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MEDICAL CANNABIS ACCESS UNDER PROBATION AND PAROLE: REMOVING BARRIERS TO DOCTOR-RECOMMENDED TREATMENT

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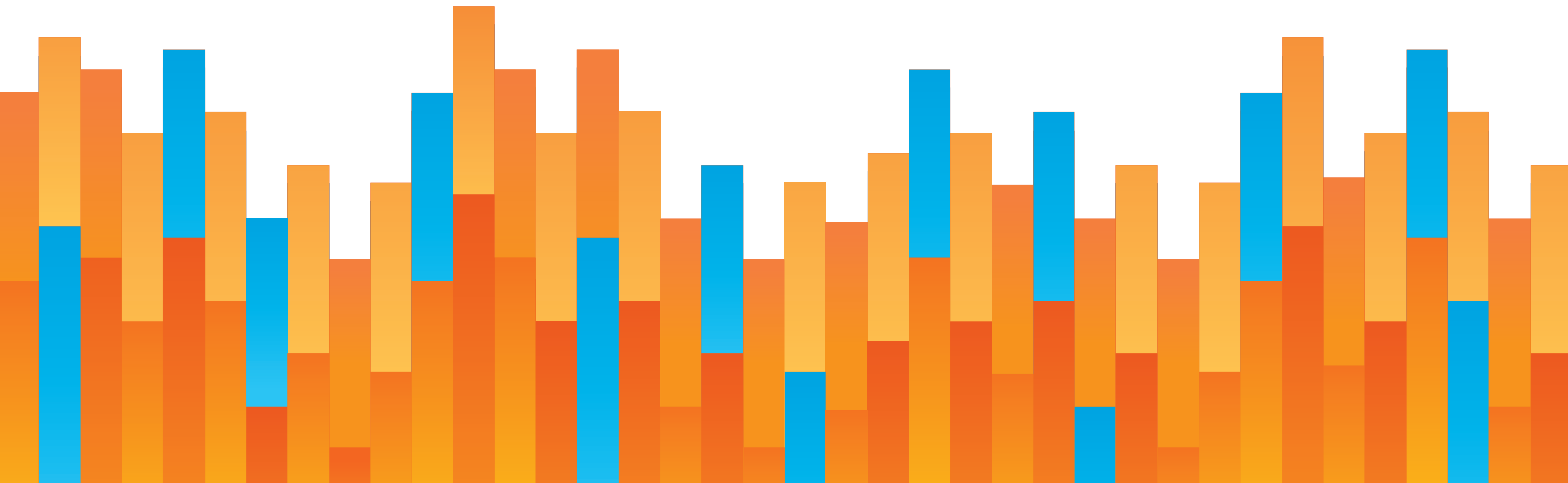

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EXECUTIVE SUMMARY

Nearly 4 million adults in the United States live under community supervision, either on probation or parole. That is nearly double the combined population of people held in jails and prisons nationwide. These individuals must navigate a web of requirements: regular check-ins with probation officers, court monitoring, and compliance with release conditions that, while often well-intentioned, can be counterproductive for successful reintegration. A single violation, even a technical violation of release conditions that involves no new criminal conduct, such as missing an appointment with a parole officer, can result in automatic reincarceration.

Many on supervision contend with chronic health conditions requiring ongoing medical attention, including conditions for which state authorities have approved the use of medical marijuana. Although 47 states now permit the use of marijuana for medical purposes, people serving supervision sentences often cannot access this physician-recommended treatment without jeopardizing their liberty.

This policy brief examines the contradiction that even states that have legalized medical marijuana exclude individuals on probation, parole, or supervised release from accessing this medicine. This exclusion undermines the purpose of marijuana reform by continuing to criminalize access and denying its potential benefits to a population that may need them most.

This brief also examines the fiscal consequences of supervision violation policies. In 2023, states spent an estimated $3 billion incarcerating individuals for technical violations that included no new criminal conduct, the same category into which a positive marijuana test typically falls.

The analysis that follows explores state-level policies that offer promising frameworks to address this problem, including statutory protections, court decisions, administrative policies, and treatment court practices. States such as Minnesota, Missouri, Connecticut, New York, and Colorado have enacted laws that protect supervisee access to medical marijuana by requiring individualized assessments before courts can restrict them from the medical marijuana market. Appellate courts in Pennsylvania, Michigan, and Arizona have struck down blanket prohibitions on the use of medical marijuana as a condition of release, finding them inconsistent with state medical marijuana statutes. Even without statutory mandates, corrections agencies in Washington, Florida, and Minnesota have adopted policies that permit registered marijuana patients to continue their treatment while under supervision.

With the federal government now moving to reschedule marijuana from Schedule I to Schedule III, the remaining state-level restrictions become increasingly difficult to defend.

With the federal government now moving to reschedule marijuana from Schedule I to Schedule III, the remaining state-level restrictions become increasingly difficult to defend. The medical value of marijuana will be expressly recognized under both state and federal law. Supervision systems designed to support rehabilitation and reentry should not erect barriers to medical care that is legal for all other citizens and may greatly impact their stability and reintegration.

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PART 1

INTRODUCTION

In addition to the nearly 2 million adults in prison, jail, or detention, the United States also maintains one of the world's largest populations of people under "community supervision"—those serving sentences on probation or parole rather than incarceration. As of 2023, an estimated 3,772,000 adults were under community supervision, required to regularly check in with parole officers, submit to court monitoring, and comply with release conditions that, if violated, can lead to reincarceration.[1]

The underlying philosophy is simple: People who have served time or avoided incarceration through a plea agreement should have the opportunity to reintegrate into society under structured oversight. The goal, at least in theory, is to reduce recidivism by providing a pathway back to stability—employment, housing, family connections, and healthcare. But the reality often falls short, particularly when supervision conditions block access to legitimate medical treatment.

1 Bureau of Justice Statistics, "Probation and Parole in the United States, 2023." https://bjs.ojp.gov/document/ppus23.pdf

Compared to the general population, those under supervision face elevated rates of chronic health conditions, substance use disorders, and mental health challenges. Research shows that individuals on supervision are four times more likely to have substance use disorders and twice as likely to have mental health disorders as the broader public.[2] Conditions like chronic pain, post-traumatic stress disorder (PTSD), anxiety, and sleep disorders—often exacerbated by incarceration—are pervasive in this population. For many of these conditions, medical marijuana represents a legitimate treatment option expressly permitted under the laws of most states.

Medical marijuana has gained broad acceptance across the country, with 47 states, the District of Columbia, and three U.S. territories now allowing the use of marijuana for medical purposes.[3] Qualifying conditions typically include chronic pain, PTSD, anxiety, epilepsy, multiple sclerosis, and symptoms associated with cancer treatment. For many patients, medical marijuana represents an alternative to opioids and other medications that carry higher risks of dependence and adverse effects.

Medical marijuana has gained broad acceptance across the country, with 47 states, the District of Columbia, and three U.S. territories now allowing the use of marijuana for medical purposes.

Yet, people under community supervision with these qualifying conditions frequently cannot access this state-authorized, physician-recommended treatment. Standard supervision conditions in nearly every jurisdiction prohibit the use of controlled substances. Because marijuana remains a Schedule I drug under federal law for now, these prohibitions typically encompass marijuana even in states where medical use is legal. The result is a two-tiered system where millions of Americans can access the therapeutic benefits of medical marijuana at the same time that millions more cannot.

[2] Prison Policy Initiative, "People on probation and parole are 4x more likely to have substance use disorders," April 2023. https://www.prisonpolicy.org/blog/2023/04/03/nsduh_probation_parole/

[3] Centers for Disease Control and Prevention, "State Medical Marijuana Laws." https://www.cdc.gov/marijuana/about/state-medical-marijuana-laws.html

This brief addresses that inconsistency. It examines the characteristics of supervision populations and their health burdens, analyzes emerging legal frameworks that protect medical marijuana access, and offers policy recommendations for states seeking to align their supervision systems with their medical marijuana laws. While medical marijuana may not be appropriate for all people on supervision, those individuals with legitimate medical needs and valid state registrations should not face incarceration for following their doctors' recommendations.

PART 2

TECHNICAL VIOLATIONS AND THEIR COSTS

As a condition of release, individuals on probation or parole must comply with requirements and restrictions imposed by judges at sentencing or by parole boards authorizing release. Violations can be classified as "non-technical violations," such as committing a new crime, or "technical violations," which include non-criminal infractions like missed check-ins with probation officers, failed drug tests, curfew violations, skipped treatment sessions, or failure to pay supervision fees.[4] Of the nearly 200,000 people admitted to prison in 2023 for violations of probation or parole, more than half involved technical violations alone.[5] States collectively spent an estimated $3 billion in public funds incarcerating people for supervision violations that involved no new criminal activity.[6]

4 Vera Institute of Justice, "Unreasonable probation requirements are sending people to jail." https://www.vera.org/news/unreasonable-probation-requirements-are-sending-people-to-jail

5 Council of State Governments Justice Center, "Supervision Violations and Their Impact on Incarceration: Key Findings." https://projects.csgjusticecenter.org/supervision-violations-impact-on-incarceration/key-findings/

6 Ibid.

2.1 STANDARD CONDITIONS AND CONTROLLED SUBSTANCE PROHIBITIONS

Under federal sentencing laws (18 U.S.C. § 3563), conditions of release for federal crimes require defendants to refrain from any unlawful use of a controlled substance and submit to drug testing.[7] The statute specifically requires defendants to refrain from excessive use of alcohol or any use of a narcotic drug or other controlled substance without a prescription from a licensed medical practitioner.[8]

> *Substance use can correlate with criminal behavior. But the blanket nature of these restrictions creates a problem for states that have authorized marijuana for medical use.*

State probation conditions mirror this federal framework. A Prison Policy Initiative analysis of standard probation conditions across 76 jurisdictions found that restrictions on drug and alcohol use appear in virtually every jurisdiction's standard conditions.[9] The conditions include a prescription carve-out, permitting the use of controlled substances when lawfully prescribed by a physician.[10] The rationale is understandable: Substance use can correlate with criminal behavior. But the blanket nature of these restrictions creates a problem for states that have authorized marijuana for medical use. Because marijuana remains a Schedule I controlled substance under federal law, supervision conditions that prohibit "controlled substance" use typically also prohibit marijuana, even in states that have legalized medical marijuana. A positive marijuana test can trigger revocation proceedings and potential re-incarceration, even when the individual holds a valid state medical marijuana registration and is using marijuana as directed by their physician.

7 18 U.S.C. § 3563, Conditions of probation. https://www.law.cornell.edu/uscode/text/18/3563

8 Ibid.

9 Prison Policy Initiative, "Probation Conditions," 2022. https://www.prisonpolicy.org/reports/probation_conditions.html

10 Ibid.

2.2 THE DATA GAP

A significant challenge in addressing these medical marijuana restrictions is the absence of data distinguishing marijuana-related violations from those involving other controlled substances. When supervising agencies collect data on failed drug tests, records typically indicate only that a substance violation occurred without detailing the specific substance that triggered it. The data is not refined enough to determine how many supervision violations are attributable specifically to marijuana use as opposed to other prohibited substances.[11]

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This limitation makes it difficult to quantify how many substance-related technical violations are linked specifically to marijuana. However, as marijuana is the most commonly used controlled substance in the United States and is detectable in standard urine tests for up to 30 days after use, it is likely that marijuana-related violations represent a substantial share of drug test failures among supervised populations.[12] Without substance-specific violation data, the number of individuals reincarcerated solely for testing positive for marijuana remains unknown.

11 Spence Purnell, "It Is Time to Stop Drug Testing Parolees and Probationers for Marijuana," Reason Foundation, August 10, 2019. https://reason.org/commentary/it-is-time-to-stop-drug-testing-parolees-and-probationers-for-marijuana/ (accessed May 28, 2026)

12 Substance Abuse and Mental Health Services Administration, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2022 National Survey on Drug Use and Health," 2023. https://www.samhsa.gov/data/sites/default/files/reports/rpt42728/NSDUHDetailedTabs2022/NSDUHDetailedTabs2022/2022-nsduh-detailed-tables.htm

PART 3

STATE STATUTORY PROTECTIONS

Some states have begun to address supervision restrictions through adult-use marijuana legalization. According to the Marijuana Policy Project, most adult-use marijuana legalization laws passed since 2021 have included protections from parole and probation revocation for recreational marijuana use.[13] Statutory protections specifically for medical marijuana patients under supervision, however, have developed more slowly and remain far less consistent across states.

Colorado was among the earliest to act, with then-Gov. John Hickenlooper signing legislation in 2015 establishing that possession or use of medical marijuana shall not constitute a probation violation, subject to narrow exceptions for offenses under the Medical Marijuana Code or cases where courts determine, based on material evidence, that prohibition is necessary to accomplish sentencing goals.[14]

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13 Marijuana Policy Project, "Parole and Probation Revocation Post-Marijuana Legalization." https://www.mpp.org/issues/legalization/parole-and-probation-revocation-post-marijuana-legalization/

14 C.R.S. § 18-1.3-204(1)(b). https://content.leg.colorado.gov/sites/default/files/images/olls/crs2024-title-18.pdf; Sensible Colorado, "House Bill 15-1267 Allows Probationers Access to Medical Marijuana." https://www.sensiblecolorado.org/house-bill-15-1267-allows-probationers-access-to-medical-marijuana/

Connecticut's 2021 legalization law established that legal marijuana use cannot serve as grounds for revocation of parole, special parole, or probation, with a narrow exception for when individualized findings indicate that use poses a danger to the person or the public.[15] Such findings may not consider prior arrests or convictions for marijuana use or possession—a provision that prevents past marijuana involvement from becoming a permanent barrier to medical marijuana access.[16]

New York's 2021 Marijuana Regulation and Taxation Act goes further, explicitly requiring that, before marijuana prohibition can be included as a condition of release, it must be "shown by clear and convincing evidence" to be "reasonably related to the underlying crime."[17] Medical patients receive additional protection and cannot be tested for marijuana even if marijuana use relates to the underlying offense.

Minnesota's 2023 legalization law allows courts to impose marijuana abstinence as a condition of release only if the defendant undergoes a clinical assessment and abstinence is consistent with the recommended level of care.[18]

Missouri's 2022 constitutional amendment legalizing adult-use marijuana blocks judges from prohibiting legal use of lawful marijuana as a condition of release. The law also prohibits drug court programs from barring registered patients.[19]

15 Conn. Gen. Stat. § 54-125k. https://law.justia.com/codes/connecticut/title-54/chapter-961/section-54-125k/

16 Ibid.

17 New York Marijuana Law, Article 5. https://www.nysenate.gov/legislation/laws/CAN/A5

18 Minn. Stat. § 342.57, Subd. 8. https://www.revisor.mn.gov/statutes/cite/342.57

19 Missouri Constitutional Amendment 3 (2022). https://ballotpedia.org/Missouri_Amendment_3,_Marijuana_Legalization_Initiative_(2022)

PART 4

JUDICIAL DECISIONS

The Pennsylvania Supreme Court's unanimous decision in *Gass v. 52nd Judicial District, Lebanon County* (2020) is one of the most important rulings on whether people under community supervision can be barred from using medical marijuana.[20] In October 2019, the American Civil Liberties Union of Pennsylvania sued on behalf of three Lebanon County residents who were registered medical marijuana patients on probation: Melissa Gass, who uses marijuana to control epileptic seizures; Ashley Bennett, who uses it for PTSD, chronic pain, and nausea; and Andrew Koch, who uses it for chronic pain after a car accident left him determined to avoid returning to opioids.[21] They were challenging a new local policy that forced them to choose between their medicine and their freedom. More than 60 people in the county faced the same choice.

The policy was implemented by the Lebanon County court. In September 2019, the court, formally the 52nd Judicial District, adopted a rule prohibiting medical marijuana use for all individuals under community supervision, including probation, parole, and accelerated rehabilitative disposition, regardless of whether they are registered patients with the

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20 *Gass v. 52nd Judicial District*, Lebanon County, 232 A.3d 706 (Pa. 2020). https://www.aclupa.org/cases/gass-v-52nd-judicial-district/

21 ACLU of Pennsylvania, "*Gass v. 52nd Judicial District*," accessed June 17, 2026, https://www.aclupa.org/cases/gass-v-52nd-judicial-district/; Class Action Petition for Review ¶ 84, *Gass v. 52nd Judicial District*, No. 574 MD 2019 (Pa. Commw. Ct. filed Oct. 8, 2019) (estimating more than 60 affected individuals).

Pennsylvania Department of Health. Affected patients were given 30 days to stop.[22] One of the main justifications for prohibiting medical marijuana use, according to President Judge John C. Tylwalk, was the federal ban on marijuana use. Tylwalk reasoned that because marijuana remains illegal under federal law, the court and its probation department "should not knowingly allow violation of law to occur."[23] In defending the policy, the county court added that Pennsylvania's Medical Marijuana Act did not give probationers a constitutional right to use marijuana free of court oversight and that medical marijuana conflicted with standard supervision conditions requiring compliance with all state and federal law. It also claimed its probation officers had faced persistent difficulties supervising patients who used medical marijuana.[24]

The court noted that the Medical Marijuana Act's immunity provisions protect patients from being "subject to arrest, prosecution, penalty, or denial of any right or privilege" solely for lawful medical marijuana use and held that this immunity extends to probationers.

The Pennsylvania Supreme Court decided to examine the case due to other counties weighing similar bans and temporarily paused the policy while it reviewed the conflict.[25] In June 2020, the Pennsylvania Supreme Court ruled against Lebanon County court. The court noted that the Medical Marijuana Act's immunity provisions protect patients from being "subject to arrest, prosecution, penalty, or denial of any right or privilege" solely for lawful

22 Class Action Petition for Review ¶¶ 64–66, *Gass*, No. 574 MD 2019 (quoting Lebanon County Medical Marijuana Policy, No. 5.1-2019 & 7.4-2019 (Sept. 1, 2019)). https://www.pacourts.us/Storage/media/pdfs/manual_uploads/file-8054.pdf?cb=ca65aa

23 Class Action Petition for Review ¶ 74, *Gass*, No. 574 MD 2019 (quoting President Judge John C. Tylwalk). https://www.aclupa.org/app/uploads/2021/05/petitioners_brief_with_attachments_01.29.2020.pdf

24 *See* Answer to Petitioners' Application for Special Relief (Declaration of Sally Barry), *Gass*, No. 574 MD 2019 (Pa. Commw. Ct. Oct. 17, 2019); *Gass*, 232 A.3d at 714–15 (holding that such supervision concerns must be addressed by the legislature rather than the courts).

25 *Gass v. 52nd Judicial District*, 223 A.3d 212, 212–13 (Pa. 2019) (per curiam order assuming King's Bench jurisdiction, staying the policy, and noting that other judicial districts had adopted or were considering similar limitations).

medical marijuana use and held that this immunity extends to probationers.[26] They also rejected the federal-illegality argument, citing *Printz v. United States* (1997), in which the U.S. Supreme Court struck down a provision of the Brady Handgun Violence Prevention Act that required state and local law enforcement to conduct federal background checks.[27] The U.S. Supreme Court held that the federal government cannot compel state officials to administer or enforce a federal regulatory program, a principle known as the anti-commandeering doctrine. The Pennsylvania Supreme Court concluded that the federal Controlled Substances Act does not and could not require states to enforce federal marijuana prohibition against individuals complying with state law. Chief Justice Thomas Saylor wrote that while, "the circumstances are certainly uneasy," he concluded that the Lebanon County court "cannot require state level adherence to the federal prohibition, where the General Assembly has specifically undertaken to legalize the use of medical marijuana."[28]

> *Arizona's Supreme Court ruled unanimously in two 2015 cases that courts cannot prohibit registered medical marijuana patients from using marijuana as a condition of probation or parole.*

The *Gass* decision gave patients and advocates in other states a clear template for challenging blanket bans, and its core logic has held: When a state legalizes medical marijuana, its courts cannot use federal prohibition as grounds to deny that medicine to individuals on supervision. For example, Michigan's Court of Appeals cited *Gass* when reaching a similar conclusion in *People v. Thue* (2021).[29] In this case, Michael Thue, a registered patient who used marijuana to manage chronic pain, was placed on probation for assault and battery with a condition prohibiting marijuana use. The Court of Appeals ruled that provisions of the Michigan Probation Act allowing courts to prohibit compliant

26 *Gass v. 52nd Judicial District, Lebanon County*, 232 A.3d 706 (Pa. 2020) (quoting 35 P.S. § 10231.2103(a)).

27 *Printz v. United States*, 521 U.S. 898, 935 (1997). https://supreme.justia.com/cases/federal/us/521/898/

28 *Gass v. 52nd Judicial District, Lebanon County*, No. 118 MM 2019, slip op. at 14 (Pa. June 18, 2020). https://www.pacourts.us/Storage/media/pdfs/manual_uploads/file-9512.pdf.

29 *People v. Thue*, 2021 WL 603522 (Mich. Ct. App. Feb. 16, 2021). https://www.courthousenews.com/wp-content/uploads/2021/02/medicalmarijuana.pdf

medical marijuana use conflict with the state's Medical Marijuana Act and that revoking probation for compliant medical marijuana use constitutes a "penalty" prohibited by the act.[30]

Arizona's Supreme Court ruled unanimously in two 2015 cases that courts cannot prohibit registered medical marijuana patients from using marijuana as a condition of probation or parole.[31] In *State v. Ferrell*, Jennifer Ferrell—a registered medical marijuana patient—was found unconscious in a parked car and pleaded guilty to driving under the influence. The plea agreement Ferrell signed contained the standard condition that she could not buy, grow, possess, or consume marijuana in any form "whether or not [she] had a medical-marijuana card." In *Reed Kaliher v. Hoggatt,* Keenan Reed-Kaliher was released from prison after serving time for illegal marijuana sales and obtained a medical card to manage pain from a hip injury. But, during the term of Kaliher's probation his probation officer added a new condition, barring him from possessing or using marijuana for any reason. In both cases, the Arizona Supreme Court ruled that such probation conditions were unenforceable because they violated the voter-approved Arizona Medical Marijuana Act, which protects registered medical marijuana patients from any "penalty" or "denial of any right or privilege," including the threat of probation revocation, for using medical marijuana.

30 Ibid.

31 *State v. Ferrell*, 236 Ariz. 604 (2015); *Reed-Kaliher v. Hoggatt*, 237 Ariz. 119 (2015). https://cases.justia.com/arizona/supreme-court/2015-cv-14-0226.pdf

PART 5

CORRECTIONAL AGENCY ADMINISTRATIVE POLICIES

Even where statutes provide protection for medical marijuana users on probation or parole, policies of agencies supervising those on release shape how those protections function in practice. Some departments of corrections have developed administrative procedures that accommodate medical marijuana patients while maintaining oversight. The agencies that have implemented such reforms have not reported public safety crises or supervision failures.

The effects of impairment among supervised populations are another legitimate concern. Marijuana affects cognitive function, and supervision agencies have legitimate interests in ensuring that people under their authority are not impaired when they report for appointments, attend treatment programs, or go to work. But impairment is already adequately addressed through other supervision conditions. The same framework can apply to marijuana, directing participants to use it as directed, do not report to appointments impaired, and do not operate vehicles under the influence. These are targeted restrictions that address actual risks without denying access to treatment altogether.

Washington State provides one of the more comprehensive examples. Following the state's legalization of recreational marijuana in 2012, the Washington Department of Corrections (DOC) announced in 2014 that it would no longer routinely test parolees for marijuana use

unless they had a specific condition prohibiting consumption.[32] DOC Assistant Secretary Annmarie Alyward explained the rationale: "We're putting some changes into effect so that we don't routinely test offenders in the community for THC. We don't want [parolees] held at that level when, as a citizen, you wouldn't be held to that level either."[33] Since at least 2021, Washington DOC policy has explicitly accommodated medical marijuana use for those under supervision. Under current policy, individuals are not subject to disciplinary action for a positive THC test if they have been approved for medical marijuana use. New admissions, re-admissions, and community violators are only tested for THC in the first 45 days if there is an imposed condition prohibiting use or if testing is for cause.[34]

Following the state's legalization of recreational marijuana in 2012, the Washington Department of Corrections (DOC) announced in 2014 that it would no longer routinely test parolees for marijuana use unless they had a specific condition prohibiting consumption.

Florida's Department of Corrections policy prevents those under supervision with a valid medical marijuana card issued by the Department of Health from being tested for marijuana.[35] The policy does not prevent testing for other controlled substances.

Minnesota's experience illustrates how litigation can drive administrative reform. In 2019, the Minnesota Department of Corrections (DOC) rescinded its policy prohibiting medical marijuana use by individuals on supervised release or parole. The decision was announced

[32] Washington Department of Corrections, Policy DOC 420.380. https://www.doc.wa.gov/sites/default/files/2025-02/420380.pdf

[33] Prison Legal News, "Washington DOC Ends Marijuana Testing for Parolees," June 3, 2016. https://www.prisonlegalnews.org/news/2016/jun/3/washington-doc-ends-marijuana-testing-parolees/ (accessed March 12, 2026)

[34] Washington Department of Corrections, Policy DOC 420.380. https://www.doc.wa.gov/sites/default/files/2025-02/420380.pdf

[35] CannaMD, "Florida Patients on Probation May Use Medical Marijuana." https://www.cannamd.com/florida-patients-on-probation-may-use-medical-marijuana/ (accessed March 12, 2026)

one day before a scheduled court hearing challenging the old policy.[36] DOC Deputy Commissioner Sarah Walker explained the rationale, noting that "[the] decision is pretty simple and makes sense: If you have a prescription from your doctor, just like with any other controlled substance that is prescribed, we are going to monitor it in the same way that we do those other drugs."[37] Supervising agents may still test for marijuana, but individuals will not be taken into custody if a positive result is the only reason for revocation.

[36] Minnesota Lawyer, "Corrections Department Rescinds Medical Marijuana Policy," April 2, 2019. https://minnlawyer.com/2019/04/02/corrections-department-rescinds-medical-marijuana-policy/

[37] *The Minnesota Star Tribune*, "Minnesota corrections department changes policy to allow medical marijuana while under supervision," April 1, 2019. https://www.startribune.com/minnesota-corrections-department-changes-policy-to-allow-medical-marijuana-while-under-supervision-p/508020072/

PART 6

THE TREATMENT COURT GAP

Even in states with statutory protections for medical marijuana use by supervised populations, gaps in protection persist throughout the criminal justice system, including in "treatment courts." Also known as problem-solving courts, drug courts, or specialty courts, these programs offer certain criminal defendants—particularly those with substance use disorders or mental health conditions—alternatives to incarceration through court-supervised treatment. There are an estimated 3,000 drug courts and 300 mental health courts operating across the United States.[38]

These treatment courts matter because they serve some of the most vulnerable populations in the criminal justice system, such as those struggling with addiction, mental illness, or both. Participants typically agree to intensive supervision, regular drug testing, mandatory treatment attendance, and frequent court appearances in exchange for avoiding incarceration and possibly having charges reduced or dismissed. The treatment court model recognizes what decades of research have shown: For many defendants, treatment works better than punishment.

[38] National Institute of Justice, "Drug Courts," May 2018. https://www.ncjrs.gov/pdffiles1/nij/238527.pdf; Council of State Governments Justice Center, "Mental Health Courts." https://csgjusticecenter.org/projects/mental-health-courts/

Marijuana use is widespread among treatment court populations. Research indicates that marijuana is the primary substance of abuse among 8 to 22 percent of adult drug court participants, with 50 to 66 percent reporting marijuana as a primary, secondary, or tertiary substance.[39] Among mental health court participants, more than 60 percent have co-occurring substance use disorders.[40] Although opponents of marijuana legalization point to this trend as evidence that marijuana causes mental health disorders, the research suggests people with mental health disorders may use marijuana as a form of medication to attenuate their symptoms.[41] Regardless, despite the prevalence of marijuana use among and its potential therapeutic benefits for this population, treatment courts have historically imposed blanket prohibitions on all marijuana use, including state-authorized medical use.

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6.1 STATE LEGAL FRAMEWORKS FOR TREATMENT COURTS

Treatment court policies toward medical marijuana use vary widely across states, shaped by what state law permits or requires. Some supervision agencies have argued that permitting medical marijuana creates enforcement difficulties. The National Association of Drug Court Professionals released a 2012 position statement supporting prohibitions on marijuana use among drug court participants, citing concerns about monitoring compliance and distinguishing legitimate medical use from illicit consumption.[42]

39 Marlowe DB, Hardin CD, Fox CL, "Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Courts in the United States," National Drug Court Institute, 2016. http://www.ndci.org/wp-content/uploads/2016/05/Painting-the-Current-Picture-2016.pdf

40 Ibid.

41 Rich, Jacob James, and Robert Capodilupo. "The Truth About Marijuana, Mental Illness, and Violence: A Review of Alex Berenson's Claims in *Tell Your Children*." Reason Foundation, May 2025. https://reason.org/wp-content/uploads/truth-about-marijuana-mental-illness-violence.pdf.

42 National Association of Drug Court Professionals, "Position Statement on Marijuana," 2012, p. 6. https://web.archive.org/web/20180903014841/https://www.nadcp.org/sites/default/files/nadcp/NADCP%20Board%20Position%20Statement%20-%20Marijuana.pdf

State laws generally fall into two groups: those where medical marijuana use by treatment court participants is expressly permitted, and those where medical marijuana use may be prohibited on a case-by-case basis.

In group A states, Arizona, Montana, and Oregon courts have interpreted medical marijuana statutes to give courts no discretion to limit a probationer's use of medical marijuana.[43]

- In Arizona, the states Supreme Court held that a sentencing court may not prohibit a probationer from using medical marijuana, nor revoke probation for medical marijuana use in compliance with state law (*Reed-Kaliher v. Hoggatt*, 2015; *Polk v. Hancock*, 2015).[44]

- In Montana, the state Supreme Court held that the medical marijuana law does not give sentencing judges the authority to limit the privilege of medical marijuana use while under supervision, and the state court may not use a violation of federal law as justification for revoking a deferred sentence based on medical marijuana use (*State v. Nelson*, 2008).[45]

- In Oregon, the Court of Appeals held in 2019 that a probation condition prohibiting marijuana use" must contain an exception for marijuana use that complies with Oregon's medical marijuana laws if the probationer holds a medical marijuana registry identification card (*State v. Kilgore,* 2019).[46] In 2021, Oregon State Court of Appeals held that marijuana is no longer a controlled substance under Oregon law therefore a probation condition against using a controlled substance no longer applies to marijuana use even without a medical marijuana card (*State v. Heaston,* 2021).[47]

Treatment courts in these states may not prohibit participants from using medical marijuana in compliance with state law but can make reasonable inquires to ensure that a participant's use is lawful, including verifying the validity of a medical marijuana

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43 Ibid.

44 *Reed-Kaliher v. Hoggatt*, 347 P.3d 136 (Ariz. 2015); see also *Polk v. Hancock*, 347 P.3d 142 (Ariz. 2015).

45 *State v. Nelson*, 195 P.3d 826 (Mont. 2008).

46 *State v. Kilgore*, 435 P.3d 817 (Or. Ct. App. 2019).

47 *State v. Heaston*, 482 P.3d 167 (Or. Ct. App. 2021).

authorization card. [48] Verifying patient registration is not difficult: Most states maintain searchable databases that supervision officers can access to confirm a client's medical marijuana status, just as they verify other aspects of a client's compliance. Distinguishing medical use from recreational use is similarly manageable through existing verification procedures.

In Group B states, including California, Colorado, and New York, courts may restrict medical marijuana use on a case-by-case basis, but blanket prohibitions are not permitted.[49]

- In California, the Court of Appeal, First Appellate District, Division 2, held that marijuana restrictions could be ordered when a participant was using a medical card as cover for illegal marijuana sales but have required courts to balance any restrictions against the participant's legitimate medical needs (*People v. Leal,* 2012).[50]

- Colorado's approach to medical marijuana has changed over time. In 2012, the Colorado Court of Appeals held that even though Colorado voters had approved medical marijuana, that approval did not change the rules for people on probation from following federal law prohibiting marijuana use entirely (*People v. Watkins,* 2012). The state legislature subsequently amended the probation statute to allow probationers to use medical marijuana.[51] By 2019, the Colorado Supreme Court confirmed that under the updated law, probationers are presumed to be allowed to use medical marijuana unless the prosecution can show that doing so would undermine the goals of their sentence. Courts can still restrict medical marijuana use in individual cases where circumstances warrant it, but they can no longer impose a blanket ban on all probationers (*Walton v. People,* 2019). [52]

- In New York prior to legislative action, a trial court modified a probationer's conditions to permit medical marijuana use after finding that the probationer had no criminal history involving drugs and that denying access would require the

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48 *State v. Nelson*, 195 P.3d 826 (Mont. 2008); *Reed-Kaliher v. Hoggatt*, 347 P.3d 136 (Ariz. 2015); *State v. Kilgore,* 435 P.3d 817 (Or. Ct. App. 2019); *Gass v. 52nd Judicial Dist. Lebanon Cty*, 232 A.3d 706 (Pa. 2020).

49 Hon. William G. Meyer (ret.), "Frequently Asked Questions: Medical Marijuana and Treatment Courts," Treatment Court Institute, p. 2 (2022). https://allrise.org/wp-content/uploads/2023/05/Med_Marijuana_FAQ_.pdf.

50 *People v. Leal*, 149 Cal. Rptr. 3d 9 (Cal. Ct. App. 2012).

51 *People v. Watkins*, 282 P. 3d 500 (Colo. Ct. App. 2012).

52 *Walton v. People*, 451 P.3d 1212 (Colo. 2019).

probationer to rely on more addictive prescription opioids, concluding that a prohibition would hardly serve any lawful and logical relation to the defendant's rehabilitation (*People v. Stanton)*. [53]

Missouri has one of the more comprehensive approaches to this issue. Their 2022 law authorizing recreational marijuana contained a provision prohibiting drug courts from categorically excluding registered medical marijuana patients.[54] This addresses the treatment court gap directly, recognizing that medical marijuana may be part of a comprehensive treatment plan for participants managing co-occurring conditions like chronic pain, PTSD, or anxiety alongside their primary substance use disorder.

6.2 FEDERAL FUNDING COMPLICATIONS

Many treatment courts receive federal funding, which may complicate their approach to medical marijuana use. Drug courts typically receive grants from the Bureau of Justice Assistance (BJA) or the Substance Abuse and Mental Health Services Administration (SAMHSA), both of which prohibit using federal funds to support programs that violate the Controlled Substances Act. Stipulations for receiving BJA grants explicitly require programs to ensure participants are "tested periodically for the use of controlled substances, including medical marijuana."[55]

In 2021, SAMHSA narrowed its grant restriction language, removing a broader prohibition that had previously prevented grants from going to any organization that permits marijuana use for treatment purposes, stating instead that funds may not be used to "purchase, prescribe, or provide marijuana or treatment using marijuana."[56]

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53 *People v. Stanton*, 60 Misc. 3d 1020 (Sullivan County Ct. 2018)

54 Missouri Constitutional Amendment 3 (2022).

55 Bureau of Justice Assistance, "Adult Drug Court Discretionary Grant Program," FY 2021 Solicitation. https://wellnesscourts.org/wp-content/uploads/2024/05/FY21-BJA-THWC-Funding-Webinar1.pdf

56 Substance Abuse and Mental Health Services Administration, "Fiscal Year 2021 Award Standard Terms," Term 11, Marijuana Restriction, p. 3. https://www.samhsa.gov/sites/default/files/grants/samhsa-fy21-award-standard-terms-conditions.pdf (accessed May 28, 2026).

PART 7

FEDERAL LANDSCAPE

The path to marijuana rescheduling began when the Biden administration directed the Department of Health and Human Services (HHS) to review its status.[57] HHS, the agency responsible for evaluating the medical and scientific basis for controlled substance classifications, recommended moving marijuana to Schedule III.[58] The Drug Enforcement Administration (DEA) subsequently initiated rulemaking to implement that recommendation, though the process stalled. On Dec. 18, 2025, President Donald Trump signed Executive Order 14370, "Increasing Medical Marijuana and Cannabidiol Research," directing the attorney general to complete the rulemaking process to reschedule marijuana from Schedule I to Schedule III "in the most expeditious manner."[59] The HHS recommendation was based on findings that more than 30,000 licensed healthcare practitioners across 43 U.S. jurisdictions are authorized to recommend medical marijuana for more than six million registered patients.[60] The executive order explicitly states that rescheduling reflects updated scientific understanding of marijuana's medical

57 Rachel L. Levine, Assistant Secretary for Health, U.S. Department of Health and Human Services, letter to Anne Milgram, Administrator, Drug Enforcement Administration, "Basis for the Recommendation to Reschedule Marijuana into Schedule III of the Controlled Substances Act," August 29, 2023. https://www.dea.gov/sites/default/files/2024-05/2016-17954-HHS.pdf (accessed May 28, 2026).

58 Ibid.

59 President Donald J. Trump, "Increasing Medical Marijuana and Cannabidiol Research," Executive Order 14370, The White House, December 18, 2025. https://www.whitehouse.gov/presidential-actions/2025/12/increasing-medical-marijuana-and-cannabidiol-research/

60 Ibid.

applications—not that the original classification was wrong, but that there is now sufficient evidence to justify a different classification.

> *People on probation and parole use federally scheduled I, II, and III drugs every day with a valid prescription from a licensed physician.*

People on probation and parole use federally scheduled I, II, and III drugs every day with a valid prescription from a licensed physician. They take Adderall for attention-deficit hyperactivity disorder (ADHD), Xanax for anxiety, and OxyContin for chronic pain. These substances carry significant risks of dependence and abuse, yet supervision agencies do not impose blanket prohibitions on their use. Instead, they require documentation of a valid prescription, monitor for signs of misuse, and intervene when problems arise.

Federal rescheduling does not automatically fix the treatment court gap, though it should eliminate the federal funding conflicts that have discouraged reform. It does not fix the data void, where most jurisdictions fail to track substances triggering positive drug tests and violations. The majority of states independently schedule marijuana in their own controlled substances acts rather than incorporating federal classifications by reference, and supervision conditions typically prohibit "marijuana" by name or require abstinence from "controlled substances" generally—a category that would still include Schedule III drugs. Those provisions will need to be revised separately.

PART 8

POLICY RECOMMENDATIONS

States should take the following steps to eliminate unnecessary barriers to medical marijuana for supervised populations:

Enact statutory protections. Legislation should establish that lawful medical marijuana use is not grounds for supervision revocation, require individualized findings to impose any marijuana restriction, and explicitly protect registered medical patients. States seeking similar protections can look to Connecticut (§ 54-125k), New York (Cannabis Law Article 5), and Minnesota (§ 342.57).[61, 62, 63] These laws provide templates that balance patient access with legitimate supervision interests.

Require evidence-based assessments. Following Minnesota's model, any marijuana restriction should require a chemical use assessment finding that abstinence is consistent with recommended care. This approach ensures that restrictions serve treatment goals rather than functioning as blanket prohibitions disconnected from individual circumstances.

61 Conn. Gen. Stat. § 54-125k (2021). https://law.justia.com/codes/connecticut/title-54/chapter-961/section-54-125k/

62 New York Marijuana Law, Article 5. https://www.nysenate.gov/legislation/laws/CAN/A5

63 Minn. Stat. § 342.57, Subd. 8. https://www.revisor.mn.gov/statutes/cite/342.57

Connect restrictions to underlying offenses. Following New York's model, any marijuana prohibition should require clear and convincing evidence that the restriction is reasonably related to the underlying crime. An individual convicted of a property offense, for example, should not face marijuana restrictions absent specific evidence that marijuana use contributed to the criminal conduct.

Develop department-level administrative policies. State Departments of Corrections (DOC) should develop comprehensive policies like Washington's DOC 420.380 that establish clear procedures for accommodating medical marijuana patients while maintaining appropriate oversight. These policies should specify documentation requirements, testing protocols, and conditions under which restrictions may be imposed on a case-by-case basis.

Reform treatment court policies. Following Missouri's constitutional amendment, states should prohibit drug courts from categorically excluding medical marijuana patients. Treatment courts serve individuals with substance use disorders, and medical marijuana may be part of a comprehensive treatment plan for co-occurring conditions. Blanket exclusions undermine treatment goals.

Improve data collection. States should collect substance-specific data on drug test violations to enable evidence-based assessment of marijuana policies' impact on supervision outcomes. Without this data, policymakers cannot determine whether marijuana restrictions serve public safety goals or simply generate technical violations without improving outcomes.

Address state supervision disparities. States should review their supervision conditions to ensure that standard probation and parole terms do not incorporate federal controlled substance prohibitions by reference in ways that effectively override state medical marijuana statues. States that have legalized medical marijuana should review their standard probation and parole conditions to make sure those conditions do not quietly cancel out the rights that the legislature granted to medical marijuana patients. Standard supervision conditions are often written in broad language that was never updated to reflect changes in state marijuana law, and that outdated language can end up prohibiting something the state has already decided to allow.

PART 9

CONCLUSION

For years, state supervision agencies justified marijuana restrictions by pointing to marijuana's Schedule I classification under the federal Controlled Substances Act. The DHHS' 2023 recommendation to reschedule marijuana to Schedule III, if finalized, would formally recognize marijuana's accepted medical value under federal law, removing the primary legal justification that state supervision agencies and courts have relied upon to override state medical marijuana statues. President Trump's December 2025 executive order directing expanded research into medical marijuana's therapeutic applications further signals a federal policy environment that is increasingly difficult to reconcile with state-level supervision practices that treat medical marijuana as categorically prohibited.

State legislatures have already made the relevant policy determination. When states enacted medical marijuana laws, they established that patients with qualifying conditions are entitled to physician-recommended treatment without criminal penalty. That determination has not been extended consistently to the nearly four million adults under community supervision. Standard probation and parole conditions commonly include prescription carve-outs that accommodate other controlled substances through documentation and monitoring, but medical marijuana patients face a separate, explicit prohibition that operates independently of those carve-outs, a product of marijuana's federal Schedule I classification rather than any individualized finding about risk or treatment need.

Appellate courts in multiple states have held that statutory immunity provisions in state medical marijuana laws extend to people under supervision and that blanket prohibitions are inconsistent with those protections. The Pennsylvania Supreme Court's decision in *Gass v. 52nd Judicial District* further established, drawing on the anti-commandeering doctrine articulated in *Printz v. United States*, that state courts cannot be compelled to enforce federal marijuana prohibition where the state legislature has chosen to legalize medical use. A growing number of state legislatures have responded by enacting statutory protections that prohibit blanket exclusions of registered medical marijuana patients from probation and parole, and treatment court law in several states now either forecloses blanket prohibitions entirely or requires individualized findings before any restriction may be imposed.

Each revocation for a positive marijuana test carries the costs of jail booking, court proceedings, and incarceration, and removes an individual from the employment, housing, and family stability that research consistently identifies as the primary determinants of successful reintegration.

The fiscal argument for maintaining these restrictions is difficult to sustain. States spent an estimated $3 billion in 2023 incarcerating people for technical violations involving no new criminal conduct. The precise share attributable to marijuana-related test failures cannot be determined because supervision agencies do not collect substance-specific violation data, a gap that prevents policymakers from evaluating whether marijuana restrictions are producing outcomes consistent with the goals of supervision. Each revocation for a positive marijuana test carries the costs of jail booking, court proceedings, and incarceration, and removes an individual from the employment, housing, and family stability that research consistently identifies as the primary determinants of successful reintegration.

The statutory and administrative frameworks already adopted in several states demonstrate that accommodation of registered medical marijuana patients within supervision systems is achievable. Corrections agencies in states including Washington, Florida, and Minnesota have implemented policies that verify patient registration and maintain oversight without a blanket prohibition of medical marijuana use, providing a replicable model for states that have not yet acted legislatively.

ABOUT THE AUTHOR

Sephria Reynolds-Tanner is a criminal justice and drug policy analyst at Reason Foundation, where she conducts policy research, provides support to state and local policymakers, and authors policy briefs on reentry barriers and supervision reform.

Reynolds-Tanner brings a unique perspective that combines six years of frontline experience, including service as a probation officer with Spokane County Probation and as a community corrections officer with the Washington State Department of Corrections, with previous policy work at the Council of State Governments Justice Center, where she led Justice Reinvestment Initiative technical assistance to state and local governments across multiple states.

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