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Rural Health Services Inquiry
Legislative Council Sessional Committee Government Administration A
Hobart, Tasmania

30 June 2022

Dear Hon Ruth Forrest, MLC (Chair) and Committee members,

Thank you for accepting this late submission to the Legislative Council inquiry into rural health services.

About me

I am a Doctoral Candidate at University of Tasmania (UTAS), I was a cosignatory and researcher on a 2020 Department of Communities Tasmania, LGBTIQ+ Grant Program that examined the mental and physical health and related service use of LGBTIQA+ people on Tasmania's East Coast. I am also a mental health professional in private practice and have counselled extensively for many years. My academic and professional experience has given me invaluable insight into the state of mental health in rural and remote Tasmania.

Rationale behind this submission

The lack of inclusion of LGBTIQA+ people, sex workers, and kink-oriented people from your terms of reference is glaring, as research from Australia and elsewhere worldwide has shown that people are marginalised based on race, age, ability, sexual orientation and identity, gender identity and expression, and because of any other presumed cause or reason for unequal power relationships (Cruwys et al., 2010). People who are marginalised can:

1) experience mutually reinforcing disadvantage, discrimination, stigma, ostraciziation, victimization, judgement, and other exogenous oppressions solely due to their diversity (Cruwys et al., 2010; Meyer, 2003; Rosenstreich, 2013)
2) experience disparities in resources and opportunities (Cruwys et al., 2010), including mental health care access
3) have worse mental health and higher rates of psychological distress, suicidality, and self-harm prevalence than those who are not due to the aforementioned aspects of marginalisation (Hughes & Hammack, 2019; National LGBTI Health Alliance, 2016; Quinn & Chaudoir, 2009)

Also, overall, LGBTIQA+ people, sex workers, and kink-oriented people have high uptake of mental healthcare due to exogenous oppressions, victimisation and threats, stigma, and minority stress (Bränström, 2017; McNair & Bush, 2016; Platt et al., 2018). LGBTIQA+ people experience more barriers to mental healthcare than non-LGBTIQA+ people (McNair & Bush, 2015; Romanelli & Hudson, 2017).

The locale of this inquiry is significant as research shows that there are inherent, widespread, harmful aspects to rurality that are detrimental to the mental health of LGBTIQA+ people, sex workers, and kink-oriented people. Specifically:

- rural areas are more socially conservative and parochial (Willging et al., 2018)
- hypermasculity is expected and even valorised in rural areas, which can produce harmful outcomes regarding gender, sexuality, violence, and aggression (Carrington & Scott, 2008)
- the prevalence of suicidality and self-harm increases with remoteness (National Rural Health Alliance, 2017; Suicide Prevention Australia, 2010)
- rural areas have fewer mental health services, particularly specialised ones or ones that offer after-hours care (Socías et al. 2016), which has resulted in a fragmented clinical care system in the state and an increase in Tasmanians accessing hospital emergency departments for mental health care (Primary Health Tasmania, 2018), or going without mental health care
- rural areas have fewer mental health professionals (Barefoot et al., 2015)
- Tasmania has the smallest mental health workforce in the country (Ahmed et al. 2017)
- rural LGBTIQA+ people, sex workers, and kink-oriented people have worse mental health that their urban counterparts (Lyons et al., 2015; Stotzer et al., 2014; Walinsky & Whitcomb, 2010; Willging et al., 2018)
- rurality is associated with increased homophobia, transphobia, isolation, identity concealment, and limited community belonging – all of which negatively affect mental health (Barefoot et al., 2015; Lyons et al., 2015; Willging et al., 2016)
- rural Tasmania is religiously conservative (Grant, 2018), which is problematic: 1) considering faith-based organisations' historical persecution of people who are LGBTIQA+ people or sex workers and 2) because of the continued predominance of faith-based organisations in rural and remote Tasmania, which are often the only places that provide mental health support

My PhD Research

My recently submitted, first-of-its kind doctoral thesis was an exploration of the mental health and service use of LGBTIQA+ people, sex workers, and kink-oriented people in rural and remote Tasmania. To clarify, people from Hobart and greater Hobart were excluded from the research.

The enclosed publications that resulted from my research demonstrate how LGBTIQA+ people, sex workers, and kink-oriented people engage with mental and physical health professionals and existing services; what factors facilitated or impeded usage; what factors harmed or helped mental health (risk and protective factors); and what gaps there are in current service provision in rural and remote Tasmania. Excerpted details from these publications that pertain to your inquiry and terms of reference follow.

Research Participants' Demographics

The research is based on 78 online surveys and 33 interviews collected between November 2019 and March 2020. Participants ranged in age from 18–78 (average age was 36.3) and represented a broad range of sexual orientations and gender identities. Here is some additional demographic information about the participants:

Table 1. Summarized, Excepted General Demographic Information of 111 Participants in PhD Thesis Research on Mental Health and Related Service Use in Rural and Remote Tasmania.

Demographic	%
LGBTIQA+	84.7
Heterosexual	15.3
Sex worker	10.8
Kink-oriented	46.8
Cisgender	74.7
Transgender	25.2
Intersex	3.6
Resided in Inner Regional Tasmania	51.0
Resided in Outer Regional Tasmania	46.0
Resided in Remote Tasmania	3.0
Experienced homelessness	29.5
Polyamourous/open relationship	25.0
Employed	53.1
Education beyond year 12	74.7
TAFE Education	36.1
Undergraduate Degree	28.0
Postgraduate Degree	15.9

LGBTIQA+ Research Participants' Mental Health Status Compared with National LGBTIQA+ People's Mental Health Findings

To put some of my mental health status findings into context, please see Table 2 for a comparion with a national study on LGBTIQA+ people from 2020 by Hill et al.

Table 2. Excerpted Private Lives 3 *National Findings Compared with Findings from Tasmanian-based PhD Research*

Mental Health Issue/Diagnosis	National LGBTIQA+%	Tasmanian LGBTIQA+%
High/very high psychological distress		
All participants	57.2	66.2
Trans participants	70.7	77.3
Depression		
All participants	60.5	79.2
Trans participants	53.9	89.7
Anxiety		
All participants	47.2	74.0
Trans participants	44.1	95.4
Suicidality		
All participants	30.3	46.9
Trans participants	49.3	72.4

This comparson demonstrates that Tasmanian LGBTIQA+ have higher prevalence of these select mental health issues than the national report suggests. This comparison also highlights the need for more and improved local research and mental health access and supports.

Correlations Between Your Terms of Reference and My Research

My rural and remote Tasmania-based findings as they pertain specifically to your terms of reference and recommendations follow.

Uptake of rural and regional physical health services:

Tasmania has the highest rate of General Practitioner (GP) consultations for mental health issues per capita (Ahmed et al., 2017). Notably, 89.7% of my survey participants saw a GP for help with general mental health issues. However, only, 57.1% found that the GP knew how to help them. Twenty (out of 33) interviewees saw a GP for help with general mental health issues; 14 had negative experiences pertaining to educational or attitudinal bias.

Primary Health Tasmania (2016) found that 66% of Tasmanian GP did not consider themselves adequately trained in mental health, which corroborates my participants' poor GP experiences. Health professionals' lack of mental health training impacts subsequent help seeking and can worsen or cause mental health issues (Mastrocola, Taylor, & Chew-Graham, 2015).

Uptake of rural and regional mental health services:

As usage of mental health services was an inclusion requirement, 98.7% of survey participants and 27 (of 33) interviewees reported seeing a mental health

professional in rural or remote Tasmania at some point in their life. However, at the close of data collection, 75.6% of survey participants and 29 interviewees were not currently seeing a mental health professional in rural or remote Tasmania. Restated, all 111 participants had reported experiencing a mental health issue (e.g., grief, financial difficulties, discrimination, stigma) or diagnosis (e.g., Post-traumatic Stress Disorder, Bipolar Disorder, Schizophrenia), yet 88 participants were not engaging with care at the time of data collection. Indeed, some participants reported historial (rather than current) issues; those few participants felt formal care was not required. The many barriers that most of the remainder of participants encountered with both services and providers explain their low engagement. An exploration of some barriers as framed within the terms of reference follows.

Availability and timeliness of health services, including mental health services:

Availability and timeliness to access mental health services was a barrier. That is:

- 65.1% of LBGTIQA+ participants indicated that they could not get a mental healthcare appointment as soon as they needed support
- 52.3% of LBGTIQA+ participants and 66.7% of kink oriented participants reported experiencing long waitlists, meaning they either relied on negative coping mechanisms, their mental health worsened, and/or they withdrew from help seeking

Barriers to mental health services:

Participants cited roughly 100 barriers to accessing mental health services in rural and remote Tasmania (many of which are outlined in the enclosed papers). For brevity, I will present three: stigma, cost, and mental health professionals shortcomings.

Stigma: For all participants, stigma was a strong predictor of psychological issues and resulted in isolation and identity concealment. Stigma was also a barrier to help seeking. One in two Australians experience mental health issues in their lifetime (Australian Institute of Health and Welfare, 2020), yet despite this prevalence, 92.9% of survey participants agreed/strongly agreed that there is stigma around having a mental health issue, and 80.8% agreed/strongly agreed that there is stigma around getting psychological help. Efforts in the state to offset this significant systemic barrier are minimal. In 2021, of the 61 anti-stigma initiatives operating nationally, only 6 were occurring in Tasmania and of those 6, only 3 were ongoing or organised by Tasmanian organisations (Morgan, Wright, & Reavley, 2021).

Partial decriminalisation of sex work in Tasmania does not prohibit the sale of sex, but it perpetuates degrading assumptions about sex work, denies sex workers' their basic human rights to be free from violence and discrimination, and adds to

considerable stigma against sex workers. Sex work participants reported experiencing:

- public stigma, when society endorsed prejudices that manifested as discrimination
- whore stigma, derision towards people who combine sex with gain
- mental health professional stigma, when a practitioner had attitudinal bias and felt disparagement that presented in a counselling session
- systemic stigma, when legislation (i.e., partial decriminalisation) limits access to human rights and opportunities

Cost: Almost 70.0% of participants indicated that they could not afford mental health care. Relatedly, the administrative effort of having to secure mental health treatment plans and the high cost of private health insurance were also barriers for roughly 46.0% of participants. Significantly, same-sex attracted and gender diverse people were found to be more likely uninsured (Jenkins Morales et al., 2014; Stotzer et al., 2014). Inability to afford care can worsen mental health and is a risk factor due to the strong causal relationships between poverty, homelessness, and psychological distress (Australian Bureau of Statistics, 2016; Australian Psychological Society, 2015).

Mental health professional shortcomings: Mental health professionals were responsible for the vast majority of reported barriers to care. Many of their shortcomings were educational; that is, almost 75.0% of participants saw a mental health professional who needed the participant to educate them; who was unaware and untrained in helping people with diversities. This placed an undue burden on a population already experiencing disparities, resulted in care avoidance, and caused or worsened participants' psychological state. Participants also encountered mental health professionals who were sexist, heterosexist, cissexist, biased, and/or who refused to treat them upon disclosure. This attitudinal bias prevented help seeking and caused or exacerbated mental distress.

Telehealth services

Telehealth is touted as an economical solution to service delivery in rural areas (Burns et al., 2014; Letvak, 2002). In the 2021-22 budget, the Australian Government promised $111.2 million to digital (i.e., online, phone) mental health services (Parliament of Australia, 2021). And yet, only 14.4% of our participants reported using phone helplines. Participants' fear of discrimination or culturally incompetent helpline staff explained this low overall engagement. More so, however, interviewee participants reported a preference for in-person support. While helplines may be a solution for the general population in rural areas, they do not appear to be a solution for many LGBTIQA+, sex worker, or kink-oriented Tasmanians.

Other matters incidental thereto – Facilitating factors

While many findings from my research pertain to factors that require improvement in the state's mental healthcare system, participants also shared some factors that facilitated their uptake and engagement with care, which improved their mental health. When inverted, some of the barriers to mental health care cited above became faciliators to care – they encouraged help seeking, reduced risk factors, and improved participants' mental health. For example:

- 26.2% of kink-oriented survey participants saw a mental health professional who was kink aware, causing participants to remain engaged with care
- 9.5% of kinky survey participants saw a mental health professional who had therapeutic experience with kink-oriented people (who did not need to be educated), which made them feel supported
- Roughly half of LGBTIQA+ participants lived in a town or area that had a mental health professional

Other factors that encouraged and improved participants' help seeking were:

- friendly and welcoming staff
- services that offered bulk billing or offered reduced rate-appointments
- mental health professionals who were allies or worked inclusively
- mental health professionals who upheld confidentiality

Other matters incidental thereto – Resilience

Resilience is a person's ability to recover from stress (Smith et al., 2008). Of the 65 survey participants who completed the Brief Resilience Scale, 46.2% scored low resilience, 50.8% scored normal resilience, and 3.1% scored high resilience. In my participants, depression and anxiety were negatively associated with low resilience. However, participants who felt accepted and supported by loved ones, their community, society, and/or the healthcare system were more likely to have normal resilience; in other words, the more people feel supported and represented, the lower their depression and anxiety prevalence and the higher their resilience.

Resilience is not fixed, but is dynamic, interactive, and can change overtime both despite and due to adversity (Kim-Cohen & Turkewitz, 2012). This means that change is possible: the health disparities and poor mental health outcomes cited herein that are associated with low resilience can be improved. Recommendations for said improvement follow.

Recommendations

1. Universalise mental healthcare in Tasmania: To give all people 'determinative importance' (Sedgwick, 1990) and to facilitate responsive, inclusive care that adheres to all people's human right to healthcare, government should render the state's mental healthcare system fully inclusive or universalise it; that is, state government should:

    a. Work with education facilities in the state (e.g., UTAS, TAFE) to ensure that cultural competence, inclusion, and trauma-informed care and practice are mandatory and sizable components of all mental health-based curricula (Similar curriculum advancements made in Canada, for example, could be adopted locally).
    b. Work with education facilities in the state (e.g., UTAS, TAFE) to ensure that mental health, cultural competence, trauma-informed care and practice, and inclusion are mandatory and sizable components of all curricula for students of medicine and physical health.
    c. Work with local branches of health professionals' governing bodies (e.g., Australian Association of Social Workers, Australian Psychological Society, Australian Health Practitioner Regulation Agency) to ensure enforcement of and adherence to the state's Anti-Discrimination legislation and mandatory, ongoing professional development that includes cultural competency, inclusion, trauma-informed care and practice, and more
2. Make mental healthcare inclusive:
    a. fund at least one mental health service for LGBTIQA+ people, sex workers, and kink-oriented people based in rural in remote Tasmania
    b. fund existing qualified, culturally competent rural and remote mental health professionals such that fees for services can be eradicated or reduced; such that (mostly untrained) GP mental health consultations and administratively burdensome mental health treatment plans are not the norm; and such that LGBTIQA+ people, sex workers, and kink-oriented people can access inclusive care
    c. fund the hiring of additional mental health professionals to existing inclusive services to address waitlists and provide outreach and after-hours services
    d. fund a minimum of one inclusive mental health professional per all rural and remote local government areas to help reduce psychological burden of underserved populations
3. Launch rural and remote anti-stigma initiatives: Create and launch locally designed, locally based, ongoing anti-stigma initiatives to reduce stigma against mental health and normalise help seeking.
4. Decriminalise sex work in Tasmania: The decriminalisation of sex work in Tasmania would enhance sex workers' workplace health and safety; improve sex workers' access to physical health care; contribute to attitudinal shifts and public acceptance by normalising sex work; and improve sex workers' mental health and wellbeing (Daniel 2010).

Urban-based approaches to mental healthcare have been found to not work in rural and remote areas (Commonwealth of Australia, 2018). Your inquiry could dilute

the urbancentricity of mental health care approaches and access and aid in the development of establishing vital, localised, rural and remote approaches to care. What's more, it could address the erasure of rural and remote LGBTIQA+, sex worker, and kink-oriented Tasmanians from mental health curricula, research, policy, and services and right egregious disparities and wrongs.

Thank you for your time.

Sincerely,

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Appendices

Reynish, T., Hoang, H., Bridgman, H., Nic Giolla Easpaig, B. (2022). Barriers and enablers to mental health help seeking of sexual, gender, and erotic minorities: A systematic literature review. *Journal of Gay and Lesbian Mental Health*. https://doi.org/10.1080/19359705.2022.2036666

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Tamara Reynish, Ha Hoang, Heather Bridgman & Bróna Nic Giolla Easpaig

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REVIEW

Barriers and enablers to mental health help seeking of sexual, gender, and erotic minorities: A systematic literature review

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ABSTRACT

Introduction: Sexual, gender, and erotic minorities experience oppressions that psychologically harm and impact help seeking. The aim of this review was to integrate available evidence on the uptake, barriers, and facilitators of mental health help seeking in sexual, gender, and erotic minorities.

Method: Systematic searches were conducted in CINAHL, Medline, and Scopus for peer-reviewed articles and in Google for gray literature using Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines. Studies published in English in Organization for Economic Co-operation and Development countries between 2008 and 2018 regarding sexual, gender, and erotic minorities older than 18 years were eligible. Quality assessments were conducted and extracted data were analyzed thematically.

Result: Ninety documents were included in the review. Uptake is generally greater among sexual, gender, and erotic minorities, but worse in those who experience intersecting oppressions. Barriers to care manifest systemically, in services, and in individual mental health professionals (MHP) and contribute to psychological distress and impede help seeking. Protective factors (resilience, inclusion) and trained MHP counter these barriers.

Conclusion: Despite the general prevalence and risk of mental illness among sexual, gender, and erotic minorities due to external, modifiable oppressions, opportunities for inclusive psychological care exist.

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Introduction

This systematic literature review aimed to consolidate the available evidence on the barriers and facilitators to mental health help seeking of sexual, gender, and erotic minorities via an exploration of review questions focused

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on determining: (1) the uptake of mental health care, (2) barriers to care, and (3) facilitators that promote care uptake. Sexual, gender, and erotic minorities can experience prejudice and oppression that can cause psychological harm and impact mental health help seeking (Hunt, 2014; Lilienfeld, 2007; Robinson-Wood, 2017). Sexual and gender minorities include people who are Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual, and a variety of other identities (LGBTIQA+). Erotic minorities are people with identities, interests, or orientations toward any consensual nontraditional sexual activity, which can include kink, bondage, discipline, domination, submission, sadism, and masochism (BDSM), polyamory, fetishism, exhibitionism, role play, sexual asphyxiation, and many other diverse, intimate, and sexual relationships (Damm et al., 2018; Moser, 2016; Pitagora, 2016).

The research on erotic minorities is relative sparse in comparison to that regarding sexual and gender minorities, yet all experience oppressions including discrimination, stigma, exclusion, violence, homophobia, biphobia, and transphobia from a range of sources (Faircloth, 2014; Qureshi et al., 2018; Riggs et al., 2014; Williams et al., 2017). Indeed, much research has been conducted on the difficulty that sexual, gender, and erotic minorities have accessing culturally competent, inclusive care (Addis et al., 2009; Barmaky & Lee, 2017; Kolmes & Weitzman, 2010; Rees et al., 2021; Romanelli & Hudson, 2017).

Existing studies also explore the mental health of sexual, gender, and erotic minorities alone or as part of a larger literature review or needs assessment (Adams et al., 2012; Banks, 2003; Chandler et al., 2005; Cornell University, 2019; Jackman et al., 2016; Jenkins Morales et al., 2014; Lee & Kanji, 2017; Marshall et al., 2016; McCann & Sharek, 2016; Rodriguez, 2016; Scott et al., 2016; Trevor & Boddy, 2013). Some studies explore mental health services use of sexual, gender, and erotic minorities (Hunt, 2014; Lee & Kanji, 2017). Overall, these studies conclude that their respective sexual, gender, and erotic minority populations had higher rates of depression, self-harm, alcohol and drug abuse, suicide, and other mental health issues than their heterosexual counterparts (Adams et al., 2012; Banks, 2003; Jackman et al., 2016; Lee & Kanji, 2017; Marshall et al., 2016; Scott et al., 2016). Due to a lack of consistency in measurement tools, rates across the studies range widely: prevalence of depression ranges from 11% to 71.4% (Banks, 2003) while prevalence of self-harm spans 15.4% to 47.2% (Jackman et al., 2016). These studies also found that sexual, gender, and erotic minorities experience more barriers to care, including real or perceived discrimination from health professionals (Chandler et al., 2005; Hunt, 2014; Jenkins Morales et al., 2014; Lee & Kanji, 2017; Trevor & Boddy, 2013).

There are no systematic reviews that explore the barriers to mental health care and those factors that facilitate the uptake of care among a broader group of sexual and gender minorities that includes erotic minorities. Given the association between preventable, modifiable external factors, and the risk of mental illness, a systematic literature review that explores mental health service use for sexual, gender, and erotic minorities is needed.

Materials and methods

Search strategies

The selection criteria for this review included peer-reviewed and gray literature published in Organization for Economic Co-operation and Development (OECD) countries between 2008-2018 in English with topic foci of mental health and related service use of sexual, gender, and erotic minorities who are 18 years of age or older. Gray or nonacademic literature was included due to the contemporary, alternate insights it provides into viewpoints often underrepresented in academic sources (Paez, 2017). OECD countries were chosen as they provide an opportunity to explore comparable services within countries that have shared economic and social aims. CINAHL, Medline via PubMed, and Scopus were searched for peer-reviewed articles and Google was searched for gray literature. Snowballing was used to search for additional citations from among those gray documents that met the inclusion criteria. The following Medical Subject Headings (MeSH) terms were searched: mental health; access; uptake; barrier; sex and gender minorities; lesbian, gay, bisexual, transgender, queer (LGBTQ); intersex; sadism, masochism, sadomasochism, bondage, domination (BDSM); kink; gender identity; sexual orientation; marginalized; and enabler. British and American English spelling, plural forms, and Boolean operators were used. The first author conducted the search, removing irrelevant studies and duplicates. All authors substantiated the abstracts and full text of the remaining studies.

Assessment of methodological quality

Peer-reviewed and gray literature were appraised for quality and relevance. The first author used the Authority, Accuracy, Coverage Objectivity, Date, and Significance (AACODS) checklist to assess the methodological quality of gray literature (Tyndall, 2010; Table 1). The remaining authors reviewed and confirmed findings. AACODS was chosen due to its specific purpose

Table 1. Gray literature that did not meet all AACODS checklist criteria.

Author & setting	Authority	Accuracy	Coverage	Objectivity	Date	Significance	Type
Barbara et al. (2018), CA	✓	✓	✓	✓	×	✓	Talk to LGBTIQ+clients manual
Herek (2012), US	✓	✓	✓	✓	×	✓	Homosexuality & MH facts webpage
Mental Health First Aid Australia (2016), AU	✓	✓	✓	✓	×	✓	Guidelines on working with LGBTIQ+
National Alliance on Mental Illness (2020), US	✓	✓	✓	✓	×	✓	LGBTQ & MH factors & finding inclusive MHP webpage
Oxfam International (2016), UK	✓	✓	✓	✓	×	✓	LGBTI human rights policy
Ross (2013), CA	✓	✓	✓	✓	×	✓	LGBTQ women & MH webinar
Royal College of Psychiatrists (2018), UK	✓	✓	✓	✓	×	✓	Psychiatry & LGB webpage
Sanders (2016), US	×	✓	✓	✓	✓	✓	Kink-informed MH provider webpage
Winn (n.d.), US	✓	✓	✓	✓	×	✓	BDSM & kink webpage
Your psychology clinic (2015), AU	×	✓	✓	✓	×	✓	Sexual & gender issues webpage

to evaluate gray literature (Tyndall, 2008). Three of the authors (HH, HB, BNGE) used the Mixed Methods Appraisal Tool (MMAT) to assess and score the peer-reviewed literature (Hong et al., 2018; Supplementary Table S2). The MMAT scoring system concomitantly critiques the methodological quality and appraisal procedures of qualitative, quantitative, and mixed-methods studies. The MMAT was selected as it is an efficient, reliable tool with which to appraise studies that use different research methods (Pluye et al., 2011).

Data analysis

The included literature was analyzed thematically (Braun & Clarke, 2006). Multiple readthroughs of the included documents produced initial systematic coding. Recurring themes and connections from the dataset were identified and combined into higher-order groupings. Groupings produced themes that were reviewed repeatedly for clarity and connection and then refined. Resulting themes were summarized and integrated systematically under the three review questions. Thematic analysis was chosen because it facilitates summarization of the main elements of a large data set; emphasizes similarities and differences across a data set; and can produce unexpected viewpoints (Braun & Clarke, 2006). The first author conducted the data identification, categorization, and synthesis, which the remaining authors reviewed, confirmed, or rejected in teams of two. Disagreements were resolved via discussion or by the author not in the team of two.

Results

From a pool of 6,147 articles and documents, 90 met the inclusion criteria (Figure 1). Of the 90 documents, 67 (74.4%) focused primarily on people who are same-sex attracted and/or gender diverse. The remainder were on kink-identified individuals ($n = 10$, 11%), transgender, gender diverse, or two-spirit people ($n = 9$, 10%), and intersex people ($n = 4$, 4.4%). There were many types of gray literature ($n = 41$) with the most prominent being informational webpages or articles ($n = 12$, 29.3%). Thirty-one gray literature documents met all ACCODS criteria. Table 1 shows the ACCODS scoring for the remaining 10 gray documents that did not meet all criteria, with most (90%) only failing the Date criterion (Tyndall, 2010).

Of the included peer-reviewed articles ($n = 49$), 36 received an MMAT quality top score of 5, seven received a 4, and six received a score of 3 (Hong et al., 2018). The population sample sizes ranged from 1 to 6,106. These studies were conducted in the United States ($n = 32$), Canada ($n = 5$), Australia ($n = 4$), and Ireland ($n = 3$). The remaining were conducted in New Zealand, Sweden, and Israel ($n = 1$ each) and two spanned multiple countries.

A variety of outcome measures were used in the included peer-reviewed documents to assess the mental health-related topics discussed in this review, including mental health conditions and statuses, contributing factors, and treatments (Supplementary Table S2). Self-reported was the most

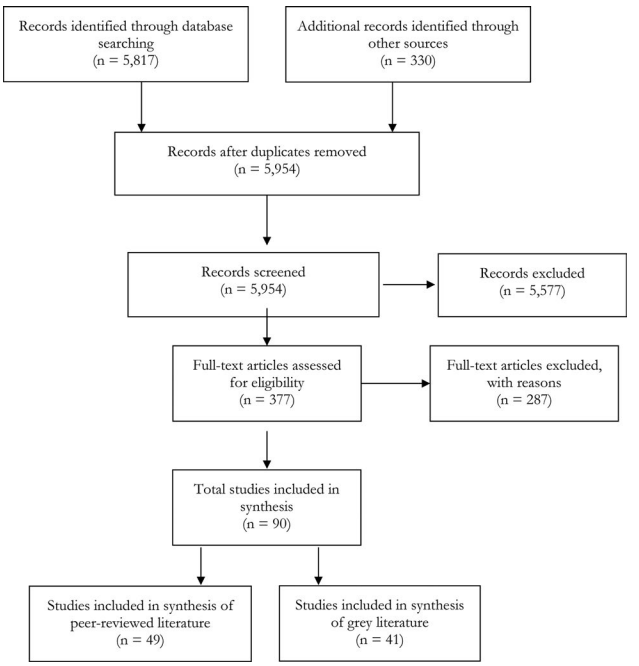

Figure 1. PRISMA 2009 flow diagram.

common measure used (69.4%). Of the formal measurement tools, Kessler Psychological Distress Scale (K6 or K10) was used five times (Cochran et al., 2017; Dunbar et al., 2017; Lyons et al., 2015; Platt et al., 2018; Stanley & Duong, 2015) and the Patient Health Questionnaire (2 or 9) was used four (Jenkins Morales et al., 2014; Parent et al., 2018; Steele et al., 2017; Williams et al., 2017). Supplementary Table S2 presents the relevant characteristics, outcome measures, and findings of the peer-reviewed literature.

Two main themes and five subthemes emerged from analysis of the 90 included documents: prevalence (mental health status and service use) and factors or barriers and facilitators affecting help seeking (systemic, service-based, and individual).

Prevalence

The mental state and related service use of sexual, gender, and erotic minorities were common topics in the included literature. Mental health status was discussed in 87.4% of the peer-reviewed literature and in 90.6% of the gray. Of the sexual, gender, and erotic minorities included in this review, the literature overwhelmingly indicated that same-sex attracted, intersex, and gender diverse people have worse mental health than heterosexual, cisgender people (people who accept the sex they were assigned at birth), which was highest in people of color (Graham et al., 2009; Hahm et al., 2016); younger people (Greene et al., 2016; Royal Australia & New Zealand College of Psychiatrists [RANZCP], 2019b; Stanley & Duong, 2015;); transgender people (Mental Health First Aid Australia, 2016; New South Wales Mental Health Commission [NSWMHC], 2014; Riggs et al., 2014; Victoria State Government Department of Health & Human Services, 2014; 2018); rural dwellers (Lyons et al., 2015; Stotzer et al., 2014; Walinsky & Whitcomb, 2010; Willging et al., 2018); bisexual people (Mental Health First Aid Australia, 2016; National Alliance on Mental Illness, 2020; Pennay et al., 2018; Rosenstreich, 2013); religious people (Zeidner & Zevulun, 2018); and intersex people who have experienced non-consensual, "corrective" surgeries (Australian Government Department of Health [AGDOH], 2013a; 2013b; Gore, 2017; Mental Health First Aid Australia [MHFA], 2016; QLIFE, 2017; Rosenstreich, 2013; Royal Australia & New Zealand College of Psychiatrists [RANZCP], 2019b; Stevens, 2013). The literature also found that sexual, gender, and erotic minorities who have additional, intersecting marginalized identities are at risk for mental health issues (Drummond & Brotman, 2014; Elm et al., 2016; Greene et al., 2016; Harrow Council London & Central & North West London, 2011; Mann, 2016; Nadal et al., 2011a; Rodriguez, 2016; Ross, 2013; Salkas et al., 2018). With one exception, all included literature on erotic minorities found that

their mental health status is the same as or better than non-kink minorities (Faircloth, 2014; Gemberling et al., 2015a; GoodTherapy, 2017; Roberts et al., 2015; Yamanouchi, 2015). Winn (n.d.) found that submissives reported the lowest mental health scores among all erotic minorities, but scores were still higher than non-kink minorities. Comparatively, however, sexual, gender, and erotic minorities all experience oppressions that contribute to mental illness, which increases the risk of psychological distress (Gemberling et al., 2015b).

Service use

Generally, sexual, gender, and erotic minorities are reported to have greater uptake of mental health services than heterosexual, cisgender, non-kink people (Bränström, 2017; Cochran et al., 2017; Dunbar et al., 2017; Graham et al., 2009; Hahm et al., 2016; Jacobsen & Wright, 2014; Parent et al., 2018; Pennay et al., 2018; Stanley & Duong, 2015). An American study on sexual minorities found that their sample's uptake was two to four times higher than that of heterosexual people (Platt et al., 2018).

When compared with white, younger, cisgender, heterosexual people, uptake was reported to be worse among sexual, gender, and erotic minorities who are people of color (Parent et al., 2018), older (Jenkins Morales et al., 2014; Parent et al., 2018), and transgender (Steele et al., 2017). Dunbar et al. (2017) reported that 61% of their participants in "serious psychological distress" did not seek mental health support (p. 294). Service use is worse for sexual, gender, and erotic minorities residing in rural areas compared with urban dwellers (Australian Government Department of Health [AGDOH], 2011; Lyons et al., 2015).

Factors affecting help seeking

Factors affecting help seeking present as barriers and facilitators to care. Generally, barriers were discussed in 83.7% (41/49) of the peer reviewed documents and in 80.5% (33/41) of the gray. The literature reveals that all sexual, gender, and erotic minorities experience a variety of similar barriers with the most common being discrimination, stigma, exclusion, violence, and homophobia, biphobia, and transphobia (Supplementary Table S1) (Faircloth, 2014; Gemberling et al., 2015b; Harris, 2017; Roberts et al., 2015; Yamanouchi, 2015).

Facilitators to help seeking were explored directly or indirectly in 93.9% (46/49) of the peer reviewed documents and in 82.9% (34/41) of the gray. Examples of social and demographic facilitators included being LGBTQA+ (Cochran et al., 2017; Parent et al., 2018); having insurance (Stotzer et al.,

2014); and being a woman or living in an urban area (AGDOH, 2011). Help seeking also occurs in response to the psychological impact of minority stress and stigma (Platt et al., 2018; Stanley & Duong, 2015). Other factors affecting help seeking are systemic, service-based, and individual which are explored below.

Systemic factors

Systemic factors are system-based or social policies or practices that can either impede or encourage help seeking. In the included literature, poverty was a commonly cited systemic barrier (Adams et al., 2012; Benson, 2013; Hsieh & Ruther, 2017; Jenkins Morales et al., 2014). Relatedly, a lack of publicly funded services and a lack of insurance were also cited as barriers (Adams et al., 2012; Hsieh & Ruther, 2017; Kattari & Hasche, 2016; Ross, 2013). Significantly, same-sex attracted and gender diverse people were found to be more likely uninsured (Jenkins Morales et al., 2014; Stotzer et al., 2014).

Other prevalent systemic barriers to help seeking were attitudinal in nature, which were more prevalent in rural areas (Lyons et al., 2015). Attitudinal barriers are negative biases or assumptions. Racism, homophobia, and other forms of discrimination against sexual, gender, and erotic minorities delay help seeking and increase expectations of a poorer level of care (Bastos et al., 2018; Roberts et al., 2015). The lack of inclusive policies and failure to enforce anti-discrimination legislation compounds attitudinal barriers (Adams et al., 2012; Jacobs & Morris, 2016; McCann et al., 2013; McCann & Sharek, 2014a; Przedworski et al., 2015; Rodriguez et al., 2018; Stanley & Duong, 2015; Stevens, 2013; Williams et al., 2017).

Pathologization, another attitudinal systemic barrier, was cited in 24.2% of the gray literature and in 31.7% of the peer reviewed. Pathologization sees sexual, gender, and erotic minorities being medicalized by some MHP and assumed to require remedying, which leads to ineffective or even harmful care (Stevens, 2013; Your psychology clinic, 2015). Conversion therapy, one attempt to "remedy" diversity, was cited as a barrier in 21.2% of gray literature and in 2.4% of the peer reviewed. This barrier can result in further psychological harm and termination of help seeking, including subsequent treatment (Australian Psychological Society [APS], 2021; Jacobsen & Wright, 2014). As such, many principal psychological organizations oppose it; for example, "the Australian Psychological Society strongly opposes any form of mental health practice that tries to change or suppress someone's sexual orientation or gender (Australian Psychological Society [APS], 2021)."

The included literature recommended changes to policies and laws, which are systemic enablers and which can improve mental health and increase help

seeking. First, policies and laws that address systemic oppressions could be enacted. This could include implementing plans to eradicate conversion therapy, systemic discrimination, prejudice, heterosexism, and enforcing anti-discrimination policies (Drummond & Brotman, 2014; Leonard & Metcalf, 2014; McCann & Sharek, 2014a; Nadal et al., 2011b; Orel, 2014; Royal Australia & New Zealand College of Psychiatrists [RANZCP], 2019a; Royal College of Psychiatrists, 2018). Secondly, insurance companies could update plans to ensure support and protection of transgender people, for example, via the banning of gender identity-based discrimination (Romanelli & Hudson, 2017). Thirdly, the promotion of access and inclusion to mental health care and to gender-affirming surgery are other systemic enablers that would offset disparities while encouraging uptake (Oxfam International, 2016; Steele et al., 2017). Fourthly, the implementation of social protection is another systemic enabler cited in the included literature (Oxfam International, 2016). Social protection enhances a person's rights through the facilitation of equitable access to service (Oxfam International, 2018). Finally, the inclusion of sexual, gender, and erotic minorities in policy, resource, and research planning and implementation could have an insulating factor against mental illness and potentially prevent substandard or absent care (Herek, 2012; NSWMHC, 2014; Williams et al., 2017).

Service-based factors

The complete absence of mental health services, including affirming services, was a barrier to support seeking cited in the literature (Adams et al., 2012; Pilling et al., 2017). A lack of services is associated with higher levels of mental illness in sexual, gender, and erotic minorities living in rural areas than those living in urban (QLIFE, 2018). Transgender people in particular felt this gap (Romanelli & Hudson, 2017).

Existing mental health services create barriers by not being inclusive and failing to meet needs (Adams et al., 2012; McCann & Sharek, 2014a; NSWMHC, 2014; Pennay et al., 2018; Romanelli & Hudson, 2017; Rosenstreich, 2013; Ross, 2013; Walinsky & Whitcomb, 2010). Mental health services failed to meet needs in 76% of respondents in an Irish study (McCann & Sharek, 2014b). Services also bar or impede access via discrimination or a lack of cultural competency within the service (Dahlhamer et al., 2016; Kidd et al., 2011; Roberts et al., 2015; Rosenstreich, 2013; Sanders, 2016; Stotzer et al., 2014). On-campus, student services were shown to reduce help seeking via unclear eligibility requirements, lack of confidentiality, cost, and inconvenient hours (Dunbar et al., 2017).

Alternately, services that are affordable, responsive, specialized, and affirmative enable uptake and improve help seeking (Barbara et al., 2018;

McCann & Sharek, 2014a; NSWMHC, 2014; Pennay et al., 2018; Romanelli & Hudson, 2017; Stanley & Duong, 2015). Specialization can extend to program offerings and treatment approaches. Specialization can also be tailored to sexual, gender, and erotic minorities, and people who are Aboriginal, First Nations, two-spirit, and older (Barbara et al., 2018; Romanelli & Hudson, 2017; Stevens, 2013; Stotzer et al., 2014). Services can encourage uptake via offering group and individual counseling (Jacobsen & Wright, 2014).

Service identifiability is another facilitator to help seeking. Achieved with outreach, community visibility, or advertising, services can address service gaps and encourage uptake (Dunbar et al., 2017; Romanelli & Hudson, 2017). Similarly, services can also facilitate help seeking through implementing effective service delivery partnerships, mental health promotion campaigns, and advocacy (NSWMHC, 2014). Finally, services could offer peer-advocacy programs, which were found to increase inclusion and help seeking (Willging et al., 2016).

Individual factors

MHP and sexual, gender, and erotic minorities comprise the specific individuals at the core of this factor. Many of the individual-specific barriers cited in the included literature originate with MHP, are attitudinal and educational in nature, prevent help seeking, and can cause mental distress (Stotzer et al., 2014) (see Supplementary Table S1). Heterosexist, cissexist MHP, including those who demonstrate stigma against sexual, gender, and erotic minorities, were found to impede help seeking (AGDOH, 2011; Faircloth, 2014; Fredriksen-Goldsen et al., 2014; Kidd et al., 2011; Mental Health America, 2020; Stotzer et al., 2014).

MHP who demonstrate a lack of cultural competence, discrimination, and bias were other individual-specific barriers noted in the literature (Bith-Melander et al., 2010; Fredriksen-Goldsen et al., 2014; Hahm et al., 2016; Kidd et al., 2011; Stotzer et al., 2014). Another barrier was MHP's lack of confidentiality around disclosure of a client's personal information. Whether real or perceived, these breaches of confidentiality prevent help seeking (AGDOH, 2011; Hahm et al., 2016; Rosenstreich, 2013).

Some MHP were found to also push their religious biases or personal beliefs onto clients, including seeking etiology for the diversity in sexual, gender, and erotic minorities such as child sexual abuse (even when inaccurate) or viewing identity as a choice (Jacobsen & Wright, 2014; Yamanouchi, 2015). MHP demonstrated these attitudinal barriers in the form of "embarrassment, anxiety, inappropriate reactions, rejection of the patient, hostility, suspicion, pity, condescension, ostracism, [and] avoidance of physical contact…" (McCann & Sharek, 2014a, p. 526; 2014b). Refusal

of treatment was another way in which MHP demonstrated attitudinal barriers (McCann & Sharek, 2014a; 2014b; Williams et al., 2017).

Individual facilitators to help seeking of sexual, gender, and erotic minorities in the included literature centered largely around protective factors, or those elements that reduce the likelihood of developing a mental illness and promote psychological health and help seeking (Commonwealth Department of Health & Aged Care, 2000). Resilience – the ability to recover from adversity and negative experiences – was one such facilitator (Damm et al., 2018; Elm et al., 2016; Leonard & Metcalf, 2014; McCann et al., 2013; Nadal et al., 2011b; Watson et al., 2018).

Inclusion is real or perceived support from social groups, family, friends, or community and is another protective factor and facilitator to help seeking cited in the included literature (Adams et al., 2012; Bränström, 2017). Inclusion improves mental health, identity development, and mediates the impacts of external and internalized oppressions (Centers for Disease Control & Prevention, 2016; Graham et al., 2009; Roberts et al., 2015; Rodriguez, 2016). Inclusion also contributes to self-worth and acceptance, which promote help seeking (Bränström, 2017; Elm et al., 2016; Kolmes & Weitzman, 2010). Examples of inclusion in the included literature are families embracing transgender identity disclosure and community involvement and belonging (Faircloth, 2014; Fredriksen-Goldsen et al., 2014; Roberts et al., 2015; Watson et al., 2018). Often in the absence of holistic, specific public or civic supports, the need for inclusion is more urgent in rural areas (Leonard & Metcalf, 2014; Lyons et al., 2015; Willging et al., 2018).

Discussion

This literature review provides a novel synthesis of research regarding the mental health status, the barriers to mental healthcare, and the factors that facilitate uptake among a broader group of sexual and gender minorities that includes erotic minorities. The findings of this review are informative to policy and practice and can advance sexual, gender, and erotic minorities' wellbeing by presenting opportunities for growth in research, in MHP training, in service delivery, and via representation in OECD countries.

Help seeking varies and many systemic, service-based, and individual barriers exist, however, there are enabling factors that improve uptake and mental health. Similar to previous literature, this study suggests that overall, sexual, gender, and erotic minorities have greater uptake than non-minorities (Bränström, 2017; Jacobsen & Wright, 2014; Parent et al., 2018; Stanley & Duong, 2015). Reasons given for this high uptake include mental distress (Pennay et al., 2018), victimization and threats (Bränström, 2017),

and to cope with minority stress and stigma (Bränström, 2017; Meyer, 2003; Platt et al., 2018; Stanley & Duong, 2015).

Sexual, gender, and erotic minorities experience more barriers to mental health care than heterosexual, non-kink, cisgender people (Dahlhamer et al., 2016; Salkas et al., 2018). These barriers represent institutional failure and result in unmet mental health care need, delays, or avoidance of help seeking (Hsieh & Ruther, 2017; Platt et al., 2009; Smith & Freyd, 2014).

The literature suggested that MHP undergo training to address barriers and improve sexual, gender, and erotic minorities' mental health and help seeking (Dunbar et al., 2017; Kattari et al., 2016; Kench, 2013; Stotzer et al., 2014). Some of the included studies found that MHP lacked even the most basic of training on sexual, gender, and erotic minorities and recommended mandatory training (Jenkins Morales et al., 2014; Kench, 2013; Kidd et al., 2011; Oxfam International, 2016; Pennay et al., 2018; Romanelli & Hudson, 2017). Training could be incorporated into tertiary curricula, conducted at local community organizations, or as continuing education (Kattari et al., 2016; Qureshi et al., 2018; Ross, 2013). Training would remove the burden from clients of having to educate MHP (Benson, 2013; Kidd et al., 2011). Upskilling by both urban and rural MHP could increase comfort in working with diverse people, enable the adoption of advocacy roles, and improve MHP's ability to make appropriate referrals (Drummond & Brotman, 2014; Walinsky & Whitcomb, 2010). Recommended training topics included gender-affirming surgery (Riggs et al., 2014); transgender issues (Benson, 2013); cultural competency (Adams et al., 2012; Nadal et al., 2011a); kink-awareness (Kolmes & Weitzman, 2010); sexuality, disability, and other areas of intersectional, marginalized identities (Drummond & Brotman, 2014; Rodriguez, 2016); and intersexuality (Thyen et al., 2014).

Despite barriers, sexual, gender, and erotic minorities generally have a favorable view of help seeking (Parent et al., 2018; Stanley & Duong, 2015). Factors that promote this include resilience and inclusion, equitable access to services, and educated MHP. In fact, given the prevalence of discussion in the included literature around the enabling role of MHP who offer quality, inclusive care for all without discrimination or distinction, they can be a significant facilitator to help seeking.

The included literature suggests that uptake of help seeking does not match the prevalence rates or risk of mental illness. Oppressions against sexual, gender, and erotic minorities continue and have spurred an overrepresentation of negative mental health indicators. External oppressions place sexual, gender, and erotic minorities at risk of higher prevalence of mental illness than non-minorities (Cochran et al., 2017; Graham et al., 2009; Roberts et al., 2015; Yamanouchi, 2015). Studies have shown that

identity and orientation in itself does not create or contribute to psychological distress, but that external, modifiable oppressions perpetuate mental illness in sexual, gender, and erotic minorities (Meyer, 2003; Roberts et al., 2015; Ross, 2013; Stevens, 2013). Many MHP governing bodies in OECD countries indicate that cultural competence is a core requirement (Australian Psychological Society [APS], 2012, National Association of Social Workers, 2015). Yet, sexual, gender, and erotic minorities still encounter MHP who pathologize sex, sexual, gender, and erotic minorities (Faircloth, 2014; Kidd et al., 2011; Rosenstreich, 2013; Yamanouchi, 2015). Whether systemic, service-based, or individual, barriers exacerbate psychological distress and result in distrust of mental health support, limiting uptake (McCann & Sharek, 2014a; Ross, 2013).

Limitations

The generalizability of this review is limited by the geographic, age and English language restrictions; therefore, these findings may not apply to non-OECD countries, populations younger than 18, or non-English studies. Generalization is also limited by the rigidity with which sexual, gender, and erotic minorities have been historically viewed. It is unknown if the sample populations in the included literature are representative of their minorities. The selected databases largely focus on the fields of medicine and health, which fit this review's aim of mental health service use exploration. Other databases, for example, may have yielded different results. The largely urbancentric focus of the included studies indicate gaps in rural population-based studies. Despite incorporation of several distinct identities under the banner of sexual, gender, and erotic minorities, this is not a singular category representing unified experiences of mental health. This focus served exploration purposes as findings across the groups generally synched due to shared risk of psychological distress, warranting their combination. This focus also reduced deeper examination of all populations represented in this review, thus potentially altering the findings. These limitations provide an opportunity for subsequent reviews and future work, which may explore alternate factors and contexts.

Conclusion

This systematic literature review novelly explored barriers and facilitators to mental health care among a broader group of sexual and gender minorities that included erotic minorities. A synthesis of 90 gray and peer reviewed documents revealed the shared experience of a range of barriers that both impede service uptake and impact mental health. Discrimination,

stigma, exclusion, violence, homophobia, biphobia, and transphobia from society, services, and MHP were the most common barriers uncovered in this review. These findings indicate the need for tailored, intersectional mental healthcare; mandatory, inclusive curricula for current and future MHP; and the creation and enforcement of anti-discrimination policies. Given the association between external risk factors and mental illness and its systemic, service-based, and individual implications, this systematic literature review is an important resource for advocates, policy makers, and practitioners.

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Kink-Oriented People and Exogenous Oppressions: Understanding Mental Health and Related Service Use in a Rural Context

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ABSTRACT

Rural, kink-oriented people experience much exogenous oppression and yet related research is scarce. This study examined the risk and protective factors of kink-oriented rural Tasmanian Australians with preexisting mental health conditions and help-seeking barriers and facilitators. Participants completed either an online survey (n = 42), an interview (n = 10), or both. Thematic analysis and descriptive statistics were used to analyze the qualitative and quantitative data, respectively. Participants aged 18 to 61 were gender and sexually diverse and better educated but had more lifetime suicide attempts than the general public. Despite the increasing normalization of kink, 90.5% of participants have never seen a kink-aware mental health professional (MHP) and nearly 83.0% did not disclose to an MHP for fear of stigma or discrimination. Self-awareness, resilience, social support and kink improved participants' mental health. Tailored support from trained MHP is vital to improve the mental health of kink-oriented people in rural areas.

KEYWORDS

Mental health; kink; rural; mental health services; service barriers; Tasmania; Australia; BDSM

Introduction

Although kink is becoming more mainstream, the mental health needs of kink-oriented people living in rural areas are insufficiently researched and often missing from traditional mental health training or care provision. Kink-oriented individuals engage in alternate, non-vanilla, non-heteronormative, or non-mononormative sexual interactions as their primary forms of sexual expression. Vanilla is conventional sex that conforms to basic cultural expectations or people who engage in it. Kink can be synonymous with bondage, discipline, domination, submission, sadism, and masochism (BDSM) and can include an array of activities including power or pain exchange, role play, polyamory, or fetishism (Damm, Dentato, & Busch, 2018; Pitagora, 2016).

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Consensual non-monogamy is associated with kink, but is not an inherent feature of kink (Pitagora, 2016). Researchers have increasingly focused on the nature and prevalence of kink (Damm et al., 2018; Gemberling, Cramer, Wright, & Nobles, 2015; Graham, Butler, McGraw, Cannes, & Smith, 2016; Hughes & Hammack, 2019; Richters, de Visser, Rissel, Grulich, & Smith, 2008; Waldura, Arora, Randall, Farala, & Sprott, 2016). With almost half of their participants interested in kink and roughly one-third having experience with kink, Joyal and Carpentier (2017) concluded that kink was more normophilic than paraphilic in their sample (N = 1,040), or less anomalous and more mainstream than previously thought. Speciale and Khambatta (2020) found that kink had therapeutic benefit and yet all of their participants experienced a lack of affirmative care.

Researchers have also examined kink in so far as it extends beyond the practice of libidinal gratification and into identity and have concluded that for some, kink is a sexual orientation (Moser, 2016; Savin-Williams, 2014; Sprott & Williams, 2019). Traditional interpretations of sexual orientation that exclude kink are challenged due to: 1) the fluidity and diversity of sexuality and identity; 2) the evolution of the construct of sexual orientation; 3) the shared experiences of discrimination and pathologization and; 4) the socio-political importance of all people with diverse sexual orientation, gender identity/expression, and sex characteristics (SOGIESC) (Pitagora, 2016; van Anders, 2015).

Estimations of kink-oriented people range substantially. Richters et al. (2008) found that 1.8% of straight Australians engaged in kink in the past year. Holvoet et al. (2017) concluded that 7.6% of the general Belgian population are BDSM practitioners while Strassberg and Lockerd (1998) reported that 64.0% of their American, undergraduate, female participants were interested in kink. Flawed or varied data collection tools and a history of pathologization impede accurate number gathering (Joyal & Carpentier, 2017). Previously, the Diagnostic and Statistical Manual of Mental Disorders (DSM) considered all forms of kink a "paraphilic disorder;" however, in DSM-5, they differentiate between mainstream kink and criminal offenses (American Psychiatric Association, 2013; De Neef et al., 2019, p. 135). Yet, society and mental health professionals (MHP) alike still pathologize a kinky sexual orientation (Hughes & Hammack, 2019).

The psychological impact of pathologization and the accompanying judgment can force people who are into kink to remain hidden (Wright, 2006). This forced secrecy as well as the perceived, anticipated, or real stigma and discrimination that can result from disclosure are strong predictors of psychological issues (Meyer, 2003; Roberts, Plante, Gerbasi, & Reysen, 2015). In the face of this marginalization and psychological burden, however, research has found that the mental health of kink-oriented people is generally the same as or better than people who are vanilla (Gemberling et al., 2015; Nichols,

2006; Roberts et al., 2015). A systematic scoping review found that while kink-oriented people generally experience lower depression scores than vanilla people, they experience comparable rates of anxiety and more posttraumatic symptoms (Brown, Barker, & Rahman, 2020). Specifically, however, submissives experience worse mental health scores than dominants or switches, but their mental health was better than vanilla peoples' (Wismeijer & van Assen, 2013). All kink-oriented people with comorbid diagnoses (Brown et al., 2020) or pronounced minority stress (Hughes & Hammack, 2019) had higher rates of suicidality than people who are vanilla.

Global mental health research is increasingly exploring the disparities that marginalized populations experience. Subsequently, there have been calls to decrease the barriers to psychological care of stigma, discrimination, and inadequate professionals and services (Wainberg et al., 2017). Despite the prevalence of the topic of kink in academic circles, explorations of rural kink-oriented people's mental health and service usage, barriers, and facilitators to psychological care remain limited. Related explorations in the Tasmanian context are, to our knowledge, hithertofore non-existent. Therefore, this study aims to explore research questions regarding personal experiences with mental health help seeking; uptake prevalence and barriers and facilitators to help seeking; and participant-determined best practices for care.

Materials and methods

Study location

Tasmania is a remote, rural Island state in Australia, with an approximate population of 540,000 people; roughly 40.0% of whom reside in and around the capital (Hobart) (Australian Bureau of Statistics [ABS], 2020). Relative to other rural parts of the country, Tasmania has greater socioeconomic and family disadvantage, a higher unemployment rate, and lower education attainment rate (Ahmed et al., 2017; Department of Health [DOH], 2018). An estimated 21.0% of Tasmanian's have mental health disorders (DOH, 2018). Tasmania has the fewest MHP in the nation with 65 psychologists per 100,000 (versus 86 nationally) and 9 psychiatrists per 100,000 (versus 13 nationally) (Ahmed et al., 2017). The state also has the highest suicide rate in the country (Primary Health Tasmania, 2019).

Theoretical approach

Intersectional feminism and sexual configurations theory rooted in promoting bodily autonomy underpin this study, which employed a mixed-methods approach consisting of online survey and semi-structured interviews. Intersectional feminism explores the various, overlapping ways in which

people are oppressed (Cho, Crenshaw, & McCall, 2013). Sexual configurations theory seeks to integrate the diversity of gender, sex, and sexuality in research and clinical practice (van Anders, 2015). The human right of bodily autonomy includes the right to integrity and self-determination without discrimination (Wicks, 2016).

This study examined risk and protective factors and barriers and facilitators to help seeking in a sample of kink-oriented, rural Tasmanians with preexisting mental health conditions. Data for this study were drawn from a larger mixed-methods research project consisting of an online survey (n = 78) and semi-structured interviews (n = 33). The larger project explored the mental health and related service use of populations with compromised access to bodily autonomy (including sex, sexual, and gender diverse people, sex workers, people who are intersex, and kink-oriented people) in rural or remote Tasmania. The current study reports results from a subset of 42 online survey respondents and 10 interview participants who had self-reported involvement in kink or BDSM. Given this is not a study of the general population, but, rather was focused on a specific group and the intent was to capture their experiences, this is a rich sample within this research area. Note that due to inherent confidentiality built into the research instruments, participants cannot be identified across each measure (IP addresses and personal data were not tracked); thus, it is unknown if n = 52 are unique or distinct. That said, however, as 80.7% of the total (n = 52) completed the survey and n = 10 completed interviews, the total number of kink-oriented participants that will be used herein is n = 52 as they are considered unique in so far as each respective research measure is concerned.

Instruments

The survey consisted of 174 questions informed by the principal author's clinical practice as a mental health counselor and previous findings (ABS, 2008; Australian Psychological Society, 2015; Reynish, Hoang, Bridgman, & Nic Giolla Easpaig, 2020, 2019). Consisting primarily of closed-ended questions with three open-ended ones, survey questions were organized according to identity (LGBTIQA+, sex worker, kink-oriented) and topic, including demographics; mental health; experiences with services and MHP; barriers and facilitators; and risk and protective factors. To determine suitability, comprehension, gaps, and to ensure optimal functionality, researchers (n = 4) and community-based SOGIESC volunteers (n = 6) piloted the online survey (Creswell & Plano Clark, 2011; Kelley, Clark, Brown, & Sitzia, 2003). Recommendations included resolving repetition and ambiguities, improving functionality, and adding questions for clarity; all were followed.

To determine preexisting acute psychological distress or safety concerns, interview registrants had to complete a telephone-screening interview, which the primary author performed (Burke Drauker, Martsolf, & Poole, 2009). All registrants passed their screening and interviews were scheduled at a time of their choosing. Interviews were completed in-person or via telephone and featured 29 questions, of which 7 were eligibility-confirming and demographic questions. The remainder expanded on the research questions and some survey questions and explored mental health status; risk and protective factors; help seeking experiences, barriers, and facilitators; and recommendations for improvement.

Recruitment and sample

Recruitment occurred via e-mail, phone, in-person contact, third-party organizations, snowball sampling, and Facebook. Survey participants were compensated via an invitation to enter a draw for a $100 Australian dollar gift voucher. Interview participants received a $30 Australian dollar gift voucher. The Tasmanian Social Sciences Human Research Ethics Committee approved the study (H0018041).

Random probabilistic sampling tends to underrepresent identities that are predominately hidden, such as kink, thus, potentially introducing bias as the data may demonstrated the overrepresented non-hidden identities (Braun & Clark, 2006). To offset this, nonproportional quota sampling was used in this study. Nonproportional quota sampling subsumes the diversity within the kink population into two overarching sampling categories and assumes the diversity is represented in the overall sample. The two sample categories were preexisting mental health issues and involvement in kink/BDSM. Inclusion criteria were: being 18 years or older, currently or formerly residing in rural or remote Tasmania, having a preexisting mental health issue, and being able to read and write in English. Informed consent was required for participation.

Analysis

Qualitative interview data and the open-ended questions from the survey were explored via inductive, deductive, and theoretical thematic analysis (Braun & Clarke, 2006; Creswell & Plano Clark, 2011). Theme identification was performed in NVivo (QSR International Pty Ltd., 2012, Release 1.5) and coding consisted of the following steps as performed by the first and/or second author: 1) develop deductive codes based on the research and interview questions; 2) develop broad, inductive codes and capture findings matching deductive codes; 3) Conduct line-by-line coding sessions adding inductive and deductive codes; 4) reorganize and refine codes into categories; 5) review codes and remove, combine, or assign new ones; 6) integrate codes vertically and

Table 1. Themes and subthemes.

Theme	Subtheme
1. Mental state	Self-assessed mental status
	Mental health conditions
	Suicidality
	Risk and protective factors (individual factors, social factors, and systemic factors)
2. Mental healthcare	Uptake prevalence
	Help providers
	Help-seeking experiences
	Barriers and facilitators to access (individual barriers and facilitators, service-based barriers and facilitators, systemic barriers and facilitators)

horizontally to cross reference and reveal similarities and differences; 7) create and refine categories to ensure the inclusion of all relevant data; 8) refine resulting themes and subthemes, until salient themes emerged (Given, 2008).

Quantitative data analysis occurred in SPSS via descriptive statistics, including frequencies, descriptives, and crosstabs analyses. Data was also transformed via compute variable and recoded into different variables to create scale measures that combined several variables into one to produce groupings and to recategorize variables. This approach provided insight into the data, facilitated pattern and trend identification, and revealed participants' perspectives while highlighting the underlying factors (e.g., individual, service-based, systemic) and addressing the research questions (Braun & Clarke, 2006).

Two main themes and eight subthemes emerged from the qualitative data (Table 1). These themes (and subthemes) expand upon this study's research questions and provide the basis for this paper's organizational structure, in which the quantitative data is presented with the qualitative themes for enhancement.

Population demographics

Participants ranged in age from 18 to 61 (Mean = 35.8, standard deviation [SD] = 11.58) and represented eight gender identities: cisgender woman (46.2%), cisgender man (25.0%), nonbinary (11.5%), gender questioning (5.8%), transgender woman (5.8%), transgender man (5.8%), brotherboy (1.9%), and demigirl (1.9%). Participants spanned 10 sexual orientations within the umbrellas of bisexual (35.3%), straight (27.5%), asexual (9.8%), gay (7.8%), pansexual (7.8%), lesbian (5.9%), and queer (5.9%). One person (1.9%) was unsure of their intersex status and 11.5% were current or former sex workers.

Most participants (57.4%) have been kink-oriented for more than five years with 42.6% reaching eight-plus years, including two interview participants who reported a more than 20-year affiliation with kink. Regardless of frequency or involvement, 64.3% of participants have been interested in kink for eight-plus years. Participants who adopted a power exchange role did so as

Table 2. Participants' relationship status, educational attainment, employment status, and location (remoteness class): kink-oriented individuals (n = 52) in rural or remote Tasmania.

Characteristic	Survey (N = 42); n (%)	Interviews (N = 10); n (%)
Relationship status		
Divorced/Separated	4 (9.5)	1 (10.0)
Married/In a relationship	22 (52.3)	2 (20.0)
Consensual non-monogamist	4 (9.5)	3 (30.0)
Single	12 (28.6)	4 (40.0)
Educationa		
Year 12 (high school) or less	12 (28.6)	—-
Vocational school (TAFE)	15 (35.7)	—-
Undergraduate degree	9 (21.4)	4 (40.0)
Postgraduate degree	6 (14.3)	1 (10.0)
Employment statusb		
Full-time job	12 (28.6)	5 (50.0)
Part-time job	10 (23.8)	0 (0.0)
Don't work/Receiving Government benefits	15 (40.1)	2 (20.0)
Don't work/home duties	2 (4.8)	0 (0.0)
Student	3 (7.1)	2 (20.0)
Australian Statistical Geography Standard (ASGA) remoteness classc		
Inner regional (RA2)	19 (45.2)	5 (5.0)
Outer regional (RA3)	17 (40.5)	5 (5.0)

[a]Optional question; n = 47
[b]Optional question; n = 51
[c]Optional question; n = 46
—- Topic not included/broached

switches (49.0%), submissives (32.7%), and dominants (18.4%). Participants primarily engaged in kink with their partners (75.0%). See Table 2 for additional demographic data.

Results

Theme 1: Mental state

Mental state is a person's psychological functioning at a certain point in time that provides a snapshot of their general mental health. This theme included four subthemes: mental status, conditions, suicidality, and risk and protective factors.

Mental status, conditions, and suicidality

Having a preexisting mental health condition was a participation requirement; thus, all participants experienced mental health issues at some point in their lives. Interviewees' self-assessed mental status ranged from "quite good" to it is "a struggle" with most describing it as fluctuating. Anxiety was the most commonly indicated mental health condition among all participants, at a total self-reported rate of 86.3%, followed by depression at 82.4% (Table 3).

Interview participants revealed some conditions and developmental disorders that survey participants did not, including Schizoaffective Disorder, Postnatal Depression, Autism Spectrum Disorder, and Attention Deficit

Table 3. Sexual orientation and self-reported mental illnesses from survey and interview data (n = 51a).

	LGBTIQA+ n = 37 (%)	Straight n = 14 (%)
Self-reported mental illnesses		
Anxiety	31 (83.8)	13 (92.8)
Depression	30 (81.0)	12 (85.7)
Post-Traumatic Stress Disorder	10 (27.0)	3 (21.4)
Non-suicidal self-injury	7 (18.9)	4 (28.6)
Eating Disorders	9 (24.3)	1 (7.1)
Bipolar Disorder	6 (16.2)	3 (21.4)
Disassociation	7 (18.9)	2 (14.3)
Borderline Personality Disorder	4 (10.8)	2 (14.3)
Obsessive-Compulsive Disorder	5 (13.5)	1 (7.1)
Paranoia	2 (5.4)	1 (7.1)
Psychosis	0 (0.0)	1 (7.1)
Schizophrenia	0 (0.0)	1 (7.1)

[a]Sexual orientation data is missing for one participant

Hyperactive Disorder. Also, 27.0% of LGBTIQA+ participants and 14.2% of straight participants reported experiencing gender dysphoria across both research instruments. Gender dysphoria is not a mental illness, but remains a psychiatric diagnostic criteria (World Health Organization, 2016). In this study, 56.8% of LGBTIQA+ and 35.7% of straight participants attempted suicide in their lifetime. Of our 32.7% transgender and gender diverse participants, 70.6% reported lifetime suicide attempts. Risk or protective factors exacerbate or assuage suicidality.

Risk and protective factors

Risk and protective factors was the fourth subtheme of Theme 1, Mental State, and are behaviors, influences, or conditions associated with negative or positive psychological outcomes, which worsen or improve a person's ability to cope with difficulty or oppression (VicHealth, 2019). Thematic analysis revealed reciprocity between the individual and their environment; thus, the uncovered risk and protective factors are explored on individual, social, and systemic levels.

Individual factors. Individual risk factors are biological or psychological characteristics within a person that can influence their psychological outcome (Substance Abuse and Mental Health Services Administration, 2019). The risk factors uncovered in this research were use of alcohol and other drugs (AOD), physical health issues, and stress. Roughly one quarter of survey participants reported AOD use, with marijuana, alcohol, and tobacco the most common. Interview participants reported having physical health problems including a spinal condition, a heart condition, and obesity. All interview participants indicated experiencing current or historical stress.

Conversely, interview participants reported having individual protective factors. When asked about factors that helped their mental health, responses spanned self-care, positive self-regard, resilience, self-awareness, and positive views about their identities; examples of which are evident in these quotations:

> I . . . take stock of where I'm at and what my emotions are doing . . .. I'm aware of my emotions . . . in the past I'd put them aside a lot more. Now, I embrace them (#2, kink-identified, straight, cisgender man).

> When I decided to [take the government-contracted job network] to court, I was lying in bed, couldn't sleep, ruminating hideously, and it was the tumble dryer of thoughts going around in my head. But then, there was a clear thought, . . . it was my voice in my own head saying, "I am better than this." . . . I've been basically punching back since then (#15, kink-identified, straight, cisgender man).

Kink orientation and involvement was another individual protective factor: 45.2% of survey participants are proud to be into kink and 81.0% indicated that BDSM and kink are part of a healthy sexuality. While 64.3% of survey participants declared that kink improves their mental health, 83.3% of survey participants and seven interview participants felt that their involvement in kink was not the cause of their mental ill health. The interplay between an individual and their environment demands that social and systemic risk and protective factors also be explored.

Social factors. Social risk and protective factors impact individuals, but arise from deeds or words by people in community, environment, and society and can negatively or positively influence a person's identity and mental health. Participants experienced the social risk and protective factors of stigma, discrimination, violence, and the absence and presence of social support. Stigma is negative judgment or shame from others. Discrimination is the manifestation of stigma and occurs as unjust or prejudicial treatment. Stigma and discrimination can also be internalized. When asked if there was stigma around having mental health issues, 92.9% of survey participants agreed or strongly agreed. Participants also experienced stigma based on their kink orientation and their profession: 21.4% of survey respondents experienced discrimination due to their kink orientation, of whom, 44.4% reported disclosing their orientation to their friends or family, a common source of prejudice. The kink-oriented participants who were also sex workers reported that stigma and discrimination based on their job as a sex worker were sources of anxiety or stress.

Violence, a social risk factor, is a correlate of mental illness. Survey participants who were also sex workers experienced violence or abuse from clients and/or police. When asked about risk factors or things that harmed their

mental health, interview participants shared that they had experienced violence, including in the form of child sexual assault and intimate partner violence, as these quotations demonstrate:

> When I was a child, I was sexually abused. That wasn't very good for me. My grandfather … was also the pedophile in the family. So that was never good for me (#23, straight cisgender woman, former sex worker, former dominatrix).

> … the put downs [by my ex] and the humiliating me in front of family and also … telling her friends … intimate things that I told her I'd like in the bedroom and all that is just utterly, utterly humiliating (#25, kink-identified, bicurious, cisgender man).

Interview participants also experienced psychological abuse from employers, disparaging homophobic slurs from family members and strangers, and lateral violence, which is displaced violence directed at peers rather than adversaries. Lateral violence can manifest either blatantly as physical or sexual violence or subtly, as prejudice, minimization or delegitimization (Undercurrent Vic, 2012). Our participants experienced this violence as bullying from other kink-oriented people, humiliation and fat shaming from other gay men, and erasure of specific kinks or sexualities by kink-oriented people and other members of the LGBTIQA+ community, with some participants experiencing this misdirected violence in multiple ways.

Social support is psychological or material support from others; it enhances quality of life and buffers against adverse events (Cohen & Wills, 1985; Hostinar, Sullivan, & Gunnar, 2014). The absence of social support is a risk factor that can contribute to mental health problems (Reynish et al., 2020). All interview participants and nearly a quarter of survey respondents (23.8%) reported lacking or deficient social support. The following quotations illustrate ways in which family and friends failed to provide social support:

> … I don't want to use that metaphor of the … black sheep in the family, but … when one person [in a family] gets diagnosed with a mental health issue, it gives everybody the permission to never be critical towards themselves and always point the finger at you. … I'd never discuss my mental health with my family now (#23, straight cisgender woman, former sex worker, former dominatrix).

> … I don't have very many friends at all anymore … I haven't managed to maintain my friendships because [of] my mental health; because no one wants to be friends with someone who has six months where they just completely drop off the radar … (#30, kink-curious, bisexual, cisgender woman).

Inadequate social support can result in isolation and feelings of not belonging or outsiderness (Cohen & Wills, 1985; Hughes & Hammack, 2019). Isolation was a risk factor for psychological distress for most interview participants and 50.0% of survey participants reported feeling like an outsider because of their kink identity. Survey and interview participants also reported the opposite of this and benefited from the protective factor of social support.

All interviewees and 76.2% of survey participants reported having good social support. Involvement in a kink community helped the mental health of 75.0% of participants across both measures. Of our survey participants: 50.0% reported not feeling like an outsider because of their kink orientation; 50.0% agreed that kink has become more accepted in the last 5 years; and 45.2% reported that their friends or family know about their kink orientation. Participants reported that having social support improved their mental health; the ability to be open with the people in their lives and the resulting acceptance and inclusion were particularly important, as this quotation demonstrates:

> . . . you get some pretty unusual beating marks . . . And, I have had a workmate see bruises on my leg . . . They responded perfectly because, at first, they went. "Aww!" And they went, "Ohhh!" [They] didn't know what to say. Ruffled my hair, and then later on, they sent me a text message say[ing], "I'm sorry. I hope that wasn't too intrusive." And I just went, "No, it was fine." . . . that was a good . . . response to it. They didn't judge at all (#2, kink-identified, straight, cisgender man).

Systemic factors. Systemic risk or protective factors can hurt or help a person's mental health and derive from fundamental faults or merits in society that present as norms, policies, or laws that can discriminate, impede participation and access, generate inequality, or provide opportunity for inclusion and access (Reynish et al., 2020, 2021). Across both measures, participants indicated several systemic risk factors, which caused psychological harm; most of which pertained to the presence or absence of legislation, processes, and resources.

Regarding legislation, all but one kink participants who were sex workers strongly agreed that decriminalizing sex work is vital to improving physical safety and mental health. As this interviewee indicated, current legislation impacts a range of factors:

> I think that the legislation must change because I don't like paying all this tax and [as a sex worker] I do not have the same access to services [such as workplace health and safety or unions] that other people do. I think it's really unfair . . . change legislation for our mental and physical health . . . (#1, kink-identified, bisexual, cisgender woman, current sex worker).

Regarding processes, half of our interviewees struggled with government bureaucracy, which impacted their mental health:

> . . . as someone with disabilities, it's always difficult dealing with [government agency that delivers social security payments] and all of that kind of thing. . . . I don't think living should have to be stressful (#16, kink-identified, pansexual, polyamorous, cisgender woman).

Access to resources was another systemic risk factor for survey participants: 70.0% could not secure an appointment with an MHP as soon as they needed support due to workforce shortages. This lack of access to care increases

vulnerability, burden, and risk. Also, 69.0% lacked the financial resources to pay for mental health support, which is a risk due to the strong causal relationship between poverty and psychological distress (Australian Psychological Society, 2015). The national average of adults with mental health issues who have experienced homelessness is 32.3% (Australian Bureau of Statistics [ABS] 2016); 29.5% of our participants experienced homelessness at some point in their lives. While mental illness can impede the ability to retain a stable home, not having one increases the risk of developing a mental illness (ABS, 2016).

Survey participants reported systemic protective factors relating to access; that is, 75.0% had MHP located in their town and 78.6% could access public transport to get to an MHP. The only systemic protective factor indicated in the interviews related to the government's facilitation of toll-free mental health lines:

> The government aren't mind readers, not yet. You know, if you've got problems . . . I know there are numbers, phone numbers out there . . . but I don't know how much more you can ask [of] the government (#25, kink-identified, bicurious, cisgender man).

Interview participants also discussed difficulties related to living in a rural, rather than an urban, region. They cited the constraints of identity concealment, isolation, and stigma, which are endemical to rural areas as well as systemic risk factors:

> So, unfortunately my family, most of them moved to the mainland, which is one of those things that happens in Tasmania; isolates you in its own way (#2, kink-identified, straight, cisgender man).

> . . . there are some societal views [in rural Tasmania] around sexuality and, and sexual behaviors that are rigid and they're definitely deleterious for my mental health because . . . they're not necessarily consistent with how I feel or how I behave (#30, kink-curious, bisexual, cisgender woman).

Corresponding to the small towns in which our interview participants lived, came small kink scenes.

> I still don't quite fit in society; I feel [the kink scene in Tasmania is] a small, very small community. And that does make you feel lonely sometimes (#2, kink-identified, straight, cisgender man).

> FetLife [social network for the BDSM, fetish, and kinky community] is an interesting place to be on because there's a lot of dramas that happen, especially in a small community scene. There's a lot of people [who] are threatened by being outed to their friends and families. A lot of them live in small towns where everyone knows each other. And so that's, that's quite difficult for people (#15, kink-identified, straight, cisgender man).

Theme 2: Mental healthcare

The second theme explores the apparatus that is mental healthcare including its components and subthemes of uptake prevalence; help providers; and help-seeking experiences. In the face of the mental health burden described in Theme 1, all participants sought either formal or informal support. Almost all survey (95.2%) and all interview participants reported seeing at least one formal MHP, of which psychologists (82.0%), counselors (68.0%), and social workers (44.0%) were the most common. Participants also saw psychiatrists (34.0%), hospital emergency department staff (27.5%), and religious or community leaders (12.5%) for help with their mental health. Only 7.1% of survey respondents saw an MHP for issues relating to kink.

All interview participants sought and benefited from informal care, such as that provided by partners, as indicated in this quotation:

> If I'm [mentally] unwell . . ., my husband, he doesn't say anything about it . . . He picks up my jobs for me when I can't do them . . . and he gets on with it. And the kids have learned that that's how to roll with it. And . . . that's exactly what I need. And it's the reason why I haven't had to be hospitalized (#30, kink-curious, bisexual, cisgender woman).

Interview participants' experiences with formal mental health support ranged from "very positive" to "it's been a bit of a nightmare." A variety of factors influenced these assessments, which comprised barriers and facilitators to care. Notably, barriers and facilitators to help seeking is a subtheme of the second theme of this study. This subtheme is organized as individual, service-based, and systemic barriers and facilitators.

Individual barriers and facilitators

Participants' own personal, individual circumstances blocked and fostered help seeking, for example, having mental health issues was an individual barrier for interview participants:

> I have a lot of anxiety that I struggle with. So when I'm feeling stressed out or overwhelmed by the world, it's really hard for me to make the phone call and book an appointment and follow through with it (#16, kink-identified, pansexual, polyamorous, cisgender woman).

> Generally, when I'm in more of a depressive state, there's overwhelming lethargy, I just don't want to get out of bed . . . and . . . don't . . . really want to go into the world, it's too loud, it's too bright. And that's generally what'll keep me from [seeking mental healthcare] (#22, kink-identified, straight, gender diverse demigirl).

Interview participants indicated that their desire to not burden others was a barrier to formal and informal help seeking. Interview participants' individual-based facilitators to help seeking also varied. Participants sought care out

of a duty to others or a need to do so for oneself. Reasons for self-motivated help seeking included not wanting to die by suicide, not functioning, and a desperation to be well.

All participants across both measures reported on a variety of individual MHP-based barriers and facilitators to care. A bad formative experience with an MHP was one barrier that can have lingering effects:

> I had a lot of issues with anxiety as I was growing up so my mum would take me to see different . . . counselors, but none of them really listened to me. I was quite young at the time, so they probably have their reasons, but it's kind of put me off the idea of going to talk to anyone because I feel like they won't respect my autonomy, my decisions (#16, kink-identified, pansexual, polyamorous, cisgender woman).

> I think for me it's a lot with past experiences [that get in the way of me getting support], yeah having especially the older [female MHP]; I think it's a generational thing because a lot of the [negative] comments I've had from [MHP] have been from like the 50 to 60 age group . . . So I think she was the worst one, she yeah kind of set me back with a lot of things, not just the sexuality [and] gender topics that I was trying to bring up with her . . .. And having someone to tell you just to ignore like a major part of your identity was really bad (#32, kink-identified, biromantic, asexual, gender questioning woman).

Reception to the 19.0% of participants across both measures who disclosed their kink identity to an MHP was less than entirely positive. Of the survey participants who did disclose, two-thirds reported that the MHP needed the participant to educate them. Interview participants who disclosed felt dismissed:

> And, yeah both psychologists . . . I'd mentioned my little side and everything to, and . . . they sort of put it in a basket almost like it's a too hard basket . . . It still feels like it's just pushed aside (#2, kink-identified, straight, cisgender man).

> And in terms of the kink stuff . . . I probably only really shared that very minimally with one . . . And they . . . were . . . visibly uncomfortable. I mean, I didn't say very much at all. And yes, [they] just quickly move[d] onto the next topic basically . . .. I never would have shared that stuff if I didn't want to talk about it. And so hearing it and then quickly moving on and shutting down any conversation around it was not . . . in any way kind of helpful . . . (#30, kink-curious, bisexual, cisgender woman).

The 81.0% of participants who did not disclose provided a variety of reasons for not doing so, including fear of judgment:

> And I don't really know how I would be able to start talking [to an MHP if I were to see one] about all these touchy issues such as BDSM and open relationships . . . I don't really know how much understanding they would have . . . mostly that they wouldn't have the experience and that, I guess they might be a bit confused or . . . if they were more traditional they might . . . I don't want to feel judged . . . (#16, kink-identified, pansexual, polyamorous, cisgender woman).

> . . . especially with kink, it sort of feels like . . . this is a just-me thing. But, I see how it could probably factor into different aspects of my mental health. But . . . it does feel like something that is definitely out of the norm and would probably raise quite a few eyebrows so I don't feel entirely comfortable in disclosing that (#22, kink-identified, straight, gender diverse demigirl).

When asked about those factors that would result in ceased contact with an MHP, interview participants discussed inadequate cultural competency and education:

> If [an MHP] is quite kind of small minded and just doesn't . . . understand my life and lifestyle. If people aren't very open minded . . . which happens in rural communities probably more than other places, I tend to just sort of switch off and think, "Oh, I don't think they're going to quite understand what I'm talking about." And so I move on (#30, kink-curious, bisexual, cisgender woman).

> . . . you kind of go in thinking this is a safe space, you can talk about whatever issue is going on in your life at the moment and they are going to be there to support you and help you through it. Whereas that's not necessarily what you get all the time, which is pretty awful . . . and it makes it harder to try and actually go to another one because you're just like, "Ah, it's just going to be the same. You know, I'm just really feeling even worse" (#32, kink-identified, biromantic, asexual, gender questioning woman).

> [When] talking to a psychologist, I find I do sort of like educating them on [my kink], but at the same time, I probably perhaps would like them to go away and do their homework on it to and learn about it and then maybe; it would just make me feel better (#2, kink-identified, straight, cisgender man).

Conversely, although not many, some individual MHP demonstrated attitudes or behaviors that facilitated help seeking. Participants continued to engage in care because their MHP was: kink aware (26.2% of survey participants); had therapeutic experience with kink-oriented people (9.5% of survey participants; n = 7 interviewees); friendly and welcoming (n = 4 interviewees; 23.8% survey participants); offered bulk billing or reduced rates (n = 5 interviewees); offered appointments longer than one-hour (n = 3 interviewees); made them feel heard (n = 5 interviewees); and established rapport (n = 4 interviewees).

Service-based barriers and facilitators

Survey participants used both private and public mental health services and reported many barriers (Table 4). Interview participants also used a mix of service types and reported that failure to provide a welcoming service (n = 5) or online booking or appointment options (n = 3) were barriers to care.

Participants were also asked what drew them to a service or made them want to use it. Participants reported experiencing a range of service-specific facilitators to help seeking

Table 4. Service-based access barriers reported as a percentage by survey participants (n = 42).

Barrier category	Barrier	No. (%)
Financial	Too expensive	23 (54.8)
	No private healthcare insurance	15 (35.7)
Proximal	No MHP/service near where I live	10 (25.0)*
	Lack of MHP in my area	15 (35.7)
	Lack of services in my area	20 (47.6)
	MHP/service too far from my home	6 (14.3)
	Not able to see MHP ASAP	28 (70.0)*
	Travel time to MHP/service 30 to 60+ minutes	9 (22.5)*
Logistical	Service with limited hours	18 (42.9)
	Long waitlists	28 (66.7)

* data missing for 2

> . . . another time I went to see a counselor . . . at the university . . . they had everything from, even little fluffy, you know, like huggable toys . . . and a little sandpit even . . . They didn't know anything about my little side either, but . . . I remarked about how it was nice to move about. . . . they also had . . . stress balls and stuff like that. . . . And they were just brighter environments. It just felt more cheerful (#2, kink-identified, straight, cisgender man).

> Generally, they are set up to be very comfortable and calming spaces. Yeah, they're generally quite welcoming and relaxing and the color schemes and décor and all that sort of is arranged in a way that does feel nice (#22, kink-identified, straight, gender diverse demigirl).

Systemic barriers and facilitators

Systemic elements are factors ingrained within the overall system that become commonplace and transform culture. Stigma was the biggest systemic barrier to help seeking reported in the study; 76.2% of survey participants either agreed or strongly agreed that there is stigma around getting help for mental health issues. Interview participants also remarked on stigma and its impacts:

> . . . a lot of people are talking about kink-friendly counselors [on FetLife], because then it goes that there's a stigma around that if you're seeing a counselor and you're opening up about your fetish or, or your sexual practices (#15, kink-identified, straight, cisgender man).

> And I know [stigma against mental ill health is] getting a bit better but, it's still not great to be in therapy or in counseling or whatever. And even though I try not to let that bother me, it still kind of does because people do make comments even though it's not really their place to (#32, kink-identified, biromantic, asexual, gender questioning woman).

Interview participants did not identify any systemic facilitators to help seeking; however, some of their comments could be interpreted as expressed preferences to destigmatize kink, potentially increasing uptake, and improving wellbeing

> I think my little side has probably had the most impact on my mental health and possibly in a negative way. Or, most likely in a negative way . . . because I just feel like I don't fit in – that's the big part of it . . . or I'm not accepted; that sort of feeds into it (#2, kink-identified, straight, cisgender man).

> I suppose there's a lack of understanding or there's a bit of discrimination . . . which . . . definitely affects my mental health that I internalize. . . . For example, I've, at times, I've been non-monogamous in our, in my relation with my husband – negotiated, like he knows. . . . I've been with women and, I . . . feel like we have such a kind of concentration on monogamy and things in our society that I have a lot of guilt about that even though he's OK with it . . . we definitely have a heteronormative society . . .. But I mean, it's not necessarily easy to live within the confines of that . . . (#30, kink-curious, bisexual, cisgender woman).

Ideologically speaking, participants craved the openness, diversity, acceptance, and change that systemic stigma seeks to stem. Taking steps to curb stigma could increase service use as well as improve mental health.

Discussion

This snapshot of the lives of kink-oriented people with preexisting mental health conditions in rural Tasmania reveals a gender and sexually diverse, relatively educated sample with lower employment rates and higher rates of lifetime suicide attempts than the general population. In 2016 and 2019 national censuses, less than 1.0% of the Australian population indicated they were gender diverse and 2.7% had a sexual orientation other than straight (ABS, 2018, 2019). However, 32.7% and 72.5% of our participants were gender or sexually diverse, respectively; only 27.5% were straight. This finding is consistent with other research—people with diverse SOGIESC are more inclined to be kink oriented than straight (Damm et al., 2018; Meltsner, 2017; Richters et al., 2008).

Findings reported elsewhere indicate that kink-oriented people tend to be more educated than the general public (Brown et al., 2020; Wismeijer & van Assen, 2013). Concurrently, 74.4% of our participants had either vocational school or university education. In comparison, only 41.4% of the general Tasmanian population have education beyond high school. Only 52.9% of our participants were currently employed, however, 88.1% of Tasmanians work either full- or part-time (ABS, 2017).

The estimated risk of suicide in people with preexisting mental health conditions such as depression and anxiety ranges from 5.0 to 61.0% (Brådvik, 2018; de Beurs, ten Have, Cuijpers, & de Graaf, 2019). 46.25% of our participants attempted suicide in their lifetime with LGBTIQA+ participants reporting higher instances than straight (56.8% and 35.7%). Researchers have found that transgender people have lifetime suicide attempts of roughly 50.0% (Rosenstreich, 2013). Our transgender and gender diverse participants reported suicide attempt rates of 70.6%. Rurality, social conservatism, and intersecting exogenous oppressions could account for our high rates.

Contradicting findings reported elsewhere, the straight people in our study reported slightly higher incidences of both anxiety and depression than LGBTIQA+ participants (Table 3) (Lyons, Hosking, & Rozbroj, 2015; Stanley & Duong, 2015). Two reasons may explain these contradictory findings. First, research demonstrates that straight men tend to prefer submissive power-exchange roles (Brown et al., 2020; De Neef, Coppens, Huys, & Morrens, 2019). More than 57.0% of our straight participants were cisgender men; of those who reported their power-exchange role, 62.5% were submissives or switches. This shift from the dominant male role that is expected in hypermasculine, rural society could compound the existing psychological burden (Carrington & Scott, 2008; Wismeijer & van Assen, 2013). Secondly, identity could explain the contradiction. Some LGBTIQA+ people tend to embrace their kink orientation later in life (De Neef et al., 2019). Our LGBTIQA+ participants could have explored their sexuality or gender before finding kink. If so, this initial identity-development experience could have resulted in improved adjustment and positive self-affirmation of their kink orientations, which could explain their slightly lower Axis I disorder presentations.

Despite intent, therapy has the potential to cause harm due to a lack of cultural validity, restricted use of psychological interventions, and adverse MHP behaviors or attitudes (Curran et al., 2019). This study found that 90.5% of participants had never worked with an MHP who was knowledgeable about or had experience working therapeutically with someone with a kink orientation. Furthermore, almost half of our interview participants reported having only negative formal help-seeking experiences.

Other research has concluded that less than 40.0% of their kink-oriented participants disclosed their sexual orientation to healthcare professionals (Waldura et al., 2016). More than 80.0% of our participants did not disclose their sexual orientation to MHP. Non-disclosure was partially due to the fact that some of our participants felt their kink orientation was unrelated to the reasons for entering therapy. Mostly, however, non-disclosure occurred out of fear of stigma or discrimination from MHP. The burden of real or perceived discrimination and identity concealment on mental health should not be ignored due to their association with psychological distress and suicidality (Hughes & Hammack, 2019; Roberts et al., 2015).

The absence of a complete picture of a client's identity places MHP at a disadvantage (Kolmes, Stock, & Moser, 2006). More importantly, however, MHP must be aware of the risk inherent in stigma, for non-disclosure of kink-orientation also often extends to friends or family, placing clients at greater risk for social isolation. Reduced proximity to services, social conservatism, discrimination, stigma, and identity concealment can be endemic rural constraints (Willging et al., 2018). These constraints can isolate kink-oriented people from vital social support and communities, worsen mental health, and

breed help-seeking avoidance. MHP must avoid contributing to these constraints by eliminating help-seeking barriers and following participant-determined best practices for care (Figure 1). Training in these areas is also recommended. The lack of training that MHP receive (or seek out) on diverse sexualities, including kink, has the potential to exacerbate psychological distress (Dunkley & Brotto, 2018; Shahbaz & Chirinos, 2017). Training would reduce stigma, increase cultural competence, contribute to ethical compliance, and improve clinical practice (Kink Clinical Practice Guidelines Project, 2019).

Participants revealed endogenous and exogenous factors that improved their psychological state and encouraged help seeking. Consistent with other research on kink-oriented people, our participants generally had good self-awareness, practiced self-care, demonstrated resilience, and had social support —all of which improve mental health (Roberts et al., 2015; Wismeijer & van Assen, 2013). Kink has been shown to improve mental wellbeing (Damm et al., 2018). Our study validates those findings: almost 65.0% declared that kink improves their mental health. These empowering protective factors insulate against exogenous oppressions and can be harnessed to reduce the high rates of anxiety, depression, and suicide attempts that our participants reported.

Specifically regarding the context of the present study, the Government of Tasmania is uniquely placed to decrease societal stigma and discrimination and expand existing MHP education and mental healthcare provision. To address erasure and resulting disparity, curricula for all mental (and physical) healthcare students could be updated to include in-depth instruction on topics unique to people with diverse, non-vanilla, non-heteronormative, or non-

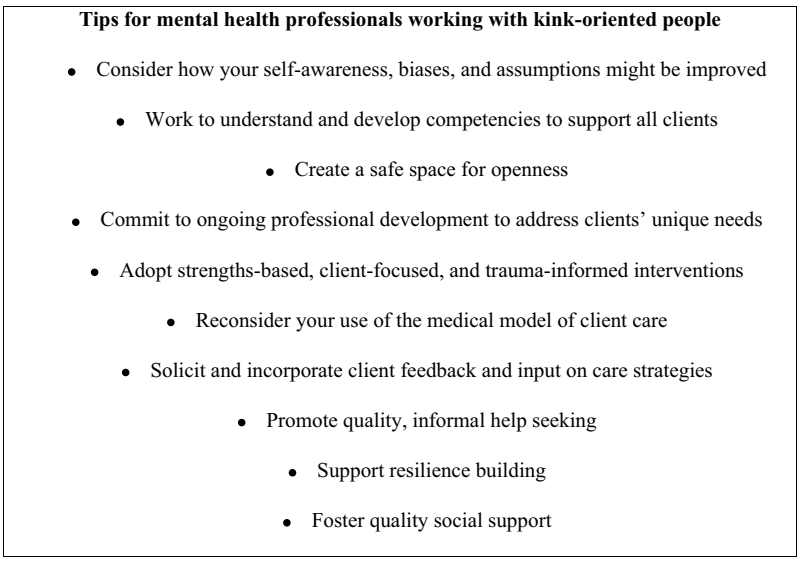

Figure 1. Participant-determined best practices for mental health professionals working with kink-oriented people.

mononormative sexual interactions. Finally, complementary to existing public-services funding, which primarily addresses triage, crisis, or episodic care, focus could also include a prioritization of preventative and tailored mental health support.

Limitations

This study had limitations. The small survey sample size may have been due to the population of rural Tasmania and the study's focus on kink-oriented people with preexisting mental health conditions. The recruitment strategies of snowballing and drawing from the principal author's own networks may have excluded or biased people and reduced the number of respondents, therefore, generalizability is limited. However, the interview sample provided a rich data set from which to triangulate and confirm findings. These exploratory findings offer valuable insight and an impetus to further explore and improve the mental health and related service use of kink-oriented people in Tasmania as well as in other rural and remote areas.

Conclusions

Kink has become increasingly normalized and, yet, this study is the first of its kind in Tasmania. As acceptance for this alternate sexual orientation grows, psychological support for this stigmatized group must evolve to match. The mental health and related care of kink-oriented people in rural Tasmania involve a complex mix of factors. This study did not find a causal link between a kink orientation and mental ill health. Rather, exogenous prejudicial factors, attitudes, and behaviors impede identity development and uptake of mental healthcare and are much more evidenced as causes for any mental ill health in our participants. If harnessed, these findings can contribute to the development of competent, tailored support for kink-oriented people that reduces risk factors, increases protective factors, and improves mental health. In the meantime, MHP and government alike can challenge the stigma and discrimination they perpetuate through reflection, training, and addressing systemic issues.

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Mental health and related service use by sex workers in rural and remote Australia: 'there's a lot of stigma in society'

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ABSTRACT

Sex workers experience risk and protective factors that affect their psychological well-being, yet little is known about sex workers' mental health and their experiences with related services in rural and remote Tasmania, Australia. Semi-structured interviews were conducted with six current or former sex workers with pre-existing mental health problems, and thematic analysis was used to identify their experiences with mental health and related care. Generally, sex work does not contribute to participants' mental health concerns; rather, social exclusion and systemic issues cause psychological harm. Ineffective mental health professionals and the lack of tailored or culturally competent support serve as barriers to care. Significantly, widespread stigma was both a risk factor to participants' mental health and a barrier to help seeking and resulted in isolation and identity concealment. Resilience, self-awareness and social inclusion reduce the psychological impact of exogenous oppression and encourage help seeking. The decriminalisation of sex work could improve sex worker mental health and reduce stigma by normalising sex work.

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Introduction

Stigma is the devaluation of a person based upon their perceived departure from social norms and can manifest in the form of discrimination, shame and condemnation. Stigma can result in psychological distress and impact help seeking (Rayson and Alba 2019). Sex workers experience considerable stigma. They face public stigma when society endorses prejudices against them that manifest in the form of discrimination, such as impeded access to healthcare, housing and justice (Platt et al. 2018). Sex workers experience perceived stigma when they believe that others view them negatively. They experience whore stigma in the form of derision towards people who combine sex with gain (Jiao and Bungay 2019). Mental health professional stigma is also a reality for many sex workers and occurs when a practitioner's attitudinal bias

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diminishes client care (Grappone 2018). Sex workers experience systemic stigma, which occurs when legislation or social processes limit access to rights and opportunities (Grappone 2018). Together, these different forms of stigma isolate sex workers and can result in identity concealment to guard against stigma's negative impacts (Meyer 2003). Together, stigma and identity concealment can contribute to psychological distress and may impede or prevent help seeking (Jiao and Bungay 2019; Rayson and Alba 2019).

According to the World Health Organization (2018, para. 2), mental health is: 'a state of well-being in which every individual realises [their] own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community'. Poor mental health is the inverse of this; it affects a person's ability to modulate their emotions and internal equilibrium and can result in mental health issues. Sex workers face many, often intersecting forms of oppression that are predictors of mental health problems and issues (Reynish et al. 2021). Lesbian, gay, bisexual, transgender, intersex, queer/questioning and asexual (LGBTIQA+) sex workers, for example, may experience homophobia or transphobia in addition to whore stigma (Jiao and Bungay 2019). Rural people tend to have worse mental health indicators than their urban counterparts, which can be due to poorer physical health, higher unemployment, reduced access to care, and restrictive social norms (National Rural Health Alliance 2017). Rural sex workers can experience these indicators as well as stigma-based oppression, which can impact their mental health. While some Australian sex workers experience poorer mental health than non-sex workers, variation between them exists (Graham et al. 2017). Harris, Nilan, and Kirby (2011) found high rates of mental health issues among urban female sex workers in New South Wales, Australia, while Seib, Fischer and Najman (2009) found that job satisfaction was associated with improved mental health in their Queensland-based participants. Both found that poor working conditions, exposure to violence, pre-existing mental health issues, and stigma contribute to psychological distress (Seib, Fischer, and Najman 2009; Harris, Nilan, and Kirby 2011).

The rural, island state of Tasmania has an estimated population of 540,000 (Australian Bureau of Statistics [ABS] 2021). Relative to other rural Australian regions, Tasmania has higher socioeconomic disadvantage, higher unemployment and lower education attainment (Ahmed et al. 2017). An estimated 21% of Tasmanians have mental health problems, yet the state has the fewest mental health professionals nationwide (Ahmed et al. 2017; Department of Health [DOH] 2018b). Sex work is only legal in Tasmania if the person works alone or with one other sex worker in either a residence or hotel. Brothels, escort agencies, businesses with more than two sex workers, street-based and public sex work are illegal in the state (*Sex Industry Offences Act* 2005 [Tas]). The *Act (2005)* also requires that workers are older than 18 and consent to the work.

Sex workers' mental health help seeking varies from the occasional (Treloar et al. 2021) to the frequent (Rayson and Alba 2019). Reasons for help seeking cited in existing literature include increased mental health problems, ability to advocate for oneself, (Rayson and Alba 2019), and the need to manage the psychological impact of stigma (Treloar et al. 2021).

Much existing research focuses on the sexual or physical health of sex workers and assumed public health concerns (Platt et al. 2018). The near-total absence of HIV and low rates of other sexually transmitted infections among sex workers in Australia adds to increasing evidence that these concerns lack salience (Jeffreys et al. 2011; Department of Health [DOH] 2018a). Research into sex workers' mental health and service usage prevalence, barriers and facilitators, however, is limited, especially in rural Australia. The prevalence of stigma and intersecting forms of oppression encourages an exploration into rural sex workers' mental health and related service use. This study aimed, therefore, to explore the mental health, barriers and facilitators to help seeking, and help seeking experiences of a sub-sample of sex workers in rural Tasmania, Australia.

Materials and methods

Data for this study derive from a larger mixed-methods research project that explored the mental health and related service use of populations with compromised access to bodily autonomy (including sex, sexual, and gender diverse or LGBTIQA + people, sex workers, people who are intersex, and kink-oriented people) in rural or remote Tasmania.

Sexual configurations theory and intersectional feminism grounded in the human right of bodily autonomy comprised the study's theoretical basis. Sexual configurations theory seeks to integrate the diversity of gender, sex, and sexuality in research and clinical practice (van Anders 2015). Intersectional feminism examines the myriad of oppression that people face based on race, gender, class and sexuality (Cho, Crenshaw, and McCall 2013). Bodily autonomy is the right to self-governance without restriction or discrimination (Wicks 2016). These theories provided the basis on which current knowledge and assumptions about sex, sexuality, gender were explored through the lenses of participants' various and intersecting identities and experiences.

In an attempt to ensure the larger study and any resulting papers reflect the work's core tenets, 10 people including researchers, people with compromised access to bodily autonomy, and sex workers were involved in the design and development of research tools and study piloting (Kelley et al. 2003; Jeffreys 2009). Suggestions regarding syntactical and logic issues and additional clarity and representation from the pilot study were incorporated in the final version of the research tools.

This study was based on a subset of data involving interview participants who were current or former sex workers. The purpose of the study was not to gather data on illegal activity; all participants reported solely on legal sex work. Semi-structured interviews enabled exploration of praxis-derived assumptions and facilitated probing of participants' responses for additional information (Austin and Sutton 2014).

Recruitment and sample

Recruitment took place through social media, snowball sampling, and third-party organisations from the primary author's networks across the state. Contacted organisations included the state's sex worker association, sexologists, an LGBTIQA + support

service and mental health professionals; all agreed to assist and were emailed a description of the study and a digital poster to disseminate or hang up. Interview participants received a $30 Australian dollar gift voucher as compensation. As sex workers are a hard-to-reach population, non-proportional quota sampling was used. This method subsumed population diversity into two sample categories: current or historical mental health issues and sex work experience. Eligibility required that participants were aged 18 years or older, currently or formerly employed as sex workers, living (or had lived) in rural or remote Tasmania, had experienced mental health problems, and had sufficient English comprehension skills to provide informed consent. The Tasmanian Social Sciences Human Research Ethics Committee approved the research protocol in September 2019.

Interviews

Participants completed two interviews. To preclude pre-existing acute distress or safety concerns, all interview registrants were required to pass a screening interview prior to participation (Draucker, Martsolf, and Poole 2009), which the first author conducted via telephone. All registrants passed the screening interview and main interviews were booked. The main interview consisted of 24 questions: 6 eligibility-confirming and demographic questions and 18 open-ended questions (a copy of the schedule may be obtained from the corresponding author on request). Main interviews were conducted in-person or via telephone between November 2019 and March 2020, lasted between 45 and 70 min, and were audio-recorded. NVivo Transcription (QSR International Pty Ltd. 2020) was used by the first author to transcribe the main interviews. The remaining authors verified a random sample of transcriptions for accuracy.

Analysis

Inductive and theoretical thematic analyses were used to analyse the interview data (Braun and Clarke 2006). The first author used line-by-line coding in NVivo to generate themes, which were latent (contained contextual meanings) and semantic (contained explicit meanings) in nature. Using vertical (question-to-phenomenon) and horizontal integration (question-to-question) cross-referencing, the primary author identified similarities, differences, patterns and commonalities, which provided contextual meaning and aided in data synthesis (Given 2008). The remaining authors verified and confirmed themes and cross-referenced results.

Researcher reflexivity

The primary author has worked for 25 years with the populations in the larger study as a mental health counsellor, researcher and community activist. The secondary authors have experience in mental health counselling, mental health service evaluation, and research with othered and rural populations. As recruitment occurred primarily via the primary author's networks, she had previously met four of this study's six participants. Overlapping relationships are not uncommon in rural areas and can

be key to establishing the trust required for hidden populations to engage in research (Schank and Skovholt 1997; Dewane 2010). To mitigate possible risk, however, no clients of the primary author's counselling practice participated in the study; all authors contributed to defining the study's ethical parameters; all authors had access to data throughout the study; the primary author engaged in ongoing critical reflection; and clear expectations, boundaries, and reciprocal levels of confidentiality were established and maintained with participants (Fook and Gardner 2007; Tracy 2010).

Results

Six cisgender people participated in this study: four women and two men ranging in age from 24 to 61 years. Two were current sex workers; the remainder were former sex workers. One was straight and one was bisexual; other participants were bisexual and either gay, queer or 'somewhere between straight and bi'. Three resided in inner regional Tasmania, two in outer regional, and one in a remote area of the state. Two did not have children. All used the pronouns historically associated with the sexes they were assigned at birth and worked indoors. Two participants were kink-oriented.

Following data analysis, two themes and six subthemes were developed: Theme 1 (mental state) offers an overview of self-assessed mental status and diagnoses and includes the subthemes of risk factors and protective factors; Theme 2 (mental healthcare) explores participants' service usage and includes the subthemes of types of care, help seeking experiences, and barriers and facilitators to care.

Mental state

Having a pre-existing mental health problem was an inclusion requirement; thus, all participants reported experiencing psychological distress at some point in their lives. Participants presented with a range of current or historical, mostly comorbid diagnoses (Table 1).

The most common comorbidity was anxiety and depression. Participants also self-reported situational crises (loss of a job, assault, sudden death of a loved one) and adverse childhood experiences. No participants presented with suicidality. Participants

Table 1. Mental health disorders reported by study participants ($n = 6$).

Diagnoses		No.[a]
Mood disorders	Major depressive disorder	4
	Grief	3
	Bipolar disorder 1	1
	Postnatal depression	1
Anxiety disorders	General anxiety	3
Personality disorders	Borderline personality disorder	1
Psychotic disorders	Schizoaffective disorder	1
Trauma- and stressor-related disorders	Post-traumatic stress disorder	1
	Unspecified trauma disorder	4
Dissociative disorders	Unspecified disassociation	1

[a] $n \neq 6$ as all participants had comorbid disorders.

primarily described their mental health as varying degrees of good; two indicated that it fluctuated.

> I think that relatively speaking, I have really good mental health. (Straight-bi woman, former sex worker)

> I'll go through waves throughout the week of my mental [ill] health being more severe [on] some days than others. (Queer woman, current sex worker)

Risk and protective factors

Risk and protective factors are behaviours, influences or conditions that impact psychological outcomes (Rickwood and Thomas 2019). Following thematic analysis, risk and protective factors were grouped as follows: (1) individual (regarding a particular person, e.g. participants and mental health professionals); (2) social (adverse societal conditions or factors); and (3) systemic (ingrained issues that are fundamental to society or politics).

Individual risk and protective factors. Participants described a range of factors that affected their mental health. The risk factor stress exacerbated mental illness in all participants. Sources of stress included personal financial concerns and issues with children, friends and family. Two participants discussed the individual risk factor of alcohol use; dependency was a factor for one. Low self-esteem and insecurity, other risk factors, were a reality for some participants:

> I have a lot of fear around abandonment or like not being heard, not being seen. And yeah like not being wanted. … little things will happen and they will just make me quite insecure. (Queer woman, current sex worker)

Sex work itself was viewed somewhat of an individual risk factor by one participant in that, along with other factors, it contributed to her mental health problems. Conversely, involvement in sex work was an individual protective factor for most participants:

> [Sex work] is extremely empowering on good days. It's helped me … in my life outside of work. Talking to men and you know to stand up for myself. Yeah, it's helped me learn a lot about consent … I have so much more confidence now. (Queer woman, current sex worker)

> I started doing [sex work] in response after a bad relationship breakup … and it was my way of asserting confidence and dominance again. (Straight woman, former sex worker)

The benefits of the job demonstrated in these quotations – boundary setting, negotiation skills, confidence and self-management – are common benefits of sex work (Treloar et al. 2021). They can also be interpreted as examples of resilience and self-esteem that serve to resist whore stigma, which one participant demonstrated passionately:

> I love it. I really like what I do. I choose my clients. If you're too much work or you don't have any respect for me, you can f*#k right off. (Bisexual woman, current sex worker)

All participants demonstrated the individual protective factors of self-care and self-awareness, which improved their mental health. For these participants, self-care was

multifaceted and included engagement in physical activity, eating well and getting enough sleep. The individual financial protective factor of having sufficient resources was also cited.

Social risk and protective factors. Social interactions both helped and harmed participants' mental health. Most participants experienced the social risk factor of violence, a correlate of mental illness. This violence, however, was not exclusively job-related. Indeed, previous estimates of on-the-job violence for sex workers are inexact, ranging from 35% to 94% (Seib, Fischer, and Najman 2009). Only two participants had experienced sex-work-related violence. Some participants shared that they did not feel unsafe while working as a sex worker:

> I think there's an assumption that all sex work is really dangerous … and yeah, and that's a reasonable thing. You know, there is violence at work for sex workers, but not the way I worked. I didn't ever feel … in danger. (Straight-bi woman, former sex worker)

Family and friends caused psychological distress to all participants either directly or indirectly. The indirect interactions included participants' inability to disclose their jobs with their family due to anticipated stigma:

> I really would like to tell my family [that I'm a sex worker] but I'm currently not ready …. I'm a bit worried about telling them because … it would really hurt my mental health if there was negative words to me outing myself. (Bisexual woman, current sex worker)

> I've never told [my family] about this work because they will not understand. So yeah. It's really hard … having a job that I really find empowering. I really love, and … It has to be a secret. (Queer woman, current sex worker)

The burden of secret-keeping required vigilance and was emotionally and psychologically difficult to carry (Treloar et al. 2021). Disclosing, however, was also difficult. Some participants met with whore stigma that manifested as rejection and verbal abuse after disclosing to their families.

> [When I told my family that I was doing sex work] that didn't work out well … because my sister has called me a slut and a prostitute [laughter] and my mother wasn't too bad, but she thought it was horrible. So, I didn't discuss it again. (Straight woman, former sex worker)

Regarding relationships, most participants were single. An absence of intimate or romantic partnerships for sex workers is associated with poor mental health as personal support in the private domain can offer shelter from the negativity that can occur in public (Jackson et al. 2009). Lacking or negative social relationships with friends also affected participants' psychological well-being. Participants' friends failed to be present when needed and disclosure to friends could be met with oppression.

> Eventually, I did tell my closest friends and that, that was nice to be able to talk about it, but it was still … even from the people I loved most and who loved me most, there was judgement and stigma. (Straight-bi woman, former sex worker)

This same participant also spoke of friends perpetrating whore phobia by making assumptions about sex work fuelled by misinformation, which tainted her disclosure experience and harmed her mental health. Peer friendships with other sex workers are

also important as they provide safe spaces for debriefing and sharing among equals (Treloar et al. 2021). No participants in this study described having such relationships.

Alternately, all participants benefitted psychologically from a myriad of social protective factors. Participants experienced positive familial relations with their children and partners. All participants praised friend-based social inclusion for contributing positively to their mental health. Inclusion is a powerful protective factor in that it contributes to self-worth, reduces severity of mental health issues, and inspires help seeking (Reynish et al. 2021). Having a four-legged friend was also a boon for one participant:

> The thing that help [my mental health is] having my dog. I think that's probably 70% of my mental well-being. My dog … is good for me. (Bi-gay man, former sex worker)

Systemic risk and protective factors. Systemic stigma from patriarchy and the government represented risk factors that harmed participants' mental health. Patriarchy is a form of structural oppression in which men govern, exploit, and oppress women (Given 2008). Patriarchal ideologies perpetuate the polarised view of women as either Madonna (most desirable) or whore (least desirable; Kahalon et al. 2019). Such a perspective places sex workers at the least desirable end of the spectrum (Brewis and Linstead 2000). Sadly, some women – and some feminists – internalise and endorse this misogyny. Participants in particular felt harmed by feminists who responded with whore stigma.

> [I'm] a lifelong feminist. There's a section of … the feminist community who are very anti-sex work. And that was also challenging to me [regarding my mental health]. (Straight-bi woman, former sex worker)

> I think it's an old school paradigm that women aren't allowed to have sexual freedom … I'd say that women perpetuate that … negative attitude, as much as men. When I've … been … called a slut, it's actually usually women that do it, not men. … I think that it's a sad thing that women, in response to patriarchy, if they feel threatened by somebody like me who is confident and in charge of my own sexual freedom … they will compete with you by taking you down and call you a slut. (Straight woman, former sex worker)

Participants shared the ways in which the public's acceptance of these harmful, views of sex and sex work impact their mental health.

> … in our society, being an IV drug user is about the bottom of the heap; it's as low as you can go. And I think a lot of people feel like that about sex workers too. It's like you don't have any rights. You don't [have] the right to be respected because you're the scum of the earth … Made me mad let me tell you. (Straight-bi woman, former sex worker)

> [W]e all feel a bit embarrassed talking about sex and … I think people feel people do sex work because they're desperate and they don't understand that it's empowering. (Queer woman, current sex worker)

Participants also discussed government-perpetuated systemic stigma deriving from existing legislation in Tasmania and the people who created it.

> I mean [the government is] very male orientated … it feels like the laws are mainly for men and … I don't feel like that should be something that a man should have to decide about what women can do with their bodies. (Queer woman, current sex worker)

Only one participant was able to describe a systemic protective factor; he lauded the existence of government-funded mental health organisations, including those for service veterans and men, as well as employee assistance counselling programmes. He was encouraged by these attempts to address the stigma around help seeking and normalising discussion regarding mental health issues.

> Men had to suck it up. We have to be tough. So [with these programmes] actually allowing you to feel like you can get help these days, I think that's really, really like encouraging. (Bi-gay man, former sex worker)

Mental health care

Participants shared specifics regarding their attempts to address their mental health problems. This theme includes the subthemes of types of care sought; help seeking experiences; and barriers and facilitators to help seeking, which were individual, service-based, and systemic.

Types of care

Regarding uptake, most participants engaged with a mix of private and public formal mental health professionals, including counsellors, social workers, psychologists, hospital-based crisis teams, psychiatrists, and work-funded employee assistance counsellors. All participants reported seeking informal support.

> I try to work on things on my own or with my partner … and … I've got a … couple of good friends [and] we have helpful talks. (Straight-bi woman, former sex worker)

Help seeking experiences

Agreeing with another Australian study reporting negative help seeking experiences (Treloar et al. 2021), participants in this study described mostly negative interactions with formal care, with only one exception, who stated 'for the most part [my help seeking experience] has been very positive'.

Other participants described their help seeking as not 'helpful' and not 'successful'. Many factors informed these assessments, including mental health professionals' responses to disclosure. Disclosure can inform the therapeutic approach and thus, impact whether or not the help received is beneficial. Most participants had disclosed to a mental health professional and only one had a positive experience. Reasons for not disclosing were multifactoral and included fear of judgement and internalised stigma, factors also cited in existing literature (Jiao and Bungay 2019).

> [I didn't disclose because] … for me it's a myth around sex workers are being exploited is so present in everyone's mind that it would have been very hard for [the mental health professional] – that is an assumption I made; I didn't test it because I didn't trust them to test it. I feel like that will be [a] really hard ideology for them to move away from. They'd be coming at it from a thinking that I'm a victim of something, which I'm absolutely not; doing sex work was my choice, my decision, and I always did it … a 100% from free will. (Straight-bi woman, former sex worker)

The barriers and facilitators to care that participants experienced also shaped their assessments.

Barriers and facilitators to care

Participants were asked to share what encouraged or prevented them from help seeking. A variety of individual, service-based, and systemic factors affected participants' formal and informal help seeking experiences.

Individual barriers and facilitators. Participants' personal circumstances created individual barriers and facilitators to help seeking. Participants' self-awareness was a facilitator of access to formal care; they monitored their thoughts and behaviours and sought help when an issue arose. Participants also sought help out of a desire to be present for others. Help seeking for this reason, however, included complicated emotions.

> …I often feel really ashamed how my mental health manifests. Especially … when I know how much it affects my family… I'm definitely driven more … to seek help and deal with it more than I would if I was alone [because of that]. (Queer woman, current sex worker)

For all participants, facilitators of informal care involved acceptance and support from friends, family or partners. A lack of judgement, advice and open-mindedness were other protecting facets of informal support. Participants identified a few barriers to informal help seeking: there were times, for example, when friends failed to listen or were struggling with their own mental health problems.

Individual mental health professionals were responsible for many barriers. Participants feared negativity or perceived stigma from mental health professionals, for example, which prevented help seeking. Of the five participants who had received formal support, all cited mental health professionals' shortcomings as a barrier to care. Participants also commented on attitudinal bias or stigma from mental health professionals, which manifested as patronisation and derision and diminished the quality of their care.

> [When I said I was gay and a former sex worker] one actually made a comment out loud and they said, 'Oh, that's a new one on me. That changes how I think about things.' Didn't quantify more what that meant, so I can only read between the lines … I felt like a leper… And don't get me wrong … I don't expect to walk into a counsellor and for them to know much about sex work … but I never expected to be treated like a leper. (Bi-gay man, former sex worker)

Participants also described several characteristics of mental health professionals' approach to therapy that contributed to their well-being and facilitated help seeking. Participants appreciated an open-minded, objective approach to care. Participants were grateful to have a mental health professional who was culturally competent or who was willing to self-educate. Connection was also a plus for participants.

> I found one really great mental health social worker and she was just terrific. … mostly that was because she and I could have been friends outside of it. You know we had an instant rapport and you can't make that happen; just has to happen. (Straight-bi woman, former sex worker)

Service-based barriers and facilitators. Service-based barriers and facilitators are factors relating to organisations or businesses, which impact uptake. Services being free of charge was the only service-based facilitator to care indicated. All participants, however, had experienced service-based barriers to mental healthcare, which included the existence of too few or no services, long waitlists, and lack of waiting room anonymity. Participants felt that those barriers existed primarily due to a lack of funding for mental health service provision in the state.

Church-based services were a source of perceived stigma for sex workers due to their long history of stigmatisation (Bowen and Bungay 2016). This stigma was particularly prevalent in areas of high religious conservatism, such as rural Tasmania (Grant 2018). Faith-based services were a barrier for half of our participants.

> I would absolutely never go to a faith-based service of any kind…. And I think it's incredibly problematic that we have so many faith-based services funded to give services to vulnerable people. It's just wrong. And for me – absolute turn off, even if, even if they said that they are pro-choice or whatever – it is going to get a pass from me and that would be a complete no deal. (Straight-bi woman, former sex worker)

Systemic barriers and facilitators. Systemic barriers and facilitators are ingrained factors fundamental to society or politics, which impact help seeking. Participants did not identify any systemic facilitators to care, however, all discussed the systemic barrier of stigma. Both a risk factor to participants' mental health and a barrier to help seeking, participants reported experiencing whore and public stigma from strangers which manifested as discrimination against sex workers and LGBTIQA + people and harmed mental health.

> In not being accepting of sex work and … making judgements … about the kind of person a sex worker is.… the whole sex negative way we are in society definitely harms sex workers' mental health and mine … (Straight-bi woman, former sex worker)

> I still think there's a lot of stigma in society. …I'm not ashamed to let people know I'm LGBTQI and I'm quite happy to let people in society know, people I work with know. But the sex worker component I'm more reluctant to [disclose]; more so for the problems that could pose. (Bi-gay man, former sex worker)

The identity concealment and isolation that resulted from stigma contributed to psychological distress for all participants. Active hiding a part of one's self from fear of devaluation is often accompanied by stress. The impacts of this stigma are worse the more central and salient the identity is (Quinn and Chaudoir 2009).

> Being discriminated against as a sex worker. Being told what I can and can't do with my body … has been impeding on my mental health lately…. Yeah, and the isolation involved in that. (Bisexual woman, current sex worker)

> When I was doing sex work, … the most difficult part was not being able to discuss what was going on in my life with my family and friends. Yeah, it's such a … stigmatised thing and … the isolation of that work was the most damaging part of it. (Straight-bi woman, former sex worker)

Discussion

This glimpse into the mental health and related service use of six sex workers with pre-existing mental health problems in rural and remote Tasmania demonstrates the

prevalence of many different forms of stigma. For participants in this study, public stigma manifested as shunning, violence or negative treatment from friends, family, and strangers. Perceived stigma came from mental health professionals and family following disclosure. Whore stigma, including assumptions of desperation and derision of sex work, came from families, friends and even feminists. Mental health professionals' stigma manifested in attitudinal biases and negative treatment. Systemic stigma's prevalence occurred via the perpetuation of the Madonna-whore dichotomy, which polices women's bodies through misogyny (overt and internalised) and controlling laws.

Anticipated stigma was also presented. An understandable response to the other stigmas, particularly when viewed within the Tasmanian context, participants expected (and feared) judgement by loved ones and mental health services, especially faith-based ones. Tasmanians have the lowest level of religious affiliation nationally (ABS 2017, para. 7) but are considered to be religiously conservative and parochial (Grant 2018, 16, 170). Tasmania's rurality compounds the stigma that results from these outlooks. As is common in rural areas, Tasmania has a general lack of services, including the smallest mental health workforce in the country (Ahmed et al. 2017) and only one sex worker organisation (with one staff member, based in the capital).

The deleterious effects of stigma on sex workers' mental health are well documented (Bowen and Bungay 2016; Treloar et al. 2021). Sex workers are exposed to a variety of exogenous stressors that affect identity, relationships and psychological well-being, which can be likened to minority stress (Meyer 2003). As with other sexual minorities, sex workers experience identity concealment, rejection (real and perceived), and struggle to manage the resulting stressors, which impacts mental health. Findings reported elsewhere indicate that Australian sex workers have mixed mental health outcomes (Seib, Fischer, and Najman 2009; Graham et al. 2017). The mental health of this study's participants existed on a continuum. That sex work itself generally had a positive impact on our participants' mental health is a rejection of the patriarchy's attempt to shame people who engage in sexual contractive work.

Findings reported elsewhere indicate that stigma can limit or prevent sex workers from help seeking (Rayson and Alba 2019; Jiao and Bungay 2019). With one exception, which occurred because there was no mental health service available in her remote town, all participants in this study had sought formal mental health support. Participants', however, reported mostly negative experiences of formal care. Beyond stigma, participants' failing assessments stemmed from shortcomings in mental health professionals' skillsets and treatment approach and a lack of cultural competence.

In the face of stigma, poor mental health (due to exogenous factors), and mental health professionals' shortcomings, participants made several recommendations for change. Mental health professionals could, for example, offer culturally competent care by assuming agency in their clients, avoiding the perpetuation of shame, and working from a whole-person and collaborative approach. Culturally competent care for sex workers could include sex worker affirmative therapy that acknowledges the impact of stigma, requires mental health professionals to remain client-centred (put aside internal bias), and uses strength-based care (focus on a person's strengths and resilience) (Bloomquist and Sprankle 2019). The state government could fund a

dedicated sex worker counselling service that is tailored to sex workers (flexible operating hours, staffed by peers). It could also better support mental health services, including ones staffed by culturally competent mental health professionals that offer outreach support and anonymity.

What participants most desired however was the full decriminalisation of sex work. Sex work is legalised in Tasmania and, as such, has stringent industry regulations. While partial decriminalisation does not prohibit the sale of sex, it does perpetuate degrading assumptions about sex work via its legislative monitoring, thus, denying sex workers' basic human rights to be free from violence and discrimination and have free choice of employment. Legalisation of sex work also exposes sex workers to needless risks. Echoing sex workers internationally, decriminalisation in Tasmania would contribute to enhancing workplace health and safety; improving mental health and well-being; improving access to physical health care; and contribute to attitudinal shifts and public acceptance by normalising sex work (Daniel 2010).

While mental health professionals and state government adoption of these recommendations would decrease the stigma surrounding sex work, change could also come about via a shift of narrative. Community-based research such as this, which involves sex workers is a form of collective action that encourages social and political change and could usefully be expanded (Treloar et al. 2021). Funding and advocacy for peer support services that challenge the status quo while creating awareness and capacity among mental health professionals and fostering reform and legislative protections could also take place (Treloar et al. 2021).

Limitations

Several limitations should be considered. A goal of the present study was to actively engage sex workers and contribute to improved sex worker research. Due to recruitment methods, the small sample obtained is not representative and findings cannot be generalised to the larger population of sex workers in Tasmania.

Importantly, this study did not include transgender or migrant sex workers. Transgender sex workers face additional stigma and discrimination regarding their gender identity. Migrant sex workers face racism, language barriers to care, and threats of deportation. The lack of these perspectives points to an area for future research. For ethical reasons, our study also excluded people with pre-existing acute psychological distress; they may have reported different experiences due to increased vulnerability. The former sex workers who participated in this study may have had different experiences and perspectives than the current ones. Former sex workers' ability to distance themselves from a past form of stigma, for example, may have influenced the responses given.

Despite these limitations and the small sample size, the rich data from this study offers a starting point to address significant gaps in the literature. Future research could explore mental health issues and problems among different subgroups of sex workers including those who are exclusively either current or former sex workers, those who work illegally, and those who are not cisgender. Future research could – and should – also examine the experiences of sex workers in other rural and remote regions.

Conclusion

This study adds to the limited available research on rural sex workers, stigma, mental health and related service use. Sex work itself was not the cause of mental ill health for participants in this study, but, rather, contributed positively to their psychological well-being. Exogenous, widespread stigma on the other hand was seen to harm sex worker mental health, pose a barrier to quality care, and resulted in identity concealment. Taken together, findings demonstrate some of the ways in which friends, family, mental health professionals and the government can support sex workers by beginning to reduce, or ameliorate, the impacts of stigma.

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Barriers and Enablers to Sex Workers' Uptake of Mental Healthcare: a Systematic Literature Review

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Abstract

Introduction Sex workers face many barriers to accessing the inalienable human right of mental health. The aim of this review was to synthesize the evidence on the barriers to mental healthcare for sex workers and the factors that facilitate uptake.

Methods A search conducted in 2018 of peer-reviewed and gray literature produced between 2008 and 2018 in OECD countries resulted in 32 documents eligible for inclusion.

Results The literature revealed that the barriers of stigma, discrimination, violence, pathologization, and criminalization exacerbate the psychological distress of sex workers while impeding uptake of mental healthcare. Personal resilience, protective factors, agency, and social inclusion offset these barriers.

Conclusions Despite the risk of pervasive mental illness among sex workers due to, primarily, external factors, few studies present comprehensive examinations of sex workers' mental health and fewer still explore sex workers with gender identities and sexual orientations that are not cisgender, heterosexual, or female.

Policy Implications Although timely, equitable treatment of sex workers in mental healthcare is currently atypical, the findings of this review suggest that inclusive, respectful psychological care is possible. Future research on holistic approaches to the mental health of sex workers could support the creation of much-needed, inclusive services and policies that improve sex workers' quality of life.

Keywords Mental health · Sex work · Uptake · Barriers · Enablers

Health, including mental health, is a fundamental, equitable, and inalienable human right without distinction or discrimination (United Nations 1948; World Health Organization 2006). Inclusive mental health support is the fulfillment of this human right. Mental health is not merely the absence of mental illness (or disorder) where one who has mental health is flourishing, one who lacks it is languishing, and one who is moderate is neither (Keyes, 2014 and 2002). Mental health is a variable, internal balance in which a person has cognitive and social skills, emotional regulation, coping, and functioning capabilities, and a congruous mind-body relationship (Galderisi et al. 2015). Inclusive care ensures every person's right to impartial, respectful psychological care that is free from discrimination irrespective of gender, sexuality, race, personal circumstance, or career (Ratts et al. 2016; Robinson-Wood 2017). Many sex workers, however, predominantly experience exclusionary mental healthcare (Benoit et al. 2016; Socías et al. 2016).

A sex worker is a person who is 18 or older who sells or exchanges sexual services (Canadian Alliance for Sex Work Law Reform 2017). To clarify, sex work occurs between consenting adults and, therefore, is not exploitation and excludes children and people under the age of 18. Sex work is not sexual assault or sex trafficking, which are explicitly nonconsensual (Canadian Alliance for Sex Work Law Reform 2017). The terms sex work and sex worker will be used throughout this review as they lack the stigmatizing and derogatory connotations associated with the label "prostitute." The sex industry includes individual workers and occurs in a variety of settings (VOS) such as street-based (SB) work and indoor work conducted in strip clubs; brothels; private homes; sensual massage parlors; escort agencies; bondage, discipline, dominance, submission, sadism, masochism (BDSM)/kink

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venues; and swingers' clubs, and can include porn film acting, webcamming, and phone sex (Selvey et al. 2017; Wong 2009). Sex workers hail from many socioeconomic, cultural, and racial backgrounds and represent a spectrum of age, education, and gender identities including cisgender (cis), transgender (trans), male, female, and gender-non conforming (GNC) or gender fluid/neutral (Chabot 2012). Cis is having a gender identity that aligns with the sex assigned at birth and trans is an umbrella term for those people who do not accept or identify with the sex assigned at birth or the related cultural expectations of said gender (Amnesty International 2016a). Sex workers represent an array of sexual orientations, such as opposite-sex attracted, same-sex attracted (lesbian, gay, bisexual, queer), or sexual attraction to people of any sex or gender (pansexual, polysexual) (Chabot 2012). Sex workers possess a range of legal residency statuses (citizens, immigrants, and migrants). Some work full-time and others part-time; some enjoy the work and others do not (Puri et al. 2017). There is a lack of data on the number of sex workers worldwide; therefore, the population size is unknown (Balfour and Allen 2014). In 2003, Kofman estimated that there was between 200,000 and 500,000 sex workers working illegally in the European Union (EU). For that same period, however, HIV prevalence data indicates that there were 978,118 female sex workers in the EU (Adair and Nezhyvenko 2016). The large gap between 200,000 and 978,118 also excludes legal, male, or trans and other sex workers. Population data for other Organization for Economic Co-operation and Development (OECD) countries is also problematic. UNAIDS numbers for sex worker population sizes for 2013/2014 was 20,500 in Australia; 13,000 in the Czech Republic; and 237,798 in Mexico; however, these numbers do not include sex workers who do not have HIV. Stigma, legalities, diverse work locations, the mobile and sporadic nature of sex work, and the conflation of sex work with human trafficking all complicate accurate data gathering (Cool 2004).

The literature has identified that stigma, discrimination, pathologization, or lack of knowledge in society and mental health professionals alike underlie the exclusionary treatment of sex workers (Healthwatch Hackney [HH] 2016; Puri et al. 2017; Wong 2009). This exclusion can exacerbate or trigger pre-existing psychological distress or mental illnesses; cause new symptoms; induce worry, shame, or discomfort; and inspire disinclination to seek support (Lilienfeld 2007; Robinson-Wood 2017). A lack of appropriate mental healthcare is egregious considering that despite differences, which are based largely on place of work, sex workers are at risk for worse mental health than non-sex workers (Platt et al. 2018). Notably, sex work itself is not causally linked to mental illness (International Committee on the Rights of Sex Workers in Europe [ICRSE] 2017). Rather, it is external factors such as violence, stigma, and discrimination that affect sex workers' mental health (ICRSE 2017; Socías et al. 2016).

Despite the increased risk of mental illness, studies on the mental health of sex workers are limited (Rössler et al. 2010). Instead, sex worker studies primarily focus on physical or sexual health and related public health concerns (ICRSE 2017). Systematic literature reviews on the mental health of sex workers are equally uncommon. Some couch mental health among explorations of addiction, physical/sexual health, and violence (Love 2015). Other reviews cover mental health along with additional topics, including factors that purportedly impact entry into sex work, physical/sexual health, and social exclusion (Balfour and Allen 2014); sexual/physical health service barriers and enablers (Ma et al. 2017); and legal and physical/sexual health associations (Platt et al. 2018).

Given the lack of a consolidated knowledge base and the strong association between those external factors and an increased risk of psychological distress, a systematic literature review that attempts to provide a balanced, inclusive examination into the mental health of sex workers is necessary. The aim of this review, then, is to synthesize the evidence on the barriers to mental healthcare among sex workers and those factors that enable the uptake of care.

Methods

Review Questions

1. What is the uptake of mental healthcare among sex workers?
2. What barriers influence sex workers' access to mental healthcare?
3. What strategies or enablers promote sex workers' uptake of mental healthcare?

Search Strategies

A systematic search of peer-reviewed literature (traditional academic publications) and gray resources (documents produced outside academia) was conducted (Tyndall 2008). Gray literature was included as it offers current, complementary insight often underrepresented in peer-reviewed literature from the fields of physical or mental health (Paez 2017; Royal Roads University 2018). PubMed, CINAHL, and Scopus were searched for peer-reviewed articles. Google was searched for gray literature and was selected due to its robustness and the breadth of results it produces from Google Scholar as well as a range of fields and industries (Bandara et al. 2015). Snowballing techniques were then applied to those gray documents that met the inclusion criteria; the references within the retrieved articles were then searched for other relevant citations. The following MeSH (Medical

Subject Headings) terms/keywords were used in the searches: mental health, access, uptake, barrier, sex work, sex workers, sex industry, prostitute, marginalized, and enabler. British and American English spelling, plural forms, and Boolean operators were used. The search was conducted by the first author (TR). After removing duplicates, titles were screened and irrelevant studies excluded. All authors cross-checked the abstracts and full text of the remaining studies.

Selection Criteria

Table 1 shows the inclusion and exclusion criteria.

Data Extraction and Synthesis

Data extracted from the reviewed articles included country, participant details, study design, description of the findings, and relevant conclusions relating to the three review questions. Extracted data from the confirmed documents was summarized, examined thematically, and integrated systematically. Key themes and associations from the entire dataset were identified and higher-order categories created. To capture the comprehensiveness of data, findings were integrated and synthesized (Whittemore 2005). The first author (TR) conducted the data extraction, identification, categorization, and synthesis, which the other authors reviewed and confirmed or rejected in teams of two. Differences were resolved through discussion or with the third author.

Assessment of Methodological Quality

Gray and peer-reviewed literature were assessed to appraise for quality and relevance to this review. The first author (TR) assessed the gray literature using the Authority, Accuracy, Coverage Objectivity, Date, and Significance (AACODS) checklist and all other authors reviewed findings, confirming them all (Tyndall 2010) (Table 2). The AACODS was selected as it was designed specifically to evaluate gray literature and is a widely used tool (Georgetown University 2019; University of South Australia 2019). The methodological quality of the peer-reviewed literature was assessed and scored by three of the authors (HH, HB, BNGE) using the Mixed Methods Appraisal Tool (MMAT) (Pluye et al. 2011) (Table 3). The MMAT was selected because it can efficiently and reliably be used to appraise qualitative, quantitative, and mixed-methods research and it is regularly updated based on user feedback (Pluye et al. 2011). One study received an overall MMAT quality score of 50%, fourteen received 75%, and seven received a score of 100% (Pluye et al. 2011). From a pool of 644 articles and documents, 32 met the inclusion criteria (Fig. 1).

Results

Eight of the documents included in this review ($n = 32$) originate in the United States (US), seven from Canada, four from the UK (England, specifically), two each from Switzerland and Australia, and one each from Mexico and Portugal. The remaining focus on Europe, Central Asia, North America, Ireland, and the US or are international in scope. The OECD countries not given specific coverage are Japan, Chile, Israel, Korea, and New Zealand. Roughly 71% of the included documents originate from countries with English as the official language. Eleven of the peer-reviewed studies ($n = 22$) employed qualitative methods, 10 used quantitative, and 1 used a mixed-methods approach. Table 3 presents the characteristics and main findings of the peer-reviewed literature.

Characteristics and Mental Health of Sex Workers in the Included Literature

Only 53% of the included literature discussed the mental health status of sex workers, presenting degrees of severity based on dissimilar assessment measures. Of those studies, 76.4% cited languishing to severely languishing mental health and 23.6% indicated a varying mental health status that is worse in sex workers who are SB, non-European, and sex and gender minorities (Koken and Bimbi 2014; Puri et al. 2017; Rössler et al. 2010). Depression and anxiety disorders were the most commonly assessed conditions. Seven (23%) included sex workers who work in a VOS while all but one of the remainder focused on SB sex workers. In total, 3651 sex workers were represented, with 64.7% working in VOS and

Table 1 Inclusion and exclusion criteria

Criteria	Inclusion	Exclusion
Time period	2008–2018	Before 2008
Language	English	Non-English
Participants	Sex workers	People who are not sex workers
Age	18 years of age and older	Children (younger than 18 years)
Location	OECD countries	Non-OECD countries
Topic foci	• Mental health	• Social, physical, sexual, or reproductive health
	• Chronic mental illnesses	• Acute mental health crises

Table 2 AACODS checklist results for all gray literature ($n = 10$)

Author and setting	Document type	Authority	Accuracy	Coverage	Objectivity	Date	Significance
Amnesty International (2016b), Switzerland	Policy on state obligations	✓	✓	✓	✓	✓	✓
Church (2017), United States	Webpage on counseling for SW	*x*	✓	*x*	✓	✓	✓
Healthwatch Hackney (2016), England	Report on borough's SW	✓	✓	✓	✓	✓	✓
ICRSE (2017), Netherlands	Briefing paper on impact of criminalization and violence	✓	✓	✓	✓	✓	✓
Koken and Bimbi (2014), United States	Book chapter	✓	✓	✓	✓	✓	✓
Ley (2017), United States	Webpage on counseling SW	✓	✓	✓	✓	✓	✓
McKeen (2018), Canada	Newspaper article on impacts of a law	✓	✓	✓	✓	✓	✓
Palmisano (2018), United States	Webpage on impacts of a law	✓	✓	✓	✓	✓	✓
Selvey et al. (2017), Australia	Summary report on a study	✓	✓	✓	✓	✓	✓
Wong (2009), United States	Master of Social Work thesis	✓	✓	✓	✓	✓	✓

35.3% SB; the workplace of 850 is unknown/not stated. Of the 17 documents that discussed mental health, 15 were urban-based samples and two did not specify locale (ICRSE 2017; Koken and Bimbi 2014); none were rural-based studies. The chief factors that impact sex workers' mental health include violence, assault, stigma, social exclusion, pathologization, criminalization, marginalization, homophobia/transphobia, and service or practitioner barriers. Common factors with positive affect include agency, non-judgmental and culturally competent service providers, professionalizing sex work, coping, and social inclusion.

Uptake of Mental Health Services

The first research question that this systematic literature review sought to explore pertained to the uptake of mental health services among sex workers. Uptake of the non-sex worker population in some OECD countries in 2010 ranged from roughly 6% for people with moderate mental health disorders in the UK to 35% for people with severe disorders in Denmark (OECD 2012). Of the 32 included studies, only 14 referred to uptake, indicating a gap in the knowledge about how sex workers avail of mental healthcare. Those 14 revealed that, generally, sex workers' uptake of mental healthcare is poor. For example, the American cohort of an Ireland-US male, sex work study had "little contact with social services" (McCabe et al. 2014, p. 99). Among a group of 235 trans female sex workers, the desire for mental health support was strong; however, barriers were many, including a lack of services (Nemoto et al. 2015).

Uptake of mental healthcare, however, is not entirely poor. While only 14% of respondents from a Western Australian study accessed counseling and only 11% accessed mental healthcare (Selvey et al. 2017), some sex workers in Canada, America, Portugal, and Dublin availed of support. A Canadian study of 338 trans and cis sex workers found that 80.8% of participants had undergone counseling (Puri et al. 2017). And 72.4% of participants (cis and trans women) in an American study sought mental health support (Wong 2009). Teixeira and Oliveira (2017) found that while 55.8% of their Portuguese cohort were diagnosed with mental illness, only 70% received support and only 37.9% had subsequent appointments. Cis male sex workers in Dublin had seen a counselor, with that contact occurring via methadone clinics (McCabe et al. 2014). Mental healthcare with outreach programs also reported positive uptake (Bodkin et al. 2015; Healthwatch Hackney 2016). It should be noted, however, that trans people wishing to undergo gender-affirming medical procedures and people accessing methadone are required to see mental health practitioners, thus likely increasing related uptake results (Benson 2013; Marel et al. 2016).

Barriers to Mental Healthcare

Twenty-six of the included studies explored the second research question, which pertained to the barriers that impede sex workers' access to mental healthcare. The literature reveals that barriers to care are a reality for sex workers. In a Canadian study of female sex workers, for example, 70% of participants reported barriers, roughly three times more than the general population (Socías et al. 2016). Specifically, sex workers encounter the barriers of stigma, discrimination, pathologization, criminalization, and violence that originate with service providers, services, and systems. Barriers can also manifest for some sex workers on an individual level.

Barriers Imposed by Service Providers and Services

Barriers to care that sex workers face include stigma, discrimination, pathologization, mistrust of mental health service

Table 3 Peer-reviewed literature findings and MMAT score

Authors & setting	Sample	Design	Measurement/method	Results/relevant findings	Relevant conclusion	MMAT score
Benoit et al. (2016), CA	209 M, F, and trans sex workers (SW), 19+ years, VOS and 499,900 non-SW	Qualitative	Interviews and a survey	SW perceived notably worse MH, poorer social health determinants (except income), and nearly triple unmet healthcare needs than CCHS respondents (40.4 vs. 14.9%).	SW 3× more prone to unmet healthcare need. Policies that reduce cost and transportation barriers may improve access.	***
Bith-Melander et al. (2010), US	20 youth and 23 adult trans SW of color, VOS	Qualitative	Interviews and focus groups	Trans people of color make decisions out of necessity, daily needs the most important. Unmet needs force trans people to use what is available, demonstrating remarkable creativity, resilience, and social support. Great need for practical and emotional support	Access to insurance and culturally competent and sensitive providers would improve the lives of this population.	***
Bodkin et al. (2015), CA	14 F, current/former SB SW, 23–49 years, and 3 health and law workers	Qualitative	Semi-structured interviews	Participants represent a vulnerable population with increased safety concerns and healthcare needs.	A program with flexible, judgment-free support and access to law enforcement is a best practice, care model applicable to many Canadian cities.	***
Bowen and Bungay (2016), CA	1 M and 7 F cis former offstreet SW, advocates, service providers, 35–49 years	Qualitative	Open-ended interviews	All SW experienced stigma, public rejection, humiliation, disowned by family, mistreatment, harassment, and denial of agency. Learning to live with, respond to, and resist stigma informed capacity building with other SWs.	SW are ostracized and victimized through stigma but resist and educate others. They urge us to join them in their fight for justice, understanding, inclusion, recognition of their agency, wellness, and rights.	***
Burnes et al. (2018), NA	31 cis and 4 trans F SW, 18+ years, VOS	Qualitative	Demographic questionnaire and semi-structured interviews	4 themes emerged that demonstrated resilience and indicated SW MH needs: (1) validating SW and eliminating whorephobic oppression; (2) safety and mobility within practice environments; (3) sexual boundary setting; and (4) social support	SW agency combines validating clients' diverse sexual expressions, creating a greater understanding of sexual expression as form of work. Social support and self-efficacy are important.	****
Choudhury (2010), MEX	20 F, establishment--based SW, early 20s–mid-50s	Qualitative	Interviews	Extreme stress and depression were MH consequences of the work. Professionals need to learn that F SW have agency and a desire to control their health and bodies. SW are not victims incapable of making changes to promote own health.	Public health interventions should consider voices of F SW to have more sustainable impact.	***
Darling et al. (2013), CH	50 cis and trans F SB SW of any age,	Quantitative	Cross-sectional questionnaire (full,	SB SW are a heterogeneous, mobile, and vulnerable	SB SW are unaware of services to which they	****

Table 3 (continued)

Authors & setting	Sample	Design	Measurement/method	Results/relevant findings	Relevant conclusion	MMAT score
	from red light district		abridged) and interviews	group: 96% migrants, 56% no insurance, 70% unaware of available services, resulting in use of emergency services. In 60% of healthcare visits, SW did not disclose their work.	are entitled; there is a need to enhance awareness and to increase provision and uptake of HIV testing.	
Gorry et al. (2010), UK	7 SB SW, 18+ years from drop-in clinic and 5 health professionals	Qualitative	Interviews	4 main impacts of SW on well-being: (1) emotional impact of selling sex; (2) self-preservation and coping; (3) barriers to change; and (4) moving on. Emotional impact affected sense of worth and caused feelings of stigmatization, shame, and degradation.	Stigma affects sense of self and MH. SWs an easy target for attack and derision; policies and policing offer little protection. Stigma hinders help seeking.	****
Gunn et al. (2016), US	24 F SW, 18+ years	Quantitative	Digital diary and semi-structured interviews	SW have disproportional MH comorbidity and face substantial barriers. Participation in research has unanticipated MH benefits, possibly due to positive interactions and discussing experiences.	Research participation can improve MH outcomes. Even with a very small sample, women experienced significant MH improvements.	***
Jackson et al. (2009), CA	16 F SW, 20–39 years, VOS and 7 of their M partners	Qualitative	Interviews and focus groups	Intimate relationships provide inclusion and safety and positive forces in general health and well-being. Stigma-fueled exclusion can enter intimate relationships, harming well-being and emotional health.	Service providers need to look beyond working lives; understand connection between work and home; and look at all ways intimate relationships can impact lives and health.	***
Mastrocola et al. (2015), UK	16 SB F SW, 18+ years	Qualitative	Semi-structured interviews	Women were living with difficult-to-manage ill health that impacted their work. Women reported poor access to care and viewed primary care consultations as unsatisfactory.	Problematic access to care and unsatisfactory GP interactions, impacting uptake. Health-seeking behaviors and self-management strategies vital in-service design may reduce unscheduled care.	***
McCabe et al. (2014), IRE and US	23 M, SB SW: 11 in San Fran, mean age (MA) is 25.36 years and 12 in Dublin, MA is 29.42 years	Mixed methods	Semi-structured interviews; psychometric tests	In both cities, the principal factor for entry into SW was drug addiction, with childhood abuse and early school leaving contributing factors. Dublin had higher levels of depression.	Both groups reported that they did not receive enough support from social services.	***
Mellor and Lovell (2012), UK	9 SB F SW from Harm Reduction Service, 32–40 years	Qualitative	Semi-structured interviews	SW have considerable life-circumstance complexity, with violence, drugs, alcohol, and housing compounding exclusion. Practitioners lack	Services and professionals have poor understanding of complex needs of SB SW and fail to engage with SW realities and the factors that keep them in this work.	***

Table 3 (continued)

Authors & setting	Sample	Design	Measurement/method	Results/relevant findings	Relevant conclusion	MMAT score
				awareness, training, and skills to work effectively with SW.		
Nemoto et al. (2015), US	235 African-American trans 18+ years SW: San Fran, 112 and Oakland, 123	Quantitative	Interviews using a structured questionnaire	All participants reported unmet needs; Oakland had more re: basic assistance, MH treatment, and healthcare services. Oakland reported less trans community ID but more support.	Investment needed for sensitive, open, affirming care to address extreme vulnerability and marginalization, particularly in Oakland.	**
Priebe et al. (2013), EU	297 generic/219 specific MH services for SB SW and homeless, asylum seekers, refugees, migrants, and unemployed	Quantitative	Face-to-face/phone interviews using structured questionnaire	In 8 European capitals, many services provide MH care to marginalized groups. Group-specific services widely established, but role overlaps with generic services and differences unclear re: staff qualifications or programs offered.	Access to services often remains difficult.	****
Prince (2013), US	11 SB F African-American SW from residential facility for exiting the trade, 24–51 years	Qualitative	Semi-structured interviews	Lack of access to affordable culturally sensitive health clinics, individual MH counseling, and healthy nutrition were unmet needs.	Cultural-sensitivity training and partnerships could integrate services. Despite substance abuse and violence, health seen as a synergy with the mind, body, and soul achievable with affordable healthcare. Judgmental healthcare providers are a barrier.	****
Puri et al. (2017), CA	692 cis and trans F SW, VOS, 28–42 years	Quantitative	Semi-annual questionnaire	Women with MH diagnoses (48.8%) were more likely to identify as SGM, to use non-injection drugs, to have experienced childhood physical/sexual trauma, and to work in informal indoor or street/public spaces.	Female SW, particularly SGM, drug using, and informal indoor and SB face a disparate MH burden. Tailored interventions addressing trauma, MH, and health services needed. Urgent need to explore trauma-informed care and practice, including training and policies re: resilience, stigma, discrimination.	****
Rodriguez et al. (2018), US	6106 18+ years, trans and GNC ppl, 591 of whom are SW	Quantitative	National survey	Rejected by families and communities due to gender identity, trans ppl are often socially marginalized. Being a SW or recognized as trans had significant effect on perceived discrimination in healthcare.	Efforts to improve access to equitable care for trans ppl should consider risk factors. There is hope to eliminate the excessive discrimination of trans ppl in healthcare settings.	***
Rössler et al. (2010), CH	193 F SW, VOS, 18–63 years	Quantitative	Interviews (structured questionnaire)	SW had high rates of mental disorders related to violence & perceived burden of SW. Work setting and	"SW is a major public health problem. It has many faces, but ill MH of SW is primarily	****

Table 3 (continued)

Authors & setting	Sample	Design	Measurement/method	Results/relevant findings	Relevant conclusion	MMAT score
				nationality-impacted MH. F SW are frequently exposed to much violence, a vital correlate of mental disorders.	related to different forms of violence."	
Seib et al. (2009), AU	247 SW: legal private = 103, licensed brothel = 102, illegal = 42, 18–57 years	Quantitative	Self-completed or interviewer--administered structured questionnaires	Illegal (mostly SB) SW were 4× more likely to report poor MH; some difference attributable to social background. Increased levels of poor MH among illegal SW were associated with more negative experiences before and subsequent to entering the trade.	Illegal, SB SW show patterns of disadvantage and health outcomes not seen in other sectors.	***
Socías et al. (2016), CA	723 self-identified F SW, VOS, 14+ years	Quantitative	Questionnaire	Even with universal health coverage (UHC), SW experience systematic, institutionally ingrained barriers. Call to remove all criminal sanctions re: SW to fulfill SW health and human rights.	Despite UHC, F SW face many barriers, with the highest burden among most marginalized. Seventy percent of reported barriers is roughly 3× higher than general population. Urgent need for interventions to remove barriers.	***
Teixeira and Oliveira (2017), PT	52 SB F SW, 18–63 years	Quantitative	Questionnaire and interviews	46.15% reported high suicidal ideation, and 44.2% had made at least one suicide attempt. Most had a MH diagnosis; 88.2% had depression. Social support and suicidal ideation moderately negatively correlated.	Suicidal ideation and attempts and high levels of work-based victimization are prevalent. There is an urgent need to reduce the prevalence of suicidal behaviors.	***

providers, and service logistics. Whether enacted or perceived, stigma is correlated with languishing mental health in sex workers and is a barrier to care (Bowen and Bungay 2016; Gunn et al. 2016; Ley 2017; Socías et al. 2016; Wong 2009). The included studies show that mental healthcare providers commonly demonstrate stigma toward sex workers, such as provider disdain, blame for destroying families, spreading sexually transmitted infections/human immunodeficiency virus (STI/HIV), and increasing crime (Burnes et al. 2018; McCabe et al. 2014; Mellor and Lovell 2012; Prince 2013). The included literature also mentions fear of practitioner judgment or bias—a common facet of stigma—as a barrier, with some authors citing it as the primary cause for sex workers avoiding care seeking (Benoit et al. 2016; Mellor and Lovell 2012; Prince 2013; Selvey et al. 2017; Wong 2009).

The comprehensive nature of stigma affects sex workers on multiple strata; that is, not only are sex workers subjected to whorephobia (fear of or derision for people who exchange sex for money/goods; Burnes et al. 2018), but also people of color, of various gender expressions and sexual identities, and of lower socioeconomic levels, or those with disabilities also experience racism, transphobia, homophobia, classism, and ableism. These prejudices worsen mental health and breed care-seeking avoidance (AI 2016a; Bith-Melander et al. 2010; ICRSE 2017; Puri et al. 2017; Rodriguez et al. 2018; Teixeira and Oliveira 2017).

Discrimination, the manifestation of stigma, is unjust or prejudicial treatment and is a barrier to care for which some mental health professionals are culpable (Mullner 2009). Discrimination, like stigma, impacts a person's mental health and can result in help-seeking avoidance (Bith-Melander et al.

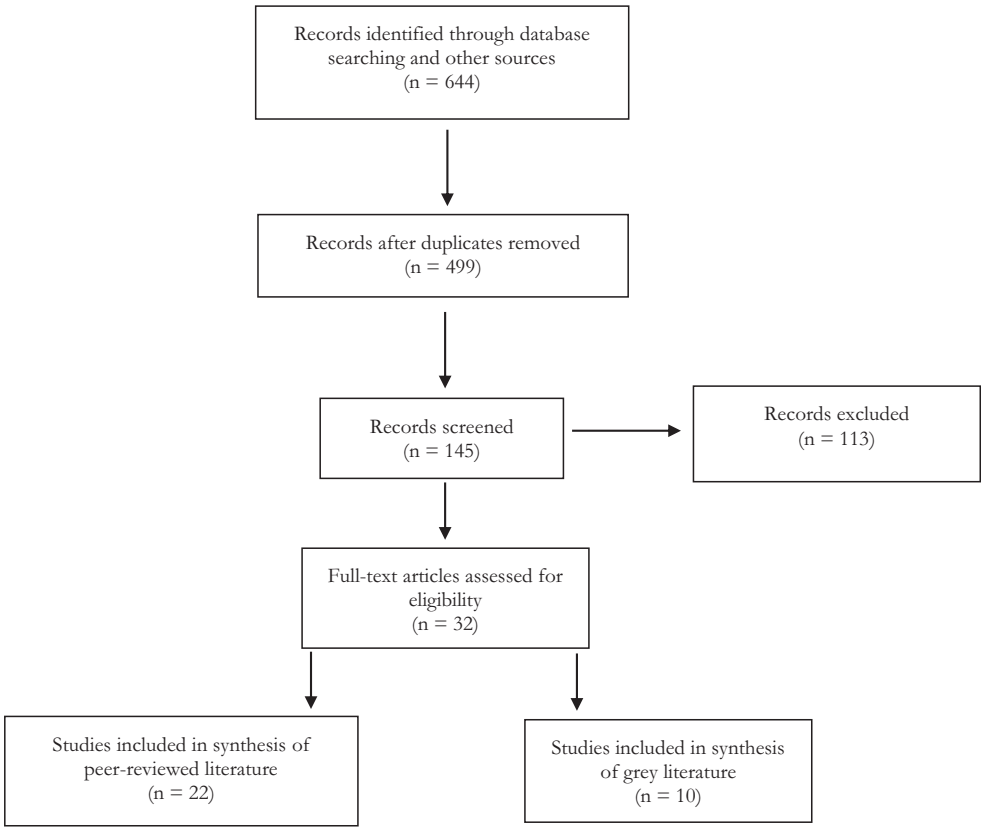

Fig. 1 PRISMA flow diagram

2010; Rodriguez et al. 2018). Sex workers, including those who use substances, are sex and gender minorities, are SB sex workers, are First-Nations people, or have a mental health diagnosis that is gender-related, have experienced discrimination in the form of refusal of, or inadequate, care (Bodkin et al. 2015; Rodriguez et al. 2018; Socías et al. 2016).

Pathologization is a barrier to uptake in that it vilifies sex work and the people engaged in it while denying the workers' agency (ICRSE 2017; Koken and Bimbi 2014). Pathologization is represented in the included studies as the medicalization of sex workers where non-medical aspects and factors are rendered medical, and, as such, seeks to determine etiology, treatment, and cure (Clabough 2017). In the literature, etiology presents as an examination of factors that lead to sex workers entering the trade, treatment focuses on identifying and combatting the health risks of being in the trade, and cure assumes that exiting or leaving the trade is the sole solution.

Determining etiology is an intrinsic quality of the medicalization of sex work, which seeks to explore why people enter the trade. The causes that receive particular attention in the literature are child physical or sexual abuse, languishing mental health, substance use, leaving home at a young age, poverty, homelessness, and a lack of education (Burnes et al. 2018; Gunn et al. 2016; Koken and Bimbi 2014; McCabe et al. 2014; Mellor and Lovell 2012; Prince 2013; Seib et al. 2009; Teixeira and Oliveira 2017). Indeed, some sex workers have had these experiences, but so too have many other people.

Pathologizing views of sex work also explore the treatment of those public health concerns regularly attributed to sex workers, namely, STI/HIV and substance use (ICRSE 2017; Rössler et al. 2010). Although articles that concentrated solely on STI/HIV and substance use were excluded from this review, many of the included documents made these factors an essential part of demographic data collection and reporting (Choudhury 2010; Darling et al. 2013; Fraser et al. 2002; Gunn et al. 2016; Jackson et al. 2009; McCabe et al. 2014; Nemoto et al. 2015; Rodriguez et al. 2018; Socías et al. 2016; Teixeira and Oliveira 2017). Puri et al. (2017) and Socías et al. (2016) even made HIV/STI and hepatitis C testing an aspect of study participation. While some sex workers have HIV/STI, prevalence varies; thus, a generalized focus on these health conditions without exploration of violence, stigma, and criminalization, those additional factors that increase risk, is pathologizing (ICRSE 2017).

The literature also demonstrates that the desired treatment outcome of some mental health practitioners who work with sex workers is to have them exit the trade, regardless of the clients' own, often contradictory, aims (Burnes et al. 2018; Gorry et al. 2010; Healthwatch Hackney 2016; Palmisano 2018; Wong 2009). Exiting is also seen as the panacea as sex work is often conflated with human trafficking, which is

inaccurate, lacks nuance, and distracts from the issues that actually enable trafficking (AI 2016a; McKeen 2018; Palmisano 2018).

Sex workers' mistrust of mental health practitioners includes confidentiality, another barrier to care. Confidentiality, indicated by 47.2% of participants in an Australian study, was one of the reasons given for attending a specific health service (Selvey et al. 2017). Confidentiality was cited by 45.5% of participants in an American study as the reason for non-disclosure (Wong 2009). The scope and exceptions to confidentiality vary worldwide. Thus, disclosure of a job in the sex industry to a mental health professional could lead to criminal charges, loss of parental rights, or financial hardship due to a loss of government support benefits. To allay these risks, many sex workers do not disclose their labor activity to mental health practitioners (ICRSE 2017; Mastrocola et al. 2015; Mellor and Lovell 2012; Selvey et al. 2017; Wong 2009). While not disclosing their work is a person's right, non-disclosure can hinder the therapeutic process or be a barrier to care (Mastrocola et al. 2015; Prince 2013).

Mental healthcare services also erect logistical barriers to care, including too few staff and a lack of or failure to enforcement an anti-discrimination policy (Rodriguez et al. 2018; Socías et al. 2016). Other service-based barriers to care are limited, inconvenient hours, poor location, wait lists, charging fees for service, and requiring scheduled appointments instead of offering a drop-in service (Bodkin et al. 2015; Darling et al. 2013; Gorry et al. 2010; Gunn et al. 2016; Mastrocola et al. 2015).

Systemic Barriers

Systemic barriers derive from policies that discriminate or prevent participation. Much of the reviewed literature cited criminalization as one such barrier that profoundly impacts sex workers' mental health and uptake. Legislation pertaining to sex work differs throughout the OECD countries. Generally, they can be categorized as full or partial criminalization, legalization, and decriminalization. For brevity, only criminalization and decriminalization will be discussed here. Decriminalization is linked to better health and makes it possible for sex workers' human rights to be upheld and protected (Chabot 2012). Criminalization, however, impedes sex workers' access to mental healthcare and encumbers general mental health through precarity. That is, the precarity of sex work due to criminalization causes anxiety in sex workers about being arrested (Chabot 2012). Regarding mental healthcare access, this anxiety prevents sex workers from help seeking or encourages profession concealment (ICRSE 2017).

Institutional "trans-erasure," which is the propensity to discount, reject, or diminish the existence of trans people, is another systemic barrier (Benoit et al. 2016). Others are the requirement of a residence permit or health insurance to access care, a lack of universal healthcare, and a lack of services (Bith-Melander et al. 2010; Darling et al. 2013; Ley 2017). Service unavailability is another barrier, particularly in rural or remote areas where there are few if any supports, including those that are specialized or offer a holistic range of care (Socías et al. 2016).

These barriers hinder uptake of mental health services and manifest in sex workers avoiding care seeking or relying on hospital emergency departments for psychological support (Bodkin et al. 2015; Darling et al. 2013; Mastrocola et al. 2015; Prince 2013). Hospitals' triage-approach to mental health, however, disallows vital, ongoing support and is often ineffective in addressing lingering complaints.

Individual Factors as Barriers to Mental Healthcare

Factors unique to an individual sex worker, which can manifest for a variety of reasons, including due to stigma and discrimination, can also be barriers to mental healthcare seeking. Some sex workers only seek help when the matter becomes more advanced or urgent (Bodkin et al. 2015; Mastrocola et al. 2015; Prince 2013). Care is not prioritized due to an inability to pay, out of fear of stigma-based recrimination, a lack of knowledge about available services (due to literacy issues, poor advertising by the services, or language issues), and a lack of services (Darling et al. 2013; Nemoto et al. 2015; Rössler et al. 2010; Wong 2009).

The literature cited several additional examples of this type of barrier: hectic schedules; substance use; lack of transportation; judgment from other public-transport travelers; limited understanding of conditions; voluntary withdrawal due to fear of being judged, humiliated, and discriminated against; housing issues; inability to afford or difficulty finding childcare; and lack of a medical card or identification (ID) (Benoit et al. 2016; Bith-Melander et al. 2010; Gunn et al. 2016; HH 2016; Mastrocola et al. 2015; Mellor and Lovell 2012; Prince 2013; Socías et al. 2016).

Violence, a personal reality for many sex workers, is another, significant barrier to mental healthcare seeking reported in the included literature. This minority or gender-based oppression against sex workers occurs in the form of rape and physical assault by clients against sex workers regardless of where they work, though violence is much more prevalent among those who are SB (AI 2016a; ICRSE 2017; McKeen 2018; Seib et al. 2009; Selvey et al. 2017; Socías et al. 2016). Other perpetrators of violence against sex workers are the general public, business owners, and romantic partners (HH 2016; Koken and Bimbi 2014; Socías et al. 2016). There is a direct connection between criminalization and violence against sex workers (Bodkin et al. 2015; Bowen and Bungay 2016; Choudhury 2010; Darling et al. 2013; Gorry et al. 2010; HH 2016; ICRSE 2017; Jackson et al. 2009; Mastrocola et al. 2015; Nemoto et al. 2015; Palmisano 2018; Seib et al. 2009). Police are also known to be perpetrators of harassment,

violence, and even brutality against sex workers (ICRSE 2017; McCabe et al. 2014; Palmisano 2018; Puri et al. 2017).

Given how it interferes with a person's physical, cognitive, emotional, or social well-being, violence undeniably contributes to sex workers' ill mental health (Burnes et al. 2018; ICRSE 2017). Countless sex workers throughout Europe and Central Asia cite violence as their principle health worry (ICRSE 2017). Gender-based violence is a recognized structural determinant of numerous negative health outcomes (Socías et al. 2016). The physical oppression of cis female sex workers can dehumanize, indicating that the perpetrators view them as expendable and that the abuse is warranted (Gorry et al. 2010; Jackson et al. 2009). This can also be said for trans sex workers who are subjected to hate crimes, including violence and murder (Rodriguez et al. 2018). Of the 2982 trans people murdered in the world from January 2008 to September 2018, 62% were sex workers (Berredo 2018).

Enablers to Mental Healthcare

The third research question focused on the enablers that promote sex workers' uptake of mental health support and services, which 27 of the included studies covered directly or indirectly. Specifically, enablers are factors that facilitate access to support. Generally, enablers are elements that assist with or contribute to mental health. The reviewed documents cited many enablers that are the inverse of the barriers; those are not repeated here. Enablers can be counterpoints to barriers, but, ideally, are more nuanced and address the complex, interconnecting factors that impact mental health. It is those holistic enablers that arose most predominantly in the included literature, which are presented in this section as they pertain to service providers, professional development, services, systemic factors, and the personal realities of social inclusion and resilience. Table 4 demonstrates that the gray literature indicated more barriers and enablers and, thus, is considered more inclusive, holistic, and solution-focused than the peer-reviewed literature.

Service Providers

The literature listed many ways in which service providers can facilitate sex workers' uptake of mental health support as well as enhance mental health. Valuing the person and having a desire to help (Bodkin et al. 2015), being empathetic (Gorry et al. 2010; HH 2016; Mellor and Lovell 2012), and working to develop trust with clients were cited as important (Gorry et al. 2010). Having experience working with marginalized populations also received significant attention. The facets of this included working with sex workers as well as in the areas of inclusion regarding sex and gender minorities and people who practice kink; sexual assault; people of culturally and linguistically diverse backgrounds; substance use; trauma-informed care; community-based care; suicide intervention and prevention; empowerment; sensitivity training; and homelessness (Benoit et al. 2016; Bodkin et al. 2015; Church 2017; Gunn et al. 2016; HH 2016; Puri et al. 2017). Another enabler cited in the included literature is service providers who advocate for mental health for sex workers by viewing their clients' lives holistically and providing an integrated team or multidisciplinary approach to care (Bodkin et al. 2015). These advocates also work to combat structural inequalities that impact mental health, including stigma, discrimination, and criminalization (ICRSE 2017).

Professional Development

The literature recommends that mental health practitioners and all healthcare providers adopt an ongoing commitment to professional development, including emergency department staff, due to the high uptake of that service by sex workers (Prince 2013). Suggestions for how requisite skills

Table 4 Predominant barriers and enablers (%) in the included peer-reviewed (PR) ($n = 22$) and gray literature ($n = 10$)

Barrier	PR	Gray	Enabler	PR	Gray
Judgment	55	80	Lack of judgment	45	50
Stigma	91	90	Acceptance	36	60
Pathologizing	72	80	Not pathologizing	22	60
Criminalization	50	90	Decriminalization	32	80
Homophobia, transphobia, misogyny, whorephobia, racism	45	90	Allyship, inclusivity	9	40
Providers lacking knowledge and experience	63	50	Educated, experienced providers	63	70
Providers lacking cultural competency	50	80	Cultural competence	55	80
Lack of services, esp. specialized ones	59	70	Services, incl. specialized ones	68	80
Lack of trust of mental health service providers	50	60	Mental health service providers building, maintaining trust	22	40

could be acquired included universities and colleges incorporating training early in academic programs and requiring practitioners to undertake experiential learning via community work (Prince 2013; Rodriguez et al. 2018; Socías et al. 2016).

The literature recommended the following training topics: exploring anti-sex work and whorephobia biases and how intersectionality can intensify these biases (Burnes et al. 2018; Wong 2009); cultural competence (Choudhury 2010; Prince 2013; Rodriguez et al. 2018; Wong 2009); working non-judgmentally (Gunn et al. 2016; Wong 2009); and compassion and social exclusion (Prince 2013). Practitioners should complete this training themselves, and not rely on clients to educate them (Wong 2009). Finally, in addition to enhancing learning to improve the mental health of sex workers, it was recommended that practitioners engage in self-reflection, address their inhibitions regarding sex and sex work, become sex-work friendly and sex-positive, and make suitable referrals (Ley 2017; Wong 2009).

Services

Mental healthcare services can enable uptake via partnerships to provide coordinated, integrated support (HH 2016; Priebe et al. 2013; Prince 2013). An open-access or barrier-reduced service was another suggested enabler, which would eliminate exclusion criteria, wait lists, proof of ID, or age-based access; accept self-referrals; and offer unscheduled or drop-in appointments and ongoing care with no cap on appointments (Bith-Melander et al. 2010; Mastrocola et al. 2015; Priebe et al. 2013). Providing a mix of crisis-based, ongoing, and transition-related care, including prevention, was also cited as an enabler (Nemoto et al. 2015; Prince 2013; Puri et al. 2017). Finally, service offerings outside clinical settings, such as mobile units and outreach support, were indicated to be enablers to care (Gunn et al. 2016; HH 2016; Priebe et al. 2013; Prince 2013; Puri et al. 2017). Outreach can offset barriers associated with formal settings, engage hard-to-reach populations in care, and give providers an opportunity to advertise their services (Selvey et al. 2017; Wong 2009). Tailored, accessible services were identified as filling gaps in service provision while also recognizing and validating the people who use them (Nemoto et al. 2015).

Systemic Enablers

Systemic enablers that arose pertain to policies or practices that address disadvantage while making mental healthcare attainable. Funding would be required to ensure an enabling form of care (Nemoto et al. 2015). Proportionate universalism healthcare was cited as an enabler to care, reducing the need for private health insurance and related fees or citizenship qualifications (Bith-Melander et al. 2010; Socías et al. 2016). Gender-specific programming is another suggested systemic enabler to care for sex workers (Socías et al. 2016).

Individual Factors

The two primary enablers that are unique to the individual and which positively influence sex worker mental health and service uptake referenced in the literature are social inclusion and resilience. Social inclusion is a perceived support from a significant other, family, friends, community, peers, or society (Jackson et al. 2009). Inclusion is an enabler that leads to increased service uptake via its contributions to an individual's self-worth, which, in turn, inspires healthier behaviors, such as seeking mental health support (Bowen and Bungay 2016; Mellor and Lovell 2012). Social support is also a protective factor that reduces the likelihood or severity of mental ill health and suicidal ideation (Jackson et al. 2009; Mellor and Lovell 2012; Nemoto et al. 2015; Rössler et al. 2010; Teixeira and Oliveira 2017).

Sex workers' experience with social inclusion varies. Family and community acceptance were cited as lacking in large degree in studies from the US and Mexico (Burnes et al. 2018; Gunn et al. 2016); however, a Dublin-based cohort of sex workers indicated having family support (McCabe et al. 2014). Family support was also affirmed by 77.7% of participants in a Swiss study (Rössler et al. 2010). Trans community support also varied. In a study that compared two cities in California, the cohort in one felt more acceptance than the other (Nemoto et al. 2015). For trans sex workers, social inclusion means support not only for their occupation but also for their gender.

Social inclusion in the form of peer support also varies. While there was evidence of connection with and assistance from peers (Burnes et al. 2018; Koken and Bimbi 2014), sex work was also seen as isolating and an impediment to peer connection (Seib et al. 2009). Allies (Palmisano 2018) and significant others (Jackson et al. 2009; Teixeira and Oliveira 2017) can also contribute to social inclusion, while the criminalization of sex work (Church 2017) and substance use (Teixeira and Oliveira 2017) were cited as detractors. Itinerant or immigrant sex workers were cited as lacking social inclusion (Rössler et al. 2010). While some people require social support, others do not due to other protective factors, including a positive sense of identity, ability to regulate emotions, and good coping skills or resilience (Selvey et al. 2017). In the absence of additional protective factors, however, being accepted influences a person's investment in their mental health and, to that end, their engagement with support services.

Resilience is another enabler to sex workers' mental health that reflects personal strength and can counter stigma, pathologization, and marginalization as well as increase uptake. Communicated as coping skills, strength, and agency in

the literature, sex workers demonstrate resilience as emotional management; establishing and maintaining sexual boundaries (condom use, included and excluded sex acts); and resourcefulness (Bith-Melander et al. 2010; Burnes et al. 2018; McCabe et al. 2014; Wong 2009). Agency is exemplified as sex workers being active contributors to the planning and implementation of peer-based counseling programs (Bowen and Bungay 2016; Burnes et al. 2018; Choudhury 2010; ICRSE 2017; Puri et al. 2017; Selvey et al. 2017; Wong 2009). Self- and co-worker-affirmations, self-confidence, promoting one's own mental health, behavioral adaptation, and enjoying sex were other examples of resilience (Burnes et al. 2018; Choudhury 2010; Mellor and Lovell 2012). Self-preservation is also an aspect of resilience and was demonstrated as cognitive reframing, injecting comedy, and even positive and negative coping mechanisms (Gorry et al. 2010). Resilience not only enables uptake of mental healthcare but is also indicative of mental health, but its consideration facilitates a holistic and ultimately more representational view of sex workers (Bowen and Bungay 2016).

Discussion

The aim of this review was to synthesize the evidence on the barriers to mental healthcare among sex workers and the factors that enable the uptake of care. While uptake is generally poor and barriers are many, factors exist to enable the uptake of mental health support services. This review found that the mental health of sex workers varies from flourishing to languishing. This difference is due to the fact that studies tend to concentrate on or combine mental health with physical health (Benoit et al. 2016; Bodkin et al. 2015; Choudhury 2010; Darling et al. 2013). The lack of one universal standard for determining the severity of mental illness also contributes to the divide. In the absence of a universal standard, either practitioners or the person affected can gauge presenting symptoms and their severity. Additional factors that can be included in severity determination are comorbidity, self-management capacity, duration of presentation, quality of life impact, life satisfaction, or impact on well-being (Griffiths 2017). There is evidence that generally, the mental health of some sex workers is similar to that of women in the general population (Seib et al. 2009). Mental illness in the general population ranges from mild (mild depression or anxiety disorder) to severe (where medication or counseling are necessary) and presents in 13–17% of people (ABS 2012; Kessler 2002; Mental Health Foundation 2016). However, 68% of cis female sex workers convicted for work-based crimes meet the criteria for post-traumatic stress disorder (PTSD), which is the same percentage for combat veterans and people who have been tortured (Mastrocola et al. 2015).

Sex worker uptake of mental healthcare varies. Those affiliated with specific services or who can avail of outreach support tend to access counseling. Those who encounter barriers to care, however, avoid seeking support. Sex workers experience almost triple the barriers that the general population encounter, 40.4% vs. 14.9% (Benoit et al. 2016). Barriers to care for sex workers relate directly to service providers, services, systems, and complicated personal realities. Mental health service providers erect barriers that primarily manifest as stigma, discrimination, and pathologization. Help seeking for mental health issues has the potential to be enabled by practitioners who possess relevant, adequate training, by services that offer tailored, barrier-free, or barrier-reduced support, and by systems that do not criminalize, but that which provide inclusive universal healthcare. The protective factors of social inclusion and resilience as demonstrated through agency, self-confidence, emotional management, and boundary setting are also enablers to improved mental health support seeking.

Of the 68% of the peer-reviewed studies that did not receive a full methodological quality score, many failed the MMAT qualitative criteria 1.4., which required that appropriate consideration being given to how findings relate to researchers' influence, for example, through their interactions with participants. Specifically, this suggests that reflexivity may have been lacking in the peer-reviewed literature and could indicate a potential research bias stemming from a lack of assumptions and preconceptions exploration during the research process (Pluye et al. 2011).

The included peer-reviewed literature largely perpetuates stigma through a lack of diversity by featuring a majority (54.5%) of cis female sex workers. Indeed, Amnesty International asserts that the majority of sex workers globally are women (AI 2016b). This prevalence of cis women, however, discounts people with a multitude of gender expressions and sexual identities who work in the industry, including cis males; trans people; gender non-conforming people; and lesbian, gay, and bisexual people (AI 2016b). The exclusion of diversity aligns extreme sexual behavior with women (Burnes et al. 2018) and contributes to the rendering of male sex workers, for example, as invisible (Chabot 2012). Of the literature that met the inclusion criteria, only two focus exclusively on male sex workers (Koken and Bimbi 2014; McCabe et al. 2014). This disproportional representation also positions cis men as reasonable and competent and cis women as defenseless, irrational victims (Koken and Bimbi 2014). A lack of diversity represented in the peer-reviewed studies also extends to place of work; that is, 35.3% focus on SB sex workers, yet those who are SB comprise as little as 5% of the trade (Australian Institute of Criminology 2017; Chabot 2012). Place of work factors heavily into sex workers' mental illness as those who are SB, for example, encounter more violence and are less likely to engage in care than their indoor

counterparts (Mastrocola et al. 2015). Of all sex workers, those who work on street tend to be more significantly disadvantaged, have languishing mental health, have greater substance abuse issues, and face the most violence. A heavy focus on the negatives inherent in this place of work not only perpetuates the associated stigmas but also implies this data is generalizable to all sex workers. Studies that explore a VOS for sex work present a broader picture of where sex workers work, and a more thorough depiction of the realities of sex workers' lives and mental health. Homogenous samples oversimplify the realities and diversity of sex workers and their mental health. When one portion of a population is standardized to represent the entire population, bias results.

A range of factors impel a person's entry into sex work: financial, job flexibility or satisfaction, personal empowerment, the ability to help others, and limited or no alternate opportunities, including for migrants or in places with high unemployment (AI 2016a; Church 2017; ICRSE 2017; Ley 2017; Rössler et al. 2010; Selvey et al. 2017; Wong 2009). Notably, these factors are quite common reasons to begin any other job, and like any other job, sex work has positive and negative elements (Palmisano 2018).

The social and structural inequalities that afflict sex workers are borne out of patriarchal and kyriarchal domination and moralizing criticism, which view society and power relations as a hierarchy and behavior as a matter for public judgment and reproach (Rubin 2007; Dawthorne 2019). What results from this is the objectification of sex workers, the disallowing of sex workers' agency, and the criminalization of sex work (Quadara 2008; Global Network of Sex Work Projects 2017). Many global organizations and researchers call for the worldwide decriminalization of sex work due to the pervasive and deleterious impacts it has on sex workers (AI 2016a; ICRSE 2017; McKeen 2018; Palmisano 2018; Puri et al. 2017; Rössler et al. 2010; Selvey et al. 2017; Socías et al. 2016; World Health Organization 2012).

Criminalization protects the buyers, not the sellers of sex making them more vulnerable to violence, reporting by clients, and limited sexual control (McKeen 2018; Palmisano 2018). Criminalization hinders sex workers' ability or desire to avail of police support (AI 2016a; Bowen and Bungay 2016; HH 2016; McKeen 2018; Selvey et al. 2017). Decriminalization normalizes and destigmatizes sex work (Selvey et al. 2017). Decriminalization offers sex workers police protection, making it possible to punish the abusers instead of the abused (McKeen 2018; Puri et al. 2017; Socías et al. 2016). Lastly, decriminalization of sex work is associated with improving sex worker mental health for the significant impact of criminalization on uptake, and the impact of the violence that occurs due to criminalization on the mental health of sex workers cannot be overstated (Bodkin et al. 2015; Bowen and Bungay 2016; Chabot 2012; Choudhury 2010; HH 2016; ICRSE 2017; Jackson et al. 2009; Mastrocola et al. 2015; Mellor and Lovell 2012; Nemoto et al. 2015; Palmisano 2018; Prince 2013; Rössler et al. 2010; Seib et al. 2009; Socías et al. 2016; Teixeira and Oliveira 2017).

There is emerging literature that views sex workers' mental health holistically not pathologically, but it is sparse. Politically or ideologically focused research further alienates sex workers through approaches that lessen them to mere acts of commercial sex. Extensive focus on substance use, HIV/STI, and childhood abuse in sex worker populations perpetuates the pathologization of the work. Legislation that ignores the complexities and diversities of sex workers through criminalization exacerbates already dire marginalization while denying legal and regulatory protection. This oppression pervades the lives of sex workers, encourages and excuses violence, and causes psychological distress. It also hinders mental healthcare seeking, erects and maintains barriers to support, and diminishes vital enablers.

Social and Public Policy Implications

The findings of this systematic literature review could inform public and social policy pertaining to sex work and sex workers. Generally, policy makers could parlay the findings of this review into the design and creation of new initiatives that result in improved, targeted outcomes for sex workers in all wellness dimensions. Such potential benefits have practical and translational implications for multidimensional wellness that could extend to the families, friends, loved ones, and clients of sex workers. Specifically, these initiatives could act to optimize the mental health treatment that sex workers receive as social and public policy declarations shape professional practice as well as research directions.

Implications for Mental Health Professionals and Researchers

Mental health professionals and researchers who work with sex workers are uniquely placed to address personal and systemic deficiencies. Counselors, therapists, psychologists, and psychiatrists can reject the dominating medical model of mental health service provision and enact a holistic, inclusive, person-centered, trauma-informed, anti-oppressive approach to practice (Mellor and Lovell 2012). Continuous learning on a multitude of topics can facilitate this approach, and content designed or delivered by sex workers can enhance it (ICRSE 2017; Palmisano 2018; Rodriguez et al. 2018; Socías et al. 2016; Wong 2009).

Researchers can eschew the pathologization of sex workers through positioning authenticity at the core of their investigations, conducting reliable, balanced explorations of a cohort's lived experience and the broader consequences of the research (Given 2008). Working from an intersectional framework

enables understanding of the complex, cumulative oppressions that sex workers face, and attempts to counter interlaced inequities.

Implications for Future Work

Future research could explore sex worker mental health with an inclusive and holistic approach that is entirely separate from physical or sexual health. Explorations that recognize sex workers as experts in their own lives and incorporate this expertise in research design and implementation are rare and provide an excellent opportunity for academics. Future research could also focus on rural and regional populations, which is overwhelmingly absent at present. Outcomes can then be applied systemically to inform policy, legislation, and education.

Limitations

The content and findings of this paper are limited by the inclusion and exclusion criteria and the databases that were searched. Although search parameters are a necessary component of any systematic literature review, they do create the risk of excluding relevant literature. Limiting the geographic location of the study to the OECD countries was necessary to establish boundaries and provide an opportunity to explore comparable services within countries that have shared economic and social aims. This restriction rendered the data not easily generalizable to non-OECD countries, but provided an opportunity for subsequent literature reviews. As this was a paper on mental health service usage, the databases selected for peer-review literature searches largely focus on the fields of medicine and health. Searches of other databases from other fields, including the social sciences, for example, may have yielded different findings. This review did not include non-English studies, which may have provided alternate findings. Finally, the included gray literature, which more so incorporated the perspectives and lived experience or were authored by sex workers than the peer-reviewed literature, was given proxy to serve as best practice. While this attempt to incorporate a holistic, agency-honoring view of sex workers' mental health is inclusive, it may represent an imperfect approach to academic research.

Conclusions

Balanced, unbiased evidence that sex work itself causes mental ill health is non-existent (ICRSE 2017). Generally, however, the mental health of some sex workers is languishing and is significantly exacerbated by stigma, discrimination, violence, and criminalization. When these oppressions coalesce, psychological distress and the need for inclusive support can increase exponentially. In reality, sex workers have low uptake of mental healthcare and encounter significant barriers to access, including those disseminated by practitioners, services, and society.

Understanding the impact of these often mutually reinforcing oppressions and their preventability could contribute to the discontinuation of their perpetuation while improving sex workers' mental health. It is corroborated that inclusive psychological care can fulfill every person's right to impartial, respectful support irrespective of gender, sexuality, race, personal circumstance, or career. Honoring the vast array of identities of the people engaged in sex work, including trans and gender fluid/neutral people, will offset trans-erasure while serving to counter the deeply engrained whorephobia that all sex workers face. More scholarly work that eschews stigma is needed, particularly after many years of discourse that pathologizes, discriminates, and fails to honor sex workers' basic human rights.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflicts of interest.

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Towards barrier-free counselling for sexual/gender minorities and sex workers in rural Tasmania

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Abstract

Aims: This paper combines a service review and proposed research and, thus, has two aims: to present a model of successful service delivery regarding the development of barrier-free counselling and to present the design of in-progress doctoral research that has been informed by this clinician's practice. Sexual and gender minorities (SGMs) and sex workers (SWs) in rural or remote (R/R) Tasmania are the focus.

Clinical practice approach: Common barriers to accessing mental health services were identified in clinical practice through a service review that included observation and client consultation. Barriers were addressed and enablers enacted to support the biopsychosocial realities of marginalised people in R/R Tasmania. Support consists of inclusive, intersectional, sex-positive counselling; free/reduced-cost counselling; after-hours appointments; all-ages counselling; client-determined settings for service; and outreach support. Practice-based and anecdotal evidence suggested reductions in severity of mental ill health; alienation caused by stigma and minority stress; and likelihood of negative health indicators (excessive drug use, self-harm, suicide).

Doctoral research methods: The PhD, a nexus between practice and research, is occurring between March 2018 and March 2021. The research will follow a mixed-methods design that is commencing with systematic literature reviews on the barriers, uptakes, enablers of mental health and related services for SGMs and SWs. The focus will then narrow in on SGMs and SWs in R/R Tasmania, specifically, with an online survey and in-depth, one-on-one interviews. The publication of papers based on research findings as well as presentations to other counsellors and services will occur to promote barrier-reducing approaches to direct practice support.

Relevance: This approach will give marginalised people in R/R Tasmania a voice in the nature and direction of their mental-health care to improve outcomes and wellbeing. The research will generate vital data that is currently lacking on these populations in this region. It will also provide improvement opportunities for service providers and users alike through the development of health access standards.

Conclusion: Improving the mental health of SGMs and SWs in R/R Tasmania through access to barrier-free or barrier-reduced counselling has the potential to improve individual lives, lessen the

burden of negative and compounding health impacts, and provide these populations with the inalienable human rights that have been restricted or denied.

Background

Poor mental health is the single largest contributor to disability worldwide and will continue to be the leading cause of disability in the coming decades.[1,2] This is particularly true in rural or remote (R/R) regions, where issues pertaining to isolation, discrimination, and access to services and treatment are more salient.[3-5] The lack of mental health services in rural areas is well known; so too is the negative impact of this gap on mental health outcomes.[6]

Tasmania, one of Australia's poorest states, has among the highest per capita on mental health with 85% of current funding allocated to public services.[7] Yet, despite this investment, mental health remains poor in rural areas. The Australian Health Care Reform Alliance has stated that government approaches to rural mental health care 'fall short of the changes we need.'[8,9] These shortcomings affect marginalised people most profoundly. Marginalised people are those who live on the fringes of society, who have significantly reduced access to resources and opportunity, and who face a mix of economic, social, and health disadvantage.[10]

Many compounding, negative health determinants and barriers to service that marginalised populations face have been observed during the course of this practitioner's counselling work in R/R Tasmania: poor socioeconomic position, low educational attainment rates, social exclusion, limited social capital, high unemployment, and low-or-no access to mental health services. Research and counselling observations indicate that sexual and gender minorities (SGMs) and sex workers (SWs) have extreme levels of general psychological distress and attempted or completed suicides as well as prevalence of self-harm.[11-15]

In Australia, same-sex attracted people are more than three times more likely to experience mental ill health than heterosexuals while lesbian, gay, bisexual, transgender, and intersex (LGBTI) people are considered to have the highest national suicide rates.[12] In SW populations worldwide, levels of depression and posttraumatic stress disorder range from 10-100%(16). This poor mental health is **not** due to the perceived burdens of sex work, but to the external, inherent risk, stigma, exclusion, and discrimination that SGMs and SWs face.[12,17]

While there is a lack of comprehensive data around estimations due to stigma, the fluidity of sexuality, legalities, and regional variations, the prevalence of same sex attracted and gender diverse people in Australia is <1%-15% and the percentage of SWs is <1%.[18-20] The range of Australians who practice bondage, discipline, sadomasochism, or dominance (BDSM)—another SGMs group—is between 2% and 62%.[21] Thus, SGMs and SWs constitute between >2% to 77% of the population.

Clinical practice

As a counsellor in Tasmania with a sexual assault support service, then a gender, sexuality, and intersex status support and education service, and currently in private practice, the researcher has counselled hundreds of Tasmanians of all ages presenting with a range of mental health issues. What is abundantly clear from this counselling work is that when marginality and intersectionality are added to rurality, mental health can decline significantly. Practitioner observation and client reporting indicate that SGMs and SWs in R/R Tasmania face significant, compounding barriers to access.

These barriers are even more challenging for people who face marginalisation in multiple ways. SGMs and SWs under this practitioner's care, for example, lack access to resources, finances, and social support and face personal and structural stigma and discrimination exposing them to intersecting marginalisation across multiple aspects of life.

Using practice-based evidence (PBE) and working from an intersectional framework that recognises the varying configurations of these interwoven, compounding oppressions, this practitioner sought to address and offset marginality based on gender, gender identity, age, sexual orientation, socioeconomic status, and sexuality. PBE does not have a formal, empirical research base; instead, it involves practitioner authority and expertise and the synthesis of patterns that emerge during service provision and from related academic studies.[23] PBE originates in community as it focuses on the successful attainment of client outcomes as determined by clients.[22] Informed consent was obtained from clients for their participation, which included discussions regarding their clinical outcomes—both those specific to this practitioner's practice and those held previously. Dozens of academic studies were also read on the issues. The general patterns that emerged were: mental health care seeking or uptake; barriers or negative experiences with either formal (counselling services) or informal (family, society) entities; the impact of these barriers; and enablers to care specifically or to improved mental health generally. Enablers were positive experiences with formal or informal individuals or organisations.

When consulted on these general patterns, clients cited several factors that contributed to their mental ill-health. Those that could be addressed in practice are outlined here; others are included below as policy recommendations.

- **Social support and peer contact:** To address the lack of social support that many clients deemed difficult and which Boza and Nicholson dub the most significant predictor of mental ill health in trans and cis people alike[24], peer support groups are offered periodically and several peer mentors have been identified to assist clients' entry into the community.

- **Financial:** To address the financial barrier to care, counselling is offered at free or reduced-cost with the client determining what they can afford.

- **Stigma and discrimination:** To address some of the stigma that SGMs and SWs face, the counselling practice is not heterosexist; does not pathologise; uses appropriate pronouns and names; is sex positive; is kink-aware and kink-friendly; does not expect clients to teach practitioner; is accepting and non-judgemental; knows that sex work is work and has no interest in rescuing SWs; offers a safe space; believes clients; and honours the diversity of identities, practices, and experiences.

- **Lack of mental health services, including inclusive or outreach based:** In addition to the above methods of attempting to address the lack of services tailored for marginalised clientele, the barrier-free service offers after-hours appointments; counselling to people of all ages with any level of mental health issues to offset common service silos; and counselling in a setting of client's choosing (office, park, telephone) with the counsellor travelling to them, if needed.

Preliminary evidence gathered through clinical observation and client consultation at this counsellor's practice seem to suggest that barrier-reduced mental health support for marginalised populations can result in improvements in mental health. Examples of these supports include: undertaking college/university programs to offset low educational attainment rates and poor

socioeconomic positions as well as regular participation in informal social gatherings thereby overcoming barriers of social exclusion and reduced social capital.

Clients' self-reported mental health outcomes have also improved through a focus on eradicating social exclusion and increasing social capital through strategies of inclusion, diversity, network building, support, and acceptance. PBE and anecdotal evidence has also suggested reductions in the severity of mental ill health; the alienation caused by stigma and minority stress; and in the likelihood of negative health indicators (excessive drug use, self-harm, suicide), thus apparently reducing the need for medical intervention. To explore the trustworthiness of these claims and refine this service delivery model, this work has been parlayed into a PhD.

Doctoral research methodology

The doctoral research will involve methodical data collection, including the gathering of lived-experience evidence from SGMs and SWs on mental health and related services using a descriptive phenomenological approach.[25] Uptakes, barriers, enablers, and their impacts on these populations' mental health will also be explored. This mixed-methods research design consists of three phases: systematic literature reviews; online questionnaire; and in-depth interviews.[26,27]

Systematic literature reviews

Broad literature searches were conducted between August and October 2018. PubMed, CINAHL, and Scopus databases were searched for peer-reviewed material and google, government agencies and departments, intergovernmental organisations, and public health agencies' websites were searched for grey literature. Keywords searched for were: mental health, sexual and gender minority, marginalised/zed, access, LGBT/LGBTQ, intersex, uptake, barrier, sex work/er, prostitute, enabler, BDSM, gender identity, and sexual orientation. Peer-reviewed and grey literature evaluations have occurred.[28-31] Documents written before 2008, that did not stem from Organisation for Economic Cooperation and Development (OECD) countries, in a language other than English, or that pertained to people under 18 years of age were excluded.

Two systematic literature review papers—one on SGMs and the other on SWs—are currently underway. The original intent was to produce one review paper, however, to honour the diversity of the populations and reflect existing research, two papers are needed. The reviews for each review paper will address the following questions:

- What evidence is there regarding the mental health and access to related care among SGMs/SWs?
- What barriers influence SGMs/SWs access to mental health care?
- What enablers influence SGMs/SWs access to and experiences with mental health care?

Online questionnaire

An online questionnaire will be developed from the literature reviews and in consultation with SGMs and SWs. The survey is intended to reach a convenience sample and build a basis for collecting descriptive, associative, analytical, and evaluative data.[26,32] Survey data will be analysed using descriptive and inferential statistics.

In-depth interviews

In-depth, one-on-one interviews will be conducted throughout R/R Tasmania to gain a description of the phenomenon under study: personal experiences with mental health, including uptake, barriers, and enablers to service access. Adhering to descriptive phenomenology, the participants will determine the narrative and direction of the interviews; general, open-ended questions will be posed should participants request guidance.[33] Ideally, interviews will be conducted in-person, however, Skype or telephone interviews will also be made available to participants to accommodate rurality. Interviews will occur in a place, date, and time of the participants' choosing. They will be audio recorded, last 60-120 minutes, and be conversational in nature. If required, two interviews will be held.

Recruitment

Recruitment for phases two and three will be conducted via direct verbal, email, telephone, or social media-based invitations and snowball sampling.[26,32] Participants who volunteer for the online survey will also be invited to participate in an interview. To optimise response rates, the study will be advertised in organisations and businesses likely to engage or have contact with participants.

Ethics

Ethics approval for the doctoral research will be obtained from the Social Sciences Human Research Ethics Committee Tasmania, University of Tasmania, prior to the commencement of phases two and three.

Anticipated outcomes

As the doctoral research is a work in progress, there is currently no data to present. However, the researcher will be mindful of obtaining a representative and ample sample size to reflect the breadth of realities and diversities of communities under investigation; limiting forced-choice questions in the online questionnaire; using inclusive, intersectional terminology so as not to deter participation; and including as many people from as many racial, educational, and socioeconomic backgrounds as possible in an attempt to be representational. The outcomes of the research will help to inform the design and delivery of R/R mental health services for SGMs and SWs as well as impact policy.

Reflexive statement

As a cisgender, white, middle class, feminist woman who is an academic and a counsellor, the researcher acknowledges that despite every best effort to be intersectional, inclusive, and culturally sensitive, there are biases and limitations inherent in the counselling practice and doctoral research. Researchers and counsellors with other frameworks for practice and lived experience may have different approaches to this work and may derive alternative conclusions from the case notes and client consultations, literature reviews, and upcoming research. To address alternate approaches and interpretations, determine suitability and comprehension of questions and instructions, and to aid in determining gaps in survey questions, the online survey and in-depth interviews will be reviewed and pilot tested by SGMs and SWs, with the researcher incorporating suggested edits.[26,32]

The researcher's interest in this doctoral project stems from decades of working with and being part of queer, trans, and SW communities; from a glut of anecdotal accounts from SGMs and SWs about the public, familial, and systemic discrimination and abuse they encounter with shocking regularity; and from a personal commitment to striving for equal and equitable rights for all.

Attraction, identity, and behaviour intersect in a myriad of ways.[18] Much of existing research groups sexual and gender diverse people together, as this work has done. The combining of SGMs and SWs

in this work stems from Nussbaum's **capabilities approach**, which theorises that people who face personal and structural stigma and discrimination are banned from living a life that honours their chosen representations of bodily integrity, emotions, and affiliations.[34] This work attempts to honour the differences within these communities, while viewing the grouping as a starting point for future, more specific research.

It is the researcher's intent to add to sexual and gender minority and sex-worker-based academic inquiry and improve clinical practice in R/R areas; however, the researcher also struggles with having to ask direct practice clients to participate in academic research. While exploring the ethics of holding those dual roles in a small state with a small population, the researcher also sits with that discomfort, takes direction from participants, and practices critical assessment and reflection while seeking regular clinical and research supervision.

Discussion

A service review combined with exigent patterns that emerged in practice provided an opportunity to not only improve service delivery, but also attempt to address presenting mental health issues. There is anecdotal evidence that the resulting counselling approach reduced some of the barriers that marginalised people in R/R Tasmania face when seeking support. By involving clients in the informal assessment and creation of inclusive approaches to care, the counsellor was able to challenge personal presumptions, empower the clients through honouring their agency and self-determination, and adhere to trauma-informed care by collaborating with clients, thereby affirming their strengths and resources.[35] A counselling practice served as the impetus for research into an under-explored and poorly addressed set of issues. There is much value in a nexus between practice and research, particularly given the potential for research to inform practice in R/R mental health service delivery.

Rural Tasmania has a paucity of mental health services tailored to work with SGMs and SWs. Despite the staggering rates of mental unwellness in remote areas of the state, there are no dedicated mental health services for these populations outside of Hobart. While Tasmania has the second highest percentage of mental-health-based general practitioner (GP) consultations, only 34% of GPs consider their practices adequate to manage mental health problems.[7]

Much of existing research and, indeed, healthcare, legal, and social systems pathologise SGMs and SWs. Some examples of pathologising uncovered during the preliminary systematic literature reviews include: mental and physical healthcare providers discriminatorily othering SGMs, causing harm in the form of ridicule, contempt or refusal of support[36]; treating same-sex attraction as something to be cured via conversion therapy[37]; clinicians serving as the gatekeepers to hormones or surgery of trans people[36]; and researchers assuming that a desire to earn money for drugs was the only motivating factor for entry into sex work.[38] Furthermore, the glut of research on sexually transmitted diseases (STDs) and infections among SGMs and SWs implies that non-heterosexuals, non-binary people, people who practice kink, and SWs are dirty or worthy of condemnation, when, in fact, STDs are incredibly common and are considered a worldwide epidemic among **all** people by the World Health Organization.[39]

To pathologise is to discriminate. To deny or offer subpar care to those who seek it based on personal prejudice and discrimination is unethical. It is hoped that the doctoral research will fill gaps in existing research including addressing the intersectionality of rurality and remoteness with barriers and how this impacts service delivery. It is also hoped that the outcomes will positively

impact service delivery and potentially, legislation, and reduce the minority stress that marginalised people face by providing access to safe, inclusive, and informed mental health support.

Policy recommendations

With a view to improving the lives and mental health of SGMs and SWs in R/R Tasmania, the following policy recommendations are suggested:

Decriminalise sex work

To ensure SWs are no longer vulnerable and isolated and gain police, legal, and medical support, legislation needs to be enacted that eradicates penalties that contribute to marginalisation.[40,41]

Remove legal barriers to equality for people of diverse genders and sexualities in Tasmania

Currently, the Tasmanian *Births, Deaths and Marriages Registration Act 1999* discriminates against SGMs by requiring sexual reassignment surgery before they can change their sex. Surgery is not desired or possible for all who are transitioning, moreover, forcing a person to undergo surgery is inhumane. The Act demands that people be unmarried to register a change of sex. This means that married trans people have to divorce. The Act also requires people to identify as either male or female, an approach that is discriminatory against genderfluid, gender nonconforming, non-binary, agender, bigender, and polygender people. The Act must be updated to be inclusive, equitable, and non-prejudicial, which will have significant mental health benefits for those suffering under the weight of this discriminatory legislation.[42]

Enforce the *Tasmanian Anti-Discrimination Act 1998*

The Tasmanian Anti-Discrimination Act 1998 'makes discrimination and certain other conduct (such as sexual harassment) unlawful. The Act also provides for the investigation and inquiry into complaints of discrimination and prohibited conduct'.[43] Yet, discrimination against SGMs and SWs flourishes unhindered.[44] Enforcing the Act would not only hold lawmakers and the public alike accountable for violations, but make positive strides toward addressing the mental health impacts of discrimination.

Make SGM- and SW-affirmative training mandatory in all mental health and healthcare education

To counter the medical field's long history of pathologising; to prepare mental and physical health workers to work with these populations; and to undo the long-standing clinical ignorance and insensitivity to same sex attracted, intersex, gender diverse people, SWs, and practitioners of kink, all degrees, diplomas for all mental health and healthcare students must include in-depth and extensive instruction on SGMs and SWs.

Conclusions

The mental health of SGMs and SWs in R/R Tasmania is arguably the worst in the nation. The outcomes of this study will be used to inform service provision, government policy, and identify gaps and solutions. This research will generate vital data that is currently lacking on these populations including an exploration of the implications for rurality and remoteness. It will also provide improvement opportunities for service providers and users alike through the development of health access standards. Finally, the research will honour the right to a minimum standard of health[45], to which all Australians are entitled and give these marginalised populations a voice and an opportunity for support that they themselves dictate and direct.

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Presenter

Tamara Reynish's extensive counselling experience includes working with marginalised populations in the areas of torture; trauma; sexual assault; domestic, family, and intimate partner violence; discrimination; and exclusion. Through a PhD at the University of Tasmania, Tamara is exploring the impact of stigma, disadvantage, and a lack social and legislative human functioning capabilities on the mental health of sex workers and people with great diversity of sex, sexual, and gender identities in rural or remote Tasmania.