

Outreach on the front line

Crack's damaging impact on the lives of Liverpool's street prostitutes

ON 20 APRIL 1989 Robert Stutman, Senior Agent in charge of the Drug Enforcement Administration's New York Division, told the Association of Chief Police Officers that Britain could experience a 'crack explosion'. He dramatically described the horrors seen in America and warned that if action was not taken immediately Britain would soon undergo the same experience.

Although Stutman's warnings were premature and dismissed by many British drug experts, there is now growing evidence to suggest that crack is taking hold in many inner-city communities in Britain.

During the four and a half years I worked as an outreach worker with female prostitutes in Liverpool I witnessed the spread of crack use on the scene and in the area where the women operated. My work brought me into contact with many users of the drug and the project was one of the few in regular contact with crack users.

The project started in September 1987 when Mersey Regional Health Authority asked me to assist with an exploratory survey of prostitution in Liverpool. It was thought that an informal 'outreach' approach would reach deeper into the hidden sector than conventional health or social work approaches.

Our main purpose was to assess the HIV/AIDS knowledge and attitudes of female sex workers in order to design interventions aimed at reducing high-risk activities within this group. Fieldwork was undertaken without delay and contact established with the women involved.^{1,2}

To achieve credibility among this group a non-judgmental approach was important. Trust was established fairly quickly by befriending and demonstrating 'unconditional regard' with respect to their activities.³ To make radical changes in their lives the women needed to feel worthwhile and

empowered. Starting from the perspective that what one does is 'bad' – or that one's entire life is pathological – was doomed to failure. Having gained the trust of the women, the project also gained the trust of many of their partners, friends and associates.

Women prostitutes were being held up at knife point by men seeking money for crack

The first reports of crack use in Liverpool were heard during 1987. By mid-1988 use of crack was becoming noticeably more prevalent among women working as prostitutes. Anecdotal evidence suggested crack use was also on the increase among drug users in the area. Around this time the women began to complain of a higher incidence of muggings and 'rip offs' attributed to local youths who "wanted money to buy rock".

At the end of 1988 increasing reports of crack on the streets became a cause for

by

Lyn Matthews

The author is Drugs Counsellor at the Merseyside Drugs Council in Southport. Until April 1992 she was an outreach worker with Liverpool Health Authority.

Crack was first reported in Liverpool in 1987. By mid-1988 crack use was prevalent among the city's prostitutes. An outreach worker describes how by the end of 1988 there was concern that the women accepted higher risk sex to buy crack and were the victims of crack-related violence. By 1990 the entire community was affected. Working with inner city crack users requires first the nurturing of a relationship of trust with a group suspicious of authority and prone to cocaine-induced paranoia.

concern. At £30-35 per rock, many of the women were working longer hours to get the money to buy the drug and possibly engaging in more high risk sexual activity, increasing the HIV risk. It was decided to survey the women to establish some facts about the local situation.

In June/July 1989 26 crack users (22 female prostitutes, and four male drug users) were interviewed. Most did not feel crack was a major problem and thought it was "easy to give up".⁴

By the beginning of 1990 the sale and use of crack was an established part of the local scene. The price of a rock had fallen from £35 to as little as £20. A range of factors, including high unemployment, poverty, lack of education and institutionalised racism, provided fertile ground for crack use to flourish in this area. Crack was clearly not just a black problem – it was an inner city problem. Both blacks and whites were involved in the trade and in selling cocaine powder. Reports of cocaine injecting in other parts of the city were also on the increase.⁵

Crack was being sold openly on certain local streets. Dealers were mainly young men, both black and white, almost invariably themselves using rock. More established dealers operated their businesses using a mobile phone and would deliver. Credit was given; failure to pay on time would result in the debtor being threatened with violence or with having valuables forcibly taken from them. The women I worked with were regular victims of such incidents; reports of violence became the norm.

Rock cocaine's impact on the community as a whole was becoming apparent. Entire families were dependent on the drug. Many of the male users were becoming more violent towards their partners. Women working as prostitutes consistently complained of being held up at knife point by men seeking money for rock, and were being forced into 'setting up' punters for robberies. Many of those involved in these

The author thanks Peter McDermott for his helpful comments on an earlier draft of this article and for his invaluable personal and professional support throughout the course of this project.

activities had committed such crimes before using crack, but there were many who would not have done so before they and those around them started using the drug.

The general health of women crack users was starting to deteriorate. Many lost weight and were more prone to chest infections; some reported fits after using rock. Virtually all suffered deep depressions and extreme mood swings. Heroin and temazepam were commonly used to cushion the come down from rock, leading to several of the women's partners becoming dependent on opiates. Many of the people I worked with did not know that cocaine could be life threatening through overdose, heart attacks, strokes or seizures.

Another major concern was women who were pregnant and still using crack. Many were reluctant to make use of services such as antenatal care and drug treatment. Their babies tended to be smaller and were sometimes premature, but did not exhibit the severe problems associated with US 'crack-babies'. This may have been due to lower levels of use, easier access to health services, or less deprived conditions.

Working with crack

The growth of this new and difficult user group has wide-ranging implications for services. Any worker making contact with this group should do so from within a strategy which can offer, or refer into, a wide range of tangible interventions. Crack users see existing services as offering nothing for them; they know that, unlike heroin addiction, no prescription can be given. Any thought of escaping crack is quickly subsumed by desire for the drug. Practical things, like ongoing support and acupuncture, may initially assist in nurturing the trusting relationship that is vital if the client is to enter counselling.

Regular supervision and support for the worker is vital. Such work is demanding

1. Ashton J. *et al.* *The New Public Health*. Liverpool University Press, 1989.

2. Matthews L. "Outreach work with female prostitutes in Liverpool." In: Plant M. *ed.* *AIDS, drugs and prostitution*. Tavistock/Routledge, 1989.

3. Springer E. "Effective AIDS prevention with drug users: the harm reduction model." In: *Counselling chemically dependent people with HIV illness*. Haworth Press, 1991.

4. Newcombe R. *Crack in Liverpool: a preliminary study of a group of cocaine smokers*. Liverpool: Maryland Centre, 1989.

5. McDermott P. *et al.* "Crack in Britain: hard times and harm reduction." In: Reinerman C. *et al.* *Crack in context*. 1992.

6. Williams T. *The cocaine kids: the inside story of a teenage drug ring*. Addison-Wesley, 1989.

7. Williams T. *Crackhouse*. Addison-Wesley, 1992.

8. Williams T. 1992, *op cit*.

Crack, paranoia and violence

One of the women I had been working with for some time was regularly being beaten up by her partner. He would have regular psychotic episodes as a result of using rock and become extremely paranoid and violent. I knew this man before he began using rock, when he was quiet and shy. His partner had asked if I could talk to him regarding his drug use.

The night I called he was alone with their child. It was obvious from the state of the room that he had had another violent outburst. When I asked about his partner he started ranting about her. The effects of the cocaine he had been smoking were starting to wear off and he was very paranoid – I could see the fear in his eyes. By constant reassurance, reminding him of the duration of our relationship, I eventually managed to calm him down and we sat and talked of

what he was feeling.

He had become convinced there were cameras in the electric sockets and police in the attic – even though the house had no attic. He believed people were constantly spying on him.

While we were talking I noticed a large knife hidden down the side of the chair. Although I had never felt threatened by him or by the situation, the presence of a knife disturbed me. I asked him to put it away, which he did. Later he told me he never went anywhere without some kind of weapon. His rock use made him feel threatened all the time and he felt he needed a weapon to "protect" himself. I explained that what was happening to him was the effect of the drug and that once he stopped using the paranoia would eventually disappear. Beyond this there seemed little I could do, other than offer my support.

and highly stressful, and it is easy to feel isolated. Managers or team leaders need to fully understand the nature of this work, provide adequate supervision, facilitate networking with other workers in similar positions, and advocate for their workers at management or team meetings.

Because of the nature of crack use, harm reduction approaches can only be tackled incrementally. Once people start they appear quickly to lose control over their crack use. I came across few users capable of confining their use to an occasional basis and who did not seem to have crack-related problems. Crack users are unpredictable and volatile; they can act out of character and distrust services and people in 'authority'.

Initially services must attract users with a caring, non-judgmental approach and be willing to work alongside them and attempt to make a positive impact in their daily lives. For example, in America sexual transmission of HIV is high among crack users, so education around AIDS prevention can provide a lead in to discussions about their drug use.

On a study visit to New York last October I spent some time with the ethnographer Terry Williams, author of the highly sympathetic studies of drug use in New York, *Cocaine Kids*⁶ and *Crackhouse*⁷. Years of studying cocaine trade and use in New York, meeting hundreds of users and coming to know some of them well, had convinced him that:

"Addiction did not take over people's lives because they were irresponsible or have some

inherent flaw. Instead, the crack users' behaviour reflected class, race, and economic factors; those who can command resources, who have the power to effect change in their lives, are very hard to find in an American Crackhouse."

This statement could easily apply to those using crack in Britain today. New York's crack problem is far greater and much more overt than anything I saw in Liverpool. In Times Square, people squatted in doorways smoking crack. Crack vials littered many of the streets I walked. It seemed as though everywhere I went there were people hustling or begging for a few dollars, to buy a vial of crack. In New York crack is a major industry, not the 'cottage' industry it has been likened to in Britain. The New York State Office of Drug Abuse Services estimates that on any given day as many as 150,000 people may be selling or helping to distribute crack cocaine in the city.

Britain's cocaine trade has appeared to follow the American pattern, losing its exclusive status and making the product more widely available in the poor neighbourhoods of many of Britain's inner cities. Cocaine still remains relatively expensive, though users report that prices are falling and quality increasing. We can no longer ignore the major problem cocaine now presents in our cities. If crack use generally rises at the rate I observed among one particular community, the consequences for our society will be enormous. To ignore this problem would be folly – and at a price Britain cannot afford. ■