

Sex workers who provide services to clients with disability  
in New South Wales, Australia

by

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### Candidate's Statement

*This is to certify that to the best of my knowledge, the content of this thesis is my own work.*

*This thesis has not been submitted for any degree or other purposes.*

*I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.*

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This project was approved by the University of Sydney Office of Research Integrity's Human Ethics committee. Ethics reference number: 08-2008/11076

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## Abstract

### SEX WORKERS WHO PROVIDE SERVICES TO CLIENTS WITH DISABILITY IN NEW SOUTH WALES, AUSTRALIA

**Aims:** Sexuality and sexual needs/desires of people with disability have historically been overlooked amongst the general public. Long standing social attitudes and stereotypes have fundamentally dictated that people with disabilities cannot and should not express their sexual agency. In particular, when people with disability have sought to express their sexual needs via the services of a sex worker, this has tended to provoke much social and political ire. This research is an exploratory study about sex workers who provide services to clients with disability. The aim of this research is to identify the nature and extent of such activities to produce empirical data to support anecdotal evidence and recent emerging research in this field.

**Method:** This exploratory online survey asked sex workers who worked in New South Wales (NSW) to share their experiences of providing services to clients with disability. This included the frequency, type and range of services provided, location of service delivery and how clients made contact. Questions were asked regarding third party assistance and the identification of any barriers or challenges faced by sex workers. The survey also encouraged sex workers to share personal reflections on what they thought were the most positive aspects of their work.

Results: The findings, from 65 respondents, indicate that sex workers in NSW have provided a wide range of sexual services to clients with disability across the state. The sex workers' ages ranged from 21 to 61 years, identifying as either female, male or transgender. Services were provided in varied locations including brothels, massage parlours, private homes, hotels, nursing homes, the client's hospital room or their client's group home/ supported accommodation. Their clients' disabilities were quite expansive, spanned both physical and cognitive disabilities and acquired and congenital disabilities. A number of issues and barriers were identified that concerned the client, carers, support staff and / or family and friends of the client. Forty seven sex workers shared their personal perspectives of what they considered the most positive aspects in providing services to clients with disability.

Conclusions: The respondents' narratives revealed their professional enthusiasm with interacting with clients with disability. This includes a desire to have further training and support to alleviate barriers and challenging situations that impede clear communication and supportive pathways between themselves and their clients. These results also contribute to an awareness of how decriminalisation can provide a supportive environment for this to occur. This study builds upon an expanding body of work that can be used to educate and influence the future development of training and awareness workshops for sex workers, disability services provider, clients with a disability, academics, policy makers and the general public.

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## Chapter 1. Introduction

Sex sells everything from cars to ice creams, but the notion of paid sexual services is still unpalatable for some. Sex workers are a much maligned group, generated from perpetual stigmatisation by discriminating stereotypes elicited from the media, moral and religious panic, abolitionists and onscreen depictions. Internationally, prescriptive and adverse sex work legislation can endanger sex workers while hindering opportunities for occupational health and safety rights, labour rights and civil rights for sex workers to be validated. As Weitzer (2015) surmised, sex work:

... is universally seen as a problem rather than an opportunity [and] is viewed as dangerous for the sellers, as attracting perverse customers (deviants and abusers), as disruptive for communities where prostitution is visibly present, and as unmanageable by state authorities (p. 81).

Despite such barriers and oppressive conditions, sex workers continue to provide services to their clients.

The sexual rights of people with disability is a highly contentious issue. Historically, they have been subjected to abject societal beliefs that they are either asexual or hypersexual, leading to abhorrent practices of forced sterilisation, being denied full autonomy over their own bodies and having restrictive policies and procedures developed to obstruct their right to enjoy a full and enriched sex life. Speculating upon the delay for progressive change where people with disability

are universally recognised as sexual human beings, equal to others in society, Shakespeare (2000) stated: "...partly, this is undoubtedly about prioritisation. Ending poverty and social exclusion comes higher up on the list of needs than campaigning for a good fuck and for access to clubs and pubs" (p. 160).

There are a myriad of ways people can enjoy sexual expression and paying for sexual services is but one option. It must be clearly stated that people with disability date, enjoy loving partnerships, are parents or choose to be celibate - equal to others in society. Paying for the services of a sex worker may not be for everyone, but the option of seeing a sex worker should not be denied just because of disability.

The intersection of these two marginalised populations has only recently been formally acknowledged via documentaries such as *Scarlet Road* ("Scarlet Road: A sex worker's journey," 2011) and the formation of organisations like Touching Base (Australia) and TLC-Trust (UK). While both organisations have created referral pathways to sex workers who are happy to provide services to clients with disability, there remains a distinct paucity of data and research pertaining to this activity (Kulick & Rydström, 2015; Liddiard, 2014). This dissertation has therefore developed out of a desire to generate empirical data in which to support incidental findings encapsulated from general sex industry research (Sanders, 2006) and anecdotal evidence gained from the researcher's own lived experience as a sex worker and committee member of Touching Base.

In *Loneliness and its opposite: Sex, disability, and the ethics of engagement*, Kulick and Rydström (2015). commented on how :... most sex workers who are asked do not accept disabled clients ...individuals with visible impairments like Down syndrome or many forms of cerebral palsy, especially if they are in a wheelchair, are turned away” (p. 207). As a sex worker with over 22 years’ experience, working in various components of the sex industry, in numerous countries, this researcher challenges this representation.

Perhaps, within the plethora of surveys, questionnaires and mandatory blood tests forced upon sex workers, researchers have just asked the wrong questions. Potential surveys that are meaningful to sex workers are often overlooked as insignificant or lacking real empirical merit. The funding for academic research is hard sought after at the best of times so it is not surprising that, until very recently, research about sex workers’ clients – especially those with disability – have been displaced by other areas of inquiry such as post-traumatic stress, levels of violence within the workplace and the endless stream of data analysis about blood-borne viruses. As someone with ‘hands –on’ experience of the sex industry (including many clients with disability) with an extensive global network with other sex workers, the researcher definitively knows that their personal experiences are mirrored by many others.

Within the state of New South Wales (NSW), Australian sex workers have predominately operated under a decriminalised regulatory system since 1995. Decriminalisation allows for frank and meaningful dialogue about sex work without fear of persecution or arrest. It also permits sex workers to openly advertise their services, where and when they are available with the ability to add specific details about being ‘disability friendly’. This enabling environment has generated requests from sex workers to learn more about how to best meet the needs of clients with disability, which have been delivered via *Professional Disability Awareness Training* workshops (Touching Base Inc, 2016c).

This research is therefore well placed to examine *NSW sex workers who provide services to clients with disability*, predicated by positive law reform, the establishment of an internationally recognised organisation that supports the rights of sex workers and people with disability, with a researcher who openly identifies as a sex worker.

Throughout this thesis the terms ‘sex work’ and ‘sex worker’ will be primarily used unless quoting others who have utilised terms such as ‘prostitute’ or ‘whore’. This change in linguistics reflects a positive shift in international terminology, indicative of the focus towards recognising sex work in labour, health and safety frameworks and away from the stigma associated with some of the before-mentioned terms (Wotton, 2007).

The definition of sex work used throughout is derived from Weitzer: *the exchange of sexual services, performances, or products for material compensation. It includes activities of direct physical contact between buyers and sellers ... as well as indirect sexual stimulation* (2010c).

The term ‘disability’ is a very broad definition. Disability has been defined here to be in alignment with both the Disability Discrimination Act (Commonwealth of Australia, 1992) and Anti-Discrimination Act (NSW, 1977). It includes both congenital disability (something a person is born with, such as spina bifida or Down syndrome) and acquired disability (an event or illness has occurred in a person’s life resulting in a disability, such as quadriplegia, brain injury or HIV). Mental illness such as bipolar or schizophrenia, are also included in this definition, because it can also disable someone’s psyche and/ or behavioural functioning.

### Aims of the research

The purpose of this research is to provide empirical evidence that sex workers in the state of NSW, Australia provide services to clients with disability. Further to this, the research aimed to identify the nature and extent of such activities and develop a greater understanding of where and how such service delivery is occurring.

Areas of focus include examining the propensity of service delivery, the range of locations where clients and sex workers meet and the diversity of sexual expression paid for by the client. Further

questions concentrate on examining what barriers and difficulties may be faced before, during and after an appointment. An opportunity was also given for respondents to share specific opinions and stories about clients with disability and to reflect upon the value of their interactions from their own perspective.

This study builds upon a slowly expanding body of work that can be used to educate and influence the future development of training and awareness workshops for sex workers, disability services provider, clients with a disability, academics, policy makers and the general public. It is also anticipated that the results of this research will assist in shifting current paradigms and presumptions around sex work by increasing awareness of the heterogeneity of this population as well as individual sex worker skills and knowledge. It also aims to increase recognition of the sexual rights of people with a disability, not only within the state of NSW but elsewhere in Australia and internationally.

All literature reviews aim to encapsulate what information is already available. The narratives of sex worker lived experiences have most frequently emerged from online modalities such as blogs, Twitter and podcasts, rather than from empirical research. These personal stories and reflections play an important role in challenging stereotypical rhetoric that general society predominantly accepts as ‘truth’. For this reason I have included a vast number of references to videos, films, blogs, presentations and media articles as the current academic literature is scarce.



Indeed, this stands true for resources pertaining to disability and sexuality. While *'Don't Talk about Me .. Like I'm Not Here': Disability in Australian National Cinema* (Duncan, Goggin, & Newell, 2005) and Kathleen Ellis' thesis *You look normal to me: The social construction of disability in Australian national cinema in the 1990s* (Ellis, 2004) both explored the representation of disability within Australian cinematography in the 1990s, there is currently an absence of any one central repository which has assembled a whole spectrum of resources created specifically by people with disability and about their sexuality.

A considerable amount of time was spent searching for and collating this collection of informative films, documentaries, photographic exhibitions, blogs and performances referenced in this thesis. Due to this, my aim is to not only present an exploratory research project about sex workers who provide services to clients with disability, but also to create a valuable and useful resource for others interested in these fields of sex work and disability and sexuality.

### Methodology

A snowball sampling methodology was utilised for this exploratory study with participants self-selecting. The source population was recruited through a number of avenues to make it as broadly representative as possible. These included distribution of the research information and online questionnaire via sex worker networks and sexual health clinics while also utilising the researcher's own extensive peer networks. It was also advertised on a number of sex worker e-lists as well as the Touching Base committee e-list.

The peer-reviewed questionnaire was developed by the researcher, drawing from her own personal experiences and knowledge about the diversity of the sex industry as well as other factors of influence involved with organising and providing services to clients with disability. As this was the first exploratory study to examine the topic of sex workers providing services to clients with disability, there was no standardised questionnaire tool available for use.

It was deemed most efficient to use an online survey program. Advantages of this include that the participant could complete it in their own time, with no additional cost to themselves. It also allowed for maximum confidentiality safeguards as each participant remained completely anonymous, as opposed to face-to-face data collection methods.

### Conclusion

This research is not fully representative of either the sex worker population or that of their clients with disability however it has satisfied its aims and objectives, which emphatically support the researcher's claim that sex workers in NSW provide services to clients with disability.

This research is definitively not about advocating for sex workers to be the one and only option for people with disability to enjoy and explore their sexual expression. Instead, it aims to

broaden such discussions to give people autonomy over their sexual rights and increase their access to pertinent information and resources to exercise informed choice.

It is anticipated that this research will add to the growing literature on this sub set of clients and input into progressive changes in attitudes, policy development, training modules and legislative reform. Additionally it can be used to further promote the sexual and human rights of both sex workers and their clients with disability both in Australia and elsewhere around the world.

## Chapter 2: Sexuality

This chapter gives a brief overview of human sexuality, with definitions of sexuality and sexual health that are recognised and used internationally. Some of the areas frequently researched are noted while also providing information about sexual orientation and sexuality scales, most notably the Kinsey Scale and the work by Masters and Johnson. The final segment concerns the sexual health and wellbeing of the population within Australia, specifically looking at the results from the Australian Study of Health and Relationships longitudinal study.

There is possibly no broader and more controversial topic, relevant to every human being, than that of sex and sexuality. Community attitudes have swayed dramatically throughout history and have been dependent upon a range of contributing factors, including religious doctrines (Jule, 2015), cultural norms (Caplan, 2013), legal decrees (Sims, 2015), moral beliefs (Fahs, Dudy, & Stage, 2013), geographical localities (Epps, Valens, & Johnson González, 2005; Gorman-Murray, Pini, & Bryant, 2012) and the advancement in medical science (DeMaria, 2005; Strasburger & The Council on Communications & Media, 2010). Competing interests, values, and the rights of people in regards to race, gender, disability, religion and belief, sexual orientation, age and occupation also have impacted upon peoples' identity and ability to express their sexuality openly.

The sexuality of humans remains a contentious issue, one which has polarised whole communities, stigmatised numerous marginalised groups and still allows for the incarceration of people whose identity and actions fall outside of ‘the norm’ (Phillips, 2009). While access to sexual expression is not included in the original Universal Declaration of Human Rights (1948) (UN General Assembly, 1948), it is increasingly being regarded as a human right.

Detailed theoretical analysis of human sexuality has been extensively examined in academic literature (Barker & Richards, 2013; Gray, 2013; Smith, 2000) with Foucault’s “The History of Sexuality Volume I: An Introduction” being perhaps one of the most well-known (Foucault, 1980). The current working definition of sexuality for the World Health Organisation (WHO) is:

... a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors (World Health Organization, 2006(a)).

Throughout their lifetime, people often experiment with a range of sexual activities. Historical norms have often focussed on sex within marriage (especially within most faiths) and

maintaining fidelity with one person. Casual sex, sex outside of marriage and homosexual activities have often been viewed as devaluing the sanctity of marriage yet the sexual revolution in the 1960s explored the concept that recreational sex is healthy and good for one's wellbeing (Diamond & Huebner, 2012). Supporting this ideology, Satcher (2001) asserted that:

sexuality is an integral part of human life. It carries the awesome potential to create new life. It can foster intimacy and bonding as well as shared pleasure in our relationships. It fulfils a number of personal and social needs, and we value the sexual part of our being for the pleasures and benefits it affords us.... Sexual health is inextricably bound to both physical and mental health. (p. 356)

While this focus amplifies the importance of a person's sexuality in regards to their overall well-being, researchers have often overlooked this aspect when studying mental and physical health over the lifespan. Instead, their central emphasis has often been the focused study of Sexually Transmitted Infections (STIs), sexual assault, abuse, unplanned pregnancies and dysfunction. Weeks (2013) noted that when we think of sexuality, we not only think of aspects such as reproduction, relationships, erotic activities etc., but also of sin, danger, violence and disease.

Indeed the heightened focus on risks and sexual problems has prompted numerous scholars to call for a paradigm shift to incorporate a greater inclusion of the positive aspects of sexuality. For example, Diamond and Huebner (2012) stated:

Our concern is with the default (and implicitly moralistic) presumption that the only health-relevant aspect of sexuality concerns its potential for risk. What if, instead, we took more seriously the potential for regular, positive sexual functioning to confer health benefits? (p. 55)

### Well known research scales for sexuality and sexual orientation

The modern era of sex research was highly influenced by Alfred Kinsey. He established the Kinsey Institute for Research in Sex, Gender and Reproduction at Indiana University in 1947 to advance sexual health and knowledge worldwide. Its current mission statement is “to be the premier research institute on human sexuality and relationships” with a vision to “foster and promote a greater understanding of human sexuality and relationships through impactful research, outreach, education, and historical preservation” (The Kinsey Institute for Research in Sex Gender and Reproduction, 2015). Since the advent of the internet, their website now hosts an expansive “collection of art, artefacts, books, journals, archives, manuscripts, film and videos and other materials” to peruse and reference.

Kinsey published *The Kinsey Report* which is comprised of two books on human sexual behaviour: *Sexual Behavior in the Human Male* (Kinsey, Pomeroy, & Martin, 1948) and *Sexual Behavior in the Human Female* (Kinsey et al., 1953). He also developed The Kinsey Scale which attempts to measure sexual orientation. This scale ranges from 0 to 6 with ‘0’ denoting exclusive attraction to the opposite sex (heterosexual) with no experience with or desire for

sexual activity with their same sex (heterosexuality) and '6' representing being exclusively attracted to the same sex with no experience with or desire for sexual activity with those of the opposite sex (homosexuality). A score between 1-5 were given for those who would identify themselves with varying levels of desire for sexual activity with either sex, including "incidental" or "occasional" desire for sexual activity with the same sex.

In later years an 'X' was also added to the ratings scale to denote asexuality. This scale was the first to assert that sexual orientation can often be a 'sliding-scale' and change over time. It also attested that sexual desires and behaviours should be considered by not only the physical actions of a person, but in conjunction with the psychological aspects of desire, fantasy, and individual sexual attraction.

While both Kinsey and the Institute itself have come under much scrutiny for engaging in the topic of sexuality and openly discussing topics that were deemed highly 'taboo' (Bancroft, 2004), his research into human sexuality controversially allowed people to examine and reflect upon sexual practices in ways previously denounced while challenging conventional beliefs about human sexuality. Moving away from mere theoretical constructs he introduced some (controversial) observational techniques alongside extensive interviews and questionnaires to gain his data. Publications into his findings explored, amongst other things, high rates of masturbation, the enjoyment of oral sex, multiple orgasms in women and differing levels of homosexual activities enjoyed amongst men throughout their lifetime.



Kinsey's work mainly analysed the frequency within the population that certain sexual activities occurred. From 1957 Masters and Johnson began to observe and record sexual activity between humans via observational work set in their laboratories. Approximately 10,000 episodes of sexual activity between 382 women and 312 men were recorded and the findings from this facilitated the development of new methods and techniques for treating a vast range of sexual problems. They opened their first sex therapy clinic in 1964 and operated until 1994. They were renowned for capturing physiological data during sexual activity and their findings framed sex as a healthy, pleasurable and natural activity. They went on to publish two books, *Human Sexual Response* (1986) and *Human Sexual Inadequacy* (1970). Their sexual surrogacy partner therapy, introduced in the later book, was revolutionary at the time and remains a contentious therapy option throughout the world today.

Like Kinsey, Masters and Johnson have since been highly criticised due to their methodologies and what they failed to address in their research (Robinson, 1976). The evaluation of human sexuality has continued though and while the Kinsey Scale was far from an all-inclusive system it did pave the way for a plethora of other sexuality scales to be developed (Eleuteri, 2014; Fisher, 2013). Amongst these were the Klein Sexual Orientation Grid (Klein, Sepekoff, & Wolf, 1985) and the Storms Scale (Storms, 1980) which have further defined sexual expression and expanded definitions of sexual desire and orientation.

Most recently the Purple – Red scale of Attraction (also known as the Purple-Red Scale of Sexuality) has gained attention in international media since being posted on Reddit (2015).

Created by Langdon Parks it states “The Purple Red Scale measures attraction in two dimensions: *\*who\** you're attracted to and *\*how\** you're attracted to them” (Neyman, 2016).

The first dimension remains the same as the Kinsey Scale, but the second is designed to measure *how* attracted you are to someone, ranging from A (Aromantic Asexuality) where friendship is the only level of attractiveness, to F (Hyper Sexuality) where the only interest is sex. This can be seen in Figure 1.

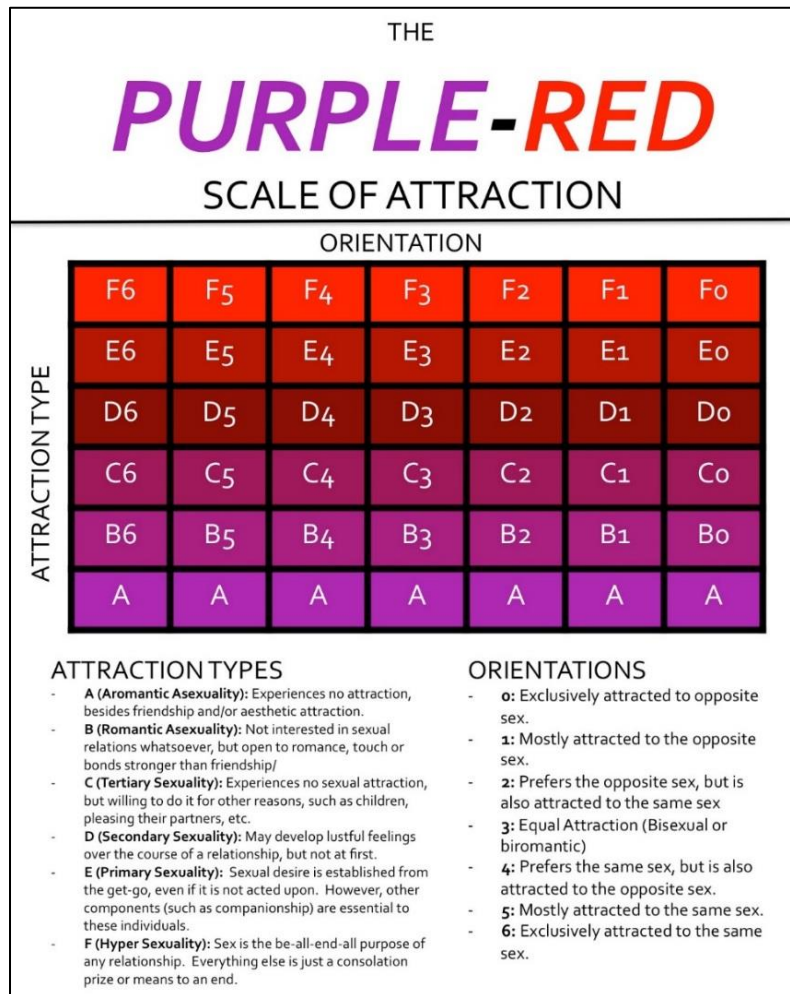


Figure 1. The Purple – Red Scale of Attraction (DiDomizio, 2015)

While there is as yet no evidence for the validity and reliability of this scale, it has potential in allowing further analysis of how we can perceive sexuality in humans.

### Sexuality within Australia

The overall sexual health and wellbeing of Australians has been a focal point of research in the last two decades. The Australian Study of Health and Relationships (ASHR; waves 2003 and 2013) was “the largest and most comprehensive population-based survey of sexuality ever undertaken in Australia and one of the largest in the world” (J. Richters, P. B. Badcock, et al., 2014). This research emulated similar comprehensive studies undertaken in Britain, the US and France (Pitts, Holt, & Mercer, 2014). Generating a dataset to guide future policy and educational programs within the country, it aims to capture and record crucial changes in the sexual health and reproductive health of Australian adults. Preliminary key findings from ASHR2 (de Visser, Badcock, et al., 2014; de Visser, Richters, et al., 2014; Grulich et al., 2014; Pitts et al., 2014; J. Richters, D. Altman, et al., 2014; J. Richters, R. O. de Visser, et al., 2014) include:

- Seventeen per cent of men said they had paid for sex sometime in their life
- Approximately 15% of men and 21% of women had used a sex toy
- Approximately 72% of men and 42% of women had masturbated in the past year
- Experience of oral sex (cunnilingus or fellatio) has become more common
- Men (39%) were more likely than women (19%) to have first intercourse with a casual partner
- There was a general agreement that premarital sex was acceptable (87%)
- There was an overwhelming belief that sex was important for wellbeing (83%)
- Younger people had sex more often, but even those in their 60s had sex about once a week

- There was a greater acceptance of homosexual behaviour than previously
- 85.3% of men and 89.5% of women are in regular heterosexual relationships
- 1.6% of men identified as gay and 0.9% as bisexual while 0.8% of women identified as gay and 1.4% as bisexual, however
- 8.6% of men and 15.1% of women reported either feelings of attraction to the same sex or some sexual experience with the same sex.

This longitudinal study allows for detailed examination of current sexual values and behaviour within the Australian population and critical analysis of trends and shifts within general paradigms relating to sexuality and sexual health. What is missing from this study though is specific information pertaining to the sexual practices and beliefs of people with disability.

## Chapter 3: Sexuality and Disability

This chapter is about the rights of people with disability, with a particular focus on the sexual rights of people with disability. It gives an overview about the level of discrimination and stigma that still prevail, especially examining the disabling environments that have impacted upon peoples' autonomy and self-determination, including systematic barriers and attitudes from support staff, family and friends. An overview of the recent Disability Rights Movement in Australia, with corresponding positive law reform and policy changes, is examined, as is the prevalence in Australia using data from the 2015 Survey of Disability, Ageing and Carers. Current working definitions of disability, used within Australia and this dissertation, are given. Finally, a broad range of recently developed resources, policies, exhibitions, media, films and documentaries pertaining to disability and sexuality are provided.

Historically, the sexual rights of people with disability has been a contentious issue and widely overlooked by society and academia. While the journal *Sexuality and Disability* was established in 1978, a plethora of myths and misconceptions surrounding the sexuality of people with disability is still reflected in society's attitudes and beliefs (Brodwin & Frederick, 2010; Parchomiuk, 2012; Tepper, 2000). They are frequently regarded as asexual (Esmail, Darry, Walter, & Knupp, 2010) or as hyper-sexual (McCabe, 1999; Taylor Gomez, 2012). Both fallacies are shrouded in fear, where the person with disability is categorised as being both socially and sexually vulnerable or someone who is 'out of control', exhibiting deviant behaviour

and needs to be managed and controlled . From this stems a misguided and dangerous assumption that peoples' only sexual experience can occur via sexual abuse and violence or by being the object of affection from 'devotees' - those who are specifically sexually attracted to people with disability. (Fowler-Smith & Olsen, 1998; Shuttleworth, 2007; Solvang, 2007).

Emanating from these misguided beliefs, the rights of people with disability have often been abused or denied, none more so than when examining their sexual rights. The systemic culture of abuse and power within the disability support sector was ignored for centuries, leading to the methodical exploitation and mistreatment of countless people with disability (Calderbank, 2000; Liddiard, 2011). Legally-sanctioned sterilisation, under the guise of protection from unwanted pregnancy (especially via sexual abuse and coercion) have previously stripped people of their sexual rights and bodily integrity while denying them their personal autonomy and self-determination (Block, 2000; Carlson, Taylor, & Wilson, 2000; Meekosha, 2010; Senate Community Affairs Committee Secretariat, 2013). A lack of sex education and even body awareness programs has led to further disempowerment, with this highly stigmatised population being further discriminated against in regards to marital prohibition, sexual segregation and physical and sexual confinement (Jungels & Bender, 2015; Sakellariou, 2006; Taylor Gomez, 2012; Tepper, 2000). These practices and beliefs deny people their own agency and body autonomy, while stripping people of their dignity and basic rights to be treated as a sexual human being. As George Taleporos stated: "disability does not abolish the need and potential for sexual expression" (2001, p. 156).

Until recently, issues of sexuality in relation to people with disability have rarely been discussed in professional health care, rehabilitation or palliative care settings. Through an examination of the literature the reasons for this include ‘opening Pandora’s box’, a lack of understanding around sexual needs, blatant disapproval and disregard for non-heterosexual desires, a fear of embarrassing the person, discomfort from the practitioner, a lack of time, believing it was someone else’s role to start the discussion and not acknowledging that a person with disability would want or need information or support around sexual expression (Dyer & das Nair, 2013; Haboubi & Lincoln, 2003; Hamilton, 2009; Magnan & Norris, 2008; Owens, 2014; Taylor, 2014; Yool, Langdon, & Garner, 2003).

People with disability have also previously identified numerous barriers which have created disabling environments for them in regards to sexual expression. These include a fear of ridicule from service providers and carers, a lack of sex education and resources, isolation, poverty, infantilism, religious beliefs, a lack of clear policies in disability organisations to guide their carers and support staff, disapproval from family and friends and an unwillingness from support staff to assist in transportation, communication or purchasing even basic equipment such as lubricant or sex toys (Magnan & Reynolds, 2006; O’Dea, Shuttleworth, & Wedgwood, 2012; Shuttleworth & Taleporos, 2016; Silverberg & Odette, 2011).



Within the framework of policies and procedures in disability support organisations, the balance between duty of care and dignity of risk needs to be implicitly acknowledged and addressed, with steps taken to alleviate the desire to ‘cotton-wool’ members of this community (Community Living British Columbia, 2011; Jones, 2012; Owens, 2014). Recognition of the important role support workers provide in upholding the sexual rights of people with disability is highlighted in the YouTube interview of New Zealand’s Claire Ryan (2012). Ryan shares over 20 years of experience as a support worker and clearly articulates a number of the before-mentioned barriers and objections, sharing her own down-to-earth perspective on how to support a person with disability in an open and pragmatic way.

### Definitions within Australia

The Australian model of a person-centred approach to disability uses the terms “person with disability ‘or ‘client with disability’ (McLoughlin, Bayati-Bojakhi, Purushothaman, & Sohal, 2014). This is in line with terminology set out by disability organisations such as People with Disability Australia (2010) and these terms will be used in this dissertation. This is different to other international views and indeed other beliefs from within disability groups. For example, Kirsty Liddiard (2011) remarked in *(S) exploring disability: intimacies, sexualities and disabilities* that she uses the terms

... ‘disabled people’ and ‘disabled person’ rather than ‘people first’ terminology such as ‘people with disabilities’ or ‘person with a disability’. This reflects the position that

‘disability’ is a valued (but not sole) part of a person’s identity and that ‘disabled’ comes from a place of pride rather than shame (p. 3).

There is no universal definition of ‘disability’, with an abundance of international, national and state legislations and policies outlining their definition in marginally different terms (Jungels & Bender, 2015). The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2008) defines disability as including “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (p. 5).

The definition of disability in the Australian Disability Discrimination Act 1992 is extremely broad. It includes:

- (a) total or partial loss of the person’s bodily or mental functions; or
- (b) total or partial loss of a part of the body; or
- (c) the presence in the body of organisms causing disease or illness; or
- (d) the presence in the body of organisms capable of causing disease or illness; or
- (e) the malfunction, malformation or disfigurement of a part of the person’s body;
- or
- (f) a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction; or

- (g) a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour;

and includes a disability that:

- (h) presently exists; or
- (i) previously existed but no longer exists; or
- (j) may exist in the future (including because of a genetic predisposition to that disability); or
- (k) is imputed to a person (Australian Government, 2012)

The Australian National Disability Insurance Agency (NDIA) has defined 'disability' as "a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities". This includes:

- loss of sight (not corrected by glasses or contact lenses)
- loss of hearing where communication is restricted, or, an aid to assist with or substitute for hearing is used
- speech difficulties
- shortness of breath or breathing difficulties causing restriction
- chronic or recurrent pain or discomfort causing restriction
- blackouts, fits, or loss of consciousness
- difficulty learning or understanding
- incomplete use of arms or fingers

- difficulty gripping or holding things
- incomplete use of feet or legs
- nervous or emotional condition causing restriction
- restriction in physical activities or in doing physical work
- disfigurement or deformity
- mental illness or condition requiring help or supervision
- long-term effects of head injury, stroke or other brain damage causing restriction
- receiving treatment or medication for any other long-term conditions or ailments and still restricted
- any other long-term conditions resulting in a restriction (National Disability Insurance Scheme, 2016)

Furthermore, the Australian Government Social Services Department has listed on its website a Guide to the List of Recognised Disabilities (2015) which is in two parts. Part 1 is a list of recognised disabilities and Part 2 outlines medical conditions.

Regardless of the type or level of disability a person lives with, the current dominant view is that everyone has the right to fully participate in their community; through work, study and social activities; and actively be involved with decision-making processes that affect their lives and their quality of life (Felce & Perry, 1997). As Tepper (2000) noted, “full inclusion means access to pleasure” (p. 289) though the specific sexual / pleasure needs of people with disability has

been substantially overlooked in the majority of discussions focused on supporting the needs of people with disability.

Internationally, Article 8 of the European Convention on Human Rights (ECHR) states that everyone has “the right to respect for their private life, family life, home and correspondence”. The notion of ‘private life’ has never been absolute but through various case law, the European Court of Human Rights has established that Article 8 can include “sexual and social identity, sexual life and orientation, a healthy environment, self-determination and personal autonomy” (European Human Rights Commission, 2012).

### Prevalence within Australia

The 2015 Survey of Disability, Ageing and Carers (SDAC) was conducted by the Australian Bureau of Statistics, to determine key information about disability prevalence in Australia as well as data about older Australians (those aged 65 years and over). First release key findings include:

- There were 4.3 million Australians with disability (18.3% of the total population), with 1.4 million people with a profound or severe disability (5.8% of the total population). Almost half of the people with a profound or severe disability were aged 65 years and over (654,600 people)

- Of the 15.4 million Australians living in households who were of working age (15 to 64 years), there were over two million people with disability, with a lower proportion of people with disability employed full-time (27.0%) compared to those without disability (53.8%). Australians with disability were more likely to be unemployed compared to those without disability (10.0%) (Australian Bureau of Statistics, 2016)

### Disability rights within Australia

Previous to the 1980s, disability was predominately looked at only within a medical model, focused on addressing specific medical needs and issues with the view that it was ‘something to be dealt with’ privately. The International Year of Disabled Persons (IYDP) was declared by the United Nations in 1981 with Disabled Peoples International holding its first World Assembly in Singapore. This created an avenue for people to reframe their lived experiences within a social context and not strictly as a medical issue. Following on from this time, the Australian disability rights movement began to gain momentum with the creation of the Disability Services Act 1986, allowing for disability rights advocacy programs to be funded.

Since then a number of key developments have occurred in Australia including a move away from institutional type services and accommodation by transitioning people out of institutions, nursing homes and hostels with the aim of re-integrating people into the general community. The

development of mental health legislation and the establishment of ‘public advocates’ and guardianship boards in most states, along with the Disability Services Act 1986 (DSA) and the Disability Discrimination Act 1992 (DDA), have further expanded the rights of people with disability in Australia. These Acts promote equal rights, equal opportunity and equal access for people with disabilities and protects people across Australia from unfair treatment in many areas of public life.

In 2008 the Australian Government adopted and ratified the United Nations’ Convention on the Rights of Persons with Disabilities (UNCRPD), an international human rights convention which determines the fundamental human rights of people with disability (United Nations, 2006). To date, the UNCRPD has now been ratified by 164 countries. Further initiatives in Australia include the *National Disability Strategy 2010- 2020* (2014) and the associated *NSW Implementation Plan 2012-2014* (2012), the Productivity Commission *Disability Care and Support Report* (2011), the *Review of the Disability Standards for Education 2005* (2010), the *NSW Service Framework to Improve the Health Care of People with Intellectual Disability* (2012), changes to the *NSW Disability Services Act* (1993) and the *NSW Health Framework for Women’s Health 2013* (2013). Further supporting the rights of people with disability, Australia has appointed, since 1993, a Disability Discrimination Commissioner which is currently based at the Australian Human Rights Commission.

## Sexual rights and disability

Within Australia, the sexual rights of people with disability are now formally being addressed within an increased number of policies and guiding philosophies. Physical Disabilities Australia states on their website “... like others, people with disabilities are sexual beings and have the right to enjoy sexual relationships and express their sexuality in the same way as other people” (2016). Family Planning NSW (FP NSW) has developed a number of resources and position papers to assist people with disability to gain a greater understanding about sex and advocate for their sexual and legal rights, including *Sex, Safe and Fun* (2014), *All About Sex* (2013a) and *Love & Kisses* (2013b).

Basing its policy on a new Recognition Model of holistic support for the sexual needs of people with disability (Couldrick, Sadlo, & Cross, 2010), the Family and Aged Care Department of the NSW Government (FACS) has recently released their *Supporting Sexuality Practice Guide for Practitioners who Support People with Disability* (2016). These policies add to the social construct of regarding people with disability as full human beings with the same wants and needs as anyone else, giving people permission to talk about sex, to creating meaningful dialog and supportive environments to best meet the needs of this sector of the community with dignity and respect.



The most recent Australian Government initiative is the National Disability Insurance Scheme (NDIS) which began its national rollout in July 2016. The aim of the NDIS is to help people with disability to “access mainstream services and supports, access community services and supports, maintain informal support arrangements and to receive reasonable and necessary funded supports” (National Disability Insurance Scheme, n.d.).

Still in its infancy (localised trials commenced July 2013), the sexual needs of people with disability with regard to the NDIS remains an uncharted grey area. While some organisations remain silent on the matter, it is pleasing to note that others are now well equipped to support the diverse sexual needs of their client base and actively advertise their support. On the west coast of Australia one organisation, the Western Australian Individualised Services (WAIIS), has recently generated a series of simple, easy to download resources, including *Sexuality and Intimacy* specifically designed to assist people with disability to understand their sexual needs and choices when formulating their NDIS goals and life plans (2015).

On the east coast of Australia, *Feel the Vibe* is a sexuality and disability expo which was initiated by a NSW disability service provider, Northcott, in 2014. Hosted at a number of locations, including Sydney, Newcastle and Canberra, it aims to facilitate discussion and break down barriers about sex and sexuality by showcasing a range of individual speakers, educators and distributors of sexual aids / products to a wide variety of people with disability, their carers and parents.

A range of positive and supportive media articles in Australia have begun to challenge misconceptions and taboos concerning sex and disability, addressing such concerns as privacy, barriers to accessing adult services and prejudicial societal attitudes that impeded their sexual expression. These include *Sex and Disability: the facts* (House With No Steps, 2016), *The last taboo: sex and disability* (Cohen, 2016), and *The sex lives of the disabled* (Silver, 2013). A frequently discussed theme is the lack of inclusiveness within the dating scene, both face to face and online dating forum, for those with disability. For a range of people living with disability, including those with an intellectual and /or sensory disability, these dating modalities are not conducive to creating a supportive or fun experience. One Sydney therapist has begun to address this issue by offering workshops around dating etiquette, love, romance and sexuality, creating 'Datable Dances' for her client base. The individual experiences of participants from one of these social dating nights has been captured in a short documentary ("The Dateables," 2015), on National TV ("The Dateables Ball: love found out of singles night for people with disabilities," 2016) and online articles such as *Burwood relationship expert Liz Dore to hold The Date-ables Dance* (Habib, 2013).

### Representation in film, TV and multi-media platforms

The highly sexualised world we are now living in, bolstered by increased levels of advertising via the internet, TV and multimedia platforms has noticeably omitted participation and acceptance of people with disability in regards to a lack of accessible venues and prescriptive 'acceptable' body imagery (Sakellariou, 2006). Additionally, there still remains a void within the

general population's views on regarding this section of the population as sexual human beings, capable of meaningful and fulfilling relationships and sexual desires. The publication of *The Sexual Politics of Disability* (Shakespeare, Davies, & Gillespie-Sells, 1996), drew much needed attention to the area of sexuality and disability. Additionally, *The Ultimate Guide to Sex and Disability* (Kaufman, Silverberg, & Odette, 2007) is regarded as one of the leading books in the field. Ground-breaking in 2001, when first published, it was written from a disability perspective with first person accounts from people sharing personal experiences regarding their sexual expression, communication issues, sexual responses, sexual activities (ranging from masturbation through to BDSM) and desire.

The convergence of new digital and multi-media technologies has had positive implications, allowing cultural shifts in the media and creating a platform for people with disability to showcase themselves as they wish to be seen instead of how mainstream media has previously dictated (Barnes, Mercer, & Shakespeare, 1999; Goggin & Newell, 2003). Disability culture, throughout all areas of the arts, within film and TV, live performances and photographic exhibitions, has increasingly become a strong and resilient voice, challenging preconceived ideas about disability. This is especially true in regards to the area of sexuality and disability, utilising the principle of participation, peer led initiatives and the motto "nothing about us, without us".

*Without Pity: A Film About Abilities* (1996) narrated by Christopher Reeve, was one of the earlier bodies of work to showcase more positive narratives from persons with disability. The Australian film *Dance me to my Song* (1998) is one of the only films where the star and co-writer is a person with disability. Heather Rose is a woman born with cerebral palsy and the film mirrors her life experience.

Since the 1990s, a number of documentaries have recently given people with disability the opportunity to speak about their sexual experiences and to share the barriers and ongoing discrimination they perpetually face. They include:

- *Untold Desires* ("Untold Desires," 1994)
- *Want (also a photo series)* (Erickson, 2007)
- *Disability and Sexuality: Exploring the Intimacy Option* (2008)
- *Otto: Love, Lust and Las Vegas* (BBC3, 2009)
- *SexAbility* (2012)
- *The Undateables*, a UK documentary series about disability and dating (2012b).
- *Sex on Wheels* (also known as *Can have sex, Will have sex*) (2013), and
- *The Last Taboo* (2013)
- *Supporting Sex and Intimacy* (2016)

Online, an 'adult modelling site' called Gimps Gone Wild (<http://gimpsgonewild.com/>) has been challenging society's perceptions for over a decade. Founded by a woman with Osteogenesis

Imperfecta (brittle bones) and 3'4", this website was created as an alternative to mainstream porn / adult online sex shops, enabling adults with disability to be seen as consenting, sexy, autonomous people who choose to sell their personal photos, videos, items of clothing and direct web chats to interested customers.

Artists with disability have also created many on-stage live performances. Matt Fraser (a man born with underdeveloped arms due to Thalidomide), alongside American burlesque star and wife Julie Atlas Muz, created a theatre production in 2014, an adult version of *Beauty and the Beast* (2014). It toured in the USA and moved on to Australia in 2015 for the Adelaide Fringe Festival to wide acclaim (Brantley, 2014; Edwards, 2015). Fraser also curated Cripfest, a new one-day festival showcasing the work of international artists and performers with disability (2015) including one of the newest burlesque performers, Cerebral Pussy, a New York University (NYU) student living with Cerebral Palsy (Graves, 2015).

Comedians Steady Eddy (Australian), and Josh Blue (American) are both men with cerebral palsy using self-deprecating humour and comedy to elicit a deeper understanding of the difficulties living with disability. Most recently, Australian comedian Adam Hills (who was born with only one foot) has hosted *The Last Leg* in the UK on Channel 4 (2012a). Co-hosted by Josh Widdicombe and Alex Brooker, this award-winning British TV talk show began in conjunction with the 2012 Paralympics coverage. In May 2014, Brooker (who was born with congenital disfigurements of his hands and had one leg amputated as a child) went on to front a 2015 media

campaign, 'End The Awkward' which used a series of short comedy films to “shine a light on the awkwardness that many people feel about disability” (Scope Disability, 2015).

The award-winning photographic exhibitions of Belinda Mason (2016) have frequently given a voice to marginalised communities. *Intimate Encounters* (2000) explores the connections between sexuality and disability through 40 candid images, with participants collaborating with Mason to create their own representation of sexuality and desire. Each piece reflects the diversity of experience in regards to sexual identity, beauty, love, marriage and sexual fantasies. It toured to 32 venues throughout Australia from 2000 to 2007 and nine international cities from 2002 to 2014, including New York, Toronto, London, Barcelona and Auckland.

Also by Mason, and premiering at the 2014 Sydney Mardi Gras, *Outing Disability* (2014) examines the lives of lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people with disability and the multilayered levels of discrimination they can face via exclusion from both disability and LGBTIQ communities. Mason combined the photographic portraits of individuals' with their personal stories of coming out, dating, transitioning and being able to express themselves in a world where their sexual identity is often negated and invisible to others. This work was supported by Family Planning NSW who has continued to utilise this body of work as education tool to create community engagement. In addition, five photographs from *Intimate Encounters* have been developed into educational posters across the state of NSW.

Another photographer, Ashley Savage, has been photographing people with disability since 1996, with *Bodies of Difference* showcasing a “part of an ongoing series of work, documenting disability, sexuality and physical ‘otherness’ ” (Savage, 2010).

In 1979 a social dating club for people with disability in the UK was established by Tuppy Owens, psychologist Dr. Patricia Gillan and two UK men with disability, David and Nigel. Called *Outsiders* it has evolved into a “social, peer support and dating club, run by and for socially and physically disabled people” (Owens, 2004). It holds regular social outings, gives referrals and support to a variety of therapists and health care professionals while also advocating for the rights of people with disability to receive good and appropriate sex education and to be seen and “accepted as sexual, loving partners”. Since its inception *Outsiders* has developed the Sexual Respect Tool Kit (2013), the TLC – Trust website (2008) and its own Sex and Disability Helpline. The organisation has also gone on to create the Sexual Health and Disability Alliance (SHADA) (2005) and coordinates the Ask a Sexual Advocate Professional (ASAP) service (2016). One of its main fundraisers is the annual Sexual Freedom Awards which honours “pioneers in sexuality, striptease artists, sexual service providers and their allies” (2014).

While it appears that there is a plethora of films, documentaries, exhibitions and blogs created by people with disability to educate the public and give a voice to those who have previously been overlooked, there is still a lack of substantial roles written for actors with disability in mainstream films and television. Apart from a few recent characters (most notably, Peter

Dinklage playing the role of Tyrion Lannister in Game of Thrones and RJ Mitte in his role as Walter "Flynn" White Jr. in Breaking Bad), characters with disability are often viewed as an anomaly rather than holistically as sexual human beings with sex appeal, the ability to date, get married or being a parent. Notably though, in one interview, RJ Mitte did believe there was a recent positive shift in perception in disability character portrayed in prime time TV shows saying “in the States, when I started, there were five and now there are 11” (Khaleeli, 2015).

### Disability and Ageing

The focus on disability within society, more often than not, is centred upon physical or intellectual disability that people are either born with or acquired via accident or injury whilst they are relatively young. With an aging population, Australia is having to focus its attention on a range of issues. These include accommodating an older workforce due to a rise in the retirement age requirements, a decline in tax paying citizens, infrastructure changes and an increase in medical and accommodation services that best meet the needs of its citizens. The sexual needs of this sector of the population is only beginning to emerge as an issue that should also be addressed, especially with the emergence of a spectrum of other disabilities directly linked to age and the increased lifespan of people.

The 2015 Survey of Disability, Ageing and Carers (SDAC) was conducted by the Australian Bureau of Statistics, to determine key information about disability prevalence in Australia as well as data about older Australians (those aged 65 years and over). First release key findings



pertinent to older Australians found that there were 3.5 million older Australians (15.1% of the total population). Around 1.8 million (50.7% of older Australians) reported living with disability (7.7% of the total population) with 654,600 living with a profound or severe disability (18.5% of older Australians) Australian Bureau of Statistics (2016).

With life expectancies increasing, many countries are having to accommodate an aging population. The impact of aging on sexual functioning has predominantly been examined through a pharmacological lens, with large pharmaceutical companies developing and promoting erectile dysfunction drugs, such as Viagra and Cialis (LaRiviere & Wolff, 2015; Lee, Nazroo, & Pendleton, 2015; Nay, McAuliffe, & Bauer, 2007). Other qualitative research is starting to emerge in the literature about the conjunction between aging and sexual health, well-being and sexual functioning; examining the general population as well as more detailed enquiries concerning people with disability (Behnegar & Marion, 2002; McAuliffe, Bauer, & Nay, 2007; Onder et al., 2003). With this comes new challenges for aged care staff to also adapt to the sexual needs of the people they are supporting.

An increased number of people also depend on residential care, including those with acquired disabilities such as spinal cord injuries and dementia. There are a number of conditions that fall under the category of dementia. Most common are Alzheimer's disease, vascular dementia, Parkinson's disease, Lewy Body Dementia (LBD), Fronto Temporal Lobar Degeneration (FTLD), Huntington's disease, alcohol related dementia (Korsakoff's syndrome) and Creutzfeldt-

Jacob disease (Alzheimer's Australia, n.d.). Issues of consent, privacy and familial expectations and attitudes around sexual expression are having to be acutely addressed (Bauer, Haesler, & Fetherstonhaugh, 2015; Bauer et al., 2014; Tarzia, Fetherstonhaugh, & Bauer, 2012; Villar, Celdrán, Fabà, & Serrat, 2014) with workforce development strategies starting to evolve to deal with these emerging issues. An example of this is a recently released comprehensive, free online educational resource (2013). Authored by Dr Cindy Jones, in collaboration with the Dementia Training Studies Centre its aim is to “increase awareness of intimacy, sexualities and sexual behaviours specific to people with dementia and to guide their carers on how to better support them” (Durack, 2013).

While not everyone in society will live with an enduring disability, what cannot be denied is that everyone is aging. The majority of people have also reveled in the joys of being sexually active beings so the challenges remain as to how people adapt their behaviour, their capacity for intimacy and touch and their environment to accommodate their sexual expression in later life.

The disability rights movement should never be seen as an ‘us versus them’ issue, but rather a continued advancement for the rights and equal access for all members of society. In the end, issues around mobility, accessibility, increased care and support, feeding, privacy, medical interventions and accommodation are similar no matter what one’s level of ability may be. The same is equally true in regards to sexual expression, the desire for intimacy and the touch of another. As William Peace recently wrote in his blog *Bad Cripple* (2016),

...it will happen eventually if you live long enough, you will become one of my people...

The typical body I had is long gone. For others it can happen in the blink of an eye. I urge those without a disability to be narcissistic. Embrace my screed. Don't do it for me. Do it for yourself. Think of it as insurance. Disability is part of life and human evolution.

Regardless of recent policy changes, international charters or specific government-funded positions, the disability sector of the community remains a much maligned and marginalised group. The recent murders of 19 people with disability, with a further 26 injured, in a residential care facility in the town of Sagami-haraiving, Japan largely went unnoticed in the international arena (Findlay, 2016b). The lack of media coverage and international public outrage and the continued use of identifying the victims as faceless statistics (instead of commemorating their lives using their own individual names) has been called out by some in the Australian disability rights movement as a clear example of how society is still treating people with disability as second class citizens. It appears that their deaths have been treated more like a by-line rather than the horrendous act that it was. As Findley noted on her blog, unlike the outpouring of grief, despair and unified solidarity witnessed after recent mass murders in such places as Paris, Istanbul, Kabul, Orlando or Niece, “this time, there is no hashtag. No public outcry. Not even prayers. When I posted about it on Facebook, people have told me they didn't know about it” (Findlay, 2016a).

A unique Facebook profile picture (Figure 2) was created by Australian disability activists to formally recognise such an atrocious act against people with disability.

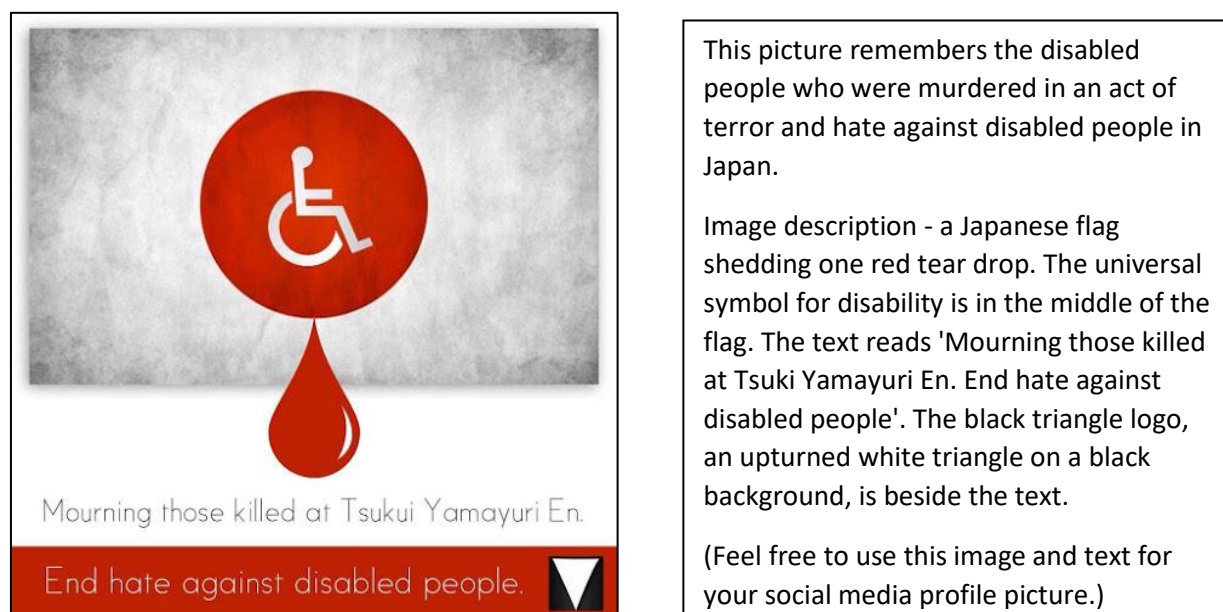


Figure 2. Facebook profile picture and image descriptor

Image and text sourced from:

<http://carlyfindlay.blogspot.com.au/2016/07/the-silence-around-sagamihara.html>

With basic rights, proper accessibility, accurate media portrayal and equal standing as members of society still being addressed on a day to day basis, it is easy to see why the sexuality of people with disability is often overlooked or not acknowledged at all by the mainstream media and society in general. As will be discussed in the next chapter, the disability sector of the community often share the same level of discrimination, stigma and misconceptions as another marginalised group, that being sex workers.

## Chapter 4: Sex Work

This chapter provides a concise overview of the sex industry in regards to linguistics and terminology, provision of services and workplace settings, misconceptions held about sex workers, the modern sex worker rights movement and legislative reforms.

Frequently regarded as the ‘oldest profession’, discussions about the sex industry are often dominated by moral panic and fear instead of an evidence-based approach. While revered in some ancient cultures as temple or sacred prostitutes (Califia, 2002) sex workers are commonly tarnished in a perpetual cloud of stigma, discrimination and perceived deviancy. Judgements are also often extended towards their clients and third parties who assist in the operations of running some businesses (such as brothel owners, receptionists, drivers, security personnel and even cleaners) as well as some academics who choose to research this topic (Hammond & Kingston, 2014).

Negative societal judgement can impede the quality of life, liberties and freedom of movement of all who are identified as being involved in the sex industry. This can be through criminal sanctions, the denial of basic medical and social services, the removal of children through discriminatory custodial hearings, visa requirements banning sex workers from entering countries or the refusal for insurance companies and banking institutions to offer services to sex

workers (Lazarus et al., 2012; Sanders, 2004; Weitzer, 2006). Immediate and extended family members, partners and friends may also share such universal marginalisation.

While quantifying the amount of sex workers in each country has been attempted, discussed, refuted and speculated upon, what is clear is that in nearly every country some form of sex work occurs. Sex workers are a part of the broader community, as are their clients, with no one set of determinants to define them.

As academia continues to shine a spotlight on the sex industry and as the voices of sex workers are increasingly becoming stronger in the media and online, the rights of sex workers and their clients are being openly acknowledged and debated. The positive influence of sex workers as safer sex educators and the roles they may play in regards to alleviating loneliness, being adjunct counsellors, increasing levels of happiness and giving their clients a safe and respectful environment to explore their sexual expression is beginning to emerge (Bates & Berg, 2014; Hartley, 2000; Sanders, 2006). Positive aspects of why sex workers choose this occupation (including autonomy, flexibility of hours and freedom from the rigors of stereotypical job demands) and what, apart from financial gain, they get out of their work (increased negotiation and boundary setting skills, opportunities for travel, job satisfaction and personal happiness) has also added to the ongoing acquisition of knowledge and understanding (Bernstein, 2007; Durocher, 2015; Lucas, 2005).

## Definitions and terminology

While ‘Sex work’ and ‘sex worker’ are now listed in the Oxford English Dictionary and the Merriam Webster Dictionary there is, however, no universal definition of sex work, with a myriad of terms utilised within academia (Allman & Ditmore, 2016). These variations mirror, to differing degrees, the one that Weitzer uses, it being “the exchange of sexual services, performances, or products for material compensation. It includes activities of direct physical contact between buyers and sellers ... as well as indirect sexual stimulation” (Weitzer, 2010c). One research study, analysing the ubiquitous nature of the sex industry, identified at least 25 different types of sex work, separating them into two main categories of ‘direct’ and indirect’ forms (Harcourt & Donovan, 2005). The former included street based sex work, brothel workers and independent sex workers, while the later included ‘sugar daddy’ type arrangements, webcam performers and erotic dancers who provide lap dances.

Terminology used to describe those who participate in the sex industry have varied with time and societal norms. Descriptors within the English language include prostitute, whore, hooker, street walker, escort, harlot, hustler, ho, call girl, callboy, lady boy, courtesan, gigolo and rent boy (Ditmore, 2006; Lauder, 2007). Terms from earlier centuries, rarely used in modern times, include floozy, strumpet and doxie.

The term *sex worker* was coined by sex worker and activist, Carol Leigh (aka Scarlet Harlot) in 1978, with the publication of the book *Sex Work: Writings by women in the sex industry* in 1987

further popularizing the term (Delacoste & Alexander, 1998). Leigh wrote in her essay “Inventing Sex Work”, which appears in the anthology *Whores and Other Feminists*, (Leigh, 1997) “The usage of the term ‘sex work’ marks the beginning of a movement...It acknowledges the work we do rather than defines us by our status” (p. 230).

The term ‘sex worker’ has gained momentum in recent decades and has been utilised by an increased number of academic publications, books, films, Non – Government Organisations (NGOs), government bodies, unions, sex worker organisations and even the media. This terminology shift is a positive one, indicative of the focus towards recognising sex work in labour and health and safety frameworks and away from the stigma associated with some of the before-mentioned terms (Wotton, 2007). A variety of sex workers, through their blogs, have expressed their discontent with the public who continue to use such terms as ‘prostitute’ and ‘whore’ as slurs, insults and as cheap, throw away one liners (Muscat, 2014), blatantly disregarding the profoundly derogatory nature of such linguistics. As outlined by the UNAIDS: “the words we choose and the way we put sentences together to share ideas and information have a profound effect on the way messages are understood and acted upon, or not” (2007 para. 3).

### Workplace locations and advertising

The provision of sexual services can occur in a wide variety of locations and situations including in brothels, massage parlours, private homes, hotels, motels, apartments, strip clubs, safe houses,



in cars, at certain truck stops, online (through web-cam and porn sites), in disability supported accommodation, nursing homes and any other location where the sex worker and the client have negotiated.

While historically sex workers have met their clients in more physically direct mediums, such as congregating in specific ‘red light area’ streets, waiting in a brothel or via discreet word-of-mouth referrals from colleagues and Madams, print media has allowed for more wide reaching options for sex workers to advertise. These have included the telephone box advertising cards in England, adult services sections of newspapers, specific ‘gentleman’s magazines as well as advertisements in the Yellow Pages’ telephone directories in numerous countries. In addition, the internet has enhanced the abilities of sex workers and sex industry establishments to advertise to a far greater market, allowing for individual websites and online advertising directories to be created. The digital revolution enabled the creation of online forums where clients can talk to each other, share sexual experiences and recommendations to individuals and establishments; while also facilitating conversations with sex workers who choose to participate in each forum. Paid virtual sex and voyeuristic Webcam shows have also emerged. Most recently social media platforms such as Facebook, Twitter and Instagram have created an additional vehicle where sex workers and clients can interact prior to initiating a booking (Flowers, 2011).

## Demographics

Sex workers are generally framed as being female with only male clients. Research about female sex workers is dominated by investigations into Sexually Transmitted Infections (STI) and condom use prevalence, surpassed only by documentation of violence levels, drug use and abuse. Issues of low socio - economic standing, literacy levels, diminished job opportunities and childhood trauma also predominately rate at conferences, in journals and vie for funding at national and international levels (McCarthy, Benoit, & Jansson, 2014). By contrast Sanders (2004) has argued that “the concentration on disease and drug use not only blurs the whole picture of prostitution but distorts the emphasis on certain occupational risks while neglecting others” (p. 560).

Emerging dialogue from academia has only recently focused upon positive aspects of sex work from - and about - sex workers. Discussions about choice, empowerment, living standards, other qualifications they may hold and their choice in taking on sex work as a second occupation for extra money have only moderately been empirically examined. The literary world has however allowed for some of these stories to be told (via a number of autobiographies) while a proliferation of articulate websites and blogs have recently emerged to fill the academic void and to create meaningful interchange of ideas and experiences. These include:

- *Bound, Not Gagged* ("Bound, Not Gagged," 2007)
- *This is not an advertisement* (2008),
- *The Honest Courtesan* (2010)

- *Because I'm a Whore* (2011)
- *Tits and Sass* ("Tits and Sass," 2011)
- *Sex Lies Ducttape* (2013)
- *Behind the Red Light District* (2014)

While the predominate focus in research, dialogue, media articles and legislative reforms is about sex workers who are female, the sex industry is made up of people of all genders (Donovan et al., 2012; Jenkins, 2009). It is imperative to clearly acknowledge at every opportunity the invisibility of male, transgender and other gender-orientated sex workers within sex work discourse otherwise it creates an imbalanced and skewed interpretation of the issues, needs and other social and legal determinants sex workers face. For example, laws, Parliamentary Bills, policies, resources, recommendations for support and services for sex workers are so often only written with gender pronouns of “she”, “female”, “woman” and “her” and so fail in their intention to encompass the complete population of sex workers (Bungay, Oliffe, & Atchison, 2015).

The majority of academic research into sex work is generally conducted through a heteronormative lens, with the ongoing assumption that all clients are male and all sex workers are female. In the article *Women are Victims, Men Make Choices: The Invisibility of Men and Boys in the Global Sex Trade*, (Dennis, 2008) this notion is clearly articulated:

... scholars who write about the theoretical, ethical, or legal aspects of sex work literally do not recall that male sex workers exist, or else frame them as a trivial aside, irrelevant to what prostitution or sex work is “really” about. (p. 17)

The most obvious reason this has often occurred is because male sex work is often hard for many to conceptualise as it falls outside the usual paradigms utilised when describing sex work. As noted by Minichiello, Scott, & Callander (2013),

...popular accounts of sex work tend to present prostitution as a product of economic necessity or individual pathology, lending support to a representation of sex workers as passive and disempowered victims exploited and coerced into sex work. (p. 264)

When male sex work is examined the major focus is often to do with HIV transmission rather than the threat of violence or coercion (two of the major themes with research about female sex work) or in regards to sexuality and homosexuality (Kay Hoang, 2013; Minichiello & Scott, 2014; Morrison & Whitehead, 2007).

One of the major differences between female sex workers, male sex worker and transgender sex workers in modern times is that police operations and other enforcement actions are predominantly focussed on the female and transgender street based sex workers and brothels. The invisibility of male sex work, combined with an apparent willingness of authorities to turn a

blind eye, has often created an environment where male sex workers are able to work unimpeded and without police targeting them or their clients. A conspicuous variance to this occurred in the USA in August 2015 with the arrests of the CEO and six employees of a Manhattan-based online male escort service ([www.rentboy.com](http://www.rentboy.com)). It is worth noting that while this website was subsequently closed down, no actual male sex workers were physically targeted or arrested (Associated Press in New York, 2015).

In the same manner that female sex workers are misrepresented and stigmatised, many myths prevail about male sex workers. A recent initiative by Professors Victor Minichiello and John Scott, of the School of Social Justice at Queensland University of Technology, aims to challenge preconceived ideas about male sex workers via the launch of a new website:

[www.aboutmaleescorting.com](http://www.aboutmaleescorting.com). A joint collaboration between researchers, advocates and extensive input from international male sex workers; this site provides a wealth of evidence-based, practical information for male sex workers globally, as well informing health professionals, the media, politicians and families and friends of sex workers (Kermond, 2016).

The majority of research about transgender sex workers tends to encompass the themes of both female and male sex workers, including HIV vulnerability, violence, coercion, as well as economic necessities and societal exclusion (Richter, Chersich, Temmerman, & Luchters, 2013; Weinberg, Shaver, & Williams, 1999). Transphobia, coupled with ongoing contempt from both law enforcement and the general public, has meant that crimes against transgender sex workers

are extremely likely to go unreported and unresolved. This has been found to be especially true for people of colour and indigenous sex workers who are street based sex workers (Chateauvert, 2014). While not without their own struggles it is refreshing to note that in *Travesti: sex, gender, and culture among Brazilian transgendered prostitutes* (Kulick, 1998), overwhelmingly those interviewed regarded sex work as being a positive and affirmative experience.

International academia primarily reports on negative elements of marginalised sex workers, adding to the high levels of stigma experienced. This can have direct impacts on the wellbeing and safety of all sex workers (Lazarus et al., 2012; Pauw & Brener, 2003; Scorgie et al., 2013) . To address some of these issues, especially in regards to street based sex workers, a number of positive initiatives in NSW, Australia have developed between sex workers and the police aimed at increasing levels of trust, communication and respect. The formation of informal Police Sex Worker Liaison Officers (PSWLOs) has been documented to increase the level of safety within the sex worker populations and decrease the level of abuse and derision transgender sex workers encountered from the general community (McMillan & Martin, 2016; Wotton, 2005).

Regardless of the gender a sex work identifies as, it is well established that there are clients who are happy and willing to pay them for services. Regardless of the levels of discrimination occurring in society, within the legal frameworks or from law enforcement itself, the most inclusive and supportive environments are always found within sex worker peer run and led

initiatives which embrace and support the diversity of sex workers within the industry (Krishnamurthy, Hui, Shivkumar, Gowda, & Pushpalatha, 2016).

### Age of sex workers

Average biological age of sex workers is commonly misrepresented, feeding into the stereotypical ideology that a sex worker must be in their late teens /early twenties. This has been proven to be a fallacy, with sex workers ranging from their teens all the way through to their seventies and eighties (Ham & Gerard, 2014). Recently the media has run a number of articles about more mature sex workers, including *'It's just like working in the Post Office!' Pensioner prostitute, 64, reveals why she won't be retiring any time soon (and why younger men adore her)* (Styles & Cliff, 2014) and the blog post *My grandma, the sex worker* (Almeida, 2015). A number of documentaries have explicitly focussed on sex workers who are of typical 'retirement age', including *Meet the Fokkens* (2011) and *My Granny the Escort* (2014).

Some sex workers remain in the industry for their whole working lives, while others enter and exit the industry according to their individual life stages and personal needs. Many choose to work part time while also pursuing other careers, while studying or only when they are not caring for their children (Roberts, Sanders, Myers, & Smith, 2010; Sanders & Hardy, 2015; Sinacore, Jaghori, & Rezazadeh, 2015). The belief that a sex worker is unable or 'unfit' to be a parent has been refuted by numerous sex worker blog posts, media articles and reports (Keep, 2016; NSWP, 2015b). A recent publication (*Mothers, Mothering and Sex Work* 2015) has given

sex workers a substantial voice to explore controversial and unique perspectives to contest conventional ideology by illuminating “the intersectional challenges facing mothers involved in sex work, and their children, extended families and communities” (Khan, 2015).

### Identity and agency

Separate discourses have concentrated on opportunistic sex work or survival sex work (often those who trade sexual services for food, commodities or temporary accommodation and do not identify as being a part of the sex industry), which often include research on younger people (those deemed as ‘minors’) who may have been thrown out of home or run away from violent situations (Lutnick, 2016). This dissertation will not enter into this deliberation, as the variety of reasons why sex workers enter the industry have been examined elsewhere (McCarthy et al., 2014).

The foundation of this research is based on sex workers who have chosen to be a part of the sex industry regardless of age, gender, sexual preferences, ethnicity, educational levels or socio-economic status. Furthermore, this dissertation will also not be examining nor critiquing the rampant anti – sex work analyses that prohibitionists / abolitionists have circulated globally. Weitzer (2005) describes such persons as utilising an “oppression paradigm“ stating:

In no area of the social sciences has ideology contaminated knowledge more pervasively than in writings on the sex industry. Too often in this area, the canons of scientific



inquiry are suspended and research deliberately skewed to serve a particular political agenda. Much of this work has been done by writers who regard the sex industry as a despicable institution and who are active in campaigns to abolish it. (p. 934)

The beliefs held by such people (often referred to as Sex Worker Extreme Radical Feminists: SWERFs) are based on the (false) premise that ‘all sex work is a form of rape’, that sex workers are degrading themselves, that those who say they choose sex work are suffering from a ‘false consciousness’, or that all sex workers are unable to have any agency or control over their lives (Weitzer, 2010b). Laura Agustin’s book *Sex at the Margins: Migration, Labour Markets and the Rescue Industry* has extensively critiqued some of these propositions while examining the relationship between the sex industry, international migration and social justice (2007). Ongoing analysis about new and emerging discussions are also found on her substantial blog: *The Naked Anthropologist* (2008).

This recent global movement has proliferated an exceedingly oppressive paradigm that has been absorbed into the human trafficking movement and reframed as sex slavery / sex trafficking; which is juxtaposed with the discussions prevailing about sex workers, including those who choose to provide services to clients with disability. As Owens (2014) rightly says,

... the terrible stigma surrounding sex work is based on unsound statistics, misconceptions and misinformation promoted widely by anti-sex radical feminist and religious campaigners, then propagated by the media and government. (p. 171)

### The modern Sex Workers' Rights Movement

The symbolic beginning of the modern international sex workers' rights movement occurred on the 2<sup>nd</sup> June 1975 in Lyons, France. Hundreds of local sex workers occupied St Nizier Church and numerous others throughout the country. They were protesting excessive fines, physical abuse, harassment and discrimination from the police who would not investigate the murders of local sex workers. The police took eight days to storm St Nizier Church but not before the sex workers created a global media frenzy, generating international attention towards the rights of sex workers and the disparaging way they were being treated (Mathieu, 2001). *La Revolte des Prostituées*, a French radio documentary about this historic moment, has recently been edited with the voices of the original 1975 strikers and current French sex workers re-voiced by Sydney sex workers, creating *The Sex Workers Revolt* (Aroney, 2016).

This activism ignited further sex worker mobilisation. The first World Whores Congress occurred on 15<sup>th</sup> February, 1985, organised by Margo St-James and Gail Pheterson. Held in Amsterdam, in the Netherlands, some 75 participants (identifying as former /current sex workers or allies) came from Germany, Sweden, the Netherlands, England, France, the United States and

Canada. The International Committee for Prostitutes' Rights (ICPR) emerged from this conference, with the Amsterdam World Charter for Prostitutes' Rights written and adopted on the last day (Pheterson & James, 2005). This Charter outlined a series of rights that are needed to support sex workers' health, safety and equality in society, under such headings as Human Rights, Working Conditions, Health, Services, Taxes, Public Opinion and Organisation.

The second World Whores Congress was held at the European Parliament in Brussels, Belgium on 1 -3<sup>rd</sup> October 1986. It once again brought together sex workers and sex workers' rights activists from around the world, utilising the European Parliament's facilities for simultaneous translation into several languages. This conference increased the scope of sex worker voices, gained increased recognition from the international press and allowed politicians, academics and the general public to hear directly from sex workers to define themselves and what they needed. The proceedings were documented in the book *A Vindication of the Rights of Whores* (Pheterson, 1989) giving further opportunities for sex workers issues to be identified and understood.

Simultaneously sex workers in South East Asia, such as Empower in Thailand (Empower Foundation, 2016); in India, with the formation of the Sonagachi Project (Durbar Mahila Samanwaya Committee, 2016) and throughout Latin America (Enriquez, 2000) were also organizing themselves, with strong resilient sex workers organisations emerging (Jana, Basu, Rotheram-Borus, & Newman, 2004; Nag, 2005). Formal sex worker activism in Kenya, Mali

and South Africa also began in the 1990s, with the last two decades showing a marked increase of sex worker activism throughout all of Africa. Sex worker-led organizations can now be found in most African countries including Cameroon, Botswana, the Dominican Republic of Congo, Ethiopia, Mozambique, Rwanda, Mauritius, Nigeria, and Uganda (Mgbako, 2016).

In the last 20 years globalisation, more economical airfares and the increased capacity to organise and share information via the internet have allowed for an increase in sex worker conferences and more intense networking. This has included the 1997 International Congress on Prostitution (ICOP) in Van Nuys, Los Angeles; the 2005 European Conference on Sex Work, Human Rights, Labour and Migration in Brussels, Belgium (International Committee for the Rights of Sex Workers in Europe, 2007), multiple National Desiree Alliance Conferences in the USA and the 2005 Forum XXX by Montreal sex worker organisation, Stella l'amie de Maimie. There has also been improved representation of sex worker issues at larger international conferences including the International Harm Reduction Conference and the International AIDS Conference.

The modern international sex worker movement has created a number of methods to provide educational opportunities for academics, policy makers, law enforcement and the general public to hear directly from sex workers. There are a number of commemorative days that have

emerged where sex workers, allies and the general public can show solidarity and support for sex workers. These include;

- 3rd March: International Sex Workers' Rights Day
- 2nd June: International Whores' Day (also known as International Sex Workers Day) and
- 17th December - International Day to End Violence against Sex Workers

At most sex worker events red umbrellas are usually the dominant unifying symbol. The red umbrella was first used as a symbol for sex worker solidarity in 2001 at the 49th Venice Biennale of Art where it was utilised to draw attention to bad working conditions and human rights abuses against sex workers. The International Committee on the Rights of Sex Workers in Europe adopted the red umbrella symbol four years later, where it became the emblem for resistance to discrimination. Since that time the red umbrella has become the international icon for sex worker rights, as a symbol of strength but also representing protection from abuse and intolerance faced by sex workers everywhere (Wotton, 2011).

The formation of local, state, federal and international peer-based sex worker organisations and groups, specifically run by current and former sex workers have increased rapidly. The Global Network of Sex Work Projects (NSWP) established in 1990, is recognised as the foremost international sex worker organisation and is “committed to facilitating the voices of sex workers from both the Global North and South” with its membership including organisations and regional

sex work networks from around the world. Its website includes resources, media, listings of sex workers organisations, international policy guidelines and academic research. Established in 1998, *Research for Sex Work* has been published by NSWP since 2004, releasing “a peer-reviewed publication intended for sex workers, activists, health workers, researchers, NGO staff and policy makers” (NSWP, 2004).

Along with a number of books and academic publications, *Research for Sex Work* has extensively published issues pertinent to the global organisation of the sex worker rights movement. These include lived experiences, documentation of successful initiatives, the facilitation of sex worker run and led organisations and the degrees of discrimination and prejudice experienced by sex workers in their workplace, in the community and within legislations (Agustín, 2005; Allman & Ditmore, 2016; Ditmore, 2006; Kempadoo & Doezema, 1998; Pheterson, 1989; Weitzer, 2013).

## Legislation

A number of legislative codes and laws currently regulate the sex industry around the world. Depending on the country or jurisdiction, sex work can be decriminalised, legalised, criminalised or have a mixture of legal frameworks depending on location, type of sex work and land use zonings with varying degrees of enforcement (NSWP, 2014a). Additionally, the *Swedish Model* is a form of criminalisation introduced in 1999 by Sweden which criminalises clients directly,

and targets sex workers, and their rights, indirectly. All legislative frameworks except decriminalisation have been documented to be detrimental to sex workers' health, safety, civil, industrial and human rights (Fawkes, 2014; Harcourt et al., 2010; Mac, 2016; *Sex workers speak. Who listens?*, 2016; Stardust, 2014; Sullivan, 2010).

Sex workers and their organisations have released reports and guidance papers outlining legislative reforms which would best support sex workers, including the Network of Sex Work Projects (NSWP, 2014a) and Scarlet Alliance – the Australian Sex worker Association (Scarlet Alliance, 2014). The complex frameworks of laws, regulations, policies and enforcement practices can also be examined via the Sex Work Law Map (Sexuality Poverty and Law Programme, 2015). Whilst focussed primarily on female sex work it highlights the disparity between legal frameworks around the world.

In regards to the sex industry, *criminalisation* is when a range of activities are deemed illegal. Specific laws are written outlining all offences that the police can charge someone with. The United States is an example of where this continues to be largely the case (Weitzer, 2010a).

*Legalisation* is where a specific set of laws are written to define which particular activities are now permissible or prohibited. It is worth noting that 'cherry-picked' activities may then become legal, but often involve special registration or licencing requirements for sex workers and operators, which in turn reduces the options of lawful working environments available to sex

workers. Examples of this include Germany, Holland, Austria and the state of Victoria, Australia. Onerous and discriminatory legislation and unreasonable over-regulation creates a two-tiered sex industry, to which only a small percentage of the sex industry can comply. The majority are unable to and are forced to operate outside of the legal framework and protection of the police, where they risk arrest, standover tactics, blackmail and a criminal record.

Prescriptive legalisation limits sex workers' choices over their working environment, type of services they can legally offer and the location of where they feel most comfortable providing such services. Legislation enabling *legalisation* of sex work is generally drafted and passed without full and comprehensive consultation of the existing sex industry, or with wilful dismissal of such consultation. This denies the true scope and variance of the sex industry the ability to be able to operate in a fair and equitable manner comparable to that of other occupations (Daniel, 2010; Donovan, Harcourt, Egger, Schneider, et al., 2010; Harcourt et al., 2010; Wotton, 2006).

The *Swedish Model* refers to the Swedish Government's current laws regulating 'prostitution'. From January 1st, 1999, it became illegal to buy, or try to buy, sexual services in Sweden. The official government position in Sweden is that the purchase of sex constitutes violence by men against women, also arguing that "sex work is inevitably and unchangeably associated with violence, abuse, and exploitation" (NSWP, 2014b) and that no form of sex work could ever been deemed of a voluntary nature.



Swedish law criminalizes the client who purchases sexual services, but not the sex worker. While providing sexual services is legal, unequivocally everything related to the sex worker's business activities has become illegal. This places the sex worker in a complete social and economic void, punishing them for working in an occupation that, while deemed 'legal', has categorized them as a 'helpless victim' instead of self-determining agents. As Swedish sex worker and activist, Pye Jacobsson commented in the interview "We want to save you. And if you don't appreciate it, we will punish you!" (2009):

Now it actually says, in the context of the law, it says that no prostitution is prostitution out of free will. It means that everybody is a victim. If you scream and shout that you're not a victim you are suffering from a false consciousness. And if you try to convince them that you're not even suffering from a false consciousness, they will say: "Well you're not representative"

The laws specifically focus on two main components; outlawing third party management (being charged with 'pimping ' or 'living off the earnings' of a sex worker) and criminalising anyone who assists in the commission of a crime. Therefore, these laws can be used against landlords, hotel management, newspapers and online websites based in Sweden who publish advertisements, flatmates, partners and children of sex workers and anyone who may drive a sex worker to their place of work.

The Swedish Model has been critiqued by numerous scholars, government agencies and organisations (Kulick & Rydström, 2015; Levy & Jakobsson, 2014; Wallace, 2010), but none more so than Swedish sex workers themselves (Lund, 2007). The 2015 release of the *Advocacy Toolkit: The Real Impact of the Swedish Model on Sex Workers* is a collection of eight evidence-based fact sheets “to be used to challenge the widespread promotion of this detrimental legal and political approach to the regulation of sex work” (NSWP, 2015a). Additionally, the Swedish sex worker organisation, Rose Alliance have just released their report *Then again, they are not totally stupid either* (Rose Alliance, 2016), basing the title on a disparaging comment included within a Swedish governmental report describing sex workers.

Regardless of such dismissal of human rights, autonomy or documented best practice health and safety objectives, alarmingly a number of other countries have adopted similar versions of the Swedish Model, that currently being Norway (2009), Iceland (2009), Northern Ireland (2015), Canada (2015) and France (2016). While debates about introducing this regulatory model continue in other countries and regions, sex workers remain hopeful that recent discussions in Norway to repeal such laws will eventuate in the near future (Sputnik News, 2016).

### Decriminalisation

In 1995, the Australian state of New South Wales (NSW) was the first jurisdiction in the world to introduce a form of decriminalisation, with New Zealand in 2003 becoming the first, and only entire country to do so, to date.

There is considerable research supporting decriminalisation as being the only effective, equitable and rationale regulatory model to support the health and safety of sex workers, their clients and therefore the general population (Abel, 2014; Abel, Fitzgerald, Healy, & Taylor, 2010; Donovan et al., 2012; Harcourt et al., 2010; Jeffreys, Green, & Vega, 2011).

*Decriminalisation* is the removal of all criminal laws pertaining to the sex industry, allowing it to be regulated with the same laws, guidelines and principles that other occupations already abide by. This includes taxation, Occupational Health and Safety (OH&S) regulations, planning, building and fire codes, employment laws and fair trading. Most importantly, the removal of the police as regulators allows for sex workers to seek legal recourse without fear of persecution, arrest or abuse, equally to that of any other citizen (Armstrong, 2014; Wotton, 2006).

The framework of decriminalisation is evidence-based and is widely supported by the World Health Organisation (WHO), The Joint United Nations Programme on HIV/AIDS (UNAIDS), Human Rights Watch, Open Society Foundations, the Global Network of People Living with HIV, the Global Forum on MSM and HIV, the Global Alliance Against Traffic in Women (GAATW), the Global Fund for Women, the Association for Women in Development, the American Jewish World Service, the Global Commission on HIV and the Law, United Nations Population Fund (UNFPA), United Nations Development Programme (UNDP), the World Bank,

the International Women's Health Coalition, the Elton John Foundation, the International Community of Women Living with HIV, the Lancet and most recently Amnesty International (NSWP, 2016).

The rhetoric from those who oppose decriminalisation as the favoured regulatory model include the opinion that it will 'entice' more people to work as sex workers, however researchers have found this to be an unfounded accusation, with no increase in the size of either the NSW or New Zealand sex industry since decriminalisation (Abel, Fitzgerald, & Brunton, 2009; Donovan, Harcourt, Egger, & Fairley, 2010). Additionally, findings from the most recent research in Australia has found that decriminalisation of sex work has not resulted in an increase of male clients (Rissel et al., 2016).

Regardless of restrictive and punitive legislative frameworks, abject media portrayals, discriminatory societal beliefs and the stigmatising false construct that all sex workers are victims and need rescuing; sex workers and their clients around the world continue to interact and enjoy mutually beneficial arrangements that transpire from participating in the sex industry. For all that sex workers endure as a much maligned and discriminated group, the same can be said for their clientele. This will be discussed in detail in the next chapter.

## Chapter 5: Clients of sex workers

This chapter provides a detailed overview about clients of sex workers, including those with disability. It discusses emerging research, notions of deviancy, punitive law reform criminalising clients and general demographics derived from specific surveys. Motivations and prevalence are examined as well as deliberations about older clients and female clients. This chapter also addresses issues relevant specifically to clients with disability, including Government subsidies, sexual surrogacy, facilitated sexual assistants, resources developed and specific organisations created to deliver services and support.

### Clients in general

While numerous aspects of the sex industry have been analysed at length, clients accessing the services of sex workers have been the least researched component. An extensive literature search identified comparatively limited data about sex industry clients in comparison to sex workers and even less about the subset of clients who present with a disability.

Historically, research and subsequent literature about clients, also referred to as “Johns”, “tricks”, “customers”, “patrons”, “punters”, “hobbyists” or “kerb crawlers”, have predominantly focused on perceived and quantifiable violence levels, high risk sexual behaviours and HIV and other STI susceptibility levels (Carael, Slaymaker, Lyerla, & Sarkar, 2006; Regushevskaya & Tuormaa, 2014). Conjectures about who clients are and what they seek from sex workers have

generally been framed in the negative, based on moralistic and religious beliefs assuming that clients are violent, disrespectful and antisocial men who are perverse, deviant and predators of vulnerable women (Birch, 2015; Kinnell, 2006a, 2006b; Prieur & Taksdal, 1993). This analysis is exacerbated by the over reliance of exceedingly skewed data samples primarily taken from arrest rates of clients from targeted police operations in street-based sex working areas (Brewer, Potterat, & Woodhouse, 2007; Hanson, 2016), reports focussed on the deterrent effect of interventions such as police arrest and “Johns Schools”(Alter, 2015a, 2015b; Roe-Sepowitz, 2013) as well as continuous media coverage agitating for heightened law and order proposals while sensationalising the deaths and murders of sex workers (Buchan, 2016; Prosser, 2016; P. Sims, 2016).

Disparaging appraisals have contributed to the extremely prejudicial attitudes of anti-sex work lobbyists who publically condemn and deny evidence-based legislative reform. The Swedish Model (also known as an “end demand” model) is based on the misguided belief that all clients are intrinsically abusive and all interactions with sex workers are a form of rape. With this type of harsh rhetoric spilling into the media, law reform debate, public policy and discussions, it is hardly surprising that, for the majority, clients choose to remain anonymous to avoid the stigma associated with such atypical stereotyping.

While Perkins (1999) indicated that prior to her own research, less than 1% of the research about the sex industry had a client focus the literature, this has definitively grown in the last two

decade (Weitzer, 2009). While in-depth face to face interviews and phone interviews have continued to be utilised, some researchers have worked directly with sex workers and outreach workers to collect data from and about their clients (Jordan, 1997; Kinnell, 2006a; Sanders, 2006). With the development of the internet and a shift towards digital interactions and communication methods, the ability to provide anonymous online surveys has broadened the scope to engage directly with this hidden population. Emerging research is beginning to capture first person experiences to understand the complex nature of the clandestine behaviour of clients, why they choose to see sex workers and how they perceive their emotional and physical needs are being met (Caldwell, 2011; Earle & Sharpe, 2008; S. Earle & Sharp, 2007; Holt & Blevins, 2007; Milrod & Weitzer, 2012; Sanders, 2008).

## Motivation

Combining empirical research with first-hand accounts from sex workers, a broad range of reasons have been identified as to client motivation to purchase sexual services. Dr Carol Queen, a writer, activist and sex worker summarised the impetus of such behaviour to include convenience, creating firm boundaries between private life and paid sexual encounters, partner and sexual variety, sexual growth and experimentation, personal comfort and healing and exploring their masculinity (Queen, 2000). Additional analysis by Atchison, Fraser & Lowman (1998) supported such motivations, adding a number of additional criteria such as physical unattractiveness, social unattractiveness/ psychological maladjustment, avoidance of gender role responsibilities and regaining a sense of power by purchasing sexual services.

A 2009 review of 220 internationally published research papers about clients of sex workers (of which 181 met the inclusion criteria) suggested seven specific motivations for paying for sex:

- Desiring sexual variety;
- Dissatisfaction with existing relationships;
- Sexual gratification;
- Loneliness, shyness or incapacities (mental and physical);
- Having no other sexual outlet;
- Being separated from a partner by travel; and
- Curiosity, risk or excitement; to exercise control (Wilcox, Christmann, Rogerson, & Birch, 2009).

Sanders (2008) encapsulated these factors into what she deemed “push” and “pull” factors. *Push* factors include elements in the clients’ lives that are lacking (lack of emotional or physical affection from their partner, disenfranchisement with the dating scene, lack of time or inclination to form meaningful long term relationships, boredom and loneliness) while *pull* factors encompass positive elements of the sex industry that are on offer (a safe, respectful environment to explore new and exciting sexual activities without fear of rejection or ridicule, an endless selection of attractive people to have ‘no strings attached’ sex with, as well as the thrill of engaging in an activity that holds a ‘taboo’ element of excitement and naughtiness to it).



In NSW, Australia, where the sex industry is decriminalised, researchers have recently confirmed that the same motivational factors contribute to client behaviour, amplifying the theory that client behaviour is not swayed by legislative reforms utilised in different parts of society (Birch & Ireland, 2015).

### Prevalence

The literature on frequency of encounters and the number of clients has certainly expanded but it is still difficult to establish up-to-date, reliable data due to difficulties accessing such a stigmatised and hidden population. Disparities can also occur due to limited access in the recruitment process, issues with memory bias, underreporting, fear of exposure, shame, not identifying that they have paid a sex worker (clients who pay for “rub and tug” services which include masturbation but not intercourse may not always identify this as a form of “prostitution”), diversity of methodology in regards to data collection (phone call, in person, paper or online survey, third party feedback) and geographical and locational differences (Soothill & Sanders, 2005).

Additionally, one needs to question the aims and objectives of each study as well as contextualising cultural norms and differences. For example, one international study called *Is trafficking in human beings demand driven?: a multi-country pilot study* (Anderson & O'Connell Davidson, 2003) showed that 37% (36 respondents) of Japanese men and 73% (65 respondents) of Thai men reported that they had paid for sex with such actions often tied to normal socially

accepted masculine behaviour and rites of passage. In the same study only eight out of 84 Swedish survey respondents acknowledged ever paying for sex. In Sweden the polarizing debates about sex work and trafficking has created a dominant social pressure emphasising a concept that ‘to be a man’ one does not buy sexual services. Indeed, the researchers noted in their introduction that *because of difficulties in recruiting Swedish men for interviews, we interviewed Danish men instead* (p.6).

The Swedish law has been framed and ‘sold’ to the public as a response to violence against women so the notion of admitting to being a client is paramount to admitting that you have raped and assaulted a woman. Remarkably, it was also noted that three out of the 19 Swedish soldiers stationed in Kosovo for peace-keeping operations admitted to paying for sex, suggesting that the willingness to participate in such surveys and the level of honesty in answering such personal questions may be reliant on the perceived context of the research, the methodology used, cultural identity and the geographical location of participants.

Regardless of the difficulties in capturing accurate and meaningful data about clients, numerous research projects have emerged. One of the most ambitious research surveys of men who have paid for sex was done by Carael, Slaymaker, Lyster & Sarkar (2006). Using data from national household surveys, from Behavioural Surveillance Surveys and research studies they estimated that in the past 20 years between 1% and 14% of men in different regions have purchased sex

from a female sex worker in the course of a year. Results from 87 surveys were used including 78 national and nine city based samples from 54 countries.

A study in Glasgow, of 2665 men attending a medicine and reproductive health service found that 10% (267) of participants reported paying for sex, with 66% of them having done so in the previous year (Groom & Nandwani, 2006). Another survey, comparing data gleaned from the UK National probability sample surveys of sexual attitudes and lifestyles (NATSAL) in 1990 and 2000, found the proportion of men who reported paying women for sex in the previous 5 years increased from 2.0% to 4.2%. The population sample only utilised men aged 16–44 who were residents of Britain in 1990 (n=6000) and 2000 (n=4762) however the 2000 NATSAL data analysis of the general population showed an 8.8% propensity for men ever paying for sex (Ward et al., 2005).

Generally in all population surveys asking about paid sex, the proportion of men who have done so throughout their lives will be substantially higher than those who have done so in the last year. Bajos *et al* found this to be true from data collected from men in Norway, Switzerland, the Netherlands and Spain, with Spanish men having the highest rate of all European clients with 38% reporting some contact with sex workers throughout their lifetime and 10% during the last 12 months (Bajos, Hubert, & Sandfort, 2014). The Second Australian Study of Health and Relationships survey also suggested 17% of people had been a client, with 2% paying for sex in the last year (Richters et al., 2014).

Sanders (2008) interviewed 50 men who self-identified as clients which elicited a range of interesting information not only about their general client preferences and actions but allowed her to develop a typology of the mens' involvement with the sex industry. This included five specific patterns of involvement;

- *Explorers* : any stage or age, with sexual experimentation, eventually becomes dissatisfied, with short-term involvement,
- *Yo-yoers* : generally starts in their 30s, enjoys the excitement and thrill of the sex industry, stops when in a relationship and comes back to the industry when single or dissatisfied in the relationship,
- *Compulsive* : at any age or stage of life, often in and out of a conventional relationship, enjoys the compulsive planning and arranging of the appointment more than the sexual fulfilment,
- *Bookends* : starting in their 20s and returning to the industry again in later life: 50 +, often is a widower and can be seeking companionship and a final chance for a sex life, often very loyal to one sex worker, and
- *Permanent purchaser*: a client throughout their life, often driven by sexual needs, may travel for work and maintain a regular life partner, frequent a range of sex workers sporadically.

Regardless of discrepancies within, and variance between research results, what cannot be refuted is that clients do exist, regardless of the country, the legal framework or societal attitudes towards sex work.

## Demographics

While Hugh Grant, Charlie Sheen and the New York Governor Eliot Spitzer have been publicly identified as (high profile) clients of sex workers, research generated from surveys of sex workers and clients has revealed that most clients are a heterogeneous group, generally considered ‘normal,’ average guys coming from a wide range of socio-economic backgrounds and occupations (Huschke & Schubotz, 2016; Kinnell, 2006a; T. Sanders, 2006). As Perkins (1999) concluded “with a few minor variations the sample would not be too dissimilar to any randomly selected group of Australian males.” (p. 40)

The age of clients can vary significantly, with some survey respondents stating their first paid sexual experience was in their late teens – early twenties with other accounts mentioning clients in their seventies or eighties. One sex worker interviewed by Tuppy Owens (2014) remarked “21-93 years. Yes, 93. He’s a sprightly young thing, full of beans” (p.187). Preliminary findings from the most recent survey of clients in Canada had an age range between 19 and 94, with the average age being 44 (Atchison, Vukmirovich, & Burnett, 2015).

While research specifically involving older clients is still sparse, initial findings from one survey have shown that the frequency of paid sex was positively associated with the advancing age of respondents (Milrod & Monto, 2016). The sexual rights and desires of older Australians living in nursing homes and aged care facilities has become a prevalent consideration for staff, family members and sex workers. Recent media coverage of positive interactions with elderly gentlemen and sex workers has helped to demystify such connections. This has included a German article, *Assisted loving: Prostitutes and the elderly* (Obermueller, 2011) and an Australian program, *Insight*, where a sex worker spoke about her regular visits to her 93 year old client in an aged care facility, all coordinated by his adult daughter (Insight, 2013; Selinger-Morris). Additionally, numerous conferences in the aged care sector are now starting to address sexual expression – including the option of seeing a sex worker. These include the *Lets Talk About Sex* Conference, (Alzheimer’s Australia Victoria and COTA Victoria, 2015) and the Nurses in Aged Care (NIMAC) *Nursing with attitude!* Conference (Wotton, 2016a).

#### Locations where clients visit

With no uniformity as to who is or can be a client, the fear of the unknown and the constant portrayal of clients as sleazy, violent or just ‘dirty old men’ has compounded an already difficult issue when planning controls and authorisation of sex industry businesses are debated. While traditional ‘red light districts’ may be revered as tourist attractions and late night entertainment areas they are also daubed as a kind of ‘honey pot’ for depravity and debauchery. Public debate can create a moral panic about ensuring the proximity of sex industry businesses – and therefore

clients – are located ‘out of sight’ and away from areas children frequent. Often industrial areas are proposed as the only suitable location for such businesses. Stringent reforms around the permissibility of such establishments that clients can attend has been “stimulated by a perception of the inherent unlawfulness and disorderliness of brothels” (Crofts, 2007) rather than utilising an evidence-based approach which affirms these establishments operate in the same manner as other businesses. Emerging research has found that the amenity impact on neighbouring land uses and residents is minimal and can in fact be a positive factor for the community, through sex workers and clients contributing economically to local businesses and providing passive surveillance to increase real and perceived levels of safety (Cooper, 2016; Cooper & Maginn, 2016; Crofts & Prior, 2012b; Kingston, 2013; Prior & Crofts, 2012).

The ideology that sex workers working from their own home or a rented workplace in residential areas are criminogenic has also been unsubstantiated (Crofts & Prior, 2012a; Hubbard, Boydell, Crofts, Prior, & Searle, 2013). The reality is that both sex workers and clients are members of the society in which they live, with each person already being someone’s daughter or someone’s son and frequently with children of their own. As McKeganey stated, as quoted in *Sex Work Now* (O'Neill & Campbell, 2006):

The secret world of the client is sustained by the belief that the men who buy sex are never our father, brother, husband or boyfriend, but someone else, who we do not know and may not even wish to know (p. 224)

## Female clients

It is pertinent to note that deliberations about sex industry participants are unfailingly crafted around male clients of female sex workers. Very limited data has been collected on female clients of sex workers or about couples who seek out the services of sex workers together. While an Australian study in the mid-90s revealed that 12% of sex workers indicated that some of their clients were women (Perkins, 1999), Dr Sarah Kington from Lancaster University recently highlighted, in the article *Male sex workers call for respect, understanding* (Kermond, 2016), how female clients have been largely overlooked;

Female clients identified experiences of intimacy, companionship and pleasure. For some, it also elicited feelings of empowerment and control. Greater recognition needs to be made in these debates to female clients and also couples who purchase sex as part of their relationship.

With an increase in male sex workers and their female clients speaking up in the media, certainly anecdotal reports support limited academic findings that a growing number of women are paying for sexual services, either in their own country or abroad (Cox, 2015; Ingram, 2016; Kingston, 2016; Law, 2016; R. Smith, 2013; Snow, 2015). Evolving from such scarce empirical data sets, Lancaster University recently launched the Women Who Buy Sex Project (Lancaster University,



2016) to examine the motivations and characteristics of female clients. Additionally the research will look at who and where they buy sex from while exploring their personal negotiation strategies for physical and sexual safeguards. Based in the UK, researchers are in the process of conducting interviews with sex workers (of all genders) who provide sexual services to women, as well as interviews with self-identified female clients. With the results culminating in the publication of a book (scheduled for 2018) entitled *Women who buy sex: Intimacy, Companionship & Pleasure*, female clients may finally be acknowledged as active participants within the sex industry and descriptors about clients may finally be recalibrated to better reflect the gender diversity of this population.

Historically clients have been demonised and vilified, experiencing similar high levels of stigma and discrimination as sex workers. This often renders them relatively voiceless and commonly without representation during the ongoing discussions and debates about legislative proposals. It is notable that at this time where the disability rights movement is becoming stronger that clients with disability are predominately the only clients willing to share their stories, experiences and most importantly, to publicly identify as purchasers of sexual services .

### Clients with disability

Discourse specifically about clients with disability diverge significantly from that of clients in general. Instead of conjectures about marital status, occupation, socio-economic standing or

levels of perceived threats of violence, an unprecedented level of concern is directed to issues of consent and trying to ascertain if seeing a sex worker would be ‘in the person’s best interests’.

While an undetermined number of clients with disability are clearly able to interact with the sex industry independently, many are only able to with the assistance of a third party (Wotton & Isbister, 2010). This could be due to support needs around communication, transportation, physical transfers, financial or their current living arrangements.

What is normally a very private, discreet interaction between sex worker and client can often evolve into what I call ‘a three ringed circus’ with an abundance of people outside of that transaction having input into the appointment, with varying levels of success, support and understanding.

Unlike with clients who do not identify as a person with disability, third parties including researchers, academics, support staff and family members have often positioned themselves as the primary decision makers about how to best meet the sexual needs of people with disability, evaluating the relevance and necessity of sex worker involvement in someone’s life regardless – or in spite of - what the person with disability may indicate. This heightened level of paternalism culminates in questions framed as ‘should people with disability be allowed to see sex workers’ instead of ‘how can we best support people with disability who choose to see sex workers’.

While duty of care obligations for disability support organisations need to be adhered to, there

needs to be a concerted effort to balance such responsibilities with the dignity of risk for individuals (Touching Base Inc, 2011).

In the article *The right to say yes: upholding the dignity of sex workers and their clients with disability* (Dearing & Isbister, 2014) the authors examined such issues including the right to self-determination;

... the dignity of risk includes the right of all adults to make their own choices and preferences about their health, care and lifestyle, even if others – including healthcare professionals or other support providers – believe those choices will endanger a person's health or longevity, or otherwise disapprove. In the context of sexual rights of people with a disability, the dignity of risk supports the right of people with disability to a personal sphere of sexuality free from arbitrary or unlawful interference by third parties (p. 26).

Some people however, including some voices from the disability community, find the suggestion of people with disability seeing sex workers abhorrent, citing that it perpetuates the myth that they are unable to form meaningful relationships, are undesirable and un-dateable. Television shows such as *The Undateables* (Channel 4, 2012b) in the United Kingdom aim to disrupt such invalid notions but in an era where disability rights are designed to deliver equal rights for all, in

all aspects of one's life, it should come as no surprise to discover that some people with disability are also clients of sex workers.

While it is an individual – and often secret – decision for anyone to decide whether or not they would like to pay for sexual services, ultimately the fundamental issue is about choice and respecting the person's autonomy, with no difference in this equation due to a person's disability.

### Motivation

Motivating factors for clients with disability are often the same as the general client population.

For instance, Sanders (2007) noted:

...the shame, guilt or embarrassment in seeking out commercial sex is rebuffed by the positive influences on quality of life, self-esteem and confidence that result from fulfilment of a range of emotional, psychological, sexual and social needs (p. 446).

Additional motivations identified by clients with disability include: learning about their sexual capacities after a significant injury or illness, increasing their experience, knowledge and acceptance about their own bodies, gaining confidence and social skills before embarking on the dating scene, finally having the opportunity to experience the touch of another in a sensual way and lose their virginity (Kulick & Rydström, 2015; Liddiard, 2014; TLC Trust; Touching Base Inc, 2016b; Wotton & Isbister, 2010). As John Blades (a client with Multiple Sclerosis) said in

the documentary *Scarlet Road* : “it made me feel like a real bloke again” (“Scarlet Road: A sex worker's journey,” 2011). Another man interviewed for The Guardian newspaper said, “I couldn't make someone fall in love with me but I could at least learn about my sexual potential and more about women by paying a sex worker”. Talking about his first sexual encounter, he described it as an “enlightenment” (Ryan, 2013).

Furthermore, some people with disability (those who have had multiple amputations, those born with shortened or no arms and others who may have significant mobility and/or dexterity impairments) are sometimes unable to masturbate without assistance. Some people in this category have been known to utilise the services of sex workers in order to gain equitable access to this form of sexual fulfilment (Heckendorf, 2013).

#### Female clients

Female clients with disability are also patrons of the sex industry though rarely mentioned or acknowledged outside of the sex industry (Anonymous, 2011 ). Client stories on the Touching Base and TLC Trust websites have recently given clients with disability – including numerous female clients - the opportunity to share their experiences and have their voices heard.

Two notable interviews of women with disability from the UK and Denmark have been published in the last few years. Andrew Rosetta, a male sex worker in the UK, shared his

experience with a female client living with cerebral palsy in his book *Whatever she wants – true confessions of a male escort* (2009). Interviewed about this experience by Tuppy Owens (2014) the woman remarked, “Andrew was amazing: Andrew was so gentle, confident, friendly and genuinely caring. Now I have become sexually confident and am enjoying all kinds of sex with my partner. I have even, slowly, been able to accept my genitals” (p. 184).

A Danish woman, Frigg Birt Muller has been incredibly open about her experiences on Danish national television. Both her and her male sex worker have given interviews on the series called *Mormors Bordel* (‘Grandmother’s Brothel’ when translated into English). Frigg used the opportunity to challenge peoples’ perceptions about people with disability, especially the perception that such people are ascribed as being asexual. She reported that it was important for her to be open and proceed with confidence, declining the use of a pseudonym when being interviewed for research subsequently collated into a recent book, *Loneliness and its opposite – sex, disability and the ethics of engagement*. She commented “I think using my real name and showing that I am a real person makes this have more impact. If I don’t use my real name, it seems like I’m embarrassed over this. And I’m not.” (Kulick & Rydström, 2015, pp. 160-162).

## Media

Numerous sex worker books, autobiographies and blogs have in the past made reference to seeing clients with disability (Cockington & Marlin, 1995; Dawn, 1998; Dee, 2007; Rowland,

2000). Annie Sprinkle, self-described “Ph.D.; Prostitute/Porn Star turned Sexologist/Artist” (Sprinkle, 2016), has often been quoted as saying some of her most favourite clients were those with disability, or ‘differently-abled’: “Our sessions were generally mutually satisfying and beneficial; even spiritual and joyous. I wouldn’t trade the experience for anything. I hope my disabled clients feel similarly” (TLC-Trust, 2008).

What has changed in the last 16 years has been the rapid increase in media articles and documentaries with people with disability and sex workers sharing their own personal stories and experiences. As Shuttleworth (2014) asserted:

...the proliferation of local and transnational media representation of the sexual lives of disabled people and importantly less stereo-typical images certainly counters the long-standing cultural perception of their asexuality (p. 80).

One recent media article written from the perspective of a queer man with cerebral palsy, *The price of intimacy: the time I hired a sex worker* (Gurza, 2016) is a very moving and reflective account of this man’s fears and anxieties about himself, his sexuality and about the actual paid experience with a male sex worker. The following examples include other media representation from the client’s perspective.

The documentary *For One Night Only* (BBC ONE, 2007) features Asta Philpott and two other British men with disability travelling to Spain to visit a legal brothel. Based on Asta's experiences, the motion picture film *Hasta la Vista (Come as you are)* was subsequently produced a few years later (Clercq & Philpot, 2011). An episode in the UK documentary series, *The Children of Helen House* (BBC, 2007) followed Nick Wallis, a young man with Duchenne muscular dystrophy, who decided to lose his virginity to a sex worker before he died (Payne, 2007). In Canada, *Short on Short* (2015) follows Paul Swartz, a short statured person, as he speaks to a range of people about sexual relationships, dating and sex work (Swartz, 2015).

*Scarlet Road*, an Australian documentary, features a number of sex workers, the work of Touching Base and the thoughts and experiences of two clients with disability ("*Scarlet Road: A sex worker's journey*," 2011; Wallace, 2013). It has been broadcast on TV in at least eight different countries and countless film festivals, while an increasing amount of international and national universities and other learning institutions have included it in the curriculum of a range of disciplines. A recent TEDx talk *Open Your Mind to What Goes on Behind Closed Doors* (Wotton, 2016b) expands upon this topic. John Blades, one of the featured clients, won a number of awards and recognition with his own ABC Radio National documentary, *The Too Hard Basket* (Blades, 2009). The multimedia essay 'I have cerebral palsy and I enjoy having sex' (Wright, 2014) has also allowed Colin Wright to share his story of seeing sex workers and what that means to him.



Feature and short films such as *The Intouchables* (2011), *L'Assistante* (2012) and *The Gift* (2013) have subsequently added to the general population's understanding of these issues, both showing caring and tender moments between a sex worker and their client with disability as well as exploring the attitudes and affirmative actions of carers, parents and support staff.

Regardless of this growing body of work sharing the voices and lived experiences of clients with disability, there is still very limited empirical data that examines the prevalence of people with disability utilising the services of sex workers. Additionally, very few organisations are set up to assist someone specifically with support, information and referrals for accessing the sex industry.

### Prevalence

In 2005, the UK based Disability Now! website conducted its 'time to talk sex' survey. The results, collated from 1115 respondents indicated that 22% of men with disability had paid for sexual services. Only 1% of female respondents answered in the positive although 16% of women with disability said they had considered paying for sex (Disability Now, 2005). This was supported by subsequent research by Liddiard (2011) which found that there was a greater proclivity of men with disability to access paid sexual services than the women. The reasons for this were varied. For instance, Liddiard suggested that,

Most had little or no access to facilitated sex or the option to pay for sex; either these options weren't easily available to disabled women, or women felt they couldn't explore them for fear that it was 'unfeminine' (p. 8).

When conducting an ethnographic study of female sex workers who worked indoors in a British city, Sanders (2006) discovered that some sex workers talked openly about their clients with disability. While no quantitative data were derived, a number of sex workers spoke about their clients being 'regulars', how they tried to best accommodate their needs, the positive interactions they shared and the professional satisfaction they experienced in providing services to clients with disability.

While specific empirical data has been lacking in this area it is clear that people with disability do access the sex industry. Other recent papers making general reference to it derive from Canada (Fritsch, Heynen, Ross, & van der Meulen, 2016) and Ireland (Bonnie, 2002; Huschke & Schubotz, 2016). The earliest known reference in Australian film comes from an obscure slapstick detective comedy called *Plugg* (1976). In one scene a receptionist at the escort agency asks the client on the phone if he has any disabilities that the sex worker should be aware of. It serves no plot function at all, but does establish a link between sex worker and clients with disability well before decriminalisation occurred in NSW.

### Organisations and access to the sex industry

Regardless of the dearth of empirical data, equal access for people with disability to sexual expression via paid sexual services has been campaigned for by a number of organisations. Led predominantly by people with disability and sex workers, these organisations were created to better support the ongoing needs of both marginalised communities, create easier communication pathways between the two groups and to advocate for the labour and sexual rights of sex workers and people with disability. The two that are most prominent are Touching Base Inc (Australia) and TLC- Trust (UK) with both organisations having their genesis in 2000. In 2013 Equitable and Accessible Sexual Expression (EASE) in Canada was also established (2013).

A number of countries have been identified as having set up Government sanctioned funding arrangements to assist with paid sexual services for people with disability. Most notably are the Netherlands and Denmark. While reports about the Netherlands indicate that state funded sexual assistance has been provided for over 30 years (Sanders, 2007), it has been extremely difficult finding further information about either country and their subsidies for people with disability. It appears that while the media headlines have sensationalised the whole concept of people with disability paying for sexual services, the reality may be that as person-centred policy approaches were implemented, people were just recognised as autonomous human beings who could choose to pay for whatever services they wanted. An article on 13<sup>th</sup> March 2014, *The Surprising Way the Netherlands Is Helping Its Disabled Have Sex* supports this theory:

While there is no direct "sex grant" per se, the benefits citizens with disabilities receive can be spent however they like. Some reports indicate that they can use these benefits to access sex services 12 times a year, but information on the specifics is elusive (Ward, 2014).

The same can be said about the Danish subsidy system whereby much has been alluded to in the media but qualitative data are lacking. In 2005 there was a wave of international media stating that the Danish Government was 'under fire' for their 'sex, irrespective of disability' campaign which supported people with disability to be able to access sexual services once a month:

In Aarhus, the second-largest city, disabled residents have been told that they may visit a brothel or call a male or female prostitute to their home once a month and pass the bill - which can be up to £300 - on to the state.

An advisory booklet produced by the Ministry of Social Affairs aims to inform the disabled of their sexual rights, and encourages their carers to contact providers of erotic services (Gravesen, 2005).

In the same year, Torben Hansen, a Danish man with cerebral palsy, came to international attention as he fought for the right to have the Government pay the extra charge incurred when organising a sex worker to visit him. This was because his disability prohibited him from accessing their services at their usual workplace. The law at the time meant that local authorities subsidised any extra costs incurred directly related to one's disability (BBC News, 2005).

Since 2005 there has been little in the way of updates to this issue and certainly no recent media or academic papers expanding on the services and subsidies apparently available in these two countries. Perhaps it is 'lost in translation' and more information can only be found published in Dutch or Danish. From personal communications, between the researcher and Danish sex workers in 2010, when filming a segment for *Scarlet Road*, it appeared that the situation in Denmark is not so cut and dry and access to funds had been difficult for some people with disability. At the time there was also mention of Copenhagen being excluded from this scheme which, if true, would preclude a large percentage of people with disability being able to connect with sex workers (many of whom work in this city).

Certainly this is an ongoing area of concern, no matter which country you reside in. The National Disability Insurance Scheme (NDIS) in Australia has yet to confirm with any certainty that a person's adult sexual needs and desires will be supported. This has led people with disability to speak up and fight for their rights and autonomy, as personified by David Heckendorf and his wife in the Australian Capital Territory ("Call to include sex work in the National Disability Insurance Scheme bill," 2013; Heckendorf, 2016). A married couple, both living with Cerebral Palsy, they successfully applied to have a portion of their funding allocated for sex worker services. Their story has been shared via appearances on the TV program *SBS Insight* ("Sex and Disability," 2016) and through print and online media (Heckendorf, 2016; "Why the NDIS should cover the services of sex workers," 2013). One South Australian MP Kelly Vincent, the elected representative for the Dignity for Disability party, has also echoed the Heckendorf's plea

for recognition of peoples sexual rights within the use of individuals NDIS funding, along with other therapists and people with disability ("Let the disabled use NDIS cash for sex: MP," 2013).

#### Other forms of assisted sexual services

While this study is solely focused on clients with disability who have chosen to access the services of sex workers, there has been much contention and confusion between the different roles people can play when providing sexual services to people with disability or assisting them with their personal, sexual needs. Due to different legal parameters in each country and the ongoing stigma associated with the sex industry, emerging roles and descriptors have evolved and are utilised globally. These include ‘sexual surrogacy’ and ‘facilitated sexual assistants’. There are many similarities and differences between sex work and sexual surrogacy (Griffiths, 2006; Wotton & Isbister, 2007) though it appears that some individuals and organisations utilise the term ‘surrogate’ purely to distance themselves from the historically nuanced term of ‘prostitute’, even though the work essentially involves the same activities. As Kulick and Rydstrom (2015) noted:

...this might help to make paying for sex more palatable to some people with disabilities or to caregivers of disabled people who are frightened or repelled by the idea of prostitution. But a claim to provide more empathy, care and concern than is offered by women who work in “classic prostitution” should also perhaps be heard as a way of staking a class (and probably a race) distinction (p. 186).

A brief overview of these categories follow:

### Sexual Surrogacy

As discussed in Chapter 3, sexual surrogacy was first developed by Masters and Johnson in America in the 1960s. Many institutions and therapists also use the terms “surrogate partner therapy” and “surrogate partnership” to describe this type of therapy and “sex surrogate” or “sexual surrogate” to describe the person who has physical, intimate contact with the client.

Sessions involve specially trained sexual surrogates interacting with clients of sex therapists to assist with the development of their physical and emotional personal growth in a safe and supportive environment. Unlike sex work, surrogacy clients do not get to individually choose the surrogate that will be working with them, but is assigned one based on a range of demographics and availability (Rosenbaum, Aloni, & Heruti, 2013; Zentner & Knox, 2013). Sessions are semi-structured and ultimately goal driven, with short-term and long-term goals established before embarking upon the sexual surrogacy sessions. The International Professional Surrogacy Association (IPSA, n.d.) is based in San Diego, America; with other surrogacy centres established in Israel, the Netherlands and the UK (“Sex Therapy Training Centres,” 2009-2016).

This form of therapy has recently enjoyed mainstream media attention since the release of the Hollywood film *The Sessions* (2012). Based on the true story of Mark O’Brien, a man who spent most of his life in an iron lung due to complications from contracting polio as a child, he hired a sexual surrogate to help him lose his virginity (O’Brien, 1990; Saratogian News, 2012). While developing affinities for the disability community and raising awareness of the difficulties some

people with severe and complex levels of disability face in exploring their sexual desires, what this film significantly omits is that sex work was – and still is – illegal in the US (except for a small number of brothels in Nevada counties). For a lot of people with disability they are very clear that they do not need nor want their sexual expression to be recalibrated into a therapeutic construct (Shakespeare et al., 1996). To be blunt – they do not need therapy per se, they just want to get laid like everyone else.

While surrogacy sessions generally remain a private interaction, one educational documentary, *Beruf: Berührerin*, encompasses the discussions and work of three sexual surrogates in Austria, Germany and Switzerland. Due to the sensitive nature of the work this film is not available online. The producers acknowledge that this area of expertise is still regarded as a taboo subject, probably due to the nature of combining sexuality, intellectual or physical impairments and paid sexual services (Dworschak & Müller, 2012).

#### Facilitated Sexual Assistants

The most contentious issues are in regards to abilities to consent and for the involvement of third party assistance for people with disability to explore their sexual expression in a safe and consensual way. Unlike clients who have a fair level of autonomy in regards to communication, their finances, dexterity and mobility, there is a portion of clients who need either part time or full time assistance and support to manage day to day activities and personal care.



Sexual liaisons sometimes have to be organised for people with disability which can be done via sexual assistants, sometimes referred to as Personal Assistance Services or care attendants (Mona, 2003) . Their continuum of activities can be quite broad in assisting someone with sexual activities. This can include the personal assistants or support staff of a care facility arranging the appointment with a sex worker on behalf of a client they support. It may take the form of personal assistants helping one – or two people – into different sexual positions to best meet their needs and accommodate their normal range of function and mobility. It has also been identified that such roles could assist in the positioning of sex toys or the purchase and viewing of pornographic materials. It could also include supporting people to go to clubs or go on a date. Earle (2001) outlined what this continuum could look like in Table 1, specifically in the context of a hospital setting, with nurses being the primary assistants:

Table 1. The continuum of facilitated sex, as outlined by Earle (2001)

Table 1 The continuum of facilitated sex	
The continuum	The role of the nurse: examples
Providing accessible information, advice and services	Arranging for information to be available in Braille, large print and audio-tape
Fostering an environment which allows intimacy	Acceptance and acknowledgement of patient's sexual needs
Offering and observing need for privacy	Closing doors, providing curtains
Encouraging and enabling social interaction	Arranging suitable transportation
The procurement of sexual goods	Purchasing or arranging the purchase of pornographic magazines
Arranging paid-for sexual services	Assistance with arranging, or information on how to arrange, paid-for-sex; willingness to discuss this as an option for the patient
Facilitation of sexual intercourse with another party	Undressing, or helping to undress, patient
Facilitation of masturbation	Assisting patient with positioning and technique
Sexual surrogacy	Assistance with arranging, or information on how to arrange a sexual surrogate

Mona (2003) expanded upon possible roles a Personal Assistant Service would entail when supporting someone's sexual needs, as seen in Table 2.

Table 2. The Sexually-Related Activities required PAS by Impairment Type, as outlined by Mona (2003)

Impairment type	Activity example
Physical, mobility	Removing clothes, positioning for masturbation, positioning for partner sex, transferring in and out of wheelchair onto floor, couch, or bed, stimulating partners' body, stimulating own body, cleaning up and getting redressed, using birth control (e.g., condoms, diaphragm, birth control pill)
Visual	Preparation for sex (e.g., transportation to and from partner's location, purchasing appropriate condoms, discussion and interpretation of sexual positions often only drawn in books)
Hearing	Sign language interpretation during sexual activity with hearing partner, phone interpretation if TTY or other telecommunication services are not available
Developmental/cognitive	Cognitive and emotional interpretation of interpersonal interactions, cueing to remind people to use birth control, discussion of appropriate sexual boundaries with partners, decision making (e.g., when to be sexual and with whom)

An affirming portrayal of how a disability support worker assisted in someone's sexual expression was portrayed in the French film, *The Intouchables* (2011) where the carer facilitates an appointment with a sex worker in a respectful and supportive manner.

Unfortunately though, the sexual needs of a person with disability is still often overlooked, due to fear of breaking the law, a belief that it's outside of someone's duties, a personal belief that it's 'wrong' or 'immoral' to assist them in any way or the misperception that such people are asexual (Bahner, 2009, 2012).

A grey area emerges where it is considered that such sexual facilitation could include masturbating someone if need be. There are a number of organisations and businesses that have

been set up to literally ‘lend a helping hand’ and offer paid or volunteer masturbation services to people with disability. These include Handisex (Denmark) ("Handisex," 2012), White Hands (Japan) (2008-2012) and Hand Angels (Taiwan) ("HandjobTW," 2016).

In some places in the world, especially where sex work is criminalised or the clients are criminalised (such as Sweden), the use of ‘sexual assistants’ and ‘facilitated sex’ services are the only legal avenues people with disability can pursue. However academic discourse in this field often falls short of including facilitating an appointment with a sex worker. Indeed some disability support workers place perceived ‘risks’ of being involved with outings to a club or allowing people the right to view pornography as a higher priority than the autonomy and decision-making process of the person with disability they are supporting (Bahner, 2013, 2015).

### Guidelines and policies

The different issues pertaining to these different roles – whether perceived or formally instilled within a person’s job description - have been examined most recently by Shuttleworth and Taleporos (2016). One of their foci is formulating concise and pragmatic policy guidelines for all who are involved in supporting someone with their sexual expression. What is interesting to note is that Denmark already has facilitated sex guidelines written into their disability policies. In Kulick and Rydstrom’s book (2015) there is also mention of parents being the antagonists for progressive policy changes:

One thing I want to say to you. My son has tried going to a prostitute, and it was good for him. You all need to damned well follow up on this.”... And so we were all forced to figure this out, even though we didn’t know one another and we’d never even spoken about things like sexuality (p. 150).

Later on her adult son has a girlfriend and the mother challenges the support workers’ ideology by saying:

They want to have sex. Surely it can’t be reasonable that I, his mother, should be the one to go into his room and lift them up onto and down from the hydraulic lift. That’s your job. I don’t want to know anything about it. Because I am his mother. I shouldn’t have to have anything to do with this. But you should. (p. 150).

While ultimately parents would rather not be involved in their offspring’s sex lives, until holistic and comprehensive policies are supported, they often are the first advocates for their son or daughter’s sexual expression. In the same book noted above, another Danish mother, Lone Hertz, is mentioned organising paid sexual services for her son who lives with disability. In the documentary *Scarlet Road*, Elaine Manitta speaks about carrying her son, Mark, up the stairs to a brothel and hanging out with the other sex workers while Mark spent quality time in one of the rooms with his sex worker of choice. She is also involved with organising a special overnight booking with a sex worker for his birthday, featured in *Scarlet Road*.

To address an obvious gap in resources, Touching Base published *Policy and Procedural Guidelines- for disability support staff assisting access to sex services* in 2011. They are designed to provide “clear principles, practical guidance and simple tools to assist their decision-making processes when supporting people with disability to access sex services” (Touching Base Inc, 2011). When adopted and implemented by organisations the guidelines can enable support staff to take over from parents in facilitating a session with a sex worker.

More recently three new resources for people with disability wanting more information about accessing sex workers have been published after wide consultation during their production (Burrell, Waters, Elrick, & Freeman, 2016). *Anna Sees a Sex Worker* and *Tony Sees a Sex Worker* are social stories that combine clear and explicit images with plain language to meet the information needs of women and men with intellectual disability. A more comprehensive guide, *Seeing a Sex Worker – a guide for people with disability* is pitched to a broader audience as a stand-alone resource but is also promoted as a “companion resource when supporting a person with intellectual disability to read one of the social stories”.

It is significant that the NSW Minister for Disability Services officiated the launch of these new resources at Parliament House in NSW. This demonstration of strong support from a Cabinet Member of the State Government was echoed a few weeks later when the Upper House of the NSW Parliament unanimously supported a Motion of Support acknowledging and congratulating Touching Base for its work in bringing together sex workers and people with disability

(Legislative Assembly - Parliament of New South Wales, 2016). Such high level endorsement suggests that people with disability accessing sex services is now recognised as a valued and viable option and is not constrained as being taboo in the State of New South Wales.

While seeing a sex worker should never be deemed the only ‘answer’ or option for people with disability to explore their sexual expression, it should equally not be omitted amongst the plethora of options people with disability should be able to choose from. In reality, outside of academia, it is already well established that a sub-set of sex worker clients are those with disability. This research aims to provide empirical data to acknowledge that it is occurring.

## Chapter 6. Research Gap

### Significance of this research

Studies in the area of sex work are mostly conducted by those who do not identify as a sex worker. The impetus to study and research sex workers has historically been about non-sex workers deciding what is of importance, instead of involving sex workers in research that is relevant and pertinent to their work within the sex industry.

A limited number of studies have collated secondary data collating information about sex workers providing services to clients with disability and how they view those clients, (most notably from Sanders (2007; 2006)). Research and surveys specifically targeting clients of sex workers who also identify as being someone with disability are also sparse. The 2005 Disability Now Survey in the UK (Kirsty Liddiard, 2013) and Liddiard's (2014) research have certainly contributed, however there still remains a significant gap in the literature specifically looking at this component of the sex industry. Until now, no one has explicitly approached sex workers who provide services to clients with disability to participate in a research project to collate their workplace experiences in this area. Areas of interest include examining the propensity of service delivery, the range of locations where the client and sex worker meet, the extent to which this is occurring, and the diversity of sexual expression paid for by the client.

Discourses about sex workers have been evolving in the last 30 years – more so since the uptake of the internet and the proliferation of social media. The narratives of sex worker lived

experiences have found a medium online in which to share personal stories and reflections on what is important to themselves. These narratives have begun to challenge the stereotypical rhetoric that has been held. The stigma and discriminatory beliefs held against sex workers has also been applied to the clients of sex workers, as outlined in the previous chapter.

While academic literature is limited, an increased level of media attention, in the last 15 years, has turned the public's focus on sex workers who provide sexual services to clients with disability. This has included newspapers, radio, TV, online blogs & news articles, documentaries, short films and full length movies. Organisations such as TLC-Trust (UK) and Touching Base (Australia) have both instigated referral processes to sex workers who are willing and confident in providing services to clients with disability. Online websites of sex workers can now be found talking about their willingness and openness in providing services for clients with disability. A small number of organisations have started providing workshops to sex workers who wish to upskill themselves and become more proficient and knowledgeable in providing services to clients with disability including Touching Base in Australia (Touching Base Inc, 2016c) and Kassandra in Germany (Mittler, 2013).

While anecdotally there is a wealth of information clearly supporting the hypothesis that sex workers do, in fact, provide a range of sexual services to clients with disability, currently there is a distinct paucity of research concerning this topic. This research aims to provide information to fill that gap.



### Personal experiences of the researcher

The researcher is a sex worker who currently has over 22 years of experience within the sex industry. This has included working in massage parlours, full service brothels, working in small collectives, working from home, working from a rental apartment and also providing 'outcalls' visiting clients in their hotel or home. While based in Sydney, Australia, this experience has been acquired from working in all states and territories within Australia as well as seven other countries.

I have also previously worked in paid employment at the Sex Workers Outreach Project (SWOP NSW) in Sydney, NSW and in a volunteer capacity with Scarlet Alliance – the National Sex Worker Association of Australia. These roles have allowed me to meet a large number of sex workers from across the globe, via many modalities. These have included participation in local, state, national and international conferences, e-lists and email exchanges, collaborations on presentations and exhibitions and through working together in different sex industry locations and businesses.

Since 2000 I have also been involved with co-founding and continuing the work of Touching Base Inc. This has included the development and facilitation of two separate workshops; the Professional Disability Awareness Training (PDAT) for sex workers and the Service Provider Awareness Training (SPAT) for people working in the disability sector. I have also been a co-creator and ongoing volunteer with the Touching Base Sex Worker Referral List. This role

includes receiving and replying to telephone and email inquiries for sex workers who are willing, experienced and / or able to provide services to clients all across Australia. I provide ongoing peer support and information to the sex workers who are included in the referrals and assist with those wishing to add their details and become individual members of Touching Base.

All aspects of my career have allowed me to have in-depth discussions with other sex workers about their clients. Anecdotal information indicates that this is not a new emerging section of the sex worker client base, but rather it has occurred much like the rest of the sex industry has operated – quietly and with utmost discretion. What has also been succinctly identified is the desire for more resources and training for sex workers to increase their confidence, skills and knowledge in this area.

My work has also identified the lack of clear policies and procedures within the disability sector. As the sexual rights of people with disability has started to be addressed in society as a whole, support workers, carers, friends, parents and siblings of people with disability, as well as potential clients themselves, are searching for relevant and specific information to guide them through this new terrain of sexual expression. The need for open and frank discussions and clear pathways to accessing the sex industry, if they so choose, has been identified by Touching Base as far back as 2000.

Touching Base held an initial Forum Sydney on 18 February 2001 so that people with disability, their carers and sex workers to meet and have the opportunity to discuss what was important for

them. The aim was to assist “the sharing of experiences and work through the social, economic, legal and other “grey areas” which present obstacles in the delivery and receipt of sex services to people with disability” (Touching Base Inc, 2016a). There were seven main themes/ issues identified by all participants that they wanted addressed in the future, which included choice, training, access, funding, privacy, consent and legal issues. The key recommendations focused on training, advocacy and partnership.

My involvement with all aspects of the services Touching Base provides has given me insight into the issues and difficulties that may arise from the perspectives of support workers, carers, parents, siblings and people with disability themselves. The information collated from this research will provide both quantitative and qualitative data to address the current lack of empirical evidence consolidating my lived experience that sex workers definitely provide services to people with disability on a regular basis. It is anticipated that these findings will also be utilised in future training developed for both sex workers and people in the disability sector. It will also assist in dispelling current myths around both sex workers and people with disability that were discussed in earlier chapters.

### Benefits of the researcher identifying as a sex worker

There are many challenges to researching sex workers. Shaver (2005) noted that “the challenges involved in the design of ethical, non-exploitative research projects with sex workers or any other marginalized population are significant” (p. 296). One such aspect identified is with “legitimizing the role of the researcher”. Sex workers have a natural distrust of researchers as the majority of surveys and data collection has been executed by non-sex workers without consultation, participation or on-going involvement by sex workers at any stage (van der Meulen, 2011). This has often been done without respect or regard for the negative impact the research can have on the participants - specifically to the physical presence in sex industry work places as well as the actual results being manipulated to legislate against, or further stigmatise, the sex workers. Breaches of confidentiality, a lack of maintaining strict privacy protocols and a lack of adherence to cultural and industry protocols have further waned the trust of sex worker involvement (Reed, Khoshnood, Blankenship, & Fisher, 2014).

Research about sex workers generally does not elicit positive changes that will benefit the sex worker participants in the future. If anything, the substantial body of work in the literature that consistently focuses on the sexual and mental health of sex workers at the expense of their legal, sexual and human rights, has skewed public opinions and left sex worker communities around the world fatigued and weary of research that could further stigmatise and discriminate against them.

Anecdotally, conversations shared with sex workers over the years have frequently included their annoyance toward researchers only viewing sex workers' usefulness in regards to their participation in Sexually Transmitted Infection (STI) surveillance. From this, a mistrust of researchers has emerged, encompassing mainstream media, who further conflate the stereotypical discourses about the sex industry by relaying stigmatising, patronising and incorrect information instead of speaking directly to sex workers, sex worker organisations and spokespersons.

Adhering to the principles of ethical research, being open and forthright as to the validity of this research and clearly identifying the potential positive benefits for the participants in the future has given this research project a good opportunity to collate unique and valuable data from applicable participants. This adheres to these principles as suggested by Metzenrath (1998):

If researchers are going to be sensitive to the needs of sex workers, service providers, legislators and those developing policy on the sex industry, then research should not only be driven by the personal and academic interests of researchers alone but they should try to support the research needs of sex workers and their supporters. (p. 11)

Trust, privacy and confidentiality concerns are often addressed in marginalised communities when the researcher self identifies with the target population. Within the sex industry, there is an intrinsic belief that if the researcher is also a sex worker then they have a better understanding of

the importance of these issues and will never objectify the participants or manipulate the data to cause harm (Jefferys, 2009). Peer education and participatory approaches have been recognised internationally as one of the key components to effectively target and educate marginalised and vulnerable populations, which includes sex workers (International Federation of Red Cross and Red Crescent Societies, 2011; World Health Organisation, 2016).

As a sex worker I am familiar with the terminology and context utilised by the survey population. I recognise the heterogeneity of the sex worker population and as my experience within the sex industry is also incredibly diverse, the data collection tool created for this research reflects real life language, options and work scenarios that sex work participants relate to and understand.

Having ‘lived experience’ and being an ‘out’ sex worker gave me the opportunity to utilise snowball sampling in the recruitment process in order to reach this diverse population. I believe that my reputation as a sex worker, with years of experience providing sexual services to clients with disability, gives participants faith that my rationale for this topic is altruistic and that unlike so many other research projects – the results of their combined participation will be utilised in the future to continue to benefit the community as a whole. This is unlike a lot of research which historically has never been utilised to inform or guide any further projects, workshops or positive changes to the sex worker community. Instead, the acquired data just languishes on a shelf, gets published once and then put aside or is used against the very community that participated, creating further law reform or discriminatory processes and policies. Unfortunately this is not

unique to just the sex worker population but to other marginalised cohorts too, as demonstrated by the paper *Researcher and Researched-Community Perspectives: Toward Bridging the Gap* (Sullivan et al., 2001).

### Researcher reflexivity

While all research endeavours to remain objective, the subjectivity of the researcher/s should always be acknowledged and reflected upon. Researcher bias is a challenge for most researchers with the validity of the data and conclusions made from their findings often scrutinised on that basis. Studies and papers, in specific reference sex worker led and driven research, have identified that the researcher's own assessments and interpretations of the data set can actually add an additional rich layer of discussion and comprehension due to their in-depth knowledge and understanding of the population sampled (Jefferys, 2009; Kerrigan et al., 2015; Wood & Goodyear, 2009). Without my own firsthand experience of providing services to clients with disability, my analysis would run the risk of only producing descriptive accounts of the experiences of the sex worker participants, instead of the ability to conceptualise the more complex meanings and interpretations.

### What this research will examine

This project is an exploratory study about NSW sex workers who provide services to clients with disability. The aim of this research is to identify the nature and extent of such activities, providing an opportunity to document:

- where such service provision occurs,
- the frequency of such services
- the type and range of services provided
- if clients arrange their appointments themselves and / or need the assistance of a third party, and
- barriers and challenges faced by sex workers providing services

The research will contribute to the very limited empirical information available on sex workers and clients with disability, increasing awareness of the diversity of sex worker skills and recognition of the sexual rights of people with a disability. It is anticipated that the results will also shift current paradigms and presumptions around what type of sexual services people with disability want to pay for, the gender of both the clients and sex workers and the location where these services are utilised.

Data gleaned from the responses will be able to inform resources and information packages specifically targeting third parties who have, in more recent times, found themselves supporting people to access sex workers. In addition, training and educational workshops specifically designed to upskill sex workers working with clients with disability can be further tailored to best meet their needs and that of their clients. This is in accordance with recent results published in the World Health Organisation's *Consultations on updating the Global Strategy: Round 1* –



*Priorities for the Global Strategy* which state “monitoring systems should be “timely, complete, relevant, specific, accurate and usable” ” (World Health Organisation, 2015, p. 33).

Questions about cost of services were not asked, because it serves no real purpose in ascertaining the aim of the project. Financial remuneration in exchange of services occurs with every appointment and is extremely varied dependent upon length of time of the booking, services requested, travel considerations and individual sex worker / establishment fee structures.

#### Why is the focus only on NSW sex workers?

The state of NSW, Australia was the first place in the world to introduce decriminalisation as the regulatory model for the majority of the sex industry (with the exception of street-based sex work, which is legally recognised with certain locational restrictions and is still regulated by the police). Decriminalisation occurred in 1995 as a recommendation that came out of the Wood Royal Commission, which showed “a clear nexus between police corruption and the operation of brothels” (1997, p. 30).

Building upon the successful regulatory model from NSW, New Zealand introduced the Prostitution Reform Act 2003 and has since led the world in its decision to recognise the labour and human rights of sex workers (Abel et al., 2010). The recognition that decriminalisation is the only successful model in which to support sex workers, their clients and all third parties has been acknowledged and formally supported by a litany of key global organisations. Most recently,

Amnesty International has released their *International policy on state obligations to respect, protect and fulfil the human rights of sex workers* (2016) stating “this policy is grounded in the principles of harm reduction, gender equality, recognition of the personal agency of sex workers, and general international human rights principles.” (p. 2) Amnesty International joins the World Health Organisation (WHO), The Joint United Nations Programme on HIV/AIDS (UNAIDS), Human Rights Watch, Open Society Foundations, the Global Network of People Living with HIV, the Global Forum on MSM and HIV, the Global Alliance Against Traffic in Women (GAATW), the Global Fund for Women, the Association for Women in Development, the American Jewish World Service, the Global Commission on HIV and the Law, United Nations Population Fund (UNFPA), United Nations Development Programme (UNDP), the World Bank, the International Women’s Health Coalition, the Elton John Foundation, the International Community of Women Living with HIV, the Lancet in the call for the decriminalisation of sex work (NSWP, 2016).

As the scope of this research did not wish to involve comparative data analysis between different States and Territories within Australia, it was decided to keep the focus clearly on sex workers who have provided sexual services to clients in NSW. In addition, while the work of Touching Base has dramatically increased in recent years to include both sex workers and people with disability throughout all of Australia, it seemed prudent at the time to gain a clear insight into what was occurring in NSW, where Touching Base originated from.

## Chapter 7: Methodology

This chapter gives an overview of the procedures and considerations utilised when developing, formulating and distributing the survey. This includes ethical approval, rationale for the chosen methodology and identifying which online survey program was utilised. Recruitment strategies are discussed as well as a brief overview of the respondents. The research survey was designed with six main sections which are discussed in detail in the final section of this chapter.

### Ethics approval

Ethics approval was obtained from the Human Ethics Research Committee at the University of Sydney on 31<sup>st</sup> July 2008 [Ref No: 08-2008/11076] (Appendix D).

Participants were assured of strict confidentiality and anonymity of the information collected in accordance with the Ethics Approval granted. Participating in this study was completely voluntary. Submission of the completed questionnaire was explained to participants as giving consent to participate in the study and, since no identifying information was collected, once submitted their responses could not be withdrawn.

All participants were initially provided with a brief overview of the study, via the Participant Information Statement (Appendix B), and were informed that submission of a completed questionnaire will be taken as consent to participate. For eligible participants the survey was estimated to take between 10-15 minutes. No question was deemed compulsory and participants

could choose which fields they wished to answer. The participants were not provided with any reimbursement.

## Recruitment

As an exploratory study, snowball sampling methodology was utilised with participants self-selecting. Due to the private nature of the sex industry and its diversity in location and scale, it is not possible to capture the entire population of NSW sex workers. There is no consolidated list or directory of all sex workers who have or are working in NSW, hence it was necessary to rely upon snowball sampling methods to allow sex workers to share the survey. Due to time and geographical restraints, it was not possible for the researcher to personally visit every establishment in NSW. Furthermore, most establishments would generally not allow researcher access to their staff and even then, it would not capture every sex worker as rosters change every day with sex workers allocated different start times for their shifts.

An advantage of the snowball sampling methodology was that it could take advantage of current sex worker networks and peer education facilities, allowing the researcher to gain a greater reach to this generally hidden population. It was deemed most efficient to use an online survey program. Advantages of this include that the participant could complete it in their own time, with no additional cost to themselves. It also allowed for maximum confidentiality safeguards as each participant remained completely anonymous, as opposed to face-to-face data collection methods.

The source population were recruited through a number of methods to make it as broadly representative as possible. This included sex worker networks, sexual health clinics, and utilising the researcher's own extensive peer networks. The advertisement/recruitment information page is included in Appendix A. Attempts were made to advertise in local and state based newspapers but due to administrative and sensitivity issues this did not occur. The Participants' Information Statement is included in Appendix B.

The study was advertised on a number of sex worker e-lists as well as the Touching Base committee e-list and via a confidential sexual health clinic e-list that reached a number of sexual health clinics in NSW (as these clinics do regular outreach to sex workers and sex industry establishments).

The researcher also emailed the survey information to a number of sex workers who had shown interest in participating but were currently living or traveling interstate or overseas. They were eligible to participate as the survey referred to their experiences when working in NSW.

The advertisement/recruitment information page was also posted on the noticeboard in the Chippindale Head Office of the NSW sex worker organisation (SWOP NSW). Due to administrative and political issues at the time, the researcher was unfortunately denied the opportunity to have an article in The Professional (the SWOP quarterly magazine for sex

workers) nor the opportunity to have a paid advertisement in it.

It must be noted that at the time the survey was launched, Facebook, Twitter and other forms of online social media were not yet being utilised broadly, hence these mediums were not used.

## Respondents

The survey was completed by respondents between 9th April 2009 and 22<sup>nd</sup> April 2010, using the online survey platform Zoomerang.

There were 65 eligible respondents who self-identified as sex workers who had past or current sex work experience in New South Wales (NSW), Australia. There was no restriction on how long ago the sex worker had last seen clients with disability, the amount of time they had working in the sex industry or the type of sexual services offered. Eligibility criteria only required that participants had previously provided sexual services in NSW to client/s with disability (according to the definition outlined below) at some stage in their sex working career. The participants were drawn from the state of NSW because it is the sole state or territory within Australia to enjoy the regulatory framework of decriminalisation.

There were seven respondents who did not meet eligibility criteria as they had not provided services to client/s with disability or had only done so in other states or countries. There was an

opportunity though for these participants to leave a comment or give feedback in relation to this research which are briefly discussed within the results chapter.

## Survey

The structured survey was developed by the researcher, drawing from her own personal experiences and knowledge about the diversity of the sex industry and also the range of services and other factors of influence involved with organising and providing services to a range of clients with disability. As this was the first exploratory study to examine the topic of sex workers providing services to clients with disability, there was no standardised questionnaire tool available for use.

The draft survey was peer reviewed by two other sex workers with experience in this field and then adjusted accordingly. The online survey program utilised was Zoomerang (now owned by Survey Monkey). The finalised survey was uploaded to Zoomerang's survey platform, piloted by both the researcher and one other peer, and launched on Thursday 9<sup>th</sup> April 2009. The survey is included in Appendix C.

The option to complete a hard copy of the questionnaire was also made available to any respondents who requested it, using a free return postage system. This was to facilitate maximum

participation by sex workers by allowing them to participate at their convenience, in a medium that best suited their needs, whilst respecting their need for anonymity.

Due to the limited scope of this research project, available budget and timeframe, this questionnaire was only made available in English.

In the initial participation information page a definition of ‘disability’ was given as follows:

*The term ‘disability’ is a very broad definition. For the purpose of this research ‘disability’ can include both congenital disability (something a person is born with, such as cerebral palsy or Down syndrome) or acquired disability (an event or illness has occurred in a person’s life resulting in a disability, such as quadriplegia, brain injury, HIV etc). Mental illness such as bipolar or schizophrenia, are also included in this definition because it can also disable someone’s psyche and/ or behavioural functioning.*

*Disability has been defined in this research project to be in alignment with both the Disability Discrimination Act (Commonwealth 1992) and Anti-Discrimination Act (NSW 1977)*

A combination of quantitative and qualitative questions were utilised. Given that this is an exploratory study, and there are potentially so many variables present at each stage of the appointment with the sex worker and client, most questions included a range of set response



options as well as an open response option to give further information about their experiences.

All questions allows for participants to choose multiple options if relevant.

The length of this survey was carefully considered at the start. The expansive nature of the questions was reflected upon, but as this was the first time sex workers had been asked to participate in a survey in this area of their work it was deemed prudent to gain a greater understanding of all the areas covered all at once.

The research survey was designed with six main sections. An overview is given below to further explain what questions were chosen in each section and the rationale behind them.

*Section 1: General demographics of age and gender of the sex workers with an eligibility question*

The first section (Questions 1 – 6), consisted of general demographics (age, gender, length of time in the sex industry) and a general eligibility question regarding if the participant had ever provided services to client/s with disability within NSW. It was anticipated that the stereotypical social narrative of ‘young, female sex worker providing services to just male clients’ would be challenged via analysis of these demographics (McNeill, 2014)

Question 1 was an open response question asking participants their age. This was designed to be able best gauge people's real age without grouping them into general age categories.

Question 2 asked the participants what gender they identified with. There were three drop down answers of *female*, *male*, *transgender* with a further open-ended box for participants to write their gender if different from the three general options provided.

Question 3 asked the participants how many years/ months they have worked in the sex industry. It was left as an open response so that a more accurate reflection of the accumulative experiences of the participants could be ascertained.

Question 4 was the eligibility question, asking participants *whilst working in NSW have you seen client/s with a disability?* There was no restriction as to the extent of providing such services as long as they identified that they had seen at least one client with disability in NSW according to the above definition. If participants answered 'yes' they were directed to proceed to Question 7.

If the answer was 'no' in Question 4 then the participant was directed to Question 5 and given the opportunity to give their reasons as to why not (6 response options with a further open-ended box for participants to write their own answers). For participants who were not eligible to

continue, they were also given the opportunity to leave any final comments or personal stories which was Question 6.

*Section 2: Number of clients with disability, frequency of visits, the clients' genders and descriptions of their disabilities*

For eligible participants, Section 2 (Questions 7 – 12) of the questionnaire focused on their client/s with disability. It aimed to establish the number of clients with disability each participant had seen, the frequency of repeat clientele as well as the gender of those clients. As little is formally known about this sub-set of clients respondents were asked to list the disabilities of their clients (Question 9) but given that they may not have known the precise 'label', there was the opportunity to give details about specific impairments that were noticeable to the sex worker (26 options including *client could not move arms*, *client had a colostomy bag* and *client in wheelchair*) in Question 10.

The data is anticipated to further support the findings of TLC-Trust, based in the UK, which has a comprehensive list on their website about the diversity of people with disability who may engage sex worker' services (TLC Trust, 2016).

*Section 3: Where sex workers were working and where they provided their services; locations within NSW where this occurred and descriptions of the actual services*

Section 3 (questions 13 -16) focused on location and actual service provision. Questions were included to gain a broader understanding about actual geographical locations of service provision throughout NSW. Additional questions were asked to establish which kind of sex industry establishment or location the sex worker was working from when providing such services (seven options including *full service brothel*, *street* and *escort agency*) and also where the actual service delivery took place (12 options, including *in a hotel*, *safe house* and *nursing home*). Participants were asked to provide information about the full range of services they had ever provided to their clients with disability (17 options, including *hand relief*, *vaginal sex* and *anal sex*).

Common societal perceptions entertain that ‘red light areas’ are the only locational settings where sexual services are provided, so questions were included to gain a broader understanding about actual geographical locations of service provision throughout NSW. While larger metropolitan areas host the largest number and range of sex industry establishments and independent private workers, the sex industry has always operated throughout regional and rural locations.

Similarly, while metropolitan areas historically have a larger range of services and support for people with disability, including supported accommodation and group homes, it would be remiss to think that people with disability do not live throughout the whole of the community, including much less populated towns and cities throughout the state.

The data from this survey can put to rest the idea of “not in my backyard” where people fail to accept that people in their neighbourhood or community are engaging with sex workers, especially not a select number of people with disability.

Questions were asked to participants to establish which kind of sex industry establishment or location they were working from when providing such services as well as where the actual service delivery took place. There can often be a difference between where the client contacts the sex worker and where the appointment actually takes place. There can be many reasons for this including privacy, convenience, mobility issues, levels of support needed for transfers and transportation, opportunity and situational factors such as access to safe houses or short-term rented work rooms.

In addition, private workers may choose to primarily work from their own home or rented work apartment but occasionally offer ‘outcalls’ to clients at their discretion. Escort agencies only offer outcall services where all appointments occur with the sex worker traveling to the client. Some brothels, while primarily running a business establishment where clients attend may also offer outcall services where their staff entertain clients in their own homes or hotels.

It was important to ask about the range of services sex workers provided their clients with disability. The scope of disabilities reflected in the data is anticipated to give further insight into the sexual needs of a broad range of people with disability. This will assist in refuting public misconceptions and stereotypical views about people with disability being asexual or not able to enjoy a broad range of sexual preferences equal to what the rest of society commonly engage in.

*Section 4: How clients located the sex workers, how appointments were made, who made the appointments and potential reasons as to why initial inquiries didn't flow through to an actual appointment*

The fourth section (Questions 17 – 21) focused on the process of arranging an appointment between the sex worker and their client. Information was collected regarding how clients accessed/found sex-workers (9 options including *through my website*, *just turned up at the premises* and *through the Touching Base Referral List*), methods of communication to book appointments (4 options including *phone* and *email*) and who arranged the appointments (8 options including *mother of client*, *father of client* and *service provider/ carer of client*).

Question 20 and 21 asked if the sex worker had ever had initial inquiries that didn't led to an appointment and inquired about reasons they thought this occurred (9 options, including *my place was not accessible for them*, *they could not travel to my place* & *they could not afford the service*, along with an open text box option to give addition reasons).

The rationale behind this section is two-fold. Firstly, in order to improve open and succinct communication between sex workers and people with disability it is imperative to explore what methods are currently being utilised and what works best. With the advancement of electronic aids, computers, tablets and the use of the internet many people with disability are now able to access a much wider range of information, resources and services that previously were inaccessible to themselves.

Secondly, this is the area where third parties, namely parents, carers, support workers, friends and siblings are often involved. This is relatively new terrain for most sex workers as historically transactional exchanges are directly between the sex worker and the client, or organised via an additional person (such as a receptionist) working in the sex industry. Understanding who is involved in organising the appointment will allow further development of information and resources that can specifically assist these ‘third parties’ through the process to allow for a mutually beneficial experience. Further training and resources can be developed to also assist sex workers in this new arena with speaking to third parties when trying to negotiate appointments with future clients.

Finally, examining reasons why initial inquiries did not lead on to an appointment is hoped to inform future resource development and training for sex workers, people with disability and those who work in the disability sector.

### *Section 5: Challenges and barriers before, during or after appointments*

The fifth section (questions 22 – 28) of the questionnaire focused on any barriers and difficulties faced before, during and after a booking. In addition, three qualitative open-ended questions offered the participants an opportunity to share more detail around any other barriers or difficulties they had experienced.

Question 22 & 23 asked *have you faced any challenges when arranging an appointment with client/s with disability?* Participants were given 7 options to tick if applicable (including *I couldn't understand the client on the phone, they wanted me to lower the price and I had to borrow equipment (ie ramp) to make workplace accessible*) as well as an open text box option to give additional feedback.

Question 24 & 25 asked *have you encountered any problems or surprises after appointments with client/s with a disability?* Participants were given 6 options to choose from (including *the client called me every day afterwards, the client's carer/ support worker turned up late to pick them up* and the client asked for a receipt) as well as an open text box option to give additional feedback.

It is important to identify and ameliorate any barriers which may be preventing sex workers from offering services to clients with a disability. The 'third parties' mentioned in Section 4 can



potentially be the client's best advocate or alternatively can be their most suppressive gatekeepers. Due to a lack of knowledge and understanding about how the sex industry operates, misunderstandings and mistakes can occur, breaches of privacy and confidentiality can happen and a lack of respect can be exhibited towards the sex worker making what could have been a pleasant and rewarding experience a highly anxious and stressful occasion.

Creating an increased awareness towards some of these core issues people may have faced previously can provide a more supportive and congenial environment for future sex workers, and their clients with disability

*Section 6: Reflections on what participants thought the most positive things about seeing clients with disability are and an opportunity to leave any final thoughts or stories in regards to this topic*

The final section of the survey involved two qualitative open-ended questions. These gave the participants the opportunity to share information about their experiences in a lot more depth.

Question 29 asked respondents to consider what they felt was the most positive thing about providing services to clients with disability. The discourse of sex workers' perceptions about their work, in general, is rarely thoroughly examined. This question allowed for participants to

share any specific thoughts about their clients with disability and to reflect upon the value of their interactions from their own perspective.

Question 30 allowed respondents to leave any final comments and feedback, with the opportunity to share any personal stories. The voices of sex workers, sharing first hand experiences and perceptions has been most notably absent from empirical data and academia until more recent times, even more so in relation to this topic of sex workers providing services to clients with disability. Before embarking upon this research, numerous conversations with sex workers alerted me to the fact that these stories had not been collated or shared outside of private peer-only sex worker circles and so this final question allowed for this to occur.

### Data Analysis

The quantitative survey results were organised by the Zoomerang online survey platform to create the data sets, figures and tables to produce my findings. The open- ended qualitative data results were manually organised, using a colour coded process, to divide them into the emerging themes. Two colleagues independently checked the data analysis and interpretation of the emerging themes for accuracy.

## Chapter 8. Results and Discussion

This chapter will discuss the data acquired from the survey participants along with an analysis and discussion of the results. The survey was divided into six sections:

1. Demographics of respondents
2. Demographics of clients
3. Workplace locations and services provided
4. Appointments
5. Challenges and barriers, and
6. Personal reflections: the most positive aspects of this work

As little is known about the sub-set of sex worker clients with disability the study explored a range of questions pertaining to types of services paid for, how the client found their contact details, the frequency of appointments and how the appointment was made. Questions about the type of disability with which clients presented were asked in two different ways as outlined in Chapter 7. The first was asking respondents to name the disability their clients had, as well as asking for general descriptors of the disability. Issues with pre and post bookings as well as any problems that might have arisen during the booking were examined. The final two questions allowed respondents to share their personal considerations relating to what they found was the most positive thing in providing services to clients with disability, as well as any other personal experiences they wished to share.

Between 9<sup>th</sup> April 2009 and 22<sup>nd</sup> April 2010 there were 72 viable survey responses. There were an additional 76 significantly incomplete, inappropriate or empty responses which were discarded and not included in the final data analysis. Of the 72 viable responses there were 7 participants who did not meet eligibility criteria as they had not provided services to client/s with disability in NSW or had only done so in other states or countries. Notably, there were two respondents in this group that were not eligible to participate as they identified as being Canadian sex workers but wanted to give their support to the beneficial aims of the research. There was also one sex worker who worked in the state of Western Australia who also wanted to have their experiences in working with clients with disability noted, even though they could not be included in this survey's final data analysis. This left a final total of 65 eligible survey responses of which the results of this survey are based upon.

The option to complete a hard copy of the questionnaire was not utilised by any respondent.

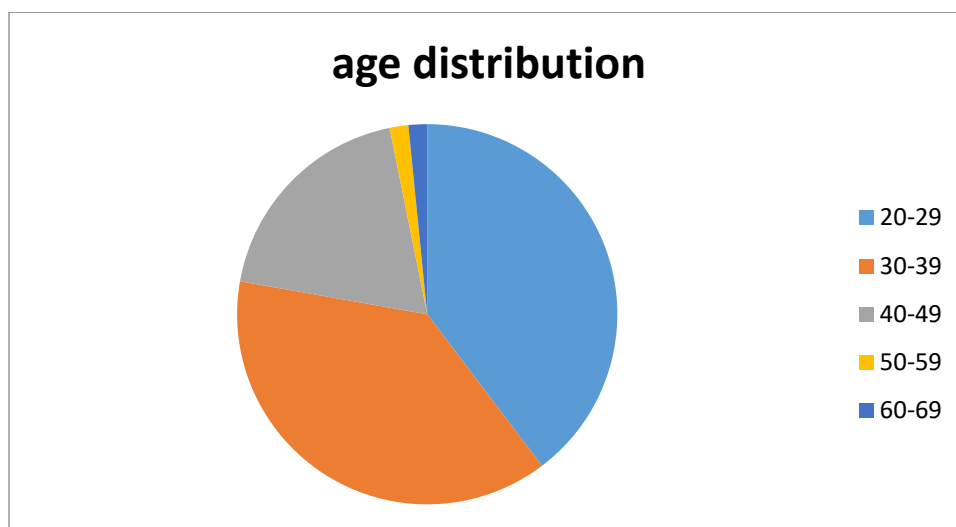
## Section 1: Demographics of respondents

### Age of respondents

Question 1 was an open ended question asking what their age was. The average age of respondents was 32.2, ranging from 21 to 61 years of age. The mean age was 31, with the majority of respondents being in their thirties or forties. Of the nine male sex workers their age

range was between 22 and 46 years of age with an average of 34.3 years. The transgendered sex worker was 23.

The age range of respondents is shown below in Figure 3.



*Figure 3. Age distribution of respondents*

### Gender of the sex workers

Question 2 allowed for people to state the gender they identified with.

There were 65 eligible respondents who completed the online questionnaire; with the gender dispersion being 55 female, 9 male and one transgender sex worker. These results reflect the general percentages of participation within the sex industry for each gender group (Donovan et al., 2012).

### Experience within the sex industry

Question 3 asked participants *how many years/ months have you worked as a sex worker?*

When analysing the 65 respondents, it was calculated that there was over 612 years of experience between them, ranging from five months up to 31 years, with an additional respondent who was 35 years old also responding *since 18yrs old on and off*. Not including this last participant the average amount of time with in the sex industry was 9.4 years, with the least experienced worker starting 5 months prior to completing the survey, through to someone with 31 years' experience. This indicates that regardless of age, gender or amount of time working within the industry that sex workers are providing services to clients with disability. This could be due to a number of factors that can only be speculated upon as clients were not directly surveyed themselves. Factors of influence could include the client desiring a certain sex worker in a specific age bracket, being happy to see whichever sex worker was available at the time, needing to see a sex worker with a particular skill-set or only trusting direct referrals from friends, other clients or previous sex worker (as seen from the results from Question 17).

### Eligibility question

Question 4 served as the general eligibility question regarding if the respondent had ever provided services to client/s with disability within NSW. Of the 72 viable respondents 65 answered *yes*. A further 7 answered *no* and were prompted to expand on why they hadn't done so, in Question 5.

### Reasons why participants haven't provided services to clients with disability

The respondents who self-identified in Question 4 as having never provided services to clients with disability were asked to give reasons in Question 5 as to why this had not occurred with Question 6 allowing these respondents to leave any final comments. Respondents were prompted to select as many of the answers as deemed appropriate to their experiences, hence eight responses from seven participants. Their reasons can be seen in Table 3.

Table 3. Reasons why respondents had not provided services to clients with disability (N=6)

Answer Choices	Responses	
lack of confidence	0.00%	0
never been asked/ approached by a client with a disability	83.33%	5
never had any training	16.67%	1
brothel/ parlour/ premises I work in is not disability accessible	16.67%	1
I choose not to see clients with a disability.	0.00%	0
would feel uncomfortable seeing clients with a disability	16.67%	1
Other, please specify	0.00%	0

The predominant reason why they hadn't seen clients with disability was they had never been asked or approached by a client with disability. however, one respondent specified that they *would feel uncomfortable seeing clients with a disability* and *never had any training*. There were also references made later in the survey from a number of respondents who also were unsure of taking the booking because they were *not confident to work with the person's level of disability*

(response to Question 20) or they had *difficulty negotiating through the disability* (response to Question 23). Specific training in this area could certainly assist sex workers with these issues.

Additionally, one respondent identified that the premises they were working at were not accessible, which is an issue that was examined in more detail in Section 4, where respondents were asked why they thought initial inquiries did not eventuate into a booking.

## Section 2: Demographics of clients with disability

The second section of the survey attempted to gauge relevant information about the respondents' clients. This included establishing the quantity of clients in this category they have provides services to, the gender of such clients, the range of disabilities their clients presented with and the frequency of their bookings.

. Each question was optional with not every question being answered by all 65 respondents.

### Number of clients with disability

The response to Question 7, *approximately how many clients with a disability have you provided services to?* generated a broad range of answers from respondents. They included:

*1, 5, 10, 13, 20, 30, 20-30 at least, 50, 55, 60, 100, 200 and without HIV+, 60 clients; HIV+ 80 clients=140.*



Out of the 57 who gave absolute numbers the total number of clients seen ranged between 1,301 and 1,535. This is because a few respondents answered with approximations such as *160-250* or *20-30*. Other responses including *no idea - it's only a few a year, approx. 2 - 3 per month, don't know* and *many*.

As this has never been asked to a cohort of sex workers before there is no way to currently determine if these figures are representative but it challenges the notion that clients with disability never seek the services of sex workers in NSW or that it is a rare occurrence.

#### Gender of the clients

Question 8 asked participants *what gender are your clients with disability?* From all respondents, 100% identified as having male clients with disability seven (11.29%) had provided services to female clients and three (4.84% ) had prior bookings with clients with disability who are transgender. The results can be seen in Figure 4.

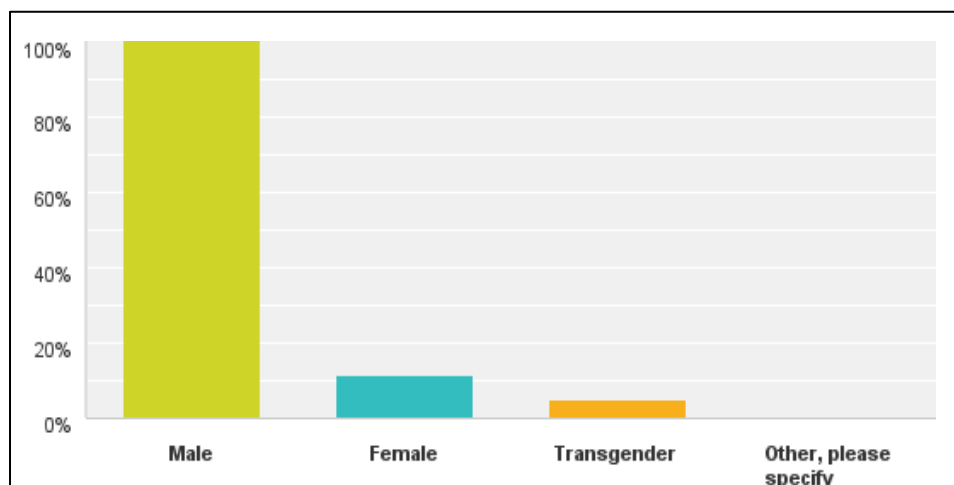


Figure 4. Gender of the clients with disability to whom participants provided services

The gender diversity of their clients echoes empirical data previously collated about clients in general (Huschke & Schubotz, 2016) as well as anecdotal reports that women are also clients (Anonymous, 2011 ). These results challenge the stereo-typical assumptions made by society that only men with disability would engage the services of sex workers and validates the researcher’s experience in her role as one of the Touching Base Referral List Officers.

Sanders (2007) noted that there is an “absence of research and literature on the thoughts and experiences of women living with impairments and sexual relationships ... and commercial sex. This is an obvious research gap which needs to be addressed” (p. 441). While this research can only assist in establishing that sex workers do occasionally see women with disability it will be interesting to see if this is also reflected in the final results from the Women Who Buy Sex Project (Lancaster University, 2016).

Identifying the range of disabilities / impairments that clients presented with

The diversity of the respondents' clients, in regards to their disability was explored in Question 9 and 10 by asking respondents for the exact name of their disability (if they knew it) and then allowing them to identify impairments in a more general manner.

Question 9 asked participants *to identify specific name or type of disability/s your clients have presented with*. Answers were derived from 50 respondents with a wide range of disabilities mentioned spanning both physical and cognitive disabilities, as well as acquired and congenital disabilities. Responses are shown below with the number of times mentioned in brackets.

Paraplegia/quadriplegia (28), Schizophrenia/Bipolar (27), Cerebral Palsy (25), Deafness / hearing impaired (17), Multiple Sclerosis (13), Blindness (10), Autism / Asperger's (9), Amputees (9), anxiety disorders (8), Parkinson's (7), Acquired Brain Injury (6), obsessive compulsive disorder (4), depression (4), the use of colostomy bags (4), spinal cord injuries (4), Down syndrome (4), Post Traumatic Stress Disorder (3), stroke survivor (3), morbid obesity (3), degenerative disorders of the spine (including spina bifida, severe scoliosis) (3), wheelchair bound (3), Severe burns (3), HIV (3), intellectually disabled (2), Muscular Dystrophy (2), mute (2), physical disabilities / birth deformities (2), Tourette's (2), Polio (2), Agoraphobia (1), Haemochromatosis (1), psoriasis (1), born with no limbs (1), Diabetes (1), Heart Disease (1), frail aged (1), ADHD (1), bone disorder (1), prostate cancer survivor (1), liver cancer (1), Elephantitis (1), Epilepsy (1), degenerative disorder of the feet (1)

The most frequent response was *Paraplegia/quadriplegia* however the second most common was *Schizophrenia/Bipolar*. In fact over a third of the nominated disabilities had a degree of cognitive impairment (including such disabilities as Multiple Sclerosis or an acquired brain injury which can impact upon a person's physical and intellectual capacities).

This is important to acknowledge and identify specifically due to the ongoing discourse around the ability for people living with an intellectual disability to give informed consent. This has continued to be a rising concern since this research was conducted, with Touching Base recently addressing this issue with the launch of three new educational booklets (Burrell et al., 2016).

***Seeing a Sex Worker – a guide for people with disability*** is a comprehensive and detailed booklet specifically for people with disability and their support workers / family. It compliments two social stories ***Anna Sees a Sex Worker*** and ***Tony Sees a Sex Worker*** which have been designed to assist people with intellectual disability in learning more about the sex industry and if seeing a sex worker is the right choice for them. These pictorial story books are the only known publications of their kind and aim to fill the gap in educational materials for people with disability who are considering seeing a sex worker. This information is also anticipated to assist with sex workers increased knowledge and understanding of people with disability and to streamline communication pathways to alleviate issues that may arise during the booking process as well as during the booking. These issues are discussed in Section 3 of the questionnaire discussion.

It is anticipated that further research in this area could include an analysis of how and why the client with disability decided to see a sex worker and what support and educational tools were utilised to reach such a decision. These findings also substantiate that there is no specific ‘type’ of person with disability who has sought the services of a sex worker, as indicative of the extensive range of responses elicited from Question 9. Furthermore, given that people with disability are constantly experiencing stigma and discriminatory attitudes, it appears that there is substantial acceptance of the diversity of clients to whom sex workers are more than willing to provide services. Consequently, this data can be used to support further discussions within the disability sector about peoples’ sexual expression, no matter what their disability may be.

Question 10 asked about identifying different disabilities in a more general manner without the need for respondents to know about specific names or conditions. The question was framed as such: *People with the same disability can often have very different levels of impairment. In addition, people with different disabilities may present with similar impairments. For this reason, this research project would like to learn more about the particular impairments that your clients present with when they see you.*

This allowed the researcher to gain a greater insight into how clients presented to the sex worker and the encompassing challenges that could exist during a booking. A higher proportion of respondents replied to this question as opposed to the previous one which asked for specific ‘labels’ or names of disability (61 compared to 50). This is understandable as not everyone would feel comfortable asking (or disclosing) about the specifics of the disability but all sex

workers are able to generally describe how their clients' abilities impact upon certain aspects such as mobility and communication.

Respondents were asked to tick all categories that described any client/s they have seen with a disability, with 61 respondents providing responses. Answers were extremely varied though the most common response was that the client was in a wheelchair. While the top five answers all made mention to impaired levels of mobility it is interesting to note that 47.54% of respondents had seen clients who were hearing impaired or deaf. The full results are in Table 4.

Table 4. Range of impairments participants' clients presented with (N=61)

Answer Choices	Responses	
client in wheelchair	73.77%	45
client needed assistance with dressing and undressing	59.02%	36
client needed assistance with walking	57.38%	35
client in bed already and could not move much	54.10%	33
client was very shaky / had tremours	54.10%	33
client had a skin condition	52.46%	32
client was hearing impaired / deaf	47.54%	29
client had a brain injury	44.26%	27
client spoke but hard to understand	44.26%	27
client could not pick things up with his hands	42.62%	26
client used a walking cane	42.62%	26
client was missing a limb	42.62%	26
client repeats the same conversation/ sentences with me	37.70%	23
client had a colostomy bag	36.07%	22
client had slurred speech	36.07%	22
client was on crutches	34.43%	21
client had a catheter	34.43%	21
client was vision impaired / blind	29.51%	18
client could not speak at all	27.87%	17
client used a communication board	27.87%	17
client could not move arms	26.23%	16
client can't remember me from one time to the next	26.23%	16
Other, please specify	26.23%	16
client was in a plaster cast	22.95%	14
client had short term memory loss	19.67%	12
client communicated through sign language	18.03%	11
client had more than one bag attached to them	9.84%	6

A number of respondents also answered in the open-ended option box of 'other'. These responses were quite informative and included:

- *was very hyperactive*
- *client had no use of legs*
- *mostly guys who are intellectually impaired*
- *clients with severe anxiety/depression and ptsd*
- *seemed to have learning difficulties*

- *used a machine to help breathing*
- *missing all limbs, flipper hands, only 2 toes*
- *client needs support for back, temp sensitive*
- *Issues relating well, ie. schizophrenia, bipolar*
- *heightened/limited sensitivity physically and mental*
- *cerebral palsy+sex ass [sexual assault] trauma + mental health*
- *general difficulty with movement*
- *erratic emotional/moods swings,*
- *client had difficulty swallowing*

Collating the data responses led to a number of themes which included:

- Mobility issues (little to no movement of the body, tremours)
- Decreased dexterity (needed help with un /dressing)
- Different communication methods (sign language or the use of communication boards)
- Difficulties in communicating (no verbal communication, slurred speech or hard to understand)
- Medical aids (catheters, colostomy bags, breathing apparatus)
- Skin conditions
- Different levels of cognitive impairments (acquired brain injury, intellectual disability, short term memory loss)



The responses to this question foster a greater recognition of sex workers being highly adaptable and capable of modifying their service delivery according to the individual needs of the client. Respondents were not asked about any prior training, though anecdotal and limited empirical evidence suggests that sex workers often utilise specialised skills and training derived from other professions, such as nursing, occupational therapy or disability support services (Sanders, 2006). Additionally, some sex workers have personal experience with supporting people with disability derived from family members and friends living with disability.

The only specific training offered, in Australia, to sex workers working with clients with disability is the Professional Disability Awareness Training (PDAT) workshop delivered by Touching Base, but respondents were not asked if they had been a previous participant. Additionally, the content delivered does not currently have the scope to convey such detailed information that would provide sex workers the new skills and knowledge to provide for such a wide variety of clients that this research data has outlined. The analysis from this research is anticipated to be able to assist in the direction and content needed for future training packages formulated for sex worker training workshops.

These results also demonstrate the diversity of clients, supporting findings within the literature outlined in Chapter 5. The generalised fear and stigmatisation of clients still leads to restrictive policies and regulations for the sex industry, even within NSW. Examining the range of disabilities mentioned within these results can assist in normalising societal perceptions of who a

client could be: a man in a plaster cast and crutches; a woman using a wheelchair; a person with social anxiety; a man with vision impairment using a cane; someone with a skin condition. All of these people challenge previously held ideologies about clients, transitioning away from the stereotypical portrayals of clients as untrustworthy, deviant predators who are lured into specific neighbourhoods because of the sex industry. Instead, this data supports other findings reflecting that clients are often a part of the local community and share the same demographics as the rest of society.

#### Regular clients

Question 11 asked *have you seen any of your clients with a disability more than once?* Out of the 65 respondents only three skipped this question and did not respond. Out of the 62 respondents 90% had seen their clients with disability more than once suggesting that their clients were satisfied with their services and chose to return regularly to the same sex worker.

#### Frequency of client visits

The final question in Section 2 concerned the frequency of visits clients with disability have with sex workers. The question asked was *we are interested to discover how frequently clients with a disability re-visit the same sex worker. Please identify below, how often your clients with a disability come back to visit you.* The responses can be seen in Table 5.

Table 5. Frequency of client visits (N= 48)

Answer Choices		Responses	
Onlywhen theycan afford to see me	Responses	60.42%	29
No set pattern	Responses	58.33%	28
Once a month	Responses	47.92%	23
Once every 3 months	Responses	39.58%	19
Once a fortnight	Responses	27.08%	13
Once a week	Responses	22.92%	11
Once every 2 months	Responses	20.83%	10
Once every 6 months	Responses	20.83%	10
Once a year	Responses	14.58%	7
Once every 4 months	Responses	6.25%	3

The most common response was *only when they can afford to see me*, hardly surprising when one takes into consideration the high percentage of people with disability being financially supported by a disability support pension and not in paid employment,. The second highest response, with over 58% of the respondents' clients having *no set pattern* further supports this, though granted there are numerous other reasons that could be attributed to this. These could include illness, variation of who the client chooses to see or the sex worker has not been available at a mutually suitable time and date.

Nearly 48% of the respondents' clients saw them regularly on a monthly schedule with a further 39.58% of clients booking once every 3 months. Every frequency option given was utilised, demonstrating that while there is no set pattern that clients with disability book sex workers, they are just as capable of regularly paying for sex as any other client. The frequency of bookings is consistent with previous research done in Australia about clients in general (Perkins, 1999).

For those who need the ongoing assistance of third parties to co-ordinate and attend appointments, this regularity of bookings may also be precipitated by the requirement to schedule specific / additional staffing and transportation. This has certainly been the personal experience of the researcher who has a number of clients who have their annual booking schedule organised at the start of the year to ensure such additional assistance is available.

### Section 3: Workplace locations and services provided

Section 3 of the survey focused on where sex workers were working, where service delivery took place and which services were provided to clients with disability. Geographic locations of service delivery within the whole of the state of NSW as well as the Greater Metropolitan area of Sydney was also examined.

#### Location of workplace

Sex work in NSW occurs under a decriminalised framework, except for street-based sex work (which is legal within the parameters of the Summary Offence Act 19 & 20 (NSW Government, 1988) but the only type of sex work still regulated by the police). It seemed prudent to identify where sex workers were working when clients with disability contacted them to arrange a booking. This will assist in dispelling the idea that only one type of sex worker could be 'acceptable' to provide services or that accessible services can only be found in one type of location.

Question 13 asked respondents *where were you working when you provided services to client/s with a disability?* . More than one location was allowed to be selected. The one respondent who selected “other” worked as an online cam model. Table 6 has the collated responses.

Table 6. Workplace location when providing services to clients with disability (N=59)

Answer Choices	Responses	
private worker (home or rented premises)	59.32%	35
full service brothel	50.85%	30
private escort (outcalls)	44.07%	26
BDSM parlour	15.25%	9
escort agency	11.86%	7
street	10.17%	6
massage parlour	6.78%	4
Other, please specify	1.69%	1

The results indicated that at least some clients with disability in NSW had an awareness of the range of options available to them. While *private sex workers* (those offering in-calls from their own location and those offering outcalls to the client’s premises) and *brothels* were utilised the most, sex workers also had bookings when working in *BDSM parlours*, *escort agencies*, *massage parlours* and while working as a *street-based* sex worker. One also offered services when working as an *online cam model*.

These results assist in diffusing negative perceptions and fears still held about sex workers and specific sectors of the sex industry. For instance, sex industry establishments, such as massage parlours and brothels, are still frequently deemed as risky places to live near and believed to

cause *detrimental impacts on local amenity, property values, criminal activity and even society in general* (Steinmetz & Papadopoulos, 2011).. These contentions are all unfounded, based on what has been discussed previously: ill-informed media, negative on-screen character portrayals and policy and law reform debates guided by moral and religious panic rather than an evidence-based approach.

The idea that clients with disability may actively choose to see a street-based sex worker would be particularly challenging for some people who, until recently, have overtly protected people with disability and denied them autonomy over their sexual needs. The same would hold true about clients choosing to explore their sexual expression at a BDSM parlour. Anecdotal evidence acquired by the researcher certainly supports this data, with the belief that these results actually under-represent the number of clients with disability who, in Sydney at least, have regularly paid for services in private dungeons and established BDSM parlours.

The increased accessibility of communication devices such as computers, tablets and mobile phones has allowed the internet to enrich the lives of some people with disability by becoming less reliant on others for information and options available to them. As pornography and sex toys were previously only sold in sex shops (historically only accessible via a flight of stairs in either basement rooms or shops above ground level) the increase in internet based shopping, free and pay-per-view porn downloads and photographic advertisements of sexual toys has given people with disability further scope to explore their sexual expression. As previously discussed, the sex

industry has also adapted to increased internet usage creating specific and targeted advertising and offering a wider range of services. Due to difficulties with transportation and/ or accessibility limitations, online Webcam services have certainly provided an additional option of enjoying sexual interactions and enjoyment previously denied to some clients with disability.

#### Location of service provision

The research also aimed to identify where the service delivery took place. This differs from Question 13 in that the first contact point between sex worker and client is not always the same location as to where the appointment will occur. For example, a private sex worker may choose to see clients at their home, a rented premise, in the client's hotel or the client's residence. Street-based sex workers may also offer services in all of these locations but with an additional option of a safe house (if working in Kings Cross, Sydney) and escort agencies will only ever co-ordinate a sex worker to visit the client's nominated premise.

Question 14 asked respondents *where have you provided services to client/s with disability?*

The three most common locations were the client's private home, in the brothel or at the private worker's premises (either in their own home or a rented premises). Interestingly, a small proportion were in nursing homes (14.04%), safe house (5.26%) and hospital rooms (5.26%). The full range of responses can be seen in Table 7.

*Table 7. The locations where sexual services were provided to clients with disability (N=57)*

<b>Answer Choices</b>	<b>Responses</b>	
their private home	<b>59.65%</b>	34
full service brothel	<b>45.61%</b>	26
in a hotel	<b>33.33%</b>	19
rented work premises	<b>31.58%</b>	18
my home	<b>26.32%</b>	15
nursing home	<b>14.04%</b>	8
group home - supported accommodation	<b>14.04%</b>	8
BDSM parlour	<b>12.28%</b>	7
massage parlour	<b>8.77%</b>	5
safe house	<b>5.26%</b>	3
hospital room	<b>5.26%</b>	3
Other, please specify	<b>5.26%</b>	3
Car	<b>3.51%</b>	2

The data demonstrate that, as the sexual rights for people with disability are starting to be addressed, policies and procedures need to succinctly accommodate for private and discreet visits of sex workers to some residents in group homes and nursing homes. This is not a new and emerging trend but something that has always occurred ‘under the radar’, regardless of what is deemed politically or morally correct. Policies of support organisations need to be updated to reflect current legal and social reforms to support peoples’ sexual rights as adults.

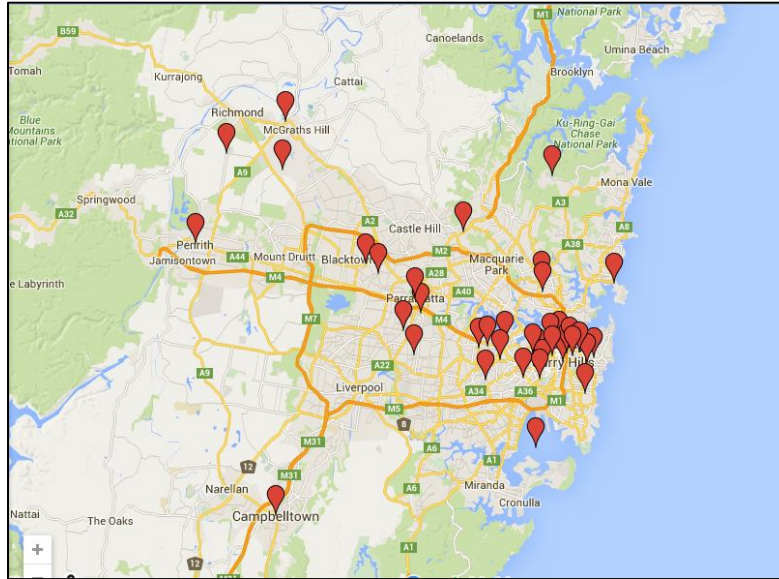


This is further exemplified by the results showing that three respondents had provided services to clients *in hospital*, two said in a *car* and a further three interactions with clients with disability occurring in a *safe house* (short term room rental establishments in Sydney where clients of street-based sex workers can hire by the half hour or full hour). All of these locations may seem perplexing and totally unacceptable to anyone who has never been involved in the sex industry, but for the booking to occur the clients would have had to directly approach the sex worker to arrange the appointment, showing clear autonomy and a willingness to participate.

These results also refute general misconceptions, discussed in previous chapters, that people with disabilities are deemed asexual or not desiring sexual and intimate contact with others equal to anyone else in society. Instead, these results demonstrate that the sexual desires and interest to employ the services of a sex worker is clearly within the realms of people with disability. There is a level of over protectiveness revealed by many when talking about the sexual rights of people with disability but within the disability sector further discussion may be needed to recognise and support the balance between duty of care and dignity of risk as outlined in Chapter 3.

#### Locations within NSW where service delivery occurred

Forty nine respondents answered Question 15, sharing what areas in the state of NSW they has provided services to their clients with disability. The majority of locations were placed within the Greater Sydney Metropolitan region (88 locations) as seen in Figure 5.



*Figure 5. Locations within Greater Metropolitan Sydney where service delivery took place*

While it was to be expected that a great portion of the locations would be identified within the Greater Sydney Metropolitan area, there were a considerable amount of regional and rural locations identified (22). These included Wagga Wagga, Albury, Orange, Tamworth, Armidale, Broken Hill, Tweed Heads and Lismore.

All locations within NSW that respondents identified can be seen in Figure 6.

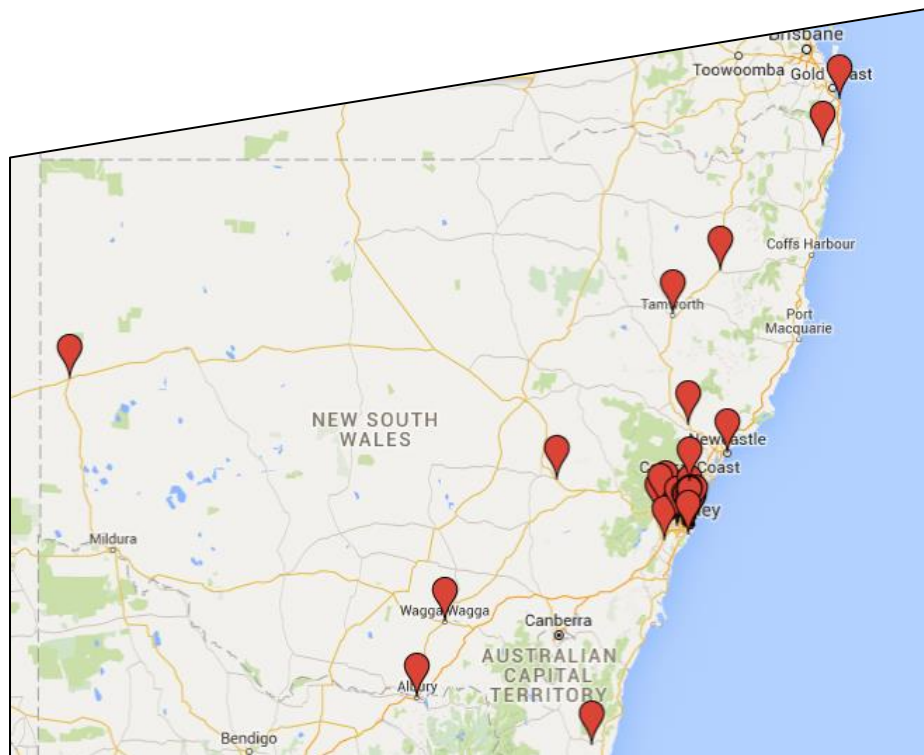


Figure 6. Locations within NSW where service delivery took place

Four respondents gave additional feedback about also providing services to clients with disability outside of NSW. These included three locations within Australia; Canberra (Australian Capital Territory), Melbourne (Victoria), Hobart (Tasmania); as well as San Francisco (USA). This information supports anecdotal evidence acquired through the researcher's own experience and data gleaned from the Touching Base Referral List inquiries that indicate that clients with disability are accessing the services of sex workers in many countries and jurisdictions, regardless of the sex worker legislation that is in place in their location.

These results undermine popular perceptions that the sex industry only operates in major cities. In fact, since the data collection phase of this research there has been increased media attention on ‘fly in, fly out’ (FIFO) sex workers, mainly due to the mining booms across Australia.

The findings also show that people with disability have been able to utilise the services of sex workers even in more traditional smaller, regional towns where people often have to navigate their way through higher privacy concerns and issues. While larger towns and cities can create a cloak of anonymity with increased traffic flow and more infra-structure, smaller towns can amplify the “five degrees of separation” rule where everyone is connected to everyone else by either work, family or social encounters. This can be particularly challenging; for instance, if a man with disability in supported accommodation, expresses a desire to see a male sex worker when he is presumed to be heterosexual by his family and friends; or the only available sex worker in a small town is the partner of one of the staff within the client’s residential care facility. There were two respondents within this survey who explicitly stated that they did not want to share locational details, perhaps wanting to safeguard the privacy and confidentiality of themselves and their client/s location if such details could easily identify either one of them.

These results can be utilised to remind disability support services that information and support must be equally delivered across the state, with staff in regional and rural areas being adequately equipped to support the diverse sexual expression needs of adults in their care in a non-discriminatory, private and respectful manner.

Sexual services provided to clients with disability

Question 16 asked respondents *what service/s have you provided to your clients with a disability?* There were 56 responses which can be seen in Table 8.

Table 8. Services provided to clients with disability? (N=56)

Answer Choices	Responses	
hand relief	96.43%	54
blow job/ French/ oral sex (client receiving)	80.36%	45
Massage	76.79%	43
blow job/ French/ oral sex (client giving)	57.14%	32
vaginal sex( client giving)	55.36%	31
Striptease	50.00%	28
toys – vibrators	48.21%	27
fantasy	42.86%	24
vaginal sex (client receiving)	30.36%	17
Spanish	30.36%	17
doubles (2 workers, 1 client)	28.57%	16
BDSM	25.00%	14
strap ons	25.00%	14
anal sex (client receiving)	23.21%	13
anal sex (client giving)	16.07%	9
Other, please specify	8.93%	5
doubles (1 worker, 2 clients with a disability)	5.36%	3
doubles (1 worker, 1 client with a disability, 1 client without a disability)	5.36%	3

The range of services paid for by clients with disability reflect the broad range of desires and sexual activity enjoyed by the general population within Australia (de Visser, Richters, et al., 2014; Richters et al., 2014). These include both physical and emotional services as reflected by the additional comments pertaining to *personal intimacy, cuddling and conversation and company*. These also reflect current empirical literature where the sex workers interviewed

clearly identified that, alongside sexual activities, services offered to clients included many therapeutic and emotional dimensions (Bates & Berg, 2014; Hartley, 2000; Sanders, 2006)

#### Section 4: Appointments

Section 4 focused on all aspects of the appointment including how clients have located sex workers, their methods of communication between the client and sex worker and who arranged the appointment. The results of Question 17, 18 and 19 are shared below, followed by a discussion and analysis of such results. The final segment of Section 4, Question 20, looks at reasons why inquiries may not have developed into an actual appointment.

##### How clients locate sex workers

Question 17 asked *how have clients with a disability found you?* The answers were quite varied and can be seen in Table 9. Answers given in the ‘other’ option included *telephone book, receptionist recommendation, friends of friends, escort agency, parents, Family Planning Association* and *referral from a therapist*.

Table 9. How did clients locate the sex workers? (N=55)

Answer Choices	Responses	
Just turned up at the premises	<b>58.18%</b>	32
Referral from another sex worker	<b>45.45%</b>	25
Via the internet	<b>41.82%</b>	23
Word of mouth	<b>40.00%</b>	22
Through my ad in the paper	<b>34.55%</b>	19
Through my website	<b>21.82%</b>	12
Referral from a support person	<b>21.82%</b>	12
Through the Touching Base referral list	<b>10.91%</b>	6
Other , please specify	<b>10.91%</b>	6
Spoke to me on the street	<b>5.45%</b>	3

### Methods of communication

Respondents were asked to share their experiences in Question 18 in regards to how the client made contact with themselves to make an appointment. Four open-ended answers were also submitted in the ‘other’ answer, which included: *via phone but in advance, take over from other worker, IM (instant messenger)* and *through advocates or carers*. The percentages of each answer can be seen in Figure 7.



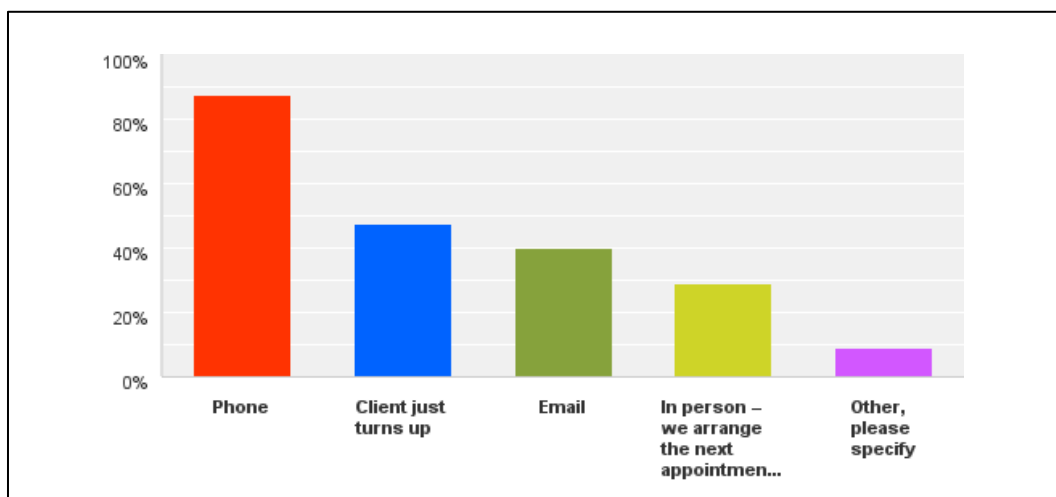


Figure 7. How the client made contact with the sex worker

### Who arranges the appointments with the sex worker?

Question 19 allowed participants to share their experiences with who arranged the appointment between themselves and their client. There were 55 responses which can be seen in Table 10. An additional three replies were given using the open-ended option. Those answers included: *other client with disability*, *BDSM parlour management* and *at the brothel, receptionist*.

Table 10. Who made the appointment? (N=55)

Answer Choices	Responses	
Client	94.55%	52
Service provider / carer of client	45.45%	25
Other sex worker	29.09%	16
Friend of client	25.45%	14
Father of client	20.00%	11
Mother of client	7.27%	4
Brother of client	7.27%	4
Sister of client	5.45%	3
Other, please specify	5.45%	3

Respondents indicated that their clients initially located them through a number of avenues as outlined by Table 10 in the Results. Overall the methods can be divided into three categories:

- turned up to the location where sex workers were waiting for clients (establishment such as a brothel or massage parlour, street-based sex work area)
- advertising (online, newspaper, yellow pages); and
- via referral (from another sex worker, Touching Base, support person, Family Planning Association, therapist, receptionist, friend of friend, parent of client)

While the first two categories are commonly used amongst clients in general, the third category identifies influential third parties who have had a positive contribution towards supporting people with disability access the sex industry. It is this category that information and networking strategies should particularly be focused upon to increase knowledge and awareness of the sex industry and its diversity. Already recognising this need, FP NSW has recently co-ordinated a number of sex and sexuality information days, specifically for parents of people with disability. Additionally, the *Feel the Vibe* expos run by Northcott have created a supportive environment, for people with disability and the third parties supporting them, to learn more about sex, sexuality and options for sexual expression. Touching Base and sex workers have specifically been invited to share information and to have a visible presence at both events.

Since the completion of this survey the activities of Touching Base have continued to expand. Most specifically the sex worker referral list has dramatically grown with multiple inquiries

being received daily instead of just a few times per week (S. Isbister, personal communication, September 1, 2016). While only six respondents indicated that clients found them via a Touching Base referral, it would be anticipated that this would substantially increase if the research was replicated now.

While some clients with disability have demonstrated that they are capable of locating sex workers and empowered enough to express their desires in seeing a sex worker, some are reliant upon others to proceed through to the booking. Respondents were asked who was responsible for making the initial contact and how this occurred.

While the majority of bookings were initiated via a phone call, email was also widely utilised as well as the client just turning up at the establishment. What is distinctive is that contact was initiated by a wide range of people other than the client themselves. This was predominantly done through a *service provider /carer of the client* though friends and family members of the client have also been involved. Additionally sex workers have assisted in arranging appointments for their clients to their peers and colleagues as well as creating manageable booking systems and coordinating the client's next booking before they leave.

These findings can inform sex workers' understanding of the variety of third parties who can potentially contact them. Talking to someone that isn't their client deviates from the usual

business practices of sex workers. These discussions can be extremely confronting as open negotiations and considerations about private sexual acts and interactions are not standard practice with someone's mother or father. Indeed the results show that all members of a client's family can be involved including brothers and sisters. Personal friends, including people with disability who had already seen the sex worker were also involved in arranging appointments.

While certain 'rites of passage' (where the father takes their son to a brothel to lose their virginity) have been identified in some cultures, for most third parties this is a 'brave new world' and an element of their work or lives that they have had little or no preparation for. The Touching Base website, resources and educational workshops have helped fill this gap in recent years, giving support, referrals and opportunities for both the disability and sex worker communities to learn more about each other with dignity and respect. Personal stories written by clients and their parents are shared on the website (Touching Base Inc, 2016b) giving first hand perspectives of the challenges and benefits of seeing a sex worker. Additionally, feedback received from participants of workshops Touching Base delivers for both sex workers and disability organisational staff, has indicated that the 'mock phone call' segment is a valuable teaching point in the day. This assists in giving sex workers an idea of things to ask and be aware of when a third party is calling on behalf of a potential client. Similarly, disability support workers are often quite nervous moving from the theoretical to practical elements of support. Showing how an initial phone call can proceed, in a 'practice run' with one of the trainers (who is also a sex worker) has allowed participants to decompress some of their fears and

apprehensions about what to expect talking to a sex worker. For both parties this activity has normalised the interaction and given them an increased level of confidence.

These results are anticipated to assist with broadening awareness of the frequency that third parties are involved in arranging appointments with sex workers on behalf of someone else. This in turn can support carers, parents and family members, knowing that they are not alone in this journey while also creating a greater awareness and understanding amongst the sex worker population about how to communicate with third parties succinctly.

#### Do some inquiries not lead to an appointment?

Question 20 asked participants *have you ever had inquiries to provide services to a client with a disability but the inquiry did not lead to an appointment with you?* Out of the 55 respondents who answered this question 70.91% answered yes.

#### Reasons why some inquiries may not lead to an appointment

If respondents answered 'yes' to Question 20 they were prompted in Question 21 to give reasons as to why they thought this occurred. Table 11 shows the full range of answers.

Table 11. Reasons why inquiries may not have translated into an appointment (N=39)

Answer Choices	Responses	
They could not afford the service	46.15%	18
They never rang back	38.46%	15
Not sure	33.33%	13
I was not available on the day they requested	28.21%	11
Other, please specify	25.64%	10
They lived too far away from me	23.08%	9
My place was not accessible for them	23.08%	9
I was not what they were looking for	23.08%	9
I did not provide the service they were looking for	20.51%	8
They could not travel to my place	10.26%	4

There were also nine specific open-ended answers supplied under the ‘other’ category. They were:

- *the couple of calls I had who cited accessibility probs [sic] did not want an outcall*
- *not yet comfortable enough to sleep with sex worker*
- *Unrealistic expectations set by another worker*
- *carer would not take them*
- *Not confident to work person's level of disability*
- *Didn't feel right!*
- *did not leave contact #, just message with name*

- *They were looking for a regular long term partner*
- *They could not travel and had no privacy at home*

Not all inquiries will lead to an actual booking, which is to be accepted in most businesses, not just the sex industry. Over 70% of respondents indicated that this had occurred at some stage in regards to inquiries from or on behalf of a person with disability. While a variety of responses could adhere to clients in general (*couldn't afford the service, they never rang back, I was not available on the day they requested, I was not what they were looking for, I didn't provide the service they were looking for*) a specific number are unique to clients with disability. Four respondents indicated that the client could not travel to their location, with additional responses also indicating that while the person was not able to travel they had no privacy at home to have a sex worker visit them there. Additionally, a number of respondents mentioned that the potential client's carer would not take them to the appointment. This is an issue of concern which warrants further attention in the disability sector, concerning the rights and responsibilities of carers and support staff.

The accessibility of the sex worker's premises was also cited as the reason appointments did not proceed, with a further respondent commenting that the client was not willing to arrange an outcall to their place by the sex worker instead. While it is the client's prerogative to choose their preferred appointment location, these responses raise the issue of whether all clients with disability have the correct level of support in regards to options and choices, especially in regards to having sex workers visit their own home. Additionally, while not every client with disability

has accessibility issues, increased discussions and dissemination of appropriate information to sex workers can allow them to take additional consideration in choosing their work space or investing in adaptations to their house (if they work from home) to create more accessible locations for this client base. These findings can also support the need for increased awareness by policy advisers, government officials and politicians in regards to sex worker legislative reform in regards to supporting sex workers' rights and needs to work from home. Granting legal authorisation and support would allow these sole traders and small businesses to be mindful of accessibility issues and increase the likelihood of people wanting to invest money into adapting their workspace to best meet the needs of their clientele.

A select number of international discourses about sex work proliferate the false idea that sex workers will do anything for money and are unable to set or sustain good boundaries in their work practices. Responses from this survey dismiss such notions as respondents' in this survey declined bookings. These reasons include *not confident to work [with] person's level of disability*, *[it] didn't feel right* and *I did not provide the service they were looking for*. While sex workers also enjoy clients being 'regulars' one respondent clearly demonstrated their level of professionalism by recognising that the person with disability was *looking for a long term partner* and didn't proceed with a booking. This issue of some clients blurring the lines between professional service delivery and personal friendship is addressed further in Section 5.



## Section 5: Challenges and barriers

The last section of the questionnaire focused on any barriers and difficulties experienced by sex workers when arranging and /or providing an appointment, or after an appointment has finished. Results for each question are given below, followed by a more detailed analysis of the data and themes that emerged.

### Did participants face any challenges when arranging an appointment?

Question 22 asked participants *have you faced any challenges when arranging an appointment with client/s with a disability?* Just over 50% of the respondents indicated yes (Table 12).

Table 12. Were there any challenges when arranging an appointment with a client (N=54)

Answer Choices	Responses	
Yes	57.41%	31
No	42.59%	23

### Details about challenges faced when arranging an appointment

If participants answered 'yes' in Question 22 they were prompted to give more details of what those challenges were, via the choice of seven static answers as well as an open-ended text box by choosing 'other'. The results are seen in Table 13.

Table 13. Challenges face by the sex worker when organising the appointment (N=30)

Answer Choices	Responses	
They wanted me to lower my price	<b>60.00%</b>	18
My workplace was not suitably accessible - so had to see them somewhere else	<b>46.67%</b>	14
I couldn't understand the client on the phone	<b>43.33%</b>	13
They kept changing the time of the appointment	<b>36.67%</b>	11
They rang every day	<b>33.33%</b>	10
Other, please specify	<b>30.00%</b>	9
I had to borrow equipment (ie ramp) to make workplace accessible	<b>6.67%</b>	2
management wont make specific appointment times for my client to see me	<b>6.67%</b>	2

The nine responses that were given in the 'other' option were:

- *service had unrealistic low price expectations*
- *carer won't take them*
- *Couldn't talk to client directly on the phone*
- *my limited sign language, a parlour receptionist being cruel*
- *client asked to speak to me directly*
- *difficulty negotiating through the disability*
- *A time when both carer & client were free.*
- *very worried about access prior to 1st apt*
- *Carers', parents' values/judgements, other apts*

### Did participants face any problems or surprises during an appointment?

Respondents were asked in Question 24 *have you faced any problems or surprises during appointments with client/s with a disability?* with 75.93% answering “yes” and prompted to move to Question 25.

### Details about problems or surprises during an appointment

Respondents were asked to expand on their ‘yes’ answer in Question 24 and give reasons as to why there were problems or surprises during the appointment with a client with disability. Their answers are collated in Table 14.

Table 14. Problems or surprises faced by the sex worker during the appointment (N=47)

Answer Choices	Responses
It took a lot longer getting the client dressed or undressed than anticipated	55.32% 26
It was hard to communicate with the client	51.06% 24
I needed someone to help me to move/ re-position the client	34.04% 16
Other, please specify	29.79% 14
I wasn't sure what the client wanted	23.40% 11
The client turned up with someone else( ie. carer/ parent) but did not tell me before hand	17.02% 8
The client had a medical problem (ie. seizure)	17.02% 8
The client wanted a different service to the one they or their support person indicated they wanted	14.89% 7
The client turned up late and didn't call to let me know.	12.77% 6
No, no problems at all	12.77% 6
Their catheter broke	10.64% 5
The client turned up early with out calling first.	8.51% 4
The client's wheelchair didn't fit through the door	8.51% 4
The client said my working name at front door	2.13% 1

Fourteen respondents also gave their own responses in the open text box option of 'other'. Their replies included:

- *my client with cerebral palsy ejaculant [sic] came out with such force it hit him in the face, he was a bit embarrassed.*
- *difficulty in explaining what the client wanted from the service*
- *carers entered room/knocked/talked through door*
- *Had trouble cleaning one client, another had poor bowel and bladder control and didn't inform me beforehand.*
- *client didn't understand about money not enough \$*
- *felt rude asking what works*
- *Mental Health concern-sexual ass (assault) triggered trauma*
- *my lack of time management*
- *The carers didn't give us privacy*
- *rude and demanding...expectations beyond basic service*
- *Wasn't informed client had communication board!*
- *a carer was present as had been advised*
- *client & I fell during showering due to no equipment*
- *spinal injury - erectile dysfunction*

Did participants encounter any problems or surprises after an appointment?

Question 26 asked *have you encountered any problems or surprises after appointments with client/s with a disability?* and 36% answered ‘yes’. These respondents were asked to go to question 27 to expand upon their initial answer here.

Details about problems or surprises after an appointment

Question 27 allowed respondents to share details *about any problems or surprises they encountered after an appointment* with a client with disability. Their responses are in Table 15.

Table 15. Problems or surprises sex workers experienced after an appointment (N=33)

Answer Choices	Responses
No, no problems at all	45.45% 15
The client called me every day afterwards	21.21% 7
Other, please specify	21.21% 7
The client asked for a receipt	18.18% 6
The client's carer/ support worker turned up late to pick them up	15.15% 5
The client's carer/ support worker turned up early to pick them up	9.09% 3
The client and/ or carer talked about the service within earshot of my door or neighbours	3.03% 1

The seven respondents who gave their own responses in the ‘other’ field replied with:

- *the service didn't understand the diversity of sex*
- *client denies incurring credit card charges*
- *wanted to pay via credit card*
- *sometimes the pre booked cabs arrive early*
- *carer overprotective but wanted to touch me also*

- *emotional attachment*
- *client called me often afterwards*

#### Other barriers or difficulties

Respondents in Question 28 were asked an open-ended question to allow them to share more detailed answers about any other barriers or difficulties they had encountered while providing services to clients with a disability. Detailed information was provided from 20 respondents. The qualitative data was manually analysed with seven major themes emerging:

- Financial aspects
- Communication difficulties
- Unrealistic expectations or actions of the client
- Third party difficulties
- Time management issues
- Medical issues
- Access issues

These themes correlate to and support the data gained from Questions 22 – 27 and will be discussed in detail below.

#### Financial aspects

Financial concerns ranged from very minor problems such as the client asking for a receipt at the end of the booking, through to more serious issues such as the *client denies incurring credit card charges*. In fact the most common challenge presented to sex workers before an appointment was

that the clients wanted them to lower their prices, with an additional respondent stating that they *had unrealistic low price expectations*. It is imperative that clients understand that this is a professional transactional encounter and are taught the importance of respecting sex workers, and the rates they charge, equal to other professions.

As previously discussed, the sex industry operates on a mutually consenting arrangement, whereby the sex worker agrees upon the services to be provided at a pre-determined price that the client is prepared to pay. Clear communication about financial matters need to occur before such interactions to alleviate discrepancies and disagreements. This includes ensuring the client has the correct amount of money available to them and they have established which methods of payment are acceptable.

As a number of people with disability have their finances coordinated by a financial guardian or organisation, or are transitioning over to the NDIS (as discussed in Chapter 5), more sex workers are being asked to provide receipts or even invoices for their services. This is a unique development for the sex industry to adapt to as historically both clients and sex workers maintain their mutual anonymity by using cash as the preferred payment system. Additionally, the disability sector is used to receiving services and paying for invoices after the fact, which is generally unacceptable for sex workers who expect payment before or at the time of the booking. This has been recognised as an area which needs further discussion and consideration by all parties involved, with Touching Base now incorporating such information into both workshops.

### Communication difficulties

There were a number of respondents that experienced communication difficulties with their clients, including 13 who indicated that they *couldn't understand the client on the phone*.

Utilising different methods of communication, such as email or text message could assist in these instances but it is sometimes dependent upon if these are available for the client or if the sex worker feels confident enough to ask the client to change communication methods without fear of offending them. A common issue is when the client may have an acquired brain injury but appear drunk, leading to sex workers or receptionists to refuse their booking request. One respondent replied *someone needs to help clients make booking [as sex workers] often think disabled people are drunk and won't see them. Carers need to organise appointment*.

This level of concern, in wanting to do the right thing by the client, is reflected in other comments where one respondent said they *felt rude asking what works*. A number of respondents mentioned that they felt bad that they didn't know Auslan (Australian sign language). Additional comments shared in the final question further support this compassion shown by sex workers where one respondent was wanting to understand *what their disability actually was e.g. where there was feeling or no feeling and what was/ was not safe to perform on them*. Another outlined their concern by saying:



*I would have liked to have some education on how to handle some clients with disabilities. For example, how to be compassionate in an appropriate (not insulting way) [and] how to deal with my own feelings of sadness for the client's situation.*

Another respondent shared that they had *difficulty negotiating through the disability* with 24 respondents stating that it was difficult communicating with the client during the booking.

Another said they were not informed of the availability of the client's communication board, which is negligent of the carer or support worker and a part of their formal duty of care towards the client. This demonstrates that further education is needed on both sides of the equation to create better communication pathways between sex workers and clients with disability, along with the third parties assisting them.

Informed consent is given via open communication and a clear understanding of the services to be provided and yet seven respondents indicated that *the client wanted a different service to the one they or their support worker indicated they wanted*. This suggests that further assistance is needed for some clients to be supported to make informed choices and be able to communicate their sexual needs in succinct and precise ways. This includes having their voice heard without third parties making assumptions on their behalf in regards to the services they actually want.

### Third party difficulties

The values and judgements imparted by carers and other third parties can negatively impede upon the enjoyment level of a booking and can create further barriers for the person with disability wanting subsequent bookings with a sex worker. One respondent summarised a particularly difficult situation created by the client and the disability service who assisted with the booking:

*I have had a situation where a service provider had negotiated a cheaper price because the client couldn't have sex but the client was able to have sex with me - including anal (on the client) - I was in a difficult situation as they didn't want me to discuss [this] with [the] service but I should have been paid the standard rate and the service was demanding a cheaper non-sex rate.*

This situation places sex workers in a precarious position between respecting their client's wishes of privacy and their own right to be paid for the range of services they provide.

A large proportion of respondents spoke about how carers would not take the client to their appointment, with others reflective upon the lack of privacy given to the sex worker and their client including mentioning that the *carers entered room/knocked/talked through door*. The worst example of crossing professional and ethical boundaries was exemplified by one respondent's statement that the *carer [was] overprotective but wanted to touch me also*. These kind of actions are extremely inappropriate and unethical and can be ameliorated by the

development of supportive organisational policy and procedure guidelines to clearly communicate the rights and responsibilities of staff. The creation of clear communication pathways between the disability and sex worker communities will also strengthen the confidence of sex workers to know that they can speak up and report such incidences without fear of reprisal, possibly where the client is denied future access to the sex worker or the organisation / carer refuses to coordinate other clients to see this sex worker.

Even those who are supportive can still unintentionally create issues by their actions. Sex workers who operate by appointment are skilled in delivering services to their client within their allotted timeframe. Five respondents indicated that carers/ support workers turned up late to pick their client up with a further three saying they arrived too early. With other professions these actions have no negative consequences, especially if there is a waiting room available, but with sex work they can. Turning up too early can mean interrupting quite intimate moments, forcing the sex worker and their client to potentially scramble for clothes and leave the client in a vulnerable state of mind and body, having their experience cut short. Arriving too late can disrupt the sex worker's schedule, potentially making them run late for their next appointment and shifts the dynamics between the client and worker, essentially moving the role of sex worker to that of carer.

Further information is also needed for receptionists and management of sex industry establishments to increase their knowledge and awareness of people with disability wanting to see sex workers. This is in relation to creating a more accessible and welcoming environment

and being receptive to taking bookings at specific times to accommodate structured staffing schedules at some disability support organisations. Additionally, management of establishments that are already accessible need to learn to prioritise those rooms for the clients who need it most. One respondent spoke at length about this issue:

*There are times when the wheelchair accessible room is taken for hours on end thus making my regulars wait some crazy long times or we'd struggle to fit his chair into a non-accessible room. We'd scrape the paint on the walls but stayed in good humour.*

#### Unrealistic expectations or actions of the client

Respondents frequently indicated that further information and support may also be required for some clients to alleviate unrealistic expectations and stop certain actions from occurring. This includes trying to bargain down the price or expecting more services than what was agreed upon and paid for. Learning about and respecting the professional boundaries sex workers have will decrease the propensity for clients with disability to become a nuisance and be denied an appointment. Ten respondents indicated that their clients *rang every day* leading up to an appointment with a further seven saying that *the client called me every day afterwards*. This is definitely not acceptable behaviour regardless of which type of professional they are interacting with. Issues with emotional attachment and having unrealistic expectations of the sex worker are something that can occur with any client, regardless of disability.

Sometimes these issues cannot be foreseen but if support workers, carers and/or family are involved with ascertaining and gaining informed consent from a person with disability then these are some of the issues to be mindful of. Certainly being *rude*, *demanding* and *boundary – pushing*, as a few respondents described clients, will diminish all future chances of that client being granted another appointment. With some clients, access to the internet and mobile phones is still a relatively new development in their lives. With this comes new responsibilities in regards to acceptable communication etiquette and an area that needs to be substantially addressed through more education in the disability sector.

#### Time management issues

Having a clear understanding about how the sex industry operates and what is expected of the client will assist in more harmonious interactions in the future. Eleven respondents indicated that clients *kept changing the time of the appointment*, six said that *the client turned up late* without letting the sex worker know and a further eight respondents said that the *client turned up with someone else (ie carer/ parent)* without letting the sex worker know ahead of time. Whilst those ‘on shift’ at a brothel or parlour have the potential to immediately substitute another client booking in place of a cancellation, private sex workers allocate additional time either side of the booking, whereby a one hour cancellation can adversely affect up to three hours of their work day. Those who are constantly making a sex worker rearrange their work schedule to accommodate their ever-changing appointment requests may often finally be denied the opportunity altogether. Additionally, sex workers will dress differently if they know that a third

person will be arriving with the client. Potentially answering the door in a sexy negligée, when a client arrives with their carer or father, can place the sex worker in a vulnerable position and negates their ability to consent to whom exactly will see them dressed in that manner.

### Medical issues

Having a third person arrive with certain clients is certainly something that is welcomed by sex workers, but needs to be negotiated at the initial contact point. A third of all respondents indicated that they have over extended their level of expertise by not having a carer or support person to assist them with transfers, un/dressing and repositioning their clients. This can compromise the sex workers' occupational health and safety standards, can cause physical or emotional distress to clients if something doesn't happen correctly and can take up an extended amount of their limited time together doing manual handling instead of enjoying the services paid for.

Having a clear understanding of the physical and medical needs of a client with disability will certainly assist a sex worker's time management and increase their confidence in being able to provide a professional but enjoyable service for their clients. Not being provided the correct equipment was mentioned numerous times and can again compromise the health and safety of both parties. One respondent said: *[my] client & I fell during showering due to no equipment*. Another was not told about their client's communication board, limiting their ability to openly communicate with each other during the booking.

Informed consent goes both ways and yet a number of respondents indicated that they were not told specific things about their client beforehand. This can be especially challenging when a client has *poor bowel and bladder control* but does not mention it prior to the booking. Not only does this place the sex worker in a position they have not fully consented to, but if they are entertaining the client in their own workspace, and not in the client's home, can essentially create an additional level of washing and cleaning they did not factor into their work day. Worst case scenario, this kind of bodily fluid incident can ruin bedding and manchester, leaving the sex worker out of pocket to replace such items. While anecdotal evidence suggests that some people with disability have experienced increased rejection when disclosing such personal medical conditions, it is anticipated that this dissertation will assist in elevating discussions around these issues so that both sex workers and people with disability can increase their ability to talk about and respect each others' needs in a more open and mindful fashion. In the example given above, if the client had explained their poor bowel and bladder control and asked to bring a number of absorbency sheets (often called 'blueys' in Australia) and extra towels to the booking, this would have allowed the sex worker to give informed consent and have the opportunity to place additional barriers on the bed to protect the manchester in case an accident occurs. Furthermore, the sex worker could have been able to adapt their services (in regards to positioning, pace and activities) to best support that client's needs, reducing any unnecessary strain or pressure on their bowel and bladder.

### Access issues

Accessibility is the issue that prevails throughout a lot of people with disability's lives.

Respondents indicated they had to change their usual work place due to accessibility issues [N=14] with another two who borrowed a ramp to make their place assessable. This shows that sex workers are willing to think laterally to accommodate the specific needs of their clients with disability. Four respondents indicated that their *client's wheelchair did not fit through the door* which is not surprising considering the increased variety of wheelchairs now utilised. Further dialogue needs to be encouraged between the disability sector and the sex industry about accessible venues and actual dimensions of doorways and turning circles to be able to give clients a broad range of locations and services to choose from. Teaching sex workers about the different specifications between manual and electric wheelchairs and encouraging clients with disability to be up front with their specific access needs will help alleviate such disappointing moments where one's wheelchair does not fit through a doorway.

### Section 6: Personal reflections: the most positive aspects of this work

There were 47 respondents who took the time to give a response to Question 29. Participants were asked an open-ended question asking them *what do you consider the most positive thing/s about seeing clients with disability?*



The final question (Question 30) allowed participants to add final comments, or share any particular stories about seeing a client with disability in an open-ended text box. Nineteen respondents shared additional information with the researcher.

The data was manually analysed with the narratives divided into the following five themes:

- Professional and personal satisfaction
- Positive contribution to the client's wellbeing and happiness
- Offering a meaningful experience for people with limited or no options
- Increased knowledge and understanding about people with disability
- Positive affirmations about their clients

Respondents revealed a high degree of professional and personal satisfaction with their work, with a range of comments stating how happy and fulfilled they felt by providing a *meaningful service*. These findings add to previous research concerning identified positive aspects of respondents' work (Bernstein, 2007; Durocher, 2015; Lucas, 2005; Sanders, 2006). Additional respondents noted how valued and appreciated they felt by their clients with disability, with frequent reference to treating all clients equally and experiencing *the same positives as seeing clients without a 'disability'*.

It is anticipated that the responses shared by respondents may increase society's recognition of sex workers' ability to adapt their service delivery according to their clients' needs, as well as being experienced in making clients feel comfortable no matter what their shape, size or ability. This was succinctly summed up by one respondent who simply said: *my client with hand issues really appreciates the massage of his hands, because I am not shy about touching them.*

Many of the responses exemplified a high level of care and compassion towards their clients, treating them with dignity and respect. One respondent said:

*... everyone needs human connection and touch. Even though I often felt a sense of sadness for the client's situation, I also felt so good about my work because it really feels like the right thing to do. Everyone needs love and it broke my heart when one client told me that no one will hold him--that was all he wanted. I feel good when I can provide this very basic human service ...it is some of my favourite work.*

The considerate responses received were quite poignant and diverge significantly from prevailing discourses about perceived connections between client and sex worker. Rather than the cold and disrespectful exchanges, proliferated in the media, legal debates and abolitionist rhetoric, respondents shared stories of kindness and empathy towards their clients. While acknowledging the challenges and difficulties that may arise, the overall discourse surmised that it was worth it. This was exemplified by these statements:

- *Clients with disabilities were some of the most challenging and yet rewarding client groups I worked with. My clients provided me with an extra dimension of enjoyment and fulfilment from my work*
- *Even when it has been challenging - around communication, etc. it has been really worthwhile providing services to clients with disabilities. This is sex positivity in action.*

Expanding further on the awareness that sex workers are capable of providing a diverse range of services, one participant said the most positive thing about seeing clients with disability was how they challenged and inspired their professional repertoire, as well as their personal growth:

*Being challenged to be sexually creative when someone has limited movement or dexterity, and in doing so discovering that a person's sexuality is not defined, or necessarily limited, by the body they inhabit, but is only limited by our imagination and willingness to explore*

In *Sex, rights, disability and some ticklish questions*, Liddiard (2013) questioned the nuances of support that people with disability commonly face when trying to explore their sexual expression. Spurred on by films such as *The Sessions*, often discussions have centred on a medicalised therapeutic approach rather than fun and enjoyment. As Liddiard stated: "...some critical reflection is timely to consider why disabled peoples' sexual desires have to be couched in notions of therapy, healing and rehabilitation in order to be socially acceptable" (Para. 16). It is clear from the range of responses in this survey that sex workers in NSW have been providing

a broad range of sexual activities to their clients with disability, which has offered them the opportunity to have fun and be recognised as a sexual being, equal to others.

Respondents of this survey were also clear in identifying the scope of services they provide alongside the specific sexual interactions:

*I think sex workers are unrecognised for the comprehensive skills we utilise in our work, particularly in the area of clients with mental health issues - depression, anxieties, PTSD, schizophrenia, drug induced psychosis, etc. I have developed a range of strategies, ethics and care to provide a meaningful service to regular and individual clients that can take into account the 'therapeutic' aspect of the relationship between sex workers and our clients.*

A recurrent theme from respondents encompassed how they positively contributed to their client's wellbeing. The emphasis was not merely about the sexual acts, but included providing a shoulder to cry on, companionship, educational opportunities and treating them as equals.

Bernstein (2007, p. 103) referred to this all-encompassing interaction between clients and sex workers "bounded authenticity". This "authentic emotional and physical connection" is a genuine relationship but one which is limited by time constraints and professional boundaries negotiated ahead of time.

*I had one client who could walk with the assistance of a cane but because of the condition of his legs could only walk very, very slowly. I walked slowly along next to him even though it took almost 5 minutes to walk to the room. He said I was the only person to ever walk alongside him*

*and that most people get frustrated and walk ahead. He has been one of my long term clients and has made me realise with most men with disabilities it's not about the sexual service you provide but trying to make them feel like everyone else. It's probably the most rewarding part of my job.*

Many respondents spoke about how they were able to bring joy to their clients' lives, filling a gap in a unique way that had not, or could not, be offered by others in society. This service positively affected not only their clients' lives but third parties supporting them. One respondent's experience exemplifies the important role sex workers can play in supporting a person's sexual expression if family and carers are willing to 'think outside the box' and embrace sex worker services as a respectful and dignified option:

*I used to see a physically and mentally handicapped guy for a year and a half, every week until he died... his mother, father and carers brought him to the place [and] dressed/undressed him and put him on the bed for me. He always remembered me and would bring me little gifts. He would communicate through a board and used a stick in his mouth to type the letters. He was always appreciative as was his family. They [brought] a shower chair that stayed on the premises. They were always on time for appointments and often would ask to come on one of my "quiet" days. His family said to me he was just a man like any other and had sexual needs and wants. They said prior to seeing me he would wank himself constantly until he bled and this had settled down once he found me.*

Another respondent spoke about how they contributed to the well-being of their client, sharing activities that are generally overlooked in the discourse of sex work:

*My favourite client is disabled. He is totally blind, uses a stick to get around, and suffers from severe high blood pressure, diabetes, and a host of other age related ailments. He can't walk more than 20 metres without a rest, and had been lonely and isolated within his family since the onset of his illnesses. His health means that he can't function sexually any more, but that doesn't mean he doesn't need to be touched. We go out for dinner... I read him the menu, tell him what the waitress looks like, describe what's happening out the windows or on the street... I'm his narrator, if you like, filling in the blanks his blindness has left as best I can. I spoon with him at night, he likes to hold hands and talk with me. He just wants the intimacy you get from being close to someone, he gets embarrassed if I try to initiate anything with him. When I see him, I KNOW I've made the world a bit brighter for someone*

Numerous respondents believe they are also positively contributing towards making their clients feel better about themselves while creating a supportive environment in which to grow and develop as a person. One respondent spoke about their client's *joy and gratitude at being able to be themselves sexually without negative repercussions.*

While accepting and embracing their clients' diversity in abilities, respondents also exhibited strong ideology about equality and how contributing factors of their services gave their clients a

sense of ‘normality’ when their lives were so often defined by difference. Respondents’ comments included:

- *Making them feel normal, by treating them to the normal horny, arousing, sexy and affectionate things people do during sex and intimacy*
- *A client once said to me he felt "like a normal person" after having seen me. It was this which made me feel as though I was helping in some way to restore some self-assurance and confidence within some of the clients I have seen which have a disability.*
- *Sex and personal intimacy are amazingly normalising activities that can overcome the discrimination and loneliness often experienced by people with disability. Most ...are so appreciative of the sexual and personal equality that can be achieved in a positive and professional SI [sex industry] service*

These views were also about being able to offer a meaningful experience for people with limited or no options. *Everyone deserves sexual pleasure - I enjoy being able to provide that to people who might have limited avenues to access sex.* The responses were not framed as pity or in an altruistic manner but rather as compassionate people who were able to stop and appreciate the difficulties some clients faced throughout their lives. As one respondent said: *they are just people as everyone else.* Respondents enjoyed the opportunity to contribute positively to a

person's happiness and were quite clear about expressing the right to sexual expression for all and treating everyone equally. This was reflected in comments such as:

- *Allowing people with a disability the same access and equity even within the sex industry*
- *everyone needs to be touched and supported and I am happy to be one of the people to do that*
- *They really liked being with a worker that didn't judge them and tried to cater the service to their needs.*
- *You know that you personally are helping disabled people get their needs seen to, as they may not be accepted by others simply because of how they look or act*
- *Just giving them some release, especially when they can't do it themselves*
- *People get to explore their sexuality and sensuality with me in ways they might not have the opportunity to otherwise*
- *They get to access a service they might otherwise not be able to get.*

Appointments with clients with disability gave the respondents personal and professional satisfaction and in doing so a number of respondents identified an additional positive consequence. A common sentiment centred on their increased knowledge and understanding about people with disability, especially around their sexual needs and rights. *It is interesting to me as it gives me further understanding about different people on an intimate level.* Another respondent said: *they do not let their disability get in the way of living their lives and exploring their sexuality.* Respondents appear to embrace this sub-section of clients, stating that a positive factor for them included *gaining diverse experience, increasing sensitivity and perspective.*



These sentiments were further extended by a range of responses sharing many positive affirmations about their clients. While a few clients with head injuries or an intellectual disability were mentioned needing more support to curtail stalking or potentially violent/ aggressive behaviours, overwhelmingly, respondents spoke very highly of their clients. Descriptors included:

- *Friendly, interesting, challenging, insight into other people's lives, usually opinionated, good sense of humour, great diversity and ingenuity in what constitutes sex*
- *They are lovely clients*
- *Clients very appreciative and usually very well-mannered/respectful*
- *Clients can be delightful, appreciative, and lots of fun!*
- *They are generally very polite, respectful and gentle people*
- *They are really genuine and reliable*
- *They have sexual needs like everyone else and can be quite erotic and cheeky*

These findings reflect an element of sex work that has scarcely been explored and never before in such depth. The outcomes of this research supports limited empirical data that has emerged, most notably from Sanders (2006, 2007), which have also reported sex workers speaking very positively about their clients with disability and reflecting on the beneficial aspects of their professional liaisons. What is unique in NSW, Australia though is the opportunity for peer run

and led training workshops from Touching Base to increase the capacity, skills and confidence of sex workers. This was succinctly shown by one respondent:

*When I first started working I provided services to clients with a disability, but my lack of knowledge, skills and confidence when providing services to them caused me to stop ...*  
*Completing disability awareness training with Touching Base has helped me move past those fears.*

The data gleaned from this survey have allowed the researcher to examine an element of the sex industry that is so often overlooked. Respondents have shared private and personal encounters with their clients with disability allowing divergent themes to be identified and discussed in detail. While numerous barriers and difficulties were acknowledged what prevails are the stories about positive human connections, compassion and a sense of pride in one's work. Overall, the responses elude to a mutually beneficial experience that has occurred discreetly, regularly and in a range of locations. The insight gained from this survey, however, may be confronting for people not accustomed to the diversity of the sex industry and the many options clients with disability have pursued.

One respondent's final story encapsulates this perfectly. It touches on the spirit of mateship, determination and 'where there's a will there's a way'. Indeed, while many people with disability are still perceived as quiet, meek and mild, this story shows that risk taking behaviour, or indeed just enjoying a fulfilling social life, doesn't necessarily stop when someone acquires a

disability. This was shared by a female street-based sex worker who used a safe house to provide services to her clients:

*In seeing a client from the street, six of his mates waited outside the room to be sure he was 'getting a good time' and also because they had to carry him into the house. Time was extended a couple of times over as client was having a very good time. One of the skills I learnt on this occasion was, for someone with no feeling beyond the nipple line, to sit on his face (which I did) while manipulating his nipples and talking about matters of an explicit sexual nature. Unfortunately, as the premises was up a flight of concrete stairs, and as his mates were quite intoxicated, they dropped him from his wheelchair as they were trying to leave the premises. The client hit his head against a drain pipe but apart from a bump on his head, appeared to be okay otherwise and off they all went with one very happy man. The client had .... come to grief in a car accident.*

Sex workers provide services to a range of clients in a multitude of locations. While people can speculate what is the 'best practice scenario', the reality is that sex workers and clients – including those with disability – will continue to navigate their way to each other to the best of their ability, using whatever resources they have at hand. With a bit of lateral thinking, determination and finding the right person at the right time, clients with disability have definitively been paying for the services of sex workers in NSW. What expedited discussions, and created a supportive environment to assist with the formation of Touching Base, was the

enactment of decriminalisation, in 1995. One respondent, summing up the benefits of this positive legal reform in relation to providing services to clients with disability, said:

*I love that the NSW laws have meant discussing explicitly with advocates or carers, and with clients - what services are required, is so much easier. Decriminalisation means sex work negotiation can occur with less barriers.*

The results presented in this chapter allow for a detailed analysis of an area of sex work previously overlooked within academic discussions. Until now, sex workers have never been explicitly asked about their experiences with providing services to clients with disability. The willingness of NSW sex workers to give detailed replies to such a broad range of questions indicate that the respondents are keen to have this area of their work validated while contributing towards a study that can help guide and develop future policies and procedures, dedicated towards assisting them with issues identified. The respondents' narratives reveal their professional enthusiasm with interacting with clients with disability, including a desire to have further training and support to alleviate barriers and challenging situations that impede clear communication and supportive pathways between themselves and their clients.

## Limitations

Empirical data about sex workers providing services to clients with disability has been largely non-existent until now. To provide further validity and substance to the results additional research would be welcomed. Repetition of the same survey again in NSW could provide significant data as it has been over 7 years since this research survey was launched.

It needs to be recognised that there were a number of limitations within this research. At the outset, it cannot accurately estimate the true extent of these activities among the entire disability population, as it is not a random sample of this whole population or of the sex worker population within NSW.

When the survey was conducted, only those who were more online in e-lists or connected to sex worker organisations had the opportunity to participate, unless they were given the information via word of mouth. As the survey was launched in 2009, the dissemination of the questionnaire was not done via Facebook, Twitter, online blogs or other online modalities that are now commonly utilised in formal and informal sex worker networks. If replicated in the future a much higher respondent rate would be anticipated by capturing the increasingly mobile and internet-based sex worker population.

Additionally, with a short timeline and limited resources the researcher did not have the capacity to personally contact individual sex workers or escort agencies, brothels or massage parlours in NSW. Predominantly younger sex workers (approximately 18 – 35) operate from establishments like massage parlours and brothels however there are also a number of distinct brothels in Sydney, NSW, that employ more mature sex workers, who are 55 years and older. Their input would have also been invaluable and it is unfortunate that the researcher was not able to specifically access this cohort.

Unfortunately there were no resources available to have the survey translated into other predominant languages, such as Thai, Korean and Chinese, that are utilised within the NSW sex industry. This has impeded the ability of the researcher to connect with a range of sex workers who have English as a second language working in NSW.

With every survey there is the potential for respondents to over or under report. As this was the first time sex workers had been asked such questions it is likely that some clients previously seen have been overlooked or forgotten. While it must be recognised that some sex workers may only want to show the positive aspects of sex work, due to prior experience where negative reported experiences have been used against them, the fact that negative experiences have been shared by respondents indicates a level of trust and honesty within the cohort of respondents.

## Chapter 9: Conclusion and Recommendations

The purpose of this research was to provide empirical evidence that sex workers in the state of NSW, Australia were providing services to clients with disability. Further to this, the research aimed to identify the nature and extent of such activities and develop a greater understanding of where and how such service delivery is occurring. The main findings supports the aim of the research, that there are indeed sex workers in NSW providing services to clients with a wide range of disabilities.

Empirical research has predominantly focussed on larger peripheral issues affecting sex workers, such as avoidance of arrest, targeted police operations and the use of condoms as evidence of prostitution. Currently there is an absence in research focused directly on what impedes sex workers from providing their services, to the best of their ability, to clients with disability. These findings are significant because it allowed for respondents to identify issues that are directly creating barriers between the client and sex worker. This allows for future training and educational workshops for people with disability and third parties to incorporate an increased understanding and awareness of these issues and develop appropriate responses.

The qualitative data set enriched and added to the overall aim of the research, providing an insight into an aspect of the sex industry previously uncharted. Considering the breadth of the

survey, the enthusiasm of so many respondents to leave such detailed answers throughout, is a testament to the willingness of these sex workers to input into research that has the potential to create meaningful changes to their work lives and that of their colleagues.. Additionally it indicates that, when asked questions that are pertinent to them, sex workers are more than happy to share their stories and experiences.

This research was inspired by the lived experiences of the researcher and anecdotal evidence amassed via participation in the activities of Touching Base. It was initiated in 2009, two years before the release of the documentary *Scarlet Road* and prior to increased media attention about this topic. At the launch of the survey only minimal empirical research had examined the topic of sex workers providing services to clients with disability, predominantly from the UK (Sanders, 2006, 2007). Additional academic findings have since emerged (Earp & Moen, 2016; Fritsch et al., 2016; C. Jones, 2013; Kulick & Rydström, 2015; Liddiard, 2014) further strengthening the resolve of the researcher to finalise this research project. This is the first time sex workers have been directly asked about their experiences with clients with disability, which has provided an enriched data set that can be utilised not only within NSW but internationally.

While sex work is a legally recognised occupation within the state of NSW, operating within a decriminalised framework, this is not always well known within general society. People with disability and their support staff, carers and family are still hesitant to engage with the sex



industry out of fear of perceived negative repercussions. It is anticipated that one day appointments made with sex workers will be treated in the same manner as appointments for the person's hairdresser, occupational therapist, masseuse or doctor. This research indicates that currently some appointments are still made clandestinely without open and meaningful communication between the third party and the sex worker. Additionally, not being told about the location of communication boards, medications or colostomy bags can detract from the sex worker's ability to provide services in a mutually supportive and enjoyable manner /environment.

Policy development and law reform, if following the principles of best practice, should be driven by an evidence based approach. This research has delivered much needed empirical evidence to ascertain that NSW sex workers provide services to clients with disability. It also allows for an increased understanding of the diversity of the NSW sex industry, who is involved, where services are offered and how clients can locate services. These results also contribute to an awareness of how decriminalisation can provide a range of options and choices for both sex workers and their clients to interact, including clients with disability.

These research findings strengthen the call for decriminalisation in other locations, demonstrating how this regulatory model creates an environment where sex workers are given the autonomy to negotiate openly and clearly about the services they are willing to provide and

create clear boundaries around their work practices. It is anticipated that these findings can be further utilised to assist in law reform in other locations, both within Australia and overseas.

Decriminalisation also allows for third parties to participate in practical aspects of the booking process without fear of legal ramifications. The results will enable disability support organisations to be guided towards important educational development pertaining to people wishing to access the sex industry. The issues discussed also provide a useful framework for disability support agencies and family members to allow them to more easily navigate the process of supporting someone access the sex industry. It is anticipated that the policies, procedures, workshops and educational resources that have been developed from organisations such as Touching Base will be further utilised to assist all parties in this process.

Millions of people – including those with disability - are married, in relationships, dating or enjoying their single life and never want nor desire to see a sex worker. That is their right, as an adult and as a sexual human being. That said, there are those who, for a multitude of reasons as outlined in Chapter 5, do seek out the services of sex workers. While it is imperative to clearly state that sex work should never be the ‘go-to’ only option for people with disability to explore their sexual expression, it should not be dismissed either. Rather it should be seen as just one of many options people with disability can choose, equal to anyone else in society. This research aims to help reposition the discourse pertaining to clients of the sex industry, allaying fears and misguided rhetoric about the demographics of clients as well as how sex workers view them.

Additionally, this research has value in increased recognition of the role sex workers can play in some of their clients' lives while acknowledging sex work as a multi-faceted occupation, involving people of all genders and ages.

The findings from this research indicate that sex workers are expressing the need for further support and education to be able to best meet the needs of their clients with disability. Funding for training workshops and further peer support will be vital to fill this gap in their professional development.

### Recommendations

The affected communities must always be fully consulted in order to enact meaningful and appropriate policies and law reform. This research has enabled sex workers to share their own experiences and to voice what is relevant and important to them. These findings also contribute to a growing area of research reflecting both personal and professional satisfaction in sex workers' occupation. It is anticipated that their lived experiences can guide and inform governments, organisations, academics, policy writers and other relevant parties in future considerations about sex industry law reform and policy development. Additionally, their input can guide the expansion of future training and educational packages. This will provide meaningful information, support and assistance to both sex workers, (potential) clients with

disability and all third parties involved in such interactions, to streamline the process in a dignified and respectful manner.

In summary, recommendations for further research, policy development, training and legal reform include:

- Further research about how other sex industry laws impede sex workers' ability to provide services to clients with disability
- The possible replication of this research in NSW to measure increased service delivery and changes since 2009
- Specific research asking clients with disability about their experiences accessing the sex industry in NSW (and elsewhere)
- Universal development of policy and procedure guidelines for disability support organisations to increase their awareness of their rights and responsibilities in regards to supporting people with disability access the sex industry.
- Increased support and information for third parties, including family and friends of people with disability, who wish to support someone with disability to access the sex industry
- Development of training workshops and educational resources for disability organisations, family members and people with disability to increase their knowledge of the sex industry

- Further development of training workshops for sex workers wanting to increase their professional capacities to provide services to clients with disability
- The implementation of decriminalisation for the sex industry, throughout Australia and in all countries

It is anticipated that this body of work can be utilised, within Australia and internationally, to create positive, meaningful changes for both the sex worker and disability communities.

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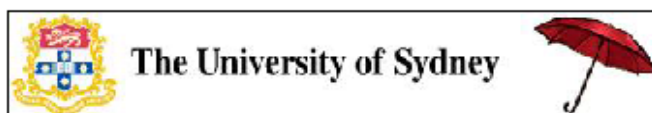
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## Appendix A: Advertisement of survey



### **NSW Sex Workers who provide services to clients with a disability.**

You are invited to participate in a unique research project focussing on NSW sex workers who provide services to clients with a disability. If you are currently, or have previously worked, in NSW as a sex worker then you are eligible to participate.

Participation involves an anonymous questionnaire which should take no more than 10-15 minutes to complete. The questionnaire is available on-line at:

[www.zoomerang.com/Survey/?p=WEB228BX3BZR3X](http://www.zoomerang.com/Survey/?p=WEB228BX3BZR3X)

Alternatively, the questionnaire can be downloaded from the above link and sent to:

Sex workers and clients with a disability study  
Rachel Wotton  
c/ Faculty of Health Science  
The University of Sydney  
PO Box 170, Lidcombe  
NSW 1825, Australia

A printed version can be sent you upon request.

I am a post-graduate student completing my Masters by Research degree at the University of Sydney. I am also a current sex worker, the Secretary of Touching Base Inc and a member of Scarlet Alliance – the Australian Sex Workers' Association.

Participation is completely voluntary and anonymous and your decision to participate – or not – will in no way affect your current or future involvement with any of the organisations I am currently affiliated with, or any personal or professional relationship I may share with you. Submission of the completed questionnaire is an indication that you have consented to participate in this research.

Participating in this study will allow you to talk about a section of your work which is rarely discussed or acknowledged and which has never been specifically researched.

It is anticipated that the final results can be used to educate and influence the future development of training and awareness workshops for sex workers, disability services provider, clients with a disability, academics, policy makers and the general public.

For more information please contact:

- Rachel Wotton: [rwot5845@uni.sydney.edu.au](mailto:rwot5845@uni.sydney.edu.au) (phone) 0449-564-226
- Dr Russell Shuttleworth: [r.shuttleworth@usyd.edu.au](mailto:r.shuttleworth@usyd.edu.au) (phone) +61 2 9351 9647

## Appendix B: Participant information statement



**The University of Sydney**

Dr Russell Shuttleworth  
Lecturer in Sexual Health  
Faculty of Health Science  
The University of Sydney  
PO Box 170, Lidcombe  
NSW 1825, Australia  
Tel - +61 2 9351 9647 Fax - +612 9351 9400  
email - r.shuttleworth@usyd.edu.au

### PARTICIPANT INFORMATION STATEMENT

**Title: NSW Sex Workers who provide services to clients with a disability.**

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#### **(1) What is the study about?**

This project aims to find out the extent to which sex workers, working in NSW, provide services to clients with a disability. It will be an opportunity to learn more about where such service provision occurs, the frequency of such services, the type and range of services provided, if clients arrange their appointments themselves and / or need the assistance of a third party, and if there are any barriers to sex workers providing these services.

#### **(2) Who is carrying out the study?**

The study is being conducted by Rachel Wotton and will form the basis for the degree of Master of Applied Science (Biomedical Sciences) in the faculty of Health Sciences at the University of Sydney, under the supervision of Dr Russell Shuttleworth (primary supervisor)

#### **(3) What does the study involve?**

This study involves sex workers, who work, or have worked, in NSW, completing a short questionnaire. This can be completed on-line or a hard copy of the questionnaire can be downloaded, filled out and sent back to the researcher. This is an anonymous questionnaire and no identifying questions are asked.

#### **(4) How much time will the study take?**

The questionnaire will take approximately 10 – 15 minutes to complete.

**(5) Can I withdraw from the study?**

Participation in this study is entirely voluntary: you are not obliged to participate, even if personally approached by the researcher.

**(6) Will anyone else know the results?**

All aspects of the study, including results, will be strictly confidential and only the researchers will have access to the participants' answers. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

**(7) Will the study benefit me?**

This study will assist both sex worker organisations and disability service providers in gaining a greater level of awareness about the frequency of this service provision and any barriers sex workers may face when working with clients with a disability. This may lead to more funding being made available to provide training and information resources for sex workers. It will also be an opportunity to talk about a section of your work which is rarely discussed or acknowledged and which has never been specifically researched. In addition, the findings of the study may counter some discriminatory attitudes held about sex workers and their clients from both the general public and government agencies.

**(8) Can I tell other people about the study?**

Yes. Please feel free to pass this information on to as many sex workers as you can!

**(9) What if I require further information?**

If you would like more information, please feel free to contact:

- Rachel Wotton: [rwot5845@uni.sydney.edu.au](mailto:rwot5845@uni.sydney.edu.au) (ph) 0449-564-226
- Dr Russell Shuttleworth: [r.shuttleworth@usyd.edu.au](mailto:r.shuttleworth@usyd.edu.au) (ph) + 61 2 9351 9647

**(10) What if I have a complaint or concerns?**

Any person with concerns or complaints about the conduct of a research study can contact the Senior Ethics Officer, Ethics Administration, University of Sydney on (02) 9351 4811 (Telephone); (02) 9351 6706 (Facsimile) or [gbriody@usyd.edu.au](mailto:gbriody@usyd.edu.au) (Email).

This information sheet is for you to keep

## Appendix C: Online research questionnaire



**The University of Sydney**

### Online research questionnaire.

This questionnaire will be created using Zoomerang.

### An exploratory study about NSW Sex Workers who provide services to clients with a disability.

This project will conduct an on-line questionnaire of sex workers who have provided services to clients with a disability whilst working in NSW, Australia. Alternatively, a hard copy of the questionnaire can be downloaded, filled out and sent back to the researcher.

The aim of this research is to find out the extent to which sex workers, working in NSW, provide services to clients with a disability. Furthermore, this will be an opportunity to learn more about:

- where such service provision occurs,
- the frequency of such services
- the type and range of services provided,
- if clients arrange their appointments themselves and / or need the assistance of a third party, and
- if there are any barriers to sex workers providing services.

This project will contribute to the very limited amount of research about sex workers and clients with a disability, increasing awareness of the diversity of sex worker skills and recognition of the sexual rights of people with a disability.

If you choose to participate in this study you will be completing a questionnaire that takes approximately 15 minutes to complete.

Participating in this study is completely voluntary - you are not under any obligation to consent. Submission of your completed questionnaire will be taken as your consent to participate in the study and, since no identifying information will be collected, once you have submitted your questionnaire, your responses cannot be withdrawn.

All aspects of the study will be strictly confidential and only the researchers will have access to results. There will be no identifiable information on the questionnaire, and once submitted it will be impossible to know who completed it. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report. The research findings will be made available on completion through the contacts below as well as through SWOP NSW, Scarlet Alliance and Touching Base networks.

If you have any additional questions after reading the above information, please do not hesitate to contact either Dr Russell Shuttleworth on (02) 9351 9647 or Rachel Wotton on 0449 564 226 or [rwot5845@mail.usyd.edu.au](mailto:rwot5845@mail.usyd.edu.au)

Any person with concerns or complaints about the conduct of a research study can contact the Senior Ethics Officer, Ethics Administration, University of Sydney on +61 2 9351 4811 (Telephone); +61 2 9351 6706 (Facsimile) or [gbriody@usyd.edu.au](mailto:gbriody@usyd.edu.au) (Email).

### Questionnaire.

The term 'disability' is a very broad definition. For the purpose of this research 'disability' can include both congenital disability (something you were born with, such as Cerebral Palsy or Down Syndrome) or acquired disability (an event or illness has occurred in a person's life resulting in a disability, such as quadriplegia, brain injury, HIV etc).

**1. What is your age?**

**2. What is your gender?**

- Male
- Female
- Transgender

**3. How many years/ months have you worked as a sex worker?**

**4. Have you seen client/s with a disability?**

Yes (please proceed to Question 5)

No (please proceed to Question 4.1 below)

Not sure, does \_\_\_\_\_ count as a disability? (please proceed to Question 5)

**4.1** If no, please give reason/s why you have not?

- lack of confidence
- never been asked/ approached by a client with a disability
- never had any training
- brothel/ parlour/ premises I work in is not disability accessible
- I choose not to see clients with a disability.
- I would feel uncomfortable seeing clients with a disability
- other \_\_\_\_\_

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE. PLEASE GO TO QUESTION 23 IF YOU WOULD LIKE TO PROVIDE ANY FINAL COMMENTS FOR THE RESEARCHER.

5. **Approximately how many clients with a disability have you provided services to?**
6. **Have your clients been:** Male / female/ transgender? (tick all applicable categories)
7. **If you know the specific name or type of disability/s your clients have presented with please write the name/s below** (ie. Blindness/ Cerebral Palsy/ Parkinson 's disease/ MS/ schizophrenia/ panic disorder/ bipolar/ anxiety disorder etc).
8. **People with the same disability can often have very different levels of impairment. In addition, people with different disabilities may present with similar impairments.**

**For this reason, this research project would like to learn more about the particular impairments that your clients present with when they see you. Please tick all categories below that can describe any client/s you have seen with a disability.**

- client in wheelchair
- client needed assistance with walking
- client in bed already and could not move much
- client used a walking cane
- client was on crutches
- client was in a plaster cast
- could not move arms
- client was very shaky / had tremours
- client could not pick things up with his hands
- client was deaf
- client was vision impaired/ blind
- client used a communication board
- client communicated through sign language
- client spoke but hard to understand
- client had slurred speech
- client could not speak at all
- client needed assistance with dressing and undressing
- client had a catheter
- client had a colostomy bag
- client had more than one bag attached to him
- client was missing a limb
- client had a skin condition
- client had a brain injury
- client had short term memory loss



- client repeats the same conversation/ sentences with me
- client can't remember me from one time to the next
- other \_\_\_\_\_

**9. Have you seen any of your clients with a disability more than once?**

**Yes (go to Q.9.1)**

**No (go to Q.10)**

**9.1 We are interested to discover how frequently clients with a disability re-visit the same sex worker.**

**Please identify below, how often your clients with a disability come back to visit you. For example, if you have 3 clients who you see once a fortnight please put '3' in the column next to "once a fortnight".**

<b>Time period</b>	<b>How many clients within this time period</b>
<b>Once a week</b>	
<b>Once a fortnight</b>	
<b>Once a month</b>	
<b>Once every 2 months</b>	
<b>Once every 3 months</b>	
<b>Once every 4 months</b>	
<b>Once every 6 months</b>	
<b>Once a year</b>	
<b>No set pattern</b>	
<b>Only whenever he/ she can afford to see me</b>	

**10. Where were you working when you provided services to client/s with a disability?**

(Please tick all applicable)

- full service brothel
- massage parlour
- escort agency
- private escort(outcalls)
- BDSM parlour
- private worker (home or rented premises)
- street
- other \_\_\_\_\_

**11. Where have you provided services to client/s with a disability?** (Please tick all applicable)

- in a hotel
- their private home
- my home
- rented work premises
- full service brothel
- massage parlour
- BDSM parlour
- Car
- safe house
- hospital room
- nursing home
- group home - supported accommodation
- other \_\_\_\_\_

**12. What area/s of NSW have you seen your clients with a disability?** Please provide suburbs or location ie. 'Newtown' or Hunter Valley area etc.(please list all applicable locations)**13. What service/s have you provided to your clients with a disability?** (Please tick all applicable)

- Massage
- hand relief
- blow job/ French/ oral sex (client receiving)

- blow job/ French/ oral sex (client giving)
- vaginal sex (client receiving)
- vaginal sex( client giving)
- anal sex (client receiving)
- anal sex (client giving)
- Spanish
- BDSM
- Striptease
- toys – vibrators
- strap ons
- fantasy
- doubles (2 workers, 1 client)
- doubles (1 worker, 2 clients with a disability)
- doubles (1 worker, 1 client with a disability, 1 client without a disability)
- other \_\_\_\_\_

**14. How are appointments made?** (Please tick all applicable)

- Phone
- Email
- Client just turns up
- In person – we arrange the next appointment before the client leaves.
- Other \_\_\_\_\_

**15. How have clients with a disability found you?** (Please tick all applicable)

- walked into the premises
- through my ad in the paper
- through the website
- word of mouth
- spoke to me on the street
- referral from another sex worker
- through the Touching Base referral list
- referral from a support person
- other \_\_\_\_\_

**16. Who arranges the appointment to see you?** (Please tick all applicable)

- Client
- mother of client
- father of client
- sister of client

- brother of client
- friend of client
- service provider / carer of client
- other sex worker
- Other \_\_\_\_\_

**17. Have you ever had inquiries to provide services to a client with a disability but the inquiry did not lead to an appointment with you? no/ yes If yes please say why**

(Please tick all applicable):

- they could not afford the service
- they lived too far away from me
- they could not travel to my place
- my place was not accessible for them
- I did not provide the service they were looking for
- they never rang back
- I was not available on the day they requested
- I was not what they were looking for
- Not sure
- other: \_\_\_\_\_

**Barriers and difficulties when arranging, providing or after an apt.**

**18. Have you faced any challenges when arranging an appointment with client/s with a disability?**

No

Yes (Please tick all applicable)

- I couldn't understand the client on the phone
- they wanted me to lower my price
- they rang every day
- they kept changing the time of the appointment
- My workplace was not suitably accessible - so had to see them somewhere else
- I had to borrow equipment (ie ramp) to make workplace accessible management won't make specific appointment times for my client to see me
- other \_\_\_\_\_

**19. Have you faced any problems or surprises during appointments with client/s with a disability?** (Please tick all applicable)

- The client turned up early without calling first.
- The client turned up late and didn't call to let me know.
- the client turned up with someone else( ie. carer/ parent) but did not tell me before hand
- the client said my working name at front door
- the client's wheelchair didn't fit through the door
- the client had a medical problem (ie. seizure)
- the client wanted a different service to the one they or their support person indicated they wanted
- it was hard to communicate with client
- I wasn't sure what client wanted
- Their catheter broke
- I needed someone to help me to move/ re-position the client
- it took a lot longer getting the client dressed or undressed than anticipated
- No, no problems at all
- other \_\_\_\_\_

**20. Have you encountered any problems or surprises after appointments with client/s with a disability?** (Please tick all applicable)

- The client's carer/ support worker turned up early
- The client's carer/ support worker turned up late to pick up my client
- The client asked for a receipt
- The client and/ or carer talked about the service within earshot of my door or neighbours
- The client called me every day afterwards
- No, no problems at all
- other \_\_\_\_\_

**21. If you have encountered any other barriers or difficulties in being able to provide services to clients with a disability, please provide details below.**

**22. What do you consider to be the most positive thing/s about seeing clients with a disability?**


**23. If you would like add any final comments, or share any particular stories about seeing a client with a disability, please do so below.**

.....

**Thank you for your time and consideration in filling out this questionnaire.**

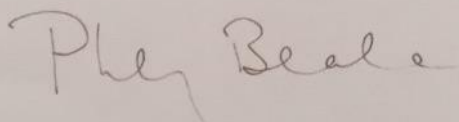
.....  
**The researcher is hoping to do some one-on-one interviews with sex workers in the future to be able to explore this topic in more detail. If you would like to share your experiences with working with clients with a disability please feel free to contact Rachel to indicate your interest on: [rwot5845@mail.usyd.edu.au](mailto:rwot5845@mail.usyd.edu.au)**  
**Your contact details will remain confidential and will not be given to anyone else.**

## Appendix D: Ethics Approval

	<b>The University of Sydney</b>	<b>Human Research Ethics Committee</b> <a href="http://www.usyd.edu.au/ethics/human">www.usyd.edu.au/ethics/human</a>
NSW 2006 Australia		<b>Manager:</b> Gail Briody Telephone: (02) 9351 4811 Facsimile: (02) 9351 6706 Email: <a href="mailto:gbriody@usyd.edu.au">gbriody@usyd.edu.au</a> Room 313, Level 3, Old Teachers College – A22
		<b>Human Secretariat</b> Telephone: (02) 9036 9308 (02) 9036 9309 Facsimile: (02) 9036 9310
5 August 2008		
Dr. R. Shuttleworth Faculty of Health Sciences Cumberland Campus – C42 The University of Sydney		
Dear Dr. Shuttleworth		
Thank you for your correspondence dated 18 July 2008 addressing comments made to you by the Human Research Ethics Committee (HREC). After considering the additional information, the Executive Committee at its meeting on <b>31 July 2008</b> approved your protocol entitled <b>NSW Sex Workers who provide services to clients with a disability: An exploratory study on the extent to which this occurs.</b>		
Details of the approval are as follows:		
<b>Ref No.:</b> <b>Approval Period:</b> <b>Authorised Personnel:</b>	<b>08-2008/11076</b> <b>August 2008 to August 2009</b> <b>Dr. R. Shuttleworth</b> <b>Dr. P. Weerakoon</b> <b>Ms. A. Arnot-Bradshaw</b> <b>Ms. R. Wotton</b>	
The HREC is a fully constituted Ethics Committee in accordance with the <i>National Statement on Ethical Conduct in Research Involving Humans</i> -March 2007 under Section 5.1.29		
The approval of this project is <b>conditional</b> upon your continuing compliance with the <i>National Statement on Ethical Conduct in Research Involving Humans</i> . We draw to your attention the requirement that a report on this research must be submitted every 12 months from the date of the approval or on completion of the project, whichever occurs first. Failure to submit reports will result in withdrawal of consent for the project to proceed.		
<b><u>Chief Investigator / Supervisor's responsibilities to ensure that:</u></b>		
<ol style="list-style-type: none"> <li>(1) All serious and unexpected adverse events should be reported to the HREC as soon as possible.</li> <li>(2) All unforeseen events that might affect continued ethical acceptability of the project should be reported to the HREC as soon as possible.</li> </ol>		

- (3) The HREC must be notified as soon as possible of any changes to the protocol. All changes must be approved by the HREC before continuation of the research project. These include:-
- If any of the investigators change or leave the University.
  - Any changes to the Participant Information Statement and/or Consent Form.
- (4) All research participants are to be provided with a Participant Information Statement and Consent Form, unless otherwise agreed by the Committee. The Participant Information Statement and Consent Form are to be on University of Sydney letterhead and include the full title of the research project and telephone contacts for the researchers, unless otherwise agreed by the Committee and the following statement must appear on the bottom of the Participant Information Statement. *Any person with concerns or complaints about the conduct of a research study can contact the Senior Ethics Officer, University of Sydney, on (02) 9351 4811 (Telephone); (02) 9351 6706 (Facsimile) or [gbriody@usyd.edu.au](mailto:gbriody@usyd.edu.au) (Email).*
- (5) Copies of all signed Consent Forms must be retained and made available to the HREC on request.
- (6) It is your responsibility to provide a copy of this letter to any internal/external granting agencies if requested.
- (7) The HREC approval is valid for four (4) years from the Approval Period stated in this letter. Investigators are requested to submit a progress report annually.
- (8) A report and a copy of any published material should be provided at the completion of the Project.

Yours sincerely



**Dr P Beale**  
**Chairman**  
**Human Research Ethics Committee**

cc: Ms. R. Wotton, PO Box 232 NEWTOWN NSW 2042

Encl. Approved Participant Information Statement  
 Approved Survey  
 Approved Advertisements