WOMEN'S SUPPORT PROJECT

MENTAL HEALTH AND WELLBEING STRATEGY

Consultation response

Response to the Scottish Government's consultation 'Mental health and wellbeing strategy'

September 2022

"Going through the sex industry and coming out the other side, no matter how far away you get from it, there's still – I think – for many a lingering feeling of being alienated from everyone else in quite a negative way and that you should hide what has happened to you and never speak of it again."

— Jade, YouMySister[1]

The Women's Support Project (WSP) is a feminist charity working to raise awareness around violence against women and girls and to improve services for those affected, including people affected by Commercial Sexual Exploitation (CSE). There are clear links between child abuse, childhood neglect and domestic abuse and women's involvement in CSE. These factors, along with poverty, problematic substance use, homelessness, trauma and mental health issues create vulnerability and inequality, which is exploited through men's payment for sexual activity.

We are responding to the Scottish Government's **Mental health and wellbeing strategy consultation** as an opportunity to highlight the barriers and changes needed to support, promote and maintain the mental wellbeing of women who have experienced gender based-violence (GBV), and specifically women who are or have been involved in CSE. The Scottish Government defines CSE as "activities such as pornography, prostitution, stripping, lap dancing, pole dancing and table dancing … activities [which] have been shown to be harmful for the individual women involved and have a negative impact on the position of all women through the objectification of women's bodies."[2]

It is paramount that any government strategy considers women's needs in line with Equally Safe, Scotland's national strategy to prevent and eradicate all forms of GBV. It is of particular importance in the aftermath of the pandemic when women are facing multiple pressure points from the ensuing crisis, many of which are pushing them into CSE[3]: This includes increased cost of living, a continuum of GBV worsened by the pandemic's lockdown measures, a crisis of affordable housing, diminished employment opportunities, and the pressure of disproportionate caring responsibilities.

> We are calling for the Scottish Government to include in this strategy specific actions to address the mental health and wellbeing of women affected by any form of gender-based violence, including commercial sexual exploitation. Failing to consider the particular ways in which abuse and violence affect all aspects of a woman's life, including her mental health, will mean that the government's vision of a Scotland where there is "better mental health and wellbeing for all" cannot be realised.

[1] YouMySister is a UK organisation which supports survivors of abuse with experience of the porn and sex industries. They do this through mental health recovery programmes created and delivered by women with lived experience.

[2] Scottish Government, *Safer lives: changed lives*, 2009.

[3] https://news.sky.com/story/cost-of-living-crisis-pushing-more-women-into-sex-work-and-unable-to-refuse-dangerous-clients-12675932

Mental wellbeing is a key consideration for women in CSE and it can have profound implications on all aspects of their lives, such as their housing situation, substance use, safety, life aspirations and access to services in general. A 2022 report by UK-based service Beyond the Streets[4] which specialises in supporting women in CSE, found that mental health was the most frequently mentioned support theme. Additionally, 96% of the women assessed said they were concerned with accessing mental health services. At the same time, the links between mental health and CSE are not simple. For some women mental health issues can be a pathway into CSE, for some the impact on their mental health is not fully seen until they have exited the industry, and for others the coping strategies used can impact long term on their mental health.

It is crucial to understand that women in CSE are not a homogenous group. Women enter for a number of reasons, move through and into different aspects with some women exiting and then returning. Some women are living with domestic abuse, come from backgrounds of disadvantage and discrimination or have long term health conditions or disabilities, other women are migrants or belong to minority groups. Women in CSE can be college students, have PhDs, and be involved whilst keeping other employment. There are women who are street-based, others may refuse direct sexual penetration, they may sell images, and some more have little or no choice about whom they have sex with or what kind of sex they will have to have. Thus, their mental health needs and the pathways into accessing mental health support and advice will differ. Mental health pilots ran with women in CSE before and during the pandemic have shown that accessing mental health support online can be a huge challenge for women who lack access to digital devices[5], and women selling sex on the streets often present more complex needs which may be better met through outreach services.[6] These are the nuances that we attempt to highlight throughout this response.

Rather than following the questions as set out in the consultation document, we chose to highlight key areas of consideration for women in CSE. Our response is divided into sections: first we discuss the need for a gender lens in developing this strategy; we then explore the mental health needs of women in CSE and how trauma may manifest in this population, followed by the barriers that they face to accessing mental health advice and support; we then delve into accessibility and quality of mental health support for women and our views on the pathologization of women's mental health issues; we end with commentary on considerations to better support the workforce in helping professions. Sections include a set of recommendations. Ultimately, our stance is that mental health should not be about treating poor mental health but about promoting and maintaining positive mental health.

1. The need for a gendered lens that considers commercial sexual exploitation

In 2020, COSLA and the Improvement Service hosted an event exploring responses to GBV which concluded that there is an urgent need to prioritise the safety and wellbeing needs of women experiencing abuse and violence, including CSE in both local and national decision-making across all policy agendas. Likewise, Equally Safe highlighted that a cross departmental interagency approach was required. On an international level, the WHO recognised that broader structural and systematic factors such as "public policy including economic policy, socio-cultural and environmental factors, community and social support, stressors and life events, personal behaviour and skills, and availability and access to health

[4] Beyond the Streets (2022), *Support needs of women involved in the UK sex industry: learning from frontline services.*

[5] Based on the Encompass Network Counselling Pilot conducted in Scotland between February-October 2021 and offering free counselling sessions for women who sell or exchange sex.

[6] Stevenson and Petrak (2007), *Setting up a clinical psychology service for commercial sex workers*.

services … [all] exercise a role in determining women's mental health status."[7] Thus GBV must be a priority area of work in any policy are in Scotland, and so collective leadership is needed at local and national levels to tackle GBV and gender inequality.

Women have distinct and specific life experiences and so there is a need for gendered approaches in strategies, policies, services and practice. All of these areas of work need to be gender-informed and have a clear gendered understanding and approach. This means considering how broader social and cultural factors, including unequal power relations between men and women, have an impact in promoting or impeding mental health. As the WHO stated, "such inequalities create, maintain and exacerbate exposure to risk factors that endanger women's mental health, and are most graphically illustrated in the significantly different rates of depression between men and women, poverty and its impact, and the phenomenal prevalence of violence against women."[8] Without a gendered understanding, Bartlett (2003) considers that there will be an ongoing "neglect not only of differences in the nature and prevalence of psychiatric pathology, but also of the reality of women's lives, their expectations, their responsibilities and the concomitant stresses that lead to mental health problems".

It is clear that a successful strategy must have a gendered lens that understands the particular ways in which women's mental health might be affected, the specific barriers to support and how women's position in society can mean poorer mental health, particularly where they have experienced CSE. We are disappointed to see that this consultation has not included specific questions in relation to women's experiences; thus, our response will attempt to make space for those experiences and present aspects which we believe are crucial to enrich the proposed mental health strategy. It is only by addressing the links between mental wellbeing and the range of ways in which GBV may be experienced that the government can truly respond to the mental health needs of everyone.

2. Mental health in the context of commercial sexual exploitation

Women involved in CSE can be involved in different elements of the 'sex industry,' from exchanging sexual images online to subscribers and having direct contact sexual activity to appearing in pornographic films. Each of these forms can have a different impact on the mental health of women who, in turn, can experience a wide range of unmet mental health needs. A recent large scale meta-analysis in 2020 suggested that mental health problems such as depression, anxiety, post-traumatic stress disorder (PTSD), and suicidal thoughts and attempts are highly prevalent among women in CSE.[9]

Studies have shown that for many women entry into CSE is a result of lack of choice, constraints, and coercion, with poverty and depravation being a common experience along with traumatic experiences – all of which have negative implications for women's mental health. Poverty is also a well-known determinant of mental health.[10] In 2018, 26% of women living in the most deprived areas reported levels of mental distress associated with a possible psychiatric disorder, compared with 16% of women living in the least deprived areas.[11] Indeed, Walls (2011) found that "women who have to have sex as a result of poverty and lack of supported and opportunities carried a far greater risk of developing depression, were more often hospitalized, and 4.5 times more likely to attempt suicide."[12] One woman involved in escorting highlighted the harms that can result particularly where financial need or coercion

[7] Bartlett A (2003), *Women's Mental Health: Into the Mainstream.*

[8] WHO (2000), *Women's Mental Health: An Evidence Based Review.*

[9] Beattie et al (2020), *Mental health problems among female sex workers in low- and middle-income countries: A systematic review and meta-analysis.*

[10] Coy, M. (ed) (2016), *Prostitution, Harm and Gender Inequality: Theory, Research and Policy*.

[11] The Scottish Health Survey 2018.

[12] Walls NE (2011), *Correlates of engaging in survival sex among homeless youth and young adults.*

meant it was not possible to select clients: *"it's traumatising to have sex with people you're disgusted by."* In the same study, another woman echoed the impact of lack of choice: *"I'm not proud of it. It's not something that I even felt was a choice. You know, because of the way it happened. Had it been a choice that I was really aware of, I wouldn't choose it."*[13]

On the other hand, whilst the specific links between child abuse and CSE are unclear, high numbers of adult women have experienced abuse during childhood. Almost a quarter of 150 women involved in CSE supported by the Encompass Network disclosed childhood abuse.[14] In 2012, Bindel et al found that almost three quarters of the women interviewed had experienced physical, sexual and verbal violence during childhood which compounded feelings of worthlessness.[15] In the same year, Dodsworth found that some women felt they no choice but to stay involved in CSE and that the "pathway they felt destined to take began to be defined in early childhood experiences of neglect, rejection and abuse."[16]

For some women, being involved in the 'sex industry' comes with repeated episodes of abuse and violence, with high numbers of women reporting they have been pressured or coerced to sell sex by a partner or a pimp, often through actual threats of violence.[17] A review of more than 25 research studies found high levels of violence in street prostitution with 82% of women reporting physical violence and 68% reporting rape.[18] Sarah Jane, a woman involved in the 'sex industry' in Scotland, described through the Inside Outside project[19] the impact that violence and abuse can have on women:

"You do become detached and you start to see yourself from the outside but not really see yourself at all. You all just become these numb statues that stand on a street corner, goes through the motions, doesn't think about anything too much because if you do, you don't know how your brain's gonna cope with it. I used to feel like screaming but I thought, 'If I start to scream now, I'm not going to be able to stop.'"

Whilst women may have mental health issues prior to their involvement in CSE, the impact of this involvement can be very harmful. Rossler et al claim that the effect of a single year of selling or exchanging sex is likely to have the same impact on mental health as an entire life of experiences prior to involvement.[20] In the Encompass Network snapshot, 121 (80%) out of the 150 women supported disclosed a mental health issue and the majority (102) experienced anxiety, depression and trauma symptoms along with formal diagnosis of PTSD, Complex PTSD, emotionally unstable personality disorder (EUPD), bipolar disorder (BPD). Equally, a small needs assessment of men and women involved in prostitution in Ayrshire and Arran found that 93% suffered depression and 78.5% had self-harmed.[21]

Women in street prostitution are, for example, a highly marginalised and stigmatised group who experience multiple and interdependent health and social problems and extreme health inequality. Benoit and Millar (2001) found that anxiety, depression, symptoms of PTSD, and use of substances were common in this group.[22] Another study found that over two thirds of

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[13] Home Office (2019), *The nature and prevalence of prostitution and sex work in England and Wales today.*

[14] Encompass is a network of services which specialise in supporting women who are or have been involved in CSE. In 2021 they released a Snapshot of support offered to 150 during one week. Read the report here: https://www.encompassnetwork.info/uploads/3/4/0/5/3405303/encompass_snapshot_2021.pdf.

[15] Bindel et al (2012), *Breaking down the barriers: A study of how women exit prostitution*.

[16] Dodsworth J (2012), *Pathways through Sex Work: Childhood Experiences and Adult Identities*.

[17] Church et al (2001), *Violence by clients towards female prostitutes in different work settings.*

[18] Raphael J & Shapiro D (2004), *Violence in indoor and outdoor prostitution venues.*

[19] Sarah Jane's testimony is part of the project Inside Outside which gives voice to the experience of women in Scotland who are or have been involved in the 'sex industry': www.insideoutsidescotland.info

[20] Rössler W. (2010), *The mental health of female sex workers.*

[21] NHS Ayrshire and Arran (2017), *Sexual health and Blood Borne Virus (BBV): Training brochure.*

[22] Benoit C & Millar A (2001), *Dispelling myths and understanding realities: Working conditions, health status, and exiting experiences of sex workers.*

the women in street prostitution also met criteria for PTSD with a strong link to substance use as a means of self-medication.[23]

As we have seen so far, the mental health issues faced by women in CSE are as wide-ranging as those of women GBV in general. However, below we highlight the specific impacts from being involved in the 'sex industry. It is important to clarify that the issues mentioned below are only some examples and not a comprehensive list, nor are they necessarily the experience of every woman in CSE. Yet, they do offer some understanding of the complexity of women's mental health needs when they have been involved in this 'industry.'

Stigma

Women in CSE identify the significant impact stigma has on their mental health as they face judgement and discrimination, for example where negative labels are applied to them. Often, stigmatisation comes when they are "othered" and derogatory terms are used to refer to them. Studies show women can internalise negative beliefs about themselves[24] with ongoing pressure to hide their involvement in CSE. As a result, women constantly judge and make decisions as to whom they will disclose their involvement to. This maintaining secrecy or selective disclosure can come with its own psychological and social burdens, such as social isolation and the inability to discuss their mental health.

Social isolation

Connected to the above, women report high levels of social isolation with fears of losing their anonymity and being "doxed" over their involvement in selling sex. This inauthenticity and fear of revealing oneself with others can have an impact on intimate relationships. A recent Australia-based study[25] revealed that the majority of the women who were in relationships believed that overall sex work affected their romantic relationships in mainly negative ways (78%). In a similar vein, Sanders (2004) writes that "negative emotions generated by the commodification of women's bodies through sex work affected their social identities and relationships, with women struggling to separate sex at work with sex for pleasure."[26] In another study,[27] 75% of the women interviewed stated that selling sex made it too difficult to sustain a relationship and 80% said that sex work interfered with romantic relationships.

Social isolation can prevent women from accessing services but the impact on their personal and social relationships and the limitations on their ability to build authentic relationships with others means they are also unable to get informal support from those around. As Katie said in Inside Outside:

"I was carrying a heavy load but I made that choice. I had no support around. I told no-one, no family and no friends. My family would be distraught, so disappointed. No way I told them. Even now I still wouldn't tell. It's basically like living two lives. You have your work life and your family, friends, partners think you do something else. You have to keep up this fake act. Something could have happened at work and they would have no idea why you were so upset. They wouldn't understand and you can't come out and tell them. No. You just wouldn't. There was times that you want to like, just scream and tell them. Then maybe they would understand why you are, like, you are. But then at the same time, it's not worth it. It's hard to keep them separate but you must."

Lost sense of self

[23] Roxburgh et al (2006), *Post-traumatic stress disorder among female street-based sex workers in the greater Sydney area, Australia.*

[24] Carrasco et al (2017), *Addressing stigma by reconstructing identity through enhancing social cohesion among female sex workers living with HIV in the Dominican Republic.*

[25] Bellhouse et al (2015), *The Impact of Sex Work on Women's Personal Romantic Relationships and the Mental Separation of Their Work and Personal Lives.*

[26] Sanders TA (2004), *The Management of Health, Physical and Emotional Risks by Female Sex Workers.*

[27] Warr DJ & Pyett PM (1999), *Difficult Relations: Sex Work, Love and Intimacy.*

For some women, becoming involved in the 'sex industry' can change their perception of themselves. Women in CSE use various strategies to protect their sense of self, mainly through drawing boundaries and limits. Nevertheless, these protective qualities can be limited as these boundaries can be comprised or overridden. One study highlighted how this can impact on women's sense of self[28] and a participant in recent research by the Scottish Government highlighted the challenges of boundary keeping: "*within prostitution, there's this thing about pleasing personalities, and I've found boundaries extremely difficult, like I didn't have the right to say no, to anyone. And it was even happening in the therapy group."*[29]

Disempowerment, substance use, exploitation and lack of control when selling sex further exacerbates women's capacities for positive self-esteem.[30] Elliott (2020) writes that women involved in prostitution reported low self-esteem and body confidence, frequently linked to their appearance, which often included dental damage, or damage and scarring to their bodies caused by physical assault.[31] The impact of CSE is evident in women's damaged or diminished self-worth and feelings of shame.[32]

Furthermore, many women involved in CSE will disassociate in order to manage the experience of seeing clients which can have a negative impact on an individual's mental health: "results from the largest prospective study of its kind indicates that for individuals who experience trauma, the presence of dissociation –a profound feeling of detachment from one's sense of self or surroundings– may indicate a high risk of later developing severe posttraumatic stress, depression, anxiety, physical pain, and social impairment."[33]

Abuse and violence

Women involved in CSE are often subjected to violence from clients, pimps, traffickers, partners, but also from the general public due to the prevalence of stigma against women selling sex. Women can be subject to high levels of violence and many recount repeated episodes of rape and assault.[34]

In an analysis of violence against sex workers participating in prostitution, Phipps[35] found that the long-term effects of violence and abuse can also include its normalisation, which can lead to further victimisation due to a lack of vigilance in accepting clients or acceptance of aggressive behaviour. Conversely, the stress of having to remain watchful can cause fearfulness, anxiety and isolation and means that, like other survivors of abuse, sex workers are highly likely to blame themselves when they are attacked.

At the same time, many women report an awareness of abuse experienced by peers. In Inside Outside, Katie recounted the impact of witnessing abuse against other women:

"I've worked with girls that, when I see them – how they'll come out of being with a customer. It's literally soul-destroying seeing them in that state. Those girls cannot hold their own and they're probably not right for it because they are being pushed about. It affects you seeing them, cos you want to help them but you can't. Unless they help themselves, there's no point in you continuously telling them like, to say no. When you know these girls and you see them every day and then you see them like that and… it's not easy."

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[28] Turcotte et al (2021), *Managing the toll of sex work with bounded agency: Perspectives of ex-sex workers.*

[29] Scottish Government (2022), *The experiences of people who sell or exchange sex and their interaction with support services.*

[30] Dodsworth J. (2012), *Pathways through sex work: childhood experiences and adult identities.*

[31] Elliott N (2020), *Meeting female street sex workers' physical and mental healthcare needs.*

[32] Brody et al (2005), *Psychiatric and Characterological Factors Relevant to Excess Mortality in a Long-Term Cohort of Prostitute Women.*

[33] news.unchealthcare.org/2022/06/feelings-of-detachment-predict-worse-mental-outcomes-after-trauma

[34] For further information on the safety issues faced by women in CSE, please see: www.cseaware.org/safety-insights.html

[35] Phipps A (2013), 'Violence against sex workers.'

This “trauma on top of trauma” that Eliot (2020) described was echoed by Wendy also in Inside Outside:

“The pain I felt for her was unbelievable. Seeing that nothin’ness in her eyes that night was kind of the start of the end for me when it came to prostitution. I thought the light had already gone out of my eyes but it hadn't gone entirely. It hadn't gone out in my heart and in my head. I still had a wee bit of life left in me and I knew I had more to give. I had to give myself a chance to be a different person.

I dream about her sometimes. I cannot get her out of my head. She is one of my flashbacks.”

The high prevalence of abuse against women and particularly against women in CSE means a constant state of vigilance, adding to the mental health burden they already carry. It can also exacerbate the victim-blaming that women frequently feel when they have been assaulted.

3. Traumatic experience and trauma-informed support for women in CSE

Women involved in CSE often have multiple and intertwined traumatic experiences that could have happen prior to or during their involvement in CSE. For instance, the Encompass Snapshot found that out of the150 women supported, 35 (23.5%) disclosed experiences of Childhood Sexual Abuse, 81 (54%) disclosed experiences of domestic abuse, 32 (21%) had children removed from their care, and 58 (38.5%) were trafficked for sexual exploitation.

In addition to the hypervigilance and the compounded trauma, studies have shown that those who sell sex need to develop coping strategies to enable them to offer sexual services to clients and to ‘block out’ or ‘dissociate’ from their experiences. For example, Sara Jane told the following story in Inside Outside:

“I can't remember anything about that first night. Nothing about that first punter. I blocked it all out. Totally blocked it out. I went home and scrubbed myself completely. I think I was in the shower for about two hours but then a few weeks later I did it again and once you'd done it the first time and money was in your hand, the option's there.”

Likewise, research undertaken in Ireland found that the impact of having unwanted sex repeatedly had a negative impact on the women interviews:

“The interviews in particular reveal some of the bodily but also emotionally harmful realities of prostitution – having to emulate non-existent sexual desire for buyers, handling demands they find repellent or frightening, enduring physical and sexual contact they can no longer bear – and the cumulative negative effects these experiences have on their own sexual lives, identities, intimate relationships and ability to trust. This sense of being violated in the context of prostitution is consistent with studies where women express similar feelings of sexual intrusion, disgust and revulsion.”[36]

There is evidence that many women in CSE have experienced trauma, with a number experiencing complex trauma. Thus, it is clear there is a need to acknowledge and consider the trauma experienced by women in CSE when designing and delivering services. Any person would benefit from systems that are more trauma-informed; however, there needs to be particular consideration of how, as we have described above, trauma plays out and continues to be re-lived when women are or have been involved in the ‘sex industry.’ A study carried out with workers who support women involved in street prostitution revealed that “three quarters of respondents felt mainstream mental health services were inaccessible or mostly inaccessible to [street sex workers] and did not meet their needs. Experience of trauma, fear of stigma and difficulty trusting mainstream services were raised as access barriers, along

[36] Breslin et al (2021), *Confronting the harm.*

with difficulties in the referral and assessment processes."[37] In more recent years, a similar study (Breslin et al 2021) concluded that women in CSE need "specialist, formal support and counselling that could be provided by an in-house psychologist, and that the need and demand for this kind of support is growing."

Although in recent years we have seen and welcomed Scotland's active efforts to create and foster trauma-informed system, we believe that this requires much more than training staff on trauma. It is about looking at how systems impact on individuals' experiences. Referral and assessment processes within mental health services can be retraumatising for individuals and often do not meet women's needs. Conversely, as a study in Australia described, women who have experienced multiple forms of trauma "flourished when services addressed all trauma impacts rather than just focusing on a single issue." This research also makes an important additional point about the focus of support for complex trauma:

"…while health professionals favour a psychological (problem of the mind) understanding of complex trauma, women with experiences of complex trauma emphasise somatic (bodily) and psychosocial (relational) aspects… Navigating a fragmented service system where the majority of services are funded to address a particular issue or concern—each with their own (formal and informal) rules—while you are in crisis is fraught for women with experiences of complex trauma. This reflects a growing body of evidence that collaboration between agencies is essential to effectively support women who have experienced domestic, family or sexual violence."[38]

Above all, women involved in CSE need access to specialist trauma-informed mental health support. Access to this needs to be based on improved identification and prioritisation of women with experiences of complex trauma within public policy and service frameworks, as well as the need to embed trauma-informed care within a holistic wellbeing framework.

Recommendations

- Ensuring mental health workforce is aware of the particular ways in which trauma can be compounded and manifest when a person has been involved in CSE.
- Improving identification and prioritisation of women with experiences of complex trauma within public policy and service frameworks.
- Specific funding for specialist trauma support and trauma-informed mental health support for women in commercial sexual exploitation.

4. Barriers to accessing mental health support and advice

As outlined, women involved in CSE have high levels of mental health needs which are often not met by current mental health services. The Encompass Snapshot showed there is a substantial gap in those with mental health issues and those accessing support from formal mental health services. Indeed, the path to getting mental health care can present a series of barriers for women in CSE, and in many cases it starts because women do not feel safe or comfortable disclosing involvement to health professionals. As a woman supported by CLiCK Scotland explained: *"I've never actually admitted to any of the services about the sex work, it's only yourselves [CLiCK] that knows about the sex work. I've never disclosed it to any other agency or my GP."*[39]

Women's isolation and fear of losing anonymity can prevent them from accessing services and instead they may feel they have to manage their own mental health through self-care and

[37] Potter et al (2022), *Access to healthcare for street sex workers in the UK.*

[38] www.anrows.org.au/media-releases/conflicting-understandings-of-complex-trauma-create-challenges-for-survivors-of-gender-based-violence

[39] CLiCK was a Scottish multi-agency project which supported women who sell or exchange sexual images online. The project ran for 2 years, and you can read and hear about the work done and women's voices here: www.clickmagazine.online

occasional additional service support. Crucially, women may not be able to speak to friends and family about their mental health, leading women to approach informal peer support groups which may not be able to meet their needs, particularly where the focus is solely on the positive aspects of the 'sex industry.' One participant in a recent Scottish Government report exploring the engagement of people who sell or exchange sex with services said: *"I was involved with a pro sex work organisation before and I felt that they did not understand why I was struggling and it felt as if I didn't speak positively about my involvement in [selling sex] then they wanted rid of me."*

For women who do manage to engage with formal support, it can be difficult to continue when their needs are not met or there is a lack of understanding of their experiences. Some of the key barriers highlighted by women include:

Mishandling of disclosures

As with any form of GBV, professionals' responses to a disclosure and request for mental health support "has a profound impact on the woman for many years to come.[40]" As discussed, many women in CSE chose not to talk about their involvement or tell it to only very few people –opening up about this part of their lives can be a huge step. The lack of understanding of CSE in general and within health services can mean poor responses. For some women, there can be either an overfocus on their experience of CSE – where it is seen as the "only cause and the root cause of mental health issues."[41] In other cases, it can be dismissed completely –a woman for example said about her experience with services: *"I think, because some women claim that they are comfortable in that industry that maybe they assume everyone is."*[42] Another participant in the same research described the following experience with a service:

"They just acted as if it's normal and it's fine, and you'll get over it and whatever. Meanwhile I was struggling with my mental health, I was struggling with a lot of things in my life but nobody actually said, 'Right, okay. I can see that you're struggling and you need some help to get out of this situation that you're in.' Nothing. It didn't matter how many times I screamed and shouted about this awful thing I was involved in, nobody did anything anyway."

Creating a safe space for disclosure is crucial for women in CSE, and this involves not only asking as a matter of routine, whether they are involved in CSE, but also knowing that services will not inappropriately share this information with other individuals or agencies. This means, for example, avoiding writing it in women's medical file as this might lead to stigma when linking with other services or women may fear negative consequences from disclosing. Women should be given the space, time and control over their personal experience. Above all, there is a need for clear protocols within mental health provision around disclosures of GBV, data protection and applying trauma-informed principles to information given – i.e. only include disclosures of CSE in a file if there is a purpose, the woman has consented to this and she was given proper information about the need to do so.

On the other hand, some women have spoken of services or professionals who make their experience of CSE the one and only cause of their mental health issues. An Australian study (Treolar 2021) described this poor treatment from mental health practitioners who did not recognise women's individual experiences and approached the issue with fascination or voyeurism.

Both refusing to address women's experiences of CSE and the inability to see beyond women's involvement can negatively affect the care women receive for both their physical and

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[40] Bailey and Taylor, *'I needed to know that I wasn't crazy': exploring the experiences of women who sought support for their mental health after sexual violence, 2022.*

[41] Ryson and Alba (2019), *Experiences of stigma and discrimination as predictors of mental health help-seeking among sex workers*.

[42] www.gov.scot/publications/lived-experience-engagement-experiences-people-sell-exchange-sex-interaction-support-services/pages/8

mental health.[43] In both cases women can feel judged, unheard and ignored, which can result in their mental health worsening and/or complete disengagement from support services. It is vital that professionals have the knowledge to understand the impact of CSE, that they feel confident to ask about women's involvement in a non-judgmental way, and that they support women as whole individuals with the understanding that their lives and needs go beyond their involvement in the 'sex industry.'

Stigma and discrimination

As described in Section 2, the stigmatisation and discrimination which comes from societal attitudes about those involved in CSE and the judgements which are made around this can stop women from talking about their experiences and lead to them burying it deep. The feeling that they need to "keep things to themselves" can be exacerbated where there are other compounding experiences of discrimination or negative responses from services or other service users; for example, for women who have also faced racist incidents when engaging with services. Women who substance misuse, for example, describe feeling a double stigma which in turn "exacerbated the judgement they experienced when accessing services" (Scottish Government 2022).

Conditioning the mental health support

Imposing conditions on access to mental health support can be hugely detrimental to women's mental wellbeing. Asking women to stop substance misusing or stop their involvement in CSE before they can get support from a mental health worker, telling women they should only attend if their mental health deteriorates (such as if they are suicidal or showing visible signs that they are not coping), requiring women to have a formal mental health diagnosis – all of these can push women to manage their mental health without support and using their own coping mechanisms which can be harmful (substance misuse, risky behaviour). For a participant in the Scottish Government's research, it took her to be suicidal to get the attention of the service she was engaged with: *"It got extreme. I was very, very seriously very suicidal, and it took me to get to that stage to get help. I did attempt suicide in a really bad way, but I thought that whatever happens, well, it's meant to be. I'll either die, or they'll listen."* Another participant felt that the doors to support were closed because she "appeared to be coping."

Similarly, denying women support because they present as 'too difficult' or 'challenging' and they 'do not meet' the expectation of a person who is 'struggling' can leave women reluctant to engage with a service. Many women in CSE may substance misuse in order to cope with traumatic experiences and they have reported situations where all their mental health issues are attributed to the substance misuse, even when they feel they are related to other experiences. A woman in the Scottish Government research expressed the following:

"I don't contact GP anymore especially not for my mental health because he just says that it's drug related and doesn't listen when I say it's not just that."

Lack of flexible and consistent support

Offering flexible services is of particular importance for this population, as women's engagement can vary given their involvement in the 'sex industry' and how this is impacting on their daily life. For instance, women's lives can be chaotic and unpredictable, they may be more active at night when they see clients, meaning they cannot attend appointments during usual working hours; they may have experienced or witness violence, which may require time for them to recover from the previous night or may lead to isolation to cope with what happened. There is also a lack of recognition that the impact of their involvement can be long-term, with assumptions made that when someone exits CSE, the problem is fixed. As Wendy describes in Inside Outside, the impacts can be life-long:

[43] www.clickmagazine.online/click-cast-4-notes.html

"I have to put it all away in a box. Sometimes the lid comes off but then the lid goes back on again. It has to 'cos of the panic and the overwhelming feelings. The box is there, it's very much there and you can only open it bit by bit 'cos if you were to let all of it out, you would be in self-destruct mode. It would be an instant overload of I've done this, these things have happened to me."

Other women have found that, despite engaging with service, what they get out of it is not worth the effort. As one of the participants described it:

"[The service is] unreliable, they say they will do things but don't but if I don't do things then it's the end of the world. They aren't really interested, they just want things done to say that it's done, they're not interested in you or things that have happened. They do one job and you're supposed to be grateful."[44]

Mental health diagnoses

Where therapy and other forms of support are only accessible if there is a formal mental health diagnosis, this can become a massive barrier for women dealing with traumatic experiences. We explore this particular barrier and its implications for both women and the mental health workforce on Section 6 of this response.

Immigration status

For women who have insecure immigration status or No Recourse to Public Funds, the requirement that they would have to pay for any treatment is a major barrier to accessing the support they need. There are limited situations where this is waived, such as when women have been trafficked and agree to be involved in the National Referral Mechanism or have been compulsory admitted due to a mental health condition. However, the hostile immigration environment can lead women to deselect themselves from health care and support and instead choose to manage on their own.

Lack of tailored support

There are currently very limited options in terms of tailored mental health support for women in CSE. Such tailored support would include well-trained professionals with a good understanding of the experiences of women involved, provide support in a non-judgmental way, free of charge and with flexibility so the women can meet at the times and in the way that works for them. Whilst there have been some counselling services piloted for women selling or exchanging sex[45], there are limited organisations that are currently resourced to offer this type of support. We explore some examples of good practice in Section 5 of this response.

Other barriers

The Scottish Government's latest research on the experiences of people involved in selling or exchanging sex and their interaction with services highlighted other barriers: the ongoing waiting lists and waiting times to get support/counselling services as well as lack of women-only services and spaces.

<u>Recommendations</u>

- Services must have clear information available about the support they provide for anyone involved in selling or exchanging sex.
- Staff in mental health services should be encouraged to routinely ask about experiencing of selling and exchanging sex, including around 'survival sex'.
- Work should be undertaken to improve responses to those who have substance misuse and mental health issues through appropriate multi-agency working.

[44] Scottish Government (2022), The experiences of people who sell or exchange sex and their interaction with support services.

[45] In 2020, the Encompass Network piloted a short-term counselling service for women in CSE. This was possible through the Encompass fund created to support women's emergency needs during the pandemic.

- Women should have the option of accessing women-only services with female staff.

5. Accessibility and quality of mental health support and advice

As discussed above, women in CSE face a number of barriers to engage with mental health support and advice. Some of these barriers relate to how accessible and appropriate mental health support is in general and specifically for women in CSE, a question which this section will address.

Accessibility

In Scotland, prior to the pandemic, mental health care was already under severe strain, with staff shortages and funding cuts, which have led to indeterminate waiting times and rejected referrals.[46] The onset of the pandemic and lockdown measures added pressure to already stretched services, with a 44% drop in referrals to psychotherapy, resulting in a backlog of support and longer waiting times for people in need of support – in some areas of the country, the waiting times were as high as 1000 days[47]. The pandemic also saw a move to online and telephone therapy –albeit in many cases temporarily, in others permanently. The result is a continued postcode lottery in terms of the availability and accessibility of mental health support, which can have a huge impact on the mental wellbeing of those who are particularly marginalised, such as women in CSE. As the Scottish Government research has pointed out, "the need for robust mental health support to be available is clear."

In addition, third sector services providing emotional and mental health support have also been faced with funding cuts and lack of recognition of the vital role they play in supporting and maintaining mental wellbeing. Third-sector services often provide first-line support which can prevent the onset of a mental health crisis and can help women build healthier coping mechanisms whilst they decide or wait to receive longer-term support. For women, these may be specialist services which have both an understanding of gender-based violence and CSE, and which offer support in safe, trauma-informed and women-only spaces.

There is also a gap in terms of tailored support[48] for a population which faces a combination of both complex trauma, stigma and exclusion from mainstream services. Such tailored mental health support has been piloted in Scotland (during the pandemic) and in other parts of the UK. These pilots are not also an excellent example of services that need to be replicated across the country, but they also offer learnings that can be used by other non-specialised mental health supports currently available in Scotland.

Quality

Although much can be said about ensuring that Scotland has sufficient and accessible mental health services available, the quality of these services should not be side-lined or underestimated. Ultimately, the appropriateness of services is key to keeping women engaged with the service and for them to gain positive outcomes. After all, women in CSE have described effective services as "life-changing."[49]

Much like the postcode lottery in terms of accessibility of services, the quality of mental health services is not consistent across Scotland. So even where women do manage to access a service, the response they get will determine whether they come back. Having negative experiences can lead them to disengage completely from this and other non-mental health services.

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[46] www.samh.org.uk/about-us/news-and-blogs/samh-says-we-wont-wait-in-the-face-of-a-mental-health-crisis

[47] news.stv.tv/scotland/patients-waiting-more-than-1000-days-for-mental-health-treatment

[48] Macioti et al (2021), *Access to mental health services for people who sell sex in Germany, Italy, Sweden, and UK.*

[49] *Ibid.*

Health professionals have a key role to play in supporting women in CSE and so it is imperative that they are well trained to understand the contextual background to these women's lives. This involves working to address the stigma among workers, understanding the context of CSE, the dynamics involved and approaches that are supportive for women. This is a priority for health staff most likely to encounter women in settings such as GP practices, maternity and reproductive health, mental health, accident and emergency and sexual health. It is also relevant for staff across mainstream services such as substance use, advice and welfare, housing and policing.

The CSE Aware project[50] lead by our organisation has started work to raise awareness of CSE among front-line workers in all sectors through events which foreground the approaches that workers have taken in specialised services. The popularity of those events has shown not only that there is appetite and interest in resourcing in this area, but also how much more serious work needs to be done among statutory services to show leadership and commitment to support women in CSE.

Staff should be proactive in engaging with women in CSE and seek to normalise routinely asking if women are involved, which should be underpinned by robust monitoring and accountability. Equally, staff and systems need to consider the impact that involvement in CSE has on women and their needs from services, as their lives may be chaotic and constantly changing (e.g., phone numbers, place of residence) so require flexibility and frequent contact. The Scottish Government reports that women felt that "leading their own support, and not being bound by particular conditions was important to their continued engagement with the service."

Additionally, it is also clear that it can take time for a person to find the right mental health support and that some approaches might not work. Yet, even in these cases, women should have the option of choice, of finding the worker that fits with her needs. Of course, this means further investment in a mental health system that allows for such choice and specialist services where women can turn to, knowing there is understanding of their context and that it is safe to disclose. However, we are certain that a country like Scotland whose ambition is that "you should only have to ask once to get help fast" will also prioritise the quality of that help so it leads to the intended positive outcomes.

One key consideration when it comes to supporting the mental health of women in CSE, particularly those with complex needs, is ensuring the mental health support works closely with other services. In their report on establishing a clinical psychology service for women selling sex, Stevenson and Petrak mentioned that the "sessions with the psychologist often involved crisis intervention, signposting and 'bridging' to other services, including information about domestic violence support, immigration advice, police contact information, housing and social services and psychiatric support."[51] The need for joint-up multi-support service provision was echoed by a pilot in Scotland (see *Examples of good practice* later in this section), where counsellors ensured any other identified needs during counselling were met, always with the consent and prior knowledge of the women, such as providing food vouchers or contraception if the woman highlighted a need during the session. Any such connection between mental health support and other services must always be done with confidentiality and the woman's safety in mind. This means women's mental health should not be reported and shared among different services where possible, as this can erode women's trust in services and their confidence to open up and seek emotional and mental health support.

Some additional points on accessibility as evidenced in the Scottish Government's recent report on service access and lived experiences of people who sell or exchange sex include

[50] See www.cseaware.org.

[51] Stevenson and Petrak (2007), Setting up a clinical psychology service for commercial sex workers.

locating services close to bus routes; offering outreach; drop-in services; opening times that include evenings/night; translation available quickly; availability of women-only services.

Examples of good practice

In Scotland, the Encompass Network piloted a crisis counselling support for women involved in selling or exchanging sex during the pandemic. Women were offered a maximum of 10 sessions to address immediate mental health needs and were welcome to use the space in any way the wanted, to meet with the counsellor as often as they wished and to attend all or some of the sessions offered to them.

Participants mentioned several elements that made this counselling effective and helpful, including being free of charge, the ability to accommodate the woman's lifestyle, and the way counsellors treated women as 'complete' persons rather than as individuals who sell sex. The women also found counselling a beneficial space to discuss a range of issues and aspects of their lives. Below are two anonymous quotes from women who took part in the pilot:

"I was reluctant to come for counselling, I didn't know what to expect. If I had known it was going to be this good for me, I would have come years ago."

"What has enabled me to continue with my counselling is the fact that I don't have to pay for the sessions."[52]

Elsewhere, other pilots have highlighted the need for a range of interventions depending on the circumstances of a woman. For example, offering online support can make mental health support more accessible as it does not require travel and it allows for anonymity if a woman decides to give a different name and/or keep her camera off. However, those who do not have access to digital devices or with low literacy levels or who do not feel comfortable making video calls may be excluded from such support. Some women may find it easier to meet the person in a confidential space that is located within their vicinity. In their own pilot, Stevenson and Petrak (2007) found that the mental health needs of women involved in street prostitution could be better met through outreach support. Established Edinburgh-based specialist service Another Way is another good example, as it offers emotional support to women involved in street prostitution and in saunas in a range of ways: through phone call, text, outreach, one-to-one sessions with the idea that the service must adjust to the way women wish to receive emotional and practical support. The service that Another Way offers means that women can become familiar with their support worker before deciding to engage in a confidential call or meeting to discuss their lives and issues they may be facing. The Encompass Counselling Pilot also showed it was helpful for the women to meet their counsellor during the outreach as a way to build trust and decide whether they wished to start counselling with her.

Overall, specialist mental health support offered through the Encompass Counselling Pilot and other pilots, as well as feedback from women in CSE has highlighted the following qualities for mental health support: flexibility and the option to remain anonymous; being seen as a 'whole' person with space to discuss any aspect of their lives without the stigma or overfocus on CSE; an understanding of the context of CSE; being judgement-free and consistent in their approach if women disengage at times. Above all, there is a recognition that women might need a variety of interventions to meet their needs. As expressed in Stevenson and Petrak's study conclusion: "the importance of establishing trust to enable women to access mental health services has been vital, as has a nonjudgemental attitude to the work, familiarity with terminology, flexibility of approach and bridging and liaising with other services such as drug and alcohol service providers."

[52] Encompass Counselling Pilot report available on request.

Overall, mental health services are not as accessible as they should be in Scotland. And for women in CSE this can result in poorer mental health or the inability to maintain or achieve better mental wellbeing. Echoing the words of SAMH, we believe it is paramount that mental health provision is upscaled in Scotland and that it upskills staff to better understand the needs and approaches that work for women in CSE. Many services are in place and need to be maintained whilst ensuring that women feel able to access them and get the help they need without fear of stigma and discrimination.

There is also a huge opportunity here to learn from and ensure the existence of specialist mental health services for women in CSE that offer psychotherapy and counselling. In the words of one of the counsellors involved in the Encompass Pilot: counselling and mental health support *"should be everybody's right and readily available certainly where adversity and trauma is involved. We know women who work within this huge industry are subject to this and as such its vital that counselling is in place as a right –to meet them, hear them and help support them with the transition to a safer life."*

Recommendations:

- Upskill all staff in mental health services by providing training on the impact of involvement in selling or exchanging sex and on the impact of trauma.
- Upscale the mental health services available for people in Scotland and for women in particular.
- Provide longer-term funding for existing mental health services.
- Create sustainable specialist mental health support for women in CSE, which women can access free of charge, which is flexible, adjusts to women's circumstances and is provided in women-only spaces.
- Consider the development of proactive intensive outreach support services delivered on a multi-agency basis to help address the multiple support needs women have and to encourage engagement.

6. Mental health diagnoses – implications for staff and service users

As part of our response, we wish to voice our views on the emphasis that this strategy seems to place on the assessment, monitoring and treatment of mental illnesses. We find this problematic for both mental health staff and service users. Many of the practitioners listed in section 15.4, such as those working in educational, employment or justice settings, will not have expertise to fulfil functions such as carrying out mental health assessments, providing treatment and monitoring diagnosed mental illness. These should remain assigned to medical doctors. Moreover, it is evident that putting such functions on workers could complicate their practice. Against the backdrop of already stretched work environment and multiple demands, this is the opposite direction of where we would like to see the Scottish workforce going (see Section 8 of this response).

Furthermore, mental illness diagnoses are contested, and it is important to be cognisant of their political aspects. For instance, James Davies, psychological therapist, draws comparison between medical and psychiatric diagnoses and how the latter fall short of evidence-based standards. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is the official manual for professionals to identify and diagnose people with mental disorders. However, Taylor (2022) echoes the critique and argues that the process of DSM development is conducted using a vote within a select group of psychiatrists, yet represented as an evidence-

based classification.[53] Yet, the DSM has a profound impact on our current understanding of mental health conditions.

The evolution of complex post-traumatic stress disorder (CPTSD) evidences that. It can result if a person experiences prolonged or repeated trauma over months or years. A person with the condition may experience additional symptoms to those that define PTSD, such as emotion regulation difficulties, persistent negative beliefs about oneself, and difficulties in sustaining relationships.[54] Domestic abuse, for instance, can result into CPTSD which some studies suggest can be more prevalent than PTSD.[55] However, whilst acknowledging the existence of PTSD, the current DSM edition does not recognise CPTSD as a separate condition. Meanwhile, it has been included in the most recent *World Health Organisation's International Classification of Diseases Revision*, again showing that diagnoses can be contested.

Having more non-specialist professionals to navigate the complexity of mental diagnoses without the adequate guidance and understanding of the wider context can be hugely problematic and act as a barrier for women experiencing trauma to access support. A recent UK report by Victim Focus (2022) found that female survivors of sexual violence will deliberately accept a mental health diagnosis in order to access support, even if they did not believe they have a disorder. Conversely, women who do not receive a diagnosis made be left out from live saving support.

Ultimately, there should be a wider focus in embedding trauma-informed practice in Scotland. Instead of having more practitioners who can diagnose, assess and monitor, we need more commitment and resources towards trauma-informed care. Even if the remit of the mental health and wellbeing workforce is expanded to include the functions listed in this strategy, it is necessary to incorporate routes of accountability if a wrong assessment or treatment is provided.

7. Solutions to current and future workforce challenges

Whilst we welcome the Scottish Government's efforts to listen to individuals with lived experience and shape policy accordingly, simultaneously, in our view it is essential to better understand the challenges and opportunities that the workforce is presented with and particularly where it relates to supporting women in CSE.

Again, we are calling for this strategy to consider the gendered dimension of the workforce. As described in the Independent Review of Adult Social Care (IRASC)'s report, [56] social care is highly gendered with 83% female workers a situation that is replicated in other sectors like mental health. Burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma are prevalent among those in helping professions – known as the "cost of caring."[57] Therefore, particular attention must be paid to the emotional labour and emotional impact for women in helping professions given the high percentage of women in Scotland who have direct experience of GBV or generational trauma due to the experiences of GBV of other women in their lives. In other words, many women in helping professions will be survivors of abuse as well.

The *Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce* does recognise that the needs of workers exposed directly to traumatic events or to the details of trauma experienced by others should be addressed in the workplace. However, it is essential to consider other factors that can impede practitioners' wellbeing. For

[53] Taylor J (2022), *Sexy but Psycho: How the Patriarchy Uses Women's Trauma Against Them.*
[54] Cloitre M (2020), *Complex post-traumatic stress disorder: simplifying diagnosis in trauma populations.*
[55] Fernandez et al (2021), *Complex PTSD in survivors of intimate partner violence.*
[56] www.gov.scot/publications/independent-review-adult-social-care-scotland/pages/12
[57] Maslach C (2015), *The cost of caring.*

instance, while the *Framework* identifies the primary and obvious reason underpinning potential trauma reactions –exposure to trauma-related content– it does not account for its complexity and compounding factors.

Caseload is one such factor –it has been shown to increase likelihood of vicarious trauma;[58] emotional demands is another one. As Jenner argues, a "manageable caseload can be tipped over into unbearable by just one client presenting with particularly acute or distressing needs."[59] A paper focusing on service providers' experiences of working with criminal justice-involved women and girls in Scotland acknowledged "intensely emotional labour in complex and diverse settings; in work environments that are often trauma saturated." Likewise, a UK-based study[60] examining trauma reactions in police officers working with rape victims suggested that that there was something specifically related to working with rape victims that increased compassion fatigue, secondary traumatic stress, and burnout over time. We therefore need to better understand how practitioners in Scotland relate to their roles and what aspects of their roles might be problematic.

Trauma reactions that workers are subjected to are of insidious nature; their onset is gradual. Hence, it is critical that we attend to risk factors that can contribute to workers' vulnerability. Collectively, this can translate into a culture of silence. It is therefore important to create a shared understanding of vicarious trauma as a "normal' outcome. Organisations need to train teams on vicarious trauma recognition, risk identification and mitigation. This could further be facilitated by standardised vicarious trauma resources, including a diagnostic checklist and self-assessment tools.

Broader external factors can also be an aggravating factor. The COVID-19 pandemic, for example, has presented a number of challenges, such as the shift towards online service provision, financial strain and prevailing anxieties about the virus within the community. The pandemic induced extreme stress, fear, burnout and unaddressed grief which in turn has led to long-lasting problems such as depression and anxiety among the workforce.[61]

Another structural barrier is resources. The Scottish Centre for Crime & Justice Research report listed precarity of jobs and inadequate work environment, including antiquated equipment and inability to access training due to lack of funds. Furthermore, some interviewed workers felt that their salary did not reflect job complexity.[62] Similarly, charity leaders interviewed in 2019 argued that the challenging financial situation facing the voluntary sector is the main contributor to increased levels of stress.[63] And as Engender reports, "the presumption that care is a product of inherently 'female' traits and preferences continues to influence how we think care work should be assigned, and what it is worth."[64] The above calls for adequate and sustainable funding, the gendered nature of care work and consideration of the wider social, political and economic landscape and its effects on the workforce.

<u>Recommendations</u>

- Commission research exploring experiences of service providers who work with traumatised populations to identify workers experiences and needs.
- Produce standardised vicarious trauma resources, including a diagnostic checklist and self-assessment tools concerning burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma.

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[58] Quitangon G (2015), *Vicarious Trauma and Disaster Mental Health.*

[59] www.bacp.co.uk/bacp-journals/therapy-today/2017/november-2017/burnout

[60] Turgoose et al (2017), *Empathy, compassion fatigue, and burnout in police officers working with rape victims.*

[61] See Forbes and Guardian articles.

[62] Burman et al (2018), *Working with women and girls: researching experiences of vicarious traumatisation.*

[63] tfn.scot/news/funding-pressures-fueling-stress-within-voluntary-sector

[64] www.engender.org.uk/content/publications/ENGENDER-RESPONSE-TO-SCOTTISH-GOVERNMENTS-CONSULTATION-ON-A-NATIONAL-CARE-SERVICE-FOR-SCOTLAND.pdf

- Ensure that organisations provide initial and refresher training on vicarious trauma and facilitate the environment where the staff can discuss work-related challenges and their impact.

Further reading

Bailey & Taylor (2022), *"I needed to know that I wasn't crazy": Exploring the experiences of women who sought support for their mental health after rape or abuse*.

Beyond the Streets (2021), *Support needs of women involved in the UK sex industry*.

CLiCK Scotland (2021), CLiCK Cast episode 4: Mental wellbeing (2021): www.clickmagazine.online/click-cast-4-notes.html

Encompass Network (2022), Encompass Focus On… Mental Health.

Encompass Network (2021), Snapshot of services.

Encompass Network (2021), Counselling pilot for women affected by commercial sexual exploitation in Scotland (available on request).

Improvement Service (2021), Understanding the mental health needs of women and girls experiencing gender-based violence.

Rossler et al (2010), *The mental health of female sex workers*.

Scottish Government (2022), The experiences of people who sell or exchange sex and their interaction with support services.

Stevenson and Petrak (2007), Setting up a clinical psychology service for commercial sex workers.

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