Marijuana Treatment Admissions in the United States.

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Executive Summary

Federally funded drug treatment admissions involving marijuana have increased from 418,066 in 1992 to 660,526 in 2006, an increase of 58% in 14 years. During this period, admissions involving marijuana has also increased from 27% of total admissions to 37% of total admissions. Admissions in which marijuana was the primary substance of abuse increased during this period from 92,518 (6% of total admissions) in 1992 to 289,988 (16%) in 2006.

From 1992 to 2006 the percentage of admissions referred by the criminal justice system also increased dramatically, by over 20%. For admissions involving marijuana the number referred by the criminal justice system increased from 39% in 1992 to 49% in 2006, and admissions in which marijuana was the primary substance of abuse referred by the criminal justice system increased from 48% in 1992 to 58% in 2006.

There were 1.8 million admissions for drug treatment services recorded by the TEDS program in 2006. The leading cause of drug treatment admissions, in terms of primary substance of abuse, is alcohol (39.9%), followed by marijuana (16.2%), cocaine (14.0%), heroin (13.8%), and methamphetamine (8.4%). Almost three-fifths (58%) of all admissions involving marijuana also involved alcohol, and where marijuana was the primary substance of abuse alcohol was an additional factor in 47%.

Less than half of the admissions where marijuana was the primary substance of abuse met DSM criteria for marijuana dependence. When marijuana was the primary substance of abuse 45% of the admissions met the DSM criteria for marijuana dependence and 30% met the criteria for marijuana abuse. Alcohol dependence was the diagnosis for 15% of these admissions.

Non-intensive outpatient treatment is the most likely treatment for patients in which marijuana is the primary substance of abuse, accounting for 68% of these admissions. This treatment is received by 71% of individuals referred by the criminal justice system in which marijuana is the primary substance of abuse, and 64% of the remaining admissions of this description.

Teenagers under the age of 18 account for 31% of these admissions, and adults age 18 to 24 comprise an additional 32%. Half of these admissions are white, and 29% are black. Almost three out of five (59%) have less than a high school education, 30% have a high school education, and only 10% have a college education. About one-fifth (22%) have full-time jobs, 11% have part-time jobs, 19% are students, 31% are unemployed and 13% were already institutionalized (such as in jail or prison). Educational and employment characteristics are, in part, a reflection of the relative youth of the admissions population.

Young people (age 12 to 17) account for 13% of annual marijuana users but comprise 31% of treatment admissions in which marijuana is the primary substance of abuse. The over-representation of teenagers is even more apparent with arrest demographics are taken into account. The 15-to-17 age group accounts for 11% of annual marijuana users, 14% of possession arrests, and 26% of this category of treatment admissions. The 18-to-20 age group accounts for 15% of annual marijuana users, 25% of possession arrests, and 15% of these treatment admissions.

Over one-third (36%) of admissions where marijuana was the primary substance of abuse did not use marijuana in the last 30 days. This is likely due to cessation of use while under correctional supervision or after initial acknowledgement of a problem requiring treatment. Thus approximately one-third of admissions have not used marijuana recently, 27% have used marijuana either One-to-three times in the last month or one-to-two times in the last week, and 37% have used marijuana more frequently, either three-to-six times in the last week or daily.

Data on the age of first use of marijuana among those where the drug was the primary substance of abuse indicate that 87% of admission began marijuana use while under the age of 18, and 56% began marijuana use under the age of 16. For admissions where marijuana was the primary substance of abuse and the DSM diagnosis was marijuana abuse, 84% had their first use of marijuana under the age of 18, and 48% were under the age of 15. When marijuana was the primary substance and the DSM diagnosis was marijuana dependence, 87% of admissions reported first use of marijuana while under the age of 18 and 55% reported first use while under the age of 15.

Just 19% of these admissions can provide for the payment for their treatment, 13.4% will pay out of pocket and 5.8% will cover their treatment with insurance. Overall government programs will pay for the treatment of 62% of all of these admissions where marijuana is the primary substance of abuse, and 60% of the admissions referred by the criminal justice system. Given that this data reflects approximately 58% of all treatment admissions, the government is paying for at least 35% of all treatment admissions where marijuana is the primary substance of abuse.

The top 10 states for criminal justice referrals in 2006 were Delaware (77.87%), Alabama (76.53%), Nevada (74.73%), Missouri (73.07%), Arkansas (72.18%), South Dakota (70.76%), Illinois (68.18%), North Dakota (66.83%), Florida (66.37%), and Texas (66.17%)

The largest increases from 1997 to 2006 were in Arkansas (81.04%), Oklahoma (79.75%), Nebraska (75.47%), Minnesota (37.83%), North Dakota (35.94%), Nevada (34.50%), Maine (33.53%), Washington (29.84%), New Mexico (25.43%), and Massachusetts (24.45%).

The largest average annual increases in the incidence of criminal justice referrals for treatment where marijuana was the primary substance of abuse were Arkansas (5.79%), Oklahoma (5.73%), Nebraska (4.59%), Minnesota (3.19%), Nevada (3.17%), North Dakota (3.08%), Maine (2.85%), Washington (2.80%), Kansas (2.19%), and Massachusetts (2.13%).

The trend of increasing criminal justice referrals for treatment for marijuana-related abuse and dependency is pronounced, pervasive, and nationwide. It is also exceptional. This data indicates that drugs with much more severe dependence liabilities result in drug treatment admissions without the need for criminal justice system intervention. In over half of the cases the individuals do not meet DSM criteria for dependency or abuse. In over two-thirds of the cases where marijuana is the primary substance of abuse the treatment is outpatient, without the need for confinement or detoxification. The sheer number of cases and the source of the referrals suggest that 20% or more of marijuana arrests result in referral to drug treatment.

The preponderance of available data suggests that many of these referrals take place as a condition of probation and that acceptance of treatment is part of a plea agreement in which

individuals avoid incarceration. While the use of the criminal justice system to advance public health goals of discouraging and/or reducing marijuana use may provide continued justification for marijuana's criminal status, it is a largely ineffective, expensive, and counterproductive use of public resources.

Introduction

Medical treatment for drug abuse problems is a public health issue. Criminal justice issues, though, frequently impact on the delivery and availability of drug treatment services. Drug treatment often plays an important role in the disposition of criminal cases involving drug abuse offenses as an alternative to incarceration, a condition of supervised release, or a necessary service in jails or prisons. In a broader context the dependence liability of illegal drugs is often used to justify the criminalization of their manufacture, sale, and use, and the assessment of data on the delivery of drug treatment services provides benchmarks that validate the rationale supporting these policies. Consequently, understanding the nature and composition of admissions for drug treatment services provides some insight regarding both the public health and criminal justice systems.

This report is based on detailed analysis of the Treatment Episode Data Set (TEDS), which provides data on federally funded drug treatment services in the United States. "The Treatment Episode Data Set (TEDS) is an administrative data system providing descriptive information about the national flow of admissions to specialty providers of substance abuse treatment. The unit of analysis is treatment admissions to substance abuse treatment units receiving federal funding. TEDS is designed to provide annual data on the number and characteristics of persons admitted to public and private nonprofit substance abuse treatment programs, as required by Section 505 of the Public Health Service Act (42 USC 290aa-4)." [1] In 1997, the last year inclusion data was compiled, the TEDS included data on 58% of all treatment admissions in the United States.

In TEDS the primary, secondary, and tertiary

Table 1. Marijuana-Related Treatment Admissions (1992—2006)

Year	Total Admissions	Marijuana Involved	Percent of Total	CJS Referrals	Marijuana Primary	Percent of Total	CJS Referrals
1992	1,560,311	418,066	27%	39%	92,518	6%	48%
1993	1,618,597	458,255	28%	39%	111,418	7%	48%
1994	1,671,039	504,649	30%	39%	142,906	9%	47%
1995	1,680,697	539,876	32%	40%	171,344	10%	49%
1996	1,643,731	557,911	34%	42%	192,918	12%	51%
1997	1,607,957	549,475	34%	43%	197,840	12%	52%
1998	1,712,268	589,992	34%	44%	220,173	13%	54%
1999	1,725,885	595,976	35%	46%	232,105	13%	57%
2000	1,759,420	608,859	35%	46%	250,622	14%	56%
2001	1,781,019	628,752	35%	47%	266,150	15%	57%
2002	1,901,007	672,962	35%	48%	289,220	15%	58%
2003	1,868,340	669,072	36%	48%	291,668	16%	57%
2004	1,892,154	694,454	37%	48%	307,429	16%	58%
2005	1,861,209	685,997	37%	48%	297,226	16%	57%
2006	1,800,717	660,526	37%	49%	289,988	16%	58%

substances of abuse are recorded at the time of admission. In addition to demographic data and data on the source of the referral to the drug treatment program, information is also recorded in many cases on whether the patient has additional psychiatric problems, their match to conventional diagnostic criteria for drug abuse and/or dependency, and the age of first use and frequency of use of the specific substances for which they are to receive treatment. Diagnostic criteria are primarily based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).

These data on admissions to drug treatment services provide important indicators of the extent and nature of drug abuse in the United States. The use of treatment admissions data to support criminal justice policies has become suspect over the last decade because of significant increases in referrals to drug treatment services by the criminal justice system. With respect to marijuana specifically this is an exercise in circular logic.

Over the last decade the criminal justice system has steadily increased annual referrals of individuals for treatment related to marijuana. Federally funded drug treatment admissions involving marijuana have increased from 418,066 in 1992 to 660,526 in 2006, an increase of 58% over 14 years. During this period admissions involving marijuana have increased from 27% of total admissions to 37%. Admissions in which marijuana was the primary substance of abuse increased during this period from 92,518 (6% of total admissions) in 1992 to 289,988 (16%) in 2006. (See Table 1.)

From 1992 to 2006 the percentage of admissions referred by the criminal justice system increased by over 20%. For admission involving marijuana, the number referred by the criminal justice system increased from 39% in 1992 to 49% in 2006, and admissions referred by the criminal justice system in which marijuana was the primary substance of abuse increased from 48% in 1992 to 58% in 2006.

Table 2. Alcohol, Cocaine, and Heroin Admission Trends (1992—2006)

		1992	1997	2001	2006
Alcohol	Involved	77%	72%	66%	61%
	CJS	36%	36%	37%	40%
	Primary	60%	50%	45%	40%
	CJS	39%	38%	38%	40%
Cocaine	Involved	35%	34%	30%	32%
	CJS	24%	24%	25%	28%
	Primary	18%	15%	13%	14%
	CJS	25%	26%	27%	30%
Heroin	Involved	14%	18%	19%	16%
	CJS	13%	12%	13%	16%
	Primary	11%	15%	16%	14%
	CJS Referrals	11%	10%	12%	14%

There were 829,630 arrests for marijuana offenses in 2006, and of these 738,920 were for marijuana possession. [2] The treatment admissions data set does not provide information on the offenses committed by those referred for treatment by the criminal justice system, nor does it provide information on their sentences and whether or not the individuals were referred to treatment in lieu of incarceration or as a condition of probation. For cases where some additional information is available (about 75% of the criminal justice system referrals where marijuana was the primary substance of abuse), 31% were referred by the courts and 52% were referred by probation, parole, or prison offices. Given these clarifications, the 168,193 referrals to treatment by the criminal justice system where marijuana was the primary substance

of abuse represent 23% of marijuana possession arrests in 2006.

The TEDS data demonstrate that the increase in these referrals is not reliable proof that marijuana is sufficiently dangerous to public health to justify criminal arrests for its use. In fact, scrutiny of drug treatment admissions data supports the opposite conclusion, that the public interest would benefit if marijuana use were treated primarily as a public health rather than a criminal justice issue. This perspective is supported by three realizations that emerge from analysis of treatment admissions data. They emerge from intuitive, empirical, and constitutional perspectives.

Intuitively it is clear that drugs with dangerous dependence liabilities will create demand for drug treatment absent the intervention of the criminal justice system. A reliable benchmark of the extent and nature of a drug's abuse is the demand it creates for drug treatment absent the intervention of the criminal justice system. Problems with the law are indeed a tipping point for many individuals with drug abuse problems, driving while intoxicated being a well-known warning sign of a potential problem with alcohol. Nonetheless the intervention of law enforcement is not necessarily the first line of defense or the primary early warning system for detecting an individual's drug abuse.

For many individuals serious problems with drugs or alcohol indicate a need for treatment absent the intervention of law enforcement. For example, referrals by the criminal justice system for treatment where alcohol is the primary substance of abuse have been consistently near 40% from 1992 to 1996, referrals where cocaine is the primary substance of abuse have risen from 25% to 30% during this period, and referrals where heroin is the primary substance of abuse have risen from 11% to 14%. (See Table 2.) Simply put, a majority of the referrals for treatment for marijuana originate from the criminal justice system while a majority of referrals for treatment for alcohol, cocaine, and heroin problems originate elsewhere, such as from individual initiative, health care providers, educational facilities, or employers.

Empirically a review of drug treatment admissions data involving marijuana use sheds further light on the need for far more effective regulation and control of access to marijuana by the young than is provided by contemporary drug policies. Age of first use and frequency of use are significant predictors of marijuana-related abuse and dependency. These factors are especially conspicuous in the review of treatment admissions data involving teenagers and underscore the prevalence of serious drug abuse problems associated with marijuana use by teenagers. These data on teenage marijuana treatment admissions do not support current criminal justice polices but rather shed light on their failure to curtail teenage access to the drug.

Constitutionally the increasing use of the criminal justice system to originate marijuana -related drug treatment referrals calls into question the actual purpose of contemporary marijuana laws. Drug abuse and dependency is a disease not a crime. It is unconstitutional and against longstanding public ethics in the United States to criminalize disease. Alcoholism, mental health problems, and drug addiction cannot be criminalized under U.S. constitutional law. (See excerpts from Robinson v. California.)

The purpose of modern drug laws is to control access to illicit drugs by prohibiting their commerce. Use of illicit drugs is discouraged, as part of this overall policy, by criminalizing possession or through use of other sanctions, such as civil penalties. The purpose of contemporary drug laws is not to

ROBINSON v. CALIFORNIA [Excerpts]
SUPREME COURT OF THE UNITED STATES
370 U.S. 660; 82 S. Ct. 1417; 1962 U.S. LEXIS 850; 8 L. Ed. 2d 758
April 17, 1962, Argued; June 25, 1962, Decided
http://www.oyez.org/cases/1960-1969/1961/1961_554/

SYLLABUS: A California statute makes it a misdemeanor punishable by imprisonment for any person to "be addicted to the use of narcotics," and, in sustaining petitioner's conviction thereunder, the California courts construed the statute as making the "status" of narcotic addiction a criminal offense for which the offender may be prosecuted "at any time before he reforms," even though he has never used or possessed any narcotics within the State and has not been guilty of any antisocial behavior there. Held: As so construed and applied, the statute inflicts a cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.

MR. JUSTICE STEWART delivered the opinion of the Court.

The broad power of a State to regulate the narcotic drugs traffic within its borders is not here in issue. More than forty years ago, in Whipple v. Martinson, this Court explicitly recognized the validity of that power: "There can be no question of the authority of the State in the exercise of its police power to regulate the administration, sale, prescription and use of dangerous and habit-forming drugs . . . . The right to exercise this power is so manifest in the interest of the public health and welfare, that it is unnecessary to enter upon a discussion of it beyond saying that it is too firmly established to be successfully called in question."

. . . The appellant could be convicted, they were told, if they found imply that the appellant's "status" or "chronic condition" was that of being "addicted to the use of narcotics." And it is impossible to know from the jury's verdict that the defendant was not convicted upon precisely such a finding. . . .

It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. A State might determine that the general health and welfare require that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.

We cannot but consider the statute before us as of the same category. In this Court counsel for the State recognized that narcotic addiction is an illness. Indeed, it is apparently an illness which may be contracted innocently or involuntarily. We hold that a state law which imprisons a person thus afflicted as a criminal, even though he has never touched any narcotic drug within the State or been guilty of any irregular behavior there, inflicts a cruel and unusual punishment in violation of the Fourteenth Amendment. To be sure, imprisonment for ninety days is not, in the abstract, a punishment which is either cruel or unusual. But the question cannot be considered in the abstract. Even one day in prison would be a cruel and unusual punishment for the "crime" of having a common cold. . . .

arrest and force individuals to receive treatment for drug abuse, dependency, or addiction. While current laws, including laws which compel individuals to receive treatment, are indeed constitutional, the extent to which the criminal justice system is increasingly being used as a means to compel individuals to receive treatment as a way to judicially dispose of marijuana arrests calls into question whether such a practice is either effective or appropriate. If the primary purpose of public policy with respect to marijuana is to encourage dependent individuals to receive treatment, then there are more effective policy options available. Law enforcement is a crude and frequently ineffective vehicle for implementing public health policies. The criminal justice system is also an expensive vehicle for promoting public health policies, one in which many priorities, such as protection from violent crime, compete for available funds.

Marijuana and Other Drug Treatment Admissions

There were 1.8 million admissions for drug treatment services recorded by the TEDS program in 2006. The leading cause of drug treatment admissions in 2006, in terms of the primary substance of abuse recorded is alcohol (39.9%), followed by marijuana (16.2%), cocaine (14.0%), heroin (13.8%), and methamphetamine (8.4%). Unless otherwise noted the data discussed below is from 2006.

Almost three-fifths (58%) of all admissions involving marijuana also involved alcohol, and where marijuana was the primary substance of abuse alcohol was an additional factor in 47%.

In almost three in ten (28%) admissions involving marijuana a psychiatric problem was diagnosed, and where marijuana was the primary substance of abuse a psychiatric problem was diagnosed in 26% of the cases.

Marijuana was indicated as a secondary substance abuse problem in 16% of admissions, compared with alcohol (17%), cocaine (15%), methamphetamines (3%), heroin (2%), and other opiates (3%). Marijuana was listed as the tertiary substance of abuse in only 7% of admissions.

When marijuana was the secondary substance of abuse, the primary substance of abuse was most frequently alcohol (52%), followed by cocaine (19%) and methamphetamine (17%). When marijuana was the tertiary substance of abuse, the most frequent primary substance was alcohol (36%), followed by cocaine (31%), heroin (16%), and methamphetamines (9%).

According to the TEDS data, heroin users account for 27% of drug treatment admissions. According to the National Survey on Drug Use and Health (NSDUH), heroin users account for 1.54% of illicit drug users. [3] According to TEDS data, cocaine users account for 28% of drug treatment admissions, while according to NSDUH cocaine users account for 17% of illicit drug users. [3] Methamphetamine users account for 17% of treatment admissions and 4% of illicit drug users. [3]

The users of these drugs are all over-represented in drug treatment admissions, compared with the proportion of illegal drug users in the overall population, because of the magnitude of the dependence liability of these particular drugs. In other words, heroin, cocaine, and methamphetamine are considered to have high dependence liabilities, or in laymen's terms are extremely addictive, because they initiate a need for substance abuse treatment in so many of the people who use them.

By comparison, marijuana users account for 71% of illicit drug users [3] but only 32% of

Table 3. DSM* Diagnosis for Treatment Admissions Where Marijuana Is the Primary Substance of Abuse (2006)

(*Diagnostic and Statistical Manual of Mental Disorders)

	Marijuana Involved		Marijuana Primary Substance of Abuse	
	Frequency	Percent	Frequency	Percent
No Diagnosis	1,104	0.44%	475	0.41%
Alcohol-Induced Disorder	1,109	0.45%	85	0.07%
Substance-Induced Disorder	3,262	1.31%	1,325	1.16%
Alcohol Intoxication	2,675	1.07%	75	0.07%
Alcohol Dependence	38,391	15.42%	1,938	1.69%
Opioid Dependence	12,302	4.94%	591	0.52%
Cocaine Dependence	25,078	10.07%	3,953	3.45%
Cannabis	**54,531**	**21.90%**	**51,045**	**44.59%**
Other Substance Dependence	28,884	11.60%	6,059	5.29%
Alcohol Abuse	15,874	6.38%	1,819	1.59%
Cannabis Abuse	**36,262**	**14.57%**	**33,838**	**29.56%**
Other Substance Abuse	2,688	1.08%	486	0.42%
Opioid Abuse	546	0.22%	79	0.07%
Cocaine Abuse	6,107	2.45%	3,349	2.93%
Anxiety Disorders	855	0.34%	383	0.33%
Depressive Disorders	3,048	1.22%	1,289	1.13%
Schizophrenia/Other Psychotic Disorder	1,312	0.53%	535	0.47%
Bipolar Disorders	1,971	0.79%	828	0.72%
Attention Deficit/ Disruptive Behavioral Disorders	1,102	0.44%	839	0.73%
Other Mental Health Condition	1,924	0.77%	1,020	0.89%
Other Condition	9,928	3.99%	4,467	3.90%
	248,953		114,478	

these drug treatment admissions. While the ratio of proportion of admissions to proportion of illicit drug users is 17.7 for heroin, 3.9 for methamphetamines, and 1.6 for cocaine, the corresponding ratio for marijuana is 0.5. With over 25 million annual and nearly 15 million monthly users, the incidence of marijuana-related dependence and abuse, in terms of drug treatment admissions, is relatively low compared with other illicit substances. TEDS cases in which marijuana is the primary substance of abuse constitute 1.1% of annual marijuana users in 2006. However, it needs to be remembered that the TEDS data does not include all drug treatment services, only those that receive federal funds. Nonetheless, the incidence of treatment admissions of marijuana is minor when compared to the number of people using the drug whether viewed in terms of either annual or monthly use.

Data on DSM diagnosis of treatment admissions were not available for every admission as data collection varies on a state-by-state basis. However DSM data is available for about 40% of these marijuana-related treatment admissions, from 248,953 admissions involving marijuana and 114,478 admissions in which marijuana was the primary substance of abuse.

Only 22% of the admissions involving marijuana fit the DSM criteria for marijuana dependence, and only 15% met the criteria marijuana abuse. However, since marijuana was not the primary substance of abuse for every admission involving marijuana, this is not surprising.

When marijuana was the primary substance of abuse, 45% of the admissions met the DSM criteria for marijuana dependence and 30% met the criteria for marijuana abuse. Alcohol dependence was the diagnosis for 15% of these admissions. (See Table 3 for a complete list of DSM diagnoses for marijuana related treatment admissions.)

These figures are roughly the same for those referred to treatment by the criminal justice system, in which 47% of those where marijuana was the primary substance of abuse fit the DSM criteria for marijuana dependence and 31% fit the criteria for marijuana abuse.

These figures clearly indicate that three-fourths of treatment admissions where marijuana is the primary substance of abuse, whether referred by the criminal justice system or not, could potentially benefit from treatment services. However, it is also clear that just over half of the admissions referred by the criminal justice system do not meet the DSM criteria for marijuana dependence, calling into question the justification for such intervention.

Another criterion for comparison of marijuana to other drug-related problems is the drug treatment service setting into which patients are admitted. Service settings include hospital stays, residential detoxification facilities, rehabilitation and residential treatment settings, and outpatient services. Eight forms of these types of service settings are detailed in Table 4 along with the distribution of patients to each setting based on their primary substance of abuse.

Residential detoxification facilities, for example, are the service setting for 24% of admissions in which heroin is the primary substance of abuse, 22% of benzodiazepine admissions, 21% of alcohol admissions, 19% of other opiate substance admissions, 14% of cocaine admissions, 8% of methamphetamine admissions, and just 2% of admissions for marijuana.

The most frequent service setting is non-intensive outpatient treatment, which overall accounts for 50% of all admissions. This

Table 4. Drug Treatment Service Setting by Primary Substance of Abuse (2006)

	All	Alcohol	Benzodiazepines	Cocaine /Crack	Marijuana/ Hashish	Heroin	Methamphetamine	Other Opiates And Synthetics
Detox, 24 Hr, Hospital Inpatient	4.4%	5.8%	8.9%	1.4%	0.2%	10.5%	0.3%	4.9%
Detox, 24 Hr, Free-Standing Residential	15.6%	20.8%	21.8%	14.4%	2.0%	23.9%	7.7%	19.4%
Rehab/Residential Hospital (Non -Detox)	0.5%	0.5%	0.8%	0.5%	0.3%	0.4%	0.3%	0.5%
Rehab/Residential Short Term (<=30 Days)	9.4%	9.0%	12.1%	15.4%	7.1%	7.4%	9.1%	10.8%
Rehab/Residential Long Term (> 30 Days)	7.2%	4.8%	5.3%	12.5%	6.1%	7.1%	15.0%	4.9%
Ambulatory, Intensive Outpatient	11.7%	10.8%	12.3%	14.4%	16.5%	6.1%	13.1%	11.9%
Ambulatory, Non -Intensive Outpatient	50.0%	47.5%	37.6%	41.1%	67.8%	39.3%	54.3%	44.2%
Ambulatory, Detoxification	1.3%	0.8%	1.1%	0.3%	0.1%	5.4%	0.2%	3.4%

Drug Treatment Service Settings
Identification of the type of treatment into which the client was admitted:

- DETOX, 24 HR, HOSP. INPATIENT: 24 hour per day acute care services in a hospital setting for detoxification of persons with severe medical complications associated with withdrawal.
- DETOX, 24 HR, FREE-STANDING RES: 24 hour per day services in non hospital setting providing for safe withdrawal and transition to ongoing treatment.
- REHAB/RES, HOSPITAL (NON-DETOX): 24 hour per day medical care in a hospital facility in conjunction with treatment services for alcohol and other drug abuse and dependency.
- REHAB/RES, SHORT TERM (<=30 DAYS) Typically 30 days or less of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency.
- REHAB/RES, LONG TERM (> 30 DAYS): Typically more than 30 days of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency; this may include transitional living such as halfway houses.
- AMBULATORY, INTENSIVE OUTPATIENT: At minimum, the client must receive treatment lasting two or more hours per day for three or more days per week.
- AMBULATORY, NON-INTENSIVE OUTPT: Ambulatory treatment services including individual, family, and/or group services; these may include pharmacological therapies.
- AMBULATORY, DETOXIFICATION: Outpatient treatment services providing for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological)

Source: TREATMENT EPISODE DATA SET (TEDS), 2006 [Codebook]

treatment service includes "individual, family, and/or group services; these may include pharmacological therapies." [1] There is also considerable variation based on the relative dependence liability of the primary substance of abuse. Only 39% of admissions in which heroin is the primary substance of abuse receive non-intensive outpatient treatment, and this type of treatment was received by 38% of patients admitted for benzodiazepine-related treatment, 41% of cocaine-related treatment, 44% of other opioid-related treatment, 48% of alcohol-related treatment, and 54% of methamphetamine-related treatment.

Non-intensive outpatient treatment is the most likely treatment for patients in which marijuana is the primary substance of abuse, accounting for 68% of these admissions. This treatment is received by 71% of individuals referred by the criminal justice system in which marijuana is the primary substance of

Table 5. Age Comparison of Annual Marijuana Users and Admissions Where Marijuana Was Primary Substance of Abuse (2006)

	Annual Users	All	CJS	Non-CJS
Age 12-17	13.16%	30.95%	28.71%	33.92%
Age 18-20	15.49%	15.18%	16.99%	12.77%
Age 21-34	40.17%	39.43%	41.61%	36.54%
Age 35-older	31.18%	14.38%	12.66%	16.65%

Table 6. Age Comparison of Annual Marijuana Users, Possession Arrests, and Admissions Where Marijuana Was Primary Substance of Abuse (2005-2006)

	Annual Users (2006)	Possession Arrests (2005)	All (2006)	CJS (2006)
Age 15 - 17	11.18%	14.27%	26.00%	24.96%
Age 18 - 20	15.61%	25.15%	15.18%	16.99%
Age 21 - 29	31.69%	20.26%	31.46%	33.91%

Table 7 Demographic Profiles of Treatment Admissions; Marijuana Primary Substance of Abuse (2006)

	All	CJS	Non-CJS
Gender			
Male	73.82%	81.36%	63.82%
Female	26.18%	18.64%	36.18%
Age			
Age 11 And Under	0.06%	0.02%	0.11%
Age 12-14	4.96%	3.75%	6.55%
Age 15-17	26.00%	24.96%	27.37%
Age 18-20	15.18%	16.99%	12.77%
Age 21-24	16.98%	18.91%	14.43%
Age 25-29	14.48%	15.00%	13.79%
Age 30-34	7.97%	7.71%	8.32%
Age 35-39	5.78%	5.21%	6.53%
Age 40-44	4.26%	3.77%	4.92%
Age 45-49	2.63%	2.24%	3.13%
Age 50-54	1.15%	0.96%	1.40%
Age 55 And Over	0.56%	0.48%	0.67%
Race/Ethnicity			
Alaskan Native	0.07%	0.06%	0.07%
American Indian	1.69%	1.60%	1.82%
Asian Or Pacific Islander	1.24%	0.97%	1.60%
Black	29.30%	31.86%	25.91%
White	51.50%	49.66%	53.92%
Other Single Race	14.44%	14.19%	14.77%
Two Or More Races	1.18%	1.10%	1.27%
Hispanic	0.59%	0.56%	0.63%
Education			
No Hs - 8 Years Or Less	13.64%	12.63%	14.99%
Some Hs 9-11	45.66%	45.70%	45.61%
Hs 12	30.50%	32.11%	28.37%
Some College 13-15	8.85%	8.46%	9.38%
College Grad 16 Or More	1.34%	1.10%	1.65%
Employment			
Full Time	22.00%	26.08%	16.30%
Part Time	10.86%	11.87%	9.45%
Unemployed	31.09%	31.04%	31.15%
Homemaker	1.02%	0.62%	1.59%
Student	18.89%	16.68%	21.97%
Retired/Disabled	3.25%	2.39%	4.46%
Other/Inmate Of Institution	12.89%	11.32%	15.09%

abuse, and 64% of the remaining admissions of this description. In cases where a DSM diagnosis was available, this treatment is provided for 64% of those diagnosed for marijuana dependence and 85% of those diagnosed for marijuana abuse.

Demographics

Individuals receiving drug treatment services in which marijuana is the primary substance of abuse are primarily male (74%), under the age of 25 (63%), lack a full- or part-time job (67%), and at best only have a high school diploma and have not spent any time in college (90%).

Teenagers under the age of 18 account for 31% of these admissions, and adults age 18 to 24 comprise an additional 32%. Half of these admissions are white, and 29% are black. Almost three out of five (59%) have less than a high school education, 30% have a high school education, and only 10% have a college education. About one-fifth (22%) have full-time jobs, 11% have part-time jobs, 19% are students, 31% are unemployed, and 13% were already institutionalized (such as in jail or prison.) These educational and employment characteristics are, in part, a reflection of the relative youth of the admissions population. (See Table 7.)

Referrals from the criminal justice system tend to have a slightly greater representation of those age 18 to 29 than non-referrals, and a greater proportion of blacks (32%) and those with full-time jobs (26%) than non-referrals (26% and 16% respectively). Otherwise the demographics of referrals and non-referrals for treatment are similar.

Tables 5 and 6 compare the proportions of different age groups between treatment admission, annual marijuana users, and those arrested for marijuana possession offenses. Young people (age 12 to 17) account for 13% of annual marijuana users [3] but comprise 31% of treatment admissions in which marijuana is the primary substance of abuse. The over-representation of teenagers is even more apparent when arrest demographics are taken into account. The 15-to-17 age group accounts for 11% of annual marijuana users [3], 14% of possession arrests [4], and 26% of this category of treatment admissions. The 18 -to-20 age group accounts for 15% of annual marijuana users, 25% of possession arrests, and 15% of these treatment admissions.

Blacks are generally over-represented in referrals for drug treatment where marijuana is the primary substance of abuse, but this appears to be due to their over-representation in marijuana arrests rather than the result of any bias in the disposition of criminal cases. Blacks account for 14% of annual marijuana users [3] but comprise 29% of treatment admissions in this category. However, blacks account for nearly 30% of marijuana possession arrests. [4] Given that 58% of treatment admissions in which marijuana is the primary substance of abuse are generated by the criminal justice system, it is not surprising that the demographics of the population of admissions is similar to the demographics of those arrested for possession.

It is difficult to make a closer comparison of the racial and ethnic makeup of arrests and admissions because of differences in data collection. While admissions and drug use surveys report data on ethnic background (i.e. Hispanic heritage), Uniform Crime Reporting Program arrest data do not. Hispanics account for 10% of annual marijuana users but only account for 0.6% of this category of treatment admissions. This may represent bias against referring Hispanics for treatment, reluctance among Hispanics to seek treatment, a lack of marijuana-related drug problems for Hispanics using marijuana, or flaws in

classifying people as Hispanics for the purpose of collecting data for the TEDS program.

Usage Characteristics

A report by the Institute of Medicine of the National Academy of Sciences reviewed research on marijuana use and its effects and, among other topics, commented on the relationship between marijuana use and other illicit drug use. "The factors that best predict illegal drug use other than marijuana are likely the following: age of first alcohol or nicotine use, heavy marijuana use, and psychiatric disorders. . . In the sense that marijuana use typically precedes rather than follows initiation into the use of other illicit drugs, it is indeed a gateway drug. However it does not appear to be a gateway drug to the extent that it is the most significant predictor or even the cause of heavy drug use; that is, care must be taken not to attribute cause to association. The most consistent predictors of heavy drug use appear to be the intensity of marijuana use, and co-occurring psychiatric disorders or a family history of psychopathology including alcoholism." [5]

It is generally recognized that teenage use of alcohol, marijuana, and tobacco places those individuals at greater risk of drug abuse or dependence. Recent trends in illicit drug use have also indicated that many youths with experience with alcohol and tobacco have also used inhalants and/or illicit opioid pain relievers, including a large population of young teens who have not used marijuana. [3] While the relationship of teenage marijuana use to abuse of other drugs is complex, the dangerous potential of youthful drug use, particularly intensive youthful drug abuse, is well recognized. Treatment admissions data on the age of first use of marijuana and frequency of use of marijuana support this concern.

Table 8. Frequency of Use When Marijuana Was the Primary Substance of Abuse

	All	CJS Referrals	Non-CJS Referrals
No Use In The Past Month	36.00%	41.22%	29.11%
1-3 Times In The Past Month	16.44%	16.65%	16.15%
1-2 Times In The Past Week	10.36%	9.68%	11.26%
3-6 Times In The Past Week	11.72%	10.28%	13.62%
Daily	25.49%	22.18%	29.86%

Table 9. Age of First Use When Marijuana Was the Primary Substance of Abuse

	All	CJS Referrals	Non-CJS Referrals
Age 11 And Under	13.43%	13.04%	13.95%
Age 12-14	42.72%	41.95%	43.74%
Age 15-17	31.30%	32.76%	29.36%
Age 18-20	8.39%	8.49%	8.27%
Age 21-24	2.37%	2.22%	2.56%
Age 25-29	1.02%	0.91%	1.17%

Over one-third (36%) of admissions where marijuana was the primary substance of abuse did not use marijuana in the last 30 days. This is likely due to cessation of use while under correctional supervision or after initial acknowledgement of a problem requiring treatment. Approximately one-third of admissions have not used marijuana recently, 27% have used marijuana either one-to-three times in the last month or one-to-two times in the last week, and 37% have used marijuana more frequently, either three-to-six times in the last week or daily. (See Table 8.) Among referrals from the criminal justice system, 22% have used marijuana daily, while among non-referrals 30% have been recent daily uses. Generally, though, for whatever reason, about three-fourths of those seeking treatment have not been recent daily users of marijuana.

Data on the age of first use of marijuana among those where the drug was the primary substance of abuse indicate that 87% of admissions began marijuana use while under the age of 18, and 56% began marijuana use under the age of 16. (See Table 9.) For admissions where marijuana was the primary substance of abuse and the DSM diagnosis was marijuana abuse, 84% had their first use of marijuana under the age of 18, and 48% were under the age of 15. When marijuana was the primary substance and the DSM diagnosis was marijuana dependence, 87% of admissions reported first use of marijuana while under the age of 18, and 55% reported first use while under the age of 15.

Closer scrutiny of the data on frequency of use provides greater support for concerns about intensive youthful drug use, especially given the data above on the age of first use. Tables 10 through 12 provide data on the frequency of use of recent marijuana users seeking treatment, without including those with no marijuana use in the totals used for calculating percentage summaries. When

Table 10. Frequency of Use by Recent Users When Marijuana Was the Primary Substance of Abuse

	All	CJS Referrals	Non-CJS Referrals
1-3 Times In The Past Month	25.68%	28.33%	22.78%
1-2 Times In The Past Week	16.18%	16.46%	15.88%
3-6 Times In The Past Week	18.31%	17.49%	19.21%
Daily	39.83%	37.73%	42.13%

Table 11. Frequency of Use by Recent Users With DSM Diagnosis of Cannabis Abuse

	All	CJS Referrals	Non-CJS Referrals
1-3 Times In The Past Month	38.77	39.89	37.3
1-2 Times In The Past Week	21.78	21.89	21.65
3-6 Times In The Past Week	17.87	17.25	18.69
Daily	21.58	20.98	22.37

Table 12. Frequency of Use by Recent Users With DSM Diagnosis of Cannabis Dependence

	All	CJS Referrals	Non-CJS Referrals
1-3 Times In The Past Month	22.78	17.31	22.78
1-2 Times In The Past Week	15.88	12.53	15.88
3-6 Times In The Past Week	19.21	19.24	19.21
Daily	42.13	50.91	42.13

marijuana was the primary substance of abuse, 58% had used marijuana between three and seven times in the last week. Among those with a DSM diagnosis of marijuana abuse, 39% had used marijuana between three and seven times in the last week, and among those with a DSM diagnosis of marijuana dependence, 70% had used marijuana between three and seven times in the last week.

While the data reviewed in the section above on marijuana and other drug treatment admissions suggest that marijuana abuse is less serious and less prevalent among marijuana users than abuse of other illicit drugs, it is clear from this data that teenage access to marijuana places teenagers at risk of marijuana abuse or dependence. Rather than validate current policies regarding marijuana's illegal status in the United States, this instead provides clear proof that current policies are not providing sufficient control of marijuana to prevent teenage access. Unregulated teenage access to marijuana is an important contributing factor to teenage marijuana abuse and dependence.

Payment

As indicated above, the TEDS program represents approximately 60% of the treatment admissions in the United States. The data represent treatment programs that receive federal funds. "Missing from TEDS are most admissions to providers receiving no public funds or providers reporting to other federal agencies, such as the Bureau of Prisons, Department of Defense, Veterans Administration, and the Indian Health Service." [1] Consequently many of the patients receiving treatment from the reporting facilities require government assistance, and the data on the income sources, health insurance, and sources of payment for treatment reflect this characteristic.

Table 13. Primary Source Of Income/ Support for Admissions Where Marijuana Is the Primary Substance of Abuse
(For children under 18, this field indicates the parent's primary source of income/support.)

	All	CJS	Non-CJS
Wages/ Salary	35.13%	39.32%	29.11%
Public Assistance	6.96%	4.81%	10.05%
Retirement/ Pension/ Disability	3.36%	2.68%	4.33%
Other	25.58%	24.52%	27.11%
None	28.97%	28.68%	29.40%

Table 14. Health Insurance for Admissions Where Marijuana Is the Primary Substance of Abuse

	All	CJS	Non-CJS
Private Insurance (BC/BS HMO)	13.57%	12.16%	15.64%
Medicaid	22.34%	18.41%	28.06%
Medicare/ Other (e.g. Tricare)	9.50%	7.81%	11.96%
None	54.60%	61.62%	44.34%

Table 15. Expected/Actual Source of Payment Where Marijuana Is the Primary Substance of Abuse

	All	CJS	Non-CJS
Self-Pay	13.41%	15.19%	10.81%
Blue Cross/ Blue Shield, Other Health Ins.	5.82%	4.30%	8.03%
Medicare, Workman's Comp	0.44%	0.29%	0.67%
Medicaid	23.84%	21.29%	27.59%
Other Gov Payments	37.55%	38.41%	36.30%
No Charge	11.72%	13.05%	9.75%
Other	7.22%	7.47%	6.85%

This discussion focuses on data regarding the patients for which marijuana is the primary substance of abuse. However, overall the characteristics of this group are consistent with the characteristics of all the admissions reported by the TEDS program. A majority of these patients lack regular income; they do not have health insurance, and their treatment services are frequently paid for by government programs.

Only 35% of admissions where marijuana is the primary substance of abuse have wages or salaries as source of income; as indicated in Table 7 only 33% have full- or part-time jobs. (See Table 13.) Only 13.6% have private insurance. While 36% report coverage by Medicaid or Medicare, nearly 55% report no insurance at all. (See Table 14.)

Just 19% of these admissions can provide for the payment for their treatment, 13.4% paid out of pocket, and 5.8% will cover their treatment with insurance. Overall, government programs will pay for the treatment of 62% of all of these admissions where marijuana is the primary substance of abuse, and 60% of these admissions that were referred by the criminal justice system. Given that this data reflects approximately 58% of all treatment admissions, the government is paying for at least 35% of all treatment admissions where marijuana is the primary substance of abuse. TEDS reports 289,988 admissions in 2006 where marijuana is the primary substance of abuse. Of these, 58% or 168,193 were referred by the criminal justice system, and of these the government is paying for the treatment of 60% or 100,915, and of these cases it is estimated that over half (53%) do not meet the DSM criteria for marijuana dependence.

The reliance on government programs to pay for treatment is particularly acute with respect to teenagers. Of those referred by the criminal justice system, for example, Medicaid is the expected source of payment for 79% of those age 12 to 14 and 67% of those age 15 to 17.

State-Level Criminal Justice Referrals

Nationwide 58% of admissions where marijuana was the primary substance of abuse were referred by the criminal justice system. In 18 states, over 60% of these admissions were referrals from the criminal justice system, in 10 of these two-thirds were referrals, and in five states over 70% were criminal justice system referrals. The incidence of 2006 criminal justice referrals where marijuana was one of the three primary substances is displayed in map form in Exhibit 1; Table 13 provides the incidence of referrals by state from 1997 to 2006. The incidence of 2006 criminal justice referrals where marijuana was the primary substance of abuse is displayed in map form in Exhibit 2; Table 14 provides the incidence of referrals by state from 1997 to 2006. The discussion below concerns referrals in which marijuana was the primary substance of abuse.

The top 10 states for criminal justice referrals in 2006 were Delaware (77.87%), Alabama (76.53%), Nevada (74.73%), Missouri (73.07%), Arkansas (72.18%), South Dakota (70.76%), Illinois (68.18%), North Dakota (66.83%), Florida (66.37%), and Texas (66.17%). In five of these states (Alabama, Missouri, Arkansas, South Dakota, and Florida) marijuana possession is subject to up to one year in jail, and in two (Illinois and Delaware) the sentence is up to six months in jail (although possession of 2.5 grams or less in Illinois is subject to a sentence of up to 30 days in jail). Texas has a sentence of probation plus mandatory drug treatment for first offenders with no felony convictions. In North Dakota the sentence for marijuana possession is up to 30 days in jail. Nevada provides for a fine for marijuana possession.

[6]

Among states that have decriminalized possession of marijuana, the percentage of admissions referred by the criminal justice system varies considerably: Nevada (74.73%), Colorado (60.52%), Oregon (60.35%), New York (56.53%), Ohio (55.92%), Nebraska (53.57%), Alaska (52% in 1997), Mississippi (51.90%), California (50.85%), Maine (43.33%), Minnesota (38.29%), and North Carolina (22.03%).

Of the states reporting data, the lowest 10 states in 2006 were Arizona (51.16%), California (50.85%), Connecticut (47.57%), Maine (43.33%), New Mexico (41.88%), Minnesota (38.29%), Kentucky (38.12%), Hawaii (23.16%), North Carolina (22.03%), and West Virginia (19.62%).

In states reporting no data in 2006, the most recent data follows: Alaska (51.87% in 1997), District of Columbia (35.71% in 2003), Georgia (40.85% in 2005), and Vermont (44.98% in 2006).

The largest increases from 1997 to 2006 were in Arkansas (81.04%), Oklahoma (79.75%), Nebraska (75.47%), Minnesota (37.83%), North Dakota (35.94%), Nevada (34.50%), Maine (33.53%), Washington (29.84%), New Mexico (25.43%), and Massachusetts (24.45%). In Arkansas referrals grew from 40% in 1997 to 72% of admissions in 2006. In Oklahoma referrals grew from 29% to 51% of admissions. In Nebraska, where possession of small amounts of marijuana is decriminalized and punishable by a fine, referrals grew from 31% to 54%. In Minnesota, another decriminalized state, referrals increased from 28% to 38%. In North Dakota referrals increased from 49% in 1997 to 67% in 2006.

The largest average annual increases in the incidence of criminal justice referrals for treatment where marijuana was the primary substance of abuse were is Arkansas (5.79%), Oklahoma (5.73%), Nebraska (4.59%), Minnesota (3.19%), Nevada (3.17%), North Dakota (3.08%), Maine (2.85%), Washington (2.80%), Kansas (2.19%), and Massachusetts (2.13%). In Arkansas, for example, referrals grew from 40% in 1997 to 46% in 1998, 56% in 2000, 63% in 2004, and 72% in 2006. In Oklahoma referrals grew from 29% in 1997 to 46% in 2000, and 55% in 2004 before dropping to 51% in 2006. In Nebraska referrals increased from 31% in 1997 to 51% in 1998, and then dropped to 42% in 1999, increased to 47% in 2001 and 55% in 2004, and then dropped to 50% in 2005 before increasing again to 54% in 2006.

These examples provide local manifestations of the national trend in which criminal justice referrals increased from 52% of cases in 1997 where marijuana was the primary substance of abuse to 58% of such cases in 2006. This is an even longer trend, though, than the detailed state-level data for this 10-year period demonstrates. Criminal justice referrals have grown from 48% of these admissions in 1992 to 58% in 2006.

Conclusion

The trend of increasing criminal justice referrals for treatment for marijuana-related abuse and dependency is pronounced, pervasive, and nationwide. It is also exceptional. As earlier data has indicated, drugs with much more severe dependence liabilities result in drug treatment admissions without the need for criminal justice system intervention. In over half of the cases, the individuals do not meet DSM criteria for dependency or abuse. In over two-thirds of the cases where marijuana is the primary substance of abuse the treatment is outpatient, without the need for confinement or detoxification. The sheer number of cases and the source of the referrals suggest that

20% or more of marijuana arrests result in referral to drug treatment.

The preponderance of available data suggests that many of these referrals take place as a condition of probation and that acceptance of treatment is part of a plea agreement in which individuals avoid incarceration. While the use of the criminal justice system to advance public health goals of discouraging and/or reducing marijuana use may provide continued justification for marijuana's criminal status it is a largely ineffective, expensive, and counterproductive use of public resources.

This practice is ineffective because marijuana use has remained widespread in the United States throughout this period. It is expensive because it diverts the resources of the criminal justice system from protecting the public from violent crime and other priorities, particularly in occupying the time and resources of correctional system personnel who must supervise individuals who receive treatment as a condition of their probation at the expense of monitoring the behavior and intended rehabilitation of offenders who have committed more serious crimes. Another cost to society is the diversion of treatment resources for individuals who do not meet medical criteria for dependency or abuse, whether paid for from public or private funds. Finally, it is counterproductive because the incidence and character of teenage admissions for treatment demonstrates the failure of law enforcement to sufficiently control marijuana's availability in ways that reduce teenage access.

Figure 1. CJS Referrals for Treatment, Marijuana One of Three Drugs of Abuse (2006)

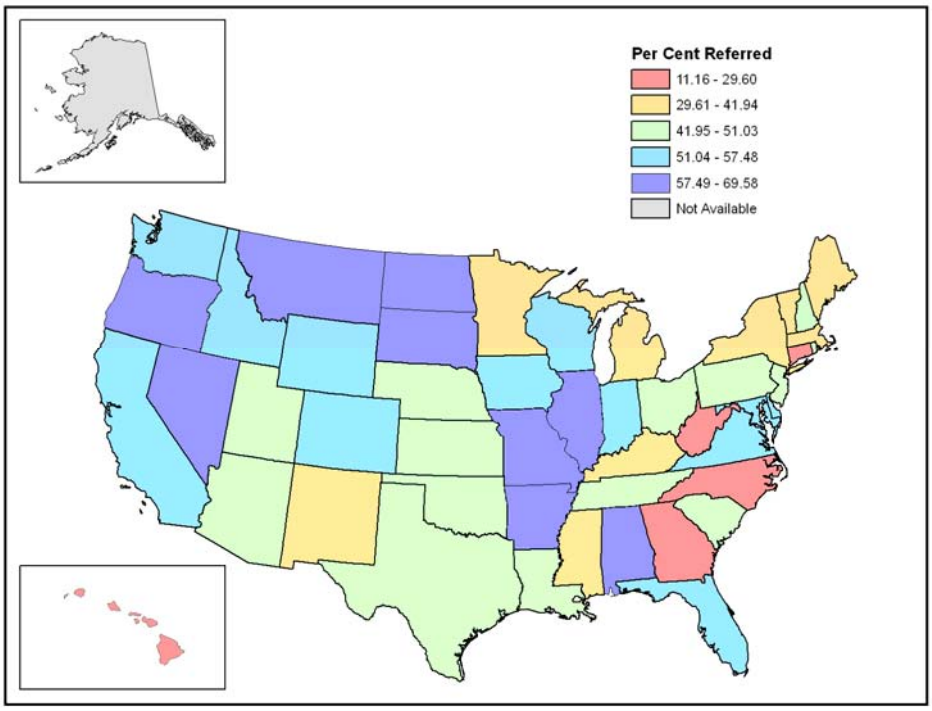

Figure 2. CJS Referrals for Treatment, Marijuana as Primary Drug of Abuse (2006)

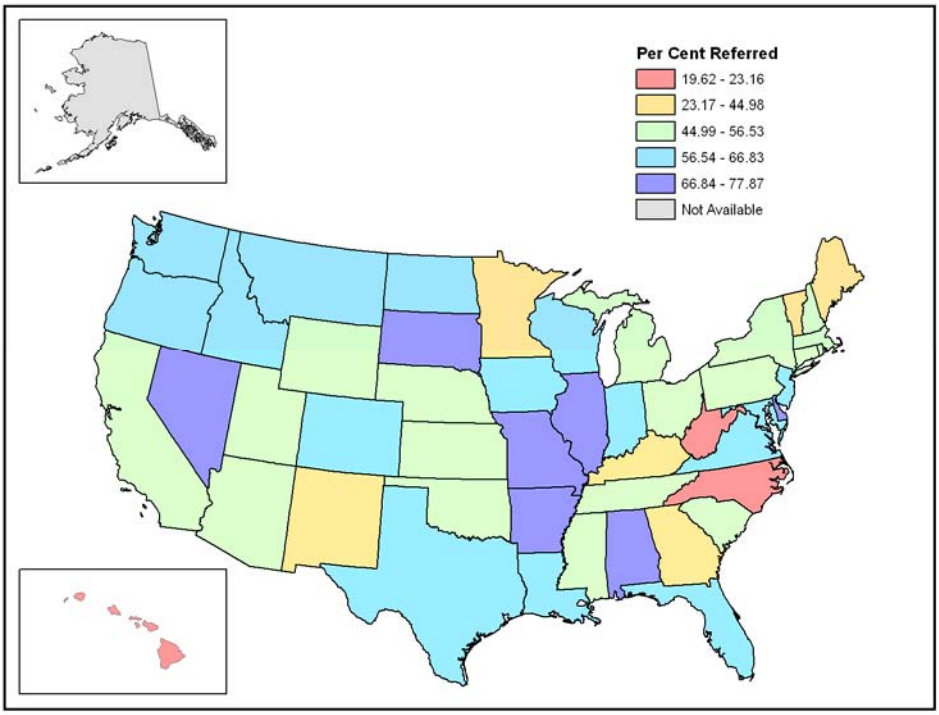

Table 16a. State-Level Criminal Justice System Referrals for Treatment Where Marijuana Is One of Three Drugs of Abuse (1997—2006)

State	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Alabama	57.90%	57.16%	62.07%	67.66%	69.06%	66.77%	69.17%	69.08%	66.58%	69.58%
Alaska	49.62%									
Arizona		32.27%	60.37%	65.23%	60.57%	56.54%	37.87%	27.71%	42.45%	44.37%
Arkansas	34.25%	39.15%	47.26%	48.34%	49.68%	46.80%	41.84%	57.86%	63.68%	66.19%
California	36.72%	39.98%	42.74%	46.38%	49.10%	55.28%	55.13%	54.10%	52.25%	53.45%
Colorado	50.36%	47.06%	50.07%	49.10%	48.92%	49.03%	47.40%	51.78%	54.44%	54.26%
Connecticut	26.80%	25.77%	28.11%	26.42%	29.86%	29.36%		29.87%	30.06%	29.58%
Delaware	47.53%	47.36%	53.02%	52.48%	58.46%	54.79%	54.38%	54.41%	51.88%	52.57%
District Of	46.61%	47.42%	46.47%	37.51%	14.48%	8.95%	20.39%			
Florida	63.56%	61.48%	64.01%	58.66%	61.19%	63.65%	58.87%	57.67%	55.75%	56.69%
Georgia	43.22%	39.05%	35.24%	33.37%	31.56%	29.25%	28.06%	26.77%	29.29%	
Hawaii	24.25%	23.90%	29.55%	28.40%	28.68%	29.56%	32.97%	32.67%	28.52%	29.60%
Idaho	62.35%	68.28%	61.60%	57.23%	53.21%	57.75%	66.99%	65.52%	42.25%	52.19%
Illinois	50.95%	49.23%	50.98%	50.89%	52.41%	57.26%	58.80%	60.50%	60.69%	61.40%
Indiana		48.51%	53.93%	54.33%	58.52%	58.43%	58.16%	58.81%	56.86%	57.48%
Iowa	52.12%	56.65%	58.14%	56.19%	58.01%	58.58%	57.33%	57.58%	55.00%	56.56%
Kansas	37.30%	41.30%	39.91%	46.75%	47.92%	47.98%	45.98%	47.59%	47.90%	49.21%
Kentucky	42.75%	41.10%	42.00%	46.16%	44.40%	43.46%	39.49%	36.22%	37.61%	36.84%
Louisiana	52.57%	39.03%	48.64%	37.84%	40.08%	37.12%	41.33%	48.51%	50.10%	48.36%
Maine	32.58%	31.17%	35.76%	36.39%	36.98%	38.39%	38.74%	41.77%	39.53%	36.60%
Maryland	52.88%	55.85%	57.54%	61.31%	59.89%	56.65%	56.82%	56.42%	55.48%	55.54%
Massachusetts	27.96%	27.49%	26.81%	28.88%	25.49%	20.29%	27.25%	29.30%	31.56%	34.25%
Michigan	40.19%	41.61%	38.09%	32.87%	34.57%	37.85%	37.63%	40.25%	42.83%	41.55%
Minnesota	25.34%	27.10%	32.14%	32.30%	33.40%	33.79%	30.01%	29.07%	29.24%	31.86%
Mississippi	48.23%	46.20%	45.85%	45.24%	46.00%	43.08%	45.99%	43.26%	40.41%	41.94%
Missouri	47.89%	53.80%	57.93%	56.83%	57.64%	55.23%	52.86%	53.59%	57.40%	60.96%

Table 16b. State-Level Criminal Justice System Referrals for Treatment Where Marijuana Is One of Three Drugs of Abuse (1997—2006)

State	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Montana	53.05%	54.06%	55.94%	57.60%	57.09%	62.00%	59.92%	60.38%	62.12%	62.29%
Nebraska	18.98%	41.87%	38.05%	38.39%	37.91%	39.22%	45.06%	48.24%	43.48%	45.77%
Nevada	50.87%	53.41%	52.22%	55.16%	57.25%	56.49%	57.95%	58.70%	60.11%	65.84%
New Hampshire	49.91%	42.59%	41.64%	44.46%	44.45%	60.48%	46.86%	53.03%	50.47%	48.91%
New Jersey	37.40%	39.66%	42.87%	45.25%	47.25%	46.95%	48.19%	46.67%	50.79%	48.67%
New Mexico	23.44%	32.53%	38.40%	30.88%	42.01%	40.48%	36.72%	43.22%	34.02%	37.97%
New York	33.63%	35.88%	38.66%	40.38%	41.73%	40.93%	38.79%	38.73%	39.75%	39.06%
North Carolina	34.27%	33.72%	33.87%	33.17%	34.54%	35.07%	33.61%	26.25%	13.79%	11.16%
North Dakota	42.53%	42.59%	45.56%	45.93%	44.37%	44.22%	52.36%	59.89%	56.04%	61.64%
Ohio	57.73%	58.96%	54.21%	40.87%	39.70%	42.59%	47.75%	51.11%	49.90%	51.03%
Oklahoma	23.44%	27.39%	33.71%	36.37%	35.22%	39.97%	40.93%	42.63%	44.14%	46.81%
Oregon	60.27%	61.74%	64.45%	64.95%	64.11%	64.78%	67.05%	65.34%	62.48%	64.57%
Pennsylvania	37.81%	38.16%	42.04%	43.03%	42.73%	43.21%	39.02%	38.48%	41.33%	44.05%
Rhode Island	37.18%	38.26%	40.88%	40.01%	43.50%	48.00%	49.45%	49.04%	46.95%	45.52%
South Carolina	53.01%	51.97%	51.67%	53.83%	47.91%	49.56%	46.70%	47.31%	47.50%	48.52%
South Dakota	58.53%	65.64%	68.59%	68.78%	66.71%	65.93%	68.27%	67.05%	69.65%	66.96%
Tennessee	34.27%	24.42%	22.27%	20.83%	25.22%	29.66%	35.56%	42.38%	47.67%	44.79%
Texas	43.71%	47.95%	45.23%	44.75%	43.63%	46.76%	48.66%	48.09%	51.61%	50.36%
Utah	49.80%	55.43%	57.73%	56.96%	58.50%	59.55%	61.11%	63.58%	59.63%	47.54%
Vermont	23.59%	24.43%	34.36%	34.06%	38.33%	41.04%	38.92%	39.32%	37.54%	
Virginia	43.28%	43.96%	45.96%	49.04%	49.98%	49.11%	47.76%	46.78%	48.87%	53.16%
Washington	41.28%	44.15%	44.48%	53.96%	53.98%	53.17%	53.38%	54.27%	53.62%	54.12%
West Virginia			43.22%		23.11%	13.14%	21.23%	17.37%	19.33%	21.25%
Wisconsin	56.03%	58.66%	58.38%	54.99%	53.81%	56.08%	51.01%	53.23%	52.15%	56.30%
Wyoming	48.87%	55.47%	57.86%	64.48%	65.03%	66.99%	66.31%	61.08%	57.30%	56.85%

Table 17a. State-level Criminal Justice System Referrals for Treatment Where Marijuana Is the Primary Substance of Abuse (1997—2006)

State	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Alabama	70.71%	69.26%	71.66%	78.25%	79.43%	77.36%	77.88%	76.88%	74.67%	76.53%
Alaska	51.81%									
Arizona		37.59%	62.89%	65.23%	63.74%	66.24%	39.71%	29.67%	49.45%	51.16%
Arkansas	39.87%	46.06%	55.86%	55.59%	56.27%	52.55%	49.18%	63.02%	73.91%	72.18%
California	48.56%	49.50%	53.09%	56.38%	56.40%	59.60%	58.26%	56.29%	50.90%	50.85%
Colorado	55.79%	51.47%	55.06%	53.01%	51.48%	52.07%	48.22%	55.07%	58.25%	60.52%
Connecticut	43.47%	41.39%	44.33%	39.85%	43.69%	44.62%		46.31%	49.00%	47.57%
Delaware	83.56%	86.50%	86.86%	80.98%	84.58%	78.56%	74.98%	79.69%	70.90%	77.87%
District Of	60.47%	60.95%	73.60%	66.12%	28.07%	17.58%	35.71%			
Florida	70.43%	66.40%	72.54%	69.13%	72.30%	74.97%	70.42%	66.62%	65.15%	66.37%
Georgia	56.54%	51.06%	47.50%	42.08%	41.51%	39.99%	38.14%	35.71%	40.85%	
Hawaii	21.22%	17.41%	24.82%	26.71%	28.54%	28.24%	27.78%	28.09%	21.40%	23.16%
Idaho	68.63%	72.66%	71.92%	64.85%	59.59%	62.27%	72.57%	71.16%	42.77%	60.41%
Illinois	57.37%	57.80%	59.46%	58.67%	60.64%	64.12%	65.92%	66.62%	67.16%	68.18%
Indiana		62.42%	63.65%	63.08%	66.80%	64.92%	63.65%	63.99%	62.91%	62.83%
Iowa	56.50%	61.51%	60.80%	57.50%	60.01%	60.56%	59.49%	60.73%	58.28%	58.98%
Kansas	45.08%	50.52%	51.31%	55.25%	56.01%	56.95%	53.52%	53.85%	53.92%	55.54%
Kentucky	42.45%	41.66%	44.85%	47.85%	45.74%	45.45%	40.84%	35.86%	38.66%	38.12%
Louisiana	62.59%	53.72%	63.59%	52.52%	55.94%	52.40%	55.74%	63.38%	64.63%	63.95%
Maine	32.45%	34.18%	43.71%	42.18%	43.58%	43.16%	42.93%	45.55%	44.14%	43.33%
Maryland	56.63%	61.26%	62.65%	64.52%	65.59%	65.06%	65.29%	64.99%	64.54%	64.20%
Massachusetts	42.01%	43.51%	44.01%	44.17%	47.17%	40.06%	44.42%	46.15%	49.88%	52.28%
Michigan	49.18%	50.78%	47.53%	40.75%	44.37%	48.69%	47.46%	50.27%	52.96%	52.87%
Minnesota	27.78%	30.25%	36.37%	37.03%	37.93%	38.58%	33.85%	33.93%	34.74%	38.29%
Mississippi	52.26%	51.71%	51.70%	51.76%	55.76%	53.70%	57.42%	53.81%	46.70%	51.90%
Missouri	60.48%	66.01%	69.64%	69.77%	70.65%	66.94%	64.80%	66.32%	70.23%	73.07%

Table 17b. State-level Criminal Justice System Referrals for Treatment Where Marijuana Is the Primary Substance of Abuse (1997—2006)

State	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Montana	53.89%	54.70%	56.58%	59.54%	56.99%	61.52%	59.95%	59.77%	63.68%	64.73%
Nebraska	30.53%	50.97%	41.84%	45.25%	46.56%	48.51%	53.12%	55.36%	50.09%	53.57%
Nevada	55.56%	55.42%	59.63%	62.90%	64.74%	62.35%	65.48%	67.38%	68.30%	74.73%
New Hampshire	46.38%	41.91%	41.98%	45.65%	47.88%	64.37%	48.97%	51.35%	57.03%	54.78%
New Jersey	51.38%	55.90%	58.59%	61.90%	63.66%	63.20%	63.13%	62.53%	66.13%	60.06%
New Mexico	33.39%	36.89%	42.47%	21.67%	30.93%	34.27%	34.86%	35.23%	35.41%	41.88%
New York	51.74%	54.68%	57.69%	58.72%	60.29%	58.33%	55.15%	54.54%	56.77%	56.53%
North Carolina	47.48%	48.49%	47.48%	40.29%	41.81%	44.15%	43.60%	41.46%	26.18%	22.03%
North Dakota	49.16%	49.51%	51.27%	53.41%	55.95%	50.00%	58.59%	56.26%	63.25%	66.83%
Ohio	61.40%	61.97%	55.71%	42.40%	43.56%	47.15%	52.87%	55.43%	54.87%	55.92%
Oklahoma	28.64%	33.08%	41.96%	46.44%	41.96%	51.89%	51.94%	55.48%	52.89%	51.48%
Oregon	56.56%	59.21%	61.05%	61.29%	60.51%	61.18%	62.16%	60.94%	56.65%	60.35%
Pennsylvania	42.53%	44.37%	47.49%	50.97%	49.45%	50.32%	48.29%	48.08%	50.76%	51.57%
Rhode Island	49.27%	48.51%	53.28%	54.43%	57.11%	57.63%	58.20%	57.18%	58.58%	52.69%
South Carolina	57.06%	58.26%	54.51%	58.80%	53.21%	54.47%	52.04%	53.04%	54.46%	55.15%
South Dakota	59.37%	67.13%	69.65%	69.70%	67.50%	67.64%	69.52%	65.64%	70.34%	70.76%
Tennessee	44.17%	33.09%	29.14%	26.21%	35.46%	38.25%	44.43%	52.03%	56.51%	52.70%
Texas	62.14%	65.05%	64.63%	63.43%	62.16%	67.74%	66.03%	64.83%	67.41%	66.17%
Utah	54.48%	57.77%	65.83%	64.11%	67.75%	66.94%	66.26%	68.11%	61.05%	51.50%
Vermont	25.55%	22.24%	29.39%	31.62%	37.36%	41.70%	41.90%	40.65%	44.98%	
Virginia	54.19%	56.49%	55.69%	56.31%	58.54%	54.67%	54.00%	56.55%	55.62%	59.46%
Washington	45.07%	49.02%	51.41%	55.67%	56.94%	56.16%	56.49%	58.44%	57.20%	58.52%
West Virginia			55.02%		28.84%	15.83%	20.69%	16.67%	17.66%	19.62%
Wisconsin	53.78%	55.26%	59.05%	56.09%	55.53%	57.25%	55.37%	55.53%	53.86%	59.30%
Wyoming	50.86%	57.84%	60.18%	65.48%	66.71%	71.99%	66.82%	63.44%	57.16%	55.62%

Source Data & Notes

[1] U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. TREATMENT EPISODE DATA SET (TEDS), 1992—2006 [Computer files and Codebook]. Prepared by Synectics for Management Decisions, Incorporated. ICPSR21540-v2. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [producer and distributor].

[2] U.S. Dept. of Justice, Federal Bureau of Investigation. Crime in the United States (2006).

[3]U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. NATIONAL SURVEY ON DRUG USE AND HEALTH, 2006 [Computer file]. ICPSR21240-v3. Research Triangle Park, NC: Research Triangle Institute [producer]. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor].

[4] U.S. Dept. of Justice, Federal Bureau of Investigation. UNIFORM CRIME REPORTING PROGRAM DATA [UNITED STATES]: ARRESTS BY AGE, SEX, AND RACE, 2005 [Computer files]. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [producer and distributor].

[5] Marijuana and Medicine: Assessing the Science Base. By Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Editors. The Institute of Medicine, National Academy of Sciences. National Academy Press, Washington D.C. 1999. pg 98 – pg 101. http://books.nap.edu/html/marimed/

[6] State by State Marijuana Laws. National Organization for the Reform of Marijuana Laws (NORML). http://www.norml.org/index.cfm?Group_ID=4516