

# Introduction to the Special Theme Issue Acknowledging the 30<sup>th</sup> Anniversary of the 1984 Dawning of the Crack Epidemic

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## Abstract

The year 2014 represents an opportunity to acknowledge the 30<sup>th</sup> anniversary of the 1984 dawning of the crack cocaine epidemic. The *Journal of Equity in Health* devotes the present Volume (3, No. 1, February, 2014) to a series of articles that highlight the significance of the public health crisis that began with the dawning of the crack epidemic. Meanwhile, crack remains a focus of public health concern, as underscored in an introduction. Thereafter, the article provides an overview of the contributions by varied authors that appear within this special theme issue. In sum, this article provides introduction to the eleven additional articles that comprise this special theme issue.

Keywords: crack cocaine, epidemic, public health, health equity, civil rights movement

## Introduction

Contemporary research continues to actively focus on crack cocaine (Cruz et al, 2014; Palamar & Ompad, 2014; Conti & Nakamura-Palacios, 2014; Persaud et al, 2013). Indeed, there are those who assert that crack cocaine use is a “growing problem” worldwide (Luca & Baldisserotto, 2013).

There is substantial evidence that crack cocaine remains an important public health concern—both nationally (Borders, Stewart, Wright et al, 2013; Ryder & Brisgone, 2013; CDC, 2011b; Ouellet, 2010; DePadilla, 2010; NIDA, 2010; Arfken et al, 2010; Wood, 2010; Tull et al, 2010; Daniulaityte, et al, 2007) and internationally (Cruz, et al, 2014; Persaud, et al, 2013; Duff et al, 2013; Narvaez, et al, 2011; Matheson et al, 2011; Ivsins et al, 2011; DeBeck et al, 2011).

Topics in the contemporary crack research literature are quite varied, spanning,

as follows: the overlap between crack use and the ongoing epidemic of HIV/AIDS in the United States (CDC, 2011a; Wechsberg et al, 2010; Bell et al, 2010; Harzke & Williams, 2009); links between crack use and violence (Daniulaityte & Carlson, 2011; Gilbert et al, 2011; Felson & Bonkiewicz, 2011; Chauhan et al, 2011; Cerda et al, 2010); effects of prenatal exposure to crack cocaine (Luca & Baldisserotto, 2013); char-

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acteristics and experiences of what are now long-term crack users (Persaud et al, 2013); and the reality of crack users having an impact on the subsequent generation with intergenerational transmission of drug-related problems (Ryder & Brisgone, 2013).

Given this broad ongoing focus on crack, the year 2014 represents an opportunity to acknowledge the 30<sup>th</sup> anniversary of the 1984 dawning of the crack cocaine epidemic in the United States. Moreover, it is an opportune time to devote the present Volume (3, No. 1, 2014) of this journal to a series of articles that serve to provide appropriate acknowledgement of the significance of the public health crisis that began with the dawning of the crack epidemic, and continues on a national and global scale. This article will introduce the special theme issue. A brief overview will be provided of each of the contributions to this special issue.

### Overview of the Special Theme Issue

This special theme issue will present the perspectives, research, scholarship, and stories of contributors from anthropology, sociology, ethnography, psychology, psychiatry, public health, community health, health education, medicine, nursing, as well as from the community of those in recovery from crack addiction. In each article, what is offered is the perspective of the authors of that piece, and not necessarily that of the theme Editor, Dr. Barbara Wallace, nor a position endorsed by the *Journal of Equity in Health*.

Readers are invited to arrive at their own insights, conclusions, and to engage in original analyses. Meanwhile, the articles are viewed as a spring-board for discussion, inquiry, research, scholarship, advocacy, and social action for social justice. This is consistent with the vision that served to guide the establishment of the *Journal of Equity in Health*: 1) helping to launch and sustain a new field of equity in health and to shift the health disparities discourse toward a global focus on moving “*From InEquity in Health to Equity In Health*” (Wallace, 2008); and, 2) to prepare global leaders for service

on transdisciplinary teams that engage in collaborative work alongside community members, forging “equity in health for all” within a twenty-first century global civil rights movement (Wallace, 2008). The intent is to ensure the civil right to health, as well as access to all that is needed to bring about the opportunity to enjoy optimal health.

### *Chronology of Crack and Nexus of Seven Repercussions*

The first article permits Wallace (2014a) to provide “*A chronology of crack cocaine and the nexus of seven repercussions that reverberate into the new millennium.*” The article provides a rationale for selecting 1984 as the year for the dawning of the crack epidemic. The article goes on to review major developments within the chronology, as well as the evidence to support the contention that there is still a contemporary focus on crack as a major public health concern—both nationally and internationally.

Wallace (2014a) then presents a nexus of seven repercussions from the crack epidemic that reverberate into the new millennium:

(1) **Public health crisis** of considerable magnitude and long duration that involves overlapping epidemics of crack/other drug use, HIV/AIDS, and violence—as well as related disease syndemics; (2) **Flawed and unjust War on Drugs policy** that has driven irrational responses to the public health crisis of overlapping epidemics; (3) **Crisis of mass incarceration** within a burgeoning United States’ prison industrial complex that has been prolonged, enduring, and includes a host of negative national and international consequences; (4) **Crisis of trust in the governing infrastructure** of the United States’ (a) legislature, (b) judiciary, (c) criminal justice system, and (d) law enforcement that manifests in the national consciousness as a widespread mistrust and suspicion; (5) **Crisis of disruption in social progress** and gains made since the civil rights movement that gave way to ongoing community mobilization efforts, as well as societal-wide improvements in human relations, and the overcoming of negative

stereotypes about members of various racial, ethnic, religious, socioeconomic, and sexual orientation groups; **(6) Crisis of special vulnerable populations** left especially at risk by facing various combinations of criminalization, stigmatization, targeted oppression, marginalization, and isolation, while not provided with adequate access to primary, secondary, and tertiary public health interventions; and, **(7) Innovation and evolution** in research, treatment, service delivery, models of practice, training, outreach, advocacy, and policy spurred from pressures that commonly attend a regional, national and international epidemic, especially when there are overlapping epidemics over an extended period of time—effectively driving development. A Figure shows the seven factors in dynamic interaction—while the nexus provides a framework that encompasses the other articles in the theme issue.

Wallace (2014a) asserts that what this article proposes through the nexus of 7 factors is a framework deemed sufficient to encompass the diverse content of the special theme issue; i.e., the perspectives, research, scholarship, and stories of all of the contributors to the special theme issue.

### ***Infectious Disease Syndemics of Crack***

Next, Singer (2014) begins by presenting “*The infectious disease syndemics of crack cocaine*,” while arguing that one of the primary factors involved in drug-related deaths among crack users is the role this drug plays in fostering infectious disease syndemics; this includes adverse interactions among HIV, tuberculosis, and a variety of sexually transmitted infections (STIs). Further, discussion covers how these infectious disease syndemics are promoted by social marginalization, poverty, trauma, and overall stress encountered in life.

Singer (2014) underscores how living in high-risk environments serves to negatively impact health and immune competence—necessitating the need for structural interventions. Structural interventions encompass the modification of social

structures and conditions, while promoting health and reducing risk in the social context. These structural interventions include modifying laws and policies, addressing homelessness, reducing reliance on commercial sex exchanges for survival, and focusing on community re-integration post-incarceration, as well as supporting the family reunification process. Not to be forgotten is the need to provide appropriate drug treatment that is easily accessible, while also seeking to alter economic relationships within society. The article concludes by asserting that such interventions would hold promise for improving the lives of large numbers of individuals, while targeting critical factors related to mortality.

### ***Crack and Links to HIV***

Bowser, Word, Fullilove and Fullilove (2014) contribute “*Post-script to the crack epidemic and its links to HIV*,” thereby also focusing upon the key factor of sex-for-drugs and money exchanges, while examining links between the crack epidemic and HIV infection rates among urban young adults. Bowser et al (2014) review how by 2000 street-level crack dealing disappeared, partly due to the intense police response; those who had openly engaged in dealing drugs were incarcerated—with City Halls around the country declaring victory. They present the view, based on ethnographic interviews, that crack use did not run its course, sales were not successfully suppressed, and crack dealing has not declined from its 1990s scale. Instead, there has been a shift in crack dealing, going underground—while taking the high risk of HIV and sex-exchange-for-drugs-and-money with it. Drug dealing is now invisible, including home delivery and White suburban buyers meeting suppliers in any place (e.g. malls).

Bowser et al (2014) acknowledge the dispersal and expansion underground of crack dealing—as a factor contributing to the dissipation of HIV transmission risks. They go on to advance hypotheses that: the unaddressed crack epidemic has served to facilitate the continued transmission of HIV

in the lowest-income communities; the AIDS epidemic has now dispersed to low-income central city and low-income suburban communities; and, that HIV risks for low-income suburban Whites have increased dramatically. Meanwhile, funding is needed for new epidemiological studies to investigate the extent to which contemporary HIV behavioral risks have generated HIV infections among high risk takers and their sexual networks. The goal is to avoid not knowing how extensive these sex exchanges may be, until it is too late—with the spreading of HIV.

***Impacts from Sex for Crack Exchange for Black Women and Their Families***

Highlighting just how important ethnographic interviews have been in documenting sex for crack cocaine exchanges within the crack epidemic, LeBlanc and Wallace (2014) present “*Sex for crack cocaine exchange: The continuing impact of crack cocaine on poor black women and their families.*” The article expounds upon and updates the analysis in the first author’s book, *Behind the Eight-ball: Sex for Crack Cocaine Exchange and Poor Black Women* [Sharpe, 2005 (note: LeBlanc was formerly Tanya Telfair Sharpe)]. The article focuses on the long-term consequences of crack cocaine addiction and crack prostitution, which include: HIV/AIDS and sexually transmitted diseases; unplanned pregnancies; children at risk for neglect, abuse and abandonment; and, the potential for drug and alcohol exposed pregnancies producing children with developmental disabilities.

Demonstrating that there is more than one way to access the stories of poor black women and their families within the crack epidemic is the next article.

***Working with Harlem Hospital’s HIV Infected “Boarder Babies”—A Love Story***

The article is based on the story of work in the trenches by a medical provider (i.e. Maxine Frere) at Harlem Hospital at the height of the crack epidemic, as well as

overlapping epidemics of HIV/AIDS and violence. More specifically, Frere and Wallace (2014) collaborate in offering the article “*Working in the trenches with HIV infected “boarder babies—Values, skills, and a prescription for working with stigmatized populations throughout epidemics.*” Using an interview to capture the “Harlem Hospital story” of Frere, the article identifies factors that contributed to health providers persevering throughout the epidemics. Relevant factors included core guiding values and vital skills—i.e. in communication, advocacy, and community outreach—while providers pioneered treatment innovations for babies and their mothers.

Frere and Wallace (2013) conclude by offering a prescription for working with stigmatized populations throughout epidemics: (1) professionalism; (2) respect; (3) knowledge; (4) recognition of a common shared humanity; (5) honesty; (6) being non-judgmental; (7) being forthright in response to relapse and non-adherence; (8) compassion; and, (9) love. Frere and Wallace (2013) assert that any caught within the “next epidemic” and at risk of stigmatization will desire care from medical providers following this 9 point prescription.

***Crack in the Lifestory: What is Needed During Drug Epidemics?***

Next, Fullilove (2014) presents the article, “*Crack in the lifestory: The experience of David Jenkins,*” based on a set of collaborative interviews audiotaped over a period of 10 years. An analysis of the resultant body of data permits a window into the complex ways in which macro issues (e.g. lack of affordable housing) and micro issues (e.g. HIV infection) are intricately interwoven with addictive disorder. The presentation of his lifestory reveals how, during the pre-addiction period, relevant factors operating included deprivation and injury that served to create vulnerabilities. Once in the period of active addiction, those factors were exacerbated, while, thereafter, the recovery process permitted the

deprivation and injury to be assuaged. The lifestory method permits readers to witness the transformation made possible through the recovery process from addiction. The transformation included an enhanced outlook on life, the repair of relationships, and an ability to make meaningful contributions to the well-being of others in his community.

The qualitative lifestory data, as a whole, permits Fullilove's (2014) conclusion that there is a need for active primary, secondary and tertiary prevention during epidemics of drug addiction. Aligning with a larger prescription for how to improve life in urban settings, what also arises from the lifestory data is how: (1) stable communities can prevent much abuse and thereby limit the inauguration of self-centered fear, the substrate for later addiction; (2) addiction treatment can mitigate addiction once it is established; and (3) addiction services can promote community rebuilding by returning people to productive and selfless roles in society.

### ***Decades of Evolution in Community-Based Drug Treatment Driven by Crack***

Creating a natural progression, in the next article, Wallace (2014b) covers "*Evolution in community-based addiction treatment driven by the crack epidemic: A professional time-line of psychological work in the trenches of the War on Drugs*"—further illustrating the benefits of addiction treatment. The article presents the author's professional time-line of psychological consultation work across decades in the trenches of the War on Drugs in order to mark major developments in the evolution of community-based addiction treatment driven by the crack epidemic. Presentation of this professional timeline sets the stage for a call for social action for social justice, and advocacy - especially *collaborative advocacy* with colleagues and community members. Also offered are eight objectives recommended to guide education and training in order to prepare a diverse workforce for engagement in collaborative advocacy.

Wallace (2014b) draws conclusions that emphasize how the crack epidemic stimulated systematic evolution in community-based addiction treatment, while the War on Drugs policy wrought devastation and trauma upon adults, infants, children, families and entire communities. Emphasis is placed upon how the crack epidemic and unjust response of the War on Drugs policy, together in toxic combination, indelibly marred the lives of members of vulnerable populations.

For example, Wallace (2014b) identifies the vulnerable populations as including the following: women, mothers, infants/children separated from parents, those who contracted HIV/AIDS, those who died of AIDS, AIDS orphans, multiproblem mandated clients, the incarcerated subject to lockdown in prolonged inhumane isolation, and MICAs (mentally ill chemical abusers). Meanwhile, there is tremendous diversity among those contemporary populations seen most recently within the community-based addiction treatment service delivery; this includes those using all substances, and of all races, ethnicities, and sexual orientations—including men who have sex with men.

### ***Achieving 10 Years Abstinent from Crack Addiction in Canada—In Her Own Voice***

Suggestive of the perspective on crack treatment advanced in this article, a woman in Canada writing a paper for an undergraduate course came across an earlier journal article also written by Wallace. The woman, Williams, was inspired to send an e-mail letter to Dr. Wallace, expressing gratitude that the journal article recognized the need for specialized care and longer term treatment for crack addicts. The e-mail exchange culminated in the article that appears by Williams (2014).

Williams (2014) delivers a powerful lifestory through her own voice—"The story of a woman who achieved over a decade of abstinence from crack cocaine and rose from the bottom: In her own voice." Williams' lifestory is especially compelling in

providing further evidence of the magnitude of the transformation (i.e. enhanced outlook on life, the repair of relationships, and an ability to make meaningful contributions to the well-being of others in the community) that occur as a result of the recovery process (Fullilove, 2014). Yet, here, we hear firsthand from Williams (2014) about her life after having achieved over a decade abstinent from crack, as well as her prior voice from “the bottom”—while a homeless crack addict living on the streets in Canada; since she shares a sample of her writing, we can all access “the looping voice” that ruled her existence during active crack addiction.

As evidence of the meaningful contributions she is making to the well-being of others, Williams (2014) shares how in recovery she has: “worked with the parents of addicts and it is heartbreaking to tell them that they may have to watch their child die. I have worked with addicts themselves and urged them to believe that anything is possible...I simply do what was done for me: I try to love them back to health by having no judgments and no agenda of my own other than creating the emotional space or the mind-shift that needs to happen to allow change to occur.”

Finally, Williams (2014) concludes this moving piece by sharing how her “hope for this letter is that somewhere in all that raw truth another soul will find hope, or another person in a place of power will realize their responsibility to keep an open mind and know that miracles can and do happen all the time—especially if nurtured by a system that promotes equality.”

To hear the story of someone who was addicted to crack, while *not* being an African American from an urban enclave in the United States, debunks stereotypes and myths, while enhancing understanding. The reality that the crack epidemic impacted diverse users globally also effectively emerges from the work of Williams (2014).

### ***Outpatient Treatment from 1995 to 2005: Lessons from War on Drug Policy***

Next, Kim, Barrett, Gilbert, Taylor, Godley and Howard (2014) provide the article “*Examining the crack epidemic and subsequent drug policy through identifying trends in outpatient substance abuse treatment for crack use/abuse: 1995 – 2005.*” Kim et al (2014) acknowledge the national and global attention paid to crack use/abuse, even though it has often been framed as an African American problem. They acknowledge the evidence showing African Americans have lower substance use/abuse compared to Caucasians, then go on to examine crack use among clients within large samples of outpatient substance abuse organizations—specifically in 1995 and 2005 data sets. Of note, only 16 percent of the outpatient units had clients that were African American in 1995, while only 17 percent were African American in 2005. A limitation of the study was that there was a lack of racial representation in the sample of outpatient program units, necessitating caution in interpreting their results. Other findings included how dual diagnoses of substance abuse and mental illness were found to have increased from 1995 to 2005, and the representation of clients over age 40 in treatment also increased by 2005.

Exploring bivariate associations with reported crack use, Kim et al (2014) found that higher rates of crack use were significantly associated with having a majority of African American clients in the unit, a higher percentage unemployed, and a higher percentage with dual diagnoses of substance abuse and mental illness. Significant findings with their multivariate logistic model showed that units with a majority of African American clients had a higher percentage unemployed, a higher percentage reporting multiple drug use, and clients more likely to have a higher level of crack use. Their findings were also consistent with national trends, given that over half of the clients in outpatient substance abuse settings had been referred by law enforcement; and, that significantly

higher levels of crack use were found in those programs with predominantly African American clients. Placing this finding in context, Kim et al (2014) note the role of legal policy and practice in the United States—specifically citing the Anti-Drug Abuse Act of 1986 in establishing national policy, the role of police engagement in racial and community profiling, and negative implications of these policies upon African Americans. The authors conclude by suggesting a need for continued examination of crack use/crack abuse trends, while there are lessons to be learned from the War on Drugs policy for healthcare policy and practice on a local and global scale.

***Crack, Policy, and Advocacy: Guiding Principles as Lessons from the War on Drugs***

Wallace (2014c) draws such lessons from the War on Drugs policy in the article “*Crack, policy, and advocacy: A case analysis illustrating the need to monitor emergent public health-related policy and engage in persistent evidence-based advocacy.*” Here, the article analyzes the quarter century of drug policy that began with the Anti-Drug Abuse Act of 1986, while ending with the Fair Sentencing Act of 2010. The analysis illustrates the importance of those working in public health engaging in both the monitoring of emergent health-related policy and persistent evidence-based advocacy in order to reverse and replace flawed or unjust policy. The analysis covers the importance of paying attention to policy, relevant public health questions, and some illustrative answers when analyzing the Anti-Drug Abuse Act of 1986.

Wallace (2014c) also analyzes the social context surrounding passage of the 1986 Act that introduced the controversial 100-to-1 drug quantity ratio. Also analyzed is the Anti-Drug Abuse Act of 1988—which added insult to the prior injury embodied in the 1986 Act with additional mandatory minimum sentences. Next, examination covers the resultant racial disparities in sentencing, law enforcement, prosecution,

and cumulative racial disparities. Attention is paid to significant developments in the new millennium that highlighted the need for urgent change across the criminal justice system. Analysis then turns to the Fair Sentencing Act of 2010 that went into effect November 1, 2011—25 years after the 1986 Act, as well as the issue of retroactive application of the new sentencing guidelines and the risk of ongoing injustice.

Focus is placed upon the thousands of incarcerated mostly Black males waiting for justice, as evidence of ongoing national impact from the crack epidemic and racial disparities in sentencing. By way of example, discussion covers the 2013 case of the *United States v. Blewett* and retroactive application of the Fair Sentencing Act of 2010.

In drawing lessons from the War on Drugs, Wallace (2014c) provides guiding principles. The guiding principles cover the importance of workers in public and community health paying attention to the policy arising in response to a public health crisis; specifically, they need to monitor policy, advocate for the reversal or replacement of unjust policy, and collaborate in proposing evidence-based policy that reflects knowledge transfer.

***Community Trauma: Promoting Recovery Through the Assets-Based and Strength-Based Approaches***

As one reviewer of the special theme issue asserted, we may have saved the best for last, or one of the best: i.e., the article by Quimby (2014), “*Promoting community recovery from crack cocaine.*” Given all that has been presented in the prior articles in the special theme issue, a logical question arises: “What has been the impact upon communities as a whole?” According to Quimby (2014), the answer is community trauma with a resultant need to pursue healing and recovery. The article covers the consequences of criminalizing crack cocaine use, instead of addressing it as a public health issue. Also stressed is the role of national policy in aggravating social

situations, eroding community relations, and fundamentally altering material conditions in neighborhoods. At the same time, there was an alliance of corporate-governmental policy that made those neighborhoods ready for the arrival of others: i.e. gentrification—with additional traumatic impact. The aftermath may be seen in traumatized urban communities with political economies and social structures that are now struggling for a recovery that is rooted in social justice, healing, holistic primary care, behavioral health and wellness.

Quimby (2014) also indicates that, fortunately, there has been evidence of longtime community residents displaying positive attributes of independence, entrepreneurship, imagination and creativity. The article also emphasizes how communities must participate in policy discourse, while taking an assets-based approach of mobilization of existing resources, as well as a strength-based approach—including research that can assist with community development that is equitable. He uses an example of qualitative community-based participatory research and a traumatized Washington, D.C. community.

Finally, Quimby (2013) demonstrates how the integration of classroom and applied learning occurred for his students (i.e., learning and service by researching, and researching by learning and servicing). Students thereby helped neighborhood-based individuals, groups and institutions document their history and assets. The results included positive portrayals of community restoration, while demonstrating how a community can develop and protect itself from gentrification; a key role involves understanding local history, promoting progressive relationships, and building on community strengths.

The result of the article is a compelling answer to the critical question, “What does community recovery look like?” Overall, the answer provides hope for devastated communities across the United States.

## Conclusion

As with any compelling story about a major event that left an indelible impact upon the historical record of an entire nation and world, the details and moral of the story may vary tremendously, depending upon the storyteller. Such is the case with the crack cocaine epidemic of the late twentieth century, and ongoing reverberations into the new millennium. The 30<sup>th</sup> anniversary of the dawning of the crack cocaine epidemic represents an opportune time for acknowledging and giving voice to varying perspectives on what transpired within the epidemic, and on the nature of the repercussions.

Thus, this special 2014 theme issue of the *Journal of Equity in Health* will present a multitude of varying perspectives on the crack cocaine epidemic, hopefully benefitting from the vantage point of time. Regardless of the particular perspective or viewpoint reviewed, and the divergent manner in which the crack cocaine epidemic was perceived, analyzed, or interpreted, consensus may be found on a major point: in a review of the significant events of the twentieth century that forever changed the course of a multitude of human being’s lives, as well as that of entire families, neighborhoods, communities, institutional systems, societies, and nations, the crack cocaine epidemic stands out as a major occurrence. It may be contended that crack cocaine is among the most significant of events to impact the course of urban, national, and global history in the twentieth century. Moreover, the magnitude of the crack cocaine epidemic, as a significant event, continues to reverberate into the twenty-first century.

By way of example, enduring inequities in health are associated with the crack cocaine epidemic, justifying the focus of this special issue of the *Journal of Equity in Health*. The theme issue’s release is consistent with the goal of seeking to spur a global twenty-first century civil rights movement for equity in health for all (Wallace, 2008a). This includes shifting the



health disparities discourse to a global focus on healthy equity, and training global leaders for this movement. As part of this ongoing training, it is important to engage in an in-depth analysis of the kind to be stimulated by the articles in this special theme issue. The wide-ranging impact of the crack cocaine epidemic that began over a quarter of a century ago can serve a practical purpose in the requisite discourse and training mission.

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