

HIGHER EDUCATION Cannabis Prevention Toolkit



Coalition of Colorado
Campus Alcohol
& Drug Educators

Introduction to the Campus Cannabis Prevention Toolkit

On behalf of the Coalition of Colorado Campus Alcohol and Drug Educators (CADE), welcome to the Campus Cannabis Prevention 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 November 2012, Colorado voters went to the polls to decide on – among other things – an amendment to allow for the use of cannabis by adults age 21 and older. Amendment 64 passed, and in 2013, dispensaries began the sale of cannabis; and while sales began to increase, so did the State’s response to higher access to use. At first, a fractured and territorial response from State agencies left prevention practitioners without resources or even common language to address the new world Coloradans found ourselves in. And while Colorado began to use the allocated tax resources for the prevention of adoption and use by K-12 populations, no allocations or State guidance was offered for those working in higher education spaces until only recently. This toolkit is a collaboration between the CADE, the Colorado Department of Public Health and Environment, and researchers with Colorado State University, and represents Colorado’s commitment to healthy populations across the lifespan.

National attention is on Colorado as other states begin to consider similar referendum and legislative approaches to adult use legalization for cannabis. That attention expands to the way in which communities, including higher education, approach the prevention of harmful cannabis use.

While use has not dramatically shifted since adult use legalization was passed in Colorado, perceptions of harm have shifted to view cannabis use as less harmful. However, we do know there are harms associated with cannabis use, especially heavy and chronic use. However, we know precariously less about cannabis than we do alcohol. Directly expecting to apply prevention frameworks from alcohol prevention will not be a sustainable approach to this work. Conducting assessment, building on campus capacity, implementing programs which show best promise for our work, and evaluation are going to be key for every campus team moving forward.

This toolkit is designed to be a guide to move forward to that goal. 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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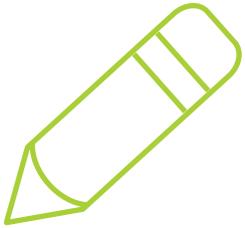
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Section I: Data



A Note about Adaptation

Collegiate alcohol prevention efforts represent a vast resource base for substance abuse prevention. This toolkit acknowledges that the field of cannabis prevention does not yet have the same body of research regarding evidence based practices. A component of working with a more novel substance (such as recently legalized cannabis) is adaptation and attempts to replicate evidence-based alcohol interventions with fidelity. This toolkit will review current research efforts regarding the impacts of cannabis use with college students, as well as evidence informed practices.

Statewide versus National Data

Introduction: In 2012, Colorado and Washington became the first two states to legalize adult cannabis use, with retail outlets opening in both states in 2014. Since then, several additional states have passed laws to legalize or decriminalize cannabis possession and use for recreational and medicinal purposes. In the U.S., adult cannabis use is legal in Alaska, California, Colorado, Massachusetts, Maine, Nevada, Oregon, Washington, and Washington D.C., while medical cannabis is legal in 30 states and cannabidiol (CBD) oil is legal in 14 states (NORML, 2018). Starting July 1, 2018 recreational cannabis use will be legal in Vermont, though it legalized medical cannabis use in 2004. Effectively, 45 states and Washington D.C. permit a form of recreational or medical cannabis use.

Prevalence and Impacts

In the United States, approximately 30% of college students report using cannabis in the past year (Pearson, Liese, Dvorak, & Marijuana Outcomes Study Team, 2017) compared to approximately 10% of adults (Hasin et al., 2015). The college environment provides **increased access** to cannabis (Suerken et al., 2014), contributing to college students' **high risk for initiation of** (Pinchevsky et al., 2012) and increased use of cannabis (Johnston et al., 2015) as they transition from high school to college. Further, there may be negative consequences that occur along with cannabis use during college years, including chronic, heavy marijuana use, which can impact cognitive functioning and academic performance (Phillips et al., 2015), resulting in lower GPA (Martinez et al., 2015; Suerken et al. 2016).

In general, prevalence of cannabis use is higher in states with legal medical and/or adult cannabis use (CBHSQ, 2015). However, higher prevalence rates have been reported both before and after implementation of new

marijuana laws, indicating that changes in legislation have occurred in states where cannabis use was already common. Among Colorado college students, legalization was associated with increased prevalence of initiation of use (i.e., having ever tried) among college students, however there was no associated increase in quantity of marijuana being used (i.e., past-month use frequency; Parnes, Smith, & Conner, 2017). Similarly, college students in Oregon reported no increases in cannabis use frequency following changes in recreational use laws (Kerr, Bae, Pibbs & Kern, 2017).

Altered **perceptions of acceptability, safety, and prevalence of cannabis** use are particularly concerning because exaggerated perceptions are associated with heavier use (Prince, Swaim, Stanley, & Conner, 2017). From a prevention stand point it is important to understand this association, as heavy use while the brain is still developing is predictive of both neurodevelopmental disruption and increased use as an adult (Lisdahl, Gilbert, Wright & Shollenbarger, 2013). Legislative changes may foster decreases in perceived harm and changes in normative beliefs, including:

- increased perceived peer use,
- perceived peer and parental approval of use,
- and perceived availability,

all of which are known predictors of increased marijuana use and related consequences (Napper, Kenney, Hummer, Fiorot, & LaBrie, 2016). Recent research has examined how cannabis use differs in Colorado compared to other states.

Campus Specific Data: Colorado State University

Concurrent Use

Approximately 25%-30% of U.S. college students report use of cannabis in the past 30 days, 33% of those also report heavy episodic drinking (drinking more than 5 drinks per drinking occasion for males, more than 4 drinks per drinking occasion for females), while up to **90% of cannabis users report co-use of both cannabis and alcohol.** This is a problem as research finds that rates of alcohol and cannabis use disorders and admissions to treatment facilities are highest among co-users of cannabis and alcohol, compared to users of either substance alone (Yrasek, Aston, Metrik, 2017). College students are an important sub-group to assess, as cannabis and alcohol use peak in young adulthood and can still have an impact on the developing brain (Lisdahl, Shollenbarger, Sagar, & Gruber, 2018). **Use of both alcohol and cannabis are associated with lower academic achievement, cognitive impairment, addiction, driving impairment and injury, and mental health effects (Yrasek et al., 2017). Past research has shown that simultaneous or concurrent use of cannabis and alcohol can lead to more negative consequences than use of either substance alone** (Subbaraman, & Kerr, 2015). Recent research at Colorado State University using data from 632 students who reported use of both alcohol and cannabis explored the relations among a variety of alcohol and cannabis co-use patterns (i.e., use of alcohol and cannabis on the same day; alcohol use first; cannabis use first; alcohol use last; cannabis use last; simultaneous use), and alcohol and cannabis related consequences both separately and combined (Prince et al., 2018). The researchers found that using cannabis

last was a significant positive predictor of alcohol, cannabis, and combined consequences. Using alcohol and cannabis on the same day, but not necessarily simultaneously, was a significant and negative predictor of alcohol, cannabis, and combined consequences. Using cannabis first negatively predicted alcohol consequences and was not associated with either cannabis or combined consequences. Similarly, using alcohol first was negatively associated with cannabis consequences but not associated with either alcohol or combined consequences. Surprisingly, simultaneous use was not associated with either alcohol or marijuana consequences.

The findings indicate that using cannabis after alcohol significantly increases the risk for both alcohol and cannabis related problems (consequences). While it is possible that there may be a manner of using both alcohol and cannabis on the same day that results in less consequences, this has not been studied yet. Further understanding how the timing of alcohol and cannabis co-use relates to alcohol and cannabis consequences provides insights that can be used in prevention and intervention efforts aimed at college students. ***Additionally, informing college students of the risk of experiencing more negative consequences when concurrently using alcohol and cannabis, especially when cannabis use follows alcohol use may allow them to make better decision regarding their use patterns. Including information about “cross-fading”, or the compounded impacts of utilizing multiple substances at the same time can be an important component of cannabis focused educational dissemination strategies.***





Section II Health Promotion Theory

Stages of Change

Published by Prochaska and DiClemente in 1979, Stages of Change is a model to explain the process people move through when changing behaviors. A key premise is that changes in behavior are neither random actions nor are they static events. In other words, change does not happen automatically and how change occurs and reasons for change vary by individual.

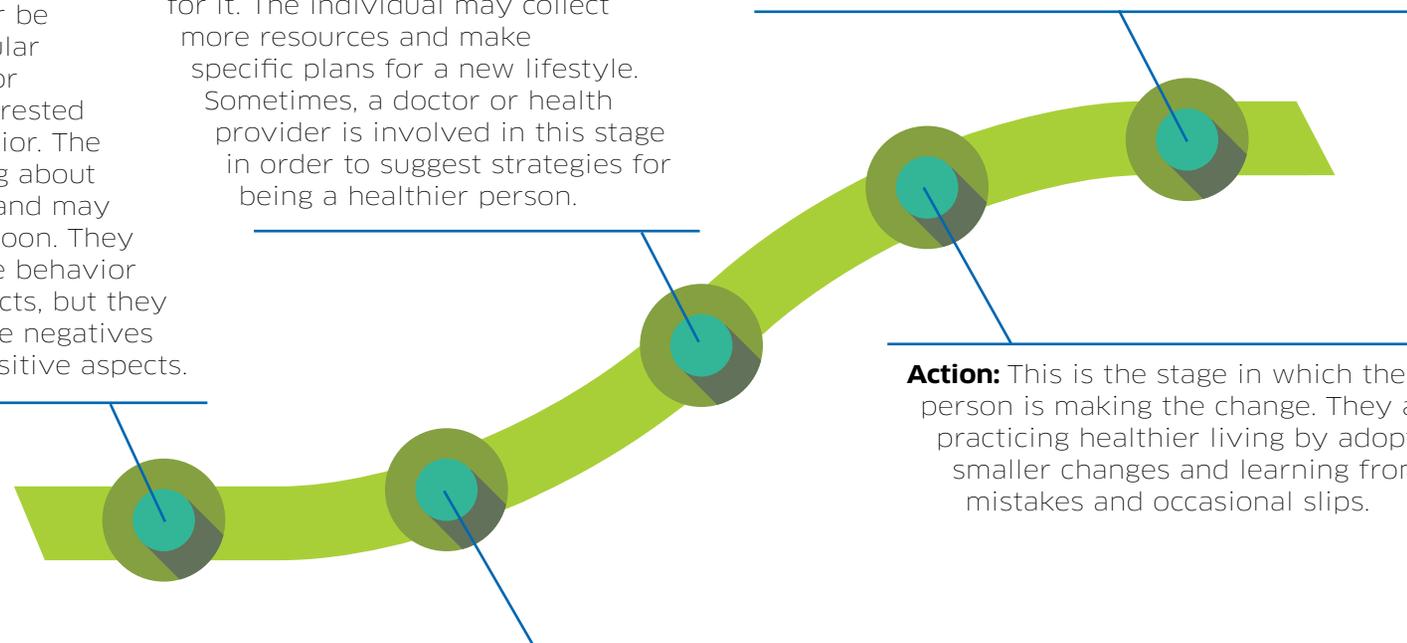
Effective prevention strategies should facilitate positive movement forward within the stages of change. In addition, this model encourages specifying interventions to the specific issues students experience within each stage. For example a student in the Precontemplation stage will respond better to education around cannabis expectancies, while a student in the Action stage will benefit from concrete skill building exercises that support behavior change from misuse.

The stages of change include:

Precontemplation: In this stage, a person 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.

Preparation: In this stage, the person 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 being a healthier person.

Maintenance: In this stage, the person has successfully made the change to a healthier behavior, though they continue to work at maintaining it. There may be temptations to slide back into the previous behavior, so the person will need tools to help keep living the change.



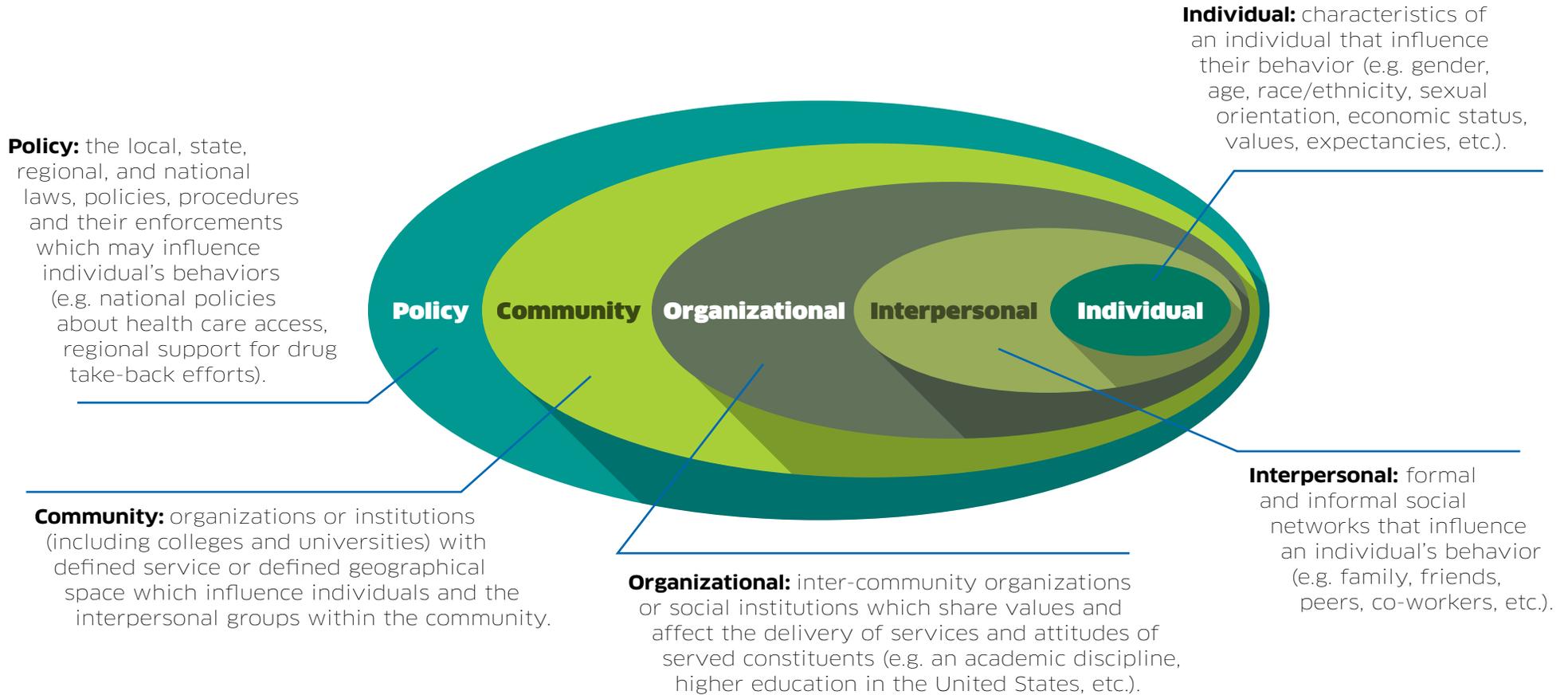
Contemplation: This stage marks a significant turning point for the individual. For whatever reason, they have decided that the particular behavior is causing some distress. This may be because of negative health effects, damaged relationships, and the like. The person begins

to gather information and contemplate making a change, seeing how it would affect their life. A person in this stage is often ambivalent or feels two ways about the change. They may see the reasons to change as well as the reasons not to change.

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

Social Ecological Model

The Social Ecological Model (SEM) is a framework for understanding the ways in which an individual and their environment share and determine an individual's behaviors, and how to approach prevention for an individual by looking at the ways in which that individual is connected within their environment. There are five nested levels of the SEM:



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 cannabis prevention. It is designed to encourage consideration of multiple audiences on and off campus.



Risk and Protective Factors

The Substance Abuse and Mental Health Services Administration (SAMHSA) 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 on Drug Abuse indicates that risk and protective factors span individual, family, peer, community and school domains.

Risk Factors for Collegiate Student Use

- Lack of caretaker supervision
- Access
- Associating with drug using peers
- Party culture
- Previous mental health diagnosis
- Permissive norms
- Adolescent risk seeking behavior
- Lack of organized activities

Protective Factors for Collegiate Student Use

- High self-esteem/sense of self
- Appropriate coping skills
- Positive norms
- Connectedness
- Campus policy
- Effective prevention programming

SAMHSA Strategic Prevention Framework

The SAMHSA Strategic Prevention Framework (SPF) is a 5-step planning process that guides the selection,

implementation, and evaluation of evidence-based, culturally appropriate, sustainable prevention activities. The five steps of the SAMHSA SPF are underlined and continually benefited from the strategies of sustainability and cultural competency.

1. Needs Assessment
2. Capacity Building
3. Planning
4. Implementation
5. Evaluation

The SAMHSA SPF can be a helpful model for campus teams moving forward with the design and implementation of a cannabis prevention strategy. For more information, visit <http://www.samhsa.gov/spf>.

Harm Reduction

In Colorado cannabis use is legal for individuals over the age of 21 and highly prevalent in those under the age of 21, much like alcohol use. **Telling students to stop using cannabis all together is not an effective strategy. Instead, adopting harm reduction approaches to prevention strategies is important.** Harm reductionists promote education on responsible and safe use of substances, including cannabis (Tatarsky, 2003). The idea is that, if use is not causing physical, mental, or social harms, then there is no need to reduce that use. However when cannabis use results in cannabis-related negative consequences, use should be reduced or patterns of use should be altered to offset the symptoms.



Section III Evidence Informed Practice

Other Research and Cross-fading

Additional research indicates that, among those that report using both alcohol and cannabis, prevalence of using both at the same time was about twice as high as use of one or the other substance at different times. The consequences from simultaneous use include:

- an increase in THC blood concentration
- getting nauseous,
- dizzy,
- or breaking out into a sweat.

The condition is typically called “*greening out*” and can be followed by vomiting and feeling a strong desire to lie down. There is evidence that smoking cannabis and then drinking alcohol could lead to excessive alcohol consumption, alcohol poisoning, and death (Scharff, 2014).

Interventions to reduce risk associated this “cross-fading” include:

- using both alcohol and cannabis protective behavioral strategies,
- reducing the amount of each substance someone takes in when using the two together, such as replacing every other alcoholic drink with water,
- slowing down the rate at which one consumes alcohol or cannabis,
- taking periodic breaks from using both substances, etc.

Social Norms

The term “social norm” refers to social rules that guide behavior. Two types of norms that receive a lot of attention in research are descriptive norms and injunctive norms.

Descriptive norms are one’s perceptions of other people’s actual behaviors.

Injunctive norms are perceptions of which behaviors are typically approved or disapproved by others. Injunctive norms assist an individual in determining acceptable and unacceptable social behavior.

Recent research on the influence that both injunctive and descriptive norms can have on cannabis use patterns among college students found that that two social norm-related factors played a primary role in influencing college students’ decisions to use cannabis (Buckner, 2013). **Injunctive norms among family members and friends who openly approve of cannabis use and descriptive norms that favor cannabis use.** When these factors are present, cannabis use is more likely. Additionally, the research

found that, in college students, those who have positive expectations regarding the benefits of cannabis use and those who use cannabis as a coping mechanism are more likely to use cannabis. Results indicated that 67% of the probability of using cannabis is accounted for by a combination of favorable descriptive and injunctive norms, low perceived harm, and use for coping.

ii. Descriptive Norms in Colorado

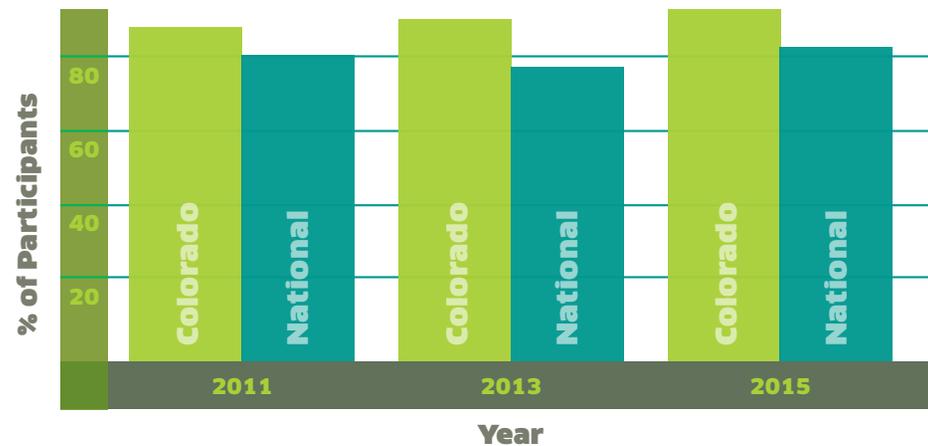
Results presented herein include data from the American College Health Association National College Health Assessment (ACHA NCHA) IIb and IIc surveys. Data were collected in the fall semesters of 2011 (i.e., prior to any legislative changes), 2013 (i.e., post legislation pre-implementation), and 2015 (i.e., post-implementation). The Colorado sample included college students attending a Colorado university who completed both the ACHA NCHA surveys and additional Colorado university-specific questions. Summary statistics from the national samples represent average participant responses from 44 universities in 2011, 57 universities in 2013, and 40 universities in 2015 (American College Health Association, 2012; American College Health Association, 2014; American College Health Association, 2016); as a participating institution, data from Colorado were included in calculations of all ACHA NCHA national summary statistics.

When looking just at the data from Colorado across the three time points, results revealed significant increases in perceived percent of peer use between the 2011, 2013, and 2015.

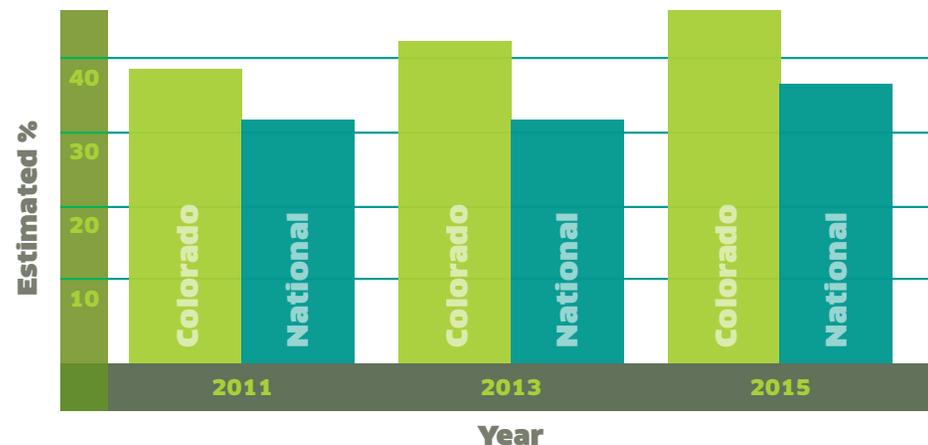
When comparing Colorado college students to the national averages, Colorado students reported significantly higher perceived percent of peer use than the national sample across all three survey years (see the Figure). Between 2011 and 2013, changes in perceived percent of peer use in Colorado (mean increase between years = 4.48, SD = 32.18) increased significantly more than at the national level (mean increase between years = 0.59; $t(936) = 2.60$, $p < 0.01$). However, perceived percent of peer use in Colorado (mean increase between years = 4.00, SD = 31.19) did not increase significantly more than national averages (mean increase between years = 4.18) between 2013 and 2015 ($t(931) = 2.48$, $p = 0.80$).

Figure 1. Comparing descriptive norms ACHA NCHA standard battery between Colorado university students and national averages (note that Colorado university students are included in the national average data).

% of participants who estimated that typical students at their school had used within 30 days of the survey



Participants' estimates of what percent of their university's student body had used within 30 days of the survey



Data collected from the American College Health Association- National College Health Assessment Colorado Statewide Data Set (11 participating institutions of higher education indicate) that 38.8% of college attending youth in Colorado report past 30 day cannabis consumption (NCHA 2017). When asked how many of their peers likely consumed cannabis in the past 30 days, students reported 94.8%. This discrepancy highlights the power of social norms, with actual use 56% lower than perceived use.

iii. Injunctive Norms

When looking at injunctive norms in the Colorado sample, results indicated that the four injunctive norms measures significantly differed between 2013 and 2015. In the 2015 sample, there was increased willingness to admit use to all four social categories than in the 2013 sample (see the Table) “Will the legalization of the use and purchase of marijuana in Colorado make you more easily admit marijuana use to these groups?”

	Friends		Family		Strangers		Questionnaires	
	2013	2015	2013	2015	2013	2015	2013	2015
Yes	228 (23%)	387 (35%)	148 (15%)	294 (27%)	139 (14%)	260 (24%)	272 (28%)	401 (36%)
No	743 (77%)	714 (65%)	823 (85%)	807 (73%)	832 (86%)	841 (76%)	699 (72%)	700 (64%)

b. MOST

Data collected from 11 Universities with varying laws pertaining to cannabis use (legal recreational and medical, legal medical, decriminalized, and criminalized) indicated that Colorado had the highest percentage of lifetime, past month, and near daily cannabis users (see table). Conversely the highest negative consequences from cannabis use occur in states where cannabis use is still criminal, with the exception of Washington.

Summary of Marijuana Use and Consequences across 11 Universities							
		% Marijuana Users			# of Negative Consequences		
State	N	Life-time	Past Month	Near Daily	M	SD	
Colorado	849	63.6	38.4	9.9	7.90	7.50	
Virginia	1397	58.1	26.4	7.1	7.87	7.78	
New Mexico	1120	62.2	30.3	7.8	8.74	7.73	
Alabama	553	42.5	19.7	3.8	9.28	8.90	
California	299	45.8	24.1	3.7	6.56	6.29	
New York	478	51.3	27.2	6.1	7.65	8.72	
Kansas	276	58.7	33.7	5.4	7.86	8.12	
North Dakota	792	49.6	21.8	3.9	7.81	8.21	
Texas	1313	43.3	15.5	4.2	8.61	8.75	
Wyoming	506	47.6	19.4	2.8	7.27	6.95	
Washington	558	55.2	38.7	5.2	8.21	6.84	
Total/Weighted Averages:		8141	53.3	26.2	5.8	8.10	7.83
Unweighted Averages:			52.5	26.8	5.4	7.98	7.80

Note: Adapted from Pearson et al., 2017

c. ACHA

2) Drug Free Schools (not part of CSU Scope of Work)

Protective Behavioral Strategies

Protective Behavioral Strategies and Substance Use

Protective Behavioral Strategies (PBSs) for moderating substance use are defined as behavioral strategies one can use:

- a) before the substance use episode begins (e.g., setting a limit);
- b) during the substance use episode (e.g., refusing the substance); and/or
- c) instead of using (e.g., not going to a party) to avoid or reduce substance consumption and/or consequences (Prince, Carey, & Maisto, 2013).

Effective use of PBSs will by definition result in reductions in substance use and consequences.

Research on PBS evolved out of theories of self-control and behavior change and in the past decade became a key construct of interest for harm reduction researchers and clinicians, especially in the alcohol field. Two reviews of alcohol PBS research indicate that there is evidence for a negative relationship among alcohol-related PBS use, alcohol use, and alcohol-related consequences (Pearson, 2013; Prince, Carey, & Maisto, 2013), such that the more strategies one uses more often is negatively associated with alcohol use. Further, PBS use intervention research has provided evidence for PBS as a mechanism of behavior change, thereby suggesting the usefulness of studying PBS use across a range of substances.



In that context, Pedersen et al. (2016) developed a measure of PBS for marijuana (PBSM), and further refined it to a short form Pedersen et al. (2017; items below). They demonstrated a direct negative relation between PBSM and cannabis outcomes (i.e., less frequent cannabis use, fewer adverse consequences). Research on cannabis PBS is still developing and researchers have begun to develop a more nuanced view of how best to use PBS.

The current thinking in the field is that using more strategies more often may not be the best strategy for many clients. In fact, a client can be more successful using one strategy effectively than using many ineffectively. Clinicians are urged to work with clients to select strategies that will best serve their needs, tailored to context. For example, one may best protect him or herself differently at a party compared to at a friend's house.

17-Item Short-Form Version of the PBSM (PBSM-17)

Please indicate the degree to which you engage in the following behaviors when using marijuana/cannabis.

1 = never, 2 = rarely, 3 = occasionally, 4 = sometimes, 5 = usually, 6 = always

-
1. Use marijuana only among trusted peers
 2. Avoid use while spending time with family
 3. Avoid using marijuana before work or school
 4. Avoid using marijuana to cope with emotions such as sadness or depression
 5. Limit use to weekends
 6. Only purchase marijuana from a trusted source
 7. Avoid using marijuana habitually (that is, every day or multiple times a week)
 8. Use a little and then wait to see how you feel before using more
 9. Avoid mixing marijuana with other drugs
 10. Avoid using marijuana in public places
 11. Take periodic breaks if it feels like you are using marijuana too frequently
 12. Buy less marijuana at a time so you smoke less
 13. Have a set amount of "times" you take a hit (e.g., passing on a shared joint if you have already hit that limit)
 14. Avoid methods of using marijuana that can make you more intoxicated than you would like (e.g., using large bong, volcano, "edibles," etc.)
 15. Only use one time during a day/night
 16. Limit the amount of marijuana you smoke in one sitting
 17. Avoid using marijuana before engaging in physical activity (i.e., exercise, hiking)
-

Pedersen E.R., Hummer J.F., Rinker D.V., Traylor Z.K., Neighbors C. (2016). Measuring Protective Behavioral Strategies for Marijuana Use Among Young Adults.

Creating a Common Language

As practitioners, it is essential we are informed of the different methodologies of cannabis use, and how they impact the brain and body. Understanding what a student means when they report to us how they consume cannabis, or how often they use, is critical to having an informed and effective interaction.

Smoking (joints, pipes, blunts)

- Bud from the marijuana plant is burned & the smoke is inhaled
- Contains THC levels at 1%-20%
- Seconds to minutes to feel effect. Effects can last up to 6 hours

Vaping

- THC extract from cannabis is heated and the vapor is inhaled
- Contains THC levels at 15%-30%
- Seconds to minutes to feel effect

Dabbing

- Uses concentrates
- Contains THC levels at 70%-90%
- Seconds to minutes to feel effect

Eating or Drinking

- THC extract from cannabis is added to food or drink to be digested
- THC and CBD levels vary
- 90mins to 4hrs to feel effect
- Effects can last up to 8hrs

Screening, Brief Intervention and Referral to Treatment

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a structured set of questions, followed by a brief conversation with a trained campus staff or peer educator. SBIRT utilizes motivational interviewing and cognitive behavioral strategies to support students in assessing their use and potentially creating change goals. SBIRT is most commonly utilized with alcohol related conversations, but has been adapted to assess cannabis use with the Cannabis Use Disorder Inventory Test-Revised (CUDIT-R).

Environmental Management

Environmental management changes the conditions in which students make decisions about cannabis consumption to reduce risks and increase healthy decision making. Environmental management strategies address factors influencing student access, attitude, and behaviors through policy, enforcement and visibility. Campus prevention teams may work to limit outlet density or hours, work with campus or campus adjacent stores to not prominently display cannabis related materials, or limit cannabis advertisements in local media.

Bystander Intervention

The bystander effect happens when students witness a concerning event or problematic statement, but do not intervene because of social influence, apprehension of being judged by peers, or diffusion of responsibility. By providing students with skills on how to safely and appropriately intervene, students become more aware about why sometimes they do not act, and become more likely to intervene in the future.

Many bystander intervention programs address intervening in a certain situation (e.g. alcohol intoxication). These programs can be adapted to utilize skills for intervening when confronted with misperceptions of cannabis use, or when concerned about a peer who may have over consumed.

Drug Free Schools and Communities Act

The Drug Free Schools and Communities Act (DFSCA) Drug-Free Schools and Campuses Regulations require at a minimum that each institution distribute the following in writing to all students and employees annually:

- Standards of conduct that clearly prohibit, at a minimum, the unlawful possession, use, or distribution of illicit drugs and alcohol on school property or as part of any school activities
- A description of the applicable legal sanctions under federal, state, or local law for the unlawful possession or distribution of illicit drugs and alcohol
- A description of the health risks associated with the use of illicit drugs and the abuse of alcohol
- A description of any drug or alcohol counseling, treatment, rehabilitation, and re-entry programs that are available to employees or students
- A clear statement that the institution will impose disciplinary sanctions on students and employees (consistent with federal, state, or local law), and a description of those sanctions, up to and including expulsion or termination of employment and referral for prosecution, for violations of the standards of conduct

The law further requires an institution of higher education to conduct a biennial review of its program:

- To determine its effectiveness and implement changes if they are needed
- To ensure that the sanctions developed are enforced consistently

Campuses must continue to recognize possession and use of cannabis on campus as unlawful (DFSCA is a federal mandate, and cannabis is federally defined as illicit substance). In regards to cannabis, the biennial review should look for consistent enforcement of campus policies. This should include preventing distribution to minors and use by minors, as well as preventing diversion for out-of-state students, and preventing growth, possession or use on campus. The DFSCA process should not happen solely with prevention team members, and may include addressing cannabis with uncommon stakeholders (such as recruitment).

Translating Research into Prevention and Intervention

One of the shifts that occurs when states such as Colorado legalize adult cannabis use is a decrease in the perceived harm of cannabis use been the general public (Hall, & Weier, 2015). Additionally, institutional change often occurs at a much slow pace than change at the level of person or culture. This can lead to disparate messages that are difficult for college students to disentangle.

Other ways to help students avoid the harms associated with cannabis use span a number of domains. When it comes to academic involvement and cannabis use, students should avoid use of cannabis prior to engagement in activities that require intact cognitive functioning, such as homework, exams, and classes; refrain from using cannabis the day or night before an important or new challenge, such as midterms or final exams; and take days or weeks off to reduce the THC buildup in their system.

Leverage Colorado's Responsibility Grows Here

Campaign about Responsible Behavior: <http://responsibilitygrowshere.com/user#before-you-take-hits>



Before Taking Hits, Remember The Tips

Take it from Meg the budtender – responsible marijuana use is the only way to fly. So let's set the bar high and understand why we all have a responsibility in using marijuana safely and respectfully. Follow along for Meg's tips and advice.

The campaign targets key responsible behaviors for those who use marijuana including:

- Public consumption
- Keeping marijuana out of sight and out of reach of others
- Alcohol & marijuana can increase impairment
- Over-consumption of edibles
- Know your limits
- Driving high
- Laws
- Health effects

Regarding cannabis use and how it affects the user, it is important for students to remember that cannabis use causes motor impairment and slowed reaction time. Motor impairment increase the risk of accidents while driving and using machinery, individuals using cannabis should not drive or operate dangerous machinery while using cannabis, or after combing cannabis and alcohol use. They should also wait at least 3 hours after last use of cannabis before driving or operating dangerous machinery.

For heavy cannabis users (high quantity high frequency use of high potency cannabis) there is increased risk of developing cannabis dependence.

Researchers estimate that approximately 10% of heavy cannabis users develop cannabis use disorder. Cannabis use disorder can interfere with academic performance, work performance, relationships, and mental health. It can reduce creativity, cause self-esteem, problems (feeling like a “stoner”), and result in social withdrawal. Physical addiction to cannabis use is possible, and users can experience withdrawal symptoms when cannabis use is discontinued.

Policy Change

Due to the lack of evidence-based marijuana research, it was essential to use proven and effective strategies and existing research from alcohol and tobacco control to inform policies around public education and youth prevention. These strategies were chosen for their proven impact on reducing youth access and supporting positive role modeling behavior. While there are a wide range of state and local policies related to marijuana - everything from food safety to driving under the influence - the following table focuses on priority public health policy recommendations for limiting marijuana availability and accessibility among youth and young adults. The table is broken out into four key P’s:

Price - the cost of a substance can impact adult overconsumption and youth initiation

Place - limiting availability to a substance can decrease accessibility and exposure in the home, in public and at retail locations

Product - enforced possession and point-of-sale requirements such as packaging and warnings can restrict sales to youth and provide usage education to adults

Promotion - restricting where and how a substance is marketed can limit exposure to advertisements

We have included both the current state level policy as well as considerations for policy work that can be implemented locally. It’s important for state and local level policies to be supportive of one another to have the most effective impact on public health outcomes.

Policies to Limit the Availability or Accessibility of the Substance for Youth

	Recommendations and Best Practices from Other Substances:	State-level Policies to Prevent Youth Access to Retail Marijuana:	Local Level Policy Considerations to Prevent Youth Access:
Price			
1	Increase the Unit Price (Tobacco: Community Guide) (Alcohol: Community Guide)	Proposition AA passed in 2013 permitting a 15% excise and 15% sales tax on all retail marijuana (updated from 10% on July 1, 2017 per Senate Bill 17-267).	If local communities need additional funding to support efforts to restrict youth access and prevent use among youth, communities have the ability to increase local taxes (excise and/or sales) on marijuana to fund local prevention work. Where possible, earmark the taxes for prevention efforts dedicated to a specific agency. Local tax measures have to be put to the voters of that jurisdiction.
Place			
2	Smoke-Free Policies (Tobacco: Community Guide)	Senate Bill 13-283 added marijuana to the Colorado Clean Indoor Air Act, banning smoking of marijuana in all public indoor areas. The state could consider strengthening the definition of smoking in the CCIAA to include vaporizers/e-cigarettes.	Local governments may consider strengthening the definition of smoking to include vaporizers/e-cigarettes. Several municipalities in Colorado have updated their smoke-free code (Durango, Edgewater, Fort Collins, Lakewood). Additionally, local governments can define “public” use in a manner that allows private clubs for marijuana consumption. It is important that public health advocate for definitions that protect health.
3	Smoke-Free parks/ amusement parks/other public spaces (Tobacco: TobaccoFreeParks.org)	Senate Bill 13-283 made it illegal to use (smoke or consume) all marijuana and related products in any indoor or outdoor public space, including sidewalks, parks, amusement parks, playgrounds, and outdoor patios.	Local prevention programs and governments may work to increase enforcement of the ban on public use, including broad education about requirements.

	Recommendations and Best Practices from Other Substances:	State-level Policies to Prevent Youth Access to Retail Marijuana:	Local Level Policy Considerations to Prevent Youth Access:
4	Smoke-Free Housing (Tobacco: Lung.org)	Amendment 64 states that private property owners are not required to permit marijuana and related product possession or use on their property. The US Department of Housing and Urban Development restricts marijuana (medical or retail) on the premises if the housing authority/management company receives federal funding. Marijuana cultivation, possession or use is grounds for denying assistance. NOTE - some allowances are being made.	Local prevention programs may inform and educate property owners of their rights to prohibit marijuana smoking, consumption, possession and/or cultivation. Programs can inform changes to lease language and smoke-free organizational policies that are more inclusive of marijuana, e-cigarettes/vaporizers. Collaborating with local programs funded by tobacco taxes to address smoke-free multi-unit housing may enhance efforts.
5	Smoke-Free Cars Laws (Tobacco: TobaccoFreeKids.org)	Senate Bill 13-283 made it illegal to use all marijuana and related products in private vehicles.	Local prevention programs and governments may work to increase enforcement of the ban on use in vehicles.
6	Tobacco-Free Schools Laws (Lung.org)	Senate Bill 13-283 made the possession or use of retail marijuana or its products illegal on all school properties.	RMC Health was funded by CDPHE to provide support to local school districts to update organizational policies to reflect state policies. As districts revise Tobacco-Free Schools policies, it is an opportune time to discuss updating/strengthening their drug/marijuana policies to reflect current marijuana laws.
7	Licensing Retail outlets to strictly regulate sales (Tobacco: Tobacco Policy Center)	Senate Bill 13-283 gave the Department of Revenue the authority to strictly license and regulate all retail marijuana facilities.	Licenses for retail shops are necessary at both the state and local jurisdictional level. Work with staff, city managers, city attorneys, and council members within your local jurisdictions to develop ordinances that help mitigate the potential impacts to children and youth (e.g. density, hours of operation, buffer limits, setbacks, signage, advertising, merchandising, coupons, free samples, etc.).

	Recommendations and Best Practices from Other Substances:	State-level Policies to Prevent Youth Access to Retail Marijuana:	Local Level Policy Considerations to Prevent Youth Access:
8	Limit the density of retail locations (Alcohol: Community Guide)	Unlike the state of Washington, Colorado did not place caps on production or the number of licensed retail marijuana stores available within the state. The US Department of Justice's Guidance Regarding Marijuana Enforcement Cole Memo is clear about the value of setting distance requirements of the marijuana industry from facilities where youth are present.	Each local jurisdiction allowing retail marijuana licenses can regulate the density of retail marijuana shops and the buffer limits from locations that have children present.
9	Retailer education (Tobacco: Community Guide) (Alcohol: Community Guide)	Senate Bill 13-283 gave the Department of Revenue the authority to implement a Responsible Vendor Program, educating retailers on the marijuana regulations and how to communicate with customers about the product.	Local prevention programs may work with DOR and local licensing authorities to increase education efforts of marijuana retailers and adjacent non-marijuana retailers.
10	Limit the hours of sale (Alcohol: Community Guide)	Department of Revenue Regulations on Marijuana <ul style="list-style-type: none"> • R308: Limited hours of operation to between 8:00am and midnight. 	Local governments may consider stricter hours of operations for retail marijuana establishments.
11	Laws directed at minor's purchase, possession or use of the product (Tobacco: Community Guide)	Senate Bill 13-250 made it a drug felony offense if an adult more than 2 years older than the minor gives or sells the minor any marijuana or related products. Senate Bill 13-250 made it illegal to sell marijuana to someone under the age of 21. Class 2 misdemeanor. Senate Bill 13-250 required identification at point of purchase for proof of age. House Bill 14-1122 allows retailers to confiscate any identification that they believe may be fake. Senate Bill 14-129 changed the Minor in Possession laws (CRS 18-18-122) to include marijuana, ban drug paraphernalia, apply good samaritan laws, and more.	Local prevention programs and governments may work to increase education about sales restrictions and enforcing point of sale restrictions.

	Recommendations and Best Practices from Other Substances:	State-level Policies to Prevent Youth Access to Retail Marijuana:	Local Level Policy Considerations to Prevent Youth Access:
12	<p>Restricted access at home (Alcohol: NIH study of where alcohol is stored in homes, KidsHealth recommendation for safe storage)</p>	<p>House Bill 14-1122 defined “enclosed” and “locked space” for growing marijuana plants to protect youth from accessing the plant and requires the cultivation to be enclosed and locked from access by anyone under 21 who lives at the location. Additionally, it requires a homeowner to reasonably restrict access to the cultivation for the duration of any minor’s visit to the home.</p> <p>Senate Bill 13-250 made it a drug felony offense if an adult more than 2 years older than the minor gives or sells the minor any marijuana or related products.</p> <p>House Bill 15-1305 banned unlicensed individuals from using hazardous solvents to extract marijuana concentrate.</p> <p>House Bill 17-1220 limited residential marijuana grows to a maximum of 12 plants, no matter how many adults live in the residence (Amendment 64 allows 6 plants per adult over the age of 21). There are some exceptions for medical marijuana.</p>	<p>Education on proper storage of medicinals and edibles may be helpful in limiting access and/or accidental ingestion by children and pets.</p>

	Recommendations and Best Practices from Other Substances:	State-level Policies to Prevent Youth Access to Retail Marijuana:	Local Level Policy Considerations to Prevent Youth Access:
Product & Promotion			
13	Restrict industry from advertising or appealing to youth (Tobacco: Lung.org) (Alcohol: Camy.org)	<p>Department of Revenue Regulations on Marijuana</p> <ul style="list-style-type: none"> • R604.C5: Products available on the general food market, such as gummy bears, will be prohibited from being remanufactured to contain marijuana. • R1001.C: Packaging cannot appeal to children or youth under 21 or use cartoon characters • R1001.H: Packaging cannot use the word “candy” or “candies.” • R1104-1105: Bans tv & radio ads unless <30% of audience is under 21 • R1106-1107 & 1115: Bans print or internet ads and event sponsorship unless <30% of audience is under 21 • R1111: Outdoor Advertising Generally Prohibited. Illegal for any Retail Marijuana Establishment to use advertising visible to the public from any street, sidewalk, park or other public place, including bans on billboards or other outdoor advertising device; signs on vehicles, hand-held or portable signs; or leaflets directly handed out in public, left on a vehicle, or posted without the consent of the property owner. Exception: fixed sign that complies with local rules identifying the location as a retail marijuana store. • R1112: Bans ads that target minors • R1113: Bans push to device ads unless recipient is over 21 and can opt out • R1114: Bans pop up ads <p>Senate Bill 17-015 bans non-licensed entities from advertising marijuana products</p>	Local entities may consider stricter marketing regulations, such as the restrictions on business signage, merchandising, giveaways, samples, coupons, sponsorship of events.

	Recommendations and Best Practices from Other Substances:	State-level Policies to Prevent Youth Access to Retail Marijuana:	Local Level Policy Considerations to Prevent Youth Access:
14a	Stronger restrictions on retailers (Tobacco: Community Guide) (Alcohol: PIRE)	<p>House Bill 14-1122 made it illegal and a class 1 misdemeanor to sell or permit the sale of marijuana to someone under the age of 21 and required child resistant packaging for both medical and retail marijuana. HB14-1122 permits licensed retail store employees to confiscate IDs they believe to be fraudulent and detain and question the person to determine if they were engaging in illegal behavior. Department of Revenue Regulations on Marijuana</p> <ul style="list-style-type: none"> • R103: Requires child resistant (for <age 5), opaque, resealable packaging • R402: Restrictions on the amount of product, including edibles and concentrates, that can be purchased at point-of sale. Effective 1/1/16 • R403: Restricted access at point-of-sale. No one under 21 is allowed inside. 	Local prevention programs and governments may work with DOR to increase education efforts of marijuana retailers on sales restrictions to persons under 21.
14 b	Stronger restrictions on retailers (Tobacco: Community Guide) (Alcohol: PIRE)	<ul style="list-style-type: none"> • R1004-1007: Packaging must include warnings: “There may be health risks associated with the consumption of this product;” “This product is intended for use by adults 21 years and older. Keep out of the reach of children;” “This product is unlawful outside the State of Colorado;” “There may be additional health risks associated with the consumption of this product for women who are pregnant, breastfeeding, or planning on becoming pregnant;” “Do not drive or operate heavy machinery while using marijuana.” Edibles include the following warnings: “This product was produced without regulatory oversight for health, safety, or efficacy.” “The intoxicating effects of this product may be delayed by two or more hours.” • R1004-1007: The Universal Symbol must be located on the front of all marijuana packaging with the following statement: “Contains Marijuana. Keep out of the reach of children.” • R604.C5: The Universal Symbol must be stamped on all 10mg servings of marijuana products (such as chocolates), where practical. 	

	Recommendations and Best Practices from Other Substances:	State-level Policies to Prevent Youth Access to Retail Marijuana:	Local Level Policy Considerations to Prevent Youth Access:
15	Increase Minimum Age to access the product (Tobacco: Preventing Tobacco Addiction Foundation) (Alcohol: CDC)	Amendment 64 set the legal age limit for access to retail marijuana at age 21.	Local governments cannot make the age limit for legal access higher than 21 since it is set in the state constitution.

Enforce Policies to Limit Accessibility of the Substance

	Recommendations and Best Practices from Other Substances:	State-level Policies to Prevent Youth Access to Retail Marijuana:	Local Level Policy Considerations to Prevent Youth Access:
16	Increased enforcement of laws: prohibiting sales to minors (Alcohol: Community Guide) (Impaired Driving: Countermeasures that Work)	DOR's Marijuana Enforcement Division has hired officers to enforce all of the retail regulations and conducted compliance checks on age restrictions. Retail Marijuana Establishments had compliance higher equal to or better than alcohol and tobacco retailers. The Department of Law has created trainings for law enforcement to better understand enforcement of the retail marijuana laws.	Local prevention programs and governments may work with officers and retailers to increase education and enforcement of state laws and additional regulations passed at the local level. Enforcement of the ban on public use often requires support of the organization or venue. Local prevention programs can work with businesses, (i.e. concert venues) to enhance enforcement.

Educate the Public and Address Community Perceptions through New and Existing Programs

	Recommendations and Best Practices from Other Substances:	State-level Policies to Prevent Youth Access to Retail Marijuana:	Local Level Policy Considerations to Prevent Youth Access:
17	<p>Community Mobilization with additional interventions (additional interventions include mobilizing for passage or enforcement of strict regulations/laws) (Tobacco: Community Guide) (All Substance Abuse Prevention: SAMHSA)</p>	<p>CDPHE’s funds tobacco prevention programs and coalitions to prevent secondhand marijuana smoke exposure through multi-unit housing smoke-free policies, expanding definitions of smoke-free policies to include vaporizers/e-cigarettes, and enforcement of smoke-free policies.</p> <p>CDHS’s funds substance abuse prevention coalitions through SAMHSA block grant funding. CDHS provides technical assistance to implement evidence-based strategies, collaborate within their community, and prioritize marijuana, alcohol, and prescription drug abuse prevention.</p> <p>Tony Gramscas Youth Services at CDHS received an additional \$2,000,000 in funding from Senate Bill 14-215 to fund primary prevention within communities at the individual and relationship socioecological levels. Using a shared risk and protective factor approach within a positive youth development framework, grantees prevent youth violence and substance use, and promote healthy behaviors.</p>	<p>Local governments and prevention programs can collaborate with existing substance abuse prevention coalitions or programs (funded through CDPHE, CDHS’ Office of Behavioral Health or TGYS) to support increased education and enforcement of marijuana laws or stricter local regulations for retailers (particularly density, buffer limits, setbacks, advertising and signage).</p>
18	<p>Mobilizing youth against the industry (Tobacco: TheTruth.com)</p>	<p>This strategy is not recommended at this time. The marijuana industry is currently a partner in prevention efforts and has an interest in preventing possession and use of marijuana by minors in order to keep marijuana legal within Colorado. The US Department of Justice’s Guidance Regarding Marijuana Enforcement prioritizes the prevention of use by minors. Use of this strategy may vary by community and should be reassessed on an ongoing basis.</p>	<p>Local prevention coalitions may include youth as coalition members. Local coalitions may establish healthier norms around substance misuse and awareness of the unique health impacts to youth. Use of this strategy may vary by community and should be reassessed on an ongoing basis.</p>

	Recommendations and Best Practices from Other Substances:	State-level Policies to Prevent Youth Access to Retail Marijuana:	Local Level Policy Considerations to Prevent Youth Access:
19	Community education on preventing youth access (Tobacco: Community Guide)	The CDPHE marijuana prevention campaign will focus on restricting youth access. CDPHE will partner with CDHS, CDE and DOR to align messaging from all four agencies.	CDPHE will provide resources to local community groups to integrate the state-level messaging into their local prevention efforts.
20	Mass Reach Health Communications (Tobacco: Community Guide) (Marijuana: Prevent the Non-Medical Use of Marijuana)	<p>CDPHE recently issued an RFP to select a media/advertising agency to implement the tasks outlined for CDPHE in Senate Bill 14-215 to implement mass reach media campaigns that educate the public:</p> <ul style="list-style-type: none"> • an 18-month campaign beginning January 2015 directed at educating the general public on the health effects of marijuana and legal use through various media tactics (traditional and nontraditional), including fact sheets and clinical prevention guidelines for physicians. The Good to Know campaign launched in January 2015. • an ongoing education and prevention campaign beginning January 2015 that educates the general public on legal use, retailers on the importance of preventing youth access, high-risk populations (youth [Protect What's Next], parents [Good to Know] on the importance of safe storage/preventing secondhand MJ smoke exposure, and pregnant/breastfeeding women), and the overconsumption of edibles. As part of this campaign, CDPHE will offer regional trainings for local MJ prevention programs implementing positive youth development strategies. Statewide media will rotate target audiences and tactics. • maintenance of the colorado.gov/marijuana website as the portal to all state agency information and advertise the existence of the website. • alignment of messaging across state agencies and integration of their information into CDPHE's campaigns/website, as appropriate. Additionally, CDPHE will supply information back to these state agencies and their local prevention programs (i.e. LPHAs, CDHS' funded communities, CDOT's funded impaired driving partners) on marijuana health effects and effective prevention strategies. <p>CDPHE will only use approved health statements from the Retail Marijuana Public Health Advisory Committee.</p>	<p>Upon completion of each campaign, CDPHE will provide LPHAs with talking points, social media content, fact sheets, research and access to the creative materials developed. LPHAs can work with local media, prevention programs, and schools to integrate messages and materials throughout prevention efforts. Additionally, CDHS' Office of Behavioral Health Speak Now or Hable Ahora campaign provides great resources for parents to talk with their teens about substance use. Local partners can help create consistency in health impact statements among local human service partners and organizations and coordinate messaging within their local communities.</p>

Data: Evaluation and Surveillance

	Recommendations and Best Practices from Other Substances:	State-level Policies to Prevent Youth Access to Retail Marijuana:	Local Level Policy Considerations to Prevent Youth Access:
21	General Education and Prevention Campaign Effectiveness	CDPHE was tasked in Senate Bill 14-215 to produce evaluation reports to the legislature. CDPHE contracted with the Colorado Schools of Public Health to evaluate the effectiveness of the campaigns, trainings, technical assistance and other prevention work to increase accurate knowledge of the retail marijuana laws and health effects of marijuana use while reducing the negative public health consequences of marijuana use. The baseline and post-assessment evaluation reports on the effectiveness of the public awareness campaign are available on CDPHE's website.	CDPHE will provide regional post-buy media analysis for interested communities. Additionally, CDHS' Office of Behavioral Health collects evaluation data on the effectiveness of the local prevention efforts that they fund.
22	Marijuana Surveillance	CDPHE was tasked in Senate Bill 13-283 to monitor changes in drug use patterns, broken down by county and race and ethnicity, and the emerging science and medical information relevant to the health effects associated with marijuana use. CDPHE included questions about marijuana on the Healthy Kids Colorado Survey (HKCS, include YRBS questions), the Pregnancy Risk Assessment Monitoring System (PRAMS), the Influential Factors for Healthy Living Survey, the Behavioral Risk Factors Surveillance System (BRFSS) and the Child Health Survey (for parents of children 0-14).	Most of this data will be available at the Health Statistics Region level per requirements in Senate Bill 13-283 (for a map of all Health Statistics Regions, click here. Every populous county is its own region, but rural areas are regionalized).

Access the full table for download: bit.ly/MJ_Policies

Section IV Helpful Resources:

Drug Facts about Cannabis Use

<https://www.drugabuse.gov/publications/drugfacts/marijuana>

[https://www.dea.gov/pr/multimedia-library/publications/Marijuana%20Use%20among%20College%20Students%20\(Final\)%20\(5-23-17\).docx.pdf](https://www.dea.gov/pr/multimedia-library/publications/Marijuana%20Use%20among%20College%20Students%20(Final)%20(5-23-17).docx.pdf)

<https://www.samhsa.gov/atod/marijuana>

Prevention Resources

<https://www.dea.gov/pr/multimedia-library/publications/DEA-Marijuana-Prevention-2017-ONLINE.PDF>

<https://www.samhsa.gov/capt/sites/default/files/resources/bibliography-youth-marijuana-use.pdf>

<https://www.samhsa.gov/capt/tools-learning-resources/preventing-youth-marijuana-use-data-resources>

Principles of Responsible Cannabis Use

<https://www.colorado.gov/pacific/marijuana/responsible-use>

<http://norml.org/principles>

Drug Treatment Resources

<https://www.drugabuse.gov/publications/research-reports/marijuana/available-treatments-marijuana-use-disorders>

<https://store.samhsa.gov/product/Brief-Counseling-for-Marijuana-Dependence-A-Manual-for-Treating-Adults/SMA15-4211>

Cannabis Use Disorder Inventory Tool (CUDIT-R)

This screening is designed to help identify concerns regarding the use of cannabis. Please answer the following questions about your cannabis use. Select the response that is most accurate for you in relation to your use of cannabis over the past six months.

1) How often do you use cannabis?				
Never ■ (0)	Monthly or less ■ (1)	2-4 times/month ■ (2)	2-4 times/week ■ (3)	4 or more a week ■ (4)
2) How many hours were you “stoned” on a typical day when you had been using cannabis?				
Less than 1 ■ (0)	1 to 2 hours ■ (1)	3 to 4 hours ■ (2)	5 to 6 hours ■ (3)	7 or more hours ■ (4)
3) How often during the past 6 months did you find you were unable to stop using cannabis once you had started?				
Never ■ (0)	Monthly or less ■ (1)	2-4 times/ month ■ (2)	2-4 times/week ■ (3)	4 or more a week ■ (4)
4) How often during the past 6 months did you fail to do what was normally expected from you because of doing cannabis?				
Never ■ (0)	Monthly or less ■ (1)	2-4 times/ month ■ (2)	2-4 times/week ■ (3)	4 or more a week ■ (4)
5) How often in the past 6 months have you devoted a great deal of your time to getting, using or recovering from cannabis?				
Never ■ (0)	Monthly or less ■ (1)	2-4 times/ month ■ (2)	2-4 times/week ■ (3)	4 or more a week ■ (4)
6) How often in the past six months have you had a problem with your memory or concentration after using cannabis?				
Never ■ (0)	Monthly or less ■ (1)	2-4 times/ month ■ (2)	2-4 times/week ■ (3)	4 or more a week ■ (4)
7) How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery or caring for children?				
Never ■ (0)	Monthly or less ■ (1)	2-4 times/ month ■ (2)	2-4 times/week ■ (3)	4 or more a week ■ (4)
8) Have you ever thought about cutting down, or stopping your use of cannabis?				
Never ■ (0)	Yes, but not in the last six months ■ (2)		Yes, in the past six months ■ (4)	

For Administrative Use Only

Scores of 8 or more indicate hazardous cannabis use

Scores of 12 or more indicate cannabis use disorder

Referral provided ■ Score: _____

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