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RESEARCH ARTICLE

"I don't think I can help you anymore." Sex workers' experiences of accessing mental health services in Ireland

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Abstract

This paper is based on a study funded by the National Office for Suicide Prevention (NOSP), exploring sex worker mental health through a qualitative study of eighteen sex workers living and working in the Republic of Ireland and with participants from service provider organizations. This paper utilizes and adapts the concept of minority stress to explain how it is the social world that contributes to difficulties in managing mental health, not just for the LGBTQ+ community but explicitly for sex workers, through intersectional stigma and discrimination. Ireland introduced the Criminal Law Amendment Act (2017) based on the Nordic model of client criminalization, which sought to prosecute those that purchase sex while reducing the legal culpability of sex workers. The paper explores how the mental health of sex workers living and working under the law is impacted and the difficulties negotiating access to mental health services once participants disclose their sex work.

Becky Leacy and Patricia Leahy have no institutional affiliation.

KEYWORDS
gender policy, sexuality

1 | INTRODUCTION

The stigmatized nature of sex work has contributed to a range of widely documented negative mental health outcomes for workers (Koken, 2012; Park et al., 2021; Rayson & Alba, 2019). These negative outcomes, including stress, addiction, and suicidal ideation, are increased in countries that enforce a model of criminalization, which can lead to prosecution and imprisonment. In criminalized environments, housing precarity with the associated fear of eviction combined with increased violence negotiating with clients has led to poorer mental health outcomes (Campbell et al., 2020; Macioti et al., 2021; Rayson & Alba, 2019). This study explores sex worker mental health through a qualitative study of 18 sex workers living and working in the Republic of Ireland and with participants from service provider organizations.

Ireland introduced the Criminal Law Amendment Act (2017) based on the Nordic model of client criminalization, which sought to prosecute those that purchase sex while reducing the legal culpability of sex workers (Ward, 2017). The law, however, does retain brothel-keeping measures that prosecute sex workers for working together with one or more workers in Ireland. This paper utilizes and adapts the concept of minority stress (Meyer, 2003) to explain how it is the social world that shapes mental health outcomes, not just for the LGBTQ+ community but explicitly for sex workers, through stigma and discrimination. This stigma against sex workers is manifested through media representation and political discourse and operationalized through legal and health services, thus requiring a structural focus to fully understand this experience. The concept of minority stress allows us to understand stress at different conceptual levels, derived at the policy level and the impact of criminalisation but also anticipated stigma and the impact on the (re)engagement with mental health services.

This article argues that the criminalisation of sex work contributes to structural violence (Krüsi et al., 2016; Shannon et al., 2008; Simic & Rhodes, 2019; Singer et al., 2023) that impedes the ability of sex workers to manage the risk environment in which they live. Furthermore, the impact of criminalisation in increasing stigma and the fear of arrest and eviction, while contributing to the social isolation of sex workers from peer networks, has contributed to negative mental health outcomes. Previous studies have found that environments where sex workers feel compelled to hide their involvement in sex work can increase stress and contribute to negative health outcomes for sex workers (Benoit et al., 2018; Lazarus et al., 2012). Research has focused on the role this associated isolation, stigma, and fear of disclosure by sex workers has on their physical health. This study is the first to explore the impact of the criminalisation of sex work has on sex workers, where the fear of disclosure may potentially lead to similarly poorer mental health outcomes.

This study focused on the role structural inequalities (immigration status, housing, and financial precarity) played in these poor mental health outcomes in contrast with an "individualization" approach present in suicide prevention strategies that view the management of mental health as an act of self-care. The criminalisation of sex workers and associated structural violence that impacts on their access to health and justice is understood through the underlying concept of stigma, which can cause isolation, anxiety, loss of social ties, low self-esteem, and the restriction of freedom (Oliveira, 2012, 2018; Koken, 2012, p. 211; Campbell et al., 2020; Minescu et al., 2022).

2 | BACKGROUND LITERATURE

Any examination of the literature on sex worker mental health must be undertaken with caution. Given the increased politicization of sex work and prostitution policy, research findings suggesting the existence of high levels of trauma, depression, or suicidal ideation, or the lack thereof, have become part of a wider polarized debate. Here the focus of contention is whether sex work is inherently harmful (Farley & Barkan, 1998; O'Connor & Breslin, 2020), or whether structural violence often within a context of criminalisation and stigma continues to fuel conditions that expose sex workers to greater isolation and harm, undermining their mental health (Singer et al., 2023). While direct personal experience of violence has been the focus of much sex work research, the notion of structural violence looks at wider social structures where "unequal power" shapes and reshapes life experiences and within which violence is embedded (Galtung, 1990; Krüsi et al., 2016). While these wider ideological debates are beyond the scope of this article, four key points about the existing literature are relevant. Firstly, given the difficulty in accessing a largely hidden population working in their own homes or hotels, the literature on mental health is disproportionately drawn from street work samples (Krumrei-Mancuso, 2017; Sawicki et al., 2019; Rayson & Alba, 2019; Treloar et al., 2021). This is problematic. While street work is now a declining segment of the sex work market, particularly within a European context (as low as 6% in the United Kingdom according to Bowen et al., 2021), the relative profile and prevalence of such studies that illustrate higher rates of mental illness skew our understanding of sex worker lives where such experiences become synonymous with all sex worker experiences.

Secondly, and by association, existing research has been slow to understand sex worker mental health beyond a lens that sees sex work as exclusively the sole cause of poor mental health that can only be solved through an exit strategy (Treloar et al., 2021, p. 2). This frustration is evident in studies like Macioti et al. (2021), where sex workers document how they struggled to communicate mental health problems that were "largely experienced as separate from sex work." Both policymakers and academic research have increasingly focused on developing and exploring exit strategies for (exclusively female) sex workers to return to mainstream employment, often being the sole lever of governance (Scoular & O'Neill, 2008). While exiting sex work is rarely a single event but rather a sequence of events that are coupled to the complexities of sex workers lives (Cusick et al., 2010; National Advisory Committee on Drugs [NACD], 2009), it has increasingly become a prerequisite for mental health treatment. As for other groups in society, multiple and intersecting forms of stigma and discrimination differentially shape experiences for sex workers based on gender identity, sexuality, race, migrant status, and so forth. Evidence internationally suggests such intersections "deny affected groups resources, opportunities, security, and power necessary for the full enjoyment of human rights. Groups most affected by discrimination and inequality are frequently over-represented in sex work" (Amnesty International, 2016a, p. 5). There has been a move towards this more intersectional understanding of the multiple disadvantaged identities sex workers carry that combine and lead to poorer health outcomes and an inability to embrace exit strategies (Singer et al., 2023).

Thirdly, the research literature has traditionally neglected evidence of resilience in sex workers' lives, ignoring the "strengths and resilience factors such as [sex workers] ability to seek and receive both formal (i.e., medical and legal assistance) and information (i.e., emotional support from family and friends) assistance" (Burnes et al., 2012, p. 138 cited in Treloar et al., 2021). The framework of minority stress (Meyer, 2003) is useful here in understanding

the relationship between social stress like prejudice and discrimination and wider mental health and the capacity for resilience. While originally developed to explore the experiences of the LGBTQ community, its application to the lives of sex workers is compelling. Four processes are identified within the model: (1) chronic and acute incidents of prejudice; (2) the expectation of minority stress or anticipated stigma; (3) the internalization of these negative societal attitudes; and (4) the concealment of sexual orientation. The model identifies maintaining strong peer and community relationships as key to building resilience in the face of minority stress. There is clear evidence that sex workers experience prejudice, stigma, and discrimination, struggle with feelings of self-worth, withdraw from family members and service providers in anticipation of negative experiences, and suffer both an emotional and health cost in the concealment of their work (Benoit et al., 2017). Sex workers frequently cite community support as essential in the management of their mental health (e.g., Restar et al., 2021; Schwartz et al., 2021), as they do in this study.

Finally, sex worker voices have been traditionally colonialized by politicians, journalists, non-governmental organizations, and academic researchers who have refused to grant sex workers agency over their lives (Ryan, 2020). Research has often focused on the experiences of those who have left the sex industry rather than those who currently work under specific legal regimes. It has routinely by-passed any collaboration with sex work activist organizations or taken the personal testimony of current sex workers in favor of interviewing non-governmental agency representatives, police officials, or documentary evidence from online escort sites (see O'Connor & Breslin, 2020). Ireland's National Women's Council's (2023, p. 43) recently published report on Gender Sensitive Mental Health used contributions from organizations serving the needs of a diverse range of women's experiences, including ethnicity, homelessness, religion, menopause, domestic violence, and asylum seekers, but not from the only front-line sex worker organization, Sex Workers Alliance Ireland. Understanding sex worker mental health in this research and policy environment is made more challenging as a result.

There is progress being made in the inclusion of research participants within the planning, design, data collection, data analysis, and dissemination stages of the research process. This is also the case within sex work research, where tokenistic collaboration is being challenged by sex workers who rightfully call for genuine participatory action research (PAR) (Sanders et al., 2022). Researchers have contacted sex working communities without peer involvement (Rössler et al., 2010), while other projects on mental health have often used sex work organizations to access a sample of sex workers and to act in an advisory capacity (Rayson & Alba, 2019; Yuen et al., 2014). Others have sought to bring sex workers more directly into the research as peer researchers (Benoit et al., 2017; Ryan & McGarry, 2021; Singer et al., 2023), although debates persist about whether the use of peer researchers can move beyond the collection of data from "hard-to-reach" communities to meaningful engagement in the analysis and dissemination of data (Lobo et al., 2021).

3 | METHODS

This research project employed a PAR design that was peer-led and community-engaged and sought to address the absence of participatory research practices in contributing to knowledge production about sex workers (Mac & Smith, 2018). The project was acutely aware of the historic exclusion of sex workers from research on their own lives, where sex workers have either been completely excluded by researchers, used as a sample to extract data, or used in a

gatekeeping role to access sex working communities. We pursued a research approach that, according to O'Neill and Laing (2018, p. 173) is "a commitment to doing research that develops partnership responses, shared ownership, and innovative ways of consulting and working with sex workers that lead to actions, interventions, and social change." Similarly, Ledwith (2016, p. 144) describes how a PAR design provides "the foundation for co-creating new knowledge as the basis for action for change," so there is both a "democratizing and emancipatory" function (Connelly & Sanders, 2020).

To embed these values within the project, a research advisory committee was formed for the project, which consisted of an established sex work academic, sex work activists, and health NGO representatives. Peer researchers were also recruited and involved in designing, organizing, undertaking, and analyzing one-to-one in-depth interviews with sex workers about their well-being and mental health in Dublin and Limerick, as well as the key informant interviews with service providers. Peer researchers are described as "members of the target population who are trained to participate as co-researchers" (Roche et al., 2010, p. 4) and have been used increasingly by researchers committed to more inclusive, democratic, and co-produced knowledge of sex working communities. Used in conjunction with PAR, peer researchers hold the potential to redefine who is constituted as an expert, enabling sex workers to become producers of knowledge in their own lives (Connelly & Sanders, 2020; Oliveira, 2019; Singer et al., 2023).

There are recognized limitations too. Peer researchers, often inhabiting an insider role, can reproduce a selection bias in recruiting a sample drawn exclusively from their existing networks (Lobo et al., 2021, p. 1437). Sex worker organizations have been critical of the use of peer researchers where they have had roles limited to recruitment while remaining excluded from the analysis and dissemination stages of the research process (Jeffreys, 2010). Both peer researchers we recruited for this project had prior training and experience working on research projects. A genuine commitment to co-production can also lead to disagreement. In this project, an original commitment to focus group methodology within the research proposal to understand how sex work communities can respond and build resilience together was changed to in-depth interviews on the advice of the peer researchers and the research advisory group. Tensions also arose over the time lag in processing hourly claim forms for peer researchers in the project, reflecting wider institutional barriers within universities that still frustrate the potential for meaningful engagement with marginalized communities (Connelly & Sanders, 2020).

The study conducted semi-structured interviews with sex workers in Dublin and Limerick ($n = 18$). Ten interviewees identified as Irish (including one Traveller Irish), two Romanian, two Mexican, one Nigerian, one Pashtun, one American, and one Italian. Fourteen participants identified as cis women, one as trans, two as gay males, and one as non-binary. The youngest participant was 26 and the oldest was 51, with over half of the participants aged in the 30s. The 18 interviewees represented sex workers (identified by pseudonyms) from a range of sex working environments, including escorting, street work, stripping, and cam work.

The interview questions, developed in tandem with the peer researchers and research advisory group, encouraged participants to speak about their general mental health, their mental health in relation to sex work, their coping strategies, and the resources they drew upon that generated resilience in their lives. Participants were asked what services they used when in a mental health crisis and what their experiences of those services were. Participants were also asked to suggest improvements to the services they had tried to access. We recruited a counseling psychologist to offer two free sessions to participants after the interviews were completed. An alternative offer available for participants was that the project pay for two free sessions with the participant's existing psychologist or counselor. We also paid participants remuneration for

taking part. Three semi-structured interviews were also undertaken with service providers (Women's Health Project, Sex Workers Alliance Ireland, and MPower) who were happy to have their contributions identified in this article. These services were chosen because they had direct contact with sex workers. Ruhama, the largest organization working with women affected by prostitution, declined to be interviewed. Participants were asked to describe their services and reflect on their encounters with sex worker clients and how they supported them with their mental health needs, particularly when in crisis. The analysis included thematic coding of the data according to the overall objectives of the study.

4 | THE STRUCTURAL CONTEXT OF SEX WORKER MENTAL HEALTH

The findings identified that poor sex worker mental health (depression, anxiety, self-harm, suicidal ideation) was made more acute by structural inequalities that disconnected sex workers from access to mental health services. Financial stress was a particular feature of the lives of our participants. This stress is exacerbated by the cost-of-living crisis, where issues of debt, utility bills, and general high cost of living were referred to by 35% of interview participants. This had devastating effects on many participants. Andrew and then Tara below describe the effect of this stress on their lives [Corrections made on XX November 2024, after first online publication, names have been changed to anonymize participants in this version.]:

> At the beginning of this month I was telling my therapist, I was like, 'I want to kill myself', Like I'm constantly thinking about things like ... you know. Because I'm like I don't want to live like this. I don't want to be in this place again where I', constantly worried about my survival.
>
> It's like as if I'm in a ... someone's after burying me alive and I'm just, I'm clawing my way out, but I can't get to the top

Kathryn, from the Women's Health Project, also spoke of debt as a key contributing stress factor for sex workers accessing their service; she goes on to describe situations where women have borrowed money to travel to Ireland for sex work.

> Another one would be like debts or, you know, trying to support a family maybe or other people, you know, that can put huge pressure and stress on women as well ... They've agreed to work in the sex industry for a period of time, you know to fund say their travel or their education, their classes and all of that, and they owe so much, and that they have to go to the end of that. You know, so it's not necessarily a trafficking situation where you know there is an amount owed, you know where the amount goes up and they can't get out. But it's a situation whereby well this is what was agreed and often the terms and conditions do not, you know, aren't what really the person thought they were signing up to, you know?
>
> (Kathryn)

Sex workers in our study are negotiating a complex structural environment when managing and seeking help to support their mental health. They reveal the importance of intersectionality

in understanding sex worker lives where issues like ethnicity and migration, gender identity, and socio-economic position coalesce to impede access to healthcare, even before the impact of the criminalisation and stigma of sex work are considered. While Meyer's (2003) theory of minority stress did acknowledge that multiple intersectional identities like race and ethnicity would compound the experiences of stress, other identities like trans and non-binary are omitted (Hunter et al., 2021). Their inclusion is central to understanding the mental health of the diverse identities of the sex workers in our study.

The findings of our study are an attempt to shift the sole burden of responsibility for good mental health away from the individual to reflect the barriers and structural violence (Macioti et al., 2021), which are prevalent in sex worker lives, mitigating their experiences with their mental health. In the absence of a recognition of this violence, the management of mental health becomes an individual responsibility to engage in "acts of self-care" (Treloar et al., 2021, p. 5). Moreover, the persistence of such ideas of mental health normalizes the notion that such self-care is only achievable through exiting sex work, and so trauma and mental ill health are inevitable for those who continue to engage in sex work (Campbell & O'Neill, 2006; Sanders, 2007).

Mental health professionals treating the participants in this study also suggested a range of online stress reduction strategies available by online celebrities but also simply to exit sex work. We know that sex work is often work that suits those with existing mental or physical health problems, offering flexible employment and better pay when they are often excluded from mainstream labor markets (Macioti et al., 2021; Treloar et al., 2021). This had been the case in this project—when long hours, low pay, and bullying had forced participants out of the formal labor market while they still grappled with the realities of the precarity of sex work in response to police raids and welfare checks and the risk management of potential violence causing financial stress and debt common among sex workers (Singer et al., 2023, p. 6; Yuen et al., 2014; Krumrei-Mancuso, 2017). The findings revealed this to be mentally exhausting for the participants in this study. The constant readjustment to a life where being identified as a sex worker can create multiple unpredictable interventions from law enforcement officials, health professionals, and family members created *perpetual stress*. This has been identified by scholars who have utilized a minority stress framework in the lives of LGBTQ people (Alessi, 2014, p. 49). Housing precarity was identified by several interview participants as a contributor to stress and insomnia. David, and then Jackie describes their experiences:

> The housing issue in August last year also had me without sleeping, because I was, my former landlord sold the place, he gave me plenty of time to find a new place, but I couldn't, I just couldn't. It was getting harder and harder. We were literally not able to sleep, we were taking pills to sleep
>
> (David)

> One of the biggest stressors for me is thinking about the future and I not feeling like I have any tangible future, if I start thinking ahead, I start to panic, it was my housing for a while because that was threatened ... people have nowhere to live, no long-term security, that naturally increases anxiety
>
> (Jackie)

The experience of housing insecurity was twofold. Ireland has been experiencing a crisis in the supply of housing leading to record rental price inflation, particularly in Dublin. The

research participants do not benefit from the levels of rental security that exist throughout the European Union, for example, in Germany, leaving them prone to eviction at short notice. The Criminal Law Amendment Act 2017 also contributed to an increased level of housing precarity when Gardai (police) would conduct "welfare checks" on sex workers, often resulting in eviction.

5 | THE EXPERIENCE OF ACCESSING MENTAL HEALTH SERVICES

The findings revealed that the stigmatized nature of sex work directly contributed to poorer outcomes for the participants when they accessed mental health services. Some interview participants felt that mental health services that viewed sex work as exclusively a form of gender-based violence led some professionals to restrict participants' access to therapy until a commitment to an "exit-strategy" from sex work was identified. Andrew describes their experience with a therapist, which is representative of this finding:

> It very much came across that she [the therapist] was disappointed in me, you know? And then sometimes she would say things about like you know, potentially leaving the industry, or you know like doing something else because I'm so smart blah, blah, blah ... she broke up with me about six months into the pandemic, and her whole thing was like—'I don't think I can help you anymore
>
> (Andrew)

Stephanie had a similar experience with her counselor, who ended their sessions—

> Like I got told by my counsellor in the crisis center that they couldn't keep on seeing me while I kept doing sex work because it wasn't respecting myself
>
> (Stephanie)

This framing of sex work as a form of gender-based violence led participants to report experiences of infantilization by mental health services. Almost half of participants with experiences of addiction regularly felt excluded from mainstream mental health services and those services supporting victims of gender-based violence. Tara describes her experience at a city center hospital and a drug treatment center:

> You feel like you're a lump of bleeding dirt off someone's shoe ... like once they see your file of addiction, like your treated like, I don't know how many times it's been said to me, ah come on, there's real sick people up here like. So, what am I? Do you know what I mean? Like am I not a person?
>
> (Tara)

Participants reported difficulties in getting a GP appointment, even when in crisis. Mary describes:

> Every day is a struggle to just live, like just not want to kill myself ... Even sometimes just trying to phone people to get an answer isn't doable some days ... I was

> in my room, I tried to cut my wrists and I rang my GP. And this day receptionist, I asked her what to do because I didn't know where to present myself because I'm living in a different county ... and she didn't know, she gave me a number and when I rang that number, they said they don't deal with outpatients. So, I could have killed myself that day
>
> (Mary)

GPs displayed an unwillingness to refer participants in crisis to psychological services—often recommending exercise or anxiety treatments by social media influencers instead. Participants regularly described GPs as the gatekeepers of further assessment and treatment to which they were regularly blocked, while others accessed services through their GPs, although they felt the system was slow. This was particularly for those who were suicidal or in crisis, and/or they saw a range of GPs in their medical practice, which led to a lack of holistic care. Other participants felt that GPs wanted to medicate rather than refer patients to other mental health services. Kathryn, from the Women's Health Project, also spoke of the difficulties of presenting mental health issues through GP services.

> The other thing would be I suppose where there's mental health needs that are acute—not suicidal necessarily—but that would need maybe a referral to a community mental health team. And that's through a GP and that can often be problematic because a lot wouldn't have a GP, or accessing a GP can be very challenging and difficult
>
> (Kathryn)

Participants, particularly those with children, distrusted mental health services and did not disclose their sex work due to concern about how the information might be used. Those who could access private medicine vetted their "sex worker friendly" counselors, while others felt if they had trust in the service (housing, addiction, sex work) they were accessing, this would lead to greater trust in the mental health professions they were referred to. Participants believed that considering the failure of mental health services to meet their needs, sex workers should be involved in the training of mental health professionals and that peer resources needed to be developed to serve the needs of the community. Mardi from the Sex Workers Alliance Ireland described the benefits of such an approach:

> Well, there's a level of trust. There's a level of understanding. When you're in a peer-to-peer space or a peer only space there is a freedom that comes with that because you know you're not going to be judged in way that you potentially could be ...
>
> (Mardi)

Our participants, on resisting the message of mental health professionals to accept a sex work exit strategy, found that they were often told their treatment could not continue. Participants struggled to get their mental health professions to see specific mental challenges as separate from their sex work, in common with a European-wide study by Macioti et al. (2021), which also found that 58% of participants had experienced judgmental or stigmatizing encounters. In Australia, sex work research participants reported being turned away from sexual assault counseling services or being told to return when a particular staff member

"comfortable" with sex work was present (AIFS, 2008, cited in Rayson & Alba, 2019, p. 280). Rayson and Alba (2019, p. 283) found that 64.4% of participants said they "had *sometimes, often*, or *always* experienced negative treatment, stigma or discrimination when seeking mental health support. Burnes et al. (2012: 142) set out recommendations to the psychological profession to counter this, advising that therapists should not assume 'the sex worker's occupation is the reason for entering therapy ... should not try to convince clients to change careers ... and not assume that the trauma caused or precipitated their entry into the sex industry." Our article has reported similar findings from participants when attempting to access mainstream gender-based violence services.

Let us return to Meyer's (2003) concept of minority stress here. Our participants encountered acts of acute discrimination when, for example, their therapists refused to continue working with them. This inevitably led to mistrust and an anticipated stigma when deciding to reengage with services and left a lingering legacy, for some that they were not worthy of the same care. Another consequence of these experiences, suggested by Meyer (2003), is the development of alternative resilience strategies—in friends and community. For sex workers, this often manifests itself in sex work activism, firstly, as this research found, in a need to be able to talk openly about the experience of being a sex worker; secondly, in a desire to support one another when experiencing similar mental health challenges; and thirdly, to work collectively to advance societal or policy change. The findings also reflected existing research revealing that sex workers wanted to be both involved in greater awareness training for mental health professionals and to develop peer resources for their community (Macioti et al., 2021; Singer et al., 2023).

Within the Irish context, an exit-based philosophy of sex work pervades most state-funded services, although individual professionals may hold alternative views. Given the diverse markets the participants in this study were working in, an immediate exit from sex work was rarely seen as compatible with their immediate financial needs. More generally, such exit strategies attempt to foster individual responsibility within a wider neo-liberal regulation of intimate life (Hubbard et al., 2008; Scoular & O'Neill, 2008), although they can often fail to meet sex workers holistic needs (Cusick et al., 2010). Moreover, in contexts where exit-based services dominate, there is a threat to the sustainability of harm reduction support for those sex workers who remain in the industry, with provision being seen as promoting the continuation of sex work (Levy & Jakobsson, 2014).

6 | SEX WORKER MENTAL HEALTH IN A CRIMINALIZED ENVIRONMENT

It is important to understand sex work within the different legislative contexts in which it takes place. Platt et al. (2018, p. 4) identified four models that are useful to understand these contexts internationally—full criminalisation (buying and selling both illegal); partial criminalisation (the organization of sex work is prohibited); criminalisation of the purchase of sex; regulatory models (sex work is legalized and licensed); and decriminalization. Our participants identified the criminalized environment in which they worked as having a significant negative impact on their mental health. The 2017 Criminal Law Amendment Act (2017) criminalized the purchase of sex but retained and increased the penalties for brothel keeping (defined as two or more sex workers working together). This criminalized environment impacted the mental health of participants. Stress arising from the fear of eviction following "welfare checks" by the Gardai

(police) to their homes. This finding is related to the concerns over housing precarity and cost, with participants feeling doubly threatened with eviction if a Garda (police) "welfare check" was carried out on their homes. Bernice talks about the experience of the Gardai (police) calling to her apartment—

> They [Gardai] came, they came at the door and there was two men, no, not a woman ... saying we know you are there, open, open the door. Otherwise, we'll take a key, and we'll enter. I asked them if they have to have a warrant? And they say they don't need to ... and I told them, I know you need a warrant, I know the laws here. And they say, we are not here causing you problems. We are here to check if you are okay. You are already causing me problems because I'd be put outside [evicted] tomorrow morning like
>
> (Bernice)

The criminalized environment increased sex work stigma, contributing to isolation and loneliness. Participants felt they were unable to confide in others and were increasingly working alone and being disconnected from peer networks for fear of arrest (under Brothel Keeping laws). Mardi, from Sex Workers Alliance Ireland, explained—

> We absolutely speak to people who express suicidal ideation, and we speak to people who are unable to, I guess, talk to other people openly about the impacts of being a sex worker ... if they're experiencing the stigma and discrimination or they're threatened to be outed or if they've experienced sexual violence or domestic violence
>
> (Mardi)

Again, Meyer (2003, p. 679) offers a useful conceptual framework to understand sex worker experiences of both physical and sexual violence, harassment, and discrimination, locating these experiences as "distal minority stress processes" that include prejudice events like discrimination and violence. Our findings show how this violence and harassment is both state sanctioned through policing and also through the increased exposure of violence by those seeking to take advantage of the legal precarity in which sex workers currently work under criminalisation in Ireland.

In addition to the impact of brothel keeping laws on increasing social isolation and undermining resilience, COVID-19 has been widely identified internationally as compounding an already dangerous mental health situation for sex workers (Kung'u et al., 2023; Singer et al., 2023). There is also a reluctance to report assaults or robberies to the Gardai and access mental health services (particularly for migrant workers who fear deportation). Kathryn, from the Women's Health Project (WHP), recognized that immigration was a barrier in getting sex workers to access their service. She explained:

> Immigration status is definitely an obstacle, like, you know, if you're undocumented or you're less likely to present to services because there's a fear that, well actually is this going to be reported, or, do you know, is this going to be reported to immigration or ... you know, even though there aren't health services, it's not the brief of a health service to do that. But it can be, you know, and our service is completely free and there's no need to have any ID, or permission or status
>
> (Kathryn, WHP)

Participants reported that the criminalized environment contributed to less regular and reliable clients, lower prices, and the increased risk of violence, which required higher levels of risk management in their daily lives and mirrored the experience of working in other jurisdictions (Treloar et al., 2021).

The findings reveal that the specific criminal context under which the participants lived in Ireland created the framework in which they managed risks, navigated police surveillance, and suffered the consequences of stigma and social isolation under the threat of prosecution under brothel keeping legislation. International evidence suggests that regulatory and criminalized sex work frameworks contribute to poorer outcomes for workers, strengthening the power of third parties (policing and immigration authorities) and reducing the ability of workers to manage health and safety risks (Rayson & Alba, 2019). They also diminish the capacity of workers to seek justice and redress (Amnesty International, 2016b; Brooks-Gordon et al., 2020; Levy, 2015; Levy & Jakobsson, 2014). According to the meta-analysis conducted by Beattie et al. (2020) when sex workers report poor mental health in low- and middle-income countries, they are more likely to report being victims of violence, to practice inconsistent condom use, and to be HIV positive compared to sex workers who did not have mental health problems (18 studies with 14,115 female sex workers).

The concept of the risk environment is useful in understanding how the participants experienced this framework in their daily lives and specifically when they sought to manage their mental health. Rhodes et al. (2005) identify key dimensions of environmental influence within the risk environment model—the physical, social, economic, and policy—and how they are experienced at the macro (societal), the meso (community), and the micro (personal interaction). In this study, the criminalisation context at the macro level created a chilling effect that was dispersed through communities at the meso level (where landlords sought to evict sex workers or mental health services sought to align a sex work exit strategy as a condition of treatment) down to the micro level daily interactions sex workers had as they encountered psychologists, clients, and members of the police. These interactions that sex workers experience are influenced by the modes of governance that exist, while internationally we know that this directly impacts their sense of self-efficacy in these encounters (Yuen et al., 2014).

7 | CONCLUSION

This study highlights the unintended consequences of the Criminal Sexual Offences Act (2017) on the mental health of sex workers living and working in Ireland. It builds upon findings across Europe that highlight the difficulty sex workers have in accessing mental health services (Macioti et al., 2021), offering a parallel to problems sex workers encounter when seeking treatment from General Practitioners. The study builds upon Meyer (2003) to expand a conceptual model that can embrace both the diversity of the identities within sex work communities but also the range of violence encountered by them in a criminalized context. The study, using a PAR approach, harnessed the co-production of knowledge in both the research journey and the research outcomes to inform collaborative efforts to address the mental health needs of sex working communities. Specifically, lessons arising point to the importance of collaborative, participatory research for genuine co-produced knowledge on sex work and mental health. Furthermore, such an approach provides critical data to inform policy and practice. Engagement with service providers suggest that strategies are needed to improve access to services, and sex

worker involvement in alerting mental health professionals of their specific community needs while offering greater flexibility to improve access to services.

CONFLICT OF INTEREST STATEMENT

No conflict of interest identified.

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