CADE Coalition of Colorado Campus Alcohol & Drug Educators

COLORADO Department of Human Services

SOCIAL NORMING CAMPAIGN

TOOLKIT

INTRODUCTION TO THE SOCIAL NORMING **CAMPAIGN TOOLKIT**

On behalf of the Coalition of Colorado Campus Alcohol and Drug Educators (CADE), welcome to the CADE Social Norming Toolkit. CADE is the only statewide coalition for campus prevention practitioners and administrators in Colorado. First convened in 1989, the CADE has supported campus implementation of evidence-based and evidence-informed prevention programs at 24 institutions of higher education in Colorado.

In collegiate prevention, we recognize that college students are bombarded with a persistent messaging that has become part of higher education lore: "everyone is misusing alcohol and other substances." The unfortunate result of this messaging is that it becomes self-fulfilling – as student misperception overestimates prevalence, use becomes more permissive, and misuse and related consequences rise. It is the duty of a comprehensive campus prevention program to correct misperceptions and better align student perception. This can be done through a social norms campaign.

Campuses need solutions that take into consideration varying levels of capacity, unique branding guidelines, and diverse student populations while preserving fidelity to the evidence supporting social norms campaigns. This toolkit is designed to be a guide to move forward to that goal. CADE staff remain committed to provide training and technical assistance to campuses in selecting and implementing social norms strategies.

Hopefully, your campus will continue to increase capacity for prevention initiatives like a social norms campaign alongside student leaders who are partners in prevention. Often termed as "peer educators," students play a unique role in designing and implementing prevention strategies. This toolkit is designed for reference and support throughout the academic year by both professional prevention practitioners and students. Effective peer educators can integrate the data, messages, and strategies into their educational efforts during any time of the year and in their daily peer-to-peer interactions.

As you and your campus build a prevention strategy, use tools like a social norms campaign described in this toolkit to identify and enhance the upstream prevention of addressing shared risk and protective factors. Enhancing social collaboration, decreasing misuse access, and resolving inequities help not only address problems associated with alcohol and other drug misuse, but also contribute to other outcomes important for the successful retention and persistence of students.

On behalf of the CADE staff, our collaborative partners, and the CADE steering committee, we hope that your campus will continue to be successful in your prevention goals and this toolkit will guide your efforts to provide a healthy and safe campus environment.

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NASPA - Student Affairs Administrators in Higher Education

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WHAT IS **SOCIAL NORMING?**

Social norming is a widely used intervention strategy for promoting positive health-related behaviors. It operates on the premise that individuals misperceive their peers' behaviors and attitudes, with evidence of under- and over-estimations of behaviors and peer approval for a range of positive and negative behaviors respectively. The greater these misperceptions, the more likely an individual is to engage in negative behaviors such as consuming heavier amounts of alcohol and other substances and reduce positive behaviors.

A successful social norming strategy should consider the following:

- College Student Risk & Protective Factors
- Descriptive Norms and Injunctive Norms
- Data Collection
- Population Behavior, Knowledge, and/or Skills Data
- Social Ecological Model
- Transtheoretical Model
- Logic Model
- Peer Education
- Paid Marketing

Each topic will help in the Planning, Data Collection, and Implementation of a social norming campaign.

COLLEGE STUDENT **RISK & PROTECTIVE FACTORS**

The Substance Abuse and Mental Health Services Administration (SAMSHA) defines risk factors as biological or psychological characteristics that are associated with a higher likelihood of negative outcomes. Protective factors are associated with a lower likelihood of negative outcomes, and may foster resiliency. The National Institute of Drug Abuse (NIDA) indicates that risk and protective factors span individual, family, peer, community and school domains.

The misuse of alcohol and other drugs by traditionally aged college or university students (age 18-25) can be uniquely impacted by a variety of factors, including a significant change in housing situation, intense academic stressors, new social situations, and emerging mental health concerns (Bland, 2012).

RISK FACTORS INCLUDE:
Lack of caretaker supervision
Access
Associating with drug using peers
Party Culture
Permissive norms
Adolescent risk seeking behaviors
Lack of organized activities

PROTECTIVE FACTORS INCLUDE:
High self-esteem or sense of self
Appropriate coping skills
Positive norms
Connectedness
Campus Policy
Effective prevention programming

By increasing utilization of protective factors and/or decreasing risk factors of traditionally aged college or university students through intentional intervention strategies can lead to upstream prevention of multiple behaviors. Ultimately leading to healthier campuses and communities. Each topic will help in the Planning, Data Collection, and Implementation of a social norming campaign.

PLANNING

For the initial planning stage of a social norming campaign, it is important to clearly identify the issue to be addressed, specific populations, and the associated interventions. It's also important to begin thinking about the goals of the project and to select the measurement criteria to be used to assess progress toward said goals. Staff should also work on advocating for the social norming campaign with key partners and stakeholders. A careful consideration of these and other issues will help staff to assess their readiness to implement a well-researched and well-designed social norms campaign.

THE RESEARCH:

Research to understand the prevention context that includes, for example (Berkowitz, 2005; Haines, Perkins, Rice, & Barker, 2005):

- **A** Defining the problem (e.g., binge drinking) to be addressed.
- **B** Identifying the audience (e.g., college students).
- **C** Identifying key stakeholders (i.e., those who can influence and/or care about program outcomes).
- **D** Determining whether stakeholders are ready and willing to implement a social norms intervention, and address any questions or concerns.

The following sections will assist further in the planning of a social norming campaign.

DESCRIPTIVE NORMS & INJUNCTIVE NORMS

The term "social norms" refers to social rules that guide behaviors. Two types of norms that receive a lot of attention in research are descriptive norms and injunctive norms. Descriptive norms are one's perception of other people's actual behaviors. Injunctive norms are perceptions of behaviors typically approved or disapproved by others. Injunctive norms assist individuals in determining acceptable and unacceptable behavior.

Research by Buckner (2013) found two specific social norms that influence college student substance use patterns. The injunctive norms of family members and friends who openly approve of alcohol and other drugs use as well as the descriptive norms that favor alcohol and other drug use, play a primary role in influencing college students' decisions to use substances. Further, Buckner found that college students who have positive expectations regarding the benefits of alcohol and other drug use as well as those who use alcohol or other drugs as coping mechanisms, are more likely to use substances than others. Results indicated that 67% of the probability of using substances is accounted for by a combination of favorable descriptive norms and injunctive norms, low perceived harm, and use as a coping mechanism (Buckner, 2013).

When developing a campaign to address social norms, it is important to know the descriptive norms and injunctive norms of your community or specific population based on the data collected.

DESCRIPTIVE NORMS & **INJUNCTIVE NORMS**

TWO TYPES

SOCIAL NORMS

DESCRIPTIVE NORM

Describes what most **do.**

INJUNCTIVE NORM

Describes what most **approve** or **disapprove** of.

DATA COLLECTION

The social norming campaign is a data-driven, integrated process. This means that both qualitative and quantitative data is gathered to determine how the project will proceed from stage to stage, and that the stages are dependent upon one another. It is important to gather data in order to establish baseline measures. From your data, you will be able to create social norming messages. With the data you will also perform process evaluation and, as part of outcome evaluation, to assess the effectiveness of the intervention.

THE RESEARCH:

Social norming interventions are based on quantitative data gathered using established research methods. The questions that are asked should provide data about the target population's:

- **A** Personal behaviors and attitudes (including protective behaviors)
- **B** Perceptions of peers' typical behaviors and attitudes
- **C** Exposure to social norm messages
- **D** Data also can include protective behaviors, such as staying with friends who have been drinking so they are not alone with strangers and asking friends to slow down when they are perceived to be drinking excessively (see Turner, Perkins, & Bauerle, 2008, p.86).
- **E** Develop social norms messages for the intended audience, or specific sub-groups, that are compelling and culturally appropriate. Effective messages tend to be simple, honest, positive, and empowering (see also Haines, 1996); tell a story; and include eye-catching details.
- **F** Elicit audience feedback (e.g., using focus groups and pilot tests) to help shape messages and select delivery methods (see also Berkowitz, 2005; Scribner et al., 2011).

COLLEGE SUBSTANCE USE DATA

Social norming campaigns require data to be evidence-based. One avenue for data collection is the utilization of the American College Health Association's National College Health Assessment (ACHA-NCHA). The ACHA-NCHA survey queries several data points about college students' overall health habits, behaviors, and perceptions.

Results presented in this toolkit includes data from the American College Health Association's National College Health Assessment (ACHA-NCHA) collected between 2017 and 2019. There were 14 institutions of higher education in Colorado that helped create a population-level dataset for collegiate alcohol substance use in Colorado.

All citations to Colorado data comes from that dataset, while citations to national data are the comparison spring 2019 data set from the American College Health Association (ACHA).

As reference to the table below, in Colorado, 70.8% of college students reported consuming alcohol in the past 30 days. Use in Colorado is higher than the national average, with 58.4% of college students reported consuming alcohol in the past 30 days.

With implementation of a social norming campaign, we must look at the perceived use of alcohol across the state and nation. In Colorado, students in Colorado perceive that 95.9% of college students in Colorado drink; however, when comparing the national average, students across the nation perceive that 92.9% of all students drink.

COLLEGE
SUBSTANCE USE DATA

Colorado percent of college students reported use and perceived use of alcohol within the last 12 months:

ALCOHOL	ACTUAL USE			PERCEIVED USE		
PERCENT (%)	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
Never used	17.5	14.4	15.7	3.7	2.0	2.6
Used, but not in the last 30 days	11.9	14.1	13.5	1.7	1.3	1.5
Used 1-9 days	48.9	54.0	52.0	39.3	33.6	35.7
Used 10-29 days	19.5	16.5	17.3	44.1	49.4	47.3
Used all 30 days	2.3	1.0	1.5	11.3	13.7	12.9
Any use within the last 30 days	70.6	71.5	70.8	94.7	96.7	95.9

National percent of college students reported use and perceived use of alcohol within the last 12 months:

ALCOHOL	ACTUAL USE			PERCEIVED USE		
PERCENT (%)	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
Never used	28.3	22.5	24.6	6.2	4.1	4.9
Used, but not in the last 30 days	16.0	17.4	17.0	2.9	1.8	2.2
Used 1-9 days	41.8	48.7	46.3	43.3	37.4	39.2
Used 10-29 days	12.5	10.8	11.3	36.3	42.7	40.6
Used all 30 days	1.4	0.6	0.9	11.3	14.0	13.1
Any use within the last 30 days	55.7	60.1	58.4	90.9	94.1	92.9

COLLEGE
SUBSTANCE USE DATA

Heavy Episodic drinking is also a prevalent issue in Colorado. In reference to the table below, in Colorado, 32.7% of college students reported heavy episodic drinking at least once in the past two weeks in comparison to the national average of 25.6% of college students reporting heavy episodic drinking at least once in the past two weeks.

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

PERCENT (%)	MALE	FEMALE	TOTAL
N/A or don't drink	22.0	19.3	20.5
none	37.4	51.4	46.3
1-2 times	28.0	22.3	24.2
3-5 times	9.9	6.1	7.4
6 or more times	2.8	0.9	1.1

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

PERCENT (%)	MALE	FEMALE	TOTAL
N/A or don't drink	33.5	27.5	29.6
none	36.8	48.6	44.8
1-2 times	21.1	18.8	19.4
3-5 times	7.1	4.6	5.3
6 or more times	1.6	0.6	0.9

COLLEGE
SUBSTANCE USE DATA

Among Colorado college students, legalization of cannabis has been associated with an increased prevalence of initiation of use (i.e., having ever tried) among college students. When comparing the percent of college students who reported any cannabis use within the last 30 days, we see a reported 30.4% in Colorado to the 22.1% national average of cannabis use.

Another level to consider is the perceived use of cannabis in Colorado is also higher than the national average. College students in Colorado perceive that 91.9% of their peers are using cannabis, while the national average of perceived use is 87.1%.

Colorado percent of college students reported use and perceived use of cannabis within the last 12 months:

MARIJUANA	ACTUAL USE			PERCEIVED USE		
PERCENT (%)	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
Never used	45.7	48.4	47.5	5.7	3.5	4.4
Used, but not in the last 30 days	20.2	23.3	22.2	4.6	3.0	3.7
Used 1-9 days	17.9	17.5	17.5	42.9	35.1	38.0
Used 10-29 days	8.5	6.2	6.9	34.6	40.9	38.4
Used all 30 days	7.7	4.6	5.9	12.1	17.5	15.5
Any use within the last 30 days	34.1	28.3	30.4	89.7	93.5	91.9

National percent of college students reported use and perceived use of cannabis within the last 12 months:

MARIJUANA	ACTUAL USE			PERCEIVED USE		
PERCENT (%)	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
Never used	58.0	57.7	57.6	10.1	6.8	7.9
Used, but not in the last 30 days	19.4	20.9	20.3	6.9	4.2	5.0
Used 1-9 days	12.5	14.0	13.7	43.9	38.4	40.0
Used 10-29 days	5.8	4.7	5.1	27.2	33.3	31.3
Used all 30 days	4.3	2.7	3.4	12.0	17.4	15.7
Any use within the last 30 days	22.6	21.4	22.1	83.1	89.0	87.1

COLLEGE
SUBSTANCE USE DATA

Last but not least, there must be consideration to the reported use of non-prescribed prescription drugs. In referring to the table below, not only do we see a higher reported total use of stimulant drugs at 8.9% in Colorado but we also see 14.6% reported use of 1 or more drugs. Nationally, college students report using stimulant drugs at 5.9% and 11.4% when reporting using 1 or more drugs.

Colorado percent of college students who reported using prescription drugs that were not prescribed to them with the last 12 months:

PERCENT (%)	MALE	FEMALE	TOTAL
Antidepressants	2.5	3.6	3.2
Erectile dysfunction drugs	1.2	0.7	0.9
Pain killers	5.4	5.0	5.2
Sedatives	4.4	4.8	4.7
Stimulants	10.0	8.3	8.9
Used 1 or more of the above	**1.2**	**14.3**	**14.6**

National percent of college students who reported using prescription drugs that were not prescribed to them with the last 12 months:

PERCENT (%)	MALE	FEMALE	TOTAL
Antidepressants	2.3	3.8	3.4
Erectile dysfunction drugs	1.0	0.7	0.9
Pain killers	3.9	4.2	4.2
Sedatives	2.7	2.9	3.0
Stimulants	6.2	5.6	5.9
Used 1 or more of the above	**10.7**	**11.4**	**11.4**

Data is crucial for effective interventions to change behavior, knowledge, and/or skills. Be mindful of the type of data needed to impact social norms.

SOCIAL ECOLOGICAL **MODEL**

The Social Ecological Model (SEM) is a framework that considers the complex ways in which an individual interacts with their communities and environments. This model focuses on making changes to the physical and social spaces, rather than simply altering individual health behaviors. As an environment can influence an individual's behavior, prevention and health promotion approaches should be tailored for each level. There are five nested levels of the SEM:

INDIVIDUAL: characteristics of an individual that influence their behavior (e.g. gender, age, race/ethnicity, sexual orientation, economic status, values, expectations, etc.)

INTERPERSONAL: formal and informal social networks that influence an individual's behavior (e.g. family, friends, peers, coworkers, etc.).

ORGANIZATIONS: inter-community organizations or social institutions which share values and affect the delivery of services and attitudes of served constituents (e.g. an academic discipline, a campus club, fraternities and sororities, an athletic team, etc.).

COMMUNITY: organizations or institutions (including colleges and universities) with defined services or defined geographical space which influence individuals and the interpersonal groups within the community.

STRUCTURES AND SYSTEMS: the local, state, regional; and national laws, policies, procedures and their enforcements which may influence individual's behaviors (e.g. national policies about health care access, state legalization of cannabis, regional support for drug take-back efforts).

SOCIAL ECOLOGICAL **MODEL**

When considering the SEM for a social norming campaign, here are few intervention strategies that impact the individual at that level:

INDIVIDUAL: have conversations with students 1-on-1 about their own use with alcohol and other drugs, increase the individual's knowledge of alcohol, discuss with the students their beliefs and values around alcohol and drug use.

INTERPERSONAL: train peer educators on the data and how to have a conversation with their classmates about social norms.

INSTITUTIONAL & ORGANIZATIONAL: awareness activities focusing on groups known for higher risk engaging in problematic behaviors.

COMMUNITY: campaigns on the radio or social media, host campus wide events or trainings.

STRUCTURE & SYSTEMS: enforcement of campus policies related to alcohol and other drugs, limiting promotions and happy hours at local bars.

Since individuals exist in a social ecological system, changing individual behaviors and creating new social norms requires working across that system. For collegiate prevention, the research strongly supports the use of comprehensive, integrated programs with multiple complementary components that address:

- Individuals, including at-risk students
- Student population as a whole
- College and surrounding community

This framework focuses on each of the three primary audiences, and the framework is a useful introduction to encourage presidents, administrators, college prevention specialists, students, and community members to think in a broad and comprehensive fashion about college substance use. It is designed to encourage consideration of multiple audiences on and off campus.

TRANSTHEORETICAL **MODEL**

Published by Prochaska and DiClemente in 1983, the Transtheoretical Model, or more commonly known as the Stages of Change, is an effective prevention strategy that should facilitate positive behavior change. It's important to conceptualize the process of intentional behavior change, there must be a focus on the individual's readiness to act on new, healthier behaviors. Change in general is a process that occurs over time, involving progression through a series of stages.

Individuals move through a series of typically five stages - precontemplation, contemplation, preparation, action, and maintenance. While progression through these stages can occur in a sequential fashion, a nonlinear progression is common as well. Individuals may recycle through these stages or may even regress to earlier stages through their process.

PRECONTEMPLATION: In this stage, an individual can either be unaware that the particular behavior is dangerous or unhealthy or be uninterested in changing the behavior. The person is not thinking about any kind of change and may not start any time soon. They may admit that the behavior has negative aspects, but they do not believe the negatives outweigh the positive aspects.

CONTEMPLATION: This stage marks a significant turning point for the individual. For whatever reason, they have decided that the particular behavior is causing some distress. This may be because of negative health effects, damaged relationships, or the like. The person begins to gather information and contemplate making a change, and weighing how it could affect their life. An individual in this stage is often ambivalent or feels two ways about the change. They may see reasons to change as well as the reasons not to change.

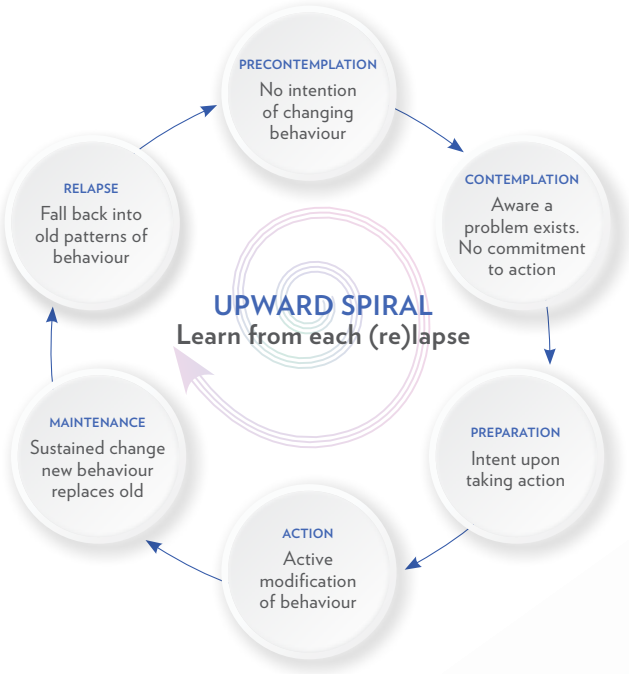
TRANSTHEORETICAL **MODEL**

PREPARATION: In this stage, an individual has decided to make the change and is now preparing for it. The individual may collect more resources and make specific plans for a new lifestyle. Sometimes, a doctor or health provider is involved in this stage in order to suggest strategies for becoming healthier.

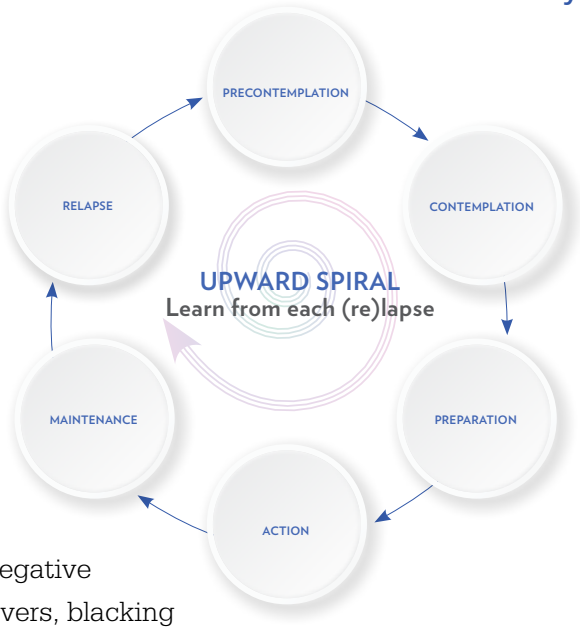
ACTION: This is the stage in which an individual is making the change. They are practicing healthier living by adopting smaller changes and learning from mistakes and occasional slips.

MAINTENANCE: In this stage, an individual has successfully made the change to a new behavior, though they continue to work at maintaining it. There may be temptations to return to the previous behavior, so the person will need tools to help them keep living the change.

RELAPSE: Some versions of the model include Relapse as a stage. Relapse represents the time when individuals temporarily return to previous behaviors. It is important to know that relapse is a normal part of trying to change a behavior. Relapse should not be a signal for someone to give up on their efforts.



TRANSTHEORETICAL **MODEL**



Below are some examples of the thoughts and actions an individual may have for each stage of their behavior change.

PRECONTEMPLATION: The individual does not think the negative consequences of substance consumption (for example hangovers, blacking out, or financial cost) outweigh the positive aspects such as social lubrication, party atmosphere, or euphoria. To help someone at this stage, you may simply ask questions to learn about their feelings about their consumption and educate them on risks.

CONTEMPLATION: The individual is thinking about changing their substance consumption but may not be set on changing yet or may not know how to. This change may be because of a negative consequence, such as an injury while intoxicated, that leads to a different balance of positive and negative consequences. To help someone in this stage, educate them on ways to help make a change and why it may be a positive change for them.

PREPARATION: The individual is working on ways to make the change, this may include finding a community that will support them, resources they can use, and building up their commitment to the change. To help someone in this stage, give them encouragement and resources and connect them to others that are making similar changes.

ACTION: The individual is actively working to change their substance consumption. This may be lowering the amount or frequency or abstaining altogether. In this stage there may be occasional mistakes, like over consumption or a deviation from the plan, however they get back on track again. To help someone in this stage, you can give encouragement, especially after a mistake, and let them know it is part of the process.

TRANSTHEORETICAL **MODEL**

MAINTENANCE: The individual has succeeded in making a change to their substance consumption, it is now a regular part of their life and routine. An individual in this stage does not usually need help, but can be a resource to others that are in different stages trying to make a similar change.

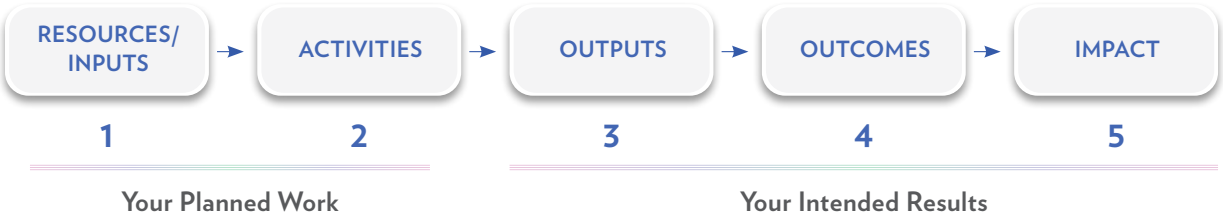
RELAPSE: The individual returns to previous behavior around substance consumption. This can occur after a disruptive life event which leads them to revert to previous behavior. This may be temporary but it may also require the individual to go through the stages again to change. To help someone in this stage, remind them that this is a normal part of the process and encourage them that they can continue to make the change they want.

Understanding the Stages of Change lends itself to adapting additional prevention and health promotion interventions to effectively support individuals to move from one stage to the next in an effort to create healthier behaviors.

LOGIC MODEL

A logic model is a systemic way to clearly explain why the chosen strategies are effective solutions for the current community and its associated behaviors, knowledge, and/or skills. A logic model gives prevention and health promotion teams direction, clear expectations, and a common language.

A logic model is a visual way to present the relationships between five components. The first two components are the planned work and the last three are the intended results. The planned work includes the resources available to coordinate a strategy and the activities planned to implement said resources. The intended results that are hoped to be achieved include outputs, outcomes, and impact.



RESOURCES: also known as inputs, are factors such as human, financial, organizational, and/or community resources, as well as anything else that would be a utilized to implement a strategy

ACTIVITIES: are what the program does with the listed resources. Another way to think about activities are the processes, tools, events, technology and action that are intended to lead to a course of change.

OUTPUTS: are the direct measurable products of completed program activities. When applicable, the outputs can include types, levels, and targets of services delivered by the strategy.

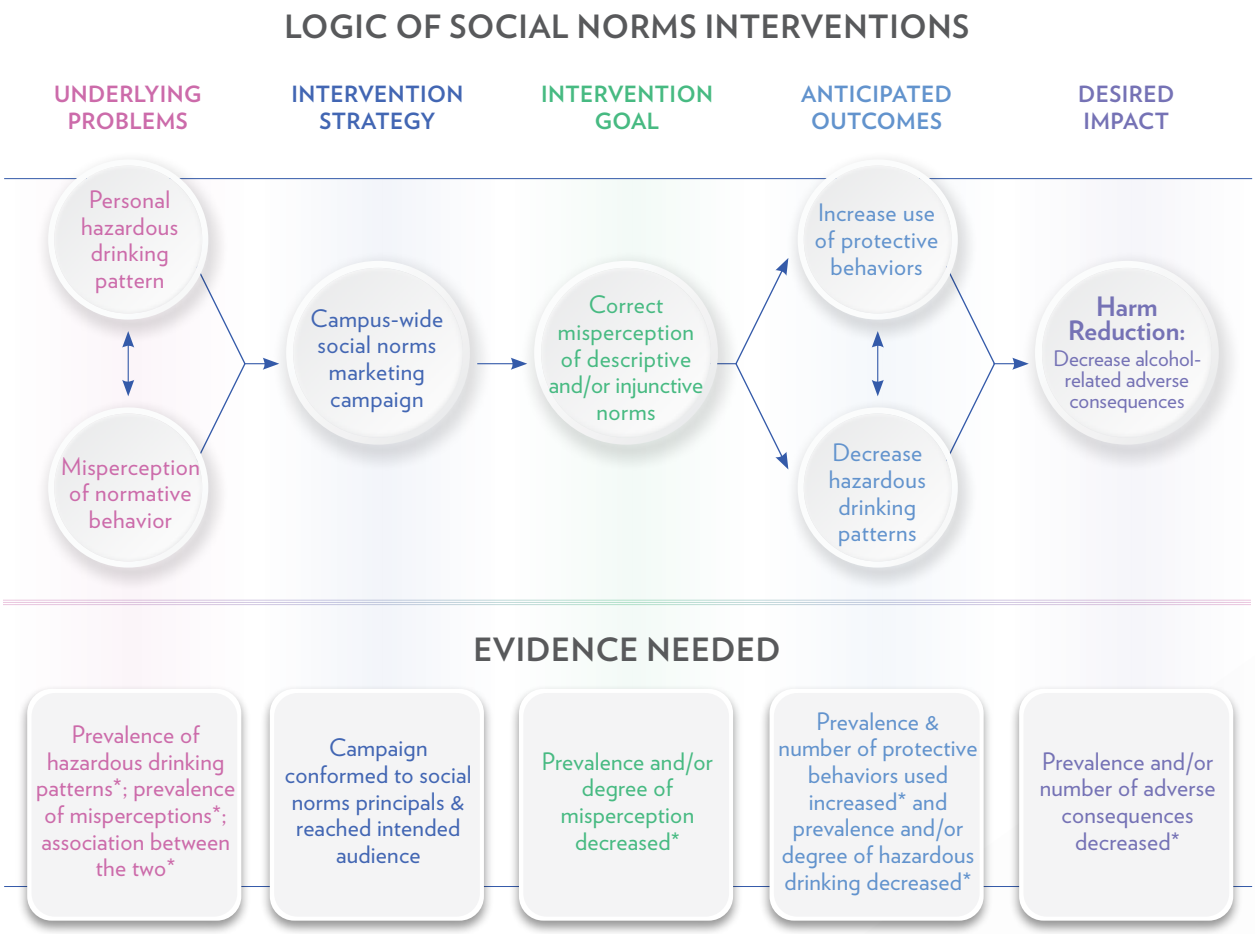
OUTCOMES: are the specific changes in the intended communities' behavior, knowledge, and/or skills.

IMPACT: is the intended change occurring in organizations, communities, or systems as a result of the program activities over time.

LOGIC MODEL

As we know, change does take time. Creating a logic model will be useful in assessing the various needed components of a successful intervention to bring about change within the next several years.

The logical model below from Keller & Bauerle (2009) is an example demonstrating a social norms campaign.



*Baseline assessment needed before intervention & follow-up assessment after intervention

IMPLEMENTATION

During the implementation stage, the production and dissemination of the social norming messages begins. This will be the introduction of the campaign to your target populations who will see the project materials on a mass scale. There are critical aspects of the intervention that happen during this stage. It is important that social norming messages are delivered frequently and consistently. During this stage, it is also very important to collect data to monitor the extent and manner in which social norming messages are reaching the target populations, and are recalled, reacted to and understood by them.

THE RESEARCH:

A clear implementation plan for the social norms campaign (Haines et al, 2005) that includes these elements:

- **A** Social norms messages to individuals based on data from their immediate reference groups (e.g., fraternities, sororities, college athletes; see also LaBrie, Hummer, Neighbors, & Pedersen, 2008).
- **B** Messages delivered consistently and frequently.
- **C** Documentation and tracking of various media placements.
- **D** Audience input to determine how well messages are reaching them.
- **E** Publicity for the social norms intervention such as a press release to help launch the campaign and provide press contacts with ongoing updates about related activities.
- **F** Utilization of student peer educators

PEER EDUCATION

Student peer education can be a useful and an effective tool in addressing safety and health issues on college campuses and can go hand in hand with the social norming campaign. Peer-to-peer influence plays a significant role in college students' growth and development. In fact, peer influence significantly impacts undergraduate students' affective and cognitive growth and development.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) released a 2002 report stating peer educators are trusted by classmates to provide reliable answers and accurate information, are an important link between the administration and student body, and can assist college presidents in reducing underage and high-risk drinking. Studies continue to note the impact peer education plays in reducing high-risk behaviors and changing attitudes of college students. Peer educators are important messengers increasing the healthy attitudes and behaviors of college students.

Within the social norming strategy, student peer educators can help address and highlight the positive and healthy social norms. They can help educate students on what positive, healthy behaviors are truly acceptable among their peers. For example, if students think that heavy drinking is normal, they'll drink more heavily. If they think responsible drinking is normal, students will drink more responsibly.

PAID MARKETING

College students are a uniquely perspective population, however they are still like any other consumer of media. There is always going to be a challenge with capturing their attention and engaging with them on campus. Using a variety of marketing materials can help give you better opportunities at getting your messaging across; one that is highly effective is paid marketing (Carbone, 2020). With paid marketing, you are purchasing advertising that will allow you to target a specific audience, instead of having to wait for them to find or see your messaging organically.

Paid marketing can be displayed on search engine results pages (SERPs) and social media channels. When you are considering paid marketing ads, select a specific channel, such as Google Ads or Facebook, and then define the target audience based on criteria ranging from location, search terms, interests, demographics, previous purchases, and other pages visited.

PAID MARKETING

You should consider the following when utilizing paid marketing:

- Use a wide range of targeting, including both granular characteristics (interests, location, and demographic) and behavior-based targeting (search history, purchase history, frequently visited websites).
- When using paid marketing for the first time, start with smaller campaigns to test which types of messages and ads resonate most with students.
- Use analytics to monitor results for future paid marketing campaigns. Popular analytics tools include Google Analytics, Branch, Crazy Egg, and SEMrush.
- Select your social media channel based on your target audience. To grow your Gen Z customer base, create a sponsored TikTok ad or utilizing Instagram.
- Consider the goal for your paid marketing campaign when allocating your budget and choosing your channel, messaging, and call to action (Paid Marketing, 2020).

RESOURCES

A Guide to Marketing Social Norms for Health Promotion in Schools and Communities

A Multifaceted Social Norms Approach to Reduce High-Risk Drinking

Making Health Communication Program Work

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