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Abstract

Based on a qualitative health needs assessment with 31 diverse sex workers and 17 key stakeholders (including two mental health practitioners) in Victoria, Australia, this article adds to the emerging literature on stigma, sex work, and mental health. It does so by focusing on one element that plays a key role in determining sex workers' experience of mental health support: whether they would disclose their sex work to a practitioner, why so, and what happens as a result. Our study finds that experiences and fears of being stigmatised by health practitioners when disclosing may prevent some sex workers from seeking professional mental health support in the first place and lead others to silence it or obfuscate; thus, potentially complicating access to safe and affirming mental healthcare. The value and role of disclosure is analysed in context by acknowledging the agency and ability of sex workers to understand, or take action in response to, their own mental health needs. Peer-to-peer support and solidarity are identified as key to sex workers' mental well-being. Criminal restrictions on sex work are found to negatively impact sex workers' access to mental healthcare. The findings from this study support ongoing efforts aimed at the full decriminalisation of sex work in order to improve sex workers' access to high-quality mental health support, should they seek it, as well as the implementation of sensitivity training for mainstream mental health providers and the creation of reliable and accessible referral lists of sex worker-friendly mental healthcare providers.

Keywords: sex work; mental health; stigma; service provision; sex work disclosure; outing

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1. Introduction

1.1. Sex Work and Mental Health

Globally, sex workers, including cisgender and trans and gender-diverse individuals, face disproportionate health inequities, including elevated risks of HIV/STIs, violence, and systemic stigma [1–3]. These disparities are driven by criminalisation, social marginalisation, and structural barriers to healthcare and legal protections [4,5]. Migrant sex workers experience compounded harms from intersecting racism, restrictive immigration policies, and anti-trafficking measures that heighten precarity [6,7]. Such structural factors intersect with sex workers' mental health and can result in psychosocial burdens rooted in exclusion,

discrimination, and institutional violence. In fact, mental health problems are documented to be disproportionately high among sex workers in a number of different settings globally (e.g., [4,8]). Until two decades ago, research on mental health and sex work mostly concentrated on seeking associations between individuals' mental health problems, their past traumas, and sex work engagement [9,10]. Such research would typically equate all sex work to an experience of harm, and would largely point to a causal relationship between selling sexual services and mental ill-health or trauma [10,11]. This body of research has since been widely criticised and discredited for being methodologically flawed and based on moral judgements rather than empirical evidence [12,13]. Recent developments in academic and community-based research have helped shift the paradigm from a pathologising lens that would frame selling sexual services as a cause or indication of mental ill-health or trauma to one that centres on the impact of structural factors such as stigma, criminalisation, working conditions and exposure to violence on sex workers' mental health, rather than sex work itself [5,14,15].

1.2. Sex Work Stigma

One social determinant increasingly recognised as shaping sex workers' health outcomes and access to health services is stigma associated with working as a sex worker [15,16]. Stigma is widely understood as the set of discrediting attributes and markers that underpin judgemental attitudes and behaviours towards specific groups or individuals [17], who are kept in a subordinate position in society as a result [18]. Stigma has been argued to function as a strong health determinant that can be internalised and have a negative impact on the mental health of affected individuals and groups [19]. Rather than simply operating as a floating force, stigma is socio-politically reproduced through concrete actions and practices, including via political discourse and action (e.g., legislation and policies) as well as the media [17,18].

Sex workers are a highly stigmatised group, whose experience of stigma can vary from being viewed as deviant vehicles of disease and social harm, to powerless victims with no agency [16]. Moreover, as most sex workers belong to further marginalised groups on the grounds of their class, gender, sexuality, and/or migration and ethnic backgrounds, their experience of stigma can be complex and intersectional [14]. A systematic review indicated that the stigma sex workers experience from medical staff functions as a barrier to accessing general health services [20]. However, scholars have also shown that stigma can be resisted by sex workers through collective organising and social interventions [21], as well as through individuals' own resilience and coping mechanisms [22].

In their influential 2018 article, Benoit et al. examine the way the so-called 'whore' stigma works as an oppressive force against sex workers at macro, meso, and micro levels, ranging from criminal law to institutional discrimination to interpersonal relations and affects [21]. The authors argue that sex workers' collective organising for their rights plays a crucial role in challenging the stigma that may negatively shape sex workers' health and wellbeing, including their mental health [21]. Recent scholarship has further critiqued how stigma operates not only as a barrier to care but as a form of epistemic violence that denies sex workers' expertise in defining their own mental health needs. Lobato's analysis of French sex workers' resistance to psychomedical narratives, which conflate sex work with trauma or pathology, highlights how stigma is weaponised to invalidate sex workers' lived experiences and agency. Lobato centres sex workers' acts of counter-framing: challenging clinical assumptions and reclaiming authority over their mental health narratives [23].

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1.3. Stigma, Sex Work, and Mental Health Support

In the last decade, stigma has been increasingly understood as a main factor shaping sex workers' mental health, and as having particularly negative effects on sex workers who need and seek professional mental health support [15,16,24–27]. Between 2018 and 2019, Rayson and Alba ran a survey relating to sex work, stigma, and mental health among 189 sex workers responding mostly from Australia and the US. The authors found that sex workers experienced high levels of stigma and that such stigma negatively influenced the likelihood of them seeking professional mental health support [25].

A qualitative study on sex work and mental health based on 128 in-depth interviews with diverse sex workers (in terms of gender, migration, and cultural backgrounds), who described themselves as having experienced mental health problems, in Germany, Italy, Sweden, and the UK, complemented the findings of Rayson and Alba, adding further nuances [15]. The study highlighted that stigma and criminalisation (including of migration) were major factors contributing to mental ill-health among sex workers. Over one in ten of the sex workers in the study expressed how fear of being judged, pitied, reported, or filed as a sex worker by a mental health professional had prevented them from seeking any professional mental health support despite experiencing the need for it. Of those who disclosed sex work to mental health staff, more than half (58%) had experienced stigmatising, pathologising reactions, and found the support they received to be detrimental to their mental health [15]. Negative experiences were far more common within the public mental health sector than other health settings, with 73% of those who reported positive experiences having been supported by outreach workers or staff within projects specialised in supporting sex workers, or lesbian, gay, bisexual, or transgender (LGBTQI+) people [15,28]. While stigma and prejudice from mental health staff were reported in all four countries, the authors indicated that in Sweden, sex workers seemed considerably more likely than in any other setting to experience stigma and ineffective or harmful professional mental health support, which they understood to be linked to the country's anti-sex work criminal laws [15,28].

Treloar et al.'s participatory qualitative study involving six focus groups and two interviews with 31 sex workers in Australia found that the sex workers' mental health was significantly impacted by the stigma attached to their work [16]. Sex worker participants in Treloar et al.'s study had invested time and effort in managing stigma, including carefully selecting who they would disclose their sex work to, self-care, and occasionally accessing professional mental health support. Several of these sex worker participants, as in the Macioti et al. report cited above [15], reported having been judged, poorly treated, and patronised by mental health professionals, who would often question their agency and/or understand sex work as their primary mental health concern, leaving their actual mental health issues unexplored [16].

Another qualitative study with six sex workers with pre-existing mental health needs in rural Tasmania, Australia, explored the way systemic stigma, including patriarchal attitudes expressed by people in government and encountered within everyday life, was experienced by sex workers as harmful to their mental health [26]. The authors found that the sex workers did not experience sex work as harmful to their mental health, yet all but one felt mental health professionals had been ineffective, patronising, and derisive after they disclosed sex work to them [26].

The extent to which stigma works as a barrier to (effective) professional mental health support for sex workers was well exposed by a recent systematic review by Reynish et al. [25], which included analysis of 32 studies on barriers and enablers to uptake of mental health care by sex workers in OECD countries. Reynish et al. proposed that stigma, discrimination, violence, and criminalisation can exacerbate psychological distress in sex

workers and hinder access to mental health care. The authors also highlighted that, however uncommon, positive examples of affirming and respectful mental health support to sex workers, where sex work is not framed as a problem per se, do exist and recommended more research in this area to identify, describe, and promote areas of good practice [25].

1.4. Sex Work Disclosure to Health Professionals

Emerging scholarship has started to address a central concern for many sex workers needing mental health support: when disclosing their sex work to health professionals, sex workers risk experiencing the same stigma society imposes on them and that is likely to have negatively impacted on their mental health in the first place, leading to their reluctance to seek help or to silencing their sex work experience. As considerable numbers of sex workers identify as belonging to the LGBTQI+ communities [27,28], it is important to note the documented parallels with non-heterosexual patients' experiences of disclosure (or not) of non-heterosexual behaviour to medical staff. Poor treatment or fear thereof of disclosing one's sexual identity or practices to general practitioners (GPs) has been found to negatively influence lesbian, bisexual, and queer women's trust in medical professionals and their willingness to engage with or seek mental health support when needed [29]. McNair et al. also found that LBQ women patients who disclose their sexuality to their GPs and are met with respect and acceptance tend to have better health outcomes and their mental health needs are recognised than those who silence their sexuality for fear of negative responses [30]. Similarly, some studies mention how previous negative experiences with medical staff when disclosing sex work may shape sex workers' approaches or considerations towards doing so in the future [31] and on the way sex work disclosure (or not) influences the outcomes of care received [15]. There has been less attention in research on the ways in which sex workers manage and navigate the risks of disclosure to health professionals, particularly in a mental health context.

1.5. The Role of Disclosure to Mental Health Professionals

As far as psychotherapy is concerned, "full disclosure", which is total openness about the patient's life circumstances with their therapist, is widely regarded as a precondition for the positive outcome of the therapy [32]. Similarly, within other forms of psychological counselling, practitioners strive to provide a safe space for patients to be able to disclose any aspect of their lives they would wish to share and discuss [33]. Yet, some patients can and do decide not to disclose specific thoughts or experiences out of feelings of shame or fear of being judged [32]. In his review of research on patients' disclosure (or lack thereof) in psychotherapy, Farber notes that, while disclosure can affect the outcomes of psychotherapy, it does so in a proportional manner to the salience given by the patient to such disclosure [32]. This is an important consideration when approaching the issue of patients' disclosure of sex work with mental health staff: sex work experience ought not to be understood as a defining aspect of one's psychological profile that must be disclosed at all costs for therapy or counselling to be effective. This would be an unfounded premise, given that research indicates that sex workers largely do not experience sex work per se as having a negative impact on their mental health [15,16,25]. However, feeling comfortable about mentioning or discussing a salient aspect of one's life (such as one's sexual behaviour or the way one pays ones' bills) without fearing judgement or pathologisation from a mental health professional is likely to determine the quality of the rapport established with the therapist and hence of the care received, particularly for stigmatised groups on the ground of their sexuality or sexual behaviour [34]. Accordingly, in this article, we focus on the importance that diverse sex workers give to sex work disclosure and on their way of managing it, rather than understanding disclosure as always necessary.

1.6. Aims

As noted above, previous research has widely documented stigma experienced by sex workers in healthcare contexts; however, little research to date has specifically examined the point of sex work disclosure and what immediately follows. As a central entry and potential referral point, such disclosure may be vital for some, necessitating close attention to ensure affirming, supportive, and non-stigmatising responses.

Therefore, within this article, we aim to expand knowledge on stigma, mental health, and sex work by examining a decisive moment in the potential encounter between a mental health professional and a sex worker seeking support: whether the latter would and will disclose their sex work to the former; what motivates such decision and the consequences that arise at the point of disclosure. We do so by analysing in-depth interviews with 31 diverse sex workers in Victoria, Australia, who discussed mental health needs; experiences of and rationales for sex work (non)disclosure with general and mental health practitioners; and their outcomes/consequences. We will also include data from interviews with 17 key stakeholders working to support the health and well-being of diverse sex workers. By focussing on the issue of (non)disclosure with health practitioners, we strive to deepen the understanding of what modes of psychological support diverse sex worker may need and want, of their resilience and coping mechanisms, as well as to provide policy-level and good practice recommendations for the mental health care sector to improve engagement, access and quality of support provided to sex workers and seriously commit to the wellbeing of this stigmatised population.

2. Materials and Methods

2.1. Peer-Inclusive Methodology

In the field of sex work research, there is a growing consensus that researchers with sex work experience are best positioned to engage ethically with sex workers, a highly stigmatised and diverse population, for research purposes. Scholars and advocates have argued that peer-based research approaches improve the ethics and quality of the data obtained through increasing the chance of trust and honesty from participants towards their peers, while they also increase the positive impact of research in the community [35,36]. Given the huge diversity among sex workers in terms of (but not only) gender, migration, and cultural backgrounds, and modality of sex work, further benefits have been identified in employing diverse peer researchers to reach out to diverse participants and improve the complexity, variety, and nuance of the research data [37]. Reaching a diverse sample is particularly important in research on mental health and sex work, which has been criticised for neglecting gender diversity and for focusing on particularly marginalised sections of sex workers, such as street-based cisgender women sex workers who consume drugs, and drawing conclusions on the overall harmfulness of sex work for mental health [13].

Hence, the data for this research were collected through a qualitative, peer-inclusive methodology aimed at reaching a diverse sample. The project was supported by a community advisory board made up of six sex worker advocates of diverse genders and backgrounds, and with different sex work and advocacy experiences. Five diverse research assistants with sex work experience were also recruited and trained in qualitative interviewing with sex workers. The peer researchers subsequently undertook all interviews with sex workers. Among the interviewers were people with experience of different modalities of sex work; with diverse migration backgrounds, including a Mandarin and a Thai speaker; and of different genders, comprising two cisgender women, one cisgender man and two nonbinary persons.

2.2. Legislative and Healthcare Context at the Time of Data Collection

Sex work legal frameworks that directly or indirectly criminalise sex workers have been found to have a strong negative impact on sex workers' experiences of and access to health services [5]. Our study took place in the Australian state of Victoria at a time when sex work was regulated through a licencing regulatory regime that made it extremely difficult to comply with sex work laws and thus effectively criminalised most sex workers [38]. Amongst other measures, sex workers were legally required (via state legislation) to certify their attendance to regular sexual health screening, thus exposing them to having to disclose their sex work with medical professionals [39].

As part of efforts to reform the aforementioned state legislation and provide a more affirming health context, the current study was commissioned by the State Department of Health (with a subset of its data used within this specific paper). In 2022, legislative reform did indeed occur, and the licencing system was replaced by sex work decriminalisation, in view of growing evidence that this model is best apt to uphold sex workers' health and wellbeing [38,40].

Mental health care in Australia (including the State of Victoria) is covered through both Medicare and state-funded services, within a mixed public–private system. Medicare covers Australian citizens, permanent residents, and some visitors from countries with reciprocal agreements; most temporary visa holders are not covered. Under Medicare, eligible people can access subsidised mental health care through the Better Access initiative, which provides rebates for GP visits, psychiatrists, and a limited number of sessions per year with psychologists and other allied mental health professionals (usually with out-of-pocket costs). Public hospitals provide free inpatient and community mental health services for severe or acute conditions, though access can involve waiting times due to resource and staffing constraints. Private mental health care (private psychiatrists, psychologists, and private hospitals) is widely used and often requires out-of-pocket payments or private health insurance. Services such as counselling, long-term therapy, and psychosocial support are only partially covered and remain a key gap.

2.3. Recruitment and Confidentiality

Sex worker participants were recruited via snowball sampling through the networks of the research team and project advisory board, informal advertising (such as posts to sex worker WhatsApp groups in the State) and the help of a non-peer service for street-based sex workers (who provide sexual health and other health services for sex workers in the State and who promoted to study to service users via flyers). Key stakeholders were identified through background research and in consultation with the community advisory board. All interviews took place via videoconference (i.e., Zoom) between July and December 2021, most of them during periods of social lockdown, imposed as part of the public health response to COVID-19. To protect the anonymity of all participants, only audio recordings were kept, all transcripts and interviewees were anonymised, and sex worker participants were assigned a pseudonym different from the names they may have used in the interview process. Sex worker participants and key informants who were not being interviewed as part of a paid role received $80 as compensation for their time. The project was accorded ethical approval by the Human Research Ethics Committee of La Trobe University. All names used in Section 3 are pseudonyms.

2.4. The Sample

2.4.1. Sex Workers

Among the 31 sex workers interviewed, 18 identified as cisgender women, five as trans women, five as cisgender men, and three as nonbinary. A majority (*n* = 23) identified

as cisgender and/or heterosexual. Nearly two-thirds (n = 19) of participants were migrants (i.e., born elsewhere than Australia to non-Australian parents), 12 were of Asian backgrounds, four from New Zealand, one from South America, one from Eastern Europe, and one from Western Europe. Three were identified as First Nations (one as Aboriginal and two as Māori). Nine out of twelve Australian participants identified as Anglo-Celtic, the rest as people of colour or of mixed ethnicities. Seven sex workers were on temporary visas, one was undocumented, and the rest had either permanent residency (n = 6) or Australian citizenship (n = 14). Most sex workers had experience working in a variety of different sex work modalities, including independent private work; street-based work; stripping; licenced (legalised) and unlicensed (outlawed) brothels; escort agencies; porn; erotic massage or BDSM. All but one participant (who had only ever worked as a stripper) mentioned not complying with the Victorian sex work licencing laws (hence risking prosecution for sex work) on at least a few occasions.

2.4.2. Key Informants

Key informants were defined as individuals who provide health-related support and advice to different sex workers, either within formal, paid positions, as volunteers, or as engaged community leaders. In total, we interviewed five community leaders who belonged to and supported different sex worker communities (including First Nations, migrant, street-based, private, and brothel workers), some of whom were also involved in peer-only sex worker organisations. Twelve individual service providers working for eight different projects/clinics/organisations were interviewed. The organisations comprising non-peer-led services for sex workers (including for street-based, brothel-based, and sex workers who use drugs), sexual health clinics, services for people living with HIV/AIDS, as well as two mental health providers with experience providing psychological support to sex workers.

2.5. The Interview Guides

The interview guidelines were designed in consultation with the community advisory board. For sex workers, the guidelines entailed open-ended questions about their health and wellbeing needs, including about their sexual, physical, and mental health; experiences with medical staff and support organisations; and what they felt needed to be accomplished at the policy and service provision level to improve their lives and wellbeing. Key stakeholders were asked about what they perceived to be the key health and well-being needs of the particular groups of sex workers they engaged with the most, about challenges and enablers to realise their work, and about their opinion on best practice for health support and service provision to sex workers.

2.6. Thematic Analysis

Interviews with sex workers and key informants were transcribed verbatim, de-identified, and analysed using NVivo (version 1.0). Reflexive thematic analysis [41] was employed, following their six-phase approach to identify patterns of shared meaning rather than descriptive topic summaries. This method aligned with the study's critical epistemology, recognising structural inequities as shaping—but not defining—participants' experiences. The analysis progressed iteratively: familiarisation with transcripts, inductive coding, theme generation through collaborative discussions with the peer research team (including sex workers), theme refinement for conceptual coherence, and finalisation of themes. Reflexivity was embedded through researcher memos documenting positionality (e.g., academic/activist roles) and Community Advisory Board feedback, which challenged assumptions (e.g., avoiding homogenisation of migrant sex workers' experiences). Consensus coding and inter-rater reliability measures were intentionally omitted, as reflexive

thematic analysis prioritises interpretive depth over code-counting. Themes were finalised based on their capacity to articulate actionable structural drivers of health inequities, rather than pursuing thematic saturation.

3. Results

3.1. Sex Worker Participants' Mental Health Needs

We start by briefly outlining the mental health circumstances of the sample and population we engaged with. Exacerbated by the COVID-19 crisis, which meant most participants were either unable to work and earn income or risked prosecution for breaching public health laws, shorter or longer periods of mental distress were recalled by all 31 sex workers in our study, who described a range of different problems and conditions. Depression and anxiety were the most commonly reported problems, similar to what is found by studies among the general population [42]. About half of the sex worker participants described having mental health challenges prior to sex work engagement.

> So yeah, my mental health was not good. Always irritated after work. And tired because of the long hours. And so yeah, my mental health was not good. I was blocked sexually as well. (Roxy, sex worker)

Unmet mental health needs in the form of poor or no professional mental health support were among the most frequently mentioned health needs by both sex workers and key stakeholders in our study. Several key stakeholders noted that sex workers should be considered experts in sexual health matters, with very high rates of STI and HIV testing and condom use at work. Nevertheless, targeted health promotion programmes for sex workers still predominantly focus on sexual health. Due to the strong stigmatisation attached to sex work, these stakeholders saw a greater need for drawing attention to sex workers' mental health needs.

> I'd definitely say that's the number one health issue [mental health]. It's the stigma and discrimination, which manifests individually for some people. You know, poor mental health outcomes. (service provider)

Sex work stigma in society and within the healthcare system, together with COVID-19-related restrictions and lack of support by the government (particularly to non-permanent-resident visa holders, migrant sex workers), were among the factors described by sex workers as having a negative impact on their mental health. A few felt that performing sex work when feeling mentally unwell had been challenging. Conversely, several sex workers expressed how their complex mental health needs and/or neurodiversity had precluded access to mainstream jobs, while sex work had allowed them to be financially independent and thus helped their mental health. A few sex worker participants experienced sex work as empowering and beneficial, while a minority (three cisgender women) found it to be potentially harmful to their mental health. These three workers were Asian ($n = 2$) and South American ($n = 1$) migrants who reported being isolated from their peers and unwilling to disclose their sex work to anyone, which indicates the strong impact stigma may have had on their experiences.

> If you're working privately, you're kind of isolated. So you're completely on your own when you've had that bad booking [. . .] It's just you and you might not want to share that with like your partner or your support network. They won't understand. (Sara, sex worker)

3.2. Circumstances of Disclosure

A clear majority of sex workers in our study ($n = 29$) had disclosed their occupation as a sex worker to at least one health professional, whether a GP, a sexual health nurse,

hospital staff, or a mental health provider. What they shared with us about their experiences is pivotal to understanding the role of disclosure for (good) mental health support to sex workers. Given the differing nature of engagement and, thus, possibilities for sex work, across different healthcare contexts, we divide the discussion between disclosure that occurs with GPs or other general practitioners from that which occurs within the context of engagement with mental health practitioners specifically.

3.3. Disclosing Sex Work to GPs or Other Health Practitioners

In the Australian context, GPs provide a vital entry and referral point into mental health services, as the development of a mental health plan by a GP is a necessary precursor to accessing state (Medicare) subsidised counselling or psychotherapy (for those eligible). For a majority of sex worker participants, disclosing sex work to medical professionals, such as GPs or hospital doctors, was met with extremely poor treatment, ranging from refusal of care, threats to be reported, to questioning the patient's mental wellbeing or other patronising reactions.

Notably, stigma frequently intersected with presumptions of drug use, with clinicians conflating sex work with substance dependency regardless of the participant's actual practices. This stereotyping manifested in two key ways. On the one hand, sex workers were presumed to be drug users solely based on their occupation; on the other, they were presumed to be sex workers based on their drug use and gender identity. Lexy, seeking care for chronic pain, recounted:

> I've had a couple of incidents where I accessed ER for pain issues and was treated both times like a drug seeker. (Lexy, sex worker)

Lexy's experience underscores how clinical assumptions of drug-seeking behaviour often override patient-reported symptoms, particularly when sex work is disclosed.

Participants who used drugs also faced heightened stigma, with providers attributing their occupation to addiction. Linda, a trans woman and drug user, noted that she does not need to "disclose" sex work to health workers as these regularly assumed she was a sex worker, because of her drug use and gender. This bidirectional stigma—where drug use is presumed to indicate sex work, and sex work is presumed to indicate drug use—reflects deeply embedded societal narratives that frame both practices as intersecting stigmatised tropes.

It is important to note that one reason why many sex workers in Victoria would have had to disclose their sex work to healthcare staff was that, at the time of data collection, all sex workers were required by law to undergo a trimonthly sexual health check. In order to work in licenced brothels, brothel workers needed to present a "sex work certificate" showing they had undergone such an STI and HIV check, which they had to obtain from either a GP or a sexual health clinic. Only one large clinic in Melbourne provided sex workers with anonymous checks and issued sex work certificates free of charge in their working names. While many sex worker participants did attend that clinic, others spoke of several reasons why they preferred not to, including long queues and waiting times, or the service being too far from their home or workplace. For those who needed it, the only other option to obtain a certificate was to get it from a GP, which necessarily required disclosure of sex work to them. Some participants recalled being refused care, dismissed, patronised, and mistreated when trying to get a certificate:

> I actually had to go see four different doctors before I could get an attendance ticket [sex work certificate] to start working. A first doctor looked at me, like this piece of shit [. . .] the moment I said I wanted an attendance certificate for sex work, he turned to me and said, 'Get out.' [. . .] by the third doctor, still no. No-one looked at my vagina at this stage at all. (Stacy, sex worker)

Another worker shared:

> I asked [my GP] for a doctor's certificate in order to be able to work. And the first thing out his mouth is, am I psychologically right of mind to be doing what I'm doing. (Alice, sex worker)

Vanessa, instead, did not proactively disclose sex work but was asked by her GP on the grounds of having regular sexual health checks:

> I had a bad experience with a local GP, when I was doing the right thing. I had my [sexual] health checks every 3 months. And he saw on my record, that I was doing it every 3 months. And he was like, 'Are you a sex worker?' And I'm like, 'Yeah'. And he was like, 'What are you doing? You know, if you have anything, if we found anything on your results, we have to report it to the police.' I'm like, 'What?' And I went out crying [. . .] It gave me nightmares. (Vanessa, sex worker)

Several sex worker participants spoke of disclosing sex work to GPs and other doctors in circumstances other than having to undergo sexual health checks. Most of them described feeling patronised and pathologised after disclosing, for instance, by being labelled as drug users, or told to see a mental health professional, a financial counsellor, or being advised to quit. A few also related having been misdiagnosed as a result of disclosing:

> I went to a doctor because I had a lump on the side of my face. [. . .] the doctor was like, 'I have no idea what this is'. And then, just as I was about to go, he was like, 'What do you do for work?' [. . .] So I said that I'm a sex worker. And then suddenly, he was like, 'Oh, it's gonorrhoea, it's definitely gonorrhoea. Go and get an STI screening. And here is a prescription for medication for gonorrhoea. [. . .] It turned out to be a blockage in my salivary gland. (Angel, sex worker)

Overall, many of the sex workers who disclosed to health professionals shared how the poor treatment they received as a result had affected them and ultimately acted as a barrier to disclosing sex work with other health practitioners in the future:

> I probably would be hesitant to [disclose sex work] even though I'm very open about what I do with people [. . .] because of the reaction that I've had in the previous experiences I've had with doctors [. . .] which they're not meant to have, they're meant to [be] non-judgmental. . . (Stacy, sex worker)

Similarly, Lexy spoke of how she was previously open about her sex work with healthcare staff, but, after having experienced poor treatment several times, would now be extremely hesitant about disclosing in the future:

> I've had a couple of incidents where I accessed ER [emergency room] for pain issues and was treated both times like a drug seeker and the second time I was bullied quite badly and gas lit by the nurses and one of the ambulance men [participant cries]. So I've really changed my mind about what I will disclose to new health care professionals [. . .] I don't want to expose [myself and] disclose anymore (Lexy, sex worker)

Accounting for lived experiences of stigma from medical staff explains and unveils reasons why many sex workers would be hesitant to disclose sex work with health professionals, including mental health providers. Further to this, negative experiences with GPs and other medical staff can preclude engaging with mental health support, as GPs are often the first step to access mental health plans or a psychologist.

Only in very few cases did participants recall positive or affirming experiences when disclosing sex work to their GPs or other health professionals. Notably, experiences of disclosure with health professionals recalled by our study participants displayed some

differences with respect to their gender. Affirming treatment by GPs after disclosure of sex work was more commonly reported by cisgender men who had accessed LGBTQI+ specific services or LGBTQI+ friendly GPs. Keith, for instance, described a positive experience of disclosure that facilitated supportive service provision.

> Q. Have you had any concerns about disclosing [sex work] to health professionals?
>
> No, no. Because in every account, you know, full disclosure means they can help me for it. And I've told people, and they've said, okay, cool, we can offer you these resources as well. I've been offered resources for help with anything, or even not even help, just assistance, or if I wanted to connect with other people. And that was offered to me once I disclosed. So I was happy with that. (Keith, sex worker)

Keith described himself as lucky and understood his experience as linked to having accessed LGBTQI+ friendly services, and sex work being more accepted in the LGBTQI+ community:

> I guess I've been lucky. But it's just the lack of judgment you'd want with disclosing any problems or anything you have. [. . .] Going to an LGBTI friendly GP versus a regular family clinic [helped]. [. . .] I think generally, like in a very broad stroke, sex work is very much tied to the LGBT community. You can see that because of the way it was less than, what 30 years ago where [homosexuality] was criminalised. So you know, these kinds of industries and things pop up on the fringe. But also there is just a demand for it, I guess. I guess the demand just brings it out in community. (Keith, sex worker)

All but one trans woman in our sample, who was an undocumented migrant and feared deportation, would disclose sex work routinely. One had some good experiences at the gender clinic she attended, where she felt staff were non-judgemental, as 'half of their clients do [sex work] in some form' (Mary, sex worker). Another trans participant felt disclosing sex work did not make a difference in the way she would experience stigma by medical staff, and shared that as a trans woman and person who uses drugs she was often assumed to be a sex worker anyway:

> I haven't really had problems disclosing my sex work because I think that I'm already so marginalized. [. . .] I think they assume I'm a sex worker. Before I tell them, they've asked me what do you do for a living. And they are like, they just knew that I was a sex worker without me saying it. (Linda, sex worker)

Cis women participants in our study were generally most likely to account for stigmatising experiences with health professionals. While most identified as other than heterosexual, they tended not to engage with LGBTQI+ friendly or specific services and experienced stigma mostly within the mainstream health care sector.

3.4. Disclosing Sex Work to Mental Health Practitioners

Out of the 16 sex worker participants who received professional support with their mental health, 14 disclosed being sex workers on at least some occasions to their mental health practitioners. Nine of them reported dissatisfaction, poor treatment, and typically stigmatising experiences when doing so, to varying degrees. Generally, these participants felt their psychologists had lacked an understanding of sex work, which had led them to either ignore it, be overly inquisitive about it, assume it was a harmful activity, or pathologise it:

> Every time I've told some kind of healthcare professional that I'm a sex worker, they see that as the immediate cause of whatever distress I might have or whatever

> mental health concern that I'm bringing to them. They are always thinking that's inherently bad. (Billy, sex worker)

Two cis women sex workers expressed how some of the mental health professionals they had encountered were incapable of understanding and successfully addressing their mental health needs, combined with their sex work experience. Daria shared having a range of negative experiences with therapists, including being refused support based on being unwilling to quit sex work:

> I struggled with quite a lot of mental health conditions. [. . .] I've seen a therapist that was referred to me by Victim Services [. . .] That was the lady who told me that I should quit sex work. Yeah, I was very surprised by that. I have seen multiple psychologists, and many of those who are just not good at all. Many were some of those who would just sit there and listen, and not talk at all, or give you any advice on how to cope, or rush through the session. I had an occasion where a psychologist told me: 'Go, Go, Go!', midsession, because he was like, 'You need this part of your life [sex work] to get sorted out. So go now', and he charged me for one hour even if I saw him for 20 min. So, I've had a lot of bad experiences with therapists. (Daria, sex worker)

Lucy, on the other hand, shared how she felt one of her psychologists had dismissed her case as 'unhelpable', which had negative repercussions on her mental health.

> I had to fire my psychologist. She was trying to pressure me to go to see a psychiatrist [. . .] And then this year in January, my New Year's resolution was to tell her why I stopped seeing her and I wrote an email that was like, 'you couldn't admit that I was too difficult a case and that you couldn't help me. And so, you wrote me off as unhelpable, and you actually made it a lot worse'. (Lucy, sex worker)

At the time of the interview, Lucy did not have a trusted therapist and made a point of needing any future therapist to be sex work positive.

Another cis woman sex worker, Melissa, told us she was diagnosed with PTSD and eating disorders and had disappointing experiences after disclosing being a sex worker to several therapists:

> They haven't been so understanding of sex work [. . .] they kind of brushed it off. The only thing they really ask is, 'Oh, are you safe?' And it's, like, just because I'm a sex worker doesn't mean I'm in an unsafe environment. Like, it makes you feel anxious that what you're doing is not right. [. . .] It would have been nice if they did understand and they were interested in it, because I do feel like sex work is very connected to my eating disorder. (Melissa, sex worker)

Melissa ended up not discussing sex work any further in therapy, even if she felt it was connected to her eating disorder. Her case illustrates how a mental health practitioner's first reaction when the patient discloses sex work to them can determine the overall quality of the support, in case the professional relation would continue. Stigmatising remarks, but also indifference or 'brushing it off' at the time of disclosure, may provoke a sustained lack of trust, the concealment of important details and experiences by the patient, and result in superficial and ineffective, if not damaging, "support".

Conversely, a few sex workers in our sample recounted good experiences with mental health providers to whom they had disclosed being sex workers. Four participants shared that they had had some good experiences, and another four had had predominantly good experiences with mental health staff. The latter four told us they were aware of how lucky

they had been in finding non-judgemental good practitioners, as Sylvia, a cis woman sex worker, told us:

> I did see a health psychologist here in Australia for a little bit and I disclosed [sex work] and it was okay [. . .] she was supportive. And I really didn't feel judged. But I think I was just lucky because I've heard from so many people that they just cannot disclose it, because they're just so afraid of what's happening to them. Like not what's happening to them, but what's being said to them on top [by the therapist]. (Sylvia, sex worker)

Good practitioners were described as either sex worker-friendly or not-so-knowledgeable but non-judgemental and ready to be led by their sex worker patients as to the extent to which they needed or wished to talk about sex work. Lexy, a cis woman sex worker who shared having complex health and mental health needs, told us how therapy was crucial to her wellbeing and about her need for accessible therapists who are sex worker-friendly:

> I find [therapy] really, really helpful. I've been with [my therapist] for two years, he's, he's a pretty good therapist, my doctor is my anchor. [. . .] I was really stressed about finding someone that was going to be a good fit for me. And so [my previous doctor] did some research to find somebody who I could claim on insurance, somebody who I could use mental health plan with, and someone who was clearly sex worker friendly. (Lexy, sex worker)

One nonbinary sex worker also spoke of how lucky they were with their psychologist, who did not seem to them to know much about sex work, but was professional and open:

> I'm just really, really lucky because with my psychologist, I've seen her for ages, and she's like this lovely soccer mom kind of looking lady [. . .] And [. . .] I've never had any, any kind of stigma, stigmatization from her. (Kelly, sex worker)

Three cis gay men sex workers related having had good experiences with gay therapists who were understanding of their sexuality and sex work. One of them specified how his therapist acknowledged that sex work was not related to his problems:

> I did let [the therapist] know [about sex work]. And he was very much open about the fact that it wasn't really a factor in the problems that were going on. [. . .] You know, I said, I also do sex work. [And the therapist responded] 'Okay, that's fine'. And then got straight back to this [the actual problems]. (Keith, sex worker)

It is important to stress that sex workers had some positive experiences with therapists after disclosing sex work. In all these cases, what defined such a positive experience was, essentially, being listened to and not being judged or patronised.

3.5. When Do Sex Workers Disclose, and Why?

When discussing sex work disclosure to health practitioners such as GPs, sex workers in our study had nuanced opinions about its necessity. Many believed disclosing was potentially beneficial when they felt sex work had or could have an influence on their physical health, but not in all circumstances. When asked whether he disclosed sex work to health professionals, Tony, a cis gay man sex worker, replied:

> Q. Do you always disclose your sex work to your GP or to health services?
>
> My GP knows. If [the health practitioner] is someone who I'm comfortable with, or who needs to know that [I do sex work], sure, yeah. But I don't just go to like, a podiatrist and be like, oh, by the way, I'm a sex worker [participant laughs] (Tony, sex worker)

Tony's point of not needing to share sex work with every health practitioner signals how disclosing may be important in specific instances, but it is not always necessary. Sex workers may assess each time whether it is worth doing so in the face of the risks they may incur. Several other sex workers, in fact, spoke of having to weigh up the risk of being judged and patronised with the need for efficient support at the moment of deciding whether to disclose:

> If I'm disclosing that I'm a sex worker, I am just aware that I will probably be lectured about what an awful job that is, and if I wish that I should do something different with my life. If I don't disclose it, obviously, I'm fine. But um, sometimes I need to disclose it because of specifically physical stuff. Because of my neck and back problems, I do have to talk about movements I do at work that impact the injury. (Sylvia, sex worker)

Most participants, like Sylvia, displayed a solid understanding of their health needs, including the risks involved with disclosing and of the circumstances in which they would run such risks, or not.

Concerning specialised mental health professionals, there was wide consensus among participants across diverse demographics over the importance of being able to disclose sex work to their therapists or counsellors. The reasons given related to four main aspects linked to disclosing: the need to feel accepted and safe in therapy even if sex work is not part of the problems to be discussed; the need to speak about one's work as it is an important part of one's life; disclosure as a strategy to assess the aptness of the therapist; and the need to explore issues related to sex work that may influence one's mental health (both positively and negatively).

Firstly, the relationship with a therapist or counsellor was described by many as needing to be one of trust, openness, and lack of judgement—regardless of their need or wish to speak about sex work in detail. All but one sex worker conveyed their wish to be able to mention sex work without being judged and felt they would not be appropriately supported by a therapist who would be biased against sex work, even if it was not connected to the issues they needed to discuss. One of the two psychologists with experience working with sex workers who were interviewed as part of this study confirmed that most of her sex worker patients do not need support because of their sex work, but do seek and want to be respected and not stigmatised further:

> Essentially, if you're seeking out support, you don't want to be triggered, you don't want to have further feelings of marginalisation or stigma [. . .] Sex workers are not actually coming to us because they want support for anything related to sex work; they'd want support for mental health or relationships or any other [of the] many issues that people generally want support for. They just happen to be sex workers, and they want to make sure that they're not being judged or stigmatised [. . .] I'd say, more commonly, it's not really about sex work, it's just, they're human, they're coming for psychological support, or support for, you know, sexual issues. Just like everyone else. (service provider)

Yet not all sex workers saw the importance of disclosing sex work in therapy:

> I feel like [sex work] is not a big part of my life anymore. So it's not important for me to bring it up in therapy. I've got some other things I need to talk about. (Nina, sex worker)

Nina described her therapy as extremely helpful, yet did not feel the need to mention sex work as she had largely reduced it and felt it was therefore not an important part of her life anymore. Similarly, other participants indicated they needed to disclose sex work not

because it was, or could be, a reason for their mental health problems, but because it was their work and, as such, an important part of their lives that had an impact on their mental wellbeing, as any work would. Mary, a trans woman sex worker, made this clear:

> Q. Are there any specific health services where you feel it's more important than others to disclose sex work?
>
> Um, mental health, I think absolutely. [. . .] I am most definitely not saying that sex work in of itself can cause mental health [problems]. But like any job, there's a reason why corporate offices have EAP [employer assistance] programs and stuff. Sex workers also need mental help sometimes, some more than others. It may not be related to the work, it may be completely unrelated. But I think it's important to disclose so the mental health worker knows where you're coming from, and again, it filters those that would be like, 'Oh, no sex workers, bad, it's gonna cause your mental things', versus one that recognizes that it's just a job, but there are aspects to it, which sometimes you need counselling for. (Mary, sex worker)

Mary also viewed disclosing sex work as a way to test a therapist and decide whether to go ahead with them or not, according to their reaction. This is an important finding as it indicates how some sex workers may be aware of the possibility to encounter non-judgemental providers and actively engage in looking for a suitable therapist.

Other sex worker participants shared wanting to disclose in order to be able to analyse, process, and work through traumas and issues, and also reflect on positive experiences that were linked to, or happened in the context of, sex work. Speaking about a 'very positive' experience with a non-judgemental counsellor who had been referred to her by another sex worker, Candy noted why she had wanted to be able to speak about sex work openly in therapy:

> I was like, this is one of the things that I do. I wanted to get it out there and make sure that was something that we were going to talk about. Because I wanted to talk about it with someone to process some of the [. . .] things, if they came up. So there was nothing specifically to process. But I wanted to be able to talk things through and hopefully process in a way that would help to bring up things that maybe I hadn't noticed. (Candy, sex worker)

Crucially, to be able to do the work of disclosing and going through issues related to sex work, participants insisted that the attitude of therapists had to be supportive and understanding:

> I definitely have experiences that I want to talk about and know that they're not gonna judge me or think it's unsafe or the wrong thing to do [. . .] I would love to have a therapist that is telling me how strong I am, how powerful I am, how my job is right, how it's not a bad thing, not discriminating against it, you know? (Melissa, sex worker)

The expectation of being misinterpreted, patronised, or judged in therapy led Billy, a nonbinary sex worker, to instead fully conceal sex work to their therapist and lie about their context in order to share specific experiences:

> Q. Did you tell [your therapist] you were a sex worker?
>
> Oh, God no. Absolutely not. Because they'll just get distracted [. . .]
>
> I find it just, like, really isolating, because there are things I want to talk about related to sex work [. . .] things that have come up through my trauma, that come up through various moments in sex work that I then can't really talk about, or

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> I have to lie in order to talk about, which is tiring in itself to have to pretend, recontextualise something that isn't true. But otherwise, then I would just stop receiving the care that I need; they'd get distracted and focus more on, like, being some kind of fucking saviour. (Billy, sex worker)

Despite wishing to speak about sex work-related issues, Billy felt that if they disclosed these, they 'would stop receiving the care they needed'. This is an indication not only of the possible negative consequences of stigma, but also of the participant's resilience and expertise in matters of their own (mental) health. Rather than being a traumatised victim needing to be saved, Billy learned to adapt to the stigmatising environment they were in, assessed their own mental health needs, and decided not to disclose in order to get the best support they could under the given circumstances.

3.6. Fear of Disclosure as a Barrier to Seeking Professional Mental Health Support

The themes outlined above speak to circumstances when participants did disclose and to the consequences—good and (more often) bad—of doing so. However, it was also the case that fear of stigma and discrimination operated as a significant barrier to engaging with healthcare professionals in the first place. This was particularly the case when considering engagement with mental health professionals. While testing or treatment for physical conditions typically could not be avoided, engaging with a mental health professional required an active choice and a belief that the benefits would outweigh the risks inherent in doing so if sex work were discussed.

Due to prior experiences of stigma with health professionals, whether their own or their peers', some participants expected that they would be poorly treated, and were unaware of where to look for unbiased professional support:

> If I want to seek a health professional for mental health, I don't even know where to go [. . .] the barrier is that I'm a sex worker. The issue is I will think, okay, they may think I'm a sex worker, and then they will just, they won't really want to talk with me. [. . .] I just feel I'm a sex worker, and I can't be like a normal person and access to anything I want [. . .] I'm like a lower [person] than like other people normally. (Mia, sex worker)

Stigma was accompanied by the fear of being reported for illegal work. This was particularly true for migrant sex workers who risked being deported if found to be breaching the law, as was the case for Amy:

> I don't feel comfortable talking to a psychologist because I worry [. . .] If I had some bad information, a bad accident with some clients, if I talk to the psychologist, I would worry. Hey, if the psychologist knows I do incalls [seeing clients at her place of residence] would he or she report me to the police, and the police come knock on my door? [. . .] So a lot of things [are] illegal, illegal things we do. We can't tell psychologists [. . .] because I do worry they will report to the police. (Amy, sex worker)

Laura, also a migrant sex worker, felt that challenging experiences during sex work had negatively influenced her mental health in the past, but told us that, at the time, she was not actively seeking support because she simply did not want to disclose sex work, as doing so could be negatively received and further compound her poor mental wellbeing

> I didn't want to talk about my job. Probably I was a little bit afraid to talk about my job to a psychologist in Victoria. And probably that they're gonna judge me or going to see me in a different way. [. . .] And so that's why I thought that I should keep it for myself and just talk to my colleagues. (Laura, sex worker)

4. Discussion

This study advances existing literature on stigma, sex work, and mental health by demonstrating how stigma operates not only at the interpersonal level but also through structural features of health care systems, translating stigma into material barriers to care. The findings further extend stigma scholarship by illustrating the intersecting and bidirectional nature of sex work–related stigma, particularly its entanglement with assumptions about drug use and gender identity in clinical settings. Importantly, the study complicates prevailing assumptions that disclosure within therapeutic contexts is inherently beneficial, showing instead that disclosure may precipitate pathologisation, refusal of care, or therapeutic rupture, while non-disclosure can represent a strategic and agentic response to anticipated stigma. Finally, by foregrounding sex workers' reflexive decision-making, risk assessment, and active negotiation of health care encounters, this research challenges victimising narratives and highlights sex workers' expertise and agency as mental health care users.

The role of sex work disclosure in sex workers' experiences of health and mental health services is both central and complex in the context of receiving quality health care. A concerningly high proportion of sex workers in our study shared experiences of poor treatment, misdiagnosis, and refusal of care when disclosing sex work to both general and mental health practitioners. These experiences reflect concrete reasons why sex workers may expect stigma and hence do not and would not disclose and possibly not engage with mental health services at all, as was the case for several participants in our study. Our research, thus, supports previous research regarding how stigma and sex work nondisclosure preclude access to (mental) health care and assistance for sex workers (see [24,31,43]. Moreover, the findings reflect similar experiences of sex work stigma as observed in other jurisdictional and legislative contexts, highlighting the pervasiveness of stigma even across varied models of sex work (de)criminalisation [39]. Such observations are a stark reminder that even as efforts to decriminalize sex work continue, it may take time to see changes in societal attitudes towards, and beliefs about, sex work, and thus reduce stigma and discrimination experienced by this population.

The extent to which sex workers can experience poor treatment upon disclosure cautions against framing disclosure as inherently necessary to meet their health needs, given the risks of refusal of care or harmful treatment. Centring sex workers' lived evaluations of disclosure's risks and benefits—rather than imposing external assumptions—adds critical nuance to this issue and epistemically prioritises their expertise in navigating their own (mental) health.

Participants' narratives starkly illustrate this tension, exposing disclosure as a practice fraught with risk, where anticipated stigma or discrimination often outweighs potential clinical benefits. For instance, many described meticulously assessing whether disclosing their occupation was relevant to their health concerns before deciding to share this information with GPs or other providers. When sex work was not felt as having an impact on their health, the risk of disclosing and being poorly treated was clearly felt to be not worth taking. Where disclosing sex work was considered relevant, however, disclosing became a complicated decision that participants navigated with care. In several instances, the option not to disclose was preferred as it was felt that this provided higher chances of receiving good care. On the other hand, in the few cases where sex worker participants did find non-judgemental GPs and were able to disclose, this resulted in them recalling very good care and positive referrals to further professional support.

As far as professional mental health support was concerned, the importance and role of disclosure was considered by sex workers with further depth and detail. Like with health providers, several recalled negative experiences with counsellors and therapists when dis-

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closing. Yet, more so than with general health providers, it was widely acknowledged that being able to disclose sex work (whether to discuss it or not) to a mental health practitioner without fearing stigma and judgment was very important. The reasons participants gave for this were multifaceted and indicated the way sex work can be experienced by sex workers in different ways at different times. Like in other studies ([15,16]), a vast majority of our sex worker participants did not see sex work as the ground for their mental health problems. Yet, most felt the need to be able to mention in therapy. For some, sex work was their main or only work and, as such, an important part of their daily lives that they would not want to hide. Others directly spoke of wanting to work through issues linked to their sex work. Hence, for most sex workers, not being able to discuss sex work in a non-judgemental environment effectively precluded access to effective mental health provision. Only a minority did not mention it in therapy and felt it was better not to do so, as it was either not relevant or too risky.

As indicated by Farber [32] regarding full disclosure in psychotherapy, (non)disclosure plays a proportional role in the salience and importance that it has for the patient. Our findings unveil how sex workers understand and manage sex work disclosure in therapy in different ways. Sex work is clearly not experienced as a homogeneous experience, likely to cause problems, and hence needs to be disclosed and processed in therapy to achieve positive mental health outcomes. This contradicts the very premises of the stigma faced by sex workers at the hands of mental health providers, who often frame sex work as harmful and needing to be 'solved' (and hence disclosed). Further to this, our research shows that, when sex workers disclose sex work and are met with openness and respect, they tend to have much better therapeutic experiences, regardless of the extent to which they need to discuss it, finding that resonates with what found among LBQ women in relation to the disclosure of their sexuality to general health professionals [30]. This also confirms the way trust and safety in a therapy or counselling setting is paramount and makes a strong case for the need to improve knowledge about sex work among (mental) health providers.

Overall, the sex workers in this study emerged as strong subjects who were very aware of their health needs and of the dangers involved in disclosing. The coping strategies sex workers displayed in order to manage their mental health through peer support and solidarity not only demonstrate emotional strength and resilience but also indicate avenues for developing and improving mental health support to sex workers.

Intersectionality and Criminalisation

The experiences of sex workers in this study in relation to their mental health needs, access to, and experience of (mental) health services varied to a certain extent according to the participants' demographics and positionalities. Experiences of stigma with both mental and other health professionals upon sex work disclosure were most common among cis women and nonbinary participants. Cis gay men sex workers, in particular those who accessed LGBTQI+ friendly or specific services, reported the least experiences of stigma, while trans women did not feel additionally stigmatised on the grounds of being sex workers, but some felt it was assumed they would be sex workers because of being trans. What these differences suggest is twofold. On the one hand, they reflect how sex work stigma is more strongly attached to women, particularly in mainstream services which assume heterosexuality as the norm. Cis women who come out as sex workers become the abject and object of stigma for deviating from normative gender roles, while the hyper sexualisation of trans women, as well as their exclusion from mainstream job markets, may lead many to assume they are sex workers. On the other hand, this confirms what was suggested by previous research: that within LGBTQI+ communities and services, there may be fewer stigmatising attitudes towards sex work than within mainstream,

cis-heteronormative ones. While sex work stigma can surely also be present in LGBTQI+ communities, a shared history of criminalisation and stigmatisation on the grounds of non-normative sexual behaviour could have led to a degree of mutual acceptance and solidarity within these communities. Our findings also speak to a longstanding tendency to 'accept' cis gay men's engagement in sex work more so than is the case for other sex worker cohorts [44], which may reflect more liberal, sex-positive views held within queer communities [45]. More in-depth research would be needed to shed better light on this topic.

Notably, stigma attached to drug use intersected with sex work in mutually reinforcing ways, irrespective of participants' actual practices. Participants described being subjected to dual stereotyping: cis and trans women sex workers reported clinicians presuming they were drug users, while others who used drugs recounted being assumed to be sex workers. For instance, one participant noted healthcare providers misinterpreting her chronic pain as "need of drugs" even when they had no history of drug use. Conversely, participants who disclosed past or current substance use described being perceived as inherently likely to engage in sex work. These narratives reveal how societal conflations of sex work and drug use—as intersecting markers—shape clinical encounters, compounding marginalisation for those navigating either or both experiences.

Other important intersectional differences in our sample emerged in relation to migration, visa status, and the consequences of sex work criminalisation. The criminalisation of many forms of sex work under Victorian licencing laws prior to decriminalisation affected all sex workers' access to health services, but migrants faced harsher consequences if convicted of criminal offences. Several migrant sex workers in our sample shared not wanting to disclose sex work to any health services for fear of being reported to police and jeopardising their rights to stay in the country. Some did not access mental health services, fearing they would find out they were a sex worker and report them. On the other hand, the requirement to undergo trimonthly sexual health checks to be able to legally work meant that many sex workers were compelled to disclose sex work to health professionals and experienced threats, stigma, and poor treatment as a result. These are crucial findings that support the need to repeal all criminal laws that govern sex work, as these can and do act as a barrier to access services and/or expose sex workers to stigma and poor treatment. Finally, our study suggests language and financial barriers may also play an important role in accessing and finding non-judgemental therapists.

5. Recommendations

Drawing on participants' lived expertise and the structural barriers identified, we propose the following measures to improve access to equitable mental healthcare for sex workers. First of all, our findings endorse the implementation of full sex work decriminalisation. The criminalisation of sex work under Victoria's former licencing regime directly harmed participants' health access by compelling disclosure (via mandatory health checks) while exposing them to stigma, discrimination, and legal risks. Decriminalisation, as implemented in Victoria in 2022, is a critical first step to destigmatise sex work and dismantle systemic barriers to care. Legislators globally must follow this evidence-based approach.

Decriminalisation being solely a first necessary step to start dismantling stigma, our research recommends the implementation of training curricula co-developed by sex workers to address stigma, challenge conflations of sex work with pathology, and equip providers to respond affirmingly to disclosure. Concurrently, publicly accessible referral lists of sex worker-friendly providers (with multilingual options) should be developed and disseminated to reduce the burden of "testing" practitioners.

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Financial barriers disproportionately impacted migrant and low-income participants. Subsidising mental health care for stigmatised groups—including through Medicare-funded programmes (national health insurance)—would improve equity, particularly for those ineligible for existing subsidies. Enhanced training of medical professionals within foundational medical education, as well as specialist extension training, would also significantly contribute to better health outcomes for this population.

Future studies should evaluate the efficacy of LGBTQI+ and sex worker-led services in reducing stigma, building on findings that LGBTQI+ affirming providers offered safer disclosure environments. Longitudinal research is also needed to assess the health impacts of Victoria's decriminalisation model, informing global policy reform.

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