol facilitates sexual opportunities (X^2=7.087, df=1, $p < 0.01$). Compared to 2011, in 2014 a lower percentage of students reported that alcohol had the following effects: (1) gives people something to talk about (X^2=13.807, df=1, $p < .0005$); (2) facilitates male bonding (X^2=9.179, df=1, $p < .005$); (3) allows people to have more fun (X^2=10.667, df=1, $p < .005$); (4) gives people something to do (X^2=16.137, df=1, $p < .0005$); (5) makes food taste better (X^2=6.390, df=1, $p < 0.05$); (6) makes women sexier (X^2=22.515, df=1, $p < .0005$); (7) facilitates sexual opportunities (X^2=51.097, df=1, $p < .0005$).

Not surprising for the college age population, the presumed increase in sexual opportunities may be a significant enticement for alcohol consumption (Table 40). Although a limited number of respondents (25% to 35%) reported that alcohol increased sex appeal (e.g. makes women sexier, makes men sexier, makes me sexier), roughly twice as many students (over half) view alcohol as a facilitator of sexual opportunities.

Table 40

Core Student Data: Beliefs Regarding Effects of Alcohol

Effects	**CHCI 2011** ***n*** **(%)**	**CHCI 2012** ***n*** **(%)**	**CHCI 2014** ***n*** **(%)**	**CT 2010-2011** ***n*** **(%)**	**US 2010-2011** ***n*** **(%)**
Breaks the Ice	4,167 (82.6)	3,790 (81.6)	2,155 (81.0)	4,849 (83.2)	69,996 (74.0)
Enhances Social Activity	4,136 (82.1)	3,750 (80.8)	2,138 (80.3)	4,837 (83.0)	69,842 (75.7)
Easier to Deal with Stress	2,395 (47.6)	2,140 (46.3)	1,291 (48.6)	2,769 (47.6)	39,930 (43.3)
Facilitates Connection with Peers	3,535 (70.3)	3,243 (70.1)	1,822 (68.9)	4,122 (70.9)	58,314 (63.3)
Something to Talk About[2]	3.712 (73.8)	3,347 (72.4)	1,844 (69.8)	4,335 (74.5)	64,163 (69.6)
Male Bonding[2]	3,437 (68.3)	3,071 (66.7)	1,694 (64.8)	3,996 (68.7)	56,561 (61.4)
Female Bonding	3,079 (61.3)	2,801 (60.9)	1,589 (60.7)	3,601 (62.1)	48,469 (52.7)
Allows People to Have More Fun[1, 2]	3,610 (71.8)	3,228 (69.9)	1,793 (68.2)	4,200 (72.3)	58,997 (64.1)
Something to Do[2]	3,952 (78.5)	3,575 (77.4)	1,955 (74.5)	4,623 (79.5)	69,048 (74.9)
Food Tastes Better[2]	1,331 (26.5)	1,210 (26.2)	766 (29.2)	1,568 (26.1)	20,053 (21.8)
Makes Women Sexier[2]	1,722 (34.3)	1,500 (32.6)	756 (29.0)	2,024 (34.9)	26,064 (28.3)
Makes Men Sexier	1,261 (25.2)	1,162 (25.2)	614 (23.5)	1,434 (24.8)	17,726 (19.3)
Makes Me Sexier	1,310 (26.2)	1,153 (25.1)	683 (26.2)	1,434 (24.8)	18,216 (19.8)
Facilitates Sexual Opportunities[1, 2]	2,923 (58.4)	2,552 (55.7)	1,288 (49.8)	3,427 (59.2)	43,377 (47.1)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)
[2] Difference between 2011 and 2014 is significant ($p < 0.05$)
* Indicates a significant difference at $p < 0.05$

Faculty and Staff Results

The faculty and staff at the sub-recipient campuses completed the Faculty and Staff Environmental Alcohol and Other Drug Survey in the spring of 2011 (*n*=1,082), 2012 *(n*=609), and 2014 (*n*=1,362). Also included in this report are the Core Faculty and Staff National data to provide national norm comparisons. In keeping with the objectives of the evaluation, analyses for this report focused on differences, if any, between the 2011, 2012, and 2014 samples. The response options for the vast majority of the survey items were either: "yes or no" or "yes, no or don't know." The "yes, no, or don't know" items were mainly items assessing knowledge about university policies and programs; thus, these items were re-coded to combine "no" and "don't know" responses to more readily compare an affirmative response to a non-affirmative response.

Demographics. Table 41 shows similar demographic information for the three samples. About half of the respondents were administrators or professionals and were in a supervisory role. The respondents were well educated with over half having a graduate degree. The majority of the respondents were white, female, married and in their mid-40's. Chi-square tests conducted on the demographic items indicated a significant difference in the gender of respondents from 2011 to 2012 (X^2=6.907, df=1, $p < 0.01$).

Table 41

Core Faculty and Staff Data: Demographics

Faculty and Staff Demographics	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	US 2006-2011 *n* (%)
Highest Education Level				
PhD	322 (30.5)	156 (26.6)	288 (21.6)	2,902 (29.3)
Masters	365 (34.6)	230 (39.2)	558 (41.9)	3,325 (33.6)
Bachelors	245 (23.2)	132 (22.5)	342 (25.7)	2,275 (23.0)
High School Diploma/GED	124 (11.7)	67 (11.4)	145 (10.9)	1,374 (13.9)
Ethnicity				
African American (non-Hispanic)	57 (5.7)	28 (5.0)	61 (4.7)	400 (4.2)
American Indian/Pacific Islander	4 (0.4)	4 (0.7)	3 (0.2)	30 (0.3)
Asian	25 (2.5)	11 (2.0)	28 (2.1)	192 (2.0)
Hispanic	35 (3.5)	17 (3.0)	46 (3.5)	381 (4.0)
White (non-Hispanic)	850 (84.6)	487 (86.5)	1,117 (85.7)	8,196 (86.4)
Other	34 (3.4)	16 (2.8)	49 (3.8)	284 (3.0)
Gender				
Female	651 (61.5)	399 (68.0)	879 (65.8)	6,139 (61.9)
Male	408 (38.5)	188 (32.0)	457 (34.2)	3,776 (38.1)
Employee Status				
Administrator/Professional	535 (50.9)	310 (53.5)	682 (51.6)	3,928 (39.9)
Faculty	388 (36.9)	189 (32.6)	492 (37.2)	4,055 (41.2)

Table 41

Core Faculty and Staff Data: Demographics

Faculty and Staff Demographics	**CHCI 2011** ***n*** **(%)**	**CHCI 2012** ***n*** **(%)**	**CHCI 2014** ***n*** **(%)**	**US 2006-2011** ***n*** **(%)**
Civil Service	20 (1.9)	7 (1.2)	12 (0.9)	521 (5.3)
Teaching Assistant	6 (0.6)	8 (1.4)	6 (0.5)	194 (2.0)
Other	103 (9.8)	65 (11.2)	129 (9.8)	1,138 (11.6)
Supervisory Role				
No	524 (50.6)	299 (51.6)	723 (54.7)	5,208 (50.5)
Yes	512 (49.4)	280 (48.4)	599 (45.3)	4,438 (46.0)
Marital Status				
Single	242 (23.2)	146 (25.4)	303 (23.2)	2,208 (22.7)
Married	706 (67.8)	367 (63.9)	895 (68.5)	6,548 (67.4)
Separated	3 (0.3)	3 (0.5)	10 (0.8)	77(0.7)
Divorced	74 (7.1)	47 (8.2)	83 (6.4)	735(7.6)
Widowed	16 (1.5)	11 (1.9)	16 (1.2)	151(1.5)
Age	Mean=46.47 SD=12.59	Mean=46.12 SD=12.22	Mean=46.86 SD=12.88	Mean=45.41 SD=12.38

Alcohol and Other Drugs Policy. The vast majority of the respondents reported that their institutions have a policy concerning alcohol and other drugs. However, the effectiveness of the policy may be limited since less than two-thirds of the respondents know where to find the policy; only about half had seen or read it, and only about one-third felt the policy was consistently enforced on campus (Table 42). Chi-square tests conducted on items related to alcohol and other drug policies indicated no significant differences between the 2011 and 2012 samples. However, in 2014, significantly more faculty and staff reported knowing where to find a copy of the "alcohol and other drug" policy (X^2=4.233, df=1, $p < 0.05$).

Table 42

Core Faculty and Staff Data: Campus Alcohol Policy

Policy and Prevention Efforts	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	US 2006-2011 *n* (%)
University has alcohol and other drugs policy	954 (88.7)	544 (89.6)	1,177 (86.4)	9,147 (89.3)
Have seen/read policy[2]	508 (47.3)	308 (51.0)	701 (51.5)	5,585 (54.6)
Know where to find copy of policy	666 (62.1)	373 (61.8)	822 (60.5)	6,442 (63.0)
Alcohol and drug policies consistently enforced on campus	362 (33.7)	198 (32.8)	418 (30.8)	3,042 (29.8)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)

[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Concern about Alcohol and Other Drugs Policy. Faculty and staff are aware of difficulties resulting from the use of alcohol and drugs on campus (Table 43). About half of the respondents viewed drugs and alcohol as a problem and about two-thirds of the respondents viewed drugs and alcohol as a concern for educators. Results from these two items are significantly different between 2011 and 2012 (X^2=19.968, df=1, $p < 0.001$; X^2=10.855, df=1, $p < 0.01$) and 2011 to 2014 (X^2=47.939, df= -1, $p < 0.05$; X^2=33.817, df=1, $p < 0.05$) suggesting an improvement in the prevention of alcohol and drug use on campus.

The vast majority of faculty and staff reported that alcohol and drugs have a negative effect on students' academic performance and overall quality of student life. However, only around forty percent of faculty and staff reported that they would like to be involved in alcohol and drug prevention efforts (Table 43).

Table 43

Core Faculty and Staff Data:
Effects of Alcohol on Students' Education and Campus Alcohol Prevention Efforts

Effects of Alcohol and Prevention Efforts	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	US 2006-2011 *n* (%)
Current alcohol and drug use on campus is a problem[1,2]	542 (53.4)	245 (41.8)	512 (39.0)	5,024 (51.4)
Current alcohol and drug use on campus is a concern for educators[1,2]	696 (68.0)	351 (59.9)	733 (56.2)	6,597 (67.1)
Student academic performance is affected by alcohol and drug use	1,011 (95.2)	575 (96.6)	1,285 (95.7)	9,743 (96.3)
Alcohol and other drug use negatively affects overall quality of student life	958 (90.0)	535 (90.4)	1,210 (90.4)	9,105 (90.5)
Would like to be involved in alcohol and drug prevention efforts	438 (41.4)	260 (43.6)	603 (44.8)	4,094 (40.8)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)

[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Respondents consistently reported that their institutions were concerned about preventing alcohol and drug abuse and that campuses should be involved in these efforts. The data suggest that universities have taken action to reduce alcohol and drug use by providing prevention programs for students (Table 44). Chi-square tests conducted on these items indicate a significant difference between the 2011 sample and the 2012 and 2014 samples for the item "Does this university have an alcohol or other drug prevention program for students?" with a significantly lower percentage of faculty and staff reporting "yes" in 2012 and 2014 compared to 2011.

Table 44

Core Faculty and Staff Data:
Effects of Alcohol on Students' Education and Campus Alcohol Prevention Efforts

Effects of Alcohol and Prevention Efforts	**CHCI 2011** ***n*** **(%)**	**CHCI 2012** ***n*** **(%)**	**CHCI 2014** ***n*** **(%)**	**US 2006-2011** ***n*** **(%)**
University is concerned about preventing alcohol and drug abuse	957 (89.0)	532 (88.1)	1,185 (87.3)	8,790 (85.9)
Institutions of higher education should be involved in alcohol and drug prevention efforts	1,032 (96.6)	581 (96.7)	1,295 (96.1)	9,621 (94.9)
University has alcohol or drug prevention program for students[1,2]	726 (67.6)	376 (62.3)	854 (63.2)	6,216 (60.8)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)
[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Professional Development. When examining issues related to professional development, the majority of faculty and staff reported that they knew the signs of problem alcohol and drug use and how to refer students or colleagues who may have alcohol or drug problems (Table 45). Further professional development on this topic is warranted since the respondents reported that they needed more information on identifying problem alcohol and drug use among students and would be willing to attend a workshop on prevention. Other indicators of professional development needs are that less than one-third of the respondents reported that their campus provided training on alcohol and drug related problems to staff and faculty and few had attended training on this topic on campus. Chi-square tests conducted on these items indicated no significant differences between the 2011 and 2012 samples. However, one item, "Would you attend a workshop dealing with alcohol and other drug prevention/education efforts?" was answered affirmatively by a significantly higher percentage of faculty and staff in 2014 compared to 2011.

Table 45

Core Faculty and Staff Data: Campus Alcohol Prevention Professional Development and Information

Professional Development and Information	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	US 2006-2011 *n* (%)
Training programs are provided for staff and faculty to identify students and colleagues with alcohol and drug problems	309 (30.7)	153 (26.5)	415 (31.6)	2,766 (28.4)
Attended alcohol and other drug abuse program on campus	226 (21.1)	119 (19.8)	252 (18.6)	1,546 (15.0)
Need more information on identifying problem alcohol and drug use among students	743 (70.6)	426 (71.4)	997 (73.6)	6,941 (69.6)
Would attend a workshop dealing with alcohol and drug prevention/ education efforts[2]	729 (68.8)	415 (69.7)	987 (73.2)	6,516 (64.7)
Know signs of problem alcohol and drug use	708 (67.1)	416 (70.2)	916 (68.3)	6,492 (65.0)
Know how to refer student or colleague with alcohol or drug problem	833 (77.6)	448 (74.3)	1,019 (75.1)	7,279 (71.4)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)
[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Awareness and Intervention. About half of the faculty and staff reported that they were personally aware of a student whose academic performance had been affected by alcohol and drug use and about one-third had provided information about alcohol or drugs to students. Nearly all of the respondents reported that they would refer students to services for suspected alcohol or drug problems (Table 46). Chi-square tests conducted on these items indicate no significant differences between the 2011 and 2012 samples. One item, "If you knew how to refer students to appropriate services for suspected alcohol and other drug problems, would you refer them to such services?" was answered affirmatively by a significantly lower percentage of faculty and staff in 2014 compared to 2011.

Table 46

Core Faculty and Staff Data: Awareness and Intervention of Student Alcohol Use

Awareness and Intervention	CHCI 2011 *n* (%)	CHCI 2012 *n* (%)	CHCI 2014 *n* (%)	US 2006-2011 *n* (%)
Personally aware of a student(s) whose academic performance was affected by alcohol and drug use	542 (50.8)	308 (51.4)	652 (48.1)	5,647 (54.8)
Provided information concerning alcohol and other drugs to students	402 (37.4)	215 (35.5)	450 (33.1)	3,531 (34.5)
Would refer students to services for suspected alcohol and drug problems[2]	1,014 (95.8)	576 (96.5)	1,258 (94.3)	9,394 (94.5)

[1] Difference between 2011 and 2012 is significant ($p < 0.05$)
[2] Difference between 2011 and 2014 is significant ($p < 0.05$)

Summary and Conclusion

The evaluation findings indicate that CHCI met its program objectives.

The findings related to Objective One demonstrate that CHCI provided a CHCI Leadership Summit, twenty-nine business and professional development monthly meetings and four intervention trainings (e.g. BASICS training). Respondents were satisfied with the programs the Coalition offered. CHCI Coalition membership has grown considerably since the initiation of the program: from 106 members in 2011 to 168 members in 2014 (an increase of approximately 58 percent). Subcommittees established under the grant contributed to the enhancement of CHCI.

The scanning exercises of the College Alcohol Risk Assessment Guide were completed by all sub-recipient campuses to address Objective Two. In response to Scanning Exercise A-1: A Quick Profile of Risks for Alcohol Problems, Campus Life items focused on the visibility and level of opportunities for socializing which may provide positive alternatives to alcohol consumption. A comparison of the 2010 and 2012 Campus Life items indicated an increase in mean scores for each activity except for Health Promotion Activities (e.g. visibility of smoke-outs, AIDS awareness week) (Table 15). Related-Samples Wilcoxon Signed Rank Tests were performed to determine whether the average number of persons in each category differed significantly ($p < 0.05$) by year. A significant increase in mean scores between 2010 and 2012 was found for Nearby Campus-Oriented Commercial Services (e.g. bars, restaurants) ($p < 0.05$) and Athletic Activity (e.g. inter/intramural sports, sports facilities) ($p < 0.05$). Items included in Alcohol Issues focused on ways a campus may address alcohol problems. The mean scores for all of the items remained the same or increased from 2010 to 2012 (Table 16). Related-Samples Wilcoxon Signed Rank Tests were performed to determine whether the average number of activities in each category differed significantly ($p < 0.05$) by year. Significant increases in mean scores were found for Support for Alcohol Policies ($p < 0.05$), and Enforcement for Alcohol Policies ($p < 0.05$). A significant increase was also found for Visibility of Alcohol

Use indicating an increase in drinking in public places on campus, greater acceptance of visible intoxication, party promotions, etc. ($p < 0.05$).

Scanning Exercise A-2: Looking Around Your Campus and Community focuses on the extent to which alcohol availability and visual messages regarding alcohol use were present on and near campus. Respondents were asked to indicate whether alcohol was sold on campus, ways in which radio and print media promote alcohol consumption, and types of messages endorsing alcohol consumption in student neighborhoods. Some variations (both increases and decreases) in the responses occurred between 2010 and 2012. Related-Samples Wilcoxon Signed Rank Tests were performed to determine whether there were significant differences by year. The tests indicated no significant differences ($p < 0.05$).

Scanning Exercise A-3: In the Having Conversations section, respondents were asked to list individuals who were potential allies and sources of information regarding student alcohol use and prevention. On average, respondents reported that they had the most colleagues in Campus Life and Activities with whom they could have a conversation and had the fewest colleagues in Academics (Table 25). Related-Samples Wilcoxon Signed Rank Tests were performed to test whether the changes differed significantly by year. Results determined that none were significant at the $p < 0.05$ alpha level.

To measure Objective Three, the sub-recipients administered the Core Alcohol and Drug Survey to students and the Faculty and Staff Environmental Alcohol and Other Drug Survey to faculty and staff. The student data indicated that college students drink frequently and to excess. In addition, their drinking appears to increase once they become of legal drinking age. They drink at both off-campus (e.g. private parties, private residences, bars and restaurants) and on-campus locations (e.g. residence halls and on-campus events). The data illustrate significant decreases from 2011 to 2014 in past 30-day alcohol use, average number of drinks per week, and consuming five or more drinks at a sitting. Although students recognize that alcohol and drug use leads to many negative consequences (hangover, vomiting, memory loss, etc.), their drinking patterns are due primarily to an increase in the sociability that alcohol is perceived to provide.

Faculty and staff are aware of difficulties resulting from the use of alcohol and drugs on campus. About half of the respondents viewed drugs and alcohol as a problem and about two-thirds of the respondents viewed drugs and alcohol as a concern for educators. Results from these two items show a significant decrease between 2011 and 2012 (X^2=19.968, df=1, $p < 0.001$; X^2=10.855, df=1, $p < 0.01$) and 2011 to 2014 (X^2=47.939, df=1, $p < 0.05$; X^2=33.817, df=1, $p < 0.05$) suggesting an improvement in the prevention of alcohol and drug use on campus. Faculty and staff reported that they knew the signs of problem alcohol and drug use and how to refer students or colleagues who may have a problem with alcohol or drugs. Further professional development on this topic is warranted since the respondents reported that they needed more information on identifying problem alcohol and drug use among students and would be willing to attend a workshop on prevention. Other indicators of professional development needs are that less than one-third of the respondents reported that their campus provided training on alcohol and drug related problems to staff and faculty and few had attended training on this topic on campus.

Strengths and Limitations:
A number of strengths and limitations need to be acknowledged regarding the results presented in this report. The Core survey, which is administered to students anonymously each year, was used to evaluate the CHCI interventions. Anonymity is both a strength and limitation. On the one hand, it is a strength in that it provides students with assurance that any responses regarding sensitive topics such as drug and alcohol use will not lead to any sanctions, and thus, increases the likelihood of candid reporting. On the other hand, anonymity is a limitation in that the longitudinal results are not "within-person" and thus cannot be interpreted as change, only difference over time. Additional caution is warranted by the demographic differences between the 2011 and 2014 samples.
Thus, whereas the current results regarding the impact of the CHCI interventions are generally encouraging, further research would be necessary to determine whether the reported differences truly reflect changes over time in reported indices.

References

Centers for Disease Control and Prevention. Alcohol and Public Health. (http://www.cdc.gov/alcohol/faqs.htm#moderateDrinking).

Muraskin, L.D. (1993). Understanding Evaluation: The Way to Better Prevention Programs. U. S. Department of Education. Washington, DC

National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism. What is a standard drink? (http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/standard-drink).

U.S. Department of Education. (2009). Office of Safe and Drug-Free Schools, Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention, College Alcohol Assessment Guide: Environmental Approaches to Prevention, Washington, D.C.

Appendix A: Professional Development Tables

Table A-1

Professional Development Satisfaction Survey Results, November 2010
Environmental Strategies (n=13)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.15	0.69
The content was relevant to my work on underage drinking prevention.	4.54	0.52
This opportunity has helped me connect with other underage drinking prevention professional.	4.38	0.65
I will share the knowledge that I have learned with others.	4.62	0.51
Was well organized.	4.54	0.52
Used teaching methods that were effective.	4.62	0.51
Used an interactive style to engage participants.	4.77	0.44
Demonstrated mastery of topic.	4.92	0.28
Respected differences of opinion.	4.62	0.65
Demonstrated cultural sensitivity.	4.08	0.95

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-2

Professional Development Satisfaction Survey Results, January 2011
Social Marketing and Social Media (n=16)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	3.75	0.93
The content was relevant to my work on underage drinking prevention.	4.25	0.68
This opportunity has helped me connect with other underage drinking prevention professional.	4.25	0.77
I will share the knowledge that I have learned with others.	4.25	0.45
Was well organized.	4.56	0.51
Used teaching methods that were effective.	4.38	0.81
Used an interactive style to engage participants.	4.50	0.63
Demonstrated mastery of topic.	4.56	0.63
Respected differences of opinion.	4.44	0.73
Demonstrated cultural sensitivity.	4.13	0.83

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-3

Professional Development Satisfaction Survey Results, March 2011
Red Watch Band (n=18)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.50	0.51
The content was relevant to my work on underage drinking prevention.	4.82	0.39
This opportunity has helped me connect with other underage drinking prevention professional.	4.56	0.62
I will share the knowledge that I have learned with others.	4.78	0.43
Was well organized.	4.83	0.38
Used teaching methods that were effective.	4.72	0.75
Used an interactive style to engage participants.	4.78	0.43
Demonstrated mastery of topic.	4.89	0.32
Respected differences of opinion.	4.89	0.32
Demonstrated cultural sensitivity.	4.67	0.69

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-4

Professional Development Satisfaction Survey Results, May 2011
Medical Amnesty and Good Samaritan Laws (n=15)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.60	0.51
The content was relevant to my work on underage drinking prevention.	4.47	0.64
This opportunity has helped me connect with other underage drinking prevention professionals.	4.60	0.51
I will share the knowledge that I have learned with others.	4.73	0.46
Was well organized.	4.87	0.35
Used teaching methods that were effective.	4.73	0.46
Used an interactive style to engage participants.	4.73	0.59
Demonstrated mastery of the topic.	4.87	0.35
Respected differences of opinion.	4.87	0.35
Demonstrated cultural sensitivity.	4.87	0.35

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-5

Professional Development Satisfaction Survey Results, September 2011
The Life Aligned: Reducing Stress, Making Better Choices, and Achieving our Goals from the Inside-Out
Total respondents (n=18) Total attendees (n=30)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	3.47	0.80
The content was relevant to my work on underage drinking prevention.	3.82	0.73
This opportunity has helped me connect with other underage drinking prevention professionals.	3.82	0.81
I will share the knowledge that I have learned with others.	4.47	0.62
Was well organized.	4.72	0.46
Used teaching methods that were effective.	4.56	0.51
Used an interactive style to engage participants.	4.50	0.51
Demonstrated mastery of the topic.	4.72	0.46
Respected differences of opinion.	4.67	0.49
Demonstrated cultural sensitivity.	4.61	0.50

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-6

Professional Development Satisfaction Survey Results, November 2011
Curriculum Infusion, (n=11)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.64	0.50
The content was relevant to my work on underage drinking prevention.	4.82	0.40
This opportunity has helped me connect with other underage drinking prevention professionals.	4.64	0.50
I will share the knowledge that I have learned with others.	4.82	0.40
Was well organized	4.91	0.30
Used teaching methods that were effective.	4.73	0.47
Used an interactive style to engage participants.	4.82	0.40
Demonstrated mastery of the topic.	4.91	0.30
Respected differences of opinion.	4.73	0.47
Demonstrated cultural sensitivity.	4.73	0.65

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-7

Professional Development Satisfaction Survey Results, January 2012
Student Recovery Supports on Campus, (n=8)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.50	1.07
The content was relevant to my work on underage drinking prevention.	4.50	0.76
This opportunity has helped me connect with other underage drinking prevention professionals.	4.75	0.46
I will share the knowledge that I have learned with others.	5.00	N/A
Was well organized.	4.62	0.74
Used teaching methods that were effective.	4.62	0.74
Used an interactive style to engage participants.	4.88	0.35
Demonstrated mastery of the topic.	4.88	0.35
Respected differences of opinion.	4.75	0.46
Demonstrated cultural sensitivity.	5.00	N/A

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-8

Professional Development Satisfaction Survey Results, March 2012
Peer Education: Empowering Student-Leaders to Promote Health and Safety (n=15)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	3.93	1.39
The content was relevant to my work on underage drinking prevention.	4.53	1.06
This opportunity has helped me connect with other underage drinking prevention professionals.	4.67	0.49
I will share the knowledge that I have learned with others.	4.53	0.52
Was well organized.	5.00	0.00
Used teaching methods that were effective.	4.80	0.41
Used an interactive style to engage participants.	4.87	0.35
Demonstrated mastery of the topic.	4.93	0.26
Respected differences of opinion.	4.87	0.35
Demonstrated cultural sensitivity.	4.53	0.74

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-9

Professional Development Satisfaction Survey Results, April 2012
Connecticut Liquor Laws, (n=8)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.50	0.76
The content was relevant to my work on underage drinking prevention.	4.50	0.53
This opportunity has helped me connect with other underage drinking prevention professionals.	4.12	0.83
I will share the knowledge that I have learned with others.	4.38	0.92
Was well organized.	4.62	0.52
Used teaching methods that were effective.	4.25	1.04
Used an interactive style to engage participants.	4.12	1.13
Demonstrated mastery of the topic.	4.75	0.46
Respected differences of opinion.	4.14	0.90
Demonstrated cultural sensitivity.	4.14	0.90

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-10

Professional Development Satisfaction Survey Results, April 2012
Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment, Treatment Improvement Protocol (TIP 50) (n=19)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.16	0.76
The content was relevant to my work on underage drinking prevention.	4.16	0.69
This opportunity has helped me connect with other underage drinking prevention professionals.	4.05	0.78
I will share the knowledge that I have learned with others.	4.47	0.70
Was well organized.	4.39	0.50
Used teaching methods that were effective.	4.22	0.81
Used an interactive style to engage participants.	3.41	1.00
Demonstrated mastery of the topic.	4.41	0.71
Respected differences of opinion.	3.89	0.90
Demonstrated cultural sensitivity.	4.00	0.84

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-11

Professional Development Satisfaction Survey Results, May 2012
How to Increase Administrator Support for Campus Prevention Efforts: Round Table Discussion (n=9)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	3.89	0.78
The content was relevant to my work on underage drinking prevention.	4.33	0.71
This opportunity has helped me connect with other underage drinking prevention professionals.	4.44	0.73
I will share the knowledge that I have learned with others.	4.44	0.73
Was well organized.	4.56	0.53
Used teaching methods that were effective.	4.22	0.67
Used an interactive style to engage participants.	4.78	0.44
Demonstrated mastery of the topic.	4.67	0.50
Respected differences of opinion.	4.56	0.73
Demonstrated cultural sensitivity.	4.33	0.87

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-12

Tip 50 Professional Development, April 2012 (n=19)

Question	Mean	SD
The presented information broadened my understanding of mental health promotion and suicide prevention.	4.16	0.76
The content was relevant to my work on mental health promotion and suicide prevention.	4.16	0.69
This opportunity has helped me connect with other mental health promotion and suicide prevention professionals.	4.05	0.78
I will share the knowledge that I have learned with others.	4.47	0.70
The presentation was well organized.	4.39	0.50
The presentation included teaching methods that were effective.	4.22	0.81
The presentation included an interactive style to engage participants.	3.41	1.00
Mastery of the topic was demonstrated in the presentation.	4.41	0.71
Differences of opinion was respected throughout the presentation	3.89	0.90
The presentation was culturally sensitive.	4.00	0.84

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-13

Connecticut Liquor Laws, April, 2012 (n=8)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.50	0.76
The content was relevant to my work on underage drinking prevention.	4.50	0.53
This opportunity has helped me connect with other underage drinking prevention professionals.	4.12	0.83
I will share the knowledge that I have learned with others.	4.38	0.92
Was well organized.	4.62	0.52
Used teaching methods that were effective.	4.25	1.04
Used an interactive style to engage participants.	4.12	1.13
Demonstrated mastery of the topic.	4.75	0.46
Respected differences of opinion.	4.14	0.90
Demonstrated cultural sensitivity.	4.14	0.90

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-14

How to Increase Administrator Support for Campus Prevention Efforts: Round Table Discussion, May, 2012 (n=9)

Question	Mean	SD
The presented information broadened my understanding about mental health promotion and suicide prevention.	3.89	0.78
The content was relevant to my work on mental health promotion and suicide prevention.	4.33	0.71
This opportunity has helped me connect with other mental health promotion and suicide prevention professionals.	4.44	0.73
I will share the knowledge that I have learned with others.	4.44	0.73
Was well organized.	4.56	0.53
Used teaching methods that were effective.	4.22	0.67
Used an interactive style to engage participants.	4.78	0.44
Demonstrated mastery of the topic.	4.67	0.50
Respected differences of opinion.	4.56	0.73
Demonstrated cultural sensitivity.	4.33	0.87

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-15

Addressing Cultural Competence for Collegiate Professionals, September, 2012 (n=14)

Question	Mean	SD
The presented information broadened my understanding about multiculturalism.	3.50	1.22
The content was relevant to my work.	3.93	0.92
This opportunity has helped me connect with other prevention professionals.	3.71	0.99
I will share the knowledge that I have learned with others.	3.29	0.99
The speaker was well organized.	3.79	1.05
The speaker used teaching methods that were effective.	3.64	1.08
The speaker used an interactive style to engage participants.	3.64	1.01
The speaker demonstrated mastery of the topic.	3.86	1.17
The speaker respected differences of opinion.	4.00	1.04
The speaker demonstrated cultural sensitivity.	3.79	1.31

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-16

Active Duty and Veteran College Students' Substance Abuse and Mental Health, November, 2012 (n=10)

Question	Mean	SD
The presented information broadened my understanding of mental health or prevention.	4.70	0.48
The content was relevant to my work in mental health or prevention.	4.60	0.52
This opportunity has helped me connect with other mental health or prevention professionals.	4.80	0.42
I will share the knowledge that I have learned with others.	4.80	0.42
The presentation was well organized.	4.80	0.42
The presentation included teaching methods that were effective.	4.80	0.42
The presentation included an interactive style to engage participants.	4.60	0.52
Mastery of the topic was demonstrated in the presentation.	5.00	0.00
Differences of opinion were respected throughout the presentation.	4.50	0.71
The presentation was culturally sensitive.	4.90	0.32

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-17

Online Screening Programs, December, 2012 (n=13)

Question	Mean	SD
The presented information broadened my understanding of mental health or prevention.	4.46	0.52
The content was relevant to my work in mental health or prevention.	4.54	0.52
This opportunity has helped me connect with other mental health or prevention professionals.	4.62	0.51
I will share the knowledge that I have learned with others.	4.67	0.49
The presentation was well organized.	4.77	0.44
The presentation included teaching methods that were effective.	4.62	0.51
The presentation included an interactive style to engage participants.	4.69	0.48
Mastery of the topic was demonstrated in the presentation.	4.69	0.48
Differences of opinion were respected throughout the presentation.	4.69	0.48
The presentation was culturally sensitive.	4.38	0.65

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-18

LGBTQI Culture, April, 2013 (n=16)

Question	Mean	SD
The presented information broadened my understanding of mental health or suicide prevention.	4.69	0.48
The content was relevant to my work in mental health or suicide prevention.	4.62	0.62
This opportunity has helped me connect with other mental health or prevention professionals.	4.69	0.48
I will share knowledge that I have learned with others.	4.81	0.40
The presentation was well organized.	4.94	0.25
The presentation included teaching methods that were effective.	4.75	0.58
The presentation included an interactive style to engage participants.	4.88	0.34
Mastery of the topic was demonstrated in the presentation.	4.94	0.25
Differences of opinion were respected throughout the presentation.	4.81	0.40
The presentation was culturally sensitive.	4.94	0.25
The panel gave me a better understanding of LGBTQI campus programs.	4.81	0.40

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-19

Developing a Comprehensive Campus Approach to Prevention: The Jed Foundation, May 2013 (n=30)

Question	Mean	SD
The presented information broadened my understanding of mental health or suicide prevention.	4.36	0.56
The content was relevant to my work in mental health or suicide prevention.	4.46	0.58
This opportunity has helped me connect with other mental health or prevention professionals.	4.64	0.56
I will share knowledge that I have learned with others.	4.68	0.48
The presentation was well organized.	4.62	0.49
The presentation included teaching methods that were effective.	4.41	0.63
The presentation included an interactive style to engage participants.	4.41	0.57
Mastery of the topic was demonstrated in the presentation.	4.52	0.57
Differences of opinion were respected throughout the presentation.	4.24	0.74
The presentation was culturally sensitive.	3.93	0.75

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-20

Professional Development Satisfaction Survey Results September 13, 2013
Latin@Culture (n=29)

Question	Mean	SD
The presented information broadened my understanding of mental health or suicide prevention.	4.66	0.48
The content was relevant to my work in mental health or suicide prevention.	4.59	0.57
This opportunity has helped me connect with other mental health or prevention professionals.	4.28	0.70
I will share knowledge that I have learned with others.	4.69	0.47
The presentation was well organized.	4.62	0.56
The presentation included teaching methods that were effective.	4.62	0.62
The presentation included an interactive style to engage participants.	4.69	0.60
Mastery of the topic was demonstrated in the presentation.	4.93	0.26
Differences of opinion were respected throughout the presentation.	4.68	0.35
The presentation was culturally sensitive.	4.93	0.26

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-21

Professional Development Satisfaction Survey Results October 11, 2013
The Value of Evaluation (n=18)

Question	Mean	SD
The presented information broadened my understanding of mental health or suicide prevention.	3.94	0.64
The content was relevant to my work in mental health or suicide prevention.	4.28	0.75
This opportunity has helped me connect with other mental health or prevention professionals.	4.39	0.61
I will share knowledge that I have learned with others.	4.11	0.76
The presentation was well organized.	4.61	0.50
The presentation included teaching methods that were effective.	4.39	0.61
The presentation included an interactive style to engage participants.	4.61	0.50
Mastery of the topic was demonstrated in the presentation.	4.56	0.62
Differences of opinion were respected throughout the presentation.	4.50	0.71
The presentation was culturally sensitive.	4.12	0.86

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-22

Professional Development Satisfaction Survey Results November 8, 2013
A Taste of Motivational Interviewing (n=18)

Question	Mean	SD
The presented information broadened my understanding of mental health or suicide prevention.	4.67	0.49
The content was relevant to my work in mental health or suicide prevention.	4.82	0.39
This opportunity has helped me connect with other mental health or prevention professionals.	4.78	0.43
I will share knowledge that I have learned with others.	4.53	0.72
The presentation included teaching methods that were effective.	4.89	0.47
The presentation included an interactive style to engage participants.	4.94	0.24
Mastery of the topic was demonstrated in the presentation.	4.89	0.32
Differences of opinion were respected throughout the presentation.	4.65	0.61
The presentation was culturally sensitive.	4.28	0.96

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-23

Professional Development Satisfaction Survey Results
Emergence of Mental Health Disorders (n=37)

Question	Mean	SD
The presented information broadened my understanding of mental health or [suicide] prevention.	4.59	0.60
The content was relevant to my work in mental health or prevention.	4.65	0.54
This opportunity has helped me connect with other mental health or prevention professionals.	4.61	0.60
I will share knowledge that I have learned with others.	4.66	0.59
The presentation was well organized.	4.38	0.68
The presentation included teaching methods that were effective.	4.22	0.79
The presentation included an interactive style to engage participants.	4.46	0.65
Mastery of the topic was demonstrated in the presentation.	4.59	0.64
Differences of opinion were respected throughout the presentation.	4.59	0.55
The presentation was culturally sensitive.	4.32	0.75

Range: 1 (strongly disagree) to 5 (strongly agree)

Table A-24

Professional Development Satisfaction Survey Results March 14, 2014
Keep the Problem Out of Gambling (n=14)

Question	Mean	SD
The presented information broadened my understanding of mental health or suicide prevention.	4.64	0.63
The content was relevant to my work in mental health or suicide prevention.	4.71	0.47
This opportunity has helped me connect with other mental health or prevention professionals.	4.64	0.63
I will share knowledge that I have learned with others.	5.00	0.00
The presentation was well organized.	4.79	0.43
The presentation included teaching methods that were effective.	4.50	0.76
The presentation included an interactive style to engage participants.	4.71	0.47
Mastery of the topic was demonstrated in the presentation.	4.86	0.36
Differences of opinion were respected throughout the presentation.	4.64	0.74
The presentation was culturally sensitive.	4.29	0.83

Range: 1 (strongly disagree) to 5 (strongly agree)

Appendix B.

Campus-Community Key Leadership Summit Evaluation

CONNECTICUT HEALTHY CAMPUS INITIATIVE

How helpful was the Campus-Community Key Leadership Summit?

___ Very helpful ___ Helpful ___ Somewhat helpful ___ Not helpful

Would you like more information about the Connecticut Healthy Campus Initiative?

___ Yes ___ No If yes, please include your name (or your designee's name) and email address below

What topics would your institution benefit from in the future?

_____ Evidence-based/environmental prevention strategies including the 3-In-1 Framework

_____ Effectively utilizing the internet and social media for underage drinking prevention

_____ Strategies for sustaining effective campus-community coalitions

_____ Evaluation of campus prevention initiatives

_____ Effective student engagement strategies

_____ Drug-Free Schools and Communities Act (DFSCA) Biennial Review and other federal mandates

_____ Implementation of recovery supports on college campuses

_____ Problem gambling among college students

_____ Suicide prevention on college campuses

Other topics: _____

(OPTIONAL)

Name : _____ **Email:** _____

Connecticut Healthy Campus Initiative
Feedback Survey I

Please help us improve Connecticut Healthy Campus Initiative (CHCI) by answering some questions. Please indicate your responses by filling in one circle for each question below.

Thank you for your participation

As an AOD professional working with an institution of higher education I currently:

Response Definition: SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly Agree

	SD	D	N	A	SA
1. attend AOD professional development events.	○	○	○	○	○
2. attend AOD networking events with other campuses and community organizations.	○	○	○	○	○
3. have access to technology that facilitates networking: website, email listserve, newsletter.	○	○	○	○	○
4. have access to technical assistance for social norms marketing.	○	○	○	○	○
5. know experts in the field of AOD prevention from whom I can seek advice.	○	○	○	○	○
6. have colleagues in the field of AOD prevention from whom I can seek advice.	○	○	○	○	○
7. know ways to implement science-based AOD prevention and intervention initiatives.	○	○	○	○	○
8. know effective ways to foster a campus-community culture that reduces high-risk alcohol and other drug use.	○	○	○	○	○
9. have access to information sharing and action planning networks for statewide issues related to high risk AOD.	○	○	○	○	○
10. engage in efforts to prevent high risk AOD use.	○	○	○	○	○
11. contribute to and receive results from a statewide data collection that monitors student health, gaps in services, etc.	○	○	○	○	○
12. advocate for state policy change regarding prevention of high risk AOD use among college students.	○	○	○	○	○

GENERAL QUESTIONS

13. What do you need most from Connecticut Healthy Campus Initiative?

14. What specific suggestions do you have for improving Connecticut Healthy Campus Initiative?

15. Please write any further comments about Connecticut Healthy Campus Initiative.

Name: (optional)

Title/ Department/ Organization:

Connecticut Healthy Campus Initiative
Professional Development Evaluation

Training instructor: Date:

We would like to know what you think about this professional development topic. Your feedback is crucial for assessing the quality of CHCI. Please indicate your responses by filling in one circle for each question below. Please keep your writing within the lines of the comment boxes.

TOPIC RATING

Response Definition: SD=Strongly Disagree D=Disagree N=Neutral A=Agree SA=Strongly Agree

	SD	D	N	A	SA
1. The presented information broadened my understanding about underage drinking prevention.	○	○	○	○	○
2. The content was relevant to my work on underage drinking prevention.	○	○	○	○	○
3. This opportunity has helped me connect with other underage drinking prevention professionals.	○	○	○	○	○
4. I will share the knowledge that I have learned with others.	○	○	○	○	○

SPEAKER RATING

The Speaker(s):

	SD	D	N	A	SA
5. Was well organized.	○	○	○	○	○
6. Used teaching methods that were effective.	○	○	○	○	○
7. Used an interactive style to engage participants.	○	○	○	○	○
8. Demonstrated mastery of the topic.	○	○	○	○	○
9. Respected differences of opinion.	○	○	○	○	○
10. Demonstrated cultural sensitivity.	○	○	○	○	○

GENERAL QUESTIONS

11. What specific information was of greatest value to you?

12. How are you going to utilize the topic information to enhance the work for your campus-community coalition?

13. Please write any additional comments in the box below.

Name: (optional)

Title/ Department/ Organization:

SCANNING EXERCISE A-1: A Quick Profile of Risks for Alcohol Problems

WHAT is your campus like? Colleges and universities have different cultures and risk factors for alcohol problems. Do certain areas quickly come to mind when you think about the role of alcohol in problems at your school? Are there factors that are specific to your campus that make the risk for problems higher or lower?

USE this exercise to record your impressions of your campus to highlight environmental factors that may be contributing to alcohol use and adverse consequences. Take a moment to contemplate the state of your campus and note your impressions on this form. Use the scale from low to high to rate your impressions of the visibility, influence, or awareness of the following activities and issues on your campus. Share your impressions with a group of others concerned with campus health and well being. Sit around a table to talk about your campus environment and the things you think can be changed to reduce risks for problems.

WHEN should you use this excercise? Scanning to identify risks can help: • new prevention coordinators get started • organize or reinvigorate campus committees • involve students and faculty by gaining academic (extra) credit as part of discipline-specific course work • annual cycles of campus review.

CAMPUS LIFE

What are your impressions of the visibility and level of opportunities for socializing on your campus? The lack of on-campus social and recreational activities may be an environmental risk factor for isolated campuses but less important for urban institutions.	PLACE AN **X** TO INDICATE YOUR INITIAL IMPRESSION OF THE VISIBILITY OF EACH LOW	MODERATE		HIGH
On-campus social activities (e.g., dances, social hours, concerts, movies, things to do)	○	○	○	○
Nearby campus-oriented commercial services (e.g., restaurants, bars, coffee houses, shops, theaters)	○	○	○	○
Athletic activity (e.g., inter- and intramural sports, sports facilities, opportunities for exercising)	○	○	○	○
Special events (e.g., Winterfest, Halloween, Spring festivals, fairs)	○	○	○	○
Greek life is an indicator of high-risk drinking practices. How active are fraternities and sororities (e.g., Rush Week, Greek-sponsored parties and events)?	○	○	○	○
Alumni activity: Alumni often influence the campus culture, through contributions and involvement in campus life (e.g., Homecoming, alumni parties).	○	○	○	○
Health and counseling services: How visible are campus health services?	○	○	○	○
Health promotion activities: How visible are activities such as smoke-outs and alcohol or AIDS awareness weeks?	○	○	○	○
Alcohol and other drug prevention responsibilities: Level of awareness of persons whose job descriptions include these responsibilities.	○	○	○	○

ALCOHOL ISSUES

What level of visibility do alcohol problems and issues command on your campus?	LOW	MODERATE		HIGH
Awareness of alcohol policies: Do people know what your campus policies are?	○	○	○	○
Support for alcohol policies: Do people support campus policies?	○	○	○	○
Enforcement of alcohol policies: Do people believe they will suffer consequences if they violate campus policies? Do they think policies are consistently enforced?	○	○	○	○
Communicating alcohol policies: How easy is it to learn your campus policies (e.g., in orientation materials, residential life information, etc.)?	○	○	○	○
Influence of alcohol task force: If you have a campus task force, how influential is it? Is it a force on campus?	○	○	○	○
Perceptions that alcohol contributes to problems: Do people think alcohol use contributes to problems on your campus?	○	○	○	○
Visibility of alcohol use: Do people drink in public places on campus? Is visible intoxication accepted on the part of faculty, staff, or students? Are there environmental indicators of drinking (e.g., party promotions, alcohol litter)?	○	○	○	○

Other impressions: _____

_____

SCANNING EXERCISE A-2: Looking Around Your Campus and Community

WHAT does your campus and surrounding community look like? An easy way to gauge issues surrounding alcohol use at your school is to look around to find indicators regarding alcohol use.

USE this exercise to help you develop a picture of your campus environment regarding alcohol use and problems. Take time to walk around campus and neighboring areas to look for environmental indicators of alcohol use. Carry a camera and take photographs. The environment may vary by time of day, day of the week, or around special times like Spring Break. Changes can be instructive, so vary the times you scan your campus. Jot down what you see so you can share your impressions with others. Note the date:_____ and time:_____ you scanned your campus.

ALCOHOL AVAILABILITY AND PROMOTION

How is alcohol promoted and made available to campus members?	YES	NO	N/A
Do bulletin boards sport party notices, banners, or posters advertising or promoting alcohol-related activities?	○	○	○
Are they for on-campus events?	○	○	○
Off-campus events?	○	○	○
Are they from commercial alcohol outlets such as bars, taverns, restaurants, liquor stores, or grocery stores?	○	○	○
Do people distribute handouts for parties or other social events?	○	○	○
If so, do the messages focus on alcohol consumption rather than the event itself?	○	○	○
Are high-risk activities part of the message?	○	○	○
Do most of the postings appear to be alcohol-related?	○	○	○
Is alcohol sold on campus?	○	○	○
If so, do on-campus alcohol outlets promote or advertise alcohol sales?	○	○	○
Are there alcohol outlets near campus or in neighborhood with large concentrations of student residents?	○	○	○
If so, do they target the campus through advertisements and promotions?	○	○	○

Other impressions: _____

_____

MEDIA ENVIRONMENT

Pick up an assortment of papers and periodicals distributed on campus, including official and underground publications. Glance through them to find out how alcohol is covered. (See also *Appendix C-2, C-3, C-4.*)	YES	NO	N/A
Do they advertise or promote alcohol-related activities?	○	○	○
If so, are they for on-campus events?	○	○	○
If so, are they for off-campus events?	○	○	○
Do the messages focus on alcohol consumption rather than the event itself?	○	○	○
Are high-risk activities part of the message?	○	○	○
Does the editorial content of the publication address alcohol use and/or adverse consequences?	○	○	○
Are there advertisements for alcoholic beverages or alcohol-related activities on the campus radio station?	○	○	○
Do messages focus on alcohol consumption or high-risk drinking?	○	○	○
Do community radio stations target your campus?	○	○	○
If so, do they advertise alcoholic beverages or alcohol-related activities?	○	○	○
Does the campus media include health promotion messages?	○	○	○

Other impressions: _____

_____

WHAT'S ON THE WALLS?

Walk the residence halls to get a feel for student living environments; Glance in open doors to student rooms to see how they are decorated.

	YES	NO	N/A
Do posters, banners, and flyers decorate the walls and ceilings, including common areas and doors to student rooms?	○	○	○
Are they alcohol-related (e.g., party promotions, beer advertising posters)?	○	○	○
Are there health promotion posters or banners?	○	○	○
Do students decorate their rooms with alcohol-related items (e.g., neon beer signs, beer posters)?	○	○	○
Do room window shelves sport pyramids of beer cans or beer advertisements?	○	○	○
Are doors to student rooms decorated with beer posters?	○	○	○
Are trash cans filled with beer cans and bottles after the weekend?	○	○	○
Do residence halls appear damaged (e.g., holes in walls, graffiti)?	○	○	○

Other impressions: _____

_____

STUDENT NEIGHBORHOOD ENVIRONMENTS

Walk around neighborhoods where students live, whether immediately adjacent to campus or not.

	YES	NO	N/A
Do beer banners hang from apartments and houses?	○	○	○
Are there pyramids of beer cans in the windows?	○	○	○
Are notices and posters advertising or promoting alcohol-related activities posted on telephone poles?	○	○	○
Are there alcohol outlets in the neighborhood?	○	○	○
Do they target students in their advertisements and promotions?	○	○	○
Do messages focus on alcohol or high-risk drinking (e.g., price discounts, student happy hours)?	○	○	○
Are there alcohol billboards or other messages on the paths that approach campus?	○	○	○

Other impressions: _____

_____

DRINKING ENVIRONMENTS

Stop by student-oriented drinking environments such as taverns, bars, or clubs, both on- and off-campus. Pick times when students gather.

	YES	NO	N/A
Are walls decorated with alcohol promotional material (e.g., posters, neon beer signs)?	○	○	○
Do servers check for identification?	○	○	○
Does the ambience appear to encourage drinking?	○	○	○
Are other activities available (e.g., pool tables, newspaper racks, air-hockey tables, darts, dancing)?	○	○	○
Do servers appear to monitor drinking rates of patrons?	○	○	○

Other impressions: _____

_____

NEIGHBORHOODS AROUND CAMPUS

Take a walk through neighborhoods and commercial areas around your campus.	YES	NO	N/A
Is there a wide variety of retailers tailored to the campus?	○	○	○
Are there alcohol outlets (e.g., liquor stores, mini-marts, restaurants, taverns, bars, pubs)?	○	○	○
Do they target students with ads or flyers?	○	○	○
Are there billboards or other types of advertisements for alcohol products?	○	○	○

Other impressions: _____

_____

PARTIES AND EVENTS

Stop by on- and off-campus activities such as openly advertised parties, receptions, dances, and residence hall parties. Consider stopping by later in the event to get a sense of how it went.	YES	NO	N/A
Is alcohol permitted at events?	○	○	○
Are other activities such as non-drinking games, dancing, or other recreational activities available?	○	○	○
Is appetizing food available?	○	○	○
Are nonalcoholic beverages available?	○	○	○
Is faculty drinking with underaged students condoned?	○	○	○
Are sober monitors present?	○	○	○
Are measures taken to prevent underage drinking?	○	○	○

Other impressions: _____

_____

CAMPUS BOOKSTORES

Stop by the campus bookstore or bookstores near campus. Walk the aisles.	YES	NO	N/A
Does it carry a variety of campus-related merchandise?	○	○	○
Does it carry alcohol-related merchandise (e.g., beer mugs, shot glasses)?	○	○	○
Does alcohol-related merchandise sport your school's name, crest, or mascot?	○	○	○
Do posters or clothing sport pro-drinking messages?	○	○	○
Do posters or clothing sport health promotion messages?	○	○	○

Other impressions: _____

_____

WHAT ELSE?

Does anything stand out as contributing to problems on your campus?

List those indicators picked up by scanning your environment. _____

_____

_____

_____

SCANNING EXERCISE A-3: Having Conversations

WHAT do people think are problems confronting your campus? Do they think alcohol use contributes to those problems? Do they have opinions? Do they have specific information about alcohol problems? Are they interested in being a part of a group working to both understand and reduce problems on your campus? Do they have resources they can bring to prevention efforts, e.g., research skills, person power? Talk to them and find out.

USE this exercise to build a campus network of people interested in helping prevention efforts and to identify people on campus who have information about problems and response. Talk to as many people as you can in a week. Split up the list among group members. Be selective. You may not need to talk with everyone. You may be one of these people yourself, or have already talked with some. Note the names of the people you talk with, whether they are interested, and if they can help.

HEALTH SERVICES: Staff and students involved in these areas are natural allies for prevention.	NAME AND TITLE	PHONE NUMBER	LIST TYPE OF INFORMATION
Campus health services			
Counseling services			
Safety awareness			
Other			
CAMPUS LIFE AND ACTIVITIES: Staff and students in these areas know what's happening on campus.			
Campus newspaper reporters			
Student government			
Disciplinary and judicial officials			
Activity directors and planners			
Student community services			
Residence and Greek life advisors			
Recreation			
Athletics			
Admissions (re: retention)			
Alumni			
Students: commuting			
residential			
international			
at-large			
Campus ministry			
Other			

COMMUNITY MEMBERS: People working and living in the surrounding community have a stake in prevention. They may also have information and resources.			
	NAME AND TITLE	CHECK IF INTERESTED	LIST TYPE OF INFORMATION
Neighborhood association members			
Business association members			
Other merchants			
Community public health officials			
Other			
ACADEMICS: Students and faculty members in these disciplines may be interested in alcohol issues.			
Economics			
Sociology			
Psychology			
Anthropology			
Political science			
Social work			
Marketing and communications			
Health sciences and public health			
Journalism			
Other			
SECURITY AND LAW ENFORCEMENT: These people are likely to have problem information and are committed to reducing problems.			
Campus security			
Local police			
State alcoholic beverage control			
Other			
ADMINISTRATION: Charged with running a campus, administrators have a stake in an institution's well-being.			
President			
Dean of students			
Dean of faculty			
Buildings and grounds/housekeeping			
Other			

Form 194

Core Alcohol and Drug Survey

Long Form

FIPSE Core Analysis Grantee Group

Please use a number 2 Pencil.

Core Institute
Student Health Programs
Southern Illinois University
Carbondale, IL 62901

For additional use:

A 0 1 2 3 4 5 6 7 8 9
B 0 1 2 3 4 5 6 7 8 9
C 0 1 2 3 4 5 6 7 8 9
D 0 1 2 3 4 5 6 7 8 9
E 0 1 2 3 4 5 6 7 8 9

1. Classification:
- Freshman
- Sophomore
- Junior
- Senior
- Grad/professional
- Not seeking a degree
- Other

2. Age:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

3. Ethnic origin:
- American Indian/ Alaskan Native
- Hispanic
- Asian/Pacific Islander
- White (non-Hispanic)
- Black (non-Hispanic)
- Other

4. Marital status:
- Single
- Married
- Separated
- Divorced
- Widowed

5. Gender:
- Male
- Female

6. Is your current residence as a student:
- On-campus
- Off-campus

7. Are you working?
- Yes, full-time
- Yes, part-time
- No

8. Living arrangements:

A. Where: *(mark best answer)*
- House/apartment/etc.
- Residence hall
- Approved housing
- Fraternity or sorority
- Other

B. With whom: *(mark all that apply)*
- With roommate(s)
- Alone
- With parent(s)
- With spouse
- With children
- Other

9. Approximate cumulative grade point average: *(choose one)*

A+ A A- B+ B B- C+ C C- D+ D D- F

10. Some students have indicated that alcohol or drug use at parties they attend in and around campus reduces their enjoyment, often leads to negative situations, and therefore, they would rather not have alcohol and drugs available and used. Other students have indicated that alcohol and drug use at parties increases their enjoyment, often leads to positive situations, and therefore, they would rather have alcohol and drugs available and used. Which of these is closest to your own view?

	Have available	Not have available
With regard to drugs?	○	○
With regard to alcohol?	○	○

11. Student status:
- Full-time (12+ credits)
- Part-time (1–11 credits)

12. Campus situation on alcohol and drugs:

	yes	no	don't know
a. Does your campus have alcohol and drug policies?	○	○	○
b. If so, are they enforced?	○	○	○
c. Does your campus have a drug and alcohol prevention program?	○	○	○
d. Do you believe your campus is concerned about the prevention of drug and alcohol use?	○	○	○
e. Are you actively involved in efforts to prevent drug and alcohol use problems on your campus?	○	○	

13. Place of permanent residence:
- In-state
- USA, but out of state
- Country other than USA

14. Think back over the last two weeks. How many times have you had five or more drinks* at a sitting?
- None
- Once
- Twice
- 3 to 5 times
- 6 to 9 times
- 10 or more times

*A drink is a bottle of beer, a glass of wine, a wine cooler, a shot glass of liquor, or a mixed drink.

15. Average # of drinks* you consume a week:

(If less than 10, code answers as 00, 01, 02, etc.)

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

16. At what age did you first use… *(mark one for each line)*

	Did not use	Under 10	10–11	12–13	14–15	16–17	18–20	21–25	26+
a. Tobacco (smoke, chew, snuff)	○	○	○	○	○	○	○	○	○
b. Alcohol (beer, wine, liquor)*	○	○	○	○	○	○	○	○	○
c. Marijuana (pot, hash, hash oil)	○	○	○	○	○	○	○	○	○
d. Cocaine (crack, rock, freebase)	○	○	○	○	○	○	○	○	○
e. Amphetamines (diet pills, speed)	○	○	○	○	○	○	○	○	○
f. Sedatives (downers, ludes)	○	○	○	○	○	○	○	○	○
g. Hallucinogens (LSD, PCP)	○	○	○	○	○	○	○	○	○
h. Opiates (heroin, smack, horse)	○	○	○	○	○	○	○	○	○
i. Inhalants (glue, solvents, gas)	○	○	○	○	○	○	○	○	○
j. Designer drugs (ecstasy, MDMA)	○	○	○	○	○	○	○	○	○
k. Steroids	○	○	○	○	○	○	○	○	○
l. Other illegal drugs	○	○	○	○	○	○	○	○	○

*Other than a few sips

17. Within the last year about how often have you used… *(mark one for each line)*

	Did not use	Once/year	6 times/year	Once/month	Twice/month	Once/week	3 times/week	5 times/week	Every day
a. Tobacco (smoke, chew, snuff)	○	○	○	○	○	○	○	○	○
b. Alcohol (beer, wine, liquor)	○	○	○	○	○	○	○	○	○
c. Marijuana (pot, hash, hash oil)	○	○	○	○	○	○	○	○	○
d. Cocaine (crack, rock, freebase)	○	○	○	○	○	○	○	○	○
e. Amphetamines (diet pills, speed)	○	○	○	○	○	○	○	○	○
f. Sedatives (downers, ludes)	○	○	○	○	○	○	○	○	○
g. Hallucinogens (LSD, PCP)	○	○	○	○	○	○	○	○	○
h. Opiates (heroin, smack, horse)	○	○	○	○	○	○	○	○	○
i. Inhalants (glue, solvents, gas)	○	○	○	○	○	○	○	○	○
j. Designer drugs (ecstasy, MDMA)	○	○	○	○	○	○	○	○	○
k. Steroids	○	○	○	○	○	○	○	○	○
l. Other illegal drugs	○	○	○	○	○	○	○	○	○

18. During the past 30 days on how many days did you have: *(mark one for each line)*

	0 days	1–2 days	3–5 days	6–9 days	10–19 days	20–29 days	All 30 days
a. Tobacco (smoke, chew, snuff)	○	○	○	○	○	○	○
b. Alcohol (beer, wine, liquor)	○	○	○	○	○	○	○
c. Marijuana (pot, hash, hash oil)	○	○	○	○	○	○	○
d. Cocaine (crack, rock, freebase)	○	○	○	○	○	○	○
e. Amphetamines (diet pills, speed)	○	○	○	○	○	○	○
f. Sedatives (downers, ludes)	○	○	○	○	○	○	○
g. Hallucinogens (LSD, PCP)	○	○	○	○	○	○	○
h. Opiates (heroin, smack, horse)	○	○	○	○	○	○	○
i. Inhalants (glue, solvents, gas)	○	○	○	○	○	○	○
j. Designer drugs (ecstasy, MDMA)	○	○	○	○	○	○	○
k. Steroids	○	○	○	○	○	○	○
l. Other illegal drugs	○	○	○	○	○	○	○

19. How often do you think the average student on your campus uses… *(mark one for each line)*

	Never	Once/year	6 times/year	Once/month	Twice/month	Once/week	3 times/week	5 times/week	Every day
a. Tobacco (smoke, chew, snuff)	○	○	○	○	○	○	○	○	○
b. Alcohol (beer, wine, liquor)	○	○	○	○	○	○	○	○	○
c. Marijuana (pot, hash, hash oil)	○	○	○	○	○	○	○	○	○
d. Cocaine (crack, rock, freebase)	○	○	○	○	○	○	○	○	○
e. Amphetamines (diet pills, speed)	○	○	○	○	○	○	○	○	○
f. Sedatives (downers, ludes)	○	○	○	○	○	○	○	○	○
g. Hallucinogens (LSD, PCP)	○	○	○	○	○	○	○	○	○
h. Opiates (heroin, smack, horse)	○	○	○	○	○	○	○	○	○
i. Inhalants (glue, solvents, gas)	○	○	○	○	○	○	○	○	○
j. Designer drugs (ecstasy, MDMA)	○	○	○	○	○	○	○	○	○
k. Steroids	○	○	○	○	○	○	○	○	○
l. Other illegal drugs	○	○	○	○	○	○	○	○	○

20. Where have you used… *(mark all that apply)*

	Never used	On campus events	Residence hall	Frat/sorority	Bar/restaurant	Where you live	In a car	Private parties	Other
a. Tobacco (smoke, chew, snuff)	○	○	○	○	○	○	○	○	○
b. Alcohol (beer, wine, liquor)	○	○	○	○	○	○	○	○	○
c. Marijuana (pot, hash, hash oil)	○	○	○	○	○	○	○	○	○
d. Cocaine (crack, rock, freebase)	○	○	○	○	○	○	○	○	○
e. Amphetamines (diet pills, speed)	○	○	○	○	○	○	○	○	○
f. Sedatives (downers, ludes)	○	○	○	○	○	○	○	○	○
g. Hallucinogens (LSD, PCP)	○	○	○	○	○	○	○	○	○
h. Opiates (heroin, smack, horse)	○	○	○	○	○	○	○	○	○
i. Inhalants (glue, solvents, gas)	○	○	○	○	○	○	○	○	○
j. Designer drugs (ecstasy, MDMA)	○	○	○	○	○	○	○	○	○
k. Steroids	○	○	○	○	○	○	○	○	○
l. Other illegal drugs	○	○	○	○	○	○	○	○	○

21. Please indicate how often you have experienced the following due to your drinking or drug use during the last year… *(mark one for each line)*

	Never	Once	Twice	3–5 times	6–9 times	10 or more times
a. Had a hangover	○	○	○	○	○	○
b. Performed poorly on a test or important project	○	○	○	○	○	○
c. Been in trouble with police, residence hall, or other college authorities	○	○	○	○	○	○
d. Damaged property, pulled fire alarm, etc.	○	○	○	○	○	○
e. Got into an argument or fight	○	○	○	○	○	○
f. Got nauseated or vomited	○	○	○	○	○	○
g. Driven a car while under the influence	○	○	○	○	○	○
h. Missed a class	○	○	○	○	○	○
i. Been criticized by someone I know	○	○	○	○	○	○
j. Thought I might have a drinking or other drug problem	○	○	○	○	○	○
k. Had a memory loss	○	○	○	○	○	○
l. Done something I later regretted	○	○	○	○	○	○
m. Been arrested for DWI/DUI	○	○	○	○	○	○
n. Have been taken advantage of sexually	○	○	○	○	○	○
o. Have taken advantage of another sexually	○	○	○	○	○	○
p. Tried unsuccessfully to stop using	○	○	○	○	○	○
q. Seriously thought about suicide	○	○	○	○	○	○
r. Seriously tried to commit suicide	○	○	○	○	○	○
s. Been hurt or injured	○	○	○	○	○	○

22. Have any of your family had alcohol or other drug problems: *(mark all that apply)*

- ○ Mother
- ○ Father
- ○ Stepmother
- ○ Stepfather
- ○ Brothers/sisters
- ○ Mother's parents
- ○ Father's parents
- ○ Aunts/uncles
- ○ Spouse
- ○ Children
- ○ None

23. If you volunteer any of your time on or off campus to help others, please indicate the approximate number of hours per month and principal activity:

- ○ Don't volunteer, or less than 1 hour
- ○ 1–4 hours
- ○ 5–9 hours
- ○ 10–15 hours
- ○ 16 or more hours

Principal volunteer activity is: _____

24. Within the last year to what extent have you participated in any of the following activities? *(mark one for each line)*

	Not involved	Attended	Active involvement, non-leader	Leadership position
a. Intercollegiate athletics	○	n/a	○	○
b. Intramural or club sports	○	n/a	○	○
c. Social fraternities or sororities	○	○	○	○
d. Religious and interfaith groups	○	○	○	○
e. International and language groups	○	○	○	○
f. Minority and ethnic organizations	○	○	○	○
g. Political and social action groups	○	○	○	○
h. Music and other performing arts groups	○	○	○	○
i. Student newspaper, radio, TV, magazine, etc.	○	○	○	○

25. In the first column, indicate whether any of the following have happened to you within the last year while you were in and around campus. If you answered yes to any of these items, indicate in the second column if you had consumed alcohol or other drugs shortly before these incidents.

	Happened to you		Consumed alcohol or drugs	
	yes	no	yes	no
a. Ethnic or racial harassment	○	○	○	○
b. Threats of physical violence	○	○	○	○
c. Actual physical violence	○	○	○	○
d. Theft involving force or threat of force	○	○	○	○
e. Forced sexual touching or fondling	○	○	○	○
f. Unwanted sexual intercourse	○	○	○	○

If yes →

26. How do you think your close friends feel (or would feel) about you… *(mark one for each line)*

	Don't disapprove	Disapprove	Strongly disapprove
a. Trying marijuana once or twice	○	○	○
b. Smoking marijuana occasionally	○	○	○
c. Smoking marijuana regularly	○	○	○
d. Trying cocaine once or twice	○	○	○
e. Taking cocaine regularly	○	○	○
f. Trying LSD once or twice	○	○	○
g. Taking LSD regularly	○	○	○
h. Trying amphetamines once or twice	○	○	○
i. Taking amphetamines regularly	○	○	○
j. Taking one or two drinks of an alcoholic beverage (beer, wine, liquor) nearly every day	○	○	○
k. Taking four or five drinks nearly every day	○	○	○
l. Having five or more drinks in one sitting	○	○	○
m. Taking steroids for body building or improved athletic performance	○	○	○

27. Do you believe that alcohol has the following effects? *(mark one for each line)*

	yes	no
a. Breaks the ice	○	○
b. Enhances social activity	○	○
c. Makes it easier to deal with stress	○	○
d. Facilitates a connection with peers	○	○
e. Gives people something to talk about	○	○
f. Facilitates male bonding	○	○
g. Facilitates female bonding	○	○
h. Allows people to have more fun	○	○
i. Gives people something to do	○	○
j. Makes food taste better	○	○
k. Makes women sexier	○	○
l. Makes men sexier	○	○
m. Makes me sexier	○	○
n. Facilitates sexual opportunities	○	○

28. On this campus, drinking is a central part in the social life of the following groups: *(mark one for each line)*

	yes	no
a. Male students	○	○
b. Female students	○	○
c. Faculty/staff	○	○
d. Alumni	○	○
e. Athletes	○	○
f. Fraternities	○	○
g. Sororities	○	○

29. Campus environment: *(mark one for each line)*

	yes	no
a. Does the social atmosphere on this campus promote alcohol use?	○	○
b. Does the social atmosphere promote other drug use?	○	○
c. Do you feel safe on this campus?	○	○

30. Compared to other campuses with which you are familiar, this campus' use of alcohol is… *(mark one)*

- Greater than other campuses ○
- Less than other campuses ○
- About the same as other campuses ○

31. Housing preferences: *(mark one for each line)*

	yes	no
a. If you live in university housing, do you live in a designated alcohol-free/ drug-free residence hall?	○	○
b. **If no,** would you like to live in such a residence hall unit if it were available?	○	○

32. To what extent do students on this campus care about problems associated with… *(mark one for each line)*

	Not at all	Slightly	Somewhat	Very much
a. Alcohol and other drug use	○	○	○	○
b. Campus vandalism	○	○	○	○
c. Sexual assault	○	○	○	○
d. Assaults that are non-sexual	○	○	○	○
e. Harassment because of gender	○	○	○	○
f. Harassment because of sexual orientation	○	○	○	○
g. Harassment because of race or ethnicity	○	○	○	○
h. Harassment because of religion	○	○	○	○

33. To what extent has your alcohol use changed within the last 12 months?

- Increased ○
- About the same ○
- Decreased ○
- I have not used alcohol ○

34. To what extent has your illegal drug use changed within the last 12 months?

- Increased ○
- About the same ○
- Decreased ○
- I have not used drugs ○

35. How much do you think people risk harming themselves (physically or in other ways) if they… *(mark one for each line)*

	No risk	Slight risk	Moderate risk	Great risk	Can't say
a. Try marijuana once or twice	○	○	○	○	○
b. Smoke marijuana occasionally	○	○	○	○	○
c. Smoke marijuana regularly	○	○	○	○	○
d. Try cocaine once or twice	○	○	○	○	○
e. Take cocaine regularly	○	○	○	○	○
f. Try LSD once or twice	○	○	○	○	○
g. Take LSD regularly	○	○	○	○	○
h. Try amphetamines once or twice	○	○	○	○	○
i. Take amphetamines regularly	○	○	○	○	○
j. Take one or two drinks of an alcoholic beverage (beer, wine, liquor) nearly every day	○	○	○	○	○
k. Take four or five drinks nearly every day	○	○	○	○	○
l. Have five or more drinks in one sitting	○	○	○	○	○
m. Take steroids for body building or improved athletic performance	○	○	○	○	○
n. Consume alcohol prior to being sexually active	○	○	○	○	○
o. Regularly engage in unprotected sexual activity with a single partner	○	○	○	○	○
p. Regularly engage in unprotected sexual activity with multiple partners	○	○	○	○	○

36. Mark one answer for each line:

	yes	no
a. Did you have sexual intercourse within the last year?	○	○
If yes, answer b and c below.		
b. Did you drink alcohol the last time you had sexual intercourse?	○	○
c. Did you use other drugs the last time you had sexual intercourse?	○	○

37. During the past 30 days, to what extent have you engaged in any of the following behaviors? *(mark one for each line)*

	Zero times	One time	Two times	3–5 times	6–9 times	10 or more times
a. Refused an offer of alcohol or other drugs	○	○	○	○	○	○
b. Bragged about your alcohol or other drug use	○	○	○	○	○	○
c. Heard someone else brag about his/her alcohol or other drug use	○	○	○	○	○	○
d. Carried a weapon such as a gun, knife, etc. (do not count hunting situations or weapons used as part of your job)	○	○	○	○	○	○
e. Experienced peer pressure to drink or use drugs	○	○	○	○	○	○
f. Held a drink to have people stop bothering you about why you weren't drinking	○	○	○	○	○	○
g. Thought a sexual partner was not attractive because he/she was drunk	○	○	○	○	○	○
h. Told a sexual partner that he/she was not attractive because he/she was drunk	○	○	○	○	○	○

38. To what extent do you agree with the following statements? *(mark one for each line)*

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know
a. I feel valued as a person on this campus	○	○	○	○	○	○
b. I feel that faculty and staff care about me as a student	○	○	○	○	○	○
c. I have a responsibility to contribute to the well-being of other students	○	○	○	○	○	○
d. My campus encourages me to help others in need	○	○	○	○	○	○
e. I abide by the university policy and regulations that concern alcohol and other drug use	○	○	○	○	○	○

39. In which of the following ways does other students' drinking interfere with your life on or around campus? *(mark one for each line)*

	yes	no
a. Interrupts your studying	○	○
b. Makes you feel unsafe	○	○
c. Messes up your physical living space (cleanliness, neatness, organization, etc.)	○	○
d. Adversely affects your involvement on an athletic team or in other organized groups	○	○
e. Prevents you from enjoying events (concerts, sports, social activities, etc.)	○	○
f. Interferes in other way(s)	○	○
g. Doesn't interfere with my life	○	○

Mark Reflex® by NCS MM201109-1 321 Printed in U.S.A.

Faculty and Staff Environmental Alcohol and Other Drug Survey

Developed by the CORE Institute for SIUC Alcohol and Drug Prevention Program

Please fill in the appropriate answer (Please use a no. 2 pencil)

Please answer the following questions marking Yes, No, or Don't Know.

		Yes	No	Don't Know
1.	Does this university have a policy concerning alcohol and other drugs?	○	○	○
2.	Have you ever seen/read a copy of this policy?	○	○	○
3.	Do the policies pertain to faculty and staff?	○	○	○
4.	Does the policy specifically address faculty/staff responsibility at events where students are present and alcohol is served?	○	○	○
5.	Do you know where to find a copy of the alcohol and other drug policy?	○	○	○
6.	Does this university have an alcohol or other drug prevention program for students?	○	○	○
7.	Does this university have an alcohol or other drug prevention program for staff?	○	○	○
8.	Do you believe this university is concerned about the prevention of alcohol and other drug abuse?	○	○	○
9.	Are you actively involved in efforts to prevent alcohol and other drug use problems on this campus?	○	○	○
10.	Does this university provide accurate and current information to students concerning the effects and health risks associated with the use and abuse of alcohol and other drugs?	○	○	○
11.	Was alcohol and other drug abuse information provided at any faculty/staff orientation that you attended?	○	○	
12.	Have you ever attended any alcohol and other drug abuse program on this campus?	○	○	
13.	Have you ever provided information concerning alcohol and other drugs to students (i.e., class, advisement, etc.)?	○	○	
14.	Are training programs provided so that staff and faculty can identify students or colleagues who have problems with alcohol and other drugs?	○	○	
15.	If you had a student or a colleague with alcohol or other drug problems, would you know how to refer him/her for help?	○	○	
16.	Are alcohol and other drug policies consistently enforced on this university campus?	○	○	○
17.	Are appropriate disciplinary actions taken when alcohol and other drug policies have been violated by students?	○	○	○
18.	Are appropriate disciplinary actions taken when alcohol and other drug policies have been violated by faculty/staff?	○	○	
19.	Does this university assess awareness, attitudes, and behaviors regarding alcohol and other drugs on campus?	○	○	
20.	Have you ever personally answered a survey regarding alcohol and other drugs on this university campus?	○	○	
21.	Does this university assess the campus environment as an underlying cause of alcohol and other drug abuse?	○	○	
22.	Do you think institutions of higher education should be involved in alcohol and other drug prevention efforts?	○	○	
23.	Do you think that alcohol and other drug use negatively affects the overall quality of student life?	○	○	
24.	Do you believe student academic performance is affected by alcohol and other drug use?	○	○	
25.	Have you personally been aware of a student(s) whose academic performance has been affected by alcohol and other drug use?	○	○	
26.	Do you wish to be involved in alcohol and other drug prevention efforts at this university?	○	○	

Funded by Department of Education, FIPSE

2/93

Printed in U.S.A. Mark Reflex® by NCS MM97650:321 A2407

Please answer questions 27 through 33 by marking Yes or No.

		Yes	No
27.	Would you attend a workshop dealing with alcohol and other drug prevention/education efforts?	○	○
28.	Do you consider the current alcohol and other drug use on this campus to be a problem?	○	○
29.	Do you consider the current alcohol and other drug use on this campus to be more of a problem than that experienced by other campuses?	○	○
30.	Do you think the current alcohol and other drug use on this campus is a concern for educators?	○	○
31.	Do you know how to identify the signs of problematic alcohol and other drug use?	○	○
32.	Do you feel that more information regarding the identification of problematic alcohol and other drug use among students would be helpful to you?	○	○
33.	If you knew how to refer students to appropriate services for suspected alcohol and other drug problems, would you refer them to such services?	○	○

34. Which of the statements below best represents (1) the attitude you have regarding alcohol use, and (2) the most common attitude of the campus in general regarding alcohol use.

a. Drinking is never a good thing to do.
b. Drinking is okay, but a person should never get drunk.
c. An occasional "drunk" is okay as long as it doesn't interfere with academics or other responsibilities.
d. An occasional "drunk" is okay even if it does interfere with academics or other responsibilities.
e. A frequent "drunk" is okay if that is what the individual wants to do.

1.	Your own attitude	Ⓐ	Ⓑ	Ⓒ	Ⓓ	Ⓔ
2.	Campus in general	Ⓐ	Ⓑ	Ⓒ	Ⓓ	Ⓔ

35. Which of the statements below best represents (1) the attitude you have regarding illicit (non-prescription) drug use, and (2) the most common attitude of the campus in general regarding illicit (non-prescription) drug use.

a. Using drugs is never a good thing to do.
b. Using drugs is okay, but a person should never get wasted.
c. An occasional "drug high" is okay as long as it doesn't interfere with academics or other responsibilities.
d. An occasional "drug high" is okay even if it does interfere with academics or other responsibilities.
e. A frequent "drug high" is okay if that is what the individual wants to do.

1.	Your own attitude	Ⓐ	Ⓑ	Ⓒ	Ⓓ	Ⓔ
2.	Campus in general	Ⓐ	Ⓑ	Ⓒ	Ⓓ	Ⓔ

Personal data

1. Highest education level

- PhD ○
- Masters ○
- Bachelors ○
- High school dip. or GED ○
- Less than high school diploma or GED ○

2. Gender

- Male ○
- Female ○

3. Age

⓪	⓪
①	①
②	②
③	③
④	④
⑤	⑤
⑥	⑥
⑦	⑦
⑧	⑧
⑨	⑨

Supervisory role? ○ YES ○ NO

Employee status

- Faculty ○
- Admin./professional ○
- Civil service ○
- Teaching assistant ○
- Other ○

Marital status

- Single ○
- Married ○
- Separated ○
- Divorced ○
- Widowed ○

Ethnic origin Black (non-hispanic) ○ Hispanic ○ White (non-hispanic) ○ Asian/Pacific Islander ○ American Indian/Alaskan Native ○ Other ○

THANK YOU