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A Chronology of Crack Cocaine and the Nexus of Seven Repercussions that Reverberate from the Crack Epidemic into the New Millennium

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Abstract

Within a chronology of crack that spans from 1981 up to the present, this article will provide the rationale for selecting the year 1984 as signaling the dawning of the crack epidemic. Next, the article will provide a nexus of seven repercussions from the crack epidemic that reverberate into the new millennium, as follows: **(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.

Keywords: crack, epidemic, public health, HIV/AIDS, policy

Given that this 2014 special theme issue of the *Journal of Equity in Health* is devoted to acknowledging the 30th anniversary of the crack epidemic, there is value in providing a chronology of crack. In doing so, this article will provide the rationale for selecting the year 1984 as the dawning of the crack epidemic, while going on to trace major developments from the debut of crack in 1981 up to the present day. The chronology also sets the stage for presentation of an emergent analysis of all that has transpired. This analysis gives rise to the author's proposition of a nexus of seven repercussions that follow from the crack epidemic—while they reverberate into the new millennium.

The intent of the article is, as follows: (1) to provide important context for all that follows in the subsequent articles in the special theme issue: (2) to introduce through the nexus a framework for understanding the contemporary import and impact of the crack epidemic as it continues to the present day—and will have ongoing consequences; and, (3) to facilitate appreciation of the significance of the crack epidemic for containing a myriad of lessons for the purpose of advancing public and community health research, funding agendas, practice, theory, models, advocacy, and policy.

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Part I: A Chronology of Crack Cocaine

Rationale for Acknowledging a 30th Anniversary – 1984 - 2014

It was in 1984 that dozens of "rock" houses seemingly appeared overnight, selling a vial for $25, according to a former Los Angeles police captain (Cooper, 2002). It was also in 1984 that $10 crack vials appeared in Miami, as their sale spread more widely to poor neighborhoods, according to the head of the Miami Police Department's street narcotics unit (Cooper, 2002). Furthermore, it has been asserted that by 1984 crack cocaine laboratories were in operation across the nation (Beaver, 2010). Thus, in recognition of these transformative events, the United States experienced the dawning of the crack cocaine epidemic in the year 1984—some thirty years ago.

Crack Debut in 1981 in Los Angeles

However, earlier on, it had been reported that crack was first created in Los Angeles in 1981 and that six crack cocaine laboratories were uncovered in that year; thus, crack likely first became available in Los Angeles in 1981 (Beaver, 2010). Cooper (2002) reported that it was in early 1983 that the *Los Angeles Sentinel*—a South Central Los Angeles neighborhood community newspaper—reported the presence of "rock" houses as a problem, given the dealing of crack cocaine.

Crack Debut in 1983 in New York

Others indicated that crack became available in New York City by 1983 (Beaver, 2010). Consistent with this, it was in December 1983 that the director of a street research unit reported hearing in the Tremont section of the Bronx about the use of crack or "rock" cocaine, as a new drug being used in that area (Cooper, 2002).

The 1984 Dawning and 1985 Spread of Crack as an Epidemic

The Drug Abuse Warning Network (DAWN) of NIDA reported a 106% increase from 1984-1985 in cocaine-smoking related injuries for the nation (i.e. from 618 to 1,274)—which were believed to be largely attributable to the smoking of crack versus cocaine freebase (Cooper, 2002). For the year 1984, it was in June that NIDA began planning a cocaine prevention campaign using the national media (Cooper, 2002).

Facilitating the spread of crack use as an epidemic was both the new socio-cultural ritual of cocaine free-base smoking that provided a more potent euphoria and higher potential for addiction, and the debut of crack that was "ready to smoke" (Wallace, 1991). Crack's addictive potential involved how it is immediately and completely absorbed when smoked, as the most efficient way to deliver the drug to the brain, taking only 6 to 7 seconds; even an intravenous user of cocaine would be impressed with the much more rapid and intense effects from the smoking route, using crack (Wallace, 1991). Of note, these findings are not without controversy, as other research has reported that crack was no more "instantly addicting" than other drugs (Golub & Johnson, 1997, p. 11). Nonetheless, there has been consensus that there was marketing genius in prepackaging cocaine for the most efficient route of administration via small, firm chunks of crack that could be easily smoked (Wallace, 1991; Hamid, 1990). Further, crack did not require knowledge and skills on the part of the user regarding how to derive or "free" the cocaine alkaloid from the cocaine hydrochloride salt or powder form, while using baking soda or ammonia (Wallace, 1991; Hamid). Thus, crack was a packaging and marketing breakthrough, given that it came ready to smoke in relatively inexpensive vials of crack for as little as $20, $10, $5, or even $3 (Wallace, 1991).

Hamid (1990) described factors that contributed to the packaging and marketing breakthrough of selling ready-to-smoke

crack in affordable vials sold at such low prices—as a process that began in 1984 and started to spread as an epidemic in 1985. As an ethnographer, Hamid (1990) had daily contact with the Caribbean African population of Brooklyn, and then increasingly with African Americans and Hispanics engaged in drug use and/or drug distribution. He thereby witnessed the passage from: the era of predominant involvement in marijuana (mid-1960s to 1981); to the era of cocaine hydrochloride powder for sniffing/snorting (1981-1982); then cocaine hydrochloride powder for conversion to freebase for smoking (1982-1984); then to crack smoking (1984/1985 onward). Hamid (1990) was able to meet with prominent Brooklyn-based Rastafari who were part of the transition from marijuana to cocaine, as they became involved in the year 1984 in the use, importation, and distribution of cocaine hydrochloride powder.

Also, as a social worker and crack specialist at a social services agency in Harlem, Hamid (1990) collected observations at a time when there was a surge in treatment requests in 1984 for those who had become addicted to cocaine freebase smoking and crack cocaine. Those requesting treatment at the Harlem agency were largely African Americans, Hispanics, and Caribbean Africans—which was not surprising in a Harlem, New York location. Through a case example, Hamid (1990) described a common progression wherein the following occurred: former snorters of cocaine hydrochloride who had suffered nasal damage readily transitioned into smoking cocaine powder; some gained expertise in cooking up supplies of cocaine hydrochloride and turning it into freebase for smoking, providing this service for others; to support their addiction, some became actively involved in selling cooked up supplies of cocaine freebase; and, such cooking experts readily collaborated with young neighborhood-based entrepreneurs and formalized the packaging and marketing breakthrough of ready to smoke crack sold in affordable vials. Some of these collaborators received the cocaine hydrochloride powder for cooking up into crack from Rastafarian suppliers, and others from Cuban and Dominican suppliers (Hamid, 1990).

From 1983 to 1985 there was a doubling of crack use, especially among African Americans and Hispanics (Beaver, 2010, p. 2538). Yet, others stressed how crack was being used by those of all races, classes, and income levels, including affluent doctors, nurses, accountants, professors, Wall Street executives, and air traffic controllers (Wallace, 1991). By the year "1985, crack cocaine was available for use by diverse clientele in nearly every major city, particularly in predominantly African American and Hispanic neighborhoods" (Beaver, 2010, p. 2538).

In 1985, the February issue of *The U.S. Journal* declared a new epidemic in Los Angeles involving "rock" cocaine in Los Angeles, as the formerly rich White man's drug was spreading as a problem in Black neighborhoods (Cooper, 2002). In the fall of 1985, crack trafficking was identified in the Bronx and upper Manhattan in New York City; and, according to the Drug Enforcement Agency (DEA), it was in 1985 that crack became a serious problem in New York City (Cooper, 2002). As the first major print media acknowledgment, it was in November of 1985 that the first *New York Times* articles appeared on crack cocaine (i.e. November 17, 1985 and November 29, 1985); the first article mentioned three teenagers seeking treatment for use of a drug called crack, and the second mentioned crack being sold on the streets of New York City (Cooper, 2002). Thus, starting in 1985, the smoking of rock and crack became even more widespread across the nation (Wallace, 1991; Hamid, 1990).

The Media Campaign Focused on Crack Cocaine that Began in 1985

Alexander (2010) offered a compelling analysis, explaining how a focused media campaign was used to "justify" the War on Drugs that had been declared June 24, 1982 by President Reagan (Cooper, 2002). The

media campaign focused on "the emergence of crack cocaine in inner-city neighborhoods—communities devastated by deindustrialization and skyrocketing unemployment" (Alexander, 2010, p. 49). The media attention was intense, perhaps because crack use became visible among a "dangerous" group, reflecting "downward mobility to and increased visibility in ghettos and barrios;" in the process, crack spread to "poor populations already beset with a cornucopia of troubles" (Reinarman & Levine, 1997, p. 19).

According to Alexander's (2010) analysis, New York City became the epicenter of the media campaign—with hundreds of presentations given to the media by the local Drug Enforcement Agency Director, Robert Stutman, starting in October, 1985. According to Alexander (2010), the goal was to convince the politicians in Washington, D.C. that drugs were a veritable national issue, while focusing on crack cocaine. At the same time, the media campaign promoted racial stereotypes of African American women as "welfare queens" having "crack babies;" and, African American men were depicted as criminal "predators" and "gangbangers" in a "criminal subculture" (p. 51). In sum, literally "thousands" of new stories were generated by Stutman on the "crack crisis," effectively dominating local newspapers, national magazines (e.g. Time, Newsweek), newspapers (The Washington Post, New York Times), and radio (p. 51).

The media campaign even included erroneous reports that the June 1986 deaths of two national sports figures (i.e. Len Bias and Don Rogers) were caused by crack; they actually died of powder cocaine overdoses. The media "bonanza" continued into the year 1989 with claims of a crack epidemic involving a substance that was instantly addictive (Alexander, 2010, p. 51).

Cooper (2002) identified the year 1986 as the point by which crack cocaine use was viewed as having reached the level of an epidemic in New York City, partly due to the media frenzy. Major news outlets were declaring the crack epidemic by 1986 (Beaver, 2010). Being indicative of the extent to which crack cocaine had become a national issue, Cooper (2002) cited the fall of 1986 as the historical point in time when the 800-COCAINE National Hotline offered the estimate that one million people in the United States had used crack. It also was in 1986 that CBS broadcast a two hour special called *48 Hours on Crack Street.* "Media coverage undoubtedly accelerated political efforts to combat crack cocaine and cocaine usage" (Beaver, 2010, p. 2539).

1986-1992 Developments

Period of a National Drug Scare. The results of the intense media and political attention focused on crack constituted a period of antidrug extremism, or a drug scare (Reinarman & Levine, 1997). Drug scares have occurred before in the history of the United States. Such a period is characterized by placing blame for a variety of social problems on a chemical substance. Yet, the drug scare associated with crack cocaine stands out as unique, as Reinarman and Levine (1997) explained, below:

> …Drug scares typically link a scapegoated substance to a troubling subordinate group—working-class immigrants, racial or ethnic minorities, rebellious youth. The period from 1986 to 1992 was in many ways the most intense drug scare of the twentieth century. With few dissenting voices, politicians and the media embraced the Reagan administration metaphor "War on Drugs" and pronounced the "drug war" to be good social policy. At dead center of all the hysteria was "crack" (pp. 1-2).

Harsh New Drug Policy Codified in 1986 and 1988 Acts of Congress. As discussed by Wallace (2014, this issue), the results of the media frenzy included political developments, such as the Anti-Drug Abuse Act of 1986, and Anti-Drug Abuse Act of 1988 that established historic drug policy

that would drive the War on Drugs in the United States for the next quarter century. A get-tough-on-crime era was propelled by the media hysteria, leading to Congress passing the Anti-Drug Abuse Act of 1986, and then the Anti-Drug Abuse Act of 1988. At the core of the 1986 Act was the introduction of penalties wherein it took 100 times more powder cocaine than crack cocaine to trigger the same statutory mandatory minimum penalties—i.e., a penalty structure that became widely known as the "100-to-1 drug quantity ratio" (United States Sentencing Commission, USSC, 2011, p. 2). Meanwhile, the 1988 Act established a mandatory minimum penalty for simple possession of crack cocaine; for example, first-time simple possession of five grams or less of crack cocaine triggered a mandatory minimum sentence of not more than one year incarcerated; and, first-time simple possession of five grams of crack or more triggered a mandatory minimum sentence of five to 20 years incarcerated. This stood in contrast to the mandatory minimum sentence of not more than one year incarcerated for first-time simple possession of powder cocaine, regardless of the quantity (USCC, 2011).

Without judges being able to exercise discretion, having to impose mandatory minimums, and the patterns of more African Americans being in possession of the ready to smoke form of cocaine—crack—and more Whites being in possession of powder (i.e. which they might then cook up into a smokeable form), the results were predictable: a mass incarceration crisis that disproportionately negatively impacted African Americans.

The Rise in Street-Level Crack Dealing. As crack cocaine use escalated at the level of an epidemic, dealers with varied backgrounds—ranging from street-level gangs, family networks, to urban and suburban outlets—realized their potential to become entrepreneurs via the production and distribution of crack; indeed, a booming cottage industry ensued centered around crack (Wallace, 1991; Johnson, Dunlap & Tourigny, 2000). Hamid (1990) documented how by 1987 crack was readily sold in neighborhoods from the apartments of users or curbside. Ordinary living rooms and dining rooms became settings for the increasingly popular use of crack; and, there was a large market for the drug. Furthermore, the nature of crack selling involved violence, especially with curb-side sales by "posses" or "crews," and tensions around sellers who were also users.

By 1992, Williams was able to describe how crack cocaine was "commonly sold on the streets of most major cities and, recently, in smaller cities as well, as urban "crews" (gangs) have increased distribution by expanding geographically" (p. 10). Furthermore by 1992, Williams was able to assert that the drug trade was "possibly the largest single employer of minority youths" (p. 10). Consider one estimate that "on any given day" in New York there were possibly 150,000 persons "selling or helping to distribute—as runners, stash catchers, steerers, spotters—crack cocaine on the streets and in parks, train stations, and other public and private locations;" crack use was seen as rising in use by adolescents and middle-class adults, as well as among former heroin addicts (p. 10). Williams (1992) also asserted that there were hundreds of crackhouses across New York City, while describing many in New York's West Spanish Harlem. Dunlap et al (1997) reported on the roles played by women in low-level sales and distribution of crack within New York City across 1989 to 1997, including their role in working for male dealers in street sales roles, making direct sales to retail customers.

Those selling drugs on the street were targeted for arrest, resulting in the swelling of the incarcerated population, White bankers were ignored (Duster, 1997). Thus, early on, Duster (1997) presented the case for massive racial injustice, given evidence of the disproportionate arrest and imprisonment of Blacks that followed from street-level crack sales. Duster (1997) explained how, under President Reagan, Vice President Bush presided over the dismantling

of an operation that had the potential to target the truly powerful players in drug distribution networks, including bankers. For example, a Miami bank branch in 1982 accepted $242 million in cash across less than 1.5 years; in 1988 a Southern California bank reported an unprecedented $3 billion in excess cash—both likely due to laundering drug money. Also, as per Alexander (2010), consider how, under President Reagan, the United States Justice Department formally announced plans to reduce by half those specialists working on the identification and prosecution of white-collar criminals. Instead, the new focus became drug-law enforcement and street crime (Alexander, 2010).

Arrests from 1987 to 1997: Evidence of Decline by 1996 or "Steady as She Goes"?

Data using urine test results for those booked for arrests from 1987 to 1997 has also been used to track the crack epidemic, using evidence of cocaine metabolites in urine and self-report data to assert this constitutes meaningful data for tracking the crack epidemic. Golub and Johnson (1997) found the following for cities selected here for illustrative purposes: for Manhattan, detected crack cocaine use hovered around 70% from 1987 to 1994, then dropped to 62% by 1996; for Miami, detected crack cocaine dropped from 61% in 1991 to 52% by 1996; for Washington, D.C., it dropped from 64% in 1989 to 35% in 1996; for Los Angeles, it dropped from 60% in 1988 to 46% in 1996; for Portland, it dropped from 41% in 1989, to 25% in 1990, then rose to 40% by 1992; for Atlanta, it remained around 60% from 1990 to 1996; for Chicago, it remained around 58% from 1993 to 1996; for Houston, it rose from 40% in 1987 to 56% in 1991, then down to 43% in 1992, then down to 37% by 1996; for Detroit, it went from 55% in 1987 to 44 % in 1993, then down to 33% by 1996; for Indianapolis, it went from 24% in 1992 to 50% in 1994; for New Orleans, it went from 59% in 1989 to 42% by 1996. Hence, Golub and Johnson (1997) concluded that by 1996 the national crack epidemic was in decline. Consistent with this, Hamid (1992) asserted that the cocaine-smoking epidemic, thereby including crack cocaine, ran a decade-long course that was consistent with most American drug epidemics, given observations of crack use declining within cities across the United States.

However, this interpretation of the data is open to debate. Or, things were "steady as she goes," suggesting onward movement of the national crack epidemic, even if past the prior height of the epidemic. Or, the repercussions of the crack epidemic were continuing, "steady as she goes."

Escalation in the War on Drugs. The above data provided by Golub and Johnson (1997) may also be used to suggest that there was a tremendous amount of ongoing activity across the United States from 1988 to 1996: i.e., involving the arrest of those who had tested positive for cocaine metabolites, while admitting to use of crack cocaine. The street crime of "curbside" crack sales (Hamid, 1990), along with community policing that targeted low-income minority neighborhoods, had clearly resulted in massive arrests and incarceration, as per that above data. Racial profiling became a major tactic deployed in the War on Drugs (Murray, 2010), targeting, in particular, low-income urban African Americans using crack cocaine via intensely focused law enforcement. The result of all of these factors was what manifested as a crisis of mass incarceration (Alexander, 2010; Drucker, 2006; Haney, 2006; Mauer & Chesney-Lind, 2002).

Developments in the New Millennium—A Documented Incarceration Crisis by 2002

Changes in Crack Dealing in the New Millennium. By the new millennium, street-level crack dealing disappeared, shifting so it became invisible and underground, while those who had openly dealt crack were incarcerated (see Bowser, Word, Fullilove & Fullilove, 2014, in this issue). Bowser et al (2014) suggest that crack did not run its

course. As a matter of potential debate, this assertion stands in opposition to what Hamid (1992) asserted was a typical decade-long epidemic (i.e. 1986 to 1996) that had run its course.

Rising Rates of Incarceration Documented by 2002. By the new millennium, what definitely did continue *without* debate was the rise in incarceration in the United States—which may be suggestive of: (1) an ongoing crack epidemic, or (2) ongoing repercussions of the crack epidemic, or (3) a national crisis that was ongoing in response to a War on Drugs that was targeting crack drug offenders for arrest and incarceration. Or, the ongoing rise in incarceration beyond 1996 and into the new millennium that reflected a combination of all three factors. A body of data speaks to these possibilities.

Examining the period from 1995 to 2002, the United States experienced a rise from 601 residents per 100,000 incarcerated in 1995 to 701 residents per 100,000 incarcerated by 2002 (Harrison & Beck, 2003). By the new millennium, numerous researchers were presenting data that the United States had surpassed all other countries in the Western world for per capita incarceration rates (Glaze, 2002; Harlow, 2003). Year 2001 data from the Sentencing Project showed how the United States had, in recent years, become the uncontested leader in detention (Farmer, 2002). The rate of incarceration in the United States was 700 in prison for every 100,000 citizens (Farmer, 2002), which contrasted sharply with international data: i.e., data showing the rates for Russia at 685 per 100,000, 125 per 100,000 for Britain, 129 per 100,000 for Canada, and 40 per 100,000 for Japan (Isralowitz, 2002). Observations included how more African Americans, Hispanics, women, as well as substance abusers were incarcerated than ever before in the history of the United Sates within a policy best described as "mass imprisonment" (Mauer & Chesney-Lind, 2002, p.1).

For prisoners with a sentence of more than 1 year per 100,000 in the U.S. resident population, Harrison and Beck (2003) reported that the prison population increased 2.6% in 2002, the largest increase in 3 years; drug offenders accounted for 13% of total growth among female inmates and 15% of growth among male inmates from 1995 to 2001; and, a full "23% of the total growth among" Black inmates "and 18% of the growth" among White inmates involved drug offenders (Harrison & Beck, 2003, pp. 10-11). Among those being arrested as drug offenders, crack use dominated, going as high as over 65% (Johnson & Golub, 2002), while other reported that a full 60 to 80 percent of prison and jail inmates, parolees, probationers, and arrestees were drug and/or alcohol involved (Marlowe, 2003).

Historical Rise in the Incarceration of Women Documented by 2002. Consistent with observations of the role of women within crack distribution networks (Dunlap et al, 1997), data documents not only women's arrest, but their over-representation among those arrested. For example, from 1995 to 2002 the average annual rate of growth for female inmates was 5.25, surpassing the annual growth rate of 3.5% for male inmates (Harrison & Beck, 2003). An historic high was reached with regard to women's imprisonment in the United States by the dawning of the millennium, while this represented a steady climb across the height of the crack epidemic; specifically, from 1980 to 1999 there was a "more than sixfold" increase from the 1980 figure of 12,000 women incarcerated to the 1999 number of more than 90,000 women incarcerated (Chesney-Lind, 2002, p. 80). The a rate of 66 women per 100,000 incarcerated in 2000 was "ten times greater than the number of women incarcerated in all of Western Europe"—being a fair comparison, since that is a region roughly equivalent to the U.S. in terms of population (Chesney-Lind, 2002, p. 81).

Racial and Ethnic Disparities in Incarceration by 2002. Moreover, there were racial and ethnic disparities in rates of incarceration for males and females by 2002. Harrison and Beck (2003, p. 9) reported that "10.4%" of Black males age "25 to 29 were

in prison on December 31, 2002, compared to 2.4% of Hispanic males and about 1.2%" of White males "in the same age group." Also, Black females, with an incarceration rate of 191 per 100,000, were more than twice as likely as Hispanic females (80 per 100,000) and 5 times more likely" than White females "(35 per 100,000) to be in prison on December 31, 2002" (Harrison & Beck, 2003). Examined another way, for those African American men between the ages of twenty-five and thirty-four, "one of every eight" was documented as being in prison or jail "on any given day" (Mauer & Chesney-Lind, 2002, p. 2). Suggestive of the process of the return of the incarcerated to their communities, for African American men, while more than "three-quarters of a million" were incarcerated, approximately 2 million were under some form of criminal justice system supervision, including probation and parole (Mauer & Chesney-Lind, 2002, p.2). Other data showed that "nearly 80 percent of inmates in state prison for drug offenses" were African American or Latino (Mauer & Chesney-Lind, 2002, p.6.). Also, data by 2002 revealed that, while African Americans made up "13 percent of the nation's monthly drug users," they disproportionately represented "35 percent of those persons arrested for drug crimes" and an even higher "53 percent of drug convictions" (Rubinstein & Mukamal, 2002, p. 40). Further, there was evidence of racial bias in sentencing, since Black inmates accounted for an estimated 45% of all inmates with sentences in excess of 1 year, while White inmates accounted for 34%, and Hispanic inmates for only 18% (Harrison & Beck, 2003). Across the United States, fueling the racial and ethnic disparities that had emerged was a pattern of excess rates of arrest, conviction and incarceration, especially for African Americans (Tonry, 2011; Drucker, 2006).

Developments within Treatment and Drug Use Trends by 2007. Volkow (2008), as the Director of the National Institute on Drug Abuse (NIDA), cited data from the National Survey on Drug Use and Health (NSDUH). Of note, crack cocaine was first added to the NSDUH survey in year 1988, and past month use of crack cocaine *has never exceeded 0.3% of the population—as an indicator of current use.* For example, for the year 2006, for those age 12 and above, 1.5 million (0.6%) had smoked crack/cocaine freebase in the past year, and *702,000 (0.3%) had smoked it in the past month, as current users* (Volkow, 2008).

Data from the NSDUH may be criticized on many counts that contribute to lack of participation in the survey: people perceive problems with the title of the survey; they need to be in a dwelling or household, and some are not at home or not available (Kennet & Gfroerer, 2005). Others refuse participation due to concerns about confidentiality, or the legitimacy of the survey. Yet others decline participation because of reasons as varied as their house being too messy, feeling too ill to participate, or having a mental or physical handicap. Some decline due to having no time, perceiving nothing of value in their participation, or perceiving it as a government survey that was too invasive. Practical barriers to participation involved speaking Spanish, or another language. Other problems include possible falsification of data (Kennet & Gfroerer, 2005).

Furthermore, many vulnerable populations are excluded (Cowell & Mamo, 2005); this includes the exclusion of "homeless persons who do not use shelters, military personnel on active duty, and residents of institutional group quarters, such as prisons and long-term hospitals"—even as "a stratified, multistage area probability design" is used that is "representative of almost 98 percent of the U.S. population aged 12 years old or older" (p. 175).

Volkow (2008) also reported national data on admissions, showing that primary cocaine admissions "decreased from approximately 278,000 in 1995 (17% of all admissions reported that year) to around 256,000 (14%) in 2005" (para 8). Furthermore, it was also reported that "(crack) represented 72% of all primary cocaine admissions in 2005. Among smoked cocaine admissions, 52% were

Black, 38% White, and 8% Hispanic, whereas a reverse pattern was evident among Blacks and Whites (28% and 52%, respectively, and 17% were Hispanic) for non-smoked cocaine" (para 8).

Regarding national drug use trends, Volkow (2008) indicated that in "contrast to the generally downward or stable trends reflected in most nationally conducted surveys, other indicators appear to suggest that cocaine abuse may be on the rise in some localities" (papa 9). As a case in point, "cocaine deaths in the State of Florida revealed a dangerous upward trend, with cocaine-related deaths nearly doubling from 2001 to 2005, from 1,000 to 2,000. The study also showed dramatic increases in the popularity of cocaine among the young and affluent, by all routes of drug administration" (para 9). Other data based on Department of Justice statistics were cited as demonstrating how the percentage of state and local law enforcement agencies" citing cocaine as their greatest drug threat increased, overall, from 2004 to 2007. Volkow (2008) concluded that these "indicators are of grave concern to NIDA" (para 9).

Main Focus in the New Millennium—On Overlapping Crises

From Mass Incarceration Crisis to National Crisis. Clearly, instead of a national policy of mandating crack drug offenders into treatment, arrests and incarceration predominated as the War on Drugs policy response. This fueled analyses of the War on Drugs as a flawed policy response (Mauer, 2011a; Human Rights Watch, 2011; Mauer, 2006; Caulkins & Iguchi, 2005; Human Rights Watch, 2000). The War on Drugs policy resulted in a crisis of mass incarceration (Alexander, 2010; Drucker, 2006; Haney, 2006; Mauer & Chesney-Lind, 2002). The War on Drug focus on the mass incarceration of drug offenders produced a national crisis (Tonry, 2011; Stanberry & Montague, 2011; Graham, 2011; Mauer, 2011b; Alexander, 2010; Clear, 2007; Mauer, 2006; Drucker, 2006; Haney, 2006; Mauer & Chesney-Lind, 2002; Tonry, 1995).

National Crisis of Collateral Consequences. The War on Drugs policy has not only been declared a massive failure, but also linked to massive collateral consequences—damaging the lives of the incarcerated, their children, families, and communities (Human Rights Watch, 2011; Pinard, 2011; Clear, 2007; Chin, 2002: Mauer & Chesney-Lind, 2002). Collateral consequences include massive health, social, economic, educational, and legal disadvantages for those released from incarceration (Tonry, 2011; Pinard, 2011; Francis & Mauser, 2011; Wheelock, 2005; Finzen, 2005; Mauer & Chesney-Lind, 2002; Iguchi et al, 2002; Tonry, 1995). There has also been an erosion of civil rights and liberties (Glasser & Siegel, 1998). For example, stop-and-frisk policies have plagued African and Latino males, in particular, while being unconstitutional (Goldstein, 2013). As another example, loss of rights for those with felony convictions included the inability to serve on juries or vote (Chin, 2002). Consequences include millions being consigned to "the margins of mainstream society, banished to a political and social space not unlike Jim Crow, where discrimination in employment, housing, and access to education was perfectly legal, and where they could be denied the right to vote"—suggesting by the year 2000 how the "New Jim Crow was born" (Alexander, 2010, pp. 56-57). Even where other countries, such as Canada, England, and South Africa, have engaged in a War on Drugs, none has gone as far as the United States in punitive punishment and violating basic human dignity, given the extent of collateral consequences that follow the incarcerated post-release and complicate the community reintegration challenge (Pinard, 2011).

Health Inequities, Health Disparities. Collateral consequences include negative health impacts and the exacerbation of inequities and health disparities (Binswanger et al, 2011; Cuddeback et al, 2010;

Freudenberg & Ramaswamy, 2009; Golembeski & Fullilove, 2005; Iguchi et al, 2005; Leukefeld et al, 2002). Results include exacerbations involving mental illness, HIV, tuberculosis, other infectious diseases, as well as violence—while the massive return of the incarcerated back to their communities involved the transfer of a greater risk of morbidity and mortality from infectious diseases to their sexual partners, children, family, and larger community (AIDS, 2010; Lattimore et al, 2010; Davis et al, 2009; Freudenberg & Ramaswamy, 2009; Moore & Elkavich, 2008; Fullilove, 2006; Drucker, 2006; Freudenberg et al, 2005; Golembeski & Fullilove, 2005; Leukefeld et al, 2002; Richie et al, 2001; Hammett et al, 2001; Petersila, 2001). Perhaps the very worst impact from collateral consequences has been upon urban Black communities (Tonry, 2010; Caulkins & Chandler, 2006; Finzen, 2005; Tonry, 1995). Collateral consequences of the War on Drugs have extended to other countries and regions in the global community (Francis & Mauser, 2011).

Contemporary Crack-Related Public Health Concerns—Nationally and Internationally

Crack and the National Scope of Public Health Concerns. As noted by Draus and Carlson (2009), the "advent of "crack" or "rock" cocaine as a drug use trend had a broad impact on American society in the late twentieth century" (p. 384). The ongoing nature of this broad national impact has been well-documented. For example, the National Institute on Drug Abuse (NIDA, 2010) reported the results of the forensic laboratory analysis of drugs for the first half of 2009; crack cocaine ranked first as the drug most frequently identified in many areas across the United States (e.g. Atlanta, Miami, and Washington, D.C., Maine, New York City, Denver, San Francisco). Cocaine ranked second as the most frequently identified drug in Chicago, Cincinnati, Detroit and St. Louis. Nationally, the manner in which crack remains a predominant drug of use has been documented by others, including in areas such as Atlanta (DePadilla, 2010), Boston, (NIDA, 2010), Chicago (Ouellet, 2010), Denver (NIDA, 2010), Detroit (Arfken et al, 2010), New York (NIDA, 2010), Dayton (Daniulaityte et al, 2007), Hawaii/Honolulu, Philadelphia (NIDA, 2010), Los Angeles (Brecht, 2010), and Washington, D.C. (Artigiani et al, 2010; Tull et al, 2010). Meanwhile, there is a body of data that supports the contention that there is an ongoing major public health impact in the twenty-first century in the United States from crack (Borders, Stewart, Wright et al, 2013; Kopetz et al, 2013; Persaud et al, 2013; Daniulaityte & Carlson, 2011; Ryder & Brisgone, 2013; CDC, 2011b).

Crack and the International Scope of Public Health Concerns. Crack is also a major international public health concern (Cruz, et al, 2014; Persaud, et al, 2013; Duff et al, 2013; Narvaez, et al, 2011), given how crack is found within international drug abuse patterns (NIDA, 2010). Globally, the reality of crack being a major public health problem continues to drive major research agendas in Brazil (Cruz et al, 2014; Cruz et al, 2013; Narvaez et al, 2011; Cunha et al, 2010; Carvalho & Seibel, 2009) and Canada (Duff et al, 2013; Persaud et al, 2013; Matheson et al, 2011; Ivsins et al, 2011; DeBeck et al, 2011; Bungay et al, 2010; Shannon et al, 2009). The global crack research focus includes countries such as the Netherlands (Nuijten et al, 2011), the United Kingdom (McGovern & McGovern, 2011; Packer et al, 2009; Reuter & Stevens, 2008), Greece (Stefanidou, et al, 2011), Spain (Barros-Loscertales, et al, 2011), and South Africa (Peltzer, et al, 2010).

Implications of the Crack Chronology

There is substantial evidence that the crack cocaine epidemic that dawned in 1984 had massive repercussions that have reverberated into the new millennium. These repercussions include inequities in health, health disparities, and an ongoing public health crisis. Moreover, there is a global focus on crack as a major public health concern. In total, the chronology provided a

major justification for a special theme issue that selects the year 2014 for acknowledging both the 30th anniversary of the dawning of the crack epidemic, as well as ongoing impacts.

Part II: Nexus of Seven Repercussions from the Crack Epidemic that Reverberate into the New Millennium

The chronology gives rise to the present analysis, resulting in this presentation of a nexus of seven repercussions from the crack epidemic (See Figure 1). The seven repercussions are conceptualized as reverberating into the new millennium; this means they continue to have a far-reaching and ongoing impact, as suggested from what follows.

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.* This crisis has spanned decades with manifestations and repercussions that are both contemporary and threaten to persist for mores decades to come.

2- ***Flawed and Unjust War on Drugs policy*** *that has driven irrational responses to the public health crisis of overlapping epidemics.* This War on Drugs policy was an irrational response based more in politics and the mis-use of power than in the moral and ethical responsibility to advance rational evidence-based medical and treatment responses as an urgent matter. Knowledge translation should have resulted in evidence being practically applied in developing and implementing new policy.

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.* This crisis led to: (a) national and international condemnation of the practice of incarceration as violating constitutional rights and international treaties, while disproportionately incarcerating African American women and men, in particular; (b) international disdain for such practices as institutionalized racism; and (c) the United States' criticism of any other countries' violations of human rights being seen as hypocritical.

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.* This mistrust and suspicion is felt among citizens and immigrant arrivals, given the massive social injustice inherent in the operation of this infrastructure; this followed from what constituted a massive collusion in the legalized oppression of minorities, and especially African Americans and Hispanics across the governing infrastructure of the United States. This mistrust and suspicion includes new knowledge of the extent to which abuses can be perpetrated by representatives of the governing infrastructure, including the un-checked loss of constitutional rights and civil liberties.

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.* This meant a disruption to positive efforts to build community, a civil society, racial harmony, and to forge social ties across former divisions based on race, ethnicity, religion, class, gender, and sexual orientation. Negative myths and stereotypes about crack addicts undermined perceptions of African American men and women, resulting in damage both within the African American community and across society as a whole; meanwhile, massive trauma suffered on the level of the individual, family and community undermined progress and gains made through community mobilization efforts made before the crack epidemic.

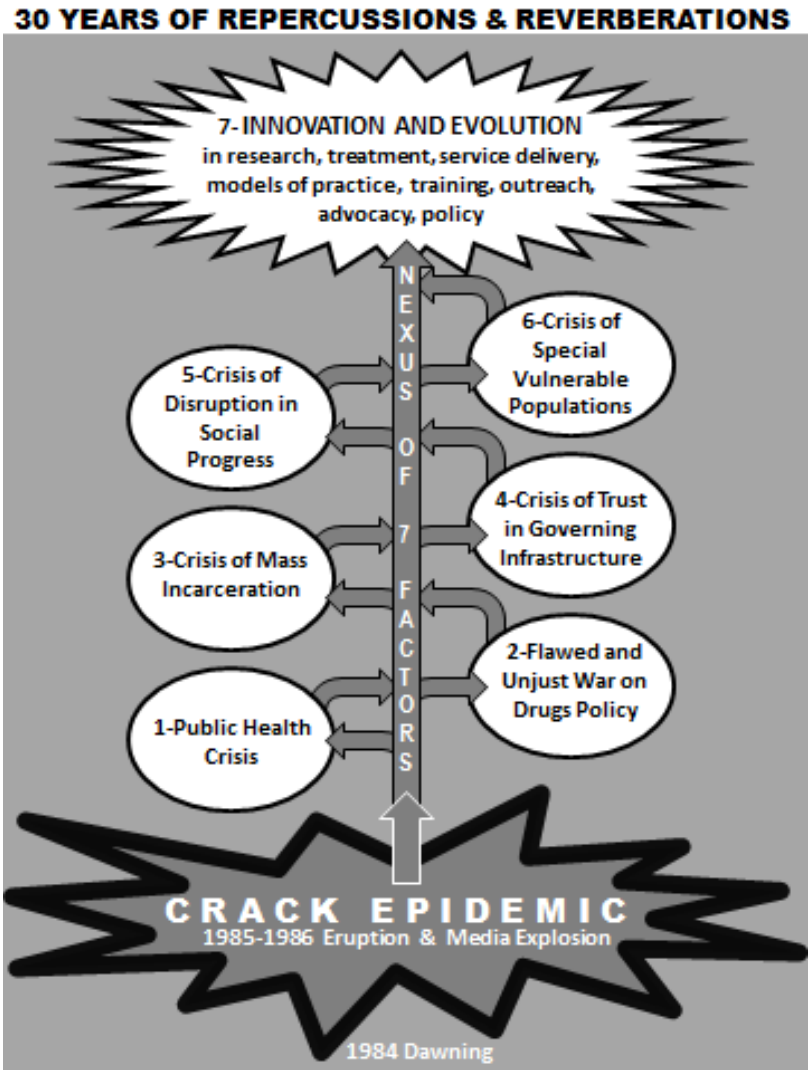

Figure 1. The Nexus of Seven Repercussions from the Crack Epidemic that Reverberate into the New Millennium. The figure depicts the dynamic interaction among the following factors: **(1) Public health crisis** of considerable magnitude and long duration that involves overlapping epidemics of crack/other 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.

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.* These groups reflect the extensive trauma and negative impacts suffered across more than one generation since the dawning of the crack epidemic, including upon individuals, families, neighborhoods, and entire communities. Emergent special vulnerable populations include, for example: all at risk for HIV/AIDS and related disease syndemics—such as young men and adult men who have sex with men, and African American women facing an altered gender ratio with a shortage of available men with risks from concurrent sexual relationships within a heterosexually driven HIV/AIDS epidemic; those with histories of incarceration and related trauma; mentally ill chemical abusers, those with co-morbid disorders, and multiple mental disorders; those at risk for violence; AIDS orphans; adolescents, and adults living with HIV/AIDS who face challenges of disclosure of their positive status; and, the homeless, those unable to access affordable housing, and those displaced due to factors such as incarceration and gentrification.

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. For example, advancements have included a focus on health equity, social determinants, cultural competence, strengths-based approach, resilience, assets-based approach, collaborations, and partnerships. This progress includes new values; for example, as with the new emphasis upon working on transdisciplinary teams and alongside community members This acknowledges the progress inherent in the emergence of innovations that are pioneered in the trenches, clinical trials and discoveries at laboratory benches, and the emergence of new evidence-based treatments and priorities in research (e.g. ethnographic interviews, community-based participatory research). What emerged, as well, were contemporary forms of advocacy, community outreach, and networking for social support while utilizing contemporary media—as well as for revealing policy as flawed and moving toward the establishment of evidence-based policy. In essence, this incredible progress propelled movement from the despair inherent in #s 1-6 (above) toward hope, inspiration and the taking of constructive action.

Conclusion

The chronology of crack that was presented has provided important context for all the articles within this special theme issue. In addition, the nexus of seven repercussions of the crack epidemic that reverberate into the new millennium provides a framework within which to discuss and analyze all of the articles within the special theme issue.

Figure 1 demonstrated the nature of the dynamic interaction among the seven factors in the nexus. This Figure, in particular, may be utilized to stimulate discussion and analysis. The nexus powerfully illustrates the manner in which we face in contemporary times ongoing public health impacts and challenges, stemming from the crack epidemic that dawned in 1984—as substantiated in the literature; for example, the reality of ongoing crack use (Palamar & Ompad, 2014); ongoing problems from crack cocaine use (Conti & Nakamus-Palacios, 2014; Luca & Baldissertto, 2013); overlapping epidemics of crack/other drug use and HIV/AIDS (Harrell et al, 2011; Cook, 2011; Bell et al, 2010; CDC, 2011a; CDC, 2011b); overlapping epidemics of crack/other drugs and violence (Cerda et al, 2010; Chauhan et al, 2011; Gilbert et al, 2011; Felson, 2005); and, the reality of special at risk populations (Tobkin et al, 2011; Carrico et al, 2011; Ingersol et al,

2011; Wechsberg et al, 1010; Harzke & Williams, 2009). Also powerfully illustrated through the nexus is the ongoing necessity of a twenty-first century global civil rights movement for equity in health for all (Wallace, 2008).

In conclusion, what this article proposes through the nexus is a framework deemed to be sufficient to encompass the diverse content of the special theme issue—i.e., 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.

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