

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

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Abstract

The 30th year anniversary of the crack epidemic that dawned in 1984 provides opportunity for analysis of how the epidemic spurred evolution in community-based addiction treatment. The author's professional time-line of psychological consultation work "in the trenches" of the War on Drugs is used for marking 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. Eight objectives recommended to guide education and training seek to prepare a diverse workforce for engagement in collaborative advocacy. A case example from the author's professional time-line demonstrates engagement in collaborative advocacy. Conclusions emphasize how the professional time-line effectively illustrated: (1) how the crack epidemic stimulated systematic evolution in community-based addiction treatment; (2) how the War on Drugs policy wrought devastation and trauma upon adults, infants, children, families and entire communities; and, (3) 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—i.e., 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). These vulnerable special populations may never have come into being—if not for the toxic combination of the crack epidemic and War on Drugs police, while they stand as a lasting legacy to their combined impact. Meanwhile, other contemporary diverse populations also entering treatment include sexual orientation minorities, and men who have sex with men. The imperative of training in competence with multicultural populations also represents evolution.

Keywords: treatment, crack cocaine dependence, HIV/AIDS, co-occurring disorders, policy

It is appropriate to analyze the manner in which the crack cocaine epidemic stimulated evolution in community-based addiction treatment, since the dawning of the epidemic in the United States thirty years ago. A professional time-line of my psychological consultation work in the trenches of the War on Drugs within a variety of settings can permit marking major developments in the evolution of community-based addiction treatment driven by the crack epidemic.

Early on in the crack epidemic, and as the epidemic persisted, there was a large body of research providing evidence on the viability of community-based addiction treatment, in general (Stitzer & McCaul, 1987; De Leon, 1988; Watson et al, 1988; Wells-Parker, 1994; NIDA, 1999; Leukefeld, et al, 2002; Hiller et al, 2002). Also rather

early in the crack epidemic, my professional work prompted a publication that specifically made available a viable crack treatment model (e.g. Wallace, 1987). Not long into the crack epidemic, an expanded model featuring relapse prevention tailored for the crack cocaine dependent (Wallace, 1989a; 1989b; 1990c; 1992e; 1992f) was made available; and, soon, thereafter, several comprehensive treatment

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approaches emerged (Wallace, 1991a; 1991b; Rawson, 1990; Washton, 1989).

If the tenets of knowledge translation had been followed, the body of evidence on “what works” in drug treatment would have been used to establish a national policy emphasizing community-based addiction treatment as an alternative to incarceration for drug offenders (Wallace, 2012). The use of knowledge translation to establish a national policy of community-based addiction treatment as an alternative to incarceration necessitates advocacy, as social action for social justice.

Given this background, this paper will: (1) use the author’s professional time-line of psychological consultation work to mark major developments in the evolution of community-based addiction treatment driven by the crack epidemic; (2) put out a call for social action for social justice so that advocacy results in the policy of the War on Drugs ending and being replaced with the policy of community-based addiction treatment as an alternative to incarceration; (3) recommend objectives for the education and training of professionals so they are prepared to engage in collaborative advocacy alongside community members—and, specifically, advocate for the end of the policy of the War on Drugs; and, (4) provide a case example of engagement in collaborative advocacy within New York State to repeal the 1970s era Rockefeller Drug Laws that drove the War on Drugs policy on the state level, while paralleling the War on Drugs policy nation-wide rooted in the Anti-Drug Abuse Acts of 1986 and 1988.

PART I - The Crack Epidemic as Driving Evolution in Community-Based Addiction Treatment

I-A-Overview of the Professional Time-Line

1984. At the dawning of the crack cocaine epidemic in 1984, the sociologist, Dr. Bruce Johnson, engaged in the timely launch of the Behavioral Science Training Program in Drug Abuse Research within

NDRI: i.e.—Narcotic and Drug Research, Inc. back then; and, now, the National Development and Research Institutes in New York City. The program was funded by the National Institute on Drug Abuse (NIDA) of the National Institutes of Health (NIH). Success in funding was partly linked to the dawning of the crack epidemic which provided evidence of need; meanwhile, injection drug use had long been helping to spur the HIV/AIDS epidemic.

1985. After defending a doctoral dissertation in clinical psychology in early September 1985, I began post-doctoral fellowship training at NDRI. Thirty years later, Dr. Johnson’s program is known as the largest substance abuse focused post-doctoral training program in the United States. Under the leadership of Dr. Johnson, weekly seminars were shared with fellows in my cohort who engaged in post-doctoral work stimulated by the crack epidemic. For example, the ethnographer, Dr. Terry Williams, became known for his observations of drug dealing, compulsive drug taking, and sexual behavior in crackhouses (Williams, 1990; 1992). The sociologist, Dr. Edmundo Morales, published seminal work on coca production within the Andean economy of Peru (Morales, 1989). And, as a clinical psychologist, my work addressed crack cocaine dependence treatment within varied settings (Wallace, 1987; 1989a; 1989b; 1990a; 1991a; 1991b).

1986. By June of 1986, I became Staff Psychologist on a new specialized crack cocaine treatment unit located at Interfaith Medical Center in Brooklyn, New York. The specialized crack cocaine inpatient detoxification unit represented an effort on the part of Julio Martinez, Director of the New York State Division of Substance Abuse Services, to respond to the epidemic. Mr. Martinez was present on October 8, 1986 to dedicate the new specialized crack cocaine unit. The unit was a pioneering treatment initiative, as the first of its kind in the New York metropolitan area, and perhaps the nation.

The post-doctoral fellowship training at NDRI allowed me to bring a research orientation to my employment; coupled with my training as a clinical psychologist, I began to codify my “front-line, in the trenches” treatment delivery experiences on the specialized crack unit. On weekends, I travelled the few blocks in Harlem from my home to the state office building where NDRI had their headquarters at that time. This included regularly crossing paths with Dr. Don Des Jarlais who was also compulsively working on the old Wang computer system at NDRI, while focused on the HIV/AIDS epidemic.

1987. By 1987 I published a description of my initial findings and emergent treatment model. This was a model tailored to the new population of the crack cocaine dependent (Wallace, 1987).

1988. In September of 1988, there was a new opportunity on a tenure track line within the City University of New York. Academia permitted more time to write and publish. This permitted documenting my experiences, having personally treated over 300 crack cocaine dependent patients (i.e., in initial assessment sessions, individual therapy sessions, group therapy), while working with another 200 in co-led group therapy sessions and community meetings.

Academia also permitted time to consult as a “trainer of trainers,” including the training of staff at other treatment facilities in New York City.

1989. Publications followed on relapse, and a model of relapse prevention. Again, the model was specifically tailored for the crack cocaine dependent (Wallace, 1989a; 1989b; 1990c; 1992e; 1992f).

Across the spring of 1989, I was invited to provide a series of training sessions at the Smithers Alcoholism Treatment and Training Center in New York City. The goal was to assist them with modifying their treatment model in order to accommodate the growing number of crack cocaine dependent clients. This entailed presentation of the overall

emergent treatment model for the crack cocaine dependent I pioneered at Interfaith Medical Center. One of the staff members at Smithers concluded, “It sounds like a book.” That book would be forthcoming in 1991 (Wallace, 1991a).

1990. A colloquia presentation of my approach to crack cocaine treatment and related research findings led to my being hired at Teachers College, Columbia University, starting in September, 1990. There, my Friday psychological consultation permitted my work in the trenches to focus on the 1990s overlapping epidemics of crack/other drugs, HIV/AIDS, and violence. Indeed, I was commissioned to write a major paper for an organization that would guide their approach to contemporary service delivery—given that service delivery was now occurring in a 1990s “culture of violence.” In reviewing my report drafts, the organization pushed me to define this violence, and I provided what follows:

Violence is defined as delivering physical blows (with or without weaponry), displaying and misusing one’s power, or bombarding a person with destructive misinformation and myths so that, in effect, an assault occurs either on a person’s physical body or to the self-concept, identity, cognitions, affects, and consciousness of the victim of violence.

This definition was first published within a summation of my overall report to the agency (Wallace, 1993b). At present, this definition remains apropos in capturing the impact of the War on Drugs policy.

1991. The book—*Crack Cocaine: A Practical Treatment Approach for the Chemically Dependent*—was published in 1991 (Wallace, 1991a). G. Alan Marlatt described the book as “innovative and refreshing,” as well as the “best book on treating crack addiction currently available.”

The book (Wallace, 1991a) presented an analysis of psychosocial data, data on relapse

episodes, a model for relapse prevention, and an, overall, comprehensive and intensive model of treatment, emphasizing a continuum of care. The goal of the book was to provide a resource for those who needed to “design, implement, and evaluate treatment programs for crack smokers” (Wallace, 1991a, p. xi). This resource (Wallace, 1991a) also emphasized the importance of conducting clinical interviews in order to obtain detailed assessment data across time, enhance client motivation (i.e. what is now called motivational interviewing), and use findings to match clients to interventions of appropriate intensity (i.e. what is now called a stepped-care approach). The book laid the foundation for my training professionals not only regionally, but also nationally and internationally—for example, in varied states such as Connecticut, California, Washington, and Texas, and in the countries of Peru, Canada, and Jamaica.

1992-1996. My Friday consultation work took me to varied types of treatment settings, allowing me to codify what was going on in the trenches. The reality of overlapping epidemics of crack/other drug use, HIV/AIDS, violence—as well as the reality of special vulnerable populations, dysfunctional family dynamics, and need for community-wide mental health promotion prevailed (Wallace, 1992b; 1993a; 1996).

1997-2005. A subsequent focus, as I moved into the new millennium, covered the crisis of mass incarceration of crack drug offenders. Within the trenches, I was witness to their massive return back into the community post-incarceration for receipt of mandated treatment (Wallace, 2005).

2006-2014. There was then a focus on pressing ethical issues within community-based addiction treatment, including the ethical dilemmas inherent in mass incarceration and the War on Drug policy (Wallace, 2006a; 2006b). Attention was given to the overlapping epidemics of crack/other drug use, HIV/AIDS, and

violence—and their consequences for public and community health; these were examined within the framework of health disparities (Wallace, 2008), and for resultant trauma (Wallace, Connors, Dass-Brailsford, 2011). An additional focus has been upon the need to replace the War on Drugs policy with evidence-based approaches reflecting knowledge transfer (Wallace, 2012). Finally, an emphasis on knowledge transfer and implications for ending the War on Drugs policy became a focus of training within the Annual Health Disparities Conference at Teachers College, Columbia University (2006-2009; revived in 2013 to present).

I-B-The Career Time-Line as Marking Evolution in Treatment Driven by the Crack Epidemic

The professional time-line summarized, above, may be further deconstructed and elaborated upon in this section. This review and analysis, specifically, focuses upon how the crack epidemic served to drive evolution in community-based addiction treatment. My psychological consultation work in the trenches of the War on Drugs from 1986 to 2010 permitted my playing a role in helping to pioneer treatment advances driven by the crack epidemic. Thus, my professional time-line permits marking major developments in the evolution of community-based addiction treatment.

1986–Crack Epidemic as Impetus for Rapid Evolution. From the very beginning, the crack epidemic provided a powerful stimulus for rapid evolution of community-based addiction treatment. Indeed, “the cocaine and crack epidemic of the 1980s provided the relatively nascent field of addiction treatment with an impetus to change and substantially evolve for the first time since the heroin epidemic of the 1960s” (Wallace, 1992a, p. 5). This was reflected in the innovation of the specialized crack cocaine treatment unit I helped to launch in October 1986 at Interfaith Medical Center—one exclusively devoted to the crack cocaine dependent. Yet, all programs (e.g. Smithers

Alcoholism Treatment and Training Center in New York City) had to evolve to meet the varied needs of the crack dependent; this followed from how client demographics shifted to include more adolescents, more young adults, more women, and more African Americans and Latinos—who could now afford the ready-to-smoke innovation of low-cost crack in a vial.

The requisite evolution also included major transformations in outpatient treatment (e.g. Washton, 1989; Rawson, 1990). Those with private insurance and those referred from employee-assistance programs—including those in upper management to those on the assembly line—began to access new state-of-the art treatment programs created for the new burgeoning population of cocaine and crack users (Rawson, 1990; Washton, 1989). However, the affordability of the packaging breakthrough of ready-to-smoke crack in \$3, \$5, \$10, and \$20 vials meant that those without private insurance, and those who lost their jobs because of their addiction, also entered treatment systems; for example, those with Medicaid and those Medicaid eligible were treated alongside those with private insurance (Wallace, 1991a).

1992—A Broad Focus on Chemical Dependence and Evolution across Varied Treatment Settings. Seven years (Wallace, 1992b) after the onset of the full-fledged crack epidemic in 1986, more evidence had accumulated that the epidemic had constituted a substantial challenge to traditional alcohol- and drug- treatment program models in existence in the 1980s. The epidemic left to fundamental alterations to the 28- and 30-day inpatient rehabilitation program models, to those shorter inpatient detoxification program models, and to longer-term residential therapeutic community (TC) models. Treatment programs had to initiate changes in order to meet the needs of the crack cocaine dependent patient population (Wallace, 1992a).

1992—Emphasis on the Broad Category of the Chemically Dependent. Also by 1992 (Wallace, 1992a), the 1990s growth in methamphetamine use, particularly, on the West coast was emerging as an epidemic. There was also the AIDS epidemic that encompassed intravenous cocaine and heroin users. In addition to the crack cocaine dependent, these other groups of drug dependent clients necessitated a broader focus. Thus, the term chemical dependency treatment was advanced as a generic or umbrella term to encompass the variety of chemicals being used—whether alcohol, heroin, or marijuana, in addition to crack and cocaine (Wallace, 1992a). Yet, the main stimulus for growth in the field of chemical dependence remained the ongoing crack cocaine epidemic.

1992—Phases of Treatment and Recovery to Guide Evolution. Work with colleagues sought to provide “the foundation of knowledge necessary to facilitate the continuing evolution of the field of chemical dependency” along with “sound, integrated theory to guide clinical practice and research” (Wallace, 1992a, p. 7). More specifically, this work (Wallace, 1992b) contributed a core evolutionary concept in 1992: *phases of treatment and recovery*. The concept of phases of treatment and recovery was advanced as a “critical concept that should guide the evolution and refinement of the field of chemical dependency” (Wallace, 1992a, p.9); the concept was recognized by clinicians from various perspectives (i.e. psychodynamic, cognitive-behavioral, and, physiological), as well as diverse practitioners and researchers. The concept of phases of treatment and recovery constituted a major advance rooted in

...conviction that specific kinds of clinical interventions derive the rationale for their implementation depending on the phase of recovery a client is in. Phases of treatment in which certain interventions are delivered thereby correspond to the phase of recovery a client currently

negotiates. The phase of recovery is defined in terms of the specific amount of time since the last use of a chemical substance. (Wallace, 1992a, p. 8)

What also followed from the concept of phases of treatment and recovery was the core recommendation to execute “thoughtful client-to-treatment” and client-to-intervention” matching strategies;” these were based on “thorough individualized assessments of clients” that occurred within each phase of treatment and recovery. The resultant findings guided placements in treatments of appropriate intensity—which varied within each phase of treatment and recovery, given the assessment findings. The treatment options that varied in intensity included, for example, twelve-step groups, inpatient, outpatient, or long-term residential therapeutic community treatment (Wallace, 1992a, p. 10). Central, also, were the concepts of a biopsychosocial approach rooted in integrated theory acknowledging the value of biological, psychological, and social-environmentally based interventions; and, also key was an emphasis on relapse prevention. This included relapse prevention occurring in every phase of treatment and recovery, being designed for the high risk situations and challenges specific to those phases (p. 11).

Reflecting the importance of this contribution to the field of chemical dependence treatment, I was honored with an invitation from Dr. Edward Khantzian to present on the topic of *"Treatment Guidelines across Phases of Recovery"* (Wallace, 1996b). This address was delivered within the Annual Addiction Symposium sponsored by Cambridge Hospital/Harvard Medical School.

1990 to 1992—Trauma of Women as Stimulus to Evolution in Drug Treatment. The extensive and overwhelming trauma among women and mothers caught up in the crack cocaine epidemic became a great stimulus to evolution in treatment methods deployed in community-based addiction

treatment (Wallace, 1992c). For example, a residential therapeutic community (TC) Program Director observed that female counselors in recovery felt challenged. Many shared in common with their clients histories of trauma in the drug culture.

The Program Director invited me to design and implement a treatment model, specifically, to address the characteristics and needs of their female clients, while providing staff training. What was launched in the early 1990s was an original once-a-week (Friday) intensive three hour group model of trauma resolution (Wallace, 1992c). The group model was tailored to respond to what was most compelling at the height of the crack cocaine epidemic: the extent to which women kept relapsing after inpatient detoxifications and within outpatient treatment. They were so severely traumatized, addicted, debilitated, depressed, and relapse-prone that they necessitated long-term residential TC treatment (i.e. 15 to 18 months). Relapse and poor treatment outcomes were related to the following: high rates of childhood molestation, incest, and various forms of abuse (sexual, physical, emotional); frequent experiences of adolescent and adult rapes in the crack culture; common experiences of battering and domestic violence in relationships; depression from the typical experience of loss of child custody (often of an infant, plus more than one child); and, instability from the loss of housing and extended family social support. So many of them had “nothing” and “no place to go”—other than the option of returning to the exchange of sex for drugs, food, and housing; this meant relapsing to compulsive crack smoking to survive (Wallace, 1993a; 1995; 1996a; 2002). Breaking this trap, they were in the TC and willing to work in group.

Common among the women were problems with self-regulation of self-esteem, affects, impulses, interpersonal behavior and self-care, along with deficits in coping in real-world environments (Wallace, 1996a; 2002). Their interpersonal relationships reflected a tendency to re-enact past traumatic relationship dynamics (Wallace,

1992c; 1996a; 2002). Quite simply, trauma abounded, creating a complex treatment challenge and high risk of relapse. Also, the group was open to any woman in the TC on a Friday afternoon. Thus, on some days there were as many as 32 women in the circle.

The success of the group model of trauma resolution implemented in the TC is reflected in specific outcomes. For example, women who participated long-term in the group model of trauma resolution successfully graduated from the residential therapeutic community at rates not witnessed before implementation of the group. Women treated within the group became empowered to the point that they began to serve as co-facilitators of the therapeutic process, while learning how to provide social and emotional support to each other within the larger TC setting. The group model played a key role in a cohort of women who were treated in the early 1990s achieving sustained abstinence from crack. Thereafter, a few of the women were also seen in my private practice in Manhattan; this included participation in a small group where their experience with the group model of trauma resolution allowed them to provide a powerful role model for how to process trauma. What had been pioneered as an evolution in community-based addiction treatment within the group model of trauma resolution found application within my private practice, improving outcomes with women who had suffered much less severe trauma (Wallace, 2002).

Some of the women who participated in the original group model of trauma resolution launched in the TC are now connected through Facebook. A few reach out to me on occasion, permitting documentation of how they have achieved over 23 years abstinent from crack cocaine.

1996—Codified Training for Community Mental Health Promotion and Breaking Cycles of Family Dysfunction. Eventually, I thoroughly codified the group therapy model of trauma resolution pioneered in the trenches (1990 to 1992) at the height of the crack epidemic (Wallace, 1996a). The model appeared within a larger

training manual for professionals and community members. This work (Wallace, 1996a) responded to the reality that the crack epidemic was very much a tale about how generations of family dysfunction and trauma kept repeating (Wallace, 1990b; 1993a; 1996a).

For example, those who had been raised by alcoholic or heroin addicted parents, and had also been sexually abused as children, now witnessed a cycle: *they* were now the parents addicted to crack who were stunned by the uncanny occurrence of their own children being sexually abused—to their shock and dismay. Thus, the training manual (Wallace, 1996a) included a psycho-educational approach to teaching parenting skills to prevent generational cycles of family dysfunction from repeating.

The recommended approach also included models for the provision of primary, secondary and tertiary violence prevention within communities devastated by the crack epidemic. A major thrust was meeting the need for comprehensive prevention, intervention, and community mental health promotion in light of the devastation wrought upon communities from the crack epidemic and crisis of mass incarceration. There was a need to support healing and the family reunification process that followed from the crisis of family dissolution—whether related to experiences of the loss of child custody or parental separation during mass incarceration (Wallace, 1996a).

1996—The Overlapping Epidemics of Crack and Other Drugs, HIV/AIDS, and Violence. The recommended approach (Wallace, 1996a) involved acknowledgment of the mid-1990s reality of the appropriateness of expanding the treatment discourse to include reference to a more generic ongoing drug epidemic, given a rise in heroin use as well as marijuana use. There was the reality of the increasing availability of a purer heroin being used intra-nasally (i.e. snorting) or smoked, and ongoing risks for injection drug use. There was also the reality of a maturing generation that grew up witnessing crack cocaine addiction ravaging their

parents and communities who vowed never to use crack, but were vulnerable to the growing use of marijuana.

In addition, there were rising rates of gun-violence that were attendant to ongoing crack cocaine distribution operations, helping to drive the epidemic of black-on-black homicide. Thus, the inclusion of models of violence prevention and intervention was essential (Wallace, 1996a).

Furthermore, the mid-1990s reality included diverse families and communities losing members to AIDS, especially in the pre-Crixivan era; this was before first-generation protease inhibitors transformed HIV care and prolonged life. Those losing their lives to AIDS during this period included: those who had injected drugs and those on methadone maintenance—while all had succumbed to crack use; and, those who had become HIV positive through high risk sex and sex-for-crack exchanges.

Thus, there was acknowledgement of the appropriateness of focusing on the overlapping epidemics of crack/other drugs, HIV/AIDS, and violence by the mid-1990s (Wallace, 1992d; 1996a). The result (Wallace, 1996a) was a comprehensive approach to community mental health promotion, while seeking to break generational cycles of family dysfunction.

1995 to 1996—Diverse AIDS Patients, Women Who Had Exchanged Sex for Crack among the Dying, and AIDS Orphans. Especially illuminating was my work in the trenches as a psychological consultant to an end-stage AIDS unit located in a hospital in Manhattan for a year and a half (1995 – 1996). There, I witnessed how crack cocaine dependence was complicating the challenge of AIDS treatment (Wallace, 1996a). Until the availability of the first-generation HIV-protease inhibitor, Crixivan, in mid-1995, the reality of death from AIDS was a haunting specter. The painful scenario of patients dying from AIDS was further devastating vulnerable communities, while adding to family dysfunction and the number of AIDS orphans.

My role as a psychological consultant on the end-stage AIDS unit included Friday bed-side assessments, social and emotional support through the death and dying process, as well as the provision of group-based treatment to address crack and other drug dependence using movie clips. The diverse group of patients included the largely Hispanic and African American patients with histories of intravenous drug use, as well as the mostly White gay males who were part of the first wave of the AIDS epidemic. Among those dying from AIDS there were also the largely African American women who had contracted HIV during the exchange of sex for drugs within the crack culture. I was witness to every conceivable way of dying from AIDS while consulting on the unit.

Yet, the most emotionally challenging aspect of providing psychological services to those dying from AIDS involved hearing the stories of women who had been mothers. Their life stories shared certain elements: they had been addicted to crack cocaine; engaged in the exchange of sex for drugs; and had lost custody of more than one child. All too often they died on the end-stage AIDS unit without the presence of family.

1997—An Award Winning HIV/AIDS Education Resource for AIDS Orphans.

As I watched these women who were mothers die from AIDS, one after the other, I decided to codify their life stories for their children. I was moved to write a book designed to inform their children—i.e. AIDS orphans—about the lives of the mothers who had disappeared into the crack culture. Instead of the children merely feeling abandoned, hurt, and angry, I wanted to “tell them why” they had lost their mothers. Knowing “why” might promote understanding, empathy, and forgiveness. The resultant children’s book, *Let me tell you why: An educational learning tool about HIV/AIDS for children age 8 and above* (Wallace, 1997), explained the following: why mothers had been vulnerable to such severe crack addiction (i.e., histories of childhood sexual abuse); why they lost custody of their children; and, why they were

among those either living with or dying from HIV/AIDS. The book was written as poetry in rhyme within the tradition of Dr. Seuss, along with colorful pictures. The book won 3rd place in a 1997 New York State competition for new HIV/AIDS education materials. In this manner, the ongoing challenges associated with the crack epidemic well into the late 1990s served as a stimulus to the evolution of this resource.

1996-1998—Residential Therapeutic Community (TC) Methadone Maintenance Treatment Evolves. There was also the reality that crack cocaine use was highly prevalent among those on methadone maintenance, along with alcohol and other drug use. The debilitating impact of crack cocaine use, in particular, required additional treatment. This included my role as a psychological consultant to a program on the Lower East Side of New York City; and, assisting in the process of client stabilization on methadone in a protected residential TC setting, while they achieved abstinence from crack, alcohol, and other drugs. Breaking the cycle of relapse to crack was a challenge, in particular. For the diverse women in the residence, in particular, this included a focus on improving their overall self-regulation and coping skills—typically rooted in trauma.

1998 to 2004—Evolving the Model for Making Mandated Addiction Treatment Work. Those crack cocaine drug offenders incarcerated within the War on Drugs policy of mass incarceration began to return to their communities—constituting a massive influx. This followed from how parole typically mandated entrance into community-based addiction treatment post-incarceration. They were also being coerced into treatment from the criminal justice system via the courts and probation.

By the new millennium, community-based addiction treatment was aptly described as pre-dominantly mandated care (Wallace, 2005). McLellan (2003) emphasized how the management and disposition of such clients was the most

timely and relevant issue facing the field of addiction treatment. At the same time, the age of evidence-based practice had begun (Sammons, 2001). These developments drove further evolution in community-based addiction treatment. This observation was personally made from the vantage point of my Friday psychological consultation work in the trenches of an outpatient setting in Harlem in New York City across 1998 to 2004. The culminating result was a focus upon *Making Mandated Addiction Treatment Work* (Wallace, 2005), as described below:

...Quite simply, all that has been compiled through empirical research with regard to what works represents an important body of knowledge on evidence-based addiction-treatment interventions. However, what remains to be clearly articulated in the literature is how to adapt evidence-based addiction-treatment interventions and deliver multiple interventions within a unified model of care in the real world with contemporary multiproblem clients; this book seeks to move the field of addiction treatment toward a unified model and theory to guide treatment delivery. For, the real-world challenges inherent in working with varied clients who have idiosyncratic combinations of multiple problems, complex characteristics, and assorted needs requires a book that can serve as a practical guide in this important work. The massive influx of those being released from incarceration back into the community in the aftermath of the historically unprecedented use of mandatory minimum sentences and attainment in the United States of record numbers being incarcerated means that this work is of the highest importance. For, in the last decade of the twentieth century, the United States became the uncontested global leader in rates of imprisonment, relying on a policy of massive incarceration that

mandated lengthy prison terms. Today we face the aftermath: an ongoing process involving the massive return of the incarcerated back into communities across the nation... (pp. xi-xii)

Contemporary clients were described as multiproblem, given the following: the common presence of multiple problem behaviors (e.g. violent acting out rooted in trauma, engagement in high risk sex, use of multiple illicit substances); and, multiple mental disorders, such as Posttraumatic Stress Disorder—and crack dependence. The recommended approach to making mandated addiction treatment “work” (Wallace, 2005) involved practitioners selecting treatment interventions from a menu of seven evidence-based approaches and seven state-of-the-art practices. Next, practitioners were to integrate those treatments selected from the menu, tailoring treatment for individual clients in light of individualized assessment findings (Wallace, 2005). This reflected how both the National Institute on Drug Abuse and addiction experts (e.g., Moos, 2003) had reached an overlapping consensus with regard to those approaches having empirical evidence.

The menu of seven evidence-based options is presented, below, while the body of research and supporting references appear elsewhere (i.e. Wallace, 2005):

- 1-Special Focus on Building a Strong Therapeutic Alliance/Social Support Network (TASS)
- 2-Motivational Interviewing/Motivational Enhancement Therapy (MET)/Brief Interventions
- 3-Cognitive-Behavioral Therapy (CBT)/Relapse Prevention (RP)/Social Skills Training (SST)
- 4-Twelve-Step Facilitation (TSF)/Guidance Using Alcoholics and/or Narcotics Anonymous

5-Individual Drug Counseling (IDC) and/or Supportive-Expressive Psychotherapy (SEP)

6-Community Reinforcement Approach (CRA)/Vouchers: Contingency Management (CM)

7-The MATRIX Model—Or, a Day Treatment Approach or “IEC” Outpatient Model That Is “I” or Intensive (4-5 days per week), “E” or Extensive (6-12 months), and “C” or Comprehensive (i.e. integrating TASS, CBT/RP, IDC, Group Drug Counseling (GDC), drug testing, etc.).

The menu of seven state-of-the-art options is, below, while supporting research and references appear elsewhere (i.e., Wallace, 2005):

- 1-Integration of Motivational Interviewing and Stages of Change
- 2-Integration of Stages of Change and Phases of Treatment and Recovery
- 3-Integration of Harm Reduction, Moderation Approaches, and Abstinence Models
- 4-Integration of Psychoanalytic and Cognitive-Behavioral Theory and Technique
- 5-Acquisition of Affective, Behavioral, and Cognitive Coping Skills—Learning New “A,B,Cs”
- 6-Integration of Motivational Interviewing, Stages of Change, and Identity Development Theory for a Diverse Identity Involving Race, Sexual Orientation, and/or Disability
- 7-Incorporating Contemporary Trends in Psychology: Multiculturalism, Positive Psychology, the Strengths-Based Approach, and Optimistic Thinking/Learned Optimism

Critical to making mandated addiction treatment work (Wallace, 2005) was following the recommendations of Moos (2003). This involved exercising both *fidelity*

and *flexibility* when seeking to deploy evidence-based interventions (Moos, 2003), such as those on the menu. *Fidelity* required drawing upon core elements of the evidence-based approaches—as rooted in research typically conducted with homogenous samples in empirical trials of treatment interventions. Yet, with the heterogeneous populations in the real world of the outpatient setting, there was the requisite addition of *flexibility*—rooted in a practitioner’s longitudinal naturalistic observations; these observations made over time in the trenches constituted a valid source of data in tailoring treatment for diverse individual clients (Wallace, 2005).

The model included placing priority upon enhancing client *coping skills* in relation to specific tasks faced in the social context; for example, learning affective, behavioral, and cognitive coping strategies (i.e. new “A, B, Cs”) for navigating interpersonal relationships with parole/probation officers, judges, family, community members, and sponsors in Narcotics Anonymous and Alcoholics Anonymous (Wallace, 2005).

The overall model (Wallace, 2005) was also consistent with a body of research indicating advantages to treatment when mandated—including enhanced retention, better treatment attendance, reduced relapse, and better treatment outcomes (Stitzer & McCaul, 1987; De Leon, 1988; Watson et al, 1988; Wells-Parker, 1994; Leukefeld et al, 2002; Hiller et al, 2002; Marlowe, Glass et al, 2001; Donovan, 1998). Also, a body of research had supported the integrated approach that combined community-based addiction treatment with close criminal justice system supervision, including swift sanctions in response to compliance (Belenko, 1999; Knight, Simpson & Hiller, 1999; Gottfredson & Exum, 2002; Marlowe, 2003; Wexler, 2003; Belenko & Logan, 2003); and, drug courts (Marlowe, 2003).

Through psychological consultation work from 1998 to 2004, the emergent model of mandated addiction treatment (Wallace, 2005) represented substantial evolution driven by the crack epidemic. What evolved was fundamentally *a new unified model of*

care (Wallace, 2005). The unified model is consistent with what has been described as the future of drug treatment (Volkow, 2008): practitioners draw on the growing body of evidence-based treatments, select those deemed most appropriate for individual clients, while also combining, integrating, and sequencing these treatments; and, treatments address unique client strengths, needs, or circumstances—including special attention to concurrent addictions and co-occurring disorders (Volkow, 2008).

2005 to 2007—Providing Integrated Addiction and Mental Health Treatment as Evolution. My psychological consultation work across the years 2005 to 2007 involved focusing on the most difficult clients with multiple problem behaviors and multiple psychiatric diagnoses. Increasingly, among those being admitted to community-based addiction treatment, there were those in need of identification for matching to integrated addiction *and* mental health treatment (Wallace, 2005). Some of these clients that I identified were in an outpatient program in Harlem in New York City, while others were in a residential component.

Diagnoses of Bipolar Disorder were becoming surprising common-place, along with risks for violent acting out. One of the most common scenarios, follows: upon their incarceration they became abstinent from a combination of chemicals used to self-medicate; they provoked fights while incarcerated; they ended up locked-down in prolonged isolation as a very traumatic experience; they were assessed in prison/jail by a psychiatrist; and, typically, had their first experience with psychiatric medication.

Or, it was the incarceration experience, itself that led to new psychiatric conditions, or exacerbated those already present. Noteworthy is how lockdown occurs for as much as 23 or 24 hours a day during incarceration in contemporary super maximum units. This prolonged isolation in lockdown is associated with many negative consequences, as follows (Lowen & Isaacs, 2012): sensory deprivation; visual and auditory hallucinations; hypersensitivity to

noise; paranoia; uncontrollable feelings of rage and fear; massive distortions of time and perception; rates of prison-suicide as much as 60 percent higher than the national average; emerging deeply traumatized and socially disabled; being unable to meet tasks upon re-entry of obtaining housing and employment; and, subsequent high rates of recidivism. Thus, advocates have pushed for the abolishment of the use of lockdown in prolonged isolation within supermax units (Lowen & Isaacs, 2012).

The uncontrollable feelings of rage and fear, alone, could contribute to a diagnostic impression of Bipolar Disorder. Also, widespread trauma made diagnoses of Posttraumatic Stress Disorder common co-occurring diagnoses.

Clearly, community-based addiction treatment had to evolve to respond to the severe trauma and disability of those who had spent time in lockdown in prolonged isolation. Whether or not they had been adequately assessed in the prison setting, it was vital to screen all who had been incarcerated for trauma and psychiatric symptoms.

Once they were in community-based addiction treatment, assessments reliably revealed how they needed to begin or continue psychiatric treatment for purposes of stabilization. This was necessary, in order to reduce psychiatric symptoms, the risks of relapse to crack use, as well as violent acting out. A related goal was to ensure safety in the treatment setting for all the other clients and staff. Early assessments were vital to identify those in need of integrated addiction and mental health treatment.

2008 to 2010—Designing and Implementing a Mentally Ill Chemical Abuser (MICA) Track as Evolution. Eventually, the Coordinator of the outpatient component of this program located in Harlem saw the need for instituting a new specialized MICA Track (i.e. for Mentally Ill Chemical Abusers). Central to the new MICA Track was cost-effective treatment that I designed for provision within a Friday group setting (2008 to 2010): i.e., the *Mental Health and*

Spirituality Group. This group sought to meet the needs of a growing population of MICA clients being referred to the agency. In addition to the group, the new MICA Track included all the components of outpatient chemical dependence treatment, as well as the following, as needed: individual psychological assessments; individual psychotherapy; and, psychiatric evaluations with stabilization on psychiatric medication.

Common client profiles for those in the MICA track involved histories of the following: lengthy drug “careers” that included as many as two decades of crack cocaine dependence, in addition to alcohol and other drug use; early trauma (e.g. sexual abuse, physical abuse) and multiple trauma (e.g. rape, domestic violence; homelessness and living in shelters; violent acting out behavior (e.g. with police, correction’s officers, in public); and, periods of incarceration for both drug offenses and violent assaults. In sum, they were the clients who had been treatment failures within many prior treatment attempts. This was partly due to the severity of their trauma and mental disorders—as suggested by psychiatric hospitalizations. Yet, it is also likely that early on in their drug careers, they *did not* have access to sufficiently evolved integrated addiction and mental health treatment—such that it was the treatment system that *failed them*. Other client profiles were of young offenders who were caught up in marijuana use and were able to access integrated addiction and mental health treatment; they were mandated or coerced, yet were having their addiction, trauma, and mental disorders adequately addressed in the MICA Track.

There was also tremendous diversity within the MICA Track. This included not only racial and ethnic diversity, but also diversity in age; clients ranged from adolescents able to give consent to treatment, to young adults, as well as older adults. There was also sexual orientation diversity, as well as men who have sex with men (MSM). Creating an atmosphere of acceptance for all diversity became essential.

All were given health education on safer sex, learning to negotiate safer sex, learning

to disclose one's HIV status, and avoiding a relapse to lack of condom use—while condoms were freely distributed. Thus, relapse prevention in the group was broad, covering non-compliance, non-adherence to medication, relapse to crack/other drug use and alcohol, and relapse to non-condom use.

Within the new group, the most complex cases dominated. For example, a 44 year old African American woman diagnosed with the following: Schizophrenia, Paranoid Type; Bipolar Disorder, Not Otherwise Specified; Posttraumatic Stress Disorder, Chronic; Cocaine (Crack) Dependence; and Alcohol Dependence. She had experienced multiple trauma, as follows: early parental abandonment; separation from siblings; group homes; trauma and sexual abuse within group homes; rape in the crack culture; prolonged homelessness and living in shelters; and, numerous men battering her in domestic violence. She achieved over a year abstinent from all chemicals, as well as psychiatric medication adherence while in the group.

Given such complex cases, it was no surprise that they had been relapse prone and considered treatment failures in prior programs. They represented the most vulnerable clients who had been made even more so as a result of getting caught up in the crack epidemic; they were also the crack users who had the hardest time escaping crack use. Thus, they were the ones available two decades after the onset of crack use for entrance into my group in the MICA Track.

Clients learn practical coping skills within the group. A core group activity was linking together related events. For example, a 39 year old Hispanic male experienced the following while in the group: a relapse to psychiatric medication non-adherence, along with relapse to crack use; getting into an argument and physical fight on a crowded subway; being arrested for assault; and, temporarily disappearing from treatment until released from incarceration. Or, consider an example for a 44 year old White female of medication non-adherence followed by an argument with another resident in a shelter, followed by being

placed on restriction at the shelter and losing privileges.

Discussing and analyzing the negative consequences of a relapse to psychiatric medication non-adherence and/or drugs/alcohol, via the experience of one group member, permitted all group members learning from that experience; all could benefit and commit to maintaining medication adherence. The main goal was for clients to acquire and refine consequential thinking and problem solving so they could independently cope outside of the group. All members were routinely asked to share how they coped in the real world, receiving feedback to improve and refine coping skills.

Other important topics in the group included, for example: how to effectively communicate with their psychiatrist about their symptoms and responses to medication; strategies for achieving and maintaining psychiatric medication adherence and abstinence from drug/alcohol use; and, how to recognize the resultant cumulative benefits of these accomplishments. The benefits included: a reduction in psychiatric symptoms; greater stability in their lives; improved interpersonal relationships; reduced risks of violent acting out; reduced risk of relapse to drug/alcohol use; and, freedom from re-incarceration.

Involvement in Narcotics Anonymous and Alcoholics Anonymous was encouraged, along with obtaining sponsors; and, spiritual coping was also advanced. Many clients in the MICA Track also benefitted from my assistance in obtaining social security disability, given being genuinely disabled.

Those successfully engaged in the MICA Track often reflected the irony of a benefit to having had psychiatric symptoms recognized during incarceration; they were responded to with psychiatric treatment, and given mandates to both mental health and addiction treatment post-incarceration. Or, as discussed earlier (Lowen & Isaacs, 2012), it was also often the case that the trauma of unjust incarceration and the inhumane use of lockdown in prolonged isolation served to exacerbate any prior mental disorders, or provoke new ones.

Following either scenario, there was a resultant need for greater access post-incarceration to integrated community-based addiction and mental health treatment; hence, the MICA Track and Friday group therapy model I assisted in designing and implementing.

I-C-Summary Reflection on the Professional Time-Line

As can be seen from my professional time-line (1986 to 2010) as a consulting psychologist in the trenches during the War on Drugs, the crack cocaine epidemic stimulated enormous change and evolution in community-based addiction treatment. To the extent that the crack epidemic was responded to with the policy of the War on Drugs, that policy's stigmatization and criminalization of crack users also became a key co-factor in driving evolution in treatment. As with many epidemics, critical advances in treatment are driven by the epidemic—literally across decades. This has been illustrated, revealing how the crack epidemic drove evolution in community-based addiction treatment from 1986 to 2010 through the review of my professional time-line. What also emerged was how many negative and traumatic consequences may never have transpired in the lives of crack users if they had not been stigmatized and criminalized within the War on Drugs. Perhaps most striking was how numerous special vulnerable populations—within the larger population of crack users—were traumatized by the War on Drugs policy: i.e. women, mothers, infants/children separated from parents, HIV/AIDS patients, those who died from AIDS, AIDS orphans, multiproblem mandated clients, the incarcerated subject to prolonged lockdown in inhumane isolation, and MICAs (mentally ill chemical abusers).

PART II - A Call to Social Action for Social Justice—Advocacy to End the War on Drugs Policy

The review of my professional time-line has also made the case for ending the national policy of the War on Drugs for a variety of reasons (Wallace, 2012). This conclusion is overwhelming supported, as follows: the policy has led to the crisis of mass incarceration within the prison-industrial complex (Alexander, 2010; Drucker, 2006; Haney, 2006); it led to a host of attendant collateral consequences for those incarcerated, their children, their families, and communities (Chesney-Lind, 1995; Mauer & Chesney-Lind, 2002); it has contributed to health disparities and health epidemics (AIDS, 2010); it is expensive and wasteful (Drug Policy Alliance, 2011; AIDS, 2010); it has neglected research pointing toward what should prevail as evidence-based community-based addiction treatment that can “work” as an alternative to incarceration (Volkow, 2008; Wallace, 2005; McLellan, 2003; Marlowe, 2003); and, it fails to meet the desired standard of being a rational policy that arises from knowledge translation (Wallace, 2012).

It is vital, therefore, to put out a call for social action for social justice, and, specifically, engagement in advocacy (Wallace, 2008). This is necessary in order to end the policy of the War on Drugs.

Ideally, professionals and researchers engage in knowledge translation, as evidence is practically translated into policy. Yet, it has been asserted that politics and the misuse of power have prevented knowledge translation from occurring (Wallace, 2012). In response to this reality, the call for social action for social justice and advocacy for new policy emerges as essential. Education and training as preparation for engagement in advocacy is highly recommended.

PART III – The Eight Recommended Objectives for Education and Training in Collaborative Advocacy

Those working in addiction treatment, public health/community health, the scientific research community, as well as diverse community members may be targeted for exposure to training and education. The goal is to prepare them to engage in *collaborative advocacy*—which involves working in harmony within collaborations, partnerships, and coalitions while advocating for changes in policy and/or new policy; and, specifically, what is recommended in this context is advocacy toward ending the War on Drugs policy. In my role as an educator, what I am recommending can be incorporated as a core part of any contemporary education and training mission. The following eight objectives are recommended for incorporation in training and education:

- 1) expose the War on Drugs policy as fueling the AIDS epidemic, increasing violence, driving up crime rates, as well as serving to destabilize families, communities, and nations as a whole (AIDS, 2010)—while making the larger point that attention must always be paid to policy and any negative consequences
- 2) reveal the wide range of negative consequences that follow, specifically, from the War on Drugs policy, including the mass incarceration crisis, the failure to reduce drug use or drug supply, while leading to the violation of human rights through the disproportionate incarceration of African Americans and Hispanics (AIDS, 2010; Human Rights Watch, 2000; 2011)
- 3) emphasize the benefits in shifting financial resources away from the War on Drugs policy and mass incarceration of drug offenders toward the implementation and evaluation of evidence-based prevention, treatment, and harm reduction interventions (AIDS, 2010)
- 4) stress the imperative to improve public health by shifting polices so they emphasize health and safety, while being rooted in a scientific evidence-base—for example, as in understanding addiction is a medical condition and not a crime (AIDS, 2010)
- 5) promote the taking of social action for social justice to reverse and replace unjust policy via advocacy (Wallace, 2012)
- 6) foster the ability to collaborate with and work alongside community members so as to more effectively challenge the politics and mis-use of power sustaining inappropriate policy, including via practicum/fieldwork experiences and pro-bono volunteer work
- 7) encourage participation within a recommended movement to bring about equity in health for all—as a civil right (Wallace, 2008), while encouraging work to reduce and eliminate disparities in health that have arisen from and/or been exacerbated by inappropriate policy
- 8) promote shifts in values and attitudes consistent with a motivation to contribute to a recommended movement to bring a final end to all caste systems (Alexander, 2010) that result in racism, oppression, and discrimination

There is an anticipated outcome from meeting all of the eight recommended learning objectives. Education and training will prepare the workforce to effectively engage in collaborative advocacy with community members. In addition, in coming decades and across the present century, a positive impact from collaborative advocacy may be seen: i.e., rational policy that arises from knowledge translation will prevail.

PART IV - A Case Example of Engagement in Collaborative Advocacy within the “Drop the Rock” Campaign

2003 to 2006 Workshop Presentations as Collaborative Advocacy. Within my professional time-line there is also a case example of engagement in collaborative advocacy. Given that I was fully aware of the negative repercussions of the War on Drugs policy of mass incarceration and the success possible through the alternative to incarceration of community-based addiction treatment, I was extended an invitation by Rev. Kenneth L. Radcliffe in 2003. As a Deacon in the Archdiocese of New York, he asked me to participate in activities being sponsored by his *Isaiah Project and the Criminal “Just Us” Committee*; “Just US” is a reference to those largely poor and Black community members who are criminalized through the War on Drugs policy. The invitation was to participate in collaboration between the *Isaiah Project* and the “*Drop the Rock*” Coalition. The goal was to further propel the “Drop the Rock” Campaign that was gaining momentum at the time. Regarding context for the campaign, within New York State, the use of mandatory minimum sentences was rooted in the 1970s era Rockefeller Drug Laws. Governor Rockefeller had Presidential ambitions, wanting to be seen as tough-on-crime. He left the legacy of unjust drug penalties that served to disproportionately incarcerate African Americans and Hispanics in New York State within the War on Drugs. The Rockefeller Drug Laws were among the harshest in the nation for establishing mandatory minimum sentences. The 1970s laws were driving the War on Drugs policy in New York State—just as the Anti-Drug Abuse Acts of 1986 and 1988 were driving mandatory minimum sentences on the national level.

Deacon Radcliffe’s invitation led to my joining a team engaged in social action for social justice so as to repeal the unjust Rockefeller Drug laws (i.e., to “Drop the Rock”). The team conducted workshops to educate varied professionals, policymakers,

congregants, students, and community members about the need for all to advocate for repeal of the Rockefeller Drug Laws. This constituted a campaign of community-wide advocacy to repeal the old penal code.

As a team member, my contribution within the workshops involved a presentation entitled, “Understanding the Disease of Addiction in An Era of Evidence-Based Practice and the Biopsychosocial Approach.” My assignment was to demonstrate how community-based addiction treatment did, indeed, “work” as an evidence-based alternative to incarceration. As a member of a team, I engaged in *collaborative advocacy* alongside the following: several experts representing coalitions advocating for policy reforms to improve the New York State corrections system: an expert on institutionalized racism, as embodied in the penal code and racial-profiling in arrests; and, Deacon Radcliffe who summarized the rationale for his *Isaiah Project and the Criminal “Just Us” Committee*, and facilitated a panel presentation by members of his *Dream Makers*—i.e., adults in recovery who had been incarcerated and shared powerful stories about the benefits of treatment and the negative consequences of unjust incarceration.

My work with the team involved travel across New York City and State from 2003 to 2006, as we were actively engaged in collaborative advocacy via our workshop. While my schedule became prohibitive, other team members persisted without interruption in collaborative advocacy until positive results finally manifested in 2009. In 2009, under the leadership of Governor David Patterson, the Rockefeller Drug Laws were revised to remove mandatory minimum sentences, while judges could exercise discretion in sentencing offenders to shorter sentences, as well as to treatment.

**2006-2009 and 2013 to the Present—
Workforce Development and Training for Advocacy within an Annual Health Disparities Conference.** Once I launched the Annual Health Disparities Conference at Teachers College, Columbia University in

spring 2006, it became a setting for our workshop and presentations by our team members. The conference also provided an opportunity for other invited speakers to offer presentations on the War on Drugs each year of the conference (2006-2009; 2013 - present). This has included education and training as preparation for engagement in collaborative advocacy.

Such a conference focus is needed, despite partial victories, such as the New York State repeal of key aspects of the Rockefeller Drugs Laws. There is still an ongoing crisis from the War on Drugs policy. For example, the War on Drugs policy includes tactics of racial profiling and stop-and-frisk procedures—that were launched nation-wide in response to the crack epidemic; these tactics continue (Alexander, 2010; Drug Policy Alliance, 2011). The results include, for example, how over 50,000 were arrested in 2010 by New York City police for possession of small amounts of marijuana, while the vast majority targeted (84%) were young African American and Hispanic males (Drug Policy Alliance, 2011). There were over 600,000 unconstitutional arrests under the New York City racially biased policy of stop-question-frisk for marijuana possession; from 2004-2012 approximately 4.4 million such stops occurred—specifically violating the constitutional rights of Black and Hispanic New Yorkers (Goldstein, 2013). This supports the assertion that another consequence of the War on Drugs policy that escalated during the crack epidemic involved erosion of fundamental rights (Alexander, 2010). Thus, there remains a need for collaborative advocacy nation-wide in response to the ongoing policy of the War on Drugs.

Conclusion

The 30th year anniversary of the crack cocaine epidemic that dawned in 1984 provided opportunity for analysis of how the epidemic spurred considerable evolution in community-based addiction treatment. The outline of the author's professional career—as a doctoral-level trained clinical psy-

chologist, post-doctoral fellow in narcotic drug research, consulting staff psychologist in community-based addiction treatment settings, trainer of treatment staff, academic, and advocate—provided a time-line. The professional time-line effectively illustrated the following: (1) how the crack epidemic stimulated systematic evolution in community-based addiction treatment; (2) how the War on Drugs policy wrought devastation and trauma upon adults, infants, children, families and entire communities; and, (3) 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—i.e., 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).

Results of a Toxic Combination. These special vulnerable populations may never have come into being—if not for the toxic combination of the crack epidemic and War on Drugs policy. These populations stand as a lasting legacy to their combined impact.

Essential Skills in Multicultural Competence as Evolution. Meanwhile, together with the special vulnerable populations that were listed, above, there are other contemporary diverse populations also entering treatment; for example, sexual orientation minorities, men who have sex with men, and new immigrant arrivals. Skills in competence with multicultural populations are now absolutely essential within community-based addiction treatment; this follows from the presence of all of the diversity inherent in the variety of contemporary special vulnerable populations. This indicates, as well, how evolutionary forces have propelled advances in treatment and training for service delivery. There is now an imperative to prioritize training in multicultural competence, so all receive service delivery from providers possessing

not only the requisite cultural competence, but that which applies in work with *multiple* special vulnerable populations.

Service Delivery in a Culture of Violence. With regard to the special vulnerable populations that, specifically, arose from the combination of the crack epidemic and War on Drugs, there is a record of destruction and trauma that is embodied in the legacy of their lives; this reveals how, indeed, service delivery in the trenches of the War on Drugs occurred within a culture of violence (Wallace, 1993b). Not only was the toxic combination of the crack epidemic and the response to it of the War on Drugs devastating, but also a reflection of massive violence; this violence occurred through calculated assaults upon entire communities across the nation that occurred in the guise of “policy.” From the vantage point of service delivery in the trenches of the War on Drugs what was witnessed was not only painful carnage; but also how treatment evolved by necessity.

Collaborative Advocacy. In light of all that emerged from presentation of my professional time-line, the article put forth a call for social action for social justice and advocacy. Advocacy is needed since the policy of the War on Drugs still prevails—even though it has been declared a disastrous failure (Wallace, 2012; AIDS, 2010; Alexander, 2010, Human Rights Watch, 2000; 2011). Our collective societal future demands a process whereby knowledge translation results in a new national policy that arises from the evidence that community-based addiction treatment “works” as an alternative to incarceration (Wallace, 2012). The article included eight recommended learning objectives for preparing a host of professionals for the task of *collaborative advocacy*—with colleagues and community members. By way of a case example, my professional time-line included a description of my personal engagement in collaborative advocacy alongside colleagues and community members.

For those formerly uninterested in advocacy, hopefully what emerged from this article is an awareness of the necessity of training and preparation so that *collaborative advocacy* is valued and embraced. What is especially important is working alongside the very members of the community in need of urgent relief from unjust policy.

“Go to where the people in need are to be found....”. What is also recommended is the actual process of service delivery whereby one enters the trenches—as well as going “to where the people in need are to be found in their very own communities” (Wallace, 1996a, p. 15). This permits witnessing first-hand the carnage that makes an end to unjust policy a moral and ethical imperative; and, permits witnessing the adaptive strengths, resiliency, and survival strategies that are purely inspirational. The resultant vantage point also provides vital fuel for the long journey to end unjust policy.

References

- AIDS (2010). *The Vienna declaration: A global call to action for science-based drug policy. The official declaration of the XVIII International AIDS Conference, AIDS 2010*. Published June 28, 2010. Retrieved February 8, 2011 from http://www.aids2010.org/WebContent/File/Vienna_Declaration_Release_EMBARGOED_Until_28_June_2010.pdf.
- Alexander, M. (2010). *The new Jim Crow: Mass incarceration in the age of colorblindness*. New York: The New Press.
- Belenko, S. (1999). Research on drug courts: A critical review: 1999 update, *National Drug Court Institute Review*, 2 (2), 1-58
- Belenko, S., & Logan, T.K., (2003). Delivering more effective treatment to adolescents: Improving the juvenile drug court model, *Journal of Substance Abuse Treatment*, 25, 189-211
- Chesney-Lind, M. (1995). Rethinking women’s imprisonment: A critical examination of trends in female incarceration. In B.R. Price & N.J.

- Skoloff (Eds.). The criminal justice system and women. New York: McGraw-Hill. pp. 105-117.
- De Leon, G. (1988). Legal pressure in therapeutic communities. *Journal of Drug Issues*, 18, 625-640.
- Donovan, D.M. (1998). Continuing care: Promoting the maintenance of change, In W.R. Miller & N. Heather (Eds.). (1998). *Treating Addictive Behaviors*, Second Edition, Plenum Press: NY, NY, pp. 317-36
- Drucker E.M. (2006). Incarcerated people, In: Levy, B.S. & Sidel, V.W., eds. *Social injustice and public health*, New York, NY: Oxford University Press; 2006: 161-175
- Drug Policy Alliance (2011). *2010 NYC marijuana arrest numbers released: 50,383 New Yorkers arrested for possessing small amounts of marijuana*. Retrieved February 12, 2011 from <http://www.drugpolicy.org/news/2011/02/2010-nyc-marijuana-arrest-numbers-released-50383-new-yorkers-arrested-possessing-small->
- Goldstein, E. (2013). NYPD's Stop-and-frisk policy ruled unconstitutional. Drug Policy Alliance. Retrieved January 4, 2014 from <http://www.drugpolicy.org/blog/nypds-stop-and-frisk-policy-ruled-unconstitutional>
- Gottfredson, D.C. & Exum, M. L. (2002). The Baltimore city drug court: One-year results from a randomized study, *Journal of Research on Crime and Delinquency*, 39: 337-356
- Haney, C. (2006). *Reforming punishment: Psychological limits to the pains of imprisonment*. Washington, DC: American Psychological Association.
- Hiller, M.L., Knight, K., Rao, S.R., & Simpson, D.D. (2002). Assessing and evaluating mandated correctional substance-abuse treatment, pp 41-56, In C.J. Leukefeld, F. Tims, & D. Farabee (Eds.). (2002). *Treatment of drug offenders: Policies and issues*, NY: Springer Publishing Co.
- Human Rights Watch (2011). *World report: 2011, events of 2010*. New York, NY: Human Rights Watch. Retrieved December 4, 2011 from <http://www.hrw.org/sites/default/files/reports/wr2011.pdf>
- Human Rights Watch (2000). *Punishment and prejudice: Racial disparities in the war on drugs*. New York, NY: Human Rights Watch. Retrieved December 4, 2011 from <http://www.hrw.org/legacy/reports/2000/usa/>
- Knight, K., Simpson, D.D., & Hiller, M.L. (1999). Three-year reincarceration outcomes for in-prison therapeutic community treatment in Texas, *Prison Journal*, 70, (3): 337-351
- Leukefeld, C.G., Farabee, D., & Tims, F. (2002). Clinical and policy opportunities, pp 3-8, In C.G. Leukefeld, F. Tims, & D. Farabee (Eds.). *Treatment of drug offenders: Policies and issues*, NY: Springer Publishing Company.
- Lowen, M. & Isaacs, C. (2012). Lifetime lockdown: How isolation conditions impact prisoner reentry. Arizona: American Friends Service Committee. Retrieved January 4, 2014 from http://afsc.org/sites/afsc.civicactions.net/files/documents/AFSC-Lifetime-Lockdown-Report_0.pdf
- Marlowe, D. B. (2003). Integrating substance abuse treatment and criminal justice supervision, *Science & Practice Perspectives*, Vol 2, No. 1, 4-14
- Marlowe, D.B., Glass, D.J., Merikle, E.P., Festinger, D.S., DeMatteo, D.C., Marczyk, G.R., & Platt, J.J. (2001). Efficacy of coercion in substance abuse treatment, pp 208-227, In F. M. Tims, C.G. Leukefeld, & J.J. Platt (Eds.). (2001). *Relapse and recovery in addictions*, New Haven: Yale University Press.
- Mauer, M. & Chesney-Lind, M. (2002). Introduction, pp 1-12, In M. Mauer and M. Chesney-Lind (Eds.). *Invisible punishment: The collateral consequences of mass imprisonment*, New York: The New Press.
- McLellan, A.T. (2003). Crime and punishment and treatment: Latest findings in the treatment of drug-related offenders, *Journal of Substance Abuse Treatment*, Vol 25, 187-188
- Moos, R. (2003). Addictive disorders in context: Principles and puzzles of effective treatment and recovery. *Psychology of Addictive Behaviors*, 17(1), 3-12
- Morales, E. (1989). *Cocaine: White gold rush in Peru*. Arizona: University of Arizona Press.

- National Institute on Drug Abuse. (NIDA, 1999). *Principles of drug addiction treatment: A research-based guide*, U.S. Department of Health and Human Services, NIH Publication No. 99-4180, National Institute on Drug Abuse: Bethesda, MD.
- Rawson, R. (1990). Cut the crack: The policymaker's guide to cocaine treatment. *Policy Review*, 10—19.
- Sammons, M.T. (2001). Combined treatments for mental disorders: Clinical dilemmas, pp 11-32, In M.T. Sammons & N.B. Schmidt, *Combined treatments for mental disorders: A guide to psychological and pharmacological interventions*, Washington, D.C.: American Psychological Association.
- Stitzer, M.L., & McCaul, M.E. (1987). Criminal justice interventions with drug and alcohol abusers, In E.K. Morris & C.J. Braukmann (Eds.). *Behavioral approaches to crime and delinquency: A handbook of application, research, and concepts*. NY: Plenum.
- Volkow ND. A note from NIDA's Director: Toward individualized treatment for substance abuse. *Addiction Sci. & Prac.* 2010; 5,2. Accessed February 8, 2011 from <http://www.nida.nih.gov/PDF/ascp/vol5no2/DirectorIntro.pdf>.
- Wallace, B.C., (2012) Controversies in knowledge translation for community-based drug treatment: The need to end policies of the war on drugs and mass incarceration of drug offenders to achieve health equity. *Journal of Urban Health*, Vol 89, Issue 6, pp. 894-904; DOI: 10.1007/s11524-012-9697-3
- Wallace, B.C., Conner, L.C., Dass-Brailsford, P. (2011). Integrated trauma treatment in correctional health care and community-based treatment upon Re-Entry, *Journal of Correctional Health Care*, Volume 17, 3
- Wallace, B. C. (2008) *Toward equity in health: A new global approach to health disparities*, New York: Springer Publications.
- Wallace, B.C. (2006a). Ethical issues surrounding access to drug user counseling/treatment. In J. Kleinig & S. Einstein (Eds). *Ethical challenges for intervening in drug use: Policy, research and treatment issues*. Huntsville, TX: Office of International Criminal Justice (OICJ) Press.
- Wallace, B. C. (2006b) Listen to the voices of the modern day enslaved in the United States prison economy: Do you hear an ethical dilemma? In J. Kleinig & S. Einstein (Eds). *Ethical challenges for intervening in drug use: Policy, research and treatment issues*. Huntsville, TX: Office of International Criminal Justice (OICJ) Press.
- Wallace, B. C., (2005). *Making mandated addiction treatment work*, Lanhan, MD: Rowman & Littlefield Publishers.
- Wallace, B.C. (2002). The healing power of groups and the residential therapeutic community: The case of Ms. E: A study in success and mutual transformation. In A. Tatarsky. (Ed). *Harm reduction psychotherapy: A new treatment for drug and alcohol problems*. Northvale, NJ: Jason Aaronson Inc.
- Wallace, B. C. (1997) *Let me tell you why: An educational learning tool about HIV/AIDS for children age 8 and above*. New York, New York: Author.
- Wallace, B. C. (1996a). *Adult children of dysfunctional families: Prevention, intervention, and treatment for community mental health promotion*. Praeger: Westport, Connecticut.
- Wallace, B.C. (1996b). Treatment guidelines across phases of recovery, A paper presented at the Annual Addiction Symposium sponsored by Cambridge Hospital/Harvard Medical School, March 2, 1996. Boston, Mass.
- Wallace, B. C. (1995). Women and minorities in treatment, In A.M. Washton (Editor), *Psychotherapy and substance abuse: A practitioner's handbook*, Guilford Press: New York, New York.
- Wallace, B. C. (1993a). Drugs, alcohol, and the dysfunctional family: Male/Female differences, In Ronald R. Watson (Ed.), *Addictive behaviors in women*, The Humana Press Inc.: Clifton, New Jersey.
- Wallace, B. C. (1993b). Cross-cultural counseling with the chemically dependent: Preparing for service delivery within our culture of violence. *Journal of Psychoactive Drugs*, 24, No. 3, 9-20

- Wallace, B.C. (1992a). Treatment and recovery in an evolving field, In B.C. Wallace (Ed) (1992). *The chemically dependent: Phases of treatment and recovery*, New York: Brunner/Mazel.
- Wallace, B.C. (Ed.) (1992b). *The Chemically Dependent: Phases of Treatment and Recovery*, New York: Brunner/Mazel.
- Wallace, B.C. (1992c). The therapeutic community as a treatment modality and the role of the professional consultant: Spotlight on Damon House, In B.C. Wallace (Ed) (1992). *The chemically dependent: Phases of treatment and recovery*, New York: Brunner/Mazel.
- Wallace, B. C. (1992d). Treatment models for special groups: Criminal, pregnant, un-insured, adolescent, HIV positive, methadone-maintained, and homeless populations, In B. C. Wallace (Ed.), *The chemically dependent: Phases of treatment and recovery*, Brunner/Mazel Inc.: New York, New York.
- Wallace, B. C. (1992e). Relapse prevention for the cocaine and crack dependent: An essential treatment component. In Ronald R. Watson (Ed.), *Treatment of drug and alcohol abuse*, The Humana Press Inc.: Clifton, New Jersey.
- Wallace, B. C. (1992f). Treating crack cocaine dependence: The critical role of relapse prevention, *Journal of Psychoactive Drugs* (in Anthology Series I: Smokeable Drugs), 24, No 2, 213-222
- Wallace, B.C. (1991a). *Crack cocaine: A practical treatment approach for the chemically dependent*, New York: Brunner/Mazel.
- Wallace, B. C. (1991b). Crack cocaine: What constitutes state of the art treatment?, *Journal of Addictive Diseases*, 11 (2), 83-102.
- Wallace, B. C. (1990a). Crack addiction: Treatment and recovery issues, *Contemporary Drug Problems*, XVII, No. 1, Spring 1990, 79-119.
- Wallace, B. C. (1990b). Crack cocaine smokers as adult children of alcoholics: The dysfunctional family link. *Journal of Substance Abuse Treatment*, 7, No. 2., 89-100.
- Wallace, B. C. (1990c). Treating crack cocaine dependence: The critical role of relapse prevention, *Journal of Psychoactive Drugs*, 22, No 2, 149-158.
- Wallace, B. C. (1989a). Relapse prevention in psychoeducational groups for crack cocaine smokers, *Journal of Substance Abuse Treatment*, 6, No. 4, 229-239
- Wallace, B. C. (1989b). Psychological and environmental determinants of relapse in crack cocaine smokers, *Journal of Substance Abuse Treatment*, 6, No. 2, 95-106
- Wallace, B. C. (1987). Cocaine dependence treatment on an inpatient detoxification unit, *Journal of Substance Abuse Treatment*, 4, No 2., 85-92
- Washton, A. M. (1989). *Cocaine addiction: Treatment, recovery, and relapse prevention*. New York: W.W. Norton
- Watson, C.G., Brown, K., Tilleskjaer, C., Jacobs, L., & Lucel, J. (1988). The comparative recidivism rates of voluntary- and coerced-admission male alcoholics. *Journal of Clinical Psychology*, 44, 4, 573-581.
- Wells-Parker, E. (1994). Mandated treatment: Lessons from research with drinking and driving offenders, *Alcohol Health and Research World*, 18, 302-306.
- Williams, T. M. (1992). *Crackhouse: Notes from the end of the line*. New York, NY: Penguin Books
- Williams, T.M. (1990). *The Cocaine kids: The inside story of a teenage drug ring*. Mass: Da Capo Press.