

PRACTICE BRIEFS



Cannabis Use and Disorder

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ABSTRACT: All professional counselors are likely to work with clients who use cannabis. Even without a specialization in substance use disorders, knowledge of cannabis use and symptoms of disordered use has important implications for assessment and treatment planning for professional counselors. This brief includes a review of prevalence rates, commonly used assessment tools, and cultural and sociopolitical considerations when working with clients who use cannabis.

Introduction

Cannabis is the most widely used psychoactive drug globally, with an estimated 219 million individuals reporting use in 2021 (United Nations Office on Drugs and Crime [UNODC], 2023), a 21% increase from 2011 (Wang et al., 2024). In the United States, cannabis use reached historically high levels in 2024, with 22.3% (64.2 million people) of people aged 12 or older reporting use (Substance Abuse and Mental Health Services Administration [SAMHSA], 2025). Among this population, 7.1% of individuals (i.e., approximately 20.6 million people) met criteria for cannabis use disorder (CUD; SAMHSA, 2025). Young adults aged 18 to 25 years demonstrated the highest prevalence with 15.8% meeting diagnostic criteria for CUD (SAMHSA, 2025). Increases in cannabis use are attributed to product modernization and marketing, shifting social attitudes, perceived health benefits, and policy changes and legislation efforts (Baldwin et al., 2024).

Cannabis consists of the dried leaves, seeds, stems, and flowers of the cannabis plant (NIDA, 2024), as well as chemically similar synthetic compounds (American Psychiatric Association [APA], 2022). Cannabis may be consumed through smoking (e.g., joints or blunts), vaping and dabbing—methods that are particularly popular among youth—or orally through edibles and beverages (APA, 2022). The primary psychoactive compound in cannabis is delta-9-tetrahydrocannabinol (THC; Nimmana & Marwaha, 2025). It is one of the 10 classes of drugs under substance-related disorders to be considered during a mental health assessment (APA, 2022). THC produces dose- and route-dependent rewarding effects, commonly described as a “high,” which may include reduced stress reactivity and an enhanced sense of well-being (UNODC, 2021). These effects are mediated through THC’s action on the nucleus accumbens, the brain’s primary reward center, and the amygdala (Hoch et al., 2025). At higher doses, acute cannabis intoxication may result in unpleasant psychological effects, perceptual distortions, and impaired functioning, including increased disinhibition and deficits in learning, attention, and psychomotor function (APA, 2022).

Overdose or unintentional exposure has been associated with psychiatric, gastrointestinal, and cardiovascular problems (Dellazizzo et al., 2022). Cannabis remains classified as a Schedule I substance under the U.S. Controlled Substances Act, indicating a high potential for abuse, no currently accepted medical use, and a lack of accepted safety for use under medical supervision (U. S. Department of Justice & Drug

Enforcement Administration, 2020). Despite this classification, the U.S. Food and Drug Administration (FDA) has approved medications that contain individual cannabinoids for specific medical use for treatment resistant seizures, nausea and vomiting related to chemotherapy, and appetite stimulation in people with HIV/AIDS and later stages of cancer, when prescribed by a licensed healthcare provider (National Center for Complementary and Integrative Health [NCCIH], 2019). Modest benefits are also reported for chronic pain and multiple sclerosis symptoms.

Counselors must remain informed about evolving cannabis legislation and its clinical implications. In December 2025, the Trump administration (2025) issued an executive order to reclassify cannabis as a schedule III drug to facilitate research into its medical applications. Changes in federal classifications may or may not affect employer policies, which has implications for documentation of client cannabis use, particularly in employer referred cases. Further, ethical decision-making regarding release of information requires careful consideration. The change to classification also has implications for medical research opportunities through clinical trials. Even when cannabis is medically prescribed, clients should be monitored and assessed for functional impairment and potential disordered use.

CUD is diagnosed when problematic patterns of cannabis use occurring within the past 12-month period result in clinically significant impairment or distress (APA, 2022). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev., *DSM-5-TR*; APA, 2022) outlines 11 diagnostic criteria to assess impairment. These criteria include: a) use in larger amounts or over a longer period than was intended; b) persistent desire or unsuccessful attempts to cut down or control; c) significant time spent acquiring, using, or recovering; d) cravings or strong urge to use; e) recurrent use resulting in failure to fulfill major obligations; f) continued use despite persistent or recurrent social and/or interpersonal problems; g) reduction or elimination of important activities; h) use in physically hazardous situations; i) continued use despite knowledge of experiencing physical or psychological consequences; j) tolerance; and k) withdrawal (APA, 2022). CUD severity is specified as mild (presence of 2–3 symptoms), moderate (4–5 symptoms), or severe (6 or more symptoms; APA, 2022).

Although the term “addiction” is commonly used in informal context to describe severe CUD, it is not a diagnostic term included in the *DSM-5-TR*. Additional specifiers include whether the individual is in early or sustained remission, as well as whether use occurs in a controlled environment (APA, 2022). A CUD diagnosis may co-occur with cannabis-induced mental disorders, cannabis intoxication, or cannabis withdrawal. Cannabis-induced mental disorders include psychotic disorders, anxiety disorders, delirium, and sleep disorders. Psychotic, anxiety, and delirium-related disorders, may have onset during intoxication, whereas sleep disorder may onset during intoxication or withdrawal (APA, 2022).

Assessment Strategies

Effective identification, evaluation, intervention, and treatment of cannabis use requires a multimodal approach that includes standardized screening tools, comprehensive assessments (Stoner, 2016), clinical interviews, professional judgement, and application of *DSM-5-TR* criteria (APA, 2022). Screening instruments are used to identify individuals who may be at risk for cannabis-related problems, whereas assessment tools evaluate the severity of use, associate risks, and protective factors to guide treatment planning. When selecting screening or assessment instruments, it is essential to consider the demographics of the client and ensure that the tools are supported by appropriate norming data to establish validity and clinical utility.

Several brief screening tools, typically consisting of fewer than 10 items and requiring less than 10 minutes to administer, are well-suited for routine clinical practice (Artigaud et al., 2020). These include, the CAGE-cannabis (Midanik et al., 1998), the Cannabis Abuse Screening Test (CAST; Legleye et al., 2007), the Cannabis Use Disorder Test-Revised (CUDIT-R; Adamson et al., 2010), the Problematic Use of Marijuana (PUM; Okulicz-Kozaryn, 2007) and the Severity of Dependence Scale (SDS; Gossop et al., 1995). The Substance Dependence Severity Scale (SDSS; Miele et al., 2000) is a semi-structured interview designed to assess the severity of dependence across multiple substances, including cannabis.

For a comprehensive review of available screening and assessment instruments for CUD, see Stoner (2016). American Society of Addiction Medicine (2025) criteria are commonly used when making a level of care recommendations.

Even with validated assessments available, differentiating problematic cannabis use from CUD can be challenging, particularly for generalist counselors. Clients may be unwillingly to disclose the full extent of their use or may not attribute psychological, behavioral, or social difficulties to use. Nevertheless, careful assessment of cannabis use patterns and associated symptoms is essential for accurate differential diagnosis and effective treatment planning. CUD, defined as a problematic pattern of use with clinically significant distress, must be distinguished from cannabis intoxication, withdrawal, and cannabis-induced mental disorders which may occur from heavy use but do not alone constitute CUD (APA, 2022). CUD frequently co-occurs with other substance use disorders (APA, 2022). In integrated health-care settings, counselors may observe co-occurring CUD with major depressive disorder, bipolar I and II disorders, anxiety disorders, posttraumatic stress disorder, and personality disorders (APA, 2022). Cannabis use has also been associated with an increased risk of psychosis (APA, 2022).

Scope of Practice

Best practice in treatment of CUD calls for specialization in substance use counseling. Credentialing requirements for such, although available in all 50 states, vary by state. National certification at varying levels is also available. As indicated above, generalists may use validated instruments to ascertain the extent of cannabis use symptoms and make a referral when expert care is needed.

Treatment Approaches

Psychotherapeutic interventions, including motivational enhancement therapy (MET), cognitive behavior therapy (CBT), relapse prevention training, and contingency management, remain the most common and evidence indicated treatments (Hayer et al., 2022; Le Foll et al., 2024) for CUD for all ages. MET focuses on enhancing intrinsic motivation to reduce or cease cannabis use and increasing self-efficacy for change. This approach employs empathetic, non-judgmental listening, psychoeducation, and goal setting, and developing individual change plans (Hayer et al., 2022; Le Foll et al., 2024).

CBT targets maladaptive thoughts and behaviors that contribute to ongoing cannabis use, with particular attention to identifying triggers. CBT promotes the development of adaptive cognitive and behavioral coping skills to support reduction or cessation of use (Hayer et al., 2022; Le Foll et al., 2024). Research indicates that combining MET and CBT produces modest but meaningful reduction in cannabis use (González-Ortega et al., 2022).

Relapse prevention training extends CBT principles by focusing on individual risk factors, strengths, and coping strategies to support sustained recovery (Le Foll et al., 2024). Contingency management (CM) applies operant conditioning principles by reinforcing abstinence, often through incentives contingent upon negative urine drug screens (Hayer et al., 2022). Evidence suggests that CM is most effective when integrated with MET and CBT interventions (Le Foll et al., 2024).

Harm reduction offers an alternative to abstinence-based approaches for clients seeking moderation rather than cessation of cannabis use. Grounded in respect for client autonomy, harm reduction emphasizes client engagement, collaboration, and empowerment to minimize the adverse consequences associated with cannabis use (Salisbury-Afshar et al., 2024). In practice, harm reduction strategies for individuals who use cannabis may include access to drug-checking services and safe consumption spaces where legally available (Salisbury-Afshar et al., 2024).

Currently, there are no FDA-approved medications for the treatment of CUD (Spiga et al., 2025; Nimmana & Marwaha, 2024). Pharmacological detoxification and other medication-based treatments remain

preliminary. Evidence is insufficient to establish standardized recommendations regarding dose, duration, formulation for routine clinical use (Nimmana & Marwaha, 2024).

Cultural and Ethical Considerations

Given the high global prevalence of cannabis use, it is essential for counselors to understand the socio-cultural factors that influence symptom presentation, diagnosis, and treatment. In the United States, the legal status of cannabis remains a highly polarized political debate (Mack & Joy, 2000). As of 2025, 24 states have legalized cannabis for recreational use, and an additional 38 states permits its use for medicinal purposes (National Conference of State Legislators, 2025). Despite increased legalization, individuals who use cannabis often continue to experience stigma, which creates barriers to seeking treatment (Rafei et al., 2023).

Ethical counseling practice requires counselors to incorporate cultural humility, avoid pathologizing culturally influenced behaviors, and consider the broader contextual factors that shape cannabis use when conducting assessment, diagnosis, and treatment planning (American Counseling Association, 2014).

Patterns of stigma and cannabis use vary across gender and sexual identities. Although cannabis use is more prevalent among men, women who use cannabis report experiencing higher levels of stigma (Hemsing & Greaves, 2020). Research examining cannabis use within sexual and gender minority subcultures remains limited; however, sexual minority stress has been associated with higher frequency of cannabis use and an increased risk of developing CUD (Hughto et al., 2021). Ethical considerations arise when counselors fail to account for these disparities, as stigma and minority stress may influence symptom expression, disclosure, and engagement in treatment.

Historically, cannabis was used for religious and ritualistic purposes, but contemporary use is multifactorial and shaped by cultural, economic, legal, and social climate (Rafei et al., 2023). Attitudes toward cannabis and patterns of use vary across subcultures, with modern use often framed as an expression of personal autonomy or a coping strategy (Rafei et al., 2023). Increased availability and economic resources may contribute to higher frequency of use, particularly among younger populations, with evidence suggesting that frequency of use is associated with diminished socioeconomic well-being over time (Rafei et al., 2023).

Research on cannabis-related risk and protective factors across racial and ethnic groups remains limited. Available data indicate that cannabis use among Asian Americans is lower than the national average, whereas use rates are slightly higher among Hispanic and Native Hawaiian/Pacific Islander populations, and considerably higher among White and Black populations (Montgomery et al., 2022). Among adolescents in the United States, Black, Hispanic, Native-American, and multiracial adolescents reported higher rates of cannabis use compared to White adolescents, whereas Asian American adolescents report lower rates (Lee et al., 2021). Authoritative parenting style with high responsiveness and demandingness has been identified as a protective factor against adolescent cannabis use, especially among younger Hispanic adolescents (Merianos et al., 2020). This protective effect diminished with age. Environmental stressors, including political instability, socioeconomic disadvantage, systemic discrimination, and limited access to resources, further increase vulnerability to cannabis initiation and continued use, particularly among adolescents and marginalized populations (Dogan et al., 2021).

Advocacy

Advocacy efforts have led to significant policy advancements, including requirements for health insurance issuers to provide CUD treatment coverage at parity with other medical and mental health services (Rosenthal et al., 2020). Despite these gains, a substantial treatment gap exists. Of the estimated 48.4 million Americans who needed substance use treatment which include CUD, only 5.9 million received specialty addiction treatment services (SAMHSA, 2025). Limited access to care is further compounded

by a shortage of trained addiction counselors and ongoing stigma associated with CUD. Stigma negatively affects both clients' willingness to seek treatment and counselors' interest in obtaining specialized training in CUD treatment (Stubbe, 2024). Addressing workforce shortages through expanded training opportunities, incentives for specialization, and stigma-reduction initiatives is essential to increasing service availability.

Advocacy efforts also need to continue to focus on the decriminalization of substance use and the promotion of treatment-oriented responses within the criminal justice system (Rosenthal et al., 2020). Continued collaboration with legal and judicial stakeholders is needed to prioritize rehabilitation over punishment for individuals with CUD whose behaviors reflect symptoms of a treatable disorder. Such policy shifts have the potential to reduce barriers to care, improve treatment engagement, and promote more equitable health outcomes.

Conclusion

Cannabis use and cannabis use disorder (CUD) have increased globally, largely due to expanded access and legalization. In the United States, problematic cannabis use is defined by the level of functional impairment, categorized as mild, moderate, or severe, based on the 11 diagnostic criteria outlined in the *DSM-5-TR*. A range of validated screening tools and assessment measures are available to support accurate diagnosis, intervention planning, and the implementation of evidence-based treatments for CUD. Best practice recommends that counselors interested in treating CUD obtain specialized training and certification in substance use counseling, which is available in all 50 states and internationally.

Additionally, counselors must remain informed about jurisdiction-specific cannabis laws and regulations to ensure culturally responsive and ethically sound treatment. Finally, counselors play a critical role in advocacy by promoting stigma reduction, expanding access to treatment services, and supporting treatment-focused alternatives to incarceration for individuals with CUD. Continued efforts in these areas are essential to improving outcomes and advancing equitable care for those affected by CUD.

Resources

- [Cannabis use disorder](#), Cleveland Clinic Health Library
- [Marijuana Anonymous](#)
- [Cannabis \(Marijuana\)](#), National Institute on Drug Abuse
- [Marijuana addiction](#), SMART Recovery USA
- [Marijuana and CBD](#), Substance Abuse and Mental Health Services Administration

References

- Adamson, S. J., Kay-Lambkin, F. J., Baker, A. L., Lewin, T. J., Thornton, L., Kelly, B. J., & Sellman, J. D. (2010). An improved brief measure of cannabis misuse: The Cannabis Use Disorders Identification Test-Revised (CUDIT-R). *Drug and Alcohol Dependence*, 110(1–2), 137–143. <https://doi.org/10.1016/j.drugalcdep.2010.02.017>
- American Counseling Association. (2014). *ACA code of ethics*. <https://www.counseling.org/docs/default-source/default-document-library/ethics/2014-aca-code-of-ethics.pdf>
- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text revision). <https://doi.org/10.1176/appi.books.9780890425787>
- American Society of Addiction Medicine. (2025). *ASAM criteria* (4th ed.). Hazelden Publishing. <https://www.asam.org/asam-criteria>

- Artigaud, L., Fener, C., Bisch, M., Schwan, R., Schwitzer, T., De Ternay, J., Adamson, S. J., Rolland, B., & Lapr evote, V. (2020). Les outils de rep erage pour les troubles de l'usage du cannabis et leur adaptation au DSM-5: une revue de litt erature [Screening tools for cannabis use disorders and their adaptation to DSM-5: A literature review]. *L'Enc ephale*, 46(5), 382–389. <https://doi.org/10.1016/j.encep.2020.02.010>
- Baldwin, G. T., Vivolo-Kantor, A., Hoots, B., Roehler, D. R., & Ko, J. Y. (2024). Current cannabis use in the United States: Implications for public health research. *American Journal of Public Health*, 114(S8), S624–S627. <https://doi.org/10.2105/AJPH.2024.307823>
- Dellazizzo, L., Potvin, S., Gigu ere, S., & Dumais, A. (2022). Evidence on the acute and residual neurocognitive effects of cannabis use in adolescents and adults: A systematic meta-review of meta-analyses. *Addiction*, 117(7), 1857–1870. <https://doi.org/10.1111/add.15764>
- U.S. Department of Justice & Drug Enforcement Administration. (2020). *Drug fact sheet: Marijuana/cannabis*. https://www.dea.gov/sites/default/files/2020-06/Marijuana-Cannabis-2020_0.pdf
- Dogan, J. N., Thrasher, S., Thorpe, S. Y., Hargons, C., & Stevens-Watkins, D. (2021). Cultural race-related stress and cannabis use among incarcerated African American men. *Psychology of Addictive Behaviors*, 35(3), 320–325. <https://doi.org/10.1037/adb0000694>
- Gonz alez-Ortega, I., Echebur ua, E., Alberich, S., Bernardo, M., Vieta, E., de Pablo, G. S., & Gonz alez-Pinto, A. (2022). Cognitive behavioral therapy program for cannabis use cessation in first-episode psychosis patients: A 1-year randomized controlled trial. *International Journal of Environmental Research and Public Health*, 19(12), Article 7325. <https://doi.org/10.3390/ijerph19127325>
- Gossop, M., Darke, S., Griffiths, P., Hando, J., Powis, B., Hall, W., & Strang, J. (1995). The Severity of Dependence Scale (SDS): Psychometric properties of the SDS in English and Australian samples of heroin, cocaine, and amphetamine users. *Addiction*, 90(5), 607–614. <https://www.doi.org/10.1046/j.1360-0443.1995.9056072.x>
- Hayer, S., Hedges, M., & Lo J. (2022). *Treatments for cannabis use disorder* [Clinician Brief]. Systematically Testing the Evidence on Marijuana (STEM) Project. <https://www.cannabisevidence.org/clinician-resources/clinician-briefs/treatments-for-cannabis-use-disorder>.
- Hemsing, N., & Greaves, L. (2020). Gender norms, roles and relations and cannabis-use patterns: A scoping review. *International Journal of Environmental Research and Public Health*, 17(3), Article 947. <https://doi.org/10.3390/ijerph17030947>
- Hoch, E., Volkow, N. D., Friemel, C. M., Lorenzetti, V., Freeman, T. P., & Hall, W. (2025). Cannabis, cannabinoids and health: a review of evidence on risks and medical benefits. *European Archives of Psychiatry and Clinical Neuroscience*, 275, 281–292. <https://doi.org/10.1007/s00406-024-01880-2>
- Hughto, J. M. W., Quinn, E. K., Dunbar, M. S., Rose, A. J., Shireman, T. I., & Jasuja, G. K. (2021). Prevalence and co-occurrence of alcohol, nicotine, and other substance use disorder diagnoses among US transgender and cisgender adults. *JAMA Network Open*, 4(2), Article e2036512. <https://doi.org/10.1001/jamanetworkopen.2020.36512>
- International Certification and Reciprocity Consortium (IC&RC). (n.d.). *IC&RC Credentials*. <https://internationalcredentialing.org/icrc-credentials/>
- Lee, M. H., Kim-Godwin, Y. S., & Hur, H. (2021). Race/ethnicity differences in risk and protective factors for marijuana use among U.S. adolescents. *BMC Public Health*, 21(1), Article 1167. <https://doi.org/10.1186/s12889-021-11159-z>

- Le Foll, B., Tang, V. M., Rueda, S., Trick, L. V., & Boileau, I. (2024). Cannabis use disorder: From neurobiology to treatment. *Journal of Clinical Investigation*, 134(20), Article e172887. <https://doi.org/10.1172/JCI172887>.
- Legleye, S., Karila, L., Beck, F., & Reynaud, M. (2007). Validation of the CAST: A general population Cannabis Abuse Screening Test. *Journal of Substance Use*, 12(4), 233–242. <https://www.doi.org/10.1080/14659890701476532>
- Mack, A., & Joy, J. (2000). *Marijuana as medicine? The science beyond the controversy*. National Academies. <https://www.ncbi.nlm.nih.gov/books/NBK224395/>
- Merianos, A. L., King, K. A., Vidourek, R. A., Becker, K. J., & Yockey, R. A. (2020). Authoritative parenting behaviors and marijuana use based on age among a national sample of Hispanic adolescents. *Journal of Primary Prevention*, 41, 51–69. <https://doi.org/10.1007/s10935-019-00576-x>
- Midanik, L. T., Zahnd, E. G., & Klein, D. (1998). Alcohol and drug CAGE screeners for pregnant, low-income women: The California Perinatal Needs Assessment. *Alcoholism, Clinical and Experimental Research*, 22(1), 121–125. <https://pubmed.ncbi.nlm.nih.gov/9514294/>
- Miele, G. M., Carpenter, K. M., Smith, C. M., Trautman, K. D., Blaine, J., & Hasin, D. S. (2000). Substance Dependence Severity Scale (SDSS): Reliability and validity of a clinician-administered interview for DSM-IV substance use disorders. *Drug and Alcohol Dependence*, 59(1), 63–75. [https://www.doi.org/10.1016/S0376-8716\(99\)00111-8](https://www.doi.org/10.1016/S0376-8716(99)00111-8)
- Montgomery, L., Dixon, S., & Mantey, D. S. (2022). Racial and ethnic differences in cannabis use and cannabis use disorder: Implications for researchers. *Current Addiction Reports*, 9(1), 14–22. <https://doi.org/10.1007/s40429-021-00404-5>
- National Center for Complementary and Integrative Health. (2019). *Cannabis (Marijuana) and cannabinoids: What you need to know*. National Institutes of Health. <https://www.nccih.nih.gov/health/cannabis-marijuana-and-cannabinoids-what-you-need-to-know>
- National Conference of State Legislators. (2025). *States can(nabis) collect millions*. <https://www.ncsl.org/fiscal/states-can-nabis-collect-millions>
- National Institute on Drug Abuse. (2024). *Cannabis (marijuana)*. <https://nida.nih.gov/research-topics/cannabis-marijuana>
- Okulicz-Kozaryn, K. (2007). Psychometric properties of the Problematic Marijuana Use (PUM) test for adolescents. *Postępy Psychiatrii i Neurologii*, 16(2), 105–111. https://www.researchgate.net/publication/287690426_Psychometric_properties_of_the_Problematic_Marijuana_Use_PUM_test_for_adolescents
- Nimmana, B. K., & Marwaha, R. (2025). *Cannabis use disorder*. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK538131/>
- Rafei, P., Englund, A., Lorenzetti, V., Elkholy, H., Potenza, M. N., & Baldacchino, A. M. (2023). Transcultural aspects of cannabis use: A descriptive overview of cannabis use across cultures. *Current Addiction Reports*, 10, 458–471. <https://doi.org/10.1007/s40429-023-00500-8>
- Rosenthal, R. N., Welsh, J. W., Connery, H. S., Barnett, B. S., DeVido, J., Hill, K., Levin, F. R., Williams, A. R., & Greenfield, S. F. (2020). Advocacy and public policy efforts of the American Academy of Addiction Psychiatry. *The American Journal on Addictions*, 29(5), 401–406. <https://doi.org/10.1111/ajad.13085>
- Salisbury-Afshar, E., Gale, B., & Mossburg, S. (2024). *Harm reduction strategies to improve safety for people who use substances*. PSNet, Agency for Healthcare Research and Quality,

U.S. Department of Health and Human Services. <https://psnet.ahrq.gov/perspective/harm-reduction-strategies-improve-safety-people-who-use-substances>

Spiga, F., Parkhouse, T., Tang, V. M., Savović, J., Le Foll, B., & Nielsen, S. (2025). Pharmacotherapies for cannabis use disorder. *Cochrane Database of Systematic Reviews*, 9, Article CD008940. <https://doi.org/10.1002/14651858.CD008940.pub4>

Stoner, S. A. (2016). *Screening & assessment of cannabis use disorders*. Alcohol and Drug Abuse Institute, University of Washington <http://adai.uw.edu/pubs/pdf/2016marijuanascreenassess.pdf>

Stubbe, D. E. (2024). Addressing stigmas that hinder addiction treatment and recovery. *Focus*, 22(4), 501–504. <https://doi.org/10.1176/appi.focus.20240023>

Substance Abuse and Mental Health Services Administration. (2025). *Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health* (HHS Publication No. PEP25-07-007, NSDUH Series H-60). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/data/data-we-collect/nsduh-national-surveydrug-use-and-health/national-releases>

United Nations Office on Drugs and Crime. (2021). *World Drug Report 2021: Global overview: Drug demand, drug supply*. https://www.unodc.org/res/wdr2021/field/WDR21_Booklet_2.pdf

United Nations Office on Drugs and Crime. (2023). *World Drug Report 2023: Executive Summary*. https://www.unodc.org/res/WDR-2023/WDR23_Exsum_fin_DP.pdf

Trump, D. J. (2025, December). *Increasing marijuana and cannabidiol research* [Executive Order]. White House. <https://www.whitehouse.gov/fact-sheets/2025/12/fact-sheet-president-donald-j-trump-is-increasing-medical-marijuana-and-cannabidiol-research/>

Wang, Q., Qin, Z., Xing, X., Zhu, H., & Jia, Z. (2024). Prevalence of cannabis use around the world: A systematic review and meta-analysis, 2000-2024. *China CDC Weekly*, 6(25), 597–604. <https://www.doi.org/10.46234/ccdcw2024.116>

To Cite This Practice Brief:

Perera, D. M. (2026, April). *Cannabis use and disorder* [Practice Brief]. Counseling Nexus. <https://doi.org/10.63134/TXPY1021>