UCF STUDENT PERCEPTIONS OF A SMOKE-FREE CAMPUS POLICY

by

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Abstract

Within the last few decades, the prevalence of cigarette smoking has decreased because of the vast amount of research which indicates that smoking leads to health problems many of which are potentially fatal. Also, smoking harms not only those whom choose to smoke but non-smokers in the area are affected by even low levels of cigarette smoke. Thus, cigarette smoking has become a public health concern. Around the globe, countries are passing smoke-free laws in public areas such as businesses, restaurants, and bars. In the United States, many universities have enacted smoke-free campus policies to ensure the health of all their students in all places on campus.

The purpose of this research is to identify the support or opposition for a smoke-free campus policy at the University of Central Florida by UCF students. A survey was distributed to undergraduate students at UCF which asks whether they would support such a policy along with characterizing questions about their smoking habits, lifestyle, history, and opinion. The analysis of the data shows that the majority of UCF student would support a smoke-free campus policy.

Dedication

For my Omi

Acknowledgment

I wish to thank my thesis chair, Dr. Ford, for helping me through the thesis process. Without his knowledge and guidance, this project may not have been possible. I sincerely appreciate all the time we spent going over the research and thesis-writing, I have learned so much.

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Introduction

For more than a century, America has been a dominant world leader with many of the world's most capable intellectuals emerging from our colleges and universities. As our society becomes even more sophisticated, college is becoming the natural next step after high school for many young people who expect a challenging, lucrative career. According to the National Center for Education Statistics (NCES), college enrollment in the United States increased by the rate of 26 percent from 1997 to 2007 taking the number of students from 14.5 million to 18.2 million. In 2008, 19 million persons were enrolled in college. The greatest increase was in full-time students whose enrollment rose by 34 percent (National Center for Education Statistics, 2009, ch.7). As of 2008, NCES has found that 69 percent of high school graduates attend college (National Center for Education Statistics, 2010). In sum, about 47% of 18-24 years olds were enrolled in post-secondary education programs in the year 2008 (National Center for Education Statistics, 2009, ch.7). These statistics confirm the popularity of higher education within our modern society.

With so many of America's most promising youth enrolled in college it is imperative that their health and safety be a top priority. The college years are a time of transition when many lifestyle practices first develop. Newcomb and Bentler (1996) perhaps says it best, "The transition out of high school is one of the most critical passages in life because of pronounced changes in social environment and role

responsibilities." In the study by Abbott et al (2006) it was found that moving away to college was significantly related to "increases in alcohol-use behavior in the period immediately after high school." Another study, by Brown and Vanable (2007), confirms higher rates of unprotected sex and alcohol consumption among college students. Chaloupka and Weschler (1996) found that "many aspects of the campus environment contribute to binge drinking." This study also found that strong state level policies on youth drinking and driving reduce binge drinking for both underage and older males. These studies support the idea that young people in college engage in risky behaviors that jeopardize their health. They also highlight that the college environment may be to blame for some of the risk taking.

Cigarette smoking is another high risk behavior that occurs on many college campuses nationwide. Not only does it adversely affect the user, but due to secondhand smoke (SHS) known carcinogens are spread to all people in the surrounding area. Results from the national Monitoring the Future survey show a rise in cigarette smoking amongst college students throughout the nineties. Particularly in 1998 and 1999, the 30-day prevalence of smoking amongst college students was up to 31%. However, the 21st century brought with it a decline in smoking for the first time in many years. By 2003, the rate was down to 23% and it continued to decline with the rate being 19% in 2006 and only 18% in 2008 (Johnston et al., 2007).

While some college students continue to smoke, there is no denying a notable decline in smoking prevalence. This decline can likely be credited to an increased

awareness of the health consequences of smoking. According to the Surgeon General report from the Center for Disease Control, smoking harms nearly every organ of the body, decreases overall health and causes numerous diseases. Smoking causes an estimated 443,000 deaths annually in the United States. That translates to 1 in every 5 deaths per year in the US attributed to the negative health effects of smoking (Center for Disease Control and Prevention, 2004). Another Surgeon General report provided by the US Department of Health and Human Services states that even people who do not smoke are still at risk due to secondhand smoke which contains hundreds of carcinogenic chemicals such as formaldehyde, benzene, vinyl chloride, arsenic, ammonia, and hydrogen cyanide (Center for Disease Control and Prevention, 2010).

. Students themselves are concerned with how secondhand smoke affects their health. Polacek and Atkins (2008) surveyed almost 3,000 university students and found the majority were concerned with the health hazards of secondhand smoke exposure. In a study by Wolfson, McCoy, and Sutfin (2009), 83% of students reported SHS exposure in the past 7 days. The majority, 93.9% of nonsmokers and 57.8% of smokers, indicated secondhand smoke as somewhat or very annoying.

Over the years, the prevalence of smoking has mostly been on a decline as people came to realize that cigarettes are harmful and even deadly. With this knowledge, support for smoke-free policy has naturally increased. At the state level, smoke-free policy may take the form of a Clean Air Act which can prohibit smoking in workplaces, restaurants, and bars. In the college environment, a comprehensive

smoke-free policy states that smoking is prohibited in all indoor and outdoor areas, unless otherwise specified. Now, more than ever, attitudes on smoking are overwhelmingly negative and even more support is being given to policy changes that include these types of public bans on smoking. This negative shift in attitudes on smoking is evident is two cases of policy change. The state of New York implemented a smoke-free law in 2003 and two years after it took effect, 80% of adults in New York (including smokers) supported the law (New York State Department of Health, 2006). Even within the smoke-filled bar culture of California, the majority of patrons support the statewide smoke-free bar laws that took effect in 1998. Two and a half years after implementation 62% of patrons approve of the law (Tang et al., 2003).

However, in the arena of college and university campuses tobacco policy change seems to be slow going. Most colleges simply abide by their state's smoking policy, which has most campuses prohibiting smoking in enclosed public spaces but not on the lawns, courtyards, and sidewalks. Considering over 18.2 million young people attend college and a vast 82% of them choose not to smoke, it is unbefitting that most university's policies disregard the rights of these students who would rather breathe clean air by not instating a smoke-free policy on campus. Based on Surgeon General Reports, The American College Health Association has adopted a policy that encourages "college and universities to be diligent in their efforts to achieve a 100% indoor and outdoor campus-wide tobacco-free environment" (Journal of American College Health, 2007).

It is the university's responsibility to provide a healthy environment to all students, yet the lack of smoke-free policy means all students may breathe harmful, carcinogenic environmental tobacco smoke (ETS). According to Johnston, Polacek, and Atkins (2008), "lack of policy enforcement indicated an indirect support of smoking by the university administration. To increase non-smoking behavior, policies must be enforced." Many universities claim to follow their state's smoking policy, but they do not explicitly provide those policies in their handbooks. The University of Central Florida is one of those schools. Often times, signs are visible indicating that smoking is prohibited inside and within 25 feet of the buildings. However, there is no policy at the university or state level that confirms the 25 foot rule. Overall, unless the college has a comprehensive smoke-free campus policy, then the rules on smoking become unclear and we cannot afford to be unclear on the health of our young scholars. The current research addresses the question: What are UCF students' perceptions of a smoke-free campus policy? The survey will assess other characteristics of students who support or oppose the potential smoke-free policy.

Literature Review

Federal Level

Smoking policies vary greatly across the globe from countries like Australia and Canada that have restrictions for smoking in virtually all indoor areas to places like Russia and much of Africa that have no restrictions whatsoever. The United States has no federal limitations on smoking; the decision is in the hands of state and local governments and thus varies widely.

Australian Smoking Regulations

The country of Australia has some of the most comprehensive public smoke-free policies in the world. In 1987, smoking on domestic airline flights was banned*. The following year, smoking was banned in other federally regulated areas such as interstate buses*. By the year, 1996 all international flights to and from Australia were subject to smoke-free policy (Riseley, 2003).

Australia's National Tobacco Strategy provided the guidelines that help set Australia as a smoke-free policy leader. Much of Australia is covered by comprehensive smoke-free laws concerning enclosed public spaces which include restaurants, shopping centers, sporting facilities, libraries, universities and public transport*. The term "public", however, does not include all workplaces such as factories. Therefore, Queensland policy prohibits smoking in all "enclosed areas" excluding only private residences and vehicles. However, licensed venues are still somewhat exempt from

smoke-free laws in Australia. These places include hotels, bars, clubs, and gaming areas (Riseley, 2003).

One of the main reasons Australia has progressed beyond other countries is because the Australian people largely support smoke-free policy. In 1993, interviews were conducted with 3,500 people. The results show that 79% of people surveyed support a total ban within workplaces, 73% support a ban in restaurants, 71% for shopping centers. Furthermore, an overwhelming 95% of non-smoking university graduates favor a workplace non-smoking ban. This study acknowledges that despite strong support for workplace bans, a third of people in the Australian workforce are not protected because smoking is either unrestricted or permitted in certain areas (McAllister, 1995). While Australia has made impressive strides in the smoke-free policy arena, public supports goes beyond the current legislation and thus more work needs to be done.

United States Smoking Regulations

In 1997, President Clinton signed into law the executive order 13058 which states “the smoking of tobacco products is thus prohibited in all interior space owned, rented, or leased by the executive branch of the Federal Government, and in any outdoor areas under executive branch control in front of air intake ducts.” Also, Title 14 of federal regulations section 252.3 states “air carriers shall prohibit smoking on all scheduled passenger flights.” Though there are exceptions to both policies, it is

significant that the US federal government has enacted those regulations. It validates state progress toward more comprehensive smoke-free policies.

Most changes by the US Federal Government to protect the people from deadly cigarette smoke do not come from no-smoking bans. In 2009, President Obama signed in the Family Smoking Prevention and Tobacco Control Act (H.R. 1256) which gives the Food and Drug Administration the power to regulate tobacco sales for the first time ever. Then, many smokers attempted to quit after congress raised the tax from 62 cents to $1.01 per pack of 20. However, the US is unable to negotiate implementation and enforcement of smoking policies because the current administration has not submitted the international tobacco control treaty to the senate for ratification. This puts us in the small minority of nations standing in the way of smoke-free legislation, as 168 nations or 86 percent of the world's population has ratified the treaty (American Lung Association, 2010). The United States currently has no federal restrictions on smoking and the decision to permit smoking in various venues is determined by state and local governments.

However, there is another avenue, under the spending power of congress further smoking restrictions are possible. The requirements for congress to be able to regulate state spending are laid out as follows: 1) the condition must be for the benefit of general federal welfare 2) the condition must be clear and unambiguous to the states 3) a relationship must exist between the condition and the funding, and 4) the condition must

not violate the constitution. First, considering most states already prohibit smoking in some venues to some degree, the argument that the condition will not be a benefit to general welfare is unpersuasive. Second, congress should clearly outline the restrictions to be implemented in order to receive funding for particular programs. Third, the relationship could be funding for state health departments contingent upon implementation of smoke-free policy. Finally, most smoking restrictions that have been examined fall well within the protection of the constitution (Niezgoda, 2006).

State and Local Level

The majority of the U.S. lives under comprehensive state-level smoking bans. According to the American Nonsmokers' Rights Foundation, 35 states have 100% smoke-free laws for restaurants and/or bars and/or workplaces, and 22 states have 100% smoke-free laws for all three venues. Also, 3,173 municipalities have local restrictions on where smoking is allowed. However, many southern states have not passed any smoking restrictions at all. Florida has made some progress by banning smoking in all workplaces and restaurants but not in bars (American Nonsmokers Rights Foundation, 2010).

California Restrictions

California entered the arena of smoke-free policy much earlier than any other state in the US. The Indoor Clean Air Act of 1976 called for no-smoking in "publicly owned buildings, health facilities, retail food production and marketing establishments and on private and public transportation." Then the Smoke-Free Act of 1994 prohibited

smoking in “all enclosed places of employment in the state, thereby eliminating the need of local governments to enact workplace smoking restrictions within their respective jurisdiction." Some prime examples within the state of California are Del Mar, Solana Beach, and San Diego which have all enacted local smoke-free laws in their beaches and parks (Niezgoda, 2006).

The data used to back up these policy changes were provided by the Gallup Organization, The Field Research Corporation, and the *Los Angeles Times*. Their results suggested that 82% of Californians do not smoke and 86% favor smoke-free workplaces, including bars. To the bar owners resisting change because they fear financial loss, the studies show that 85% of bar patrons don’t care or are more likely to go to a smoke-free bar (Kiser & Boschert, 2001).

New York Restrictions

Learning from California’s example, New York State enacted their Clean Indoor Air Act in 1989 which banned smoking in “elevators, food stores, gymnasiums, auditoriums, shared taxicabs and limousines.” However, New York City took it a step further and in 1995 passed the Smoke-Free Air Act which aimed to eliminate smoke in all workplaces, including commercial office space (Clarke et al. 1999). Business owners exercised their new right to ban smoking and employees were often seen smoking in outside alleyways. Then in 2003, the State of New York amended the 1989 CIAA to eliminate smoking in nearly all indoor public areas (Niezgoda, 2006).

Florida Restrictions

In 1985, the State of Florida enacted the Florida Clean Indoor Air Act (Florida Department of Health, 2007) which states that “a person may not smoke in an enclosed indoor workplace.” According to the law, *enclosed indoor workplace* means “any place where one or more persons engages in work, and which place is predominantly or totally bounded on all sides and above by physical barriers, regardless of whether such barriers consist of or include, without limitation, uncovered openings; screened or otherwise partially covered openings; or open or closed windows, jalousies, doors, or the like.” Educational facilities fall under the category of “enclosed indoor workplace”. Notable exceptions include private residences and stand-alone bars (Florida Department of Health, 2007).

College and University Bans

There are at least 420 universities across the US that have developed a smoke-free campus policy. In Florida, these include the University of Florida and soon-to-be Florida International University.

UF

The University of Florida went completely tobacco-free on July 1, 2010. Smoking and the use of tobacco products are prohibited everywhere on campus including inside buildings, parking lots, and cars. Smoking was previously prohibited within 50 feet of all UF facilities, now that boundary is pushed to outside the perimeter of campus. Everyone

on campus is subjected to this policy including students, faculty, visitors, volunteers, vendors, and contractors (University of Florida, 2010).

Prior to the implementation of UF's tobacco-free campus policy, a task force was created by the Healthy Gators 2010 coalition to promote the initiative. This task force distributed a survey to UF faculty, staff, and students. The questions were open ended, the first one being "What are your major concerns about tobacco use among faculty, staff and students and its impact on the campus community/environment?" Responses were discussed at subsequent task force meetings. This collaborative effort of people committed to gathering data about smoking and tobacco issues on campus led to UF eventually going tobacco-free. The task force now evaluates the policy on a bi-annual basis.

There are ten recommendations from the Healthy Gators 2010 coalition which were published in 2008 before UF went completely smoke-free. The first is to set a date for the implementation of a comprehensive smoke free policy. The second states that this policy should be clear and reflective of the best practices in tobacco control. The third recommendation states that an effective enforcement plan should be created. The next recommendation calls for the promotion of education on the risks of tobacco use. Another recommendation seeks to accommodate cultural differences in health communication and special outreach efforts for high-risk populations. Another critical recommendation calls for comprehensive, effective tobacco cessation programs for students, faculty, and staff. Next, set a goal to offer coverage for tobacco dependence

counseling in the health insurance policy. Also, the advertising, sale, and sampling of tobacco products in any university context should be prohibited. Along those same lines, tobacco companies should not be allowed to sponsor university event. The tenth and final recommendation states that the university should not hold stock in tobacco companies nor accept donations or research funds from those companies.

UCF-specific Policy

You can walk around campus at the University of Central Florida and see signs posted on nearly every building prohibiting smoking indoors. However, by the Reflection Pond, throughout Memory Mall, and right outside the residence halls you will see students puffing away on their cigarettes. You will commonly hear that no smoking is allowed with 25 feet of the buildings, particularly the residence halls, but most smokers seem to disregard this rule. Perhaps, they have some reason to do so… there is no UCF-specific tobacco or smoking policy. It's not in the handbook or anywhere online. The University or Central Florida simply adheres to the Florida Clean Indoor Air Act.

Current Study

The current study will offer a quantitative look at UCF student's perceptions of a smoke-free campus policy. The University of Central Florida is one of Florida's 11 public universities. Fall 2010 undergraduate enrollment was at 47,580 students, with 45.6% male and 54.4% female. The student profile is predominantly white, with 63.54% of students in this racial category. Followed by Hispanic students with 15.64% of the

population and then blacks with 9.6%. All other racial categories take up less than 12% of the population (University of Central Florida, 2010).

A survey will be distributed which asks the follow critical question: “Should UCF implement a smoke free campus policy?” This question is the dependent variable in the survey. A smoke free campus policy is defined in the survey with the following statement *“smoking and tobacco use are prohibited in all facilities and areas of campus, indoor and outdoor, with no exception.”* A Likert-type scale will be provided that includes the options *strongly agree, agree, neutral, disagree, strongly disagree.*

On the independent variable side, categories of questions will be presented that include demographics, lifestyle, history, and opinion. These sections will explore the participants’ other life choices and beliefs to try and understand if support of opposition to a smoke-free policy correlates with any other personal characteristics such as risky behaviors, health, peer influence, etc. The demographics section will ask about sex, age, race, class standing, and sexual orientation. The lifestyle section will collect data pertaining to athletic participation, nutrition, health, smoking status, sex partners, car safety, drug use, and alcohol use. The history section will ask about family history of lung cancer and family history of smoking. Finally, the opinion section will ask about religion, politics, and perception of personal liberties related to smoking and breathing clean air.

This survey will provide a comprehensive assessment of students that support or oppose a smoke-free campus policy. The direct outcome may be the majority of students favor a policy change. However, whether support is overwhelming in favor or opposed, this study will provide a look into the types of students that oppose so that researchers and administrators can then learn why. A few studies have been done to explore student perceptions of smoke-free policies. However, every university is unique and at a different stage in their process of implementing a smoke-free policy. UCF is far behind; meetings between the local American Lung Association and the university on this topic have led nowhere. Data is absolutely essential to moving forward with policy change. Therefore, this research will fill an important gap and provide a first look into UCF student perceptions of a smoke-free campus. From there, the data on students who support or strongly support a smoke-free policy can be presented to leaders within the UCF community. These campus leaders should be students, faculty & staff, administrators, and board members who will take the next step to garner more support for a smoke-free campus.

With UCF lacking any specific policy that dictates smoking and tobacco use, the first step is to assess UCF students' attitudes toward a smoke-free policy. Colleges and universities all over the country have been through the process of creating a smoke-free campus but none of them ever achieved success without strong data in favor of the proposed change. This study will provide that data in regards to the UCF community.

Methodology

The survey was administered in two stages. First, a web-based survey was opened on January 13, 2011 via Survey Gizmo. The survey web link was posted on WebCourses for three different classes: one lower-level anthropology class, an upper-level medical sociology class, and an upper-level magazine writing class. The survey web link was closed on February 10, 2011. Online data collection ended February 8, 2011 after 146 undergraduate students at the University of Central Florida had completed the survey. Second, paper surveys were distributed in three different classes: two lower-level anthropology classes and an upper-level sociology class. This method resulted in 419 completed surveys. This brought the total number collected (both web and paper based) to 565.

Classes where data collection took place were chosen on the likelihood that most of the students enrolled would be within the population: undergraduate students at UCF over the age of 18. The short time frame for data collection (4 weeks) coupled with the need for a large sample size meant that larger classes were needed. Classes were also chosen based on the researcher's access to them; professors whom the researcher already knew were contacted first.

Given that the first stage of the survey was distributed online, it is important to discuss the value of web-based surveys against traditional paper surveys. Researchers will find that web-based surveys are significantly less expensive than paper surveys given that both free and low cost survey hosting sites are available. Another benefit to

web-based surveys is that respondents report a greater feeling of anonymity and will give less socially desirable answers (Thornton & Gupta, 2004). The main potential problem is access because not everyone in any given population has a computer. However, given that the population for the current study is UCF undergraduate students, the entire population has access to the internet. The university provides many public computer labs where any students can gain access to the internet.

Non-probability convenience sampling was used. However, despite a less-than-ideal sampling method the final sample demographics reflect the population (undergraduate UCF students), though there are some notable differences. As of fall 2011, the UCF undergraduate population was 47,580 students. Of these students, 54.4% are female. The current sample has an overrepresentation of females with 66.5%. This can, perhaps, be explained by the types of classes where data collection took place. Most of the classes, with the exception of the magazine journalism class, were social science classes, specifically anthropology and a medical sociology class. According to UCF's diversity profile, 63.5% of the population is white. The current sample mirrored this parameter with 64% of the sample checking "Caucasian" as their race. Also, 5.4% of UCF students are Asian, while 2.9% of the current sample identifies as "Asian/Pacific Islander"; 9.6% of UCF students are black, while 7.1% of the current sample identifies as "Black/African America;" 15.64% of UCF students are Hispanic, while 17% of the current sample identifies as "Hispanic;" .35% of UCF students identify as American Native, while .7% of the current sample identify as "Native

American/Alaskan Native." The university claims the average age of its undergraduate students is 23. The current sample had an average age of 20.89, almost 21 years. The average age of the current sample is lower because some of the classes chosen for this study were introductory classes comprised mainly of freshman. In all, 40.2% of students whom participated in the survey are freshman, 16.2% are sophomores, 26.7% are juniors, and 14.4% are seniors.

Dependent Variable

The dependent variable in the current study measures at UCF student perceptions of a smoke-free campus policy. The question, which was presented near the end of the survey (question 30 out of 35), specifically asks, "Should UCF implement a smoke free campus policy?" The options are arranged on a Likert scale and coded 5-1 like so: "Strongly Agree" = 5; "Agree" = 4; "Neutral" = 3; "Disagree" = 2; "Strongly Disagree" = 1.

Independent Variables

The current study includes thirty-five questions, one measuring the dependent variable and the other thirty-four addressing various independent variables of interest to the researcher. The survey that was presented to participants was arranged into five categories: smoking status, lifestyle, history, opinions, and demographics.

There are twenty-two independent variables which were used in six regression models. In this section I will cover the exact wording of the questions along with how the responses are coded. The first set of independent variables includes the demographic characteristics of the respondents. Respondent *age* is coded 18 through 24. A small number of respondents were over the age of 24, the age of these respondents were recoded to equal 24. Next the *gender* variable originally stated as "What is your sex?" and is coded 0 = Male and 1 = Female. Next is the *race* variable, originally stated as "Which one or more of the following would you say is you race?" Race was coded 0 = Nonwhite and 1 = White.

Another variable, *personal smoking related deaths,* was based on the variable which originally states "Have any of your close family members or friends suffered from lung cancer or another smoking related disease? (such as chronic bronchitis, emphysema, etc.)" coded as 0 = No and 1 = Yes. Given that data was collected using two different methods, the type of survey (*survey format*) was also included as a control in all regression models, coded 0 = paper and 1 = online.

Three variables measure smoking behavior among the respondent's and their parents and friends. The *lifetime cigarette use* variable asks, "Have you ever tried cigarette smoking, even one or two puffs?" with the options "Yes" coded as 1 and "No" coded as 0. The original *parents' cigarette use* variable asks, "Do your parents smoke cigarettes?" with the options "Both"; "Neither"; "Mother only"; "Father only"; and "I don't know." The recoded version codes 1 for any affirmative response ("Both"; "Mother only";

"Father only") and 0 for any negative response ("Neither" or "I don't know"). The final variable is the *friends' cigarette use* variable stated as "Do any of your closest friends smoke cigarettes?" with the options "All of them" = 1; "Most of them" = 2; "Some of them" = 3; "None of them" = 4. I expect those who respond "Yes" to the *lifetime cigarette use* variable, some of those people being current smokers, to be less likely to support a ban than those who respond "No." I also expect those who answer with any affirmative response to the *parents' cigarette use* variable to be less likely to support a ban than those with any negative response. Finally, those who answer "All of them" or "Most of them" to the *friends' cigarette use* variable may be less likely to support a ban than those who responded "Some of them" or "None of them."

These variables measure health in terms of activity, perceptions of personal health, professional care, and personal satisfaction. The *physical activity* variable asks, "Think back over the past 7 days. On how many days did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard, such as basketball, soccer, running, swimming laps, bicycling, or similar aerobic activities?" with a blank for a written response. The *general health* variable asks, "Would you say that in general your health is…" with the options *"*Excellent*"* coded as 5; "Very good" coded as 4; "Good" coded as 3; "Fair" coded as 2; "Poor" coded 1. Then, the *doctor visit* variable which states, "About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition (excluding gynecological exams for females)" with the options

"Within past year (anytime less than 12 months ago)" coded as 4; "Within past 2 years (1 year but less than 2 years ago)" coded as 3; "Within past 5 years (2 years but less than 5 years ago)" coded as 2; "5 or more years ago" coded as 1. The last variable of *life satisfaction* asks, "In general, how satisfied are you with your life?" with the options "Very satisfied" coded as 5; "Satisfied" coded as 4; "Neutral" coded 3; "Dissatisfied" coded as 2; "Very dissatisfied" coded as 1. It is expected that people who are generally healthy will be more likely to support a ban. Generally healthy meaning they are physically active, visiting a doctor, feeling healthy, and satisfied with life.

These variables measure what could be categorized as deviant behavior in terms of sexual behavior and drug use. The *sexual partners* variable asks, "How many sexual partners have you had in the past 12 months" with the options "0" coded as 0; "1" coded as 1; "2" coded as 2; "3-5" coded as 3; "6-11" coded as 4; "12 or more" coded as 5. The *monthly hookah use* variable asks, "In the past month have you smoked from a hookah?" with "Yes" coded as 1 and "No" coded as 0. The *monthly marijuana use* variable asks, "In the past moth have you used marijuana?" with "Yes" coded as 1 and "No" coded as 0. The *monthly illegal prescription drug use* variable asks, "In the past month have you used any prescription drugs that were not prescribed to you?" with the options "Yes" coded as 1 and "No" coded as 0. Next, the *monthly illicit drug use* variable asks, "In the past month have you used any illicit drugs? (such as heroin, LSD, ecstasy, cocaine, amphetamines, etc.) with the options "Yes" coded as 1 and "No" coded as 0. The final variable of *binge drinking* asks, "During the past two weeks, have you had at

least 4 drinks in a row?" with the options "Yes" coded as 1 and "No" coded as 0. It is expected that people who have had more sexual partners will be less likely to support a ban. Also, people who have used more drugs in the past month may be less likely to support a ban. These expectations exist because these variables measure risk-taking behaviors and smoking is also a risk-taking behavior.

These variables measure beliefs and attitudes in terms of secondhand smoke, politics, religion, and government. The variable for *perceived harm of secondhand smoke* states, "Do you think the smoke from other peoples' cigarettes is harmful to you?" with the options "Definitely yes" coded as 5; "Probably yes" coded as 4; "Neutral" coded as 3; "Probably not" coded as 2; "Definitely not" coded as 1. Next, the *political identity* variable asks, "Politically speaking, would you say you are…" with the options "Very conservative" coded as 1; "Conservative" coded as 2; "Moderate" coded as 3; "Liberal" coded as 4; "Very liberal" coded as 5. The *religious importance* variable states, "Religious beliefs are a very important part of your life" with a Likert scale of "Strongly agree" coded as 5 then all the way through "Strongly disagree" coded as 1. The final variable of the *role of government in health* states, "The government should protect people in health related matters" with another Likert scale of "Strongly agree" coded as 5 through "Strongly disagree" as 1. It is expected that people who affirm that secondhand smoke is dangerous will be more likely to support a ban. Also, people who agree that the government should protect people in health related matters may be more likely to support a ban than those who do not.

Analytic Strategy

The main research question in this study is “What are UCF students’ perceptions of a smoke-free campus policy?” Before initiating this study, the researcher stated two main hypotheses. H1 is “The majority of undergraduate students at UCF who participated in the survey will support a smoke-free campus policy” and H2 states “Of the undergraduate UCF students who participated in the survey, current smokers will be less likely to support a smoke-free campus policy than non-smokers.”

In order to test Hypothesis 1, the descriptive statistics for the smoke-free campus policy will be examined. For Hypothesis 2, a series of ordinary least squares (OLS) regression models are estimated. A total of six different regression models are estimated to determine which independent variables are significantly correlated to the dependent variable. The current study is considered exploratory research given that there is a lack of research on student perceptions of smoking policies, specifically at UCF. Thus, the main goal is to determine what variables are significant correlates with the support of a smoke-free campus policy.

The six regression models can be labeled by the category they represent (summary below). There is the ***baseline*** model, ***smoking behavior*** model, ***health*** model, ***deviant behavior*** model, ***attitudes*** model, and the ***full*** model. The variables from the baseline model – *age, gender, race, personal smoking related deaths,* and *survey format* – are included in all six models. Model 2, the *smoking behavior* model,

adds three variables to the *baseline* model, they are *lifetime cigarette use, parents' cigarette use*, and *friends' cigarette use*. Model 3, the *health* model, adds four variables to the *baseline* model, they are *physical activity, general health, doctor visits,* and *life satisfaction.* Model 4, the *deviant behavior* model, adds six variables to the *baseline* model, they are *sexual partners, monthly hookah use, monthly marijuana use, monthly illegal prescription drug use, monthly illicit drug use*, and *binge drinking*. Model 5, the *attitudes* model, adds four variables to the *baseline* model, they *are perceived harm of secondhand smoke, political identity, religious importance*, and *role of government*. Lastly, the *full* model includes all twenty-two independent variables that were chosen for analysis.

Findings

This section will describe the frequency in which certain items appeared within the sample along with the overall outcome of the research. It will also report the significant results of the six regression models used in analysis. Some of the variables used in analysis were found to have a positive correlation with opposition to a smoke-free policy. The frequencies of some of those variables within the sample will be reported in this section. The descriptive statistics for the dependent variable support the first hypothesis, “the majority of undergraduate students at UCF who participated in the survey will support a smoke-free campus policy.” 52.8% of respondents either “agree” or “strongly agree” that UCF should implement a smoke-free campus policy. Another 23% are “neutral” to a policy. Only 24.3% respondents “disagree” or “strongly disagree” and a mere 8.7% responded “strongly disagree” for UCF implementing a smoke-free policy. On a 5-point scale, with 1 being “strongly disagree” and 5 being “strongly agree, the mean is 3.51. The averages and percentages for other variables can be found in Table 1 below.

Table 1 Descriptive Frequencies by Mean and Percent

	Mean	% “Yes” (if applicable)
Age (18 - 24)	20.89	
Gender (male – 0, female – 1)	.66	66.5 (female)
Race (nonwhite – 0, white – 1)	.64	64.0 (white)
Personal Smoking Related Deaths	.38	38.1
Survey Format	.74	
Lifetime Cigarette Use	.47	47.5
Parents’ Cigarette Use	.94	23.2
Friends’ Cigarette Use	1.59	
Physical Activity	2.80	
General Health	3.91	
Doctor Visit	3.31	
Life Satisfaction	4.23	
Sexual Partners	1.06	
Monthly Hookah Use	.18	17.6
Monthly Marijuana Use	.22	21.5
Monthly Illegal Prescription Drug Use	.06	5.9
Monthly Illicit Drug Use	.02	2.3
Binge Drinking	.40	39.9
Perceived Harm of Secondhand Smoke	4.65	
Political Identity	3.26	
Religious Importance	3.14	
Role of Government in Health	3.87	

For the next stage of the data analysis several *OLS* regression models were estimated to determine which variables were significantly correlated to the dependent variable. Model 1, the ***baseline*** model *with age, gender, race, personal smoking related deaths*, and *survey format*, had only one significant outcome: *gender* (*b* = .503). Females are more likely than males to support a smoke-free policy at UCF.

The second model which looks at ***smoking behavior*** added *lifetime cigarette use, parents' cigarette use*, and *friends' cigarette use* to the baseline model. Once again, females are more likely to support a smoke-free policy (*b* = .429). Also, based on the results of the *lifetime cigarette use* (*b* = -.644) variable in this model, people who have used cigarettes in their lifetime are less likely to support a smoke-free policy. Lastly, based on *friends' cigarette use* (*b* = -.577) variable in this model, people whose friends smoke are less likely to support a smoke-free policy.

Next, the ***health*** model (model 3) added *physical activity, general health, doctor visits*, and *life satisfaction* to the baseline model. Again, females are more likely to support a smoke-free policy (*b* = .532). According to the results of the *general health* (b = .235) variable, people who give a positive rating to their own health are more likely to support a smoke-free policy. Then based on the *doctor visits* (*b* = .104) variable, people who visit the doctor more frequently are more likely to support a smoke-free policy than those who visit the doctor less frequently. According to the last significant outcome in this model (based on the result of the *life satisfaction* variable), people who are more

satisfied with their life are more likely to support a smoke-free policy than those who are less satisfied with their life.

The fourth model which looks at ***deviant behavior*** added *sexual partners, monthly hookah use, monthly marijuana use, monthly illegal prescription drug use, monthly illicit drug use*, and *binge drinking* to the baseline model. This is the only model where *age* is significant; older people are more likely than younger people to support a smoke-free policy. For the fourth time, *gender* proved to be significant with females more likely to support a smoke-free policy. Also, based on the results of the *monthly hookah use* variable, people who have used hookah within the past month are less likely to support a smoke-free policy than those who have not used hookah. The same correlation was found for the *monthly marijuana use* variable; people who have used marijuana within the past month are less likely to support a smoke-free policy. Lastly for this model, the result from the *binge drinking* variable show that people who have participated in binge drinking within the past two weeks are less likely to support a smoke-free policy.

The fifth model covers ***attitudes*** and adds *perceived harm of secondhand smoke, political identity, religious importance*, and *role of government* to the baseline model. Again *gender* has proved to be significant; females are always more likely to support a smoke-free policy. Next for this model, the results of the variable *perceived harm of secondhand smoke* showed that the people who agree that secondhand smoke is harmful are more likely to support a smoke-free policy. As for the results of the

political identity variable, people whom identify as more conservative are more likely to support a smoke-free policy. For the *religious importance* variable, people who agree that religion is important in their life are more likely to support a smoke-free policy. Finally, for the *role of government* variable, people who agree that the government should protect people in health related matter are more likely to support a smoke-free policy.

Finally, the full model (model 6) includes all the variables that have been used in analysis thus far. There were nine variables with significant outcomes: *age, gender, lifetime cigarette use, friends' cigarette use, general health, monthly hookah use, monthly marijuana use, binge drinking, perceived harm of secondhand smoke,* and *role of government*. Based on the results of all those variables, the following correlation statements can be made for this regression model. Older people are more likely than younger people to support a smoke-free policy. Females are more likely to support a smoke-free policy than males. People who have used cigarettes in their lifetimes are less likely to support a smoke-free policy than people who have not. Also, people who have friends that smoke are less likely to support a smoke-free policy. People who rate their personal health at a high level are more likely to support a smoke-free policy. People who have use hookah and/or marijuana with the past month are less likely to support a smoke-free policy than those who have not. People who have participated in binge drinking in the past two weeks are less likely to support a smoke-free policy than those who have not. People who agree that secondhand smoke is harmful are more

likely to support a smoke-free policy than those who disagree. Finally, people who agree that the government should protect people in health related matters are more likely to support a smoke-free policy than those who disagree.

Lastly, various correlation matrices were created to understand the relationship between variables. A correlation matrix was created between the *lifetime cigarette use* and *friends' cigarette use* variables. People who have smoked in their lifetime (including current smokers) is strongly related (r = .402) to having friends that smoke.

There are many significant correlations between variables at the .01 level. Variables that have a strong positive relationship with the *lifetime cigarette use* variable are the *monthly hookah use* (r = .232) variable, the *illegal prescription drug use* (r = .173) variable, the *monthly illicit drug use* variable (r = .162), the *binge drinking* (r = .308) variable, and the *friends' cigarette use* variable (as mentioned in the previous paragraph). On the other hand, variables that have a strong negative relationship with the *lifetime cigarette use* variable are the *perceived harm of secondhand smoke* variable (r = -.202), the *general health* variable (r = -.124), and the *religious importance* variable (r = -.154). Basically, there is a strong positive relationship between drug users and cigarette smokers and a negative relationship between cigarette smokers and people who believe religion is important, people who believe they are healthy, and people who believe secondhand smoke is dangerous.

Table 2 Regression Models 1-6

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
Age	.017	**.030***	.021	**.029***	.015	**.027***
	(.015)	(.013)	(.014)	(.014)	(.013)	(.012)
Gender (female)	**.503*****	**.429*****	**.532*****	**.394*****	**.255***	**.221***
	(.118)	(.106)	(.119)	(.115)	(.110)	(.106)
Race (white)	-.170	-.089	-.148	-.060	-.018	.089
	(.115)	(.104)	(.114)	(.111)	(.107)	(.101)
Smoking Related Deaths	-.018	.045	-.033	-.054	-.026	.024
	(.114)	(.103)	(.113)	(.110)	(.104)	(.098)
Survey Format	-.037	-.022	-.077	.055	-.098	-.078
	(.126)	(.114)	(.125)	(.125)	(.116)	(.112)
Lifetime Cigarette Use		**-.644*****				**-.305****
		(.109)				(.110)
Parents' Cigarette Use		-.005				.046
		(.120)				(.120)
Friends' Cigarette Use		**-.577*****				**-.420*****
		(.086)				(.087)
Physical Activity			.027			.036
			(.028)			(.024)
General Health			**.235****			**.215*****
			(.077)			(.066)
Doctor Visit			**.104+**			.038
			(.061)			(.054)
Life Satisfaction			**.136+**			.003
			(.078)			(.068)
Sexual Partners				.044		.078
				(.056)		(.050)
Hookah Use				**-.358***		**-.295***
				(.152)		(.135)
Marijuana Use				**-.447****		**-.248+**
				(.146)		(.131)
Prescription Drug Use				-.373		-.147
				(.243)		(.220)
Monthly Illicit Drug Use				-.534		.203
				(.380)		(.336)
Binge Drinking				**-.506*****		**-.191+**
				(.120)		(.112)
Secondhand Smoke					**.723*****	**.587*****
					(.075)	(.073)
Political Identity					**-.118+**	-.026
					(.062)	(.059)
Religious Importance					**.079+**	.047
					(.041)	(.040)
Government in Health					**.173****	**.125***
					(.064)	(.061)
F-Test	**4.611*****	**20.218*****	**5.208*****	**8.802*****	**17.909*****	**13.668*****
R-square	.041	.231	.081	.158	.233	.354

Table includes unstandardized regression coefficient with standard error in parenthesis (+ $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .00$).

Discussion

The purpose of the current study is to explore the significant correlates of support for a smoke-free campus policy at UCF. There has been very little research in this area, specifically for the UCF population. This research is important because the attitudes of UCF students toward a smoke-free campus policy have never been assessed. Being that this is a public health issue and many other universities in the country have implemented smoke-free policies, input from UCF students is crucial to the discussion of the policy at UCF. An examination of the significant correlates will illuminate the characteristics of students whom support the policy.

To summarize, the following statements reflect the variables that are significant in the full model. Of the respondents, older and female respondents are more likely to support a smoke-free policy at UCF, along with respondents who agree that secondhand smoke is harmful and people who believe the government should protect people in health related matters. Respondents who answered affirmative to the *lifetime smoking use* variable and the *friends' cigarette use* are less likely to support the smoke-free policy, along with respondents who used either a hookah or marijuana in the past month or report binge drinking in the past two weeks.

The results of the current study support both hypotheses. For H1, which states the majority of respondents will support a smoke-free campus policy, the findings validate this. The majority of undergraduate UCF students do support a smoke-free

campus policy at UCF, 52.8% responded with agree or strongly agree. The second hypothesis, current smokers will be less likely to support a smoke-free campus policy, was also supported. The regression coefficient shows a significant relationship (b= -.305) between smokers and opposition to the policy.

A closer inspection of the significant findings illustrates some clear relationships to the dependent variable. First, the *age* variable is significant (*b* = .027) with older respondents more likely to support a smoke-free policy. One possible explanation is that younger students, including freshmen and first-time in college students, are just entering the phase in which they are independent and more likely to experiment with substances; therefore, they are not interested in restricting those risk-taking behaviors they are just beginning to experience. The next significant variable, *gender* (*b* = .221) shows that females are more likely than males to support a smoke-free policy. This might be explained by the well-known tendency of women to be more health conscious than males; it is possible that women are more in tune with the ailments of their bodies. Research has shown that women are more likely to go to the doctor when something is wrong than men (Galdas, Cheater & Marshall, 2005). This greater concern for health matters in women would naturally correlate with their support of a smoke-free policy.

The next two significant findings demonstrate an obvious association to the opposition a smoke-free policy. The *lifetime smoking use* variable, which includes all current smokers, is significant (*b* = -.305) meaning that if the respondent has ever tried cigarette smoking they are less likely to support a smoke-free policy. Whether someone

has merely tried smoking or is a current smoker, clearly they do not have an aversion to cigarette use and would not be in favor of the smoke-free policy. Also, if they are a current smoker, then a smoke-free policy on campus would greatly inconvenience them. A similar logic will explain the next significant outcome, *friends' cigarette use* (*b* = -.420), which shows that people whose friends smoke are less likely to support a smoke-free policy. People who have friends that smoke are more likely to be around smoking when socializing with those friends; their lack of aversion to cigarettes will make them more likely to oppose a ban. Also, for the sake of their friends' convenience in continuing their habit and addiction, people with friends who smoke will be more likely to oppose the policy.

The next three significant outcomes are all related to risk-taking behavior. Thus, they can be explained in a similar manner. First, *the monthly hookah use* variable is significant (*b* = -.295) meaning that those who have used hookah in the past month are less likely to support a policy. Next, the *monthly marijuana use* variable is significant (*b* = -.248) meaning that respondents who have used marijuana in the past month are less likely to support a smoke-free policy. Lastly, the *binge drinking* variable is significant (*b* = -.191) meaning that those who have participated in binge drinking in the past two weeks are less likely to support a smoke-free policy. The main possible explanation of these findings is that people who participate in risk-taking behaviors are more likely to oppose a ban that restricts a similar risk-taking behavior. Risk-taking behavior is considered any activity that is harmful, dangerous, or unhealthy. People who enjoy or

habitually engage in these types of behaviors are most likely going to want the freedom to engage in them at will, despite putting other peoples' health at risk.

The final two significant outcomes are opinion-based. First, *the perceived harm of secondhand smoke* variable is significant (*b* = .587) meaning those who agree that secondhand smoke is harmful are more likely to support a smoke-free policy. The possible reason for this correlation is that people who acknowledge that secondhand smoke is harmful are more likely to want to avoid exposure to it, thus they realize a smoke-free campus policy will provide some relief from the harmful substance. The last significant factor is for the *role of government in health* (*b* = .125) meaning that people who believe the government should protect people in health related matters are more likely to support a smoke-free policy. The main idea behind this correlation is that if people believe that the government should protect (possibly via federal policies) the people in health related matter, then they will be more likely to support the governing body at UCF implementing a policy which offers protection in regards to health. Basically, people who support policy change for the benefit of the public on a national level will support it at the university level.

The current study is not without limitations. The findings are not generalizable to this university or others. Colleges and universities in different regions have unique student populations that do not necessarily reflect the same attitudes or characteristics of UCF students. The study is not necessarily generizable to the UCF population due to the small sample size and the effect of social desirability on responses. The sample

consisted of a mere 565 students who participated in the survey; there are 47,580 undergraduate students at UCF. The smaller the sample size means that the results cannot be generalized. Also, because the second stage of the survey was the traditional paper survey method, the effect of social desirability plays a role. Students responded to personal and potentially sensitive questions in public surrounded by their peers. It is possible that some responses were not truthful and the subject answered based on how his peers or society would expect.

Given these limitations and for the sake of expanding research on this subject, another study examining UCF students' perceptions of a smoke-free campus policy but on a larger scale is proposed. It may be beneficial to conduct another study that is completely online in order to reach more students and to reduce the effect of social desirability. It may also be interesting to ask students directly why they support or oppose a smoke-free campus policy. Future research may not fall in the realm of quantitative survey research but in qualitative case studies or focus groups. Students should be given the opportunity to expand on their stance of for or against a smoke-free policy.

Given that the current research has found the majority of undergraduate students at UCF support a smoke-free campus policy being implemented at UCF, the administration should begin to discuss and consider implementing such a policy. However, it will take students, faculty and the administration to make this policy a success. Once administration is open to the idea, it will be up to the students to rally

together and gather more support for the policy. Other schools in the state, such as UF, have utilized a tobacco-free task force that created campaigns against smoking and held regular meetings to discuss the topic. The task force can conduct further research on smoking at UCF and then present the data to the administration. UCF will want to develop a plan of action which focuses on specific problems such as smoking prevention and cessation.

Additionally, further research should focus on the students which oppose a smoke-free policy. The respondents who oppose a smoke-free policy were found to be current smokers, people with friends that smoke, recent hookah users, recent marijuana users, and recent binge drinkers. Further research should aim to assess the reasons why students with these characteristics oppose the policy. Also, this study has shown that people who are aware of the dangers of secondhand smoke are more likely to support a smoke-free policy. Thus, people who oppose the policy should be made aware of the dangers of smoking and secondhand smoke.

Finally, there is a fairly large percent of students who were “Neutral” to the smoke-free policy (23%). Education and awareness may help these students decide how they feel about smoking and secondhand smoke. It seems likely that not having enough information on a topic is a likely reason to be neutral, especially when the question is one of policy change. Thus, further research and efforts in this arena should focus on providing more information to students on smoking, secondhand smoke, and smoking policy.

APPENDIX: SURVEY QUESTIONNAIRE

INFORMED CONSENT

Purpose of the research study: The purpose of this study is to determine the support and opposition for smoke-free policy at UCF

The person doing this research is Alyssa Roman, a student at the University of Central Florida. If you have questions regarding this research, Ms. Roman can be reached at alyssaroman323@knights.ucf.edu

Voluntary participation: You should take part in this study only because you want to. There is no penalty for not taking part, and you will not lose any benefits. You have the right to stop at any time. Just leave any and all items that you don't want to fill out blank

Confidentiality: This study is *anonymous*, meaning that at no point in time will your name be collected

Contact IRB about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901

Since I am not gathering names, *your participation in this survey constitutes your informed consent*. Please feel free to keep this form for your records and contact me if you have any concerns related to this study

Smoking Status

1. Have you ever tried cigarette smoking, even one or two puffs?

( ) Yes ( ) No

2. During the past 30 days, about how many days did you smoke cigarettes?

_____

3. During the past 30 days, on the days you smoked, how many cigarettes did you smoke per day?

( ) I did not smoke cigarettes during the past 30 days

( ) Less than 1 cigarette per day

( ) 1 cigarette per day

( ) 2 to 5 cigarettes per day

( ) 6 to 10 cigarettes per day

( ) 11 to 20 cigarettes per day

( ) More than 20 cigarettes per day

4. Do you want to stop smoking cigarettes?

( ) I do not smoke now

( ) Yes

( ) No

5. Do you think the smoke from other people's cigarettes is harmful to you?

( ) Definitely yes

( ) Probably yes

( ) Neutral

( ) Probably not

( ) Definitely not

Lifestyle

6. Are you a member of a social fraternity or sorority?

( ) Yes ( ) No

7. In the past 30 days, how many hours per day on average have you spent socializing with friends in an unstructured environment?

( ) 0

( ) 1

( ) 2

( ) 3

( ) 4

( ) 5 or more

8. Think back over the past 7 days. On how many days did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard, such as basketball, soccer, running, swimming laps, bicycling, or similar aerobic activities?

_____

9. In the past month have you smoked from a hookah?

( ) Yes ( ) No

10. In the past month have you used Marijuana?

( ) Yes ( ) No

11. In the past month have you used any prescription drugs that were not prescribed to you?

( ) Yes ( ) No

12. In the past month have you used any illicit drugs? (such as heroin, LSD, ecstasy, cocaine, amphetamines, etc.)

( ) Yes ( ) No

13. Would you say that in general your health is—

( ) Excellent

( ) Very good

( ) Good

( ) Fair

( ) Poor

14. About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. (excluding gynecological exams for females)

( ) Within past year (anytime less than 12 months ago)

( ) Within past 2 years (1 year but less than 2 years ago)

( ) Within past 5 years (2 years but less than 5 years ago)

( ) 5 or more years ago

15. During the past two weeks, have you had at least 4 drinks in a row?

( ) Yes ( ) No

16. How often do you use seat belts when you drive or ride in a car? Would you say—

( ) Always

( ) Nearly always

( ) Sometimes

( ) Seldom

( ) Never

17. During the past 30 days, have you driven when you've had perhaps too much to drink?

( ) Yes ( ) No

18. How many sexual partners have you had in the past 12 months?

( ) 0

( ) 1

( ) 2

( ) 3 – 5

( ) 6 – 11

( ) 12 or more

19. In general, how satisfied are you with your life?

( ) Very satisfied

( ) Satisfied

( ) Neutral

( ) Dissatisfied

( ) Very dissatisfied

History

20. Do your parents smoke cigarettes?

( ) Both

( ) Neither

( ) Mother only

( ) Father only

( ) I don't know

21. Is either of your parents a former cigarette smoker?

( ) Yes ( ) No

22. Do any of your closest friends smoke cigarettes?

( ) None of them

( ) Some of them

( ) Most of them

( ) All of them

23. Are any of your closest friends former cigarette smokers?

( ) Yes ( ) No

24.) Have any of your close family members or friends suffered from lung cancer or another smoking related disease? (such as chronic bronchitis, emphysema, etc.)

( ) Yes ( ) No

Opinions

25. Politically speaking, would you say you are—

( ) Very conservative

( ) Conservative

( ) Moderate

( ) Liberal

( ) Very liberal

26. During the past 12 months, how many times did you attend religious services? Do not include special occasions such as weddings, funerals, or other special events in your answer.

( ) 0 Times

( ) 1 to 2 Times

( ) 3 to 5 Times

( ) 6 to 24 Times

( ) 25 to 52 Times

( ) More than 52 Times

27. Religious beliefs are a very important part of your life.

( ) Strongly agree

( ) Agree

( ) Neutral

( ) Disagree

( ) Strongly disagree

28. The government should protect the people in health related matters.

( ) Strongly agree

( ) Agree

( ) Neutral

( ) Disagree

( ) Strongly disagree

29. As a society, we have a responsibility to protect nonsmokers from exposure to secondhand smoke

( ) Strongly agree

( ) Agree

( ) Neutral

( ) Disagree

( ) Strongly disagree

30. Should UCF implement a smoke free campus policy?

( ) Strongly agree

( ) Agree

( ) Neutral

( ) Disagree

( ) Strongly disagree

Demographics

31. What is your age?

_____

32. What is your sex?

[ ] Female [ ] Male

33. Which one or more of the following would you say is your race?

[ ] Asian/Pacific Islander

[ ] Black/African-American

[ ] Caucasian

[ ] Hispanic

[ ] Native American/Alaska Native

[ ] Other/Multi-Racial

[ ] Decline to Respond

34. What is your current year in school?

( ) Freshman

( ) Sophomore

( ) Junior

( ) Senior

( ) 5th year

( ) Grad student

35. How would you describe your sexual orientation?

( ) Heterosexual

( ) Homosexual

( ) Bisexual

Thank you for completing this survey!

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