

Crack Cocaine

and

Harlem's Health



Beverly Xaviera Watkins and Mindy Thompson Fullilove

Harlem is one of the most famous urban all-black communities in the United States. In its early years, Harlem prospered and gained international recognition as a center of African-American music, art, and literature. Between 1960 and 1990, four disparate forces—suburbanization, economic decline, epidemic disease, and municipal public policy—transformed Harlem from a functional “urban habitat” to a deurbanized area with a hyper-concentration of poor people with serious health problems.

In 1990, Colin McCord and Harold Freeman published a special article in the *New England Journal of Medicine* that described the relative risk of death for Harlem residents in comparison with other areas of New York City. Harlem had the highest rate of age-adjusted mortality from all causes. The rate was more than double that of U.S. whites and was 50 percent higher than that of U.S. blacks living in other areas. Cardiovascular disease, cirrhosis, homicide, neoplasms, and drug dependency were the five major causes of death. Homicide, cirrhosis, and drug-related deaths accounted for 40 percent of excess mortality in Harlem, suggesting a corresponding excess burden of substance abuse-associated morbidity. They concluded, “Black men in Harlem were less likely to reach the age of 65 than men in Bangladesh.”

Zip code-level data for all New York City hospital admissions, covering 1989–1990,

released by the New York State Health Systems Agency (HSA), complement McCord and Freeman’s analysis. HSA found that the five Harlem and East Harlem zip codes were ranked among the “top ten” (out of a total of 168 citywide) with respect to substance-abuse admissions; three of the five were ranked among the highest ten with respect to hospital admissions for psychosis (much of which was drug related); and two of the five were ranked among the top ten with respect to HIV and cirrhosis admissions.

In 1996, the unique nature of the problems of Harlem was underscored by Arline Geronimus and colleagues, who compared mortality rates for white and black Americans living in poor or more prosperous communities in four parts of the United States.² They found that men and women living in Harlem had the lowest likelihood of surviving to age sixty-five (37 percent for men; 65 percent for women). The authors note: “The situation in Harlem was particularly dire. Comparison of the estimates by McCord and Freeman with ours shows that in Harlem mortality among women relative to that nationwide has not improved since 1980, whereas mortality among men has deteriorated. On the other hand, groups that might have been expected to have excess mortality rates equivalent to or higher than the rates in Harlem did not.” Their findings suggest that social factors in addition to race and income are needed to explain excess mortality in Harlem.

Harlem—looking south from 155th St. Photo copyright Chester Higgins Jr. All rights reserved.

The crack cocaine epidemic of 1985–1995 significantly contributed to the decline of health in the Harlem community. Crack was both a direct and an indirect cause of excess morbidity and mortality. Lives were lost as a result of crack use and crack-related violence. In the course of crack use, many addicts contracted and died from HIV/AIDS and other illnesses. The adverse health effects of the crack epidemic included increases in rates of sexually transmitted diseases, respiratory conditions, and psychological problems. The epidemic also caused social disruption that undermined the community fabric and, in turn, further aggravated health. In order to describe the contributions of crack to ill health in Harlem, this article will review the general features of the crack epidemic and will relate stories of the epidemic as recalled by Harlem residents.

The Crack Cocaine Epidemic

Few people in the United States, other than those involved in the drug underground, recognized the emergence of a smokable form of cocaine. The first mention of crystallized cocaine occurred in an early 1970s guide to illegal drug use, entitled *The Gourmet Cokebook*.³ It next appeared in 1981, as a footnote in another underground publication, David Lee's *Cocaine Handbook*.⁴ That same year, the near-death experience of comedian-actor Richard Pryor introduced the practice of smoking cocaine, in this case "freebasing," to the general public.⁵ However, the process of reconstituting cocaine for smoking was not fully understood.⁶ Freebase, the base-state form of cocaine without adulterants, was not clearly distinguished from crystal cocaine, the form that contains the impurities and filler from the hydrochloride as well as from the processing products. Even among many users, particularly at the street level, the two were considered equivalents.⁷ In the mid-1980s, the

unadulterated smokable cocaine rock form became known as "crack" because of the crackling sound made during heating and drying once the cocaine hydrochloride is dissolved in water and sodium bicarbonate (baking soda).⁸

Crack first received media attention in 1984. The *Los Angeles Times* reported that in "South Central, cocaine sales explode with \$25 rocks."⁹ It would be almost a year before the term "crack" appeared in print. On November 17, 1985, while covering a story on a drug-treatment center, a *New York Times* reporter discovered that this "new form of cocaine, known as crack, was for sale in New York City."¹⁰ Two weeks later a *Times* headline read: "A New Purified Form of Cocaine Causes Alarm as Abuse Increases."¹¹ As crack moved north from Miami, west from New York and Washington, D.C., and east from Los Angeles, intense national media coverage followed.¹²

According to a 1988 Drug Enforcement Agency (DEA) report, the availability of crack was first noted in Los Angeles, San Diego, and Houston in 1981. Crack was localized in those areas until 1985, when crack use became a serious problem in New York City. According to the DEA, "Crack cocaine literally exploded on the drug scene during 1986 and was reported available in 28 states and the District of Columbia."¹³ The presence of crack was attested to by street surveillance, emergency-room visits, and arrest records. For example, crack arrests accounted for 72 percent of all New York Police Department (NYPD) Narcotics Division cocaine arrests during the first seven months of 1987. In 1989, lifetime prevalence reached 1.9 percent.¹⁴

Political Response

Fueled by the media, political campaigns, and the national elections, illicit drug use and associated crime, in particular crack-related crime, dominated public policy debate between 1986 and 1990. In the summer of

1986, *Newsweek* declared crack "an authentic national crisis," comparable to the civil rights movement, the Vietnam War, and Watergate.¹⁵ Crack had become widely available in U.S. cities and was largely concentrated in inner-city areas.

On July 15, 1986, the Committee on Governmental Affairs' Permanent Subcommittee on Investigations held a hearing "to examine a frightening and dangerous new twist in the drug abuse problem—the growing availability and use of a cheap, highly addictive, and deadly form of cocaine

known on the streets as crack."¹⁶ Senators William Roth, William Cohen, Lawton Chiles, Sam Nunn, John Glenn, and Alfonse D'Amato convened the "Crack" Cocaine Hearings. In turn, each described crack as "an egalitarian drug, attracting users of all races colors and creeds, all walks of life and income, and all degrees of dependence."¹⁷ The hearings clearly established that crack use had reached near-epidemic proportions and required immediate combative measures aimed at treatment, prevention research, and education.¹⁸

The following month, on August 4, 1986, President Ronald Reagan announced a new antidrug policy. The governmental response focused almost exclusively on interdiction and eradication of the drug supply. On September 14, 1986, in a nationally televised address, Reagan, determined to begin "a sustained, relentless effort to rid America of this

scourge by mobilizing every segment of society against drug abuse, declared a 'War on Drugs.'"¹⁹ The next day, *Time* magazine ran a ten-page story entitled: "Fed Up and Frightened, the Nation Mounts a Crusade Against Drugs."²⁰ On October 27, 1986, the first Anti-Drug Abuse Act was enacted. Of the \$1.7 billion allocated, approximately 86 percent

went to law enforcement, prisons, and interdiction, and 14 percent went to treatment, education, and prevention.²¹ In addition, an annual White House Conference for a Drug-Free America was established.

They noted that "during the past three years, a growing epidemic of cocaine use in the United States has resulted in widespread physical, psychiatric, and social problems that have alarmed medical experts, parents, and law enforcement officials." The brief duration of the drug effect and rapid onset of compulsive use made this drug an ideal product from the prospective of drug marketers.

Over the next two years, drug use and sales increased, and social, legal, and medical problems proliferated.

At the time, little was known about the long-term outcome of addiction to crack, but even short-term use produced important physical consequences, including cardiovascular complications (heart attack, stroke), pulmonary complications (chronic cough, aggravation of asthma), and psychiatric complications (paranoia, depression). Arnold Wash-ton and colleagues warned, in 1986, that addiction to crack was growing at alarming rates. They noted that "during the past three years, a growing epidemic of cocaine use in the United States has resulted in widespread physical, psychiatric, and social problems that have alarmed medical experts, parents, and law enforcement officials."²² The brief duration of the drug effect and rapid onset of compulsive use made this drug an ideal prod-

uct from the perspective of drug marketers. Crack, they argued, was a "self-marketing product" that "assures the dealer a reliable clientele and a high profit margin."²³

The Second War on Drugs

Drug abuse, in particular crack use, remained at the forefront of social issues during the 1988 presidential election campaign. As a result, on October 22, 1988, Congress enacted a second anti-drug abuse act. This time \$2.8 billion—a \$1 billion increase—was set aside to bolster antidrug efforts.²⁴ The focus on eradication and interdiction of the drug supply continued. However, 50 percent of the first year's budget and 60 percent of each year's thereafter were allocated to demand reduction. The 1988 legislation also created two new government offices, the White House Office of National Drug Control Policy, which was responsible for the annual National Drug Control Strategy, and the Office of Substance Abuse Prevention, which focused on treatment and prevention. This new drug policy placed an emphasis on severely penalizing crack users and dealers.²⁵ Steven Belenko, an antidrug policy researcher, argued that "what distinguished this anti-drug campaign was its strong emphasis on a single drug—crack cocaine."²⁶ He stated that the policy was driven by four assumptions about the effects of crack: (1) Crack is rapidly and strongly addictive, (2) crack users become irrational and exhibit bizarre and violent behavior, (3) the involvement of youth in crack dealing means more chaotic and violent distribution networks, and (4) crack is linked to promiscuous sexual activity. In turn, crack "is viewed as the quintessential 'hedonistic' drug and as such is in polar opposition to the prevailing white Protestant conservative morality of America."²⁷

Public Concern

Although Reagan's antidrug campaign failed to stem the growth of drug use and related illegal activity, it succeeded in generating an unprecedented level of public concern.²⁸ The 1989 National Drug Control Strategy contained the following statement in its introduction: "One drug—crack—has stubbornly resisted our prevention efforts. Crack's stranglehold on hundreds of thousands of young Americans is tightening. To date, the crack plague has been concentrated in our central cities, but it has begun to spread to small suburbs and small towns."²⁹ The idea that crack was extending into nonurban middle-class areas terrified the public.

In the mid-1980s, it was rumored that crack was so highly addictive that one-time use could cause addiction. In order to continue consumption of the drug, addicts spent their money, dispersed valuable possessions, and participated in sex-for-money-or-drugs exchanges. Concurrently, those areas affected by crack reported an increase in the rates of common sexually transmitted diseases, particularly syphilis and gonorrhea.³⁰ In the course of binges—episodes of incessant drug use that might last up to several days—parents neglected their children, and all users neglected basic health care needs for adequate food, clothing, and shelter. As the epidemic of crack use proceeded, the violence among drug dealers for control of territory fed into a growing epidemic of gun-related homicide, predominately among young African-American men.³¹ The escalating violence was steadily transforming peaceful neighborhoods into war zones.

Media coverage reinforced the idea that crack was destroying America. The *New York Times* continuously ran front-page articles about crack: February 20, 1989, "After Three Years, the Crack Plague in New York Grows Worse"; May 10, 1989, "Crack Spreads Fear

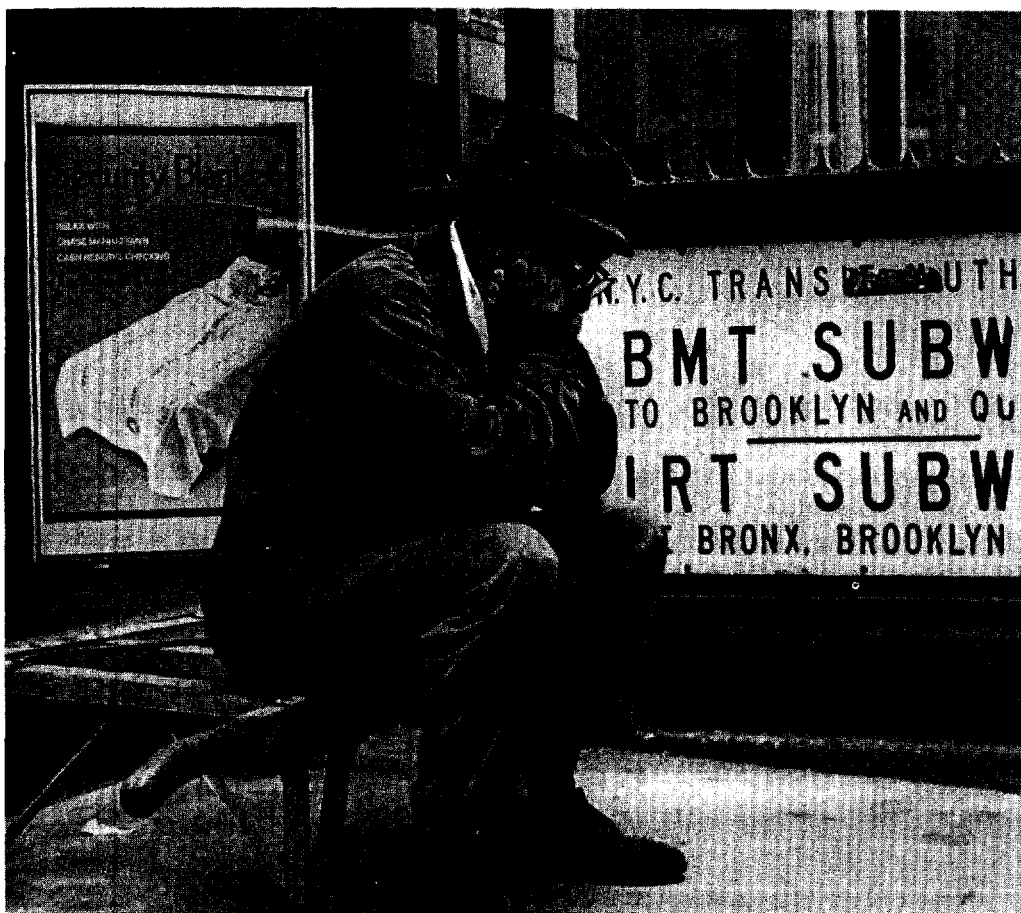


Photo copyright Chester Higgins Jr. All rights reserved.

and Frustration, Overwhelming Hospitals"; October 1, 1989, "Crack, Bane of Inner City, Is Now Gripping Suburbs."³² The next day, an article entitled "The Spreading Web of Crack" appeared.³³ The *Washington Post* cover stories included: June 3, 1989, "Small Towns Wrestle with the 'Scourge'"; September 22, 1989, "Drug Buy Setup for Bush Speech: DEA Lured Seller to Lafayette Park"; December 18, 1989, "For Pregnant Addict, Crack Comes First"; January 6, 1990, "She Smoked Crack, Then Killed Her Children."³⁴ The *Wall Street Journal* headlines read: May 4, 1989, "Spreading Plague"; July 18, 1989, "Born to Lose: Babies of Crack Users Crowd Hospitals."³⁵ The

Wall Street Journal's July article on crack babies was followed by two *New York Times* articles, one in August and another in November.³⁶ One of the most striking features of this coverage was the fact that with few exceptions, the faces of crack babies were black. As the non-white crack user/dealer became a familiar image in U.S. news reports and magazine articles, the characterization of the crack epidemic began to change.

By 1990, crack was no longer considered an egalitarian drug. Crack use and crack-related crime were largely concentrated in poor nonwhite communities, and it appeared that the pattern would continue. In 1991, the

National Institute on Drug Abuse (NIDA) reported a decline in crack use among middle-class high-school and college students. Subsequently, crack lost its place on the national agenda. The *1991 National Drug Control Strategy*, a 122-page document, mentioned crack only three times, once in the introduction. By contrast, a year earlier, in the ninety-page *1989 National Drug Control Strategy*, crack had been mentioned twenty-nine times, ten of those times in the

fourteen-page introduction.³⁷ Neither crack nor cocaine appeared in the *1991 National Strategy on Emerging Drug Trends*.³⁸

The withdrawal of public and political support for crack research and treatment left affected communities defenseless against crack and its attendant social and health problems. All the while, the actual number of people addicted to crack continued to rise.³⁹ In 1988, a San Francisco community leader, Shirley Gross, wrote: "Nothing in the history of substance abuse has prepared us for the devastation that is caused by the use of cocaine 'crack' . . . Crack has destroyed entire communities by engulfing families in the web of crack sales or use."⁴⁰ Largely African-American sections of Oakland, San Francisco, and Los Angeles were "taken over" by drug dealers. Addiction and drug-related violence created massive alteration in the social conditions of these communities. An ethnographer, Ben Bowser, described marked changes in the Bayview-Hunter's Point community in San Francisco.⁴¹ In particular, he signaled that drug traffickers were forming their own social sys-

tems, complete with common expectations, beliefs, values, and rules and that women, drawn into crack-related prostitution, might be far more effective transmitters of HIV infection than were women addicted to heroin.

Crack and Health

The crack epidemic undermined health in the affected communities, most of which were poor. Crack's disastrous impact on health could be measured in the spread of sexually transmitted diseases, including

HIV, and the rapid escalation of violence (handgun violence related to drug sales). In 1988, the U.S. Centers for Disease Control (CDC) cited crack use, coupled with the practice of bartering sexual services in exchange for the drug, as a factor in the increase in STDs (sex tied to drugs).⁴² An association between crack use and HIV infection, noted among women with pelvic inflammatory disease in New York City, was the first indication that crack use might become an important factor in the spread of HIV infection.⁴³ Several lines of evidence have since substantiated the fact that levels of risk behavior and infection with STDs, including HIV, are high among crack users.⁴⁴ Mary Ann Chiasson and colleagues at the New York City Department of Health (NYCDOH) examined the link between HIV infection and crack use.⁴⁵ The overall seroprevalence rate among the 201 crack users, who denied traditional HIV-associated risk behaviors, was 12 percent. The Centers for Disease Control conducted a multiyear, multisite study designed to assess HIV seroprevalence among crack users inter-

Harlem. Like so many other poor, inner-city communities, lacked the economic and social resources necessary to ward off crack's destructive forces. Harlem's hollowed-out landscape of abandoned and deteriorating buildings provided an optimal setting for the crack trade.

Metropolitan Counties," *Journal of the American Medical Association* 267 (1992):3054-3058.

32. *New York Times*, February 20, 1989; May 10, 1989; October 1, 1989.

33. *New York Times*, October 2, 1989.

34. *Washington Post*, June 3, 1989; September 22, 1989; December 18, 1989; January 6, 1990.

35. *Wall Street Journal*, May 4, 1989; July 18, 1989.

36. *New York Times*, August 7, 1989; November 24, 1990.

37. Cocaine is referred to 69 times in the text and 22 times in the introduction. Cocaine references increased to 102.

38. Belenko, *Crack and the Evolution of Anti-Drug Policy*.

39. U.S. General Accounting Office, *Cocaine Treatment: Early Results from Various Approaches* (Washington, DC: June 1996).

40. Shirley Gross, CEO of the Bayview-Hunter's Point Foundation, San Francisco, quoted in *MIRA Crack Project: Preliminary Report* (1988), p. 2.

41. Benjamin Bowser, "Crack and AIDS: An Ethnographic Impression," *Journal of the National Medical Association*, p. 540. Bowser conducted his ethnographic work during 1987 and 1988 in the Bayview-Hunter's Point section of San Francisco.

42. Goldsmith, "Sex Tied to Drugs = STD Spread."

43. Hoegsberg et al., "Social, Sexual, and Drug Use Profile of HIV(+) and HIV(-) Women with PID."

44. See R. E. Fullilove et al., "Risk of Sexually Transmitted Disease Among Black Adolescent Crack Users in Oakland and San Francisco, CA," *Journal of the American Medical Association* 263 (1990):851-855; R. E. Booth, J. K. Watter, and D. D. Chitwood, "HIV Risk-Related Sex Behaviors Among Injection Drug Users, Crack Smokers, and Injection Drug Users Who Smoke Crack," *American Journal of Public Health* 80 (1990):853-857; R. Rolfs, M. Goldberg, and R. Sharrar, "Risk Factors for Syphilis: Cocaine Use and Prostitution," *American Journal of Public Health* 83 (1993):1144-1148; S. K. Schwarcz et al., "Crack Cocaine and the Exchange of Sex for Money or Drugs: Risk Factors for Gonorrhea Among Black Adolescents in San Francisco," *Sexually Transmitted Diseases* 19 (January-February 1992):7-13.

45. M. A. Chiasson et al., "Heterosexual Transmission of HIV-1 Associated with the Use of Smokable Freebase Cocaine (Crack)," *AIDS* 5 (1991):1121-1126.

46. B. R. Edlin et al., "Intersecting Epidemics: Crack Cocaine Use and HIV Infection Among Inner-City Young Adults," *New England Journal of Medicine* 331 (1994):1422-1427.

47. Institutes of Medicine (IOM), *The Hidden Epidemic: Confronting Sexually Transmitted Diseases* (Washington, DC: National Academy Press, 1997).

48. Edlin et al., "Intersecting Epidemics: Crack Cocaine Use and HIV Infection Among Inner-City Young Adults," p. 1426.

49. J. Fagan and K. Chin, "Violence as Regulation and Social Control in the Distribution of Crack," NIDA Monograph Series No. 103, p. 36.

50. *Drugs and Violence: Causes, Correlates and Consequences*, USDHHS, NIDA Monograph Series No. 103 (1990).

51. I. Wilkerson, "Crack's Legacy of Guns and Killing Lives On," *New York Times*, December 13, 1994, presents a chart showing the sharp rise in homicides following the introduction of crack in New York, Los Angeles, and Chicago.

52. See L. A. Fingerhut, D. D. Ingram, and J. J. Feldman, "Firearm and Non-Firearm Homicide Among Persons 15 Through 19 Years of Age: Differences by Level of Urbanization, United States, 1979 through 1989," *Journal of the American Medical Association* 267 (1992):3048-3053.

53. Fingerhut, Ingram, and Feldman, "Firearm Homicide Among Black Teenage Males in Metropolitan Counties."

54. Fingerhut, Ingram, and Feldman, "Firearm and Non-Firearm Homicide Among Persons 15 Through 19 Years of Age," pp. 3052-3053.

55. Crack houses were also the site of many sex-for-drug exchanges. For a detailed account, see M. T. Fullilove et al., "Crack Hos and Skeezerz," *Journal of Sex Research* 29 (1992), p. 282. Also see "South Central Cocaine Sales Explode with \$25 Rocks," *Los Angeles Times*, and E. Dunlap, "Street Status and the Sex-for-Crack Scene in San Francisco."

56. R. Wallace, M. T. Fullilove, and D. Wallace, "Family Systems and De-Urbanization: Implications for Substance Abuse," chap. 71 in Ed Lowinson et al., *Comprehensive Textbook of Substance Abuse*, 2d ed. (Baltimore: Williams and Wilkins, 1992), pp. 944-955.

57. B. X. Watkins, M. T. Fullilove, and R. J. Grele, *Remembering Harlem: An Oral History, 1960-1990*, unpublished.

58. Ibid.

59. Patricia A. Jones, "Cocaine and Violence: A Marriage Made in Hell," *Crisis* 75 (March 1989):34.

60. Ibid., pp. 17-19, 32.

61. Ibid., p. 17.

62. Watkins, Fullilove, and Grele, *Remembering Harlem*.

63. Ibid.

64. Fullilove et al., "Crack Hos and Skeezerz."

65. Watkins, Fullilove, and Grele, *Remembering Harlem*.

66. Ibid.

67. Ibid.