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Topical Manuscript

Sorting Through the Weeds: The Intersection of Legislation, Workplace Policy, and Medical Marijuana and Its Impact on Vocational Rehabilitation

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Medical marijuana has proven to be quite effective in treating and addressing negative symptoms associated with a number of disabilities such as cancer, glaucoma, and chronic pain, and although its use is legal in 38 states, it is still considered an illegal substance at the federal level. The incongruent state and federal laws, along with the conflict between marijuana's positive treatment benefits and the penalties associated with its illegal use, affect how rehabilitation counselors, specifically certified rehabilitation counselors (CRCs), provide services to consumers in this position. In an effort to understand the impact of these factors, the current study sought to identify if CRCs and other related professionals (non-CRC such as mental health counselors, addiction counselors) support: (a) the legalization and/or decriminalization of medical marijuana, (b) amendments to the Americans with Disabilities Act to ensure employment protections for consumers using medical marijuana, and (c) adjustments to agency policies that would prevent or lessen penalties for medical marijuana use. Significant results were noted only for decriminalizing medical marijuana. Implications from the study highlight a call for education and training, advocacy and ethical considerations, and consultation and collaboration.

Marijuana is the most commonly used illicit drug in the United States, and in 2023, 61.9 million individuals consumed this substance (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). Marijuana has a long history of use as a medicinal antidote and researchers have spent decades studying how it can be used to treat a host of physical and psychiatric disabilities. The terms medical marijuana and medicinal marijuana will be used throughout this article. *Medical* refers to the treatment of a disease while *medicinal* is used to indicate marijuana's beneficial effects such as pain reduction or increased appetite (Merriam-Webster, 2025a, 2025b). Support for the use of marijuana is at an all-time high. Eighty-eight percent of American adults report that marijuana should be legal for medical use only (32%), legal for both medical and recreational use (57%), and approximately 11% report that marijuana should not be legal for any purpose (Pew Research Center, 2024). As a sign of growing support, most states have passed legislation that allows the use of marijuana to treat "qualifying conditions" such as cancer, Parkinson's disease, glaucoma, multiple sclerosis (MS), HIV/AIDS, and chronic pain. Legalizing marijuana for medical and recreational purposes is favorable among rehabilitation counselors (RCs), other counseling professionals, and many of those working with individuals with disabilities.

Lusk et al. (2020) found that RCs were very likely to support consumers who are considering marijuana use to treat chronic health conditions, up to and including educating employers in an effort to secure competitive employment for consumers. In terms of addiction counselors, Wildberger and Katz (2019) reported that most of the substance use clinicians in their study support medical marijuana but also recognize its addictive properties. This study revealed that 71.3% of participants support marijuana legalization and 63.6% note its potential for abuse. Additionally, Swartz (2010) found that medical marijuana use did not adversely affect positive treatment outcomes. In fact, individuals in Swartz's study faired just as well or even better than non-medical marijuana users on several measures such as treatment completion, medical matters, and criminal justice involvement. The author found that "while addiction is the primary focus of treatment and not the legal/illegal aspects of drug acquisition and use…counselors must reevaluate treatment approaches and personal attitudes toward marijuana use" (pp. 87-88). Further, Walker et al. (2022) called to remove the stigma associated with marijuana use among counselors working with individuals with substance use disorders. In terms of mental health counselors, the American Counseling Association calls for counselors to shift from viewing "marijuana as an illegal sub-

stance to something that medical doctors can condone or even recommend" in the treatment of numerous physical and psychiatric disabilities (Bray, 2022, para. 3).

It would be irresponsible to deem marijuana a panacea; not every treatment works for every person or every condition, as some researchers have reported adverse side effects or outcomes after use. We would, however, be remiss if we failed to recognize that a large number of individuals grappling with various disorders, both mental and psychological, have reported experiencing significant benefits from the use of marijuana and cannabinoids (Vulfsons et al., 2020). For example, cancer patients often contend with symptoms like loss of appetite and nausea due to chemotherapy, both of which can be alleviated by marijuana's appetite-stimulating and antiemetic properties (Elliott et al., 2016). Furthermore, individuals coping with depression and anxiety may find relief in marijuana's ability to modulate neurotransmitter activity and reduce inflammation, thereby ameliorating mood disturbances and enhancing overall well-being (Zádor et al., 2012). Likewise, individuals with MS often contend with muscle stiffness, neuropathic pain, and sleep disturbances, all of which can be improved through marijuana use (Haddad et al., 2022). This growing body of evidence underscores the need for comprehensive research, education, and access to alternative therapies like medicinal marijuana to better serve the diverse needs of individuals living with chronic illness and disability (CID). In these and many other instances, medical marijuana can address symptoms related to CIDs or ameliorate them entirely. However, federal and state legislation, policies, and other guidelines reduce or completely block its access.

Juxtaposing Federal and State Legislation, Agency Policies, and Other Guidelines

At the writing of this manuscript, 38 states, three territories (Puerto Rico, United States Virgin Islands, and Guam), and the District of Columbia have sanctioned medical marijuana products (Chapekis & Saha, 2024). As such, 74% of individuals live in a state where marijuana is legal for medical use, and 79% of individuals live in a county with at least one dispensary. Additional reporting by Chapekis and Saha noted an increased number of such facilities, approximately 15,000, with 3659 in California alone. In most instances, marijuana is legal at the state level; however, it is classified as an illegal substance at the federal level, thus creating a conundrum for RCs trying to navigate their work with consumers and employers.

Laws and policies related to substance use, workplace health and safety, and disability criteria frame the work of RCs, and many of these regulations include explicit language prohibiting the use of illegal substances, such as marijuana. Federal and state entities primarily fund vocational rehabilitation (VR) agencies. They are expected to follow guidelines such as creating and adhering to drug-free workplace policies for both their employees and for those receiving services, even if medical marijuana is allowed in their state. The same applies to employers receiving federal contracts or grants (U.S. Department of Labor, 1990).

Federal Legislation

Title II of the Comprehensive Drug Abuse Prevention and Control Act (also known as the Controlled Substance Act) was enacted on October 27, 1970, to ensure substance regulation under existing legislation. As such, the Controlled Substance Act classified substances through *formal scheduling* with five categories resulting (see Table 1).

Marijuana is a Schedule 1 drug, and this classification muddles the research needed to understand its medicinal properties better, how it is prescribed/dosed, and how to properly manage its use. Marijuana's schedule is antithetical to state medical marijuana laws and creates the potential for legal and ethical dilemmas. These matters also extend to federally funded state programs that impact individuals with disabilities (e.g., vocational rehabilitation, Temporary Assistance for Needy Families [TANF], housing, utility bill assistance).

As previously noted, support for the medical and recreational use of marijuana has steadily increased among those working with individual with physical and psychiatric disabilities. However, there are still barriers in the form of legislation and workplace policies that impede medical marijuana use among VR consumers. These barriers prevent individuals from choosing between a viable treatment option and competitive employment and other services. Federal laws like the Drug-Free Workplace Act and the Occupational Safety and Health Act (OSHA) drive policy at many levels, including those that interface with individuals with disabilities. State laws that either legalize or decriminalize marijuana often collide with federal laws, leaving those with disabilities and their support team struggling to find the best way forward.

Drug-Free Workplace Act. The Drug-Free Workplace Act of 1988 addresses workplace substance use and guides actions employers may take against employees who engage in such behavior. This Act applies explicitly to federal contract recipients who receive more than $100,000 in funding and to any organization or agency that receives a federal grant of any size. Examples include funding for vocational rehabilitation (VR) services, Substance Abuse Prevention and Treatment block grants, and Community Mental Health block grants. Any organization must follow the guidelines to retain its contract. Failing to adhere to the guidelines can result in being banned from receiving new contracts for up to five years. Organizations must include in their workplace policy that the manufacture, distribution, dispensation, possession, or use of a controlled substance is strictly prohibited. A *controlled substance* is defined as a drug regulated by existing federal law (U.S. Drug Enforcement Administration [DEA], n.d.) such as marijuana. Even as more states move to legalize or decriminalize marijuana use, the U.S. Office of Personnel Management (OPM; 2016) issued Executive Order 12564 to federal agencies reinforcing that marijuana is still considered an illegal substance under federal law and all federal employees are prohibited from using it, even when off duty (Office of Federal Register, 2016).

Table 1. U.S. Drug Enforcement Administration Drug Scheduling

Schedule	Definition	Examples
Schedule 1	(a) Drugs, substances, or chemicals with no currently accepted medical use (b) Possess a very high potential for abuse	Heroin LSD Ecstasy Marijuana/Cannabis
Schedule 2	(a) Drugs, substances, or chemicals that have a known medical use/ are used to treat known medical conditions (b) Possess a very high potential for abuse, which can lead to severe psychological and physical dependence	Oxycodone Fentanyl Cocaine ADHD medications (i.e., Adderall and Ritalin) Methadone (used to treat opioid dependence)
Schedule 3	(a) Drugs, substances, or chemicals that have a known medical use/ are used to treat known medical conditions (b) Possess moderate to low potential for abuse which can lead to severe psychological and physical dependence (c) Abuse potential is less than Schedule 1 and 2 but more than Schedule 3	Tylenol with codeine Ketamine Anabolic steroids Testosterone Buprenorphine (used to treat opioid dependence)
Schedule 4	(a) Drugs, substances, or chemicals that have a known medical use/ are used to treat known medical conditions (b) Possess low potential for abuse (c) Abuse potential is less than Schedule 1, 2, and 3	Xanax Valium Tramadol Soma
Schedule 5	(a) Drugs, substances, or chemicals that have a known medical use/ are used to treat known medical conditions (b) Possess very low potential for abuse (c) Consists of preparations containing limited quantities of certain narcotics	Robitussin AC (antitussive with less than 200 milligrams of codeine) Lomotil (antidiarrheal medication with a low dose of diphenoxylate) Lyrica (treats nerve pain with a low dose of pregabalin)

Occupational Safety and Health Act. The Occupational Safety and Health Act (OSHA) of 1970 ensured safe working conditions to offset unsafe working environments that previously led to injuries and illnesses that significantly impacted work productivity and contributed to lost wages, increased medical expenses, and disability compensation payments. Per OSHA, people who ingest illegal substances increase on-the-job accidents and injuries and are a hazard to the work environment. As a result, employers and employees should create and maintain safe and healthy working environments by enacting appropriate protocols.

Americans with Disabilities Act. The Americans with Disabilities Act (ADA, Americans with Disabilities Act of 1990, 1990) includes information about how disability is defined, how individuals are protected under this law, and how matters, such as illegal substance use, impact opportunities for services. The ADA Amendments Act (ADAAA) of 2008 broadened the definition of disability to ensure "coverage of individuals to the maximum extent permitted by the terms of the ADA" (U.S. Equal Employment Opportunity Commission, n.d., para 1). This change further increased access to competitive employment and protection from discrimination (U.S. Equal Employment Opportunity Commission, 2008). One of the principal goals of the ADAAA is to find and place individuals with disabilities into competitive employment. Essentially, RCs must determine if a consumer is qualified for a specific job, ensuring they meet the definition of disabled as described by the ADAAA, and that the consumer possesses the requisite skills for said job or is otherwise qualified. Other professionals come into play when services, such as addiction treatment, mental health services, or social supports, are required.

The ADAAA defines a qualified individual as someone with a disability with the skills, education, or other requirements for gainful employment. These individuals can perform essential job functions with or without appropriate accommodations. ADA Section 104 notes that an individual actively using illegal drugs is not considered a qualified individual with a disability. The current law makes it illegal for employers to discriminate against *qualified individuals* (i.e., those not actively using) in hiring and promotion practices. Individuals actively engaged in illegal substance use are not, however, protected from employment discrimination under the Act.

The ADAAA defines *illegal drug use* as the use, possession, or distribution of a substance that is unlawful under the Federal Comprehensive Drug Abuse Prevention and Control Act (Controlled Substance Act) of 1970. Drugs prescribed and used under the supervision of a licensed healthcare professional are allowed, such as highly addicting opioids, but marijuana is not. The ADAAA protects employers who may choose to fire an employee for their current use of marijuana. Current use is not limited to the day of use or recent days or weeks but is determined on a case-by-case basis (U.S. Equal Employment Opportunity Commission [EEOC], 1992). Employers cannot discriminate against qualified individuals if they have a history of drug use or if they are currently enrolled or have a history of enrollment in a treatment program.

State Law

One of the most critical questions related to this matter is: *What does it mean if (medical) marijuana is illegal under federal law but legal under state law?* To answer this question, the principle of *preemption* might be considered. Preemption is a legal concept that notes that the laws of higher levels of government supersede the laws of the lower levels. In this instance, one would assume that federal laws related to marijuana use, even for medical reasons, reign over state and local law. When it comes to marijuana, however, preemption is a moot point. According to the Marijuana Policy Project (2025), "the federal government is free to enforce its own marijuana laws [but] requiring states to enforce federal laws is unconstitutional commandeering of a state's resources" (para. 6). During the Obama Administration, federal prosecutors were encouraged to curb their prosecution of individuals who disseminated medical marijuana by state law.

Up until now, there have been two options for addressing the legality of marijuana use at the state level—legalization and decriminalization. Legalization would allow individuals to obtain, possess, and use marijuana without fear of criminal prosecution (National Organization for the Reform of Marijuana Laws, 2022). Examples of legalized substances include alcohol and tobacco. Although legal, the government provides guidelines to determine the products and timing of their sale. If decriminalized, marijuana use would remain illegal, but there would be few to no penalties applied for possession under a certain amount (Caulkins & Kilmer, 2016). Examples of penalties include civil fines, drug education, or drug treatment. Passed by the 117th Congress/House of Representatives in early 2022, the Marijuana Opportunity Reinvestment and Expungement Act seeks to decriminalize marijuana. The passing of this Act would prompt the reclassification of marijuana on the DEA's controlled substance list, eliminate criminal penalties for many who manufacture, distribute, or possess marijuana, and direct OSHA to study the impact of marijuana use on the workplace. There are significant implications associated with the passage of this Act.

Reclassifying marijuana could create opportunities for additional federal funding to support research on how medical marijuana might be "prescribed" and monitored under the supervision of qualified healthcare providers and further extend treatment options for individuals with disabilities. Reclassification and data from OSHA employment outcome studies can help shape guidelines for addressing such a complicated issue. The resulting guidelines may perhaps be akin to the current stance on prescription opioid use and employment. See the EEOC's 2020 technical assistance document, "How Health Care Providers Can Help Current and Former Patients Who Have Used Opioids Stay Employed", for additional information. This bill currently sits at the Senate level, awaiting a vote.

Employer Accommodation Obligations

White et al. (2017) wrote about the obligations states and employers have in accommodating individuals with disabilities who use medical marijuana. According to their work, accommodation obligations fall into four categories: (a) state law explicitly requires employers to attempt to make reasonable accommodations for those who use medical marijuana; (b) state law does not definitively note accommodation obligations, but the employer is allowed to prohibit the use of marijuana while the employee is at work; (c) state law notes that an employer is not required to accommodate an employee who uses medical marijuana in the workplace; and (d) state law that does not address accommodation obligations or an employer's ability to prohibit the use of marijuana at the worksite.

An *explicit directive* requires that the employer attempt to accommodate medical marijuana use for employees with a qualifying condition and registered marijuana card (White et al., 2017). States that encompass such directives includes Connecticut, Nevada, and New York. Employers are not, however, required to make an accommodation if it poses a risk to the health and safety of the person, coworkers, or the work environment itself, creates an undue hardship for the employer, or prevents the employee from fulfilling their work responsibilities. There are some state laws (e.g., Missouri) where no specific language on obligations to accommodate medical marijuana is included. In these states, employers can still decide to prohibit the use of medical marijuana for working employees and also prohibit employees from working under its influence. Many states' medical marijuana laws definitively assert that employers are not required to accommodate medical marijuana use during work hours. Employers in Alabama and Washington state can completely restrict medical marijuana use. Finally, laws in some states (e.g., Hawaii and Maryland) do not address these issues. Their state medical marijuana laws are silent on both providing accommodations and the employer's right to prohibit the use of marijuana while at work.

The Intersection of Legislation, Advocacy, and Support for Change

Lawmakers are straightforward in their stance toward drug use and their desire to offset its consequences, which is reflected in legislation surrounding drug-free workplace policies, health and safety standards, access to social service programs, and even how disability is defined and protected. VR agencies require and enforce drug-free workplace policies, and RCs are beholden to these guidelines and expected to uphold them both as an employee and provider of services. The RC aims to place consumers in competitive jobs while considering employers' needs and regulations. They are also responsible for helping consumers understand options for treatment and care, which may very well include medical marijuana. RCs stand in the middle of this and are in a prime position to advocate and drive changes to legislation and policies that benefit both the consumer and the employer. To gauge how RCs might take on this charge, we designed a study to help identify their support for modifications or amendments to current legislation or the creation of new laws and policies supporting medical marijuana use.

Current Study

The data analyzed in this study were collected as part of a more extensive study that focused on RCs support for consumer medical marijuana use. Most of those in our study work in traditional rehabilitation settings, such as state/federal agencies or community rehabilitation programs; others work in mental health agencies and treatment programs or other organizations/agencies that support individuals with disabilities. Participants included students in disability-related fields; professionals in the field of rehabilitation, mental health, or addiction; counseling supervisors; administrators; and faculty. This subset of data focused specifically on the relationship between certified rehabilitation counselors (CRCs) and non-CRC participants and their support for legalizing or decriminalizing medical marijuana, as well as their support for changing federal/state laws and policies surrounding medical marijuana. As such, the following research questions guided this study:

> **Research Question 1:** Do certified rehabilitation counselors (CRCs), as compared to non-CRCs (i.e., students, administrators, addiction professionals, mental health professionals, faculty), support the legalization/decriminalization of marijuana for medicinal purposes?
> **Research Question 2:** Is there a significant relationship between those working with individuals with disabilities and support for changes to the Americans with Disabilities Act that would allow the use of medical marijuana for qualifying conditions?
> **Research Question 3:** Is there a significant relationship between those working with individuals with disabilities and support for changes to agency policies that would allow the concurrent use of medical marijuana and receipt of VR services?

Method

Procedure

After receiving approval through the Institutional Review Board at the first author's institution, a link to a Qualtrics survey, which included a description of the study and a consent form, was distributed through various rehabilitation listservs (e.g., National Council on Rehabilitation Education, Commission on Rehabilitation Counselor Certification). The researchers forwarded a link to departments and chairpersons, rehabilitation and other counselor education program coordinators, and community agency organizations' rehabilitation professionals. Reminders were sent twice after the initial email. Researchers did not offer incentives to participants to participate in the study.

Instrumentation

The researchers developed a simple questionnaire for this portion of the study. Participants noted their support for (a) legalizing and decriminalizing medical marijuana, (b) amending the ADAAA in an effort to ensure employment protections for consumers using medical marijuana, and (c) adjusting agency policies that would prevent or lessen penalties for medical marijuana. Answer options included *yes, unsure,* and *no*. The researchers collapsed *unsure* and *no* into one category for analysis due to the smaller number of responses. Additionally, the researchers collapsed participant categories into two groups: (a) certified rehabilitation counselor (CRC) and (b) non-CRC. DiStefano et al. (2021) reported that collapsing categories, mainly when data cells have smaller responses, proved beneficial for chi-square analysis, as this helps to reduce the likelihood of Type I errors.

Participants

Researchers recruited the participants in several ways, including contacting those who met the study's participant criteria, using snowball methods, and using a listserv purchased from the Commission on Rehabilitation Counselor Certification. A total of 2000 individuals were contacted via email through these means. After initial contact, 717 individuals began the survey and 478 completed it in its entirety (67%). Only complete surveys were included in the data analysis. Standard demographic information was collected (e.g., age, gender, race/ethnicity, occupation). Participants identified as male (n = 142, 30%) and female (n = 333, 70%). Most participants were White (n = 358; 75%), followed by Black or African American (n = 48, 10%), Latino/Latina or Hispanic (n = 37, 8%), Asian American (n = 12; 3%), Native American/American Indian (n = 5; 1%), and Other (n = 15; 3%). The most reported occupation was a practicing vocational rehabilitation counselor (n = 186; 39%). Demographic data also revealed that most of the participants held the CRC credential (77%). See Table 2 for complete demographic information and note pertaining to missing data.

Results

Results from Research Question 1 found no significant difference between CRCs and non-CRCs in their support for the legalization of medical marijuana, X^2 (N = 478) = 2.76, p = .10. Results from Research Question 2 revealed a significant difference between the groups. Those holding the CRC credential are more likely to support decriminalization when compared to those without the CRC credential, X^2 = (N = 478) =18.03, p < .0001. The last two analyses—support for changes to the ADA and support for changes to agency policy—note no significant differences between the groups, X^2 ^(N = 478) = 3.46, p=.06 and X^2 (N = 478) = 2.15, p =.14, respectively. See Table 3.

Discussion

Legalization vs. Decriminalization

There are numerous benefits of decriminalizing marijuana, so much so that the House of Representatives passed the Marijuana Opportunity Reinvestment and Expungement Act. A significant advantage of decriminalization, compared to legalization, is that it focuses more on sup-

Table 2. Frequencies for Demographic Variables and Subsets with CRC Credential

	Full sample *N* = 478		With CRC credential (*n* = 368, 77%)	
	n	%	*n*	%
Gender (Missing = 3)				
Female	333	70%	255	77%
Male	142	30%	111	78%
Race (Missing = 3)				
White	358	75%	299	84%
African American	48	10%	30	63%
Hispanic	37	8%	15	41%
Asian American	12	3%	8	67%
Native American	5	1%	5	100%
Other	15	3%	9	60%
Age				
18-24	36	8%	2	6%
25-34	110	23%	74	67%
35-44	94	20%	80	85%
45-54	93	19%	80	86%
55-64	120	25%	108	90%
65+	25	5%	24	96%
Occupation				
Undergraduate student	26	5%	0	0%
Master's student	44	9%	3	7%
Doctoral student	21	4%	16	76%
Practicing VR counselor	186	39%	172	92%
Practicing MH counselor	29	6%	28	97%
Practicing addiction counselor	7	1%	6	86%
Counseling supervisor	29	6%	22	76%
Administrator (Agency)	29	6%	27	93%
Administrator (Policy, Legislation, Grants)	7	1%	6	86%
Faculty	35	7%	33	94%
Other	65	14%	55	85%

Note. VR = vocational rehabilitation; MH = mental health.

porting the person. Decriminalization is built on a public health framework which serves to support the use of marijuana for medicinal reasons and increase access to specialized care without the fear of being ostracized or penalized (American Public Health Association, 2020). Consumers would have access to a viable treatment option and more support for work accommodations. Another benefit of decriminalization is the decreased likelihood of being arrested and charged with possession. Having a disability and a criminal record decreases the likelihood of finding competitive employment. Decriminalization benefits consumers, RCs, and employers (Harris & Martin, 2019).

The Americans with Disabilities Act and Federal Law

Although participants noted their support for decriminalizing marijuana, results did not note significant support for changes to the ADAAA. Notably, however, most participants indicated their support for change. This Act supports the use of legal medications to treat disabilities; however, marijuana remains classified as an illegal substance and, therefore, is illegal. The use of marijuana can hamper access to VR services and, subsequently, competitive employment. There are, however, places in the ADAAA where clarity is desperately needed, such as its definition of current use. As mentioned earlier, employers need to assess current usage on a case-by-case basis. Since marijuana use is not bound to the length of time, drug tests cannot pinpoint the exact time an employee used a substance, and there are no

Table 3. Responses of CRC Credential Holders and Chi-Square Analyses

	Do you support the legalization of marijuana for medicinal use?			
CRC Credential	Yes	No/Unsure	Total	χ^2
Yes	292	76	368	2.76, p ≈ .10
No	79	31	110	
Total	371	107	478	
	Do you support the decriminalization of marijuana for medicinal use?			
CRC Credential	Yes	No/Unsure	Total	χ^2
Yes	278	90	368	18.03, p < .0001*
No	60	50	110	Cramer's V = .20
Total	338	140	478	
	Would you support changes to the ADA that would allow the use of medical marijuana for qualifying conditions?			
CRC Credential	Yes	No/Unsure	Total	χ^2
Yes	295	73	368	3.46, p ≈ .06
No	79	31	110	
Total	374	104	478	
	Would you support changes to your agency's policy that would allow for the concurrent use of medical marijuana and receipt of VR services?			
CRC Credential	Yes	No/Unsure	Total	χ^2
Yes	292	76	368	2.15, p ≈ .14
No	80	30	110	
Total	372	106	478	

Note. Use alpha = .01 (.05/5); * = significant.

distinctions made between the type of drug used (i.e., legal substances such as opioids and alcohol vs. illegal drugs such as marijuana). Also, many employers do not possess the training or skills to make this call.

Failing to identify support for amendments to the ADAAA in this study is interesting. This historic law ensured protections for individuals with disabilities and is a major victory for the disability community; however, this law does not protect those who may use marijuana to treat said disabilities. Results from this study revealed support for decriminalizing marijuana for medical use, but this could potentially leave consumers in a tenuous situation and unsure of how to proceed. In this instance, the consumer would take a risk by using marijuana to treat their disability and forgoing the employment protections provided by the ADAAA. Conversely, they could miss out on the many medicinal benefits of marijuana in their effort to obtain and maintain employment. In order to address and potentially offset the conundrum these matters present, it is imperative that we do our due diligence in training burgeoning RCs and also ensure practicing professionals are informed as well.

One way we might address this issue is through rehabilitation counseling curricula. The 2024 standards developed by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) for all counseling and, more specifically, rehabilitation counseling programs can be used to guide how this content can be integrated across the entire curriculum (CACREP, 2023a, 2023b). Standards in Section 3.A address the role and function of counselors across specialized practice areas along with legislation, regulatory processes, and government/public policies relevant to and impacting on service delivery. This would be applicable across service delivery modalities and specialized practice areas. Section 3.B focuses on social and cultural identities and experiences. The effects of stereotypes and discrimination, principles of independence and inclusion, and ability to identity and eliminate barriers are all factors worthy of consideration when working with consumers who may use marijuana for medicinal purposes. Other standard areas, such as Section 3.D (Career Development) and Section 3.E (Counseling Practice and Relationships), exist where information related to the role of RCs and the consumers' use of medical marijuana can be incorporated. Section G is specific to rehabilitation counseling programs, and standards such as G.7 – classification, terminology, etiology, functional capacity, and prognosis of disabilities is especially relevant to medical marijuana. Another example of where this topic can be further incorporated is standard G.13 – consultation and collaboration with employers regarding the legal rights and benefits of hiring individuals with disabilities, including ADA adherence, accommodations, universal design, and workplace disability prevention.

Policy Changes and Advocacy

The potential for change in federal laws related to medical marijuana is possible; however, this achievement will require a more nuanced, long-term plan. In the interim, RCs can back local policies that support consumers who use medical marijuana. RCs should be knowledgeable about the current legislation surrounding its use as this allows them to engage in meaningful discourse with consumers, employers, and even their congressional representatives who shape state and federal laws. Movement at this level is limited since VR policies are influenced by higher-level federal and state laws, but it is a tangible point for advocacy. A few suggested resources for staying abreast of these matters include the Marijuana Policy Project (https://www.mpp.org/), the NORML Foundation (https://norml.org/), and the National Conference of State Legislatures (n.d.).

Implications for Rehabilitation Professionals

As more individuals choose to utilize medical marijuana and other cannabinoids as a way to alleviate negative symptoms associated with CIDs, and as more states pass laws to support its use for medical treatment, professionals must be mindful of any attitudes that might impact their effectiveness in working with these clients. *Education and training* are the best ways to approach changing attitudes toward medicinal marijuana use and to increase the knowledge base of rehabilitation counseling students, practitioners, and professionals. Specifically, professionals are encouraged to seek continuous professional development through regular training sessions and workshops focusing on current research, legal frameworks, and ethical considerations surrounding medicinal marijuana use. Integrating discussions on medicinal marijuana and cannabinoids into academic curricula for rehabilitation counseling programs ensures that upcoming professionals receive current knowledge and skills essential for efficient client support.

Advocacy and ethical considerations are also paramount in supporting clients who choose medicinal marijuana as part of their treatment regimen. Professionals should actively champion policies that facilitate safe and lawful access to medicinal marijuana options. Simultaneously, they must adhere to rigorous state and federal regulations governing its use. Additionally, professionals should be equipped with robust frameworks for ethical decision-making, prioritizing principles such as client autonomy, beneficence, nonmaleficence, and justice when navigating medicinal marijuana scenarios. For instance, monitoring and evaluation processes could be implemented to track client outcomes and experiences with medicinal marijuana use, enabling professionals to adjust interventions and support strategies based on feedback and results. Additionally, ongoing evaluation of educational initiatives and client support strategies related to medicinal marijuana is essential to continually enhancing client care and professional development.

Medical marijuana and cannabinoids are proving to be an effective way to address negative symptoms associated with several disabilities and chronic illnesses that impact quality of life, full engagement in one's environment, and employment. Promoting *open dialogue and awareness* is essential in navigating the complexities of medicinal marijuana use within rehabilitation counseling. Rehabilitation professionals who are aware of and open to other forms of treatment that may increase positive prospects for their clients are better positioned to provide support to address varying needs. Professionals should foster opportunities for open discussions to explore evolving attitudes towards medicinal marijuana, allowing for the sharing of experiences and addressing concerns. Additionally, raising awareness among clients and stakeholders about the potential benefits and risks associated with medicinal marijuana is crucial. It is essential to emphasize evidence-based practices and provide clear insights into legal implications.

Moreover, *consultation and collaboration* play pivotal roles in ensuring holistic client care. Rehabilitation counselors are encouraged to establish collaborative relationships with healthcare providers, including physicians, to facilitate comprehensive care planning tailored to clients who utilize medicinal marijuana. Furthermore, regular consultation with supervisors and policy advisors is essential. This practice enables professionals to navigate agency policies, adhere to legal requirements, and address ethical considerations, effectively supporting informed decision-making in client care. By following these practices, rehabilitation counselors benefit from meeting with employers and consulting physicians, supervisors, and policy experts, as it enhances their knowledge and support to help clients with CIDs make informed decisions regarding the use of marijuana and cannabinoids.

Limitations

The authors noted a few limitations in this study. First is the intrinsic problem that results from self-reported, online surveys. The questionnaire, designed and administered through Qualtrics, was tested numerous times for flow and accuracy before being made available to participants; however, there were instances in which participants started the study but did not finish or inadvertently skipped questions, which may have had an impact on the overall results.

Secondly, we did not ask participants if medical marijuana was legal or decriminalized in their respective states or if they had previously/currently worked with consumers who used marijuana, as this may have influenced their response. Finally, we collapsed participant groups (e.g., CRC vs. non-CRC), which likely caused us to miss slight response variances.

Conclusion

Mitus and Levine (2021) noted that the advocacy, once fervent among RCs and others in the disability community, appears to have drifted, resulting in less progress toward goal attainment. When considering the legislation related to marijuana use and the medicinal benefits for people with disabilities, it is apparent that these are complicated issues that demand our attention. We find ourselves at an intersection and must consider how laws and policies support our work as RCs and potentially hinder it. These matters are

essential and will take some time to weed through; however, the continuation of our profession, the success of our consumers, the concerns and needs of employers, and the economy are contingent upon it.

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