

Crack use in North American cities: the neglected 'epidemic'

When claims of crack use as a new 'drug epidemic' emerged in the scientific and mass media in the 1980s, experts were quick to dismiss such suggestions as politically motivated fear-mongering within the context of Reagan's 'drug war' [1,2]. A quarter-century later, we wished those initial observations had been less prophetic. In many North American cities today, crack is a 'staple . . . in the street drug pharmacopeia', and its users often far outnumber injection drug user populations [3,4]. Yet the problem is not mainly one of quantity. The phenomenon's devastating traits are that its users (disproportionately African American men, at least in US settings) feature some of the worst and most detrimental characteristics with regard to health and social consequences of their drug use. Equally debilitating is the fact that in terms of interventions (whether prevention or treatment) the crack problem has been treated like the proverbial stepchild's ugly cousin. A further heavy cloud is blown into this already gloomy sky by Falck *et al.*'s paper (published in this issue) [4] which confirms, based on a longitudinal sample of urban crack users from a mid-western US city, that most crack users will engage in their drug use habit for extensively long times (i.e. many years) without interruptions or even phases of abstinence. This, among other things, means that even under optimistic circumstances crack use is here to stay in our cities for a long time to come, and will continue to impose a heavy toll on users and communities unless dramatic changes occur on key fronts.

In recent years, a sizeable body of literature has documented that crack users typically feature severely compromised somatic health status and a large proportion suffer from severe mental health problems, including both affective and personality disorders [3,5,6]. In fact, crack users are probably one of the highest-risk drug-user populations in which the interactive dynamics of comorbidity and substance use as an act of self-medication for undiagnosed and untreated psychiatric problems are most detrimentally pronounced [5,7,8]. While often not involved actively in injection drug use, crack users (often at a young age) have been shown to be at highly elevated risk for human immunodeficiency virus (HIV) and other blood-borne viruses/sexually transmitted infections (BBV/STI), as the 'protective' effects of less or absent involvement in injection drug use are frequently far outweighed by increased intensities of sexual risk behavior, whether related to sex work, sex-for-money exchanges or high-risk sex practices in the context of stimulant use

[9–11]. More recent epidemiological warning indicators suggest that populations of crack users are at elevated risk for hepatitis C virus (HCV), prompting the (biologically) as yet unanswered question of whether HCV transmission may, in addition to drug use and sex-related risk, also occur through crack use paraphernalia sharing [12–15]. Several studies show crack users to be the most socially disadvantaged—the 'marginalized among the marginalized'—even when compared to their street drug-using peers with the highest rates of homelessness, extreme poverty or lack of basic subsistence and highest barriers to social or health care: a picture amplified by the fact that a large proportion of crack users come from disadvantaged socio-ethnic backgrounds [16–18]. At the same time, it is crack users who typically stand out among street drug users in terms of crime involvement—regrettably involving disproportionate levels of violent crime, as also evidenced by systematic studies on longitudinal crime patterns in US cities [19–21].

It is both frustrating and distressing to see how empty the armory of targeted interventions for the high-risk populations of crack users has remained. While needle-exchange services and opioid maintenance treatment programs are widely available mainstay interventions in most western countries, and some jurisdictions are going as far as offering costly medical heroin prescription programs, the main offers to crack users may be scorn or pity. Pharmacotherapeutic treatment options for cocaine/crack dependence appear to indicate 'no evidence' for efficacy [22], with new agents being experimented within early and speculative stages at best, and other approaches (whether cognitive, psychotherapeutic or contingency management) have not demonstrated convincing long-term effects [23–25]. Rudimentary preventive interventions—such as community-based 'safer crack use kits' initiatives launched in several Canadian cities—have not yet been allowed to demonstrate their potential public health impact and have remained largely socio-politically controversial and under-resourced [3,15].

In North America and elsewhere, researchers and policy makers need to embrace the fact that both quantitatively and qualitatively crack use is one of the largest and most destructive pieces in the overall picture of our cities' illicit drug problem, and is likely going to be around for some time. Over the period of a quarter-century, we have made little if any progress concerning effective interventions. It is time to recalibrate our aim and focus drastically, and devote concerted energy to

developing knowledge and measures that will make crack users less prone to disease, crime and marginalization and more likely to be offered effective therapeutic interventions, so that in years from now this commentary will have no need to be repeated.

BENEDIKT FISCHER^{1,2} & MICHELLE COGHLAN¹

Centre for Addictions Research of British Columbia,
University of Victoria, Victoria, Canada¹ and BC Centre for
Disease Control, Vancouver, Canada².
E-mail: bfischer@uvic.ca

References

1. Reinarman C., Levine H. G. *Crack in America: Demon Drugs and Social Justice*. Los Angeles, CA: University of California Press; 1997.
2. Hartman D. M., Golub A. The social construction of the crack epidemic in the print media. *J Psychoact Drugs* 1999; **31**: 423–33.
3. Fischer B., Rehm J., Patra J., Kalousek K., Haydon E., Tyndall M. *et al.* Crack across Canada: comparing crack and non-crack users in a multi-city cohort of opioid and other street drug users. *Addiction* 2006; **101**: 1760–70.
4. Falck R. S., Wang J., Carlson R. G. Crack cocaine trajectories among users in a midwestern American city. *Addiction* 2007; **102**: 1421–31.
5. Falck R. S., Wang J., Siegal H. A., Carlson R. G. The prevalence of psychiatric disorder among a community sample of crack cocaine users: an exploratory study with practical implications. *J Nerv Ment Dis* 2004; **192**: 503–7.
6. Cornish J. W., O'Brien C. P. Crack cocaine abuse: an epidemic with many public health consequences. *Annu Rev Public Health* 1996; **17**: 259–73.
7. Grant B. F., Stinson F. S., Dawson D. A., Chou S. P., Dufour M. C., Compton W. *et al.* Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Arch Gen Psychiatry* 2004; **61**: 807–16.
8. Khantzian E. The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harv Rev Psychiatry* 1997; **4**: 231–24.
9. Edlin B. R., Irwin K. L., Faruque S., McCoy C. B., Word C., Serrano Y. *et al.* Intersecting epidemics: crack cocaine use and HIV infection among young inner-city young adults. *N Engl J Med* 1994; **331**: 1422–7.
10. Ross M. W., Hwang L. Y., Zack C., Bull L., Williams M. L. Sexual risk behaviours and STIs in drug abuse treatment populations whose drug of choice is crack cocaine. *Int J STD AIDS* 2002; **13**: 769–74.
11. Logan T. K., Leukefeld C. Sexual and drug use behaviors among female crack users: a multi-site sample. *Drug Alcohol Depend* 2000 Mar 1; **58**: 237–45.
12. Nyamathi A., Dixon E. L., Robbins W., Smith C., Wiley D., Leake B. *et al.* Risk factors for hepatitis C virus infection among homeless adults. *J Gen Intern Med* 2002; **17**: 134–43.
13. Thorpe L. E., Ouellet L. J., Levy J. R., Williams I. T., Monterroso E. R. Hepatitis C virus infection: prevalence, risk factors, and prevention opportunities among young injection drug users in Chicago, 1997–1999. *J Infect Dis* 2000; **182**: 1588–94.
14. Koblin B. A., Factor S. H., Wu Y., Vlahov D. Hepatitis C virus infection among noninjecting drug users in New York City. *J Med Virol* 2003; **70**: 387–90.
15. Haydon E., Fischer B. Crack use as a public health problem in Canada—call for an evaluation of 'safer crack use kits'. *Can J Public Health* 2005; **96**: 185–8.
16. Fischer B., Monga N., Manzoni P. Differences between co-users of cocaine and crack among Canadian illicit opioid users. *Sucht* 2005; **51**: 217–24.
17. Bourgeois P. Crack and the political economy of social suffering. *Addict Res Theory* 2003; **11**: 31–7.
18. Williams D. R. Race, socioeconomic status, and health: the added effects of racism and discrimination. *ANYAS* 1999; **896**: 173–88.
19. Grogger J., Willis M. The emergence of crack cocaine and the rise in urban crime rates. *Rev Econ Stat* 2000; **82**: 519–29.
20. Baumer E. Poverty, crack, and crime: a cross-city analysis. *J Res Crim Del* 1994; **31**: 311–27.
21. Best D., Sidwell C., Gossop M., Harris J., Strang J. Crime and expenditure amongst polydrug misusers seeking treatment: the connection between prescribed methadone and crack use, and criminal involvement. *Br J Criminol* 2001; **41**: 119–26.
22. de Lima M. S., de Oliveira Soares B. G. Pharmacological treatment of cocaine dependence: a systematic review. *Addiction* 2002; **97**: 931–49.
23. Kampman K., Pettinati H., Lynch K., Dackis C., Sparkman T., Weigley C. *et al.* A pilot trial of topiramate for the treatment of cocaine dependence. *Drug Alcohol Depend* 2004; **75**: 233–40.
24. van den Brink W., van Ree J. M. Pharmacological treatments for cocaine and heroin addiction. *Eur Neuropsychopharmacol* 2003; **13**: 476–87.
25. Preti A. New developments in the pharmacotherapy of cocaine abuse. *Addict Biol* 2007; **12**: 133–51.