

Exploring the experiences of people with disability who access sex worker services, in Australia

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Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

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Abstract

Background

While millions of people with disabilities are in relationships, dating, or married, some fulfill their sexual and intimacy needs through sex worker services. Despite growing academic interest in sex worker clients over the past two decades, there remains a significant gap in knowledge specifically about clients with disabilities. Previous academic inquiries have often been part of broader studies that did not formally record disability status or were embedded within disability-specific research with minimal focus on this topic. Some insights have also come from studies involving sex workers. This thesis is significant because it focuses on the firsthand experiences of people with disability who access sex worker services. It contributes to the discourse championed by disability scholars and activists, emphasising the importance of first-person narratives and supporting the autonomy and self-determination of individuals with disability.

Research Aims

This study aims to develop a deeper understanding of the experiences of people with disabilities who have accessed sex worker services in Australia. Despite anecdotal evidence suggesting that people with disability do visit sex workers, there is a lack of empirical data from first-person accounts. Therefore, this research seeks to translate individual experiences into a robust empirical dataset to inform evidence-based policy development, training programs, and educational workshops.

To address these aims, the following questions were posed:

1. What are the experiences of people with disabilities who have accessed sex worker services?
2. What are the motivational factors for people with disabilities in Australia to access sex worker services?

Methodology

This study employed two data collection methods: an online survey and semi-structured in-depth interviews. Eligibility criteria included being at least 18 years old, identifying as a person with disability, and having accessed in-person sex worker services in Australia at least once. The definition of disability used in this study is based on the Australian Disability Discrimination Act. Participants included those with psychosocial, cognitive, intellectual, and/or physical disabilities of a congenital, developmental or acquired aetiology.

The study utilised a sexual citizenship framework focusing on the central considerations of control, access, and choice, alongside a sex-positive approach to broaden the scope beyond narrow heteronormative frameworks. This allowed for the inclusion of diverse sexual expressions, genders, and sexualities of both participants and the sex workers they engaged.

A total of 108 eligible surveys were collected across Australia, with an additional 27 interviews conducted with self-nominated participants. Interviews occurred in-person, over the phone, online (Zoom), and through text messages. For ethical reasons, former or current clients of the researcher were ineligible to be interviewed.

Areas of inquiry included motivational factors, appointment frequency, gender of sex workers, types of services, and service locations. The study also investigated barriers to access, third-party support mechanisms, and difficulties in finding suitable sex workers, along with financial and funding concerns.

Findings and Recommendations

The findings reveal that a diverse range of people with disability have accessed sex worker services in Australia. Participants varied in age, gender, sexuality, and the types of sexual services they paid for. Numerous barriers were identified, including difficulties with sex worker advertising, inadequate or discriminatory support systems, and a lack of accessible venues. Positive accounts of third-party support from friends, family, and allied health practitioners also emerged. Participants shared personal reflections on both positive and negative experiences, highlighting how sex workers contributed to their sense of self, wellbeing, and confidence.

Eight motivational factors were identified for seeking sex worker services: sexual enjoyment, desire for sexual variety, combating loneliness and isolation, seeking genuine intimacy and connectivity, lack of other sexual outlets, increasing sexual literacy, therapeutic healing, and recovery and rehabilitation.

The research findings are expected to contribute to future policy development and educational programs to support people with disabilities in Australia. Key areas include specialised training for staff in the disability, aged care, and rehabilitation sectors, as well as those working with veterans and returned service personnel. Additional training and awareness workshops for the sex industry are also recommended.

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CHAPTER 1

Introduction

1.0 Introduction

I embarked on this PhD journey in early 2020, right at the onset of the COVID pandemic. In fact, Sydney, NSW entered its first lockdown two weeks after I commenced. For the briefest moment in time the world was united in acknowledging the profound importance of physical touch and human connection. What emerged was a collective societal cry for the deep need to be close to friends and to embrace loved ones. A plethora of articles appeared emphasising how skin-to-skin contact was essential for people's physical and mental wellbeing (Durkin et al., 2021; Pierce, 2020; Sharkey & Lamoreux, 2021) as well as a growing body of scientific evidence identifying social isolation and loneliness as important social determinants of health (Farmer et al., 2020; Lim, 2018; Lim et al., 2023; Smith & Lim, 2020). Social distancing measures elicited creative uses of technology, however, as one online commentator remarked "while this is a worthwhile testament to human resilience and adaptive abilities, it's also no substitute for the real thing. These methods are only palliative; people need to have sex" (Rodriguez, 2020).

This feeling is called skin hunger – also known as 'touch starved' or 'touch deprived' (Benabio, 2020; Kale, 2020; Von Mohr et al., 2017). However, while most of the world pined for another hug, many within the disability sector were still being prevented from initiating their first one. These barriers have continued well after borders re-opened and lockdowns ended. As Australian disability activist and academic, Dr George Taleporos once remarked, "disability does not abolish the need and potential for sexual expression" (2001, p. 156). Individuals, governments and policy makers have consistently underestimated the immense pleasure physical and emotional relationships can bring into peoples' lives. Additionally, unlike basic necessities such as food, water, shelter or clothing, intimacy and touch have often been overlooked as essential components for creating a sense of happiness or wellbeing. Instead, support in the disability sector has primarily focused on more tangible elements, such as accessible venues, increased employment opportunities, housing and medical provisions (Beqiraj et al., 2017; Quinn et al., 2014; Shakespeare et al., 2021). These are all components that constitute citizenship (Marshall, 1950a). Historically, discourse about the sexual lives and experiences of people with disability were firmly entrenched within protection and prevention frameworks (Benedet & Grant, 2012; Feely, 2016; McGilloway

et al., 2020), with concerns about capacity and consent often being prioritised (Arstein-Kerslake, 2015; Arstein-Kerslake & Flynn, 2015; Bartlett, 2010). Until recently, discussions of pleasure and sensuality were notably absent. As Finger (1992, p. 9) once observed:

“...sexuality is often the source of our deepest oppression; it is also often the source of our deepest pain. It’s easier for us to talk about and formulate strategies for changing discrimination in employment, education, and housing than to talk about our exclusion from sexuality and reproduction.”

The Sexual Politics of Disability (Shakespeare et al., 1996) stands as a seminal body of work in the field of disability and sexual expression. Based on 42 interviews with people with disability discussing their sexual lives and experiences, the book delves into themes such as body image, identity, and participants’ hopes, dreams and fears concerning sexuality and relationships. Although the authors anticipated that their work would be an immediate precursor to further research of this nature, academic inquiries evolved more slowly than anticipated (Shakespeare & Richardson, 2018).

The article ‘Sexuality and disability: the missing discourse of pleasure’, further addresses this, noting that “full inclusion means access to pleasure” (Tepper, 2000, p. 289). Only recently has there been a shift towards more detailed academic attention on this topic (Gruskin et al., 2019; Loeser et al., 2018; Santos & Santos, 2018). For some, inclusion involves creating accessible social venues, like bars and clubs where people can socialise and go on dates, or providing increased support for marriage and parenthood. For others this includes integrating discussions of sexual functioning and pleasure within rehabilitation programs (Bryant et al., 2022; Prior et al., 2019; Simpson et al., 2006; McLaughlin & Cregan, 2005). Additionally, some people with disability have opted to access paid sexual services to fulfil their sexual expression (Benoit et al., 2022; Wotton, 2020; Liddiard, 2014, 2018; Wotton, 2016; Sanders, 2007).

The focus of this PhD is to develop a greater understanding of the experiences of people with disability who have accessed sex worker services, in Australia. In this study the term ‘sex worker services’ denotes in-person appointments where hands-on interactive services are provided. The eligibility criteria excluded paid on-line, video, text or phone call types of sex worker services or access to porn streaming/Only Fans subscription services. This decision reflects the importance of real-life touch, and acknowledges previously identified barriers to accessing such services, as outlined in existing literature.

1.1 Research aims and questions

This research aims to consider and better understand the diverse range of experiences and perspectives of people with disability who access sex worker services, in Australia.

It seeks to position them centrally, as key stakeholders and decision-makers in their own lives by creating a platform for their voices to be heard and recognised through personal first-hand accounts. As the narrator of a 1983 documentary ‘The Skin Horse’ commented: “professionals have spent far too much time talking about the needs of disabled people and maybe it’s about time to ask them what they feel their needs are” (Evans & Samson, 1983). This research aims to expand upon the relatively small number of first-person accounts in the literature on this subject.

While there is a notable gap in academic research, increased anecdotal evidence suggests that people with disability are indeed seeking out the services of sex workers, and are increasingly willing to share their experiences. Examples can be found in multimedia stories (Kasmawan, 2013; Blades, 2009; Wright, 2014), online news articles (Todd, 2023; Anonymous, 2022; Ley, 2022; Dominic, 2021), personal commentary (Touching Base, 2023a; Calzoni, 2021; Canale, 2019) and documentaries (Moore & Ford, 2019; Young, 2013b; Paradigm Pictures, 2011).

Overall, the aims of this research are to create meaningful representation of people’s lived experiences, amplify the voices of the participants within the academic sphere, and to translate these individual experiences into a more robust empirical dataset that can inform evidence-based policy development and training programs. To address these goals the following questions were posed:

1. What are the experiences of people with disability who have accessed sex worker services, in Australia?
2. What are the motivational factors for people with disability, within Australia, to access sex worker service?

1.2 Significance of the research

This research was designed to place people with disability front and centre, prioritising their voices and experiences as both sexual human beings, and as people who have autonomously chosen to access sex worker services.

Questions pertaining to sexual expression and accessing sex worker services have most commonly been embedded within larger, more general studies, which have not recorded participants’ disability status (Chow et al., 2021; Richters et al., 2014; Rissel et al., 2003), or situated within broader disability-specific research that includes only a few questions on this topic (Bryant et al., 2022; Disability Now, 2005). The research presented in this thesis is significant because its *primary* focus explores the experiences of people with disability who access sex worker services. This approach acknowledges ongoing calls from

both disability scholars and activists to prioritise first-person accounts and support self-determination and autonomy for people with disability (Bigby & Hough, 2024; Shakespeare, 2023; Bahner, 2021; Woodward, 2020). Australian disability advocate, Hannah Diviney, emphasised this need in a blog post (Diviney, 2021 para. 4), saying:

A lot of my work as a disability advocate centres on the idea that disabled people are often missing; onscreen, at work, in the community and from conversations where their voices deserve to be heard and their stories told. Our visibility is still not normalised. And if things are ever going to get better for our community, that needs to change. Like, now.

This research is also built on the premise that ‘sex work is work’. Academia is filled with critical discourse involving perceived legal, ethical and moral positions about the sex industry, but as Kulick and Rydström (2015, p. 180) noted, when such arguments become the focal point, what is lost is:

[a]ll the details and textures and fine nuances – the reasons why some people with disabilities purchase sexual services; the reasons why some sex workers accept disabled clients; the kinds of interactions that occur when disabled clients are visited by sex workers ... all those dimensions of social life and erotic desire are elided in debates that focus exclusively and dogmatically on the issue of whether prostitution is right or wrong.

Approaching my research from this standpoint allows the voices of the participants to remain in focus and creates space for the exploration of meaningful experiences and views from the perspective of people with disability.

1.3 Research Gap

In recent decades, there has been growing academic interest in clients of sex workers in general, exploring their personal reflections, rationales, motivations and patterns of behaviour (Chow et al., 2021; Huysamen, 2020, 2022; Kosloski & Diamond-Welch, 2021; Sanders, 2008; Soothill & Sanders, 2005). Within this broader context, a smaller emerging body of literature has focused on the experiences of people with disability who access sex worker services (Pinho et al., 2020; Bahner, 2019a; Fritsch, 2016). However, while some research indicates individuals actively seek out sex workers to fulfil different aspects of sexual expression (Pinho et al., 2020; Wotton, 2016; Liddiard, 2014), inquiries more often than not prioritise issues such as consent, and the legal frameworks that support or prohibit people with disabilities’ access to sex workers (Jones, 2013; Jones, 2012). This approach frequently overlooks the motivations, decision making processes, experiences and outcomes of such activities for this cohort.

This study addresses the absence of empirical research that specifically explores the lived experiences of people with disability accessing sex worker services, in Australia, and in so doing fills a gap in current research and literature. There is also a paucity of academic inquiries that examine first person accounts of such experiences in other countries. One notable exception is *Loneliness and its opposite: Sex, disability, and the ethics of engagement* (Kulick & Rydström, 2015), which amplified the voices of people with disability who paid for sexual services in Denmark and Sweden.

A significant gap in the literature, is the lack of research specifically asking clients of sex workers if they identify as a person with disability (Chow et al., 2021; Grönvall et al., 2021; Kosloski & Diamond-Welch, 2021; Oliveira & Janssen, 2021; Huysamen, 2020; Sterling & van der Meulen, 2018). Instead, the most relevant data has emerged as secondary, often accidental disclosures where, even in the absence of a specific sampling strategy, individuals have self-disclosed their disability while relating their experiences as a paying client (Sanders, 2007, 2015). From this inadvertent data collection, several issues have been identified, including barriers to locating experienced sex workers, access limitations, personal, moral and ethical considerations from disability support staff, and funding issues due to limited work opportunities and a lack of government assistance schemes. Research with sex workers, talking about their experiences providing services to clients with disability (Pinho et al., 2020; Wotton, 2016; Sanders, 2007) supplements this limited understanding about clients with disability.

A significant feature of the research shared in this thesis is its inclusive approach, encouraging the participation of people with disability of all genders and sexual identities. Within the limited empirical research on clients accessing sex worker services, inquiries are mostly based on either a heteronormative framework, where the client is cis-male and the sex worker is cis-female, or focused on homosexual and men-who-have-sex-with-men cohorts. While there has been a more recent focus on women who access sex worker services, inquiries exploring non-heteronormative experiences between individuals with disability and sex workers are currently sparse within academia. Therefore, this doctoral research was developed to be inclusive and welcoming of the full diversity of gender and sexual identities among its participants.

It is anticipated that this research will contribute to the small but evolving body of work in this field and build upon previous findings. For example, one of the final recommendations in a UK study (Sanders, 2007) was for increased “research into moral, social, practical, financial, legal and emotional dynamics of buying a sexual service for people with impairments” (p. 453). Additionally, a study with Portuguese sex workers who provided services to clients with disability noted the absence of female clients with disability,

and emphasised the need for more training and information for both the sex worker and disability communities (Pinho et al., 2020).

1.4 Research Methodology

A mixed methods approach, involving the use of an online survey and in-depth, semi-structured interviews, was utilised to explore the research questions. The survey method was chosen for its ability to ensure participant anonymity, while reaching a broad cross section of individuals across a wide geographical area in Australia. This approach was crucial as discussing a topic often deemed ‘taboo’ can be uncomfortable for some, while others may not want to ‘out’ themselves as a client, their engagement in specific sexual activities, or their preference for booking sex workers of the same gender.

This method also allowed participants time to consider the questions and compose their answers thoughtfully. The online survey instrument was designed to accommodate and support participation from a diverse range of people with disability, including those who use augmentative and alternative communication (AAC) systems. The survey collected both quantitative and qualitative data, with the latter providing insight into attitudes, opinions and experiences in the participants’ own voice, rather than merely collecting and reflecting on statistical variants from pre-determined response options (Braun et al., 2020).

Eligibility criteria included being at least 18 years of age, identifying as a person with disability and having accessed in-person sex worker services in Australia at least once. The definition of disability used in this study is drawn from the Australian Disability Discrimination Act (Australian Government, 2023). Eligible participants included people with psychosocial, cognitive, intellectual and/or physical disabilities of a congenital, developmental or acquired aetiology.

A total of 108 eligible surveys were collected. Additionally, 27 semi-structured in-depth interviews were conducted with participants who self-nominated at the completion of the survey to speak further about their experiences. To maintain professional boundaries and adhere to ethical research practices, former or current clients of myself, the researcher, were ineligible to participate in an interview. Interviews were done in-person, over the phone, utilising Zoom and one via a long series of text messages. Excluding the latter (which was conducted slowly over 6 hours and 18 minutes), the length of each interview ranged from 35 minutes through to 2 hours.

The survey and interviews explored a range of topics including the frequency of appointments, diversity of services paid for, gender of the chosen sex workers and location of service provision. The research also examined potential organisational, societal, and

personal attitudes and practices that may have enabled or constrained participants' access to sex worker services, participants' access to financial supports, and barriers or difficulties individuals may have experienced in locating suitable sex workers.

In summary, an online survey was chosen to elicit a broad range of quantitative and qualitative data (Braun et al., 2020). However data gleaned from the interviews provided a greater opportunity for thick description (Geertz, 2008) which, in turn, allowed for a deeper level of analysis than online survey data alone could provide.

1.5 Accessibility

The research was designed to create equitable opportunities for individuals to participate. This included the creation of an Easy Read Participant Information Sheet, using a font that is easier for people with dyslexia to read, providing printable versions of the survey for people to manually fill out and send in via ReplyPaid free post, designing the online survey with a larger font size, creating online pop-up boxes with Plain English versions of the questions, ensuring that the survey didn't 'time-out' and keeping the survey open for nearly six months. A dedicated website page was created to store all information about the research including: the recruitment advertisement, the participant information sheets, the interview consent form, and the withdrawal of consent form. These can be found in Appendices 2-9.

As the formal title of this research 'Exploring the experiences of people with disability who access sex workers services, in Australia', is long and cumbersome to say, it was shortened and subsequently referred to as the PASA-Research study. A professional graphic designer was engaged to create a unique visual representation for the research, which was used on the website, recruitment advertisements and on all documents developed for participants.

The interviewees were able to choose where, how and when they felt most comfortable participating, including in-person, over the phone, via Zoom and by text message. In-person interviews were conducted in NSW, Queensland and Victoria, in either the participant's own home, or private meeting rooms situated in public libraries, community centres and a Western Sydney University campus. All venues were accessible and catered to the individual needs of the participants. The choice to conduct an interview in a participant's own home allowed for individuals to be in a safe, supportive location. While Ethics Committees still prioritise the use of cafes or other public venues to conduct interviews, these locations were deemed inappropriate due to the nature of the topics to be discussed, a lack of privacy and the potential for sensory overload from lighting, sounds and smells in such venues. Gift vouchers were provided for each interviewee in recognition of their time and expertise shared. Electronic vouchers from www.Prezzee.com.au, or physical gift

cards of the individual's choosing, were given on conclusion of the interview. This allowed for equitable payments given to participants, with the understanding that not everyone has access or has the capacity to utilise online electronic payment systems.

1.6 Theoretical Framework

Sexual citizenship theory has informed the development of this study. Sexual citizenship shares many common features with other claims of citizenship, such as matters of inclusion, enfranchisement, belonging, equity and justice (Lister, 2002). The theory of sexual citizenship (Weeks, 1998) expands upon these elements, with Richardson (2000, 2017) describing it as the right to express one's sexual desires, the right to define one's sexual identity, and the right to have these acknowledged by state bodies and institutions. For this study, Dailey's (1981) Circles of Sexuality Model best describes these multidimensional elements of sexual citizenship, with the term 'sexual expression' used to reflect the totality of sexual experiences encompassed.

This research is also underpinned by a biopsychosocial framework provided by the International Classification of Functioning, Disability and Health, known more commonly as the ICF (World Health Organisation, 2021). Viewing this topic through a biopsychosocial lens allows for a thorough examination of the contextual features of the participants' experiences in relation to social, environmental, and personal factors, as well as in comparison to other participants' experiences.

In order to approach sexual citizenship with integrity, a sex positive lens was also employed. Encapsulating notions of empowerment, diversity and choice, sex-positivity views each individual's sexuality as a unique set of preferences, experiences and values (Kangaude, 2009). This shifts the gaze away from heteronormative stereotypical assumptions to widen the scope of inquiry to include participation of individuals of all gender and sexual identities. It also encompasses participants' diverse selection of sex worker services, with such choices both respected and considered valid and free from shame or judgement within this research.

1.7 Situating the research

This research was conducted within Australia where sex work is a legally recognised occupation (Scarlet Alliance – the Australian Sex Workers Association, 2024). While others have critiqued the moral, legal, ethical and human rights discourse around the sex industry and its participants, the basis for this research draws from the premise that sex work is work (NSWP, 2017).

Similarly, moral considerations about whether people with disability should or should not pay for sex, do not play a role in this research. Instead, the foundational starting point of this research is based on the acknowledgement that anyone of legal age, in Australia, can choose to access sex worker services if they have the motivation, the financial means, and can give informed consent to the sex worker for the services they wish to enjoy.

According to the Australian Bureau of Statistics (2024), 21.4% of the total Australian population (5.5 million people) live with disability. It is also estimated that 7.9% of all Australians have a profound or severe disability. While 17.1% of all Australians were aged 65 years and over, 52.3% of this cohort live with disability. This indicates that with increased life expectancy, disability-related issues will affect over half the population. Consequently, elderly clients and aged care related matters are included in this disability-based research.

The representation and inclusion of people with disability has notably expanded within Australia over the last 30 years. For example, the Australian Federation of Disability Organisations (AFDO) is the peak organisation within the Australian disability sector with its membership made up of a wide range of organisations run and led by people with lived experience of disability. Their vision statement asserts that “all people with disabilities must be involved equally in all aspects of social, economic, political and cultural life” (Australia Federation of Disability Organisations, 2023 para. 2). Additionally, the Disability Advocacy Network Australia (DANA) is the national representative body for a network of independent disability advocacy organisations throughout Australia, with their stated purpose being “to strengthen, support and provide a collective voice for independent disability advocacy organisations across Australia that advocates for and with people with disability” (2023 para. 3).

Historically, people with disability were excluded from sex education programs, but this approach has shifted in Australia. For example both the Living Safer Sexual Lives (Johnson et al., 2001) and the Sexual Lives and Respectful Relationships (SL&RR) peer education project (Barrett & Dyson, 2013; Frawley & O’Shea, 2020) focused on supporting the sex education needs of people with intellectual disability. Royal Rehab, based in Sydney, NSW operates a specific Sexuality Unit (2023), Family Planning NSW provides a Disability and Sexuality Service (2023), and the Occupational Therapists Australia website recently introduced a specific Intimacy and Sexuality ‘area of practice’ search options (2023). A resource for occupational therapists, ‘Sex is for everyone: Occupational therapists supporting sexuality for people with intellectual disability’ (Piantedosi et al., 2023; Rainbow Inclusion, 2023) is now available, alongside numerous co-designed resources recently developed by, and for, people with disability. Encompassing a specific focus on relationships, sex, sexuality, safety and consent, they include: Introduction to Consent (SHFPACT & SECCA, 2024a),

Introduction to Sexual Consent (SHFPACT & SECCA, 2024b) and Creating Social and Sexual Safety: National Guidelines for organisations and workplaces (SHFPACT, 2024).

Additionally, a nation-wide resource released in 2022, ‘Sexuality, Relationships and Your Rights – a book about sexuality and the law for people of all abilities’ (SECCA, 2024) includes references and legal information about accessing sex worker services. It links to Touching Base, an unfunded not-for-profit Australian organisation that supports people with disability and sex workers, advocating for their labour rights, sexual rights and the ability to connect with each other (Touching Base Inc, 2000). Operating since 2000, Touching Base provides training to both the disability and sex worker communities and have developed numerous resources, including a ‘Policy And Procedure Guide For Disability Service Organisations Supporting Clients To Access Sex Services’ (2011), ‘Anna sees a sex worker’, ‘Tony sees a sex worker’, ‘Seeing A Sex Worker – A Guide For People With Disability’ (2016), and ‘Clearly Picturing Your Sexual Needs – supporting communication between people with disability and sex workers’ (2018). The Touching Base website also hosts a Clients’ Stories page which allows people with disability, their parents and support workers to share personal stories about accessing sex worker services (2023a).

Since 2002, Touching Base has also operated a unique Sex Worker Referral List inquiry form, which provides contact details of sex workers who are willing and experienced in providing services to clients with disability. Data released at their 2023 AGM indicated there were 654 inquiries received between 1st July 2022 – 30th June 2023 (Touching Base, 2023a), with 322 being submitted by the potential client (person with disability), 318 by a carer/support worker and 18 by a family member/friend. These inquiries came from every Australian state or territory with the self-determined gender of the potential client being male (551), female (20), transgender (Female-to-Male)¹ (6), and transgender (Male-to-Female)² (5).

While not all inquiries develop into actual bookings, and the organisation has not provided data determining how many inquiries may be repeat requests, this information reflects a growing need among people with disability who are seeking sexual services from sex workers in Australia. Notably, just over half (50.5%) of the inquiries were from individuals who had ‘never paid for sex before’ and at least 126 (19.2%) indicating they had ‘never had sex before’. What is also unique is that 57.2% of inquiries indicated they needed a receipt from the sex workers, with 26.4% requiring an invoice. This reflects a shift in the financial payment system that sex workers may need to accommodate in the future, moving away from the traditional cash-up-front method to one which has a more formalised payment structure.

1 transgender (Female-to-Male) was the data collection term used by Touching Base

2 transgender (Male-to-Female) was the data collection term used by Touching Base

Australia has introduced two unique insurance schemes to financially support people with disability to live their best possible life. The first is a Lifetime Support Scheme. Operating as a no-fault scheme, people who receive injuries resulting in permanent disability (e.g. paraplegia, brain injury, serious burns or blindness) from motor vehicle accidents qualify for financial support. Each jurisdiction has created their own law. For example South Australia introduced the Motor Vehicle Accidents (Lifetime Support Scheme) Act (2013) while NSW residents are supported by the Motor Accidents (Lifetime Care and Support) Act 2006 which is run by Insurance and Care NSW (icare) (2018). Calculations for lifetime care and support are now starting to include sex worker services for individuals.³

The National Disability Insurance Scheme (NDIS) is operated by the Australian Government to fund costs associated with disability (2023a). Legislated in 2013, with a full rollout by 2020, it provides person-centred funding to support each participant to access appropriate services and supports to “live an ordinary life” equal to others (NDIS, 2021a, para. 3). The NDIS was designed to conglomerate the former State and Territory funding systems into one consistent scheme throughout Australia and to give more choice and control to individuals regarding which services would best suit their needs (2021b). While currently supporting over 610, 000 Australians with disability (NDIS, 2023b), the NDIS has, to date, failed to develop a Sexuality and Relationships Guidelines or specific policy to support peoples’ intimacy or relationship needs (Disabled People’s Organisations Australia (DPOA) & Touching Base, 2019). In 2020, one individual won their case against the NDIS in the Federal Court of Australia, which allows them to include sex worker services into their NDIS Plan (2020). However, the lack of clear, instructive Guidelines has created ongoing confusion within the disability sector and is reflected within the findings of this research.

1.8 Positionality of the researcher

I commenced this research with a deep understanding of the topic. Having worked as a sex worker for more than three decades I am professionally and publicly known as someone who provides services to people with disability (Paradigm Pictures, 2011a; Wotton, 2016; Wotton, 2017; Wotton, 2021; Wotton & Isbister, 2010). For years I have been asking my clients if they would like a platform where their voices and experiences could be shared. Their response was always a resounding ‘yes!’

In conjunction with my sex work profession, I was one of the co-founders of Touching Base, which has led to decades of advocacy, training, and presenting opportunities in the disability sector. My intimate knowledge and understanding of the gaps I identify within

3 This observation is made on the basis of personal experience: (1) lawyers have previously contacted Touching Base when I was on the Committee, and we referred them to individuals who delivered Court Reports supporting this service (2) lawyers have contacted me directly for insights and information (3) I have provided services to clients who have paid me via their insurance payments.

this research have also been formulated from extensive candid and honest conversations with people with disability, their parents, siblings and friends, Disability and Aged Care workers, medical professionals, Allied Health practitioners and other sex workers. Additionally, my Masters by Research explored the topic of ‘Sex workers who provide services to clients with disability in New South Wales’ (Wotton, 2016). I view this current PhD inquiry as a natural progression and extension from my previous work, activism, publications and research.

Finally, the phrase ‘nothing about us, without us’ is used by both the disability and sex worker communities, and while I would have supported a person with disability to lead this research, many are too busy fighting for equitable access to healthcare, housing, work and education to focus on this topic. As Shakespeare noted “Partly, this is undoubtedly about prioritisation. Ending poverty and social exclusion comes higher up the list of needs, than campaigning for a good fuck, and for access to clubs and pubs” (2000, p. 160). Therefore, my aim was to use my relatively privileged position, as an ally, with enough time and energy to be able to navigate the academic world, to develop a platform for people to share their personal experiences, and to develop robust empirical evidence which could be utilised to better support people with disabilities’ sexual expression in the future.

While concerns about the interviewer–participant dynamics, especially when the ‘client-of-sex-worker’ participants are male, have been noted (Huysamen, 2016) the open approach used in disclosing my sex worker experience elicited a level of trust that other researchers who aren’t sex workers (or choose not to disclose) may not enjoy so quickly (if at all). Additionally, my extensive paid and volunteer employment history, media profile, and involvement in relevant lobbying and activism within the sex work and disability sectors, allowed individuals to quickly identify who I was, put a face to a name and feel comfortable knowing that my intentions always follow a best practice ethos that has been consistently demonstrated in my work and advocacy.

1.9 Ethical Considerations

Conducting research with a marginalised community, and discussing the private and somewhat taboo topic of paid sexual services, necessitated additional ethical considerations to ensure the ‘do no harm’ principle. Beyond standard data protection and anonymisation of interviewees, stringent measures were taken to maintain confidentiality. Only the researcher had access to private information, such as contact details of participants entering the gift card draw or self-nominated interviewees. Survey results were accessible to supervisors only. An interview safety protocol was developed for home visits and audio files and transcription data were stored securely on an external hard drive rather than cloud servers to prevent unauthorised access. Participants were given the chance to review their

transcripts, fostering trust and ensuring informed consent, with audio recordings then deleted to ensure participants' voices could not be identified.

The research aimed to provide a safe, supportive, and non-judgmental environment for people with disabilities to share their experiences. To avoid conflicts of interest and maintain the integrity of the research, current or former clients of the researcher were excluded as interview participants. This measure was crucial to prevent undue influence, ensuring that participants did not feel pressured to modify their responses to please the researcher or from fear of losing services.

In line with the ethical commitment to the community, accessible formats of these findings will be developed to share with participants and the wider disability and sex worker communities. For example, an accessible, Plain English summary of the research findings will be uploaded to the PASA-Research website and disseminated through previously used communication channels.

1.10 Thesis structure

The framework for this thesis has been developed to guide the reader from the inception of the research through to the findings, discussions and recommendations.

This first chapter gives an overview of the topic and situates the research in Australia. It has briefly outlined identified gaps in the literature that align with the research questions that guided this study and speaks to the significance of this study.

This is an emotive topic and the terminology, definitions and laws differ greatly from each country and jurisdiction. Chapter 2 has been designed to provide a clear framework as to the language, terms and principles used throughout this research, as well as the rationale for each. This includes the definition of disability, support worker, allied health, sex work, sex worker and sexual expression. The different regulatory models sex workers operate under within Australia's six states and two territories is also explained. A detailed summary of sexual citizenship theory, Dailey's Circles of Sexuality Model, sex positivity and the Biopsychosocial Model of Disability is provided, which underpins how this research has been approached.

Chapter 3 and 4 provide an overview of the current literature pertaining to this topic. The former starts by examining the sexual agency of people with disability, including the importance of inclusive film and TV representation. Global and national charters of support for people with disability are discussed before outlining current organisational and financial support mechanisms found within Australia. Chapter 4 provides a review

of empirical research conducted about clients of sex workers, including demographics, perceived motivations, and patterns of behaviour. The focus then narrows to people with disability who pay for sex worker services, highlighting the limited data available for this cohort. The last section identifies existing gaps in the literature and outlines specific areas this research aims to address.

Chapter 5 outlines the methodology of this research. The discussion includes ethical considerations, research design and data collection methods. The sampling, recruitment, and eligibility criteria of participants are provided alongside an overview of the researcher's positionality. A description of the unique image created to visually represent this research, and the rationale for using the specific colour scheme and design is also given. Data analysis, with consideration given to the rigour and validity of the data, is shared, with a final section dedicated to identifying limitations of this research.

Chapter 6 provides the findings from the PASA-Research study, incorporating data from both the survey and the interviews. This chapter follows the same structure as the survey with information shared under five distinct sections titled 'who', 'what', 'where', 'how' and 'why':

WHO includes the demographics of the 108 survey participants, categorising their disabilities, along with their age range, geographical locational, nationality, sex, gender and sexuality. Demographics for the 27 interviewees are also provided.

WHAT focuses on elements of the participants' appointments, including the number of sex workers visited, participants' age when they first paid for sexual services, the gender of the sex workers, frequency of appointments and the range of services paid for.

WHERE provides data for both the geographical and situational locations of where services were received.

HOW outlines both barriers and considerations for how participants located and booked suitable sex workers. How participants paid for sex worker services, regarding different funding streams is also provided.

WHY identifies eight specific motivational factors for why participants sought out sex worker services, along with reasons for why they stopped accessing these services.

The final section of Chapter 6 provides personal reflections from participants, capturing their diverse interactions and outcomes from appointments, presenting both positive and negative experiences. Additionally, updates on significant developments in participants'

lives since their interviews are included, offering a dynamic perspective on their ongoing journey as sexual beings. This section also highlights what participants wish the general public to know and understand about people with disability who chose to access sex worker services. These insights aim to challenge stereotypes, foster empathy and promote a more informed and respectful discourse on this topic.

Chapter 7 contextualises the PASA-Research findings within the current academic literature, utilising a sexual citizenship lens for analysis. This includes the following areas of discussion: barriers to accessing sex worker services, frequency of appointments, third party involvement, financial and funding considerations and motivational factors. Age of first appointment and patterns of engagement are also discussed.

Chapter 8 provides a summary of the main findings and limitations of this research. It concludes with suggestions for further research inquiries, policies and practice.

1.11 Summary of findings

The PASA-Research study provides a comprehensive examination of the experiences of people with disabilities in Australia who have accessed sex worker services. Findings were developed from 108 survey responses and 27 semi-structured interviews. Participants represented a diverse demographic spectrum, encompassing a wide range ages, genders, sexual orientations, and geographic locations. Respondents self-identified living with 48 different disabilities or conditions, with representation from all six disability categories: physical, intellectual, sensory, mental illness, neurological, and neurodivergent.

Participants accessed a diverse range of services from sex workers of various genders and ages, with appointments taking place in sex services premises, participants' residences, independent sex worker workspaces and hotels, across all Australian states and territories. Various methods were used to locate suitable sex workers, including the use of online platforms, referrals, third-party support, and print media. The choice of sex workers was influenced by factors such as the worker's prior experience with clients with disability, overall impressions from advertisements, attractiveness, and the specific services offered. Third-party support was often crucial in this process, with both positive and negative experiences reported. Financial barriers, particularly inconsistencies in NDIS funding, emerged as significant issues affecting participants' ability to access these services.

A key focus of the study was understanding the motivations behind seeking sex worker services. Eight primary motivational factors were identified: sexual enjoyment, desire for sexual variety, combating loneliness and isolation, seeking genuine intimacy and connectivity, a lack of other sexual outlets, increasing sexual literacy, therapeutic healing,

and recovery and rehabilitation. These motivations highlight the multifaceted reasons people with disability seek out these services and the critical role they play in fulfilling emotional, psychological, and physical needs, often unmet by traditional support and education systems.

Participants shared a range of outcomes experienced from these bookings. Positive reflections included feelings of pleasure, acceptance, increased confidence, and emotional well-being, demonstrating a significant impact these services had on their lives. However, negative experiences also highlighted issues of discrimination, accessibility, funding difficulties, and a lack of suitable sex workers.

The PASA-Research study underscores the importance of recognising and supporting the sexual agency of people with disability through the lens of sexual citizenship theory. This theory extends traditional concepts of citizenship to include sexual expression, emphasising individuals' rights to express their sexual desires, define their sexual identity, and have these recognised by state bodies and institutions. Bahner's (2019b) distinction between policy-based and practice-based sexual citizenship is particularly relevant here. Policy-based sexual citizenship refers to structured, institutional support for sexual expression, which is currently lacking in Australia with an absence of comprehensive policies or guidelines. Practice-based sexual citizenship, on the other hand, is provided at the grassroots level, often on an ad hoc basis and dependent on the moral and ethical compass of individual support workers. This study identified a pressing need for formal training to be provided to third party supports to ensure consistent and respectful support for the sexual citizenship of people with disability throughout Australia.

1.12 Recommendations

These findings illustrate a significant gap in the support for the sexual citizenship of people with disability. To ensure their rights and needs are fully supported and respected the need for greater public awareness, policy changes, improved education, and more inclusive practices was identified. Addressing financial barriers, combating stigma, and providing comprehensive support systems are crucial steps toward achieving this goal. Such measures are essential for enhancing the well-being and autonomy of people with disability in Australia.

For example, to improve policy-based sexual citizenship, the study calls for policy changes that include the creation of comprehensive guidelines and supportive frameworks within existing disability and health services. This includes ensuring consistent NDIS funding for sexual services and addressing financial barriers more broadly. Practice-based sexual citizenship can be improved by fostering a more inclusive and supportive environment

at the grassroots level, ensuring that people with disabilities have access to accurate information, empathetic support, and community resources that respect their right to sexual expression, including their choice to seek out sex worker services.

It is anticipated that results from this research may contribute to future policy and educational program development to support people with disabilities, in Australia. Areas of focus include:

1. **Geographical and Demographic Research:** Conduct targeted research in regional and rural areas to better understand the barriers and issues faced by people with disability accessing sex worker services in different geographical contexts. Future inquiries should adopt a sex positive framework to encourage a more diverse representation of gender and sexuality.
2. **Inclusivity in Research:** Expand research to include underrepresented groups such as those with complex communication needs, those with profound disabilities who rely completely on third party support, culturally and linguistically diverse (CALD) communities, First Nations people and older Australians. This will provide a more comprehensive understanding of the diverse experiences and needs within the disability sector.
3. **Specialised Training:** Advocate for comprehensive training within disability and aged care sectors, particularly with staff working in rehabilitation settings and supported accommodation. Additionally, implement further training and education workshops for the sex industry, focusing on improvements in advertising, accessibility, and venue adaptations to better accommodate clients with disability. Awareness training for people with disability is also recommended, to enhance their capacity to communicate their sexual needs effectively with both third-party supports and sex workers, before and during the booking process.
4. **Enhanced Financial Support Systems:** Address financial barriers, such as inconsistent NDIS funding, and explore the potential for other governmental departments, like the Department of Veterans' Affairs (DVA), to include sex worker services as part of treatment plans for conditions like PTSD and depression.
5. **Sexual Citizenship and Comprehensive Policy Frameworks:** Advocate for the promotion of sexual citizenship by ensuring people with disability have control, access, and choice in their pursuit of sexual and intimate relationships. This includes developing comprehensive policy frameworks that support individuals in realising their sexual and intimacy needs, including access to sex worker services if they so choose.

These recommendations aim to bridge the gap in support for the sexual citizenship of people with disabilities, ensuring their rights and needs are fully acknowledged, supported and respected.

1.13 Conclusion

Supporting the sexual citizenship of people with disability has been one of the last bastions of change within society. Traditionally, efforts towards equal and equitable rights have prioritised education, housing, employment and physical access needs. However, this approach overlooks a holistic support system, denying individuals their sexual citizenship rights. Sexual expression can be realised through various means including casual dating, forming relationships, forming long-term partnership and marriage, however some individuals also choose to seek out sex worker services.

There is a paucity of academic inquiries into the experiences of people with disability who access sex worker services and none that have focused exclusively on this cohort. This research aims to fill that gap by providing a platform for people with disability in Australia to share their personal stories and experiences accessing sex worker services. It also examines their motivations to do so, highlighting the importance of recognising and supporting the sexual citizenship of people with disability.

The following chapter provides an overview of the definitions and terminology used throughout this thesis, situating the research within Australia. It establishes a clear framework for the language, terms, and principles used, along with the rationale for each. This includes definitions of key terms such as disability, support worker, allied health, sex work, sex worker, and sexual expression. The chapter also explains the different regulatory models under which sex workers operate within Australia's six states and two territories. Furthermore, it provides a detailed summary of the theoretical frameworks underpinning this research, including sexual citizenship theory, Dailey's Circles of Sexuality Model, sex positivity, and the Biopsychosocial Model of Disability. This comprehensive overview clarifies the lens through which the literature and findings from this research are viewed and analysed.

CHAPTER 2

Definitions, Theoretical Framework and Approaches

2.0 Introduction

The Joint United Nations Programme on HIV/AIDS (UNAIDS) states that “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). This chapter therefore provides a clear framework and rationale for the language, terms, principles and theories used throughout this research. This includes definitions for the terms disability, support worker, allied health, sex work, sex worker and sexual expression. The different regulatory models sex workers operate under within Australia’s six states and two territories are also explained. Finally, a detailed summary of sexual citizenship theory, Dailey’s Circles of Sexuality Model, sex positivity and the Biopsychosocial Model of Disability is provided, which underpins how this research has been approached.

2.1 Terminology used

Language is a powerful medium. It can be used to validate someone or destroy a person’s sense of self-worth. Throughout the world, different terminology is employed within the disability sector to represent the same thing. Whilst a particular word may be viewed as derogatory in one location, it might be perfectly acceptable in another. Even within one country, words can be employed differently depending upon the context of the speech or written sentence, the medium in which it is used, and who is saying or writing it.

Language also changes as societies evolve, social norms change, and marginalised communities gain autonomy to speak out. Certain terms from previous times are now acknowledged as slurs, with such stigmatising language called out in both academic literature and social media (Brown, 2020; McKay et al., 2015). In the context of the language of disability, the most notable examples are the ‘R’ word and the use of the term ‘spastic’ (Aruma, 2019a, 2019b). While ‘mental retardation’ was originally used in the 1960’s as a medical term, it later became used in everyday language as a demeaning insult, often with a lack of forethought about the negative impact it has on individuals in the community (Special Olympics, 2023). As Gabrielle, a participant in a Western Australian initiative to inform the public about how deeply hurtful this word is, stated: “The R word makes me feel

like I’m a second-class citizen, not quite as good as everyone else, and not really part of society” (Citizen Network, 2018 para. 4).

In order to respect the autonomy and self-determination of participants, this research has been designed to prioritise, amplify, and elevate their voices. It also aims to convey deep respect and consideration towards the individuals and communities involved in this study, and therefore takes great care with the language it uses. This demands adherence to clear descriptions and definitions, and ethical best practice in addressing and discussing the experiences of participants. As the research is situated in Australia, this chapter provides definitions and rationales for the terminology used throughout this thesis and recognises that some of these that may be unique to this context. However, quotes from participants, and extracts from research literature and social media will retain any original language or terms and will not be altered.

2.1.1 Definition of Disability

The definition of disability used in this study is drawn from the Australian *Disability Discrimination Act* (2023a) which defines disability as:

- total or partial loss of the person’s bodily or mental functions
- total or partial loss of a part of the body
- the presence in the body of organisms causing disease or illness
- the malfunction, malformation or disfigurement of a part of the person’s body
- a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction
- 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:

- presently exists; or
- previously existed but no longer exists; or
- may exist in the future (including because of a genetic predisposition to that disability); or
- is imputed to a person.

To avoid doubt, a disability that is otherwise covered by this definition includes behaviour that is a symptom or manifestation of the disability.

This research welcomed the participation of people with psychosocial, cognitive, intellectual and/or physical disabilities of a congenital, developmental or acquired nature. As detailed in Chapter 5, participants were given the opportunity to describe their disability in their own terms, rather than choose from predefined tick-boxes and labels. This approach enhanced autonomy and accessibility by allowing participants to decide how much information they wanted to share about themselves. It also made the survey more user-friendly by eliminating the need to scroll through a lengthy list of predetermined categories and disability descriptors to find the one/s that best described participants own personal circumstances. This approach also reduced perceived researcher bias regarding what disabilities participants may have, and facilitated open access to anyone who met the specified criteria.

2.1.2 People with disability

The use of acronyms is common in reports and theses. For example, the descriptor ‘people with disability’ is often shortened to PWD, or ‘people living with disability’ is abridged to PLWD (Benoit et al., 2022). In order remind the reader that these discussions are about real people, with real emotions and real experiences, I have chosen not to use these acronyms in this thesis.

I will also be using person-first terminology, such as ‘person with disability’, or ‘man with Autism’, in accordance to People With Disability Australia’s (PWDA) language guide (2021). However, I would like to acknowledge that many within the disability community prefer identity-first language, using terms such ‘disabled person’ or ‘autistic person’ (Wong, 2021; Kenny et al., 2016;) which some view as less stigmatising than person-first language (Gernsbacher, 2017). A recent article ‘Furthering the person-first versus identity-first language debate’ provides a detailed overview of the uses, preferences and arguments for and against person-first and identity-first language and explores the implications of these language choices for identity, advocacy, and inclusivity in both academic and social settings (Grech et al., 2023). A salient commentary on the evolution of terminology within disability communities can also be found in the article “# SaytheWord: A disability culture commentary on the erasure of “disability” (Andrews et al., 2019).

2.1.3 Support worker vs Carer

Many people with disability rely on third-party support for assistance to do a wide range of daily tasks and activities. In Australia, paid staff are generally called a ‘support worker’ though other terms such as ‘Disability Support Worker’ (DSW), ‘personal carer’ or ‘personal care attendant’ are also used. Their roles can include mobility support, un/dressing, transportation, and personal hygiene facilitation (such as showering, bowel care or assistance with uridoms), as well as helping with shopping tasks, food preparation,

housework, or assisting an individual at social events. Support workers are guided by prescribed work ethics and a duty of care, often needing to meet formal qualifications and educational requirements to be employed. However, parents, siblings and friends who provide unpaid ‘informal’ practical and emotional support to an individual are defined as ‘carers’ (Hire Up, 2021; Mable, 2023). Carers Australia, a national peak body organisation, advocates for better policy and services to “support the caring role and enhance the health, wellbeing, resilience and financial security of Carers” (2023 para. 3).

In other countries, such as the USA or the UK, support workers may be referred to as ‘aids’, ‘care assistant’, ‘personal assistants’ or ‘home care’. All of these terms, but most specifically ‘support worker’ and ‘carer’, are often used interchangeably by people with disability, and this was reflected in the interviews conducted for this research.

2.1.4 Allied Health

The term ‘allied health’ refers to professionals who work with people to provide a “broad range of diagnostic, technical, therapeutic and direct health services to improve the health and wellbeing of the consumers they support” (Allied Health Professions Australia (AHPA), 2023). Allied healthcare professionals sit alongside nursing, midwifery, doctors or dentistry and include the roles of social workers, occupational therapists, psychosexual therapists, psychologists, counsellors, rehabilitation specialists (sometimes called a rehabilitation counsellor), speech therapists, podiatrists, chiropractors and physiotherapists. This is a rapidly growing workforce within Australia, with over 200, 000 registered allied health practitioners working across the mental health, disability, aged care and health sectors (Australian Government, 2023a).

2.1.5 Sex worker

Historically a wide variety of terms have depicted those who work in the sex industry, with many used as derogatory slurs and insults (Akard, 2024). Within the English language such descriptors include prostitute, hooker, escort, courtesan, call girl, whore, street walker, harlot, hustler, hoe/Heaux, fallen woman, scarlet woman, jezebel, callboy, gigolo, rent boy and ‘woman of ill repute’. Older, more historical, terms include floozy, strumpet and doxie (WordHippo, 2023; Lauder, 2007; Ditmore, 2006). Additionally, these terms are often steeped in negative connotations, commonly used to signify coercive and exploitative situations, where the individual (generally a woman) has no autonomy over her work conditions or location or is perceived to have made dubious life choices.

The term ‘sex work’ is predominately attributed to American sex worker and activist Carol Leigh (AKA ‘Scarlet Harlot’) who started using it in a public forum in 1978⁴ (Walkowitz, 2024). Since then, the terms ‘sex work’ and ‘sex worker’ have been utilised by an increased number of academics (in both teaching modules and publications), government bodies, sex worker organisations, and within print, online, TV and film media. This positive terminology shift is indicative of the focus towards recognising sex work as real work, approaching it within labour and occupational health and safety frameworks, and away from the stigma associated with some of the before-mentioned terms (Wotton, 2007). As Leigh later wrote in her essay ‘Inventing Sex Work’: “The term ‘sex work’ marks the beginning of a movement... It acknowledges the work we do rather than defines us by our status” (2013, p.230)⁵

This research is based in Australia where the preferred terminology is *sex work*, *sex worker* and *sex industry*. As Scarlet Alliance – the Australian Sex Worker Association states: “Sex workers in Australia reject the term ‘prostitute’ and other oppressive language such as ‘prostituted woman’, which sees sex workers as objects without agency or choice, and makes invisible all sex workers who do not identify as women” (2014, p. 4). Unless taken from a direct quote or title of a paper, the terms *sex work*, *sex worker* and *sex industry* are used throughout this thesis.

2.1.6 Sex work

This research employs Weitzer’s definition of sex work as “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, 2009, p. 1).

The provision of in-person sex worker services can occur in a wide variety of locations. This includes brothels, massage parlours, private homes, hotels, motels, apartments, safe houses, in cars, disability supported accommodation, nursing homes, residential aged care facilities, rehab accommodation or any other location negotiated between the sex worker and their client. While previous research has identified at least 25 different types of sex work (Harcourt & Donovan, 2005), expansion of the internet and online streaming services means ‘sex work’ now includes the selling of visual sexual content such as pay-per-view porn imagery or videos. However, as outlined in Chapter 5, for the purpose of this research, only in-person appointments, where ‘hands on’ interactive services were provided, will be examined. Accessing paid on-line, video, text or phone call type of sex worker services or access to porn streaming/Only Fans subscription services were excluded from the eligibility criteria.

4 While Carol Leigh made this term popular, the Oxford English Dictionary states the earliest evidence of the term ‘sex work’ was from 1934, in *American Journal of Botany* (Oxford English Dictionary, 2024).

5 RIP Carol Leigh (January 11th, 1951–November 16th, 2022)

This research specifically focused on people with disability who access sex worker services. However, there is often confusion in both the academic literature and the media as to what sex work is, and is not, particularly within the context of service provision to people with disability. This confusion stems from several factors: firstly, sex work is not legally recognised as an occupation in many countries. Additionally, in some regions, sex workers are not perceived as capable of providing the nuanced and specific services required to meet the needs of people with disability, largely due to the lack of formal accredited training, akin to other professions. This deters some individuals from considering sex work as a legitimate option to address their sexual needs. As a result of these factors, other forms of sexual services – often reframed as types of ‘therapies’ – have emerged. These services often operate under different legal frameworks than the sex industry and do not experience the same stigma and societal disdain that sex workers experiences. These types of services include sexual surrogacy (also known as partner surrogacy), in USA, Canada and Israel; sexual assistants, found throughout Europe; and a couple of variations of paid and volunteer masturbation services, in Taiwan and Japan. A detailed comparative analysis of the similarities and differences between these different roles can be found in the book chapter ‘Paid sexual services for people with disability: Exploring the range of modalities offered throughout the world’ (Wotton, 2020).

2.1.7 Sex worker services

The term ‘sex *worker* services’ and not ‘sex work services’ is specifically used throughout this thesis. As previously discussed, marginalised community members are often lost within discussions that use acronyms or statistics. It is important to acknowledge that this research explores the experiences shared between two (or more) mutually consenting people. It is also important to note, in discussions around access, barriers and services, that it is *humans* who are providing the services and who are a part of the interactions. For this reason, the term ‘sex worker’ is used to reinforce the point that these are human interactions with real people.

2.1.8 Legal framework of sex work throughout Australia

Within Australia, sex work is a legally recognised occupation, with the Australian Taxation Office (ATO) providing a number of unique taxation codes for people working in different areas of the sex industry: *Adult shop operation* 42793; *Entertainers* 90021; *Escort agency service* 95340; *Massage (adult industry) services nec* 95340; and *Prostitution service* 95340 (Australian Tax Office, 2021). The ATO has also developed a number of taxation support documents to assist sex workers with legal deductions (2023a) and to understand the Australian Goods and Services Tax (GST) system (2023b).

Australia is made up of six States and two Territories, and sex industry businesses and sex workers are required to follow the legal framework for whichever jurisdiction they operate within (Scarlet Alliance, 2014). New South Wales (NSW), the Northern Territory (NT), Victoria and Queensland have all introduced decriminalisation as their legislative framework for the sex industry (in 1995, 2019, 2022 and 2024 respectively). Legislation in Tasmania, the Australian Capital Territory (ACT), Western Australia and South Australia all have different combinations of *legalised* and *criminalised* regulatory systems. Most importantly, sex workers are able to operate in all locations throughout Australia, in varying degrees and capacities (Scarlet Alliance – the Australian Sex Workers Association, 2024).

While there are a few laws in different jurisdictions (most notably to do with street-based solicitation) that a client of a sex worker can *technically* be charged with, generally it is sex workers who are most at risk of being charged with non-compliance of a law (Nagy & Powell, 2016). Most critically though, none of the eight jurisdictions within Australia have introduced what is known internationally as *the Swedish Model* (also known as ‘end-demand’ laws or the ‘Nordic Model’), which specifically criminalise clients and any third-party who contributes to a sex worker’s ability to run their business (Levy & Jakobsson, 2014; Nielsen, 2018). Without the fear of criminal sanctions, all interview participants within this research were able to speak freely about their experiences when being interviewed (Kulick, 2003; Sterling & van der Meulen, 2018).

2.1.9 Sexual expression

The terms *sexual health*, *sexual rights* and *sexuality* are often used interchangeably, but their meanings, experiences, and actions can vary significantly depending upon the context. This research utilises the term ‘*sexual expression*’ to encompass various elements of participants’ sexual experiences that they may share within this study. These elements are specifically drawn from Dennis Dailey’s (1981) Circles of Sexuality Model (Figure 1) which provides a holistic and multi-layered approach to examining sexual expression. The model examines five distinct areas: Sensuality, Intimacy, Sexual Identity, Sexual Health & Reproduction, and Sexualization. Some academic interpretations have since included a sixth circle, *values*, or *power and agency*, as an additional central, interconnecting element (Corinna, 2020; Turner, 2020).

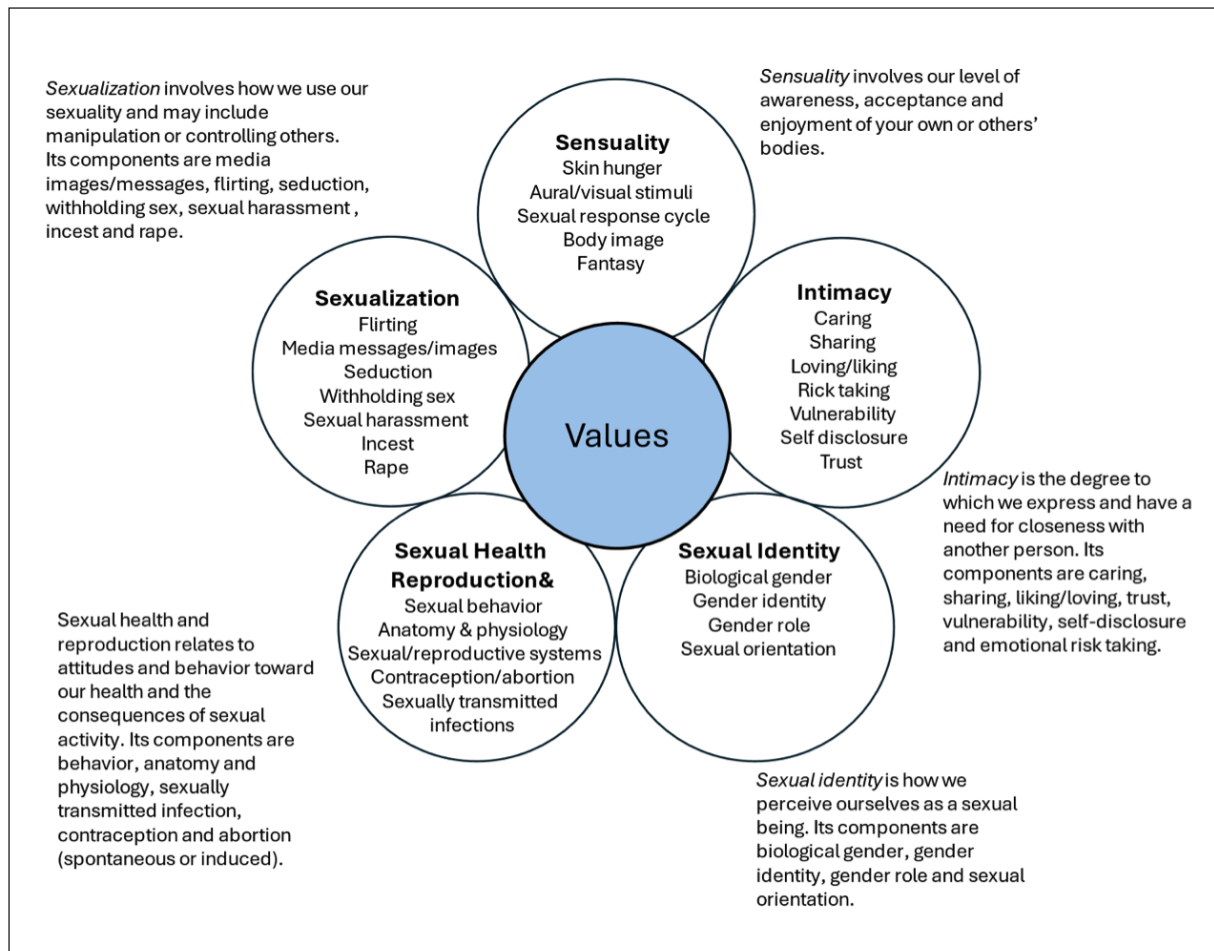


Figure 1: Circles of Sexuality Model, adapted from Curtiss, 2012

Sexual agency is the ability to make autonomous decisions about one's sexual life and is crucial for achieving sexual citizenship, as outlined below. Supporting sexual agency empowers individuals, validates diverse sexual identities, and ensures access to sexual rights and health services. It also helps reduce stigma and discrimination, promotes informed consent and safe practices, and strengthens advocacy for the legal recognition of sexual rights. In essence, affirming the sexual agency of individuals is essential for fostering an inclusive society that respects and values all forms of sexual expression and identities.

In summary, Dailey's Model provides a holistic, multi-layered perspective to encapsulate what this research will refer to as 'sexual expression'.

2.2 Sexual citizenship theory

Academic research regarding people with disability and sexual expression has predominantly focused on studies embedded within the premise of risk, rehabilitation, or assault. While these areas of inquiry have merit, they often overlook crucial aspects of the human experience and can reinforce the stigmatising notion that people with disability are asexual and devoid of the need for touch, intimacy, and sexual expression. As Tepper

(2000, p. 289) remarked, “Full inclusion means access to pleasure.” Employing a sexual citizenship lens in this research recognises the sexual autonomy and diversity of each participant in their pursuit of pleasure and sexual expression.

The theory of sexual citizenship (Weeks, 1998) broadens traditional notions of citizenship to include sexual rights and freedoms. Plummer (2011) referred to this as intimate citizenship, highlighting how public notions of citizenship intersect with private experiences of intimacy, eroticism, and relationships. Richardson (2000, 2017) further described sexual citizenship as encompassing the right to express one’s sexual desires, define one’s sexual identity, and have these acknowledged by state bodies and institutions.

Expanding on this foundation, Bahner (2019) identified two critical components of sexual citizenship:

- Policy-based sexual citizenship, which involves legal and institutional recognition and protection of sexual rights.
- Practice-based sexual citizenship, which focuses on the implementation of inclusive policies and practices that translate into tangible, everyday support for individuals’ sexual expression.
- Together, these components provide a comprehensive framework for supporting the sexual agency of all citizens. Bahner’s work underscores the necessity of both robust policy structures and practical support mechanisms to ensure that people with disability can fully exercise their sexual citizenship.

Despite the inclusive aims of sexual citizenship theory, some scholars have critiqued how dominant discourses of embodiment continue to exclude people with disability from fully realising their sexual rights. For example, Shildrick (2007, 2013) has examined how societal norms may reinforce a dichotomy between “legitimate” sexual citizens—often defined by idealized able-bodiedness—and those whose sexual autonomy is restricted or denied. She argues that these normative frameworks marginalise people with disability by framing their sexuality as deviant, dangerous, or in need of regulation. To counter these exclusions, Shildrick called for a more expansive and inclusive understanding of sexuality that ensures the full participation of people with disability in sexual citizenship.

Expanding on this perspective, Ignagni, Fudge Schormans, Liddiard, and Runswick-Cole (2016) define sexual citizenship as the right to make personal and private decisions about intimate relationships. Benoit, Mellor, and Premji (2022, 2023) further this discussion by examining the structural barriers that prevent people with disability from accessing their sexual rights. They critique existing policy and institutional frameworks for failing to adequately recognise and address the diverse sexual needs of people with disability.

Additionally, they highlight how mainstream discourses frequently misrepresent or overlook the sexual desires and experiences of people with disability, further marginalising them in discussions of sexual rights, sexual health, and sexual expression. In response, they advocate for an inclusive, intersectional approach to sexual citizenship that prioritises lived experiences over abstract policy rhetoric. Moreover, they call for systemic reforms to dismantle these barriers to ensure that people with disability can fully exercise their sexual citizenship.

While other theoretical frameworks—such as gender inequality, power imbalances, and feminist perspectives—have informed disability research, sexual citizenship theory is particularly well-suited for the PASA-research study due to its emphasis on inclusivity and self-determination. This research draws on three specific dimensions of sexual citizenship (Lister, 2002; Weeks, 1998):

- **Control:** The ability to express feelings and make independent decisions about intimate relationships.
- **Access:** The availability of, and access to, information, services, and potential partners.
- **Choice:** The right to determine one’s lifestyle, sexual identity, gender, and sexual experiences.

The principles of sexual citizenship align with key international frameworks discussed in Chapter 3, including The World Health Organization’s definition of sexual health (2015), the UN Convention on the Rights of Persons with Disabilities (2017), and the World Association for Sexual Health’s Declaration (2019). These documents advocate for a rights-based approach to sexual expression, challenging traditional hierarchies in relationships and emphasising the importance of choice and intimacy (Bahner, 2019b; Martino & Campbell, 2019).

Chapter 7, Section 7.5 provides a focused examination of the PASA-Research findings through the lens of sexual citizenship, highlighting key insights and their alignment with this theoretical perspective.

2.3 Biopsychosocial Model of Disability

Acknowledging the multi-dimensional and integrative nature of sexual citizenship (Weeks, 1998), this research will employ a biopsychosocial perspective. Developed by Engel in the 1970’s and later adapted by Waddell and Aylward to inform the UK Government’s approach to disability (Shakespeare et al., 2017), the Biopsychosocial Model extended beyond both the Medical Model and the Social Model of Disability (Petasis, 2019).

The Medical Model of Disability places an emphasis on disfunction (of body or mind), viewing disability as a condition which needs medical intervention to achieve ‘normal’ functioning. In contrast, the Social Model of Disability, developed by Mike Oliver in 1983 (Oliver, 2013) posits that a person’s disability – reflected by systemic discrimination, physical access barriers and a lack of employment opportunities – was socially and politically constructed, and was separate from their physical impairment (Haegele & Hodge, 2016).

The Biopsychosocial Model combines these approaches, offering a comprehensive framework that considers biological, psychological and social factors. This model is embodied in the International Classification of Functioning, Disability and Health (ICF) (World Health Organization, 2001) which views an individual’s level of functioning as a dynamic interaction between these three factors. The ICF is structured around specific components such as body functions and structures, activities, participation, and both environmental and personal factors, conceptualising an individual’s level of functioning on a spectrum (see Figure 2).

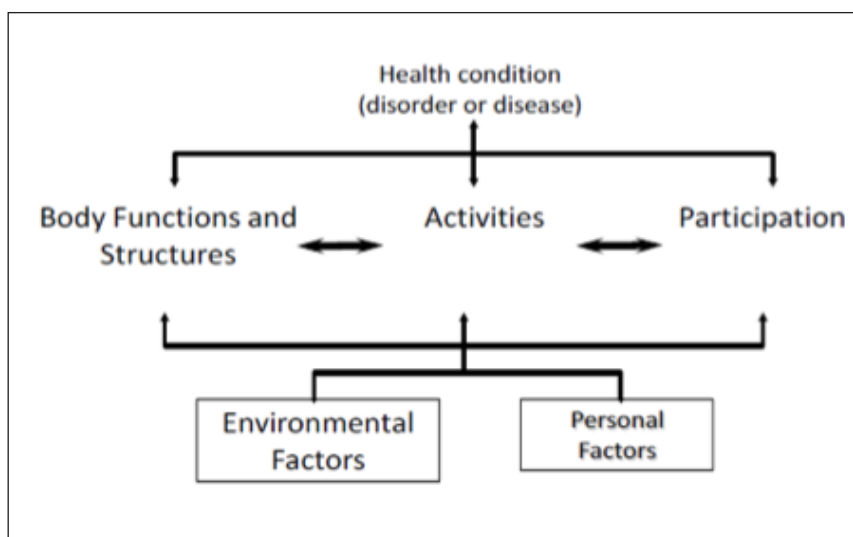


Figure 2: Interactions between the components of ICF World Health Organisation (2001)

Evaluating the findings of this study through both a biopsychosocial and Sexual Citizenship theory lens can create a deeper understanding of both the individual and collective experiences shared by research participants. For instance, the dimensions of sexual citizenship – control, access and choice – can be analysed using data generated from different age groups or genders (personal factors) or comparisons can be made between participants who live independently and those who live in supported accommodation, or in the family home (environmental factor). This approach allows for a comprehensive exploration of how different factors influence sexual citizenship and personal experiences.

2.4 Sex Positivity

To approach sexual citizenship with integrity, this research will also employ a sex positive lens. The term ‘sex positivity’ was coined by psychoanalyst Wilhelm Reich in the 1920s (Jrdev, 2021) with a core tenant centred on “being open-minded, non-judgmental and respectful of personal sexual autonomy, when there is consent” (Ivanski & Kohut, 2017, p. 216). Encapsulating notions of empowerment, diversity and choice, sex positivity views each individual’s sexuality as a unique set of preferences, experiences and values (Kangaude, 2009). This contrasts with historically sex negative perspectives which often frame sexual practices as primarily risky, dangerous, or difficult to manage.

Sex positivity compliments a sexual citizenship approach by acknowledging “risks and concerns” while also emphasising “the importance of sexual pleasure, freedom and diversity” (Williams et al., 2015, p. 6). Carol Queen expanded upon this perspective, stating that “sex positivity allows for and in fact celebrates sexual diversity, differing desires and relationships structures, and individual choices based on consent” (Queen & Comella, 2008, p. 278). By utilising a sex positive lens this research moves beyond heteronormative

stereotypes and widens the scope of inquiry to include participation of individuals of any gender and sexual identity. It also encompasses participants’ diverse selection of sex worker services, with such choices both respected and considered valid within this research, free from shame or judgement.

Applying a sex positive perspective also allows for a nuanced analysis of participants’ experiences of sexual expression, utilising Dailey’s Circles of Sexuality Model. For example, understanding why participants chose specific sex workers or services may reveal different ways participants fulfil their sexual, educational, or romantic needs. This might involve exploring their sexual identity (gender identity/sexual orientation), to expand their sensuality (increased awareness and acceptance of their body – especially after accident or injury), satisfying their need for intimacy, or perhaps increasing their sexual, social, and dating capacity by learning about sex, STI prevention and how to correctly use condoms and lubricant (sexual health and reproduction).

As Fahs notes, “sex positivity has laid the groundwork to depathologize sexuality, particularly for women, sexual minorities, people of color, and sex workers” (Fahs, 2014, p. 268). Building on this foundation, this research combines sex positivity with the principles of informed consent, to explore the diverse range of experiences by people with disability who access sex worker services.

2.5 Conclusion

Narratives about disability and sexual expression often revolve around the notion of sexual expression as a fundamental human right. This thesis extends this by employing a sexual citizenship framework to analyse the capacity of participants to access sex worker services and the range of experiences they have in accessing such services. The sexual citizenship approach is guided by three main considerations: *control*, *access*, and *choice*, while also incorporating a sex positive approach to expand the scope of inquiry beyond narrow heteronormative constraints. This enables the inclusion of diverse forms of sexual expression and recognises the varied gender and sexual identities of both the participants *and* the sex workers they have paid. Dailey's Circles of Sexuality Model is used to capture the breadth and depth of what participants' sexual expression can incorporate, drawing from five distinct areas of human sexual experience; Sensuality, Intimacy, Sexual Identity, Sexual Health & Reproduction, and Sexualization; while also considering a person's *power and agency*. Furthermore, applying a biopsychosocial lens facilitates an understanding of how biological, psychological, and societal factors interact to shape participants' individual and shared experiences in relation to accessing sex worker services.

The following chapter will explore specific mechanisms of support that affirm the sexual agency of people with disability. This includes an overview of global charters and instruments before concentrating on Australia's legal obligations. The chapter will examine national policies and guidelines alongside non-governmental organisations, projects and resources developed with and for people with disability, with a focus on sexual expression and accessing sex worker services. It will also provide an overview of the various funding support schemes available in Australia for people with disability.

CHAPTER 3

Supporting people with disability: charters, policies, guidelines and funding

3.0 Introduction

This chapter examines the sexual agency of people with disability and some of the crucial charters, policies and guidelines developed to support and uphold their sexual citizenship rights. It provides an overview of current research in the disability and sexuality sector and discusses increased representation of these issues in film and TV. The purpose of the discussion of media representation is to highlight the discrepancy between current government policies and practices and the positive shift in societal acceptance of people with disability. The chapter also outlines international charters and instruments that support the rights of people with disability, while identifying systematic barriers people may face. Specific international policies and guidelines that speak directly to a person's sexual rights are identified before shifting to an Australian perspective, discussing relevant federal and state laws, and guidelines related to the rights of people with disability. An examination of current resources and policies that support the sexual expression of people with disability is also provided.

This chapter will conclude by identifying different forms of Government and non-Governmental financial support available for people with disability in Australia. It identifies potential gaps in existing policies that omit explicit financial support for sexual expression and explores the potential for including sex worker services in each type of funding scheme. The chapter also considers some of the issues currently being debated around policy formulation, including proposals and challenges for change.

Funding is a contentious issue because it intersects with multiple complex factors, including the allocation of public resources, societal attitudes towards disability and sexuality, and legal constraints. Financial support for sexual expression often challenges traditional views on what constitutes necessary support for people with disability and raises questions about the prioritisation of such services within broader funding frameworks. Such debates also involve concerns about the ethical implications of providing public funds to access sex worker services while balancing these against other needs within the disability community.

3.1 Recognising the sexual agency of people with disability

Research within the disability sector acknowledges that a significant number of people with disability may experience greater social isolation, poorer mental health, lower self-esteem, and decreased opportunities for social and sexual connectivity within the community, when compared to people without disability (Egard et al., 2022; Beqiraj et al., 2017; Migliorini et al., 2008). For human beings, sexual expression has the capacity to be both physically and mentally stimulating, fulfil a need for intimacy, provide a level of stress-relief and can increase a person's sense of wellbeing and self-esteem (DeLamater, 2012; Diamond & Huebner, 2012; Gianotten et al., 2021; Hopper, 2020; Mitchell et al., 2021). Sexual expression may also function as a form of pain management (Komisaruk & Whipple, 1995), or as an antidote to “skin hunger” (Kale, 2020; Von Mohr et al., 2017; Findlay, 2012).

While the global disability rights movement has fought to secure equal rights and opportunities in the areas of accessible housing, employment, and education, sexual rights for people with disability have still not been enjoyed equitably. This was observed by Shakespeare, Davies and Gillespie-Sells (1996, p. 87) who stated:

Policy and provision around disability often neglect to consider sexuality as one of the basic human needs. While housing, transport, education, and other needs are dealt with, albeit inadequately, consideration of social and sexual factors is not high on the welfare agenda... This failure to prioritize matters which are highly important to most adults, including most disabled adults, reflects a failure to consider disabled people as fully human. Just like elderly people, disabled people are not seen as having sexual needs, and provision consequently neglects this.

Historically, people with disability, particularly those with intellectual or cognitive disabilities, have been variously deemed asexual, as uncontrollably hypersexual, or as dangerous deviants (Alexander & Taylor Gomez, 2017; Wilson et al., 2013; Taylor Gomez, 2012; Esmail et al., 2010; Kangaude, 2009; McCabe, 1999; Kempton & Kahn, 1991). These stigmatising beliefs and attitudes have led to research and education being predominately framed in the negative, skewed towards issues of abuse and control (Collier et al., 2006; Feely, 2016; Lam et al., 2019; McGilloway et al., 2020); negating capacities of consent (Sandland, 2013); or involving involuntary medical interventions and eugenics, including forced sterilisation and exclusions from the right to marry or become a parent (Esmail et al., 2010).

Support and advocacy in the disability sector have traditionally focused on tangible things such as accessible venues, increased employment opportunities, housing and medical provisions (Beqiraj et al., 2017; Quinn et al., 2014). While these elements are crucial components of citizenship, as outlined by Marshall (1950b), only recently has a more

holistic awareness of the needs of people with disability emerged, including attention to sexual health and the right to experience sexual pleasure (Mitchell et al., 2021; Gruskin et al., 2019; Loeser et al., 2018; Santos & Santos, 2018). This aligns with the rights encompassed by sexual citizenship (Martino & Campbell, 2019), as outlined in Chapter 2. For some, this means the development of accessible bars and clubs where people can meet socially and go on dates, as well as increased support and recognition for people to marry, or the right to enjoy parenthood. For others it has included incorporating discussions of sexual functioning and pleasure within rehabilitation programs. Additionally, some people with disability choose to access paid sexual services to enjoy and explore their sexual expression, which is the focus of this research (Wotton, 2024; Liddiard, 2014, 2018; Sanders, 2007).

The Sexual Politics of Disability: Untold Desires (Shakespeare et al., 1996) was hailed as ground-breaking research when it was published, explicitly recognising the sexual agency of people with disability. This publication featured first-person accounts of pleasure and enjoyment, derived from the interviews of 42 people with disability, with participants describing systemic barriers to sexual expression and the stigma and discrimination they faced while seeking to realise their sexuality. This landmark work instigated a slow but significant increase in both activism and academic inquiry within the disability and sexuality landscape (Shuttleworth & Mona, 2021; Martino & Campbell, 2019; Liddiard, 2018; Shakespeare & Richardson, 2018; Kulick & Rydström, 2015; Shuttleworth & Sanders, 2010).

There has also been a notable shift towards developing more inclusive and informative resources about sexual expression for individuals with progressive disabilities (i.e. Multiple Sclerosis or Muscular Dystrophy) and acquired disabilities (i.e. spinal cord injuries) (Piantedosi et al., 2023; Bryant et al., 2022; Sakellariou, 2006; Schmidt et al., 2005). One of the more comprehensive guidelines developed in this area is from the UK. The Open University's Sexuality Alliance created a Sexuality Guidance and Standards document to assist staff who support people with life-limiting conditions: 'Talking about Sex, Sexuality and Relationships: Guidance and Standards for those working with young people with life-limiting or life-threatening conditions' (Open University Sexuality Alliance, 2015). Such research and resource development has challenged common myths and preconceived ideas about peoples' sexual identity and sexual citizenship and disrupted previously held notions of what sexual activities may be deemed 'acceptable' for people with disability to engage in (Santos & Santos, 2018; Martino, 2017; Reynolds, 2007).

One such area is sexuality and aging. Discussions about sex and disability are often skewed towards younger generations, yet Australia has an aging population where one in

two people will experience some form of disability as they get older (Australian Institute of Health and Welfare, 2024a). Increased scholarly focus has emerged identifying a range of issues regarding the intersection of old age, disability and sexuality, which are not dissimilar to those encountered by younger populations of people with disability. These issues include navigating gender and sexual identities, sexual health matters, cyber safety and online dating (Barrett, 2018; Barrett et al., 2015). Additional research has examined issues of consent in the context of dementia (Grigorovich, 2020; Hillman, 2016; Cindy Jones, 2013; Tarzia et al., 2012), issues of privacy, and the impact of staff and family attitudes on the sexual expression of people living in residential care facilities (Rahn et al., 2016; Villar et al., 2014; Bauer, Nay, et al., 2014; Everett, 2007). Sexual expression and sexual identity can also change and evolve throughout a person's life. One of the major barriers faced by older generations is being denied the right, and the appropriate supports, to remain sexual human beings, which is exacerbated when additional assistance and support is needed due to disability and decreased independence.

3.1.1 Film and TV representations

Alongside the rise in academic inquiry, there has been a notable increase in the representations of people with disability with sexual desires and agency in documentaries, film, and TV series. This includes: *Untold Desires* (1994), *Want* (also a photo series) (2009), *Disability and Sexuality: Exploring the Intimacy Option* (2008), *Monica & David* (2009), *Otto: Love, Lust and Las Vegas* (2009), *SexAbility* (2012), *The Last Taboo* (2013), *Supporting Sex and Intimacy* (2016), *Special* (2019) and *Latecomers* (TV series) (2022).

This increased representation is beneficial as it helps to dismantle long-standing stereotypes and misconceptions about people with disability. For example, Mat Fraser, an internationally renowned performer and actor (noted for his role in the TV series *American Horror Story*), has long been exploring the relationship between disability and sexuality. In one interview he remarked: “When you are disabled the two things people think you can’t do are fight and have sex...so I’ve got a black belt and I’m really good at shagging. The physical pleasures in life are really important to me” (Quarmby, 2015, para. 4).

Concurrently, there has been an increase in documentary-style TV series, specifically focused on people with disability negotiating the dating scene in their desire to find love and a relationship. These include *The Undateables* from the UK (2012), *Born This Way* (2015) and *Autism in Love* (2015) from the USA, *Better Date Than Never* (2023) and *Love on the Spectrum* (2019) from Australia, and *Down for Love* from New Zealand (2022). These series are often promoted as ways to challenge the narrative of what people with disability – especially people with Down Syndrome and autism – are capable of achieving when afforded the same level of dignity and respect as everyone else in society. As the director

of *Better Date Than Never* wrote: “To me this series is the antithesis of the ‘hot people on islands’ dating shows, and I hope audiences will come along for the ride without the need for heavy conflict and villains” (Knox, 2023, Director’s Statement, para. 2).

However, these shows have also faced criticism for potentially further stigmatising and segregating people with disability by delivering aesthetically pleasing and well organised depictions of dating, in what Malinowska (2017) describes as a “problematic ‘normative gaze’”. With taglines such as ‘A heartwarming quest for love, this feel- good reality show follows several people with Down syndrome as they navigate the trials and triumphs of dating’ (TVNZ, 2022), there is a fine balance between authentically depicting the lived experiences of people with disability and producing an uncomfortable voyeuristic program that infantilises its subjects. This is evident where the audience coos and ahhs over individuals accomplishing – on camera – some of the most basic elements of life, such as choosing what to wear on a date or ordering a coffee (Bossinakis, 2023), or where the adult cast members are still chaperoned by their parents, sitting just out of sight (Reay, 2023). As Green-Adenowo (a cast member of *The Undateables*, as well as a wheelchair dancer and content creator) said in one interview: “When people said they loved [*The Undateables*], I always question what it is that makes them love it. Is it because it makes you feel better?” (Reay, 2023, para. 16).

Overall, increased TV and film representation of people with disability as sexual beings can be an empowering and affirming experience, allowing individuals to see their own experiences reflected and validated. It is crucial though, that such portrayals are done with sensitivity and respect, avoiding the reinforcement of stereotypes and ensuring that the narratives are inclusive and authentic. These portrayals can not only contribute to a broader societal acceptance but may also help people with disability see themselves as active and valued members of society, capable of experiencing love, intimacy, and sexual expression. This visibility also contributes to a more inclusive and respectful view of sexuality and disability, aligning with the principles of sexual citizenship and supporting the broader movement advocating for equality and human rights.

As an extension of this increased visibility, depictions of people with disability engaging the services of sex workers have also emerged on our screens, through the airwaves and via streaming services. These include the radio show *The Too Hard Basket* (2009), feature films *The Intouchables* (2011) and *Come as you are (Hasta la Vista)* (2011) and short films *L’Assistante* (2012) and *The Gift* (2013). Documentaries, which provide the opportunity for people with disability to share lived experiences direct to camera, include *For One Night Only* (2007) and *Scarlet Road* (2011), along with online multimedia content such as *I have cerebral palsy and I enjoy having sex* (2014) and *Sex on Wheels* (also known as *Can have sex*,

Will have sex) (2013). Collectively these works represent choice, autonomy and diversity of sexual expression while highlighting the affirmative roles parents, support staff and carers can play in creating supportive pathways for a person with disability to access sex worker services of their choosing.

These depictions have also facilitated increased awareness and support for people with disability to access sex worker services, moving away from the negative perceptions often held about both of these marginalised populations. For example, drawing from personal experience, one of the most common things people have said after viewing the documentary *Scarlet Road* was: ‘it wasn’t that I don’t support people with disability having sex, I’d just never thought about them wanting it’.

The discourse on the sexual agency of people with disability is best understood within the context of broader rights. The next section of this chapter examines international charters and instruments designed to uphold and expand the rights of people with disability. These frameworks aim to ensure that sexual rights and services are accessible and equitable for all individuals, including those with disabilities. When media portrayals and societal attitudes align with these global standards they help highlight gaps and challenges, thereby guiding the development of effective policies, practices and resources. This alignment can ultimately support the creation of a more inclusive environment where people with disability can fully exercise their sexual citizenship and access the services they need.

3.2 Global charters & international instruments

Discussions about ‘access to sex is a human right’ often occur without a clear understanding of various international charters that have been developed. Approximately one billion people, or 15% of the world’s population experience some form of disability (The World Bank, 2022) with several international instruments designed to uphold the rights of people with disabilities, including their sexuality and relationship rights.

The Universal Declaration of Human Rights (1948) was designed to outline the fundamental human rights for *all* humans to be universally protected. The document includes 30 individual rights, among them the principle of non-discrimination, the right to marry and have a family, and the right to rest and leisure. The United Nations’ Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol were also adopted in 2006 (United Nations, 2024). Ratified by 185 countries (2017), including Australia in 2008, it is a comprehensive treaty that explicitly recognises the rights of persons with disabilities, including the right to “enjoy legal capacity on an equal basis to others in all aspects of their lives”. Article 23 of the CRPD specifically addresses the rights of persons with disabilities to equality in marriage and family life. It recognises the right to choose one’s spouse, have

a family, and access reproductive and family planning information and services on an equal basis with others. However, explicit support for the sexual expression of people with disability is absent from the CRPD.

The World Health Organisation has recognised that the free practice of a person's sexuality, sexual expression and behaviours may be constrained by various factors including “biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual” influences (2006). A recent report on the advancement of Sexual and Reproductive Health and Rights (SRHR) reaffirms that these factors continue to limit positive development, acknowledging that “progress has been stymied because of weak political commitment, inadequate resources, persistent discrimination against women and girls, and an unwillingness to address issues related to sexuality openly and comprehensively” (Starrs et al., 2018, p. 2642).

Although these international instruments are well-known and often cited, the understanding of sexual rights has slowly evolved to encompass more than just reproductive rights and freedom from violence (Heidari, 2015). This has led to the development of instruments which now include concepts of pleasure and safety, and acknowledge that a diversity of sexual experiences and expressions are integral elements of wellbeing (Gruskin et al., 2019; International Women's Health Coalition, 2015). For example, the World Health Organisation (WHO) defines sexual health as (2015, p. 5):

... a state of physical, emotional, mental and social wellbeing in relation to sexuality. It encompasses not only certain aspects of reproductive health... but also, the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. Indeed, it has become clear that human sexuality includes many different forms of behaviour and expression, and that the recognition of the diversity of sexual behaviour and expression contributes to people's overall sense of well-being and health.

In conjunction with this definition, WHO also declares that “good sexual health is fundamental to the overall health and wellbeing of individuals, couples and families, and to the social and economic development of communities and countries” (World Health Organisation, 2015, p. 4).

The World Association of Sexual Health (WAS) is an international confederation that has been operating since 1978, with membership comprising sexologists, healthcare professionals, educators and activists (World Association of Sexual Health, 2024). In 1997 they released the Declaration of Sexual Rights, which was revised and expanded in

2014 (Kismödi et al., 2017; World Association of Sexual Health, 2014). This declaration states that all people have the right to autonomy and bodily integrity, sexual privacy, and the highest attainable standards of health. In 2021 WAS went further by ratifying their Declaration of Sexual Pleasure and, mirroring the World Health Organisation, it asserts that sexual experiences should be free of discrimination, coercion, and violence. Developed as a call to action, it states: “Sexual pleasure is the physical and/or psychological satisfaction and enjoyment derived from shared or solitary erotic experiences, including thoughts, fantasies, dreams, emotions, and feelings” (World Association of Sexual Health, 2021, p. 2). The Declaration goes on to reaffirm:

Self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate sexual relations are key enabling factors for pleasure to contribute to sexual health and well-being. Sexual pleasure should be exercised within the context of sexual rights, particularly the rights to equality and non-discrimination, autonomy and bodily integrity, the right to the highest attainable standard of health and freedom of expression. The experiences of human sexual pleasure are diverse and sexual rights ensure that pleasure is a positive experience for all concerned and not obtained by violating other people’s human rights and well-being.

This declaration acknowledges that access to sexual pleasure is a fundamental aspect of the human experience and a crucial component of a person’s sexual rights and well-being (Rudolph et al., 2024; Coleman et al., 2021). While the development of these new instruments and declarations mark significant progress, their real impact will depend on how effectively they translate into supportive pathways and policies for people with disability. This is, in essence, what ‘sexual citizenship’ encapsulates, as discussed in Chapter 2, Section 2.2. whereby scholars of sexual citizenship argue that access to sexual rights and experiences is deeply intertwined with broader structures of inclusion, autonomy, and social recognition (Richardson, 2017; Plummer, 2003). Additionally, the ability to exercise sexual agency without systemic or institutional barriers is a critical marker of full citizenship and for people with disability, achieving sexual citizenship requires dismantling both attitudinal and structural barriers that limit access to sexual expression, services, and education (Bahner, 2020). Thus, while declarations such as WAS’s Declaration of Sexual Pleasure provide an important framework, their true significance lies in how they inform tangible rights-based policies that support sexual agency and equity for all individuals, including those with disability.

Furthermore, non-discriminatory and equal access to support, resources, decision-making processes and education must also embody *substantive equality*. This may require the innovative tailoring of support to meet individual needs and capacities, while upholding

principles of autonomy and choice. For instance, this may include accommodating diverse communication and physical access requirements (Miller et al., 2015).

These international instruments and charters collectively emphasise the importance of safeguarding the sexual and relational rights of people with disabilities, ensuring that they have equal access to opportunities and services. However, implementation and enforcement can vary significantly from one country to another. Given that this research is based in Australia, the next section of this chapter will explore how these issues are addressed within an Australian context.

3.3 An Australian perspective

3.3.1 Charters and instruments

According to the Australian Bureau of Statistics (2024) 21.4% of the total Australian population (5.5 million people) live with disability. It is also estimated that 7.9% of all Australians have a profound or severe disability. Additionally, while 17.1% of all Australians were aged 65 years and over, 52.3% of this cohort live with disability. The rights of people with disability in Australia are protected and promoted through various national and international instruments.

In 1992 Australia introduced the Disability Discrimination Act, which prohibits discrimination on the grounds of disability. It covers various areas of life, including relationships, and ensures that people with disabilities have equal access to services and opportunities. As previously stated, Australia is a signatory to the UNCRPD treaty, which represents a significant step forward in recognising the rights of persons with disabilities and promoting their full inclusion and participation in society. It covers a wide range of areas, including civil and political rights, access to justice, education, employment, and health. As a party to the UNCRPD, Australia is committed to taking measures to ensure that persons with disabilities enjoy their human rights on an equal basis with others. This includes implementing legislative, policy, and programmatic measures to eliminate discrimination and promote the full inclusion of persons with disabilities in all aspects of life. Born out of this commitment, Australia has developed three policy instruments which focus on enhancing the quality of life for people with disabilities, and their families and carers. These are the National Disability Strategy; the National Disability Agreement and the National Disability Insurance Scheme (NDIS) (Olney & Dickinson, 2019).

The National Disability Strategy (NDS) (2019) is a national policy framework that outlines the government's commitment to improving the lives of people with disabilities. Operating from a ten-year plan, its focus is to guide government agencies, businesses, and the community in improving social inclusion, economic participation, and the well-being of people with

disabilities. The policy covers a wide range of areas, including health, education, employment, social participation, and rights protection. The strategy emphasises the importance of a whole-of-community approach to creating a more inclusive and accessible society.

The Australian National Disability Agreement (NDA) (2021) aims to improve the lives of individuals with disabilities by promoting consistency and collaboration across different jurisdictions. It outlines the roles and responsibilities of the Australian Federal Government and State and Territory governments in providing disability services. Its purpose is to provide a collaborative framework for the provision of disability services and supports across the nation. The NDA outlines the roles and responsibilities of each jurisdiction, funding arrangements, and key objectives related to disability services. It covers a broad range of areas, including health, education, employment, and community participation. Overall, the NDA aims to coordinate efforts and resources among different levels of government to create a more cohesive and efficient disability support system. However, findings from a 2019 Productivity Commission study indicated that the current NDA was out of date, recommending that a new National Disability Agreement between the Australian, State and Territory Governments is needed to facilitate cooperation, enhance accountability and clarify roles and responsibilities (Productivity Commission, 2019). At the time of writing, this has not yet eventuated.

The National Disability Insurance Scheme (NDIS) was designed to provide individualised support and services to people with significant and permanent disabilities. It operates under the National Disability Insurance Scheme Act 2013 and focuses on giving participants choice and control to live an ‘ordinary life’ equal to others (NDIS, 2021a). It does this by providing funding based on individual needs and goals and allowing participants to choose service providers and supports that suit their requirements. The NDIS covers a range of supports, including assistance with daily activities, community participation, and access to employment and education. It is intended to complement other mainstream services such as the medical and hospital systems. The NDIS is overseen by the National Disability Insurance Agency (NDIA) which is involved with assessing individuals for eligibility, developing individualised support plans, and managing the funding allocated to participants. It is then the responsibility of the NDIS to oversee the allocation and distribution of funds to actively support individuals with disability, up to the age of 65⁶. Those over 65 years have access to support via the Australian Government Aged Care system.

6 There is one exemption to this rule: if an individual is already a NDIS participant before the age of 65 then they are eligible to continue being financially supported by a NDIS Plan, either in their current residential care facility or if they move out (ie to live with family members): <https://ourguidelines.ndis.gov.au/home/becoming-participant/leaving-ndis/what-if-i-start-getting-supports-aged-care-services/what-if-you-were-already-residential-aged-care-you-turned-65>

In summary, these three instruments – the NDS, NDA, and NDIS – work together to create a comprehensive and coordinated approach to disability policy and support in Australia. The NDS sets the overarching goals and principles, the NDA outlines the collaborative and funding arrangements at the national level, and the NDIS provides a mechanism for individualised support and services. However, not everyone with disability is financially supported via the NDIS and, in the case of sexual expression, the NDIS has, to date, failed to holistically support people’s sexual and intimacy needs. As discussions around access to sex workers are predominantly of a fiscal nature, a later section of this chapter will provide an overview of financial support schemes for people with disability in Australia and consider if support and access to sex worker services is a viable option. Along with the NDIS, this includes the Aged Care system, the Disability Pension, the Department of Veterans’ Affairs, motor vehicle insurance schemes and superannuation payouts. It is important to discuss these various forms of support because one of the most contentious issues for people with disability accessing sex worker services is about who should be responsible for payments.

3.3.2 Government Policies and Guidelines

While the NDS, the NDA and the NDIS are all national instruments, many policies and guidelines are developed and operated at the state or territory level. When elections precipitate a change of government in these jurisdictions, this sometimes leads to the renaming and consolidation of different government departments. Several supportive sexuality and relationships policies, which included specific sections that supported individuals to access sex worker services have been developed – and then lost – via these departmental shifts. A good example of this is within the state of NSW. The NSW Department of Communities and Justice was formerly known as the Department of Family and Community Service (FaCS) (and before then the Department of Community Services (DoCS)). In 2016, FaCS released an expansive policy called ‘Supporting Sexuality: Practice Guide for Practitioners who Support People with Disability’ which included a reference to sex work within their Advocacy section:

It is important that the person with disability develops skills of self-advocacy where possible, is aware of their sexual rights and knows how to exercise them. Where personal and sexual rights are not being supported, it may be necessary to advocate for a solution. Examples include:

- arranging education around accessing sex work services, securing funding or practical support if required to access sex work services or sexual aids. (NSW Government, 2016, p. 20).

The precursor to DoCS was the Department of Ageing, Disability and Home Care (ADHC). In 1996 they had developed their ‘Sexuality and Human Relationships Policy and Procedures’, amending it in 2010. Included as a stand-alone section within its Operational Procedures was ‘Section 4.11 Sex workers and sex aids’ which included the following guidelines:

A client’s choice and right to use a sex worker or sex aids is to be respected and treated with confidentiality by staff members.

The employment of sex workers is to be closely matched to meeting a client’s sexual needs. Sex workers are to be considered as only one of a range of options in meeting the sexual needs of a client ... (2010, p. 11)

Despite the existence of these former guidelines the website for the current NSW Department of Communities and Justice does not have any publicly available policies of this nature. However, there are currently at least two state governments with policies that do explicitly mention supporting a person with disability to access sex worker services, as one of many options for people to explore their sexual expression. These include the Tasmanian Government’s ‘Personal Relationships and Sexuality Guideline’ (2019) and the Victorian Government’s ‘Personal relationships, sexuality and sexual health policy and guidelines’ (2006).

3.3.3 Non-government organisations and resources

The rights of individuals with disabilities, including their sexual rights, are crucial aspects that should be addressed in any comprehensive disability policy, especially at the ‘grass roots’ level where service delivery and person-centred support systems are implemented. Separate to government departments, this section outlines some of the various organisations, policies, guidelines, and resources that have been developed to support the sexual expression of people with disability throughout Australia. It also specifically focuses on the intersection between people with disability and sex workers.

There are a number of disability organisations in Australia who ensure people with disability are represented and heard at a national level. The Australian Federation of Disability Organisations (AFDO) states it is the national voice representing people with disability in Australia (2023). Its membership is made up of a wide range of organisations run and led by people with lived experience of disability supporting the vision statement shared on their website which states that “all people with disabilities must be involved equally in all aspects of social, economic, political and cultural life” (para. 1). In conjunction, the Disability Advocacy Network Australia (DANA) is the national representative body for a network of independent disability advocacy organisations throughout Australia with their stated purpose being ‘to strengthen, support and provide a collective voice for independent disability advocacy organisations across

Australia that advocates for and with people with disability’ (2023, para. 2). The Disabled People’s Organisations Australia (DPOA) is also an alliance of four national Disabled Peoples’ Organisations, all of which are run and led by and for people with disability. Its membership is comprised of four national peak bodies: National Ethnic Disability Alliance (NEDA), First Peoples Disability Network (FPDN), Women With Disabilities Australia (WWDA), and People With Disability Australia (PWDA)(2023). The right to sexual expression and the ongoing barriers people with disability still face is reflected in the position statement, published by Women with Disabilities Australia, which states (2017, p. 9):

Women and girls with disability express desires for romantic, sexual and intimate relationships but report limited opportunities and difficulty negotiating relationships, often due to lack of support and paternalistic attitudes ... Attitudes toward women and girls with disabilities’ expression of their sexualities remain restrictive and laws against sexual exploitation are often interpreted as a prohibition of consensual relationships.

In 2019 DPOA and Touching Base released a *Joint Position Statement: A call for a rights-based framework for sexuality in the NDIS*, calling for the National Disability Insurance Scheme to develop a comprehensive sexuality and relationships policy (Disabled People’s Organisations Australia & Touching Base, 2019). This was endorsed by over 40 organisations, including every Australian peak disability organisation. As outlined in the NDIS section below, this has yet to eventuate.

Within the research sector numerous collaborations and projects are now also driven by people with disability. They include the University of NSW Disability Innovation Institute (UDII) (2017) and a number of Griffith University collaborative research projects: *BioSpine* (Menzies Health Institute Queensland, 2019), *Ballet for Brain Injury* (Queensland Ballet, 2023) and *The Dignity Project* (The Hopkin Centre – Research for Rehabilitation and Resilience, 2023).

Historically, people with disability were either excluded from sex education programs or provided inadequate information (Bahner, 2021; Sellwood, 2019; Shildrick, 2009), but that is no longer the case in Australia. For example both the Living Safer Sexual Lives (Johnson et al., 2001) and the Sexual Lives and Respectful Relationships (SL&RR) peer education projects (Barrett & Dyson, 2013; Frawley & O’Shea, 2020) included the lived experiences of people with intellectual disability. Royal Rehab NSW has operated a specific Sexuality Unit since early 2020 (2023), Family Planning NSW provides a Disability and Sexuality Service (2023), Northcott operates the Sexuality and Relationship Education service (2023), and the Occupational Therapists Australia website recently introduced a specific Intimacy and Sexuality ‘area of practice’ search option (2023). Additionally, there have been four new

resources released in the last year. They include *Sex is for everyone: Occupational therapists supporting sexuality for people with intellectual disability* (Piantedosi et al., 2023; Rainbow Inclusion, 2023); *Introduction to Consent* (SHFPACT & SECCA, 2024a); *Introduction to Sexual Consent* (SHFPACT & SECCA, 2024b); and *Creating Social and Sexual Safety: National Guidelines for organisations and workplaces* (SHFPACT, 2024).

Both the *Introduction to Sexual Consent* and a 2022 nation-wide resource *Sexuality, Relationships and Your Rights – a book about sexuality and the law for people of all abilities* (SECCA, 2024), included information about accessing sex worker services. Touching Base, an unfunded not-for-profit organisation is the only specific entity in Australia that brings together people with disability and sex workers, to advocate for their labour rights, sexual rights and the ability to connect with each other (Touching Base Inc, 2000). Operating since 2000, Touching Base operates a unique Sex Worker Referral List, allowing people with disability (or their third-party support) to receive referrals to sex workers who are members of the organisation, and who may be best suited to offer the type of services sought out by an individual. Additionally, Touching Base has developed several resources, including a *Policy And Procedure Guide For Disability Service Organisations Supporting Clients To Access Sex Services* (2011), *Anna sees a sex worker, Tony sees a sex worker, Seeing A Sex Worker – A Guide For People With Disability* (2016), and *Clearly Picturing Your Sexual Needs – supporting communication between people with disability and sex workers* (2018).

An independent research survey commissioned by Touching Base in 2002, aimed to identify barriers preventing service providers in NSW from supporting people with disability to access sex worker services. It identified that a lack of internal policies and training for staff negatively impacted their ability to provide meaningful support (Robinson, 2002). Although it took time for the disability sector to address this deficit, several disability organisations have now developed guidelines and fact sheets that include the option for sex worker services. Notable examples include Family Planning NSW's fact sheet *Seeing a Sex Worker* (Family Planning NSW, 2017), Life Without Barriers' *Relationships, Intimacy and Sexuality – Policy Guideline* (2023), Northcott's *Sexuality and Relationships Policy* (Northcott, 2016) and Aruma's *Sexuality Policy* [available in an Easy Read format] (Aruma, 2022). Additionally, in September 2023 Hire Up, an online platform enabling people with disability to find, hire and manage their own support workers, also released their *Statement on Sexual Activity Support policy* (2023). The Sexual Health & Family Planning ACT's (SHFPACT) *Disability, Sexuality & Relationships: a policy development resource and template for providers of services to people with disabilities* (Heckendorf & Bavinton, 2013) is also currently under review and being updated.

In the aged care sector, a Sexuality Assessment Tool [SexAT] has been developed to assist staff working in residential aged care facilities (RACFs) better support residents' sexual expression, and identify areas of improvement (Bauer et al., 2013). This tool examines facility policies, determines residents' needs, identifies staff education and training needs, ensures appropriate information and support is provided to residents and their families, audits the physical environment, and determines appropriate safety and risk management systems (Bauer, Fetherstonhaugh, et al., 2014). Notably, the inclusion of the residents' right to access sex worker services is embedded within this assessment tool.

While this assessment tool has certainly advanced awareness among staff about how to identify and support aged care residents' sexual and intimacy preferences (Hafford-Letchfield, 2024; Jones et al., 2024), it is not yet housed within a supportive framework of sexuality and intimacy policies to guide staff and residents about their rights. A recent survey of almost 3,000 Australian residential aged-care facilities by La Trobe University's Australian Centre for Evidence Based Aged Care, found that only half of the facilities surveyed had written policies on sexuality, and only one third had policies on sexual behaviour (Lefevre, 2023; McAuliffe et al., 2023). The study also revealed that only one in six had policies on sexual health, and only one third addressed sexual behaviour (La Trobe University, 2023).

However, developing a policy is merely the starting point for organisations. The Touching Base 2002 report identified another significant barrier: a lack of suitable training options for staff to become upskilled and knowledgeable in this area. In the last two decades a range of training workshops and webinars have also emerged for those working within the disability sector to best support the sexual expression of people with disability. These includes Touching Base workshops: 'Service Provider Awareness Training' (SPAT) for service providers; and the 'Professional Disability Awareness Training' (PDAT) for Sex Workers (Touching Base, 2024a); DSC's 'Supporting Intimacy, Sexuality and Sex' workshops (DSC, 2023) and Care Rehab's 'Talking about sex in disability – how to bring it up and then what?' workshops (Care Rehab, 2023).

These advancements in policies, education and support mechanisms are welcome additions within the disability and aged care landscape. Despite these advancements, a key challenge remains: how are individuals able to pay for specific sex worker services? This will be addressed in the next section of this chapter which provides an overview of the different financial support systems available in Australia that may assist individuals in meeting their unique needs and situation.

3.4 Financial support for people with disability in Australia

Accessing sex worker services, and being supported by third-party support networks if needed, is of great importance to many people with disability. However, funding these services can be challenging. Although many people with disability are employed, significant barriers to work opportunities still exist, and living with disability can often incur many additional costs.

Article 27 of the CRPD addresses ‘Work and Employment’ (United Nations, 2024) supporting the rights of people with disability to have equal access to employment opportunities. Despite this, equitable access to employment in Australia is still lacking due to stigma, discrimination, prejudice and diminished work opportunities, particularly for people with intellectual disability (Meltzer et al., 2020; Ruhindwa et al., 2016). The 2018 Australian census results for the working aged population (between 15-64 years) reflect these issues, with only 47.8% of people with disability in employment compared to 80.3% of people without disability in the same age range. People with psychosocial disabilities, an acquired brain injury, or who have experienced a stroke were also least likely to be participating in the labour force (Australian Bureau of Statistics, 2019a).

Beyond income from work, or money received from a government pension (such as the general Aged Pension, or Service Pension for veterans), there are various financial support systems available to people with disability in Australia, which may be accessed at different stages of a person’s life, depending on their personal circumstances. These include the NDIS, the Australian Aged Care system, the Disability Support Pension, Medicare, insurance companies, Veterans Care, and the Total and Permanent Disability (TDP) component of a person’s Superannuation package. Each of these systems will be discussed below, with a specific reference to whether they financially support accessing sex worker services.

3.4.1 NDIS

The National Disability Insurance Scheme (NDIS) is an Australian Government initiative designed to fund costs associated with disability. Underpinned by the rights enshrined in the UNCRPD, the NDIS adopts a person-centred approach. Legislated in 2013, with a full roll out by 2020 (NDIS, 2023b), it amalgamated former State and Territory funding systems into a single, consistent scheme across Australia. The primary goal of the NDIS is to offer individuals more choice and control over the services that would best suit their needs (NDIS, 2021c). This is based on an assessment of what is deemed ‘reasonable and necessary’ to the specific needs of individuals, to ensure they can live ‘ordinary lives’ equal to the rest of the community (NDIS, 2022a, 2023c).

As of February 2024, the NDIS supports over 646, 000 Australians with disability, referred to as ‘participants’ of the scheme (NDIS, 2024b). Upon its launch, the Australian government declared that ‘no person would be worse off’, promising that State and Territory funded supports for people with disability would be maintained as people transitioned into the NDIS (NDIS, 2024d; Goggin & Wadiwel, 2014). While provisions were made for accommodation, employment, medical, therapy, and psychosocial care, many NDIS participants have reported their individualised funding packages are inadequate to meet their needs and have raised concerns over inconsistencies regarding eligibility and service inclusions (Cowden & McCullagh, 2021; Australian Human Rights Commission, 2020). Due to this, the definition of what is deemed ‘reasonable and necessary’ has been subject to intense scrutiny (Venning et al., 2021; Foster et al., 2016), with many individual funding plans referred to the Administrative Appeals Tribunal (AAT) for an external review and to secure additional and adequate support (Coombes, 2024c; AustLII, 2023).

One of the major criticisms of the NDIS is its refusal to develop specific Sexuality and Relationships Guidelines, or a formal policy to support people’s intimacy and relationship needs. This omission has been a point of contention for many years, with extensive advocacy challenging the NDIS and highlighting the importance of addressing this critical aspect of support. Despite repeated efforts and submissions from various organisations, the issue remains unresolved, even after being raised with multiple NDIS Ministers. Below, details of public statements, reports, correspondence and submissions are presented in chronological order, illustrating the ongoing struggle people with disability face in trying to get the NDIS to address this critical area.

In 2019 the Disabled People’s Organisations Australia (DPOA) and Touching Base Inc released a *Joint Position Statement: A call for a rights-based framework for sexuality in the NDIS* (2019). This call for action precipitated increased discussion within both the media and academia regarding access to paid sexual services for people with disability (Henriques-Gomes, 2019a; Meltzer & Davy, 2019; Rawlinson, 2019). The conversation gained further traction when a 2020 Federal Court ruling supported the rights of a woman with Multiple Sclerosis (MS) to access sex worker services via her NDIS funding (referred to as *National Disability Insurance Agency (NDIA) v WRMF*) (Federal Court of Australia, 2020).

Notwithstanding the Federal Court ruling, the NDIS Minister at that time, Stuart Roberts, declared his intention to change Federal Legislation to specifically *exclude* a range of sexual supports, including sexual aids and access to sex worker services (Gingold, 2021b; McHugh, 2021). This amendment did not eventuate, with subsequent media coverage generating broader support for the sexual and intimacy rights of people with disability. This came not only from the community but also the ACT Minister for Disability, Emma

Davidson, who publicly stated that people with disabilities should have the right to use NDIS funding for sex worker services as part of their broader support needs (Whyte, 2021). This perspective emphasised that the NDIS should empower individuals to have greater control and choice over their support services, including the right to intimacy.

Since the 2020 landmark ruling between NDIA v WRMF, the NDIS Minister's office has corresponded with a national NDIS and Sex Work advocacy group (of which I am a member), indicating that the NDIA *would* be developing draft Operational Guidelines (OG) to reflect the outcome of this High Court ruling. However, a subsequent letter sent to this group in April 2023, stated:

following the Full Federal Court WRMF decision in 2019⁷ [sic], the law is currently that Sexual Activity Supports may be reasonable and necessary supports under the *National Disability Insurance Scheme Act 2013* in specific circumstances based on the facts, evidence and the unique individual circumstances of the participant. The current policy position that is being implemented in the NDIA is consistent with the WRMF decision. As noted in my previous letter, we have started drafting an OG, limited to the narrow and specific Full Federal Court decision on WRMF and the policy position. Given other competing and significant priorities, we are not progressing the OG at this time.

While the NDIA may have formulated a private, in-house 'policy position', the public one being shared via their phone information lines and the online automated answering service firmly state:

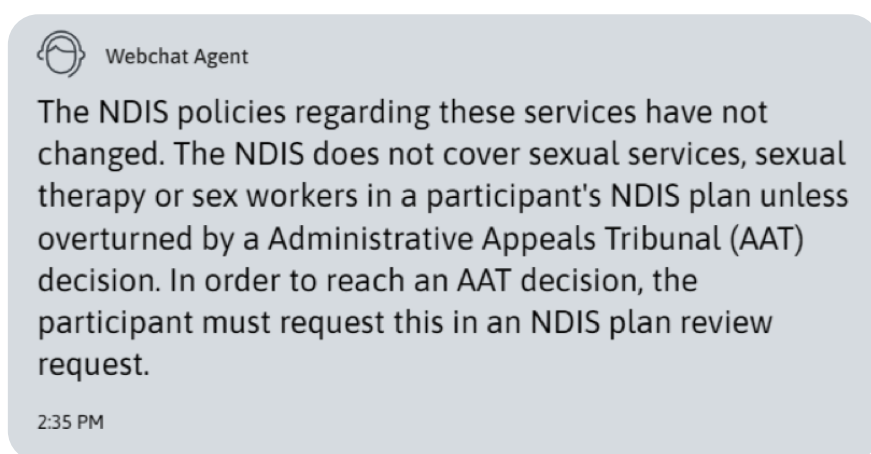


Figure 3: Screenshot of automated reply from the NDIS stating they do not have a policy about sexual services. [screenshot shared in personal correspondence: 18th July 2023]

Through professional networks and ongoing personal experience as a sex worker, it has been established that sex worker services are being funded via individuals' NDIS Plans.

7 This is the Ministerial office's typographical error – the final ruling was handed down on 12 May 2020 not 2019.

This is also confirmed in the findings of this research (see Chapter 6). However, without clear, concise, and publicly available Operational Guidelines for NDIS Co-ordinators, Plan managers, Local Area Coordinators (LACs) and participants themselves, people’s right to sexual expression are not being considered nor supported in a transparent or equitable manner. This exemplifies Bahner’s (2019b) concept of practice-based versus policy-based sexual citizenship, where sexual expression is supported at the ‘grass-roots level’ but operates ad hoc without the backing of comprehensive policies or guidelines.

Third party support mechanisms always require a balanced consideration between *duty of care* and *dignity of risk* (Marsh & Kelly, 2018). However, an added component to this equation now includes the prevalent fear of being audited by the NDIS/NDIA for paying for services retrospectively deemed not ‘reasonable and necessary’. While the NDIS proclaims to be person-centred, striving to give autonomy of choice and decision-making procedures back to the participant, there is an increasing amount of gatekeeping by third parties. For example, the NDIS states that “the role of a plan manager is not to determine whether the supports or services purchased are ‘reasonable and necessary’” (NDIS, 2021b). Essentially, plan managers are employed to process and pay invoices on behalf of participants, ensure they do not overspend their allocated budget and provide financial reports. Yet there have been numerous cases where plan managers have either flatly refused to support a participant’s request or developed their own prerequisites before sex worker services can be accessed. For instance, one plan management company unilaterally decided that “Yes, the NDIS can fund a sex worker, provided you have a letter of approval directly from the NDIA or your LAC” [personal correspondence with interviewee]. In a Women with Disabilities Australia presentation, a Western Australian woman, Melanie, also shared her experience of contradictory behaviour where her sex worker’s invoice had already been paid: “...the claims from my sex worker... I got a call from my LAC’s manager saying that they have denied the claims, even though they paid them” [40:10] (2023).

Some of these concerns were formally shared during a 2022-2023 inquiry held by the Joint Standing Committee on the National Disability Insurance Scheme. This inquiry, comprised of five Members and five Senators examined the Capability and Culture of the National Disability Insurance Agency (NDIA), held 13 public hearings between 3rd November 2022 and 7th November 2023 (Commonwealth of Australia, 2023d). The final half-day of the public hearings [8:30 – 11:50am] provided an opportunity for various advocacy, disability organisations and representatives to give testimonies specifically addressing the ongoing lack of adequate NDIS support mechanisms for participants’ sexual expression (Commonwealth of Australia, 2023e). This included testimony and submissions from People with Disability Australia, Touching Base, Yooralla, Northcott, Family Planning Australia, Sexual Health and Family Planning ACT (SHFPACT), and Sexuality Education Counselling

and Consultancy Agency (SECCA). Issues raised by these organisations were documented in the official Hansard records (Commonwealth of Australia, 2023e), in supplementary written submissions (SECCA, 2023; Touching Base, 2023c) and summarised in the final report in a section titled ‘Sexuality, sexual development and sexual expression’ (Commonwealth of Australia, 2023b, pp. 27-36).

However, the formal recommendations of this inquiry fail to specifically address the overarching concerns tabled. From the 27 recommendations tabled, the closest the inquiry came to explicitly supporting participants’ autonomy and choice, which could therefore support their sexual expression, is reflected in Recommendation 20. Additionally, there is a single mention of sexuality found in Recommendation 24, but it only references supporting LGBTQIA+ participants:

Recommendation 20

6.49 The committee recommends that the National Disability Insurance Agency allow participants to use plan budgets more flexibly, including in situations where short term or emergency accommodation is required (p.105).

Recommendation 24

LGBTQIA+

6.58 The committee received evidence on the importance of co-design in developing and implementing policies related to sexuality (p.106).

The 2023 NDIS Review also emphasised the need for all governments to invest more in research, evaluation and knowledge translation to demonstrate the value of the NDIS to both governments and taxpayers, and to help participants meet their goals through innovative and evidence-based supports (Gingold et al., 2023).

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This is not the only recent assessment of the operations and deficits of the NDIS. A report commissioned by DANA: ‘Redesigning the NDIS – An International Perspective on an Australian Disability Support System’ (Duffy & Brown, 2023), shared 10 recommendations for change to move the NDIS to a more sustainable and equitably run support system. The authors of the report reflect on the various models of support that the NDIS is, or has been, operating under, specifically critiquing what they called the Professional Gift Model, the Bureaucratic Gift Model and the Citizenship Model (Duffy & Brown, 2023, p. 36). While the

former two disenfranchise the individual, positioning them as mere recipients of services and care, the citizenship model situates the person as an active participant, allowing for autonomy, control and choice while being part of a more symbiotic relationship with service providers, their environment and the community they live in. As Duffy and Brown (2023, p. 37) explain:

But it is the Citizenship Model that reflects the true values that inspired the creation of the NDIS and it offers a much better framework for developing a sustainable and stable system. We need an approach that supports people to be citizens, not consumers of services, but active and contributing members of the community. We need an approach that provides people with robust and flexible entitlements that people can use to work in partnership with professionals or to invest in their own communities. The NDIS plays an essential role in moving resources towards people with disabilities based upon their needs; but it must be open to learning, as an equal partner, alongside people with disabilities and their allies, how best to use those resources. Citizenship should provide both the goal and the animating spirit of NDIS 2.0.

While the concept of citizenship is employed here to support people with disability to live a life ‘equal to others’, what is missing is specific consideration of their sexual citizenship. As long as this remains an unspoken and assumed component of ‘citizenship’ as a whole, the sexual expression of people with disability will continue to remain unsupported and devalued as an integral component of their lives. This oversight deviates from the guiding principles of the NDIS which was designed to employ a person-centred approach.

This commitment to a person-centred approach in the operations of the NDIS were re-emphasised in the findings of an independent review, commissioned by the Australian Federal Government. This 329-page report, entitled ‘Working together to deliver the NDIS’ made 26 recommendations and 139 supporting actions (Commonwealth of Australia, 2023f). Among these, Recommendation 3 included two specific points:

3.5 The National Disability Insurance Agency should allow greater flexibility in how participants can spend their budget, with minimal exceptions.

3.6 The National Disability Insurance Agency should adopt a trust-based approach to oversight of how participants spend their budget, with a focus on providing guidance and support. (p. 6)

The co-chairs of the review, Bruce Bonyhady and Lisa Paul, emphasised that “we must ensure the NDIS experience is centred around the whole person and their disability-related support needs” (Commonwealth of Australia, 2023f, p. ii). However, the concept of sexual

citizenship is largely absent from the formal report and recommendations, with only a brief mention of increased support for participants within the LGBTQIA+ communities. Support for a person's actual sexual expression is not mentioned.

The current NDIS Minister Bill Shorten tabled the National Disability Insurance Scheme Amendment (Getting the NDIS Back on Track No. 1) Bill 2024 in the Australian Parliament in March 2024 (NDIA, 2024). The intention of the Bill was to incorporate recommendations from the previously mentioned inquiries and reviews, to address systemic issues within the NDIS and to improve its overall efficiency and participant experience. Key proposals outlined significant changes to the fundamental way the NDIS would operate, including: the introduction of new needs assessments; longer and more flexible funding packages; an altered definition of 'NDIS support'; changes to plan lengths and plan periods; new powers to monitor and modify plans for participants who over- or under-spend their funding; and proposed changes to access early intervention support (Coombes, 2024a, 2024b). The Bill was initially considered by the Senate, where it underwent debate and scrutiny. During this process, concerns were raised regarding certain provisions, prompting further examination. As a result, amendments were proposed, leading to the Bill being referred back to the Senate Community Affairs Legislation Committee for additional review. To ensure comprehensive stakeholder input, the Committee sought further public consultations through formal submissions to the Senate Community Affairs Legislation Committee Inquiry into the *National Disability Insurance Scheme Amendment (Getting the NDIS Back on Track No.1) Bill 2024*, with their final report due in August 2024.

From public consultations, media discussions and submissions received from both individuals and organisations, the overall sentiment from the disability sector is that the Bill is problematic and developed without genuine co-design or consultation from people with disability. Disability advocates and organisations expressed concern that these proposed changes would ultimately negatively affect participants, resulting in less choice and control for people with disability (Henley, 2024; Parliament of Australia, 2024; Taleporos, 2024; Taleporos, 2024).

During this consultation period the NDIS Minister, Bill Shorten, stated in an interview that if the Amended Bill passed, sex work would not be included in the list of 'acceptable services' funded by the NDIS, reiterating these sentiments in subsequent interviews (Shorten, 2024a, 2024b, 2024c; Wang, 2024). This comment sparked significant media attention and backlash from the disability and sex worker sectors who argued that excluding sex work from the NDIS undermines the sexual rights and autonomy of people with disability. They emphasised the importance of recognising and supporting sexual expression as a fundamental aspect of their sexual citizenship and criticised the move as a step backward

in achieving comprehensive and inclusive support for NDIS participants (Evans, 2024a; FitzSimons, 2024; Scarlet Alliance & Touching Base, 2024; Touching Base, 2024b; Triple J, 2024; White, 2024).

As previously stated, in 2020 the Federal Court directed the NDIS to fund sex worker services for a woman with Muscular Sclerosis (Rayment, 2019). While this case is often cited as the sole example, anecdotal evidence from both sex worker and disability communities, along with findings from the PASA-Research study (see Chapter 6), indicate that other NDIS participants have also used their funding for such services. However, it remains unclear if the NDIS maintains formal records of how many participants may have been doing so.

On the 7th July 2024, NDIS Minister Bill Shorten stated in a radio interview that “we’re only aware of one case where it’s been asked for though...the reality is that I’ve got one or two examples that I’m aware of that it’s ever happened” (Shorten, 2024a). However, the following day, Shorten disclosed in another radio interview that “we received 228 requests for advice related to requests for sexual activity supports in 12 months, up to the 30th of April. None were granted.” (Shorten, 2024b). This information highlights that there is a clear need for sexual services to be formally included within participants’ NDIS funding plans. It also reflects a systemic refusal to adopt formal policy-based sexual citizenship mechanisms within the NDIS. Furthermore, these statistics suggest that the NDIS, a federal government agency, has disregarded the Federal Court’s ruling since 2020 that sex worker services can be deemed ‘reasonable and necessary’ for some individuals with disability. At the time of writing, the total number of requests for sexual services remains unknown.

3.4.2 Aged Care

Not every person with disability in Australia has been deemed eligible for NDIS funding support. Critics of the NDIS highlight the inequities of access for people with disability, particularly for those who are socio-economically disadvantaged or lack social or familial support systems (Hui et al., 2018). Additionally, individuals who are not accepted as NDIS participants before they turn 65, or were aged 65 years or older when the NDIS was implemented in their area, are not eligible for NDIS support, relying instead on Federal Aged Care funding packages. Additionally, anyone who is a NDIS participant who moves from independent living into permanent residential aged care is automatically removed from the NDIS and placed within the My Aged Care scheme. That funding, unlike the NDIS, is means tested and capped at \$56, 000 a year, which respondents in a class action against the NDIS have stated is insufficient for people to be adequately supported (9News Staff, 2022).

As the Australian population is living longer, there is an increased likelihood that a person will develop a disability or life-changing illness, affecting them either cognitively (e.g. dementia), or physically (e.g. impaired eyesight, decreased mobility, cancer). A person's sexuality and desire for connectivity and touch does not dissipate due to disability or altered living arrangements (Barrett, 2018). However, there are currently no policies, guidelines nor funding for access to sex worker services within either the Commonwealth Home Support Programme (Australian Government, 2023b) or the Home Care Packages (HCP) (Australian Government, 2023c) that My Aged Care offers people. The closest area of support on offer is categorised as 'Social outings, groups and visitors'. These are described as "a type of help at home service... services that help you stay social and connected" and include practical daily living supports such as "Arranging social activities and providing or coordinating transport to social events. Arranging for you to attend group-based activities in a centre", and "Assistance setting up phone and internet communication services to keep in touch with loved ones" (Australian Government, 2023d). There is an absence of any explicit mention of support for a person's sexual expression.

3.4.3 Disability Support Pension

The Disability Support Pension is available for people with a permanent physical, intellectual or psychiatric condition that either hinders them completely from working or reduces their ability to work as many hours as previously undertaken (Australian Government, 2023e). It is paid as a lump sum every fortnight with no stipulations or requirements for the individual to adhere to, so expenditure is at the recipient's own discretion. Due to this, as seen in Chapter 6, many individuals have saved up their pension monies to be able to pay for sex worker services.

3.4.4 Medicare

While there is a range of specific medical support systems designed to assist people with disability in Australia (Australian Government, 2023f), most individuals are also eligible to utilise Medicare. Medicare is an insurance scheme that provides Australian citizens and permanent residents access to a wide range of health and hospital services at no cost or low cost. Funded through a compulsory 2% payment out of individuals' taxable income, Medicare ensures broad healthcare coverage is accessible to those who need it.

The Medicare Benefits Schedule, in conjunction with the Pharmaceutical Benefits Scheme, allows every Australian to access a range of procedures, services and medications. These are either 100% subsidised by the Australian Government or provided at reduced costs. While there is support for discussing therapy plans, disease management and pain management with their medical team, sexual health services and medications are primarily limited to reproductive needs and male sexual performance. These include birth control

options, support with conceiving, pregnancy and birth, blood tests for hormone levels and sexual functioning medications such as Cialis or Viagra. Although a recent inclusion for mental health plans allow access to 10 free sessions with a psychologist, sex therapy is neither subsidised or recognised, and sex work is not covered.

3.4.5 Insurance companies

Australia has introduced two unique insurance schemes to financially support people with disability to live their best possible life. The most well-known one is the NDIS, however there is also a Lifetime Support Scheme. Operating as a no-fault scheme, people who sustain injuries resulting in permanent disability from motor vehicle accidents (e.g. paraplegia, brain injury, serious burns, or blindness) qualify for financial support. Each jurisdiction has created its own legislation. For example, South Australia introduced the Motor Vehicle Accidents (Lifetime Support Scheme) Act (2013), while NSW residents are supported by the Motor Accidents (Lifetime Care and Support) Act 2006, which is run by icare⁸ – Insurance and Care NSW (2018). Calculations for lifetime care and support are now starting to include sex worker services for individuals in some legal cases⁹, however icare’s Lifetime Care Sexuality Policy (icare – Insurance and Care NSW, 2021) still explicitly excludes financial support to pay for or access sex worker services.

3.4.6 Department of Veterans’ Affairs

The Australian Department of Veteran Affairs (DVA) offer a range of financial, and service supports for veterans of Australia’s armed forces. A service pension can be paid to veterans based on ‘age or invalidity’ but is subject to an income and assets test. Other payments include the Disability Compensation Payment, Incapacity benefits and the Permanent Impairment (PI) payment. Like the Disability Support Pension, individual recipients have complete autonomy over how and where they choose to spend their pension monies.

The DVA offers a comprehensive range of health care and support services for eligible veterans and their eligible dependants. These include general practitioner services; allied health services (e.g. Podiatry and physiotherapy); medical specialist services (i.e. pathology or radiology); dental care; community nursing; home support services; and medical aids and appliances (Rehabilitation Aids and Appliance Program: RAP). Additionally, the DVA provides extensive mental health treatments including support from GPs, psychologists, social workers (mental health), occupational therapists (mental health), psychiatrists, or hospital services for those who need it (including trauma recovery – PTSD programmes).

⁸ icare is written with a lower case ‘i’ in all public and published documents

⁹ I know this through a few ways (1) lawyers have previously contacted Touching Base when I was on the Committee, and we referred them to individuals who delivered Court Reports supporting this service (2) lawyers have contacted me directly (3) I have provided services to clients who have paid me via their insurance payment

Moreover, the DVA also offers specific services to support a person's independence, supporting at-home living, facilitating a safe return-to-work, and to improve their quality of life. These services include assistance with domestic tasks such as lawn-mowing, laundry, shopping and house cleaning; assisting with managing personal care needs; provision of respite services and assistance with modifications to vehicles; and aids and appliances (Department of Veterans' Affairs (DVA), 2021).

The term 'quality of life' is not specifically defined within the DVA's documentation. Additionally, the only recognition of personal relationships within the DVA is in relation to Partner Service Pensions, War Widow's/Widower's, and Orphan's Pensions, as well as through psychosocial rehabilitation support. As outlined on their website (Department of Veterans' Affairs (DVA), 2021), this is offered in order to:

help you to manage and live a better quality of life which can also assist you to accomplish your goals. Services available may help you to better manage issues that arise day-to-day and to get more from your life – be that family, friends or the wider community.

There is no reference to supporting a person's sexual expression, and sex worker services are neither subsidised nor recognised.

3.4.7 Total and Permanent Disability (TPD) Superannuation Insurance

Total and permanent disability (TPD) insurance provides a lump sum benefit if the insured person is injured or ill and unable to return to their place of employment (MoneySmart, 2023). While TPD insurance can be purchased individually, it is most commonly integrated into a person's superannuation retirement fund (around 86%) (ASIC, 2021). Recipients have complete autonomy over how they spend their benefits, and while TPD legislation does not specifically reference sexual expression or sex worker services, one PASA-Research survey participant explicitly mentioned using their TPD funds to pay for sex worker services (see Chapter 6, Section 6.5.4).

3.4.8 Trustee and Guardianship

Each State and Territory of Australia operates a similar form of Guardianship program. In NSW it is known as the NSW Trustee and Guardianship (TAG), which defines a guardian as "someone who can make healthcare, lifestyle and medical decisions on behalf of a person who lacks decision-making ability" (NSW Trustee and Guardian, 2020, para. 1). A formal Guardianship Order is appointed when an individual's decision-making capacity is impaired due to disability, age, mental illness, or injury. Either a private guardian known to

the person is nominated, or someone from the Government Guardianship is allocated the responsibilities.

Due to effective advocacy and supportive networks, some individuals in Australia have successfully accessed sex worker services through the release of their funds managed by their appointed Guardians [personal experience and communication with colleagues].

3.5 Prior governmental support for sex worker services

“I hope they’ll understand that no government has ever funded prostitution before ever that we can find in the history of the Commonwealth” (Whyte, 2021)

The former NDIS Minister, Stuart Robert, was incorrect in this media statement. Prior to the rollout of the NDIS, various Government disability funding schemes throughout Australia were previously used to discreetly support individuals to access sex worker services (Ings & Lees, 2013; McDougall & Morri, 2011)[also known via personal experience and communication with colleagues]. An example of this, from Tasmania, was mentioned within an article entitled ‘Australian and Danish Governments Providing Prostitutes for the Disabled’ (LifeSite, 2005, para. 4):

Disability Services’ guidelines include a section developed in 2001, titled “Access to a Sex Worker.” It states, “Sex workers should be seen as one of a number of options to consider when supporting people with disabilities to make decisions about their sexual needs.” The report in *The Mercury* says that though the men usually pay for the services themselves, guidelines exist for social service funds to be made available should they be strapped for cash.

This article also cited funding supports for sex services for people with disability in other countries. This most notably occurs within online and print media articles, with only limited academic inquiries on this topic. This could be due to a lack of scholarly inquiry or due to relevant material not being published in English. While there have been isolated references to Germany (Kale, 2017; Tapp, 2017) and Belgium (Indische & Storm, 2023), the jurisdictions most commonly referred to are the Netherlands (Bahner, 2019b; McRuer, 2011), Denmark (BBC News, 2005; Kulick & Rydström, 2015) and England (Dominic, 2021; Mooney, 2010; Pitt, 2010; Sims, 2010; Swerling, 2021).

It is beyond the scope of this thesis to provide a detailed examination of the historical prevalence of these proposed funding schemes, though a detailed summary of this nature would be of great benefit to future discussions. Additionally, it’s worth noting that the Israeli Government funds – and originally set up – a sexual surrogacy program,

grounded specifically within a therapeutic and rehabilitation framework to assist people with disability. Although the focus of this thesis is primarily on services delivered to people with disability from sex workers, a comparative analysis of the similarities and differences between this sexual surrogacy program and sex work services can be found in the book chapter: ‘Paid sexual services for people with disability: Exploring the range of modalities offered throughout the world’ (Wotton, 2020).

3.6 Conclusion

Without clear policies and guidelines, individuals’ sexual rights and supports are often left in limbo. Transparent determinations regarding government and non-governmental financial support and responsibilities are essential to support the sexual expression of people with disability. As a signatory to the Convention on the Rights of Persons with Disability, Australia is obligated to uphold the comprehensive human rights framework established by the convention, which should encompass all – not some – of the rights it stipulates. However, sexual citizenship frequently remains the ‘missing piece of the puzzle’ within charters, policies and guidelines, with access to sex worker services still considered a taboo subject and difficult to navigate within current funding schemes within Australia.

Regardless of who is or is not funding sex worker services, it is evident that some people with disability *are* accessing these services. Chapter Four offers a detailed review of the academic literature concerning clients of sex workers, followed by a more nuanced discussion on research about people with disability as clients. Both sections outline patterns of involvement, demographics, and the motivations of each cohort. An overview of current gaps in the literature in this area of inquiry is then provided.

CHAPTER 4

Literature review: clients of sex workers

4.0 Introduction

This chapter provides an overview of available literature about clients of sex workers. The first section examines international literature that discusses clients in general. This includes demographics of this cohort, identified patterns of involvement and motivational factors that may contribute to their decision to purchase sexual services. This is followed by research specifically grounded within the Australian client population. The chapter also identifies what is known about people with disability who have accessed sex worker services, including scholarship focused on demographics, identified patterns of involvement and motivations. An overview of current gaps in the literature in this area of inquiry is then provided.

4.1 Research about client of sex workers

Historically, research about sex workers' clients has concentrated on 'risky behaviours', couched within sexual health frameworks, STI transmission and concepts of exploitation (Dewey et al., 2018; Soothill & Sanders, 2005). Additionally, clients have also been portrayed as sexual deviants, perverts or violent predators (Davis et al., 2020; Kinnell, 2006a; Prieur & Taksdal, 1993), with the title of one book chapter: *Clients of female sex workers: men or monsters* (Kinnell, 2006b) encapsulating the extreme dichotomy of societal attitudes held about those who pay for sex. This perspective also reflects the narrow heteronormative lens that has been historically applied to discussions and research about the sex industry and its clientele.

More recently though, a growing body of work has shifted the focus to explore clients' personal reflections, motivations and patterns of behaviour (Wakefield, 2024; Huysamen, 2020; Sanders et al., 2020; Sanders, 2008; Soothill & Sanders, 2005). These studies aimed to understand why clients may access sex work services as well as the range of factors that impact their experiences. The following section will review the literature on clients, focusing on demographics, patterns of involvement and motivational factors.

4.1.1 Demographics

Research on sex workers' clients has historically been disproportionately focused on male clients, particularly those of female sex workers (Wakefield, 2024; Sanders et al., 2020;

Huysamen, 2020; Milrod & Weitzer, 2012; Perkins, 1999; Sanders, 2008;). Studies have often utilised small and non-representative sample sizes with inquiries limited to specific areas of the sex industry, especially street-based or illegal work locations, where clients were more visible and easily identified (Monto & Julka, 2009).

The advent of the internet has transformed the research landscape, enabling an increased capacity for direct communication with self-identified clients of sex workers (Regushevskaya & Tuormaa, 2014; Sanders et al., 2020). Pre-internet, clients' voices were largely obscured, as this notoriously hard-to-reach population was wary of researchers due to the clandestine nature of the sex industry and the often illegal nature of their actions (Holt & Blevins, 2007; Holzman & Pines, 1982). Additional barriers which reduced the willingness of clients to participate in research included internalised shame in purchasing sexual services and the fear of being 'outed' as a client. Researchers and ethics committees often exercised undue caution, limiting face-to-face interviews with clients, which created additional impediments to expanding knowledge about this cohort. This was especially due to the demonisation of male clients as violent, deviant men, coupled with the added stereotypical perceptions that they may be 'perverts' or be emotionally or physically volatile (Hanson, 2016; Prieur & Taksdal, 1993).

4.1.2 Age range

One notably different study in the pre-internet era, was a New Zealand (NZ) research project which conducted 13 semi-structured interviews with men who self-identified as clients of the sex industry. This inquiry was initiated by several clients actively writing to the author of *Working Girls* (Jordan, 1991) (a book about female sex workers' experiences in NZ), offering to share their unique experiences, to complement the sex worker narratives shared within the book. In this NZ client study, the participants' ages ranged from 21-74, with the majority in the 30-40 years age group (Jordan, 1997).

Subsequent international research has consistently reported this broad age range of clients. For example, a UK project conducted 35 interviews with men who paid for sex worker services, with ages ranging between 29 and 69 years (Hammond, 2015). An earlier study reported participants having an age range between 22–70 years, with the average age being 45 years (Sanders, 2008). Findings from a Canadian survey of clients identified an age range between 19 and 94, with the average age being 44 (Atchison et al., 2015), and in an Australian study involving 309 men in an anonymous quantitative survey, the age range was between 29 and 76 years (Birch & Ireland, 2015). Additionally, a South African inquiry recruited 43 cisgender men for online and face-to-face interviews, with participants aged between 22 and 67 years (Huysamen, 2020).

The largest cohort of clients surveyed, to date, came from the UK's Beyond the Gaze study (Sanders et al., 2019) which examined "the attitudes, practices, attitudes and experiences of individuals who purchased sexual services" (Sanders et al., 2020, p. 12). Out of 1, 323 participants there were 1, 241 who paid for in-person services. Of the 1, 309 (98.6%) individuals who responded to the age question, only 2.6% were between 18-24 years, while the majority of respondents (63%) were between 35 – 60 years, and 9% were over 65.

4.1.3 Female clients

While an Australian study in the mid-90s noted that 12% of sex worker participants indicated that some of their clients were women (Perkins, 1999) specific research on female clients' experiences of purchasing sexual services has only gained attention in recent years (Kingston et al., 2020; Berg et al., 2019; Caldwell, 2018; Kingston & Hammond, 2016;). Despite being a relatively newer area of study, research has already reflected a broad age range among female clients. For example, one UK study found that clients ranged between 19 and 60 years of age (Kingston et al., 2020), while an Australian study interviewed women between the ages of 18 to 69 (Caldwell & de Wit, 2021a).

Research on female clients has shown this cohort accessing the services of both male and female sex workers (Oliveira & Janssen, 2021). This has been confirmed through studies focused on male sex workers and their clientele. For instance, a global overview of male sex worker advertising websites found that while the majority were designed to attract male clients, 11% specifically targeted female clients and 10% were aimed at heterosexual couples (Kumar et al., 2017). This aligns with an earlier study that identified 17% of male escort websites catered exclusively to female clientele (Lee-Gonyea et al., 2009).

4.1.4 Older clients

There has been a small but specific focus on older clients who seek out paid sexual services. For example, a New Zealand study (Jordan, 1997) surveyed participants aged 21-74, with most within the 30-40 age bracket. In Italy, a study focused on heterosexual men between 50-70 years, exploring their opinions and experiences in paying for sex through 36 in-depth interviews (Bertone & Ferrero Camoletto, 2009; Camoletto & Bertone, 2010).

Similarly, a Canadian study (Atchison et al., 2015) included participants ranging from 19 to 96 years, with an average age of 44. In the USA study Milrod and Monto (2016), focused on 208 participants between 60 and 84 years of age, while a UK study conducted by Sanders (2008) conducted interviews with 50 men aged between 22-70 years who had bought sexual services. This UK study explored their "motivations, experiences, emotions, stigma, networks and 'rules of engagement' regarding buying sexual services" (Sanders, 2015, p. 184), with nearly half of the participants (23/50) being over 50 years in age. Drawing

from this sub-cohort's social and sexual stories, the researchers separately examined their motivations and experiences in purchasing sex at an older age, as well as examining patterns of engagement over their lifetime (Sanders, 2015). Notably, in Sander's study, of the 23 participants aged 50 years or older, six self-disclosed in having a "physical or sensory impairment" (Sanders, 2015, p. 186). Finally, in a broader UK study 'Beyond the Gaze' (Sanders et al., 2019) participants' ages ranged from 18-24 years (2.6%) up to 65 years or older (9%), with the majority falling between 35 – 60 years (63%).

Positive media coverage has also highlighted interactions between sex workers and elderly men, addressing the specific needs and motivations of this cohort. For example, an article titled 'Assisted loving: Prostitutes and the elderly' (Obermueller, 2011) showcased the experiences of German sex workers with their elderly clients, an Australian TV program, *Insight*, featured a sex worker discussing her regular visits to her 93 year old client in an aged care facility (Insight, 2013; Selinger-Morris, 2016) and a recent article featured two Australian sex workers who provided services to clients in nursing homes (Simon-Lawrence, 2024).

4.1.5 Patterns of involvement

Clients of sex workers are certainly not a homogenous group, however there has been some attempt to gauge the frequency and rationale for accessing sex worker services. A key study by Sanders (2008) identified five distinct patterns of behaviour, or 'sexual scripts' based on the frequency and rationale for male clients seeking out the services of sex workers. These specific models of engagement include (p. 48):

- **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.

More recently, Wakefield's (2024) study in the United States also sought to categorise male clients, revealing six patterns of consumption: generalists, internet-only buyers, brothel-only buyers, experimenters, routinized buyers, and opportunists. However, both of these typologies are framed within a heteronormative context, and specific inquiries into patterns for men seeking male, trans, or gender-diverse sex workers, or female clients seeking sex workers of any gender, remain underexplored. The PASA-Research study, utilising a sexual citizenship and sex positive framework seeks to address this gap by exploring a broader range of client experiences, particularly for gender-diverse individuals.

4.1.6 Motivations

Insights into clients' motivations for seeking out sex worker services span a wide range of reasons, though predominantly centred on the experiences of male clients. These motivations include excitement, companionship, a desire for varied sexual experiences (especially those not provided by their current partner), and to combat loneliness and feelings of isolation, especially due to an inability to form intimate and sexual relationships (Wakefield, 2024; Lever & Dolnick, 2000; Xantidis & McCabe, 2000; Bertone & Raffaella, 2018; Campbell, 1998; Holzman & Pines, 1982;).

Separate analyses by Atchison, Fraser and Lowman (1998) and Dr Carol Queen (2000) a writer, activist and sex worker, also acknowledged broad motivating factors and criteria for clients. These included clients' personal beliefs of their own 'physical unattractiveness', avoidance of gender role responsibilities, sexual growth and experimentation, personal comfort and healing, exploration of their masculinity, and to create firm boundaries between private life sexual experiences and paid sexual encounters. An earlier Australian study identified 14 similar and overlapping reasons for client – sex worker engagement including relieving stress, seeking sex not provided by their partner and it being the only avenue to enjoy sex with someone (Perkins, 1999).

Researchers have also noted that some clients are also drawn to this sometimes-illicit encounter as a thrill-seeking activity (Monto, 2000), while others enjoy the opportunity to discreetly explore specific fetishes and kinks (Kosloski & Diamond-Welch, 2021). Men have also been found to be attracted to 'no strings attached' sexual interactions, while appreciating that the contractual style agreement between client and sex worker can be cheaper, more convenient and ultimately more satisfying than traditional types of dates and meet ups (Bernstein, 2010; Hammond & Hooff, 2020; Huysamen, 2022).

What has also emerged from the literature is that some clients actively seek out moments of genuine intimacy and connection within their sex worker interactions (Grönvall et al., 2021; Huysamen & Boonzaier, 2015; Earle & Sharpe, 2008; Sanders, 2008). Bernstein

has described this phenomenon as *bounded authenticity* (Bernstein, 2007a, 2010). This concept of pleasure and intimacy seeking behaviour contrasts with historical or contemporary rhetoric that depicts male clients to be acting on misogynistic tendencies or displaying a fragile masculinity by exerting power over passive, receptive female bodies (Birch et al., 2017; Brents et al., 2020; Hammond & Hooff, 2020; Joseph & Black, 2012; Prieur & Taksdal, 1993).

A review of 220 internationally published research papers about clients of sex workers (Wilcox et al., 2009b) also provided a summary for clients' motivations for paying for sex, creating seven specific categories (p2):

- (1) desiring sexual variety, (2) a dissatisfaction with existing relationships, (3) sexual gratification, (4) loneliness, shyness or incapacities (mental and physical),
- (5) having no other sexual outlet, (6) being separated from a partner by travel, and
- (7) curiosity, risk or excitement; to exercise control.¹⁰

An Australian inquiry focused on male clients surmised that the majority of their cohorts' motivations for purchasing sexual services were influenced by three specific factors: *ease*, *engagement*, and *arousal* (Pitts et al., 2004). However, Sanders (2008) encapsulated these motivation aspects into what she deemed *push* and *pull* factors. *Push* factors include elements in the clients' lives that are lacking, such as a 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. Alternatively, *pull* factors encompass positive elements of the sex industry on offer, such as a safe, respectful environment to explore or learn 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.

4.1.6.1 Older clients

Some of these motivational factors, while applicable to all age groups, are acutely relevant to older clients. The latter stages of a person's life can include such stressors such as divorce, the advent of illness or disability, death of a partner, family or friends, retirement, relocation, and potential isolation. One UK study where 23/50 of the interviewed participants were older men (aged 50+), specifically identified a number of key motivational themes including the desire for men to overcome or work through sexual dysfunction by regularly seeking sex worker services, the desire to maintain regular sexual interactions, and being able to try new experiences (Sanders, 2015). A debate on Twitter (now known as X) about clients who see sex workers when their wives have cancer, gave rise to the blog post 'Sex work

¹⁰ Quoted as is from text.

for broken-hearted care givers’ (Sage, 2021), which asked the question: who cares for the carers? While society acknowledges the huge physical and emotional toll experienced by caregivers, sex workers have occasionally been identified as being able to provide a safe and confidential space to ‘recharge’ both body and mind, offering a sympathetic ear during a client’s time of crisis.

4.1.6.2 Female clients

Social commentary about female clients does not generally elicit the same negative reactions and moral panic as depictions of male clients paying female sex workers. This difference in societal attitudes is shaped by a range of complex factors, including cultural norms, gendered expectations, and media representations. Emma Thompson’s portrayal of an older divorcee hiring a male sex worker to explore her sexual desires in *Good Luck to You, Leo Grande* (Caldwell, 2022) is one such representation that has contributed to broader discussions on the topic. Within academia, a large scoping study looking at the motivations of women who purchase sex worker services, identified only 25 studies that explicitly examined female clients of predominately male sex workers (Berg et al., 2019). One of the largest studies, based in the UK, identified both diverse and overlapping motivations between male and female clients (Kingston et al., 2020). This includes a lack of sexual interest from their long-term partner, exploring new sexual experiences, seeking fun and pleasure, alleviating loneliness, or wanting an escort for a work or social function. Additionally, some enjoy what is known as ‘sex tourism’, holidaying in locations where economic, power and sexual dynamics can be exploited. For example, the English pound is stronger than any currency in the Caribbean, where research has identified white women are able to exert more autonomy and power over the local black men. Further, women who do not conform to stereotypical western definitions of beauty and body shape may be revered and sought after as larger, older women. Additionally, as with male clients, critical life-course moments such as divorce, relationship breakdowns, and illness or death of a partner appears to precipitate motivations to seek out sex worker services for female clients (Kingston et al., 2021). Overall, this UK study grouped the female clients’ motivations into the following categories: *functional* (sexual release, specific sex act, and variety of partners); *self-indulgent* (control, client focused experience, new experiences and experimentation); *emotional* (intimacy, companionship, pleasing a partner); and *convenience* (no emotional attachment, discretion).

4.1.7 Australian research

Australian studies reflect similar findings to those identified in international scholarship. Early knowledge about clients was derived from research with female sex workers (Lovejoy et al., 1995; Perkins et al., 1994), which found that “12% of sex workers indicated that some of their clientele were women” (Perkins, 1999, p. 39). To acquire a direct representative

sample of clients' experiences, a further study utilised a telephone questionnaire with 667 male respondents (Perkins, 1999). Mirroring the findings of other studies, respondents represented a wide variation in ages, with two being under 18 years and six reportedly over 70. Concurrently, a large research study about clients of male sex workers was conducted between three Australian cities (Minichiello et al., 1999). Coordinated by peer sex worker outreach officers, 186 male sex workers kept a client diary over a two-week period. By completing a series of questions after each booking, they collectively recorded 1, 776 individual clients over 2, 088 encounters. Once again, the age range reflected a bell-shaped curve with most clients in their 30's or 40's, while 1.8% (n=32) of clients were reported to be in their late teens and 4.7% (n=83) in their 60's or older.

A more recent study on men who pay for sexual services in NSW, Australia involved 309 participants completing an anonymous survey, with an age range between 29 and 76 (Birch & Ireland, 2015). From this cohort 13 individuals self-nominated to do subsequent in-depth interviews. Overall, their motivations to visit sex workers reflected previous findings, including a desire for intimacy and connectivity alongside the actual sexual activities available (Birch, 2015; Birch et al., 2017). An additional reason not raised in other studies, was the attractiveness of the sex worker (n = 138/52.7%) (Birch et al., 2017, p. 1112). It was unclear whether this was interpreted as an attraction to something specific about the sex worker which was different from what was available 'at home', or merely seeking sex workers with preferred attributes. However, this aligns with findings from an Italian study (Bertone & Raffaella, 2018, p. 7):

Mariano justifies his transgression by naturalizing his desire for sexual variety, expressed in his search not only for "other sexual practices" beyond vaginal intercourse, but also in his attraction towards different bodily shapes ('big tits' or 'long legs', 'blonde' or 'brunette').

Respondents from the NSW study by Birch and Ireland (2015) were also asked if they had disclosed their client status to anyone else, with 260 men answering. Of those, only 53.8% (n = 140) indicated that they had talked about accessing sex workers to another person. Reasons for non-disclosure were due to feelings of shame, embarrassment, stigma, the belief that others would stop talking to them, or they would be labelled "as a pervert or sad (17.3%, n = 45)" (Birch & Ireland, 2015, p. 16).

The Australian Study of Health and Relationships (ASHR) is a longitudinal study, conducted every decade, to provide "a snapshot of the sexual health and well-being of the Australian population and provides information essential for the development of policy and the delivery of sexual and reproductive health programs across Australia" (ASHR, 2022, para.

1). ASHR1 (data collected 2001-2002) involved telephone interviews with a representative sample of 19, 307 men and women, aged 16-59 years. Imbedded within the total survey, respondents were asked if they had ever paid for sex worker services and if so, were asked a series of questions about their experiences as clients (Rissel et al., 2003). Findings indicated almost one in six Australian men (15.6%) had paid for sex; with 1.9% doing so in the last year. The men predominantly (97%) paid female sex workers with only 3% paying for sex with a man. Only 0.1% of women had ever paid for sex. A decade later, ASHR2 (data collected 2011 – 2012) phone interviews were done via landline and mobile phones, with a representative sample of 20, 094 men and women, aged 16–69 years. Results about experiences of paying for sex worker services were similar to the previous ASHR1 survey with 16.0% of men under 60 years in ASHR2 having ever paid for sex, and only 0.3% of women (Richters et al., 2014a).

A small number of studies have examined the experiences of long-term male clients in Australia (Caldwell, 2011) and the characteristics and motivations of female clients in Australia (Caldwell & de Wit, 2017, 2018). Motivations reflect those of data collected in other countries, including wanting to enjoy pleasure and sexual connection, moments of intimacy, learning more about their bodies, processing issues of stress or trauma, and experimenting sexually in a safe and supportive environment (Caldwell & de Wit, 2021b). One woman commented to the media, that visits to a sex worker helped her after “a period of significant work stress. ...I almost wanted someone just to hug me a lot for an hour.... It can be that sort of healing and cleansing stuff ... it was huge for me.” She noted that her sex worker also helped her to feel “much lighter” and was able to “clear out that stress in a way that conventional mental health practice probably never would have or would have cost me a lot more time and money” (Kelesy-Sugg & Payne, 2019). Additionally, a short survey was conducted at the Melbourne Sexual Health Centre (Victoria) between March and April 2019 to determine the proportion of male and female attendees who had paid for sex (Chow et al., 2021). However, this study should be viewed within the context of its narrow sampling methodology, as the cohort was drawn only from individuals who attended the Centre in that timeframe. Additionally, they were only asked if they had paid for sex in the past 3 months which should not be extrapolated to represent societal norms as a whole.

While Australian-based research about clients of sex workers has generated findings about demographics and motivations that reflect those of other studies, data pertaining to a person’s disability status is critically absent from most data collections. Pleasingly, this has started to change. For example, while findings from ASHR3 (data collected 2022-2023) have not yet been released, questions about a person’s disability status have been included in the third stage of this longitudinal Australian study.

The next section of this chapter examines the literature, and other corresponding data, that specifically addresses people with disability who have accessed sex worker services. As scholarship in this area is remarkably small, sources from Australia are included within each focal point instead of providing separate commentary.

4.2 Research about people with disability as clients of sex workers

The proliferation of research about clients over the last 3 decades has not translated equally into exploration of the experiences of people with disability who access sex worker services. Consequently, such inquiries are more limited. Additionally, unlike research that typically focuses on services, occupation, costs or patterns of engagement, research with persons with disability has often focused on the capacity to consent, and legal and moral parameters of supporting peoples' access to sex workers (Freckelton, 2021; Geiss & Egner, 2022; C Jones, 2013). Furthermore, while an undetermined number of people with disability independently engage sex workers, many rely on the assistance of a third party (Kulick & Rydström, 2015; Wotton, 2016; Wotton & Isbister, 2010). This can be due to support needs around communication, transportation, physical transfers, applying for/accessing personal finances, or because their current living arrangements do not support visits of an intimate nature. Having other people involved in this process can create additional issues of confidentiality, barriers to access and personal choice, questions around roles and responsibilities, and the need for increased education for all stakeholders (Dominic, 2021; Curryer et al, 2020; East & Orchard, 2014).

While still limited, our current understanding about this cohort has developed via a range of first-person accounts (Anonymous, 2008; Atchison et al., 2015; Kulick & Rydström, 2015; Liddiard, 2014, 2018; TLC Trust, 2020; Touching Base, 2023b), and from sex workers who provide services to people with disability (Canale, 2019; Sanders, 2007; Wotton, 2016; Wotton & Isbister, 2010). Concurrently, there has been an increase in the number of documentaries, films and radio programs that highlight the experiences of people with disability and the sex workers who provide services to them (as outlined in Chapter 3, section 3.1.1 Film and TV representations).. While these accounts help inform and challenge public perceptions of disability, sex workers and clients, they lack the rigour of formal enquiry (Noble & Smith, 2015).

Knowledge about people with disability who access sex worker services has most commonly emerged from research inquiries imbedded within broader sex and sexuality research within the disability sector, rather than as stand-alone inquiries. Leading examples of inquiries which include, but do not exclusively feature, participants accessing sex worker services include: 'The sexual politics of disability: untold desires' (Shakespeare et al., 1996), 'Loneliness and its opposite: Sex, disability, and the ethics of engagement'

(Kulick & Rydström, 2015), ‘The Intimate Lives of Disabled People’ (Liddiard, 2018) and ‘Sexual Citizenship and Disability: Understanding Sexual Support in Policy, Practice and Theory’ (Bahner, 2019b). An example from Australia includes a recent study focused on the range of sexuality support mechanisms provided to individuals after a spinal cord injury, which included a small number of questions about referrals to sex worker services (Bryant et al., 2022).

There is also a notable absence of specific sampling strategies to include people with disability in research about clients of sex workers. Instead, data concerning clients with disability most commonly emerges as secondary, accidental findings. For example, a UK study on clients reflected that six out of the 50 older men interviewed self-identified as a person with disability (Sanders, 2008).

While clients of sex workers are usually extremely private, due to the stigma surrounding the purchase of sexual services, people with disability often exhibit the opposite behaviour, with this cohort more likely to engage in online and print media, documentaries, YouTube videos and podcasts. For instance, Frigg Birt Müller, a woman with Cerebral Palsy, was featured on a TV show called *Mormors Bordel: Grandmother’s Brothel*, where she shared her experiences with a male sex worker. When interviewed for *Loneliness and it’s Opposite* (Kulick & Rydström, 2015) she spoke about wanting to push back against the preconceived ideas people with disability were asexual. Refusing the opportunity to be assigned a pseudonym she replied: “I think using my real name and showing that I am a real person make this have more impact. If I don’t use my real name, it seems like I’m embarrassed over this. And I’m not” (p. 182).

In Australia, one of the few platforms where people with disability can publicly share their personal stories and experiences is via the ‘Clients’ Stories’ page on the Touching Base website (Touching Base, 2023b). Additionally, the Australia media has also increasingly highlighted individual voices and experiences of people with disability who have accessed sex worker services (Hoban, 2006; Ley, 2022; Ryan, 2022; Stathis, 2023; Todd, 2023; Wright, 2014), as well as parents who support the right of their adult offspring to sexual expression (Anonymous, 2022). This increased focus on clients with disability and sex workers in Australia may be attributed to several legal and social factors. For example, the legal parameters for the sex industry are much broader and accommodating throughout the states and territories of Australia than in most other countries (see Chapter 2). Consequently, while stigma and discrimination still occur (Fenwick, 2022; Jobe et al., 2022), sex workers and clients do not typically fear arrest for speaking out.

In 2002, the organisation Touching Base commissioned a scoping review of disability service providers within the state of NSW. The review identified a lack of current guidelines and practices for staff to assist people with disability access paid sexual services if they required assistance (Robinson, 2002). In response, Touching Base developed educational workshops for disability support workers (Service Provider Awareness Training) and sex workers (Professional Disability Awareness Training) (Touching Base, 2024d). They also published a 'Policy and Procedural Guide: for disability service providers supporting clients to access sex services' (Touching Base, 2011). The organisation's advocacy contributions to this field have also included various government submissions, briefing papers and face-to-face educational and briefing presentations to Government officials and politicians throughout Australia (Touching Base, 2024c).

The following section summarises the current scholarship and knowledge regarding demographics, patterns of involvement and motivations for people with disability who pay for sexual services.

4.2.1 Demographics

While research on clients of sex workers often captures data on gender, age, marital status and occupation, it frequently excludes the active inclusion of people with disability within the sampling methodology. Studies specifically developed for and about the disability community, often omit questions about the sex industry or imbed only a limited number of questions within the project. Consequently, only the most general aspects of participants' demographics, actions or experiences have been captured to date.

This is evident in the UK Disability Now 'Time to talk sex survey' (Disability Now, 2005), which provided an opportunity for their membership – people with disability – to explicitly share their sexual experiences. It covered a range of topics including sexual education, sexual activity, and sexual well-being but also included two questions about the sex industry. The first asked if the person *had* paid for sexual services. Of the 1,115 respondents, 11.7% of the men had paid for sexual services at least once, while less than 1% of female participants answered in the affirmative. What is unique about this study is that it also asked respondents if they had ever considered visiting a sex worker to meet their sexual needs, with 37.6% of the men and 16.2% of the women answering that they had (Liddiard, 2013; Sanders, 2007). With the absence of comparable data, it is unknown if this reflects a higher prevalence for people with disability or if it is similar to the general population. Understanding this through additional research could assist in developing tailored support services, inform inclusive policies and effectively allocate educational training resources to better support people with disability in accessing paid sexual services.

In Australia, the most detailed information about people with disability who have accessed, or wish to access, sex worker services has been generated by Touching Base. A report tabled at their 2023 Annual General Meeting (AGM) provided preliminary findings extrapolated from inquiries received via their ‘Referral List of Disability-Friendly Sex Service Providers’ form between 1st July 2022 through to 30th June 2023 (Touching Base, 2023a). The report indicated that out of 654 requests, the age range spanned from between 16-24 years of age up to over 65 years¹¹, as shown in Figure 4.

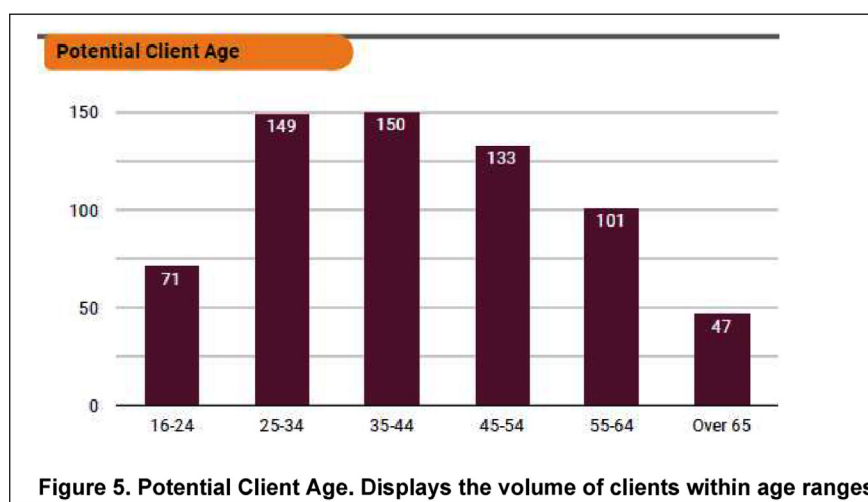


Figure 4: Potential client age from inquiries to the Touching Base Sex Worker Referral List:
1st July 2022–30th June 2023

Out of these inquiries, 551 were from men, and 60 were from women. A further 6 inquiries came from individuals who identified as trans men and 5 from trans women. While no other identifiable features are shared about the individuals identifying as Trans, their inclusion alone is unique as empirical evidence about this cohort accessing sex worker services is scarce. The only other data, also from Australia, comes from an online survey of 65 sex workers who provided services to clients with disability in the state of NSW (Wotton, 2016). This study identified that three sex workers (2 female; 1 male) had bookings with clients who were transgender, though no further determinations regarding whether they were trans women, trans men, or trans non-binary were asked of the participants.

4.2.2 Older clients with disability

Over the last decade, more attention has been given to issues of sexuality in older people with disability (Haesler et al., 2016), particularly regarding capacity to consent (Henrickson et al., 2020), staff support mechanisms/interventions and the right to sexual expression in nursing homes and other aged care facilities, especially for those living with dementia

¹¹ While there were 654 inquiries, the columns in the graph only reflect 651, as three inquiries did not indicate the client's age (personal correspondence with Touching Base, June 2024).

(Bamford 2011; Barrett et al., 2015; Bauer, Nay, et al., 2014; Durack, 2013; Jones, 2013; Lyons, 2024; McAuliffe et al., 2023; Tarzia et al., 2012). This attention is timely as Australia's aging population is expected to live longer, but with increased support needs (Australian Bureau of Statistics, 2016). An Australian study, looking at the attitudes and behaviours of staff working in aged care, briefly mentioned one resident being supported with his decision to have sex workers visit him (Shuttleworth et al., 2010, p. 190):

We had a gentleman who had a stroke, was 55 years old, whose marriage had broken up and he would organize call girls on his cell phone. The facility facilitated his needs by providing privacy and putting a "Do not disturb" sign on his door when he had "guests" ...we just had to facilitate and provide additional training for the staff as the residents have every right to their sexuality and that needs to be respected.

The development of an Australian Sexuality & Dementia eLearning resource for staff (Jones, 2014; Jones & Moyle, 2016) includes a brief mention to accessing sex workers when addressing strategies to support options for the sexual expression of individuals living with dementia. Similarly, in New Zealand, a project entitled 'What counts as Consent? Sexuality and ethical deliberations in residential aged care', explicitly included questions on staff attitudes to residents' access to sex worker services (Henrickson et al., 2020). Their findings indicated that residents accessed sex workers "if not in all facilities, at least in a number of them around the country, in urban, suburban, and rural areas" (p. 8). While these studies are integral to increasing the capacity of third-parties to support older individuals to access sex workers, first-person experiences from older clients, especially those living in supported accommodation facilities, are notably absent from the literature.

Apart from a few media accounts (Simon-Lawrence, 2024; Insight, 2013) the most detailed data about elderly clients accessing sex workers in Australia comes from Touching Base. Their 2020 submission to the Royal Commission into Aged Care Quality and Safety inquiry, indicated that a total of 1, 238 online referral requests were received over a four-year period from September 2015 to September 2019. Of these, 115 requests were for clients aged 65 and older (9%), and 27 for clients aged 80 or older (2%) (Touching Base, 2020a, p. 2). All but three of the 115 requests came from men, with the three requests from women all within the 65-79 age bracket. Table 1 provides the breakdown of inquiries for each of the four years, comparing total inquiries, clients older than 65 and older than 80.

Year	Total referral requests	Clients 65 and older	Clients 80 and older
Sept 2015-16	303	28	9
Sept 2016-17	245	24	5
Sept 2017-18	347	34	7
Sept 2018-19	343	29	6
Total	1238	115 (9%)	27 (2%)

Table 1: Total referral requests to the Touching Base Sex Worker Referral List and older age groups: Touching Base Submission to the Royal Commission into Aged Care Quality and Safety inquiry.

The Touching Base report identified that among the 27 potential male clients aged 80 or older, their age range spanned between 80 and 101 years old, with 10 individuals in their 90's (Touching Base, 2020a, p. 3). Additionally, only three of these men made the inquiry themselves, with the rest made by family members (8), support staff (15), or a friend/ neighbour (1) inquiring on their behalf. This reflects the increased need for training and capacity-building for third-party support persons to support older people to access sex workers.

Additional documentation submitted to the Royal Commission into Aged Care Quality and Safety inquiry from Touching Base included testimony from Emma Arvo, a sex worker in her 70's. She supplied first-person accounts of her work (Touching Base, 2020b, p. 1) saying:

From my experience, I can affirm, they are also single, widowed, middle-aged and a number having reached a degree of seniority. Some being in their late 80s and 90s living in nursing homes, retirement villages or with in-home care packages.

She further explained (Touching Base, 2020b, p. 2):

My services today are geared to senior clients many of whom are living with a disability, often including a level of age related dementia. Some are in nursing homes or in retirement villages and some are still living at home with in home care packages where carers visit once or twice a day. Some have quite advanced dementia.

Additionally, the 2023 report tabled at the Touching Base AGM, also identified that within the 2022-2023 timeframe, 47 inquiries came from potential clients who were aged 65+ (Touching Base, 2023a, p. 2). While there is no available data about who made the initial inquiry for these 47 individuals, what is known is that from the total number of inquiries (n=654), 322 were by the potential client, 318 were by carers/support workers and a further 14 were made by a family member/friend (p. 3). This indicates that the desire to seek out sex worker services within the older population of people with disability in Australia is of continued importance, especially regarding the need for third-party assistance.

While these individual experiences bolster general awareness of the existence of older clients with disability, there remains a lack of refined understanding of this cohort due to the absence of formal targeted research in this area.

4.2.3 Patterns of involvement

There is less written about the frequency of appointments made by clients with disability than clients in general. This is largely because data collection from people with disability has most often emerged from qualitative in-depth interviews rather than quantitative surveys. However, such interviews often provide detailed rationale in conjunction with inquiries about the frequency of bookings. For example, one UK man with disability said in his interview (Sanders, 2007, p. 446):

I go for two hours rather than one because you can sit down and have a chat, you know, be a bit friendly, chatting about what's happening in the world and what's happening in your life. The girls I have chosen have been really good to me ... but it's also just the fact that you're having a chat like a bit of companionship because I'm a single lad and you know sometimes you just want to talk to a woman. You can talk to your friends but its different talking to a woman.

What is most commonly referenced, in both literature and media commentary, is that people with disability often forge ongoing working relationships with their sex worker/s of choice, and book regular appointments with them as frequently as their finances allow (Sanders, 2010). In her book 'Pros & Cons', an Australian former sex worker and agency owner shared in depth stories about two clients with disability (Dawn, 1998, pp. 102 – 112). The first was a 30-year-old man whose mother instigated the bookings, while the other, "a wheelchair bound disabled client" who lived semi-independently in a granny flat behind his family's home, only booked an appointment when he knew the family was not home. Both had regular appointments over a long period of time. More recently, a 32 year old Australian woman with cerebral palsy, spoke out about her once-a-month-appointments with her male sex worker (Henriques-Gomes, 2019b). This correlates with data produced from a survey with NSW based sex workers where nearly 48% of respondents indicated that they had monthly visits with their clients with disability (Wotton, 2016, p. 155). Other appointment schedules included; once every three months (39.58%), once a fortnight (27.08%) through to once a year (14.58%) as seen in Table 2. Notably, over 60% of participants replied that their clientele with disability booked 'only when they can afford to see me', reflecting the potential lack of financial support available for some individuals to access these services (as discussed in Chapter 3). The idea that clients become 'regulars' of a particular sex worker was also reflected in the previous research with NSW based sex workers, with one participant (female, 36 years, 18 years experience) stating:

“I used to see a physically and mentally handicapped guy for a year and a half, every week until he died” (Wotton, 2016, p. 197).

Answer Choices	Responses	Responses
Only when they can 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

Table 2: Frequency of client visits (N= 48) as cited in Wotton, 2016, p. 155

4.2.4 Motivations

It appears that many of the motivating factors for clients with disability mirror those identified in the general client population. For instance, Sanders (2007), in her interviews with male clients with disability, noted (2007, p. 446):

...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.

This sentiment was reflected by an Australian woman with Multiple Sclerosis, who shared in an interview that sex worker services have been “so beneficial in helping maintain my mood and self-esteem and maintaining my sense of wellbeing” (Henriques-Gomes, 2021, para.18).

Other reasons clients with disability seek out sex worker services 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; and having the opportunity to experience touch and sensuality (Kulick & Rydström, 2015; Liddiard, 2014; Sanders, 2007; Shakespeare, 2023; Touching Base, 2023b; Wotton & Isbister, 2010). As Sam, a South Australian man with a physical disability remarked: “accessing the services of a sex worker is a lifeline to intimacy” (Briggs, 2019). Similarly, Oliver Morton-Evans, a Sydney-based man who uses a wheelchair, emphasised that his bookings were for more than just seeking out physical

pleasure, stating that the intimacy his sex workers provided to him motivated him to continue dating to find a long-term partner: “... so when I see a sex worker it tends to make me feel a lot more able to then go out and find the kind of relationship I want” (Matthews, 2018, para.13).

Accounts of motivations beyond the immediate physicality of sexual pleasure are a common theme in the literature. For example, a 44 year old male participant from a UK study shared his experiences seeing sex workers in the three years since his workplace accident (Sanders, 2007, p. 446):

You know it's wonderful to feel flesh on flesh when you haven't felt it for years. And quite apart from anything else, I say the two women [sex workers] I seen most often I don't always have penetrative sex with and I say to them that in one sense that does not matter because I'm enjoying being with them. We have what the Irish would call the craic, and we talk and share things. Like this woman I saw yesterday, she likes the same music as me so we listen and appreciate that together. I don't want it to get any closer than that. But just to know that there's that sort of link as well – it's nice.

Due to social, educational and financial barriers, individuals with congenital disabilities – either physical and/or intellectual – are often denied opportunities to even begin to explore their sexuality. An example of this is Ash King, who was born with a severe spinal and muscular condition which was making him increasingly weak. By the age of 35 Ash reported feeling isolated and depressed. His story mirrors that of many others (Catling, 2021; Liddiard, 2014; Rose, 2023; Stathis, 2023), with him sharing in a media article that when he decided he did not want to ‘die a virgin’ he sought out the services of a sex worker (Ryan, 2013, para. 2:

“I couldn't make someone fall in love with me,” he says, “but I could at least learn about my sexual potential and more about women by paying a sex worker.”

Looking back at his first sexual encounter, King describes it as an “enlightenment.”)

The motivating factor of ‘losing one's virginity’ with a sex worker is not a new concept. In the UK documentary, *The Skin Horse* (Evans & Samson, 1983), a man with disability described how his experience with the sex worker - who he lost his virginity to - made him feel much more relaxed and increased his self-confidence. Research has also identified that individuals not only learn about ‘what sex is all about’ but utilise sex worker bookings to navigating how their disability may impact their ability to initiate and explore intimacy with another person. As a male participant in a UK study (Sanders, 2007, p. 447) stated:

I got disabled when I was about 19, so it took us a couple of years to get over the shock and trauma and then I was unemployed. So the normal basics for most teenagers, say under 25 is you get yourself a job or go to university and socialize. Well frankly, that didn't happen to me. ... I was 29 and a virgin and I had a compelling wish not to die a bloody virgin ... at least now I won't be bloody petrified with a girlfriend and think what do I do now. ... I mean I'll be able to negotiate that a bit more easily.

For those denied access to sexual education and support mechanisms, particularly those with an intellectual disability, their sexual desires may present in inappropriate ways and locations. This includes touching themselves or others in public settings or talking about explicit activities to staff or strangers in the street. Sex worker services have sometimes been utilised to provide a consensual sexual outlet while providing learning opportunities about what is, and is not, appropriate. An example of this came from an Australian sex worker (Dawn, 1998, p. 106):

Sam worked at a sheltered workshop. The workshop manager called a meeting to enlighten Dulcie [Sam's mother] about Sam's inappropriate sexual behaviour, which included touching any female breast within reach then proudly displaying the erection he gained as a result of the contact. Without the social skills to start or keep permanent relationships Sam was becoming more and more sexually frustrated.

Individuals with limited experience, due to low self-esteem or being self-conscious about their disability, have also sought out sex worker services to satiate their skin hunger and loneliness, or to practice what they had so seldomly experienced. One man summed this up by saying: "it's a bit like taking a driving test, it was alright on the theory but it's coming to the practical. You're out of practice" (Alan, 50, retired teacher, divorced), (Sanders, 2015, p. 193). This was also reflected in the experiences of Melanie, a 43 year old Western Australian woman, born with transverse myelitis. Having never experienced sensual non- medical touch she sought out the services of a male sex worker, telling a reporter (Todd, 2023, p. 5):

Now, I'm seeing Chayse regularly. He's opened me up to a world I'd been missing for so long, and I'm loving every minute...I want him to teach me everything, so I know what I do and don't like. My long-term goal is to find a partner. Before now, I hadn't had the confidence to put myself out there.

Additionally, a number of first-person accounts have mentioned that sex worker interactions not only created an increase in confidence and wellbeing but also reduced pain levels. For example, in the UK a 30 year old man with autism and cerebral palsy shared that

his time with his sex worker “boosted his moods and health, dramatically reducing his pain from previous surgeries “for up to four days”” (Catling, 2021). Another participant, quoted in ‘The Ultimate Guide to Sex and Disability’ book, stated: “the truth is that orgasm is most important to me if I am sore and wanting to sleep” (Kaufman et al., 2007, p. 137).

However, motivations for seeing sex workers can sometimes inadvertently elicit other emotions and feelings, highlighting the inequitable status of some individuals in society. For example, Liddiard observed in a blog post (2013, para. 12):

Many of the disabled men in my research paid for sex because as they suggested, there was little other alternative ... For most of them, paying for sex could be sexy, fun and exhilarating, but was also a source of great sadness which highlighted their social and sexual isolation and affirmed their feelings of undesirability.

Some individuals who have an acquired brain injury may also need assistance with re-learning appropriate social cues and respectful sexual interactions in an effort to alleviate what is deemed ‘behaviours of concern’ (Jones, 2013). The inclusion of sex worker involvement to support the psychosexual needs of their clients is starting to being utilised more frequently, at least within Australia (Wotton, 2023). There is, however, scant formal documentation available about this approach, especially about sex workers operating in conjunction with medical and allied health staff. One notable exception is the detailed article ‘Remediating serious inappropriate sexual behaviour in a male with severe acquired brain injury’ (Kelly & Simpson, 2011).

4.3 Gaps in the literature

The Sexual Politics of Disability (Shakespeare et al., 1996) is often regarded as a seminal work in the field of disability and sexual expression. Borne out of 42 interviews with people with disability, it explored themes such as body image identity, and aspirations regarding sexuality and relationships. Despite the authors’ anticipation that the book would be a precursor to further research of this nature, academic inquiries evolved more slowly than expected (Shakespeare & Richardson, 2018). This is particularly true regarding people with disability accessing sex worker services. Although scholarship in this area has expanded in the last three decades, there are some notable gaps that can be identified.

A recent scoping article, ‘Access to Sexual Rights for People Living with Disabilities: Assumptions, Evidence, and Policy Outcomes’ (Benoit et al., 2022) aimed to identify the breadth of academic inquiry into the area of people with disability accessing a range of sexual services. It precipitated a number of academic responses (Bahner et al., 2023; Crehan, 2023; Di Nucci, 2023; Frawley, 2023; Shakespeare, 2023) indicating that this is still an emerging field of study with vastly divergent views on how the sexual needs of people

with disability should be met, and by whom. Di Nucci had previously commented: “the issue of sexual satisfaction for disabled persons is an extremely serious one that academics and policy makers alike should not shy away from” (Di Nucci, 2020, p. 1). However, what is critically missing from Di Nucci’s reflection is the prioritisation of first-person narratives from people with disability. Indeed, one of the most striking findings in the Benoit et al. scoping paper was the limited number of studies that reported first-person accounts from people with disability about what they themselves wanted and needed in order to “realise their sexual capacities” (Benoit et al., 2022, p. 47).

Historically there has been a lack of first-person accounts within Australian research, though positive changes have occurred with an increase in co-designed studies emerging in the disability sector. For example, a recent inquiry into the range of sexuality supports available for someone after a spinal cord injury indicated that 51% (n=20) of health professionals who participated referred individuals to sex worker services (Bryant et al., 2022). However, this cohort of spinal cord injury patients have yet to be directly asked about their experiences, needs or gaps in the available sexuality support mechanisms.

This gap is also evident within the aged care sector, with a specific lack of research on who and how many individuals are paying for sexual services while living in residential aged care facilities, or how often third-party support is required. Most importantly, while policies and guidelines are emerging to help aged care and disability staff navigate their professional rights and responsibilities, the clients themselves have not had an opportunity to share their experiences, identify any barriers or recommend any changes to better support their needs. Popular TV shows (Insight, 2013) or social media (Klower, 2018) highlight issues of loneliness, or widowhood, as reasons why some older citizens access sex worker services, however formal academic inquiries into this cohort’s demographics, motivations and frequency in accessing such services are limited.

Gaps in the literature can be addressed by incorporating specific and targeted sampling strategies within general sexuality research as well as inquiries on and about clients of sex workers. For example, the most recent comparative analysis of clients between the UK and USA acknowledged that no questions were asked to clients in either country about if they identified as a person with disability (Sanders et al., 2020). An earlier UK study admitted that “despite no sampling strategy to include this group, of the 50 who were interviewed there were 6 men who described themselves as having a physical or sensory impairment” (Sanders, 2015, p. 186). Furthermore, the inclusion of sex work specific questions within relevant disability research is needed to address these current gaps in the literature. For example Campbell (2017), in her comprehensive literature review about ‘Disabilities and Sexual Expression’, identified two key areas of research needing further examination:

(1) the sexual expression and activity of people with disabilities, and (2) barriers and challenges to sexual expression that people with disabilities often experience. The inclusion of accessing sex worker services as one of many options to pursue such sexual expression would add to this growing body of knowledge regarding the intersection of sex work and the disability community.

People with disability are often portrayed as a homogeneous group, disregarding their position within society as equals, with inevitable gender diversity, sexualities and desires for sexual expression like everyone else. The limited amount of literature about people with disability accessing sex worker services has predominantly emerged from heteronormative inquiries, primarily focused on cis-men with disabilities as the clientele of cis-female sex workers (Sanders, 2007). Inquiries about women with disability who pay for sexual services is even more limited, with Bahner commenting “the difficulty in finding disabled women who are willing to share experiences on the topic mirrors societal norms around whom sex work is for” (Bahner, 2019b, p. 23). A study with Portuguese sex workers also noted the absence of female clients with disability, as well as recommending more training and information for both the sex worker and disability communities (Pinho et al., 2020). Liddiard also emphasised this skewed gender bias within inquiries about clients of sex workers, stating (2018, p. 131):

[T]he exclusion of disabled female sexuality and desire from commercial sex work contexts not only reinforces the highly gendered nature of such practices but.... that such practices *reproduce* a heteronormative sexuality which is predicated on a mode of sexuality that requires female passivity, meaning disabled women (and others) are unable to participate in this form of sexual access.

As highlighted earlier in this chapter, there is a notable absence in the literature concerning people who are gender diverse. This is true within research about clients in general, as well as people with disability who pay for sexual services.

In ‘Sexual Citizenship and Disability: Understanding Sexual Support in Policy, Practice and Theory’ Bahner commented that: “The relationship between federal and local policy thus becomes an added aspect in analysing sexual citizenship, and particularly the link between policy and practice” (2019b, p. 209). The current lack of data about people with disability who access sex worker services has real-life implications for both sex workers and people with disability. For example, in the Canadian sex worker law reform hearings, one press release stated: “there is no data to support [disabled clients hiring sex workers] as a reason for the legalization of prostitution” (Fritsch, 2016, p. 87). Within the Australian context, arguments about whether sexual services should be funded by the NDIS oscillate between whether it would be deemed ‘reasonable or necessary’ support (Foster et al.,

2016; Henriques-Gomes, 2020) and the importance in supporting an individual's choice and control over what would best meet their needs (Warr et al., 2017). As stated on the NDIS website, all policies and guidelines are developed within an evidence-based framework (NDIS, 2024a). It is therefore anticipated that empirical evidence generated by the PASA-Research study will fill an essential gap in the current knowledge about the demographics, motivations and experiences of people with disability who pay for sexual services in Australia.

4.4 Conclusion

While an expanding body of work has emerged focused on clients of sex workers, identifiable gaps in our knowledge and understanding about people with disability who pay for sex worker services remain. Specifically, there is a paucity of academic inquiries examining first person accounts which explores the lived experiences of this cohort in Australia. The PASA-research study aims to address a number of gaps in the current literature, including examining the experiences of gender and sexually diverse participants. It is anticipated that this research will also build upon previous findings and contribute to the limited but evolving body of work in this field. For example, one of the final recommendations in a UK study (Sanders, 2007) was for increased “research into moral, social, practical, financial, legal and emotional dynamics of buying a sexual service for people with impairments” (p. 453).

The following chapter will detail the methodological approach and methods employed in this research. It outlines the rationale behind the chosen research design as well as ethical and accessibility considerations. The data collection methods are provided along with the eligibility criteria and sampling and recruitment pathways. The chapter will also discuss the researcher's own positionality, including my unique insider/outsider perspective relative to participants' experiences of accessing paid sexual services in Australia. Additionally, the chapter will cover data analysis, rigour and validity of the data, and identify specific limitations of the research.

CHAPTER 5

Methodology

5.0 Introduction

This chapter outlines the methodological approach and methods used for this research. As outlined in Chapter 1, the title of the research, *Exploring the experiences of people with disability who access sex worker services, in Australia*, has been contracted to the acronym PASA-Research. An explanation of the acronym is given in Section 5.4 (Accessibility and Inclusion). The rationale for utilising the chosen research design and data collection methods is provided, as well as ethical and accessibility considerations. The eligibility criteria, sampling and recruitment pathways are documented, and the researcher's own positionality is discussed in relation to their unique insider/outsider perspective relative to the participants' experiences of accessing paid sexual services from sex workers in Australia. The final section of this chapter outlines how the data was analysed, as well as discussing limitations of this research.

5.1 Ethics

Ethical approval was sought from the Western Sydney University Human Research Ethics Committee (HREC), with HREC approval (# H14609) received on the 1st February 2022 (Appendix A).

Considerations regarding informed consent, privacy, confidentiality, conflict of interest, and issues associated with recruitment were informed by the principles outlined in the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council (NHMRC), 2023), the Australian Code for the Responsible Conduct of Research (National Health & Medical Research Council, 2018) and the Western Sydney University's Responsible Conduct of Research Policy (Western Sydney University, 2024).

It was anticipated that I would be working with participants who may identify as a person with "an intellectual disability, a cognitive impairment or a mental health illness" (National Health and Medical Research Council (NHMRC), 2023, p. 75). Due to this, additional guidance was drawn from the UNSW Disability Innovations Institute's (2020) 'Doing Research Inclusively: Guidelines for Co-Producing Research with People with Disability' (Strnadová et al., 2020), as well as publications from leading disabilities scholars, such as 'Ethical research involving people with intellectual disabilities' (Griffin & Balandin, 2004).

Six letters of in-principle support were provided within the ethics application, from Australian organisations and businesses who work within the disability sector. They were: Integrated disAbility Action, Consentability, Royal Rehab Sexuality Services, SECCA, Touching Base and the Australian Occupational Therapy Sexuality Special Interest Group. These letters indicated support for this research to occur and a willingness to assist in the recruitment phase of the PASA-Research study.

Due to the sensitive nature of the dataset, and the potential risks of participant identification, it was specified within the Ethics Application that the raw research data derived from this study would not be shared with future researchers. However, it was also stipulated that the researcher could use their discretion in making future decisions about sharing specifically requested information and data.

5.2 Research Design

The PASA-Research study utilised mixed methods to generate both quantitative and qualitative data. The definition of a mixed method research design is drawn from Johnson, Onwuegbuzie and Turner, (2007, p. 123) who identified that this type of research:

...combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration.

A collection of broad rationales for utilising mixed methodology was introduced by Greene, Caracelli, and Graham (1989) and is still drawn upon today. They identified five specific purposes:

- (a) *triangulation* (i.e., seeking convergence and corroboration of results from different methods studying the same phenomenon),
- (b) *complementarity* (i.e., seeking elaboration, enhancement, illustration, clarification of the results from one method with results from the other method),
- (c) *development* (i.e., using the results from one method to help inform the other method),
- (d) *initiation* (i.e., discovering paradoxes and contradictions that lead to a re-framing of the research question), and
- (e) *expansion* (i.e., seeking to expand the breadth and range of inquiry by using different methods for different inquiry components)

As cited in: Johnson et al., 2007, p. 115

These five rationales have since been expanded by other researchers, with Bryman (2006) creating a substantially more detailed and expansive classification system, providing additional aspects as to why mixed methodology may be chosen. They include the following (p. 106):

Completeness – refers to the notion that the researcher can bring together a more comprehensive account of the area of enquiry in which he or she is interested if both quantitative and qualitative research are employed.

Process – quantitative research provides an account of structures in social life but qualitative research provides sense of process.

Credibility – refers to suggestions that employing both approaches enhances the integrity of findings.

Context – refers to cases in which the combination is justified in terms of qualitative research providing contextual understanding coupled with either generalizable, externally valid findings or broad relationships among variables uncovered through a survey.

Illustration – refers to the use of qualitative data to illustrate quantitative findings, often referred to as putting “meat on the bones” of “dry” quantitative findings.

A mixed methodological approach was therefore chosen to fulfil the aims and objectives of this study and to answer the research questions in the fullest possible sense (Schoonenboom & Johnson, 2017; Wisdom & Creswell, 2013; Johnson & Onwuegbuzie, 2004). This method also created the best opportunity for the collection of rich, comprehensive data to reflect the diverse voices and experiences of participants (Creswell & Clark, 2017).

5.3 Data Collection methods

There were two components to data collection: (1) an anonymous survey (which generated descriptive, quantitative, and qualitative data), and (2) in-depth, semi-structured interviews (which produced qualitative data). An embedded design model was used with both data collection phases operating concurrently. This data collection structure is visually reflected via Figure 5:

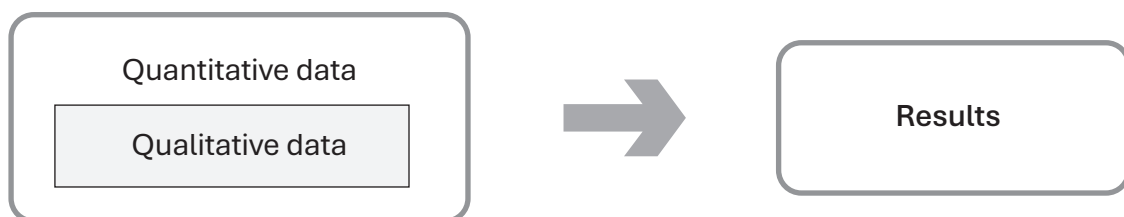


Figure 5: Embedded design model application to data collection for the PASA-Research Study

There were several reasons for this approach. Firstly, this was due to a limitation of time and resources. As this was a (mostly) unfunded PhD study, operating without the benefits of a research grant or a team of researchers, it was not feasible to conduct research utilising a sequential design model or to have multiple recruitment phases for each unique phase of the study. Additionally, this model was chosen to create accessible options for people with disability to be able to participate in the manner that best meets their needs. For example, an individual may be able to click fixed multiple-choice answers in the survey but providing long, detailed written answers in an open text box may not be feasible. In this instance an interview, where the participant can talk directly with the researcher, may provide a more accessible pathway to share broad and detailed experiences without the need for typing. Further information pertaining to the design of accessibility options within this research is provided in Section 5.4 Accessibility and Inclusion. Finally, interviews allowed participants the opportunity to raise issues or experiences that the survey may have failed to identify. A more detailed discussion of both data collection tools is provided in the following sections.

5.3.1 Online Survey

Many have critiqued the strengths and weaknesses of utilising online surveys (Best et al., 2001; Evans & Mathur, 2018; Mudavath & Narayan, 2019). However, as community use of social media and electronic multimedia platforms has increased, this has also contributed to a faster level of dissemination of information, with a higher uptake of participation and increased engagement occurring within some sections of the disability communities (Miller, 2017; Morris, 2013).

Traditional quantitative surveys adhere to a standard approach of aiming for a minimum number of respondents (i.e. 100) for inferential statistics to be meaningful. Qualitative surveys, however, focus more on generating rich insights from participants instead of creating statistical significance or saturation (Braun et al., 2020). The survey designed for the PASA-Research study was a mix of closed and open-ended questions, which elicited both quantitative and qualitative datasets.

The online survey method was chosen for its ability to allow participants to remain anonymous, while potentially reaching a broad cross-section of participants living across a wide geographical area throughout Australia. This is important, as not all people feel comfortable talking to a researcher about what is still often deemed a ‘taboo’ subject, while others may not want to ‘out’ themselves as a client or as someone who has engaged in sexual activities with sex workers of the same gender. This method also allows participants to take time to consider the questions and compose their answers, in a timeframe that suits them. To assist this process the survey data collection phase was opened for approximately 6 months, May – November 2022. To support people of low income and those without

access to electronic devices, a free Reply-Paid postage option was given so that individuals could access and return a paper copy of the survey. The printable version (Appendix 6) was available from the purpose-built webpage designed for this study: www.pasa-research.com.au. While the Reply-Paid option was not utilised, two participants completed a paper version of the survey and handed it directly to their sex worker to pass on to the researcher. These answers were then manually submitted into the Qualtrics system. Additionally, one participant opted to be asked each question verbally and have their answers directly recorded into the survey. This was done concurrently with their participation in an interview, as it was easier for the participant to engage with the research questions and the researcher verbally, due to their disability.

5.3.1.1 Survey design

The survey was created utilising a customised online survey program, Qualtrics, with development and design procedures drawn from a range of sources (Australian Bureau of Statistics, 2023a; Granello & Wheaton, 2004; Vehovar & Manfreda, 2017). Additionally the arrangement of the questions was formatted to mirror prior research, *Sex workers who provide services to clients with disability in New South Wales, Australia* (Wotton, 2016), so as to provide an opportunity to compare data generated between sex workers and clients with disability, such as services provided, types of disability of the client and location of service delivery. However, as discussed in Chapter 8, Section 8.2.5, the survey tool had several omissions that may have limited a more nuanced understanding of participants' circumstances and decision-making processes, highlighting areas for improvement in future research.

An online web-based survey was utilised as it permits “complex questionnaires to be administered more quickly, flexibly, and inexpensively than conventional survey methods” (Best et al., 2001, p. 131). Advantages include the ability of participants to complete it in their own time, increased data capture capabilities regarding response rates, and distribution and access via a wide variety of electronic devices (Evans & Mathur, 2018; Granello & Wheaton, 2004; Lefever et al., 2007; Vehovar & Manfreda, 2017). Additionally, the survey was able to be disseminated broadly, being accessible throughout Australia, while also affording the participants a high level of anonymity and confidentiality. The survey was designed to stay open as long as the browser remained open. By not ‘timing out’ participants were able to complete the survey over a series of sessions, working to their level of alertness, comprehension, daily life routines and activities. This also allowed people who use augmentative and alternative communication devices, document readers or need additional support to read, comprehend and respond to questions, to participate in a meaningful way, with no time constraints being placed upon them by the researcher. Having the survey open online for 6 months also provided time for participants to contemplate both the questions and their answers. This also took into consideration

individuals who needed third party support to complete the survey, understanding that they may only get limited hours with their preferred support workers, making participation in the survey a protracted activity.

A total of 374 surveys were submitted. After discarding ineligible entries there were 108 viable survey submissions, from which the findings in this chapter have been drawn. An incongruent surge in survey completions occurred within the last 48 hours of the recruitment phase, which was tracked back to multiple ineligible Twitter users sharing the survey link outside of Australia. While social media platforms certainly have the capacity to reach a larger eligible audience, the downside to this recruitment method is that it's replete with bots, individuals who want to negatively skew the data or those who participate solely to win a gift voucher. This phenomenon was recently depicted as "malicious actors (who) can exploit the monetary incentives and anonymity of online surveys, threatening the integrity of survey data" (Goodrich et al., 2023, p. 762) For the PASA-Research survey, all ineligible surveys were easy to detect due to duplicate responses and non-sensical answers that reflected an absence of knowledge pertaining to Australian geographical locations.

Questions were grouped into five main segments classified under **who**, **what**, **where**, **how** and **why**; as well as a final section where **personal stories, opinions and suggestions** could be shared. Both closed and open-ended questions were utilised with most tick-box questions offering an 'other' option for participants to write their own response if different to the choices provided.

The survey was designed with a variety of answer formats to capture attitudes, opinions and experiences in the participants' own words rather than solely relying on pre-determined response options and statistical analysis (Braun et al., 2020). This approach included fixed answer click-box options in conjunction with a broad range of open-ended questions with text-boxes, allowing participants to elaborate on their answers and provide additional comments and information relevant to the questions. This method ensured a richer and more nuanced understanding of the participants' perspectives.

Eligibility was determined at the start with two specific questions: 'do you identify as a person with disability?' and 'have you paid for sexual services from a sex worker, in Australia?' Eligible participants were then asked to nominate their current age range, needing to be at least 18 years old to proceed. Informed consent was given by the act of submitting the completed survey at the end. As the survey was anonymous, consent was not able to be retracted after submission.

Participants who submitted their survey had the opportunity to enter a draw to win one of four \$100 gift cards and were directed to a separate survey page which collected their

name, phone number and email address. For those using a paper copy of the survey, a paper version of this entry form was provided. Participants' details were numbered according to submission date, and at the conclusion of the data collection phase, a random number generator was utilised to select four winners. Additionally, after completing the survey, participants were asked if they wished to participate in a separate interview with the researcher (if eligible). The interview method will be discussed next.

5.3.2 In-depth semi-structured interviews

While an online survey can elicit a broad range of quantitative and qualitative data (Braun et al., 2020), interview data can provide a greater opportunity for thick description (Geertz, 2008) which allows for a deeper level of analysis than online survey data alone could provide. It was for this reason that 27 semi-structured, in-depth interviews were conducted with participants, all of whom self-selected to do so.

A semi-structured interview guide was developed with the capacity to adjust the direction of the questions to include exploration of specific themes which may emerge from the respondents' survey answers. This modality of talking permits a reciprocity of exchange between the participant and the interviewer and allowed for a sensitive but detailed exploration of each participant's experiences. This flexibility within the semi-structured interview was recognised by McIntosh and Morse, stating: "it makes it unique among interview methods for the degree of relevancy it provides the topic while remaining responsive to the participant" (McIntosh & Morse, 2015, p. 1). Additionally, this facilitates access to the chronology of peoples' experiences with the capacity to examine potential levels of development, growth and learning from the participant's unique perspective. Following the lead of the participants within interviews can also highlight new lines of inquiry that may have been overlooked or omitted within the survey data.

5.3.2.1 Interview design

The opportunity to participate in an interview was launched at the same time as the survey opened, in May 2022, and details were included in the Participant Information Sheet. At completion of the survey, participants were asked if they would like to also do an interview. Those responding 'yes' were directed to a new page to provide their name, email address, phone number and preferred time periods in which they would like to be contacted. They were also asked which state or territory they were in, so the preferred contact times aligned. This is due to Australia having up to four different time zones, depending on location and if daylight savings had begun. Eligibility was the same as for the survey – identifying as a person with disability and previously paying for sex worker services, in Australia. However individuals were deemed ineligible to participate in an interview if they were a former or current client of the researcher. The rationale for this determinant is outlined in Section 5.7 (Ethical Considerations).

Initially a group of 10-20 self-nominated individuals was sought for in-depth interviews. It was not a priority to achieve “saturation of knowledge” (Bertaux, 1981, p. 37). Instead, it was anticipated that the sample size would produce enough data to sufficiently describe the phenomenon and address the research questions. While social media discussions indicated a high level of enthusiasm for people with disability to have their voices heard, it was unknown if this would translate into a willingness of individuals to be interviewed within a formal academic arena. However, at the completion of the recruitment phase 27 interviews were conducted, and due to the overwhelming number of applications, the interview phase was closed 2 months early.

A semi-structured interview guide was developed and submitted as a part of the formal Ethics application. It included a checklist for before the interview, at the start of the interview, and at the completion of the interview, as well as a section outlining the general question structure and flow for each interview. Complementing the researcher’s extensive experience in working with people with disability, additional resources, such as ‘Interviewing People with Intellectual Disabilities’ (Perry, 2004) were drawn upon to ensure the researcher was well versed in providing a supportive and safe environment for each person. This included a focus on providing information and questions in the most accessible manner as well as maintaining participant privacy, confidentiality, and anonymity.

The importance of choosing a pseudonym was explained to each participant and they were then given the opportunity to choose their own. These decisions were cross-checked with the real names of each participant at the end of the interview phase to ensure there were no real-name inclusions. Only one person’s pseudonym was changed because they used it in a media article. Additionally, each participant had full control over how their disability/s would be described to ensure they could not be identified. This privacy consideration was also applied to their location, with some participants comfortable with their local council area being used and others choosing to be placed only within a larger geographical region, such as ‘metropolitan Sydney’ or ‘regional NSW’.

Interviews, conducted between May and October 2022, were offered using a range of mediums, dependent upon the participant’s access needs, geographical location and preference. There were nine (9) interviews via zoom, six (6) by phone, and eleven (11) conducted in-person. Six (6) in-person interviews occurred in hired rooms at public libraries, community centres and university meeting rooms booked by the researcher with the other five (5) conducted in the participants’ own home. One interview also happened via text message.

Two people (1 male, 1 female) were driven to face-to-face interviews by support workers who waited in a nearby area (but out of the room) during the interview to provide maximum privacy. Conducting the interview phase during COVID restricted opportunities to conduct more in-person interviews, however lockdowns had introduced more people to the functionality of Zoom, leading many participants to feel comfortable utilising this medium. Zoom's messaging function was of great assistance to be able to clarify particular words or sentences that were unclear when the interviewee spoke.

The length of each interview ranged between 35 minutes and 2 hours. The single text message interview was conducted slowly over 6 hours and 18 minutes. Excluding the latter, on average the interviews took 1.5 hours to complete.

All interview participants were given a Consent Form (Appendix H) and a Withdrawal of Consent Form (Appendix I) ahead of the interview date. Consent was provided in writing for most participants, with consent also recorded at the start of each interview, either verbally or via the person's communication device. All interviews were recorded via a portable audio recorder as well as on the PASA-Research iPhone to provide an additional backup audio recording. Transcriptions for all interviews were initially done via the online transcription service Otter.ai™, with supplementary transcription and edits done by the researcher. To ensure that all participants were in control of their narrative, each person's transcribed interview was sent back to them to provide an opportunity to redact or amend their contribution. When the participant had reviewed/edited their transcription the final version, along with their informed consent, was sent back to the researcher to be used in the data analysis and findings. This allowed each person time to reflect on what they had shared 'in the moment' and gave them full control over how they wished to contribute to the research. While this took additional time and energy, these additional interactions with participants allowed for ongoing discourse around the topic, with 13 interviewees providing additional updates to their lives since their interview. These updates, with participants' consent, are incorporated within the overall analysis and findings of this PASA-Research.

All participants were given a \$100 gift voucher to compensate their time, and in recognition of sharing their lived experiences. This was provided via an online gift voucher service (www.prezzee.com.au), or by a physical gift voucher nominated by the participant in cases where individuals may not have access to the internet or online shopping services.

5.4 Accessibility and Inclusion

The PASA-Research study adhered to all legal requirements outlined in the National Statement on Ethical Conduct in Human Research including identifying that participation of the study would include *People with a cognitive impairment, intellectual disability or mental*

illness (National Health and Medical Research Council (NHMRC), 2023, p. 75). The ethics process only examines (1) if researchers are able to identify who may be a part of this cohort, and (2) how they will be able to provide informed consent. While both steps are critically important, there is a profound difference between ‘available for all who are eligible’ and being ‘accessible for all who are eligible’. This section outlines the additional steps, actions and considerations that were taken to create a more accessible pathway for individuals to participate in this study.

A purpose-built website page: www.pasa-research.com.au was developed to share all information, updates, publications, and findings from this research project. More research projects are starting to incorporate this into their research framework, including the Beyond the Gaze UK research project (Sanders et al., 2019) and the Supporting Autistic Adults’ Intimate Lives project (SAAIL, 2024). Collating all information in one dedicated location allowed potential participants to access and assess information in their own time. It also provides accountability and an ongoing commitment to share the findings of the research to the participants and the broader disability and sex worker communities, with consistent communication pathways to contact the researcher in the future. The font type utilised in the webpage was chosen to support engagement with people who are dyslexic, and the font size was enlarged to assist with people who are vision impaired.

As the research name was long, a shortened acronym was developed to refer to the study. The explanation for the name ‘PASA-Research’ was included on the webpage with a text description underneath (*Figure 6*):

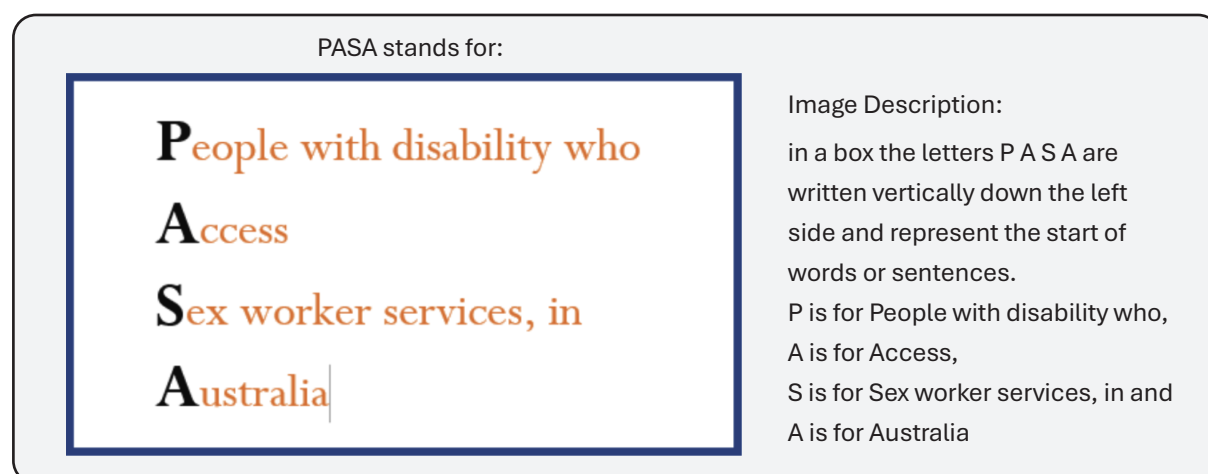


Figure 6: PASA-Research explanation provided on www.pasa-research.com.au

A logo to visually represent the research was also developed with the researcher working in conjunction with a graphic designer (*Figure 7*):



Figure 7: PASA-Research logo design

The rainbow colours were chosen to welcome participants of all sexualities and genders, and a range of disabilities were represented in the figures used. One is holding a red umbrella at the top, which is the international symbol for sex worker rights (Archer & Schreiber, 2024). This was used to visually represent the intersection of people with disability accessing sex workers. The logo was placed at the top of the webpage with a text description provided underneath. It was also used in all print and digital advertisements associated with this research (Appendix B and C), along with the consent form (Appendix 8) and withdrawal of consent form (Appendix 9) to provide consistent identification for participants wishing to engage with this research.

The Council for Intellectual Disability (CID) (2024) was employed to create an Easy Read version (Appendix E) of the Participant Information Sheet (Appendix D), as well as Plain English versions of the survey questions (Appendix G). The latter was utilised in two ways. The Plain English questions were provided in one distinct document and used as the downloadable version of the survey direct from the website. In addition, pop up boxes with Plain English versions of nearly every question were incorporated into the Qualtrics survey platform. This involved working with the Western Sydney University's Qualtrics specialist to create a unique question-mark “ ? ” symbol to sit in the top right-hand corner of each question. By clicking on this question mark, a pop-up box would appear with the Plain English version of the question. This was based on feedback from the CID that a separate Guidance Document, with the plain English questions listed, would not provide equitable access for participants who may need additional support in understanding each question. Additionally, the arrows used to navigate forward and back in the online survey were also changed to support increased understanding and awareness for participants. This included allocating a colour for the arrows, increasing their size, and including the words ‘next’ and ‘back’ inside each of them.

The consultation process with the CID also included paying one of their peers – a person with intellectual disability – to do a test run of the survey questions. Feedback from this person highlighted the difficulties of trying to be accessible, without creating barriers for others. For example, their feedback included that there were too many multiple-choice answers, yet for people using Augmentative and Alternative Communication (AAC) devices (such as a head-pointer), clicking one or multiple-choice answer boxes may support their participation more than having to provide all answers in open text boxes. Additionally, it was acknowledged that having so many choices could be overwhelming for some individuals with an intellectual disability, and they suggested the diverse range of sexual services could be condensed into a smaller list to provide just a few general options. The decision not to incorporate these suggestions in the final version was twofold. Firstly, this survey aimed to reflect previous data generated in Australia about the varied sexual services enjoyed by clients, including clients with disability. Secondly, it acknowledged that the sexual expression of people with disability should not be distilled into a handful of palatable and more ‘socially acceptable’ sexual acts, but to provide the prompts – and therefore the permission – to share whatever range of sexual experiences they felt comfortable with.

The PASA-Research survey was open for six months and was designed to accommodate the varying needs of potential participants. As long as the tab remained open on a person’s electronic device the survey was programmed not to time out. This feature allowed participants to answer questions at their own pace, even if that meant responding to only one or two questions per day. This consideration was particularly important for those who may need extended periods of time to type responses, needed assistance from third party support, might tire easily, or needed time to reflect on their prior experiences before responding.

As previously mentioned, participants who completed the survey were able to enter a prize draw to win one of four \$100 e-Gift vouchers and every person interviewed received \$100. This reflects current best practice within the disability community. For example, the Australian Federation of Disability Organisations’ (AFDO), advertised the following remuneration amounts for participants in a focus group (2020, para. 5):

Remuneration will be \$60.00 per hour (inc GST) deposited onto a debit card (EFTPOS card), which will be posted after delivery of services. The sessions are anticipated to run for 90 minutes with a short break included.

The Council for Intellectual Disability also communicated that they offer between \$100-150 for 90-minute focus group participation. This reflects the Australian National Health and Medical Research Council (NHMRC) Guidelines: *Payment of participants in research: information for researchers, HRECs and other ethics review bodies*, which states: “levels of

payment appropriately align with the objectives of providing the payment (e.g. to recognise contribution to the research...)” (National Health & Medical Research Council, 2019, p. 5). This is also in alignment with People with Disability Australia’s support for ethical research protocols that “properly and respectfully remunerates people with disability and their representative organisations for research participation in any form” (People with Disability Australia, 2023, para. 8).

Additionally, the option to provide physical gift vouchers nominated by the individuals, instead of electronic eGift cards, was made available. This alleviated a common barrier to participation often identified by people with disability, where individuals may not have access to the internet or online shopping services. This is especially true for people with intellectual disability where physical vouchers or gift cards are often the preferred method of payment.

5.5 Participants

The inclusion criteria set out for eligible participation for both the survey and an interview included: individuals who identify as a person with disability, have previously accessed in-person sex work services within Australia, are 18 years + and able to provide informed consent. Additionally, to maintain professional boundaries and adhere to ethical research practices (outlined further in Section 5.7 Ethical Considerations), former or current clients of the researcher (i.e. had previously paid for sexual services from her) were ineligible to partake in an interview.

The definition of ‘disability’ was drawn from the Australian Disability Discrimination Act 1992 (Australian Government, 2023e) which is very broad and inclusive. As the Australian Human Rights Commission outlines, this includes “people who have temporary and permanent disabilities; physical, intellectual, sensory, neurological, learning and psychosocial disabilities, diseases or illnesses, physical disfigurement, medical conditions, and work-related injuries” (Australian Human Rights Commission, 2014, p. 1). As shared in the Participant Information Sheet, a disability could be periodic, permanent, progressive, or dynamic – where symptoms vary from day to day. Some people may also identify having more than one disability. It was explicitly mentioned that participation was welcome from those who live and work independently, people supported by family, those who may rely on Disability, NDIS, Aged Care, Workers’ Compensation or Insurance payout support systems, and people who are of retirement age. Regardless of cause or diagnosis, anyone who identified as a person with disability was deemed eligible to participate.

Consent for the survey was obtained when participants actively submitted their completed survey and, due to the anonymous nature of participation, could not be withdrawn after

that time. For interview participants, consent was recorded in various ways based on each participant's preferred communication method including written, verbal, or conveyed via the use of an augmentative and alternative communication (AAC) system. Participants had the right to withdraw consent at any time up to the point that their data had undergone analysis. Beyond this point, they were informed that individual quotes drawn from their interview would not be used within the findings, but their experiences would still inform analysis and interpretation.

5.6 Recruitment

Participants were recruited using a purposive, snowball sampling approach (Rahi, 2017), with recruitment documentation being distributed via preferred communication channels of disability support organisations, sex worker networks, online disability communities, and social media. A QR code linking to the PASA-Research website: www.pasa-research.com.au was included in all recruitment documentation and correspondence. The social media version of the recruitment advertisement is displayed in Figure 8:



Figure 8: Social media recruitment advertisement for the PASA-Research study

The researcher also attended three disability expos – the Brisbane Disability Expo, the Sydney Disability Expo, and the Sunshine Coast Regional Disability Expo – where the research was discussed with stall holders and advertisement fliers were distributed. At the Sunshine Coast Expo a large poster promoting the PASA-Research was displayed at the entrance and a paid advertisement was placed in the expo booklet given to all attendees. While the plan was to attend disability expos in each state and territory COVID restrictions, lockdowns and event rescheduling prevented this. Additional advertising included a

paid banner ad in LINK magazine's online weekly e-newsletter (LINK, 2024), Australia's leading national cross-disability publication. During the recruitment phase the researcher also appeared as a guest speaker on the 'Have The Nerve' podcast (Spinal Cord Injury Australia, 2022).

Survey participants self-screened for eligibility based on the information supplied in the Participant Information Sheet (PIS) and the initial screening questions at the start of the survey. Recruitment for the interviews was conducted simultaneously through all recruitment materials. Potential participants were informed about the interview opportunity via the PIS and were reminded at the start of the survey. After submitting their survey responses, interested respondents were directed to a separate page to provide their contact details. These details were cross-checked to ensure they did not include former or current clients of the researcher. Eligible individuals were then contacted via their nominated communication pathway to set up an interview. Nine individuals were deemed ineligible due to being former or current clients and were notified by email and given the opportunity to submit any additional information they might have omitted in their anonymous survey.

During the recruitment phase a Twitter account (now known as X) was created to enhance the dissemination of the recruitment advertisement. This decision was influenced by answers given in the surveys and early interviewees who indicated that Twitter was the key platform used for locating and contacting sex workers. Additionally, a blind friend noted Twitter was more accessible for sharing information than platforms such as Facebook. Furthermore, several sex worker colleagues mentioned they had shared the information via their own Twitter pages and recommended creating a specific Twitter account for this research study.

5.7 Researcher positionality

I approached this study from a unique position, identifying most closely with the specific (insider) outsider position outlined by Nakata (2015). While my positionality remains as an outsider because I do not identify as a person with disability who has accessed sex worker services, I do have detailed insider knowledge of how the sex industry operates. Within the scope of the commercial transaction between the purchaser of services (the client) and the provider of services (the sex worker), I have extensive experience as a sex worker, especially one who provides services to people with disability. This allows for an acute understanding of the booking procedure, terminology used, payment methods and activities experienced within sex worker appointments.

A range of concerns, anxieties and hesitations has been identified within ethics committees and researchers regarding the complex participant – researcher dynamic when the

participants are clients of sex workers (Huysamen, 2016; Huysamen & Sanders, 2021). However, due to my sex worker experience, I am comfortable interacting with people who identify as clients and do not deem them ‘dangerous’ or ‘risky’ individuals. Furthermore, disclosing to participants that I am a sex worker allayed participants’ fears that they may accidentally offend or upset me, as the researcher, by talking about intimate sexual interactions. Indeed, due to my positionality I was able to understand nuanced references to advertising platforms, client discussion boards, terminology and booking procedures that are unique to the Australian sex industry (Coghlan, 2007; Unluer, 2012). This insider position has been utilised previously in Australian research on clients, as highlighted by Perkins; “A sex worker was hired to receive the calls, since she would be best equipped to sieve out client fantasies and extrapolate factual information” (Perkins, 1999, p. 38).

The skill set of a sex worker includes the ability to create and maintain good boundaries, to be able to immediately create a safe and welcoming environment with someone they have just met, and to constantly assess and manage the emotions of the person throughout their interactions. This includes monitoring and managing levels of hesitancy, discomfort, agitation, or anxiety in the person. I was able to draw upon these skills during the interview component of this research to provide a safe and supportive environment for each participant. Conducting the interview with participants openly knowing my status as a sex worker facilitated a high level of trust and openness within the participant – researcher dynamic. This level of trust and openness was enhanced by the fact that participants knew the aims and objectives of the research. As Kim and Jeffreys previously identified: “when research is undertaken by a community member, the tensions that exist between the researcher and participants are alleviated by the united aims of both researcher and participants” (Kim & Jeffreys, 2013, p. 69).

In alignment with Van Heugten, who stated that “values, beliefs and personal interests should not only be declared but challenged on an ongoing basis” (Van Heugten, 2004, p. 208), I remained reflexive throughout the interview phase. I actively encouraged interview participants to be open and honest with their accounts, regardless of how their experiences and beliefs may reflect upon sex workers, assuring them that I would remain objective and would not take anything personally. I was also attentive to the possibility that participants may just ‘want to please’ or feel obliged to only talk about ‘the nice things’. To counter this, I specifically told each participant that I welcomed stories and discussions that encompassed *the good, the bad and the ugly*, giving explicit permission that it was ok to not only talk about good experiences but also negative or difficult situations, including those that may involve sex workers, support workers, parents, disability organisations or government agencies, such as the NDIS.

It was with great sadness that I found out one of my most elderly clients had died, only one day before I was going to see him for the first time since borders had re-opened after COVID lockdowns between NSW and Queensland. He was excited about meeting me again and having me assist him in posting his completed survey back. Sex workers, including myself, operate under pseudonyms which allowed me to advertise the survey to clients under my working name, without exerting undue pressure or coercion. This gentleman specifically asked me to print out and send him a copy as he had no access to the internet. He was also not able to rely on his adult son for help as he was openly contentious towards his father's decision to pay for sex worker services. Having known at least part of his story, it is a real shame that his experiences and thoughts will never be shared.

Finally, as an 'out' sex worker, I have been able to engage in this research without the added layers of stigma and discrimination that some sex industry researchers face, whether as outsiders or as researchers who are uncomfortable disclosing their lived experience (Bowen & Bungay, 2016; Hammond & Kingston, 2014; Orbay & Küçükkaraca, 2023). This openness aligns with the principles of sexual citizenship, by enhancing *access* -ensuring that people with disability have the opportunity to share their experiences and perspectives in an accessible research context that respects and values their voices. It also promotes *control* by allowing participants to guide the discussions and contribute based on their own experiences. Finally, it upholds *choice* by providing participants with the freedom and platform to openly discuss their sexual experiences accessing sex worker services, in their preferred way and manner, thus supporting a more inclusive and respectful dialogue about their sexual citizenship.

5.8 Ethical considerations

Working with a marginalised community who are talking about the private and oftentimes taboo topic of paid sexual services, meant additional considerations were employed to ensure ethical standards of 'do no harm' were maintained. In conjunction with standard data protection systems, and the anonymisation of all identifiable features of the interviewees, the following additional procedures were followed.

The contact details of survey participants going into the gift card draw, as well as the details of self-nominated potential interviewees, were captured using Qualtrics™. Only the researcher had access to this private information, with doctoral supervisors only given access to the survey results. This security measure was relayed to interviewees to provide additional peace of mind that their privacy and confidentiality would be safeguarded throughout this study. Audio files and transcription data were stored on an external hard drive in the researcher's lockable home office instead of using cloud or filesharing servers provided by the university. This alleviated the potential for the data to be seized in the

unlikely event of these data storage systems being compromised. A specific interview safety procedure was developed for when interviews were conducted in a participants' home (Appendix 10), however only the primary supervisor was given the personal details of the interviewee.

Additionally, as individuals could be identified by their voice, the audio recordings of interviews were deleted from all recording devices as soon as consent was provided for the final approved transcript. Subsequently, the transcripts and audio files were also deleted from my account with the online transcription service Otter™. Providing individuals an additional opportunity to review their interview transcripts gave participants both the confidence and reassurance that they were in full control of their personal narrative, while ensuring that informed consent was given freely and without coercion. This in turn increases the validity of the data collected.

In reflecting upon the researcher's (insider) outsider position, it was decided that this research would exclude current or former clients of the researcher as eligible interview participants. The foundational requirement when conducting research is to minimise all foreseeable harm to the participants, and to produce ethical research that has not been generated via undue coercion or manipulation. This can occur if participants feel (overt or covert) pressure to adapt their answers to please the researcher, or if they feel that future services may be rescinded if they speak openly and honestly (in a way that may be perceived negatively), or they are made to feel unsafe or judged. It was important for this research to allow people with disability to share their experiences in a safe, supportive, and nonjudgemental environment, therefore, this ineligibility criteria helped maintain the validity and rigour of the research while minimising potential conflicts of interest created by interviewing people the researcher had already shared a professional connection with.

However, the availability of the online survey instrument allowed this cohort of potential participants to still contribute in a meaningful and anonymous manner. Additionally, all ineligible participants received an email explaining why an interview could not occur, but were given an additional opportunity to send back supplementary information they may have omitted from their survey answers, or that they may have shared in detail during an interview. This opportunity was not taken up by the nine former or current clients who indicated their enthusiasm to do an interview, although it was important to acknowledge their willingness to do so in return correspondence.

While the formal requirement of the PhD is to submit this thesis, my personal ethical framework includes ensuring that I relay back to the participants, and the wider disability and sex worker communities, the findings of this research in accessible formats. After

submission I will be developing an accessible, Plain English summary of the findings and uploading it onto the PASA-Research website, as well as sharing via the communication pathways previously utilised during the recruitment phase. The PASA-Research web page will remain available online into the foreseeable future.

5.9 Data Analysis

The PASA-Research study generated both quantitative and qualitative data sets through the survey and interviews. Statistical analysis of the quantitative data was generated through Qualtrics and used to summarise trends within the survey responses, while thematic analysis was employed for the open-ended survey questions and interview transcripts.

The 27 interviews were transcribed verbatim using the Otter™ transcribing program. This took a substantial amount of time due to the limitations of this software's accuracy, providing inaccurate or incomplete transcriptions from many of the audio recordings. While this could be expected for some interviews, where the participant's speech and articulation were affected by their disability, even the researcher's own syntax was often transcribed inaccurately. Despite these challenges, this protracted process allowed extensive opportunity to become familiar with the data and for the creation of unique participant summary documents to identify the most pertinent issues discussed within each interview.

Completed transcriptions were sent back to participants for review, giving them the opportunity to edit or redact any information. This process ensured that participants had full control over what they wished to contribute to the research and anything that, after further consideration, they did not want to 'put on record'. It also allowed people to speak openly knowing they did not have to monitor their conversation or responses during the interview. Final approved transcriptions were received from all participants before being included in the analysis process.

A reflexive thematic analysis was applied to both the interview data and the open-ended questions from the survey. Braun and Clarke describe thematic analysis as "a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data" (Braun & Clarke, 2006, p. 78). Guided by Braun and Clarke's 6-phase method of thematic analysis (ibid, p. 87), an inductive approach to coding was employed (Terry et al., 2017). Inductive coding methods are commonly used in exploratory studies when there is a paucity of existing research available on the topic, with this method allowing for the emergence of themes formulated directly from the data, alongside the identification of unique patterns or topics not previously anticipated. Considering the researcher's (insider) outsider positionality, a reflexive approach to the thematic analysis (Braun & Clarke, 2019)

was decided to be the most suitable method, with Byrne summarising this rationale by stating (Byrne, 2022, p. 1393):

(it) highlights the researcher's active role in knowledge production ... Codes are understood to represent the researcher's interpretations of patterns of meaning across the dataset. Reflexive thematic analysis is considered a reflection of the researcher's interpretive analysis of the data conducted at the intersection of: (1) the dataset; (2) the theoretical assumptions of the analysis, and; (3) the analytical skills/resources of the researcher.

For the thematic analysis I opted for a manual approach by printing the survey responses and using highlighters to categorise themes. This hands-on method allowed for a deep, reflective engagement with the data. Various colours and symbols were used to represent unique themes and patterns of behaviour, supporting an inductive approach by allowing themes to emerge from the reflexive relationship between the researcher and the participants' responses. This process involved multiple reviews of the highlighted responses to refine and adjust the themes. Engaging with the data in this physical format enabled the researcher to maintain a reflexive stance, continually questioning and re-evaluating the themes as they developed, ensuring they accurately reflected participants' experiences. To supplement this, the interview summaries were instrumental in identifying emerging issues highlighted by participants and provided rich insights into their experiences. They also allowed constant reengagement with the interview transcripts, facilitating a deeper and more nuanced understanding of the data. By revisiting the summaries and interviews the researcher was able to continually refine the analysis and ensure the themes developed were well-grounded in the participants' own words and experiences.

5.10 Limitations

No research project is ever designed and executed perfectly, and the PASA-Research study was no exception. Accordingly, several limitations regarding recruitment, funding, survey content and access have been identified.

The researcher commenced study in March 2020 when COVID-19 had just been declared a global pandemic and the first of many lockdowns had been enacted. While the recruitment phase occurred in 2022, COVID had forced the scheduling of many disability and aged care expos to be delayed or cancelled. This impeded capacity to schedule attendance at many events throughout Australia, which in turn led to a decrease in face- to-face interactions and presentations about the research process. At the same time, the understaffed and overworked disability and aged care sectors had their limited resources directed to immediate front line service provision, with less time and energy allocated to other non-essential services. Both factors played a role in limiting the scope of recruiting participants

for this project, especially in some geographical locations. Additionally, it must be recognised that while there was an overwhelming amount of support both in-person and online, there was also the potential for third party supports (such as parents and support workers), and disability organisations to act as gatekeepers, and deny individuals the right to know about this study or the ability to freely participate. This is especially true for individuals with more complex support and communication needs who are reliant on 24 hr care from third party support systems.

As an exploratory study it was never intended to be representative of all demographics within the disability population. However, Australia does have an aging population, with many individuals living in very isolated circumstances, with no access to the internet or capacity to print out and send the survey back. While the disability sector as a whole was the focus of the research, no targeted recruitment campaign was undertaken for specific participant groups included within this broad community, such as Aboriginal and Torres Strait Islander people or those within culturally and linguistically diverse communities. Australia is a multicultural society with the 2021 census stating that the “top 5 languages used at home, other than English, were Mandarin (2.7 per cent), Arabic (1.4 per cent), Vietnamese (1.3 per cent), Cantonese (1.2 per cent) and Punjabi (0.9 per cent)” (Australian Bureau of Statistics, 2022a). However, this research was only able to be conducted in English due to lack of time or funds to translate the survey. This is a real access barrier that needs to be acknowledged as a limitation in creating equitable access for participants throughout Australia. If research of this nature were to be conducted again, with the capacities of a research grant, it is recommended that these additional considerations should be factored in.

The survey tool itself had several omissions that may have provided a more nuanced understanding of participants’ circumstances and decision-making processes. For example, it did not address participants’ relationship or marital status, educational level, or whether they had any financial dependents. Information on participants’ annual income, sources of income, and employment status was also not included. These exclusions were not due to a lack of relevance but rather a conscious decision to minimise participant burden, as the survey was already extensive. and its primary focus was on participants’ experiences accessing sex worker services and their motivations for doing so. Notably though, the survey did not ask individuals if they were participants of the NDIS, which, in hindsight, was the most critical oversight. Furthermore, the survey did not ask whether participants required third-party assistance to complete it or if they used augmentative and alternative communication (AAC) methods. These limitations, as discussed in Chapter 8, Section 8.2.5 Survey Tool Limitations, highlight areas for potential refinement in future research.

While Section 5.7 Researcher Positionality outlined several benefits of having an ‘out’ sex worker conduct the PASA-research study, it is also important to acknowledge potential limitations. My insider status within the sex industry may have inadvertently influenced survey participant responses, as some may have adjusted their responses—consciously or unconsciously—to align with what they perceived as the researcher’s perspective or expectations. Additionally, as outlined above, omitting certain questions may have limited a more nuanced understanding of participants’ circumstances and the broader socio-economic factors influencing their access to sex worker services. Furthermore, given the stigma surrounding both sex work and disability, some participants may have been hesitant to disclose certain experiences, particularly negative interactions, due to concerns about how they might be interpreted by a researcher who is also a sex worker. These potential limitations highlight the complexities of researcher positionality and the need for ongoing reflexivity in research design and analysis.

Finally, the researcher acknowledges their own social media limitations. While many researchers are proficient in utilising Twitter (now known as X), the researcher’s lack of knowledge regarding the use of different social media platforms such as Instagram, Tik Tok, and Twitter no doubt limited the possible expansion of this study’s reach, especially with younger populations. Additionally, while Facebook was used to advertise the study, a specific PASA-Research page was not set up.

5.11 Conclusion

This chapter outlined the methodological approach and methods used for the PASA-Research study. The rationale for utilising the chosen research design and data collections methods was provided, alongside ethical and accessibility considerations. The eligibility criteria, sampling and recruitment pathways were also discussed, along with identified limitations of this research. The thematic analysis method and approach, with consideration to the researcher’s own insider/outsider positionality was also outlined.

The next chapter will provide a detailed account of the findings from the PASA-Research study, capturing both broad trends and in-depth personal insights. The chapter will present findings in the sequential order of the survey, organised under the headings of who, what, where, how, and why. It will also share participants’ personal reflections on their experiences, addressing challenges such as third-party support issues, financial barriers, stigma, and discrimination, alongside positive outcomes like pleasure, acceptance, and increased confidence.

CHAPTER 6

Findings of the PASA-Research Study

6.0 Introduction

As outlined in Chapter 5, the PASA-Research study utilised two instruments of data collection. The first was an anonymous online survey, with the opportunity for (eligible) participants to also nominate themselves for a subsequent interview. This allowed individuals to provide additional insights into accessing sex worker services within Australia that were either too difficult or detailed to share via the survey format. This chapter shares the results generated from this study. Findings are presented in the same sequential order as the survey, under the broad headings of **who**, **what**, **where**, **how**, and **why**. The last portion of this chapter shares participants' personal reflections on how their bookings with sex workers made them feel. Issues regarding third part support mechanisms, financial barriers, stigma, discrimination and negative experiences are identified alongside positive personal accounts of pleasure, acceptance and increased levels of confidence and wellbeing. As the PASA-Research study aims to prioritise the voices of people with disability, verbatim quotes are used throughout this chapter to ensure participants' personal experiences and thoughts are accurately represented and not distorted via generalisations.

6.1 'WHO' – demographics of survey participants

6.1.1 Participants' disability/s

The definition of disability used in this study was drawn from the Australian Disability Discrimination Act (2023c) as outlined in Chapter 2 (Section 2.2.1 Definition of Disability) with participation explicitly welcomed from people with psychosocial, cognitive, intellectual and/or physical disabilities of a congenital, developmental or acquired nature. An open-ended question of 'How would you describe your disability/s?' allowed participants to share additional information. The formal diagnosis or medical label of their disability were often supplied, though many participants chose to also describe how their disability impacted both their physical and psychological wellbeing. For example:

I am autistic, have ADHD and dyscalculia. I have a range of chronic health conditions that often result in physical disability, ranging from mild fatigue to effectively housebound.

(female, 45-49 years, heterosexual)

Spinal muscular atrophy (type 2) a degenerative neuromuscular condition requiring assistance in all aspects of daily life (showering/toileting, eating, mobilises using a power wheelchair).

(female, 40-44 years, bisexual)

Language disorder which negatively impacts my social life, academic achievements, employment status, and mental health.

(male, 45-49 years, heterosexual)

I am a veteran on a disability pension. I have PTSD & Depression related to my service in Iraq as a soldier. During my service I experienced and took part in various missions that placed me into traumatic and frightening situations. In the years following my service my symptoms of PTSD & Depression affected my social, professional, family and sex life.

(male, 55-59 years, heterosexual)

Fucked, I'd also describe it as debilitating, soul sucking and very painful bordering on torture but I guess you want medical terms.... I am a C2 incomplete quadriplegic with a frontal lobe brain injury, severe bedsores on four points on the back of my body (tailbone, heels and head) that caused me extreme pain whenever I'm in bed or sitting in my wheelchair. The only silver lining is that I have sexual function.

(male, 40-44 years, heterosexual)

In total there were 48 different types of disabilities or conditions provided by participants. A table of all disabilities reported arranged in descending order from most frequently mentioned, is shared in Appendix 10. As many people have dual diagnosis, participants often provided two or more responses to describe their disability. For example, individuals chose *depression*, *anxiety* and *autism* together, while others included an *acquired brain injury (ABI)* in conjunction with a *spinal cord injury* or a *physical disability*. There were also two additional answers where people responded with *invisible* or *it was a car accident that made me disabled*.

Within Australia, there is no one standard way to define and identify disability, with variations contingent upon the Government agency, and type and purpose of the survey collection. The most prominent categorisations come from the Australian Disability Discrimination Act (2023c), Australian Bureau of Statistics' (ABS) 2018 Survey of Disability, Ageing and Carers (SDAC) (2019a), other ABS surveys, such as the National Health Survey (2023b), and the NDIS eligibility criteria which assesses significant impairment to a person's

functional capacity (2023c). Drawing from these, and categories provided by several Australian disability organisations, the disabilities given by the survey participants were subsequently grouped into the following six categories: physical, intellectual, sensory, mental illness, neurological and neurodivergent. Table 3 shows the distribution of the participants' nominated disabilities within these six categories, noting that the allocation of some disabilities may sometimes fall into two or more categories. For example, some people with Cerebral Palsy may also have an intellectual disability, a person with a spinal cord injury (SCI) may also be classified as having a physical disability, and the reason a participant is experiencing erectile dysfunction could be due to nerve damage from a SCI.

Category	Description	Disabilities	Total
Physical ¹²	Physical disabilities may affect, either temporarily or permanently, a person's physical capacity and/or mobility. Can include breathing difficulties, chronic or recurrent pain, or incomplete use of limbs Causes include inherited or genetic disorders, serious illnesses, and injury.	'Physical disability'(13) Cerebral Palsy ¹³ (29) Spina Bifida (3) Autoimmune illness (3) Sexual dysfunction/Erectile Dysfunction (3) Hydrocephalus (2) Fatigue (2) Chronic pain (2) Bowel & Bladder issues (2) Dwarfism (1) Motor Vehicle Accident injury (1) Genetic lung condition (1) Arthritis (1) Incurable blood cancer (1) Obesity (1) Heart bypass (1)	65
Intellectual ¹⁴	Difficulty in communicating, learning, and retaining information.	Mild intellectual disability (1) Learning impaired/Developmental delay (3)	4
Sensory ¹⁵	Can affect one or more senses; sight, hearing, smell, touch, taste or spatial awareness	Blind/vision impaired (7) Deaf/hearing impaired (4) Sensory Impairment (1)	12
Mental Illness ¹⁶	Mental illness is a general term that refers to a group of illnesses that significantly affects how a person feels, thinks, behaves, and interacts with other people.	Depression (7) Anxiety (6) Bipolar disorder (2) Avoidant personality (1)	25

Category	Description	Disabilities	Total
Mental Illness (cont..)		Schizophrenia and Schizoaffective Disorder (5) Obsessive-compulsive disorder OCD) (1) Post-traumatic stress disorder (PTSD) (3)	
Neurological ¹⁷	Neurological conditions affect the brain, spinal cord, and the nerves that connect them	Spinal cord injury (SCI) (14) Multiple Sclerosis (4) Muscular dystrophy (3) Stroke (3) Acquired Brain Injury (ABI) (3) Sleep disorders : Narcolepsy & Delayed Sleep Phase Syndrome (2) “Neurological” (2) Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) (1) Spinal Muscular Atrophy (1) Epilepsy (1) ‘Limited mobility due to nerve damage’ (1) Parkinson’s Disease (1)	36
Neurodivergent ¹⁸	A “neurodivergent” person refers to someone whose brain processes information in a way that is not typical of most individuals	Autism (ASD) (20) ADHD (10) “Psychosocial/mental health” (2) Language disorder (1) Dyscalculia (1) “Neurodivergent” (1)	35

Table 3: Distribution of participants’ nominated disabilities within six categories: physical, intellectual, sensory, mental illness, neurological and neurodivergent

12 <https://www.aruma.com.au/about-us/about-disability/types-of-disabilities/types-of-physical-disabilities/>

13 I have included Cerebral Palsy into the physical disability section because it “is a physical disability that affects movement and posture” <https://cerebralspalsy.org.au/cerebral-spalsy/>. The Cerebral Palsy Alliance does note that “People who have cerebral palsy may also have visual, learning, hearing, speech, epilepsy and intellectual impairments” but as participants in this survey had the option to share that additional information, it is assumed any additional conditions would be recorded in other categories.

14 Source: <https://www.aruma.com.au/about-us/about-disability/types-of-disabilities/types-of-intellectual-disabilities/>

15 <https://mapleservices.com.au/types-of-sensory-disabilities-and-impairment/>
<https://www.aruma.com.au/about-us/about-disability/types-of-disabilities/types-of-sensory-disabilities/>

16 <https://www.aruma.com.au/about-us/about-disability/types-of-disabilities/types-of-mental-illness/>

17 <https://www.health.gov.au/topics/chronic-conditions/what-were-doing-about-chronic-conditions/what-were-doing-about-neurological-conditions>

18 <https://www.healthdirect.gov.au/autism>
<https://thespectrum.org.au/autism/>

These results show that people with disability who access sex worker services in Australia are not a homogenous group.

6.1.2 Age range of participants

Survey participants provided their age by clicking on the appropriate age range. The results are shown in Table 4 below:

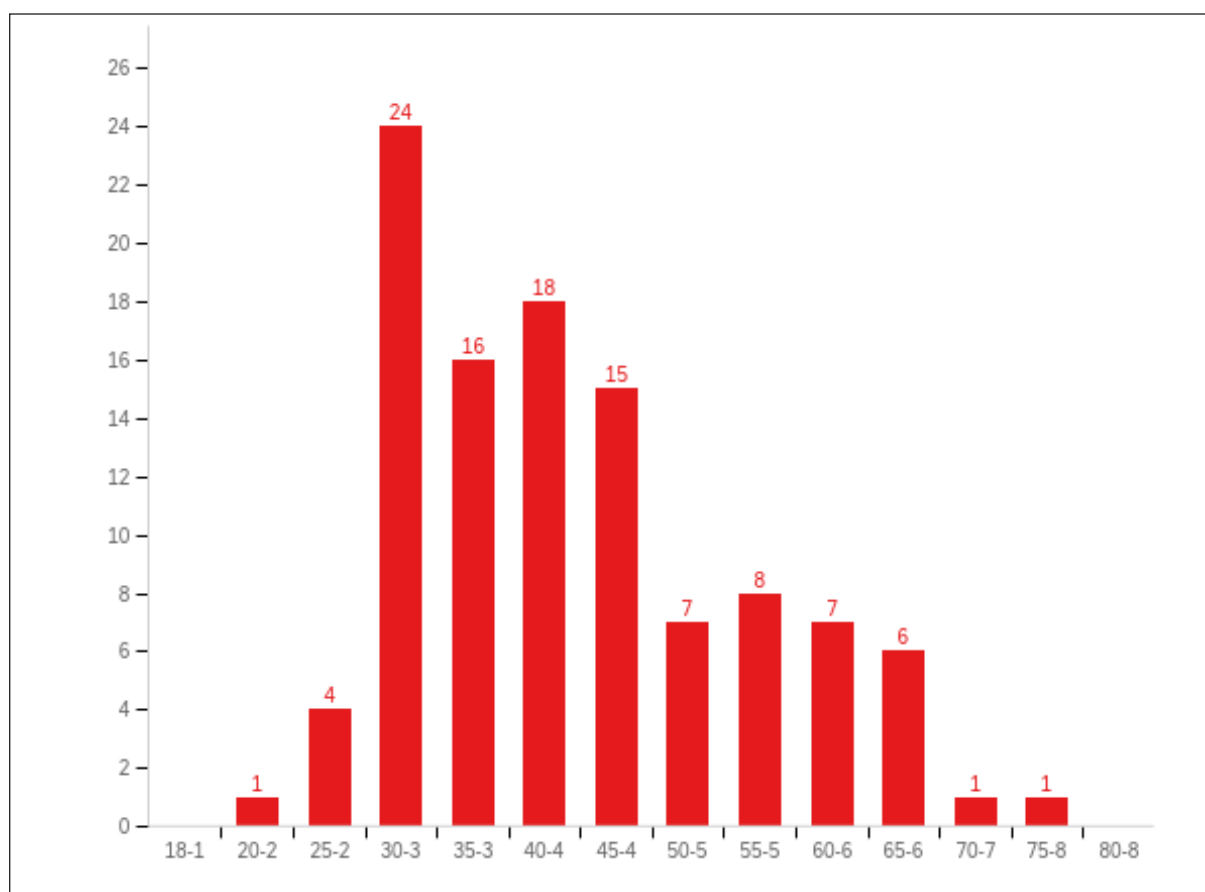


Table 4: Age range of survey participants (n=108)

There was no participation from anyone 18-19 years old with the majority of participants (69%) aged between 30 and 49 years ($n=73$). The total age range spanned between the 20-24 year bracket through to the 75-80 age bracket¹⁹. As both the youngest and oldest participant chose to be interviewed a definitive age range of 21 – 76 years could be confirmed.

¹⁹ It was only after the survey had closed that I realised that this age bracket had been input incorrectly and should have been 75-79 years instead of 75-80.

6.1.3 Where participants lived in Australia

Participants were asked to identify which State or Territory they currently lived in. The findings are represented visually in Figure 9.

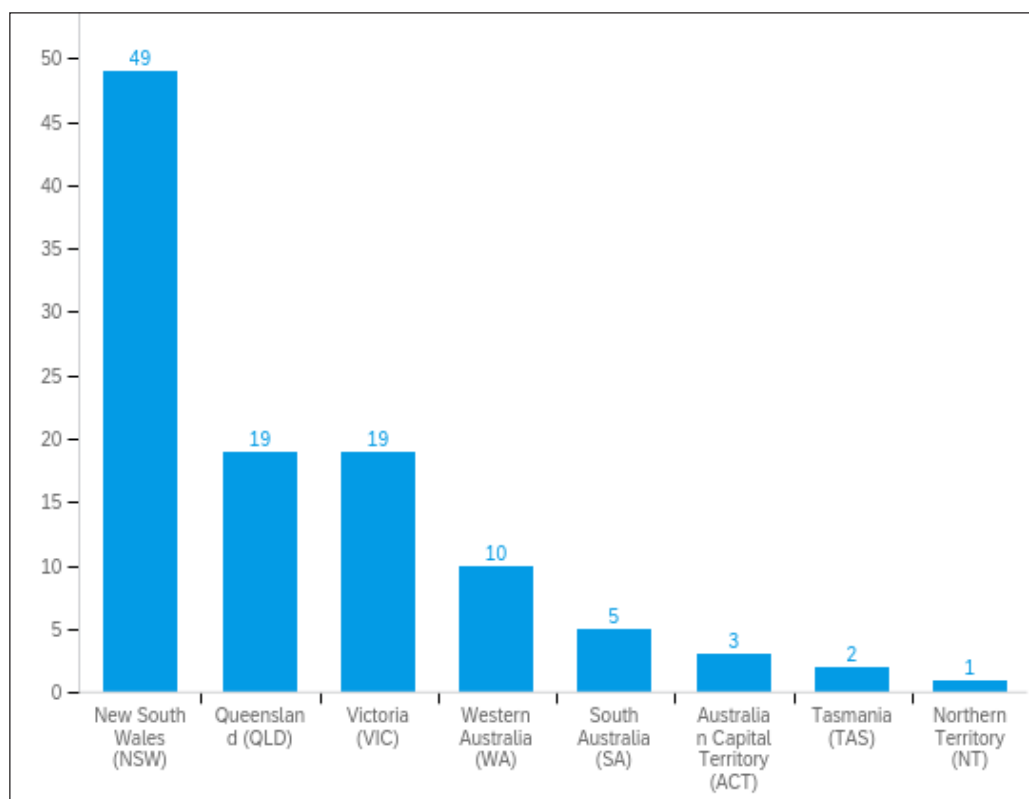


Figure 9: Location of survey participants within Australia's states and territories.

Over 45% ($n=49$) of respondents resided in the state of New South Wales (NSW). Nineteen respondents each lived in Queensland or Victoria with a further 10 living in Western Australia. There were five participants from South Australia, three from the Australian Capital Territory, two from Tasmania and one living in the Northern Territory.

These findings reflect the distribution of where people with disability reside within Australia as reported by the Australian Bureau of Statistics (Australian Bureau of Statistics, 2019a, p. 9) in Table 5.

People with disability by state or territory of usual residence - 2018

[Download](#)

All with reported disability						
State or territory of usual residence	2015			2018		
	'000	%	RSE of Estimate (%)	'000	%	RSE of Estimate (%)
New South Wales	1372.4	18.1	2.3	1346.2	16.9	2.0
Victoria	1098.8	18.5	2.1	1098.2	17.0	2.2
Queensland	859.0	18.3	3.2	938.1	19.1	2.6
South Australia	382.7	22.9	2.4	332.5	19.4	5.7
Western Australia	362.7	14.6	3.1	411.5	16.4	2.5
Tasmania	131.7	25.8	2.8	140.1	26.8	6.2
Northern Territory	20.7	11.7	5.9	20.7	11.6	13.8
Australian Capital Territory	62.0	16.2	3.4	80.0	19.4	6.1
Total	4290.1	18.3	1.1	4367.2	17.7	1.2

Table 5: Australian Bureau of Statistics: People with disability by state or territory of usual residence – 2018.

6.1.4 Nationality and Ethnicity of participants

There were five participants who identified as Aboriginal and/or Torres Strait Islander which represents 4.63% of the participants, though one person chose *Prefer not to say* in response to this question.

The subsequent question asked; ‘Do you identify as a person who is culturally and/or linguistically diverse (CALD)?’. There were ten individuals who responded with some identifying with multiple CALD communities. They included: Australian or New Zealander (n=3), Chinese (n=2), Eastern European (n=1), Middle Eastern (n=1), South East Asian (n=1), United Kingdom/Ireland (n=1), Nepali (n=1), Chinese Malaysian (n=1), Baltic/Latvian (n=1), and second generation Egyptian, Ottoman/Christian grandparents (n=1).

6.1.5 Participants’ sex, gender and sexuality

People of all genders and sexual identities were encouraged to participate, which was positively reflected in the results. There were 84 participants (77.8%) who stated their defined sex at birth was *male*, with the other 24 choosing *female* (22.2%). The gender identity of participants included: *Man or male* (n=80), *Woman or female* (n=19), *Non-binary* (n=7) and one person independently describing their gender identity as *demigirl*²⁰.

20 **Demigirl:** “This nonbinary gender identity describes someone who partially identifies with being a girl, woman, womxn, or feminine. The term demigirl tells you about someone’s gender identity but doesn’t convey any information about the sex or gender assigned to someone at birth. A demigirl can be cisgender or trans”. Abrams, M., LCSW, & Ferguson, S. (2024). 68 Terms That Describe Gender Identity and Expression. <https://www.healthline.com/health/different-genders>

Participants were also asked to define their sexuality, with multiple answers provided by some participants. In descending order, answers ranged from straight (heterosexual)($n=88$); bisexual ($n=9$); queer ($n=9$); pansexual ($n=2$); asexual ($n=1$); don't Know/questioning ($n=1$) and lesbian ($n=1$). Three participants also chose *I use a different term*. Their answers were *Grey asexual*²¹, *Polysexual*, and *Straight – but that's getting more blurred*. Table 6 shows the range of answers provided.

Answer	%	Count
Straight (heterosexual)	77.19%	88
Gay	0.0%	0
Lesbian	0.88%	1
Bisexual	7.89%	9
Pansexual	1.75%	2
Asexual	0.88%	1
Queer	7.89%	9
I use a different term (please specify)	2.63%	3
Don't know/questioning	0.88%	1
Prefer not to answer	0.0%	0
Total	100%	114

Table 6: Sexuality of PASA-Research survey participants

6.1.6 Participants' living arrangements

The last question in Section 1 of the survey asked participants about their living arrangements. There was a wide variety of answers, with the results shared in Table 7. Some participants chose more than one answer, with four expanding upon their description via additional comments provided under 'Other'. They included *I'm in my own home with support from my workers*; *I live with my mother and brother*; *partner/carer*; and *cluster home*.

21 **Grey Asexual**: a term to describe people who identify as asexual but don't fit into the main types of asexuality. They may feel sexual attraction rarely, at low levels, or only in certain situations. More information can be found here: Gillespie, C. (2023). What Does It Mean To Be Graysexual? *Health*. <https://www.health.com/mind-body/lgbtq-health/graysexual>

Answer	%	Count
I live alone	41.74%	48
I live with my parents	20.87%	24
I live with my partner/wife/husband/girlfriend/ boyfriend	15.65%	18
I live in supported accommodation	8.70%	10
I live with my offspring (ie. son/daughter)	5.22%	6
I live with my sibling/s (ie. sister/brother)	1.74%	2
I live in a retirement home	0.87%	1
I live in a group home	0.87%	1
I live in a boarding house	0.87%	1
I live with flatmates/friends	0.0%	0
I live in a nursing home	0.0%	0
Other (please specify)	3.48%	4
Prefer not to answer	0.0%	0
Total	100%	115

Table 7: Living arrangements for PASA-research survey participants

Of note here is that none of the participants indicated that they lived with *flatmates/friends* or *in a nursing home*, with the significance of this to be discussed in Chapter 7.

6.2 Demographics of the interviewees

Interview participants lived in NSW (n=16) Western Australia (n=4), Victoria (n=4), Queensland (n=2) and South Australia (n=1). Participants' disabilities were of a congenital, degenerative or acquired nature and represented all six categories of disability, as previously outlined: physical, intellectual, sensory, mental illness, neurological and neurodivergent. They included: spinal cord injuries (SCI); ADHD; anxiety; degenerative neuromuscular condition; pituitary gland deficiencies; hemiplegia; hydrocephalus; partial deafness; epilepsy; acquired brain injuries (ABI); PTSD; depression; quadriplegia; Multiple Sclerosis(MS); fatigue; Blind and vision impairment; speech impediments (stuttering); autism spectrum disorder (ASD); prostate issues; bowel and bladder issues; mental illness; anxiety; chronic back pain; arthritis; cerebral palsy (CP); Pathological Demand Avoidance (PDA); paraplegia; rare genetic conditions and intellectual disability.

The gender of the interviewees was expressed as: male (n=19), female (n=6), female/non-binary (n=1) and demigirl (n=1), with their identified sexualities being: heterosexual (n=19), bisexual (n=5), queer (n=2) and grey asexual (n=1). The age of the interview participants reflected the general age range of the survey participants, spanning between 21 years of age up to 76. This range can be seen in Table 8 below:

Age range	Participants' ages
20-29	21 * 27
30-39	30 * 32 * 34 * 34 * 37 * 38 * 38 * 38
40-49	40 * 41 * 42 * 43 * 44 * 45 * 45 * 49
50-59	50 * 50 * 56 * 57
60-69	62 * 64 * 67
70-79	73 * 76

Table 8: Age range of PASA-Research interviewees

Overall, the demographics of the interviewees reflected a balanced representation of the diversity of the total survey cohort. Information gleaned from the interviews is used throughout this chapter to provide a deeper level of understanding to the findings.

6.3 'WHAT' – appointments with sex workers and their demographics

The second section of the PASA-Research survey included five specific questions:

1. How many different sex workers have you visited, in total?
2. What age were you when you first paid for sexual services?
3. What gender/s were the sex worker/s? (click all that apply)
4. What services have you paid sex worker/s for? (click all that apply)
5. How often do you visit sex worker/s?

The findings are shared below in the same order.

6.3.1 How many sex workers participants had visited

Participants were asked how many *different* sex workers they had visited. The answers (as shown in Figure 10) were varied, ranging from *one sex worker* ($n = 20$) up to *more than 10* ($n = 30$). Respondents for the latter were asked to provide more information, with responses including *think it's at least 12, 13, 15* ($n=6$), *19, 20, 25, 35*, and *Over 100 since 2010*. One

person stated they were *starting to lose count*, with another providing a very specific answer of 884 [*and counting*]. As the survey was anonymous there is no way to verify whether this figure was a typographical error.

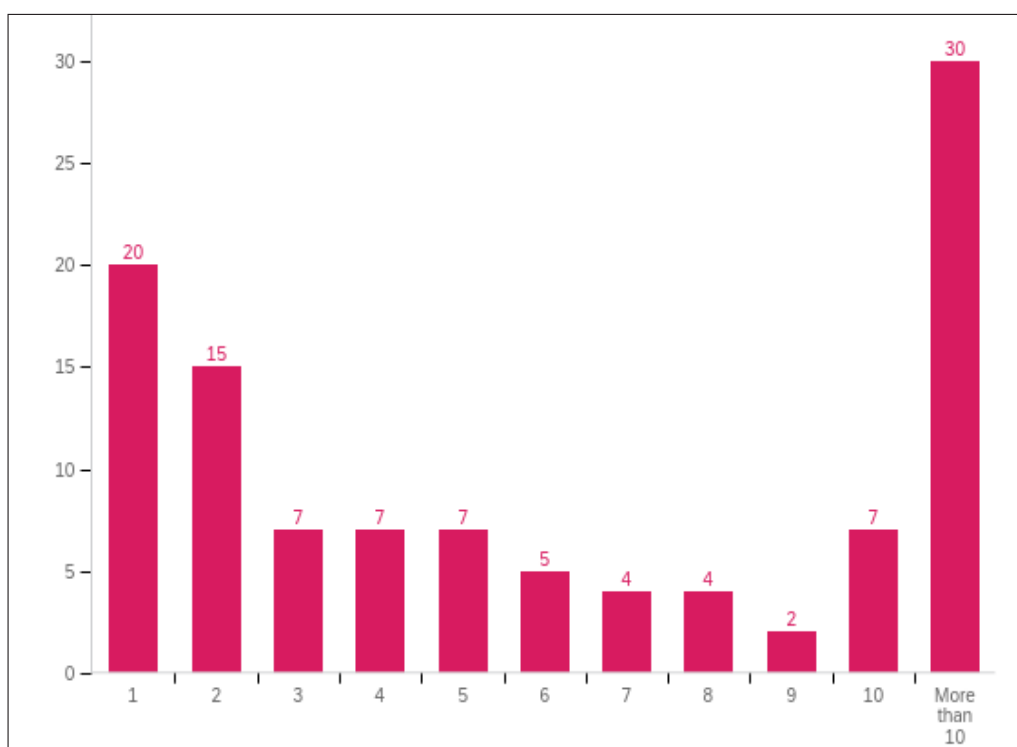


Figure 10: How many different sex workers had survey participants visited

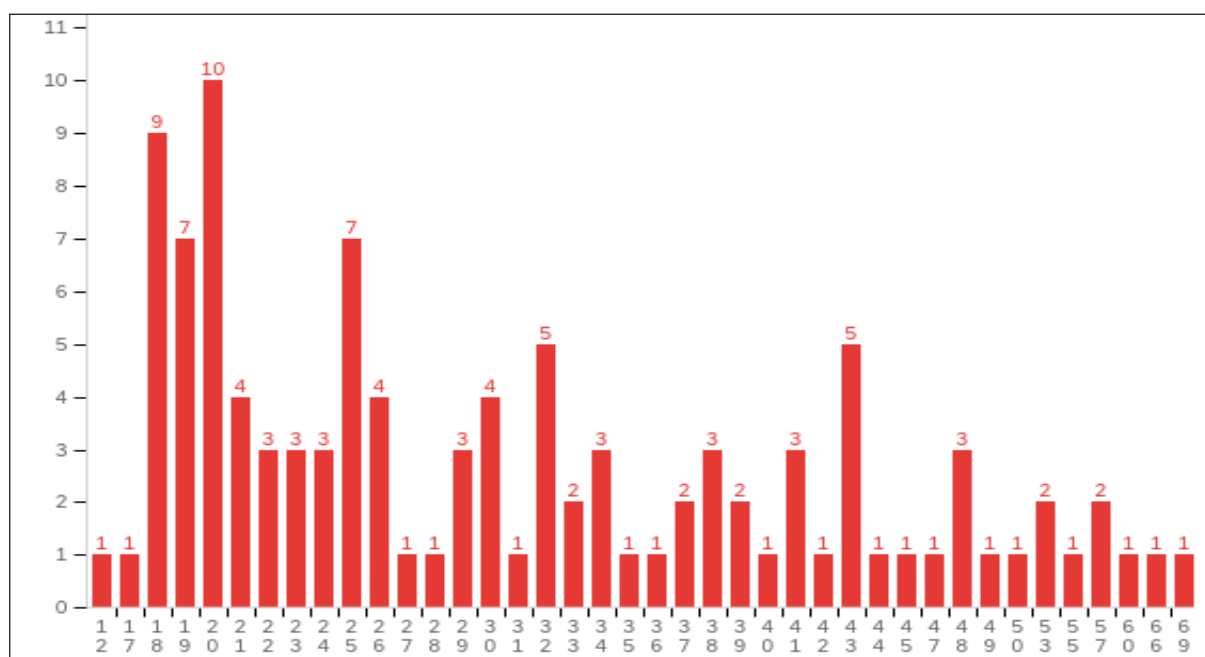
These findings primarily show that people with disability in Australia have seen a wide variety of sex workers over a long period of time, providing confirmation that this is not a new phenomenon.

6.3.2 Age of participant when they first paid for sexual services

PASA-Research survey participants were asked how old they were when they first paid for sex worker services. Their responses varied widely, from 12 to 69 years. Treating the '12 years' answer as an outlier, the adjusted age range was between 17 and 69 years, with 20 ($n=10$), 18 ($n=9$), 19 ($n=7$), 25 ($n=7$), 32 ($n=5$) and 40 ($n=5$) the most frequent ages for first paid encounters. However, as presented in Figure 11, there was no significant age where individuals tended to first start paying for sexual services.

Each survey participant's answer was subtracted from their current age range to determine how long ago such bookings occurred. Appendix 13 provides a detailed table of these findings, while also listing each respondent – and their disability – under the six corresponding disability categories: physical, intellectual, sensory, mental illness, neurological and neurodivergent.

One difficulty with anonymous surveys is the inability to ask follow-up questions or to clarify a person's answers. For example, one man provided the answer of *12 years of age* yet reported their current age to be in the 50-54 age bracket. He identified Touching Base as the only avenue used to locate suitable sex workers, however Touching Base has only been operating as an organisation since late 2000 and did not start referring people to sex workers until 2002²². One can only speculate if this individual meant to type 21 instead of 12, or that his answer was meant to reflect that visits to sex workers had been occurring for the last 12 years.



6.3.3 Gender of the participants' sex workers

Participants were asked to identify the gender/s of the sex workers they received sexual services from. Reflective of previous literature about the sex industry, the majority of participants said they visited female sex workers ($n=89$). However, male ($n=20$), non-binary ($n=4$), transgender (M-F) ($n=3$) and transgender (F-M) ($n=1$) sex workers were also sought.

6.3.4 Sexual Services paid for

Participants were asked to indicate which services they had paid for by selecting all applicable answers from a list of 19 specific options. Additionally, an 'other' option was included to allow participants to provide alternative answers in an open-ended text box. The total results are provided in Table 9:

²² As per correspondence from the Touching Base President: "By February 2002 we were starting to provide referrals with contact details of sex workers who had attended our 1st PDAT workshop who wanted to be on the list. When we got our 1st website up and running in 2004 the Referral List process became more easily available to people with disability and support staff/families etc, who wanted referrals to sex workers".

Sexual Service	Count
Oral sex/blow job/French (you receiving)	79
Vaginal sex (you giving ie. your sex worker has a vagina)	72
Hand relief/masturbation	68
Nude massage	66
Oral sex/blow job/French (you giving)	60
Sex toys ie. Vibrators	47
Anal play (fingers/toys in your bottom)	31
Double booking (2 sex workers)	27
Fantasies/role plays	20
Vaginal sex (you receiving ie. you have a vagina)	19
Anal play (fingers/toys in sex worker's bottom)	16
Anal sex (you giving)	16
Anal sex (you receiving)	12
Using a Strap-on ('pegging')	11
Double booking (you and a partner [with disability] with 1 sex worker)	2
Double booking (you and a friend [without disability] with 1 sex worker)	1
BDSM {Bondage, Discipline, Sadism, Masochism} services	0
Double booking (you and a partner [without disability] with 1 sex worker)	0
Double booking (you and a friend [with disability] with 1 sex worker)	0
Other (please specify)	15

Table 9: Services paid for by PASA-Research survey participants

From the 19 static answers, the six sexual activities most commonly paid for were:

1. Oral sex/blow job/French (you receiving) ($n=79$),
2. Vaginal sex (you giving ie. your sex worker has a vagina)($n=72$),
3. Hand relief/masturbation ($n=68$),
4. Nude massage ($n=66$),
5. Oral sex/blow job/French (you giving) ($n=60$), and
6. Sex toys ie. Vibrators ($n = 47$)

The generic answer of *BDSM (Bondage, Discipline, Sadism, Masochism)* services was not chosen, however participants provided a range of specific sexual activities in the *other* comments which would be classified under the BDSM category. They included: *Fetish (being urinated on); foot fetish. I love licking women's dirty feet and then getting hand relief* and two who specifically mentioned *cross dressing and feminisation*. As an extension of the latter service, one person went on to say *I buy the clothes off her after our sessions*. Further into the survey, when asked to share their most favourite or memorable moment with a sex worker, one participant also shared a very specific type of fetish:

I saw a provider who did a roman shower experience. She drank lots of milk and ate blue jelly then threw up on my dick. It was a unique experience
(ASD²³, male, 30-34 years, queer)

Finally, during his interview, Paul (hemiplegia/epilepsy/stutter, male, 40 years, heterosexual) shared details about his specific fetish for being tied up by a BDSM mistresses and being tickled.

Four other specific services were mentioned in the survey: *Spanish, Facial, Orgy (once)* and *Rimming: Give/Receive* along with a range of service classified within what one person called *Social/companionship*. This included *cuddles*, watching movies together, going on outings to bookstores, museums and the theatre, with three participants also nominating *showering together*. Multiple participants spoke about the importance of their 'dinner dates', sharing specific experiences of restaurant dining as an integral part of their booking. This indicates that services sought out with sex workers can often mirror activities that people enjoy within either romantic or platonic relationship structures.

One service not included in the static list was kissing, however the importance of this activity was raised multiple times during the interviews, in conjunction with other intimate activities such as hand-holding and cuddling. For example, Anna said:

...when I was sort of interviewing who I wanted to see [I included] "will you kiss me?" because I thought that was really important. And I know that that's something that not everybody's comfortable with. So she did. And that's what I enjoy the most. I think that's the most intimate thing you can do with another person is kissing them. So yeah, there's a lot of kissing involved. A lot of the time it was just touching and exploring my body and having her be able to move my hands so I could explore her body and stuff like that, because I couldn't do it... yes, I generally had sex while I was with my sex worker, but most of the time, the time was taken up cuddling, because that's what I needed. I just needed that.

(degenerative neuromuscular condition, female, 41 years, bisexual)

23 ASD stands for Autism Spectrum Disorder

Finally, two other answers had an educational focus, with participants saying *Instructional* and *Tantra Massage ejaculation control*. Services of this nature are discussed in Section 6.6.1 when examining the motivational factors of why individuals choose to pay for sexual services.

6.3.5 Frequency of appointments

Participants were asked ‘How often do you visit sex worker/s?’, with some participants choosing more than one answer. The frequency of participants’ appointments is provided in Table 10, with the six most common answers being:

1. no set pattern (37.2%)
2. whenever I can afford it (24.8%)
3. once a month (9.7%)
4. whenever I travel to the same location as the sex worker (5.5%)
5. whenever the sex work travels to my location (4.8%), and
6. once a fortnight (4.1%)

Answer	%	Count
No set pattern	37.24%	54
Whenever I can afford it	24.83%	36
Once a month	9.66%	14
Whenever I travel to the same location as the sex worker	5.52%	8
Whenever the sex work travels to my location	4.83%	7
Once every 3 months (every 12 weeks/4 times a year)	4.83%	7
Once a fortnight	4.14%	6
Once a week	2.07%	3
Once every 2 months (every 8 weeks/6 times a year)	2.07%	3
Once every 6 months (twice a year)	2.07%	3
Once every 4 months (3 times a year)	1.38%	2
Once a year	1.38%	2
Total	100%	145

Table 10: Frequency of appointments with sex workers

6.4 ‘WHERE’ – geographical and situational location of where services were received

The third section of the survey focused on location. It included two specific questions; asking first about geographical location/s within Australia where sexual services were paid for, before identifying the type of premises they were in when receiving services.

6.4.1 The locations throughout Australia where sexual services have been accessed

Participants were asked ‘in which State or Territory have you received services from a sex worker?’ and asked to tick all applicable answers. A subsequent open-ended text box was provided for each state or territory chosen, asking: ‘please list the suburb/region you were in at the time you received services from a sex worker’. The distribution throughout the Australian States and Territories is provided in Table 11:

State or Territory	%	Count
New South Wales (NSW)	39.4%	61
Victoria (VIC)	21.9%	34
Queensland (QLD)	14.8%	23
Western Australia (WA)	8.4%	13
South Australia (SA)	6.5%	10
Australian Capital Territory (ACT)	6.6%	10
Tasmania (TAS)	1.9%	3
Northern Territory (NT)	0.7%	1
Total	100%	155

Table 11: Geographical location where services were provided within Australia’s states and territories

Apart from the Northern Territory, more services have been provided in every state and territory than the number of participants who currently reside in each place. Comparison tables are provided below in Figure 12. Through interview discussions, it is understood that these figures account for interstate travel specifically undertaken to meet a sex worker, as well as sex worker bookings incorporated into individuals’ business or holiday travel plans. Additionally, some participants had moved interstate during their lives which also influenced this discrepancy in the data.



Figure 12: Comparison between where PASA-Research survey participants currently lived and where services have previously been provided throughout Australia

Below is the overview of locations nominated within each state and territory. To protect people's anonymity this question invited general rather than specific locations. For example:

Please list where in New South Wales (NSW). You can name suburbs or a general area ie. 'Metropolitan Sydney' or 'the Northern Rivers region'. To maintain your confidentiality, individual suburbs will not be shared in the public findings of this research.

6.4.1.1 New South Wales

The state of New South Wales (NSW) was nominated by the highest number of participants ($n=61$) as a location where sex worker bookings had occurred, with many nominating more than one suburb or region in NSW. Among these, Sydney, the capital city of NSW, was the most frequently cited location, with suburbs in the Sydney Greater metropolitan area being the most common ($n=70$). The Greater Sydney region is made up of five specific zones: Sydney Eastern -Sydney City, Sydney Eastern & South, Sydney North, Sydney Central (GPOP) and Sydney Central (Western) (NSW Government, 2024). Suburbs from all five zones were mentioned with the Sydney City/CBD area being the most frequently noted.

Additional regions mentioned throughout NSW included the Illawarra, Southern Tablelands, the South Coast, the Northern Rivers, the Murray region, Northern Sydney, the Hunter region, Central Coast, and the Central West region.

6.4.1.2 Victoria

There were 34 participants who said they had received sex worker services in the state of Victoria. Suburbs within metropolitan Melbourne, the capital of Victoria, were most

frequently nominated ($n = 31$). Various suburbs in North, North East, South East and South West Melbourne regions were also nominated. Mornington Peninsular was the only region outside of the greater Metropolitan Melbourne area that was nominated.

6.4.1.3 Queensland

There were 23 participants who said they received sex worker services in the state of Queensland. The capital is Brisbane, located in the City of Brisbane council, and it was the most frequently nominated location ($n=18$). Other areas included the City of Moreton Bay, the Gold Coast region, the Western Downs *Region*, *South East Queensland region*, North Queensland and Far North Queensland.

6.4.1.4 Western Australia

There were 13 participants who said they had received sex worker services in the state of Western Australia. The state is divided into 10 distinct regions, Perth metropolitan area and nine regional areas (Infrastructure Western Australia, 2024). Perth is the capital of Western Australia and suburbs within that region were nominated 11 times as locations where sex worker services were accessed. Suburbs in both the Pilbara and the Goldfields–Esperance regions were also mentioned. One participant also wrote: *Not sure of the address of the place as my sister took me.*

6.4.1.5 Australian Capital Territory

Ten participants said they saw sex workers in the Australian Capital Territory (ACT). Canberra is both the capital of the ACT and the federal capital of the Commonwealth of Australia. It is comprised of nine districts which include: Belconnen, Gungahlin, Molonglo Valley, Inner North and City, Inner South Canberra, East Canberra, Tuggeranong, Weston Creek and Woden Valley.

The most common location to receive sex worker services was in the Canberra CBD area ($n=5$), followed by Woden Valley ($n=3$), Tuggeranong ($n=1$) and the two legalised brothel areas in the districts of Gungahlin (Mitchell council area) and South Canberra (Fyshwick council area). One person also just said *Various residential suburbs*.

6.4.1.6 South Australia

Ten participants said they had paid for sex worker services in South Australia. Adelaide is the capital city and all ten nominated metropolitan Adelaide for the location of the sex worker bookings.

6.4.1.7 Tasmania

Three participants said they had paid for sex worker services in Tasmania. Hobart is the capital city and three participants nominated suburbs within Hobart city. Launceston, the second largest city situated in North Tasmania, was also mentioned by one individual.

6.4.1.8 Northern Territory

One participant said they had received sex worker services in the Northern Territory, though they did not provide a specific city or suburb in their response.

6.4.2 Premises where sex worker services have been provided

Participants were asked to specify the physical locations where sex worker services had been provided to them. Table 12 displays the variety of responses selected from the multiple-choice options provided.

Answer	%	Count
The sex worker's private workplace (house/unit)	21.5%	56
Hotel	20.3%	53
My home/where I live	19.9%	52
Brothel	18.0%	47
Massage parlour	8.1%	21
Motel	5.0%	13
BDSM house/parlour	2.3%	6
Private BDSM dungeon	1.5%	4
Hospital	0.8%	2
Car	0.8%	2
Safe house	0.0%	0
Rehab Accommodation	0.0%	0
Other (please specify)	1.9%	5
Total	100%	261

Table 12: locations where sexual services were provided to participants.

The five most common locations where participants reported receiving sexual services were:

1. the sex worker's private workplace (house/unit)($n=56$; 21.5%)
2. a hotel ($n=53$; 20.3%)
3. the participants home/where they live ($n=52$, 19.9%)
4. brothel ($n=47$, 18.0%), and
5. massage parlour ($n= 21$; 8.1%)

Additionally, 13 participants selected ‘motel’ and one person mentioned *Airbnb* in the ‘other’ option. When combined with the hotel responses, these findings suggest that external short-term rental accommodation options were the most frequently used locations for clients with disability to engage in services with sex workers.

Interview participants spoke about utilising hotels or motels for a range of reasons. This included booking sex worker services when on holidays or a work trip (which could also be reflected by the *Airbnb* answer), or the sex worker was touring and only worked from their hotel room. Privacy concerns were also another common reason, for example if participants lived with family members and could not have the sex worker visit them at home, or they did not want support staff to know about the sex worker visits to their own home. An additional consideration was when their preferred sex worker did not have an accessible workspace. In this instance the client (i.e. the participant in this survey) provided the venue if the sex worker was unable to rent an accessible workspace for that appointment.

6.5 ‘HOW’ – Locating, booking and paying sex workers

Section 4 of the survey focused on how appointments with sex workers were made, including questions about how participants initially located the right sex worker and if they relied upon third party support to make the booking or attend the booking. There were opportunities for participants to also share personal stories about these experiences. The last question in Section 4 explored how participants paid for services, specifically examining where they generated or accessed their funds from.

6.5.1 How participants located their sex workers

Participants were asked ‘How did you locate the sex worker/s? (click all that apply)’. They were provided with 19 specific answers to choose from in addition to the ‘other’ option. In total there were 287 responses, with 10 respondents also providing additional information. Total responses are provided in Table 13 below with the five most nominated answers being:

1. via sex worker’s website/advertisement (n= 68, 23.7%)
2. arrived at the premises and chose from the sex workers available (ie. brothel/ massage parlour) (n = 39, 13.6%)
3. saw the sex worker on Twitter (n = 32, 11.2%)
4. via the Touching Base Referral List (n= 27, 9.4%), and
5. referral from another sex worker (n= 26, 9.1%)

Answers given in the ‘other’ option included: *referral from a friend; called directory assistance on telephone and asked for numbers for “escorts” in the area; Yellow Pages in the old days; called*

a brothel; my partner booked it as a birthday present, after prior discussion; mates; Google; Locanto²⁴; and went for a massage – put 2 and 2 together.

Answer	%	Count
Sex worker's website/advertisement online	23.7%	68
Arrived at the premises and chose from the sex workers available (ie. brothel/massage parlour)	13.6%	39
Saw the sex worker on Twitter	11.2%	32
Touching Base Referral List	9.4%	27
Referral from another sex worker	9.1%	26
Support worker helped me	5.2%	15
Newspaper advertisement	4.5%	13
Referral/suggestion from another person with disability	3.5%	10
Saw the sex worker on Instagram	3.1%	9
Coordinator helped me	2.8%	8
Therapist helped me	2.8%	8
Saw the sex worker on Facebook	2.1%	6
Saw the sex worker in the media/documentary/TV	2.1%	6
Approached the sex worker at an event/conference/performance	1.7%	5
Approached the sex worker in a street (where sex workers stand to meet clients)	0.7%	2
Rehab nurse/rehab support worker helped me	0.4%	1
Saw the sex worker on TikTok	0.4%	1
Sibling (brother/sister) helped me	0.4%	1
Parent helped me	0.0%	0
Other	3.5%	10
Total	100%	287

Table 13: How participants located their sex worker/s

²⁴ Locanto is an online directory based in Australia, which provides similar services as the now defunct USA based backpage and Craig's List.

Participants also provided information about additional research they did before making their decision to see a sex worker. For example:

The decision to give my virginity to a SWer²⁵ was taken only after more than a decade of discernment; this included watching the films *The Sessions* and *Scarlet Road*, and having non-penetrative sex with a SWer before deciding to take the next step of FS.²⁶

(depression/OCD/PTSD(undiagnosed), male, 40-44 years, heterosexual)

I deliberately researched workers with a reputation for their professionalism and support for disabilities. I also chose older workers in the hope of greater life experience and nuanced understanding of my limitations and needs.

(MVA²⁷ injury and autoimmune illness, male, 35-39 years, heterosexual)

Before even making my first appointment I spent months preparing. Talking to trusted family members and friends about it and talking to my doctor about concerns and fears I had as I would be having sex for the first time and my self esteem is really bad so I needed support.

(autism/depression/anxiety, demigirl, 30-34, Grey asexual)

These accounts show that for many participants the decision to access sex worker services was not taken lightly and was often influenced by the individual's ability to access information and/or support mechanisms. Personal and professional interactions with trusted individuals in their lives also played a role in both the early decision-making process and the subsequent pathway to locate a suitable sex worker.

Consolidating all responses from this question identified five main pathways that participants used to locate their preferred sex worker/s:

1. online ($n=124$),
2. receiving specific referrals ($n = 65$),
3. with the assistance of third-party support ($n=55$),
4. in-person (at the sex worker's workplace or at an event) ($n= 48$), and
5. via print media advertisements ($n=15$)

The next section provides further details about each of these five pathways.

²⁵ SWer is shorthand for 'sex worker'

²⁶ FS is shorthand for 'full service' which generally refers to a standard booking which includes intercourse.

²⁷ MVA is shorthand for Motor Vehicle Accident

6.5.1.1 Online

The internet was used in a variety of ways to locate sex workers. This included accessing sex workers' online advertisements and websites; using online sex worker directories, via social media (Twitter, Facebook, Instagram, TikTok); and initially seeing a sex worker in the media, on TV or in a documentary and contacting them. General search engine platforms such as Google were also mentioned. Multiple participants said they read sex workers' social media accounts in detail before booking, to see if they had things in common and to try to get a feel for their personality. For example, one participant said, *they had a vibe of being a comforting person after taking a look at their listings and social media* (ASD/ ADHD²⁸, male, 25-29 years, heterosexual).

6.5.1.2 Referrals

Utilising referrals was the second most common method for participants to locate suitable sex worker. These came from the Touching Base Referral List ($n=37$), other sex workers ($n = 26$), other people with disability ($n=10$) or from a friend ($n=2$).

There was also one participant who mentioned receiving *recommendations from a sex therapist*, which fits within this theme of relying on a trustworthy source to provide suitable referrals that had already vetoed the sex worker as being compatible.

6.5.1.3 Third party support

There were 55 survey participants who located sex worker/s with the assistance of third-party support. This included support workers, therapists/counsellors, (NDIS) Coordinators, rehabilitation nurse/support worker, friends, or a sibling. These third-party support persons played a variety of roles during the booking process including conducting initial searches and inquiries to find suitable sex workers, looking up phone numbers, calling on behalf of the client, and navigating family dynamics while balancing the privacy of the individual's sexual expression. The latter was expressed by one man who shared: *When I lived with my parents ... my carers had to make sure my mother would be out when I had a visit from a sex worker* (cerebral palsy, male, 65-69 years, bisexual). For another participant it was the support worker's willingness to actively assist in coordinating the booking that made the difference: *my current sex worker was seeing someone else at my accommodation. I asked the support worker and they mentioned to the sex worker and sent them to me* (cerebral palsy, male, 50-54 years, heterosexual).

6.5.1.4 In-person

There were 48 participants who nominated that they had located sex workers in-person. This included arriving at the sex services premises (i.e. brothel or massage parlour) and

28 ASD stands for Autism Spectrum Disorder. ADHD stands for Attention Deficit Hyperactivity Disorder.

choosing from the available sex workers on shift, approaching street-based sex workers, or approaching the sex worker at an event, conference, or performance. This correlates with answers provided earlier in Section 6.5, where ‘brothel’ was the fourth most common location for where services were provided, along with other in-person locations such as ‘massage parlour’ or ‘car’. Rationales for choosing the in-person option often mentioned convenience, with one participant stating: *First time was a brothel because it required no organizing, just turn up and pick* (paraplegic, male, 40-44 years, heterosexual).

Another response provided insight into one man’s historical experiences with sex workers, stating: *I was able to visit a brothel before the progression of my disability* (paraplegic, male, 30-34 years, heterosexual). This statement highlights patterns of behaviour discussed in Chapter 4 that clients may exhibit throughout their lives. Although this response came from an anonymous survey participant, several interviewees also shared their interactions and varying experiences with the sex industry, both before and after acquiring their disability. Such patterns of behaviour are discussed further in Chapter 7.

6.5.1.5 Print media

There were 15 participants who said they located their sex worker/s via print media. These responses spanned both recent and historical visits to sex workers and reflected the use of both old and new methods of advertising. The former included state and local newspapers, along with business telephone directories such as the Yellow Pages, which use to be the predominant avenues in Australia for both independent sex workers and sex work establishments to advertise to potential clients. Since the advent of the internet, print media has been largely replaced by online websites, advertising directories and social media platforms to elicit client engagement. Advances in electronic communication devices have increased internet accessibility for some people with disability, affording them more equitable – and discreet – access to information and sex industry advertisement. However, the decline in newspaper advertising has also inadvertently limited access options for some individuals with disability. This was discussed at length by Fred (legally blind, male, 62 years, heterosexual) who predominately relies on print media to source sex workers. In recent years one of his local newspapers had stopped all ads for sex workers, while the other now provides only limited options. While disability support mechanisms have provided him with internet access and a physical device to help magnify things in front of him, he spoke about a lack of assistance to increase his computer literacy, while contending with the decline of his eyesight and the changes in how the sex industry now advertised:

Fred: Yeah but I can’t get the newspaper up on it. See that’s the thing too, because I’ve got a computer, everyone’s like “Oh, you got a computer do it on that”. I’m 62 years old. I’m computer illiterate ... I mean I just know the basics

Interviewer: So no one's ever shown you how to use ... Google search engines?

Fred: No

For individuals struggling to receive assistance to use the internet for the most basic applications, it stands to reason that they would be reticent to ask for assistance to search for sex workers, or other private issues related to sexual expression.

6.5.2 Reasons why participants chose specific sex workers

The previous section identified five main pathways participants used to find their preferred sex workers: (1) online, (2) referrals, (3) third-party support, (4) in-person (at the sex worker's workplace or an event), and (5) print media advertisements. An open-ended question followed, invited participants to share additional details about how and why they chose their sex workers. Sixty-three individuals responded, revealing five key themes in their decision-making:

1. If the sex worker had experience working with people with disability
2. Overall impression of the sex worker and how that made them feel
3. The attractiveness of the sex worker
4. If the sex worker provided the services they were seeking
5. If they had third party support

6.5.2.1 *If the sex worker had experience working with people with disability*

Referrals were the second most common way participants located suitable sex workers. Analysis of the responses indicated that participants prioritised referrals to ensure sex workers were competent in providing services to people with disability. For example, 13 survey participants specifically mentioned seeking sex workers with prior professional experience, highlighting factors such as:

- Being 'disability-friendly'
- Having knowledge and compassion for people with disability
- Experience working with people with various disabilities
- Exhibited kindness, understanding and non-judgemental attitudes

Five participants specifically mentioned using the Touching Base Referral list, expressing confidence that the referred sex workers would have the necessary expertise to meet their needs. Another participant noted accessing an escort website where *they listed seeing 'disabled people' in their list*. Additionally, several interviewees mentioned using online sex worker directories that featured 'disability-friendly' as a searchable category.

Interview discussions also emphasised the importance of finding a ‘disability-friendly’ sex worker to ensure they were treated with dignity and respect, and to avoid concerns about the sex worker reacting negatively to how their body looked or moved. As Jerry commented: *they don’t judge me for what has happened to me. They judge me for who I am* (paraplegia, male, 57 years, heterosexual). A couple of participants also mentioned that their chosen sex worker/s knew how to operate a hoist which gave them confidence in being able to receive adequate support without needing a support worker present.

Additionally, a couple of participants spoke about the need for sex workers to actively choose to see them, despite their disability. For example, one person said: *For the woman I see now a support worker found a sex worker who was happy to see me* (schizophrenia, male, 60-64 years, heterosexual), while another shared:

I would send a message introducing myself, and telling them a bit more about myself and my disability and making sure they comfortable see me. I would also explain what support i may require on the day of the appointment, and if they comfortable to proceed we would then set up a time and a date to go through the appointment.

(cerebral palsy, male, 30-34 years, heterosexual)

This need to locate sex workers who are willing, able, and experienced in providing services to people with disability appeared to stem from previous negative experiences of rejection, and prior difficulties in finding accessible venues. As Matthew explained during his interview:

... trying to find a sex worker is complex because you’ve ... it’s one of the first things I say, you know, “is your premises wheelchair accessible?” and ... “will you see a disabled client?”... you often won’t get a reply ... so you sort of wait. And ... I understand that sex workers probably get a 1000 people and so they ignore the ones that ... that they don’t have to respond to and respond to the ones that they do. It’s an interesting challenge ... Now I don’t know whether that’s because people are nervous about ... But that’s one of the reasons I started to narrow my focus to, if I can get someone who says ‘disabled’ in the first place ... And then you’ll get peoples in-premises are often inaccessible ... It can take some time just to get a booking that ... you know, you actually get someone who’s got an accessible premises and who’s not scared by the disability.

(spinal cord injury, male, 50 years, heterosexual)

Two other interview participants shared details of being rejected due to their disability. Ben, a 31-year-old queer man with cerebral palsy, spoke about how some sex workers

cancelled on him after he told them about his disability via text message, stating *they didn't know how to communicate with him*. When asked how that made him feel, he spoke about feeling disrespected, *like I'm not worthy*, adding later that he felt *very disappointed because it takes a lot of time for me to find people*. In a different interview, Paul shared his own experiences:

Anyway after the session a few days later I said “can I see you next week or something?” and she said “oh umm I think you should find someone else. You don't kiss very well ... you don't give oral on me, and you probably won't be very good at it because you can't kiss very well ... as a sex worker I've been doing this for about eight years and I kind of want easy bookings.

(hemiplegia, male, 40 years, heterosexual)

6.5.2.2 Overall impression of the sex worker and how that made them feel

Numerous participants shared how they based their decisions on how comfortable and safe they thought each sex worker made them feel, along with how well they connected with them. Answers included:

- *The connection felt right;*
- *I feel comfortable with him;*
- *I explained what I needed and wanted and we hit it off;*
- *Ones who like the activities I like and click with and*
- *It all comes down to the rapport built when arranging a booking and feeling comfortable and safe with them.*

Other observations about the general character of their sex workers included: *they seemed genuine and compassionate*, and *she looked so caring and understanding*. One person reflected that the sex workers' *communication was respectful* while another specifically *sought a non-smoker of similar age*. Age was also a specific determinant with comments such as: *she was the right age* and *I try to find SW's who are older because I feel more comfortable with those SW's*. For some older participants, a prominent consideration was to find a sex worker who was older than their adult children, with one woman saying: *For me it's all about age. I have a soon to be 33yo son. He [her sex worker] was the oldest (38yo), most were in their 20's* (physical disability, female, 55-59 years, heterosexual).

6.5.2.3 The attractiveness of the sex worker

Reflecting previous findings in the literature about clients, many PASA-Research participants made their decision about who to book based on the physical attributes of the sex workers. Answers included general descriptors such as *physical attractiveness; I liked the*

look of them; I liked the sound of her voice; and he wet my whistle. One participant expanded on their answer to state:

I am not attracted to very many people sexually (it's super rare) and when I was looking I was not expecting to come across someone I was attracted to and when I did I was surprised and knew I had to book him.

(autism/depression/anxiety, demigirl, 30-34, grey asexual)

6.5.2.4 If the sex worker provided the services they were seeking

As outlined in Section 6.3.4 participants in this study paid for a wide range of services. Therefore, it is a reasonable outcome that one of the predominant factors in choosing a sex worker was the type and variety of services they offered. Responses included:

- *Offered foot fetish and hand relief*
- *I chose sex workers who specialise in BDSM services*
- *They allow oral which I love the most*
- *I chose providers based on price or if they provided unique experiences, and*
- *I love kissing*

One participant also reflected on their changing desires: *When I was younger it was all about the physical act and intimacy. Now I crave the mental stimulation more and the closeness of another human being* (cerebral palsy, male, 40-44 years, heterosexual).

6.5.2.5 Third party support

The involvement of third-party support was discussed in Section 6.5.1.3, with 55 participants indicating that they relied on third-party support to locate a sex worker for themselves. Additional information about who assisted them and in what context was provided when asked about the booking process. For example: *There was a TV documentary about the subject a few years back. I was helped by my sister whom researched and found out about this particular sex worker* (intellectual disability/autism, male, 35-39 years, heterosexual). A response from another participant also provided a positive example of how allied health can meaningfully contribute to a person's autonomous decision to access sexual services:

My counsellor helped me find her after I brought it up. She found the sex worker by using the internet and filled out the Touching Base referral list form. I got about 5 names/referrals. My sex worker was the first one who answered my phone call.

(cerebral palsy, male, 60-64 years, heterosexual)

These examples show that the level of support can vary greatly between individuals. For this man, assistance was only needed at the beginning to find contact information for suitable

sex workers so he could autonomously start the booking process. For others, without assistance at every stage they would be unable to facilitate a booking. The next section of this chapter continues to focus on third-party support mechanisms, when assistance is also needed on the day of the booking.

6.5.3 Attending sex worker appointments

The second question in Section 4 moved the focus away from locating suitable sex workers, to being able to attend a booking. Participants were asked ‘have you had any assistance or support to access sex worker services?’ with the option of choosing two specific answers: ‘No [I organise and meet the sex worker independently without anyone else involved]’, or ‘Yes’. There were 31 participants who answered yes, with these respondents being directed to an additional question to determine the types of support provided. Eight specific options were given, with participants able to nominate all that applied. From these 31 participants, a total of 82 answers were chosen, including 6 utilising the ‘other’ option to give additional information. Total responses are provided in Table 14:

Answer	%	Count
Someone drives me to/from the appointment	20.7%	17
Someone helps me get ready for the appointment (ie. Showering/dressing)	17.1%	14
Someone helps me with transfers to and from the bed	13.4%	11
Someone helps me pay the sex worker (gets my money from my bank account/organises invoice and then transfer of payment)	12.2%	10
Someone helps me book the appointment (via email/online/phone/text/Facebook messenger etc)	12.2%	10
Someone answers the doors and lets the sex worker into my house when they arrive	8.5%	7
Someone helps me with un/dressing	8.5%	7
Other (please specify)	7.3%	6
Someone helps me get my home ready (cleaning the house, getting clean sheets and towels ready, making sure I have enough tissues etc)	0.0%	0
Total	100%	82

Table 14: Assistance PASA-Research survey participants received to access sex worker services

The findings show that assistance was provided for many aspects of the booking process and attendance, from booking the sex worker appointment on behalf of the client ($n=10$, 12.2%), driving the person to the booking ($n=17$; 20.2%), helping with transfers ($n=11$,

13.4%) and assisting with payments ($n=10$, 12.2%). Additional information provided included *a staff member who lives at my boarding house drives me to the bank to get my money* (schizophrenia, male, 60-64 years, heterosexual), and a therapist of another participant helping to organise their appointments. While the question presumed that assistance would be about attending locally based appointments, one response reflected a deeper level of investment and support provided by those closest to them:

I need help with travel. Because I have to go to Melbourne to see him (unless he comes to Sydney) I need someone to come with me and help me book plane tickets, accommodation etc and to help navigate the airport and make sure I don't get lost in a city I don't know well.

(autism/depression/anxiety; demigirl, 30-34 years, grey asexual)

A secondary open-ended question was also provided to all survey participants stating:

Please share any other information about this process. This could include any difficulties you may have experienced organising the booking, or stories about support staff/family that have made the experience either extra special or very difficult.

A total of 73 individuals (67.6%) provided additional insights into their experiences during the booking process. From their responses five main areas of focus emerged:

1. Engagement with the sex industry, both positive and negative experiences
2. Positive support from third parties
3. Negative experiences regarding support staff
4. Personal feelings and experiences
5. Funding and payments

6.5.3.1 Engagement with the sex industry, both positive and negative examples

There were both positive and negative experiences shared by participants regarding interactions with sex workers during the booking process. Much of the positive feedback spoke to a smooth and supportive process which was easy to navigate and guided by the sex workers. For example:

Both booking processes were fairly easy. The first booking was via email of which I asked if I was a suitable client as many would feel I don't have a "traditional disability". She understood the anxiety I had when it came to sex and was so welcoming and understanding.

(social and sexual anxiety, male, 30-34 years, heterosexual)

The sex worker was the one whom was very good at explaining what was required when making the booking and subsequent instructions for example getting there, etc. It is the sex worker that should guide the process of booking, paying etc. as it's all new to support workers/family. It was a very good process and was happy with it.

(intellectual disability and autism, male, 35-39 years, heterosexual)

Some participants also highlighted the sex workers' willingness to adapt their availability to support individuals' needs. For example: *Sometimes my availability doesn't suit their schedule but most try and accommodate* (quadriplegic, male, 35-39 years, heterosexual), with another stating:

Planning ahead/pre-booking is often very difficult for me due to my unpredictable sleeping times. So what helps a lot is flexible arrangements where I can get in touch on a given day when I am doing well and can be mindful, present, and enjoy the mutual experience.

(sleep disorders, male, 40-44 years, heterosexual)

However, several difficulties were reported regarding interactions with sex workers, as well as with establishments such as brothels and hotels. General dissatisfaction included sex workers not replying to emails, failing to confirm payments or bookings promptly, and a lack of suitable furniture in their workspace. A notable example was shared by Susie Q, a 76-year-old woman with a spinal cord injury who uses a wheelchair. She was driven to the appointment by her support worker and shared details of her experience with her male sex worker: *much to my carer's and my amazement the sex worker's bed consisted of a floor mattress with sheets and doona which is what we laid on*. She highlighted the significant occupational health and safety risk posed by this, not only for herself but to her support worker who was required to transfer her to and from the mattress on the floor. As this sex worker was referred to her by Touching Base and advertises as someone who provides services to clients with disability, there was a very real expectation from Susie Q that the sex worker would be well versed in being able to properly accommodate the physical and mobility needs of people with disability.

A lack of 'disability-friendly' sex workers was a prominent topic. As one participant said, there's *lots of discrimination, many don't want to see people with disability* (cerebral palsy, male, 30-34 years, heterosexual), with another saying *when I mention I have a disability, I often don't hear back from the sex worker* (quadriplegic, male, 50-54 years, heterosexual). This emerged as prominent issue from the interviews with participants who were seeking male sex workers, as well as those living in rural or regional locations.

Issues raised about sex services premises (brothels) included a lack of disabled parking, being provided an unsuitable shower chair, changing opening times and being *homophobic towards female clients*. The inaccessibility of establishments was a prominent theme that emerged within the interviews. For example, Matthew said:

Look, it's not that easy getting a sex worker for a person with a wheelchair, to be frank. Most brothels are really, really terrible. You know, in terms of disability and the social model of disability, for example, you know, it isn't me who is broken in the world. I mean, the sex work environment is one in which there is barriers to accessing a sex worker. It's one of the things I thought actually worth talking to you about in the context of this. So most establishments are in the back of buildings, down/up thin stairs.

(SCI/quadruplegia, male, 50 years, heterosexual)

Discriminatory and confusing outcall practices were also mentioned with one man sharing how an establishment sent someone to do what they described to him as 'an initial security check' of his place. This turned out to be a security man arriving at his front door with a credit card reader in hand, with the escort standing behind him. While this is not common practice for an outcall booking, it accentuates the need for sex industry staff to be mindful in explaining what the standard procedure will be and the rationale for doing so, to alleviate feelings of awkwardness and concern from the client.

The lack of accessible sex worker spaces prompted some participants to use hotels or motels. One man recounted a particularly difficult occasion:

I booked an accessible room but on the day only a normal room was available. Difficulty accessing the hotel, day of booking the hotel driveway blocked... I was unable to get out of my car to check in. It required help from the sex worker for me to access car park, check in to hotel.

(paraplegic, male, 40-44 years, heterosexual)

While this example speaks to an accessibility difficulty it also exemplifies how some sex workers can go out of their way to provide additional support to clients when needed. In his interview Joseph identified an additional issue with hotels, describing the absence of ceiling hoists in accessible rooms. He described his own process of hiring a portable hoist and having it delivered to his chosen hotel before his sex worker arrived. Reflecting on this additional barrier people with mobility support needs experience in these premises, he said:

yeah, something definitely to change. You know, there has to be some new legislation that says every hotel must have, at least one hoist, one ceiling hoist or a hoist on the premises to assist people with disabilities.

(cerebral palsy, male, 30 years, heterosexual)

Within the interviews there was an additional issue raised in relation to when the participants' preferred sex worker retired. This was an unexpected finding and not one that has been previously identified in the literature. Multiple interview participants spoke about the anguish and sadness of losing contact with their preferred sex worker, alongside the difficulties in finding new connections. This was partially alleviated when sex workers were able to give notice of their retirement or relocation, and provided referrals to other colleagues who they felt would be a suitable match with the participants, however this did not always occur.

6.5.3.2 Positive support from third parties

Responses from many survey participants indicated that they relied on external supports to be able to pursue daily life activities, including being able to attend bookings with sex workers. Third party supports identified by participants included parents, siblings, cousins, adult offspring, friends, and disability support workers. Positive comments outlining their involvement included:

Understanding support workers definitely gave me the courage to seek out a worker.

(physical impairment/sensory impairment, male, 40-44 years, heterosexual)

At the time I had an amazing carer who supported enthusiastically with access to dressing and underdressing after the appointment

(quadriplegia, female, 75-80 years, heterosexual)

My family and support are very open and supportive that I'm still able to fulfil my wants and needs both physically and emotionally, which really makes it more comfortable for me not to feel judged, embarrassed or ashamed as we are all human and have desires to be fulfilled.

(quadriplegic, male, 35-39, heterosexual)

One man, who is blind, also gave a detailed example of how they utilised their support staff in the preliminary booking stage:

It is definitely a lottery as to how assistance with the help of a support worker can be done. I sometimes get my workers to look at the pictures to make sure the worker doesn't have any signs of drug use... not everyone is willing to do this. Fortunately I now have a little more confidence to navigate the sites myself and

bookmark the pages myself so when I get a visit from my support workers who are non-judgemental I can get their opinion ... so as a blind person I can say there's a bit of work to do in this area.

(Blind, male, 55-59, heterosexual)

This man's experience highlights that people with disability do not receive universal standards of care, with the opportunity to access sexual services often reliant on the availability of non-judgemental and supportive support workers in their lives. As the next section illustrates, many participants also shared negative experiences, due to the action – or inaction – of disability support staff.

6.5.3.3 Negative experiences regarding support staff

Survey participants provided a range of negative accounts of staff being actively unsupportive of their choice to pay for sexual services. For example, one man with cerebral palsy (50-54 years) said: *I have had staff walk in during my booking, despite the fact I have a do not disturb sign on my door*; while Anna, a woman with degenerative neuromuscular condition (41 years), shared that some staff openly showed their disapproval of her being sexual, of her sexuality, and her decision to hire a female sex worker. This included not wanting to assist in transferring Anna before or after sexual activity, complaining that they should not have to help with her showering and toiletry needs after sex, and telling her that they were writing about what she had been doing in the shared support notes with staff. Other participants spoke about having to organise their scheduled appointments around when the 'good staff' were on shift. For example:

For a long time I saw the same sex worker once every 8 weeks but it had to be booked in on a certain day to correspond with the staff's RDO²⁹ day so that there were less staff working at the house and those staff were the good supportive ones.

(cerebral palsy, male, 65-69, bisexual)

I have had some judgment from support workers about engaging with a sex worker but I try to organise appointments around days where I know my supportive workers are on.

(spinal muscular atrophy, female, 40-44 years, queer)

What also emerged was a lack of forethought from some staff about the importance of the sex worker appointments to the client. When individuals are reliant on support staff for all areas of coordination and transportation they are often disempowered and unable to actively ask for assistance. This was encapsulated by one man who shared:

²⁹ RDO is shorthand for 'rostered day off'

When I've had to miss or cancel appointments (because of COVID or our boarding house is in lockdown/isolation) the staff have never asked me if I would like to organise a catch-up appointment. It's always been my sex worker who has asked me if I want to have a catch-up booking. When I say yes I ask her to email or call my support workers to organise it and then it has happened.

(schizophrenia, male, 60-64 years, heterosexual)

Again, while this shows a lack of active support from staff, it does outline how sex workers may provide additional support outside of their primary role as sexual service provider, especially if they already have a professional working relationship with their client's support team.

These findings show that support workers can either be the most staunch advocates or the worst gatekeepers regarding the ability of people with disability to access sex worker services. This was acutely reflected in the last participant's experience where a 20-year gap occurred between sex worker visits due to a lack of appropriate support:

In 2012 I was in a different boarding house and I had a support worker who suggested he could take me to a sex worker. This was because I had been commenting on peoples' feet and the colour of the girl's toenails. I had told them about all the other sex workers in the past. This current sex worker I have seen since 2014. She in the first one in 2 decades. The last one before that was 1994.

(schizophrenia, male, 60-64 years, heterosexual)

Another man shared how he relied on one specific support worker to coordinate his visits to a brothel, which ceased when she stopped work:

my carer found a boyfriend and left her job and stopped working with me so it was a long time before I could find another carer I could trust to organise this again.

(cerebral palsy, male, 65-69 years, bisexual)

Disability organisations, who provide support workers can also create internal policies that can impede a person's ability to access sex workers. This was highlighted in one response from a man who visits brothel-based sex workers : *the agency only allows male support workers to take me and there is only one of them now so I have to rely on him* (brain injury, male, 45-49 years, heterosexual).

These examples indicate that support workers can play a pivotal role in the sexual lives of a person with disability, with many participants also mentioning trust as an integral factor in deciding if they could broach the subject of sex or sex workers with members of their support team.

6.5.3.4 Personal feelings and experiences (emotional labour and stress)

There is an absence of literature that examines the range of emotions people with disability may experience when trying to book a sex worker. However, this was a prominent theme that emerged from insights provided through both the surveys and the interviews. Multiple participants stated that the booking process was stressful, very difficult, time consuming, or they became quite nervous and concerned they would do or say something wrong. Insights from one man highlighted this emotional impact:

I was very scared to make a booking the 1st time. It took me 2 days to build up the courage to call the sex workers. It was overwhelming the 1st time because I had never done this before. But now I'm good and confident in making new bookings.

(cerebral palsy, male, 60-64 years, heterosexual)

Raven, who in addition to her diagnosed disabilities, experiences a lot of social anxiety and self-esteem issues, spoke about taking over six months to build up the courage to book her first appointment with a male sex worker, which was also her first sexual experience with another person. When talking about the lead up to this first booking, they shared:

you know, I had heaps and heaps of anxiety. It was like the scariest thing I've ever done.... the first time I went, you know, like, I didn't sleep at all the night before or anything. Like I was just so freaking the fuck out.

(autism/PDA/anxiety/ADHD, demigirl, 34 years, heterosexual).

After five years of seeing the same sex worker twice a year, Raven noted a significant change in how they now approached this booking process:

I am more comfortable and adept with doing it now, you know, the whole process of making a booking and going and doing it, like I'm not as completely and utterly on edge and, you know, messed up as I was the first time. You know, like, it's gotten a lot easier.

(autism/PDA/anxiety/ADHD, demigirl, 34 years, heterosexual)

These experiences shared by participants underscore the potential emotional impact the booking process can be for some individuals with disability, while familiarity and experience can eventually alleviate such intense feelings

6.5.3.5 Funding and payment issues

Participants identified a variety of funding and payment issues experienced during the booking process. With the introduction of internet banking, money apps and cardless deposits at ATMs, many sex workers have been able to alter their business practices to incorporate deposits and pre-payments into their booking procedures. This moves away

from the historical process of clients paying cash on arrival and gives a level of assurance to independent sex workers that clients are making a genuine booking and will turn up at the mutually agreed upon time and date. This has reduced fake bookings and no-shows, while providing an automatic cancellation fee for sex workers when this does occur. This shift has also been welcomed by many with disability as removing the need to carry large sums of money in public alleviates their fear of being robbed or potentially losing the money in transit. This was reflected in the interviews, along with one survey response stating: *the booking process is generally very smooth. BeemIt³⁰ is a gamechanger* (ASD³¹, male, 30-34 years, queer).

However, the ability to be able to pay a deposit is often dependent on the level of autonomy and independence a person has over their finances, so this new deposit requirement was also cited as a difficulty experienced during the booking process. Adding to this, several answers reflected how *cost was a significant issue*, with one person mentioning that escort fees were too expensive and another sharing that *as a pensioner I could not afford any more visits although I would have liked to* (quadriplegic, female, 75-80 years, heterosexual).

Four survey respondents shared additional difficulties with their NDIS funding, with two reporting negative reactions from NDIS workers. One described feeling judged by their NDIS manager, while another recounted that *the NDIS's LAC visibly recoiled and said NO!!* when they asked to include sex worker services in their new NDIS Plan.

In interviews, Nicky (cerebral palsy, female, 64 years, bisexual) said that while her NDIS coordinator was supportive of her including sex worker services, someone working in a NDIS office had explicitly told her 'no we don't do that'. Additionally, Fiona (neurological/ psychosocial & complex physical disabilities, female, 57 years, heterosexual) mentioned that her Local Area Coordinator (LAC) refused to include sexual services within her NDIS Plan review. Most troubling to her though, was that her new case manager refused to authorise her sex worker's invoice, despite her previous plan management doing so. Due to this, it had been over a year since Fiona had seen her sex worker, saying she was *absolutely devastated*.

While Joseph (cerebral palsy, male, 30 years, heterosexual) eventually had sex worker services approved by the NDIS, he struggled to receive correct information from the government. As he shared: *I kept getting conflicting information. 'Yes, you can', 'No, you can't'. And then they were like 'yes you can' and I'm like 'OK, cool' and then a few months later I called to double check and they were like 'no you can't'*. He was told his request was refused due to

30 BeemIt is now known as Beem. It is an Australian instant money transfer App that is backed by EFTPOS: <https://www.beem.com.au/>

31 ASD stands for Autism Spectrum Disorder

an internal NDIS policy which participants, LACs and Coordinators were denied access to. A detailed report from his occupational therapist eventually secured approval, though Joseph found this to be an arduous and demeaning process. As he explained: *well it makes you feel that my opinion doesn't matter. That my word is a lie. You know that what I'm telling you, what I'm telling them, is not true ... unless it's justified by a professional.* Joseph also shared that an NDIS representative advised him to fraudulently invoice for 'support worker' time to cover their sex worker fees, advice he did not follow.

Additionally, Sally (cerebral palsy, female, 64 years, bisexual) shared that before the roll out of the NDIS she was able to use her state/territory specific disability support funding to pay for sex worker services, but had been denied the equivalent funding when becoming an NDIS Participant. This lack of continued care and support left her feeling 'gutted'.

Additionally, Sally (cerebral palsy, female, 64 years, bisexual) shared that before the roll out of the NDIS she was able to use her state/territory specific disability support funding to pay for sex worker services, but had been denied the equivalent funding when becoming an NDIS Participant. This lack of continued care and support left her feeling 'gutted'.

Another issue directly related to the NDIS, involved sex workers refusing to see clients who required them to invoice their NDIS Fund. Reasons cited included the sex worker wanting to be paid cash at the start of the booking (historically how the sex industry operates), not having an ABN³², having no experience in generating invoices and being fearful of the NDIS breaching their privacy by sharing their personal identity with their clients.

Finally, one man recounted a negative experience where he transferred the payment in full, only for the sex worker to ignore his calls and not turn up to the arranged booking. Although he won his case against her at the state tribunal, she took down her advertisement and changed her phone number, preventing authorities from recovering his money. Despite the sex worker later resurfacing on adverting sites, the emotional and physical effort required to take up the issue has deterred him from re-engaging with authorities to retrieve his money. The police were also unsupportive, dismissing his complaint as a scam and refusing to intervene, even though he explained that it was a case of theft, and they had a professional role in recovering stolen property.

Findings generated from a subsequent question about finances and payments is provided next.

32 ABN is an Australian Business Number. Sole traders can operate in Australia under their tax file number. It is only if a worker has to invoice for services and/or has an annual turnover of more than \$75,000 and needs to register for Goods and Services Tax (GST) that an ABN is required.

6.5.4 Funds used to pay for sex worker bookings

The third question in Section 4 asked participants: ‘where did you get the money to pay for the sex worker/s? (click all that apply)’. There were 12 static answers to choose from along with the ‘other’ option. There were 169 responses given including 14 individuals who shared additional information. The findings are provided in Table 15:

Answer	%	Count
From paid work/income	34.9%	59
Disability Pension	30.8%	52
NDIS funding	10.7%	18
Saved up my money from Christmas/birthday presents	8.3%	14
Insurance payout	2.4%	4
Inheritance	2.4%	4
Guardianship and Trustee releases my money	0.6%	1
Aged Care Pension	0.6%	1
Parent/s paid for it	0.6%	1
Sibling/s paid for it	0.6%	1
Offspring paid for it	0.0%	0
Used gift vouchers given to me	0.0%	0
Other	8.3%	14
Total	100%	169

Table 15: Funds PASA-Research survey participants used to pay for sex worker services

The four top responses were:

1. from paid work/income ($n=59$, 34.9%),
2. disability pension ($n=52$, 30.8%),
3. NDIS funding ($n=18$, 10.7%) and
4. saved up my money from Christmas/birthday presents ($n=14$, 8.3%).

There were 14 additional responses given in the ‘other’ open text box option, including two regarding insurance payouts (Total and Disability Insurance Payout (TDP)³³, and a lawsuit won against their insurance company); four spoke about using their own money (i.e. through selling a car, money saved after ‘a split’, collecting cans and bottles), one person paid using

33 <https://moneysmart.gov.au/how-life-insurance-works/total-and-permanent-disability-tpd-insurance>

Superannuation³⁴ payments; another used their Jobseeker³⁵ welfare entitlements, while one used the COVID payments provided by the Australian Government during COVID-19 lockdowns³⁶. Two participants also mentioned additional types of pensions with one sharing : *I save a certain amount from my veteran pension every fortnight and have a SW³⁷ fund and depending on the service required I set my financial goal to meet the payment* (PTSD & depression, male, 55-59 years, heterosexual).

Earlier in the survey, when asked about locating suitable sex workers, two participants said they specifically looked for sex workers who were ‘NDIS friendly’. While the survey findings indicate 18 participants have utilised NDIS funding to access sex worker services, several responses showed that others are being denied the same support. As one participant said: *I have ndis funding but they won’t allow me to use it for sex workers*. Participants also spoke of being fearful of their current NDIS funding being taken away from them if they spoke up about wanting to include sexual services, or of being subjected to an internal review process as a kind of ‘punishment’. For example:

Difficulties in getting NDIS on board, during my review when I asked for a sex worker to be added to my plan. The NDIS’s LAC visibly recoiled and said NO!! She then went onto tell me I’m being I’m being audited.

(physical disability, female, 55-59 years, heterosexual)

It was an unfortunate oversight that survey participants were not asked if they were NDIS participants. However, this question was posed to all 27 interviewees, with 19 indicating they were supported by the NDIS in some capacity. Of these, only five had been able to utilise their NDIS funding to pay for sex worker services. Reasons for not using such funding included preferring to use income generated from their full-time employment, fear of being judged by the NDIS Planner or coordinator, and being told the NDIS does not cover sexual or relationship needs. One interviewee mistakenly believed that NDIS participants received a fixed amount of funding that would not increase regardless of changing circumstances or needs, leading him to worry that booking a sex worker would reduce his already limited therapy funds.

Interviewees spoke at length about their frustration with the lack of NDIS support, the misinformation provided by people ‘in charge’, how arduous the application process was, and the increased number of service providers who were required to provide professional

34 <https://www.ato.gov.au/individuals-and-families/super-for-individuals-and-families/super/what-is-super>

35 <https://www.servicesaustralia.gov.au/jobseeker-payment>. This welfare payment use to be known as ‘the dole’ and then the Newstart allowance. The name changed to JobKeeper on 20th March 2020 <https://www.servicesaustralia.gov.au/newstart-allowance>

36 https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp2122/Quick_Guides/COVID-19DisasterPayments

37 SW = sex work or sex worker. Important to note that within the disability community ‘SW’ is also used to refer to a support worker, so context is everything

assessments regarding their private sexual needs. Most importantly, participants shared how their own assessment concerning what types of services would provide the most benefit to their growth and development were often ignored. For example, Paul (hemiplegia, male, 40 years, heterosexual) said: *well, I'm looking at this confidence building goal. And yes, psychology helps and everything but there's one thing that really helps me with like confidence building and that's sex work.* He went on to talk about the level of documentation provided to the NDIS about his requests for funding and the subsequent reply:

That OT³⁸ – she was fantastic. She wrote a long report, with some background research. I think she even got some research from Touching Base and some academic research about how sex work is important for my confidence building and integration into society ... all this stuff ... and it was just fantastic because she referenced it appropriately. She sent that to my NDIS case manager and he wrote back and said “oh nahhh I don't think sex workers would be supported here. Perhaps you should speak to your MP”.

(hemiplegia, male, 40 years, heterosexual)

Phillip also emphasised the importance of having autonomous choice and flexibility within each person's plan, saying:

People should be able to have choices. Some people want this, others want that, and some people just want extra anchovies. There's nothing wrong with ordering extra anchovies if that's what you want that day.

(SCI³⁹/anxiety/depression, male, 49 years, heterosexual)

These findings reveal that people with disability draw from diverse sources of funding to pay for sex worker services. This included using their own income, disability pensions, insurance payouts or personal savings. These findings also underscore significant financial barriers faced by participants, particularly regarding NDIS funding. For example, despite 18 survey participants reporting use of NDIS funds for sex worker services, several were given misinformation and experienced a lack of formal support, while others feared negative repercussions for requesting such services.

6.6 'WHY' – motivations for accessing/ceasing sex worker services

The fifth section of the PASA-Research survey focused on participants' motivations for accessing sex worker services and if they continue to do so. It included two main questions. The first asked why participants sought out sex workers, providing a list of predefined answers and an open-ended prompt: 'Please share any other information about your decision to visit a sex worker, including any advice or information you received,

38 OT is shorthand for Occupational Therapist

39 SCI is shorthand for spinal cord injury

or if someone suggested it to you’. The second question inquired if participants were still paying for these services. Those who answered ‘no’ could explain why they had stopped by selecting from the multiple-choice options, with the option to add additional comments in an open-text box.

6.6.1 Motivation for seeking sex worker services

The first question, ‘Why did you decide to visit a sex worker? (click all that apply)’, provided 12 multiple choice answers for participants to choose from. There were 387 responses with 29 participants also giving additional information via the ‘other’ option. Findings are presented in Table 16 in descending order of preference, with a visual representation also provided in Figure 13. Ten out of the 12 static options were nominated by participants. Only ‘All my friends were doing it, so I went with them to the brothel’ and ‘Partner/husband/wife had passed away, but I still wanted intimacy/sex’ were not chosen. However, two different references to friends were provided in the comments section:

- *all my friends were doing it but I didn’t want to go with them so I went by myself at a different time,*
- *all my friends were doing it so I asked my carer to organise that where she could take me to see what sex was all about.*

Answer	%	Count
I enjoy sex and touching!	18.4%	71
I was lonely	15.3%	59
I couldn’t get a girlfriend/boyfriend	12.7%	49
To try new or different sexual activities	10.1%	39
To practice how to touch and talk to someone sexually	8.8%	34
To lose my virginity	8.0%	31
To learn about sex	5.9%	23
To find out what my sexual functioning was (‘if it all still worked’) after accident or illness	5.7%	22
To experience specific sexual activities that I can’t do with my partner	4.1%	16
To gain confidence after an accident	3.6%	14
Partner/husband/wife had passed away, but I still wanted intimacy/sex	0.0%	0
All my friends were doing it, so I went with them to the brothel	0.0%	0
Other reason/s	7.5%	29
Total	100%	387

Table 16: Reasons why PASA-Research survey participants chose to pay for sex worker services

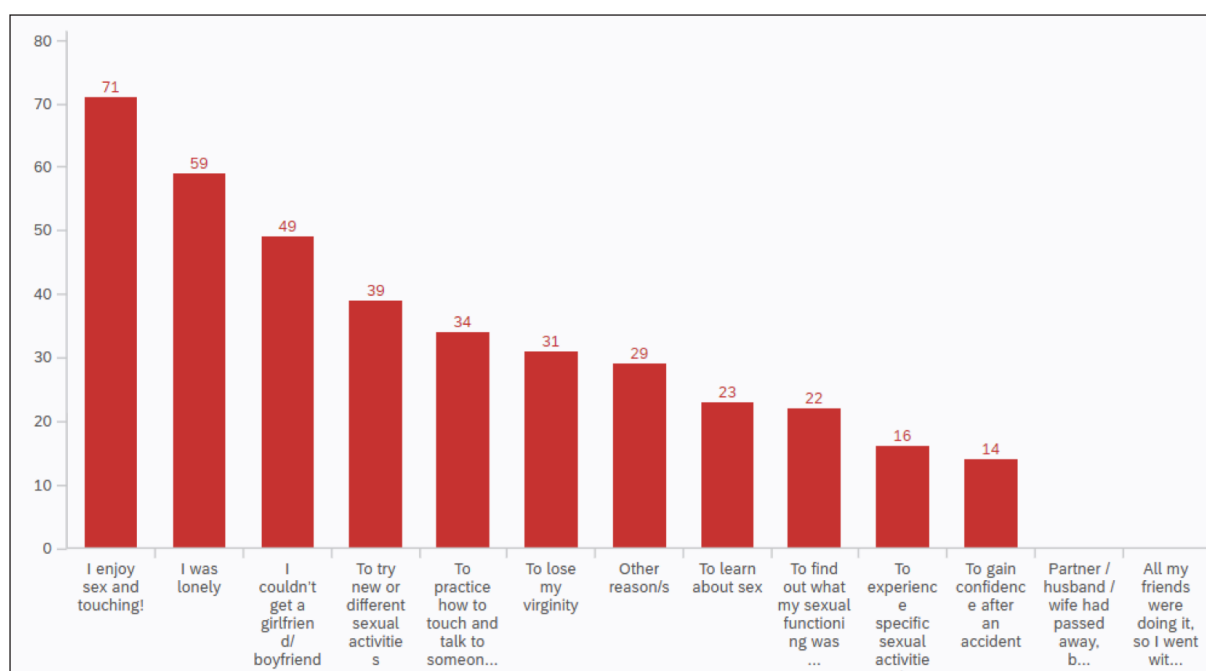


Figure 13: Motivations of PASA-Research survey participants to seek out sex work services

A thematic analysis of the answers from the survey revealed eight specific motivational categories. These were reinforced by what was shared in the interviews. They were:

1. Sexual enjoyment
2. A desire for sexual variety
3. To combat loneliness and feelings of isolation
4. Seeking genuine intimacy and connectivity
5. Lack of other sexual outlets
6. To increase sexual literacy
7. Therapeutic healing
8. Recovery and rehabilitation

These factors were also reflected in a later response, when participants were asked to share a favourite time or experience with a sex worker. In both sections extensive written details of their motivations were provided including how interactions with their chosen sex worker/s enriched their lives. Many shared more than one reason with one of the most profound answers being:

- a. To experience another human's touch without rubber gloves and in a non-medical, non-clinical way.
- b. To pretend, just for a moment, to have a 'normal' physical relationship.
- c. To experience sex. It is incredibly sad to think that the vast majority of animals enjoy, at least to some degree, and yet my community inhibits me from enjoying, what is for some, a daily pleasure: sex.

- d. Stress release, mental health, and an immunity boost.
- e. Most importantly, for the enjoyment! It is the best experience ever.
(cerebral palsy, male, 55-59 years, bisexual)

These eight different motivational factors are discussed next.

6.6.1.1 Sexual enjoyment

The most common answer regarding the motivations for booking sex workers was *I enjoy sex and touching* ($n = 71$, 18.4%). As one participant surmised: *it's good to have skin on skin contact with someone*. This aligns with findings from previous client research and also dispels the myths that people with disability are asexual and not interested in enjoying sexual activities. Answers referenced it being a fun activity, needing release from sexual frustration, and *I was horny and masturbating wasn't enough* (cerebral palsy, male, 30-34 years, heterosexual). Some approached this decision in a very practical manner, with one man stating: *I wanted sex for years and I wasn't getting it* (Asperger's⁴⁰, female, 30-34 years, bisexual), and *I just had been thinking about it for a while and just decided to do it* (stroke, male, 25-29 years, heterosexual).

6.6.1.2 A desire for sexual variety

Participants did not just talk about wanting sex but wanting *to try new or different sexual activities* ($n = 39$). Specific activities included fulfilling a fantasy, enjoying certain fetishes and engaging in BDSM services. Section 6.3.4 previously outlined the diverse range of services participants had paid sex workers to provide, which demonstrates that not only do people with disability want and enjoy sex, but equal to the general population, may also enjoy sexual activities that fall outside of the stereotypical 'normal' or 'socially acceptable' variety.

The desire for sexual variety also included the opportunity *to experience specific sexual activities that I can't do with my partner* ($n = 16$). This last option refutes the idea that people with disability are unable to find romantic or intimate partners, but, equal to clients in general, may sometimes seek sexual activities that are not enjoyed within their primary relationship.

6.6.1.3 To combat loneliness and feelings of isolation

The second most common reason for participants to seek out sex worker services was *I was lonely* ($n = 59$). Participants provided the rationale for their answer as well as examples

⁴⁰ Aspergers is how the participant described their disability however this diagnosis is no longer used, with it now classified as autism spectrum disorder (ASD), level 1.

showing the positive impacts sex worker appointments had had on their lives, and their sense of well-being. For instance, one man said:

I had been single for a few years and the loneliness was making me beyond stir-crazy, and dating was so hard because I was sleeping so much due to health problem ... she was lovely, it made my week and I felt so much better for over 1 month after...

This man later went on to say:

I'd like sex workers to know that a short time with them, can mean 3x, 5x, 10x as long later, of feelings of connectedness, gratefulness, excitement, relief from anxiety or loneliness, and a sense of groundedness as a human.

(sleep disorders, male, 40-44 years, heterosexual)

Multiple participants spoke about how sex workers provided the only meaningful interactions in their lives, helping to alleviate their sense of isolation and loneliness when their disability precludes them from being able to make friends easily. As shared in the survey:

SW's make me feel wanted and desired ... I find it better to see the same SW as it provides me with a sense of continuity that eases my loneliness ... I am extremely lonely, isolated, awkward and I do not have the ability to create a loving mutually affectionate relationship. I can think of nothing better than finding a mutually loving relationship. However, this eludes me and visiting SW's provides some ease.

(PTSD & depression, male, 55-59 years, heterosexual)

This sense of isolation and loneliness was especially profound in Merlin's life, who explained ... *someone looking at me and actually smiling. I don't get that much from anyone.* He added:

I don't mean to completely expose my inadequacies as a human being ... I know I really shouldn't be relying on sex workers, and them alone, for any happiness in life, but I'm just not getting happiness from ... from ... I'm not getting many avenues of happiness these days ... And well, sex workers ... they've been pretty much the only people that I can turn to in terms of kindness ... I don't have many friends left in the world.

(autism/depression/anxiety/paranoia/mild ID⁴¹, male, 32 years, heterosexual)

Many life events can compound feelings of loneliness or contribute to a person's level of isolation, including divorce, retirement, or relocation. The onset of illness or disability,

41 ID is shorthand for intellectual disability

or being separated from one's partner when moved to a nursing home or hospital, are additional factors that people with disability may contend with. This can be compounded when both partners are living with disability or illness, as reflected by one participant who shared: *my wife is in a nursing home for the last 11 years but I live alone in a retirement village. I was lonely.* This man went on to say:

The boys from work – when I use to work – told me about them [sex workers] as they were concerned about my health and happiness. I wasn't myself for a long time as my wife had a freak/unexplained illness and has full time care in a nursing home.

(cerebral palsy, male, 60-64, heterosexual)

The decline in a person's physical or mental health can take a huge toll on a person's sense of self and wellbeing. It is on these occasions sex workers provided a safe and confidential space for participants to 'recharge' both their body and mind, while addressing their skin hunger and need for connectivity with another human being. This was apparent in the interview with Hans (PTSD/depression, male, 56 years, heterosexual). Leading up to the interview he sent a preliminary email, outlining how his disability had impacted him:

My family life, social skills, intellectual ability and professional abilities have been terribly distorted and over the years and up until the present day has left me isolated, socially and emotionally inadequate and at times I have had painful experiences with alcohol. Suffice to say I find it challenging to get up in the morning. It's a life of positive bursts followed by negative outcomes.

Within the interview he shared more details of his life, his previous job in the armed services, how he acquired his disability, and the impacts that has had on his life since:

... then I was diagnosed with PTSD, quite severe depression, and my social life was pretty bad. I couldn't talk to people. Even though I don't like being alone, I get very lonely, but I can't be with people. I just irritate ... I irritate the fuck out of people ... You know, I'm lonely ... like so lonely.

This acknowledgement brought Hans to tears, with the pain of his current situation etched across his face. It was only when talking about his current sex worker that a big grin emerged, his demeanour became lighter, and he spoke with joy in his voice. He went on to explain more about his motivations, saying:

I love being touched. I love touching and there's something about it for me ... I literally get a sense of ... I just feel normal ... And if I don't have it for a long time, I ache. Like ache. I get a sore heart. And I'm like ... I just hunger for it. And so I thought about going to see sex workers for a long time.

(PTSD/depression, male, 56 years, heterosexual)

6.7.1.4 Seeking genuine intimacy and connectivity

The concepts of pleasure, intimacy and connectivity were frequently mentioned in both the responses and the interviews. As Peter succinctly said: *Needed touch, cuddles, genuine girlfriend experience*, providing a unique perspective on how sex workers contributed to his emotional sense of well-being. When talking about what initially motivated him to seek out sex worker services he said:

I just needed some, some intimacy, some sexual contact. ... And you know it's not all just about sex, we normally spend just an hour laying there just chatting about things, you know. Which is nice. You know, just the intimate contact and talking about things is quite pleasurable. I enjoy it.

(prostate cancer/blood illness, male, 73 years, heterosexual)

He went on to explain how his favourite sex worker became his confidant throughout his prostate cancer diagnosis and subsequent prostatectomy. During his recovery he shared his personal feelings of loss with her, commenting *I felt like I had lost my manhood* while explaining that she supported him both emotionally and physically, especially when he became reliant on using Caverject⁴² injections to get an erection for his bookings. In the interview he divulged that his erections were getting weaker, and he was contemplating a penile pump, with his sex worker being the only person he could discuss the pros and cons with. As he explained:

whether I'd like to do that, I don't know, because it's not a very pleasant procedure. It's very painful, apparently. So that's what I'm thinking and she discusses it openly with me and she's actually said "I don't think you'd like ... you know, if it didn't work? and so it's good having somebody to talk to. She's the only person I could talk to on an intimate basis. You know, I have plenty of friends, male and female, but I could talk to her ... I can talk about anything.

(prostate cancer/blood illness, male, 73 years, heterosexual)

This theme of being accepted for who they were without judgement, while being able to enjoy genuine moments of intimacy resonated throughout most interviews. For Yoshi his motivations included the following:

just to build up confidence and to have those needs met as well, for intimacy ... connection. It's not about the sex of me. It's just about being able to, you know, be accepted for who you are and not judged and yeah, feel like a human being ... I still haven't had vaginal sex yet. And it's not interested me but just feeling loved as a human being and having connection is more important.

(blind/pituitary gland deficiencies, male, 38 years, heterosexual)

42 Treatment for erectile dysfunction

<https://www.healthdirect.gov.au/medicines/brand/amt,43991000168102/caverject>

Participants also spoke about the importance of experiencing a wide-range of activities that emulate what people would enjoy within a real-life relationship. For example, Samantha (Cerebral Palsy, female, 39 years, bisexual) spoke about having a dream of slow dancing in a field of flowers so her sex worker created that scenario using her hoist in her home. For Anna, it was about experiencing a type of ‘girlfriend experience’:

So most of the time, it was here at home. But we have done also a couple of social outings as well. So we went to see a couple of shows, which I thought was amazing getting to experience that. You know, that intimacy without the sexual component? Was just lovely, just holding someone’s hand in the show. So yeah, it was great
(degenerative neuromuscular condition, female, 41 years, bisexual)

Accessing sex worker services to experience intimacy and connectivity was sought after not only between the person with disability and their sex worker but to induce a newfound or increased level of intimacy between partners. This was especially true when both partners live with disability and have limited mobility. For example:

My husband and I both have physical disabilities. We chose to try a sex worker. I think that its important to bond with my husband... I managed to have sex with my husband for ten years. Although I was very embarrassed at first, after a few sessions I felt relaxed and closer to my husband.
(cerebral palsy, female, 60-64 years, heterosexual)

In her interview Sally (cerebral palsy, female, 64 years, bisexual) spoke about how seeing a sex worker keeps her marriage alive and allows her to maintain a close connection with her husband. For example, they enjoy a whole ‘date day’ ritual which starts with going out for coffee in the morning, then getting ready for the sex worker, enjoying the booking together, having another shower when the sex worker leaves, then going back to bed together and falling asleep holding hands and cuddling.

6.6.1.5 A lack of other sexual outlets

Within the survey, 49 participants chose, ‘I couldn’t get a girlfriend/boyfriend’ as a motivational factor for booking sex worker services. Combining this with the additional answers given identified two underlying reasons: (1) an absence of a current sexual partner, and (2) an inability to form intimate and sexual relationships. While the former reason aligns with motivational factors previously determined in the literature for clients in general, the latter was found to be a direct correlation to a person’s disability, as seen by the following statements provided in the survey:

- *I guess it was a natural progression as my disability made things harder for me*
- *Can’t masturbate*

- *Need sex and can't have relationships due to my disabilities ie prefer to be alone after sex, schizoid etc*
- *I lack the social skills and confidence to get a girlfriend, and*
- *I'm too anxious to leave the house for dating purposes*

During their interview, Raven (autism/PDA⁴³/anxiety/ADHD, demigirl, 34 years, heterosexual) shared how their disabilities, including social anxiety and low self-esteem, had precluded them from finding anyone they were attracted to. Interactions with a sex worker created a safe opportunity to explore different sexual experiences that they had witnessed friends and family enjoying with partners. Raven's motivation reflected the same rationale as many other participants, saying: *So, I've sort of gone through my whole life, like wanting to do these things, but just not having anyone to do them with.*

The absence of a current partner in their lives was a fluid issue for some participants. Six participants mentioned that they stopped paying for services once they found a regular partner (as outlined in Section 6.7.2). For others, sex workers provided a short-term solution to meet their current physical and emotional needs. For example:

Covid travel shutdown meant I couldn't see my usual occasional partners. I was very aware of missing physical intimacy, the touch and snuggling much more than sex. I was also aware I was letting that affect my relationships with some friends – my need for intimacy was not their problem and I wanted to take steps to stop feeling deprived and grumpy about it. I was newly divorced and diagnosed and didn't think I could cope with a new relationship/liaison as I wasn't very emotionally stable.

(autistic/ADHD/dyscalculia, female, 45-49 years, heterosexual)

This level of sexual self-awareness, and the desire to avoid negatively impacting those close to them were also evident in responses that mentioned their partners:

- *My wife can't do it as much as I can,*
- *Wife is not well herself and I needed to still be sexually active but it's hard, and*
- *Partner not interested any more in sex.*

Finally, some participants, in lieu of having a regular partner, chose to book sex workers to celebrate special occasions. For instance, Bobby (cerebral palsy, male, 34 years, heterosexual) celebrated his 30th birthday with a female sex worker, Samantha (cerebral palsy, female, 39 years, bisexual), celebrated her 38th birthday with her preferred male sex worker, and one survey respondent shared:

43 PDA stands for Pathological Demand Avoidance

recently, I had my 40th birthday and organized to go to a hotel with an escort. We had dinner with him and then we walked on the beach. Then we had sex.

(cerebral palsy, female, 40-44 years, heterosexual)

The activities detailed in the interviews, and survey responses, illustrated how bookings of this nature often mirror activities that would be expected to occur between intimate partners in a relationship.

6.6.1.6 To increase sexual literacy

The sixth motivational factor for seeking out sex worker services was to increase a person's sexual literacy, with 34 participants choosing *to practice how to touch and talk to someone sexually*, 31 participants answering *to lose my virginity*, and 23 participants nominating *to learn about sex*. One participant also described how he wanted to maintain his ability to be sexually intimate, emulating the common phrase 'use it or lose it':

To maintain a sense that the ability to be intimate and very close, is still possible if I meet someone special in future in regular life. ie: If I don't utilise the ability to be intimate, even in a scenario of sex work where it is not the same as a relationship, then I have feeling that it is one of those skills or abilities that can somewhat atrophy or degrade over time. So keeping that window of possibility open is part of it.

(sleep disorders, male, 40-44 years, heterosexual)

The interviews revealed that approaching birthdays sometimes played a significant role in deciding to have sex for the first time. This was noted in the experiences shared by:

- Rick – for his 18th birthday (cerebral palsy, male, 42 years, heterosexual)
- Christopher – leading up to his 21st birthday (cerebral palsy, male, 38 years, heterosexual)
- Merlin – just after his 26th birthday (autism/depression/anxiety/paranoia/mild ID, male, 32 years, heterosexual)

Anna also spoke about losing her virginity with the encouragement of her friends. This coincided with her moving out of home, providing increased independence and space to explore her sexuality:

So I wanted to not be a virgin when I was 40 years old ... well, it sort of was something I was thinking about a long time before ... but when I finally got to live by myself, my friends said, "Come on, it's time. You need to". And they encouraged me because I probably wouldn't have done it by myself. And yeah, I finally got the guts and, yeah, two weeks before my birthday I saw my first person, and she was wonderful.

(degenerative neuromuscular condition, female, 41 years, bisexual)

As Anna's story illustrates, sex workers have provided a safe and supportive environment for LGBTQIA+ participants to explore their sexuality. Their services also helped individuals address issues of discrimination related to their disability, as Ben explained:

I face a lot of discrimination when I go to the gay spa out in the community so lose some of my confidence. So I book them to make me feel wanted, to boost my confidence levels and because sometimes I just want to have sex with someone who I'm safe with and knows how to fuck me the way I want.

(cerebral palsy, male, 31 years, queer)

The theme of increasing confidence and skills to start dating was common among participants. As one participant noted, this allowed them to explore different roles as an adult: *to allow me to be more than a worker, teammate, family member, patient ... develop skills needed to move thru the stages of life* (cerebral palsy, 40-44 years, heterosexual). Several participants discussed how their disability impeded their ability to naturally experience important growth and development stages alongside their peers, leading them to seek the services of sex workers:

Talking about stuff, going seeing counsellors, putting movies to try to pick up, how to interact with someone of the other sex – it just does not compare to actual physical practise and when you miss the window of development which is usually teenagerhood you pretty well by necessity going to have to create a kind of artificial situation to develop skills. Lack of confidence around sexual capabilities probably keeps a lot of people with disabilities out of long-term relationships, with a pretty big impact on taxpayers' dollars due to the lack of informal supports.

(quadriplegia, male, 45-49 years, heterosexual)

During his interview, Paul discussed his learning process with sex workers, attributing his ability to start dating to the encouragement and support he received from them:

and the self confidence thing, I mean, it's helped with dating. So I've been on a few dates. ... but sex workers have been giving me advice, like on my dating profile or if I go on a date they say "oh you can text me how it goes or you can text me during the day". ... by seeing sex workers and interacting with them, and learning about the female form it helped me to build confidence to date more. So that's certainly something I'd attribute to (sex work) ... learning also about my likes too with a female ... what kinds of females I like. What ones, in terms of dating and moving forward, what type of partner I'd be interested in too.

(hemiplegia, male, 40 years, heterosexual)

Building on Paul's previous point, numerous participants discussed how engaging with sex workers provided them the freedom and time to discover their desires, preferences and boundaries without the pressure of having to fulfil their partners' expectations, as expected in a real-life relationship. Patricia (autism/ADHD/depression/anxiety/chronic pain, non-binary, 21 years, bisexual) clearly articulated this sentiment, saying: *I also like that it's very much just focused on my pleasure then, and not on someone else's pleasure or meeting someone else's wants and expectations.* Additionally, as mentioned before, Anna talked about booking a female sex worker to explore her sexuality, in conjunction with learning how to pleasure another person and exploring her own body's sexual and functional capacities. These experiences gave her the confidence to start dating, ultimately leading to her meeting her current girlfriend. When reflecting on what she gained from seeing her sex worker she said:

I swear that she's the one that really gave me the confidence to be able to express what I need to my partner ... if I'd have met her (GF) 12 months before, I don't know that we would have worked because I couldn't have said what I needed. And I couldn't express my needs. And I would have felt very inadequate and [my sex worker] worked with me to help me find my voice and find out what I liked and wanted and needed and how to express that to another person.

(degenerative neuromuscular condition, female, 41 years, bisexual)

The concept of utilising sex worker services as a safe 'practice run' was highlighted by numerous participants, including Joseph. When discussing his motivations to pay for an overnight booking he expressed:

I've never slept next to someone ... and also it would give me a good picture of what it would look like when I move out of home as well. And so that's one of the other reasons ... I wanted to sort of get a mental picture in my head of what it could look like if ... when I decide to move out of home.

(cerebral palsy, male, 30 years, heterosexual)

An essential component to learning about sex, sexual functioning and enjoyment is how to use safer sex equipment. Sex workers played a specific educational role for participants, as highlighted by two interviewees who mentioned receiving assistance from their sex workers to determine the correct condom size for themselves. For example, Bruce spoke about encountering persistent issues with condom breakage, which had made him fearful of dating and lacking confidence in being able to initiate intimacy safely in future relationships. However, he expressed delight in how his current sex worker had taught him how to use condoms properly, while also helping him find the right size and brand:

... that was a lot of fun! We actually went through, well I went through and got a whole range of different shapes and sizes, and ... 'cause they're all different. They've got all different materials and different shapes that fit better or worse and all the rest of it, so I've got about 10 different types and we spent two hours working out which one works the best.

(multiple sclerosis/speech impairment, male, 44 years, bisexual)

6.6.1.7 Therapeutic healing

The seventh motivational factor to book sex workers involved utilising their services for therapeutic healing. Several participants independently shared their experiences about prior sexual assaults and leaving 'toxic relationships', then explained how engaging with sex workers assisted in their physical and psychological recovery. For instance:

I choose a sex worker as my only sexual experiences were with my X Perpetrator, my first experience was actually rape. I was coerced into things that made me uncomfortable and I didn't want to do. I choose a sex worker who was age appropriate, knew my history and knew that I would have full say over what we did and didn't do. It also allowed to experiment with things I had always wanted to try.

(PTSD/Trauma, female, 60-64 years, heterosexual)

Later in the survey this woman elaborated further on her reasons for seeing a sex worker, saying:

Although I have been sexually abused, I still wanted to have some pleasurable experiences with a man. Choosing a sex worker afforded me personal and physical safety, it went at my pace. Some sexual positions I can't do due to all the Trauma, a trained sex worker has knowledge of many ways to achieve pleasure. It gave me more confidence that I was actually ok with the things I was doing to pleasure them as well. It has helped me become in contact with me as a sexual being and given loads more confidence.

(PTSD/Trauma, female, 60-64 years, heterosexual)

Section 6.7 highlights a range of positive outcomes experienced by participants, however one man was particularly articulate in expressing his recognition of the therapeutic value of accessing sex worker services:

... for many, a sex worker is the single most important person who can unlock so much emotional pain and provide deep physical relief not possible by traditional care. It is in my opinion a very different experience to what much of the public

experience. In some cases it can open up ones life and I'm sure in some cases save a person's life.

(social and sexual anxiety, male, 30-34 years, heterosexual)

6.7.1.8 Recovery and rehabilitation

The eighth motivation for seeking sex worker services involved participants' recovery and rehabilitation after an accident, illness or injury. In the survey 22 participants chose to *find out what my sexual functioning was ('if it all still works') after accident or injury*, with 14 also nominating to *gain confidence after an accident*. These motivational factors were reflected in additional comments provided by survey participants:

I'd like to emphasise that lots of people who have acquired a disability (or grown up with one) employ the services of sex workers in order to figure out what works (or doesn't work) and to gain confidence for re-entering the dating pool in the future.

(spinal cord injury – paraplegia, male, 40-44 years, heterosexual)

I was very sexually active with a strong sexual appetite before my injury and after adjusting to my life with a spinal cord injury. My desire for sex and appetite for physical and emotional intimacy didn't change just because I broke my neck but had to learn how to go about having a sex life in a different way.

(quadriplegic, male, 35-39 years, heterosexual)

The involvement of sex worker services in a person's recovery and rehabilitation was also addressed in the interviews. For example, Jerry (paraplegic, male, 57 years, heterosexual) spoke about the lack of sexual contact in the six years after his accident, with his sex worker allowing him to *get back on the horse*, work out what was physically possible and made him feel *liberated*. This importance of sexual functionality was also articulated by both Matthew and Phillip:

I mean, sex is a hot topic for spinal cord injury. It's one of the major areas of loss when people sort of talk about spinal cord injury as it's "terrible, you can't walk" most people ... most, a lot of guys don't ... they couldn't care less about walking but loss of sexual function is a huge part of the injury.

(Matthew, quadriplegia, male, 50 years, heterosexual)

sometimes you just want to work it out ... kind of like "oh right yeah, no that was fun" ... or "yeah that didn't work". Because it's just ... you get practical straightaway. Don't bloody talk to me about how I feel about it. That's ... like I'll do that as well, I love counseling. But yeah, I gotta see, well, know the mechanics.

So part of seeking out a sex worker would be, hey, I want to get this sort of sorted out, so I know what I'm dealing with.

(Phillip, SCI/anxiety/depression, male, 49 years, heterosexual)

Multiple participants also acknowledged the medical benefits of seeing sex workers, specifically around reducing chronic pain and spasms during and after their sex worker appointments.

6.7.2 Reasons why participants stopped seeing sex workers

The final question in Section 5 asked participants 'do you still see sex worker/s?'. From the 104 participants who answered this question, 83 (79.8%) individuals responded in the affirmative. The 21 participants who responded 'no' were given an additional question asking why they were no longer paying for sex worker services. There were six who had stopped because they 'now have a partner/girlfriend/boyfriend', with another choosing 'I got married'. The other reason given was 'I wanted to spend my money on other things' (n=4). Their answers are provided in Table 17:

Answer	%	Count
I now have a partner/girlfriend/boyfriend	25.0%	6
I wanted to spend my money on other things	16.7%	4
I got married	4.2%	1
My funding was stopped when I moved onto an NDIS Plan	0.0%	0
I moved and the new staff won't support me	0.0%	0
My support worker moved/retired so I don't have anyone to take me/organise the appointment for me	0.0%	0
My preferred sex worker retired	0.0%	0
My friends/family didn't approve	0.0%	0
It went against my religious beliefs	0.0%	0
Other	54.2%	13
Total	100%	24

Table 17: Reasons why PASA-Research survey participants no longer pay for sex worker services

Thirteen participants provided supplementary answers, with financial difficulties emerging as the most prevalent reason, with responses such as: *cost too much*, and *cannot afford it*. Similarly, four participants explicitly mentioned issues with securing sex work services as a part of their NDIS Plans:

During my review the LAC visibly recoiled when I asked for a sex worker to be added to my plan, she did tell both myself and my SC⁴⁴ that I was going to be audited.

(physical disability, female, 55-59 years, heterosexual)

I haven't had the money to be able to have one since becoming totally blind and on NDIS.

(blind, male, 60-64 years, heterosexual)

Just too hard and lots of other things going on. Went the AAT route – but is top of my list (as part of a goal to have partner).

(quadriplegia, male, 45-49 years, heterosexual)

I haven't had OT⁴⁵ touch on the subject so hasn't been put in my plan.

(partial paraplegic – spinal cord injury, male, 30-34 years, heterosexual)

Other reasons included difficulty with logistics, an inability to find a sex worker (especially in regional and rural locations), not knowing where to look, deciding it went against their personal beliefs and focusing on other areas of their life. One man also shared his experience of visiting a sex worker when he was 25, feeling an immense amount of guilt afterwards. As he explained:

I have only seen a sex worker once in my life and I regret it. I feel like I exploited them and their vulnerability for my own sexual gratification.

(language disorder, male, 45-49 years, heterosexual)

Two respondents also mentioned not needing or wanting to see sex workers at the current time but acknowledged that it would still be a viable option in the future if circumstances changed in their lives.

6.7 Outcomes of sex worker appointments – personal reflections

The findings outlined in this chapter have shared how participants located their sex workers, their experiences with the booking process, if they needed support to attend the appointment, what services they paid for, where the bookings occurred, how they paid and the motivational factors as to why they sought out the services of a sex worker. This last section shares the impact of these bookings and how interactions with sex workers have made participants feel. These include both positive and negative experiences.

44 SC stands for Support Coordinator

45 OT stands for Occupational Therapist

6.7.1 Positive interactions and outcomes

Participants provided comprehensive feedback about the positive impact their sex workers had on their lives, with one declaring: *they make me feel like my life has meaning* (Motor vehicle injury, female, 30-34 years, heterosexual). Another man elaborated on this perspective, stating:

To me, sex workers make such a difference. You all keep me going in a world that makes it very clear that people like me are not considered part of it. The kindness, gentleness, understanding ... it all makes a difference to us.

(autism/anxiety/depression, male, 35-39 years, heterosexual)

Many expressed a desire to create a sense of normalcy in their lives, with one stating: *Not treated as broken. Feel normal again* (multiple sclerosis, male, 40-44 years, heterosexual), while another shared: *every time is amazing – she makes me feel like an ordinary man* (autism movement disorder/OCD, male, 40-44 years, heterosexual). This sentiment resonated with the interview participants who identified an upsurge in their confidence, encompassing both their social skills and sexual literacy. For example, Joseph discussed how deciding to see sex workers empowered him to pursue other ambitions in life, distinct from his sexual expression:

and I can tell you from experience that even just for the first time I've seen a sex worker I felt like my mood, my outlook, just my goals in life changed dramatically, and it leaves me feeling a lot more fulfilled in life and just happy with where I'm at ... It's probably one of the best decisions I've ever, ever made. Honestly, like after seeing a sex worker for the first time, I realized that there was so much that I could do. And I'm not talking just in terms of the bedroom, I'm talking in terms of life goals, in terms of what I could achieve, and so that sort of opened the door and showed me that 'yes, you can do it if you really want it'. And now I'm currently doing my Diploma in [redacted].

(cerebral palsy, male, 30 years, heterosexual)

Furthermore, Fiona reflected on her initial decision to book a male sex worker in response to questioning her sexuality and desires. She needed to determine whether her aversion to sex stemmed from her former partner's erectile dysfunction issues or was a symptom of menopause. She delighted in telling me: *And the only thing I can say is, well, my sex drive is alive and well! He really re-ignited a passion back in me that I'd been missing for so long*. When asked about the impact these bookings had on her, she replied:

Wanted! Wanted! I haven't felt wanted in friggin years... Apparently I'm walking around like a Cheshire Cat for about two weeks after, and two weeks prior too... and even my psychologist ... I was seeing him and I knew [my sex worker] was due to come over ... and he actually picked up on me, that my whole demeanour had changed from being sort of serious, to being like a giddy child. That's what he does for me. That's how excited I get!

(neurological/psychosocial/complex physical disabilities,
female, 57 years, heterosexual)

Additional positive feedback highlighted an enhanced sense of purpose and well-being, feelings of relaxation and happiness, as well as decreased feelings of loneliness and isolation. Sex worker bookings also facilitated an increased acceptance of participants' bodies, while teaching them how to adapt and embrace new avenues for sexual expression, in light of their disability and newly acquired physical limitations. Moreover, several participants acknowledged the medical benefits experienced after sex worker bookings, particularly in terms of reducing chronic pain and spasms, enabling individuals to be able to relax and sleep better in subsequent days.

The sentiment, *Feeling of safety. No pressure. No judgement* (Neurological/physical, female, 45-49 years, pansexual), was reflected in multiple responses, and often hinged on how sex workers were non-judgemental, and provided a safe and supportive environment to explore, with no pressure to perform or take on the role of an attentive partner. Feeling safe emerged as a recurrent theme, with comments such as: *that is often the safest way to have needs met* (Neurological/physical, female, 45-49 years, pansexual), and *people with disability are much less likely to be taken advantage of by a sex worker than by a random member of the public* (ASD/ADHD, male, 25-29 years, heterosexual). Fiona elaborated on this in her interview when discussing the disparity between seeing her sex worker and the prospect of going out on a social date with someone new:

It IS safer. Because I do realize that being a disabled person, I am vulnerable. And then also being a woman of almost 60 years old, that makes me vulnerable again. So like I said, while I tend not to pay a lot of attention to my own safety. I am aware that by seeing him I am also reducing any risk factors that are to myself.

(neurological/psychosocial & complex physical disabilities,
female, 57 years, heterosexual)

This research was conducted following a series of COVID lockdowns across Australia. During the data collection phase in 2022, COVID continued to circulate within the community at fluctuating rates. Consequently, some participants expressed feeling safer visiting a sex worker one-on-one rather than attending large social gatherings or sex/

fetish parties, where they perceived the risk of compromising their health and contracting COVID-19 was still high.

In addition, many survey participants highlighted the positive attributes of the sex workers' demeanour and character as significant contributors to a positive experience. For example:

My worker [redacted] was remarkable. She was understanding, kind, and enthusiastic. After a few years of no sex and zero confidence in my body, she made me feel at ease. Ultimately, I saw a professional because I needed a sexual encounter where there was no onus on me to 'perform', no need to complete the encounter with orgasm, and no need for me to have maintained my own level of attractiveness.

(multiple sclerosis, male, 45-49 years, heterosexual)

I felt accepted, wanted and desired, confident in myself, connected and always on cloud 9! Pretty much everything a "normal" couple would do in an intimate encounter and experimenting with things I've wanted to try or do again but have to adapt in a different way being paralysed from the neck down..... I found most sex workers I've had bookings with are incredibly genuine and caring people which only made my encounters more enjoyable and treasured.

(quadriplegic, male, 35-39 years, heterosexual)

At the end of the day most of us desire the same things as everyone else. To be understood, heard, to give and receive intimate touch, to have an orgasm when the urge strikes and to find a safe environment, free of judgement where we for even a brief moment can forget the limitations of our disability and share a human connection.

(quadriplegic, male, 35-39 years, heterosexual)

The therapeutic aspects of increasing a person's sense of self-worth were also evident in the responses, with a specific emphasis on enhancing their mental health while simultaneously decreasing self-deprecating feelings held about themselves. As one woman reflected: *it's great for mood and self esteem. It's literally a real game changer in terms of managing stress and depression* (muscular sclerosis, female, 45-49 years, lesbian). Others echoed similar sentiments:

Also, the mental health benefits are noticeable, and occasionally incredible. It can feel like a huge burden is lifted mentally, feeling lighter in oneself, feeling more human, feeling more optimistic and connected. Feeling less nihilistic. Liking people more, in general. Liking oneself more, in general.

(sleep disorders, male, 40-44 years, heterosexual)

It actually helped me mentally. It made me feel better about myself. I didn't feel ugly. I didn't feel nasty. I didn't feel like a loser.

(PTSD/depression, male, 56 years, heterosexual)

And finally:

The best sex workers understand often its far more than sex they are offering to a client. Generally the ultimate benefit is mental freedom of external and self judgement, negative assumptions, self criticism, feeling not good enough. For the majority of people with disability I feel the experience is such a power health tool both physically and mental. I wish it was more widely accepted and used as a tool for one's care.

(social and sexual anxiety, male, 30-34 years, heterosexual)

6.7.2 Negative interactions and outcomes

Preceding findings in this chapter have identified a spectrum of negative experiences encountered by participants when attempting to either locate, book or attend a sex worker appointment. Participants also identified undesirable experiences during a booking, as well as negative feelings and emotions induced by booking sex workers. For example, Fred (male, 62 years, heterosexual), who is legally blind but can detect different light sources, spoke about his discomfort with the escorts' drivers/security men lurking around his house during the booking, setting off the sensor lights in his yard as he was having sex with his sex worker in the bedroom. He also felt quite vulnerable having the men come to his front door to take the payment at the start.

Susie Q described a distressing experience where she had an unexpected bowel movement due to the pressure of her sex worker lying on top of her:

when you lie down, if you are having intercourse, or sex, or whatever you want to call it, and you've got a man on top of your body and you're not really able to open your legs to use your legs to wrap around theirs or anything like that, you've almost got a dead weight on your and what I discovered, very unfortunately, afterwards ... was that I had a small bowel motion, and if I'd been lying on a bluey, which is really like an underpad, it wouldn't have been so embarrassing...I could have died with embarrassment at the time. I felt terrible. But all we could do was cover it up with "oh, well, not to worry....You know, shit happens. Ha ha", sort of thing.

(quadriplegic, female, 76 years, heterosexual)

In his interview, Charlie (cerebral palsy, male, 45 years, queer) recalled an incident where his neighbour knocked on his door mid-booking threatening to report him to the building's strata. This, along with a support worker's likely adverse reaction to finding lingerie or a

dildo in his home, has left him too anxious to continue booking sex workers for the time being.

Several responses highlighted discrepancies between the appearance of the sex worker who arrived and the depiction in their advertisement. Another participant mentioned: *some sex workers have been a bit mean to me* (physical disability/vision impairment/learning impairment, male, 45-49 years, heterosexual), while additional comments described instances where sex workers failed to show up for appointments, cancelled at the last minute without explanation, or ignored requests for future appointments. As Bobby noted:

I've had one person ghost me after ... well, we'd finished, but then I kind of contacted them again and said, 'Hey, do you want to chat again?' And got no response ... and I know they're still working. So I was wondering whether I'd done something wrong or something like that.

(cerebral palsy, male, 34 years, heterosexual)

Additionally, as outlined by one man's experience in Section 6.5.3.5 (Funding and payment issues), a few participants recounted instances where deposits were paid but the sex worker failed to show up. Furthermore, one man shared an incident of discrimination in which the sex worker refused to provide services but retained his money:

The only bad experience was when a sex worker came to see me in a group home a long time ago. The staff paid her but when she saw I had a disability she wouldn't have anything to do with me. When the staff asked her for my money back she refused and left. We rang up the agency where we had booked her from and they wouldn't do anything. We didn't get a refund. So I lost my money and didn't get anything.

(cerebral palsy, male, 65-69 years, bisexual)

The issue of sex workers not respecting personal boundaries was also brought up. For example, one man (MVA⁴⁶ injury/autoimmune illness, male, 35-39 years, heterosexual) shared: *One worker tried to upsell services during the session and after we had agreed on boundaries, payment, and needs. This was not conducive to my comfort or repeat business.* In addition, two significant incidents were shared concerning sex workers breaching the physical boundaries of individuals. The first involved a male sex worker who provided services to a woman:

46 MVA is shorthand for motor vehicle accident

The second time I just wanted massage. I was very emphatic about not wanting anything sexual, and at the end of the 2hr booking he concluded by putting his finger on the opening of my vagina and telling me we're finished. It was extremely awkward and boundary crossing.

(invisible disability, female, 45-49 years, queer)

The second incident involved a man seeking to explore his sexuality with a trans (woman) sex worker. Although taken aback that the person was not post-op he proceeded with the booking out of curiosity. He shared what transpired next:

anyhow before I could do anything before we had put on condoms he grabbed both our dicks unprotected and it shocked me, I mentioned I want to put on protection, he did without an argument and I haven't seen him again (his account has not been up since). The bad news is I tested positive to Herpes not long after and I feel so stupid, and a bit hard done by as I've never not worn protection with an escort in 20 years.

(quadriplegic/ABI, male, 44-49 years, heterosexual)

Stereotypical myths and prejudices against sex workers further exacerbated participants' anxiety during or after the booking. This encompassed concerns about whether the sex worker was there of their own volition, particularly when the sex worker was from South East Asia, as well as and fears of contracting sexually transmitted infections (STIs). As one man explained, this apprehension stemmed from the belief that: *sex workers have sex with a lot of people and that could put me in jeopardy* (ASD/CDD⁴⁷, male, 25-29 years, heterosexual).

Concerns for the physical and emotional well-being of the sex worker were also voiced, with one man stating:

sometimes, occasionally, sex workers have been possibly drug-affected or maybe suffering from mental health or emotional issues, which meant I didn't feel comfortable around them and politely made my exit in a gentle but fairly swift manner. It's very hard to know what to do in these scenarios, there's not a lot you can do to help as a client, and thankfully it's been very rare.

(sleep disorders, male, 40-44 years, heterosexual)

Lastly, for some participants negative feelings emerged after the booking, including a sense of shame associated with paying for services, which originated from the sadness of not being able to find a partner. This sentiment was echoed by one participant who

47 ASD stands for autism spectrum disorder. CDD stands for childhood disintegrative disorder

expressed *Feeling very vulnerable afterwards. It had been a long time since I felt “wanted” and I struggled emotionally afterwards with knowing it was just business* (neurological/ physical, female, 45-49 years, pansexual).

6.7.3 Since the interviews

During the process of obtaining informed consent to use each participants’ interview transcription, over half the interviewees provided updates on their lives, including whether they still booked sex workers and any feedback or progress with NDIS applications or requests. All gave explicit permission to include this additional information in the findings of this research. A few examples, relevant to this research, are shared next.

Ben, a 30-year-old self-managed NDIS participant had undergone a random compliance check with the NDIS. He provided comprehensive evidence to the government authorities about what and how his funds were used. As he stated: *It was important for me to be honest and transparent so I included sex workers in my evidence*. He received a call three months later saying everything looked fine. A bit dubious, Ben called the representative back to double check saying: *I asked her about my sex work claims and she said the way I described it and how it related to my disability was perfect and she didn’t have to second guess it*.

In contrast to Ben’s experience, Yoshi revealed that not only had the NDIS rejected the comprehensive reports supporting his request to include sex worker services, but his Plan Manager refused to pay invoices from his psychosexual therapist. In addition, the Plan Manager was demanding the therapist refund monies paid from previous invoices. The discriminatory and erratic nature of NDIS decisions is evident through Figure 14 which displays a screenshot of the automated response the NDIS web bot provided to Yoshi’s LAC when trying to advocate on his behalf. It is also worth noting that Ben and Yoshi received these inconsistent rulings from the NDIS around the same time.

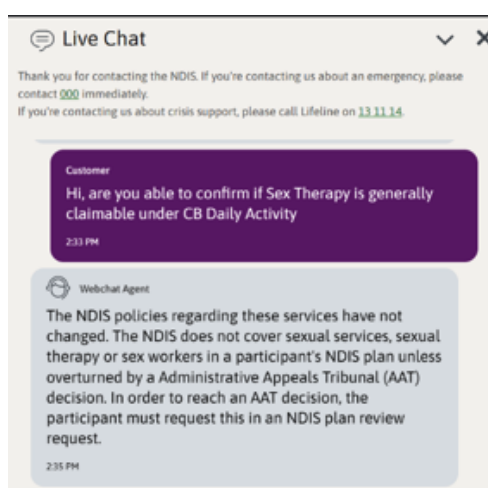


Figure 14: Automated NDIS web bot information provided for an enquiry about sex therapy.

Since his interview, Phillip had embarked on a journey of investing in his own sexual growth and development. He had begun appointments with a sexological bodyworker and had been actively participating in various workshops and sex/intimacy coaching sessions. Additionally, he had visited a couple of new sex workers for sexual massages, noting that he now feels more relaxed and able to enjoy these appointments more than before.

Raven shared the milestone of traveling independently for the first time in her life, flying interstate to meet their sex worker while handling all aspects of the booking and travel arrangements. Despite finally being approved as an NDIS participant, her funding did not cover all essential therapy requests, leaving her to speculate how she could express the importance of sex worker bookings for her and be believed. Additionally, her sex worker had substantially raised his prices up, which concerned Raven that her bi-annual appointments would have to decrease to once every couple of years due to a lack of funds.

In their interview, Charlie talked about exploring their sexuality and gender identity with the assistance of sex workers and articulated a four-year plan of moving towards ‘coming out’ and fully transitioning. This has included choosing their real (female) name, which is different to the name used when sex workers helped transform them into their female persona during bookings. They also mentioned having to start over to find sex workers of a different gender as they no longer felt that female sex workers could provide the most suitable services for their needs.

Several participants had, for various reasons, stopped seeing sex workers since their interviews. Two women expressed that the progression of their disability had significantly reduced or eliminated their capacity to enjoy sex or intimacy in any meaningful way, leading them to reluctantly stop seeking sex worker services. One man had also finally experienced an overnight booking with his sex worker, which subsequently boosted his confidence enough to start dating, eliminating his desire to pay for sex worker services.

Finally, since her interview, Anna and her girlfriend have become engaged. She expressed to me how grateful they both were to the sex worker who facilitated the physical and emotional space for Anna to explore her sexual needs and learn how to confidently communicate them with her now fiancé.

6.8 What participants would like the general public to know and understand

Survey and interview participants were invited to share their thoughts on what they would like the general public to understand about people with disability who chose to pay for sex worker services. The prevailing viewpoint emphasised the need to recognise people with

disability as sexual beings and respecting their autonomy to articulate their own desires and needs rather than making decisions on their behalf. Perspectives included:

- It would be nice if the general public had a more enlightened view of people with disability – there seems to be a disinclination to consider us as sexual beings or as being desirable.

(ASD/ADHD/dyscalculia/physical disability, female, 45-49 years, heterosexual)

- That people with a disability are not asexual and that we have desires just like people without a disability.

(cerebral palsy/bilateral sensorineural hearing loss, male, 30-34 years, heterosexual)

- that we have sexual intimacy needs just like everyone else and we need to be respected and supported.

(autism movement disorder/OCD, male, 40-44 years, heterosexual)

- We are human and have wants, needs and desires.

(paraplegic, male, 30-34 years, heterosexual)

- We are human with needs and wants just like everyone else.

(physical disability, female, 55-59 years, heterosexual)

- We may look different but we have the same sexual feelings as the general public.

(cerebral palsy, male, 65-69 years, bisexual)

- Sex is part of a human experience and disabled people should be able to have access to that as well.

(PTSD/Trauma, female, 60-64 years, heterosexual)

- Do not judge as it has improved my quality of life immensely and I feel like a different person.

(mild intellectual disability/autism, male, 35-39 years, heterosexual)

- Our right to a sex life and to experience all parts of the human experience should be no different to anyone else. It's just that sometimes due to the constraints of our disability or the constraints of our environment/community we benefit from the services of someone who has particular knowledge and experience and where we are not required to play the dating game where many of us are at massive disadvantage so that we too can share in what is at its core a very human experience.

(quadriplegic, male, 35-39 years, heterosexual)

Being less judgemental and discriminatory was also a common sentiment conveyed by participants:

Just want to get through to them that they need to accept people with disability and not want to segregate people with disability into different rooms or parts of society. People shouldn't be able to discriminate against us. People should stop thinking we can't or shouldn't have sex or get married. Stop living in the past and live in the present and support people with disability to live our lives the way we want to.

(hemiplegia, male, 60-64 years, heterosexual)

Additional messages included removing negative attitudes and stigma associated with paying for services, as well as increasing the social and professional status of sex workers and their occupation. As Peter reflected:

I think the way society perceives sex work is frankly, just awful. Sex, and sex workers ..has made a big difference to me, in my life, and I'm very grateful to them. And they're just ordinary people. They are just nice people. People think they're some sort of nasty, weird, strange people or marriage breakers, whatever. But they're not. They're just ordinary ladies, just doing a job and getting paid well for it and it's sort of a valuable service. They've really helped me in life.

(prostate cancer/blood illness, male, 73 years, heterosexual)

Participants also expressed a desire for society to acknowledge the significance of sexual contact in a person's life, with one commenting: *the sector, which disapproves of sex work should try living without sex (including masturbation) in their intimate relationships* (cerebral palsy, male, 55-59 years, heterosexual). Another encouraged the public to contemplate what it would be like to live with disability, saying: *Don't judge. Put yourself in their shoes. I believe many people could not even handle 1 year in their shoes, let alone a week, so take a look in the mirror first before making snap judgements and jokes* (sleep disorders, male, 40-44 years, heterosexual). Additionally, responses emphasised the importance of treating people with disability with dignity, respect and equal to anyone else in society:

Stop with the judgement, enough with the frowns and the negative stigma. Why is it that you all can go and see a sex worker or go and be with a partner but a person with a disability is not allowed to do the same? Why do we have to miss out? We have feelings too. We have desires to be held and loved and wanted just like the rest of you. We want the same things too. We deserve those chances as well. Your support and understanding would be highly loved by us and appreciated.

(autism/anxiety/depression, male, 30-34 years, heterosexual)

Multiple people wished to relay how their disability impedes their ability to organically find a partner in society, while also experiencing ablest attitudes during social activities. One participant described the decision to access sex workers services as *an ethical alternative to celibacy* (depression/OCD/PTSD, male, 40-44 years, heterosexual), with this perspective supported by another:

Living with a disability is frustrating. The desire for sex, without an outlet is frustrating. The ability for me to find a suitable partner for intimacy is impossible. What are my options? I can't masturbate, i can't find a suitable partner, what are my options? A life without intimacy for me is sad and depressing long periods of depression and frustration are not healthy.

(paraplegic, male, 40-44 years, heterosexual)

Finally, to understand the significance of their sex worker appointments, interview participants were asked how they would feel if they could no longer see their sex worker/s. Samantha (Cerebral Palsy, female, 39 years, bisexual) responded by saying: *oh my god. I would cry. No, no, no, I would cry. I would think what the fuck am I gonna do now?* Nicky (Cerebral Palsy, female, 64 years, bisexual) said, *I would probably feel profound sadness*, adding that she would also feel incredibly disappointed and depressed, while voicing concerns about the negative physical repercussions on her body, stating: *my spasms would get worse, and I can't talk clearly.*

6.9 Conclusion

These findings provide a comprehensive overview of the multifaceted experiences of people with disability who have accessed sex worker services in Australia. Participants self-identified with 48 different disabilities or conditions, grouped into six specific categories: physical, intellectual, sensory, mental illness, neurological and neurodivergent. They represent a broad demographic spectrum, including various ages, genders and sexual orientations, with responses provided from every Australian state and territory.

Participants' preferences for sex workers varied widely in both gender and the services paid for, reflecting their diverse sexual needs. Various methods were used to locate sex workers, such as online platforms, referrals, third-party support, in-person and via print media. The choice of sex worker was influenced by factors such as the worker's prior experience providing services to clients with disability, overall impressions from their advertisements, attractiveness and services offered. Third-party support was often crucial for locating and accessing services, with both positive and negative experiences reported. Financial barriers, especially regarding NDIS funding inconsistencies, were raised as significant issues.

Motivations for seeking sex worker services included sexual enjoyment, a desire for sexual variety, to combat loneliness and isolation, seeking intimacy and connection, and increasing sexual literacy. Some participants also utilised sex worker appointments to assist in their therapeutic healing, recovery and/or rehabilitation journey.

Participants shared both positive and negative reflections on their experiences with sex workers. Their narratives underscored the essential roles that sex workers played in their lives, not only with sexual fulfilment and exploration, but in fostering emotional well-being and self-confidence. Negative experiences highlighted issues such as discrimination, emotional stress, inadequate education and support mechanisms, funding difficulties and a lack of suitable sex workers.

These findings offer valuable insights into the experiences of people with disability who access sex worker services, significantly contributing to the current literature. Chapter 7 will analysis these findings in the context of current research and explore how they align with and support the principles of sexual citizenship. This analysis will focus on four key areas: participant demographics (disability types, age, and geographical locations), access to sex worker services (including services paid for, locations of service, appointment frequency, advertising pathways, and motivations), third party involvement, and financial considerations, particularly in relation to NDIS issues. By examining these aspects through a sexual citizenship lens, the chapter will illuminate the various levels of access, choice and control that were reflected in participants' experiences, and identify potential areas where further research is needed to enhance understanding and address existing gaps in the field.

CHAPTER 7

Contextualising the PASA-Research findings within current academic literature

7.0 Introduction

The PASA-Research study was designed to examine the personal experiences of people with disability who have accessed sex worker services, in Australia. Chapter 6 presented a detailed account of the findings, incorporating both survey and interview data. This chapter approaches the data with a focus on four key areas:

1. **Participant demographics:** examining the types of disabilities, age ranges, and geographical locations of participants;
2. **Access to sex worker services:** investigating aspects of the booking, such as the type of services paid for, locations where services were provided, appointment frequencies, advertising pathways, and the motivations of participants for seeking out such services;
3. **Third party involvement:** exploring the roles of third-party supports, such as support workers, parents, friends, medical practitioners and allied health; and
4. **Funding and Financial considerations:** analysing funding and financial issues particularly concerning barriers presented by to the National Disability Insurance Scheme (NDIS) and other funding mechanisms.

This chapter aims to contextualise these findings within the current academic literature, discuss key issues that emerged from the data, and identify areas where further research is necessary to deepen understanding and address existing gaps. The concluding section will integrate these insights to offer a comprehensive overview of how the experiences of people with disability accessing sex worker services in Australia align with the principles of sexual citizenship. This includes an examination of the extent of choice, access, and control participants had over their sexual expression, as well as identifying areas where both policy-based and practiced-based support require improvement to better uphold the principles of sexual citizenship.

7.1 Demographics of the clients

This section discusses the demographics of the participants, including their disabilities, geographical distribution across Australia, age range, nationality and ethnicity, as well as their gender and sexual orientation.

7.1.1 Types of disability

Survey respondents reported a total of 48 different types of disabilities or conditions, representing all six main disability categories: physical, intellectual, sensory, mental illness, neurological and neurodivergent (see Appendix 12).

These findings corroborate earlier research conducted in New South Wales (NSW), where sex workers identified over 40 different types of disability among their client base (Wotton, 2016, p. 147). The combined results from these two studies highlight the extensive diversity among people with disability who access sex worker services in Australia, demonstrating that individuals with disabilities are making informed decisions about their sexual expression.

Notably, the PASA-research study reported a higher prevalence of participants with either a mental illness or neurodivergent conditions, compared to the earlier study. These conditions, often referred to as invisible or dynamic disabilities (Abi, 2024; Benness, 2019), are characterised by symptoms that fluctuate, may not be apparent by looking at the person, and can negatively impact a person's capacity and functioning to varying degrees (Sarmiento, 2021). For example, people with chronic illness or autism may be capable of performing everyday tasks on one day but struggle to complete the same activities the following day. The PASA-Research findings reflect this variability, with participants needing to schedule sex worker appointments around their fluctuating energy levels, sleep patterns, and overall physical and psychological functioning. Consequently, it is understandable that these disability categories were less frequently mentioned in the 2016 study, as sex workers likely encountered their clients during times when they had the physical and mental capacity to attend appointments. This underscores the importance of direct consultation with specific communities to prevent overgeneralising the needs of people with disability and to ensure their diverse experiences and requirements are accurately understood and addressed. This issue is explored further in Section 7.2.6 which examines the motivations behind seeking paid sexual services. For instance, individuals with acquired spinal cord injuries may utilise the services of sex workers to adapt to and explore their new level of sexual functioning.

Including individuals with dynamic disabilities in the PASA-Research study provides a richer understanding of their unique experiences when accessing sex workers services.

For example, a co-produced research study, commissioned by Autism Spectrum Australia (Aspect) sought to determine what a good life meant for autistic people, their family and carers, and what would help or hinder them from achieving that (Clark et al., 2022). The study defined eight priority areas, including the following (p. 5):

- **Relationships** – establishing and maintaining relationships
- **Mental health** – taking care of mental health
- **Acceptance** – self-acceptance and acceptance in the community, and
- **Adult life and the future** – transition to adult life and outlook for the future

The findings from this Aspect study highlighted that most adults with autism also reported diagnoses of anxiety and depression, and experienced difficulties in establishing and maintaining social connections, including intimate relationships. These issues, reflected in the PASA-Research findings, are often compounded by experiences of stigma, discrimination and a lack of acceptance of neurodiversity within schools, workplaces and social settings (Beato et al., 2024). Of the 35 individuals from the PASA-Research survey who identified their disability to be within the neurodivergent category, 20 were individuals with Autism Spectrum Disorder (ASD). Personal testimonies shared in the interviews shed light on the difficulties experienced by people with ASD, with their experiences with sex workers providing valuable insights into how sexual and intimate connections increased their sense of self and wellbeing. Therefore, these findings are crucial for future discussions on the development and funding of services that support neurodivergent individuals to achieve their goals and lead fulfilling lives.

The diversity of disabilities represented in the PASA-Research study demonstrate that people with disability who access sex worker services in Australia are not a homogenous group. Instead, they represent a broad spectrum of individuals who have autonomously chosen to access these services.

7.1.2 Geographical Location

The geographical distribution of participants showed that over 45% ($n=49$) reside in NSW, with 19 individuals living in either Queensland or Victoria, and an additional 10 in Western Australia. These findings align with locational data collected by Touching Base which reported similar patterns of inquiries from people with disability seeking suitable sex workers throughout Australia (Touching Base, 2023a, p. 2).

Within each state or territory, the geographical distribution of PASA-Research participants mirrors urban patterns, reflecting greater access to disability support services and sex workers in major cities. This is due to a higher concentration of public services and

disability support services in urban areas. Consequently, individuals with disability are more likely to also live or work in these locations. Similarly, sex workers are drawn to urban environments rather than regional or rural locations, due to the larger client base, availability of accommodation and cheaper flights to major cities. Additionally, the anonymity and privacy offered by cities are also significant factors that attract more sex workers to urban environments.

Despite the predominance of urban participants, a small percentage accessed sex worker services in rural and regional areas, supporting previous research (Wotton, 2024). These responses highlighted several barriers to equitable access, demonstrating that people in these urban areas have more opportunities to engage with sex worker services than those residing in regional, rural, or remote regions. Targeted research in these regions could provide a deeper and more nuanced understanding of the challenges faced by people with disability outside metropolitan centres when trying to access sex worker services.

7.1.3 Age

The PASA-Research participants ranged in age between 21 and 76 years with the majority falling between 30 and 50 years ($n=73$, 69%). Notably, there were 31 participants aged 50 years and over (28.7%), with 8 over the age of 65 (7.4%). The wide age range of participants and inclusion of older individuals highlights the ongoing importance of sexual expression throughout life, and confirms that older adults with disability also seek and benefit from paid sexual services. These findings also align with data released from Touching Base (Touching Base, 2023a) which identified that Australians in this older age group are actively seeking the services of sex workers.

The most recent population data from the Australian Bureau of Statistics indicates that one in every six Australians (approx. 3.9 million people) is aged 65 years and over, and nearly half (49.6%) of all older Australians live with disability (Australian Bureau of Statistics, 2019a). Continued sexual expression for older adults has been recognised as a positive contributor to their quality of life and overall wellbeing (DeLamater, 2012; Robinson & Molzahn, 2007). However, the sexual lives of residents in long-term care facilities have historically been a neglected area of support (Earle, 2001). For example, Berger (2000) identified that “nursing homes actively create environments in which residents can have a satisfying rich lifestyle, although, commonly, attention to sexuality is absent” (p. 309).

Therefore, the findings from the PASA-research study contribute to a greater understanding and awareness of the sexual needs of older citizens with disability. As the Australian population ages, it is important to recognise that older generations will continue to pursue their sexuality and intimacy needs. Therefore, it is crucial to ensure that older adults,

including those with disability, have the autonomy and support to make informed choices about their sexual lives, have access to relevant resources and services and are encouraged to maintain control over their sexual and intimate relationships – including the choice to engage the services of sex workers.

7.1.4 Nationality and Ethnicity of participants

From the 108 survey respondents, five identified as Aboriginal and/or Torres Strait Islander, which represents 4.63% of participants (though one person chose *Prefer not to say* in response to this question). There is no comparable data about Aboriginal and/or Torres Strait Islander people paying for sexual services in Australia. The most recent census, in 2021, shows this cohort makes up approximately 3.8% of the total Australian population (Australian Bureau of Statistics, 2023c). However, this data also indicates that “8.2% of Aboriginal and Torres Strait Islander people identified requiring assistance with core activities” (Australian Bureau of Statistics, 2022b). Additionally, the Aboriginal and Torres Strait Islander Health survey (2018-2019) identified that 46% of people had at least one chronic condition (Australian Bureau of Statistics, 2019b).

Given the absence of specific data we can only speculate about the low representation of this population within this study. It is possible that additional cultural or physical barriers prevent access for First Nations people with disability from accessing sex worker services. This aligns with research findings that First Nations sex workers experienced stigma and discrimination, both within and outside of their own communities (Sullivan, 2021). Moreover, as discussed in Chapter 5 (Section 5.10 Limitations), no specific recruitment campaigns were directed to Aboriginal and Torres Strait Islander people. Therefore, future engagement with networks such as the Aboriginal Health and Medical Research Council (AHMRC), and specific Aboriginal and Torres Strait Islander Health and Medical Services throughout Australia (Australian Indigenous Health *InfoNet*, 2024), could contribute to increased participation from this cohort in subsequent studies.

Additionally, while there were thirteen participants who identified as culturally and linguistically diverse (CALD) there is currently no comparable data available regarding clients from CALD backgrounds who pay for sexual services in Australia. Therefore, further research specifically engaging with CALD communities is recommended to explore and understand their unique experiences in accessing sex worker services, particularly within the disability sector.

7.1.5 Participants' gender and sexuality

Participation was encouraged by people with disability of all genders and sexual identities, which was positively reflected in the results. The gender diversity among participants included male, female and non-binary, with one person also identifying as demigirl. These findings align with existing literature on clients in general, indicating that individuals across a spectrum of genders seek out sex worker services, challenging the notion that this need is exclusive to those who are male.

It is notable that no participants identified as Trans despite findings from an earlier Australian study where sex workers provided services to clients with disability who identified as transgender (Wotton, 2016, p. 145). Additionally, inquiries to the Touching Base Referral List included individuals with disability who identified as 'male, female or transgender' (Touching Base, 2023a). While research on clients of sex workers has predominantly focused on male or female clients, there is a notable absence in the literature addressing the engagement of trans, non-binary, or gender-diverse individuals who pay for sexual services, including those with disability.

The sexual diversity of the PASA-Research participants was equally varied, encompassing heterosexual, lesbian, bisexual and grey asexual, which challenges stereotypical assumptions that all people with disability are either heterosexual, asexual or uninterested in sexual activities. Notably none of the participants identified as gay, despite extensive research in Australia about gay men, and men who have sex with men (MSM), who pay for services from male sex workers (MacGibbon et al., 2020; Pitts et al., 2004; Scott et al., 2014). This lack of literature addressing gay men with disability highlights a need for further exploration as current evidence mainly comes from anecdotal first-person accounts shared online in multimedia platforms (Gurza, 2016, 2023).

Additionally, literature identifies that people with disability, especially those with an intellectual disability, can experience a type of 'layered stigma' due to being a part of the LGBTQIA+ community (Bennett, 2002; McCann et al., 2016; O'Shea et al., 2020). Commenting on this type of multifaceted discrimination, Martino stated: "The pervasive heteronormativity in most of the literature, coupled with the assumption that disabled people cannot identify as queer, has obscured the rich array of sexualities among individuals with disabilities" (Martino, 2017, p. 1). Several PASA-Research participants reported experiencing similar layered stigma, either from their support staff or from members of the LGBTQIA+ community. These experiences are discussed in Section 7.2.6.3 (to increase sexual literacy) where participants shared personal reflections about how accessing sex worker services helped combat feelings of self-doubt, low confidence and body-image issues resulting from this layered discrimination.

These insights underscore the need to recognise and respect diverse sexual identities within the disability community, challenge existing stereotypes and promote greater inclusivity in research, disability support services and broader LGBTQIA+ communities.

7.2 Accessing sex worker services

The PASA-research findings offer valuable insights into the experiences of people with disability, shedding light on specific services paid for, the types of premises where services were provided, and the advertising pathways used to locate suitable sex workers. Inquiries also examined the frequency of bookings, and the underlying motivations for participants to seek out sexual services.

7.2.1 Sexual services paid for

The PASA-research survey participants reported engaging in a wide range of paid sexual services including oral sex (giving and receiving), vaginal sex, hand relief/masturbation, nude massage, a range of BDSM services, using sex toys (such as vibrators), kissing and companionship style bookings. These findings align with previous research regarding services sex workers provided to their clients with disability (Wotton, 2016). This diversity of service provision is significant, especially in the context of historical assumptions about the sexuality of people with disability, where individuals have often been perceived through a narrow heteronormative lens or viewed as asexual without sexual desires. Such perspectives have tended to minimise or overlook the sexual agency and needs of people with disability. Instead, the broad range of services reported by the PASA- research participants challenge these misperceptions, highlighting that people with disability engage in a diverse spectrum of sexual activities, much like the general population. For example, these findings are consistent with broader patterns of sexual behaviour documented in a longitudinal research study, the Australian Study of Health and Relationships (ASHR2) (de Visser et al., 2014; Richters et al., 2014a)⁴⁸, which detailed a broad range of sexual activities the general Australian population have paid sex workers for including vaginal, anal and oral sex, BDSM, roleplay and the use of sex toys.

Additionally, within the PASA-Research findings, 51 male participants specifically chose the service ‘nude massage’, however that number increased to 63 when combining the answers ‘nude massage’ with ‘hand relief/masturbation’. This is relevant because the term nude massage is often used as an umbrella term to represent ‘hand relief/masturbation’ in massage parlours. Such findings help to dismantle preconceptions that male clients with disability would primarily seek or desire penis-in -vagina sexual contact and supports prior observations about the diversity of sexual expression sought by people with disability.

48 Data collect for the Third Australian Study of Health and Relationships (ASHR3) occurred in 2023. Analysis and publication was planned for 2024, however availability of findings had not been made public at time of submission <https://ashr.edu.au/about-ashr>

As Martino and Campbell (2019, p. 103) reflected:

Traditional understandings of sex often view intercourse as a phallocentric and heteronormative act that involves two, unassisted ‘able’ bodies, and ends in mutual genital orgasms. Yet, many disabled people have developed their own understandings of what constitutes sex, as well as new and different sets of sexual practices that do not necessarily rely upon phallocentric, heteronormative and ableist norms (e.g., penetration, ejaculation and genital orgasm).

Sensual or nude massage services were also important within bookings for female clientele. From the 18 participants who identified as ‘woman or female’, 12 specifically indicated that they paid for ‘nude massage’. Additionally, 50% ($n=3/6$) of participants who identified as either ‘non-binary’ or ‘demigirl’ also paid for massage services. This desire for sexual services which deviate from penis-in-vagina-sex, is supported by previous first-person accounts derived from research with female clients of sex workers. For example, a woman in a UK study (Kingston et al., 2021, p. 536) shared:

I think it started with an idea when I began being more experimental about 37, 38 (5 or 6 years ago), so I contacted an escort ... I read about these sensual massages with a happy ending for women by men and decided to treat myself to one.

(Misty Robinson, 45, client)

Moreover, the PASA-Research data shows that the range of services people with disability pay sex workers for mirror those accessed by both female and male clients, in general. For instance, a study on female clients of sex workers in Australia found that they paid for “heterosexual sex, same-sex attracted sex, threesomes with any gender, fetish services described as bondage and discipline (BDSM) and educational services such as body work therapy” (Caldwell & de Wit, 2021b, p. 553). Similarly, research on female clients in the UK identified requests for massage, foreplay, oral sex, BDSM activities and penetration. (Kingston et al., 2021, p. 532). ‘Beyond the Gaze’, a large study in the UK, which explored male clients’ interactions with sex workers, (Sanders et al, 2019) also identified a broad range of services paid for including oral sex (82.1%), vaginal sex (70.1%), masturbation (42.9%), anal sex (31.2%), girlfriend or boyfriend experience (61.9%), BDSM (13.3%), roleplay (14.8%) and erotic massage (28.5%).

The list of sexual services provided to participants in the PASA-Research survey, was identical to an earlier study conducted with Australian sex workers (Wotton, 2016) to allow for direct comparisons of the findings. However, since data collection with the sex worker participants occurred over a decade earlier, several service options were not included, such as kissing, Girlfriend Experience (GFE) and Porn Star Experience (PSE). This was because

kissing during the early 2000's was less commonly offered or provided as an 'extra' for an additional cost, while the terms PSE and GFE had not yet become standard terminology in sex industry vernacular. A PSE service is centred on the sexual components, replicating explicit sexual activities seen in porn films, along with deep French kissing. In contrast, a GFE service is often requested when the potential client is wanting to kiss during the booking, along with experiencing a more relaxed social/companionship style booking (Milrod & Monto, 2012). As research has expanded to incorporate the experiences of female clientele, this service is also known as a Boyfriend Experience (BFE). As articulated in the PASA-research interviews, this type of appointment was desired by some participants to specifically replicate a real-life date, or a social activity commonly shared with either a romantic or platonic friend, including dining together, visits to bookshops and attending the theatre. As outlined in Chapter 6, Section 6.6.1 (Motivations) there were many reasons for this including a desire for intimacy and connectivity, to increase a person's sexual and social literacy, or because individuals had no other significant person in their lives to share these kinds of experiences with.

Statistically, more participants paid for massage services in the PASA-research study than in the Beyond the Gaze UK study. It can be speculated that this is due to the establishment and open advertisement of sexual massage parlours in Australia, especially in NSW, where erotic/nude massage, bodyslides and hand relief are provided (sometimes with 'extra services' like oral also available) in authorised sex services premises. These businesses are unique to the Australian sex industry because they are not 'covers' for unauthorised or illegal brothels⁴⁹ and the staff do not provide 'full-service' (intercourse). For that reason, sex workers choose to work in sexual massage parlours, and clients – including people with disability – actively seek out these establishments as an alternative to full-service brothels. For example, previous research indicated that four sex workers provided services to clients with disability in massage parlours (Wotton, 2016, p. 157), with 'massage services' being the third most common service provided (Wotton, 2016, p. 166).

Older participants from the PASA-Research study were one cohort that frequently sought out massage services. Among the 30 participants aged 50 and above, 23 paid for services that included nude massage and/or hand relief. Data from Touching Base also supports a more specific interest from older clients in services that "provide intimacy, erotic massage, mutual touch, hand relief and/or oral sex" (Touching Base, 2020a, p. 6). This interest may stem from various factors, such as the progression of their disability affecting sexual functioning or decreased sexual desires and arousal. Further research with this cohort

49 This is due to decriminalisation, however it is well documented that due to a lack of support at the local council level and a lack of translated information into preferred languages such as Thai or Chinese that some massage businesses may still operate as a 'front' for a brothel. One interview participant spoke about his experiences in these type of massage parlours, which were operating clandestinely due to the regulatory framework operating in his state/territory at the time.

could offer deeper insights into the services that older clients with disability may seek from sex workers.

The findings from the PASA-Research study decisively challenge the ableist stereotype that people with disability are asexual, or uninterested in exploring beyond traditional and socially accepted sexual activities. This research reveals that they, like anyone else, engage in a diverse array of sexual preferences which encompass both physical and psychosocial activities. By documenting the broad spectrum of services sought by participants, the research aligns with contemporary understandings of sexual diversity and challenges outdated, heteronormative assumptions about disability and sexuality.

7.2.2 Where sexual services were provided

Bookings with sex workers were conducted in one of four types of locations: (1) at a sex services premises; (2) at the sex worker's workplace; (3) at short-term rental accommodation; or (4) the sex worker travelled to the participant's location.

This correlates with previous research regarding the type and range of premises identified by sex workers who provided services to clients with disability (Wotton, 2016, p. 160).

Sex work research typically categorises locations into either 'outdoor sex work' or 'indoor sex work' which translates primarily as street-based sex work or sex work that happens inside and behind closed doors. While specific issues may be unique to street-based sex workers and their clients, service delivery locations are often interchangeable among different types of sex workers. For example, both indoor and outdoor sex workers may use hotel rooms, their own home or travel to the client's home to provide services. In contrast, sex services premises, such as brothels, massage parlours and BDSM establishments, provide different environments than hotels, a home, or a rented workspace. Therefore, by utilising these four distinct locational categories outlined above, a more robust analysis of the rationale for where and why participants sought sexual services in these locations is possible. Significant contributing factors included the correlation between the participants' residence and their chosen service location, as well as how a person's disability influenced these decisions.

7.2.2.1 Sex Services Premises

Participants' motivations for travelling to sex services premises include privacy, convenience, cost and choice, consistent with general client motivations identified elsewhere (Atchison et al., 2015). This included going to establishments that provide specialist equipment, such as BDSM dungeons, and not wanting support staff or family members to know about sex worker visits. Additionally, fees charged in brothels and

massage parlours are generally lower than independent worker costs. However, due to their disability, participants experienced a unique range of difficulties, including: (1) a lack of accessible venues to choose from; (2) a lack of sex workers on shift willing and experienced in providing services to a person with disability; and (3) internal environments that reduced a person's sense of well-being.

For example, Fred (legally blind, male, 62 years, heterosexual) shared that as his eyesight deteriorated, he found visits to brothels too challenging due to dim lighting that made it difficult for him to navigate the space or to clearly identify sex workers when they greeted him. Not being able to turn down or be in control of the music in brothels was another factor that contributed to him now feeling more comfortable organising escorts to visit him at home. In another interview, Dirk (ABI⁵⁰/epilepsy, male, 45 years, heterosexual) spoke about his rising anxiety in bracing for the loud buzzer at the end of the booking which induced additional stress and negatively impacted his ability to relax and fully enjoy his interactions with the sex worker. Additionally, he was not able to book the same sex worker, necessitating the need to explain his disability each time, taking up precious minutes during his half hour booking. Finally, the 'house rules' of having to take a shower at the start of the booking, instead of allowing him to shower before he left home, also contributed to his anxiety. Due to his current financial situation, visiting a private sex worker was not an option for Dirk, however these issues could be suitably mitigated in a private setting where environmental and procedural adaptations could occur to best support his needs.

Narratives from the interviews included the need for more training and education for staff working in brothels and massage parlours. This included improvements to their advertising and website to indicate the level of accessibility for the premises and which staff are 'disability-friendly'. Specific training for receptionists and sex workers, learning how to communicate better with clients with disability, providing adaptations to the venue such as handrails, investing in an accessible shower chair and having a hoist to transfer a person from their wheelchair to the bed were also recommended.

7.2.2.2 The sex worker's workplace

Participants chose to visit independent sex workers because they are primarily the ones who advertise their willingness and experience in providing services to people with disability. Participants appreciated being able to contact sex workers directly to discuss specific requirements to accommodate their disability. For instance, they could negotiate showering at home before traveling to the appointment, particularly when support worker assistance was required. Direct communication also enabled participants to verify whether the sex worker's venue was accessible, while regular interactions with the

50 ABI stands for acquired brain injury

same worker fostered a sense of familiarity allowing participants to relax without fear of judgement. Independent sex workers particularly sought out by those who could not host appointments at their own homes due to living with family members, making these arrangements essential for maintaining privacy, confidentiality, and sexual autonomy.

Participants also booked independent sex workers for similar reasons as other clients, (Birch, 2015) including being attracted to the character of sex worker, their attractiveness,

and the type of services they provided. Many participants become regular clients with the same sex worker, enjoying the familiarity and closeness that this type of professional relationship offers (Bernstein, 2007b; Liddiard, 2014) and were able to provide longer dinner-date style bookings which emulated real-life experiences with a romantic or intimate partner. Barriers to accessing independent sex workers identified by participants included a lack of suitable sex workers in their area (discussed further in Section 7.2.5) and higher costs compared to establishments.

7.2.2.3 Short-term rental accommodation

A significant finding from this study is how frequently hotels and motels were utilised, especially when the preferred independent sex worker did not have an accessible workspace. For participants such as Joseph (cerebral palsy, male, 30 years, heterosexual), hotels also provided him privacy from his home life while giving him additional time to prepare for the booking. This included hiring a portable hoist delivered directly to the hotel to assist with transfers from his wheelchair to the bed. His exasperation with the absence of hoists permanently available in hotels who promote having accessible rooms is a valid one and something that, if addressed, could help alleviate the lack of accessible venues for people with disability to engage the services of sex workers. Equitable access to accommodation options for people with disability is outside of the scope of this study but warrants mention for future research.

Engaging with sex workers in hotels and motels is often met with discrimination and stigma by hospitality staff. Both media and recent academic attention have highlighted Australian sex workers being forcibly removed from hotels, often based on assumptions made by staff about their occupation or misinterpretations of sex worker laws (Gillespie, 2022; Jones, 2017; Stardust, 2014, 2017). Additionally, short term accommodation businesses such as Airbnb have increasingly discriminated against sex workers, with bookings cancelled and accounts being abruptly closed, even when sex workers made bookings for family vacations, birthday trips away or to celebrate their engagement (Blue, 2020; Dickson, 2020; Larson, 2016; Paul, 2016; Taylor, 2019; G. Turner, 2020).

In 2020 Airbnb launched Project Lighthouse, a project to ‘uncover, measure and overcome discrimination’ (Airbnb, 2020) with a specific focus on racial discrimination and unlawful guest profiling. Improvements announced in the Airbnb project update (Airbnb, 2022) included eliminating access to guest profile photos prior to booking, making more people eligible for Instant Book (bookings without requiring a Host’s approval), and expanded educational programs for hosts. This update also included a commitment to improve support for guests with disability:

Continuing our commitment to guests with mobility needs

Our accessibility feature search filters make it easier for guests to find and book stays that meet their needs. Through Accessibility Review, we review every accessibility feature submitted by Hosts for accuracy. Our Adapted category, launched in November 2022, features hundreds of listings adapted for wheelchair access, with verified step-free paths into the home, bedroom, and bathroom and at least one accessibility feature in the bathroom.

At face value Airbnb appeared to foster a supportive and inclusive culture, with their website pages punctuated with their Airbnb Community Commitment statement (Airbnb, 2022):

Since 2016, we’ve asked everyone who uses Airbnb to commit to treating others with respect and without judgment or bias by agreeing to the Airbnb Community Commitment. Anyone who doesn’t agree is removed from our platform – as of 2022, that’s 2.5 million people.

In 2024 Airbnb went even further, introducing a comprehensive anti-discrimination policy (Airbnb, 2024a), requiring users to agree to:

treat everyone in the Airbnb community – regardless of their race, religion, national origin, ethnicity, disability, sex, gender identity, sexual orientation or age – with respect, and without judgement or bias.

As outlined on their website, Airbnb’s policy is based on two foundational principles: inclusion and respect, intended to apply to both hosts and guests, with Airbnb emphasising: ‘we are all committed to doing everything we can to help eliminate all forms of unlawful bias, discrimination, and intolerance from our platform’ (Airbnb, 2024a). Somewhat ironically, Airbnb also released their Community Policy for Illegal and Prohibited Activities in 2024 (Airbnb, 2024b, p. 2), which states:

Airbnb doesn't allow illegal activities and other behaviours that could harm our community....[including] "Incall commercial sex work: A stay, Experience or its surrounding property should not be used for paid sexual services, such as erotic massages or prostitution.

Within Australia, sex work is a legally recognised occupation. Additionally, under the Queensland *Anti-Discrimination Act 1991* sex work is classed as "lawful sexual activity" (Queensland Human Rights Commission, 2024) and the Victorian Equal Opportunity Act 2010 explicitly states that it is unlawful to discriminate against a person on the basis of their 'profession, trade or occupation, such as being a sex worker' (Victorian Equal Opportunity & Human Rights Commissioner, 2023). By imposing restrictions on sex workers, Airbnb not only contradicts its own principles of inclusion and non-discrimination but also violates several state laws.

For people with disability who enjoy paid sexual services in this type of rented property – whether by choice or necessity – Airbnb's restrictive policies create additional barriers to their ability to enjoy consenting sexual activities with sex workers. While this ongoing issue is beyond the scope of this research, it is hoped that future inquiries will address this discriminatory practice.

There is also a need for the development of information and training sessions for people with disability, to highlight specific issues experienced by sex workers, such as the need for discretion in short term accommodation options. For example, during Joseph's interview (cerebral palsy, male, 30 years, heterosexual) he disclosed he always left a second key at reception so his sex worker could come straight up to the room instead of himself or a support worker meeting them downstairs. When asked further about this practice he said he informed staff that the second key was for his sex worker and provided her name. This lack of discretion and essentially 'outing' the sex worker to staff can have serious negative repercussions that Joseph seemed oblivious to. For instance, apart from potentially violating a hotel's internal (and often discriminatory) policy against sex workers operating on the premises, this practice could lead to the sex worker being recognised by staff in future encounters with other clients or compromise their privacy in public settings. This includes scenarios such as being identified at their child's school, at the supermarket or at social gatherings.

7.2.2.4 The sex worker travelled to the participant's location

Findings from the PASA-Research survey indicate that 52 participants organised sex workers to visit their homes. Those that were interviewed revealed that these bookings were made mostly out of necessity, directly related to their disability. This was often due to a reliance

on their own hoist and mobility aids to transfer into bed, while others emphasised feeling most comfortable and safe in their own surroundings. However, since many participants relied on regular support staff to assist with daily activities, bookings often had to be coordinated around the staff's schedules to maintain a sense of sexual privacy. Those in supported accommodation similarly depended on the positive involvement of disability support staff for the booking to take place, balancing their need for the service with the likelihood that other residents and staff would become aware of their sex worker visits. This logistical challenge also impeded their ability to spontaneously engage in sexual activities, with bookings often requiring meticulous planning and coordination between the individual and staff. For those questioning or exploring their sexual identity or sexual preferences, this intrusion into their privacy was compounded by their sex worker not complying with the expected gender, appearance or age that aligned with heteronormative assumptions held by some support staff. As Anna (degenerative neuromuscular condition, female, 41 years bisexual) experienced, this led to staff withholding support before or after the booking, stating they did not think it was part of their role, and detailing her sexual activities in the shared staff communication notebook.

The PASA-Research interviews also revealed that higher fees associated with sex workers providing outcall services to participants' residential homes created an additional financial barrier for some participants, even though this was the preferred – or only – option available for individuals to be able to engage in sexual activities. Previous research conducted with NSW sex workers identified that 59.7% of respondents had travelled to the homes of their clients with disability, with 14% also visiting either nursing homes or group homes (Wotton, 2016, p. 160). In comparison, a study on male clients (which did not identify any participants with disability) in NSW, Australia, revealed only 3.8% chose outcall services to their home (Birch, 2015, p. 89). Therefore, these findings suggest that the requirement for sexual services to be provided in a person's home may be substantially greater for a person with disability than the general population. This disparity should be taken into consideration during deliberations about possible funding and financial support systems for people with disability, such as the NDIS.

Finally, two participants nominated a hospital room as the location where sex worker services were provided but failed to provide further details throughout their survey responses. This finding supports results from a previous sex worker study, which identified that sexual services were provided in hospital rooms by three sex workers (Wotton, 2016, p. 160). Without further information it can only be speculated as to whether these were opportunistic experiences, bookings to explore specific fantasies or fetishes, a proactive activity to ward off loneliness or a thrill-seeking experience sought out by the individual with disability.

In summary, sex worker services were provided in various locations, each with distinct positive and negative factors. Independent sex worker workspaces offer discretion with an experienced sex worker who can provide services tailored to the client's needs. However, this option requires the person with disability to travel. A lack of accessible workspaces and limited experienced sex workers to choose from were issues identified by participants. Sex services premises provide a specific type of environment, often with specialised equipment or theme rooms, but often present accessibility issues, and a shortage of experienced staff. Hotels and short-term accommodations are convenient and accessible but can be expensive, provide a lack discretion, and restrictive and discriminatory policies may be in place. Finally, clients' homes offer comfort, familiarity, and tailored accessibility, but additional costs are incurred for the sex worker to travel there, it requires careful coordination with support staff and may compromise the privacy for the person with disability.

7.2.3 Frequency of appointments

Participants were asked about the frequency of their bookings for sex worker services, revealing three predominant patterns: no set pattern, whenever I can afford it, and once a month. While participants were not asked about their income or job status, statistically only 53.4% of people with disability in Australia are employed, compared with 84.1% of people without disability⁵¹ (Australian Bureau of Statistics, 2020). This disparity may reflect why 37.2% of participants from the PASA-Research survey had no set pattern or only booked services when it was financially feasible.

These findings are consistent with previous Australian research. For example, a study with Australia sex workers (Wotton, 2016, p. 155) also identified that clients with disability booked them whenever they could afford it, with no set pattern, or once a month. Similarly, research with Australian men indicated that once a month was the most common frequency for seeking sex services (Perkins, 1999, p. 41). A more recent study with 309 men in NSW, Australia (Birch, 2015) also identified monthly appointments to be the most prevalent pattern.

The PASA-Research findings also align with findings from a UK study involving male clients, which identified two distinct frequency patterns: monthly (41%, $n = 505/1231$) or a few times a year (43.4%, $n = 534/1231$). Researchers suggested that the later pattern might be attributed to opportunistic behaviour such as scheduling bookings during private or business travel (Sanders et al., 2020, p. 113).

⁵¹ Refers to working aged people, those in the age group 15-64 years.

This opportunistic behaviour was also observed in the PASA-Research findings. Eight survey participants reporting scheduling appointments when travelling to their preferred sex worker's location, while seven booked services when sex workers toured near their home location. These findings demonstrate that participants were able to exercise choice and control over whom they booked, rather than settling for whoever is locally available. However, these findings also highlight an additional barrier, a scarcity of suitable sex workers in participants' local areas who are not only able to provide the requested sexual services but are experienced in working with people with disability. This issue was particularly pronounced for those seeking male sex workers. For example, one survey participant mentioned having to drive two-and-a-half hours to their booking due to the absence of local male sex workers. Similarly, one interviewee, Raven, needed to travel interstate to meet her preferred male sex worker:

I need help with travel. Because I have to go to Melbourne to see him (unless he comes to Sydney) I need someone to come with me and help me book plane tickets, accommodation etc and to help navigate the airport and make sure I don't get lost in a city I don't know well.

(autism/PDA/anxiety/ADHD, demigirl, 34 years, heterosexual)

Establishing patterns of frequency for sex worker services is increasingly relevant for those advocating for Government funding, particularly for assessing NDIS requests and insurance payments. The majority of interview participants ($n=21$) were asked about their ideal frequency and duration of appointments, if financial constraints were no longer an issue. Most participants preferred once a month ($n= 11$), three preferred fortnightly bookings, one person stated between 4-6 weeks (dependent upon their disability), and another was content with once every 6 weeks. Only one person indicated a preference for once every two months. Additionally, three participants, whose financial situations had prevented them from accessing sex worker services, expressed a willingness to see a sex worker again regardless of the frequency, emphasising that any opportunity to do so would be appreciated. These findings highlight that systematic, one-size-fits-all funding models are inadequate for addressing the diverse needs of people with disability, underscoring the need for flexible, individualised support solutions, based on what's deemed 'reasonable and necessary' to their individual circumstances.

The duration of the booking is also an important consideration, with the need to factor in both the type of services sought, and how each person's disability may impact their mobility and communication. For instance, while a few interview participants were content with one-hour bookings, the majority typically saw their sex worker for at least two hours. Other booking lengths included 3 hours, 4 hours, 4-6 hours, overnight and full

weekends away. While some participants preferred longer dinner-date style bookings to replicate a girlfriend/boyfriend experience, others required extended bookings to specifically accommodate their disability needs, such as extended time for un/dressing, communicating, and walking.

These findings are poised to inform future discussions on potential funding support mechanisms. For instance, the contentious issue of NDIS funding for sex worker services in Australia has garnered significant attention. As outlined in Chapter 3, a notable Federal Court case: WRMF and National Disability Insurance Agency [2019] AATA 1771 (Rayment, 2019), determined that funding for sex worker services for a woman with multiple sclerosis (MS) was ‘reasonable and necessary’, sparking widespread debate. This decision raised concerns from both government officials and community members, including former NDIS Minister Stuart Robert, who argued that such funding does not align with community expectations, stating he feared it might lead to excessive use of these services if the NDIS was forced to include them in their funding scheme (Gingold, 2020; Henriques-Gomes, 2019a). This matter is discussed further in Section 7.5, however it’s worth noting here that none of the interviewees expressed a desire for weekly bookings, with Fiona commenting */ don’t need weekly because he’d be in my face too often* (Neurological/Psychosocial & complex physical disabilities, female, 57 years, heterosexual). Furthermore, participants highlighted how their daily obligations – such as family responsibilities, medical appointments, therapy sessions, and work – demand a substantial portion of their time. Consequently, many participants articulated the belief that scheduling a session with a sex worker once every four weeks would strike a balance between addressing their psychosexual needs and managing other life priorities.

Finally, these findings suggest that engagement with sex worker services is not necessarily a constant need for clients with disability throughout their lives. Among the survey participants six had stopped booking sex workers when they found a ‘partner, girlfriend or boyfriend’, while another had ceased appointments due to marriage. Four participants said they chose to allocate their money to other things, while two mentioned not currently needing or wanting to see sex workers at that stage in their life. Section 7.2.6 delves further into the motivations of why participants sought out sex worker services, revealing that some participants use these services as a means for personal growth and confidence, enabling them to start dating or pursuing romantic relationships in their private life. These findings will also be addressed in Section 7.5 when discussing potential funding and financial support mechanisms within the NDIS.

7.2.4 Advertising pathways

PASA-Research participants used Five primary advertising pathways to locate their preferred sex worker/s. These included: (1) online; (2) receiving specific referrals; (3) with assistance from third-party support; (4) in-person (at the sex worker's workplace or at an event) ($n= 48$); and (5) via print media advertisements.

These pathways align with prior research conducted with Australian sex workers providing services to clients (Wotton, 2016, p. 167) which categorised these methods into three distinct groups:

1. **in person:** 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);
2. **through advertising:** online, newspaper, yellow pages ; and
3. **via referrals:** from another sex worker, Touching Base, support person, Family Planning Association, therapist, receptionist, friend of friend, parent of client.

High internet usage among PASA-Research participants is consistent with findings from other studies about clients in general. For instance, *Paying for Sex in a Digital Age* (Sanders et al., 2020) compared findings between two studies conducted in the UK and the USA, analysing advertising pathways and 'avenues of access' utilised by clients. The UK's *Beyond the Gaze* study found that 88.4% of respondents used online escort directories to search for sexual services, with 56.9% also accessing independent sex worker websites. Although the study indicated that "social media was not a common method for searching online sexual services" (Teela Sanders, Rosie Campbell, Jane Scoular, Jane Pitcher, & Stewart Cunningham, 2019, p. 2) their larger sample size of 1323 participants showed that the 11.56% ($n= 153$) of their participants who used Twitter (now known as x) is comparable with the 11.15% ($n = 32$) of PASA-Research respondents who located suitable sex workers through Twitter.

Similarly, the US survey revealed that the majority of respondents (66.2%, $n = 450/680$) used the internet to locate sex workers. Given that massage parlours and brothels are predominately illegal in both the UK and the US (apart from 19 legal brothels operating within 10 specific counties within the state of Nevada (Decriminalise Sex Work, 2024)), it is not surprising that a high percentage of their participants relied on the internet to locate sex workers. In contrast, in Australia where sex services premises are often authorised businesses that legally operate and advertise, clients have greater opportunities to directly access brothels and massage parlours and locate a suitable sex worker in person.

The PASA-Research interview participants articulated various issues with online advertisements for both establishments and independent sex workers. Suggestions for improvements included having sex services premises clearly identify the accessibility features of the business and to specify which sex workers on shift each day were experienced and/or willing to provide services to people with disability. Additionally, participants wanted independent sex workers to offer more detailed information about their professional experience with clients with disability, and to explicitly state their willingness to provide services to people who are neurodivergent. As Raven expressed:

he said that, on his website that he does, you know, clients with disability, but it was just like a little sort of add-on thing ... I sort of didn't know what he meant by that, whether it was just, you know, people with physical disabilities who were visibly disabled, whereas, you know, people would look at me and be like, 'Oh, you don't look disabled', you know, 'you don't seem disabled – you can talk and have a conversation'.

(autism/PDA/anxiety, demigirl, 34 years, heterosexual)

Only 15 out of 108 PASA-Research survey participants (13.9%) reported using newspaper ads to locate sex workers, though it is unclear whether these instances occurred recently or earlier in their lives. This figure is significantly lower than those who used the internet and aligns with a US study that found only 26.1% ($n = 175/670$) relied on print media to find sexual services (Sanders et al., 2020). However, widespread use and reliance on the internet have significantly reduced the need for sex workers and establishments to advertise through print media outlets. For example, online directories, search engines, and SEO configurations to direct attention to websites and social media accounts all offer free or low-cost advertising options, with a substantially wider reach than location-based newspapers. In Australia, local and state-based newspapers have struggled to remain competitive, refusing to adjust their fees to reflect these changing advertisement pathways. Consequently, some newspapers, which once featured 10-20 pages of sex industry ads during the Christmas season⁵², now have none, losing all revenue from this once lucrative market.

This shift in advertising pathways can significantly impact those with disability, especially older adults who have not been supported in learning how to engage with emerging technology and online platforms. For instance, one interviewee, Fred (legally blind, male, 62 years, heterosexual), spoke about being provided internet access but received no assistance in learning how to use it properly. Due to this lack of support, individuals like Fred either lose the opportunity to access services or have to rely on individual staff or

52 For example, the Wentworth Courier which is freely available in the eastern suburbs of Sydney

friends to assist them. This reliance is specifically seen in older generations, with data shared by Touching Base showing that the majority of people with disability, aged 80 years and older, relied on third-party support to access their Sex Worker Referral List inquiry form on their behalf (Touching Base, 2020a, p. 3).

PASA-Research survey participants utilised various referral pathways to find suitable sex workers, including the Touching Base Referral List, other sex workers, other people with disability, from friends or allied health practitioners. Previous research with Australian sex workers reported that only six respondents were referred to clients via this referral list, however it was noted in those findings that a dramatic increase in inquiries to Touching Base occurred between the data collection phase and publication of the findings (Wotton, 2016, p. 171). The most recent data released by Touching Base shows a continued rise, receiving 641 referral requests between 1st July 2022 – 30th June 2023 (Touching Base, 2023c). This indicates there are significantly more people with disability in Australia who are seeking, and have accessed, paid sexual services than those who participated in the PASA-Research study.

Findings from both the PASA-Research survey and the interviews indicated the importance of this kind of dedicated referral pathway to sex workers who were experienced and knowledgeable in providing services specifically to people with disability. Respondents expressed trust and confidence in receiving referrals to experienced workers, using it as a kind of vetting process to alleviate the fear of being rejected or ridiculed (see Section 6.5.2.1). Participants also emphasised the desire for a formalised referral service to include more areas throughout Australia and spoke of their difficulties when residing in locations where suitable sex workers were scarce. For example, one survey participant said:

We [he and his wife] preferred to keep to the same ladies as it is incredibly stressful meeting new ones and time consuming explaining our needs. We also feel vulnerable because we are home alone when they arrive. We are currently between workers and we are almost giving up on sex because the stresses and anxiety involved with finding a worker.

(cerebral palsy, male, 55-59 years, heterosexual)

Another issue raised by interview participants was their frustration and disappointment over the lack of response from some sex workers. Many suggested that even a simple response like ‘thanks for your email however I am unavailable to provide services to you’ would be better than nothing. As Matthew recounted:

you know, it does become a little disheartening and soul destroying – another person who just ignores me because I’ve got a disability.

(SCI⁵³/quadriplegia, male, 50 years, heterosexual)

Joseph (cerebral palsy, male, 30 years, heterosexual) also noted: *you know, ... often in their bios they say ‘please be respectful’, but why aren’t we shown the same respect to them... that they’re looking for?* He also discussed his anxiety due to the unresponsiveness of sex workers to email inquiries:

Oh yeah. I think did I say something wrong? Was I a bit too forward? Did I word stuff properly? Did I explain myself, you know? So all these questions that come into your head and you’ll be like ‘ahhhh’. You start second guessing yourself.

(cerebral palsy, male, 30 years, heterosexual)

Participants also emphasised the importance of timely responses with many expecting a reply within a day. However, from a sex worker’s perspective, these are unrealistic expectations. Sex workers may not respond within 24 hours due to a variety of reasons: they might work part time, be with other clients, be on holidays, with their family, studying, or at a second job. Additionally, responding, even to decline a service request, is generally considered unpaid labour with the assumption that no reply automatically indicates unavailability or disinterest in providing services.

The findings indicate that although there are existing workshops and training sessions for both disability support staff and sex workers who provide services to people with disability, there is a distinct need for targeted education initiatives aimed on improving communication and understanding between people with disability and sex workers. By offering specific guidance on managing expectations and how to streamline the booking process, such education can help bridge communication gaps and foster more effective interactions. This approach would help ensure that both parties are better equipped to navigate the complexities of the booking process, ultimately improving the overall experience for people with disability and sex workers.

7.2.6 Motivations

The PASA-research findings mostly align with a range of motivational factors identified in the literature, as detailed in Chapter 4. The survey findings, supported by the interviews, revealed eight specific motivational categories for why PASA-Research participants sought out sex worker services. Sanders (2008, p. 40) categorised client motivations into two distinct categories: ‘push’ factors and ‘pull’ factors. ‘Push’ factors include elements

53 SCI stands for spinal cord injury

in the clients' lives that are lacking, accounting for four of the motivations identified in the PASA-Research: (1) a desire for sexual variety; (2) lack of other sexual outlets; (3) to combat loneliness and feelings of isolation; and (4) seeking genuine intimacy and connectivity. Alternatively, 'pull' factors encompass positive elements of the sex industry that are on offer, corresponding to the other four identified motivations from the PASA-research findings: (1) sexual enjoyment; (2) to increase sexual literacy; (3) therapeutic healing; and (4) recovery and rehabilitation.

The stereotypical view of client motivation is often centred on sexual gratification and the desire to experience a variety of sexual services not available in their current relationship. However, while the pursuit for pleasure is a valid and significant reason for seeking paid sexual services, the therapeutic benefits that sex workers may provide, particularly for clients with disability, needs further attention. For example, there is a notable lack of academic inquiry into the role of sex workers in assisting with clients' recovery and rehabilitation, and a complete absence of research on how sex workers can support therapeutic healing from physical and/or psychological trauma.

These factors are discussed in more detail below, but it is anticipated that these findings can contribute to a more nuanced understanding of diverse roles sex workers may play in their clients' lives and encourage additional research in this area.

7.2.6.1 Loneliness

The PASA-Research findings identified loneliness as the second most common reason survey participants sought out sex worker services. This aligns with existing literature, which frequently cites loneliness as a key motivational factor for clients, including those with disability, to seek sex worker services (Klower, 2018; Kulick & Rydström, 2015; Lowman & Atchison, 2006; Sanders, 2007, 2015; Wilcox et al., 2009a). For example, an Australian study reported 33.6% of male participants cited loneliness as a reason for procuring sexual services (Birch, 2015, p. 91).

Recent research has also started addressing the importance of the type and context of physical touch in reducing feelings of social exclusion and loneliness. For instance, one article, 'The soothing function of touch: affective touch reduces feelings of social exclusion' (Von Mohr et al., 2017), identified that slow affective touch significantly decreased feelings of social exclusion compared to fast, neutral touch (p. 1). This was reflected in the PASA-Research findings where differences between support worker touch, necessitated by assisting with daily living activities, and that of a sex worker were highlighted. For example, one participant articulated that the importance of his sex worker visits was *to experience another human's touch without rubber gloves and in a non-medical, non-clinical way* (cerebral palsy,

male, 55-59 years, bisexual). These different experiences of touch was also documented in the Australian documentary *Scarlet Road* (Paradigm Pictures, 2011a) which contrasts John Blades, a man with multiple sclerosis (MS), showering with the assistance of his support staff, with Mark Manitta, a man with cerebral palsy (CP), sharing a more intimate shower with his sex worker. The first scene portrayed a more sterile, time- sensitive experience with staff wearing gum boots and a waterproof apron in the shower area, while the latter depicts a more intimate experience enjoyed in a less rushed and more sensual manner.

The impact of loneliness and social isolation has emerged as a global health priority, with additional scrutiny placed on this issue due to the COVID-19 pandemic forcing people to experience prolonged periods of physical distancing and isolation (Channel 10, 2023; Michelle Lim et al., 2023; Smith & Lim, 2020; Wigfield et al., 2023). Research has identified clear links between loneliness and mental health distress (UK Government, 2022), with studies on middle-aged and older adults identifying the cumulative affects these factors may play in life expectancy and mortality (Yu et al., 2023). In response, the UK Government set up the Jo Cox Loneliness Commission to improve citizens' health and well-being (Jopling, 2017), which developed into a first-of-its-kind loneliness reduction strategy (HM Government, 2018). This strategy includes a commitment to reduce loneliness via increased funding to services, with one initiative encouraging front line doctors to 'socially prescribe' by referring lonely patients to appropriate local groups and services (UK Government, 2024). While the role of sex workers in such initiatives has not yet been formally recognised, it is hoped that the findings from the PASA-research study will inspire further inquiries into this potential area of support.

Within Australia, specific initiatives have also emerged, providing research and organisations such as the Australian Loneliness Report (Lim, 2018), the Telstra Talking Loneliness Report (2021), the Loneliness Project (2021) and Ending Loneliness Together (2024). The latter launched their State of the Nation Report on Social Connection in 2023 to coincide with Australia's inaugural Loneliness Awareness Week (Lim et al., 2023). Insights from this national survey, with over 4, 000 participants, provided a snapshot of Australia's understanding and experiences of loneliness and social isolation. For instance, it found that nearly 1 in 3 Australians felt lonely and reported a higher use of mental health care services, such as psychiatrists, psychologists, and mental health nurses, compared to those who did not feel lonely. Additionally, individuals reporting severe loneliness were more likely to visit emergency rooms (without being hospitalised), than those who did not.

The Australian government has also recognised that loneliness can directly impact health and wellbeing, by including this factor in population research inquiries and including a chapter called 'Social isolation, loneliness and wellbeing' within the 2023 Australia's

welfare report (2023). Similarly, the latest report ‘People with Disability in Australia 2024’ released by the Australian Institute for Health and Welfare, (AIHW) (2024b, p. 5) states:

People with disability may experience lower rates of **social participation** and greater risk of **isolation and loneliness** than those without disability [bold emphasis from original text]:

- 1 in 4 (27%) people with disability aged 5 and over, living in households, do not leave home as often as they would like (2018)
- 1 in 4 (23%) people with disability aged 15–64 sometimes or often have difficulty getting to the places they need to reach, compared with 17% of those without disability (2019)
- 1 in 5 (19%) people with disability aged 15–64 experience social isolation (lack of social contact with others), compared with 9.5% without disability (2021)
- 3 in 10 (29%) people with disability aged 15–64 say they often feel lonely, compared with 17% without disability (2021).

The social model of disability recognises that societal barriers, rather than individual impairments, are the primary obstacles to equality and access. The AIHW findings highlight that both structural and financial inequalities limit opportunities for individuals with disability to organically meet new friends in social settings, subsequently reducing their opportunity to form romantic or sexual relationships. For example, those on fixed incomes, or reliant on NDIS funding to supply third party support and transportation costs, need to prioritise outings to medical appointments and therapies over potential social events, while a lack of accessible venues restricts participation in social activities. Although policies and practice in Australia are adopting a person-centred approach, these limitations still hinder some individuals from expanding their support and friendship circles⁵⁴, contributing to feelings of isolation and loneliness. This was evident from the PASA-Research findings where participants reported multiple ways that sex workers played a crucial role in alleviating feelings of loneliness and provided meaningful human connection. Further attention is therefore needed to formally recognise the positive role that affection, intimacy and physical touch can play in easing these feelings, including the opportunity to access sex worker services as one of many avenues to be supported.

54 Circles of support include friends who are interested and involved in the life of a person with disability and who assist in helping the individual reach their goals and be involved in their community. Strohm, K. (2023). Understanding Circles of Support (CoS) for People with Disabilities. *Siblings Australia Inc* <https://siblingsaustralia.org.au/blog/circles-of-support-guide-for-disabilities/>

7.2.6.2 *Intimacy and connectivity*

Tom Shakespeare once remarked “most people are not looking for sex itself, they are searching out intimacy, warmth, validation, connection. That is, relationships rather than sex are what counts” (2000, p. 164). He also recommended further research to explore the issue of physical touch, and the lack of intimacy in the lives of many people with disability. The PASA-Research study has addressed this issue, revealing that participants’ motivations extended beyond immediate sexual relief. Instead, the desire for touch and connectivity, described in Chapter 3 as ‘skin hunger’, emerged as a key motivational factor in both survey responses and the interviews for seeking sex worker services. As outlined next, in Section 7.2.6.3, engagement with sex workers often enhanced individuals’ sexual (and social) literacy which, in turn, positively impacted the confidence of some participants to start dating and go on to form intimate relationships.

These findings align with previous research on clients with disability where the desire for intimacy and companionship were often contributing factors in seeking paid sexual services (Wotton, 2024; Kulick & Rydström, 2015; Liddiard, 2014). Additionally, literature on clients in general has established that many seek moments of genuine intimacy and connection with sex workers (Grönvall et al., 2021; Huysamen & Boonzaier, 2015; Atchison et al., 2015; Milrod & Weitzer, 2012; Sanders, 2008; Earle & Sharpe, 2008; Bernstein, 2007).

Findings from the PASA-research identified an additional situation where intimacy and connectivity were sought by couples with disability. In these instances, participants combined their desires for sexual gratification with a sex worker with the opportunity to increase their capacity to touch each other during the bookings, when their disabilities preclude them from doing so without assistance. This type of support – where disability support workers assist in positioning two people with disability in bed so they can be intimate together – is referred to as ‘sexual facilitation’ in the literature (Bahner, 2015; Deakin University, 2015a, 2015b; Kulick & Rydström, 2015; Bahner, 2013) though is not formally recognised in Australia. This role – albeit an expensive one – has occasionally been filled by sex workers. Future research is warranted to better understand the desires and motivations for couples with disability who employ sex workers, and to determine if this need arises primarily from a lack of support workers that can position individuals so they can be intimate with each other, or in a dual capacity so the sex worker can engage with the couple sexually, while also assisting with positioning.

In fact, very little is known about couples in general, who pay for sex worker services. This phenomenon has predominately been identified through studies examining sex workers advertisements, to determine if they cater to couples (Scott et al., 2021; Kingston & Smith, 2020; Kumar et al., 2017; Minichiello et al., 2002) or via online media commentary (Kibbe,

2022; Little, 2018; Hay, 2018; Dingle, 2016; Stryker, 2016). However, sex workers in one UK study did report a number of motivations for why couples booked them, including for sexual enjoyment, exploration of sexuality or to add excitement to a relationship (Kingston et al., 2021, p. 534). The researchers described this experience as ‘bounded experimentation’ speculating that sex workers offered couples a degree of confidentiality without posing a threat to the relationship. For instance, one sex worker they interviewed said (Kingston et al., 2021, p. 535):

it’s easier to pay for it because then if they tried it with someone else, a friend or something, it can go wrong then can’t it. One person can get jealous. (Samantha, 37, provider/w)

Future research in this area would be recommended and would especially benefit from incorporating disability as a standard component of demographic data collection.

Bernstein has described this phenomenon of intimate connections between sex worker and client as ‘bounded authenticity’ (Bernstein, 2007a, 2010), with a friend of mine, also a sex worker, recently commenting: *it’s not just about the sexual intercourse but the social intercourse*. This type of service delivery includes an element of emotional labour, previously documented as an important element of the booking sought from sex workers (Koch, 2020; Nelson et al., 2019; Carbonero & Gómez Garrido, 2018; Pinsky & Levey, 2015). Brents and Jackson (2013) identified three levels of emotional labour performed by sex workers: (1) attending to the physical sensations of customers; (2) attending to the emotional needs of customers, producing an emotional result in the customer; and (3) managing and modifying their own emotions on the job and as a result of the work (p. 80).

The emotional labour component of a booking occasionally places sex workers in a unique position where they are the only significant person in their clients’ lives, or the only person the individual can talk and be intimate with. As one PASA-Research interviewee, Hans, shared:

...the majority of people we know we are in relationships, you know, like our friends. I mean, I don’t know any other single people...and people don’t understand what it’s like to live in a city and not have connection, let alone a sexual connection.

(PTSD/depression, male, 56 years, heterosexual)

Due to this, these intimate connections offering emotional support can resemble what a close friend or partner would usually provide. This was reflected in Peter’s (prostate cancer/ blood illness, male, 73 years, heterosexual) experience where his sex worker became

his confidant throughout his prostate cancer diagnosis, subsequent prostatectomy and recovery. The role of sex workers supporting people through periods of grief, whether it be a loss of sexual or physical functioning, or the illness or death of a significant other, is an under-explored area of inquiry, only occasionally mentioned in the literature. For example, in a UK study, John, a 58-year-old man shared (Sanders, 2008, p. 410):

I mean certainly at the moment I am getting support because last year my father died and one of the girls was very kind to me and helped me get through it. She was there for me and even helped me with the funeral.

Further research is warranted on the role of sex workers as support persons for clients experiencing grief or loss. This area is particularly relevant for older clients who statistically have a higher likelihood of losing their life partner or experiencing disability due to disease, illness, or injury.

7.2.6.3 *To increase sexual literacy*

PASA-research participants sought out sex worker services to enhance their sexual literacy for various reasons, with the findings aligning with existing literature and personal testimonies in social media, from clients with disability. Motivations included: expanding their sexual health education, losing their virginity, exploring sexuality and sexual preferences, practicing new sexual acts in a safe and supportive environment, increasing confidence and social skills before dating, and maintaining their ability to be sexually intimate with someone between relationships (Shakespeare, 2023; Touching Base, 2023b; Kingston et al., 2020; Klower, 2018; Kulick & Rydström, 2015; Liddiard, 2014; Sanders, 2007; Sanders, 2006; Pitts et al., 2004; Wotton & Isbister, 2010).

People with disabilities, particularly those with autism spectrum disorder (ASD), have often been denied access to adequate sex education and the typical adolescent experiences, such as the ‘kissing behind the shed’ awkward moments of early romance. Research co-designed by the Australian Aspect Research Centre for Autism Practice highlights that establishing and maintaining relationships is a crucial priority for people with autism to lead fulfilling lives (Clark et al., 2022). Supporting this, a study from Portugal (Beato et al., 2024) emphasised the need for specialised and targeted sexual education programs. The study described a ‘guided discovery of sexuality’ and included practical role-playing sessions to help participants understand social cues and body language. However, it did not cover sexual activities or interactions that might occur during dating. Similarly, a study in the US with 24 individuals with ASD, aged 18-61, (Barnett & Maticka-Tyndale, 2015, p. 171) found that:

Individuals on the autism spectrum would benefit from sex education that normalises differences (i.e. in identities and experiences of sexuality), is offered throughout young adulthood, addresses disability-relevant sensory and communication needs, and includes practicing neurotypical sociosexual norms.

In some countries a therapeutic learning modality, involving ‘hands-on’ sexual experiences, may be provided to people with disability within the framework of sexual surrogacy or sexual assistance services (Wotton, 2020). However, as identified in the PASA-Research findings, these educational roles can also be incorporated into sex workers’ service provision. PASA-Research participants noted that sex workers provided a safe and supportive environment for a person to learn about their sexual preferences and become more confident in how to communicate with others. This need for hands-on learning opportunities was exemplified in the literature, with Tiefer (1995, p. 12) reflecting:

Imagine how you would feel if playing gin rummy, and playing it well, was considered a major component of happiness and a major sign of maturity, but no one told you how to play, you never saw anybody else play, and everything you ever read implied that normal and healthy people just somehow ‘know’ how to play and really enjoy playing the very first time they try!

To extend this analogy, merely watching people drive, being a passenger in a car or playing driving simulation videos does not make someone capable of safely operating a vehicle. Learning to drive requires understanding the road rules and then gradually building knowledge and experience through lessons and supervision. The intricacies of driving, along with the potential consequences of mistakes, must be fully understood before obtaining a driver’s license. Similarly, despite being surrounded by sexual imagery, access to online digital pornography, and intimate and sexual relationships being depicted on TV and in films, opportunities are limited for some individuals to learn about the practicalities of sex and relationships. This is where sex workers, as identified in this research, can play a role in providing a safe and supportive environment for a person with disability to increase their sexual literacy.

As the PASA-research findings have shown, this hands-on assistance involves learning skills with real life applications. This includes learning how to put a condom on, undo a bra, touch another person’s genitals, and interact with another person while ensuring everyone is providing consent. This has previously been reflected in another study, with one UK man stating (Sanders, 2007, p. 447):

I was 29 and a virgin and I had a compelling wish not to die a bloody virgin ...
at least now I won’t be bloody petrified with a girlfriend and think what do I do now.
... I mean I’ll be able to negotiate that a bit more easily.

Utilising sex worker services as ‘the starting point’ to boost a person’s confidence for future dating opportunities, also emerged from the PASA-Research findings, aligning with previous research. For example, in a UK study, participants with disability talked about it being a purposeful, albeit temporary, transaction that aided in their understanding and learning of what they deemed ‘necessary’ sexual skills and experiences. As one UK participant shared: “It was the first time I realised a woman’s body was warm, with no clothes on, naked, she was warm and that was a shock to me” (Graham, in-person interview) (Liddiard, 2014, p. 845). This mirrored what Joseph shared in his PASA-research interview:

I’ve never slept next to someone ... and also it would give me a good picture of what it would look like when I move out of home as well. And so that’s one of the other reasons ... I wanted to sort of get a mental picture in my head of what it could look like if ... when I decide to move out of home.

(cerebral palsy, male, 30 years, heterosexual)

The literature has also captured how experiences, especially first-time experiences, with sex workers can positively shape peoples’ personal growth and development. For instance, Denise Beckwith, an Australian woman with cerebral palsy (CP), shared in a news article (Nightingale, 2012, para. 9):

I have a disability and my first sexual experience was with a sex worker, and I really value that experience because it gave me confidence to then pursue other relationships, so sex work has an educative function.

Andrew Rosetta, a male sex worker in the UK, documented his interactions with a female client with cerebral palsy, in his book *Whatever she wants – true confessions of a male escort* (2009). When later interviewed about this experience the woman remarked (Owens, 2014, p. 184):

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.

The need to keep practicing until finding the right partner was also a motivational factor identified by PASA-research participants. This was echoed by a UK man with physical disability who paid for sexual services (Sanders, 2015, p. 193):

so I have quite a low self-image and I thought hey even a bloke like me can do this and as much as anything else Teela it was a matter of feeling in inverted commas ‘normal’ because remember I’d been celibate for about 16 years. And I mean

I said to one or two of the girls that I've seen it's a bit like taking a driving test, it was alright on the theory but it's coming to the practical. You're out of practice (Alan, 50, retired teacher, divorced).

For people with disability who are a part of the LGBTQIA+ communities, enhanced sexual literacy can encompass additional factors. PASA-Research participants sought sex worker services for reasons such as addressing feelings of exclusion and rejection, not fitting an 'acceptable' body archetype within the LGBTQIA+ community, and a lack of accessible options to socialise and meet prospective partners. This aligns with the literature (Abbott et al., 2019; Chen, 2018) as well as personal accounts shared in online media articles. For example, Andrew Gurza, a Canadian gay man with cerebral palsy shared his difficulties in meeting people on queer apps due to ableism, choosing to pay sex workers who allow him to fully embrace his 'queerness and crippledness' (Ley, 2022). As Gurza stated, 'I think that all disabled people should have access to sex work (if they choose) because it has transformed – no – saved my sex life, and I am very proud about that'.

As Martino (2017) remarked, "the pervasive heteronormativity in most of the literature, coupled with the assumption that disabled people cannot identify as queer, has obscured the rich array of sexualities among individuals with disabilities" (p. 1). The findings from the PASA-Research study contribute to the limited knowledge about people with disability who have paid for sexual services, with the hope that future inquiries about clients of sex workers will include disability within their demographic data and use a more sex positive lens to capture the motivations and interactions between sex worker and client that fall outside of the stereotypical heteronormative behaviours most commonly researched.

Finally, evidence indicates that men with intellectual disability are disproportionately susceptible to becoming caught up in the judicial system, often due to inappropriate touching and sexual actions done in public settings (Edberg et al., 2022; Latvala et al., 2023; Martí-Agustí et al., 2019). This vulnerability often stems from difficulties in understanding social cues or boundaries, with individuals unable to effectively translate written concepts of acceptable behaviour and boundaries into practice without engaging in role-playing exercises (Jacob et al., 2022). A Norwegian study (Svae et al., 2023) conducted focus group interviews with allied health practitioners working in health, social, care and criminal justice services with experience working with people with intellectual disability who had exhibited 'harmful sexual behaviours'. Findings in that study indicated that participants believed a lot of sexualised behaviour occurred due to a lack of age-appropriate sex education available to people with intellectual disability, with many lacking the correct vocabulary to be able to describe sexual acts and feelings. As one allied health participant said (p. 179):

Feelings as a theme is something I spend a lot of time on with them, to teach them what happiness, fear, sadness and sexual arousal are. When talking about emotions in general, sexual arousal is often excluded. It's a subject that's difficult to talk about. Handling sexual arousal is a part of sexuality, to get help to regulate it. (P2, focus group 1).

This issue has also been identified for individuals who have an acquired brain injury (ABI) who may have lost the ability to self-regulate according to acceptable social cues and behaviours (Kelly et al., 2022). These inappropriate actions are often classified as 'behaviours of concern' or 'complex and challenging behaviours' (Bigby & Hough, 2024, p. 161; Chan, 2016; Michael Doyle, 2004). A systematic literature review examining interventions and strategies to enhance social skills for people with intellectual disability identified 12 different approaches (Jacob et al., 2022). This included: classroom-based interventions; emotional intelligence training; a combined use of video modelling and social stories; peer support and storytelling; the use of computer games for emotion regulation; puppet play therapy and video modelling. As previously outlined, implementing role-playing and systematic practice is often essential for people with intellectual disability to learn and internalise social boundaries, however when this involves learning appropriate psychosexual responses, teachers and therapists are bound by professional codes of conduct that prevent role-play which simulates real life interactions with a sexual or intimate context. This limitation underscores the need for innovative and ethically sound approaches to teaching appropriate social and sexual behaviours to individuals with intellectual disability or an ABI, which could include working with sex workers. One PASA-Research survey participant explicitly reflected on his experiences in this context, stating:

It really helps me deal with my issues and challenges. Without sex workers, I would be depressed and unhappy. There should be more trained in this area as it is a growing need as people start to realise how important the service is for people like me. I am so grateful for being able to access this and the improvements in my behaviour from it.

(autism and intellectual disability, male, 35-39 years, heterosexual)

From an insider perspective I know that integrating sex workers into behaviour management plans and support services can significantly enhance a person's capacity to learn and understand appropriate social and sexual behaviours. This approach provides positive interventions which can prevent judicial punishment or the implementation of restrictive practices. To date, only one academic paper has systematically documented the positive involvement of a sex worker in supporting a person who has presented with behaviours of concern (Kelly & Simpson, 2011), however this area has recently garnered interest,

particularly in collaborations between medical and allied health professionals and sex workers (Wotton, 2023).

These interdisciplinary approaches highlight the potential benefits in addressing and managing behaviours of concern among individuals with disability. While the PASA-Research findings did not include participants who indicated sex worker services were specifically utilised in this manner, further investigation is warranted. For example, engaging third-party supports – such as psychosexual therapists, behavioural therapists, psychologists, house managers, parents and sex workers – could provide invaluable insights in future research inquiries. This collaborative approach could then inform the development of a comprehensive framework to guide future interventions and support plans.

7.2.6.4 Therapeutic healing

Several PASA-Research survey participants shared personal experiences concerning prior sexual assaults and ‘toxic relationships’. Some participants also explained in their interviews how engaging with sex workers had positively assisted in their physical and psychological recovery.

Emerging fields of study have begun to reconceptualise the roles that sex workers may play in the lives of their clients including those of a therapeutic nature (Bates & Berg, 2014; Hartley, 2000; Sanders, 2006). For some individuals, talk therapy is not enough, needing a safe and supportive environment to embody what they have learnt. For those without a partner, sex workers have been identified as suitable service providers who are able contribute to a person’s psychosocial and sexual development and growth. For instance, in an Australian study with female clients of sex workers, half of the participants nominated ‘therapy’ as the common reason for paying for sex, with underlying therapeutic factors encompassing healing from childhood sexual abuse or domestic violence, stress, depression and vaginismus (Caldwell & de Wit, 2021a; Mirage News, 2019).

Ongoing research has documented that people with disability face a significantly higher risk of experiencing physical and/or sexual abuse throughout their lifetime (Australian Government, 2023g; Frohmader, 2019). While the prevention of such crimes is paramount, it is equally important to explore therapeutic services that facilitate recovery, tailored to meet the unique needs of the individual. The PASA-research findings have highlighted that processing and re-establishing positive connections to their body via sex worker services has provided supportive and healing outcomes for some people with disability. Therefore, further research into this specialised area of service delivery by sex workers, particularly with clients with disability, is warranted to better understand its potential benefits and applications.

Finally, despite some academic exploration into the impact of PTSD and military trauma on sexual health, well-being, and interpersonal relationships (Badour et al., 2016; Cameron Ritchie, 2016; Ellis & Dennison, 2014; Ellis et al., 2021; Kolaja et al., 2022), there is a notable absence of effective initiatives to address these issues, particularly for individuals without current partners. In the PASA-Research study, three participants with PTSD were surveyed, including Hans, a 56-year-old heterosexual male whose PTSD originated from military service. In his interview Hans described how engagement with sex workers was therapeutically beneficial, enhancing his sense of self and well-being. This underscores the need for targeted research into the role of sex worker services as a support option for military personnel not in committed relationships, to better understand how such services could address the unique needs of individuals dealing with trauma.

7.2.6.5 Recovery and rehabilitation

Twenty-two PASA-Research participants sought sex worker services ‘to find out what my sexual functioning was (‘if it all still worked’) after accident or injury’ with a further 14 participants stipulating that they did so to regain confidence following such incidents. Detailed insights were gained through interviews with four individuals who had sustained spinal cord injuries.

Academic inquiries often focus on congenital disabilities; however, a significant number of Australians unexpectedly acquire disabilities at various stages of life due to incidents such as car or motorcycle accidents, sporting injuries, workplace incidents, assaults (i.e. gunshots, stabbings) or domestic violence. Despite the Australian Government tracking annual mortality rates and causes of injury and hospitalisation (Australian Institute of Health and Welfare, 2024a) there is currently no national data which records the number of individuals who acquire permanent disability from road accidents, or other traumatic events (Whiting, 2024).

For those who did not sustain injuries as a children or young adult, it could be reasonably assumed that many experienced intimacy and sex prior to their disability. However, after initial hospitalisation and rehabilitation, which primarily focus on managing pain and physical recovery, issues related to sexuality have previously been skewed towards fertility and family planning. Yet anecdotally one of the first questions people ask upon waking from surgery or a coma is ‘will it work?’ and ‘can I have sex again?’ (Sakellariou, 2006). In fact, people with disability have commonly reported that gaining or regaining sexual functioning is one of their top priorities (Peta, 2018) with one US study (Anderson, 2004) revealing that recovering sexual function was *the* most important priority identified by persons with paraplegia. Tepper highlighted this importance in an article outlining his personal experiences of sustained a spinal cord injury at the age of 20, sharing: “I was

deeply concerned about my sexual capabilities from the moment the breathing apparatus was removed and I was able to speak again” (Tepper, 1999, p. 38). This was reiterated by Matthew, who said in his PASA-Research interview:

I mean, sex is a hot topic for spinal cord injury. It’s one of the major areas of loss when people sort of talk about spinal cord injury as it’s” terrible, you can’t walk” most people ... most, alot of guys don’t ... they couldn’t care less about walking but loss of sexual function is a huge part of the injury. So it does get talked about in the spinal units.

(SCI/quadruplegia, male, 50 years, heterosexual)

Another PASA-research interviewee, Jerry (paraplegic, male, 57 years, heterosexual) spoke about sustaining a spinal cord injury at the age of 24. Before becoming a paraplegic, he had enjoyed an active sex life however had no sexual contact with anyone for six years after his injury. He also recounted how his first interaction with a sex worker had made a positive impact on him:

Jerry: it was a totally different experience than what I’d previously had, when I was having sex. But it also made me feel liberated.

Interviewer: in what way?

Jerry: that I knew that having a disability wasn’t a barrier to do something as enjoyable as having sex with another person.

Within Australia, the proactive integration of supporting a person’s sexual functioning and sexual expression, during the rehabilitation phase of a person’s recovery, is only a recent phenomenon (Bryant et al., 2024; Royal Rehab, 2023; Bryant et al., 2022; Fraser et al., 2022; Care-Unger, 2021). Personal experiences shared in a podcast by Heidi Hayden (Care Rehab, 2024) exemplified some of the challenges people face after a spinal cord injury, including adapting to new body limitations and experiencing a lack of confidence in her ability to navigate new sexual and intimate interactions. Heidi compared this experience to going through puberty again. While she connected with her current partner organically, without needing or wanting the services of a sex worker, the findings from the PASA- Research demonstrate that this is an area where sex workers can have a positive impact on those who are wanting to re-establish their sexual sense of self and are without a partner in their lives.

Public comments by John Blades, an Australian man with Multiple Sclerosis, also underscored the significance of touch and intimacy, as highlighted in his award-winning radio program *The Too Hard Basket* (Blades, 2009) and the documentary, *Scarlet Road*, where he proclaimed “she makes me feel like a real bloke again!” (Paradigm Pictures, 2011a). While John’s experiences came from exploring his sexual capacities as his

disease progressed, the importance of sexual intimacy was a key factor for PASA-research participants to sustain their sense of self and wellbeing while navigating changes to their body, changes to sexual functioning and throughout their recovery and rehabilitation. For example, Peter’s interactions with his preferred sex worker emphasised that her role went far beyond mere physical performative acts, with Peter showing deep appreciation for her companionship, care, knowledge, and support – both emotionally and physically. For example, while apprehensive about dating and what a woman might think of him for relying on injections to get an erection, the non-judgemental support provided by the sex worker made him feel secure and supported. Peter’s story mirrors that of a UK man who spoke about how his impotency was accepted by the sex workers he visited (Sanders, 2015, p. 192):

I’m actually impotent and, um, I have to use, er, mechanical means to overcome that, but, um, even so, um, and here again this could be something else, um, why I, er, use prostitution. I’ve only in all this time found one girl who was in the least put out by this fact. Um, most of them are very encouraging and very helpful. (Liam, 70, retired teacher, widower)

In conclusion, the PASA-Research study identified eight motivational factors for why participants chose to access sex worker services in Australia. They included sexual enjoyment; a desire for sexual variety; to combat loneliness and feelings of isolation; seeking genuine intimacy and connectivity; due to a lack of other sexual outlets; to increase sexual literacy; therapeutic healing; and to assist in their recovery and rehabilitation. These findings align with broader research on client motivations while also identifying additional factors where sex workers can play crucial roles in the therapeutic, rehabilitation and recovery processes for some individuals with disability.

7.2.3 Age of first appointment and patterns of engagement

The age at which the PASA-Research survey participants first paid for sexual services varied widely, from 17 to 69 years (Appendix 13). Additionally, participants’ experiences with sex workers were drawn from diverse timelines, with some only recently paying for the first time, while others shared experiences that occurred over four decades ago. Notably, there was no significant ‘start’ age, which deviates significantly from research findings for clients in general. For example, the average age of first procurement for sexual services by male clients in an Australian study was 22 years (Birch, 2015), which also reflects international literature on this cohort (Lowman & Atchison, 2006; Monto, 2000).

While the survey did not ask if participants had paid for services both before and after they acquired their disability, one respondent independently shared: *I was able to visit Brothel before progression of disability* (incomplete paraplegic, male, 30-34 years, heterosexual).

Another, replying to the question ‘how many sex workers have you seen? said: *40 + (but over life time) not just when disabled (1 since disabled)*. While specific information about his disability was not provided, his first paid experience was at 25, and he provided additional information about his current arrangement:

Exclusively with one lady now. Have known her on & off for more than 20 years now, but exclusive since disabled. When we reconnected 4 years ago, it was like it was last week. Very caring & understanding. She helped me rediscover my sexuality. Full of surprises. Lead me through new experiences, pegging etc.

(disability not provided, male, 65-69 years, bisexual)

These findings give rise to many questions. For instance, how many people with disability think about – and access – sex worker services for the first time only *after* they have acquired a disability, or their disability has progressed to a stage where it negatively impacts their social and sexual lives? Is there a continued reliance on sex workers after this point or do they stop paying for sexual services if they become confident enough to start dating again? Do they, like many clients, return to paid sexual services in between relationships, or were sex workers only utilised during that initial adjustment period in their lives?

Experiences shared in the interviews provided additional insights into such questions. For example, 12 out of the 27 interviewees paid for sex worker services only after they acquired their disability, or their disability progressed to a point which negatively impacted their lives. From these 12, two participants only booked sex workers when in-between relationships, with eight who relied exclusively on sex workers to have their sexual/psychosocial needs met. Additionally, there were also two interview participants who shared they were in long term happy partnerships but paid for sexual services because their husband or wife was no longer interested in sex. A male participant indicated their wife’s disinterest stemmed directly from him acquiring a disability, while the female interviewee said that while they had enjoyed many decades of sexual intimacy with each other, her husband’s sexual desires had just waned due to his age.

It could be that the onset of disability is a contributing factor to why there is such a wide age range provided by PASA-Research participants regarding their first sex worker appointment. If so, this is a unique pattern of engagement not previously identified within the literature, and one that warrants further research and consideration. For example, as outlined in Chapter 4, Section 4.1.5 Patterns of involvement, Sanders (2008, p. 48) identified five specific models of engagement to describe when and why male clients, in general, may seek sex worker services. They included:

- **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.

While the motivations and behaviours of many PASA-Research participants reflect Sander’s five categories, the findings also suggest the need for an additional category:

Life circumstance: individuals who purchase sexual services due to illness, injury or disability. This could include for therapeutic, rehabilitation or educational purposes. This may also include those where their disability precludes a person from being able to form an intimate relationship.

7.3 Third party involvement

There were 55 survey participants who located suitable sex workers with the assistance of third-party support, with 31 participants also needing assistance to attend the booking. Third party supports identified in the survey included: parents, siblings, cousins, adult offspring, friends, support workers, therapists, counsellors, NDIS Coordinators and a rehabilitation nurse. Their involvement varied, including locating suitable sex workers, making inquiries and bookings on behalf of the client, assisting with pre and post showering needs, driving the person to the booking, helping with transfers and un/dressing, assisting with payments, and navigating family dynamics while balancing the privacy of the individual.

The responses given by PASA-Research participants reflect both findings in academic literature and first-person anecdotal accounts that emphasise the positive contributions third-party supports can make to a person’s life (Anonymous, 2008; Benoit et al., 2022; SBS Online, 2014; Todd, 2023; Touching Base, 2023b). For example, one news story, entitled ‘A sex worker gave my autistic son the gift of confidence – and I organised the encounter’ (Anonymous, 2022), shared a parent’s perspective on assisting her adult son, while

Melanie, a woman with disability, remarked on how her experience with a male sex worker came about: ‘... yeah it’s a whole new world that opened up to me just because of that ... chance conversation I had with one of my support workers’ (Women with Disabilities Australia, 2023).

The PASA-Research findings also correlate with previous academic research which identified the reliance on third-party involvement for some people with disability to access paid sexual services (Kulick & Rydström, 2015; Wotton, 2016; Wotton & Isbister, 2010). Andrew Gurza, in the YouTube documentary, *Disability and Desire* (Osborne, 2023) talks about the necessity of support workers and carers touching parts of his body as ‘transactional touching’. He shared:

... imagine it – you’re lying in bed and this person, who’s basically a stranger to you, comes in and touches you personally, to get things done, and often times I don’t want them to touch me either. I don’t like everyone down in my junk touching me, but I know I have to do it to get on with my day. In that moment when they’re touching you, that body part isn’t yours anymore. They have taken control of that to give you the care you need and it’s no longer yours. That’s what I would refer to as transactional touch ... and you just crave real touch, and somebody wanting to touch you.

Disability support staff are required to balance their professional duty of care towards a person while supporting the individual’s dignity of risk, especially when addressing matters of informed consent and autonomy of choice. 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).

This precarious balance between supporting the sexual autonomy of a person with disability, with their reliance on third party support was also discussed in the book ‘Loneliness and it’s Opposite’ where Kulick and Rydström (2015, p. 269) highlighted that:

To frame the issue of disabled people’s sexuality in terms of “agency” and “independence” is clearly crucial. But to do so without simultaneously acknowledging *and documenting* the fact that certain physical and intellectual impairments also entail dependency can lead to an emphasis on independence and privacy at the expense of a careful consideration of engagement and responsibility.

The authors further discussed how classifying ‘private sexual activities’ as an individual issue has led some support staff and organisations to falsely believe they have no responsibility in assisting individuals to pursue their sexual needs. This misconception continues to be a contributing barrier to the lack of support people with disability receive in this area (Fraser et al., 2022; Robinson, 2002), often compounded by various ethical and moralistic attitudes, as well as personal prejudices exhibited by disability support staff (De Santos, 2014; Lesseliers & Van Hove, 2002; Pariseau-Legault et al., 2019).

These types of barriers were identified in the PASA-research findings with both survey and interview participants reporting a range of negative experiences with unsupportive staff. These experiences included discriminatory attitudes, refusal to provide adequate care and support, and judgemental behaviour towards individual’s sexuality and their decision to pay for sexual services. Participants also shared instances where allied health and medical practitioners were dismissive, or completely opposed, to their idea of accessing sex worker services. For example, Hans (PTSD/depression, male, 56 years, heterosexual) recounted his psychologist’s advice of ‘it’s no good for you’, while his psychiatrist warned that seeing a sex worker would be detrimental and that sex workers would take advantage of him.

This gap in professional attitudes and behaviours underscores the urgent need for specialised training and guidelines for allied health and medical practitioners. As highlighted within the literature, targeted educational and awareness workshops can significantly enhance the capacity of these professionals to offer non-discriminatory and supportive services to individuals with disability (Abbott & Howarth, 2007; Benoit et al., 2022; Bryant et al., 2022; Crehan, 2023; East & Orchard, 2014; Evans et al., 2009; Martino & Perreault-Laird, 2019; Pariseau-Legault et al., 2019; Wotton, 2024). Such initiatives are crucial for improving the quality of care and support for people with disability seeking to explore their sexual needs, particularly through accessing sex worker services.

As outlined in Chapter 3 this targeted training must also extend to staff working in the aged care sector (Hafford-Letchfield, 2024; Jones et al., 2024; Lefevre, 2023; McAuliffe et al., 2023). Given that the propensity for acquiring a disability increases with age, yet the desire for sexual expression does not necessarily diminish, it is crucial to address the evolving

sexual. Finally, overbearing parents and financial abuse were identified in the lives of two interviewees. Charlie (Cerebral Palsy, male, 45, queer), spoke of his emotionally and financially restrictive mother, sharing that he was unable to pursue any form of sexual expression until he was 37. He was only able to start paying for sexual services after his mother had passed away. Another participant, Dirk (ABI/epilepsy, male, 45 years, heterosexual) spoke about his mother's lack of empathy and understanding, telling him to "just go in, don't talk to the girls about yourself and just get it done". Although this man had received a substantial compensation payout due to his injuries, his mother, acting as his formal guardian, refused to release these funds to pay for sex worker services. Instead, he was forced to collect and recycle bottles and cans⁵⁵ to save up for his half hour brothel bookings.

Dirk spoke during his interview about his difficulty in being able to relax, the inability to book the same sex worker at each visit, and his increased anxiety to 'perform' before the loud buzzer went off to signal the end of the booking. Drawing from my professional experience, what would improve Dirk's situation, would be for his mother – and others in similar roles – to recognise the importance of sexual contact and its impacts on his well-being. By acknowledging and supporting Dirk's needs for regular, meaningful interactions with a sex worker, rather than minimising or deprioritising these services, his mother could facilitate a more supportive environment. Regular private bookings with an independent sex worker, where Dirk could build trust and rapport in a quieter, stress-free environment, would likely reduce his anxiety and enhance his overall experience each time. Providing Dirk with this type of support would not only improve his sexual and emotional well-being but also affirm his right to sexual autonomy and fulfilment.

While addressing financial abuse within the disability and aged care sectors falls outside the scope of this research, the examples provided can enhance the understanding of professionals working in these areas. These insights highlight the necessity of expanding awareness about additional support individuals may require to live independently, including recognising the importance of incorporating sexual expression into their overall support plans.

7.4 Funding and financial considerations

Research focused on clients, in general, frequently asks about their employment status (Sarah Kingston et al., 2020; Kosloski & Diamond-Welch, 2021; Richters et al., 2014), or *how* clients pay, with a focus on payment methods i.e. cash, cheque, credit card, PayPal, Bitcoin (Sanders et al, 2019, p. 17). However, neither of these questions were included in

⁵⁵ In Australia there is a container deposit scheme where people can earn money by recycling certain bottles and cans: <https://recyclingnearyou.com.au/containerdeposit/>

the PASA-Research survey. Instead, the focus was primarily on which funds participants drew from to pay for sex worker services. As outlined in Chapter 3, a higher percentage of people with disability are unemployed in Australia than the general population, and it was therefore important to ascertain which monies participants used to identify potential gaps in funding and support. Chapter 6, Section 6.5.4 provided the range of funding sources participants used to pay for their sex worker services.

While none of the PASA-Research survey participants said their offspring paid for their bookings, drawing from my professional experience and anecdotal evidence (Insight, 2013), this is something that adult offspring of people with disability, in Australia, have previously been involved in. Additionally, although only one participant indicated that either a sibling or a parent paid for their booking, feedback from sex workers suggest this number is much higher in the community than reflected in this study (Wotton, 2016; Wotton & Isbister, 2010). This disparity suggests that the recruitment phase for this research did not adequately reach these specific cohorts. Future targeted research involving parents, siblings, and adult offspring of people with disability is recommended to identify the specific needs and difficulties experienced within these distinct populations.

The disability, aged care and veterans' pension, along with JobKeeper payments are drawn from different areas of the Australian government welfare system, with recipients provided a pre-determined amount of money each fortnight. How such funds are spent is decided by the individual. However, Australia has come under scrutiny for providing inadequate financial support for recipients and for failing to adjust payments adequately, in alignment with the Consumer Price Index (CPI)⁵⁶ and average wage increases (Arthur, nb; Phillips, 2015). One analysis, comparing Australia with other OECD countries⁵⁷, remarked that Australia 'consistently retains its status as one of the least generous welfare states in the OECD' (Starke et al., 2014, p. 234).

This is important to note because living with disability can often be expensive, with many needing to cover out-of-pocket expenses, such as medical costs, mobility and/or communication aids, remedial or therapeutic allied health appointments, or additional transportation fees for those not able to independently drive. It is understandable within this context that social and political campaigns for increased funding are primarily directed towards increased daily living and medical expenses. As Shakespeare said; "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 access to pubs and clubs" (Shakespeare, 2000, p. 160). Shakespeare also noted that 'being sexual costs

⁵⁶ <https://www.rba.gov.au/inflation/measures-cpi.html>

⁵⁷ OECD = The Organization for Economic Co-operation and Development <https://www.oecd.org/about/members-and-partners/>

money’, yet the diversity of funds the PASA-Research participants drew from shows the importance these individuals placed on their sex worker bookings. For example, a number of participants used monies derived from Christmas or birthday presents while it emerged from the interviews that others saved portions of their pension for up to four months so they could pay their sex worker, prioritising this over the purchase of other goods or services.

This demonstrates the stark contrast between how the PASA-research participants prioritised the need for sexual services, with the current lack of financial support available to them. As one survey participant proclaimed:

... sex and sexuality is a normal part of the human condition and this doesn’t magically vanish for people who have a disability. An hour or two with an understanding, well skilled and compassionate sex worker can be better therapy than weeks spent with a Nurse, Physio, OT⁵⁸ and Psychologist.

(quadriplegic, male, 35-39 years, heterosexual)

There was also one participant who expressed a desire for the Department of Veteran Affairs (DVA) to subsidise sex worker payments as a part of their treatment plan for PTSD and depression. This was a government department which had not been considered during the development of this research and one that, as discussed in Chapter 3 (Section 3.5.6), the DVA does not currently incorporate sexual health or wellbeing within its funding or treatment policies. Further inquiries into this area by this Department could greatly support their constituents’ recovery and wellbeing in the future.

7.4.1 NDIS

Funding and financial issues related to the National Disability Insurance Scheme (NDIS) was a prevalent theme which emerged from both the survey and interviews. As outlined in Chapter 3 (Section 3.5.1), the NDIS was introduced by the Australian Federal Government as an additional funding mechanism to provide people with disability full access to supports deemed ‘reasonable and necessary’ to live ‘ordinary lives’ equal to others in the community (NDIS, 2022c, p. 2). With the absence of a specific policy to explicitly support the funding of sexual services (Disabled People’s Organisations Australia (DPOA) & Touching Base, 2019) participants of the NDIS have been forced to individually advocate for the inclusion of sexual services within their funding packages. Due to this absence of relevant policies or guidelines, determinations are currently influenced by the personal interpretations, and the ethical and moral position and decision making of NDIS coordinators, Local Area Coordinators (LAC) and Plan Managers, as well as through formal legal proceedings taken against the NDIS.

58 OT stands for occupational therapist

To date, only one court decision is available to the public, where the Federal Court of Australia ruled in favour of a woman in her 40s, with Multiple Sclerosis (MS), allowing her to utilise NDIS funding to access sex worker services (Federal Court of Australia, 2020). Since then, subsequent cases have been brought to the Administration Appeals Tribunal (AAT) or are still in progress (personal communications). However, Non-Disclosure Orders (NDOs) attached to these AAT rulings prohibit the publication of these court decisions. This has created an uneven playing field, leading to divergent information being shared within the disability community or relied upon in subsequent applications. For example, while 18 (10.7%) PASA-Research survey participants used NDIS funding to pay for sex worker services, others said they were denied the same support. One man shared a number of comments on funding throughout his survey, including: *I have NDIS funding but they won't allow me to use it for sex workers, and yes I have tried to get funding from NDIS but have been knocked back, despite academic evidence being provided by my OT (hemiplegia/ hydrocephalus, / epilepsy/partial deafness, male, 40-44 years, heterosexual).*

The discrepancy of information and the overt level of discrimination participants experienced when trying to include sexual services in their NDIS Plan, were two of the main issues which emerged from the findings. Individuals also expressed apprehension about being believed, a lack of support from planners and coordinators, and systematic confusion regarding NDIS funding policies in this area. One participant was told he would be audited immediately after requesting the inclusion of sex worker services in his NDIS Plan, with others fearful their current NDIS funding would be taken away or reduced. As Michael said in his interview:

I think for a lot of people, if they asked the NDIS for funding for sexual services, I think they're almost worried that NDIS would put like a little star on their files saying 'this person might be trying to get us to pay for things like sex'.

(stroke, male, 27 years, heterosexual)

These fears reflect concerns raised during a recent consultation by Touching Base for their submission to the NDIS Provider and Worker Registration Taskforce. For example, their report stated: “the fear of being singled out and judged due to the necessity of explicitly including sexual services in their NDIS plan further compounds the reluctance of individuals to seek support” (Touching Base, 2024d, p. 12).

While it was an unfortunate oversight that survey respondents were not asked if they were NDIS participants, this question was asked during the interviews. From the 27 people interviewed, 18 were NDIS participants⁵⁹ with five of those sharing their experiences of

59 One participant's NDIS application was approved after their interview, so was not included in this total.

using NDIS funding pay for sex worker services at least once. The other 13 participants were asked why they hadn't used NDIS funding in this manner, with six main reasons given:

1. They now had a partner, so had stopped seeing sex workers;
2. They wanted to use their own income;
3. They had tried to utilise NDIS funding but had been refused;
4. They didn't have anyone to help them in the application process;
5. They were too scared to bring up the subject due to fear of being reprimanded by the NDIS and having their funding cut even further; and
6. They had been told NDIS doesn't fund such services, so had never tried.

Additionally, two of the five participants who had used NDIS funding had stopped doing so by the time they were interviewed, as they had either found a regular partner or were currently dating. This illustrates that even when sex worker services are fiscally available, NDIS participants' will cease using these services if their circumstances, and needs, change. This is supported by recent anecdotes shared in the media. For instance, an Australian woman with disability shared her experiences – through the media (Stathis, 2023) and in a public webinar (Women with Disabilities Australia, 2023) – of booking a male sex worker numerous times over 6 months. As a self-managed NDIS participant, she used personal savings in conjunction with her allocated NDIS funding. However, she stopped paying for sex worker services once her sexual literacy increased and she felt confident to start dating.

One participant's NDIS application was approved after their interview, so was not included in this total.

To date, it appears there have been three main objections put forward by the NDIS for not wanting to include sex worker services within formal NDIS funding. They are:

1. Concerns about financial sustainability
2. It wouldn't represent 'value-for-money'
3. It does not meet public expectations.

7.4.1.1 Concerns about financial sustainability

The woman with MS who was successful in securing a legal determination on the use of NDIS funding for sex worker services, initially won her case through an AAT ruling before receiving an affirmative decision from the Federal Court. During the AAT hearing NDIS lawyers presented a 'worst-case scenario' analysis, suggesting that awarding her

request would lead to every NDIS participant demanding the same. However, this claim was unsupported by empirical evidence and the Federal Court dismissed these ‘rather dramatic predictions’ (Henriques-Gomes, 2021a, para. 11). Advocacy and disability organisations have also dismissed fears of a future NDIS cost blowout for sexual services, with a spokesperson for Speak Out Association of Tasmania, Mr Vittori, acknowledging that ‘if people are fulfilled in one aspect of their life, like with sexuality, it may decrease their need for other support’ (Young, 2020).

However, the NDIS Minister at the time, Stuart Robert, continued to comment in the media that if the NDIS was forced to pay for sexual services at the same rate that the woman with MS was provided with, it would cost at least half a billion dollars. In response, the organisation DSC⁶⁰ calculated that Robert’s estimate would equate to funding approximately 46, 296 individuals which represented, at that time, 21% of adult NDIS participants (Gingold, 2021a). This type of inaccurate financial forecasting presented by Minister Robert is not only unnecessarily alarmist but has never been applied to any other type of goods or service funded by the NDIS. For example, while electric wheelchairs are expensive, their inclusion within NDIS is undisputed. However, it is also universally accepted that this financial support does not imply that everyone wants or needs a wheelchair.

The PASA-Research findings provide ample evidence to allay such unsubstantiated fears that every NDIS participant will ‘suddenly’ want to access sex worker services and want to do so all the time. Section 7.2.3 (Frequency of appointments) offered a detailed analysis of how often the PASA-Research participants accessed sex worker services, as well as their optimal booking frequency if adequate funding was available. It also provided evidence that engagement with sex worker services stopped when individuals found a partner, got married, allocated their money to other things, or decided these services no longer met their specific needs. As one survey participant said:

I would really like it if there was much less stigma/restriction/etc around using funding for sex workers. At the moment it does not apply as I’m in a relationship, but if I was single and had another period of increased physical disability I would definitely want the option to use my NDIS funding to engage sex workers on occasion. Meeting people socially or on dating apps only works when I have enough physical and mental functioning. I don’t always.

(autistic/ADHD/dyscalculia, female, 45-49 years, heterosexual)

60 <https://teamdsc.com.au/about/>

Section 7.2.3 also provided data analysis regarding the age of each survey participant when they first paid for sexual services and identified there was no one specific age that people with disability predominately sought out sex worker services. The participants' diverse patterns of engagement highlight that the NDIS cannot forecast such needs, or overarching costs, as citizens of Australia may sustain injuries and disabilities at different times throughout their lifespan, and the motivational factors for seeking sexual services, as outlined in Section 7.2.6, differ according to the individual. Instead, feedback from participants highlighted the need for greater flexibility in NDIS Plans to incorporate sex worker services if deemed reasonable and necessary to their particular needs.

Finally, the financial sustainability of the NDIS should not be the responsibility of people with disability who are simply seeking services necessary to live an 'ordinary life' equal to others in the community. The NDIS has faced intense scrutiny for cost blow outs, which include substantial legal fees incurred by contesting thousands of applications in the AAT court (and the Federal Court as previously mentioned) (ABC News, 2022; Henriques-Gomes Luke, 2021; Luke, 2022). NDIS participants have also spoken out against the requirements of costly specialist reports to secure formal approval to buy equipment and services, with one man told to provide \$35, 000 worth of professional assessments to be funded for \$14, 000 worth of equipment to assist him live and work (Jones, 2022).

In 2022 an Oversight Committee was established to monitor the processes and outcomes of an Independent Expert Review (IER) trial (NDIS, 2022b) which was designed to reduce the NDIS case backlog at the AAT and enhance the dispute resolution processes of the NDIS. As a result over 7, 000 NDIS AAT cases were resolved between 1st June 2022 and 30th June 2023, when this IER initiative ended (NDIS, 2023d). However, this highlights that while media attention is focused on the assumption that applications for sexual services will jeopardise the fiscal sustainability of the NDIS, it is perhaps the internal decision-making processes within the NDIS that should be changed.

For example, while some may argue the amount awarded to the woman with MS, (\$10,800 per annum) is excessive, it is, in comparison, extremely low compared to the legal fees the NDIS paid to their lawyers, barristers and QCs⁶¹ to contest this NDIS participant's request for sex worker services to be included in her NDIS funding plan. It could be argued that a more cost-effective approach for the NDIS would be to include requests for sexual services. For instance, a recent statement from the NDIS Minister, Bill Shorten, in a July 2024 radio interview said "we received 228 requests for advice related to requests for sexual activity supports. In 12 months, up to the 30th of April. None were granted" (Shorten, 2024a).

61 QC is shorthand for Queens' Counsel. This title has now been changed to King's Counsel (KC) since King Charles ascended the throne. Some barristers also opt for the alternative term Senior Counsel (SC). As a member of the Commonwealth these titles are used within the Australian judicial system.

Every formal request would include several expert reports supporting the inclusion of sexual services to be ‘reasonable and necessary’ while explicitly relating the request back to the participants’ goals. Such reports cost thousands of dollars to produce. Denying such requests goes against the fundamental principles of the NDIS which states decisions are made using an evidence-based approach and with the “consensus of expert opinions” (NDIS, 2024a).

A summary of all sex worker-related cases adjudicated at the AAT, along with a detailed analysis of the total amount paid in legal fees by the NDIS to contest such requests – including the Federal Court case – would significantly contribute to future advocacy efforts to highlight the discrepancies between projected costs to fund requested services and monies spent to actively deny such requests.

7.4.1.2 It wouldn’t represent ‘value-for-money’

The NDIS will only fund services that are deemed ‘reasonable and necessary’ for participants who meet all eligibility criteria (Commonwealth of Australia, 2013a). These include examining if the support is directly related to the person’s disability, will help them pursue their goals and aspirations, will increase their social and economic participation, and is ‘value for money’. Costs have been deemed reasonable (NDIS, 2022c, p. 2):

- when compared to the benefits to be achieved, for example, whether purchasing the support is likely to reduce the cost of funding other supports in the long term.
- when compared to alternative options that may provide you with the same outcome at a similar or cheaper cost.

An additional criterion includes assessing if the support is likely to be effective and beneficial for the participant, taking into account ‘good practice and evidence’. As the first line from the NDIS webpage ‘What is the NDIS?’ (2024d) states:

The NDIS provides funding to eligible people with disability to gain more time with family and friends, greater independence, access to new skills, jobs, or volunteering in their community, and an improved quality of life.

The AAT accepted the premise, from the woman with MS, that supporting the “achievement of sexual release [from sexual services provided] was good for her mental well-being, her emotional well-being and her physical well-being” (Rayment, 2019) with an understanding that “her mood is less dull, it releases tension and anxiety, and improves her outlook on life” (Hermant & Clark, 2019). These facts were not challenged in the Federal Court which eventually ruled in favour of the woman’s request to include sex worker services in her NDIS funding (Federal Court of Australia, 2020).

Participants in both components of the PASA-Research clearly articulated their motivations for seeking out sexual services and how these services positively contributed to their lives, sense of self and well-being. As evidence of this, one survey participant said:

For at least 6 or 7 years, I've hired sex workers using my NDIS funding. This is important to me because it gives me a level of independence and autonomy which I wouldn't have without being a participant on the NDIS scheme.

(cerebral palsy, 30-34 years, male, queer)

Section 7.2.6 provided a detailed analysis of the broad motivational factors for seeking sex worker services, revealing that some participants used these services to work towards their long-term goal of finding a partner. Participants also shared examples of their personal growth and development, including gaining confidence to start dating and pursuing romantic relationships in their private lives. As Anna remarked in her interview:

... it's a human need. Everybody needs to experience that and some people physically can't do that independently. Like, I can't masturbate ... so I do need that help. And it's not a perversion ... it's a human right. And we should be able to explore those goals if we want to explore those goals in our NDIS funding because... I see it, almost like a therapy, skills building, capacity building. If I didn't see [sex worker], I would not have been able to have a partner and that was a goal of mine was to find a partner. She gave me the skills to be able to find a partner – like that is no different to seeing a psychologist to build those skills to access the community, it's the same sort of thing.

(degenerative neuromuscular condition, female, 41 years, bisexual)

The concept of 'value for money' was a recurring theme discussed in the interviews, with some participants feeling that it imposed an additional burden on them to demonstrate how they would – or could – contribute to society. Others also spoke of the discriminatory way in which NDIS participants were viewed, with social commentary making them feel undeserving of services that best meet their needs. An example of this was when the Shadow NDIS minister Michael Sukkar commented (Kenny, 2022):

So, our position and my position is very clear, it is improper. It should not be something that is allowed because ultimately every dollar that's spent on a prostitute is one less dollar that can be spent on worthy recipients under the scheme.

Additionally, participants felt that their voices were not being heard, their concerns dismissed, and decisions about what services were 'acceptable' for them to access were being made by people who had never met them, disregarding their ability to maintain 'choice and control' over their lives. As Alexander remarked:

If everyone else is entitled to enjoy their sexual selves, then so should people with disabilities. So there shouldn't be any restrictions placed on people with disabilities and there should be account taken on the fact that some people – because of the nature of their disabilities and the way society works – some people live in different arrangements to most people in the community, and so that needs to be taken account of in terms of people enjoying their sexual selves or their sexual lives. So, I think that's the key lesson for any NDIS worker or support worker or allied health professional, is to not necessarily think about sexual interactions with the blinkers on of their own situation, where they can choose to be out in the community, get married or not have relationships or not have sex or not. Recognize that for many people with disabilities, it's a far more torturous process and so part of their role should be to facilitate that.

(blind, male, 67 years, heterosexual)

In his interview, Merlin also provided a unique perspective on addressing the issue of 'contributing to society', saying:

I really dislike the fact that ... about how anything pleasurable is mentioned about 'what good can that do to the economy? I mean here's the thing – I may not necessarily be putting too much money into the into the economy, but I guarantee you the money ... the workers that I pay, they are certainly putting that money into the economy.

(autism/depression/anxiety, male, 32 years, heterosexual)

7.4.1.3 It does not meet public expectations

Directly after the 2020 Federal Court decision was handed down (NDIA v WRMF), the NDIS Minister at the time, Stuart Robert, publicly denounced the ruling (Dickson & Smith, 2020, p. 2), saying:

While the government respects the court's decision, the government does not believe that use of NDIS funds to pay for the services of a sex worker is in line with community expectations.

The current NDIS Minister maintains that including sex worker services within the NDIS fails to meet 'community expectations' or 'the pub test' (Wang, 2024). However, this position is challenged by numerous public submissions and joint statements of support (see Chapter 3), which demonstrate substantial backing for integrating sex work services into the NDIS framework. These responses highlight significant community and stakeholder support for addressing the sexual rights and needs of people with disability, revealing a notable disconnect between official perspectives and public opinion.

Additionally, the belief that public support should dictate what is included within NDIS funding is problematic. As Piantedosi states, “As a publicly funded scheme, the allocation of funds remains open to public scrutiny. This blurs the boundaries between public and private accountability” (2022, p. 427). This assumption should be formally resolved by the government by emphasising that all medical and financial support schemes are developed through an evidence-based framework, not personal or moral beliefs. For example, services and medications are provided by Medicare and the Pharmaceutical Benefits Scheme (PBS) to the Australian public. This means that while ultrasounds are available to individuals for a range of conditions, not everyone will need one in their lifetime. Viagra is a subsidised medication yet not all men want or need it. Birth control is also subsidised, giving individuals options and choices to best fit their needs. Medicare and the PBS are funded by public taxes and run by the government, yet do not face the same level of scrutiny for the diversity of services available, or medications prescribed by doctors. Similarly, the armed forces, who fund breast reductions for female employees, also draws from public taxes without ongoing controversy. Yet alarmist media headlines continue to target the NDIS, such as (Lea, 2022):

Jonathan Lea investigates the cost-plagued National Disability Insurance Scheme and uncovers evidence of sex work being billed to the taxpayer – while the entire budget is expected to blow out to \$100 billion a year in the next decade.

What many social commentators forget though, is that many people with disability are also active, tax-paying members of the Australian society, including those interviewed for this research. All 27 interviewees, regardless of whether they were NDIS participants, were asked if sex worker services should be included as a ‘reasonable and necessary’ option in NDIS funding. Without exception, all 27 participants said ‘yes’. As one survey participant stated:

Seeing sex workers does wonders for our mental health and should be seen as a more open and comfortable thing. Less judgement from ignorant people and so called “experts” would also be very welcomed. It’s very easy for a person in a medical or disability field to sit there and say “seeing a sex worker shouldn’t be important” when they can go home and be with their partner and enjoy that type of event without judgement.

(autism/anxiety/depression, male, 35-39 years, heterosexual)

As of February 2024, the NDIS supports over 646, 000 participants throughout Australia (NDIS, 2024c). It is therefore worth highlighting some of the general principles which guide the NDIS (Commonwealth of Australia, 2013b) including:

Principle 1. People with disability have the same right as other members of Australian society to realise their potential for physical, social, emotional and intellectual development.

Principle 4. People with disability should be supported to exercise choice, including in relation to taking reasonable risks, in the pursuit of their goals and the planning and delivery of their supports.

Principle 8. People with disability have the same right as other members of Australian society to be able to determine their own best interests, including the right to exercise choice and control, and to engage as equal partners in decisions that will affect their lives.

Public expectations, especially from the disability community, are for the NDIS to adhere to its own principles. For the participants of the PASA-research this meant being supported to exercise choice and control over their sexual expression needs and being able to seek sex worker services if suitable for their individual circumstances.

7.4.1.4 Should NDIS develop a specific policy?

The 27 interview participants were also asked if they believed the NDIS should develop a clear policy, or guidelines, to support the intimacy and sexual needs of NDIS participants. Their answers were all in support. As Bobby remarked:

Yes. 100%. Put that in big capital writing. YES!

(cerebral palsy, male, 34 years, heterosexual)

A 2019 content analysis of the NDIS Act, NDIS Rules, Operational Guidelines and Price Guide examined the extent to which participants' inter-personal relationships were supported by the NDIS (Meltzer & Davy, 2019). While these documents recognised the importance of relationships to a person's sense of wellbeing, the practical support mechanisms of the NDIS focus primarily on existing familial informal supports or encouraging people to engage in community and group activities. There is a notable gap in the framework regarding support and funding for increasing a person's capacity to instigate and maintain new friendships or personal, intimate relationships. This includes a lack of formal pathways to support a person's sexual expression, including the option to purchase sexual aids or access psychosexual therapy or sex worker services.

Previous advocacy efforts to change this, via the widely supported 'Joint Position Statement: A call for a rights-based framework for sexuality in the NDIS' (Disabled People's Organisations Australia (DPOA) & Touching Base, 2019) has failed to initiate critical changes or policy directives needed to adequately support NDIS participants' sexual expression.

Additionally, the inquiry into the Capacity and Culture of the NDIA (Commonwealth of Australia, 2023d) received detailed written and oral submissions (Commonwealth of Australia, 2023c, 2023e) from a broad range of organisations, outlining support for the inclusion of sexual aids, sex education and sexual services to be included into individuals' NDIS funding plans. The detailed Capacity and Culture of the NDIA report provided a concise summary of these submissions, titled 'Sexuality, sexual development and sexual expression (Commonwealth of Australia, 2023b, pp. 27 – 36).

Additional statements of support have recently been released from disability and sex worker organisations (Scarlet Alliance & Touching Base, 2024; Touching Base, 2024b; White, 2024) in response to the current NDIS Minister stating in July 2024 that sex worker services would be banned if the proposed National Disability Insurance Scheme Amendment (Getting the NDIS Back on Track No. 1) Bill 2024 (NDIA, 2024) was passed in parliament (Wang, 2024). Subsequent media has continued to highlight the overarching support for NDIS participants to be able to exercise choice and control over accessing sex worker services to support their individual needs (Evans, 2024a, 2024b; FitzSimons, 2024; Groarke, 2024; Kelly, 2024; Masia, 2024). The comprehensive findings from the PASA-Research study are expected to significantly contribute to this growing body of evidence to encourage the Australian Government to formally recognise and support the diverse sexual and intimacy needs of its citizens including access to sex worker services when deemed 'reasonable and necessary'. By doing so the Australian Government would be adhering to its own policies, while enacting recent recommendations.

For example, the 2023 NDIS Review emphasised the need for all governments to invest more in research, evaluation and knowledge translation to demonstrate the value of the NDIS to both governments and taxpayers, and to help participants meet their goals through innovative and evidence-based supports (Gingold et al., 2023). Recent government announcements have included an additional \$468.7 million pledged to the NDIS over the next four years, which includes funding an Evidence Advisory Committee to provide advice on effective supports for participants. (Young & Campanella, 2024). Additionally, the NDIS Research and Evaluation Strategy 2022-2027 states that it provides 'a pathway to build and mobilise evidence to enhance the NDIS and shape innovative services and supports that optimise the lives of participants' (NDIS, 2023e). In conjunction with this Strategy, the 'Evidence-based Best Practice' page on the NDIS website (NDIS, 2024a) states:

We only fund supports that will be, or are likely to be, effective and beneficial for you, having regard to current good practice. This means we consider if there is evidence that the support is effective and beneficial for someone with similar disability support needs...The primary source of evidence we rely on, and give

the greatest weight to, is evidence from sources that are reliable and widely recognised. This includes published and refereed literature, and any consensus of expert opinions.

Finally, as outlined in Chapter 3, neither the NDIS, the Department of Social Security, the Department of Health and Aged Care, nor the Department of Veteran Affairs have policies or guidelines that specifically address the potential sexual expression needs of the Australian citizens they seek to support. However, the 2023 Australian Disability Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability included the following recommendations (Commonwealth of Australia, 2023a, p. 2):

National disability leadership should be focused, with dedicated skills and capabilities. We recommend establishing:

- an Australian Government portfolio with responsibility for disability policies and programs.
- a ministerial position, the Minister for Disability Inclusion, that has responsibility for disability inclusion strategy, policies and programs.
- a Department of Disability Equality and Inclusion that has responsibility for national disability and carers policies and programs, including those currently the responsibility of the Department of Social Services.

Therefore, to address many of the gaps identified within the PASA-research study, I recommend establishing a new initiative called the National Intimacy and Relationships Department, to sit within this new Department of Disability Equality and Inclusion. The appointed Director would facilitate the development of co-designed Relationships and Intimacy Guidelines, along with extensive resources and training packages available for people with disability, and those who provide support and services to them. The creation of an accessible national sexuality, relationships, and intimacy resource library, uploaded to the Department's website, would facilitate additional learning and development by providing current co-designed research, training, and resources available in Australia and internationally. Additionally, in line with the current NDIS commitment to its participants to be responsive, and operate with transparency and respect (NDIS, 2022c), designated inquiry and communication channels would be made available to participants, and third party support, to expediate requests for information, training, resources and support. Finally, this new Department would facilitate internal awareness training for staff in all relevant departments and take over the role of assessing all future inquiries regarding the inclusion of sex therapy, sexual aids, or sexual services for NDIS participants.

The NDIS states that ‘We want to make a difference in the lives of Australians and deliver a world-leading Scheme’ (NDIS, 2022b). In a press release celebrating the ten year anniversary of the NDIS, the current Minister Bill Shorten also stated (2023):

In the next ten years, I want us to be able to say, together, we made the Scheme better and who knows, by then we might be the blueprint for other countries wanting to change how they support their citizens with disability.

It is hoped that these intentions can come to fruition, with the inclusion of people with disabilities’ sexual citizenship being incorporated into all future support mechanisms and frameworks.

7.5 Approaching the PASA-Research findings through a sexual citizenship lens

As outlined in Chapter 2, sexual citizenship theory expands traditional notions of citizenship to include the right to sexual expression, highlighting the ability of individuals to express their sexual desires, define their sexual identity, and have these aspects recognised by state bodies and institutions. The findings from the PASA-research study offer a nuanced perspective on how the sexual citizenship of its participants has been upheld or denied, in line with the three main principles of sexual citizenship: choice, access and control.

Bahner’s distinction between policy-based and practice-based sexual citizenship is of particular importance when addressing these findings. Policy-based sexual citizenship refers to formal, institutional support for sexual expression, while practice-based sexual citizenship involves direct support by third-parties, which, while crucial, often lacks systemic integration into public and organisational policy.

7.5.1 Choice and sexual agency

The PASA-Research findings reveal how sex worker services can support the sexual agency of people with disability by offering them the autonomy to make informed choices about their sexual expression. This is evident from the diverse range of sexual services accessed, the variety of service locations, the selection of sex workers chosen (including their age and genders), and the scheduling preferences for bookings.

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The concept of ‘skin hunger’ – the yearning for physical touch – and emotional connection, as identified in the PASA-Research, aligns with Shakespeare’s (2000) call for deeper exploration into the role of physical touch in the lives of people with disability. The findings reveal that many participants often sought sex worker services not only for sexual pleasure but also for meaningful human contact, which may otherwise be lacking in their lives.

The distinction between medical and intimate touch, as noted in the findings, illustrates the unique and invaluable role of sex workers in addressing feelings of social exclusion. This highlights the necessity of recognizing sex work as a legitimate means of alleviating loneliness and enhancing social connection, reinforcing a crucial aspect of sexual citizenship: having the opportunity to form meaningful connections and experience affection, which were integral to participants’ emotional and social fulfillment.

Additionally, the study reveals that the engagement with sex worker services is often context-specific rather than a constant need. Some participants discontinued services due to entering relationships, marriage, or reallocating funds to other priorities, suggesting that these services are used within a broader personal and financial framework rather than as an ongoing necessity.

However, the research also identifies barriers that impede the equitable exercise of choice for some participants. These barriers include limited options for sex workers who are experienced with disabilities, a scarcity of sex workers in rural and regional areas, and a shortage of male sex workers available to female clients. Addressing these issues is essential for ensuring that all individuals can fully exercise their sexual agency and choice.

7.5.2 Access

Access is central to sexual citizenship, ensuring that all individuals can obtain suitable services that support their sexual expression and overall well-being. The PASA-Research findings reveal significant disparities in access to sex worker services, particularly for those living in regional and rural areas.

The study indicates that individuals in rural and regional areas often face geographical isolation, which limits their ability to access to sex worker services. For example, participants in these areas experienced long travel distances, higher associated costs, and a scarcity of available services which impeded their ability to exercise their sexual citizenship fully.

Access issues are also evident in how sex workers advertise their services. The predominance of online advertising excludes individuals with disability who have limited access to or proficiency with the internet. Some participants reported difficulties finding suitable sex workers, particularly in establishments like brothels and massage parlours who didn't provide specific information about which sex workers on shift were 'disability-friendly'. There was a clear desire for more detailed information in all sex worker advertisements about their experience and willingness to accommodate people with disabilities, including clients who are neurodivergent or have invisible disabilities.

Accessibility issues extend to the physical spaces where sex work is conducted, with many participants reporting that sex worker establishments and private workspaces were not always accessible. This lack of accessibility was compounded by a reliance on third-party support where access to sex worker services was contingent upon support from others, and discriminatory attitudes or moral objections from these third parties significantly hindering access.

Financial constraints also affected access to preferred sex worker services. Participants faced challenges such as inadequate NDIS funding, financial abuse by family members, limited opportunities to earn independent income due to their disability, and the need to prioritize funds for medical expenses directly related to their disability. These financial barriers also restricted their ability to fully exercise their choice in accessing sexual services at a frequency that best met their individual needs.

The findings underscore the need for a more inclusive approach to service provision, addressing geographical, locational, and financial barriers to ensure that people with disabilities can fully access and benefit from sexual services.

7.5.3 Control and Autonomy

Control and autonomy are crucial components of sexual citizenship, reflecting an individual's capacity to manage and decide upon their sexual experiences. The PASA-Research findings highlight the significant role sex worker services play in empowering individuals with disability to exercise autonomy and control over their sexual expression.

Participants demonstrated control through their choice of sex worker services based on various motivational factors. For example, many sought sex worker services to address concerns related to the loss of sexual function following spinal cord injuries. This need underscores the importance of integrating sexual expression into rehabilitation processes as sex workers provided individuals the opportunity to regain confidence in their sexual abilities, reconnect with their bodies, and adapt to new forms of sexual activity. Participants

also reported that therapeutic interactions with sex workers helped them process past experiences of sexual, physical, and emotional abuse, reinforcing their sense of control and respect in a safe environment.

Furthermore, participants exercised control over their sexual experiences by making decisions about when to lose their virginity and how to explore their sexuality beyond traditional heteronormative frameworks. This autonomy was a key factor in their overall sexual satisfaction, increased self-confidence, and well-being.

However, the research also identified limitations in the participants' control over their sexual experiences. For example, some participants had to schedule sex worker appointments around the availability of specific support workers, or when discriminatory staff were not 'on shift', which restricted equitable access to services. Additionally, financial constraints often dictated the frequency of bookings, with many participants expressing a desire for more regular and frequent sessions if their financial situation improved.

Overall, the PASA-Research findings highlight the importance of sex worker services in enhancing the control and autonomy of individuals with disability. These services empowered participants to make informed decisions about their sexual experiences and regain confidence in exploring the diversity of their sexual expression. However, despite these advances, significant barriers persist that hinder people with disability being able to fully exercise their sexual citizenship. To address these barriers, necessary changes can be viewed through both a policy-based or practice-based sexual citizenship lens. By addressing both policy and practice-based aspects, a more inclusive and supportive framework can be developed that allows all individuals with disability to fully exercise their sexual citizenship.

7.5.4 Policy-Based Sexual Citizenship

Policy-based sexual citizenship, as outlined in Bahner's (2019) framework, underscores the need for formal policies and institutional frameworks that support and protect sexual rights. It involves advocating for the development and implementation of comprehensive policies that support equitable access to sexual services and protect the rights of individuals with disability. This includes improving funding mechanisms, creating inclusive guidelines, and enhancing support structures. The findings from the PASA-Research highlight several critical gaps in this area regarding the needs of individuals with disability.

A notable deficiency is the absence of national, comprehensive policies specifically supporting the sexual expression of people with disability and their equitable right to enjoy intimacy and relationships equal to the rest of society. This gap reveals the need for more

inclusive and responsive policies that also acknowledge and support the role of sex worker services in enhancing the sexual citizenship of individuals with disability, if they so choose.

The research findings suggest that when policies or institutional supports are present, participants are better able to assert their sexual preferences and autonomy. However, the lack of comprehensive and inclusive policies within the Australian disability and aged care sectors significantly hampered participants' ability to exercise these choices fully. Instead, many participants faced considerable barriers due to discriminatory support systems, inadequate funding mechanisms, and insufficient NDIS policies that fail to accommodate their sexual expression needs. These constraints limited their access to diverse sexual services and impeded their ability to make informed decisions that best suited their needs.

Additionally, discriminatory policies at short-term rental accommodations – such as hotels, motels, and Airbnb properties – can significantly restrict access to sex worker services. Many of these venues impose bans on sex workers being able to rent rooms or provide services on-site, exacerbating the challenges faced by all clients, including individuals with disabilities, in exercising their sexual citizenship. The PASA-Research findings highlight that people with disability often rely on short-term accommodations to facilitate sex worker bookings due to limited availability of accessible sex worker venues. Thus, these discriminatory policies not only impede the general access to sex worker services but disproportionately affect people with disabilities by limiting their options for accessible and supportive environments.

Overall, advocating for the development and implementation of comprehensive policies is crucial. This involves improving funding mechanisms, creating inclusive guidelines, and enhancing support structures to ensure equitable access to sexual services and uphold the rights of individuals with disability. Addressing these issues through policy-based sexual citizenship is essential for recognising and supporting the diverse needs of individuals with disability, thus fostering a more inclusive and equitable framework for sexual expression.

7.5.5 Practice-Based Sexual Citizenship

Bahner's (2019) concept of practice-based sexual citizenship highlights the crucial role of everyday interactions and support practices in advancing sexual rights and agency for individuals with disability. This approach emphasises the need for better communication, heightened awareness and greater sensitivity among disability service providers and sex workers, as well as ensuring that services are both accessible and accommodating. The PASA-Research study reveals both positive impacts and significant barriers present within this domain.

For example, the research demonstrates that sex worker services played a critical role in enhancing the sexual agency and confidence of participants. Reported positive experiences included receiving non-judgmental support from sex workers who respected their needs and provided safe environments for exploring their sexual expression. For those reliant on third-party assistance, such support was essential for locating, communicating with, and accessing sex worker services, thereby empowering them in their sexual choices.

Despite positive outcomes reported by participants, the study reveals significant barriers experienced by some in accessing services. Persistent stigma and discrimination from disability support workers highlight critical gaps in organisational practices concerning the sexual citizenship of people with disability. These issues underscore the need for systematic improvements, such as the development and implementation of targeted training and guidelines to ensure support workers provide non-judgmental and equitable assistance.

Effective solutions identified by participants emphasise the importance of improved communication, heightened awareness, and greater sensitivity among all service providers when supporting people with disability to explore their sexual and intimacy needs. This includes those working in disability and aged care, as well as medical practitioners, allied health professionals, and sex workers.

Addressing both policy-based and practice-based approaches is essential for developing more inclusive and supportive professional practices. This will ultimately create a framework that enables all individuals with disability to fully exercise their sexual citizenship, including accessing sex worker services if they so choose. This chapter has presented numerous recommendations to support this objective. These recommendations, along with proposals for future research and suggestions for policy and practice developments, will be comprehensively summarised in the following chapter.

7.6 Conclusion

The PASA-Research findings demonstrate that people with disability who access sex worker services in Australia are not a homogenous group but rather a diverse range of individuals with unique needs and experiences. The diversity in disabilities reported by participants underscores the complex ways in which disability may impact sexual agency but demonstrates that people with disability share the same healthy desire for a broad range of sexual activities as those without disability.

Participants' narratives underscore the significant role that sex workers play in their lives, contributing not only to sexual fulfillment but also to emotional well-being and self-

confidence. The research also offers valuable insights into what people with disability consider important and what changes are necessary, both in policy and practice. Central to this is the recognition of people with disability as sexual beings with the right to articulate their own desires and needs, rather than having decisions made on their behalf. Participants called for a reduction in societal judgment and discrimination, an acknowledgment of the importance of sexual contact, and the elimination of stigma associated with paid sexual services. They also advocated for elevating the social and professional status of sex workers.

When analysed through the framework of sexual citizenship, the PASA-Research study reveals both progress and shortcomings in supporting the sexual rights and autonomy of individuals with disability. While the study reflects adherence to the principles of choice, access, and control, it also uncovers significant gaps in policy support and inclusivity. Addressing these gaps is crucial to advancing sexual citizenship and ensuring that individuals with disability can fully exercise their rights to sexual expression and intimacy.

Finally, the findings also emphasise the urgent need to tackle financial and access barriers to ensure equitable access to sexual services. This entails developing a more inclusive approach to disability funding that respects individual autonomy and addresses diverse needs, thereby reinforcing the principles of sexual citizenship.

The final chapter will provide a comprehensive summary of the study, outline the limitations of the PASA-Research study, offer recommendations for future research, and propose policy and practice developments to enhance support for the sexual citizenship among people with disability in Australia.

CHAPTER 8

Conclusion

8.0 Introduction

This concluding chapter provides a summary of the PASA-Research study. It outlines the main findings before identifying some of the limitations of the research. Recommendations regarding future research, along with both policy-based and practice-based initiatives that would contribute to upholding the sexual citizenship of people with disability in Australia who wish to access sex worker services, are provided.

8.1 Summary of the PASA-Research study

While millions of people with disability enjoy being in relationships, dating, or marriage, some meet their sexual and intimacy needs through sex worker services. Despite increasing academic interest in clients of sex workers, there remains a significant gap in understanding the needs, motivations and experiences of people with disability who pay for sexual services. Predominantly, knowledge about this cohort has emerged as secondary data from broader studies on clients of sex workers that failed to formally record participants' disability status or alternatively came from disability-specific research with a limited focus on paid sexual experiences. Other insights have come from studies where sex workers shared experiences and information about their clientele.

The PASA-Research study seeks to gain a deeper understanding of the experiences of people with disability who have utilised sex worker services in Australia. While anecdotal evidence indicates that individuals with disability do engage with these services, there is a notable lack of empirical data to substantiate this. Therefore, this research is crucial as it leverages first-person narratives to generate robust empirical data, aimed at filling this gap and provides a solid foundation for future research and policy development.

To address these aims, the following questions were posed:

1. What are the experiences of people with disabilities who have accessed sex worker services?
2. What are the motivational factors for people with disabilities in Australia to access sex worker services?

The methodology involved a mixed-method approach using two data collection methods: an online survey and semi-structured in-depth interviews. Eligibility criteria required participants to be at least 18 years old, identify as a person with disability, and have accessed in-person sex worker services in Australia at least once. The definition of disability used was based on the Australian Disability Discrimination Act and includes psychosocial, cognitive, intellectual, and/or physical disabilities of a congenital, developmental, or acquired nature.

The study utilised a sexual citizenship framework and focused on the central considerations of control, access, and choice, alongside a sex-positive approach to broaden the scope beyond narrow the heteronormative frameworks that characterises much of the research in this field. This allowed for the inclusion of diverse sexual expressions, genders, and sexualities of both participants and the sex workers they engaged.

In total, 108 eligible surveys were collected from across Australia, and 27 interviews were conducted with self-nominated participants through various formats, including in-person, phone, online (Zoom), and text messages. To ensure ethical practices, former or current clients of the researcher were excluded from the interview component.

The research provided unique insights into various aspects of accessing sex worker services, including the types of services paid for, the different premises where services were provided, and the frequency of bookings. It also explored how participants located their sex workers and the age at which they first engaged in these services. Furthermore, the study investigated barriers to access, the role of third-party support systems, challenges in finding suitable sex workers, and issues related to financial constraints and funding.

Eight specific motivational factors for accessing sex worker services were identified: sexual enjoyment, desire for sexual variety, combating loneliness and isolation, seeking genuine intimacy and connectivity, lack of other sexual outlets, increasing sexual literacy, therapeutic healing, and recovery and rehabilitation. Additionally, the findings underscored the complexities of managing sexual autonomy and privacy while relying on necessary third-party support structures.

It is anticipated that the translation of these research findings may inform evidence-based policy development, training programs, and educational workshops to improve the ability of people with disability to recognise and enjoy full sexual citizenship through accessing sex worker services, if they so choose.

8.2 Limitations

While the PASA-Research study created valuable insights into the experiences of people with disability who access sex worker services, numerous limitations regarding access and recruitment were identified. These limitations are outlined below.

8.2.1 Impact of COVID-19

The study began in March 2020, coinciding with the onset of the COVID-19 pandemic. The ensuing lockdowns and restrictions during 2020 and 2021 led to the postponement of many disability and aged care expos, limiting opportunities for face-to-face interactions and presentations about the research. Additionally, resources were redirected away from non-essential activities and support services, further affecting recruitment efforts, as it is likely that facilitating participation in an online survey was not a priority for staff during this period. These disruptions may have led to a skewed participant sample and affected the overall reach of the study.

8.2.2 Access Issues

Despite receiving substantial support from various third-party sources, potential barriers may have arisen from the personal, moral and ethical beliefs of some parents and support workers. These beliefs could have hindered individuals with complex support and communication needs from learning about and participating in the study. Moreover, individuals with limited or no internet access, including those in rural, regional, and remote locations, may have also been excluded from participating, especially if they lacked the ability to print out, complete and return a paper survey autonomously.

8.2.3 Demographic Representation

As all research communications were conducted exclusively in English, this likely presented a barrier for individuals from culturally and linguistically diverse (CALD) backgrounds, who may experience language barriers or prefer communicating in other languages. Additionally, recruitment was focused on disability and aged care community networks, however, a targeted approach to marginalised communities such as CALD, First Nations, and LGBTQIA+ communities may have increased the study's representativeness of these broader populations.

8.2.4 Technical and Social Media Limitations

The researcher's limited proficiency with various social media platforms, such as Instagram, TikTok, and Twitter (now known as x), restricted the study's reach, particularly among younger populations. Although Facebook was used for recruitment, the absence of a dedicated PASA-Research Facebook page also potentially reduced visibility and engagement.

8.2.5 Survey Tool Limitations

The survey tool had several omissions that may have provided a more nuanced understanding of participants' circumstances and decision-making processes. For example, it did not address participants' marital status, educational level, or whether they had any financial dependents. Information on participants' annual income, sources of income, and employment status was also not included. Notably, the survey did not ask participants if they were supported by the NDIS. Additionally, participants were not asked if they needed third-party assistance to complete the survey or used augmentative and alternative communication (AAC) methods. Finally, the survey did not specifically ask if referrals to sex workers came through friends, which could have provided a more comprehensive understanding of how participants located sex worker services and who in their social circle supported their sexual expression.

These limitations highlight areas for improvement in future research, including enhancing recruitment strategies, addressing access barriers, and leveraging different social media platforms. Further research is warranted in multiple areas, as identified in Chapter 7. These recommendations will be outlined next.

8.3 Recommendations

The findings from the PASA-Research study underscore significant gaps in the support for the sexual citizenship of people with disability in Australia. Addressing these gaps requires concerted efforts in public awareness, policy development, education, and inclusive practices. Key areas for future research, and ways to advance policy-based and practice-based sexual citizenship, are proposed in the following recommendations.

8.3.1 Research

8.3.1.1 Rural and regional areas

Conducting targeted research in regional and rural areas would offer a deeper understanding of what people with disability experience when accessing – or trying to access – sex worker services. Such research could examine potential barriers and issues specific to these geographical locations.

8.3.1.2 Gender-diversity

Future inquiries should adopt a sex positive framework to encourage a more diverse representation of gender and sexuality. For example, research on clients of sex workers has predominantly focused on male or female clients with a notable absence in the literature about the engagement of people who are trans, non-binary or gender-diverse who pay for sexual services.

8.3.1.3 Culturally and linguistically diverse communities

There is an absence of specific research exploring the experiences of clients, including clients with disability, from culturally and linguistically diverse (CALD) communities in Australia. Examples of potential benefits of such research may include cultural challenges that preclude the open discussion of sexual expression with younger support workers or those of the opposite sex, an absence of accessible and linguistically relevant resources, and an absence of sex workers with relevant language skills.

8.3.1.4 First Nations communities

With limited empirical data to draw on, future engagement with First Nations people with disability is recommended to explore their experiences, learn more about how frequently they access sex worker services, and identify potential barriers they may face. Engaging networks such as the Aboriginal Health and Medical Research Council (AHMRC) and specific Aboriginal and Torres Strait Islander Health and Medical Services throughout Australia could help increase participation from this cohort in subsequent studies.

8.3.1.5 Older citizens

Further research into the sexual and intimacy needs of older Australians is essential to identify barriers unique to this group in accessing sex worker services. A comprehensive understanding of the experiences of older Australians with disabilities – particularly those residing in supported accommodations such as aged care facilities, nursing homes, hospitals, and hospices – is also needed. Investigating how sex worker services might benefit individuals in these settings, including their potential impact on those experiencing sundowning -a phenomenon where individuals, particularly those with dementia, experience increased confusion, agitation, and behavioural changes during the late afternoon and evening (Boronat et al., 2019; Gnanasekaran, 2016; Wornell, 2013) – could provide valuable insights.

Moreover, given that a notable proportion of older participants specifically sought sexual massage services, further research should explore the reasons behind these findings. Factors such as the progression of disability affecting sexual functioning, or changes in sexual desire and arousal, may play a role. Gaining insight into these aspects will help clarify the services older clients, including those with disability, seek from sex workers and enhance our understanding of their unique needs.

8.3.1.6 Couples with disability

Future research is warranted to better understand the desires and motivations for couples with disability who engage sex workers, and to determine if this need arises primarily from a lack of support workers that can position individuals so they can be intimate with each

other, or in a dual capacity so the sex worker can engage with the couple sexually, while also assisting with positioning.

8.3.1.7 Individuals who use complex and diverse communication methods

Survey participants were not asked about their use of Augmentative and Alternative Communication (AAC) methods for communication or survey participation. Only limited academic research has focused on the barriers faced by individuals with complex communication needs in developing romantic and sexual relationships (Sellwood et al., 2022; Sellwood et al., 2017). Targeted research on this cohort's experiences with accessing sex worker services would enhance understanding of their specific needs, challenges, and experiences.

8.3.1.8 Individuals with profound and complex disabilities

Similarly, there is an absence of research about persons with profound intellectual disability who have accessed sex worker services, and this cohort was not represented in the PASA-Research findings. Even the authors of the book *Narrowed Lives: Meaning, Moral Value, and Profound Intellectual Disability* (Vehmas & Mietola, 2021) acknowledged that they commenced their research holding discriminatory views about their participants and with an absence of awareness that this cohort could and would enjoy sexual activity. Further research is needed to explore the sexual expression and needs of people with profound intellectual disabilities, to ensure their experiences are understood and included in discussions about sexual citizenship and access to sex worker services.

8.3.1.9 Roles of sex workers

There is limited academic research on the role of sex workers in enhancing clients' sexual literacy, education, rehabilitation, recovery, and therapeutic healing from physical or psychological trauma. While the PASA-Research findings offer a broad understanding of the diverse roles sex workers can play in clients' lives, further research is needed to comprehensively explore and clarify these contributions. For instance, men with intellectual disabilities or acquired brain injuries (ABI) often face legal issues related to inappropriate sexual behaviour, and while role-playing is crucial for learning social and sexual boundaries, teachers and therapists are bound by professional codes of conduct that prevent role-play which simulates real life interactions with a sexual or intimate context. This highlights the need for innovative and ethical approaches, potentially involving sex workers, to teach appropriate social and sexual behaviours.

Currently, only one study has documented the benefits of sex worker services for individuals with behaviours of concern (Kelly & Simpson, 2011), though emerging evidence suggests a growing use of this modality (Wotton, 2023). While the PASA-Research findings did not

include participants who utilised sex worker services to address behaviours of concern, further research could explore this therapeutic application by involving various third-party supports, such as psychosexual therapists, behavioural therapists, psychologists, house managers, parents and sex workers.

Additionally, despite some academic exploration of the impact of PTSD and military trauma on sexual health, well-being, and interpersonal relationships, there remains a significant lack of effective initiatives to address these issues for individuals without a partner. Focused research on the role of sex worker services as a potential therapeutic support for military personnel who are not in committed relationships is needed. Such research could offer valuable insights into how these services might better meet the needs of individuals dealing with trauma.

Finally, the role of sex workers in supporting clients through grief – whether from loss of sexual or physical function or the death of a loved one – remains underexplored and warrants further investigation.

8.3.1.9 Family involvement

While only one participant in the PASA-Research study nominated either a sibling or a parent paid for their booking, lived experience (Wotton & Isbister, 2010) and anecdotal evidence (Anonymous, 2022) reveal that this is a more frequent occurrence than reflected in the findings. Additionally, while no participants chose ‘offspring paid for it’ in the survey, anecdotal evidence (Insight, 2013), along with my own professional experiences, indicate that some adult offspring in Australia are also involved in organising and paying for sexual services for a parent. This suggests that the scope of the recruitment phase for this research failed to adequately reach people with disability who rely on extended family to access sex worker services. Future targeted research involving parents, siblings and adult offspring of people with disability is recommended to increase the capacity for individuals they support to participate in future research, to be able to establish the frequency this may occur, and identify specific needs and difficulties experienced within this distinct familial population.

8.3.1.10 Third-party support

During the recruitment phase of the PASA-Research I spoke to many people at disability and aged care expos. This included allied health practitioners, support workers, NDIS Co-ordinators, house managers, travel and day-program coordinators, and transport facilitators who shared personal stories of either themselves or a colleague assisting individuals with disability to access sexual services. Some stories were affirming and positive while others spoke about issues of neglect where staff used their personal, moral or religious views to deny services and support. Many mentioned individuals who exhibited

behaviours of concern which led to either staff ignoring their requests for sexual expression or being punished for exhibiting signs of arousal and sexual desires. Examples of individuals being over-medicated to reduce their libido and forced isolation were also shared.

To address these issues comprehensively, specific research is needed to capture the experiences and opinions of third-party supports for people with disabilities. This research will provide valuable insights into how sex worker services have positively impacted individuals' lives and identify restrictive practices and policies that require attention through specialised training and awareness initiatives.

8.3.2 Specialised Training

While there are existing workshops and training sessions for both disability support staff and sex workers (See Chapter 3), there is a distinct need for targeted education initiatives that enhance communication and understanding between people with disability, third-party supports and sex workers. Such initiatives should include specific guidance on managing expectations and how to streamline the booking process. By bridging communication gaps and fostering more effective interactions these programs would better equip all parties to navigate the complexities of the booking process, ultimately improving the overall experience for individuals with disability and sex workers. Training should be provided to the following groups:

8.3.2.1 Disability and aged care staff

The findings highlight a pressing need for comprehensive sexuality awareness training across disability and aged care sectors, including those in rehabilitation and supported accommodation settings. While discussions often focus on consent in relation to the sexual lives of people with disabilities, they frequently overlook aspects of sexual pleasure and enjoyment, particularly for individuals who are non-verbal or have profound disabilities that severely restrict their mobility and communication. To address these gaps, it is crucial to develop training that challenges existing misconceptions and ingrained beliefs, thereby enhancing staff capabilities to offer respectful and informed support to individuals seeking sexual services.

8.3.2.2 Allied health and medical practitioners

Training for allied health and medical practitioners is essential to enhance their ability to integrate sexual expression needs into clients' and patients' treatment plans. Practitioners should be educated about the potential roles that sex workers can play within educational, therapeutic, and rehabilitation frameworks for individuals with disability. Initiatives should also include fostering strong professional networks with experienced and willing sexworkers who can provide services tailored to the needs of people with disability. Such training can

improve overall support structures and ensure that sexual expression is appropriately addressed within comprehensive care plans. Disciplines where targeted training would benefit include medical, nursing, occupational therapy, rehabilitation, behavioural therapy, urology, gynaecology, social work, psychology, psychiatry and psychosexual therapy.

8.3.2.3 People with disability

Awareness training is recommended to help individuals with disabilities effectively communicate their sexual needs to both third-party supports and sex workers. Additional training should focus on managing expectations, advertising pathways, and understanding the operations of sex worker businesses to better facilitate professional interactions.

8.3.2.4 Sex Services Premises

The PASA-Research study identified the need for tailored training and education for staff at sex services premises, including brothels and massage parlours. This should encompass enhancements to advertising and websites to clearly indicate the level of accessibility for each premises and to identify staff who are ‘disability-friendly.’ Training should be provided for receptionists and sex workers to improve communication with clients with disabilities. Additionally, it was identified that venues should implement practical adaptations, such as handrails, accessible shower chairs, and hoists for transferring individuals from wheelchairs to beds, to ensure a more inclusive and supportive environment.

8.3.2.5 Sex workers

Targeted training and education workshops for sex workers is crucial for enhancing their ability to support clients with disability. These workshops should focus on improving advertising practices, enhance workplace accessibility, and deepen their understanding of various disabilities to better meet the needs of clients with disability. Participant insights suggest that training should also address the perspectives of people with disability, highlighting the additional anxiety or stress they might experience when booking services. This will help sex workers provide more supportive services by allowing extra time for communication and assistance during initial inquiries and bookings. Moreover, there is a need for additional training for sex workers interested in enhancing their proficiency in providing services that support the educational, therapeutic, and rehabilitation needs of individuals with disability. This training should also emphasise the importance of building robust professional networks with allied health and medical practitioners to deliver comprehensive, team-based support

8.3.3 Enhanced Financial Support Systems

8.3.3.1 Inclusion of sexual services in government funding

The findings highlight the urgent need for the Australian Government to address the financial barriers faced by some people with disability. This includes rectifying inconsistencies in NDIS funding and exploring opportunities for other governmental departments, such as the Department of Veterans' Affairs (DVA), to incorporate sex worker services into funding options.

8.3.3.2 Inclusion of sexual services in insurance claims

The PASA-Research findings represent the first empirical data demonstrating the inclusion of sex worker services in insurance claims. Further investigation is recommended to explore the frequency, processes, and specific instances in which these services are covered by insurance.

8.3.3.3 Fiscal accountability

To advance discussions on including sex worker services in NDIS funding, a thorough analysis of the number of cases involving sexual services requests reviewed by the AAT is essential. Additionally, a comprehensive review of the legal costs incurred by the NDIS in opposing these requests at both the AAT and the Federal Court would provide valuable insights to support advocacy efforts.

8.3.4 Comprehensive and Supportive Policy Development

8.3.4.1 National Sexuality and Relationships policy

To address the gaps identified in the PASA-research study and enhance the support for sexual and intimate relationships for people with disability, I propose the establishment of a new initiative, the National Intimacy and Relationships Department (see Chapter 7, Section 7.4.1.4). This department would be spearheaded by a Director responsible for overseeing the development of co-designed Relationships and Intimacy Guidelines. These guidelines would be complemented by comprehensive resources and training packages designed for people with disability, as well as for those who support and provide services to them. Furthermore, this Department would be responsible for conducting internal awareness training for government staff across all relevant departments.

In parallel, the development of a National Sexuality and Relationships Policy is crucial. This policy should advocate for the promotion of sexual citizenship by ensuring that people with disability have autonomous control, access, and choice in their sexual and intimate relationships. The policy framework must support individuals in meeting their sexual and intimacy needs, including access to sex worker services if desired. Policy development

should extend beyond the NDIS to encompass the aged care sector and insurance schemes, ensuring a holistic approach to supporting sexual citizenship for all citizens across relevant sectors.

8.3.4.2 Continued development of sexuality policies for organisations and service providers

It is recommended that all disability and aged care providers develop and implement inclusive policies on sexuality, intimacy, and relationships that address the diverse sexual expression needs of their clients. These policies should establish clear guidelines for staff, outlining their rights and responsibilities in delivering support services. To ensure effective implementation, the development of these comprehensive policies and guidelines should be accompanied by targeted training and professional development workshops. This approach will enhance staff understanding and competency, fostering a supportive environment that respects and supports the sexual and relational needs of individuals they provide services to.

8.3.4.3 Short-term accommodation policies and practices

Restrictive policies at hotels and Airbnb can create significant barriers for people with disability seeking to engage in consensual sexual activities with sex workers. While this issue was outside the scope of the current research, it is anticipated that future studies will address the discriminatory practices of banning sex workers from renting rooms or providing discreet services at short-term accommodation venues. Additionally, the PASA-Research participants highlighted the lack of hoists in hotels that provide ‘accessible rooms’ as an unnecessary barrier. Addressing this deficit is crucial for ensuring equitable access for individuals with disability in short-term accommodation venues.

8.4 Conclusion

The PASA-Research study provides valuable insights into the experiences and needs of people with disability who access sex worker services in Australia. While this exploratory research offers a snapshot rather than a comprehensive representation of all individuals with disability, it effectively illuminates the unique and diverse needs of this group. The study also presents crucial evidence that highlights both the challenges participants faced alongside the positive aspects of their experiences.

Overall, the findings reveal a compelling desire among the 108 participants for society to recognise them as sexual human beings with the same legitimate sexual and intimacy needs as anyone else. They also wished to be afforded the same opportunities as others, including their pursuit of sexual expression through accessing sex worker services. Participants reported experiencing profound discrimination at both interpersonal and

systemic levels with their sexual and intimacy needs often overlooked, dismissed or subjected to bias. This disparity underscores the urgent need for reform in how sexual citizenship is understood and supported.

Many of the challenges and barriers identified are entrenched in ableist and outdated policy frameworks and institutional practices. These obstacles were found to impede participants' ability to fully experience their sexual citizenship, especially those who relied on others for support. However, participants' insights also offer valuable guidance on potential improvements and avenues for positive change.

This research aims to honour the experiences of the PASA-Research participants, prioritise their voices, and contribute to greater awareness and further exploration of the issues and gaps identified. The findings underscore the necessity for significant improvements in research, policy, and practice. Addressing these areas through targeted research, inclusive practices, specialised training, enhanced financial support systems, and comprehensive policy development will contribute to upholding the sexual citizenship of people with disability and ensuring equitable access to sex worker services is made possible.

By implementing these recommendations more inclusive practices can be developed, affirming the sexual expression and autonomy of individuals with disability. Ongoing efforts to address these insights are expected to contribute to the creation of a national framework that respects and accommodates the diverse sexual and intimacy needs of people with disability. This framework should include recognising access to sex worker services as a legitimate option for people with disability, ensuring their needs and choices are supported with dignity and respect.

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APPENDIX A

WSU Human Research Ethics Committee Approval

WESTERN SYDNEY
UNIVERSITY



HUMAN RESEARCH ETHICS COMMITTEE

1 February 2022
Professor Kerry Robinson
School of Social Sciences

Dear Kerry,

Project Title: "Exploring the experiences of people with disability accessing sex worker services, in Australia"

HREC Approval Number: H14609

Risk Rating: Moderate

I am pleased to advise the above research project meets the requirements of the National Statement on Ethical Conduct in Human Research 2007 (Updated 2018).

Ethical approval for this project has been granted by the Western Sydney University Human Research Ethics Committee. This HREC is constituted and operates in accordance with the National Statement on Ethical Conduct in Human Research 2007 (Updated 2018).

Approval of this project is valid from 1 February 2022 until 1 February 2024.

This protocol covers the following researchers:

Kerry Robinson, Rachel Wotton, Peter Bansel, Michael Houlbrook

Summary of Conditions of Approval

1. A progress report will be due annually on the anniversary of the approval date.
2. A final report will be due at the expiration of the approval period.
3. Any amendments to the project must be approved by the Human Research Ethics Committee prior to being implemented. Amendments must be requested using the HREC Amendment Request Form.
4. Any serious or unexpected adverse events on participants must be reported to the Human Research Ethics Committee via the Human Ethics Officer as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the Committee as a matter of priority.
6. Consent forms are to be retained within the archives of the School or Research Institute and made available to the Committee upon request.
7. Approval is only valid while you hold a position or are enrolled at Western Sydney University. You will need to transfer your project or seek fresh ethics approval from your new institution if you leave Western Sydney University.

8. Project specific conditions:

There are no specific conditions applicable.

Please quote the registration number and title as indicated above in the subject line on all future correspondence related to this project. All correspondence should be sent to humanethics@westernsydney.edu.au as this email address is closely monitored.

Yours sincerely

Associate Professor Gabrielle Weidemann
Presiding Member,
Western Sydney University Human Research Ethics Committee

Western Sydney University
ABN 53 014 069 881 CRICOS Provider No. 00917K
Locked Bag 1797 Penrith NSW 2751 Australia
westernsydney.edu.au

APPENDIX B

Social Media Advertisement



People with disability who access sex worker services, in Australia

- ☐ Do you have a disability?
- ☐ Do you live in Australia?
- ☐ Have you paid for sexual services?
- ☐ Are you 18 years or older?

*Seeking people to do an online anonymous survey / interview
about your experiences*

www.pasa-research.com.au

All information found on the website or scan the QR code



SCAN ME

APPENDIX C

Advertisement



People with disability who access sex worker services, in Australia

- ☐ Do you have a disability?
- ☐ Have you paid for sexual services?
- ☐ Do you live in Australia?
- ☐ Are you 18 years or older?

Ethics Approval Number:
H14609



***Seeking people to do
an online anonymous survey /
interview about your experiences***

www.pasa-research.com.au

All information found on the website or scan the QR code



SCAN ME

APPENDIX D

Participant Information Sheet



Exploring the experiences of people with disability who access sex worker services, in Australia

- Do you live in Australia?
- Are you a person with disability?
- Are you 18 yrs or older?
- Have you ever paid a sex worker?

** If you answered yes to all four questions you are eligible to participate **

.....

This research aims to prioritise the voices of people with disability, to create an opportunity for people to share your own experiences about accessing sex worker services.

Questions will be grouped into five main areas of **who, what, where, how** and **why**, as well as a final section where you can share **personal stories, opinions and suggestions**.

People of all genders and sexual identities are welcome to participate.

APPENDIX D – Participant Information Sheet

This survey asks you about your personal experiences.

It is up to you how much information you wish to share.

You are not required to provide any personally identifying information.

Your responses are anonymous so can never be linked back to you.

All information about why the research is being done and what it will involve is provided in the [Participant Information Sheet](#).

You give consent to participate in the survey when you send it back. It is free to send it in the mail. No stamp needed.

As it is anonymous, once you submit your answers they cannot be withdrawn.

If you need more space, please use extra paper and attach to this survey

The closing date for this survey is 1st November 2022

All information about this research project can be found on the website: www.pasa-research.com.au

.....

Interview option

The researcher is also wanting to interview 10–20 people throughout Australia.

The interview will be an opportunity to expand on the answers you have given in this survey, especially if you have had many experiences with different sex workers. You can also provide other information for this research that wasn't asked in the survey.

If you are eligible and interested, you can fill out the form at the end of this printed survey and send back to the researcher in a separate envelope.

Your survey answers will not be linked to your contact details.

.....

Go in the draw to win 1 of 4 x \$100 eGift vouchers

Everyone who completes this survey can enter the draw to win 1 x 4 eGift Vouchers worth \$100 each (physical gift cards can also be sent if they are easier for people to use).

There is a form to fill out at the end of this survey to enter the draw.

Your survey answers will not be linked to your contact details.

.....

START OF SURVEY

Eligibility Questions

Do you identify as a person with disability?

- ☐ No
- ☐ Yes

How would you describe your disability/s?

Have you paid for sexual services from a sex worker, in Australia?

- ☐ Yes
- ☐ No

Section 1. WHO (demographics)

The following 8 questions are questions about yourself

What is your age? (tick or circle correct answer)

- ☐ 18-19
- ☐ 20-24
- ☐ 25-29
- ☐ 30-34
- ☐ 35-39
- ☐ 40-44
- ☐ 45-49
- ☐ 50-54
- ☐ 55-59
- ☐ 60- 64
- ☐ 65-69

APPENDIX D – Participant Information Sheet

- ☐ 70 -74
- ☐ 75-80
- ☐ 80-84
- ☐ 85-89
- ☐ 90-94
- ☐ 95-99
- ☐ 100+

What State or Territory do you live in? (tick or circle correct answer)

- ☐ Australian Capital Territory (ACT)
- ☐ New South Wales (NSW)
- ☐ Northern Territory (NT)
- ☐ Queensland (QLD)
- ☐ South Australia (SA)
- ☐ Tasmania (TAS)
- ☐ Western Australia (WA)
- ☐ Victoria (VIC)

**Do you identify as Aboriginal and/or Torres Strait Islander?
(tick or circle correct answer)**

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

**Do you identify as a person who is culturally and/or linguistically diverse
(CALD)?
(tick or circle correct answer)**

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

APPENDIX D – Participant Information Sheet

If yes, what best describes your family background? (Select all that apply)

Tick all the boxes that are right for you

- ☐ Aboriginal and/or Torres Strait Islander
- ☐ Australian or New Zealander
- ☐ Caribbean
- ☐ Central American
- ☐ Central Asian
- ☐ Chinese
- ☐ Eastern European
- ☐ Indian
- ☐ Japanese
- ☐ Korean
- ☐ Middle Eastern
- ☐ North African
- ☐ North American
- ☐ Northern European
- ☐ Oceania (Melanesian, Micronesian, Polynesian)
- ☐ Pacific Islander
- ☐ South East Asian
- ☐ South American
- ☐ Sub Saharan African
- ☐ United Kingdom/Ireland
- ☐ Western European
- ☐ Prefer not to say
- Any others?

What was your sex recorded at birth? (tick or circle correct answer)

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Prefer not to answer

APPENDIX D – Participant Information Sheet

How do you describe your gender? (tick or circle correct answer)

(Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents).

- ☐ Man or male
- ☐ Woman or female
- ☐ Non-binary
- ☐ I use a different term (please specify).....
- ☐ Prefer not to answer

What is your sexuality? (tick or circle correct answer)

- ☐ Straight (heterosexual)
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Pansexual
- ☐ Asexual
- ☐ Queer
- ☐ I use a different term (please specify)
- ☐ Don't know / questioning
- ☐ Prefer not to answer

What are your living arrangements? (tick or circle correct answer)

- ☐ I live alone
- ☐ I live with my parents
- ☐ I live with my partner /wife/ husband/ girlfriend/ boyfriend
- ☐ I live with my offspring (ie. son / daughter)
- ☐ I live with my sibling/s (ie. sister / brother)
- ☐ I live with flatmates / friends
- ☐ I live in supported accommodation
- ☐ I live in a group home
- ☐ I live in a boarding house
- ☐ I live in a retirement home
- ☐ I live in a nursing home
- ☐ Other (please specify)
- ☐ Prefer not to answer

Section 2. WHAT

The next section has five questions, asking about your appointments with sex workers & the services you paid for

How many different sex workers have you visited, in total?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ More than 10 (please specify)

What age were you when you first paid for sexual services?

.....

What gender/s were the sex worker/s? (click all that apply)

- ☐ Male
- ☐ Female
- ☐ Transgender (M – F)
- ☐ Transgender (F – M)
- ☐ Non-binary
- ☐ Other
- ☐ Prefer not to answer

**What services have you paid sex workers for?
(circle or tick all that apply)**

- ☐ Nude massage
- ☐ Hand relief / masturbation
- ☐ Oral sex / blow job / French (you receiving)
- ☐ Oral sex / blow job / French (you giving)
- ☐ Vaginal sex (you giving ie. your sex worker has a vagina)
- ☐ Vaginal sex (you receiving ie. you have a vagina)
- ☐ Anal play (fingers/ toys in your bottom)
- ☐ Anal play (fingers/ toys in sex worker's bottom)
- ☐ Anal sex (you giving)
- ☐ Anal sex (you receiving)
- ☐ Using a Strap-on ('pegging')
- ☐ BDSM {Bondage, Discipline, Sadism, Masochism} services
- ☐ Sex toys ie. vibrators
- ☐ Fantasies / role plays
- ☐ Double booking (2 sex workers)
- ☐ Double booking (you and a partner [with disability] with 1 sex worker)
- ☐ Double booking (you and a partner [without disability] with 1 sex worker)
- ☐ Double booking (you and a friend [with disability] with 1 sex worker)
- ☐ Double booking (you and a friend [without disability] with 1 sex worker)
- ☐ Other (please specify)

.....

.....

APPENDIX D – Participant Information Sheet

How often do you visit sex worker/s? (tick or circle correct answer)

- ☐ No set pattern
- ☐ Whenever I can afford it
- ☐ Whenever I travel to the same location as the sex worker
- ☐ Whenever the sex work travels to my location
- ☐ Once a week
- ☐ Once a fortnight
- ☐ Once a month
- ☐ Once every 2 months (every 8 weeks/ 6 times a year)
- ☐ Once every 3 months (every 12 weeks/ 4 times a year)
- ☐ Once every 4 months (3 times a year)
- ☐ Once every 6 months (twice a year)
- ☐ Once a year

Section 3. WHERE

The next 2 questions ask about the location of where you receive services.

In which State or Territory have you received services from a sex worker? (circle or tick all that apply). Please write the name of the suburbs or general areas on the line next to your answers.

For example, in NSW you might name a specific suburb (Surry Hills) or a general area (the Inner West). For QLD it could include " Nundah" as a suburb, or 'Metropolitan Brisbane' or 'the Far North Queensland (FNQ) region'.

To maintain confidentiality, the individual suburbs will not be shared in the public findings of this research.

- ☐ Australian Capital Territory (ACT).....
- ☐ New South Wales (NSW).....
- ☐ Northern Territory.....
- ☐ Queensland.....
- ☐ South Australia.....
- ☐ Tasmania.....
- ☐ Western Australia.....
- ☐ Victoria.....

Where have sex worker/s provided services to you?

(tick/ circle all that apply)

- ☐ Brothel
- ☐ Massage parlour
- ☐ Hotel
- ☐ Motel
- ☐ My home / where I live
- ☐ The sex worker's private workplace (house/ unit)
- ☐ BDSM house / parlour
- ☐ Private BDSM dungeon
- ☐ Safe house
- ☐ Hospital
- ☐ Rehab Accommodation
- ☐ Car
- ☐ Other (please specify).....

Section 4. HOW

The next six questions are about finding the right sex worker, organising the appointment, support & payments

How did you locate the sex worker/s?

(Circle / tick all that apply)

- ☐ Arrived at the premises and chose from the sex workers available (ie. brothel /massage parlour)
- ☐ Sex worker's website / advertisement online
- ☐ Newspaper advertisement
- ☐ Referral from another sex worker
- ☐ Referral / suggestion from another person with disability
- ☐ Touching Base Referral List
- ☐ Therapist helped me
- ☐ Support worker helped me

APPENDIX D – Participant Information Sheet

- ☐ Coordinator helped me
- ☐ Rehab nurse/ rehab support worker helped me
- ☐ Parent helped me
- ☐ Sibling (brother / sister) helped me
- ☐ Saw the sex worker on Facebook
- ☐ Saw the sex worker on Twitter
- ☐ Saw the sex worker on Instagram
- ☐ Saw the sex worker on TikTok
- ☐ Saw the sex worker in the media / documentary / TV
- ☐ Approached the sex worker at an event / conference/ performance
- ☐ Approached the sex worker in a street (where sex workers stand to meet clients)
- ☐ Other (please specify):
.....
.....
- ☐ Prefer not to answer

Please share any other information about how and why you chose the sex worker/s you have spent time with

Have you had any assistance or support to access sex worker services?

- ☐ **No** [I organise and meet the sex worker independently without anyone else involved]
- ☐ **Yes**

If 'Yes', please tick all that apply

- ☐ Someone helps me book the appointment (via email/ online / phone / text / Facebook messenger etc)
- ☐ Someone helps me pay the sex worker (gets my money from my bank account/ organises invoice and then transfer of payment)
- ☐ Someone helps me get ready for the appointment (ie. Showering/ dressing)
- ☐ Someone helps me get my home ready (cleaning the house, getting clean sheets and towels ready, making sure I have enough tissues etc)
- ☐ Someone answers the doors and lets the sex worker into my house when they arrive
- ☐ Someone drives me to/ from the appointment
- ☐ Someone helps me with un/dressing
- ☐ Someone helps me with transfers to and from the bed
- ☐ Other (please specify)

APPENDIX D – Participant Information Sheet

Please share any other information about the booking process

This could include:

- any difficulties you may have experienced organising the booking, or
- stories about support staff / family that have made the experience either extra special or very difficult.

A large, empty rectangular box with a thin blue border, intended for participants to write their responses to the questions above.

**Where did you get the money to pay for the sex worker/s?
(tick or circle all that apply)**

- ☐ From paid work / income
- ☐ Disability Pension
- ☐ Aged Care Pension
- ☐ NDIS funding
- ☐ Insurance payout
- ☐ Guardianship and Trustee releases my money
- ☐ Inheritance
- ☐ Parent/s paid for it
- ☐ Sibling/s paid for it
- ☐ Offspring paid for it
- ☐ Saved up my money from Christmas/ birthday presents
- ☐ Used gift vouchers given to me
- ☐ Other (please specify)

.....
.....

Section 5: WHY

The next three questions ask about your reasons for accessing sex worker services

Why did you decide to visit a sex worker?

(tick or circle all that apply)

- ☐ To lose my virginity
- ☐ To gain confidence after an accident
- ☐ To find out what my sexual functioning was ('if it all still worked') after accident or illness
- ☐ To experience specific sexual activities that I can't do with my partner
- ☐ To try new or different sexual activities
- ☐ I was lonely
- ☐ To learn about sex
- ☐ I couldn't get a girlfriend/ boyfriend
- ☐ To practice how to touch and talk to someone sexually

APPENDIX D – Participant Information Sheet

- ☐ Partner / husband / wife had passed away, but I still wanted intimacy / sex
- ☐ I enjoy sex and touching!
- ☐ All my friends were doing it, so I went with them to the brothel
- ☐ Other reasons

Please share any other information about your decision to visit a sex worker.

This could include:

- who you spoke with,
- what you read to help you make your decision, or
- if someone else suggested it as an option for you to try

Do you still see sex worker/s?

- ☐ Yes
- ☐ No

**You answered 'No'. Why don't you see sex workers any more?
(you can tick more than one answer)**

- ☐ I now have a partner / girlfriend/ boyfriend
- ☐ I got married
- ☐ My funding was stopped when I moved onto an NDIS Plan
- ☐ I moved and the new staff won't support me
- ☐ My support worker moved/ retired so I don't have anyone to take me/ organise the appointment for me
- ☐ My preferred sex worker retired
- ☐ I wanted to spend my money on other things
- ☐ My friends / family didn't approve
- ☐ It went against my religious beliefs
- ☐ Other reason/s

Section 6: Personal stories, opinions and suggestions

These final six questions ask you to share personal experiences and feelings about visiting a sex worker.

They also provide an opportunity to share what you would like others to know.

Your answers can be as short or as long and detailed as you would like.

APPENDIX D – Participant Information Sheet

Apart from anyone who assists you before, during or after a booking, does anyone else in your life know you visit sex worker/s?

This could be friends, family, people you work, socialise or study with or people you chat to in online groups.

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

If you answered YES:

Who? What was their reaction when you shared this information with them?

If you answered NO:

Why haven't you told anyone?

APPENDIX D – Participant Information Sheet

Please describe a favourite time or experience with a sex worker that you've had.

This could include:

- how they made you feel,
- what you did during the booking, or
- anything else that contributed to making the booking memorable.

You can share more than one story if you'd like.

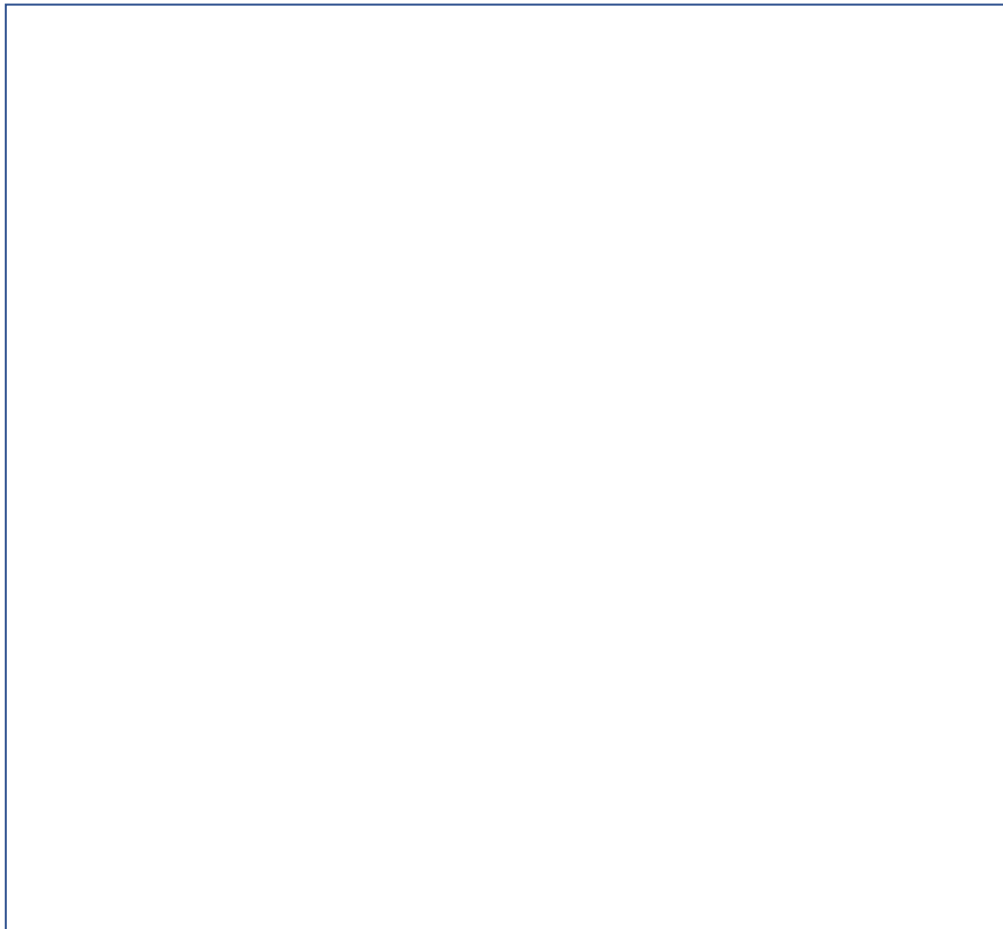
APPENDIX D – Participant Information Sheet

Please share any difficulties you've experienced:

- **visiting a sex worker (either before, during or after the booking), or**
- **when trying to book someone who you didn't end up seeing.**

This could include:

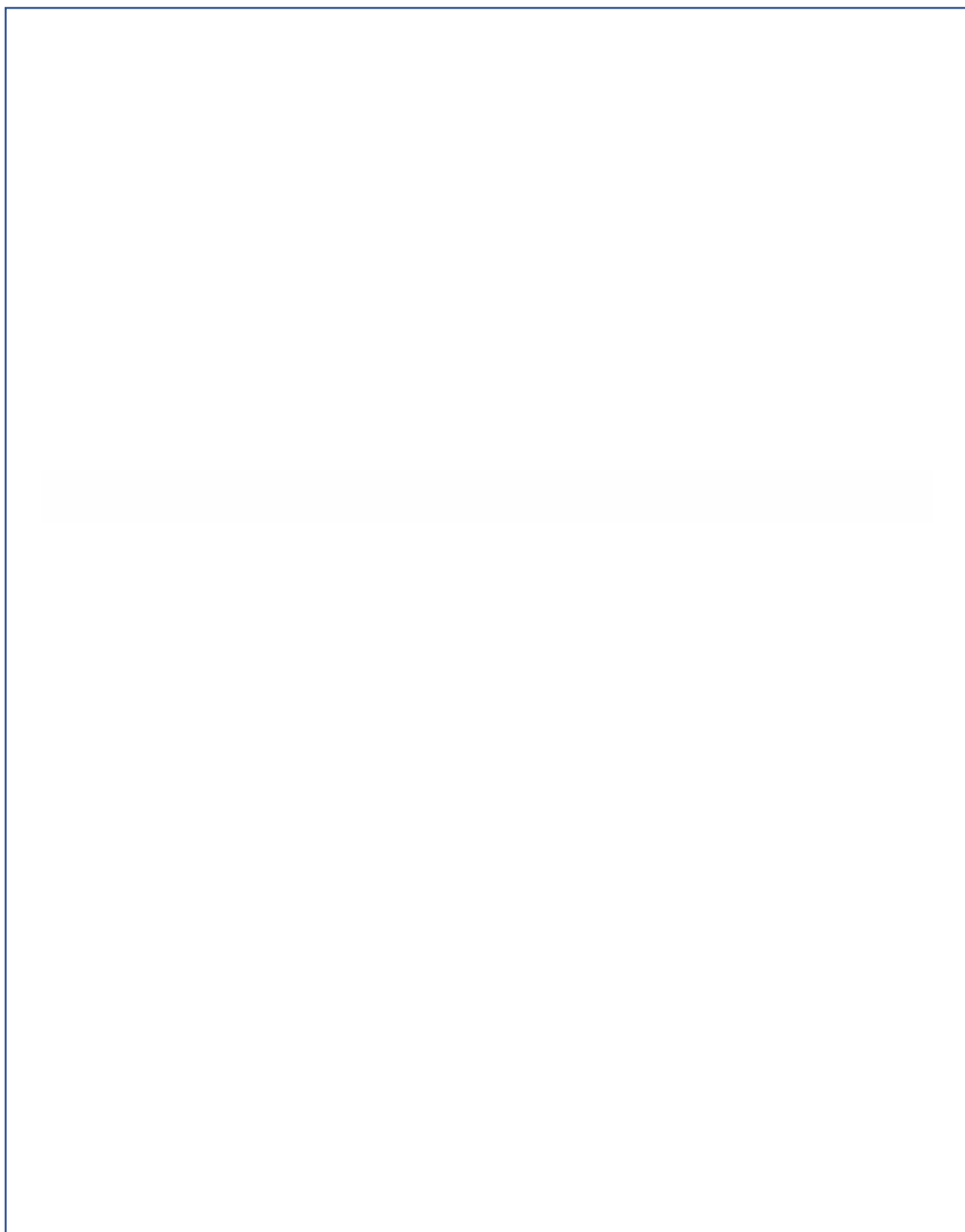
- dealing with moralistic or judgemental attitudes
- medical issues
- staffing problems
- transport issues
- lack of availability of sex workers in your area, or
- anything else that you experienced.



APPENDIX D – Participant Information Sheet

What would you like people in the **disability / aged care/ health care / medical sector** to know, to better support people with disability to visit sex workers?

What would you like **sex workers** to know, about people with disability who want to visit them?

A large, empty rectangular box with a thin blue border, intended for participants to write their responses to the question above. It occupies the majority of the page area below the question.

What would you like to tell the **general public** about people with disability who want to visit sex workers?

Is there anything else you would like to say?

Thank you for doing the survey

By sending this survey in the mail, you give your consent for your answers to be used.

It is FREE to send this survey using this address:

Reply Paid 75953
Western Sydney University
PASA Research (Rachel Wotton)
Locked Bag 1797
Penrith NSW 2751

*the next page will let you sign up for a chance to win a \$100 gift card

*the last page is if you want to do an interview



Chance to win \$100 gift card

If you did the survey you can sign up for the chance to win a \$100 gift card.

- Fill in your email address if you prefer an online gift card
- Fill in your postal address if you want us to send a gift card by post
- Fill in your phone number if you want us to call or text you to tell you if you won

Name

Phone number

Email address

Put this form into a new envelope and close it.

Write gift card on the front.

Put the envelope into the big envelope with your survey.

We will not link your contact details to your survey answers.



Do you want to take part in the interview?

Rachel wants to talk to 10 to 20 people about how it is for them when they go to sex workers.

You might want to do the interview if

- You have been to many sex workers and have lots to tell
- You want to tell us things that were not in the survey
- You have more things to add to the survey

Rachel will call you within 7 days to let you know if you can take part in the survey.

You can ask her questions.

You can work out a date, time and place for the interview together.

Interviews can be done

- In person
- Over the phone
- Online on Zoom, Skype or Teams

APPENDIX D – Participant Information Sheet

Contact details

Name

Phone number

Email address

Your survey answers will not be linked to your name and contact details

Tick the **State or Territory** you live in.

☐

Australian Capital Territory **ACT**

☐

New South Wales **NSW**

☐

Northern Territory **NT**

☐

Queensland **QLD**

☐

South Australia **SA**

☐

Tasmania **TAS**

☐

Western Australia **WA**

☐

Victoria **VIC**

APPENDIX D – Participant Information Sheet

Tick how you want Rachel to contact you.

☐

Email

☐

Phone

☐

Video call on Zoom, Skype or Microsoft Teams

Tick which time is good for Rachel to contact you.

☐

Between 9am and 12pm

☐

Between 12pm and 3pm

☐

Between 3pm and 6pm

☐

Between 6pm and 9pm

Send this form to

Reply Paid 75953, Western Sydney University, PASA Research (Rachel Wotton),
Locked Bag 1797, Penrith NSW 2751

Do not send the form in the same envelope as your survey.

APPENDIX E

Easy Read Participant Information Sheet



Participant info sheet

Study about people with disability
who go to sex workers



Easy Read

www.pasa-research.com.au

About this info sheet



This is an info sheet for people who would like to be part of a study.



The study is about people with disability who go to sex workers.

A **sex worker** is a person you pay money to have sex or do sexual things with you.



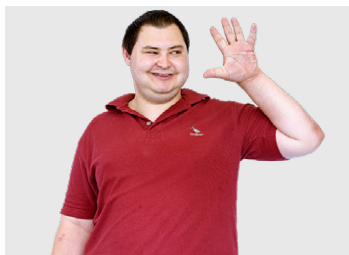
This info sheet will tell you

- What the study is about
- Who can be part of the study
- How you can be part of the study



The information will help you choose if you want to take part in the study.

About the study



The study is about people with disability who go to sex workers.



We want to talk to people with disability about how it is when you go to a sex worker.



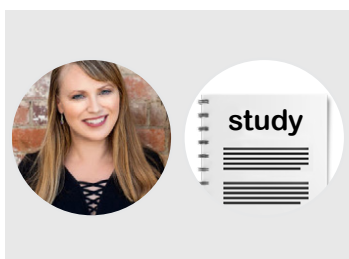
We want to find out if it is easy for you to go to a sex worker.



We want to know what can be difficult.



We want to find out why you go to a sex worker.



Rachel Wotton is doing the study.

It is part of her work at Western Sydney University.



Rachel has been a sex worker for over 20 years.



She might share what she finds out in this study with disability organisations and others.



She will not share your name or where you live.

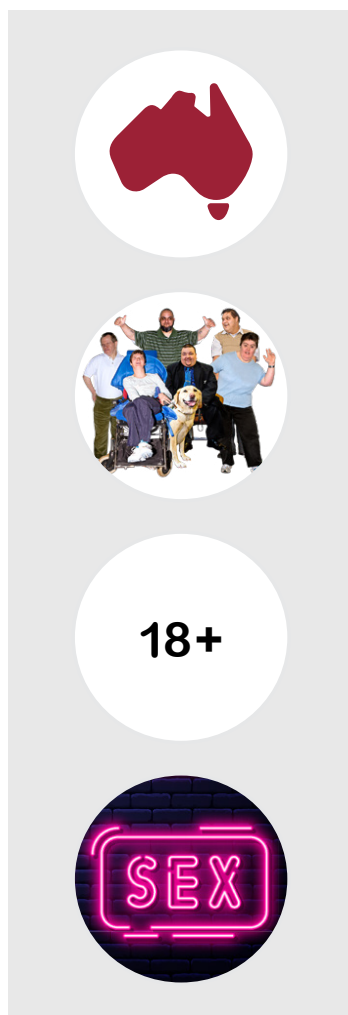


The study might help make it easier for people with disability to go to sex workers.



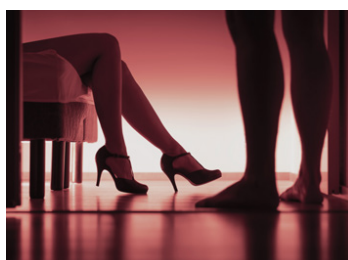
It might help staff at service providers better understand the needs of people with disability.

Who can be part of the study



To be part of the study you must

- Live in Australia
- Be a person with disability
- Be 18 years or older
- Have been to a sex worker in Australia before

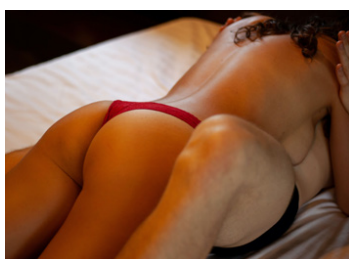


The things you do with the sex worker must be in person.

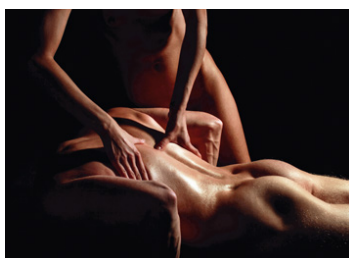
APPENDIX E – Easy Read Participant Information Sheet



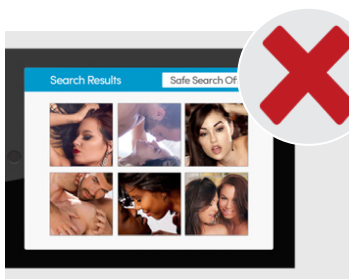
It can be things like dinner or talking to each other.



It can be having sex or doing sexual things in any way you like.

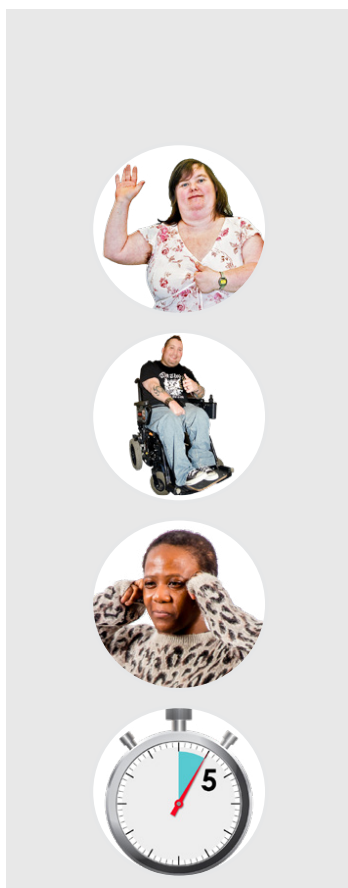


It can be getting a nude massage.



It does not count for the study if you do things online with a sex worker.

It also does not count if you watch porn.



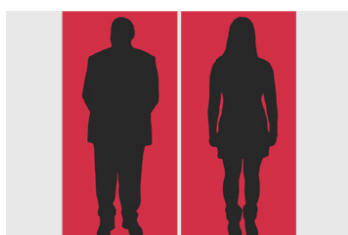
You can take part in this study no matter what disability you have.

You might have

- An intellectual disability
- A physical disability
- Mental health issues
- A disability that only lasts for a short time or happens sometimes



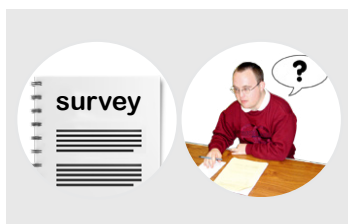
It does not matter what your gender or sex is.



Gender means how you see yourself as a person.

This can be different from the sex you were born with.

How does the study work



For the study we want you to

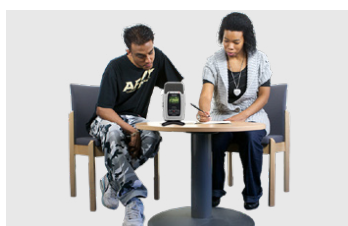
- Fill in a survey
- Do an interview



Survey means that you fill in a form with questions.



Interview means that someone from the study will talk to you.



You can do the survey and the interview.



You can also just do 1 of them.

The survey



The survey will ask you things like

- How old you are
- What disability you have
- Where you live

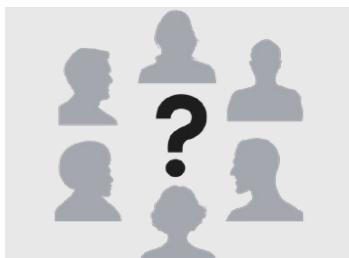


It will also ask you about how it is when you go to a sex worker.

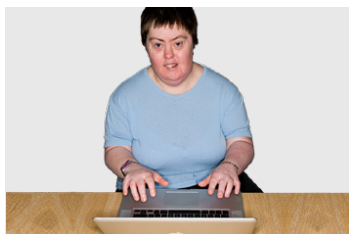


The survey is online.

You can do it on paper if that is easier for you.



We will not know who you are when you fill in the survey.



Some questions are very personal.

You might want to fill in the survey when you are alone.



You can stop doing the survey at any time if you change your mind.



We only get your answers when you

- Click submit
- Send it off by post.



You can win a \$100 gift card if you do the survey.



It is ok to do the survey if Rachel is the sex worker you go to.

The interview

10 to 20 people



We want to talk to 10 to 20 people for the study.

You might want to do an interview if

You have many things to share about going to sex workers.



You want to talk about something that is not part of the survey.



It is easier for you to talk about something than to write it down.

APPENDIX E – Easy Read Participant Information Sheet



Only the people doing the interview will know who you are.



We will not share with others who you are and where you live.



You can stop the interview at any time.



You will get a \$100 gift card for the interview.



If we meet in person we can pay for your transport and parking.



You **cannot** do the interview if Rachel is the sex worker you go to.

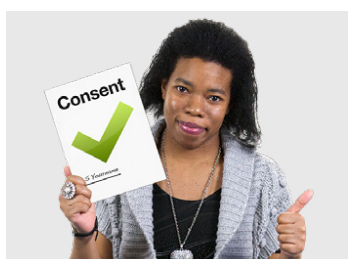
How you can be part of the study



To do the survey online go to

www.tinyurl.com/2a88zyuk

You must click **submit** at the end to send it off.



When you click submit you consent to the survey.

Consent means that you say yes to be part of the survey.



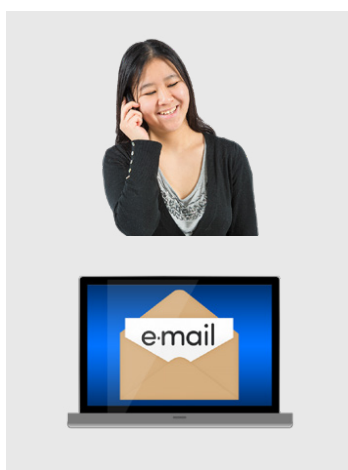
You can also print the survey and write down your answers.

You can send it for free to this address

Reply Paid 75953
Western Sydney University
PASA Research (Rachel Wotton)
Locked Bag 1797
Penrith NSW 2751



You can ask Rachel to send you the survey if you do not have a computer or printer.



If you want to take part in an interview

- Call Rachel on 0402 543 052
- Send Rachel an email at **20080642@student.westernsydney.edu.au**

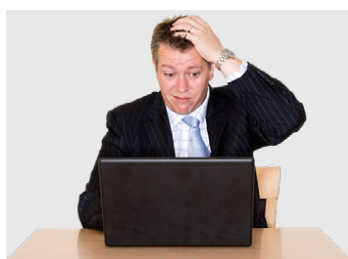


You can also contact Rachel if you have questions about the study.

More information and support



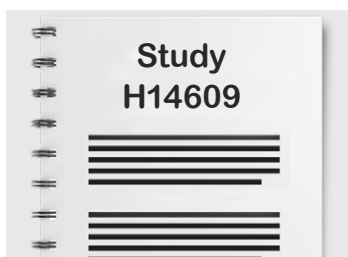
Western Sydney University said yes to this study.



You can tell them if you have any issues with the study.

You can

- Call them on (02) 4736 0229
- Send an email to **humanethics@westernsydney.edu.au**



Western Sydney University gave this study the number H14609.



You must tell them the number if you contact them about this study.

The number tells them which study you mean.



It is good to talk to someone you trust if you feel upset after the survey or the interview.



You can also call a support service like

- Beyond Blue on 1300 224 636
- Lifeline on 13 11 14
- 1800Respect on 1800 737 732
- Blue Knot on 1800 421 468

Council for Intellectual Disability made this document Easy Read. **CID** for short.
You need to ask CID if you want to use any pictures in this document.
You can contact CID at **business@cid.org.au**.

APPENDIX F

Print version of PASA-Research survey



Exploring the experiences of people with disability who access sex worker services, in Australia

- Do you live in Australia?
- Are you a person with disability?
- Are you 18 yrs or older?
- Have you ever paid a sex worker?

** If you answered yes to all four questions you are eligible to participate **

.....

This research aims to prioritise the voices of people with disability, to create an opportunity for people to share your own experiences about accessing sex worker services.

Questions will be grouped into five main areas of **who, what, where, how** and **why**, as well as a final section where you can share **personal stories, opinions and suggestions**.

People of all genders and sexual identities are welcome to participate.

This survey asks you about your personal experiences.

It is up to you how much information you wish to share.

You are not required to provide any personally identifying information.

Your responses are anonymous so can never be linked back to you.

All information about why the research is being done and what it will involve is provided in the [Participant Information Sheet](#).

You give consent to participate in the survey when you send it back. It is free to send it in the mail. No stamp needed.

As it is anonymous, once you submit your answers they cannot be withdrawn.

If you need more space, please use extra paper and attach to this survey

The closing date for this survey is 1st November 2022

All information about this research project can be found on the website: www.pasa-research.com.au

.....

Interview option

The researcher is also wanting to interview 10–20 people throughout Australia.

The interview will be an opportunity to expand on the answers you have given in this survey, especially if you have had many experiences with different sex workers. You can also provide other information for this research that wasn't asked in the survey.

If you are eligible and interested, you can fill out the form at the end of this printed survey and send back to the researcher in a separate envelope.

Your survey answers will not be linked to your contact details.

.....

Go in the draw to win 1 of 4 x \$100 eGift vouchers

Everyone who completes this survey can enter the draw to win 1 x 4 eGift Vouchers worth \$100 each (physical gift cards can also be sent if they are easier for people to use).

There is a form to fill out at the end of this survey to enter the draw.

Your survey answers will not be linked to your contact details.

.....

START OF SURVEY

Eligibility Questions

Do you identify as a person with disability?

- ☐ No
- ☐ Yes

How would you describe your disability/s?

Have you paid for sexual services from a sex worker, in Australia?

- ☐ Yes
- ☐ No

Section 1. WHO (demographics)

The following 8 questions are questions about yourself

What is your age? (tick or circle correct answer)

- ☐ 18-19
- ☐ 20-24
- ☐ 25-29
- ☐ 30-34
- ☐ 35-39
- ☐ 40-44
- ☐ 45-49
- ☐ 50-54
- ☐ 55-59
- ☐ 60- 64
- ☐ 65-69

- ☐ 70 -74
- ☐ 75-80
- ☐ 80-84
- ☐ 85-89
- ☐ 90-94
- ☐ 95-99
- ☐ 100+

What State or Territory do you live in? (tick or circle correct answer)

- ☐ Australian Capital Territory (ACT)
- ☐ New South Wales (NSW)
- ☐ Northern Territory (NT)
- ☐ Queensland (QLD)
- ☐ South Australia (SA)
- ☐ Tasmania (TAS)
- ☐ Western Australia (WA)
- ☐ Victoria (VIC)

**Do you identify as Aboriginal and/or Torres Strait Islander?
(tick or circle correct answer)**

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

**Do you identify as a person who is culturally and/or linguistically diverse
(CALD)?
(tick or circle correct answer)**

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

If yes, what best describes your family background? (Select all that apply)

Tick all the boxes that are right for you

- ☐ Aboriginal and/or Torres Strait Islander
- ☐ Australian or New Zealander
- ☐ Caribbean
- ☐ Central American
- ☐ Central Asian
- ☐ Chinese
- ☐ Eastern European
- ☐ Indian
- ☐ Japanese
- ☐ Korean
- ☐ Middle Eastern
- ☐ North African
- ☐ North American
- ☐ Northern European
- ☐ Oceania (Melanesian, Micronesian, Polynesian)
- ☐ Pacific Islander
- ☐ South East Asian
- ☐ South American
- ☐ Sub Saharan African
- ☐ United Kingdom/Ireland
- ☐ Western European
- ☐ Prefer not to say
- Any others?

**What was your sex recorded at birth?
(tick or circle correct answer)**

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Prefer not to answer

How do you describe your gender? (tick or circle correct answer)

(Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents).

- ☐ Man or male
- ☐ Woman or female
- ☐ Non-binary
- ☐ I use a different term (please specify).....
- ☐ Prefer not to answer

What is your sexuality? (tick or circle correct answer)

- ☐ Straight (heterosexual)
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Pansexual
- ☐ Asexual
- ☐ Queer
- ☐ I use a different term (please specify)
- ☐ Don't know / questioning
- ☐ Prefer not to answer

What are your living arrangements? (tick or circle correct answer)

- ☐ I live alone
- ☐ I live with my parents
- ☐ I live with my partner /wife/ husband/ girlfriend/ boyfriend
- ☐ I live with my offspring (ie. son / daughter)
- ☐ I live with my sibling/s (ie. sister / brother)
- ☐ I live with flatmates / friends
- ☐ I live in supported accommodation
- ☐ I live in a group home
- ☐ I live in a boarding house
- ☐ I live in a retirement home
- ☐ I live in a nursing home
- ☐ Other (please specify)
- ☐ Prefer not to answer

Section 2. WHAT

The next section has five questions, asking about your appointments with sex workers & the services you paid for

How many different sex workers have you visited, in total?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ More than 10 (please specify)

What age were you when you first paid for sexual services?

.....

What gender/s were the sex worker/s? (click all that apply)

- ☐ Male
- ☐ Female
- ☐ Transgender (M – F)
- ☐ Transgender (F – M)
- ☐ Non-binary
- ☐ Other
- ☐ Prefer not to answer

**What services have you paid sex workers for?
(circle or tick all that apply)**

- ☐ Nude massage
- ☐ Hand relief / masturbation
- ☐ Oral sex / blow job / French (you receiving)
- ☐ Oral sex / blow job / French (you giving)
- ☐ Vaginal sex (you giving ie. your sex worker has a vagina)
- ☐ Vaginal sex (you receiving ie. you have a vagina)
- ☐ Anal play (fingers/ toys in your bottom)
- ☐ Anal play (fingers/ toys in sex worker's bottom)
- ☐ Anal sex (you giving)
- ☐ Anal sex (you receiving)
- ☐ Using a Strap-on ('pegging')
- ☐ BDSM {Bondage, Discipline, Sadism, Masochism} services
- ☐ Sex toys ie. vibrators
- ☐ Fantasies / role plays
- ☐ Double booking (2 sex workers)
- ☐ Double booking (you and a partner [with disability] with 1 sex worker)
- ☐ Double booking (you and a partner [without disability] with 1 sex worker)
- ☐ Double booking (you and a friend [with disability] with 1 sex worker)
- ☐ Double booking (you and a friend [without disability] with 1 sex worker)
- ☐ Other (please specify)

.....

.....

How often do you visit sex worker/s? (tick or circle correct answer)

- ☐ No set pattern
- ☐ Whenever I can afford it
- ☐ Whenever I travel to the same location as the sex worker
- ☐ Whenever the sex work travels to my location
- ☐ Once a week
- ☐ Once a fortnight
- ☐ Once a month
- ☐ Once every 2 months (every 8 weeks/ 6 times a year)
- ☐ Once every 3 months (every 12 weeks/ 4 times a year)
- ☐ Once every 4 months (3 times a year)
- ☐ Once every 6 months (twice a year)
- ☐ Once a year

Section 3. WHERE

The next 2 questions ask about the location of where you receive services.

In which State or Territory have you received services from a sex worker? (circle or tick all that apply). Please write the name of the suburbs or general areas on the line next to your answers.

For example, in NSW you might name a specific suburb (Surry Hills) or a general area (the Inner West). For QLD it could include " Nundah" as a suburb, or 'Metropolitan Brisbane' or 'the Far North Queensland (FNQ) region'.

To maintain confidentiality, the individual suburbs will not be shared in the public findings of this research.

- ☐ Australian Capital Territory (ACT).....
- ☐ New South Wales (NSW).....
- ☐ Northern Territory.....
- ☐ Queensland.....
- ☐ South Australia.....
- ☐ Tasmania.....
- ☐ Western Australia.....
- ☐ Victoria.....

Where have sex worker/s provided services to you?

(tick/ circle all that apply)

- ☐ Brothel
- ☐ Massage parlour
- ☐ Hotel
- ☐ Motel
- ☐ My home / where I live
- ☐ The sex worker's private workplace (house/ unit)
- ☐ BDSM house / parlour
- ☐ Private BDSM dungeon
- ☐ Safe house
- ☐ Hospital
- ☐ Rehab Accommodation
- ☐ Car
- ☐ Other (please specify).....

Section 4. HOW

The next six questions are about finding the right sex worker, organising the appointment, support & payments

How did you locate the sex worker/s?

(Circle / tick all that apply)

- ☐ Arrived at the premises and chose from the sex workers available (ie. brothel /massage parlour)
- ☐ Sex worker's website / advertisement online
- ☐ Newspaper advertisement
- ☐ Referral from another sex worker
- ☐ Referral / suggestion from another person with disability
- ☐ Touching Base Referral List
- ☐ Therapist helped me
- ☐ Support worker helped me

- ☐ Coordinator helped me
- ☐ Rehab nurse/ rehab support worker helped me
- ☐ Parent helped me
- ☐ Sibling (brother / sister) helped me
- ☐ Saw the sex worker on Facebook
- ☐ Saw the sex worker on Twitter
- ☐ Saw the sex worker on Instagram
- ☐ Saw the sex worker on TikTok
- ☐ Saw the sex worker in the media / documentary / TV
- ☐ Approached the sex worker at an event / conference/ performance
- ☐ Approached the sex worker in a street (where sex workers stand to meet clients)
- ☐ Other (please specify):
.....
.....
- ☐ Prefer not to answer

Please share any other information about how and why you chose the sex worker/s you have spent time with

Have you had any assistance or support to access sex worker services?

- ☐ **No** [I organise and meet the sex worker independently without anyone else involved]
- ☐ **Yes**

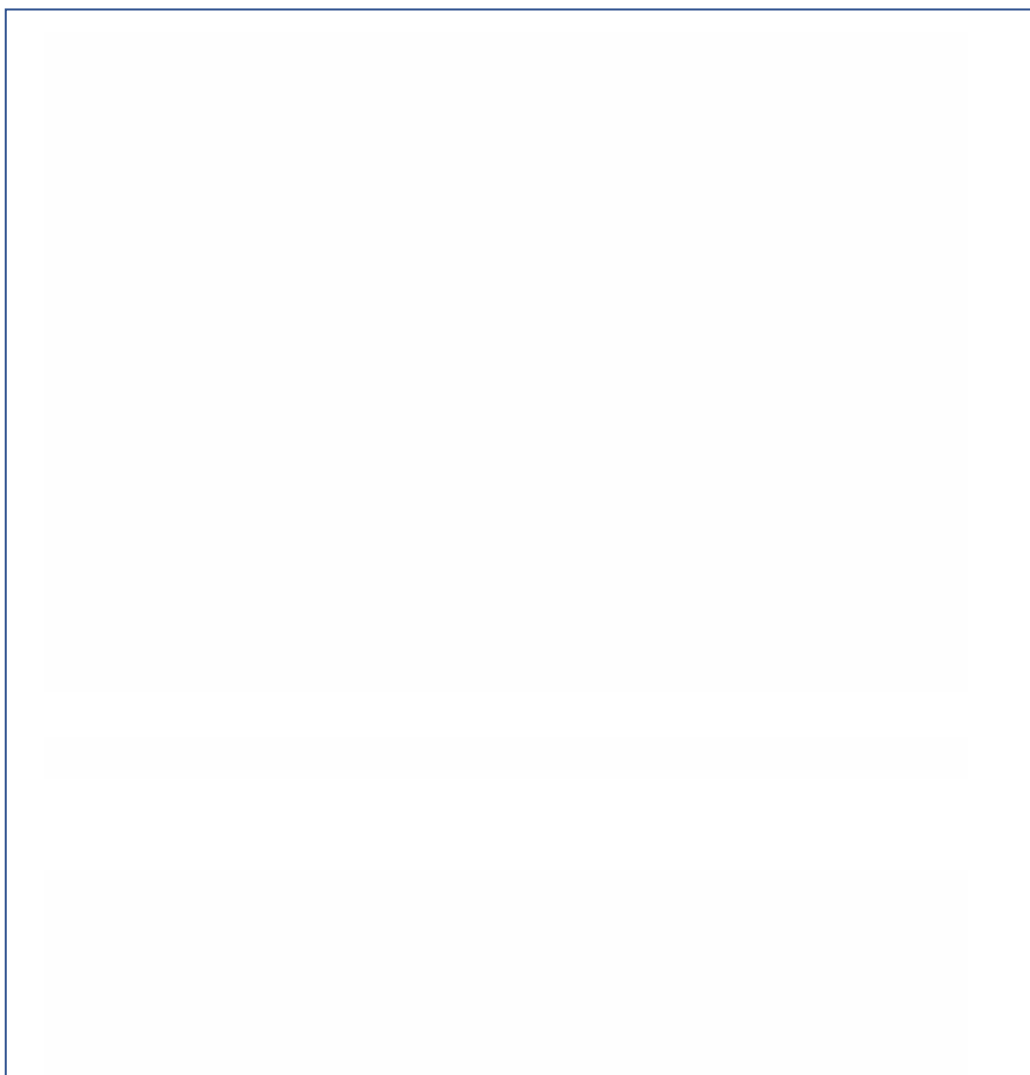
If 'Yes', please tick all that apply

- ☐ Someone helps me book the appointment (via email/ online / phone / text / Facebook messenger etc)
- ☐ Someone helps me pay the sex worker (gets my money from my bank account/ organises invoice and then transfer of payment)
- ☐ Someone helps me get ready for the appointment (ie. Showering/ dressing)
- ☐ Someone helps me get my home ready (cleaning the house, getting clean sheets and towels ready, making sure I have enough tissues etc)
- ☐ Someone answers the doors and lets the sex worker into my house when they arrive
- ☐ Someone drives me to/ from the appointment
- ☐ Someone helps me with un/dressing
- ☐ Someone helps me with transfers to and from the bed
- ☐ Other (please specify)

Please share any other information about the booking process

This could include:

- any difficulties you may have experienced organising the booking, or
- stories about support staff / family that have made the experience either extra special or very difficult.



Where did you get the money to pay for the sex worker/s?
(tick or circle all that apply)

- ☐ From paid work / income
- ☐ Disability Pension
- ☐ Aged Care Pension
- ☐ NDIS funding
- ☐ Insurance payout
- ☐ Guardianship and Trustee releases my money
- ☐ Inheritance
- ☐ Parent/s paid for it
- ☐ Sibling/s paid for it
- ☐ Offspring paid for it
- ☐ Saved up my money from Christmas/ birthday presents
- ☐ Used gift vouchers given to me
- ☐ Other (please specify)

.....
.....

Section 5: WHY

The next three questions ask about your reasons for accessing sex worker services

Why did you decide to visit a sex worker?

(tick or circle all that apply)

- ☐ To lose my virginity
- ☐ To gain confidence after an accident
- ☐ To find out what my sexual functioning was ('if it all still worked') after accident or illness
- ☐ To experience specific sexual activities that I can't do with my partner
- ☐ To try new or different sexual activities
- ☐ I was lonely
- ☐ To learn about sex
- ☐ I couldn't get a girlfriend/ boyfriend
- ☐ To practice how to touch and talk to someone sexually

- ☐ Partner / husband / wife had passed away, but I still wanted intimacy / sex
- ☐ I enjoy sex and touching!
- ☐ All my friends were doing it, so I went with them to the brothel
- ☐ Other reasons

Please share any other information about your decision to visit a sex worker.

This could include:

- who you spoke with,
- what you read to help you make your decision, or
- if someone else suggested it as an option for you to try

Do you still see sex worker/s?

- ☐ Yes
- ☐ No

**You answered 'No'. Why don't you see sex workers any more?
(you can tick more than one answer)**

- ☐ I now have a partner / girlfriend/ boyfriend
- ☐ I got married
- ☐ My funding was stopped when I moved onto an NDIS Plan
- ☐ I moved and the new staff won't support me
- ☐ My support worker moved/ retired so I don't have anyone to take me/ organise the appointment for me
- ☐ My preferred sex worker retired
- ☐ I wanted to spend my money on other things
- ☐ My friends / family didn't approve
- ☐ It went against my religious beliefs
- ☐ Other reason/s

Section 6: Personal stories, opinions and suggestions

These final six questions ask you to share personal experiences and feelings about visiting a sex worker.

They also provide an opportunity to share what you would like others to know.

Your answers can be as short or as long and detailed as you would like.

Apart from anyone who assists you before, during or after a booking, does anyone else in your life know you visit sex worker/s?

This could be friends, family, people you work, socialise or study with or people you chat to in online groups.

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

If you answered YES:

Who? What was their reaction when you shared this information with them?

If you answered NO:

Why haven't you told anyone?

Please describe a favourite time or experience with a sex worker that you've had.

This could include:

- how they made you feel,
- what you did during the booking, or
- anything else that contributed to making the booking memorable.

You can share more than one story if you'd like.

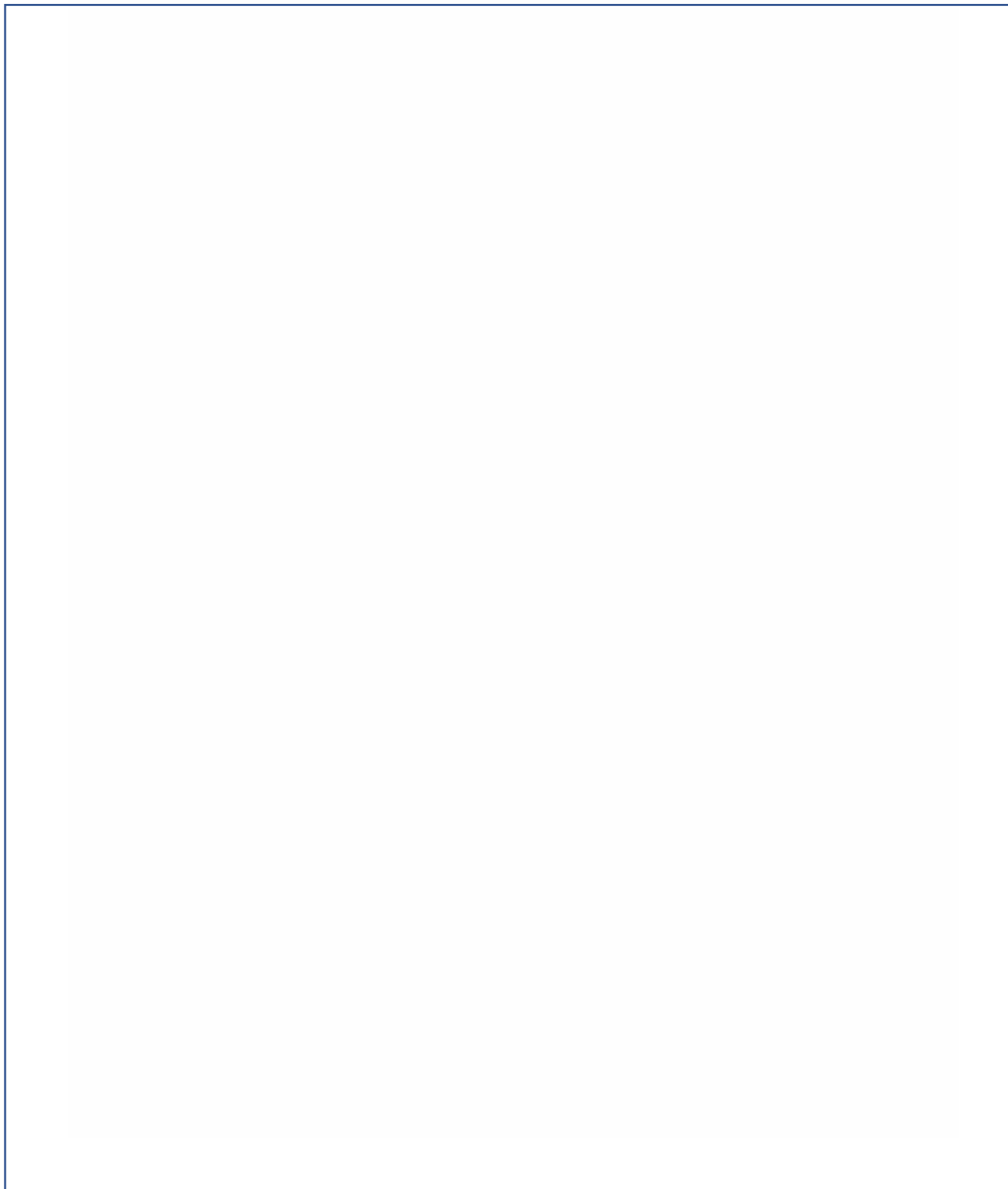
Please share any difficulties you've experienced:

- **visiting a sex worker (either before, during or after the booking), or**
- **when trying to book someone who you didn't end up seeing.**

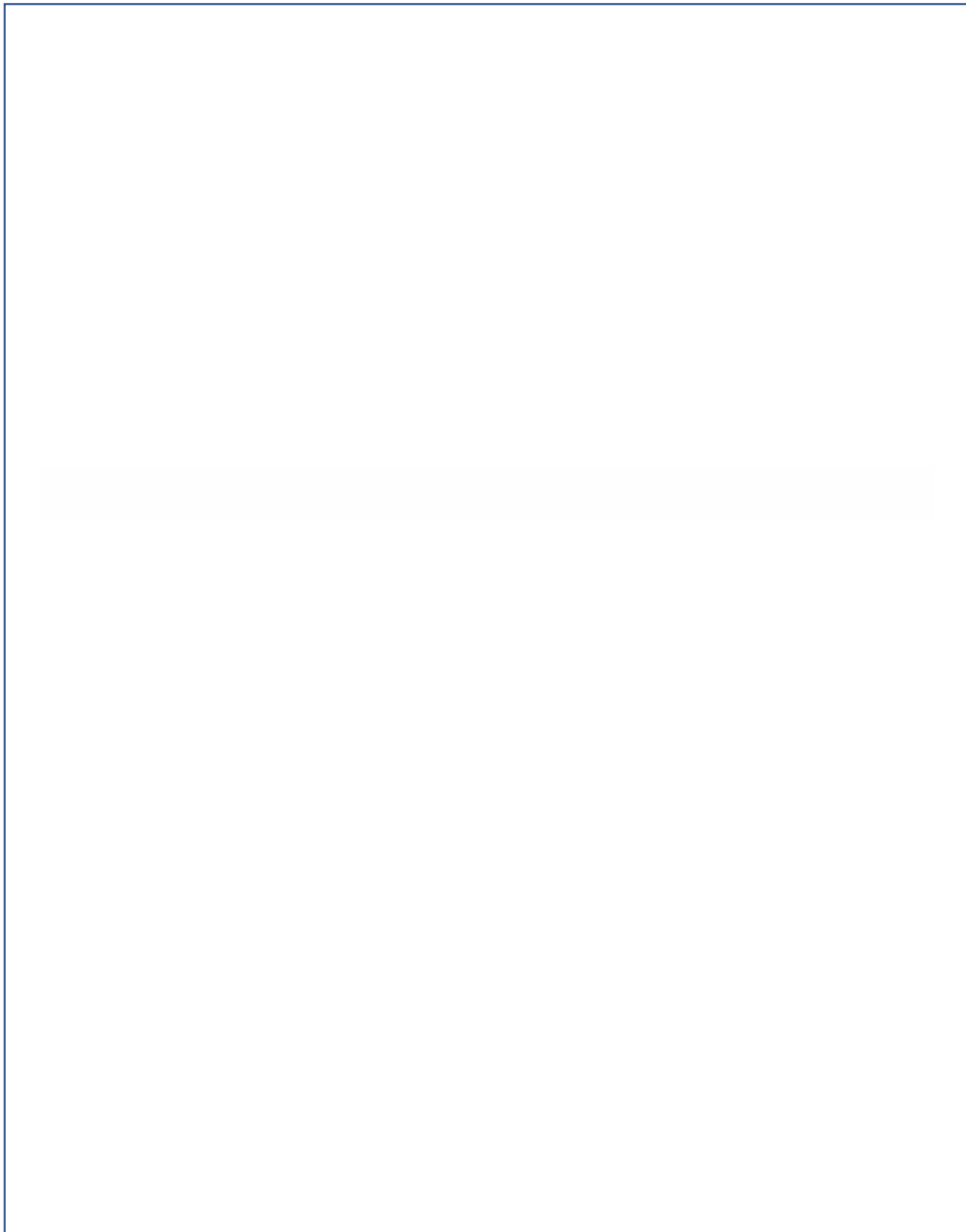
This could include:

- dealing with moralistic or judgemental attitudes
- medical issues
- staffing problems
- transport issues
- lack of availability of sex workers in your area, or
- anything else that you experienced.

What would you like people in the **disability / aged care/ health care / medical sector** to know, to better support people with disability to visit sex workers?

A large, empty rectangular box with a thin blue border, intended for respondents to write their answers to the survey question above it.

What would you like **sex workers** to know, about people with disability who want to visit them?



What would you like to tell the **general public** about people with disability who want to visit sex workers?

Is there anything else you would like to say?

Thank you for doing the survey

By sending this survey in the mail, you give your consent for your answers to be used.

It is FREE to send this survey using this address:

Reply Paid 75953
Western Sydney University
PASA Research (Rachel Wotton)
Locked Bag 1797
Penrith NSW 2751

*the next page will let you sign up for a chance to win a \$100 gift card

*the last page is if you want to do an interview



Chance to win \$100 gift card

If you did the survey you can sign up for the chance to win a \$100 gift card.

- Fill in your email address if you prefer an online gift card
- Fill in your postal address if you want us to send a gift card by post
- Fill in your phone number if you want us to call or text you to tell you if you won

Name

Phone number

Email address

Put this form into a new envelope and close it.

Write gift card on the front.

Put the envelope into the big envelope with your survey.

We will not link your contact details to your survey answers.



People with disability who go to sex workers in Australia

Do you want to take part in the interview?

Rachel wants to talk to 10 to 20 people about how it is for them when they go to sex workers.

You might want to do the interview if

- You have been to many sex workers and have lots to tell
- You want to tell us things that were not in the survey
- You have more things to add to the survey

Rachel will call you within 7 days to let you know if you can take part in the survey.

You can ask her questions.

You can work out a date, time and place for the interview together.

Interviews can be done

- In person
- Over the phone
- Online on Zoom, Skype or Teams

Contact details

Name

Phone number

Email address

Your survey answers will not be linked to your name and contact details

Tick the **State or Territory** you live in.

☐

Australian Capital Territory **ACT**

☐

New South Wales **NSW**

☐

Northern Territory **NT**

☐

Queensland **QLD**

☐

South Australia **SA**

☐

Tasmania **TAS**

☐

Western Australia **WA**

☐

Victoria **VIC**

Tick how you want Rachel to contact you.

☐

Email

☐

Phone

☐

Video call on Zoom, Skype or Microsoft Teams

Tick which time is good for Rachel to contact you.

☐

Between 9am and 12pm

☐

Between 12pm and 3pm

☐

Between 3pm and 6pm

☐

Between 6pm and 9pm

Send this form to

Reply Paid 75953, Western Sydney University, PASA Research (Rachel Wotton),
Locked Bag 1797, Penrith NSW 2751

Do not send the form in the same envelope as your survey.

APPENDIX G

Plain English print version of PASA-Research survey



Survey

For people with disability
who go to sex workers



Plain English

www.pasa-research.com.au

Take part in our study

Our study is about people with disability who go to sex workers.

A sex worker is a person you pay money to have sex or do sexual things with you.

We want to find out how it is for people with disability in Australia to go to a sex worker.



You can only take part in the study if your answer is yes to all of these 4 questions.

- Do you live in Australia?
- Are you a person with disability?
- Are you 18 years or older?
- Have you ever paid for a sex worker?

For the study we would like you to

- Fill in a survey
- Do an interview

It is ok if you just do the survey and not the interview.

About the survey

The survey will ask you lots of different questions.

The questions will be about

- You
- The sex workers you went to
- The things you did with the sex worker
- Why you go to sex workers

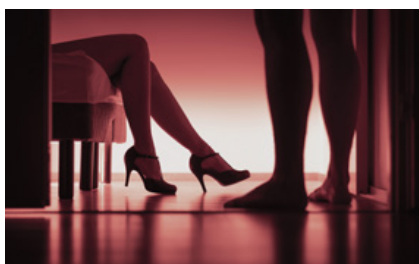
It is up to you how much you share with us.

You do not have to tell us who you are.

That means we do not know that the answers are from you.

This survey has lots of questions.

You might want to get support from someone you trust to fill it out.



Name

Address

If you want to know more about this study you can read the info sheet.

Go to www.tinyurl.com/2a88zyuk

The survey closes on the 1st November 2022.

You do not have to fill in the survey all at once.

You can leave the page open and finish the survey later.



Click **Submit** at the end of the survey to send us your answers.

When you click submit it also means you give consent.

To **give consent** means that you say yes to be part of the survey.

Once you click submit you cannot change your answers or take them back.

This is because we do not know who you are and what answers are yours.

About the interview

After you finish the survey and click submit there will be information about the interview.

We would like to talk to 10 to 20 people.

We can do the interview online so that people from all over Australia can do it.

It is up to you if you do the interview.

You might want to do the interview if you want to tell us things that are not in the survey.

We will only use your contact details to do the interview.

We will not link them to your survey answers.



Win a \$100 gift card

If you finish the survey you can sign up for the chance to win a \$100 gift card.

We will only use your contact details if you win.

We will not link them to your survey answers.

The survey

Part 1 Who



This part asks questions about you.

1. Are you a person with disability?

☐

Yes

☐

No

Please tell us more about your disability if you like

2. Have you ever paid for a sex worker in Australia?

☐

Yes

☐

No

3. How old are you?

Tick the box that shows your age.

☐

18 or 19

☐

60 to 64

☐

20 to 24

☐

65 to 69

☐

25 to 29

☐

70 to 74

☐

30 to 34

☐

75 to 80

☐

35 to 39

☐

80 to 84

☐

40 to 44

☐

85 to 89

☐

45 to 49

☐

90 to 94

☐

50 to 54

☐

95 to 99

☐

55 to 59

☐

100 or older

4. Where do you live?

Tick the box where you live.

☐

Australian Capital Territory ACT

☐

New South Wales NSW

☐

Northern Territory NT

☐

Queensland QLD

☐

South Australia SA

☐

Tasmania TAS

☐

Western Australia WA

☐

Victoria VIC

5. Are you Aboriginal or Torres Strait Islander?

☐

Yes

☐

No

☐

I do not want to say

6. Do you come from a different culture or speak a language other than English?

☐ Yes ☐ No ☐ I do not want to say

If you ticked yes please tell us more about your family background.

Tick all the boxes that are right for you.

You or your family are from

☐ New Zealand	☐ North America
☐ The Caribbean	☐ Northern Europe
☐ Central America	☐ Oceania like Melanesia, Micronesia or Polynesia
☐ Central Asia	☐ The Pacific Islands
☐ China	☐ South East Asia
☐ Eastern Europe	☐ South America
☐ India	☐ Sub Saharan Africa
☐ Japan	☐ The United Kingdom or Ireland
☐ Korea	☐ Western Europe
☐ The Middle East	☐ Other
☐ North Africa	☐ I do not want to say

7. What was your sex when you were born?

☐

Male

☐

Female

☐

Other

☐

I do not want to say

8. What is your gender?

Gender means the way you see yourself.

This can be different from the sex you were born with.

☐

Man or male

☐

Woman or female

☐

Non-binary if you do not see yourself as only male or only female.

☐

Other

☐

I do not want to say

9. What is your sexuality?

☐

Straight. I like people from the other sex.

☐

Gay. I am a man who likes men.

☐

Lesbian. I am a woman who likes women.

☐

Bisexual. I like men **and** women.

☐

Pansexual. I like people from **all** genders.

☐

Asexual. I like people but not in a sexual way.

☐

Queer. This word means a lot of different sexualities that are not straight.

☐

Other. I am

☐

I am still finding out about my sexuality

☐

I do not want to say

10. How do you live?

Tick all the boxes that are right for you.

☐

I live alone

☐

I live with my parents

☐

I live with my partner

☐

I live with my children

☐

I live with my brother or sister

☐

I live with flatmates or friends

☐

I live in supported accommodation

☐

I live in a group home

☐

I live in a boarding house

☐

I live in a retirement home

☐

I live in a nursing home

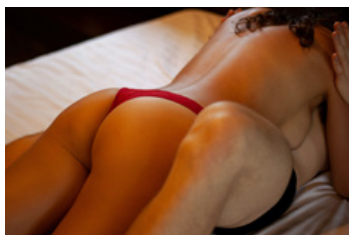
☐

Other

☐

I do not want to say

Part 2 What



This part asks questions about the sex workers you see and the things you do with them.

11. How many different sex workers have you been to?

12. How old were you when you went to a sex worker for the first time?

13. What gender were the sex workers?

Tick all the boxes that are right for you.

☐

Man or Male

☐

Woman or Female

☐

Transgender from man to woman

☐

Transgender from woman to man

☐

Non-binary

☐

Other

☐

I do not want to say

14. What services have you paid sex workers for?

Tick all the boxes of things you have done with sex workers.

☐

I had a nude massage.

☐

Hand relief or masturbation means the sex worker used their hands on your penis or vagina.

☐

The sex worker did oral sex to me.

Oral sex means that someone uses their mouth or tongue to touch your penis or vagina.

☐

I did oral sex to the sex worker.

☐

I did vaginal sex to the sex worker and put my penis or fingers in their vagina.

☐

I got vaginal sex. The sex worker put their penis or fingers in me.

☐

We did anal play and the sex worker put their fingers or toys in my bottom.

☐

We did anal play and I put my fingers or toys in the sex worker's bottom.

☐

I got anal sex from the sex worker.

Anal sex means 1 person puts their penis in the other person's bottom.

☐

I did anal sex to the sex worker.

Anal sex means 1 person puts their penis in the other person's bottom.

☐

We used a strap on. This is also called pegging.

A **strap on** is a fake penis you tie to your body.

☐

We did BDSM which could be things like bondage, discipline, sadism, masochism.

BDSM means things like tying each other up, whipping each other or hurting each other in a way the other person likes and says yes to.

☐

We used sex toys like vibrators.

☐

We did fantasy role plays like dressing up.

☐

Double booking with me and 2 sex workers at the same time.

☐

Double booking with me, my partner who has a disability and 1 sex worker.

☐

Double booking with me, my partner who does not have a disability and 1 sex worker.

☐

Double booking with me, a friend who has a disability and 1 sex worker.

☐

Double booking with me, a friend who does not have a disability and 1 sex worker.

☐

Other

15. How often did you go to sex workers?

Tick all the boxes that are right for you.

- ☐ Whenever I feel like it
- ☐ Whenever I have enough money
- ☐ Whenever I travel to where the sex worker is
- ☐ Whenever the sex worker is close to where I live
- ☐ Once a week
- ☐ Once every 2 weeks
- ☐ Once a month
- ☐ Once every 2 months
- ☐ Once every 3 months
- ☐ 3 times a year
- ☐ 2 times a year
- ☐ Once a year

Part 3 Where



This part asks questions about where you go and see sex workers.

16. In which States or Territories did you go to sex workers?

Tick all the boxes that are right for you.

- ☐ Australian Capital Territory ACT
- ☐ New South Wales NSW
- ☐ Northern Territory NT
- ☐ Queensland QLD
- ☐ South Australia SA
- ☐ Tasmania TAS
- ☐ Western Australia WA
- ☐ Victoria VIC

17. Fill in the suburbs or areas where you went to see a sex worker.

We will not use the suburbs for the report about this survey.

We will only use council areas or regions.

18. Where did you go to see a sex worker?

Tick all the boxes that are right for you.

☐

At a brothel.

A **brothel** is a place where many sex workers work.

☐

At a massage place

☐

At a hotel

☐

At a motel

☐

At my house

☐

At the sex worker's house

☐

At a BDSM brothel

☐

At the sex workers own BDSM place

☐

At a safe house

☐

At a hospital

☐

At the place I stayed for rehab

☐

In a car

☐

Other place like

Part 4 How



This part asks questions about things like

- Finding the right sex worker
- Booking a meeting with a sex worker
- Support to go to sex workers
- Paying the sex worker

19. How did you find your sex workers?

Tick all the boxes that are right for you.

☐

I went to the brothel or massage place and picked 1 of the sex workers there.

☐

I went to the sex worker's website.

☐

The sex worker had an advertisement in the newspaper.

Advertisement can be a picture with a phone number.

☐

Another sex worker told me about the sex worker.

☐

Another person with disability told me about the sex worker.

☐

I used the Touching Base Referral List.

☐

My therapist helped me.

- ☐ My support worker helped me.
- ☐ Staff at the rehab place helped me.
- ☐ My family helped me.
- ☐ I found the sex worker on social media.
- ☐ I saw the sex worker in the media or on TV.
- ☐ I met the sex worker at an event.
- ☐ I went to one of the streets where sex workers wait for people to pay them for sex.
- ☐ Other

Why did you pick this sex worker?

☐

I do not want to say.

20. Did anyone help you go to a sex worker?

Tick the answer that is right for you.

☐

No I booked and went to the sex worker by myself with no help.

☐

Yes someone helped me book and go to the sex worker.

If someone helped you book or go to a sex worker tell us how.

Tick all the boxes that are right for you.

☐

Someone helped me book the meeting with the sex worker.

They emailed, texted or called the sex worker.

☐

Someone helped me pay the sex worker.

They got money for me from the bank or put the money into the sex workers account.

☐

Someone helped me get ready to go to the sex worker.

They got me dressed or helped me have a shower.

☐

Someone helped me get my home ready.

They cleaned, changed the sheets or got new towels and tissues.

☐

Someone opened the door and let the sex worker into my house.

☐

Someone drove me to see the sex worker.

☐

Someone helped me take my clothes off and put them back on.

☐

Someone helped me get on and off the bed.

☐

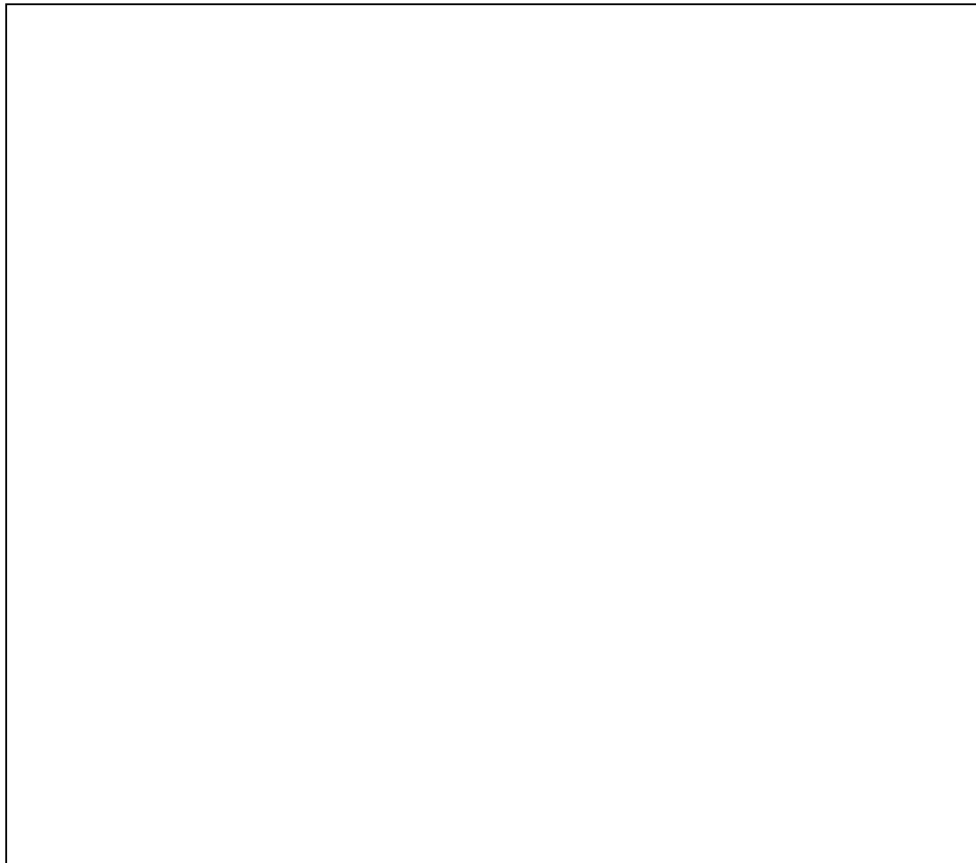
Other

Tell us more about how it is when you book or see a sex worker.

You can tell us about things that help you a lot to see a sex worker.

This could be things that other people do to help you like your family or support workers.

You can tell us about things that make it hard for you.

A large, empty rectangular box with a thin black border, intended for the respondent to write their answers to the questions above.

21. How did you get the money to pay for the sex worker?

Tick all the boxes that are right for you.

☐

I used the money I make at work.

☐

I used my Disability Pension.

☐

I used my Aged Care Pension.

☐

I used my NDIS money.

☐

I used money I got from my insurance.

☐

My guardian or trustee gave me my money.

☐

I used the money I got when someone I knew died.

☐

My parents paid for it.

☐

My brother or sister paid for it.

☐

My children paid for it.

☐

I used the money I saved from my Christmas or birthday presents.

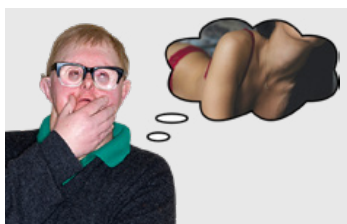
☐

I used gift vouchers that I got from people.

☐

Other

Part 5 Why



This part is about why you go to sex workers.

22. Why did you decide to go to a sex worker?

Tick all the boxes that are right for you.

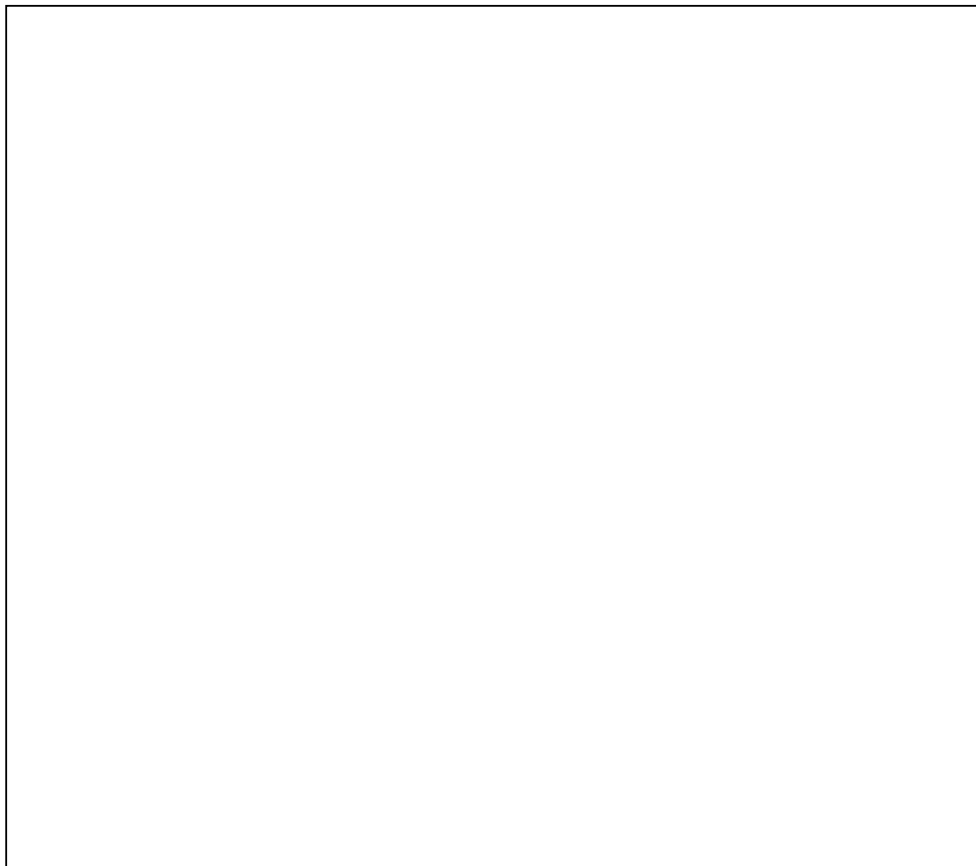
- ☐ I wanted to have sex for the first time.
- ☐ I had an accident and wanted to get more confident again.
- ☐ I wanted to see if everything still works after my accident or illness.
- ☐ I wanted to do sexual things that I cannot do with my partner.
- ☐ I wanted to try new sexual things.
- ☐ I was lonely.
- ☐ I wanted to learn about sex.
- ☐ I cannot find a girlfriend or boyfriend.
- ☐ I wanted to get better at touching and talking to someone in a sexual way.
- ☐ My partner has died but I still want to have sex or be close to someone.
- ☐ I enjoy sex and touching.
- ☐ All my friends go to sex workers so I went.
- ☐ Other

20

You can tell us more about why you go to sex workers.

This could be things like

- Who you talked to about it
- What helped you make the decision.

A large, empty rectangular box with a thin black border, intended for the respondent to provide details about why they go to sex workers.

23. Do you still go to sex workers?

☐

Yes

☐

No

If you said no tell us why not

Tick all the boxes that are right for you.

☐

I now have a partner, girlfriend or boyfriend

☐

I got married

☐

I got no more money since I moved onto an NDIS Plan

☐

I moved and the new staff do not support me to go

☐

I do not have anyone to support me to go

☐

The sex worker I liked does not work anymore

☐

I want to use my money for other things

☐

My friends or family do not want me to go

☐

My religion does not allow me to go

☐

Other

Part 6 Your personal stories



This part is about your own stories with sex workers.

You can tell us

- How you feel about going to sex workers
- Things that can better
- What others should know about it.

It is up to you if your answers are long or short.

24. Do people in your life know that you go to sex workers?

That means people other than the ones that support you to go.

☐

Yes

☐

No

☐

I do not want to say

Who knows about it and what did they say when you told them?

Why have you not told anyone?

25. Tell us about the best time you had with a sex worker.

This can be

- How they made you feel
- What you did with them
- Anything else that made it so good.

You can tell us more than 1 thing if you like.



26. Tell us about things that made it hard for you to go to a sex worker.

This could be about

- What other people think about sex workers
- Health issues
- Issues with support workers or transport
- Finding a sex worker where you live



27. What should disability workers, aged care worker or health workers know to better support people with disability to go to sex workers?

28. What should sex workers know about people with disability who want to go to them?

29. What should people in the community know about people with disability who go to sex workers?

30. Is there anything else you would like to say?

Thank you for doing the survey.

You need to click the arrow to send your answers off.

If you printed the survey and filled it in by hand please send it to

Reply Paid 75953

Western Sydney University

PASA Research (Rachel Wotton)

Locked Bag 1797

Penrith NSW 2751



People with disability who go to sex workers in Australia

Chance to win \$100 gift card

If you did the survey you can sign up for the chance to win a \$100 gift card.

- Fill in your email address if you prefer an online gift card
- Fill in your postal address if you want us to send a gift card by post
- Fill in your phone number if you want us to call or text you to tell you if you won

Name

Phone number

Email address

Put this form into a new envelope and close it.

Write gift card on the front.

Put the envelope into the big envelope with your survey.

We will not link your contact details to your survey answers.



People with disability who go to sex workers in Australia

Do you want to take part in the interview?

Rachel wants to talk to 10 to 20 people about how it is for them when they go to sex workers.

You might want to do the interview if

- You have been to many sex workers and have lots to tell
- You want to tell us things that were not in the survey
- You have more things to add to the survey

Rachel will call you within 7 days to let you know if you can take part in the survey.

You can ask her questions.

You can work out a date, time and place for the interview together.

Interviews can be done

- In person
- Over the phone
- Online on Zoom, Skype or Teams

Contact details

Name

Phone number

Email address

Your survey answers will not be linked to your name and contact details

Tick the State or Territory you live in.

☐

Australian Capital Territory **ACT**

☐

New South Wales **NSW**

☐

Northern Territory **NT**

☐

Queensland **QLD**

☐

South Australia **SA**

☐

Tasmania **TAS**

☐

Western Australia **WA**

☐

Victoria **VIC**

Tick how you want Rachel to contact you.

☐

Email

☐

Phone

☐

Video call on Zoom, Skype or Microsoft Teams

Tick which time is good for Rachel to contact you.

☐

Between 9am and 12pm

☐

Between 12pm and 3pm

☐

Between 3pm and 6pm

☐

Between 6pm and 9pm

Send this form to

Reply Paid 75953, Western Sydney University, PASA Research (Rachel Wotton),
Locked Bag 1797, Penrith NSW 2751

Do not send the form in the same envelope as your survey.

APPENDIX H

Consent Form for interviews

Consent form



People with disability who access sex worker services, in Australia

I have read and understand the attached Participant Information Statement

I consent to participating in an interview

I have been given a copy of the Participant Information Statement to keep

The researchers have agreed not to reveal my identity and personal details

I know that I can withdraw consent at any time

I have been given a copy of the Withdrawal of Consent Form

Participant

Name:

Signature:

Date:



Ethics Approval Number: H14609

APPENDIX I

Withdrawal of Consent Form

Withdrawal of consent form

(to be used for participants who wish to withdraw from the project)



People with disability who access sex worker services, in Australia

I wish to withdraw my consent to participate in the above research project.

I understand that such withdrawal will not affect my relationship with Western Sydney University
or the research team.

Name:

Signature:

Date:

Email or post this form to Rachel Wotton:

20080642@student.westernsydney.edu.au

Reply Paid 75953
Western Sydney University
PASA Research (Rachel Wotton)
Locked Bag 1797
Penrith NSW 2751



Ethics Approval Number: H14609

APPENDIX J

Risk Management Plan for the Researcher

Risk Management Plan for the Researcher

The researcher will adhere to all protocols, outlined in the Ethics Application, to maintain confidentiality and safety of participants and the researcher. As an extension of this, the interviews will be conducted either online or in public spaces, in locations that maintain the confidentiality of the participant while ensuring the safety and comfort of both parties. However, there is also the possibility that a participant may nominate to be interviewed in their own home. This may be to ensure essential care and support is provided throughout the interview regarding medical and physical needs. Additionally, the individual can regulate their environment to best support their psychosocial wellbeing and have support person/s nearby if needed.

The researcher is committed to providing equitable access to all eligible interviewees so will utilise a risk management plan each time an interview in a private residence is scheduled. This will include the following steps:

1. The name, address and phone number of the participant will be emailed to her supervisor/s, along with the date and time of the scheduled interview.
2. The researcher will create a system with her supervisor/s to set up a safety word protocol, to be used if under duress at any stage during the interview process at a participant's location. This will signal to the supervisor in a subtle way that they are in trouble or danger and to contact the police.
3. The researcher and supervisor will also agree to a procedure to follow if the researcher hasn't check in at their nominated time. For example, the supervisor will call the researcher 15 minutes after they were due to receive a text/ email from the researcher in the field. If there is no answer they will next call the participant with the number previously supplied to the researcher. If contact cannot be established they will alert the authorities.
4. On the day of the interview the researcher will text / email the nominated supervisor to confirm arrival to the participant's location and the anticipated time of departure.
5. The researcher will text/ email when she has departed the interviewee's location.
6. If the interview is longer than the anticipated time period the researcher will check in via text/ email and give a new departure time. She will then follow Step 5 for when she has departed the participant's residence.

A similar safety protocol has been successfully used by the researcher for over 25 years for her work within the sex industry. Therefore she feels confident to be able to apply this safety protocol to any situation during the data collection phase of the research where she may be interviewing a person in a private residence.

APPENDIX K

List of all disabilities provided by Survey participants

A table of all disability descriptors provided by the PASA-Research survey participants, arranged in descending order from most frequently mentioned.

#	DISABILITY	TOTAL
1	Cerebral palsy (CP)	29
2	Autism Spectrum Disorder (ASD)	20
3	Spinal cord injury (paraplegia & quadriplegia)	14
4	Physical Disability	13
5	ADHD (Attention Deficit Hyperactivity Disorder)	10
6	Depression	7
7	Blind / vision impaired	7
8	Anxiety	6
9	Schizophrenia & Schizo Affective disorder	5
10	Multiple Sclerosis (MS)	4
11	Deaf / hearing impaired	4
12	Learning Impairment / Development delayed	3
13	Post Traumatic Stress Disorder (PTSD)	3
14	Acquired Brain Injury (ABI)	3
15	Spina Bifida	3
16	Stroke	3
17	Muscular Dystrophy (MD)	3
18	Sexual dysfunction/ Erectile Dysfunction (ED)	3
19	Autoimmune illness	3
20	Hydrocephalus	2
21	Neurological	2
22	Psychosocial disabilities / mental health	2
23	Fatigue	2
24	Sleep disorders (Narcolepsy & Delayed Sleep Phase Syndrome)	2
25	Chronic pain	2
26	Bowel & bladder issues	2
27	Bipolar Disorder	1
28	Avoidant personality	1
29	Language disorder	1
30	Sensory impairment	1
31	Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS)	1
32	Spinal Muscular Atrophy Type 2 (SMA Type 2)	1
33	Motor Vehicle Accident injury	1
34	Genetic lung condition (partial lung removal and reduced breathing capacity)	1
35	Arthritis	1
36	Limited mobility due to nerve damage	1
37	Dyscalculia	1
38	Neurodivergent	1
39	Epilepsy	1
40	An incurable blood cancer	1

APPENDIX K – List of all disabilities provided by Survey participants

38	Neurodivergent	1
39	Epilepsy	1
40	An incurable blood cancer	1
41	Dwarfism	1
42	Obsessive Compulsive Disorder (OCD)	1
43	Obesity	1
45	5 bypass heart operation	1
46	Language disorder	1
47	Mild Intellectual disability	1
48	Parkinsons Disease	1

APPENDIX L

PASA-Research participants separated into six disability categories

Appendix 12: PASA-Research participants separated into six disability categories

Category	Description	Disabilities	Total
Physical¹	Physical disabilities may affect, either temporarily or permanently, a person's physical capacity and/or mobility. Can include breathing difficulties, chronic or recurrent pain, or incomplete use of limbs Causes include inherited or genetic disorders, serious illnesses, and injury.	'Physical disability' (13) Cerebral Palsy ² (29) Spina Bifida (3) Autoimmune illness (3) Sexual dysfunction/ Erectile Dysfunction (3) Hydrocephalus (2) Fatigue (2) Chronic pain (2) Bowel & Bladder issues (2) Dwarfism (1) Motor Vehicle Accident injury (1) Genetic lung condition (1) arthritis (1) incurable blood cancer (1) obesity (1) heart bypass (1)	65
Intellectual³	Difficulty in communicating, learning, and retaining information.	Mild intellectual disability (1) Learning impaired/ Developmental delay (3)	4
Sensory⁴	Can affect one or more senses; sight, hearing, smell, touch, taste or spatial awareness	Blind / vision impaired (7) Deaf/ hearing impaired (4) Sensory Impairment (1)	12
		Depression (7) Anxiety (6)	

¹ <https://www.aruma.com.au/about-us/about-disability/types-of-disabilities/types-of-physical-disabilities/>

² I have included Cerebral Palsy into the physical disability section because it "is a physical disability that affects movement and posture" <https://cerebralpalsy.org.au/cerebral-palsy/>. The Cerebral Palsy Alliance does note that "People who have cerebral palsy may also have visual, learning, hearing, speech, epilepsy and intellectual impairments" but as participants in this survey had the option to share that additional information, it is assumed any additional conditions would be recorded in other categories.

³ Source: <https://www.aruma.com.au/about-us/about-disability/types-of-disabilities/types-of-intellectual-disabilities/>

⁴ <https://mapleservices.com.au/types-of-sensory-disabilities-and-impairment/>
<https://www.aruma.com.au/about-us/about-disability/types-of-disabilities/types-of-sensory-disabilities/>

Appendix 12: PASA-Research participants separated into six disability categories

Mental Illness⁵	Mental illness is a general term that refers to a group of illnesses that significantly affects how a person feels, thinks, behaves, and interacts with other people.	bipolar disorder (2) Avoidant personality (1) Schizophrenia and Schizoaffective Disorder (5) obsessive-compulsive disorder (OCD) (1) Post-traumatic stress disorder (PTSD) (3)	25
neurological⁶	Neurological conditions affect the brain, spinal cord, and the nerves that connect them	Spinal cord injury (SCI) (14) Multiple Sclerosis (4) Muscular dystrophy (3) Stroke (3) Acquired Brain Injury (ABI) (3) Sleep disorders : Narcolepsy & Delayed Sleep Phase Syndrome (2) “neurological” (2) Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) (1) Spinal Muscular Atrophy (1) Epilepsy (1) ‘Limited mobility due to nerve damage’ (1) Parkinson’s Disease (1)	36
Neurodivergent⁷	A “neurodivergent” person refers to someone whose brain processes information in a way that is not typical of most individuals	Autism (ASD) (20) ADHD (10) “psychosocial/ mental health” (2) Language disorder (1) Dyscalculia (1) ‘neurodivergent’ (1)	35

Table X: The categorisation of PASA-Research participants’ disabilities⁵ <https://www.aruma.com.au/about-us/about-disability/types-of-disabilities/types-of-mental-illness/>⁶ <https://www.health.gov.au/topics/chronic-conditions/what-were-doing-about-chronic-conditions/what-were-doing-about-neurological-conditions>⁷ <https://www.healthdirect.gov.au/autism>
<https://thespectrum.org.au/autism/>

APPENDIX M

Survey participants categorised under disability category, and listing current age range and age of first paid sexual service

Appendix 13: Survey participants categorised under disability category, and listing current age range and age of first paid sexual service

DISABILITY CATEGORY	CURRENT AGE RANGE	AGE OF FIRST SW APT	HOW LONG AGO
PHYSICAL			
Cerebral palsy	55-59	42	13-17
Cerebral palsy	35-39	19	16-20
Cerebral palsy	60- 64	53	7-11
Cerebral palsy	35-39	20	15-19
Cerebral palsy	50-54	44	16-20
Cerebral palsy	40-44	32	8-12
Cerebral palsy	45-49	21	24-28
Cerebral palsy	45-49	37	8-12
Cerebral palsy	30-34	19	11-15
Cerebral palsy	40-44	23	17-21
Cerebral palsy	35-39	38	0-1
Cerebral palsy	30-34	20	10-14
Cerebral palsy	30-34	25	5-9
Cerebral palsy	30-34	20	10-14
Cerebral palsy	60- 64	23	37-41
Cerebral palsy	40-44	29	11-15
Cerebral palsy	40-44	18	22-26
Cerebral palsy	65-69	25	40-44
Cerebral palsy	35-39	20	15-19
Cerebral palsy	60- 64	60	0-4
Cerebral palsy	30-34	18	12-16
Cerebral palsy	30-34	32	0-2
Cerebral palsy	30-34	24	6-10
Cerebral palsy	35-39	31	4-8
Cerebral palsy	30-34	32	0-2

Appendix 13: Survey participants categorised under disability category, and listing current age range and age of first paid sexual service

Physical disability	40-44	32	8-12
Physical disability	35-39	37	0-2
Physical Disability	45-49	17	28-32
Physical disability	55-59	55	0-4
Physical disability	55-59	50	5-9
Physical disability	45-49	43	2-6
physical (arthritis, chronic back pain)	20-24	20	0-4
Missing left arm	30-34	19	11-15
dwarfism	30-34	34	0
Spina Bifida	45-49	33	12-16
Spina Bifida	50-54	12	38-42 **
Spina Bifida	50-54	28	22-26
Prostate cancer /blood cancer	70 -74	66	4-8
Systemic autoimmune with multiple organ damage	55-59	18	37-41
Motor Vehicle Accident (MVA) injury & autoimmune illness	35-39	38	0-1
Physical injuries from car accident	30-34	26	4-8
Obesity	35-39	22	13-17
Genetic lung condition (with reduced breathing capacity)	50-54	19	21-25
INTELLECTUAL			
Mild Intellectual disability	35-39	34	1-5
Development delayed	35-39	18	17-21
Learning Impairment	45-49	17	28-32
SENSORY			
Legally blind	60- 64	43	17-21
Blind	35-39	34	1-5
Vision impaired	35-39	37	0-2
Vision impaired	30-34	20	10-14

APPENDIX M – Survey participants categorised under disability category, and listing current age range and age of first paid sexual service

Appendix 13: Survey participants categorised under disability category, and listing current age range and age of first paid sexual service

Vision Impaired	45-49	17	28-32
Totally blind	55-59	53	2-6
Totally blind	65-69	22	43-47
Deafness/anxiety	35-39	30	5-9
bilateral sensorineural hearing loss	30-34	18	12-16
Partial deafness	40-44	21	19-23
sensory impairment	40-44	32	8-12
MENTAL ILLNESS			
Social and sexual anxiety	30-34	19	11-15
Depression and anxiety	35-39	30	5-9
Depression and anxiety	30-34	26	4-8
Depression and anxiety	40-44	41	0-3
Clinical depression and anxiety	30-34	29	1-5
Depression	35-39	37	0-2
Schizo Affective disorder, mood disorder and depression	45-49	18	27-31
PTSD & depression	55-59	49	6-10
PTSD and trauma	60- 64	57	3-7
Depression / OCD /PTSD (undiagnosed)	40-44	36	4-8
OCD	40-44	32	8-12
Mental Health - psychosocial	60- 64	20	40-44
Mental Illness (Bipolar and Schizophrenia)	40-44	18	22-26
Schizophrenia	45-49	20	25-29
Schizophrenia	60-64	20	40-44
Schizoid personality, Avoidant personality	65-69	21	44-48
NEUROLOGICAL			
Neurological	45-49	43	2-6

Appendix 13: Survey participants categorised under disability category, and listing current age range and age of first paid sexual service

Spinal muscular atrophy (type 2) (SMA type 2)	40-44	39	1-5
ME [Myalgic encephalomyelitis/ chronic fatigue syndrome:CFS]	40-44	40	0-4
Muscular Dystrophy (MD)	40-44	33	7-11
Muscular Dystrophy (MD)	30-34	26	4-8
Muscular Dystrophy (MD)	50-54	25	25-29
Multiple sclerosis (MS)	40-44	41	0-3
Multiple sclerosis (MS)	45-49	43	2-4
Multiple sclerosis (MS)	30-34	26	4-8
Multiple sclerosis (MS)	45-49	47	0-2
Incomplete Paraplegic (SCI)	30-34	18	12-16
Incomplete paraplegic (SCI)	30-34	30	0-4
Incomplete paraplegic (SCI)	40-44	41	0-3
Paraplegia (SCI)	40-44	30	10-14
Incomplete quadriplegic (SCI)	75-80	69	6-11
Quadriplegic (SCI)	35-39	25	10-14
Quadriplegic (SCI)	35-39	19	16-20
Quadriplegic (SCI)	50-54	48	2-6
Incomplete quadriplegic with a frontal lobe brain injury (SCI & ABI)	40-44	23	17-21
Major spine injury (SCI)	35-39	18	17-21
Spinal injury	50-54	19	21-25
Stroke	25-29	25	0-4
Stroke, hemiplegia, hydrocephalus, epilepsy	40-44	21	19-23
Narcolepsy	35-39	22	13-17
Sleep disorders - Narcolepsy, Delayed Sleep Phase Syndrome	40-44	19	21-25
Chronic pain, limited mobility due to nerve damage	30-34	24	6-10

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Appendix 13: Survey participants categorised under disability category, and listing current age range and age of first paid sexual service

NEURODIVERGENT			
Neurodivergent	50-54	35	15-19
Autism (ASD), ADHD	30-34	26	4-8
Autism (ASD), ADHD	50-54	19	21-25
Autism (ASD)/ ADHD	25-29	24	1-5
Autism (ASD), ADHD	30-34	21	9-13
Autism (ASD), ADHD	35-39	34	1-5
Autism (ASD), ADHD, Psychosocial disabilities	65-69	45	20-24
Autistic (ASD), ADHD, dyscalculia.	45-49	43	2-6
Autism (ASD) (childhood disintegrative disorder,)	25-29	22	3-7
Aspergers (ASD)	35-39	30	5-9
Asperger's (ASD)	30-34	27	3-7
Autism (ASD)	35-39	34	1-5
Autism (ASD)	40-44	41	0-3
Autism (ASD)	30-34	29	1-5
Autism (ASD)	30-34	18	12-16
Mild Autism (ASD)	45-49	39	6-10
Autism (ASD)	60- 64	20	40-44
Autism (ASD)	65-69	21	44-48
Autism (ASD), movement disorder	40-44	32	8-12
Invisible	45-49	38	7-11
Language disorder	45-49	25	20-24