

(Re)Claiming Health: The Human Rights of Young LGBTIQ+ Indigenous People in Australia

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Abstract

The human rights of both LGBTIQ+ and Indigenous peoples are far from realized. When conjoined, intersecting identities reveal how racism and queer phobia affect well-being, negating the right to health and resulting in devastating impacts on people's social, cultural, and emotional well-being. This paper documents the lived experiences of a sample of young gender- and sexuality-diverse Aboriginal and Torres Strait Islander peoples from a research project conducted in New South Wales, Australia. Their perspectives reveal how, for this cohort, discrimination and privation is manifest at the family, community, and institutional levels. This paper informs an understanding of human rights as experienced by Aboriginal and Torres Strait Islander LGBTIQ+-identified peoples, where racism and queer phobia are evident in the spheres of education, employment, and service provision. Adopting a critical human rights stance, our analysis illustrates how settler colonialism manifests through the processes and outcomes of settler colonial institutions and structures.

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“These are structural colonial problems that aren’t gonna be fixed by services.”

—survey participant

Introduction

The human rights of First Nations peoples around the world have been eroded through settler colonialism. “Modern” formulations of human rights, with their legal dominance, fail to be attentive to settler colonial history and violations that occurred before human rights were formally deliberated.

Despite ongoing neglect within settler colonial societies, there have been attempts in Australia to restore rights to First Nations peoples. Current endeavors include programs to “close the gap.” This First Nations-led effort aims to pressure the Australian government to achieve health equity for First Nations peoples by 2030.¹ The gap is far from closed, as social and economic disparities between Indigenous and non-Indigenous populations deny Indigenous peoples their full humanity.

For people identifying as LGBTIQ+, rights denial has occurred through prohibition, criminalization, and queer phobia. Laws in Australia have gradually become inclusive of sexuality-diverse people.² The most recent transformation in the public domain was a majority “yes” vote on a survey on marriage equality and its subsequent introduction into Australian same-sex marriage legislation in 2017. Despite hard-fought gains, the experiences of young LGBTIQ+ people, including the Indigenous cohort in our study, reveal that further progress is warranted that does not rest solely on legislative change.

Growing scholarship on intersectionality supports this claim, evolving from the landmark work of Kimberly Crenshaw from the late 1980s.³ Although this is a broad concept yet to be influential in the field of human rights, particularly normative human rights, it offers insights when examining multiple axes of oppression that have their roots in historical subjugation stemming from settler colonialism that manifest in poor institutional practices outlined in this paper. For Collins, emergent and diverse intersectionality theorizing and

praxis can address social problems and the social changes required to solve them. Categories such as gender, sexuality, race, and age are not merely academic but constitute resistant knowledges for people who oppose the injustices that they have experienced.⁴ Unlike research that is frequently confined to two categories alone, our project explores three identities as they intersect—namely, Indigenous and LGBTIQ+ and young, as noted below.⁵ In doing so, we recognize that incorporating intersectionality into human rights frameworks has lagged, although some scholars see this as an area that requires attention so that issues of class, gender, and race are taken into account.⁶ Similarly, Johanna Bond argues for an expansive definition of human rights to encompass harm caused by multiple, intersecting forms of subordination.⁷

The paper is informed by young Aboriginal and Torres Strait Islander LGBTIQ+ peoples who spoke out about their experiences and aspirations in a project based in New South Wales, Australia. The project, entitled Dalarinji (the Gadigal word meaning “your story”), reveals the complex journey for participants in endeavors to surmount their “intersectional disadvantage,” providing leads for human rights-restoring measures. In order to center and privilege the voices of Aboriginal and Torres Strait Islander LGBTIQ+ youth, all components of the research process were co-designed and co-led by First Nations LGBTIQ+ people. Service proposals to be developed at the end of the research process will similarly be co-designed. These measures resist the dominance of settler colonial heteropatriarchal paradigms within human rights frameworks. In the well-being sphere, physical and mental well-being is dominated by psychological and medical frameworks that fail to achieve the full potential of young Indigenous LGBTIQ+ cohorts.⁸ There is a tendency to impose Western ideas of mental health that fail to recognize the legacy and endurance of settler colonialism.

As a backdrop to participant testimonies in the findings section, we begin with critical reference to normative human rights understandings, followed by a probing of the intersection between colonization and the right to health. As argued by Corrinne

Sullivan, the privileging of Indigenous LGBTIQ+ voices “is intended to un-silence and demarginalize our position as queer, Indigenous Australians and our voices are raised to bolster knowledges of our own sexual landscapes.”⁹

The terminology used reflects current norms and is used interchangeably according to the perspectives from which they are drawn. Terms include “Indigenous,” “First Nations,” and “Aboriginal and Torres Strait Islander” peoples, while recognizing that many Indigenous peoples and our participants use identifiers from their own nations. We also recognize that for international readers, terminology can have multiple meanings of inclusion and exclusion, and we emphasize that the terminology in this paper reflects the current Australian context. The term “LGBTIQ+” denotes lesbian, gay, bisexual, trans, intersex, queer or questioning, and other diverse identities.

Globally, scholarly research on the social and emotional well-being and mental health needs of Indigenous gender- and sexuality-diverse youth is limited, rendering this population an invisible minority within a minority group.¹⁰ Our scoping review found only one published report that included young First Nations LGBTIQ+ people in Australia.¹¹ This invisibility extends beyond academic research and literature. As our research reveals, absences are reflected in everyday community practices in institutional settings such as schools and places of employment. Such deficiencies contribute to a trajectory of mental health and well-being concerns that lead those experiencing multiple forms of discrimination to seek out professional services. When entering service structures, similar barriers are frequently encountered that limit the capacity for restorative health and well-being and reinforce biomedical and psychological Western constructs of “treatment.” For young people identifying as Indigenous and LGBTIQ+, their identities and experiences tend to be perceived as deficits by some service providers.

This paper focuses primarily on in-depth qualitative interviews drawn from a selection of 15 participants. Although the interviews produce information across a gamut of topics published

elsewhere, including family and community obstacles and strengths, the conceptual framework of our paper derives from a human rights lens by expounding the intersection between settler colonialism and the right to health and well-being, emphasizing institutional and structural barriers to the achievement of this right.¹² The implications of not addressing existing gaps are threefold: perpetuating absences in scholarly domains and communities of practice; minimizing voices and perpetuating service responses that fail to recognize the rights of this cohort; and limiting opportunities for restorative and equitable lived outcomes.

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Human rights and the right to health

Globally, the human rights of Indigenous peoples are advanced through Indigenous leadership and allied work. In Australia, the realization of such rights has been hampered by the Australian government’s failure to adhere to international instruments to which it subscribes, which is partly attributed to an absence of national human rights legislation. As a federated nation, some jurisdictions have introduced human rights laws, but this has not occurred in the site of our research—New South Wales.

A significant achievement for Indigenous peoples was the United Nations’ adoption of the 2007 International Declaration on the Rights of Indigenous Peoples. The passage of the declaration through United Nations processes took two decades, with resistance coming from Australia, Canada, New Zealand, and the United States. For Indigenous communities, it trumps the more universal declarations such as the Universal Declaration on Human Rights (1948), the International Covenant on Civil and Political Rights (1976), and the International Covenant on Economic, Social and Cultural Rights (1976), which although worthy as universal statements do not cover the specificity of Indigenous LGBTIQ+ rights.

For LGBTIQ+ peoples, both Indigenous and non-Indigenous, there is no treaty or convention that focuses specifically on their rights. Nonetheless, there have been mentions of LGBTIQ+ peoples within the United Nations committees that oversee the different treaties, with language becoming more inclusive of sexuality and gender diversity.¹³ Support for the idea that human rights apply to sexuality- and gender-diverse people can be found in several statements from the United Nations, the most important being the Human Rights Council's Joint Statement on Sexual Orientation and Gender Identity.

An applicable federal law for First Nations peoples in Australia is the federal Racial Discrimination Act of 1975. The act purports to promote equality before the law for all people, regardless of their race, color, or national or ethnic origin, and to make discrimination against people on the basis of their race, color, descent, or national or ethnic origin unlawful. Actions that constitute statutory racial discrimination are nonetheless of limited applicability to the LGBTIQ+ cohort of our research. The act is unlikely to remedy the discrimination that they experience, as such discrimination is frequently covert and insidious and unlikely to find remedy through legislation that has not kept pace with their rights.

Rights negotiation in Indigenous human rights is heightened when advocating for collective rights, known as “third-generation rights,” that extend beyond individualism. Unlike codified rights, collective rights are not enshrined in any United Nations instrument. They are particularly important to Indigenous societies in the quest for self-determination and as a challenge to settler colonial practices.¹⁴ They receive little support in mainstream Western societies, which privilege civil and political (first-generation) rights and, to a lesser degree, economic, social, and cultural (second-generation) rights. Resistance to collective rights is illustrative of the problems of legal discourse whereby human rights understandings are “top-down” in their reliance on human rights declarations, conventions, charters, and laws, which are inevitably drafted by powerful people, such as

politicians and lawyers, resulting in the hegemonic diffusion and narrowing of human rights outcomes experienced at the margins.¹⁵

It is not merely collective rights that are of significance when discussing Indigenous rights but the way in which these ideas are voiced. Narratives such as those expressed in our research reveal, for example, that Indigenous peoples see health, mental health and well-being in a more holistic way than dominant Western societies.¹⁶ With medical models of health dominating, Indigenous peoples' more holistic world views and knowledges are trounced by an uneven balance of power that is reflected in traditional human rights formulations.

Hegemonic and universal application of human rights frameworks underpin the 1948 Universal Declaration of Human Rights. Article 25(1) states that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family.” This codification has been reiterated in subsequent treaties and declarations and has taken hold in the global health sphere.¹⁷ Yet more than 70 years on, these health and well-being ideals are largely unachieved and continue to reflect Western heterosexual normativities.

In the context of our research, the right to health refers not only to health care provision but to the conditions that promote Indigenous LGBTIQ+ human rights. This includes overt recognition of colonial processes and the provision of measures required to transcend them. For health to be seen as a human rights issue, acknowledgment of past and continuing settler colonialism's subjugation of Indigenous peoples must occur. The Human Rights Council argues that “forced assimilation, political and economic marginalization, discrimination and prejudice, poverty and other legacies of colonialism have also led to a lack of control over individual and collective health.”¹⁸

The World Health Organization notes that a human rights approach to health provides clear principles for setting and evaluating health policy and service delivery, through targeting discriminatory practices and unjust power relations that underly inequitable health outcomes.¹⁹ Ill-health and chronic conditions experienced by Indige-

nous peoples in settler colonial nation states are traceable to settler colonialism, as is the situation in Australia.²⁰

Robert Parker and Helen Milroy point out that British colonization had devastating impacts on both the physical and mental health of Indigenous peoples.²¹ Tom Calma and Pat Dudgeon say that building on culture and social and emotional well-being is core to responsiveness to Indigenous mental health and disturbing suicide rates, warranting renewed prominence of the right to health.²² A national Australian roundtable held in 2015 emphasized that sexuality- and gender-diverse populations are a group at higher risk of suicide and that Aboriginal and Torres Strait Islander sexuality- and gender-diverse populations remain invisible.²³ In recognition of the paucity of research on the intersection between Indigeneity and gender and sexuality diversity, a 2021 Western Australian project captured the experiences of Aboriginal LGBTIQ+ people living in that state.²⁴ The methods adopted in the Dalarinji project, outlined below, contribute to growing scholarship in this area, with a focus on young people.

Methods

The Dalarinji project research was undertaken in three consecutive stages:

1. In-depth interviews with 15 young Aboriginal and Torres Strait Islander LGBTIQ+ people.
2. An online survey of Aboriginal and Torres Strait Islander LGBTIQ+ people, with 16 respondents, co-designed with our research partner BlaQ Aboriginal Corporation. Interview participants were asked to suggest survey questions, which were incorporated into the design.
3. A series of workshops led in conjunction with BlaQ Aboriginal Corporation to obtain guidance from community members and service providers on the interview findings and survey results.

Recruitment of interview participants occurred through First Nations networks, social media posts, and service provider networks. Later, in-

terviews took place via Zoom due to COVID-19 restrictions. The research participants identified across LGBTIQ+ communities included bisexual, fluid, gay, lesbian, non-binary, queer, and trans individuals. They all identified as proud First Nations peoples from New South Wales. Qualitative interviews were thematically analyzed using an inductive approach whereby analysis arose from participant narratives rather than preconceived themes.²⁵ All phases of the research process have been guided by an advisory group of First Nations LGBTIQ+ young people and service provider representatives from our community partners—namely, BlaQ Aboriginal Corporation and the Aids Council of New South Wales.

Participant voices provided rich material on family and community barriers and strengths, which have been described elsewhere.²⁶ This paper focuses on institutionalized hurdles to human rights realization, offering proposals for a way to ensure that human rights are centered. Although we focus on the manifestations of institutional responses, we analyze these within the context of settler colonialism, arguing that on-the-ground responses need to be located within a collective, as narrated by respondents.

Findings

First Nations peoples worldwide have been impacted by policies and practices that followed colonization, including “protection” and assimilation. In Australia, the approaches adopted to meet the country’s ideologically driven policy goals included the displacement of Indigenous peoples to sites such as missions and reserves.²⁷ One of the most profoundly disturbing practices, which resonates throughout subsequent generations, was the forcible removal of children from their families and communities and their placement into children’s homes, foster care settings, and adoptive white families.²⁸ In this way, assimilationist policies targeted children of “mixed race” in order to “breed out” their Aboriginality through miscegenation. Karen Menzies posits that collective, historical, and intergenerational trauma are important for understanding the health and

social challenges within Indigenous communities.²⁹ This was reinforced by one interview participant:

I think a lot of queer people or multiple minority people do carry some form of trauma with themselves, whether that's struggling with accepting your identity, aspects of community, anything. I think there's some elements of trauma that we all hold and have a responsibility to ourselves to work through.

The impact of growing up and being told that both Indigenous and LGBTIQ+ identities were invalid was recounted by one participant:

So, I wasn't black 'cause I was white and being gay is bad. So, it kind of had adverse effects on your mental health, which I'm still coping and struggling with, but thriving today. But I guess you could say that's how my cultural identity and my sexual identity intersect like that.

Another participant noted:

I find being Aboriginal within Australia is its own issue but then being gay within Australia has its own issue. But then to be Aboriginal and gay within Australia is like a whole other ball game.

Findings outlined below fall within the realm of public human rights that are vested in societal institutions and ought to be protected by the state and non-state actors, as opposed to those manifested in the private realm. Although most participants did not confine their comments to categories and spoke of well-being in an integrated way, it has been possible to extricate features in education systems, workplaces, and service organizations that converge to paint a picture of the erosion of Indigenous and LGBTIQ+ human rights.

Schools

The worth of schooling and education is encapsulated in the statement of a participant who said:

It's so important. It's a very vital and pivotal part and you're so vulnerable at that age. Like for a start, your brain is still forming, and you're very easily influenced and it's crazy.

Another participant spoke of the racism experienced at school, including being called (the highly offensive slur) “half-caste” and then having to deal with sexual discrimination:

Then a few weeks later they went around that they thought I was gay and all this stuff, so they were saying, “Now you are a gay half-caste” and all that kind of stuff, and so stupid gestures. All the girls in the change room would come up to me and try and touch me. So, I was very depressed. I think no matter how much racism I got, I was born Aboriginal, I can't help it. So, it never really affected me to a point where they were calling me half-caste, like a gay half-caste. That's when it affected me 'cause it was both and it was both things I couldn't really control, but I think it was more so being queer and stuff like going through that transition, not being able to tell. I felt okay at home to go and say “Mum, they've been racist.” I wasn't comfortable about what they're saying all this stuff about me being gay. So, I think because it was years and years of trying to suppress it and I felt disgusting. Felt like no one would love me anymore, just horrible things.

Feeling safe at school was not always possible for another participant:

Absolutely it was not safe, I believe, back when I was 14, to hold my girlfriend's hand walking to school—no way. We were definitely closeted. I think what made me so certain that I needed to be closeted and take advantage of that passing privilege, although I wouldn't have the language to put to it back then.

White passing was a protective measure for one participant:

But I am white passing, and you could say that my Aboriginality, like my sexuality, was invisible, therefore it was easy to suppress growing up ... I've always known being black and being gay—always knew I was different, couldn't really put a finger on it until I was older. But being able to pass as a white person and growing up in high school realizing that people are pretty conservative and that gay was a bad thing. It was very easy to suppress that as well, to pass as a white hetero-cis man, but eventually that just got too much physically and emotionally to keep suppressing. It's definitely about performing masculinity. It was just about performing that to

fit in, to say safe, to make—have people like me, so I wasn't alone. I grew up in high school with a bunch of lads, if you will, and I felt fine and stuff, but obviously as I got older and matured, I realized that this can't go on and I drifted apart and found my own people.

Finding support within the school system was fraught for one participant:

I saw the school psych, once or twice, because of my depression and 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."

Sex education at school was problematic, as expressed by a participant:

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.

Having a child from a former relationship presented a barrier for a participant in revealing their sexual orientation in a school setting:

I probably just would keep that to myself 'cause they get around and they'll talk about their husbands, and the houses they own and whatnot, and I'm just the odd one out, the young gay mum ... Yeah, a major fear of being judged.

Exacerbating these feelings, their son's father believed that their boy would be bullied "if all his friends know that his mum is gay."

One participant experienced post-school discrimination after coming out on social media and subsequently being unfriended by some high school friends. They also referred to having "dark times at school, but university was a more positive experience, and I was comfortable with self."

Workplaces

The right to work is recognized in the Universal Declaration of Human Rights, whose article 23 states, "Everyone has the right to work, to free choice of employment, to just and favorable conditions of

work and protection against unemployment." For the study participants, questions of free choice, work conditions, and protections against unemployment were compromised by discriminatory practices.

Working in a hospital resulted in one participant adopting avoidance strategies:

I learned to avoid wards and things like that ... the patients, just some shit they're saying, like "Oh God, I don't wanna hear you," they will say stuff about gay people and Aboriginals.

Referring to their workplace, another participant stated:

I started a job and I found it really hard because the job that I was doing was as a support worker, and I couldn't tell any clients about like my gender or stuff ... I don't know how to have that conversation with other Aboriginal people, especially if I hear them making homophobic comments, just while I'm with them. It was like, I'm not going to bring that up to them, like I'm there for them, they're not there for me. So, it just made me uncomfortable because it was like, "Oh this is just not working yet."

And another said:

And with employment now, I don't even tell them I'm trans. I just go without because young men, they need young men in the industry I'm working in. So, I'm just gonna be a young man, let's not complicate it.

Service provision

To foster the realization of human rights, external institutions such as schools and workplaces play a formative role. By the time individuals reach the stage of seeking well-being and health services, challenges are apparent. While medical services are pivotal to well-being, it is evident from our research that the right to health is not evenly implemented for the young Indigenous LGBTIQ+ demographic.

Participant narratives reveal mixed responses in their detail, but relationships with health providers were seen as central to well-being. Particularly important were relationships with general practitioners (GPs), who are usually the first contact point of medical service provision in Australia. GPs

are influential in both providing primary health care and making referrals to specialists. Views were expressed by participants about mainstream mental health services, queer services, and Indigenous health services. The snapshot below reveals diversity and commonality. Arising from participant stories were implicit and explicit suggestions for developing and implementing services that advance social, cultural, and emotional well-being.

One participant spoke positively about receiving help from a mainstream youth mental health service, Headspace. In the regional location where the branch was located, they became part of a youth reference group:

They were pretty helpful. I just did everything with them just because they were the only place in [name removed] that I knew supported LGBT people and Aboriginal people. Like I was like, "This fits so well." So yeah, I spent so much time there. I gave them a lot of my time which like no regrets, it was really fun.

For this participant, there were identifiable reasons for their positive comments, both in the form of services and visibility, with the latter indicating cultural awareness:

The first time I go in there, they ask me if I need 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. It was just simple things, but I think that makes a difference.

Another participant had positive experiences with a Headspace service in the Greater Sydney metropolitan area, where they were introduced to a helpful yarning circle. Headspace instilled confidence for them, enabling them to seek hormones. Specifically, this service was affirming because

you are not streamed. When I walked into Headspace I didn't feel judged. I was perceived as a person. They asked what they should call me and then only asked for the name on my Medicare card.

Another survey participant reinforced the importance of visibility:

I feel a lot safer when there is an Acknowledgment of Country in a prominent place in a health service.

Varied responses were received from participants in discussing how sensitive services were about culture, with one participant stating that you could tell when staff were trained to be culturally sensitive.

Participants described problematic responses by practitioners, including the following:

"Oh, you're feeling depressed, you take this anti-depressant, get out of my office, it's too hard."

A lot of doctors don't know what a pronoun is.

They also noted that sexuality diversity could be viewed as deleterious by service providers:

If I said I had depression and anxiety, they were like, "So you're trans?" And I'm like, "Yes," and they're like, "Hmmm," and I'm, "What, treat me if I have depression and anxiety" like they would just, they were acting like my problem was that I was trans and that was very frustrating.

The education of practitioners played a role:

Yes, there was one doctor that I do like. I think they could probably—I don't know, she's not very knowledgeable but she's learning about it, but it also feels that I shouldn't be the one educating her.

One participant minimized the cultural aspect based on their experience with a therapist they were seeing at college:

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 well-being. 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.

Another expressed their negative experience:

Definitely the service is what is important. I have a GP just down the road to me that I don't go anymore

'cause I feel like he maybe doesn't understand the queer side of sexual health.

A participant who identified as bisexual spoke about how sexual health checks “can be really tricky because they ask a lot of questions and they're usually pretty heteronormative”:

I can feel a bit nervous about what the GP is going to do if I asked for a sexual health check-up. What questions are they going to ask? Am I gonna feel comfortable? So, I guess I'm just preparing myself and going through mentally in my head like, okay, for me I try and do my own check in my brain of what the doctor should ask and then answer the questions based on that if I'm not comfortable.

Actually, I think I prefer it when they don't ask any questions at all ... I've been to the doctor's once and she was so confused, 'cause she's like, “Tell me about your partner” and I have to be like, “I don't know what that means in this context. I think you have to be more specific than that.” So, when I go to a doctor, I either want them to ask no questions at all or be much more open about different gender identities and not being so heteronormative in the questions that they have been asking me.

This participant was able to find a way to resolve this discomfort:

Going to the ACON [Aids Council of New South Wales] 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.

An affirming experience with a GP was recounted by a participant who said:

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 counseling 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 aunties and all that. So, I went to a service near his office ... I check in every now and then with him as well. He's a good doctor. He always does my mental health plans for me. They're very big on Aboriginal culture too. They have Close the Gap.

When probed about services that would make a difference, responses included the following:

Maybe like a support group or something for queers. A more modernized Aboriginal health center with young workers, like younger health workers to help with the coming out process and bringing in family interventions. I think that's what I needed at the time.

For another:

So, I can only imagine what that would have been if there was a lesbian, an Aboriginal person or an Indigenous mental health professional that I was receiving that support from 'cause it was incredible to have those conversations with someone who genuinely did get it rather than talking to a professional who they just say they do. But I have found it difficult to find particularly mental health services that are Indigenous and queer. But in the queer space, I found people are much more aware of Indigenous aspects of it than in the heteronormative space.

One participant proposed:

Aboriginal medical services could be more comfortable for queer people by being more front facing and queer facing.

They added:

There is a lack of services for young queer people. Something needed is a service to target parents and siblings of young queer people to build up family support and provide guidance for families. There is also a lack of services for trans men, compared with those available for sistergirls.

Also for this participant:

Services that bring out the positives are important instead of seeing LGBTIQ experiences as negative.

The detailed narrative from the following participant, who describes themselves as “picky,” encapsulates a range of dimensions related to service, including the relational, professional, and respectful dimensions:

So, when it comes to me venting and telling someone my problems, I don't necessarily want it just to be a 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 counseling and stuff, sometimes they don't necessarily understand cultural issues and cultural backgrounds as well. So, it's great to say we have a service here, look into it, but then I think there needs to be a bit more look into it to make sure that it's the right person that they're talking to and not just someone who's there just wanting to give a chat and gets paid for it. There actually needs to be a bit more emphasis behind the importance of that.

I find going to just my normal, with my home family GP better for me just 'cause I've got a bit of a relationship with them but I do understand not wanting to go to the AMS [Aboriginal Medical Service] 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. But for me, personally, I feel more comfortable going to my own family GP just 'cause I've known him for years, but if I wasn't to, in regards to sexual health and stuff, I would probably go to more of a queer-based one. I know when I went into AMS once to try it, I just didn't ask, I just went in and walked straight back out.

Discussion

Qualitative, narrative-guided research presented an opportunity for individual stories to emerge, providing leads for a subsequent quantitative survey and workshops. By capturing individual

stories, the project demonstrates the differing levels of agency. Some participants were emboldened by equitable service provision and found strength in being "out and proud" First Nations people through such relationships. Some responses highlighted the ways in which young Aboriginal and Torres Strait Islander LGBTIQ+ people continue to navigate a mire of discrimination, imposition, and inadequate responses that ignored their humanness and the right to a dignified life. Such factors do not align with the right to health, including mental health, despite global and localized norms and pronouncements. For schools and workplaces in particular, the right to health, including mental health and well-being, as opposed to the right to education or the right to employment, is minimized. It is in the services arena where fractures between the right to health and everyday practices are most apparent.

Interview participants demonstrated that First Nations LGBTIQ+ people were far from positive about places they were expected to frequent in the public domain. Schooling produced challenges, with bullying, discrimination, racism, and queer phobia reported as being prevalent and therefore creating unsafe environments. In some instances, workplace culture and practices meant that people weren't always able to be out and proud. Some individuals developed strategies to conceal their identities and thus feel safe in the workplace, but this meant hiding an important part of themselves. Participant stories about service providers were mixed. Finding a good mental, sexual, or physical health provider was generally though trial and error. Participants shopped around for GPs, counselors, and organizations, testing out whether they were allies to First Nations peoples who could provide Indigenous- and LGBTIQ+-appropriate services. Once they had done so, participants exhibited a strong capacity to use available services, asserting their rights to high-quality mental, physical, and sexual health service provision that met their demands as both First Nations and LGBTIQ+ people.³⁰

In singling out schools, workplaces, and professional services as institutional barriers to attaining rights, the 1986 Ottawa Charter for Health

Promotion provides guidance. The charter states that the foundational prerequisites for improvements to health include education, income, and social justice and equity.

The agony of racism and queer phobia has lifelong impacts on health and well-being, pointing to the urgency of transforming schools, places of employment, and services to be affirming of Indigenous LGBTIQ+ human rights and specifically the right to achieving parity in health, including mental health, which combines universal provision with attention to the unique experiences of this community. Restorative measures require sensitivity and thoughtfulness and are not necessarily demanding of resources. Research participants valued symbols that created visibility of their existence. This could occur, for example, by displaying Aboriginal and Torres Strait Islander and Rainbow flags; such displays would signal that service providers are more open and socially and culturally aware. A participant spoke of the importance of “acknowledgment of country.” This presents an opportunity for service providers, as formal acknowledgments are now well established in many organizations and settings throughout Australia. Acknowledgments recognize that services are located on unceded Aboriginal land. They affirm that the notion of country has particular meaning, with land “as a living entity, the essence of Aboriginality and includes the human and non-human; people, culture, spirituality, history, land, waterways, animals, plants, insects, habitats and ecosystems.”³¹

When respondents discussed inadequate service provision, there was clear direction as to what elements promising services should contain. In this regard, relational aspects were important, as was positive recognition of both culture and sexuality. One aspect that stood out was the ignorance of many service providers. The comment by one participant who said it was not their role to educate practitioners leads to the question of whether human rights education programs would minimize the challenges experienced by research participants. Such programs could overhaul existing training approaches, such as inclusive cultural awareness, by aligning good practices with human

rights from below; these programs could be run by young Indigenous LGBTIQ+ people and could move away from legalistic constructs while benchmarking against the Declaration on the Rights of Indigenous Peoples. They could be crafted around the rights of self-determination, the rights of young people to express themselves without judgment, and the rights afforded to people experiencing “double challenges,” such as those in our cohort. Bringing these individuals’ knowledges and experiences to the forefront would challenge the ethnocentric, normative hegemony of traditional human rights education delivery and center Indigenous pedagogies.³²

Given that most of the criticism was leveled directly at practitioners, the role of professional associations, peak bodies, trade unions, and educational institutions—particularly medical schools and general practitioner peak bodies—requires consideration. The codes of ethics of professional organizations could be amended to affirm the rights of young, queer Indigenous people. Indeed, professional practices would benefit from an overhaul of underlying assumptions. For social workers seeking to understand how to serve LGBTIQ+ Aboriginal communities in Australia, Bindi Bennett and Trevor Gates adopt the term “cultural humility.” They see this as a way of overturning monolithic educational practices that reinforce an imbalance of privilege and power enshrined in notions of cultural competency and associated training.³³ Human rights education is not a top-down endeavor, and it requires critical reflection and critical consciousness for it to be meaningful. Because of intersecting realities for Indigenous LGBTIQ+ people, a grounded approach would recognize the struggles of participants in environments that should be foundational to well-being. As posited by Fuad Al-Daraweesh and Dale Snauwaert, for human rights to achieve equality for all, it is the people who should have the right to decide on their own interests.³⁴ This is reinforced by the 1986 Ottawa Charter, which states that “health promotion is the process of enabling people to increase control over, and to improve, their health.”

It can be deduced from participant stories that

a legacy of settler colonialism remains present in the lives of First Nations peoples. Racism and queer phobia continue, despite existing international human rights instruments designed to eliminate discrimination through universality. Failure to eliminate injustices in health care has been detrimental to the research participants, signaling a societal failure to foreground human rights in Indigenous LGBTIQ+ health care.

Conclusion

The research presented in this paper investigated factors that presented health and well-being challenges for young Indigenous LGBTIQ+ people in New South Wales, Australia. We analyzed the challenges through a human rights lens by examining the institutional settings of schools, workplaces, and service providers.

Participant narratives make clear that health and mental health services must be attentive to Indigenous LGBTIQ+ specificities, with service provision located within a historical and cultural context that recognizes the effects of settler colonialism and the resultant trauma for First Nations LGBTIQ+ peoples. Recognition of the rights of young LGBTIQ+ First Nations communities has yet to make its way into institutional policies and practices, and the nexus between intersectionality and human rights has not had a significant impact. Contributing to the lag is uneven academic work on intersectionality across disciplines, such as education, psychology, and social work, revealing the need for ongoing transformative research.

The human right to health, including mental health, is enshrined in international norms, although universal instruments and global statements fall short of application to groups that have been historically oppressed and subject to racism and queer phobia. The concerns outlined in our paper necessitate active measures to be taken by human rights educators, educational institutions, places of work, and a range of health and well-being service providers. In order to “reclaim” the rights of those whose stories have been told and to minimize harms

arising from multiple oppression, ongoing research and activism from below is an urgent quest.

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