

Endnotes

- 1 The calculations reported in this study used data from a variety of sources. Most sources were unavailable for 2000, and when that was the case, we projected estimates into 2000. Except where the text notes otherwise, we used linear projections based on data from 1997 through 1999. Some data were unavailable for 1998, in which case we projected backward using data from 1989 through 1991. Occasionally data were missing for a single year (e.g. 1989), and in that case we set the missing value equal to the average of the preceding and following years. To summarize available data for major sources:
 - National Household Survey on Drug Abuse – the Substance Abuse Mental Health Services Administration (SAMHSA) had published NHSDA tabulations that were current as of 1999.
 - Drug Use Forecasting system – the National Institute of Justice provided DUF data for 1988 through 1999.
 - Uniform Crime Reports – The FBI provided data from the UCR system for 1988 through 1999.
 - System to Retrieve Information from Drug Evidence – The Drug Enforcement Administration (DEA) provided STRIDE data from 1981 through the second quarter of 2000.
 - Drug Abuse Warning Network – DAWN reports, provided by SAMHSA, were current through 2000.
 - Treatment Episode Data Set – The TEDS data, also provided by SAMHSA, were limited (by this study) to reports from 1998, the most recently publicly available data.
 - Federal Drug Seizure System – FDSS data, from the DEA, were available for 1991 through 2000.Occasionally the survey designs changed so that a question asked on early surveys did not appear on later ones. For example, as of 1995 the NHSDA stopped asking respondents about the number of joints and the amount of marijuana used. We necessarily projected estimates for 1995 through 2000. These cases are noted in the text.
- 2 M.Layne, P. Johnston and W. Rhodes, *Following the Flow of Cocaine: The Sequential Transition and Reduction (STAR) Model, 1996-2000*, January 2002; A. Bruen, P. Johnston and W. Rhodes, *Estimation of Heroin Accountability in the United States*, January 2002.
- 3 W. Rhodes, P. Johnston and Ryan Kling. *The Price of Illicit Drugs: 1981 through the Second Quarter of 2000*. Office of National Drug Control Policy. October 2001.
4. By comparison, Americans spent about \$43 billion on tobacco in 1993. This figure is unadjusted for inflation. *The Tax Burden on Tobacco* (Washington, D.C.: The Tobacco Institute, 1993).
5. The NHSDA excludes military personnel, those incarcerated in jails and prisons, and those who are residents of treatment facilities. Military personnel, whose consumption of illicit substances is monitored through urinalysis, do not have the opportunity to be heavy drug users. Those incarcerated in jails and lockups may use drugs, but that consumption must necessarily be limited by restricted availability. A Bureau of Justice Statistics study reports “In State correctional facilities, 3.6 percent

of the tests for cocaine, 1.3 percent for heroin, 2.0 percent for methamphetamine, and 6.3 percent for marijuana found evidence of drug use. In Federal prisons, 0.4 percent of the tests for cocaine, 0.4 percent for heroin, 0.1 percent for methamphetamine, and 1.1 percent for marijuana were positive.”

C. Harlow, *Drug Enforcement and Treatment in Prison, 1990* (NCJ-134724, July 1992). These percentages are probably high because tests are most likely to be conducted when drug use is suspected. In any case, drug use in prisons cannot account for much of the drug use that occurs in America. Sources at the National Institute on Drug Abuse consider drug use by those in residential treatment facilities to be minimal.

6. Evidence that a large segment of the drug-using population is excluded from the NHSDA comes from a number of sources. According to the 1991 NHSDA, drug use is twice as high among respondents who lived in households considered unstable than it is among those who lived in more stable environments, indicating that the NHSDA’s bias toward reporting on stable households is likely to miss many heavy drug users. Additional evidence comes from interviews with nearly 35,000 intravenous drug users who were contacted by National Institute on Drug Abuse-sponsored researchers as part of an AIDS outreach project. Abt Associate’s tabulations show that of these drug users, an estimated 40 percent lived in unstable households and about 10 percent could be considered homeless.

Available evidence indicates that NHSDA’s respondents understate heavy drug use. A. Harrell, K. Kapsak, I. Caisson, and P. Wirtz, “The Validity of Self-Reported Drug Use Data: The Accuracy of Responses on Confidential Self-Administered Answer Sheets,” paper prepared for the National Institute on Drug Abuse, Contract Number 271-85-8305, December 1986. M. Fendrich, T. Johnson, S. Sudman, J. Wislar and V. Spiehler, “Validity of Drug Use Reporting in a High-Risk Community Sample: A Comparison of Cocaine and Heroin Survey Reports with Hair Tests,” *American Journal of Epidemiology* 149(10): 955:62, 1999. Consistent with these observations, the Substance Abuse Mental Health Services Administration reports that virtually no heroin addicts answer the National Household Survey on Drug Abuse. Substance Abuse Mental Health Services Administration, *Preliminary Estimates from the 1993 National Household Survey on Drug Abuse* (June 1994).

A comparison of the demographic characteristics of the heavy cocaine users in the NHSDA with those of heavy cocaine users based on other sources (the Drug Use Forecasting program, the Drug Abuse Warning Network, and the National AIDS Demonstration Research project) shows a marked difference between those populations and the one represented in the NHSDA. Incomes are greater, unemployment is lower, and there are fewer respondents using more than one drug in the NHSDA.

D. Hunt and W. Rhodes, “Characteristics of Heavy Cocaine Users Including Polydrug Use, Criminal Behavior, and Health Risks,” paper prepared for Office of National Drug Control Policy (ONDCP), December 14, 1992.

Finally, estimates of heavy drug use reported in the NHSDA are difficult to reconcile with other data sources maintained by the Substance Abuse Mental Health Services Administration, especially with reports of the treatment for cocaine or heroin. These incompatibilities are discussed later in this report.

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7. A large percentage of heavy drug users are arrested at some time in their drug-using “careers,” so the criminal justice system provides valuable supplemental data when counting heavy drug users. For example, in the 1993 Household Survey, about 58 percent of weekly cocaine users surveyed had been arrested and booked at some time, 39 percent during the year prior to the survey. In the National AIDS Demonstration Research data, 81 percent of heavy cocaine users had been arrested at some time in their lives, and one-third had been in jail or prison during the six months prior to the interview.
 7. One change in nomenclature in this document, from previous reports, is the replacement of the word “hardcore” with “chronic”. The term “chronic” more accurately reflects the behavior and nature of frequent drug use.
 9. The population of chronic users is not identical to the population of users who need substance abuse treatment. Still, using the 10 days per month threshold, the DUF data show that 57 percent of chronic cocaine users and 77 percent of chronic heroin users deemed themselves to be in need of treatment. These self-reports probably understate the need for treatment, because denial of the need for treatment is high among chronic users.
 10. Because urinalysis will detect cocaine and heroin use within two to three days of its consumption, it is unlikely that urinalysis will fail to identify an individual who uses cocaine on at least a weekly basis. (Most weekly users use it more frequently than once a week.) An occasional user is however likely not to have used cocaine or heroin within two to three days of his or her arrest. Consequently, DUF would frequently fail to identify occasional users. Arguably, the EMIT test used by DUF understates drugs in the urine of arrestees. C. Visher and K. McFadden, *A Comparison of Urinalysis Technologies for Drug Testing in Criminal Justice*, NCJ-129292, June 1991. However, it seems reasonable that occasional users are more likely than chronic users to have an erroneous negative urine test, so we have not adjusted the DUF urine test results to reflect the EMIT test’s false negative rate of about 20 percent. For evidence supporting this decision, see T. Mieczkowski, “Immunochemical Hair Assays, Urinalysis, Self Reported Use and the Measurement of Arrestee Cocaine and Marijuana Exposure in a Large Sample,” paper presented at the Annual Meetings, American Society of Criminology, New Orleans, November 7-22, 1992.
 11. S. Everingham, C. Rydell and J. Caulkins, “Cocaine Consumption in the United States: Estimating Past Trends and Future Scenarios,” *Socio-Economic Planning Sciences*, Vol. 29 (4) December 1995: 305-314. The authors report that heavy users of cocaine use 70 percent of all cocaine. Estimates based on retail sales expenditure, reported later, are consistent, but also show that chronic heroin users account for a larger fraction of heroin sales than chronic cocaine users account for cocaine sales.
 12. Drugs are sometimes received as income-in-kind, especially by drug-using dealers who keep part of what they otherwise would deal, and also those who exchange drugs for sex. Income-in-kind is not included in the retail sales dollar amounts, but it is factored into the measures of metric tons of drugs consumed.
 13. An appreciable number of drug users use both heroin and cocaine. According to the 1998 TEDS data, about 421,000 people were treated for cocaine as either the primary or secondary abused substance. Another 247,000 were treated for heroin as the primary or secondary abused substance. There were

about 79,000 people for whom cocaine was the primary drug and heroin was the secondary drug or for whom heroin was the primary drug and cocaine was the secondary drug. This overlap in cocaine and heroin use suggests that about 88 percent of the total number of chronic heroin and chronic cocaine users are unique.

14. The Treatment Admission Data Set accounted for about 87 percent of treatment admission to publicly funded treatment programs during 1987. If all cocaine and heroin users receive treatment funded by the Government, then estimates based on the TEDS data should be inflated by $1/0.87$. This assumption gives the lower estimate. The TEDS data accounted for 67 percent of all treatment admissions during 1987. If cocaine and heroin users were as likely as other drug users to be treated in programs that receive Government funding, then the estimate based on the TEDS data should be inflated by $1/0.67$. This provides the upper estimate.
15. W. Rhodes, S. Langenbahn, R. Kling, and P. Scheiman. *What America's Users Spend on Illegal Drugs: 1988-1995* (Washington, D.C.: Office of National Drug Control Policy, Fall 1997). See Appendix A.
16. D. Hamill and P. Cooley, *National Estimates of Heroin Prevalence 1980-1987: Results from Analyses of DAWN Emergency Room Data*, RTI Technical Report, (Triangle Park, N.C.: Research Triangle Institute, 1990).
17. R. Simeone, W. Rhodes, D. Hunt and L. Truitt, *Methodology for Estimating the Number of Hardcore Drug Users*, report submitted to the Office of National Drug Control Policy, March 1997.
18. According to TEDS data for 1998, about 88 percent of people treated for cocaine or heroin abuse were treated for use of both drugs. The estimate reported in the text is the sum of chronic cocaine and heroin users for 1995 multiplied by 0.88.
19. SAMHSA estimated that 7.1 million people needed treatment in 1994. Persons needing treatment were divided into two categories, Level 1 and Level 2. The Level 2 category was the more severe category of need and contained about 3.6 million people. We have used this 3.6 million figure in our calculations under the assumption that Level 2 users are similar to the chronic drug users described in our report. See: Substance Abuse and Mental Health Services Administration, "The Need for and Delivery of Drug Abuse Services: Recent Estimates," February 22, 1996.
20. SAMHSA defines those who are severely in need of drug treatment using four criteria. NHSDA respondents were classified as in need of treatment if they reported any of the following in the past 12 months:
 - Been dependent on any drug other than marijuana;
 - Reported injecting cocaine, heroin or stimulants;
 - Received drug abuse treatment at a specialty facility; and
 - Used drugs frequently.

To account for the underestimation of hard-core drug use in the NHSDA, SAMHSA adjusted the

number of people needing treatment using a ratio estimation technique that linked NHSDA data to data from the Uniform Crime Reports and the National Drug and Alcohol Treatment Unit Survey. This ratio estimation technique inflated estimates of treatment need by 20% in 1991 and 1992 and 30% in 1993. Although we did not have figures for the ratio estimation in 1994, we assumed a similar adjustment of 20 to 30%. See: Substance Abuse and Mental Health Services Administration, "The Need for and Delivery of Drug Abuse Services: Recent Estimates." February 22, 1996 and "Estimating Substance Abuse Treatment Need for a National Household Survey," by Joan Epstein and Joseph Gfoerer, OAS Working Paper, presented at the 37th International Congress on Alcohol and Drug Dependence, August 20-25, 1995, UCSD Campus, La Jolla, California.

21. Using SAMHSA's description of their technique for estimating the number of persons needing treatment, we developed the following algorithm using the NHSDA. Persons were classified as severely needing treatment if they met at least one of the following criteria:
- Dependence on any drug other than marijuana in the past 12 months. Six question types from the 1994 revised NHSDA were used to approximate the DSM-III-R criteria for drug dependence. Respondents were classified as dependent if they answered at least three of these six questions positively for any drug except marijuana. We originally defined dependence using positive answers to at least two of the six questions, since the DSM-III-R uses three of nine questions to determine dependence. However, this procedure yielded estimates that were too high.
 - Reported using needles to inject cocaine, heroin or stimulants at least once during the last year.
 - Reported receiving drug treatment at a hospital (as an inpatient), a drug treatment facility (as an inpatient), or at a mental health facility over the past year.
 - In the past year, reported using marijuana daily and met the criteria for marijuana dependence described above, reported any heroin use, reported using cocaine at least weekly, or reported daily use of other drugs, including inhalants, hallucinogens, stimulants, sedatives, analgesics, and tranquilizers.

We inflated the estimate obtained through this method by 25% to approximate the ratio estimation technique used by SAMHSA.

22. National Institute on Drug Abuse, *Epidemiological Trends in Drug Abuse, Volume I: Highlights and Executive Summary*, Community Epidemiological Work Group, December 1996: Exhibit 5, page 18. We excluded Minneapolis/St. Paul from this summary, because that site did not exclude alcohol only from its treatment statistics.
23. Treatment Episode Data Set (TEDS): 1992-1997. SAMHSA, August 26, 1999. Downloaded from the Internet 11/18/1999: www.samhsa.gov/teds9297.htm
24. Center for Disease Control and Prevention, *HIV/AIDS Surveillance Report 1998*, Vol. 10 (No. 2).

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25. Trends in lifetime prevalence of heroin use among 12th graders rose from 1993 to 1997. It remained fairly constant until a sharp increase in 2000. Johnston, L., O'Malley, P and Bachman, J. (2001) *Monitoring the Future National Results on Adolescent Drug Use., Overview of Key Findings* (NIH Publication No. 01-4923). Bethesda, Maryland: National Institute on Drug Abuse.
 26. Treatment data are difficult to interpret. From the Treatment Episode Data, we observe that treatment admissions for heroin increased from 167,000 in 1992 to 218,000 in 1997; furthermore, while 77 percent of heroin users injected in 1992, only 68 percent injected in 1997. Perhaps these trends imply more heroin users in the late 1990s. It certainly implies a larger prevalence on non-injection drug use. Substance Abuse Mental Health Services Administration, Treatment Episode Data Set (TEDS): 1992-1997.
 27. Table 2.10 Downloaded from the Internet on 11/15/99: www.samsha.gov/oas/p0000018.htm
 28. R. Simeone, W. Rhodes, Hunt, D. and L. Truitt. *Methodology for Estimating the Number of Hardcore Drug Users*. Report submitted to the Office of National Drug Control Policy by Abt Associates Inc., March 1997.
 29. Weekly expenditures on cocaine and heroin have decreased over time, but this change results from using the CPI to convert expenditures to 2000 dollar equivalents. Many chronic users spend two-thirds of their incomes on drugs, but they probably do not see themselves as spending less over time because the price of cocaine and heroin has fallen in real terms since 1988. The CPI is not a good reflection of a chronic drug user's market basket.
 30. For a review, see W. Rhodes, M. Layne, P, Johnston and L. Hozik. *What America's Users Spend on Illegal Drugs 1988-1999*. (Washington, D.C. Office of National Drug Control Policy). Appendix B.
 31. Reuter and Kleiman estimated that the market for cocaine was about \$8 billion in 1982. This is about \$14 billion in 1998 dollars. Because of the accelerating use of cocaine from that time until the mid-1980s, and after accounting for inflation, it is not surprising that their estimate is less than the figure reported here. Their \$8 billion estimate for heroin expenditures equals about \$14 billion in 1998 dollars. That is considerably less than our 1989 estimate. P. Reuter and M. Kleiman, "Risks and Prices: An Economic Analysis of Drug Enforcement,": In *Crime and Justice: An Annual Review of Research*, volume 7, ed. M. Tonry and N. Morris (Chicago: University of Chicago Press, 1986), 194. Carlson, who conducted a study of the underground economy for the Internal Revenue Service, reported that an estimated \$11 billion was spent on cocaine in 1982. K. Carlson et al., "Unreported Taxable Income for Selected Illegal Activities: Volume I: Consensual Crimes," paper prepared for the Internal Revenue Service under contract number TIR-81.57, September 1984. In an update of his study, Carlson estimated that cocaine expenditures increased from \$5.8 to \$6.6 billion between 1988 and 1991. K. Carlson, "Unreported Illegal Source Income 1983-1995," paper prepared for the Internal Revenue Service under order number 89-11565, May 15, 1990. Since he relied heavily on the NHSDA, and because his estimates are not adjusted for inflation, it is not surprising that his estimate is much lower than the one reported here. Carlson's estimate of heroin expenditures, based on the National Narcotics Intelligence Consumers Committee estimates for 1982, was in keeping with Reuter

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- and Kleiman's \$8 billion figure. His updated study, based on NHSDA data, put that figure at roughly \$7 billion a year between 1988 and 1991.
32. Elsewhere in this report we noted that heroin use could have fallen over time because of the AIDS epidemic and because heroin addicts were increasingly incarcerated during the decade. Nevertheless, we would expect any effect resulting from AIDS and incarceration to be gradual, while in the previous report the decrease in chronic drug users was inexplicably precipitous. Then the number of chronic heroin users abruptly increased. A possible explanation was that new users were drawn into heroin use by the advent of low-priced high-purity heroin. While this may in fact be true, the increase was almost as marked as the previous decrease. This was difficult to understand. Except for what appears to be a data blip, the NHSDA does not suggest a large increase in casual heroin use, and even if it did, a rapid onset of chronic use would be difficult to understand.
 33. W. Rhodes, M. Layne, P. Johnston and L. Hozik. *What America's Users Spend on Illegal Drugs 1988-1990*. (Washington, D.C.: Office of National Drug Control Policy). See Appendix B.
 34. Heroin distribution seemed to change toward the end of the 1980s and 1990s. There was a marked decrease in the cost of heroin and an equally marked increase in the purity of heroin available to American consumers. At least as of 1995, Colombia had replaced Southeast and Southwest Asia as the principal source of heroin sold in the United States, and distribution practices changed as a consequence. As Appendix B argues, ethnographers increasingly reported that heroin was being distributed by profit dealers instead of users.
 35. Using the CPI to inflate expenditure on drugs is arguable. The Federal government computes the CPI from a weighted average of prices paid by consumers for what is deemed to be a typical market basket. The problem when applying this CPI to chronic users is that their market basket is grossly atypical two-thirds to three-quarters of their income may be spent on illicit drugs. (See J. Fagan, "Drug Selling and Illicit Income in Distressed Neighborhoods: The Economic Lives of Street-Level Drug Users and Dealers," in *Drugs, Crime and Social Isolation*, edited by A. Harrell and G. Peterson, (Washington, D.C.: The Urban Institute Press, November 1994). Because the nominal prices of cocaine and heroin have fallen over much of the period examined through the retail sales calculations, chronic users have seen a deflation, not an inflation, in how much they spend on their typical market basket, most of which may be for illicit drugs. Thus, when asked about drug expenditures, chronic users may well say they spend about the same amount in 1998 as they spent in 1988.
 36. Recent reports by the Community Epidemiological Work Group have told of increasing numbers of heroin users: In the 1997-1998 reporting period, heroin indicators continued to increase in 12 CEWG cities. In some cities, heroin use indicators have been trending upward for more than three years. December 1998 Advance Report. Downloaded from the Internet 11/15/99: www.cdmgroup.com/cewg/docs/1298-miami/1298adv.ntm#heroin.
 37. M. Childress, B. Dombey, and S. Reseter. *A Systems Description of the Cocaine Trade* (Santa Monica, CA: Rand, 1994).
 38. M. Childress, et al. *A Systems Description of the Cocaine Trade* (Santa Monica, CA: Rand, 1994).

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- 39 W. Rhodes and R. Kling, Estimating the Prevalence of Hardcore Drug Use Using ADAM Data, report delivered to the National Institute of Justice by Abt Associates, January, 2002.
- 40 The assumption that 79 percent of treatment admissions for amphetamines are attributable to methamphetamine was based on early tabulations of data. Subsequent to our tabulations, SAMHSA has reported estimates that suggest that 94 percent of treatment admissions for amphetamines are attributable to methamphetamine. See Office of Applied Studies, Treatment Episode Data Set (TEDS) 1994-1999. , WWW.SAMHSA.GOV/OAS/teds/99teds/99teds.pdf. If we had used 94 percent to adjust our estimates, they would be about 18 percent larger than reported in the text.
- 41 We applied the same computing steps as were used to estimate the number of compulsive cocaine and heroin users to estimate the number of compulsive methamphetamine users. Call the resulting estimates N_{1988} , N_{1999} ... N_{2000} . We used these estimates to compute a trend, defined as $T_{1988} = N_{1988}/N_{1998}$, $T_{1989} = N_{1989}/N_{1998}$... $T_{2000} = N_{2000}/N_{1998}$. As was true of the heroin and cocaine estimates, this trend was based principally on the DUF data. Then, using the 1998 TEDS data, we estimated the number of chronic drug users in 1998 as M_{1998} . Estimates for earlier and later years were defined as $M_{1988} = M_{1998} * T_{1988}$, $M_{1989} = M_{1998} * T_{1989}$, ... $M_{2000} = M_{1998} * T_{2000}$.
- 42 W. Rhodes, M. Layne, P. Johnston and L. Hozik. What America's Users Spend on Illegal Drugs 1988-1991. (Washington, D.C.: Office of National Drug Control Policy). See Appendix B.
- 43 W. Rhodes, M. Layne, P. Johnston and L. Hozik. What America's Users Spend on Illegal Drugs 1988-1992. (Washington, D.C.: Office of National Drug Control Policy). See Appendix B.
44. The DEA reports: "According to University of Mississippi analyses, the THC content of commercial-grade marijuana has risen slowly over the years from an average of 3.71 percent in 1985 to an average of 5.57 percent in 1998. These analyses also show a corresponding rise in sinsemilla THC content from 7.28 percent in 1985 to 12.32 percent in 1998. Drug Intelligence Brief: The Cannabis Situation in the United States - December 1999. Downloaded from the Internet on December 10, 2001: <http://www.usdoj.gov/dea/pubs/intel/99028/99028.html>
- 45 W. Rhodes, M. Layne, P. Johnston and L. Hozik. What America's Users Spend on Illegal Drugs 1988-1993. (Washington, D.C.: Office of National Drug Control Policy). See Appendix B.
46. The estimate of 0.0136 ounces is equivalent to 0.39 grams. The 1997 NNICC report says that a joint contains one-half gram on average, and that a "...blunt may contain as much as 6 times this amount." If the NNICC estimate is correct, our estimates would be about 25 percent too low, but the source of the NNICC estimate is unknown. The NNICC Report 1997: The Supply of Illicit Drugs to the United States (Washington, DC: DEA, November 1998).
47. Researchers disagree about trends in reporting practices, but they agree that self-reported tobacco use is only about three-quarters as large as reports based on foreign imports and tobacco sales resulting in state and federal excise taxes. K.E. Warner, "A Possible Increases in the Under reporting of Cigarette Consumption," Journal of the American Statistical Association, 73 (1978):314-317. E.J. Hatziadreu, J.P. Pierce, M.C. Fiore, et. Al., "The Reliability of Self-Reported Cigarette Consumption in the United States," American Journal of Public Health, 79, (1989): 1020-1023.

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48. In 1993, about 74 percent of arrestees who tested positive for marijuana use at the time of booking reported some marijuana use during the month before the survey.
 49. Using several self-report surveys, BOTEC Analysis Corporation estimated that marijuana costs \$222 an ounce and that an ounce could be divided into 60 joints, yielding a unit price of \$3.70 per joint. Based on these assumptions, BOTEC estimated that Americans spent \$13.1 billion on 1,599 tons of marijuana in 1992. After adjusting for inflation, BOTEC's estimate is greater than the estimate presented in this report. The difference can be accounted for by three factors: methodological differences in estimating the number of users based on the NHSDA; BOTEC's inclusion of criminally active user estimates; and BOTEC's different price estimates. A..L. Chalsma and D. Boyum, "A Marijuana Situation Assessment," (Washington, D.C.: Office of National Drug Control Policy, September 1994).
 50. We noted previously that heavy cocaine users and heavy heroin users frequently appear in the DUF data, but infrequently appear in the NHSDA data. The reverse occurs for other illicit substances. With few exceptions, which are specific to cities, other illicit substances have relatively low prevalence among arrestees.
 51. Their answers, which were in ranges of days per year, were converted to a fixed number. For instance, the range three to five days became four days.
 52. Estimates of frequency of use from the 1991 NHSDA were applied to earlier years.
 53. Drug Enforcement Administration, *Illegal Drug Price/Purity Report United States: January 1990 December 1993, April 1994*. Community Epidemiology Work Group, *Epidemiologic Trends in Drug Abuse*, (Rockville, MD: National Institute on Drug Abuse, June 1994).