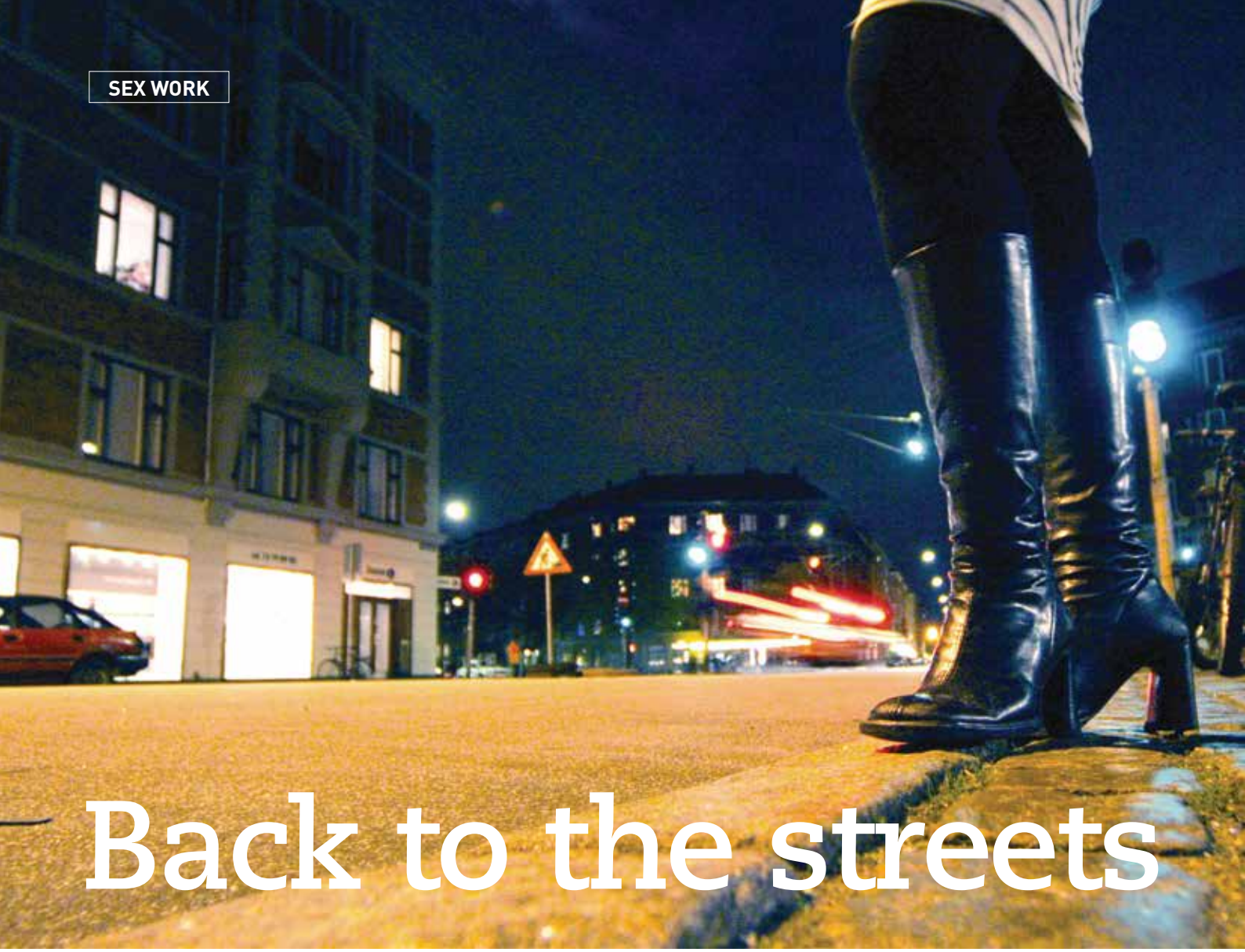

Back to the streets

Lyn Matthews worked as a health researcher in Liverpool's red light district during the late 1980s – at a time when the city opened the world's first drug harm reduction service. In January she found herself, a quarter of a century later, back in the same job. Here, she reports on how the scene has altered, yet in some ways, remains the same.

Going back out on the streets for the first time in 25 years felt strange at first. In 1987, my husband, a drug worker, talked me into becoming involved with a female sex workers project. Despite having no background in this type of work, I agreed to assist in a small exploratory survey of the sex industry on Merseyside. Little did I know that I was to go on to work on this project for the next five years and, during this time, not only established a good service with the clients but also built a strong rapport with the women which gave me a deeper, more meaningful insight into their lives, their problems and I formed relationships on those streets that would last long after I had left the project.

In 1986, Liverpool had initiated the world's first injecting equipment exchange scheme at the Mersey Region Drugs Training and Information Centre (MRDTIC) to prevent the spread of HIV. It is hard to imagine now that the syringe exchange scheme, which was then seen as a radical approach to the problems of drug use, was regarded as

highly controversial and, in the words of one community activist, on a par with giving 'guns to murderers'. Now syringe exchanges have been adopted in many countries. And it still seems exactly what is was to us then – common sense. From its humble beginnings in the ground floor toilet of an office, the harm reduction model that started at MRDTIC flourished. It is now firmly established in drug service provision around the globe.

Even though the syringe exchange scheme was only advertised by word-of-mouth, in the first six weeks of operation it attracted over 300 people. As well as supplying clean injecting equipment, staff at the centre also provided free condoms and advice on safer sex. Among the women who attended the scheme were a few female sex workers who also injected drugs. Initial discussions with these women revealed that sex workers operating in a particular area, near to the city centre, were experiencing difficulties in obtaining sufficient supplies of condoms. It soon became apparent that immediate intervention was needed and more detailed information was required in order to formulate effective prevention programmes for Liverpool's street sex workers. To this end, the street female sex workers outreach project was launched the following year.

So I was surprised to find myself, in 2011, once again working with these women. The opportunity came about following a restructure of the Armistead Centre service earlier this year, where I had been working with the lesbian, gay, bisexual and transgender (LGBT) drug users. In February I started a new role working for Armistead's outreach service for Liverpool's street sex workers, which has been helping women since 2003.

There have been many changes since those early days. Back in 1987, Liverpool's red light district was confined to what is now known as the 'Georgian Quarter' of the city. For decades, Liverpool's street sex workers had operated in this area, which once housed many of the city's student and bohemian populations and was known locally as 'bedsit land'. To the women, it was known as 'the block'. But following gentrification of the area, the women were displaced and now work across several different parts of the city, making it harder to identify those who are working and to keep track of the ever shifting scene.

Though the need to fund drug use still remains the main driving force for women to turn to sex work, the nature of their use has changed. In 1987 many of the women were injecting temazepam, which caused terrible physical damage and led to many of them losing limbs. At that time crack cocaine was beginning to emerge and was rapidly gaining popularity amongst the city's drug users.

While crack use is now the norm, the days of temazepam have – thankfully – long since gone and it would appear that injecting drug use has decreased amongst the women over the years, with fewer requests on the streets for injecting equipment. This may be because equipment is more readily available through pharmacy exchange schemes and established services. However, many of those who do inject are at very high risk and the most at risk are the women who are 'speedballing' heroin and cocaine, which increases the risks of an overdose.

HARM REDUCTION IS STILL AS IMPORTANT TODAY AS IT WAS 25 YEARS AGO, ALTHOUGH IT DOES FACE NEW CHALLENGES

Modern technology has made a huge difference, as most people now have mobile phones. When I first went on outreach, mobile phones were only just being developed and the one I had been given was like carrying a brick around. Now mobile phones are used to contact punters and dealers alike. Mobiles are often used as deposits with drug dealers until such time as the debt is honoured. Mobiles have also meant dealing has become more sophisticated and drugs more accessible than ever before.

Although a few street dealers remain, more covert methods are used to distribute drugs with mobile phones playing an important part in this 'deals-on-wheels' culture. And, just like in The Wire, numbers change frequently and old phones are disposed of, as dealers try and avoid detection. In the 1980s, drug dealers also attended the syringe exchange and they too were given harm reduction advice to pass on to their customers. Modern technology has made dealers less visible and harder to reach, as they remain aloof and unapproachable in the safety of their cars.

With so much time having passed and driving along unfamiliar streets it felt alien, as only two streets now remain where I used to work, the rest having been built over. I certainly didn't expect to bump into anyone I had originally worked with. Yet one night I heard a familiar voice. "Hello Lyn, what are you doing back out here?" And there stood Susie. She approached me and we shared a hug. Susie had been a young girl when I had first met her. Like many of the woman who work the streets, she had spent the last two decades in and out of the treatment and criminal justice system. "I am scripted again now so I don't have to come out as much," she said. "I stopped injecting a few years back and I have a flat. I've been homeless a few times and am getting too old now to be on the streets anymore. I don't come out late and just do a couple of mushes (punters), make my money and get off. That's how I have survived all these years."

The next evening I was met by a few more of the women I had first met all those years ago. Word had spread I was back on the scene. This was very humbling for me – two decades on they still remembered me and I felt overwhelmed by their response. I soon found out how things had changed. One woman said: "It's not the same now Lyn, the way the girls used to look after each other doesn't happen anymore, it's dog eat dog out here now."

Despite earlier efforts by the police to tackle the sex trade by simply arresting the women and moving them on, it is clear it has refused to go away. Between 2009 and 2010, the Armistead's street team contacted 304 street sex workers on outreach alone.

Catching up with Susie over the next days and weeks, I heard that some of the women I had originally got to know had become drug free and made new lives. Some had lost their battle with addiction and died while others, like Anne Marie Foy, who I knew very well, had been murdered. Since 1987, nine Liverpool street sex workers have been killed.

The murder of Anne Marie in 2005 caused a big shift in the way prostitution is policed in Liverpool, both on an ideological front as well as operationally. In November 2006, Merseyside Police became the first force in the world to declare that any crimes committed against sex workers would be defined as 'hate crimes'. This is a massive leap forward, as I can still clearly remember the first time I took a victim to the police to report a particularly vicious rape.

The woman had initially been reluctant to report this attack because she had outstanding warrants for her arrest for Common Prostitute Loitering (CPL). I had been assured that she would be dealt with sympathetically as the offence of rape was deemed far more serious than her outstanding offences. However, when she reported the rape to police, she found the desk officer was

High risk: crack use is now the norm among street sex workers in Liverpool

PHOTO: LIVERPOOL ECHO

rude and unhelpful. After a few checks she was arrested for her outstanding charges and spent the night, traumatised and withdrawing from heroin, in a cell.

Now, thanks to the work of Shelly Stoops, the Armistead's specialist independent sexual violence advisor, police attitudes have changed dramatically. Since 2006, when Shelly's role was established, there have been 25 men brought before the courts for violent and sex-related crimes against sex workers, 19 of whom are now serving jail sentences.

Outreach was established to not only encourage people into services, but also to ensure that those who would not or could not enter treatment were monitored and, therefore, provided with a safety net. Despite easier access and improved service provision nationally, I have found there are still those who are unwilling to engage with the treatment system. I recently met one woman – let's call her Jane – who was raped three years ago, but the offender was found not guilty. Deeply traumatised, Jane dropped out of all services but had been recently contacted in relation to another rape committed by the same perpetrator. Jane's case reinforces the need for, and value of, assertive community based outreach projects that maintain contact with those clients who are still reluctant to use more mainstream services.

Having damaged all accessible veins, Jane had begun 'skin-popping' in her legs. The injections in her legs had formed deep abscesses that had turned to badly infected ulcers. I have not seen such extreme injecting-related damage since those early days of harm reduction. Left to her own devices for three years whilst collecting injecting equipment from the chemist, meant that no-one had enquired about her injecting technique. When asked why she did not want a methadone 'script she was very clear: "I get my drugs delivered every two weeks to my door. I have had the same dealer for 17 years who looks after me very well. Why would I want to have to stand in a chemist's every day and be watched while I drink my methadone?" Despite the terrible damage to her legs, Jane was also reluctant to go to hospital because previous experiences had made her feel judged and humiliated.

When I first began this work I spent many a day or night in the A&E departments of hospitals around Merseyside, supporting and advocating on behalf of my clients. I was disappointed to find, whilst trying to get medical treatment for Jane, that, 25 years on, there are still some medical staff that hold the same judgmental attitudes towards drug users as they did all those years ago. The suspicion that drug users present to A&E to get drugs still prevails. In Jane's case, she finally got the help she needed. Even though she was still unwilling to go into drug treatment, the harm reduction advice she was given – try snorting your heroin instead of injecting – helped prevent any further harm and allowed her legs to heal. For me, harm reduction has, and always will, play an important part towards the recovery process for drug users. Harm reduction is still as important today as it was 25 years ago, although it does face new challenges.

Trust still remains an issue, and the women are still suspicious of services if they are pregnant or have children. Now, outreach is far more formalised with many policies and procedures in place and, along with the ever-increasing need for evidence and statistics, more personal information is now required than ever before. Importantly, the one thing that has not changed, and probably never will, is the vulnerability of those women who find themselves in the position of walking dark and lonely streets to sell sex for money to buy drugs.