Suicide Prevention and Response Strategy

Project Respect Submission

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General Comments

Project Respect is a Victorian based support and referral service for anyone who self-identifies as a woman as well as gender diverse and non-binary people in the sex industry, including those who have experienced human trafficking for sexual exploitation. We provide support to women throughout Australia, and work in collaboration with other organisations in sectors such as legal services and family violence to provide multifaceted care to service users.

We provide the following comments on the Suicide Prevention and Response Strategy 2022 in the context of our experience as a service provider where the voices of lived experience are elevated.

We note that as a small and currently underfunded service our ability to provide a thorough response to the consultation is constrained by resources and staffing. We make the offer to the Suicide Prevention and Response Office to further expand on our submission through engaging with the interview process during the consultation period.

Priority populations – Question 2

2a. In the discussion paper we have listed a series of groups that may need a greater focus in the strategy. Is this list appropriate? (Yes/No)

2b. If not, which other higher risk groups do we need to prioritise for targeted and comprehensive action now?

We note that the proposed priority groups for the strategy are presented in table 3, and that the discussion paper acknowledges an intersectional approach to these groups would be taken. The groups have been identified as representing people with increased risk of suicide. The groups include (amongst others):

- Aboriginal people
- Young people aged 15-24
- Culturally diverse people
- LGBTIQ+ communities
- People living in rural and remote communities
- People living with mental illness
- People living with substance use and additions (including gambling addiction)
- People with a lived experience of suicide
- People with disability and neurodiverse people
- Women, with particular co-occurring risk factors identified including mental illness, family and relationship issues, domestic violence, cultural expectations and eating disorders.

The service users and communities that Project Respect interact with regularly, as women and gender diverse people with experience in the sex industry, including experiences of trafficking for sexual exploitation, have significant intersections with these priority groups. We have worked with a high

proportion of service users with mental health challenges, which can include suicidality. We generally agree that the prioritisation of these groups when developing a suicide prevention and response strategy would be justified. However, we would also offer some additional suggestions regarding the challenges experienced by people within these groups, particularly within the category of women with co-occurring risk factors.

Within our work supporting service users, we have seen additional risks presenting. We are also aware of some research indicating that there are additional suicidality risks that impact victim survivors of family, domestic and sexual violence, which includes (but is certainly not limited to) women and gender diverse people with experience in the sex industry and/or of trafficking for sexual exploitation. Some of these have not been expressly identified in the discussion paper. We recommend at a minimum the inclusion of these specific risk factors within the identified priority groups, as this will impact the design and availability of services and suicide prevention programs that should intersect with prevention of the underlying risks.

We identify the following as risk factors, but also as representing potential priority groups in their own right.

1. Victim Survivors of Sexual Violence

Evidence exists that suicidality is increased in the population of victim survivors of sexual violence, sufficient to have victim survivors of sexual violence be recognised as a specific priority group. Evidence suggests that this is a risk factor for all genders, and includes sexual violence experienced as a child[1] or adult[2].

Further, we have seen the impacts on mental health where an individual's experience is denied or disbelieved, or the disclosure is mishandled. For example, in an instance where a sex worker may have disclosed sexual violence to a police officer, health worker or other service provider who does not take the disclosure seriously or minimises the impact due to the sex worker's occupation, the negative impact on mental health is increased.

There is also evidence that complex trauma presentations specific to sexual assault, and also to sexual exploitation, can be missed, or misdiagnosed[3]. This may occur where there is a reluctance to disclose the sexual violence, which can in turn be due to barriers to that disclosure through stigma, discrimination, or cultural differences. We have also seen immediate (but potentially long lasting) negative impacts where trafficking for sexual exploitation has been rebutted, denied or minimised by parties the victim survivor has disclosed to, or this third party has too quickly raised arguments about whether or not the experience fits into existing legislative frameworks or has the potential to result in

[1] Cutajar, M. C., Ogloff, J. R., & Mullen, P. E. (2011). Child sexual abuse and subsequent offending and victimisation: A 45-year follow-up study. Canberra: Criminology Research Council.
[2] Ullman, S.E., & Najdowski, C.J. (2009). Correlates of serious suicidal ideation and attempts in female adult sexual assault survivors. *Suicide & life-threatening behavior, 39 1*, 47-57 .
[3] Salter, M., Conroy, E., Dragiewicz, M., Burke, J., Ussher, J., Middleton, W., … Noack-Lundberg, K. (2020). "A deep wound under my heart": Constructions of complex trauma and implications for women's wellbeing and safety from violence (Research report, 12/2020). Sydney: ANROWS.

successful prosecution. These approaches can add to the feeling of disconnection for the victim survivor, and act as barriers to further help seeking.

In relation to the incidence of sexual violence, in particular against women, as quoted in ANROWS (2020) Violence against women and mental health: research synthesis. Australia's National Research Organisation for Women's Safety, Sydney. - (*ANROWS Insights*; 04/2020):

> "Research shows that women (cisgender and trans) commonly experience sexual violence (Ussher et al., 2020)[4] and that there is a strong relationship between sexual violence and poor mental health (Quadara, 2015)[5]."

Multiple references cited in research undertaken by O'Dwyer et al[6] indicate that sexual violence is generally not identified by mental health services. This impact needs to be considered for victim survivors of sexual violence including within prevention and response to suicide, with education around this issue a priority for mental health services.

2. Victim Survivors of Modern Slavery

While one of the priority groups has been identified broadly as culturally diverse people, the particular stress experienced by those with visa insecurity who have experienced highly traumatic events has not been recognised as a risk factor.

This is particularly apparent with migrant populations who are victim survivors of modern slavery, including trafficking for sexual exploitation, where there can be a mixed experience with being a victim of crime, barriers to reporting for fear of deportation, reliance on their exploiters for housing, fear of authorities, and/or various forms of stigma. Where visa insecurity and the threat of deportation have been removed, in addition to removal of the acute incidence of the modern slavery being experienced, mental health recovery can begin.

There are also victim survivors of domestic modern slavery who experience trauma which impacts mental health in a variety of ways, even though visa insecurity is not a factor. This experience is not currently recognised among the priority groups within the discussion paper.

We have seen in our service the impact of these stressors on mental health, including suicidal ideation and behaviours.

Studies in this area are difficult to source. While we acknowledge the differences in experiences that will exist between countries and communities, one study of suicidal ideation and suicide attempts among

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[4] Ussher, J. M., Hawkey, A., Perz, J., Liamputtong, P., Marjadi, B., Schmied, V., … Brook, E. (2020). Crossing the line: Lived experience of sexual violence among trans women of colour from culturally and linguistically diverse (CALD) backgrounds in Australia (Research report, 14/2020). Sydney: ANROWS

[5] Quadara, A. (2015). Implementing trauma-informed systems of care in health settings: The WITH study: State of knowledge paper (ANROWS Landscapes, 10/2015). Sydney: ANROWS.

[6] O'Dwyer C, Tarzia L, Ferbacher S, Hegarty K (2019) Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units *BMC Health Services Research.* 19:839

female sex workers in China indicated that female sex workers who were deceived or forced into commercial sex were more likely to report suicidal ideation, and those who had experienced sexual coercion were more likely to report a suicide attempt. These findings were in contrast with workers who did not experience deception, force or coercion (although other factors that increased the likelihood of suicidal ideation or attempt were also present across the groups)[7].

3. Women living in poverty

The community we work with includes women impacted by homelessness and food insecurity. This was exacerbated during COVID-19 lockdowns in Melbourne. During this time, we saw a number of women entering the sex industry for the first time for financial reasons, including a cohort of international students who could not access other financial supports, some of whom expressed that they would not have chosen to do so if not for these financial constraints. Many of the women we support have experienced difficulties in accessing mental health care, with insufficient financial means to do so being a significant barrier.

Australian data indicates that in 2020, the overall suicide rate for people living in the lowest socioeconomic (most disadvantaged) areas (18.1 deaths per 100,000 population; Quintile 1) was twice that of those living in the highest socioeconomic (least disadvantaged) areas (8.6 deaths per 100,000 population; Quintile 5)[8]. Further, those with higher income uncertainty had higher odds of suicide death relative to those with lower income uncertainty. Relative to those in the lowest income uncertainty quintile, the odds of dying by suicide increased by 1.91 (95% CI 0.29 to 0.44) for those in the highest income uncertainty quintile[9].

Current data indicates that the fastest growing group of Australians facing homelessness are women over 55[10]. In relation to the communities we provide services to, some women who work in the sex industry have told us they face increasing challenges maintaining income as they become older, which intersects with the risk of homelessness and food insecurity.

While poverty impacts all genders, the impact on women has also been shown to include an increased risk of exploitation and violence, including exposure to sexual violence. Being poor can make women and girls more vulnerable to perpetrators of abuse and prevent them from escaping abusive situations, while the impact of abuse can trap women in poverty. A study undertaken in the UK found that of women who have experienced extensive abuse and poverty, a third (38%) had attempted suicide, compared with 4% of women in poverty who had not been abused[11].

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[7] Hong, Y., Li, X., Fang, X., & Zhao, R. (2007). Correlates of suicidal ideation and attempt among female sex workers in China. *Health care for women international*, *28*(5), 490–505. https://doi.org/10.1080/07399330701226529

[8] Australian Institute of Health and Welfare, Deaths by suicide, by socioeconomic areas (2020).

[9] Australian Institute of Health and Welfare, Social and Economic Factors and Deaths by suicide (2020).

[10] Older Women's Risk of Homelessness: Background Paper (2019), © Australian Human Rights Commission 2019.

[11] Joining the dots: The combined burden of violence, abuse and poverty in the lives of women. Sally McManus, S. and Scott, S. (DMSS Research) with Sosenko, F (Heriot-Watt University), September 2016.

Recent studies have indicated that women leaving family violence situations have a high risk of entering poverty when they leave[12]. Mental health declines due to the experience of family violence are cited within the same study.

Poverty increases barriers to accessing mental health services, with a sizeable contrast in access between those with and without financial means. The 2019 Jean Hailes Women's Health Survey found that almost all (99%) of respondents who described themselves as 'living comfortably' could afford to see a health professional when they needed to. Only 63% of respondents who stated that they were 'just getting by' could afford to see a health professional when needed, with only 20% of respondents who were 'finding it very difficult' to manage financially being able to afford to see a health professional.

These barriers need to be broken down for this group to equitably access mental health services. Service design needs to consider accessibility and the intersectional experiences of women who are experiencing poverty.

Priority areas – Question 3. What priority areas should be included in the strategy to create the greatest impact and help us achieve our vision?

Initiatives and Actions – Question 5b. What opportunities should be created for the Victorian community to be part of the change to reduce the stigma associated with suicide, increase understanding and awareness, and prevent suicide?

The priority areas in the strategy are currently listed as:

- lived experience partnerships
- self-determined Aboriginal suicide prevention
- intersectional and targeted approaches for groups disproportionately affected by suicide
- data and evidence to drive outcomes
- workforce and community capabilities and responses
- whole-of-government leadership, accountability and collaboration
- a responsive, integrated and compassionate system.

Within these priority areas, we recommend that specific diverse groups be consulted in relation to best approaches suited that are culturally sensitive and likely to be impactful with that community. This has been planned for with Aboriginal communities, and in a similar way could be planned for with multiple migrant communities.

We recommend that specific consultation occur across individuals, organisations and groups representing, and working with, people with experience in the sex industry, and people who have experienced trafficking for sexual exploitation due to the specific intersections of these groups with the priority populations and risk factors described. We caution that this needs to occur across a range of

[12] Summers, A. (2022). The Choice: Violence or Poverty. University of Technology Sydney. https://doi.org/10.26195/3s1r-4977

organisations and groups, as this is not a homogenous population, but views and experiences tend to cluster within each specific organisation or group, as ethos and presentation of each tends to appeal to individuals with matching experiences to one another across this diverse cohort.

To give some context to this suggestion, within our work Project Respect has seen specific types of violence perpetrated against women in the sex industry, occurring at the intersection of family, domestic, and sexual violence. We have seen women we support entering the sex industry in order to secure an income upon leaving a violent partner and violence being perpetrated towards women in the sex industry in targeted ways.

Our preliminary data indicates that in 2021-22, 57% of women we supported disclosed current or historical experiences of family violence. 20% identified support for sexual assault as a support need during our engagement with them.

The gendered nature of the sex industry, the type of work, and the combined impact of stigma, isolation and discrimination often places women at higher risk of experiencing sexual harassment, abuse and exploitation from customers, management, and intimate partners. These conditions increase the likelihood of women in the sex industry to experience family violence and sexual assault, and the nature of the violence perpetrated can be different to that experienced in the broader community. As we have outlined above, this can have an impact on mental health needs and access to services.

Further, Project Respect estimates that 70-80% of women working in licensed brothels in Melbourne are women from migrant and culturally and linguistically diverse backgrounds, including women on temporary visas. Women in the Australian sex industry can experience additional barriers to help seeking and services due to language, migration status, navigation of services available in Australia, stigma and discrimination.

Question 5 - Initiatives and actions 5a. In addition to the Royal Commission's recommended initiatives, what other initiatives should be included in the strategy?

In consideration of the initiatives within the strategy, we offer the following examples of experiences of the service users we have worked with, for considerations when building initiatives:

- Navigation of the mental health system as it currently stands can be difficult, particularly where services are based on hospital networks. Without an understanding of the network system, providing place-based care can be a barrier to service users, particularly those without English as a first language and/or without experience in the navigation of systems or support to do so;
- Navigation of other service systems in Victoria that are LGA based which are then a pathway to the mental health system can create barriers where such service pathways are geographically based. This is particularly noticeable when service users move from one area to another;
- Some service users connect better to online, non-geographic based systems. This is particularly true of people who are isolated and may wish to initially interact anonymously. Support for online based or telehealth mental health services should be maintained;

- There is a lack of gender informed or gender-based services for women. For some of our service users, particularly where complex trauma is a factor, the service user will not work with a male mental health service provider. Often, the service user is unable to articulate why this is the case, and will disengage. This can then be a barrier to being able to access an alternate service – when one service has been declined this often results in no other pathways being available. Where sexual violence has been experienced, research has also recognised a bi-directional relationship between mental illness and sexual violence, in that sexual violence predisposes and maintains mental illness, but that conversely severe mental illness can increase women's risk of experiencing sexual violence[13]. A small study in Victoria (n = 50), Australia noted that almost half (45%) of women reported historic sexual assault and 67% reported sexual or other harassment while accessing a psychiatric inpatient unit[14]. Options for female only care services for women experiencing complex trauma, particularly where this has intersected with past gendered violence, should be considered;
- Emergency departments are limited in their ability to work with people presenting with elevated suicide risk. We have had service users discharged when the initial risk has passed without an effective discharge plan, including situations where the service user has been discharged alone;
- Visa insecurity, lack of financial resources and language barriers can make accessing mental health services difficult, particularly where an intersection of these exists.

We also recommend that within the strategy, models of care are developed that are effective for people who require long term interventions (for example, where complex trauma is present), that are not limited by short term access, and have integrated service system responses. As reported in one study regarding the relationship between intimate partner abuse and depression in women, women interviewed:

> *"emphasised the importance of being able to easily access appropriate ongoing trauma-informed services that share information, provide referrals, and support women in accessing help for their complex issues at all times, not only during crises".*[15]

Where a longer term mental health program is required, for example, regular GP referrals can be a barrier. If a service user has developed trust with a mental health practitioner but has not reached this level of trust with a GP, requirements for regular GP referral can operate as a disrupter to care. Programs where the mental health practitioner can determine the length of the care required, alongside the service user, would seem more logical.

In regard to immediate responses to suicidality, programs that skill professionals and community members to respond to the signs of suicide (such as the ASIST) program would be beneficial to

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[13] O'Dwyer C, Tarzia L, Ferbacher S, Hegarty K (2019) Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units *BMC Health Services Research.* 19:839

[14] Victorian Mental Illness Awareness Council (VMIAC). Zero tolerance for sexual assault. Brunswick: Victorian Mental Illness Awareness Council. 2013

[15] Hegarty, K., Gunn, J., Chondros, P., & Small, R. (2004). Association between depression and abuse by partners of women attending general practice: Descriptive, cross sectional survey. BMJ (Clinical research ed.), 328(7440), 621–624.

community cohorts that are currently unable to access such programs due to financial constraints. Funding for this programs that make them accessible across the priority cohorts and service providers to them would be of benefit.

Finally, in relation to the priority groups, and other difficult to reach cohorts experiencing an intersection of the risk factors identified, specialised service providers who service a unique cohort of the community that could not otherwise access services, should be further supported to undertake additional research and report data that informs ongoing improved service design and collaborative approaches across the service sector. Without data, and without education around the needs of specific communities, particular diverse community groups risk being invisibilised, as data will not be captured – especially relating to those service users who 'disappear' when a service provider fails to engage them due to inadequate understanding of how to service their diverse needs.

Small organisations require support and recognition from Government funders to increase the capacity of their otherwise constrained internal resources to provide important research, however, are in a unique position regarding data and knowledge that may not be otherwise adequately captured and utilised. Project Respect is currently insufficiently supported by government funding to service our unique community and the results are likely to be felt throughout the service system, including on the mental health outcomes of the community we provide services to.