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“I felt invisible”: First nations LGBTIQSB+ young people’s experiences with health service provision in Australia

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ABSTRACT

There is an absence of research into the effectiveness of service provision for First Nations LGBTIQSB+ young people in Australia. To address this gap, interviews were conducted in Australia to highlight young people’s perspectives on essential components of service provision. Participants expressed their concerns about the ongoing impact of implicit and explicit settler-colonial heteronormativity and racism on services providing support for young First Nations LGBTIQSB+ peoples. Although set in Australia, this research supports the body of international research. This research has the potential to create policies and practices centered on the voices and needs of First Nations LGBTIQSB+ youth.

KEYWORDS

Aboriginal; Australia; LGBTIQSB+; service provision; Torres Strait Islander

Introduction

There is very little evidence about health service provision for First Nations LGBTIQSB+ people (Lesbian Gay Bisexual Trans Intersex Queer Sistergirls Brotherboys¹) in Australia. This is despite this group being targeted in national policy documents as at particular risk of having poor well-being outcomes and in need of targeted, culturally appropriate service provision to meet and support their physical, mental, social, and emotional well-being needs. Overall, First Nations LGBTIQSB+ young people’s service needs have largely been ignored with the potential for this group to be further marginalized, isolated, and neglected by service providers. This also has a carry-on effect with little information and guidance available for service providers interested in improving service delivery for this cohort of young people.

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Research does exist, however, into the social determinants of poor health and well-being for both First Nations and LGBTIQ+ peoples in Australia. This body of research highlights the adverse impacts that institutional racism, marginalization, and discrimination have on outcomes for First Nations, youth, and LGBTIQ+ well-being (AIHW, 2018; Smith et al., 2014; Zubrick et al., 2005). Both First Nations in general and First Nations LGBTIQSB+ peoples, in particular, are exposed to detrimental, negative life experiences over their life courses. These include forced removal from family and community, forced relocation, genocide, ethnocide, and loss of lands and waters that lead to collective intergenerational and individual trauma, isolation, social exclusion, psychological distress, and homelessness (Carlson & Frazer, 2018; Hill, Bourne, McNair, Carman, & Lyons, 2020). For First Nations young people, these structural and interpersonal issues have had a huge impact with higher reported levels of psychological distress than their non-Indigenous peers (AIHW, 2018). This has important implications for well-being outcomes with suicide rates increasing for First Nations peoples across Australia during the period 2009–2017 (ABS, 2019). Suicide has been the leading cause of death for First Nations children (aged 5–17 years), accounting for more than a quarter (26.5%) of all child deaths (ABS, 2019). Young First Nations people aged 15–17 also made up 69.2% of all child suicides, with girls making up more than half (61.5%) of child suicide deaths (ABS, 2019). LGBTIQSB+ youth similarly experience higher levels of anxiety and depression, self-harm, and suicide than their heterosexual and cisgender (people who identify with the gender assigned at birth) peers (Dudgeon, Bonson, Cox, Georgatos, & Rouhani, 2015; Hill et al., 2020; Robinson et al., 2020; Smith et al., 2014).

Despite the potential for these intersecting risks to adversely impact Indigenous LGBTIQSB+ young people's daily lives, there is little written about their well-being. A small body of research exists that includes adult First Nations LGBTIQSB+ people, which although valuable in itself, provides little insight into young people's lived experiences and needs (Bayliss, 2015; Bennett & Gates, 2019; Clark, 2015, 2017; Costello, 2004; Day, 2020; Dunn-Holland et al., 1994; Farrell, 2015; Hodge, 1993, 2015; Hope & Haire, 2019; Kerry, 2014, 2017a, 2017b, 2018; O'Sullivan, 2015; Riggs & Toone, 2017; Ross, 2014; Sullivan, 2018, 2021; Uink, Liddelow-Hunt, Daglas, & Ducasse, 2020; Willis, 2003).

This is slowly changing, however, with an emerging body of evidence that provides some insight into the well-being of First Nations LGBTIQSB+ young people. These studies highlight the social determinants of well-being that have emerged out of the impact of centuries of settler-colonial policies on First Nations communities. Dudgeon et al. (2015) and Bonson (2017) studied First Nations sexuality and gender diverse people's

perspectives to identify the success of (or lack thereof) suicide prevention programs in Australia. Participants highlighted the various factors they believed to play an important part in the health and well-being of gender and sexuality diverse First Nations people in Australia (Bonson, 2017; Dudgeon et al., 2015). These included intergenerational, historical trauma, as well as grief and persistent dislocation from lands, waters, family, and community (Bonson, 2017; Dudgeon et al., 2015). This is backed up by Soldatic, Briskman, Trewlynn, Leha, and Spurway (2021a) review of the evidence, which found that the impact of settler-colonial heteronormative values, processes, and practices created an environment that encourages racism, LGBTIQSB+-phobia, and exclusion. The authors highlighted the important impact these structural factors have on young people's well-being. In a second paper, Soldatic, Briskman, Trewlynn, Leha, and Spurway (2021b) interrogated the ways in which family and community exclusion/inclusion impact the social, cultural, and emotional well-being of First Nations LGBTIQ+ youth. Study participants highlighted the important role played by both immediate and extended family members in young people's strategies to regain and sustain well-being (Soldatic et al., 2021b).

Despite this small surge of interest in young First Nations LGBTIQSB+ people's experiences and perspectives, there is little written about potential barriers to health and well-being service availability and use in Australia. The lack of information about the experiences and needs of First Nations LGBTIQSB+ people in relation to health service provision has been highlighted in the recent Australian community and government reports (AHRC, 2015; National LGBTI Health Alliance, 2016; Robinson et al., 2020). These reports underscore the fact that First Nations LGBTIQSB+ people are sidelined in service provision and encounter significant barriers accessing appropriate, supportive, and welcoming services. They also make a call for the inclusion of First Nations LGBTIQSB+ people within national and state policy frameworks, services, and programs (National LGBTI Health Alliance, 2016; Robinson et al., 2020).

A handful of studies, however, do provide some information about the service provision needs of First Nations LGBTIQSB+ people in Australia. Dudgeon et al. (2015) roundtable report on suicide prevention calls on Australian state and commonwealth governments to be more responsive to the needs of First Nations LGBTIQSB+ people; to better coordinate between jurisdictions the use and funding of targeted research and the need for more appropriate mental health and frontline community programs. Uink et al. (2020) list several components of what they call the "next steps in healthcare provision" (p. 203). The authors argue that to improve service provision for First Nations LGBTIQSB+ youth, healthcare providers must take into consideration their clients' multiple, intersecting

identities and social positioning; acknowledge First Nations and LGBTIQSB+ ways of knowing; and consider the power differentials between practitioners and clients (Uink et al., 2020). Service providers also need to recognize the implications of decisions made on behalf of their clients in terms of their identities and social positioning, keep up to date with the dynamics of changing client social positioning and identities, and ensure that social justice principles are embedded into healthcare services policies and practices (Uink et al., 2020). Robinson et al. (2020) found that First Nations LGBTIQSB+ people reported the most difficulties and distress when attempting to access certain services, such as counseling or mental health services, low-cost housing services, services aimed at pansexual/bisexual people, and Centrelink (p. 81). Robinson et al. (2020) also called for better quality and culturally appropriate services with suitably trained workforces with sufficient resources required to meet the needs of First Nations LGBTIQSB+ people in Western Sydney. The authors recommend that services “provide visual evidence of inclusivity”; that they provide training for staff in “cultural awareness and competency”; that practitioners listen carefully to client needs; and the need for quality service provision outside of central Sydney (Robinson et al., 2020, p. 14).

In a similar vein to Australia, there is little evidence available on Indigenous LGBTIQ+ young people’s needs in terms of well-being and health care support. Some papers include younger participants and do provide general guidance on the service provision needs of First Nations LGBTIQ+ peoples. These papers conclude that services of all kinds must create safe, healthy, and culturally diverse and appropriate spaces with appropriately trained and knowledgeable staff (Balsam, Huan, Fieland, Simoni, & Walters, 2004; Brotman, Ryan, Jalbert, & Rowe, 2002; Evans-Campbell et al., 2012). Studies also highlight the fact that non-Indigenous models of health and social service programming focus too much on individual models of disease and ill-being, ignoring collective, intergenerational, historical traumas and stressors (Balsam et al., 2004; Brotman et al., 2002; Evans-Campbell, Walters, Pearson, & Campbell, 2012).

Brotman et al. (2002) contend that if service providers do not scale up their approaches, negative experiences with service providers will cause feelings of distrust, shame, exclusion, and isolation, with Two-Spirit people in Canada potentially delaying critical visits to healthcare providers. Two-Spirit service providers spoke about the need for strong role models and for increased visibility of culture and gender/sexuality diversity in services and the important role that culturally aware and trained healthcare workers play in making services supportive, safe spaces for Two-Spirit people. Balsam et al. (2004) agree that high-quality services are important given that rates of mental health service use are higher for their American Indian

Alaska Native (AIAN) LGBTQ2S+ (Lesbian, Gay, Bisexual, Trans, Queer, and Two-Spirit) participants than for their heterosexual AIAN peers. To meet this need, mental health services need to locate any assessment of Indigenous LGBTQ2S+ clients within a historical, cultural, and social context that integrates culturally relevant approaches to treatment regimens (Balsam et al., 2004). The impact of the removal of AIAN children from family and community and their placement in boarding schools in the United States is a good example of how colonial-settler policies have caused significant intergenerational trauma and poor well-being outcomes for AIAN peoples (Evans-Campbell et al., 2012). In discussing a culturally appropriate approach for social workers in the United States, Crow, Wright, and Brown (1997) argue that it is imperative to avoid “culture-centric beliefs” based on non-Indigenous understandings (p. 28) that ignore the cultures, histories, and experiences of First Nations peoples.

There is clearly a need to better understand the needs and experiences of First Nations LGBTIQSB+ peoples in Australia regarding health and well-being service provision. This paper attempts to fill some of the gaps in knowledge by providing analysis from 13 interviews with First Nations LGBTIQSB+ young people living in New South Wales, Australia. The interviews initially aimed to give young people a voice, to enable them to set out their experiences, needs, and aspirations regarding mental health service provision. However, during the course of the interviews, it became clear that young people did not separate out different healthcare needs into neat packages. Most of the participants mixed and matched service providers, using primary health care providers for mental as well as physical health needs, for example. This depended on the availability and accessibility of appropriate services, young people’s needs at the time, and their evaluation of the appropriateness of service providers to meet those needs. This paper will first examine some of the issues around terminology and identities, then discuss the methods used, study findings, and conclude with discussion and conclusions.

A note on terminology

Resistance to colonial-settler and binary, heteronormative, heteropatriarchal, cis-gendered values has meant that the identities, and hence nomenclature, of First Nations LGBTIQSB+ peoples, have shifted and continues to change over time. In this paper, we use the term “Indigenous” when speaking of Indigenous peoples globally but use country-appropriate terms wherever possible. The term “First Nations” is increasingly accepted and used by Indigenous peoples in Australia. Many of our participants use “country” to describe a deeply-felt connection with places they strongly

identify with as First Nations peoples. In Australia, “Many Indigenous people derive their self-identity from the land and seas. In contemporary Indigenous Australia, Indigenous people often identify themselves as coming from their ancestral country, or ‘their’ place” (Burgess & Morrison, 2007, p. 180).

For gender and sexuality diverse people, we use acronyms, such as LGBTIQSB+ dependent on their use in the literature or as used by participants. LGBTIQSB+ is a First Nations acronym unique to Australia and includes people who identify as Lesbian, Gay, Bisexual, Trans, Intersex, Queer, Sistergirl, and Brotherboy.

The project used a working definition of well-being, focusing on strength-based, Indigenous understandings that integrate community, sovereignty, and culture, that acknowledges the impact of intergenerational collective trauma, racism, disadvantage, and discrimination on health and well-being (Gee, Dudgeon, Schultz, Hart, & Kelly, 2014). For the purposes of this study, “young people” were aged 14–25 years. Given the diversity of First Nations in Australia, we acknowledge these terms do not reflect the social, political, and cultural identities of First Nations gender and sexuality diverse peoples in Australia.

Methods

This paper analyses data from a set of interviews with First Nations LGBTIQSB+ youth in Australia. It is the second in a series of papers from a larger project that investigated the well-being and lived experiences of First Nations LGBTIQSB+ youth. The study was funded by the Australian National Health and Medical Research Council (NHMRC) under its Targeted Call 2018 Indigenous Social and Emotional Well-being Funding Round (Grant ID: 1157377). The NHMRC project aimed to improve the understanding of young First Nations LGBTIQSB+ people’s well-being and their experiences and aspirations regarding service provision.

The analysis in this paper emerged from 13 in-depth interviews of First Nations LGBTIQSB+ young people aged 14–25 years living in New South Wales. Participants were recruited using First Nations LGBTIQSB+ social networks, social media posts, and service provider networks including ACON, BlaQ, Twenty10, Campbelltown City Council, and Infant Child Adolescent Mental Health (ICAMHS) in NSW Health. All interviews took place via zoom due to Covid-19 restrictions in Australia at the time. Overall, the project focused on a strengths-based approach that stressed well-being rather than just dis-ease, deficit, and loss.

These interviews were the first phase of this research project and will inform the second phase, an online survey of First Nations LGBTIQSB+

young people living in New South Wales, Australia. The survey aims to gather a broader data set on the cohort's well-being, risk, protective factors, and their experiences with different service providers. This information will be shared with the community to co-design new and improved service provisions for this group. All phases of the research process were co-designed and co-led by First Nations LGBTIQSB+ people.

This paper has been reviewed by First Nations LGBTIQSB+ people on the project's Indigenous research governance group, and the NSW Aboriginal Health and Medical Research Council's (AH&MRC) Human Research Ethics Committee (HREC). The project received ethics approval from the AH&MRC (HREC Ref. 1536/19) on August 27, 2019. All quotes have been reviewed and approved for publication by each of the participants quoted in the paper in acknowledgment of their ownership and control of their own stories. The project's working name reflects this ownership: "Dalarinji," a Gadigal word for "Your Story."

Each participant's interview was thematically analyzed to allow for concepts and themes to emerge. The analysis was inductive, that is, the analysis started with pre-conceived concepts but also allowed themes to emerge during analysis (Charmaz, 2006). Analysis used different levels of open, axial, and selective coding as foundational techniques to interrogate the text (Charmaz, 2006; Strauss & Corbin, 1998). The research team initially read through the transcripts to open up the text and identify broad themes that lead to a more in-depth examination. Interview transcripts were then read line-by-line to further capture common themes and conceptual categories. Themes were organized into categories, identifying key relationships and linkages between cases (participants) and concepts (Charmaz, 2006; Strauss & Corbin, 1998). Using an iterative approach, the themes, and categories built on each other and generated higher levels of abstraction and concepts, which then informed later stages and generated increasingly meaningful and thick descriptions. Researchers constantly referred back to the interviews to make sure that the emerging themes maintained a close relationship to the original texts.

Findings

The interviews included a wide range of participants who identified as proud First Nations peoples from the Birpai, Bundjalung, Djangadi, Gumbayngirr, Kamilaroi, Meriam, Murri, Muruwari, Mineng/Noongar, Nunukul, Wakka Wakka, Wiradjuri, Wuthathi, and Yuin peoples. Many participants identified with more than one First Nations people and also had a variety of intersecting genders and sexualities. These included Bisexual, Brotherboy, Fluid, Gay, Lesbian, Non-Binary, Demisexual, Non-

Binary, Omnisexual, Pansexual, Queer, Trans, and Unsure. Participants all lived in urban areas (ABS, 2016), mostly located within the greater Sydney area but one participant came from Inverell, a regional urban center in the northern tablelands of NSW. Despite living in urban areas, participants reported strong connections with First Nations' peoples and the lands and waters under their custodianship.

Participants also described their strategies for finding, accessing, and using services. In speaking about finding the right provider for a given issue, many spoke about using non-Indigenous primary health and mental health services. Many participants do not necessarily seek out Aboriginal Community Controlled Health Organizations (ACCHOs) or LGBTIQSB+ providers. Many used local General Practitioners (GP) for concerns about their physical, sexual, and mental well-being. Others "shopped around," using their GP, sexual health providers, and mental health providers depending on the issue and their experiences with each service provider.

Participants also spoke about the importance of sustaining their overall well-being, not just one aspect of it. They demonstrated an ability to find what they needed, when they needed it, and make sure that they make time for regular physical, mental, and sexual health checkups in their daily lives. A young Djangadi lesbian cis-woman spoke of how she had to put the work in to maintain a holistic approach to her well-being:

So, I just try to make it to every therapist appointment I can. I put work second sometimes because if I'm having a bad day, I need to go and see them. I can work flexible so I can move around, work a bit. Like today, I could have work for this appointment and all that, so they're pretty good about it. I've come to a realisation that I need to do it because I've put on a lot of weight and I don't feel good about myself and I'm starting to get a bit depressed again and I don't want to be back there, so a bit of self-motivation to get it.

Participants also selected providers depending on how they were received by services as First Nations and/or gender and sexuality diverse people. They felt more comfortable and accepted if there were visible signs of the service being aware of, and sensitive to, their identities and needs. Finding and staying with a service provider depended on these initial encounters and, depending on young people's feelings of acceptance and welcome at a given service, they would either remain a client or move on to try out another provider.

"I'm a bit of a picky person": finding the right service provider

Participants spoke about the amount of time they spent trialing and testing different primary health and mental health service providers. Participants, in part, chose service providers based on purely practical concerns: if they were

near where they lived or worked, whether they bulk-billed (i.e., directly charged through the national public health insurance system, Medicare, without cost to patients) if they were recommended by social networks or on social media, and whether they had to sit for a long time in waiting rooms while waiting to see a practitioner. This demonstrates the importance of having more high-quality, culturally appropriate services that are more equitably distributed across urban spaces. This will facilitate access to services that provide health and well-being support for young First Nations LGBTIQSB+ people.

A young Murri Meriam Wuthathi bisexual cis-woman talked about the importance of finding an accessible service provider, “One that’s easy for me to access, so whether it’s close to work, close to my house, short waiting time, bulk-billed, that’s the kind of the thing that I’m looking at.” She also described how she initially selected service providers through her personal networks, Sydney Mardi Gras, and social media posts:

I think maybe my partner, she was a lesbian, and she was the first woman I’ve been in relationship with, so I think she told me about ACON ‘cause she went to the clinic. I think I might have seen them around at Mardi Gras, things like that, and seen them on Facebook ads, maybe, but it was my partner who told me that I should go to the ACON clinic ... Usually when I see messages like that, it’s from people on social media and it might be, for example, an Aboriginal person who’s got a big following on Instagram talking about what they’ve done, ‘cause that feels more approachable. They talk about their experiences, it’s almost like word of mouth.

A Wiradjuri queer cis-man also said that he would choose services based on more practical concerns. This in part depended on his family history of using AMSs, but also depended on whether the service was close to where he was living at the time:

I went to Dharug which is the medical, the Aboriginal medical centre there, for dental work or to see the doctors there. That was occasional – that was based in Mount Druitt. I’m in Doonside, so closest GP was normally best. I did go to – what’s the one in Redfern? Yeah. I did go there when I lived in St Peters when I [was] in year one or something, year two, but I had gone there. These were just places my parents took me to get check-ups and stuff, but as an adult, I guess I’ve just gone to whatever’s closest and just based on that decision of not really knowing what’s out there, whatever’s closest.

A Kamilaroi gay cis-man describes how important it is to be “picky” and take your time to find the right kind of service provider for you:

I’m a bit of a picky person. So, when it comes to me venting and telling someone my problems, I don’t necessarily want it just to be random. I obviously want it to be somewhat of a professional. So, for me, it does take a bit of time just to find that right person. The general services are there, don’t get me wrong, they’re obviously there, there’s someone to talk to, but whether or not it’s a good quality and it’s a good person to talk to, and sometimes the services you’re offered like counselling and stuff, sometimes they don’t necessarily understand cultural issues and cultural backgrounds as well.

Although at first, this seems obvious, in fact, what these responses highlight is the lack of, and need for, more accessible, culturally-appropriate, and queer-friendly services for First Nations LGBTIQSB+ in general but more particularly in under-resourced areas, such as Western Sydney.

“I just asked the GP for what I need”: general practitioners

Many participants reported that their first port of call for any concerns about their well-being and health were their local GPs. In Australia, GPs are the principal primary health care providers, arranging for referrals onto different specialist services for a variety of concerns, such as sexual health, counseling, and psychological support through Medicare (AIHW, 2019). This reliance on GPs as the first point of contact is in keeping with the wider Australian population’s use of GPs to access primary health care and referral onto other service providers (AIHW, 2019, p. 5). Eleven out of the 13 participants used GPs for a variety of well-being concerns including physical and sexual health checks and tests as well as referrals onto mental health support services.

Young people’s experiences with their GPs were mixed, some very positive, others negative. Some participants reported understanding, sensitivity, and acceptance from their general practitioners that acknowledged and demonstrated respect for both their Aboriginality and LGBTIQSB+ identities. A Djangadi lesbian cis-woman has had a very positive experience with her GP and she uses him for all her health and well-being concerns:

So, I went to the GP and just spoke to him, I just laid it all out on the floor and I said, ‘I need help. I’m suicidal, I need help right now’. So, he offered me a few things – he offered me like Aboriginal counselling services as well, but I didn’t want to go there because my family is from around this area as well, mum’s family, my aunts and all that. So, I’m like, “No, is there anything else?” So, I went to a service near his office ... I check in every now and then with him as well. He’s a very good doctor. He always does my mental health care plans for me. They’re very big on Aboriginal culture too. They have “Close the Gap.”² They make sure to – you know how you get ten sessions a year free. They give Aboriginals fifteen.

Other GPs, however, was not as understanding of the needs of their patients, and this was especially true of trans people. A young non-binary transperson of the Mineng people of Noongar country now living in Western Sydney talked about their experiences of going to a GP:

I guess my experiences with a lot of health services, like in general, haven’t been that great, like a lot of the doctors that I’ve been to don’t know what a pronoun is. They know what the word pronoun means, but they’re like, they don’t know ... Yeah, and not like even after I had that conversation with these three or four GPs that I spoke to, they all reacted that way, but then when writing about me, in their notes or when they sent letters out to me, they’d use my old name, they used she/her and

I'm like, we had like a conversation about this, like fair enough if you need to put my old name in the notes, or like for Medicare or whatever.

Other participants discussed the difficulties of finding a GP who could meet their needs, especially in terms of sexual health. A Wiradjuri queer cis-man discusses his initial negative experiences with a GP, but how he finally succeeded in finding an understanding GP:

I have a GP just down the road to me that I don't go to anymore 'cause I feel like he maybe doesn't understand the queer side of sexual health and so, I asked to be on PrEP [Pre-exposure Prophylaxis for HIV] for me and my partner, and I guess he only saw it as – “Have you been exposed to it?” “No.” “Okay, I can't prescribe you.” And it wasn't a lifestyle choice, and he didn't consider that even though I gave him enough information into my sex life and my choices, he still saw it as – “If you haven't been exposed or you think you've been exposed to it, then no I'm not gonna prescribe it.” So, for that reason, I don't go there anymore. I go to a clinic in ... Oxford Street 'cause I know that's where I can be comfortable and I went there, I told him the same thing, and he was like, “No worries. You wanna get on PrEP?” I said, “Yes.” He was like, “Have you had a test?” I said, “Yes, here's my test.” And then prescribed it like nothing – it didn't feel like there was any tension there or anything.

Other participants also spoke of the need to be persistent, to not give up until you found a service provider that met your needs:

I think I went to one GP that was asking me questions and assume that I was a straight person and then I started talking about having other partners, she was like, “Alright, our blood tests, let's...” She didn't really wanna talk about it. And then the other GP I went to didn't ask me anything and she was like, “Okay, you can get a blood test and urine sample,” and I was like, “I also want a throat swab,” and she was like, “Okay,” no questions asked. Because they didn't know that much about - I think the way that this information is available about what you should ask for from the GP, I just asked the GP for what I need [bisexual Murri Meriam Wuthathi cis-woman].

“I think they just cared more”: aboriginal medical services (AMS)

First Nations peoples in Australia have created and sustained a strong community-controlled health sector that has worked successfully since the 1970s to improve the health and well-being of First Nations communities. Their most notable recent success was the sector's ability to successfully manage the Covid-19 crisis through systematic community organizing that protected their communities from the epidemic (McQuire, 2020). These First Nations organizations are called either Aboriginal Community Controlled Health Organizations (ACCHO) or Aboriginal Medical Services (AMS) in Australia. The National Aboriginal Community Controlled Health Organization (NACCHO), the peak body for First Nations primary health care providers in Australia, defines an

ACCHO/AMS as, “a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management” (NACCHO, 2021). This paper will use the term “AMS,” as this is a more everyday term and is used by participants.

In a similar way to GPs, the majority of participants used Aboriginal Medical Services but, like GPs, their experiences of AMSs were mixed. Some participants’ reluctance to use their local AMS was related to ease of access, with no Aboriginal services close to where they lived or worked. However, young people did say they would use an AMS if it was convenient even if there were other services in that locality, “... if it were offered at the same convenience, let’s say that they were both next to each other down the road from me, I think I’d go to the Aboriginal service” [Wiradjuri queer cis-man]. At the same time, this was not unconditional, “If I’m getting good service at an Aboriginal health centre, then I’d go there. But if the quality isn’t up to par or the service doesn’t match, then I would go elsewhere” [Wiradjuri queer cis-man].

Some participants who used their local AMS found them to be strongly supportive and accepting of their gender and sexuality diversity. A young Mineng Noongar non-binary transperson also spoke very positively about their local AMS, especially with regards to gender diversity:

I think they [Mount Druitt AMS] just cared more, that centre has cared a lot, like they –when I was filling out my, like registration form for the service, it had gender, and then it had like a line that we fill in your gender, whereas at the other centres, it was male or female, and I was like, “Oh, none, “I mean I tick neither of them, and then they’d be like, “So why didn’t you,” and I’m like, “Because it’s neither,” so that first thing was like, “Oh that’s really nice” ... Yeah, and like I think, I think even on the registration form, they had a section for Medicare name, but like preferred name and I was like, like that’s so simple to do, it’s made so much of a difference, because from then on, they only called me on my preferred name. I’ve never heard them use my name that’s on the Medicare card, even though I give them that every time, it’s like it’s so good. Like that’s what I need, because I can’t change my name legally yet, so it’s good.

Others found that their local AMS was the place they felt most comfortable, and where they had been going since they were a small child:

My mum done my antenatal at the AMS. So I think it’s just being comfortable. I don’t think I could go to another – I could [go] to another AMS. I don’t think I could another surgery or clinic because I’m always just known to go there, I know everyone there, I feel comfortable there. That’s just my people [Djangadi gay cis-man].

Some participants raised the issue of a lack of confidentiality with their local Aboriginal Medical Service. This concern arose in part because young

people had relatives working as practitioners in the service who potentially had accessed their files and medical histories. It was also due to the fact that, in some close-knit communities, it was very hard to go to the local AMS without being seen by other community members. Two participants talk about some of the issues that can arise:

It was just bit nerve-racking because my local AMS, as I said before, a lot of my family were just – my nans, my mum is Aboriginal practitioner, my nan was a practitioner, my uncle was practitioner, my aunt was in the clinic. So, my aunty is actually looking at what tests I've actually done in the computer. And I guess it all just comes down to confidentiality and I'm so close to all my aunts who work in the clinic that I don't care. It is what it is [Djangadi gay cis-man].

And I think if people are in the closet that you would – if you were from Mount Druitt and you were secretive or you were, I don't know, subconscious about the situation, you definitely – you would avoid the AMS, you'd avoid Marrin Weejali. You'd avoid all of that because as much as it's a confidential place but if you go to Marrin Weejali, everyone knows you go to Marrin Weejali. Someone there will see you and like, "Are you using drugs?" "Are you getting alcohol counselling?" "Why are you in Marrin Weejali?" So, if you went with your partner and you didn't want anyone to know, they would know ... Yeah, and it's not the staff, it's just that there's gonna be someone in the waiting room that knows your auntie, that knows someone, it would just get out [Wiradjuri cis-woman in same-sex relationship].

Some participants, however, have had negative experiences with their AMS but still used them for certain services. A Wiradjuri cis-woman in a relationship with another cis-woman explains how, due to negative experiences, she does not use her AMS much for her own health and well-being concerns, but she does use the AMS for her children's checkups:

I have never really gone to AMS that much, but I went to AMS when I was a kid about my mum and stuff, but you obviously hear the same things that you hear in the community, like it's nothing – and they're not the greatest service. So I have my own GP and so does my partner. In saying that, we do take the girls to AMS because they're in FACS's [Family and Community Services] care and I know that the FACS is 100% better. So we have taken them. I just don't really think that that's great that I would – if the kids get sick, I don't go to AMS, I got to go to my own GP.

Other participants who were not using an AMS, also spoke of their experiences of homophobia or transphobia and lack of awareness within some First Nations services:

I do understand not wanting to go to the AMS and wanting to go to more a queer-based one, just because you feel more comfortable that they understand you. Obviously in our society two men together is not normal. So there hasn't been a lot of education around, safe, sex with two men or two women and stuff like that. So, I do understand that there is a bit of a sense of shame going to the AMS. I know I felt like that, just purely because although I'm a proud Aboriginal man, I do know within our Indigenous community, there's a lot of homophobia and transphobia that

still does go on, and so going into it and being, “Oh, yeah –” to me, it’s a little disrespectful as well, that’s just my opinion. So, I do definitely get the whole being more comfortable going to a queer-based one because they’re people like you, they share the same stories, so I definitely get that [Kamilaroi gay cis-man].

I don’t have any information about how I’m being safe or what a healthy relationship looks like for me because I’m just seeing hetero-normative styles of education in my schooling and there’s no information at my local Aboriginal doctor that I go to. So, I think probably in a negative way in that there’s information that I could have had that I would not receive until much later in life when I sought it out myself [Wiradjuri Kamilaroi lesbian cis-woman]

***“I felt comfortable to ask any questions that I wanted to”:
LGBTIQSB+ services***

In Australia, a national network of community-based service providers supports people living with HIV. The state-based AIDS Councils are among the best known of these organizations and have been advocating for people with HIV and sexuality and gender diverse people since the early to mid-1980s (AFAO, 2021). The AIDS Council of NSW (ACON) is one of the oldest and best known of these community-based service providers and was established in 1985 to respond to the HIV/AIDS epidemic in NSW (ACON, 2021). Another organization mentioned in the interviews is Twenty10. Twenty10 (incorporating Gay & Lesbian Counseling Service) offers LGBTIQ+ focused services in mental health, social support, and housing in central Sydney. It provides services for young people between the ages of 12 and 25 years as well as running training courses and consultancies for government and other service providers (Twenty10, 2021).

However, despite the history, scope, and strength of the LGBTIQSB+ community sector, only four participants reported using LGBTIQSB+ service providers. Given these service providers’ mandates in HIV and youth support, participants only used them for sexual health concerns, to obtain sex education, or attend youth support groups. The overwhelmingly positive experiences of participants have to be balanced with the fact that not many young people accessed these services. Some participants were even unaware of their existence.

A Murri Meriam Wuthathi bisexual cis-woman explains why she feels comfortable and accepted at ACON:

Even I went to the ACON clinic and that one is really good ‘cause I feel like they were pretty – they could tell me exactly – you know what I mean? They were more specific than, “Did you have sex?” It was like, “Did you have penetrative penis and vagina sex?” I think it’s much easier for me to talk to the doctor if they’re using that language ‘cause then I feel like my health is also better looked after ... So there was a stuff from school. I think I would see information probably from ACON or other

similar organisations that would publish stuff about sexual health, particularly for queer people. Going to the ACON clinic and asking questions there where I felt more comfortable, and then from there, I felt like I could go to any GP and ask for the tests that I needed ... I think they have campaigns about it or information on their website. And then when I went to the clinic, the nurse was much more approachable than other health professionals I've been to, so I felt comfortable to ask any questions that I wanted to. It was a lot more in detail than usual.

Other participants had similar positive experiences with other AIDS Councils:

So my first ever full-time job was actually in sexual health. I worked at the Victorian Aids Council, now Thorne Harbour Health, and I was doing their cultural sexual health there. My first ever job, I didn't even know what I was doing. No, I did know what I was doing, but I was 19, and I was talking about gay sexual health, and transsexual health, and I guess it was the first of its kind doing that transcultural sexual health sort of stuff but that was inclusive of Aboriginal people, and same with even cultural awareness training in LGBTIQSB+, and also inclusive of the transgender aspect. They're talking about how transgender identity affects you culturally is really important. And as for sexual health, it was part of, I guess, not just my own personal life, getting sexual health test and that done but I'm actually advocating for it in my first ever job [Wakka Wakka Murri Brotherboy]

And one young Mineng Noongar non-binary transperson has had very positive experiences with Twenty10:

... and when I go into the city, I do go to Twenty10, which I've met a few friends there, but yeah, I haven't met a lot of other Aboriginal LGBT people, I don't know if they're just hiding from me or like I don't know. If they're just not – I just don't know where they're at ... Yeah, I definitely get that and it's just hard to know like, you know, look at Facebook groups, I think that was the main reason I was following ACON, I just want to – because I want to like reconnect and find other people and stuff but it's just hard to know how – where's gonna be safe as well, like just for all – yeah.

***“That’s really, really good for me to feel like my voice is being heard”:
non-indigenous and non-LGBTIQSB+ mental health services***

Participants also used non-Indigenous and/or non-LGBTIQSB+ services for concerns about their emotional well-being. Of the 13 participants, seven reported using some kind of psychologist or counselor at some point in their lives. Participants used counselors and psychologists in private practice, medical clinics, specialized mental health providers as well as school and university counselors.

One issue that came up in interviews was the way some services assumed that it was participants' sexuality or gender identities that led to poor mental and emotional health concerns. A young non-binary Mineng transwoman from Noongar country talked about how mental health was

often linked to their gender and/or sexuality diversity. She had to make it clear that this was not the case:

I just need to sort out my mental health, but it's like very stigmatised, like, "Oh you're a trans, that's the problem right there." It's like, no, not necessarily ... I was going to other doctors and I was like, they were treating – they weren't – like if said I had depression/anxiety, they were like, "So you're trans?" And I'm like, "Yes," and they're like, "Hmm," and I'm, "What?" Treat me as if I have depression/anxiety like they would just, they were acting like my problem was that I was trans and that was very frustrating. I was like, "I know that I am trans, and it's not what I, like I've come to terms of who I am, it's not quite what I need help with right now."

Given the lack of specific service provision available for First Nations LGBTIQSB+ youth, some participants spoke about the importance of non-Indigenous service providers, such as Headspace, a mental health organization. Although they felt that some of these providers were open to and supportive of the voices and experiences of First Nations gender and sexuality diverse people, they also felt they could improve their service provision. A young non-binary Mineng Noongar transperson explains how important it is to be heard:

... because I'm part of the YAC [Youth Advisory Council] for the Mount Druitt and Penrith Headspace. So, I went to that last night, that's really, really good for me to feel like my voice is being heard and things like that ... So, before Headspace makes decisions, they asked that group, if it's a good idea or if it's a crappy idea. That's really nice because we can be honest about it and they're very chill about young people being pretty brutally honest, I was like, that's a horrible idea, it's not gonna work ... You get paid for it, it's \$20 an hour, that's pretty good, because I mean, it's two hours, but you could – I signed up for the committee before it, so I get three hours, it's pretty good. And then I think you can even sign up for like being on interview panels as well, so like when they need to hire a new person into the Headspace group, they bring a young person in as well to see if the person fits well ... It's like your opinion, like influences whether someone is gonna work there or not ... It's very good.

Some participants also used counseling or psychological services at their schools and universities. Some found this a useful and positive experience:

... at college, there is a therapist and I started seeing her for my own personal reasons ... So I started having sessions with her. She's very accommodating to black and queer people, so I felt safe. I don't think she has any cultural training though, but my problems weren't with culture. It was mainly just emotional wellbeing. So, I felt safe with her and we got to the root of the problem and I'm on medication now and I'm thriving [Muruwari Birpai queer cis-man]

Other participants took advantage of work-based emotional support and counseling:

My current employer, they have a service there known as EAP [Employee Assistance Programme]. So you can access three free sessions with the counsellor and stuff like

that, but it's something that I do definitely when I look more into 'cause I'm <inaudible> depression, so I've seen the dark sides of it all, and I definitely have my moments. That's why I think it's human nature to go through that all. I'm still in the process of reaching out and trying to find someone to talk to 'cause I do definitely feel that it's a good outlet for me personally 'cause I do tend to let it all build up and then it's just been firework or stuff and it's pretty fireworks sometimes [Kamilaroi gay cis-man]

However, some participants reported negative experiences with school counselors. A Mineng Noongar Non-binary Transperson said that going to her school counselor actually made her feel worse:

I mean, I saw the school psych, once or twice because of my depression/anxiety being so bad. They were terrible. They were so bad, I just remember leaving crying, and I'm like, "Why am I feeling worse."

School-based sexual health education was also reported to be completely inappropriate for young First Nations LGBTIQSB+ youth. Participants felt their sexuality and gender diversity was ignored and marginalized at school and many did not find support or information about sexuality and gender diversity until they were adults:

I think I learnt it in school. It was compulsory sexual health education. That was mostly focused on male and female, cis-male and female partners. So when I started having sex with cis-women or people with vaginas instead, that was a lot more different. I had to figure out what was going on and then it actually was helpful to go – I went to ACON after that and had a conversation with the nurse there, and I was like, "What kind of protection are you supposed to use?" or "What are the risks associated with having sex with a person with a vagina? [Murri Meriam Wuthathi bisexual cis-woman]

Like everyone else is getting hetero-normative Sex Ed and I'm getting none of that. I don't have any information about how I'm being safe or what a healthy relationship looks like for me because I'm just seeing hetero-normative styles of education in my schooling and there's no information at my local Aboriginal doctor that I go to. So I think probably in a negative way in that there's information that I could have had that I would not receive until much later in life when I sought it out myself [Wiradjuri Kamilaroi lesbian cis-woman].

"It was just simple things": what service providers need to do

Visibility, safety, sensitivity, and respect were important issues for First Nations LGBTIQSB+ young people. In discussing the reasons why they chose or stayed with certain providers, many young people spoke of the importance of services just doing simple things to demonstrate understanding and support for First Nations LGBTIQSB+ people. Displaying the Aboriginal flag or openly supporting the "Close the Gap" campaign, for example. Others spoke of the importance of the sign-up form: did it

include non-binary, fluid, and sexuality/gender diverse options, such as non-binary pronouns? And the ways in which service providers treated participants once they became clients were very important. Were they supportive and inclusive of their clients' identities? Did they have a hetero-normative approach to treating, supporting, or assisting young people?

Service providers need to visibly and openly acknowledge and respect First Nations cultures. Staff needs to be trained to be culturally sensitive, to speak and act in culturally appropriate ways:

It's like, you know, the first time I go in there [Headspace], they asked me if I needed like a translator, if English was my first language or if they needed to find someone with that same language group. I'm like, "No I speak English," but the fact that they offered, I was like, "That's really cool that you have that option there." I think another thing was, you know, they do have the flags and stuff as well, and then they have Aboriginal art in the waiting room. I mean it was just simple things but I think that makes a difference and they have – I don't know, I guess you could just tell the staff were trained to be culturally sensitive, I guess, because you meet like a lot of the people in like public health, going out to the hospital like psych ward and stuff and they just don't know, they're just not being educated in it, but you could tell that they had that education just based on how they respond into things that you said or, you know, they understood the values that were probably important to me, but they'd asked first [non-binary Mineng Noongar transperson].

Services also need to employ more First Nations staff:

Yeah, they [Headspace] were very good with gender and sexuality for sure and maybe Aboriginal, they could have had like an Aboriginal worker there. I don't think they did, but I think they were trying, they just couldn't find anyone that fit. But I think they were trying to, which was my tip to them before I left, I'm like, "You gotta have an Aboriginal worker here, just one at least, that might get a lot of work, but at least have that one there" [non-binary Mineng Noongar transperson].

Many participants also spoke about a lack of appropriate queer-friendly services in New South Wales metropolitan and regional urban areas where most First Nations peoples live in Australia. Many key services, such as ACON and Twenty10 have their main offices and primary service provision located in central Sydney. Participants also discussed how LGBTIQSB+ services need to train staff to be culturally sensitive and appropriate when working with First Nations LGBTIQSB+ people:

No, there's not much out here [Western Sydney]. This is probably one of the first modernised Aboriginal community centres [Kimberwalli] I've ever seen. So I wish there was more out in Campbelltown where the area is quickly populating [Djangadi lesbian cis-woman].

I think – well I really like the drop-in centre that Twenty10 have. I think if they have one out here [Western Sydney], it would probably work, I mean, I don't know the area that well because I'm only here like not even a year yet, but I think that that would work like I would really go to that and enjoy it, I think. But, also, services,

maybe a bit more specific at least for LGBT and make it broad and then have people trained and to deal with aboriginal people and stuff like that would be good, too, I think. But yeah, I don't know the area, I don't feel like I can speak for the area because I don't know it too well [young non-binary Mineng Noongar transperson]

Four of the women interviewed were mothers of young children. They spoke of the need for more support services for young queer parents in Western Sydney:

There's a few women's – young mum groups and whatnot that I'm in around Western Sydney. There's a few young mum groups I'm in, in the Western Sydney area, but it would be good to have – there probably is one, I just haven't looked around, like an LGBTQ parenting group. That would be good, like interacting with other – 'cause that's my biggest issue at [child's name] school. I can't interact with other parents because there's no relatable – there's nothing relatable between us ... Yeah. I'd love to have like an LGBTQ parenting group. That would be amazing to be a part of [Wiradjuri lesbian cis-woman].

Service providers need to acknowledge sexuality and gender diversity, get the pronouns right, treat their clients with respect and make them feel cared for, comfortable and welcome:

So that we [brotherboys] get pulled under the banner of an Indigenous health service, or an LGBTI service, and that's where our funding goes, and we expected to fall under one of those. I guess it's really hard because we <inaudible> this world in so many ways that we don't really get that tailorised support for our small community. There're really serious issues going on in the community that I can see. I can see there's really bad drug and alcohol issues, and now there's justice issues because people taking things too far ... a lot of them [service providers] are relying on these archaic systems, that you can't change the name on the system, you got to have your legal name on this, or it could be just admin lady doesn't like transgendered people and won't be willing to change it... And it takes so much energy to address those issues that people just give up. Go out and go out of your way until you're now referred to legislation or policy or taken by – it's just too much energy [Wakka Wakka Murri Brotherboy].

So, my only – it just – it wasn't existing. There weren't conversations – when I would go to the doctors, I never remember seeing like a sign of like rainbow mob, like make sure you get tested, or something like that – never. I felt invisible. This just didn't exist in my community and it was a weird thing that I was. So there was no one to really talk to about that [Wiradjuri Kamilaroi lesbian cis-woman]

Maybe like a support group or something for queers. I don't know. A more modernised Aboriginal health centre with younger workers, like younger health workers and stuff to help with that kind of stuff with the coming out process and bringing in family interventions. I think that's what I needed at the time I was 14–13 ... [Djangadi lesbian cis-woman].

Participants also spoke about how it is important for services to critically reflect on some of the assumptions underpinning a service's philosophy and approach. Services need to pro-active and remove implicit

organizational structures based on heteronormativity that erase and marginalize First Nations LGBTIQSB+ people:

It's the signs that were given to me and the non-action on these things by leaders in these types of institutions. It's a record that there are a multitude of queer and trans black students at this particular institution, yet they still have [employed] a cultural elder who opposes and tries to erase all those identities. And although he is super deadly in a cultural regard and has superior knowledge in all that, it's a very complex idea that having him there keeps the things going. It feels almost there's invisible heteronormative masculinity practice there, the way in their power structure is developed, and it's like an invisible feeling that is imposed on you by being there that if you don't comply with this masculinity and dominance that you don't belong. So, I'd say evaluate the institution that you think you feel safe in and if you feel there are these structures and invisible powers that necessarily try to erase your identity or don't enable you to feel like you fit in there or accepted – maybe accepted is a better word – then I think that would be a sign that it's not safe [Morowari Birpai gay cis-man]

Discussion and conclusions

Young First Nations LGBTIQSB+ people are “picky” about their service providers. They carefully select services based on, at its most basic level, the accessibility and availability of services that meet their needs. Once they identify a potential service, they evaluate its suitability starting from the waiting room and reception they receive. They notice if the service has visible displays of some kind of acknowledgment and awareness of their intersecting identities. They evaluate the service's forms for gender and sexuality diverse categories that acknowledge and respect their chosen pronouns and identities. They believe it is important for services to have visible First Nations workers and for staff to be trained in gender and sexuality diversity and Indigenous cultures and values. First Nations LGBTIQSB+ youth want to play an active role in their health and well-being, they want their opinions and perspectives to be recognized and respected by service providers. It is clear that many participants want more, higher-quality services that meet their needs and respect their lived experiences and aspirations. This is especially the case for young people living in Western Sydney: they want queer-friendly services that are culturally appropriate and visibly supportive and welcoming.

This study adds considerably to the small body of literature on the service provision needs of First Nations LGBTIQSB+ peoples in Australia. It provides a snapshot of evidence that stresses the importance of acknowledging, addressing, and understanding the health and well-being needs of First Nations LGBTIQSB+ young people. The findings highlight how incompatible some service providers are with the needs and wants of First Nations people generally and explain the incompatibility for those that are also sexually and/or

gender diverse. Whilst this paper has focused on the provision of services to First Nations LGBTIQSB+ young people, there is a need for further research that examines First Nations LGBTIQSB+ experiences of service provision and service providers more broadly.

There remain significant gaps in the provision of services between Indigenous and non-Indigenous people in Australia, as in other settler-colonial countries. As the participants illustrate in this paper, these gaps become more significant for First Nations peoples who also identify as sexually and/or gender diverse. Health and well-being researchers, service providers, and health and well-being educators worldwide need to reflect upon and question how their research, practices, programs, and policies continue to replicate and reproduce discourses of settler-colonial heteronormativity and cis-normativity to redress these longstanding gaps.

Notes

1. These last two identities are often translated as “transwomen” (Sistergirls) or “transmen” (Brotherboys), this is not a completely accurate depiction as it ignores a First Nations understanding of gender diversity embedded within a specific cultural context that is closely connected to kinship and country (Anae, 2020; Kerry, 2014; Riggs & Toone, 2017). The terms Sistergirl and brotherboy are not used across all First Nations communities or by all First Nations trans people (Sullivan, 2018).
2. “Close The Gap” is a campaign led by First Nations health and community organisations with support from non-Indigenous organisations that aims to get the Australian government to take real action to achieve health equity for First Nations peoples by 2030 (ANTaR, 2021).

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